



State of Louisiana
Department of Health and Hospitals
Office of Management and Finance

November 16, 2011

TO: Bruce D. Greenstein
Secretary, Department of Health and Hospitals

FROM: Jerry Phillips 
Undersecretary, Department of Health and Hospitals

RE: Annual Management and Program Analysis Report (AMPAR)

Louisiana Revised Statute 36:8 requires the Undersecretary of each Department to submit an Annual Management and Program Analysis Report (AMPAR) by November 25th to the Department's Secretary. Please find attached DHH's AMPAR for state fiscal year 2010/11. The report summarizes the activities of the offices and Medicaid relating to management and program analysis, outstanding accomplishments, areas where we are making significant progress and specific management/operational issues that exist.

Louisiana Revised Statute 36:8(B) (1) requires the secretary of each department to submit his AMPAR to the governor, commissioner of administration and legislature by December fifth.



**DEPARTMENT OF HEALTH
AND HOSPITALS**

Bruce D. Greenstein, Secretary

**FY 2010 – 2011
Annual Management and Program Analysis Report (AMPAR)
Jerry Phillips, Undersecretary**



Department of Health and Hospitals

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Annual Management and Program Analysis Report

Fiscal Year 2010-2011

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

Department Head: Bruce D. Greenstein, Secretary

Agency Head: Michael E. Teague, Executive Director

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

Open Access in Adult Behavioral Health Clinics

A. What was achieved?

As a Performance & Quality Improvement (PQI) initiative, Jefferson Parish Human Services Authority piloted, and then fully implemented, an open access model in its Adult Behavioral Health Clinics.

B. Why is this success significant?

The Behavioral Health Services Division Directors (adult and child/adolescent) used internally generated decision-support statistical reports to monitor service recipient engagement and provider productivity. Data showed negative impacts of “no show” appointments on both engagement and on clinic capacity. After a successful pilot in the Adult Behavioral Health Clinics, JPHSA adopted an open access model utilizing triage by acuity level in the two adult clinics.

C. Who benefits and how?

Adults seeking and receiving services benefit from a greatly reduced wait time between their first contact with JPHSA and their first clinic appointments. Additionally, initial screening is accomplished telephonically, which improved ease of access as well as wait time. JPHSA benefits as well. The “no show” rate decreased significantly, which in turn, positively impacted provider productivity and reduced unused capacity. (Please note: Individuals, who are employed, attending school, or who have a clinical status indicating the need, are accommodated with appointments.)

- D. How was the accomplishment achieved?
JPHSA has utilized the Accountable Care Model, endorsed by the National Council for Community Behavioral Healthcare, for several years. This model identifies open access scheduling as a mechanism to minimize the no-show rate, increase productivity, and enhance service recipient engagement. The Behavioral Health Division Directors developed a proposal based on Accountable Care, and initiated the pilot in the adult clinics upon the approval of their proposal. With continuous monitoring and process improvement, open access was embraced and adopted.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Adoption of open access in JPHSA's Adult Behavioral Health Clinics contributes to the success of the Authority's Strategic Plan. A plan objective is to increase access to services by 15% by the end of FY 2015-2016 with FY 2009-2010 used as the baseline measure. A Performance Indicator is: percent increase in community access to mental health, addictive disorders, and/or developmental disabilities services. At the end of FY 2010-2011, JPHSA reported an actual increase of over 21%. The transition to open access in the adult clinics was a significant contributor to this achievement. Specific to the Adult Behavioral Health Clinics, JPHSA served nearly 1,000 more adults than initially anticipated during FY 2010-2011. The positive impact on engagement also influenced successful admission to and completion of programs.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Open access is a component of the Accountable Care Model. A former Executive Director of JPHSA brought this model to the State Office of Mental Health and it is now embraced by the new Office of Behavioral Health.

Entry into the Managed Care Arena

- A. What was achieved?
On January 3, 2011, Jefferson Parish Human Services Authority (JPHSA) completed commercial and Medicare provider agreements with Comprehensive Behavioral Health Care (CompCare).
- B. Why is this success significant?
JPHSA successfully completed the application and credentialing processes for the Authority's first two contracts with a private managed care insurance company. (JPHSA is the first Local Governing Entity to implement a contract with a private insurer.) Experience with these managed care contracts will prepare JPHSA in terms of establishing infrastructure and developing business processes for the Louisiana Behavioral Health Partnership and working with the Statewide Management Organization.

C. Who benefits and how?

Individuals covered by the CompCare commercial and Medicare HMO plans now have the option of choosing JPHSA for in-network Behavioral Health services. Currently, JPHSA has the capacity to initiate assessment and treatment services on a significantly narrower timeline than other providers in the area.

The Authority also benefits from the two CompCare contracts. With admissions gained through the contracts, JPHSA has opened a new revenue stream. Additionally, the contracts have served to “jump start” the Authority in building infrastructure and business processes to efficiently and effectively operate in a managed care environment.

D. How was the accomplishment achieved?

JPHSA researched private insurers doing business in the Greater New Orleans Area to locate a company that had: achieved accreditation; covered a moderate number of lives; followed a utilization management plan compatible with the JPHSA plan; and, needed to add Behavioral Health providers. Upon selection of CompCare, the Management Services Division facilitated the application and credentialing processes with the Division Directors over adult and child/adolescent clinic-based services. In preparation for active contracts, the three Directors familiarized themselves and their staff members with the CompCare provider manual. Once the contracts were signed, JPHSA’s Fiscal Services Department set up the billing modality. Ongoing Performance & Quality Improvement issues and activities are addressed in JPHSA’s Business Processes Committee.

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

JPHSA’s entry into the managed care environment through acquisition of two provider services contracts makes a tangible contribution to the sustainability of the Authority and its Mission, and hence, to the success 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?

Local Governing Entities (LGEs) will participate in the Louisiana Behavioral Health Partnership and will work with the Statewide Management Organization. Additionally, with state funding continuing to decrease, acquisition of contracts with private managed care companies will provide new and needed revenue streams. The LGEs will all need to build infrastructure and business processes to remain viable in this new environment.

Performance & Quality Improvement: Behavioral Health Service Recipient and Employee Satisfaction

A. What was achieved?

For several years, Jefferson Parish Human Services Authority (JPHSA) has fielded

proprietary Behavioral Health service recipient and employee satisfaction surveys. Responsibilities were delineated as follows:

The Management Services Division fielded the service recipient survey.

The employee committee, Esprit de Corps, fielded the employee survey.

The Executive Management Team analyzed data and developed action plans for improvement.

During FY 2010-2011, the Executive Director, in collaboration with the members of the Executive Management Team, restructured these two Performance & Quality Improvement (PQI) initiatives to gain qualitative information and to more precisely identify targets for improvement. First, consultants from the Louisiana Public Health Institute were retained to conduct in-depth interviews with individuals (parents, if a child was determined to be too young to participate) receiving services in the Behavioral Health Clinics and focus groups with employees. Second, PQI activities focused on consumers were turned over to an employee-facilitated work group and those focused on employees were turned over to Esprit de Corps.

B. Why is this success significant?

The commitment to process change provided expanded quantitative and qualitative data for use in decision-support, assured reduced opportunity for bias, and placed PQI into the hands of a cross-section of middle managers and front line employees. The Executive Director and members of the Executive Management Team made a commitment to and an investment in PQI, and relinquished a measure of control to assure collaboration and buy-in on the part of employees.

C. Who benefits and how?

The Behavioral Health service recipients – adults and child/adolescents – as well as JPHSA and its employees benefit from this Performance & Quality Improvement Initiative. Satisfaction with service quality impacts client engagement and retention in treatment. Satisfaction with employment and the employer impacts staff morale, productivity, and retention.

D. How was the accomplishment achieved?

JPHSA leadership contracted with an outside third party for qualitative data collection; empowered an employee committee and work group to initiate and implement Performance & Quality Improvement activities; monitored committee and work group progress; and, facilitated ongoing communication between the Executive Management Team and employee participants.

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

JPHSA's Strategic Plan states that the Authority "...operates within the context of continuous performance and quality improvement, utilizes data-based decision-making,

seeks feedback from employees and other stakeholders, empowers employees to problem solve...” The Strategic Plan describes a culture committed “to practice the Service Statement – we promise courtesy, empathy, and respect in meeting the expectations of those we serve and each other – during daily interpersonal interactions.”

The Behavioral Health service recipient and employee satisfaction PQI initiatives support JPHSA’s philosophy and provide tangible evidence that it is embraced. As indicated previously, satisfaction with services has a positive influence on client engagement and retention and on treatment outcomes. Job satisfaction has a positive influence on employee morale, productivity, and retention. These positive outcomes help insure the achievement of JPHSA’s Strategic Plan Goals and Objectives.

- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
JPHSA has a Performance & Quality Improvement Plan and has incorporated PQI into the Authority’s daily operations. PQI is a management best practice and should be utilized by all Local Governing Entities and State Offices in their daily operations.

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

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

Overall, Jefferson Parish Human Services Authority (JPHSA) remains on target toward achieving Strategic Plan Goals and Objectives. JPHSA met or exceeded most of its performance standards set for FY 2010-2011.

In addition to utilizing strategies outlined in its Strategic Plan, the Authority deepened its commitment to ongoing Performance & Quality Improvement (PQI), continuously monitoring, analyzing, and utilizing fully developed action plans for improvement initiatives.

◆ Where are you making significant progress?

Jefferson Parish Human Services Authority (JPHSA) continues to demonstrate progress on Strategic Plan Goals:

Goal 1: Provide comprehensive services and supports which improve the quality of life and community participation for persons in crisis and/or with serious and persistent mental illness, emotional and behavioral disorders, addictive disorders, and/or developmental disabilities, while providing appropriate and best practices to individuals with less severe needs.

Goal 2: Improve personal outcomes through effective implementation of best practices and data-driven decision-making.

As stated previously, JPHSA utilizes all Strategic Plan strategies with emphasis on

continuous Performance & Quality Improvement including both business and service delivery processes.

1. To what do you attribute this success?

JPHSA attributes its success to the following: 1) organization-wide commitment to the accreditation process through the Council On Accreditation; 2) continued adherence to the Accountable Care Model; 3) increased focus on continuous Performance & Quality Improvement; 4) implementation of integrated and holistic service delivery; 5) continued expansion of the Electronic Health Record and the mining of its data warehouse; and, 6) communication of clearly defined performance expectations for all employees in compliance with the JPHSA Staff Development & Supervision Guidelines.

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 a result of a one-time gain; rather, it is continuous. JPHSA utilizes annual division-specific plans and Performance & Quality Improvement Initiatives to assure gains in performance and/or quality continue to drive forward at a pace needed to ensure sustainability of the Authority and its Mission.

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

None.

However, current economic conditions continue to create significant challenges for Jefferson Parish Human Services Authority (JPHSA).

♦ **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?

JPHSA eliminated a Strategic Plan Goal: Retain an adequate workforce to fulfill the Mission and Priorities of Jefferson Parish Human Services Authority. Turnover of staff has remained at 3% or lower. Further, the Authority has demonstrated a strong and continued commitment to measuring employee satisfaction and developing targeted action plans to achieve improvement; and, adherence to JPHSA's Staff Development & Supervision Guidelines assure retention of qualified, competent, and motivated staff.

Additionally, Performance Indicators were refocused more on outcomes and less on outputs along with the elimination of some "G" measures viewed as no longer useful. New strategies, reflective of the current environment, were put into place as well.

- ♦ **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 monthly updates and an annual Ends Policy Monitoring Report detailing progress toward achieving Strategic Plan Goals and Objectives.

As an organization that has adopted and acculturated Accountable Care and Performance & Quality Improvement models/philosophies, JPHSA continuously communicates, monitors, reports, and implements corrective action and/or process improvement activities with regard to Strategic Plan Goals, Objectives, and Performance Indicators via a broad range of venues (individual supervision, work groups, the employee electronic newsletter, all-staff meetings, accessible data reports, etc.).

Each Division Director is required to develop an annual division-specific plan to support the JPHSA Strategic Plan. Each Director is also required to provide quarterly progress reports to the Executive Director, to his/her colleagues on the Executive Management Team, and to the members of his/her division during regular division-wide meetings. Additionally, the Performance & Quality Improvement Committee develops, adopts, and implements annual cross-divisional Performance & Quality Improvement Initiatives to further ensure JPHSA will meet and/or exceed Strategic Plan Goals and Objectives and to support the sustainability of the Authority's Mission. Quarterly progress reports are delivered during a meeting of the full Performance & Quality Improvement Committee and reported in *Have You Heard*, the employee electronic newsletter.

JPHSA uses *Have You Heard* as an important tool for communicating with employees about Strategic Plan Goals, Objectives, and Performance Indicators. Directors involve employees in data collection, analysis, and reporting of Performance Indicator outcomes and in work groups formed to drive performance and quality improvement. The Executive Director schedules three all-staff meetings each Fiscal Year. Performance and quality improvement is a routine component of the interactive agenda.

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 correction action and/or performance and quality improvement plans. The Executive Director holds the Executive Management Team accountable on both an individual and group basis for successful implementation of the JPHSA Strategic Plan, Annual Division Plans, and the Annual Performance & Quality Improvement

Initiatives. The Executive Director gauges a significant portion of the Executive Management Team members' annual performance reviews on their contributions to the Strategic Plan and Performance & Quality Improvement Initiatives as well as on their degree of success in accomplishing Annual Division Plan goals and objectives.

Each JPHSA employee has job-specific performance factors and expectations to support Authority goals included in his/her annual planning document. Supervisors are expected to meet with their subordinates as outlined in JPHSA's Staff Development & Supervision Guidelines (weekly for new employees, monthly for established employees, and as needed for employees with performance deficits). The supervision meetings are used to review and discuss progress toward meeting expectations. Active participation and open discussion are encouraged.

JPHSA leadership approaches implementation of the Authority's 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 parts of the process as are compliance and improvement activities.

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

Reductions in State Funding

A. Problem/Issue Description

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

As in FY 2008-2009, FY 2009-2010 and FY 2010-2011, Jefferson Parish Human Services Authority (JPHSA) experienced another decrease in state funding for FY 2011-2012.

2. Is the problem or issue affecting the progress of your strategic plan?

JPHSA continues to make incremental progress in achieving Strategic Plan Goals and Objectives; however, standards set for FY 2011-2012 were adjusted for two Performance Indicators:

- # of youth with a Behavioral Health illness served in Child & Youth Clinic-based Behavioral Health Services (reduced by 225)
- % of persons with a developmental disability employed in community-based employment (reduced by 5%)

JPHSA's Performance Indicators, for the most part, are outcome measures rather than output measures, and should not be negatively impacted by changes in funding, e.g. the fidelity of the evidence-based practices remains constant and outcomes will be maintained.

Additionally, the Performance Indicator "% of individuals admitted to social

detoxification who compete the program” was eliminated and this program closed July 1, 2011

3. What organizational unit in the department is experiencing the problem or issue?
The ongoing funding reductions, including the cap on positions, impact JPHSA’s Administrative as well as Service Delivery functions.
4. Who else is affected by the problem?
 - Reduced capacity in Child & Youth Clinic-based Behavioral Health Services will result in fewer children and adolescents receiving treatment.
 - Reduced employment supports will lead to fewer individuals with Developmental Disabilities being able to work in the community.
 - Eliminated social detoxification services will force over 450 individuals to seek these services elsewhere.
5. How long has the problem or issue existed?
The negative impact of reduced state funding was noted in FY 2008-2009 and every year thereafter.
6. What are the causes of the problem or issue? How do you know?
The state’s budget deficits led to the reductions in funding to JPHSA. Information about the deficit and solutions to achieving a balanced budget was provided by the Office of the Governor, the Division of Administration, the Department of Health & Hospitals, and the Office of Behavioral Health.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
JPHSA must: address all impacts and potential impacts of decreased funding with urgency; use effective and flexible strategies/tactics to achieve continuous performance and quality improvement; and, identify and capture alternate 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?
 - Continue Performance & Quality Improvement (PQI) initiatives.
 - Continue implementation of the JPHSA Utilization Management (UM) Plan.
 - Seek additional contracts with private insurance companies.

- Participate in the Greater New Orleans Community Health Connection (GNOCHC), Medicaid 1115 Waiver.
 - Seek additional contracts for services and grants.
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 the FY 2009-2010 Annual Management and Program Analysis Report.
4. Are corrective actions underway? Yes.
- a. If so:
- What is the expected time frame for corrective actions to be implemented and improvements to occur?
 - How much progress has been made and how much additional progress is needed?

All corrective actions identified above are being implemented with no end date established. JPHSA's PQI and UM Plans are fully operational with assigned committee accountability. JPHSA has two managed care contracts in place and will seek a third in FY 2011-2012. JPHSA is enrolling individuals for GNOCHC, providing services to enrollees, and preparing to set up the billing modality in the Authority's Management Information System. Further, JPHSA is actively seeking contractual agreements and grant opportunities.

5. Do corrective actions carry a cost?

No.

Corrective actions are considered business and service delivery processes and part of the daily operational activities of Jefferson Parish Human Services Authority (JPHSA). Primary responsibility for setting expectations and monitoring progress rests with the Executive Director. Primary responsibility for execution of corrections rests with the members of the Executive Management Team.

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?

Medicaid Managed Care Reimbursement and Statewide Management Organization Requirements

A. Problem/Issue Description

1. What is the nature of the problem or issue?
Forecasting and planning are difficult with a significant number of “unknowns” for reimbursement and provider requirements, i.e. Managed Medicaid covered services, reimbursement rates, and provider credentials. Additionally, without delineation of responsibilities for intake and assessment and utilization management, staff resources cannot be appropriately assigned.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
At this point in time, the issue is not having a negative impact on the progress of Jefferson Parish Human Services Authority’s (JPHSA) Strategic Plan Goals and Objectives. JPHSA leadership continuously seeks information, and planning is based on multiple scenarios.
3. What organizational unit in the department is experiencing the problem or issue?
The Executive Director and Executive Management Team are dealing with the inception of Managed Medicaid as part of ongoing strategic and business planning and continuous performance and quality improvement.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
All of JPHSA – every Division and all levels of employees – participates in performance and quality improvement initiatives.
5. How long has the problem or issue existed?
JPHSA initiated strategic and business planning and launched performance and quality improvement initiatives for entry into a managed care environment beginning in FY 2009-2010.
6. What are the causes of the problem or issue? How do you know?
Managed Medicaid is a local, state and national issue. The accelerated cost of providing services and supports necessitated this change in service delivery model. Specific to Louisiana, the Department of Health & Hospitals has provided ongoing information regarding the move to managed care and the implementation of a Statewide Management Organization.

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

Very simply, JPHSA will close its doors.

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?

JPHSA and all other Local Governing Entities must build infrastructure and assertively initiate ongoing and intensive performance and quality improvement initiatives.

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

These discussions have occurred within the context of the Human Services Interagency Council and internally within JPHSA.

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

Infrastructure change was initiated in FY 2010-2011. Performance & Quality Improvement Initiatives were introduced in FY 2006-2007 and became formalized and “house-wide” in FY 2010-2011. Infrastructure cannot be completed until Managed Medicaid is fully operational; however, JPHSA has significant components in place with the acquisition of two contracts with a private managed care company. Performance & Quality Improvement Initiatives will be ongoing.

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.

Corrective actions are considered business and service delivery processes and part of the daily operational activities of Jefferson Parish Human Services Authority (JPHSA). Primary responsibility for setting expectations and monitoring progress rests with the Executive Director. Primary responsibility for execution of corrections rests with the members of the Executive Management Team.

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?

Barriers to Competition

A. Problem/Issue Description

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

To remain viable, Jefferson Parish Human Services Authority (JPHSA) must position itself to compete with private sector Behavioral Health providers. The continuously changing and expanding data collection and reporting required by the State Offices cost significant productive time. With decreasing resources provided by the State, JPHSA must maximize use of staff time for service delivery, performance and quality improvement, and business operations. Loss of this resource, i.e. employees' productive time, poses a deficit for JPHSA that private providers do not have. Additionally, use of data by State Offices is not always defined.

2. Is the problem or issue affecting the progress of your strategic plan?

Yes. Barriers to flexibility and productivity pose ongoing difficulties to the successful operation of JPHSA and create stressors on all levels of staff. However, with intensive effort on continuous performance and quality

improvement, the Authority will remain as focused as possible on Strategic Plan Goals and Objectives.

3. What organizational unit in the department is experiencing the problem or issue? These barriers impact every division and every level of staff.
4. Who else is affected by the problem?
Individuals seeking and receiving services are impacted by these barriers. The quality of services and supports will not be compromised; however, the timeliness of intake and delivery is impacted when the type of credentialed staff needed may not be in place when the need is identified and when service providers are distracted by data collection that is overly expansive and at times redundant. For example, ever excessive data collection at intake and assessment impact engagement and expand the time to actually receiving services.
5. How long has the problem or issue existed?
These barriers have always existed. In times of diminishing resources and the need to effectively compete with private providers, the impact is exacerbated.
6. What are the causes of the problem or issue? How do you know?
State Offices are not on the ground providing direct services within a changing and increasingly competitive environment. The Local Governing Entities must position themselves for successful sustainability now.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
JPHSA and the other Local Governing Entities will continue to have barriers to overcome that private providers do not experience.

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.

JPHSA's Executive Director will continue to work with the other members of the Human Services Interagency Council to address these barriers.

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

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?

- a. If so:
 - What is the expected time frame for corrective actions to be implemented and improvements to occur?
 - How much progress has been made and how much additional progress is needed?
 - b. If not:
 - Why has no action been taken regarding this recommendation?
 - What are the obstacles preventing or delaying corrective actions?
 - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?
5. Do corrective actions carry a cost?
- No. If not, please explain.
- Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
 - b. How much has been expended so far?
 - c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
 - d. Will additional personnel or funds be required to implement the recommended actions? If so:
 - Provide specific figures, including proposed means of financing for any additional funds.
 - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

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

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

- Internal audit
 JPHSA's Management Services Division provides ongoing monitoring of clinical and administrative functions. Audit tools, with identified criteria and targets are utilized; results are reported; and, appropriate performance and quality improvement and/or corrective actions are executed. JPHSA has three process improvement teams – Service Delivery Area, Environment of Care, Administrative and Management – to audit Authority performance using benchmarks set forth in Council On Accreditation standards and to implement

performance and quality improvement and/or corrective action as needed. A member of the Management Services Division serves on each of the three teams to assure there is no duplication of effort. The Business Process Committee's mission is to increase operational efficiencies and maximize service revenue. This chartered committee meets once each month and includes representatives from Behavioral Health Services Divisions, Administration (Fiscal Services), and Management Services. Focus is on JPHSA processes beginning with the service recipient's initial access to the service delivery setting, continuing through the clinical encounter, and ending when all financial matters associated with the service encounter are resolved.

- 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 as well as by the Department of Health & Hospitals Office of Behavioral Health licensing function, the State Office for Citizens with Developmental Disabilities, and the Louisiana Department of State Civil Service. Additionally, the Authority is periodically audited by the Louisiana Public Health Institute (LPHI) as part of Primary Care Access Stabilization Grant (PCASG) funding requirements and by other entities for additional federally funded programs.
- Policy, research, planning, and/or quality assurance functions in-house JPHSA's Management Services Division has overall responsibility for policy development and management and for the Authority's quality assurance functions. The Executive Management Team, headed by the Executive Director, is responsible for short- and long-term planning; and, the Performance & Quality Improvement (PQI) Committee, chaired by the Management Services Director, is responsible for the development and monitoring of annual PQI Initiatives and for monitoring PQI work groups. The Research Committee, chaired by the Medical Director, has overall responsibility, for review and approval of research studies involving service recipients. All such studies must be consistent with the JPHSA Mission.
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff Performance is monitored on an ongoing basis utilizing the JPHSA Strategic Plan, Operational Plan, Division Annual Plans, Annual Performance and Quality Improvement Initiatives, Utilization Management Plan, and position-specific performance expectations. All have clearly stated expectations and performance targets. The Executive Director, Executive Management Team, Supervisory Staff, and the Management Services Division share responsibility. Outcomes are reported on no less than a quarterly basis.
- Program evaluation by contract

- ☒ Performance Progress Reports (Louisiana Performance Accountability System)
JPHSA collects data, performs statistical analyses, and reports outcomes into LaPAS on a quarterly basis. Detailed notes of explanation are provided for positive and negative variances of 5% or more from the target; each outlines any needed corrective action or process improvement activities. JPHSA also provides data to the Department of Health & Hospitals' Office of Behavioral Health and Office for Citizens with Developmental Disabilities on an ongoing basis.
- ☒ In-house performance accountability system or process
JPHSA utilizes the following to model its performance accountability process: the National Council for Community Behavioral Healthcare endorsed Accountable Care Model; the Council On Accreditation Standards and Rating System; Staff Development & Supervision Guidelines in conjunction with the Louisiana Department of State Civil Service Performance Planning & Review System; ongoing internal monitoring with appropriate follow-up activity; and, ongoing data mining and analysis for decision support via the JPHSA Electronic Health Record.
- ☒ Benchmarking for Best Management Practices
JPHSA has a highly developed decision support function supported by the availability of data from the Electronic Health Record and Scheduler modalities of its Management Information System as well as other internal data warehouses. Data analysis includes comparative studies to benchmark against national statistics and internally set targets. Studies range from individual and aggregate no-show rates to billing denial rates. JPHSA also utilizes benchmarks set forth in the Accountable Care Model and Council On Accreditation Standards and Ratings System for ongoing performance and quality improvement initiatives.
- ☒ Performance-based contracting (including contract monitoring)
All JPHSA contracts have explicit performance requirements, i.e. plans of work with deliverables, and include monitoring plans with assigned monitors.
- ☒ Peer review
JPHSA's three Process Improvement Teams – Service Delivery Area, Environment of Care, Administrative and Management – all use 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 of service recipient suicide or death not associated with a physical disease or chronic physical condition. He also schedules ongoing peer reviews during regular meetings of the Medical Staff.
- ☒ Accreditation review
JPHSA is in the self-study phase of the accreditation process with the Council On Accreditation with a completion date of November 22, 2011. The site visit

by a Peer Review Team is scheduled for January 30, 2012.

- 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 Behavioral Health Clinics on an annual basis to better identify opportunities for improvement. The Authority's Adult Community Support Division conducts satisfaction surveys with the service recipients of all contractors as part of standard contractual requirements. JPHSA also partners with the Office of Behavioral Health to hold an annual addictive disorders community forum for the residents of Jefferson Parish. 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. As part of the accreditation process, JPHSA invited individuals served, contractors, stakeholders, and community leaders to participate in satisfaction surveys sponsored by the Council On Accreditation. Results of the surveys will be shared with the Authority after completion of the self-study.

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, and has a well developed decision-support function in place. Data is analyzed and discussions are held during weekly Executive Management Team meetings and Performance & Quality Improvement Committee meetings. Findings are shared during individual and group supervision and at all-staff meetings, as appropriate. Corrective action and/or performance and quality improvement plans are developed and executed as needed, and are monitored by the Management Services Division on a routine basis and by the Executive Director as determined to be necessary.

Information concerning JPHSA's internal reports may be obtained by contacting:

Michael E. Teague, Executive Director
 Jefferson Parish Human Services Authority
 504-838-5215
 mteague@jphsa.org

Annual Management and Program Analysis Report

Fiscal Year 2010-2011

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

Department Head: Bruce D. Greenstein, Secretary

Agency Head: Melanie Watkins, Executive Director

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

Initiated the Implementation of an Electronic Behavioral Health Record (EBHR)

In collaboration with Capitol Area Human Services District and South Central Human Services Authority, and in consultation with the Department of Health and Hospitals, FPHSA developed a Request for Proposals and selected a vendor for an EBHR and electronic billing system. This marks the transition of FPHSA as a “paperless” agency. Clients will benefit by the improved efficiency an electronic record will provide. This accomplishment contributes to the goals of FPHSA’s strategic plan as the improved efficiencies provided by the EBHR will enable staff to focus more on the efficacy of services provided and will greatly contribute to data-based decision making.

Initiated Preparation to Become Accredited through/by the Commission on Accreditation of Rehabilitation Facilities (CARF)

FPHSA made the determination to become accredited by CARF and began the operational fine-tuning required for accreditation. Accreditation will prepare FPHSA for participating in the state’s Coordinated System of Care (CSOC) and Louisiana Behavioral Health Partnership (LBHP) and will help to ensure the agency’s long-time viability as a provider of community behavioral health. Individuals residing in FPHSA’s catchment area will benefit from the agency’s accreditation as it will signify a level of service that is consistent with national standards. This accomplishment will contribute to FPHSA’s strategic plan as the consistency required for accreditation will improve the agency’s ability to provide services that are comprehensive in nature and reflective of treatment modeled after best management practices.

Reorganized Addictive Disorders Services’ Inpatient Treatment Program

In order to reduce costs associated with the provision of substance abuse treatment services

provided by FPHSA, the agency reorganized its male and female units. The units, which are separate but located within the same facility, now share staff that can “float” between each unit as needed. This reorganization reduced the cost-per-client day so that it is more competitive with the similar 28-day treatment programs in the private sector. The combined cost-per-client day went from \$128 in FY 2010 to \$118 in FY 2011, a reduction of 8 percent. FPHSA prepared a plan and obtained approval from state Civil Service prior to the reorganization. This accomplishment contributes to FPHSA’s strategic plan as reducing the cost-per-client day helps ensure that FPHSA can continue to provide these services “in-house” rather than through a contracted provider, thus allowing the agency greater ability to assure that services and supports improve the quality of life for persons with addictive disorders.

Co-located Services Related to Mental Health and Substance Abuse at Two Facilities

FPHSA relocated staff and services to combine, in two facilities, the provision of both mental health and substance abuse services. These changes were significant as they enhanced FPHSA’s service delivery system and facilitated the transition from one service area to another for clients with co-occurring disorders. Additionally, as FPHSA was able to terminate the lease on one building after co-locating staff and services, this accomplishment resulted in a savings of approximately \$135,000 in operational expenses. Co-location of services and staff is one way FPHSA is meeting its strategic plan goal of improving efficiency of services using data-based decision making.

Increased Services Related to Permanent Supportive Housing

FPHSA continued the Permanent Supportive Housing Services (PSHS) program and increased the number of families residing in permanent supportive housing from 154 (FY 2010) to 190 (FY 2011). PSH is a major policy objective of Louisiana's "Road Home Program" and funded through a Community Development Block Grant. PSH combines permanent affordable rental housing with flexible supportive services to help eligible individuals attain and maintain stable housing. Services are tailored to each participant’s needs and goals through an Individual Service Plan. Services are flexible and responsive to the needs of the individual and their family and are geared toward assisting the individual to maintain tenancy thereby avoiding homelessness and/or inappropriate institutionalization. This program benefits homeless individuals (including those displaced by Hurricane Katrina) as well as low-income individuals/families with long-term disabilities. It contributes to FPHSA’s strategic plan by allowing the agency to expand its provision of comprehensive services and supports which improve the quality of life and community participation for individuals with addictive disorders, developmental disabilities, and mental illnesses.

II. Is your department five-year Strategic Plan/Department 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.**

The overall effectiveness of FPHSA's strategies is positive. Strategies are working as expected and proceeding as scheduled. Although the agency is making significant progress at meeting its objectives, the demand for services continues to far outweigh capacity due to growth in the number of individuals presenting for services. The number of individuals presenting for addictive disorders and/or mental health services increased from 7,749 in FY 07 to 10,606 in FY 11—a 36.9% increase. The population increase in FPHSA's catchment area is likely an external factor that has contributed to the increased demand for services. The U. S. Census for FPHSA's catchment area reflects a population of 438,121 for 2000 and 541,234 for 2010—a 24% increase. Most of FPHSA's anticipated outcomes (goals and objectives) are being attained as expected.

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

FPHSA has made progress toward meeting this goal. The agency provides direct clinical services and coordinates an array of services designed to provide treatment on an outpatient basis, as well as a 28-day residential treatment program for addictive disorders. Other community-based supportive services include the following: case management, group home placement, consumer care resources, cash subsidy, in-home crisis intervention, family preservation, and respite.

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

FPHSA has made progress toward meeting this goal. The agency has made efforts to move toward treatment of co-occurring disorders. FPHSA began co-housing Addictive Disorders Services and Mental Health Services staff this fiscal year. Clients with co-occurring disorders can now see substance abuse and mental health professionals at FPHSA's Lurline Smith Mental Health Center/Northlake Addictive Disorders Clinic and FPHSA's Slidell Addictive Disorders Clinic.

Area Supervisors (Addictive Disorders Services, Developmental Disabilities Services, and Mental Health Services) met regularly with the Executive Director to discuss service and client data from various systems (LADDS, OARS, ITS, OHMIIS, ARAMIS, etc.) and ways in which service strategies could be adapted and resources allocated to meet demands reflected by the data.

The agency began preparation for accreditation and initiated implementation of an EBHR—both will increase quality and effectiveness of services as well as prepare it for the ongoing evolution of health care.

Goal 3: To promote healthy and safe lives for people by providing leadership in educating the community on the importance of prevention, early detection and intervention, and by facilitating coalition building to address localized community problems.

FPHSA is meeting this goal in several ways. Major educational initiatives include the Addictive Disorders Services Prevention program and the Permanent Supportive Housing program. FPHSA staff of each of the agency's service areas participate in numerous coalitions across the five-parish area including St. Helena Social Services Network, Tangipahoa Social Services Council, St. Tammany Commission on Families, Washington Parish Human Services Coalition, Livingston Parish Human Services Coalition, the 22 Judicial District Court Child and Youth Planning Board, Northlake Homeless Coalition, Families In Need of Services, Truancy Assessment and Service Centers, etc.

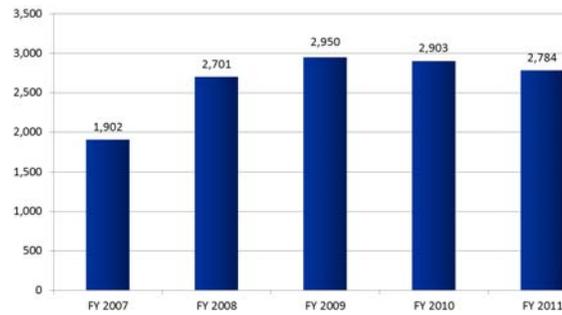
Additionally, FPHSA's Executive Administration and Board of Directors held stakeholders' meetings in each parish of the FPHSA catchment area. Focus was placed on educating the community on FPHSA's role as the area's Human Services Authority and on obtaining feedback regarding the communities priorities related to behavioral health and developmental disabilities. FPHSA also coordinated and participated in community meetings to educate stakeholders on statewide initiatives such as the CSOC and LBHP.

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

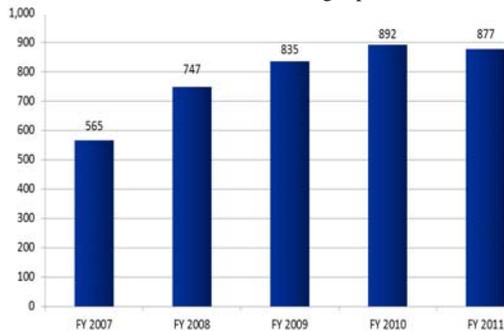
FPHSA is successfully meeting its objective related to providing treatment services to individuals with addictive disorders. The total number of people with addictive disorders served increased 46 percent (from 1,902 to 2,784—see chart below) between FY 2007 and FY 2011.

The number of people receiving inpatient treatment increased from 565 in FY 2007 to 877 in FY 2011—a 55 percent increase (see chart below). The cost-per-client day for inpatient services decreased from \$169 in FY 2007 to \$118 in FY 2011, representing a decrease of 30 percent (see chart below).

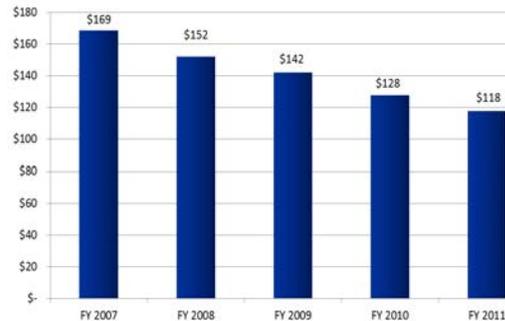
Addictive Disorders Treatment Services: Total Served



Addictive Disorders Services:
Number of Persons Receiving Inpatient Services

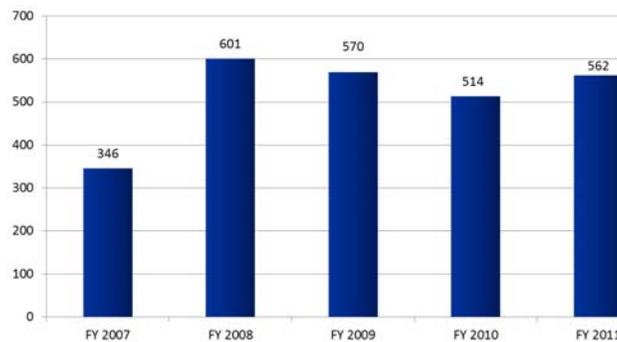


Addictive Disorders Services: Cost per Client Day



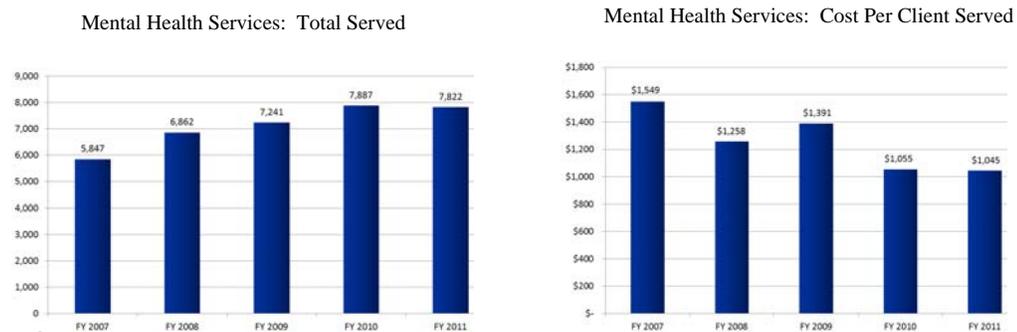
FPHSA is successfully meeting its objective relating to people with developmental disabilities. The objective is to provide services that emphasize person-centered individual and family supports. The total number of individuals served annually increased 62 percent (from 346 to 562-see chart below) between FY 2007 and FY 2011.

Developmental Disabilities Services: Total Served



FPHSA is successfully meeting its objective related to people with mental illness. The objective is to provide services emphasizing recovery for adults

and resiliency for youth for those diagnosed with mental illness. The total number of people served in FPHSA's Community Mental Health Centers increased 34 percent (from 5,847 to 7,822-see chart below) between FY 2007 and FY 2011. The average cost-per-person served saw a reduction from \$1,549 in FY 2007 to \$1,045 in FY 2011 (see chart below), representing a decrease of 33 percent. The primary reason for this reduction was implementation of a more restrictive formulary which resulted in reduced expenditures for pharmaceuticals. During this period, FPHSA enhanced its focus on and expanded pharmaceuticals provided through patient assistance programs (PAPs).



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

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?

Management does not deem modifications to the strategic plan necessary at this time.

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

FPHSA has monthly meetings with its Board of Directors and conducts routine (weekly) Management Team meetings. The supervisors of each service area hold

regular meetings with their staff at which information related to the agency's overall plan and strategies is discussed. Community stakeholders' meetings are held throughout the 5 parishes served by FPHSA.

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, condition of the state fisc, 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

Recruitment and retention issues have negatively impacted services across the agency—both those provided by staff directly and those provided by contract providers. The problem has been acutely critical in the case of psychiatrists and clinical staff. While psychiatric coverage issues primarily impacted MHS, the staffing crisis was pervasive across all service areas. Clients become impacted as staffing resources are stretched. As the problem continues, it results in staff overload, potential staff burnout, and diminished service capacity.

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 (Cash Receipts, Petty Cash, Compliance-Billing Policy)
- External audits (Louisiana Property Assistance Agency; Office of Risk Management; Louisiana Department of State Civil Service)
- 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): 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. Cash Receipts
 - b. Petty Cash
 - c. Billing
 - d. Louisiana Property Assistance Agency (LPAA)-Certification of Annual Property Inventory
 - e. Office of Risk Management (ORM)-ORM Compliance Review
 - f. Louisiana Department of State Civil Service-Human Resources Evaluation report
 - g. Louisiana Performance Accountability System (LaPAS)
 - h. Contract Monitoring
 - i. Annual Financial Reports
2. Date completed
 - a. Monthly
 - b. Quarterly
 - c. Monthly
 - d. August 31, 2010
 - e. January 13, 2011
 - f. November 09, 2010
 - g. Last completed 8/23/2011 (FY 11)
 - h. Quarterly
 - i. Last completed 8/25/2011 by DHH/Fiscal Management (FY 11)
3. Subject or purpose and reason for initiation of the analysis or evaluation
 - a. FPHSA Accounting Policies and Procedures
 - b. FPHSA Accounting Policies and Procedures
 - c. FPHSA Accounting Policies and Procedures

- d. FPHSA Property Control Policies and Procedures (LPAA requirement)
 - e. FPHSA Risk Management Policies and Procedures (ORM requirement)
 - f. Compliance to State Civil Service requirement
 - g. Compliance to LaPAS requirement
 - h. FPHSA Contract Regulations Policies and Procedures
 - i. Compliance to State requirement
4. Methodology used for analysis or evaluation
 - a. FPHSA Policies and Procedures 301-901 Cash Receipts
 - b. FPHSA Policies and Procedures 301-951 Petty Cash
 - c. FPHSA Policies and Procedures 301-920 Billing Policy
 - d. Physical Inventory
 - e. Compliance Review done by ORM, LP Officer
 - f. Evaluation done by State Civil Service, Program Accountability Division
 - g. DOA-required methodology; performance indicators developed by FPHSA and approved by DOA
 - h. FPHSA Contract Regulations Policies and Procedures
 - i. Policies and practices established by DOA or in accordance with Generally Accepted Accounting Principles as prescribed in the Governmental Accounting Standards Board.
5. Cost (allocation of in-house resources or purchase price)
 - a. \$12,967.81
 - b. \$ 4,327.65
 - c. \$12,967.81
 - d. Not calculated
 - e. Not calculated
 - f. Not calculated
 - g. Not calculated
 - h. Unknown
 - i. Not calculated
6. Major Findings and Conclusions
 - a. None
 - b. None
 - c. None
 - d. Un-located assets in the amount of \$16,092.92. It was determined that 10 computers were disposed of because they were out-of-warranty and determined obsolete; however, staff failed to acquire appropriate approval prior to disposal. Additionally, disposal of a fax machine was mistakenly reported as a non-tagged item when in fact it was tagged; therefore, the fax machine was reported as un-located because it was not entered in the system as disposed of.

- e. Agency was compliant, with a score of 89.47%. Under General Safety, two items were found to be deficient and recommendations were made.
- f. Corrective action required on two items.
- g. None; minor variances from targets
- h. None; no major findings
- i. None

7. Major Recommendations

- a. None
- b. None
- c. None
- d. None
- e. 1.) Ensure that safety rules are distributed and reviewed annually with all employees, and such actions are documented. 2.) Conduct and document all required number of safety meetings based on the agency's classification.
- f. 1.) Maintenance of Required Documentation-position descriptions (SF-3's) updated timely. 2.) PPR Ratings-signed and dated by employee and supervisor/rating conducted timely.
- g. None
- h. None
- i. None

8. Action taken in response to the report or evaluation

- a. Audit results are discussed at weekly management team meetings and trouble shooting is done.
- b. Audit results are discussed at weekly management team meetings and trouble shooting is done.
- c. Audit results are discussed at weekly management team meetings and trouble shooting is done.
- d. Staff were retrained to follow FPHSA procedure and acquire approval prior to disposal of assets
- e. Sign-in sheets at safety meetings, which specify the subject to be covered and the date, will provide the documentation required.
- f. 1.) The HR Staff will maintain official position descriptions for all positions within the agency as described in the HR Handbook. The HR Analyst responsible for this task has developed spreadsheets for each facility that will be shared with the managers and supervisors of the facilities for use in tracking when updates of SF-3s are necessary. The HR Analyst will track compliance with timelines using a comprehensive spreadsheet. 2.) Supervisors will be reminded (through FPHSA's monthly HR tidbits/staff meetings) of the importance of meeting all Performance Planning and Review requirements as described in Civil Service Rule 10.5. The HR staff will also continue to utilize

the tickler system as another method of keeping supervisors informed of deadlines. In addition, the Executive Director will issue a memo to all supervisors informing them that they will be held responsible for the proper execution of their PPR responsibilities.

- g. None
- h. None
- i. None

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

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

10. Contact person for more information:

Name: Melanie Watkins
Title: Executive Director
Agency & Program: Florida Parishes Human Services Authority
Telephone: 985.748.2220
E-mail: melanie.watkins@la.gov

Name: Trent Myers
Title: Administrative Director
Agency & Program: Florida Parishes Human Services Authority
Telephone: 985.748.2220
E-mail: trent.myers@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2010-2011

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

Department Head: Bruce D. Greenstein, Secretary

Agency Head: Jan Kasofsky, PhD, Executive Director

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

CAHSD is the Convening Agency for the Regional Coordinated System of Care (CSoC) Application

Louisiana's "Medicaid Office" is supporting the development of a statewide CSoC to establish family and youth-driven care to keep children with significant behavioral health challenges or co-occurring disorders at home, in school, and out of the child welfare and juvenile justice system. Cabinet Secretaries of child-serving agencies have worked for a year to design the framework and processes of the CSoC and funds for the system will be removed from their budgets to support this new managed Medicaid funded system of care.

An important CSoC goal is the reduction of costly, highly restrictive out of home placements through the creation and maintenance of coordinated and effective community-based, public/private partnership services.

CAHSD is supporting this initiative which will be implemented in regions deemed ready to be "early implementers", January, 2012. Regions deemed ready for implementation will be selected based on a competitive application process. The application must be conceived of and supported by community services providers and family members of the target population of children/adolescents who are deemed "high risk" for out of home or school placement due to their serious behavioral problems. Participants in the application process include: local school officials, juvenile court judges and their Youth Boards, treatment and service providers, churches and local leaders, advocates, and officials of involved local governmental agencies.

Once implemented, this program will provide services and care management to a maximum of 5,000 youth statewide.

CAHSD has provided substantial human capital to support a developmental framework and timeline for the application that ensures all voices are heard and that participation and representation spans all impacted parties and locales.

Public meetings were initiated in January 2010, and an intense schedule of weekly meetings has been held. Responsibilities of our broader engaged community includes leadership from all stakeholder groups and criteria and selection of local providers able to meet the application requirements for the regional Family and Peer Support Organization and the Wraparound agency. The date for submission of the application to be an early implementing region was May 13th.

On June 13, 2011, we were notified that the CAHSD Region has been selected as 1 of 5 regions in the state chosen as “early implementers”.

Optimizing Service Delivery of Critical Services

Due to the relocation of people who are being deinstitutionalized from mental health intermediate care hospitals, short-term acute mental health units, and more people with serious needs within the Capitol region, CAHSD has been continuously challenged to implement innovative approaches to client access and treatment.

The new innovative services include:

- A rapid, social worker-manned telephonic triage, screening, assessment and immediate clinic entry for clients meeting admission criteria.
- A walk-in process that has reduced wait times for adults from 13 weeks to 24 to 48 hours. Appointments are still offered for our clients.
- Adult and Child Mobile Outreach Treatment teams and our Forensic/Assertive Community Treatment (F/ACT) team provide treatment, housing, employment, and medical support to our clients outside of our clinics.
- The Mental Health Emergency Room Extension at EKL Medical Center, providing assessment, stabilization and referral to community-based services or hospitalization, has reduced the number of hospitalizations from 100% to 34% due to coordinated discharges to community-based services. This saved the state \$9M the first year due to decreased hospitalizations, while not fully opened. It is projected to save the state \$20M annually, beginning this year, with access to all 20 beds available.

Preventing Fetal Exposure to Alcohol and Other Drugs & Providing Treatment to Impacted Infants and Children

Over 10 years ago, CAHSD staff initiated research into the growing population of young children in our Child and Adolescent Behavioral Health Services clinic who had behaviors typical of Attention Deficit Hyperactivity Disorder (ADHD), but did not have ADHD. This research led us to become more involved in the identification and early treatment intervention of pregnant women who were using drugs, alcohol and tobacco early in their pregnancies. Prenatal exposure to alcohol, tobacco, and illicit and other drugs is the leading preventable cause of birth defects and developmental disabilities among infants. Substance-exposed children may be born with heart, kidney, and skeletal defects, eye problems, growth deficiency, abnormal facial features, and brain damage. Neurological damage can result in seizures, deficits in executive functioning, problems with communication, attention, social skills, and hyperactivity.

Without early intervention, these prenatally exposed children have difficulties in school due to poor impulse control, distractibility, inability to stay on task, and difficulty with emotional regulation. They tend to be at higher risk for diagnosis with mental disorders including ADHD, depression, anxiety, and substance abuse disorders later in life.

Prevention of substance use during pregnancy and early intervention services for prenatally substance-exposed infants are critical components of CAHSD's efforts to improve the health of children and families in the Greater Baton Rouge community. A collaborative of over 40 agencies in the region has been working since 2002 to raise awareness and provide services to address the problem of perinatal substance use and its negative effects on children and families.

A continuum of care has been established to include prenatal screening for substance use, domestic violence, and depression. Brief intervention and assessment/treatment services are provided to women screening positive. Over 10,000 pregnant women have been screened in this region and provided education and supportive services which have resulted in their quitting or decreasing use of substances during pregnancy.

If treated, the potential cost savings for a child prenatally exposed to substances is \$130,000 in the first five years of life.

Use of alcohol and other drugs during pregnancy at any level is unsafe for the unborn child. To address the specialized needs of prenatally exposed infants and children, CAHSD established the Infant, Child, and Family Center (ICFC) to provide specialized, comprehensive assessments that may include medical, psychological, infant mental health, and developmental evaluations. The Center also provides infant mental health services which are designed to strengthen the parent-child relationship. The team works collaboratively with a variety of systems affecting the lives of infants and toddlers, including child welfare, legal, educational, health care, and mental health care systems. ICFC's goal is to improve the child's development, enhance the child/caregiver relationship, reduce the chance of further maltreatment, and ameliorate disturbances in early childhood. This service is available through a collaboration of CAHSD in partnership with Our Lady of the Lake Regional Medical Center, The Department of Child and Family Services, and the ARC of Baton Rouge.

A new birth outcomes initiative from the Secretary's Office is being instituted. This decision discontinued the work that was described above. This change will create a 6 month period where no women will be screened and no interventions provided.

Regional Services for Substance-Exposed Children

In response to the specialized needs of children under age 6 who are in foster care or have been exposed prenatally to alcohol, tobacco or other drugs, a multidisciplinary team with expertise in infant mental health and developmental psychopathology has been working together at the CAHSD Infant, Child, and Family Center (ICFC).

The team is staffed by a physician, social workers, psychologists, occupational therapists, and paraprofessionals who provide comprehensive assessments and treatment to young children and their families. ICFC's goal is to improve the child's development, enhance the child/caregiver relationship, reduce the chance of maltreatment, and ameliorate disturbances in early childhood. The team works collaboratively with a variety of providers who can impact the lives of infants and toddlers, including child welfare, legal, educational, health, and mental health care systems.

The major partner organizations are Our Lady of the Lake Regional Medical Center, the Department of Children & Family Services (DCFS), The Arc Baton Rouge, and Louisiana State University.

During the past year, ICFC received 154 referrals from agencies such as the DCFS, the Office of Public Health, private physicians, and the school system, among others. The top diagnoses for the children and families were Parent-Child Relational Problems, Intrauterine Alcohol and/or Drug Exposure, Language Disorders, and other Developmental Delays. ICFC also takes an active role in advocating for developmentally appropriate practices by providing training to DCFS staff, organizing the formation of a specialty court team, and providing preventive education regarding the effects of prenatal substance exposure.

Referral forms may be obtained by calling 225.765.8715.

Recovery Oriented System of Care-Peer Support Services Kickoff

CAHSD held a kickoff event this December to promote the Recovery Oriented System of Care-Peer Support Services. A certified Peer Support Specialist is available to help clients meet their goals to improve their health, wellness and recovery.

CAHSD has adopted the Substance Abuse and Mental Health Services Administration (SAMHSA) guiding principles of recovery and elements of systems of care that provides a framework to guide activities and dialogue among stakeholder groups. A critical component of the recovery process is the presence and involvement of people who contribute hope and support and suggest strategies and resources for change. Peers, as well as family members and other

allies, form vital support networks for people in recovery. Providing service to others and experiencing mutual healing help create a community of support among those in recovery.

The CAHSD Peer Support Program includes the following services: Facilitation of support groups; One-to-one peer mentoring and coaching; Liaison with clinic treatment program; Assistance with recovery planning; Referral to community resources and follow-up (e.g. education, transportation, childcare, housing, job training/ employment); and, Community outreach and education. Referral into the CAHSD Peer Support Services Program will be through clinician referral or self-referral for clients age 18 years or older.

A special thank you for those that donated materials for the kickoff: the Crowne Plaza Baton Rouge, the American Cancer Society, Capital One, Dr. Henry Manning, DDS, Dr. Robert Delarosa, DDS, and Dr. Michael Hillar, DDS.

Blood Pressure and Blood Sugar Screenings

Last year CAHSD completed a parish by parish assessment and plan for needed physical health and wellness services to uninsured clients who utilize the Public Health Units and CAHSD's mental health and addiction recovery clinic services. Our physical health initiative is focused on the major diseases/health risks impacting this region including: heart disease, lung disease, pre-conception and pre-natal care, sexually transmitted diseases, including HIV, diabetes, obesity and high blood pressure. These plans have been used to implement smoking cessation and health screening services using CAHSD, parish government, and private foundation resources.

In response to an identified need in West Feliciana Parish, CAHSD and the Irene W. and C.B. Pennington Foundation are co-sponsoring free blood pressure and blood sugar screenings every fourth Wednesday of each month from 9:30 am until 12:00 noon. The screenings are provided at the West Feliciana Parish Health Unit at 5154 Burnett Road, St. Francisville. For more information, call 225-635-6707.

One in three adults has high blood pressure, 30% of which don't know they have it. High blood pressure increases a person's risk of heart attack, heart failure, stroke or kidney disease. Those with diabetes are twice as likely to have heart disease or a stroke as a non-diabetic. Testing is the only way to determine high blood pressure and to make sure blood sugar levels are in a healthy range.

Celebrating Prom and Graduation Season by Keeping it Drug and Alcohol Free

The pressure to drink and use drugs to celebrate prom and graduation can be overwhelming for many young people. To support our youth to make good decisions, CAHSD is collaborating with parish communities to promote a safe, alcohol and drug free prom and graduation season.

The national initiative of "Parents Who Host Lose the Most®: Don't be a party to underage drinking. It's against the law" is the basis for a billboard and print media campaign directed at both youth and their parents.

Letters to parents and teens along with specialized advertisements and tips about preparing for peer pressure, and the safety and legal implications of drug and alcohol use will be published in newspapers and local parish newsletters.

Drugs and alcohol affect one's ability to think clearly, react quickly and control impulses. Under the influence, people take unsafe risks that lead to violent behavior, unprotected sex, and driving while impaired. Parents can be a positive influence by talking with their teens about underage drinking and also helping them to make plans for these joyous events that do not include risky behavior.

CAHSD would like teens and their parents to remember that good choices will promote their safety and the safety of others, and avoid unnecessary legal consequences. We thank all of our school-based partners for their many efforts to keep our children safe and prepare them for many years of success.

'Louisiana's Top Doctors' Among CAHSD Staff

Two of CAHSD's physicians are identified among America's top doctors in the autumn edition of *Louisiana Life*. Best Doctors, Inc., a Boston-based company, is a preeminent organization for gathering professional peer ratings. Their selection is based on a nationwide survey of more than 30,000 doctors. Ranked among the top doctors in Louisiana are CAHSD's Medical Director Gerald Heintz, MD and staff psychiatrist Brian Monette, MD. CAHSD is grateful to count these physicians among its dedicated staff.

II. Is your department five-year Strategic Plan/Department 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 common goals and objectives by specific programmatic disabilities with pre-set performance standards used to establish funding needs and efficient use of allocated resources. The District is on target with the expected accomplishments set forth in this plan.

The District's Internal 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. A few examples are listed below:

- ◆ **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:

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.

- ◆ **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:

DHH Plan: None

CAHSD Plan: Accreditation Preparation - The District is preparing its facilities and operations for CARF accreditation. Much progress has been made towards this initiative (i.e. Staff has been oriented to CARF Standards, Self-Assessments on CARF Standards have been completed and the Work Plan to achieve compliance on standards has been completed).

- ◆ **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?

The plan was developed to address the anticipated move toward a SMO system and requirements for an electronic health record, electronic billing, CARFP accreditation and to address long wait times for clinic access.

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 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?

Historical Funding Allocations Hurting the Capital Region

Budget restraints and an increasing demand for services at Capital Area Human Services District (CAHSD) have strained service delivery by causing clinical treatment staff shortages, longer wait times for treatment and contribute to more costly hospitalizations.

Limiting clinic access to these crucial behavioral health treatment services to citizens in need will strain local hospitals' and parish governments' budgets due to demands on: parish jails, hospital emergency departments, emergency responders, and law enforcement agencies.

In many cases, CAHSD is the only provider for these citizens.

The Greater Baton Rouge Area has gained 9.9% of the state's overall population, as documented by the latest census report, and it is now the largest metropolitan area in the state. The region also continues to receive a disproportionate number of people in need of mental health, addiction recovery and developmental disabilities services.

The demand for critical behavioral health services and medicines will increase as more clients are discharged from short-term acute and intermediate mental health hospitals, developmental centers and jails.

Now, at almost six years after Hurricane Katrina, CAHSD continues to serve a disproportionate and increasing number of people who have serious need for mental health, addiction recovery, and developmental disabilities services.

CAHSD's budget allocation remains based on an historical allocation that is not adequate to address the demands placed on its clinics due to a more acute/less stable and increasing population. Statewide proportionate budget cuts compound the problem. DHH and the legislature need to base statewide allocations and cuts on current population distributions and their own data

on the relocation of people with serious behavioral health needs to ensure clients can access care in a timely way and public safety is maintained.

As the State continues to deinstitutionalize people into our region, funding consideration for outpatient mental illness, addictions, and physical/mental disabilities services must be made accessible and available. We urge DHH officials to reconsider our budget allocation in light of the increased demand in the greater Baton Rouge Area and to allocate funding based on known population statistics.

Higher Demand and Diminishing Resources for Crucial Services

With growing numbers of people with serious mental illness and more with need for substance abuse treatment locally, clients are overwhelming our capacity.

CAHSD is doing everything it can to avoid long treatment wait times and subsequent need for hospitalizations and/or need for/involvement with first responders. What we see in this region is:

Thirty percent of all statewide acute psychiatric patients are being discharged to CAHSD's catchment area.

Double (68%) the number of patients from public intermediate psychiatric hospital beds are discharged to CAHSD than any other region of the state. This is where these individuals are choosing to live.

This region houses one of two community-based forensic facilities and these patients access CAHSD's limited services and medications without any cost off-set to CAHSD.

It is expected that the majority of people (200) being transitioned from Developmental Centers this year will relocate here and access CAHSD's clinic services for behavioral issues.

Post-Katrina, there has been a sustained increase of 57% in new seriously mentally ill CAHSD clients with a three-fold increase in acuity.

As people lose their job/insurance they are looking for services from public providers.

Aside from a mental health/psychiatry worker shortage, many private providers will not accept indigent or Medicaid eligible clients due to the low payment rates.

To manage the budget deficit this year, CAHSD has let go of all vacant positions and most probational staff, foregone all merits, offered a retirement incentive, implemented seven furlough days and 10 people were laid off.

The CAHSD has submitted the following Resolution to the appropriate officials requesting corrective action be implemented at their level.



**Capital Area Human Services District's Seven Parishes
PARISH & POLICE JURY PRESIDENT RESOLUTION**

**PARISHES OF ASCENSION, EAST BATON ROUGE, EAST FELICIANA, IBERVILLE, POINTE
COUPEE, WEST BATON ROUGE, WEST FELICIANA**

In the months of April and May, 2011, we do sign this resolution as representatives of the seven above noted parishes, to unanimously adopt the following resolution:

Be it resolved that we, the presidents of the seven parishes comprising the Capital Area Human Services District's service area do hereby request support from our respective regional legislative delegation to ensure that the state appropriation to the Capital Area Human Services District be reflective of the increased population and the heightened acuity level of those seriously mentally ill citizens relocated to this geographic area as a result of deinstitutionalization. These new citizens to the Capitol region will place enormous financial pressure on local parish government and hospital budgets due to their anticipated impact on local law enforcement and hospital emergency departments. Citizens who have relocated to our parishes have created a hardship on our publicly funded support services and have substantially impacted our parish hospitals, emergency responders and law enforcement providers, as state appropriations to increase the capacity of mental health and addictive disorders services have not been re-aligned with the increased population in this service area.

Unadjusted funding for public mental health services in this region and applying uniform percentage cuts leads to clinician shortages, long treatment wait times and subsequent hospitalizations. This region has been disproportionately impacted due to the state's deinstitutionalization initiative.

- Thirty percent of all statewide acute psychiatric patients are discharged to CAHSD.
- More than double (34%) the number of patients from intermediate psychiatric hospital beds (ELSH & Central) are discharged to CAHSD than any other region of the state.
- This region houses the sole community-based forensic facility and these patients access CAHSD's limited services and medications without any cost off-set to CAHSD.
- It is expected that the majority of people (400) being transitioned from Developmental Centers this year will relocate here and access CAHSD's clinic services for behavioral issues.
- Post-Katrina, there has been a sustained increase of 45% in seriously mentally ill CAHSD clients with a three-fold increase in acuity.

We hereby request that the Department of Health and Hospitals and the Division of Administration address this increased demand for mental health and addictive disorders services in this region within the Governor's 2012 budget, that the appropriation be based on the new and increased population distribution of the de-institutionalized's need and usage of these public services delivered through the CAHSD providers and it be consistent with the increase that is documented within the Department of Health and Hospital's (DHH), service delivery information systems.

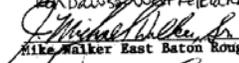
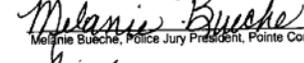
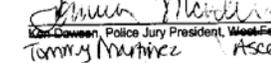
We also do hereby request that the DHH, Office of the Secretary, submit revisions to the Division of Administration during the 2012 budget development process, to fund the increased demand for mental health and addictive disorders services for the de-institutionalized population now residing in the seven parish district to be incorporated into the Governor's 2012 Executive Budget.

Whereas CAHSD has served as the convener of service responses throughout the seven parishes and has provided outreach and clinic based services for the de-institutionalized population, and

Whereas the CAHSD has received no increased budget authority to provide for the increase in new mental health clients now being seen in its clinics nor for the deployment and outreach to people in alternative sites,

Therefore, the Parish and Police Jury Presidents of the seven parishes of the Capital Area Human Services District's service area do hereby request support for a reallocation of appropriated funds or a Budget Adjustment that allows the "funds to follow the client" and therefore provides the resources to de-institutionalized citizens relocated to the Greater Baton Rouge Area and qualify for state funded services by meeting the criteria as established by the Department of Health and Hospitals, Office of Behavioral Health.

The above resolution is supported by us, the undersigned.

	6/14/11
Tommy Martinez, Ascension Parish President	Date
	6/8/11
Mike Walker, East Baton Rouge Parish Mayor-Pro-tem	Date
	5/12/11
Dennis Aucoin, Police Jury President, East Feliciana Parish	Date
	4-19-11
Mitchell Corso, Jr., Iberville Parish President	Date
	4/26/11
Melanie Bueche, Police Jury President, Pointe Coupee Parish	Date
	4-13-11
Riley Berthelot, West Baton Rouge Parish President	Date
	5-14-11
Tom Dawson, Police Jury President, West Feliciana Parish	Date
	Ascension

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. 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 (i.e. wait times study and MHERE clinic referrals kept)
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- 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)
Louisiana Legislative Auditor Procedural Report
2. Date completed
LaPas: September 2011
Audit: May 04, 2011
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.

Audit: Review of internal controls, tests of financial transactions, tests of adherence to applicable laws, regulations, policies and procedures governing financial activities and review of compliance with prior report recommendations.
5. Cost (allocation of in-house resources or purchase price)
LaPAS: Cost uncalculated
Audit: \$51,502
6. Major Findings and Conclusions
LaPas: None-minor variances from targets
Audit: None
7. Major Recommendations
LaPas: None
Audit: None
8. Action taken in response to the report or evaluation
LaPas: None
Audit: None
9. Availability (hard copy, electronic file, website)
LaPas: www.louisiana.gov/opb/lapas/lapas.htm
Audit: www.la.state.la.us
10. Contact person for more information, including
Name: Jan Kasofsky, PhD
Title: Executive Director
Agency & Program: Capital Area Human Services District
Telephone: 225-922-2700
E-mail: Jan.Kasofsky@la.gov

Name: Carol Nacoste
Title: Deputy Director
Agency & Program: Capital Area Human Services District
Telephone: 225-922-2708
E-mail: Carol.Nacoste@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2010-2011

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

Department Head: Bruce D. Greenstein, Secretary

Agency Head: Sandee Winchell, Executive Director

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 quantity and quality of community-based services for individuals with developmental disabilities. Through the Council technical assistance provided to two grassroots advocacy organizations, 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 restoration of a million dollars for state funded community-based services that are the only option for many individuals with developmental disabilities and their family members; the distribution of over three million dollars for one-time expenditures to individuals with developmental disabilities as a result of the sale of the Metropolitan Developmental Center; language regarding sexual abuse of individuals with disabilities maintained the personal freedoms and rights of these individuals; an increase in the pace of New Opportunities Waiver (NOW) slots being offered; improved information about the implementation of resource allocation to NOW recipients; and, an end to

the phase-in for resource allocation that resulted in cost savings for more slots.

Educational policies influenced by the advocacy efforts of LaTEACH and the Council leadership include regulations governing the use of restraint and seclusion practices on students with disabilities in schools; a number of targets and criteria to increase the percentages of students served in inclusive settings and attaining diplomas and meaningful educational outcomes; and, behavior analysts were included among professionals eligible to receive Ancillary School Certifications.

Other significant results of advocacy efforts include the adoption of Employment First language by the Office for Citizens with Developmental Disabilities and acceptance of Council recommended criteria for selection and support of family advocates to serve on Coordinated Systems of Care regional and state advisory panels.

II. Is your department five-year Strategic Plan/Department 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?

Collectively the policy changes influenced described under ‘outstanding accomplishment’ demonstrate significant progress toward accomplishing Council targeted goals and objectives. The strategies utilized to achieve these outcomes are effective and efficient.

- ◆ **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 organizations 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.

Due to budget constraints faced by the state, there was a very strong possibility that many of the advocacy attempts to preserve services would fail. However, due to years of education regarding the benefits of these programs and the implementation of Council promoted and supported cost efficient quality services policy makers realized that home and community-based services and programs provide the highest benefit to individuals while being most cost efficient for the state.

- ♦ **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 Council's five year plan was ratified in July 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, condition of the state fisc, 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. The Council's federal funds are not currently in jeopardy, but the substantial reductions to state general fund dollars have already created significant issues with the regional Families Helping Families Centers' capacity to provide their core functions. These Centers play a critical role in connecting, informing and supporting individuals with developmental disabilities and their family members. Unfortunately, large portions of the individuals served live in rural areas and have limited use of computers. Considering the capacity to provide support in a lot of Louisiana's rural areas is contingent on travel, budget constraints have had a significant impact on the services and outreach provided to individuals who cannot travel into large metropolitan areas.

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?

Provision of funding at increased levels to support the core functions of the regional Families Helping Families Centers.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
Yes, Beginning in 2010.
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?

No. State revenue constraints appear to prevent increased funding levels to address the issue.

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?

Restoration of funds to the SFY09 level is needed for Families Helping Families Resource Centers to adequately meet the demand in their regions at a cost of \$130,000.

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 of 2010 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 2010-2011. A report covering the remainder of the state fiscal year will be submitted to the federal

government in December of 2011.

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:

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Annual Management and Program Analysis Report

Fiscal Year 2010-2011

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

Department Head: Bruce D. Greenstein, Secretary

Agency Head: Judge Calvin Johnson, Executive Director

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

Access Center Implementation

During FY2010-2011, Metropolitan Human Services District (MHSD) adopted an Access Center Model. This is a refinement of the design of the single point of entry process that was initiated in the prior fiscal year with the creation of the Care Center. The Access Center is now the single point of entry for all clients in need of MHSD services. The Access Center uses standardized guidelines to ensure individuals receive services appropriate to their needs.

This accomplishment primarily contributes to Goal IV of MHSD's FY2009-2013 strategic plan: To deliver a seamless, integrated, and comprehensive system of services that is responsive to consumer strengths, needs, interests, and choices.

Transition to an Electronic Health Record

During FY2010-2011, MHSD completed a comprehensive review of its existing information systems to determine the quality of existing information and to assess the capacity to generate high quality information to support planning and decision-making. This assessment revealed significant gaps between the capacity of existing systems and the capacity needed to meet the agency's information needs. As a result, the agency developed a list of requirements and technical specifications and released a request for proposals for an electronic health record (EHR). MHSD focused on off-the-shelf products that were well

developed enough to meet current needs, but also flexible enough to meet any future needs. Once implemented, the EHR will allow real-time documentation of MHSD service delivery, as well as allow more comprehensive information sharing across the agency. This effort contributes to Goal IV of MHSD's FY2009-2013 strategic plan: To deliver a seamless, integrated, and comprehensive system of services that is responsive to consumer strengths, needs, interests, and choices.

Standardization of Clinic Administrative Processes

During FY2010-2011, MHSD standardized the client registration protocols for obtaining client demographics and financial information. The agency benefits by ensuring duplicate records aren't created, client demographic and contact information is regularly updated and accurate billing is improved.

MHSD also implemented centralized billing for services provided at the behavioral health clinics. This required realigning staff, changing claims processing procedures, and implementing new procedures to improve reconciliation of accounts receivable. This change has improved the collection of accounts receivable, reduced delays in claims processing, and increased focus on resolving denied claims.

During FY2010-2011, MHSD also implemented an electronic scheduling system for clinical appointments, began more effective utilization of patient assistance programs, and adopted a stricter generic formulary. These changes have improved the efficiency and cost effectiveness of clinic operations.

These accomplishments primarily contribute to Goal III of MHSD's 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.

Development of Targeted Case Management Services

In FY2010-2011, MHSD began providing targeted case management (TCM) services. TCM is case management that is directly tied to a client's level of need. The primary focus of TCM is to support consumers with serious mental illness who may also exhibit some co-occurring conditions in being functional members of their community and reducing inpatient hospitalization, unnecessary emergency room visits, unnecessary use of police officers to manage behavioral health challenges and improving community tenure. TCM is offered when the level of need is not so acute as to require Intensive Case Management (ICM) or Assertive Community Treatment/Forensic Assertive Community Treatment (ACT/FACT) services. The typical TCM candidate has identified needs in four or more life domains, one of which is the addictive disorder or mental health domain. Services focus on, but are not limited to: information, referral, support, advocacy, development of an individualized service plan, and the acquisition of non-MHSD resources. By improving access and engagement, TCM will improve patient safety and quality of care and reduce costs.

This accomplishment primarily contributes to Goal II of MHSD's strategic plan: To develop meaningful innovative research-based activities and programs directed towards the self-actualization of individuals and families throughout the community.

Implementation of Crisis and After Hour Services

During FY2010-2011, MHSD began the Metropolitan Crisis Response Team (MCRT). MCRT's mission is to prevent psychiatric hospitalizations and incarcerations by identifying less restrictive, appropriate interventions to address client issues/behaviors MCRT began seeing its first clients in November 2010. By the end of the fiscal year, the team had served a total of 600 clients in Orleans, St. Bernard and Plaquemines Parishes. These clients, an average of 71 per month, identified themselves as experiencing either a mental health or substance abuse emergency. Each received an individualized face to face or telephonic assessment and subsequent follow-up in order to plug them into MHSD service delivery at the right level of care.

Approximately 10% of calls for service resulted in face-to-face assessments and interventions with clients in the community. Clients were seen in their homes, on the streets, in fast food restaurants... wherever the crisis materialized. These were all clients with serious needs. That is, the vast majority would have been hospitalized or jailed if MCRT was not able to respond and de-escalate. Less than 20% of all face to face interventions required hospitalizations. MCRT facilitated linkages that made it possible to keep clients experiencing crises in their respective community setting.

In addition to crisis services, MCRT serves as MHSD's community presence after hours. A call to any MHSD clinic after hours is now responded to by a MCRT mental health professional that can assess and address client needs for information, referral and other non-emergency services to clients. MCRT is also the after-hours gatekeeper for MHSD's transitional housing services and detoxification services.

This accomplishment primarily contributes to Goal V of MHSD's FY2009-2013 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.

Enhancement of Housing Services

During FY2010-2011, MHSD implemented four significant initiatives to improve housing options and resources for clients:

- 1. MHSD initiated a partnership with Volunteers of America (VOA) to place appropriate clients in permanent housing through their SRO program. The cost of maintaining a client in the SRO for one full year is less than the cost of keeping a client in transitional housing for 12 days. In the first 8 months of 2011, this initiative has yielded permanent housing with supports for nine ACT/FACT/ICM clients.*

2. *MHSD diversified transitional housing services by contracting with an additional provider. MHSD now contracts for up to 25 beds at Pyramid House and up to 15 beds at Grace Outreach Center (GOC). In the prior contract year, GOC had a 40 bed contract. This new arrangement has allowed MHSD to save money on days that bed occupancy at either provider is not 100%. It also allows MHSD to use those cost savings to increase the number of beds on days where extra beds are needed.*
3. *MHSD took a more active role in managing UNITY, the subcontractor for the HUD Shelter Plus Care grant. By more clearly delineating expectations and strategizing methods to increase use of the grant, MHSD reduced the amount of unspent money returned to HUD in FY2011. One of these options involved pairing Shelter Plus Care units with ACT and ICM services teams, thereby increasing the number of MHSD clients who actually utilized the Shelter Plus Care grant. Moving forward into the coming year, MHSD is researching the use of Shelter Plus Care funds to pay for group homes for individuals with mental illness. MHSD has contacted such group homes in Washington, DC and Region 7 in Louisiana and is determining whether similar models could work locally as part of MHSD's Shelter Plus Care grant.*
4. *MHSD played a major role in the successful Intermediate Discharge process aimed at discharging 118 individuals living in intermediate level care at State psychiatric hospitals. The lion's share of intermediate discharge clients moved to MHSD's catchment area. MHSD participated in bi-weekly discharge meetings and provided care coordination services for these individuals by assigning them service teams and transitional housing to ease their re-entry into the appropriate community settings. This care coordination and access to resources greatly contributed to the success of the program, locally as well as statewide.*

These accomplishments contribute primarily to Goal I of MHSD's FY2009-2013 strategic plan: To identify, strengthen and link relevant resources that will foster community collaboration resulting in a dynamic and comprehensive system of service delivery for Citizens of Orleans, St. Bernard and Plaquemines parishes.

Expansion of Addiction Services

During FY2010-2011, MHSD signed contracts with providers for Suboxone services and an Intensive Outpatient Program (IOP) to provide treatment for addiction and pathological gambling. This allowed reinstatement of Suboxone services, which had been discontinued in the MHSD clinics. In addition, it allowed expansion of IOP services and fee for service billing.

A contract was also initiated with NO/AIDS Task Force to provide individual counseling to clients who are HIV positive and require addiction services. This service allows clients to have their medical, substance abuse, and/or co-occurring needs met at one site. This contract expands services for HIV positive clients, most of whom would not necessarily seek services at an MHSD clinic.

In addition to these three new contracts, the provision of psychiatric services was incorporated into all residential contracts and the provision of Methadone for opiate dependent pregnant women was added to two contracts. Fifty slots were also added to the Intensive Case Management Program (ICM) to assist those clients with substance dependence who need a more closely supervised and supportive relationship.

This accomplishment contributes to Goal IV of MHSD's FY2009-2013 strategic plan: To deliver a seamless, integrated, and comprehensive system of services that is responsive to consumer strengths, needs, interests, and choices. It also contributes to Goal IV: 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.

Enhanced Developmental Disability Services

In FY2010-2011, MHSD sponsored the Sibshops NOLA program. Sibshops NOLA was developed by Monica Roberts, a parent of a child with Autism, and has the following goals:

- Provide brothers and sisters of children with special needs an opportunity to meet other siblings in a relaxed, recreational setting*
- Provide siblings with an opportunity to learn more about the implications of their sibling's special needs*
- Provide parents and other professionals with opportunities to learn more about the concerns and opportunities frequently experienced by brothers and sisters of people with special needs*
- Provided parents an opportunity to access additional information about community related events and news pertaining to their special needs children*
- Provide siblings the opportunity to speak in an informal, relaxed environment with professionals about their unique concerns as it relates to having a sibling with special needs*

Brothers and sisters will have the longest –lasting relationship with a sibling who has a disability. One that can easily exceed 65 years. During their lives, they will experience most of the unique concerns and joys their parents do. However, until now, few siblings get a chance to talk about their issues with others who share the same concerns. Sibshops NOLA is significant to MHSD because it presents an opportunity for MHSD to service the needs of the entire family unit.

MHSD also collaborated with the Human Development Center at Louisiana State University Health Sciences Center to create Playing to Learn, Side by Side. This project was developed to promote the full inclusion of families of young children, ages three to five years, in community-based early childhood programs. This effort was accomplished in collaboration with two community-based programs, Prime Time Reading-Preschool and Music Together. Prime Time is a humanities based program that emphasizes the importance of families reading together. In the preschool program, families learn how to

interact and engage their child in emergent literacy and literacy activities, like pretend and constructive play and reading. Music Together is an early childhood music and movement program that uses a developmentally appropriate music curriculum designed to actively involve the whole family. MHSD enrolled 12 families in the 10-week Music Together sessions and four families in the 6-week Prime Time preschool session.

This project enabled teachers working in community-based early childhood programs to receive ongoing support before, during, and after each music or literacy. This project also gave families and children with and without disabilities multiple opportunities to engage in play, literacy and music activities, side by side and learn from one another. Additionally, it provided a natural venue for social networking and peer support. This project is in direct alignment with MHSD's mission of building the capacity of educators and other professionals to support families of children with disabilities, providing individualized support to families of young children with disabilities and increasing opportunities for families of children with disabilities to participate in educational and recreational programs in their communities.

Finally, MHSD implemented a mentoring program. The M.A.T.C.H. Program provides mentoring, advising, tutoring, and counseling for adolescents, ages 8-14, with mild to moderate intellectual disabilities. Over a 12-month period, the adolescent is matched with a same sex, college student who offers supportive services and skill development with the goal to reduce juvenile delinquency, violence, drug usage and abuse, truancy, and gang participation and to increase academic performance, school participation, graduation rates and social competency.

These initiatives all contribute to Goal III of MHSD's 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.

Formalization of Prevention Services

During FY 2010-2011, memoranda of agreement were developed between the prevention providers and the schools. The intent was to have a formalized agreement and to provide an incentive to schools to ensure students would attend sessions. This was the first time an attempt was made to formalize this process. It is still under review to determine its effectiveness. Additionally, two prevention providers will be serving St Bernard Parish. Prevention services have not been provided in that parish in the last two years. These accomplishments primarily contribute to Goal III of MHSD's 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.

Transition of Children's Services

MHSD Children Services transitioned from providing direct services in School Based Health Clinics to working in collaboration with OBH CABHS to address the substance abuse needs of their population. MHSD also developed a memorandum of understanding for a pilot program with DHH, OBH, OPJC and YSC to begin to deliver behavioral health services to children who are classified as delinquent in OPJC. Screening, assessment and treatment are provided to children who have mental health or substance abuse concerns and are referred directly by Juvenile Court judges. These changes have allowed MHSD to address the behavioral health needs of a larger group of children in the New Orleans area. This accomplishment primarily contributes to Goal III of MHSD's 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/Department 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 is steadily progressing toward achieving the goals outlined in the five-year strategic plan. MHSD has made significant progress in refining its services to better address the needs of the service population.

- ♦ **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 in strengthening and linking internal and external resources to support a seamless, integrated, and comprehensive system of services.

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

None

- ♦ **Has your department revised its strategic plan/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 strategic plan was recently revised (June 2009).

- ♦ **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 staff and management team ensure that the District’s goals are consistent with DHH’s goals relative to prevention, treatment, support, and advocacy for persons with serious and persistent mental illness, addictive disorders and/or developmental disabilities.

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, condition of the state fisc, 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?

MHSD continues to struggle with a lack of information to support planning and decision making.

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?

Implementation of an electronic health record (EHR)

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

No.

4. Are corrective actions underway?

a. If so:

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

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?

MHSD is in the process of implementing an EHR. It is anticipated that the EHR will be operational by the end of this calendar year.

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

The implementation of the EHR has required a significant allocation of financial, as well as staff, resources. The financial costs are being managed within the context of the existing budget.

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

A. Check all that apply. 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):

MHSD is audited on a biennial basis through the Office of the Legislative Auditor. MHSD is a learning organization. MHSD collects and reports performance data into LaPAS on a quarterly basis. Performance standards are reviewed and adjusted on an annual basis during the budget process. All MHSD contracts contain explicit performance expectations and reporting requirements.

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, phone & email.

Annual Management and Program Analysis Report

Fiscal Year 2010-2011

Department: Department of Health and Hospitals
09-305/306 Bureau of Health Services Financing

Department Head: Bruce D. Greenstein, Secretary

Undersecretary: Jerry Phillips

Agency Head: Don Gregory, Medicaid Director

The Bureau of Health Services Financing is comprised of Agency 09-305 Medical Vendor Administration and Agency 09-306 Medical Vendor Payments.

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

For each accomplishment, please discuss and explain:

Coordinated Care Networks (CCNs)

A. What was achieved?

DHH issued a Notice of Intent on February 20th, Requests for Proposals on April 11th and Final Rule on June 20th to implement Coordinated Care Networks (CCNs). This was the culmination of a three year planning process during which we did exhaustive research into the Medicaid managed care models in other states, obtained input from stakeholders through individual meetings with provider associations and providers, meetings with advocates, and nine forums throughout the state.

B. Why is this success significant?

Coordinated Care Networks (CCNs) are anticipated to fundamentally reform the delivery of Medicaid and CHIP health care services in Louisiana and improve quality and access while increasing budget predictability.

C. Who benefits and how?

The biggest benefit will be for the almost 900,000 Medicaid and LaCHIP enrollees who will be enrolled in a Coordinated Care Network. In addition to new time and distance requirements for access to medical care, CCNs are offering disease management programs, enhanced benefits, and incentives to members that are not provided under the existing fee-for-service Medicaid program. Enrollees will benefit from fewer hospitalizations, identifying and treating health conditions earlier, and improvements in health/outcomes which result in higher quality of life. Taxpayers benefit as the cost per member per month will be less than it would have been under fee-for-service Medicaid. Providers will benefit through the potential for higher rates than Medicaid fee-for-service and having someone responsible for overall care coordination.

D. How was the accomplishment achieved?

A new section in Medicaid was established to conduct research, design and develop the Coordinated Care Network (CCN) Program. DHH contracted with Mercer Government Services for actuarial support.

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.

Medicaid Behavioral Health Section**A. What was achieved?**

In FY10/11, the Medicaid Behavioral Health Section (MBHS) experienced achievements in both the programs managed by the section and in the collaborative efforts surrounding the Louisiana Behavioral Health Partnership (LaBHP).

B. Why is this significant?

Within the program the authorization process has been streamlined through the implementation of the Authorization Request Form (ARF), a simplified form that promotes efficiency for both the provider and Medicaid staff. Our Provider Performance Indicator tool (PPI) was implemented to improve timeliness, efficiency and to also impact a broader range of providers in reference to quality management.

C. Who benefits and how?

This benefits recipients, providers and Medicaid in that it is a tool used to ensure appropriate care is provided and billed properly, and that providers are educated on deficiencies.

D. How was the accomplishment achieved?

MBHS established quarterly meetings with Multi-Systemic Therapy providers and national partners to review program data, communicate and discuss program issues, and to implement a new authorization process to allow providers to deliver services above the established limits. This collaboration has improved communication between Medicaid, providers, and the national partners. Achievements were achieved through interagency collaboration, programming upgrades via our software maintenance contracts and through the overall efforts of the MBHS staff.

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

Program goals are discussed, areas for improvement are targeted, and strategies for improving recipient outcomes are established. MBHS expanded the number of recipients served with an overall reduction in the cost per recipient per month. This was accomplished by updating of the authorization process through the use of recipient profiles to match the right service to the right recipient.

Future initiatives were also targeted by MBHS, and considerable strides have been made with regard to LaBHP. MBHS has been instrumental in collaborative efforts with other agencies to develop the authority documents, service definitions, staff and agency qualifications and administrative Rules associated with the planned 3/1/12 implementation of this new Behavioral Health system. This achievement will also impact all parties involved due to the expansion of services to recipients, the increased capability of providers to provide needed services and the contracted management of the program to ensure efficiency, accessibility and integrity within the system.

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

These achievements show MBHS' aggressive efforts towards promoting effectiveness and efficiency in our programs and our dedication to improving quality of services as well as access in our community. In addition, they reflect Best Management Practices. Specifically, collaboration between state offices and agencies is a best practice, and this collaboration and our expanded use of technology are both streamlining recommendations.

Pediatric Day Health Care Program**A. What was achieved?**

Louisiana Medicaid is ready to implement the Pediatric Day Health Care Program;

however, we are awaiting CMS approval of the State Plan Amendment. There are two Pediatric Day Health Care centers ready to open in Baton Rouge.

B. Why is this success significant?

This program is significant because it provides access to an array of services that children with multiple significant conditions can access all in one place. The combination of these services is designed to improve the condition and quality of life of children who attend the facility.

C. Who benefits and how?

The families benefit as it would allow caregivers to work outside of the home and their child daily medical needs can be met in a safe environment. The state would achieve providing for the complex medical needs of the medically fragile population through one single point of contact by the collaborative efforts of a multi-vendor service providing physician services, therapy services, nursing services, educational services, and socialization skills.

D. How was the accomplishment achieved?

This accomplishment was achieved through a cooperative effort with the Department and agencies that are experienced in operating similar facilities in other states and various other stakeholders. The state licensing rule became a final rule published in the Louisiana Register in December 2009.

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

Claim Check

A. What was achieved?

‘ClaimCheck’ is a nationally recognized comprehensive procedure code prepayment auditing solution integrated into Medicaid’s claims processing system May 25, 2010, that assists Louisiana Medicaid with proper physician and outpatient reimbursement by automatically evaluating physician claims via sophisticated clinically-based “logic” before reimbursement. Drawing on the latest industry benchmarks and national clinical standards of care, ClaimCheck addresses Medicaid claims coding issues by identifying services billed incorrectly prior to being paid and educating providers as to the reason for denials. Additionally, this product decreases the amount of manual intervention required to

maintain national coding compliance. The systematically updated ClaimCheck product is integrated with the current claims processing system and increases payment accuracy and consistency based on national clinical guidelines and specifically incorporated Louisiana Medicaid policy where appropriate. In SFY 10/11, Louisiana Medicaid has taken further advantage of the capability of the product to allow additional customization of some payment and program policies which contributed to the overall prepayment savings. Savings are an expected result of implementing correct coding practices and policy through an effective prepayment editing tool such as ClaimCheck. The approximate savings seen in SFY 10/11 was \$14 million. The overall savings since implementation in May 2010 is estimated to be \$16.9 million.

The ClaimCheck claim auditing solution also has the capacity to separately edit claims using the National Correct Coding Initiative (NCCI) methodologies. This capacity has enabled Louisiana Medicaid to move towards compliance with the Healthcare Reform Act NCCI mandate for Medicaid services. Effective June 21, 2011, Louisiana Medicaid began editing the NCCI procedure to procedure methodologies for practitioner and outpatient hospital claims. Further compliance with the additional NCCI 'medically unlikely edit' (MUE) methodologies (units of service) is expected with the integration of the recently updated version of the ClaimCheck product into the claims processing system. These methodologies will also impact DME claims as well as practitioner and outpatient hospital services. The estimated savings realized in SFY 10/11 based on two weeks of procedure to procedure NCCI editing was \$319,000.

B. Why is this success significant?

With the ClaimCheck product integrated with the claims processing system, there is increased payment accuracy and consistency as well as bringing Louisiana Medicaid processing in line with national standards, prepayment savings of Medicaid dollars, and compliance with the NCCI mandate.

C. Who benefits and how?

Providers can anticipate accurate and consistent processing of claims and reimbursement. Use of this editing product automates some processes which then decreases the administrative burden for providers and their practices. Savings realized can be used by Medicaid to mitigate further reductions in provider reimbursement which may prevent loss of providers and ultimate issues with access to care for the Medicaid-eligible population.

D. How was the accomplishment achieved?

Louisiana Medicaid collaborated with the fiscal intermediary and its subcontractor, McKesson Corporation, to integrate McKesson's ClaimCheck editing tool into the Medicaid claims processing system, as well as assessed and incorporated appropriate

Louisiana Medicaid policies into the final product. The capacity of the product to separately edit appropriate claims based on NCCI methodologies was implemented in the same fashion as the clinically based edits already being used. This collaboration involved both the technical aspect of the implementation and integration and the assessment and modification of medical policy where indicated, to align with national clinical standards as well as the Healthcare Reform Act's NCCI mandate for Medicaid programs.

- 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.

Diabetes Self-Management Training (DSMT)

A. What was achieved?

Effective February 20, 2011, Louisiana Medicaid began providing coverage for Diabetes Self-Management Training (DSMT) services.

B. Why is this success significant?

This initiative is significant because it promotes health of Medicaid recipients by providing education on how to better manage diabetes and complications related to this disease. By providing better management of the diabetes and secondary complications we are improving recipient health outcomes.

C. Who benefits and how?

Medicaid recipients benefit from DSMT because it provides a more comprehensive education plan so that recipients may better manage their diabetes, potentially reducing or preventing future secondary complications.

D. How was the accomplishment achieved?

New state rules and policy were developed to provide guidance on what services are included in DSMT.

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? N/A

Louisiana Medicaid Professional Services

A. What was achieved?

Effective with data of service September 1, 2010, the Louisiana Medicaid Professional Services program began covering the weekly intramuscular injections of 17 Alpha-Hydroxyprogesterone Caproate (17P) for use in pregnant women with a history of pre-term delivery before 37 weeks gestation.

B. Why is this success significant?

This initiative is significant because we significantly increased our vaginal delivery rates (including attempts for a vaginal delivery after a cesarean delivery that results in a cesarean delivery). We at first anticipated a neutral budget impact, however, we have realized savings from 17P utilization and savings from decreased hospital stays for vaginal versus cesarean deliveries.

C. Who benefits and how?

Medicaid pregnant and children.

D. How was the accomplishment achieved?

Policy was developed to provide guidance on what services are included, how they are administered and the medical requirements. This change was communicated to providers on their weekly remittance advice.

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, there is a national push to attempt to reduce the number of cesarean deliveries and this makes Louisiana a part of that effort.**Immunization Pay-For-Performance (P4P) Initiative****A. What was achieved?**

Louisiana Medicaid implemented the immunization pay-for-performance (P4P) initiative in 2007, which includes supplemental payments to providers and was recognized by the Centers for Medicare and Medicaid Services (CMS) as a Medicaid Promising Practice. This initiative was implemented to promote up-to-date immunizations of Louisiana Medicaid eligible children and to increase the number of providers utilizing the Louisiana Immunization Network for Kids Statewide (LINKS) immunization registry. Eligible providers are required to be CommunityCARE PCPs utilizing the Vaccines for Children Program and the LINKS immunization registry. The 2008 National Immunization Survey (NIS) ranked Louisiana second in the nation, up from 28th in 2007, for 19-35 month old children up-to-date with all recommended immunizations (81.9%). The 2009 NIS now reports on a higher (tougher) benchmark

as the base for measurement and Louisiana again ranks as second best in the nation (53.7%) for children of this age being up to date with immunizations (US National rate reported at 44.3%). The most current NIS ranking published in June 2011 for this higher (tougher) benchmark again ranks the state of Louisiana as second best in the nation (59.7%) for children of this age being up-to-date with immunizations (US National rate reported at 47.1%).

B. Why is this success significant?

The P4P initiative encourages providers to ensure Medicaid children in their practice are up to date with recommended childhood vaccines ensuring optimal health outcomes for Louisiana children. In collaboration with the Office of Public Health (OPH) Immunization Program in 2007, 264 providers received payments; 62% of those providers saw an increase in the percentage of 24-month old recipients; and the average increase in immunization rates increased by 9.76%; In 2008, immunization rates among providers increased by 14.37%; 317 registered providers received payments; and, 57% of the 317 providers saw an increase in the percentage of 24-month old recipients. In 2009, immunization rates for participating providers that received P4P payments increased on average by 12.82%; payments were made to 332 providers; and 50.9% of these providers had an increase in 24 month old children up-to-date. In 2010, immunization rates for participating providers that received P4P payments increased by 13.75%; 355 registered providers received payments; and 50% of the 355 providers had an increase in the percentage of 24-month old recipients up-to-date with immunizations. Future plans are to restructure this initiative as necessary related to healthcare and Medicaid reform initiatives and hopefully expand the initiative to include an adolescent measure to incentivize providers in improving immunization rates of the adolescent population, dependent on funding availability. With the forthcoming implementation of the ending of the CommunityCARE program and the implementation of the Coordinated Care Networks (CCNs), this immunization P4P initiative will be ending.

C. Who benefits and how?

Louisiana Medicaid children benefit by having all recommended childhood immunizations provided to prevent the associated diseases. The State benefits by a reduction in health care costs for illnesses caused by these diseases as well as having immunization data entered in the LINKS registry.

D. How was the accomplishment achieved?

Collaboration between the Office of Public Health Immunization Program/LINKS with Louisiana Medicaid. Rulemaking and a Medicaid State Plan Amendment were necessary.

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

These accomplishments contribute toward the Strategic Plan in the following area:

Financial Considerations

Medical Homes

The “medical home” concept is a prerequisite to effective disease management and quality improvement and performance measurement in health care services.

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

A trend in national Medicaid and other healthcare programs encourage providers to perform in a specific manner.

Eligibility Division – Outstanding Children’s Coverage Retention

A. What was achieved?

Due to policy and procedure simplifications implemented by the Medicaid Eligibility Division, employees closed less than 1% of children’s cases at annual renewal for procedural reasons, such as failing to return a renewal form, again during SFY11.

B. Why is this success significant?

By keeping eligible children enrolled at renewal, stability of coverage is increased and administrative costs are reduced. Louisiana has been singled out by the director of the CMS Centers for Medicaid and State Operations as the state with the best retention rates for children and the national model. Retention of eligible children at renewal has emerged as a key to further reducing the number of uninsured children. For comparison purposes, some states report closures at renewal for procedural reasons at rates of 50% or more.

C. Who benefits and how?

The high retention rate benefits not only eligible children and their parents, but the administrative streamlining and paperless processes that have been put in place improve customer service, reduce agency administrative costs, and promote “green government.” Cases closed at renewal for procedural reasons often result in a new application. Processing a renewal is less resource-intensive than processing a new application, for agency and customer alike. The vast majority of renewals are completed by phone interview and/or electronic systems checks. Where information needed to make an eligibility decision can be found on electronic systems, the renewal is processed without customer contact.

Where information is needed beyond what can be found on electronic systems, it is most often obtained by telephone interview. Phone interviews allow for improved rates and speeds customer contact, better quality information, and more timely renewal processing. Today, approximately 5% of all renewals are completed from a paper form, meaning less printing, scanning and shredding for employees and less paper cost and waste for the agency. In addition, unbroken coverage reduces the amount of uncompensated care payments by the state for hospital services provided to children who are eligible for Medicaid or LaCHIP, but not enrolled.

D. How was the accomplishment achieved?

The Medicaid/LaCHIP Eligibility Division has streamlined the annual renewal process and implemented policies allowable under federal law, including using electronic Supplemental Nutrition Assistance Program (SNAP) eligibility data to determine Medicaid and LaCHIP eligibility, elimination of the requirement for a signed renewal form, telephone interviews, and administrative renewals for cases identified as having a low risk of ineligibility. Eligibility caseworkers are pro-active and make aggressive attempts to locate families when mail is returned by the United State Postal Service as “Undeliverable.” This has required fundamental change in the culture of eligibility. The number of closures for procedural reasons is monitored at the state, regional, local office, and individual staff member level and is a key factor in performance measurement.

In SFY11, the Eligibility Division continued to use electronic SNAP eligibility data to determine eligibility for children in Medicaid and LaCHIP, but its use was expanded. Now, this data is used to make coverage renewal decisions in 16% of cases that are up for renewal. This initiative is another way that the Eligibility Division has reduced the amount of paper used to process a renewal and the level of effort required of the affected children’s parents or caretakers and staff members.

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

Yes, it is a major factor in reducing the number of uninsured children.

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 achievement has generated great interest and we were asked to share information through presentations at national meetings in the past year hosted by the following groups: the Centers for Medicare and Medicaid Services Medicaid, Southern Health Partners, the National Academy for State Health Policy, and the East Coast Regional SNAP Directors. We believe that the lessons learned are transferrable to other departments and agencies within Louisiana.

Eligibility Division – LaCHIP Affordable Plan**A. What was achieved?**

Enrollment in the LaCHIP Affordable Plan has continued to grow, thereby reducing the number of uninsured children in Louisiana and increasing access to quality health care. There were 3,511 children enrolled in the LaCHIP Affordable Plan as of June 30, 2011, which represents an increase of 368 children during SFY11.

B. Why is this success significant?

Increased enrollment in the LaCHIP Affordable Plan has helped reduce the number of

uninsured children.

C. Who benefits and how?

Uninsured children in Louisiana families with household income between 201-250% of the federal poverty level benefit from this program. Eligible households are able to buy into the Office of Group Benefits PPO plan that is available to state employees. Families are charged a premium of \$50 per month per family, regardless of the number of the children in the family.

D. How was the accomplishment achieved?

Enrollment was increased due to outreach to the target population.

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

Yes, this increase in enrollment has resulted in a reduction in the number of children who do not have health coverage.

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

Other state agencies can use the LaCHIP Affordable Plan as a model for learning to leverage existing state resources and technology. By contracting with the Office of Group Benefits (OGB), DHH was able to gain the benefit of OGB's tremendous experience in administering health benefits, and by utilizing the auto-draft functionality in use by OGB, DHH has been able to keep more children enrolled in this plan.

Pharmacy Program Savings

A. What was achieved?

The Pharmacy program achieved over \$543 million in saving and decreased expenditures in other Medicaid programs.

B. Why is this success significant?

Coordination of Benefits (COB) -This process eliminates duplicate payment from multiple payors, allowing other payors to be billed first. Savings: >\$31 million/year

ProDUR-This process alerts pharmacists of duplications, early refills and pregnancy precautions. Savings: ~\$59 million/year

RetroDUR-Savings: ~\$1.2 million based on Federal Fiscal Year not including potential savings in other programs (hospitalization or physician visits)

PDL, State Supplemental Rebates and prescription PA program (operated by the ULM College of Pharmacy and Provider Synergies)-Savings: >\$42 million/year; Prescriber PDL compliance: >91%.

Generic utilization rate in the Medicaid pharmacy program: 74% (Above the national generic utilization rates for PBMs).

Pharmacy Provider Compliance Audits and Rebate Resolution-Improper billing by providers may result in a payment disallowance and/or administrative sanctions by Medicaid and/or the Board of Pharmacy. Pharmacy staff works closely with Medicaid Program Integrity and the Attorney General's staff on potential fraud cases. Audits have encouraged provider compliance resulting in \$1.1 million in audit recovery as well as savings of \$2.1 million in rebate resolution totaling \$3.2 million in total savings

Provider Fees – Louisiana Medicaid charges a \$0.10 per prescription provider fee on all prescriptions dispensed in the state. This fee is applied toward the state general fund match requirements for financing the cost of the Medicaid program. PBM collected \$8.2 million stemming from prescription drugs.

Lock-In–One year after recipients were Locked-In, physician and emergency visits, inpatient admissions and total pharmacy costs decreased, improving health outcomes for these recipients.

The Pharmacy Rebate program- Staffed by UNO personnel, this process generates quarterly rebate invoices, reconciles payments and resolves disputes with manufacturers and identifies and recovers mis-billed claims from providers (\$413,472,678 collected for FY2011). This program performs many other tasks when needed.

C. Who benefits and how?

The pharmacy program has implemented numerous efficiencies in securing cost savings while continuing to provide necessary medication to Medicaid recipients.

D. How was the accomplishment achieved?

The pharmacy program is highly monitored by State and Federal auditors as many facets of this program are statutorily required and must comply with the Board of Pharmacy rules and regulations.

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

While the Pharmacy program is one of the largest in services and expenditures, pharmacy services improve health status, reduce cost and promote a healthier population by providing drug therapies.

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

Waiver Assistance and Compliance Section – Money Follows the Person Demonstration Program (MFP)

A. What was achieved?

As of July 31, 2011, the Money Follows the Person Demonstration program (MFP) has helped 179 persons move out of institutions (nursing homes, hospitals, group homes) into the community. We have also established specific training components, mentioned below, to further strengthen our transition infrastructure.

B. Why is this success significant?

The MFP is a national initiative by Centers for Medicare & Medicaid Services (CMS) to assist states in rebalancing their long term care systems toward community living. These transitions are part of that nationwide effort to remove barriers to community living for people of all ages with disabilities or chronic illnesses. This is significant progress toward transition targets that are a CMS requirement of the MFP funding award. Additionally, the demonstration provides a means by which the state may address provisions in the Olmstead decision.

C. Who benefits and how?

Firstly, the MFP participant, whose quality of life is enriched by moving out of an institution and reconnecting with the community. CMS requires MFP states to assure the continued provision of home and community-based long-term care services (HCBS, or waivers) to these individuals as well as ensuring that procedures are in place to provide quality assurance and to provide for continuous quality improvement in such services.

D. How was the accomplishment achieved?

A cooperative effort between Medicaid, OAAS and OCDD, focused on coordination with existing programs and resources at the state and regional level, to build on the state's ongoing strategies to address housing and other barriers to transition. Medicaid, OCDD, and OAAS have worked very well together in a team format to implement the demonstration successfully across the disability populations. The collaboration stems from joint work in systems change initiatives throughout the past decade. Additionally, we are working to include the populations served by the Office of Behavioral Health.

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

The state effort to rebalance its long-term care system (LTC) benefits in three ways: (1) an enhanced FMAP for services delivered to individuals during their 365-day participation in the program, (2) savings realized from moving the individual out of institutionalized care, and (3) 100% federal funding for state MFP administrative operations.

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

Yes. Collaboration between state office and agencies is a best practice and a streamlining recommendation.

II. Is your department five-year Strategic Plan/Department 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?
 - Currently, the National Correct Coding Initiative (NCCI) revised implementation has taken longer than anticipated, but CMS has approved such delays as long as we are making a good faith effort at completion. Our strategies are effective to meet CMS requirements and anticipated returns on investment are absolutely being realized.
 - Diabetes Self-Management Training is a new initiative. Future financial and quality assessments are planned to ensure objectives are met in relation to cost savings for the state.
 - Implementation of the Louisiana Medicaid Professional Services program initiative that covers weekly intramuscular injections of 17 Alpha-Hydroxyprogesterone Caproate (17P) for use in pregnant women with a history of pre-term delivery before 37 weeks gestation is complete and returns are being realized in improved quality of care for Louisiana Medicaid pregnant women and their children.
 - The Medicaid/LaCHIP Eligibility Division's goal of reducing the percentage of children's cases that are closed at annual renewal due to paperwork reasons has been reached, as this percentage has been dramatically reduced since 2000. This goal has been achieved because of the multiple renewal simplification changes mentioned above. The Eligibility Division is now working to maintain this low percentage and further reduce it through new options made available to states by the 2009 CHIP Reauthorization Act.

- LaCHIP Affordable Plan - Through continued targeted outreach and awareness, enrollment in the LaCHIP Affordable Plan (LAP) has been steadily growing over the past fiscal year. 3,511 children were enrolled in LAP at the end of SFY11.
 - Medicaid Behavioral Health Section (MBHS) is making progress towards the goals set forth in the MVA strategic plan. We have increased access as witnessed by the increased number of recipients served, as well as decreased the cost per recipient by implementing strategies focused on utilization management. In addition, technological advances are proving to have an effect on the program and staff's efficiency and effectiveness.
- ♦ **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 attributes the success of the launch of Pediatric Day Health Care Program (PDHC) to the cooperation between the Department and stakeholders as well as providers who are experienced in providing these services. The progress in the PDHC program is expected accelerate as more providers are licensed and more families see the benefit of PDHC services for their children.
 - Significant progress has been attained in the following year on ClaimCheck and National Correct Coding Initiative (NCCI). Both internal and external factors contributed to ClaimCheck progress. The same results could have not been generated without specific department action. Progress is directly related to specific department, such as a FTE was reallocated and specifically assigned to this task. Progress is related to the efforts of Program Operations and MMIS, with Program Operations contribution is significant as the lead. This progress is

not the result of a one-time gain. Progress will continue steadily until task is complete. Savings however will be ongoing every year into the future – dramatically dropping with reduction of fee-for-service.

- Progress is complete with the implementation of the Diabetes Self-Management Training (DSMT) program. Measuring the effects must be done at a future date. Progress is complete with the implementation of the initiative and continues every day in the lives of Louisiana residents.
- The Medicaid/LaCHIP Eligibility Division has made significant progress towards reducing the percentage of children's cases that are closed at annual renewal due to paperwork reasons. This success can largely be attributed to policies implemented within the agency that simplified this process for the client by requiring less effort and paperwork. Since this measure is now below 1%, another significant decrease cannot be expected, but the Eligibility Division will continue its work to further reduce this percentage and maintain achieved gains.
- LaCHIP Affordable Plan - Success in achieving the increase in enrollment of children into LaCHIP Affordable Plan can be attributed to coordinated, targeted outreach initiatives. The increase of 368 children in SFY11 is not a one-time gain and the program is expected to grow to 3,661 children by the end of SFY12. According to the results of the 2009 Louisiana Health Insurance Survey, 4.6% of children in the LaCHIP Affordable Plan range of 201-250% of the federal poverty level are uninsured, so there is still work to be done. This same report also shows that the level of awareness surrounding LaCHIP has dramatically increased, proving that outreach initiatives have been effective.
- Waiver Assistance Compliance Section- The strength of the operational systems of our waiver services was cited by CMS in their March 2010 site visit as superior to those observed in other MFP states, giving them confidence that Louisiana would see positive outcomes and sustained transitions. The department's commitment to systems change and flexibility in addressing barriers has been recognized by CMS during our technical assistance calls and national meetings. Joint cooperation between Medicaid, OAAS, and OCDD is directly attributable to the success of the MFP to date. In addition to built-in performance indicators for each component above, facilitated discussion groups—inclusive of training components—will be open to providers working with transitions and supporting waiver recipients to provide a forum for discussing barriers and sharing best practices. Roundtables will be hosted in 8 areas of the state 2 times per year, and will be integrated with program office provider relations and quality management efforts for waiver programs.
- Medicaid Behavioral Health Section (MBHS) has made significant strides towards streamlining work processes and increasing productivity through technology by expanding the utilization of electronic tools for both the providers and the Medicaid administrative staff. MBHS has directed staff time

and fiscal resources to the development of electronic tools used to promote efficiency within our programs. Technological advances have been made to improve the ease with which our providers can operate their programs in a less costly and less time consuming manner. We have made advances in the way in which we can collect, trend and follow up on authorized services data, as well as complaints received. These streamlining efforts will increase efficiency for staff and providers, as well as promote cost savings through increased monitoring capabilities. In addition, we have made significant progress towards defining and setting the parameters of services within LaBHP, so that scheduled implementation may be successfully achieved through the collaboration of multiple agencies and dedication of current MBHS employees to this project. MBHS has been established as a leader in these efforts and have become a proponent of education of other state staff, inclusive of offering training on LaBHP outside of Medicaid.

- ◆ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state “None.” However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:
 1. To what do you attribute this lack of progress? For example:
 - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
 - Is the lack of progress due to budget or other constraint?
 - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
 - Other? Please specify.
 2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?
 - The lack of progress in the Pediatric Day Health Care Program is due to external delays. The Department is awaiting approval of the State Plan Amendment for this program from CMS. The Department has responded to CMS’s requests and is awaiting their decision.
 - ClaimCheck - It is anticipated that the medically unlikely edits component of this editing project will experience delays. A significant number of Medicaid’s units of service for procedure codes are not the same as those on the CMS medically unlikely line limit file. Extensive staff and system resources will be needed to align the two.
 - Despite significant preparation and advance notice by DHH regarding InterQual Phase Two, the State Hospitals did not have staffing need to comply with the

pre-cert process. The staffing issue seems to have been rectified. The lack of progress will take time to work through. DHH has made progress by working through process issues with the State Hospitals and being flexible with the pre-cert policy/procedures until they hardwire their processes. The State Hospitals have hired additional staff to assist with case management and utilization review.

- Program Operations is experiencing a significant lack of progress due to the difficulty time the State Hospitals have had adjusting to precertification requirements.
 - While the growth in the LaCHIP Affordable Plan has not been as high as initially projected, more children become enrolled each month and the program is expected to continue to grow. Efforts to educate enrollees about the auto-draft option for premium payment are underway and have been effective in reducing the number children lost due to failure to pay the monthly premium associated with this program.
 - Waiver Assistance Compliance Section - We have identified the following problem areas: access to housing, access to qualified state plan providers (primary care, specialists) and case managers. Additionally, we are unable to serve some of the MI population since the state does not currently offer a comprehensive community-based service package targeted for persons with mental illness.
- ♦ **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?

Waiver Assistance Compliance Section - Utilizing 100% administrative funding in support of the demonstration has had a significant impact on the problem issues identified. We have expedited supplemental administrative funding elements tied to pre-move funding, provider training, housing relocation assistance, and post-move direct services in order to support the 20% downsizing of OCDD public supports and services centers. Also implemented was training of Ombudsmen and the Support Coordination Agencies serving the regions, which increased the number of referrals.

- No. If not, why not?

- Pediatric Day Health Care Program (PDHC) is not specifically addressed in the strategic plan; however, it does align with the overall goal of expanding community based services in order to

avoid institutionalization.

- Eligibility Division - Current policies in place have been extremely successful towards achieving this goal. While the Eligibility Division will continue to explore new ways to further reduce this percentage, the goal of the strategic plan to simplify the renewal process has not changed.
 - LaCHIP Affordable Plan - Current strategies of increasing enrollment through outreach and awareness have not changed as they relate to this goal of increasing the number of children enrolled in the LaCHIP Affordable 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?**
 - ClaimCheck - departmental notification of needed review is sent to appropriate staff.
 - Eligibility Division - All levels of the Department of Health and Hospitals are devoted to streamlining and providing quality health insurance to uninsured children. The low percentage of children lost at renewal is directly tied to the number of uninsured children throughout the state. By achieving this goal, the Eligibility Division also contributes to the department's "green government" initiatives.
 - Increasing the number of children enrolled in the LaCHIP Affordable Plan contributes to providing quality health insurance to uninsured children, which is a goal at all levels of the Department of Health and Hospitals. To further the department's streamlining initiative, it was determined to be more efficient to have this program run by a third-party administrator, the Office of Group Benefits, instead of spending government resources to set up a new system. The Eligibility Division is also working towards the department's "green government" initiative by encouraging online applications and offering an auto-draft option for premium payments.
 - Waiver Assistance Compliance Section - Regular monthly conference calls with our CMS project office staff, technical assistance contractors, and regional CMS support staff are conducted to report on progress and barriers identified. Program office and Medicaid staff regularly discuss MFP progress internally. Monthly meetings of executive office staff are also conducted to review progress, ensure effective utilization of resources and funding to meet program expectations, and for strategic planning.

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, condition of the state fisc, 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

Program Operations

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

Limited human resources and an increase in state initiatives have caused a delay in the implementation of new initiatives.

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

Although this issue has the potential to impact the strategic plan, the Department, although delayed, has implemented this major initiative and it will help fulfill the Department’s mission and goals.

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

Program Operations

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

- Both internal and external customers were affected by the lack of human resources and the increase in responsibility to successfully manage these programs and initiatives.
- Even though ClaimCheck has been implemented, it is not being utilized to its full potential and thus, its full savings.
- Medicaid recipients are affected by the lack of staff resources.

5. How long has the problem or issue existed?

The issue has been in existence for approximately 3-4 years and program progress has suffered.

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

The lack of human resources has limited our ability to hire qualified staff to institute new programs in a timely fashion. Although new programs aimed at providing better services to the public and cutting cost to the state are finally becoming a reality, they have been delayed.

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

Implementation of new programs will be significantly delayed and the quality of programs will suffer and savings potential is diminished.

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

Program Operations

1. **What is the nature of the problem or issue?** The State Hospitals complain about the work intensity involved with the Pre-cert process. They continue to point out that any shortfall due to the Pre-cert process results in a State General Fund responsibility.
2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)** This issue has a potential impact to the strategic plan, but the Department has initiated this major initiative which helps fulfill the Department's mission and goals.
3. **What organizational unit in the department is experiencing the problem or issue?** Program Operations/MVA.
4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)** The State Acute Inpatient Hospitals are the external stakeholders affected by the Pre-cert process.
5. **How long has the problem or issue existed?** Since the August 30th implementation date.
6. **What are the causes of the problem or issue? How do you know?** The causes of the problem is due to the State Hospitals lack of efficient processes related to admissions, case management, utilization management and discharge planning. The Department also underestimated the impact that the retrospective pre-cert policy would have on the State Hospitals. This policy has been amended.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
Since denied days are not included in the DSH calculation, these days potentially become a State General Fund responsibility.

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

Eligibility Division: Outstanding Children's Coverage Retention and LaCHIP Affordable Plan

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

The primary challenge that faced the Eligibility Division in SFY11 was a reduction in the workforce without a corresponding reduction in workload. From July of 2009 to June of

2011, there was an increase in applications of 13.9% and an increase in average caseload per Medicaid analyst of 24.8%, while the number of Medicaid analysts declined by 11.6%. The exorbitant workload has contributed to an increase in turnover within the Eligibility Division which further compounds the problem when it takes up to 12 weeks to fill vacant positions..

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

The Eligibility Division continues to strive to gain efficiencies and streamline processes in order to maintain the increasing workload with a reduced workforce.

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

This staff shortage is affecting primarily the Field Operations Section within the Eligibility Division.

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

The staff shortage affects applicants and enrollees because of the increased amount of time it takes for applications and coverage renewals to be processed. It also has an impact on enrollment due to reduced capacity to conduct extensive outreach efforts to enroll eligible children. The agency continues to use partnerships with community organizations to help reach out to the citizens of Louisiana and encourage health care coverage for eligible children.

5. How long has the problem or issue existed?

Staff shortage began in 2009.

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

State budgetary constraints.

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

As indicated above, the staff shortages affect applicants and enrollees because of the increased amount of time it takes for applications and coverage renewals to be processed. It affects the number of uninsured children in Louisiana when Eligibility staff is unable to conduct outreach to educate and enroll eligible children. It also impacts morale within the Eligibility Division and results in high staff turnover.

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
Waiver Assistance Compliance Section

1. **What is the nature of the problem or issue?** Primary issues for MFP are as follows: Barriers to reducing institutional utilization and increasing waiver capacity remain, including access to housing, access to qualified state plan providers (primary care, specialists) and case managers.
2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)** These issues impact our ability to transition individuals into the community and meet the transition benchmarks agreed upon with CMS.
3. **What organizational unit in the department is experiencing the problem or issue?** Medicaid, OAAS and OCDD.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)** Individuals assessed for MFP enrollment may be affected by these issues since service coordination, housing, etc., are key factors affecting the date of transition into the community.
5. **How long has the problem or issue existed?** These problems are not new but have been highlighted since the MFP demonstration has gotten underway.
6. **What are the causes of the problem or issue? How do you know?** While some issues are systemic in nature, problems with affordable and available housing are larger issues beyond the MFP, but we continue to partner with housing providers to strengthen collaboration.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?** As stated above, some of these issues affect transitions, which impact our ability to meet the transition benchmarks. CMS plan to evaluate progress in the demonstration nation-wide in 2012 to ensure adequate funding allocations.

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?** Using the 100% administrative funding to support our program to address these issues has helped. Approved in August and authorized through 2014, the \$14.4 million package is designed to address specific challenges relative to developing housing, training for families, direct service workers, and transition teams—all identified as areas in need of support. This funding requires no state match. Medicaid, OAAS, and OCDD are moving forward to implement the package.
3. **Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?** Unknown.
4. **Are corrective actions underway?**
 - a. If so:
 - **What is the expected time frame for corrective actions to be**

implemented and improvements to occur? Although no specific time-frame has been set by CMS, they monitor our progress through monthly conference calls with the CMS Project Officer, wherein the state MFP team report on progress. Medicaid and Program offices meet regularly internally to assess progress as well.

- **How much progress has been made and how much additional progress is needed?** The current economic crisis affecting state agencies has had some impact on the hiring component of the funding package, but progress is being made by the program offices toward realizing the other initiatives.

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.** All MFP administrative operations are 100% federally-funded, which includes the elements that were added to operations in order to address corrective actions.

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
Medicaid Behavioral Health Section (MBHS)

1. **What is the nature of the problem or issue?**
 MBHS is being reorganized within Medicaid. The need for MBHS will no longer be required after March 1, 2012.
2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)**
 No, this action is a part of the Department's strategic plan.
3. **What organizational unit in the department is experiencing the problem or issue?**
 Medicaid Behavioral Health Section (MBHS)
4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
 The whole department.
5. **How long has the problem or issue existed?**
 The Department began planning for this initiative approximately two years ago.
6. **What are the causes of the problem or issue? How do you know?**
 Transition to all Medicaid reimbursement behavioral health services being managed by a state management organization.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
 There is a concern about continued effective and efficient operations (enrollment, authorization, training, planning, monitoring) until the time that LaBHP is implemented due to this reorganization in staff, combined with the growth of our current program. The timeline for certifying new providers has been extended and the frequency of training has been reduced due to the reduction in staff.

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):

Learning Management System

In May 2011, the Eligibility Division employed usage of a Learning Management System (LMS) to assist with the delivery of necessary and required staff training. Through utilization of the LMS, the Eligibility Division can assign training content to staff and track completion. The system also allows for voluntary classes to be placed on a public schedule, where staff can sign up to refresh skills learned at earlier points in their careers. One of the key benefits of the LMS is the ability of a user to review training material in the future as needed and at their own pace. The Eligibility Division's current plan is to continue usage of the LMS to deliver messages of high importance to the field, and monitor staff completion.

Medicaid Eligibility Quality Control

Louisiana is a pilot state for its Medicaid Eligibility Quality Control (MEQC) function. This means the Eligibility Division selects the specific eligibility criteria or program on which the MEQC reviewers will focus their efforts. Selection of the pilot area is a collaborative decision of management and MEQC staff. The pilot is based upon areas in which we suspect eligibility staff may be having problems and is also used to gauge how well a new program, procedure, or eligibility requirement is being understood and executed. Each month MEQC staff review cases and report findings to eligibility staff and management. When a sufficient number of cases have been reviewed and error trends identified, MEQC reviewers and management meet to discuss corrective actions that will be implemented. Corrective actions range from training of eligibility staff to changing or modifying policy or procedure, to adding or clarifying recipient eligibility notices. Each year, findings are summarized and a corrective action plan is provided to the Centers for Medicare and Medicaid Services. The MEQC function is audited by the state legislative auditor every year in order to determine cases are being reviewed timely and correctly.

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

MVA Program Operations

- 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

State Hospitals Alternate Cost Savings Report

2. Date completed

Monthly report with 90 day lag

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

To evaluate the effectiveness of Phase 2

4. Methodology used for analysis or evaluation

Month to month comparison of admissions, recipients, LOS, cost/case and expenditures

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

None, the reporting was part of the SOW/Contract Amendment

6. Major Findings and Conclusions

- Decrease in LOS by 0.74 days over 9 months (Sept 2010 – May 2011) for a total decrease in expenditures paid for acute inpatient hospitalization of \$53,411,655 (this excludes the 40% rate reduction and does not include any payments made for authorizations approved via the appeal process. It also does not account for the decrease in patient volume experienced by the State Hospitals).
- The \$53,411,655 savings is based on paid claims. If the State Hospitals have not submitted requests for recipients who obtained Medicaid retrospective to the hospitalization then those expenditures are not captured.
- Over the last 9 months there is an average of 396 less admissions per month base on paid claims data when compared month to month. This accounts for 3,564 less hospital days. With an average LOS of 4.8 days and an average payment/day of \$1,380.27 this results in \$23,612,554 less expenditures over a 9 month period due to decreased admissions.
- Actual Savings directly related to InterQual Phase 2 for first 9 months of implementation = \$29,799,101

7. Major Recommendations

I recommend continuing with the program. The State Hospitals have made significant progress in complying with the precertification requirements. This requirement has done a great deal to prepare the State Hospitals for the CCN implementation.

8. Action taken in response to the report or evaluation

None

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

Electronic File

10. Contact person for more information, including

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Title: Medicaid Program Manager 1-B

Agency & Program: DHH/OMF/BHSF/MVA/Program Operations

Telephone: (225)342-5691

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Annual Management and Program Analysis Report

Fiscal Year 2010-2011

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

Department Head: Bruce D. Greenstein, Secretary

Undersecretary: Jerry Phillips

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

Louisiana Earns Perfect Score in Public Health/Emergency Preparedness

State is Tops in Readiness for Health Emergencies

For the second consecutive year, Louisiana scored a perfect 100 on the Centers for Disease Control and Prevention's (CDC) evaluation of the state's public health emergency preparedness and response capabilities. Louisiana and seven other states scored 100 two years in a row. Louisiana's public health laboratories also received exemplary marks. The CDC's "[Public Health Preparedness: 2011 State-by-State Update on Laboratory Capabilities and Response Readiness Planning](#)" report evaluates the state over a three-year period, from 2007-2010.

In the report, all 50 states and 4 localities directly funded by the Public Health Emergency Preparedness Cooperative Agreement were graded on their ability to effectively receive and distribute the CDC's Strategic National Stockpile (SNS), a cache of drugs and medical supplies to protect the American public if there is a public health emergency severe enough to cause local supplies to run out. The CDC and state public health departments conduct annual technical assistance reviews (TAR) to assess emergency preparedness plans for receiving, staging, storing, distributing and dispensing the SNS to ensure continued readiness for all disasters. The state must attain a score of 79 or higher in order to continue to receive preparedness funding from the federal government.

Division of Health Economics (DHE)***Medicaid Forecasting & Statistical Analysis/Research***

Through excellence in its economic, statistical analyses and research, the Division of Health Economics (DHE) maintained a high accuracy on the Monthly Medicaid Expenditures Forecast Report, which is mandated by the Louisiana Legislature (HB1), and provided appropriate and innovative recommendations/ideas through analytical support that helped the department's executives make proper data driven policies in order to maintain the appropriated budget. A State Fiscal Year (SFY) Medicaid Expenditures Forecast Report provides advanced information, enabling the executives/legislatures to see the direction the budget is heading throughout the SFY so they can make appropriate budget adjustments/plans without major surprises. DHE also provided innovative and appropriate ideas that helped the Department in making data supported/driven decisions that would impact the programs future and manage the budget within the appropriated levels. The forecast benefits the State of Louisiana as a whole, Executives of the department, Division of Administration, Legislature, Governor's office, provider community (Hospitals, Nursing Homes, Physicians, etc), recipients and all other stakeholders who are directly or indirectly impacted by the Medicaid program, policies, etc. These accomplishments (high accuracy rate and other) are achieved due to highly efficient health economists, supporting staff and cooperation from Medicaid and other program staff. DHE employs appropriate analytical statistical/forecast models developed in-house, suitable specifically for the Louisiana Medicaid Program. Through the forecasting process DHE is able to provide the Department's executives and senior managers with accurate and timely analyses during policy deliberations and decision making processes. With subject to appropriate resources DHE could apply these models/approaches with suitable modifications to fit each department's needs/requirements.

Division of Health Economics (DHE)***Five Year Federal Medical Assistance Percentages (FMAP) Projections***

Through excellence and expertise in its economic analysis, the Division of Health Economics (DHE) developed five year projections of the Federal Medical Assistance Percentages (FMAP) based on Louisiana state and national (US) Per Capita Personal Income data (PCPI) from the Bureau of Economic Analysis. DHE's projected FMAP rates are within 99.9% of official CMS rates each year. Since these estimates are not available from any other source, the five year FMAP projections are very useful in that they allow the Division of Administration (DOA) to make their five year long budget projections based off of DHE's estimations. Also, the projections are useful for DHH executives and state officials in the Medicaid budget development process (occurs September/October) since actual CMS's official published one-year FMAP is not released until November of each year. These projections benefit the executives of the department, sister agencies, associations, Division of Administration, Legislature, and the Governor's office. The DHE is able to achieve these accomplishments (high accuracy rate and other) due to highly efficient health economists using appropriate data (PCPI) and statistical models. Through these

estimations DHE is able to provide the Department's executives, DOA & Governor's office with accurate and timely analyses for the budgeting process. With subject to appropriate resources and data DHE could make projections for other needed elements.

Governor's Games Continues to Draw Record Number of Participants

Promoting Physical Activity and Wellness Throughout the State of Louisiana

The Governor's Council on Physical Fitness and Sports (GCPFS) added new physical activities and sporting events totaling more than 60 sporting events across the state, and introduced a new program called S.O.M.E. (So Others May Exercise). Louisiana Governor's Games are the state's premier amateur sporting event, where sports enthusiasts from around the state participate in a variety of athletic competitions. Louisiana Governor's Games provide an opportunity for competition and fitness for all ages, skill levels and economic demographics. Held in cities across the state, events include basketball, volleyball, gymnastics, boxing, tennis, track and field, girls' softball, youth baseball and much more.

This is significant because kids in poor, underserved communities now have opportunities to participate in high-profile Olympic-style sporting events at little to no cost. Adults and children in low-income communities now have programs and events that will help them be physically more active. Local establishments received an economic boost from participants traveling to these areas to take part in various sporting competitions. Also, by having such high-profile events, these activities had a positive impact on reducing crime and dropout rates among youth.

Through a collaborative effort between the GCPFS and community partners such as park and recreation departments, local sports foundations, local school boards, city and parish government, other state agencies such as Louisiana Tobacco Control Program, LaChip, local and national sponsorships and partnership grants from the national level, i.e. CDC, HHS.

A general assessment of overall timeliness and progress is due to hard-working Council Members throughout the state developing new partnerships and identifying new funding sources. The best return on GCPFS' investment is seen through the number of participants:

- | | |
|---|--|
| ▪ Elementary Fitness Testing and Competition: | 225,157 (up from 217,822) |
| ▪ Governor's Games
still up from 18,600 in 2009) | 27,750 (down from 27,150 in 2010, but
still up from 18,600 in 2009) |
| ▪ Weightlifting Development Center | 589 (up from 345 in 2010) |
| ▪ Project S.O.M.E. (So Others May Exercise) | 350 |
| ▪ Total Number of Participants | 247,846 |

These accomplishments constitute a Best Management Practice and should be shared with other branch departments and agencies as an example how GCPFS used its partnering and networking capabilities to accomplish its goals. This initiative will also help contribute to the success of the department's strategic plan.

Performance Planning and Review (PPR) Focus Date

DHH Transitions to Annual Focus Date

As part of DHH Secretary Bruce Greenstein's initiative to focus on positive, smarter ways for employees to do their jobs better and more effectively serve our state's people, DHH implemented a department wide PPR Focus date of July 1 for all employees.

Performance Planning and Reviews for all DHH employees are scheduled to be conducted annually during a focused timeframe with a rating period of July 1 thru June 30. Utilizing a department wide PPR focus date of July 1 will allow for the fiscal year goals of the agency and section to be linked to each employee's PPR. Along with the focus date, DHH will implement a Mid-Year Review to enhance the two-way communication and feedback between supervisors and their employees.

Implementation of the Focus Date began July 1, 2010 and will continue every year thereafter on July 1.

II. Is your department five-year Strategic Plan/Department 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 Department's strategic planning efforts have improved over the past few years. The Office of the Secretary has 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. Considerable progress has been made in hiring, assigning, and training personnel. Our new 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 that agency

performance information will be credible. For example, most performance indicators in the plan include baseline or trend data and projections against which to assess performance.

In the next few weeks, the Department of Health and Hospitals will release the agency's 2012 business plan, "Leading Transformation: Our FY 2012 Priorities for a Healthier Louisiana." The plan, developed over the course of several months, outlines the Department's priorities for fiscal year 2012 and sets out detailed goals and deliverables to meet each of those goals.

- ◆ **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.

Governor's Council on Physical Fitness and Sports

Success is the result of internal and external factors. The Governor's Council on Physical Fitness and Sports (GCPF) assist communities with technical assistance to help with implementing physical activity programs, where communities must take ownership of these programs by providing enough volunteers, in-kind donations and venues to host events. But none of these programs would take place if GCPFS did not identify funding sources and apply for them through grant awards and foundations.

GCPFS reallocated funds to areas with the greatest need, where no physical activities and sports programs existed, and then shifted remaining funds to supplement current programs.

GCPFS upcoming policies will make sure new sporting events and activities get the maximum amount of exposure as possible through local and statewide media outlets. An upgraded website with health and wellness tips, along with information and locations on all 55 sporting events throughout the state and information on events and programs in other states has taken GCPFS to a higher level.

All progress is related to collaboration between several state and local agencies. GCPFS gauge its success through the increase of participants each year, number of hits on its websites and a significant increase in requests from communities needing our services.

Progress of the Governor's Council on Physical Fitness and Sports is never a onetime gain. It has been consistent and performing at high levels for 18 years and is still growing. Each of its programs has staying power and is well-respected around the country.

- ◆ **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.

No section/activity within the Office of the Secretary reports experiencing any significant 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?

The Department completed its 5-Year Strategic Plan in July 2010. In the new plan, all agencies have incorporated a section titled "Executive Summary" and have implemented new outcome performance indicators. In the Executive Summary, this addition to the strategic plan is intended to highlight the vision of the agency's assistant secretary. It contains a brief overview and information on where the agency is headed in the next five years, major goals, recent accomplishments or important themes they hope to accomplish within this time frame. The new plan also incorporates charts and graphs of performance indicators. Our 5-year strategic plan also provides a general picture of intended performance across the agency, a general discussion of strategies and resources the agency will use to achieve its goals.

On September 22, 2011, the department's secretary, Bruce Greenstein, unveiled the agency's 2012 Business Plan, "Leading Transformation: Our FY 2012 Priorities for a Healthier Louisiana." The plan, developed over the course of several months, outlines the department's priorities for fiscal year 2012 and set detailed goals and deliverables to meet each of those goals.

The business plan has three primary components. The "Health Care in Louisiana Today" section examines some of the challenges facing Louisiana on the health care front and much of the work already under way to address those challenges. The second section is the "Business Review," which is a first-of-its-kind summary of the extensive business and reach of DHH, which has a budget of \$8.2 billion and nearly 9,000 employees. The final and largest portion outlines 20 "Transformational Priorities." Each priority is grouped into separate themes:

- Building Foundational Change for Better Health Outcomes
- Promoting Independence through Community-Based Care
- Managing Smarter for Better Performance

◆ **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**

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.

Each agency within the department is required to develop and maintain a strategic plan, as mandated by DOA guidelines. Each agency is also required to complete and submit quarterly progress reports in the Louisiana Performance Accountability System (LaPAS). These quarterly progress reports are reviewed by DHH Planning & Budget staff and results are shared and discussed with management staff during weekly meetings, as applicable.

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

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

No significant operational problems or issues to report.

A. Problem/Issue Description

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

resolve the problem or issue?

B. Corrective Actions

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

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

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

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

No. If not, please explain.

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

Please discuss the following:

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

requests?

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

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

Internal audit

The Office of the Secretary maintains ongoing monitoring of programmatic and administrative functions. This ensures that transactions are executed according to management's authority and recorded properly; allows for the preparation of financial statements; that operating efficiency is promoted; and that compliance is maintained with prescribed federal and state laws and regulations and management policies.

External audits

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.

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

The Division of Program Support and Evaluation within the Office of the Secretary conducts quality assurance and program evaluations for the department.

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

Annual Management and Program Analysis Report

Fiscal Year 2010-2011

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

Department Head: Bruce D. Greenstein, Secretary

Agency Head: Lisa Schilling, Executive Director

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

For each accomplishment, please discuss and explain:

BP Disaster Funding

A. What was achieved?

The South Central Louisiana Human Services Authority (SCLHSA) received \$2,182,663.00 for behavioral health services as part of the state's commitment from BP after the gulf oil spill. Of these funds, approximately \$1,463,663.00 was designated for for LA Spirit Outreach Teams. The goal of the South Central Louisiana Human Services Authority (SCLHSA)/LA Spirit Outreach Program was to provide crisis counseling services to persons and communities impacted by the Mississippi Canyon 252 oil rig explosion through engagement, brief intervention, counseling and referral consistent with the evidence based Department of Health and Hospitals (DHH)-Office of Behavioral Health (OBH) Louisiana Spirit Program model. Teams were identified as SCLHSA/Louisiana Spirit teams in order to assure continuity in services and branding of services across the parishes and provider organizations. The Louisiana Spirit team logo and program model is a recognized disaster behavioral health-crisis counseling model, and is now recognized and understood as an effective program by the public and other caregiver agencies.

Additionally, \$719,000.00 of the BP funding was mandated for Clinical Treatment and Therapy. SCLHSA was able to provide additional clinical services at its clinic sites by hiring licensed mental health clinicians and nurse practitioners to follow clients referred to the clinics by our LA Spirit Teams. The clinical staff hired followed all SCLHSA policies and procedures and input performance and treatment data into SCLHSA

information/treatment tracking systems as required. The clinical staff provided appropriate treatment and counseling services for individuals needing services longer than that the regular three to five brief interactions provided by the crisis teams. The clinical treatment occurred over a period of several months as appropriate. SCLHSA designed the clinical treatment protocol and treatment record used in this program. Persons requiring longer term treatment were referred to the appropriate South Central Louisiana Human Services Authority (SCLHSA) clinic and/or other community program. Clinical staff worked in a performance improvement capacity and in program enhancement and development as assigned. Part of the clinical funding also was used to provide medication for those directly impacted by the oil spill crisis. Clients seen in the South Central Louisiana Human Services Authority (SCLHSA) clinic setting were evaluated for need and reviewed for eligibility for medication assistance per South Central Louisiana Human Services Authority (SCLHSA) formulary and patient medication assistance guidelines.

A new component added to the LA Spirit Model through South Central Louisiana Human Services Authority (SCLHSA) is the “Workforce Liaison” concept to assist the teams to provide “rapid reattachment” to employment that will be needed for some of the people impacted by this disaster. The Workforce Liaison works directly with local, state and federal workforce programs that are developed for the impacted communities. The workforce liaison recruits and assists disaster victims to access the training and employment programs as needed. The liaison also works with local employers to create pathways for new employment for the disaster victims and to promote the skills and talents of the people in the impacted communities. The workforce liaison assists people to return to their previous livelihoods as appropriate and will help to coordinate small business development and assistance programs. This assistance may include skill based trainings in work readiness and/or small business development. In some instances, the workforce liaison will assist people to develop new small businesses to supplement and/or replace their original small businesses.

B. Why is this success significant?

SCLHSA utilized the services of the ASO model operated by the contractor, Options for Independence. The ASO employment model promotes the rapid attachment to temporary and/or permanent hire for persons with significant barriers to employment, in this case, people whose livelihoods were disrupted due to a disaster. The services were used to coordinate with the various local, state and federal workforce development organizations and to provide supervision and support for the workforce liaison. The workforce liaison coordinated and intersected with the crisis counseling team members as needed, but operated an independent schedule to accomplish the activities set for by South Central Louisiana Human Services Authority (SCLHSA).

In addition to assisting the general population impacted by this disaster with rapid reattachment to employment, the workforce liaison functioned as a job placement specialist for persons identified as having a serious mental illness and/or a substance abuse disorder. For these persons referred by South Central Louisiana Human Services

Authority (SCLHSA) clinics, the workforce liaison secured temporary or permanent employment and served as a job coach as needed to maintain employment. The ASO model allowed for participants to work directly for the ASO organization with their wages and benefits paid by the employers. This “temp feature” allowed employers to get to know the person with a disability and overcome many of the fears of employers and stigmas attached to people with disabilities which can act as barriers to employment. The goal of the temporary employment was to facilitate supportive relationships between employers and employees and create opportunities for direct hire and career paths. The ASO organization provided additional job coaching services as needed to support the persons working temporary and direct hire jobs within the ASO model. This “temp to permanent” service offered South Central Louisiana Human Services Authority (SCLHSA) clinicians an option for clients who are not able to utilize the traditional supported employment services offered by Louisiana Rehabilitation Services (LRS). Individuals referred who need longer term supportive employment services and are not in need of “rapid reattachment” to employment were referred to LRS and other employment organizations.

C. Who benefits and how?

All of the residents who were directly or indirectly impacted by the Mississippi Canyon 252 Oil Spill event benefited from the behavioral health services provided by the funding from BP through the Department of Health and Hospitals. The Mississippi Canyon 252 oil rig explosion was a catastrophic event that affected our entire region with extensive economic, environmental and human cost. To this date, many individuals living and relying on the gulf for their livelihood have not had restitution made for their losses. Individuals earning their living on the water and their family members along with the communities they support are still suffering from depression and anxiety concerning their future. The funding from BP enabled the South Central Louisiana Human Services Authority (SCLHSA) to provide much needed services in the community utilizing an evidenced based program with proven results.

D. How was the accomplishment achieved?

The Department of Health and Hospitals (DHH) was selected as the recipient of funding from BP to assist individuals in the affected areas of the oil spill with behavioral health services. DHH provided funding to four of its local governing entities to ensure that services were provided in the parishes affected by the gulf oil spill. As one of those recipients, the South Central Louisiana Human Services Authority (SCLHSA) partnered with the Jefferson Parishes Human Services Authority (JPHSA) to hire a mutual contractor to provide behavioral health services in the communities for the two local governing entities. This choice was made with the goal of providing mirroring services to the affected parishes with performance improvement and monitoring processes that were reflective of the services provided by the department’s Louisiana Spirit Model.

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

The services provided through the BP Oil Spill funding support the South Central Louisiana Human Services Authority (SCLHSA) Strategic Plan short term goals to include; 1.) Create staffing patterns that are reflective of population shifts and service needs, 2.) Integrate service provision among behavioral health clinics and 3.) Integrate Community Support teams to outlying communities. The LA Spirit Model used as the basis for the South Central Louisiana Human Services Authority (SCLHSA) behavioral health services provided mechanisms for ongoing performance and quality improvement; facilitated concurrent documentation of service delivery; streamlined operations; enhanced productivity; and enabled ongoing daily monitoring for performance improvement, medical necessity, and treatment/service outcomes. Therefore, it may be concluded that the utilization of the LA Spirit Model behavioral health outreach services in the affected communities had a positive impact on achieving the goals set forth in the South Central Louisiana Human Services Authority (SCLHSA) 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?

South Central Louisiana Human Services Authority (SCLHSA) shared the results of its outreach activities with the Department of Health and Hospitals (DHH) and the parishes affected by the gulf oil spill. Performance improvement data along with statistics of individuals seen, referrals made and number/type of services were shared with the department as well as the parish officials in Terrebonne, Lafourche and St. Mary. LA Spirit Team members and South Central Louisiana Human Services Authority (SCLHSA) staff made presentations of findings to each parish on a quarterly basis and DHH on a monthly basis. South Central Louisiana Human Services Authority (SCLHSA) also provided a monthly newsletter that documented services provided in the community, stories of hope and despair from clients impacted by the oil spill and a calendar of events for all the parishes participating in the project.

Performance & Process Improvement

A. What was achieved?

South Central Louisiana Human Services Authority (SCLHSA) developed and implemented a formal Performance Improvement Plan and process to ensure a systematic, coordinated and continuous approach to improving individual and program performance by focusing on all processes and mechanisms conducted in daily operations.

B. Why is this success significant?

Performance Improvement is integrated into the culture of the South Central Louisiana Human Services Authority (SCLHSA) by emphasizing the value of quality, positive outcomes, effective use of resources, efficient service delivery, and the achievement of strategic goals. Employee involvement and participation in Performance Improvement activities is the key to the overall success of the Authority.

C. Who benefits and how?

The individuals and families served by South Central Louisiana Human Services Authority (SCLHSA) and the communities in our catchment area benefit from the Authority's commitment to Performance and Quality Improvement. Consistent and effective use of Performance Improvement models and practices assure the organization is productive, efficient and performs at a high level. Feedback from stakeholders, including persons served, provides a mechanism to ensure South Central Louisiana Human Services Authority's (SCLHSA) service delivery is efficient, effective and follows the goals and objective outlined in the Strategic Plan..

D. How was the accomplishment achieved?

The South Central Louisiana Human Services Authority (SCLHSA) Executive Director and Management Team assume the responsibility for implementing Performance Improvement activities through planning, education, setting service priorities, and providing support and resources as appropriate. The Performance Improvement model and plan is supported by monitoring functions at all levels and by consistent, ongoing communication with internal and external stakeholders.

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

South Central Louisiana Human Services Authority (SCLHSA) Performance Improvement activities support the strategic plan and goals by assuring that the appropriate approaches are utilized to plan processes of improvement; set priorities for improvement; assess performance systematically; implement improvement activities, based on assessment findings; and maintain achieved improvements. The Authority evaluates the Performance Improvement program for effectiveness at least annually and as necessary. Results from the evaluations are discussed with management staff and the South Central Louisiana Human Services Authority Board. Corrective action plans are developed if necessary and plans are modified.

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

Performance Improvement plans are critical to any organizations ongoing success and viability. The Performance Improvement plan/program should be developed specific to an organizations strategic goals.

II. Is your department five-year Strategic Plan/Department Business Plan on time and on target for accomplishment?**♦ Please provide a brief analysis of the overall status of your strategic progress.**

Overall, South Central Louisiana Human Services Authority (SCLHSA) remained on target with progress toward achieving our Strategic Plan Goals and Objectives. The Authority consistently utilized all strategies outlines 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 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?**

During FY 2010-2011, South Central Louisiana Human Services Authority (SCLHSA) demonstrated progress on each of the three goals included within its Strategic Plan:

Goal 1:

Create short term staffing patterns that are reflective of population shifts and service needs.

Goal 2:

Integrate service provision among Behavioral Health Clinics.

Goal 3:

Implement Mobile Crisis/Community Support teams (outreach to outlying communities).

As stated previously, the South Central Louisiana Human Services Authority (SCLHSA) utilized all Strategic Plan strategies with increased focus on utilization management, monitoring and related follow-up activities, client engagement, and positive outcomes.

1. To what do you attribute this success?

Success may be attributed to the following:

- 1) continued adherence to the Accountable Care Model;
- 2) renewed emphasis on performance and continuous quality improvement throughout every area of South Central Louisiana Human Services Authority (SCLHSA) operations;
- 3) continued focus on person centered service delivery;
- 4) clearly defined performance expectations for all South Central Louisiana Human Services Authority (SCLHSA) staff supported by ongoing monitoring and consistent supervision.

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

The South Central Louisiana Human Services Authority (SCLHSA) strives for continued progress toward achieving Strategic Goals and Objectives in support of the Authority's 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?**

South Central Louisiana Human Services Authority (SCLHSA) experienced no lack of progress in achieving its Strategic Goals and Objectives during FY 2009-2010. However, Standards set for Performance Indicators related to employment for both Behavioral Health and Developmental Disabilities proved to be difficult to achieve. Success was negatively impacted due to the external factors of an economic downturn, coupled with higher unemployment and increased competition for jobs; and to the internal factors caused by budget constraints.

♦ **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?

South Central Louisiana Human Services Authority's (SCLHSA) revised Strategic Plan retained short term Goal 1, Goal 2, and Goal 3 (see above) with Objectives developed to coincide with Authority functions identified during the FY 2011-2012 budget process. Additional Strategies were added specific to: expansion of eligibility criteria, strengthened collaboration with community partners/stakeholders; intensified focus on evidence-based and best practices for treatment/services delivery; increased access to social support systems; increased monitoring; increased technical assistance to contractors; and, pervasive performance and quality improvement activities. All Strategies were geared to assure sustainability, increase capacity, and continue the delivery of high quality effective services and supports. The Authority also honed Performance Indicators, retaining some trending data with the bulk of the attention on true 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?**

South Central Louisiana Human Services Authority (SCLHSA), a Local Governing Entity, adheres to the Carver Policy Governance Model. The Board of Directors establishes the Authority's Mission, Vision, and Priorities, and selects an Executive

Director to provide ongoing administration and operational management of the Authority. The Executive Director presents the Board of Directors with monthly updates and an annual Ends Policy Monitoring Report detailing progress toward the organization's Strategic Plan Goals and Objectives.

As an organization that has adopted and actively practices both Accountable Care and Performance and Performance Improvement models/philosophies, South Central Louisiana Human Services Authority (SCLHSA) 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 all staff).

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

South Central Louisiana Human Services Authority (SCLHSA) 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 meetings each Fiscal Year, in the clinic setting. 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 (SCLHSA) Strategic Plan and Performance Improvement Initiatives as well as on their degree of success in accomplishing organizational goals and objectives.

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

Division-specific Plans, and Performance Improvement Initiatives.

Each South Central Louisiana Human Services Authority (SCLHSA) staff member has job-specific performance factors and expectations included in his/her annual planning document to support Authority Goals. Managers and Supervisors are expected to meet with individual staff members reporting to them as outlined in South Central Louisiana Human Services Authority's (SCLHSA) 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 (SCLHSA) 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?

Reductions in Funding

A. Problem/Issue Description

1. What is the nature of the problem or issue?
During FY 2010-2011, South Central Louisiana Human Services Authority (SCLHSA) experienced a reduced level in State General Funds (SGF's) its ability to fill positions. Vacant positions in service areas are, of course, the priority to fill.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
Yes, South Central Louisiana Human Services Authority (SCLHSA) revised its Strategic Plan goal and amended its strategic plan objectives.
3. What organizational unit in the department is experiencing the problem or issue?
Every activity of South Central Louisiana Human Services Authority (SCLHSA), i.e. Behavioral Health Services, Developmental Disabilities Services, and Administration (which includes utilization management, monitoring, and billing functions) is experiencing the problem/issue.
4. Who else is affected by the problem?
 - Individuals Served
 - Residents of South Central Louisiana Human Services Authority (SCLHSA)- Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne parishes.

- Every employee (all areas and 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 are a new local governing entity.
6. What are the causes of the problem or issue? How do you know?
Causes are a reduced State budget; a depressed economy; and, reduction in Federal funding.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
South Central Louisiana Human Services Authority (SCLHSA) must address all impacts and potential impacts if decreased funding with urgency and must utilize effective and flexible strategies/tactics to continuously improve performance and quality AND to identify and capture alternate 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 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.
 - Continue implementation of the South Central Louisiana Human Services Authority (SCLHSA) Risk Management Plan.
 - Continue to explore and seek relationships with private payors to open new streams of revenue.
 - Support, encourage, and seek Medicaid funding for evidence-based practices offered in the home and community.
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 first year that the SCLHSA participates in the budget and AMPAR

process as a new local governing entity.

4. Are corrective actions underway? **YES**

All corrective actions identified above are underway and will continue in the future with no end date establishes\d. Progress has been made in all areas; however, progress must be accelerated to position the South Central Louisiana Human Services Authority (SCLHSA) for continued success with the dramatic changes anticipated with the full implementation of Healthcare Reform in 2014.

5. Do corrective actions carry a cost?

No

Yes

Corrective Actions for the South Central Louisiana Human Services Authority (SCLHSA) are viewed as business and service delivery processes woven into the fabric of South Central Louisiana Human Services Authority's (SCLHSA) 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 Management Team. Resources needed to successfully carry out these processes are Human Resources; related duties and responsibilities are included in each Executive Management Team member's position description and in employees performance planning and rating documents. Executive Management Team members are expected to manage priorities with flexibility and their respective staff to assure processes are ongoing and expectations are met or exceeded.

Expansion of Medical Revenues

A. Problem/Issue Description

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

Currently, Louisiana Medicaid reimburses certain Mental Health services delivered by licensed providers in clinic-based settings. The only community-based service approved for reimbursement is Multi-Systemic Therapy (MST), an evidence-based practice. Other evidence-based practices and services delivered to support treatment regimens are not eligible for reimbursement. Further, no Addictive Disorder services are eligible for reimbursement whether delivered in a clinic-or community-setting.

With regard to those services that are billable, South Central Louisiana Human Services Authority (SCLHSA) is only allowed to bill for one service per visit, e.g. a client receives a psychiatric assessment, medication management, and individual therapy during a single visit but South Central Louisiana Human Services Authority (SCLHSA) can only bill for one of these three services; and, the maximum South Central Louisiana Human Services Authority (SCLHSA) can bill for a service is \$100.

2. Is the problem or issue affecting the progress of your strategic plan?

Yes. Please refer to Section III, Reductions in Funding. Without expansion of this revenue stream to counter balance the reduction or elimination of State General Funds (SGFs), South Central Louisiana Human Services Authority (SCLHSA) expects to make further modifications to its Strategic Plan Goals, Objectives, and Performance Indicators.

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

The inability to obtain reimbursement for the services described above negatively impacts every Activity of South Central Louisiana Human Services Authority (SCLHSA), i.e. Behavioral Health Services, Developmental Disabilities Services, and, Administration (which includes risk management, monitoring, and billing functions).

4. Who else is affected by the problem?

- Individuals Served
- Residents of South Central Louisiana Human Services Authority (SCLHSA)- Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne parishes.

5. How long has the problem or issue existed?

The services referenced in this section of AMPAR have never been eligible for reimbursement. The cap placed on the number of services allowed to be billed per visit has been in place since before the formation of South Central Louisiana Human Services Authority (SCLHSA); and the cap of \$100 on the amount allowed to bill has been in place since FY 2006-2007.

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

The array of services eligible for reimbursement and the rates of reimbursement are identified in Title 48 of the Louisiana Administrative Code and in the Louisiana Medicaid Program Mental Health Clinics Provider Manual.

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

As previously stated, South Central Louisiana Human Services Authority (SCLHSA) must expand alternate revenue streams to mitigate the consequences of diminishing State General Fund funding with a sense of urgency. In tandem, the Authority must utilize effective and flexible strategies/tactics to continuously improve performance and quality.

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 action do you recommend to alleviate or resolve the problem or issue?

Once the proposed Medicaid State Plan is finalized and approved for implementation, South Central Louisiana Human Services Authority (SCLHSA) will:

- 1) Make necessary adjustments to its staffing patterns to assure providers delivering services are eligible to bill and
- 2) Modify its charge master and the billing component to assure all allowable services are billed.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
Medicaid funding for evidence-based practices offered in the home and community has been discussed in the Department of Health & Hospitals Human Services Interagency Council (HSIC).

4. Are corrective action underway? **YES**
South Central Louisiana Human Services Authority's (SCLHSA) Executive Director and Behavioral Health Clinical Division Director, Human Resources Director and Chief Fiscal Officer have completed an assessment and analysis of South Central Louisiana Human Services Authority's (SCLHSA) current staffing patterns. Adjustments have already been instituted within the Authority's Access function to assure licensed clinicians who can diagnose and bill manage the intake and initial assessment processes. Additional actions with regard to staffing patterns will not be taken until the proposed Medicaid State Plan Amendment is in final form and released for implementation. Procedures for modification of the South Central Louisiana Human Services Authority (SCLHSA) charge master and the billing component are in place but will not be initiated until the Amended State Plan is in hand.

5. Do corrective actions carry a cost?

- No
 Yes

South Central Louisiana Human Services Authority (SCLHSA) has the in-house expertise to carry out all components of these identified corrective actions.

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

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

- Internal audit
South Central Louisiana Human Services Authority's (SCLHSA) Management 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 (SCLHSA) 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 Management 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 (SCLHSA) is audited on an Annual basis through the Office of Legislative Auditor as well as by the Department of Health & Hospitals Office of Behavioral Health (former Office of Mental Health and Office for Addictive Disorders) licensing function 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 (SCLHSA) Executive Management Team and the Management Services Division provide these functions.
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
Performance is monitored on an ongoing basis utilizing the South Central Louisiana Human Services Authority's (SCLHSA) Strategic Plan, Operational Plan, Performance Improvement Plan, Risk Management Plan, and position-specific performance expectations. All have clearly stated expectations and performance targets. The Executive Director, Executive Management Team, and the Supervisory Staff share responsibility. Outcomes are reported on no less than a quarterly basis.
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)
South Central Louisiana Human Services Authority (SCLHSA) collects data, conducts statistical analysis, and reports outcomes into LaPAS on a quarterly

basis. Detailed notes of explanation are provided for positive and negative variances and to outline any needed corrective action or process improvement activity. South Central Louisiana Human Services Authority (SCLHSA) also provides data to the Department of Health & Hospitals Office of Behavioral Health (Office of Mental Health and Office for Addictive Disorders) and the Office of Citizens with Developmental Disabilities on an ongoing basis.

- In-house performance accountability system or process
South Central Louisiana Human Services Authority (SCLHSA) 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 including corrective action and/or process improvement action plans with assigned accountability.
- Benchmarking for Best Management Practices
South Central Louisiana Human Services Authority (SCLHSA) 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 (SCLHSA) 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 (SCLHSA) 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 (SCLHSA) 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 bi-annually.
- Accreditation review
South Central Louisiana Human Services Authority (SCLHSA) is implementing an Authority-wide plan for 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 (SCLHSA) has active process improvement functions that focus on meeting and/or exceeding requirements set forth in the Commission on Accreditation of Rehabilitation Facilities (CARF) Standards.

- Customer/stakeholder feedback
 South Central Louisiana Human Services Authority (SCLHSA) 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 (SCLHSA) 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 (SCLHSA) 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.

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

Information concerning South Central Louisiana Human Services Authority’s (SCLHSA) internal reports may be obtained by contacting:

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Annual Management and Program Analysis Report

Fiscal Year 2010-2011

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

Department Head: Bruce D. Greenstein, Secretary

Undersecretary: Jerry Philips

Agency Head: Hugh Eley, Assistant Secretary

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

1. *Completion of resource allocation (Service Hours Allocation of Resources, or “SHARe”)*
2. *Approval of Community Choices Waiver (CCW)*
3. *Improvements to Medicaid Adult Day Health Care (ADHC) program*
4. *Application for and receipt of supplemental funding for Money Follows the Person (MFP)*
5. *Rent up and services to majority of Permanent Supportive Housing (PSH) units in Louisiana GO-ZONE*
6. *Transfer of Independent Living Services from Division of Children and Family Services (DCFS) to OAAS and improvement of transferred programs*
7. *Award of contract for statewide single point of entry to Medicaid home and community-based services*
8. *Consolidation and streamlining of nursing facility admissions*
9. *Privatization of John J. Hainkel Nursing Home and Rehabilitation Center*
10. *Completion of Phase 1 implementation of OAAS Participant Tracking System*

#1 Completion of resource allocation (Service Hours Allocation of Resources, or “SHARE”)**A. What was achieved?**

In March, 2009, the Office of Aging and Adult Services (OAAS) began implementing SHARE (Service Hour Allocation of Resources), a standardized, evidence-based method of allocating service hours and/or budgets for recipients of in-home services in the Elderly and Disabled Adult (EDA) Waiver and Long Term Personal Care Services (LTPCS) programs. With SHARE, service hour allocations and/or service budgets are directly tied to the recipient’s condition as identified using a uniform assessment tool, the Minimum Data Set for Home Care [MDS-HC]). During FY 2011, OAAS finished implementation of SHARE, and revised the methodology for LTPCS. The LTPCS methodology was adjusted in conjunction with lowering the maximum number of LTPCS hours from 42 to 32 hours per week in response to budget reductions. Effective September 9, 2010, LTPCS hours were allocated using the ADL (activities of daily living) Index. The number of “levels” of hours assigned was reduced from 23 categories to 4. Largely as a result of this methodology (although provider rate cuts were also a factor), OAAS programs served an additional 5000 recipients while spending \$2 million fewer dollars (\$314 M vs. \$316 M) in FY 2011 as opposed to FY 2009.

B. Why is this success significant?

SHARE was originally developed to provide participants and providers more flexibility in scheduling weekly care. It subsequently proved to be the key tool used to restore the EDA waiver to compliance with federal cost-neutrality rules. More importantly, however, during a time of budget constraints, SHARE enabled OAAS to continue to increase the number of persons receiving waiver slots and to absorb the continued growth in LTPCS, while actually spending less money. It also helped reduce the need for rate cuts to Home and Community Based Service (HCBS) providers. Most importantly, participant outcomes remained stable during and after implementation. There was no change in the percentage of persons transitioning from the community to nursing facilities, no change in percentage of deaths in the waiver, and no discharges due to health and welfare concerns following a reduction in services.

C. Who benefits and how?

The primary beneficiaries are those 5,000 additional persons who were able to get waiver or LTPCS services even while spending was being reduced. The SHARE savings allowed services to current recipients to continue and more people to be served despite budget reductions. Providers benefitted by avoiding additional rate cuts. Without SHARE further rate cuts to providers and/or a freeze on waiver slots would likely have been necessary. The overall state budget benefits from savings and cost avoidance attributable to SHARE. Long term, this method helps preserve HCBS services by moving average costs closer to national norms and ensuring sustainability.

D. How was the accomplishment achieved?

OAAS developed this methodology using internal resources, with help from consultants at the University of Michigan. OAAS trained all assessors in the new process prior to beginning implementation and conducted a “trial run” with a sample of cases. Once implementation began, the OAAS SHARe Workgroup met weekly to troubleshoot issues, review and revise procedures as needed, and monitor implementation. The major issue that arose was a huge increase in the number of appeals filed as services were reduced. A backlog did develop but was eventually worked through. Recipients outcomes were monitored closely and information reviews of outliers and other cases of concern were reviewed to determine where the methodology needed to be revised and/or exceptions needed to be made for specific recipients.

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

Yes. Moving Louisiana’s per person average cost for HCBS services closer to national norms is a key to continuing to increase the percentage of persons served in community based settings. SHARe has been a key policy change which has allowed the percentage of persons receiving HCBS services to continue to rise, even though the percentage spending of HCBS has fallen in the past two fiscal years. SHARe provides a rational means to allocate limited resources. This accomplishment contributes to the OAAS strategic goal “To expand existing and develop additional community-based services as an alternative to institutional care.” It is a significant component of OAAS’s transformational initiative of “Right balancing institutional and community-based long term care for older adults and people with adult onset disabilities” as described in the DHH Business Plan for SFY 12-13.

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

Yes. Use of an assessment-driven, evidenced based “case-mix” system to allocate resources or set payment levels in home and community based long term care services is relatively new. A number of states are moving in this direction but Louisiana, through OAAS and a similar effort in the Office for Citizens with Developmental Disabilities (OCDD) is at the front of this trend.

#2 Approval of Community Choices Waiver (CCW)**A. What was achieved?**

Approval by federal authorities at the Centers for Medicare and Medicaid Services (CMS) of a more comprehensive Home and Community Based Services waiver – the Community Choices Waiver – to replace the current Elderly and Disabled Adult (EDA) waiver currently operated by OAAS. OAAS’s application to CMS was approved rapidly by federal authorities with minimal questions and requests for revision, indicating that the application was of high quality and well-prepared.

B. Why is this success significant?

The current EDA waiver provides a limited number of services, thus encouraging heavy reliance on one-on-one personal care delivered by a paid worker who goes to the participant's home. This is a costly way to deliver care, and may also result in unnecessary service dependency as opposed to promoting, improving, and maintaining independent functioning. The Community Choices waiver will provide a much broader array of services, including home delivered meals, in-home sensor monitoring, assistive devices/technology and nursing and skilled maintenance therapies that can substitute for one-on-one care and can improve independence in the home. Approval of the Community Choices waiver clears the way for OAAS to deliver a fundamentally different approach to community-based services, and will also change the way that support coordination services are delivered and quality monitored in the waiver program.

C. Who benefits and how?

Primary beneficiaries will be waiver participants and their family members and caregivers who will have a richer and more flexible array of services with which to address individual needs. The array of new services will also create opportunities for home health agencies, nursing homes, adult day health care centers, and respite centers to diversify product lines and expand their customer base.

D. How was the accomplishment achieved?

OAAS executed small consulting contracts for national experts to assist in program design and preparation of the waiver application. OAAS Policy Division took the lead in preparing the application and coordinated closely with Medicaid and other entities within DHH. The OAAS Division for Research and Quality did extensive preparatory research and developed the very critical Quality Improvement Strategy (QIS) that is a key component of the federal waiver application and approval process.

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

The Quality Improvement Strategy described in the Community Choices waiver application is a national best practice for the operation of community-based waivers and has been presented at several conferences. The QIS is a cross-population approach that is also being used by the DHH Office for Citizens with Developmental Disabilities.

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

This accomplishment contributes to the OAAS strategic goal "To expand existing and develop additional community-based services as an alternative to institutional care." It is a significant component of OAAS's transformational initiative of "Redesigning the community-based long term care infrastructure" as described in the DHH Business Plan for SFY 12-13.

#3 Improvements to Medicaid Adult Day Health Care (ADHC) Program

A. What was achieved?

A number of changes were made to licensing and Medicaid participation rules, and to rate structure and reimbursement that make it easier for existing Adult Day Health Care (ADHC) Centers to succeed as businesses and for new centers to open and succeed.

B. Why is this success significant?

ADHC is a cost-effective alternative to nursing home care. Unfortunately, OAAS lacks ADHC capacity in several areas of the state, has lost additional providers, and recognized that many existing providers were struggling in part because of problems in program design and licensing requirements. Unnecessarily burdensome licensing requirements worked against new centers starting, and program design discouraged ADHCs from offering hours of service that would be most helpful to working family caregivers. Perverse incentives that encouraged ADHCs to stay open for less than 8 hours a day were eliminated with the result that many ADHCs are expanding their hours of operation.

C. Who benefits and how?

While providers of ADHC are the most immediate beneficiaries, there are many individuals on the waiting list for ADHC services that have not been able to receive this service because there is no provider in their area. These individuals and others that apply for ADHC services will benefit as new ADHC centers open in underserved areas. Because it provides a center-based program of nutrition, social, and health-related services, ADHC is of particular benefit to working family caregivers. These caregivers will benefit from improved hours and capacity in the ADHC program.

D. How was the accomplishment achieved?

OAAS convened several workgroups of providers and other internal and external stakeholders to review licensing and access issues and data and to implement recommendations resulting from HCR 190 of 2009. OAAS also used an existing contract within Medicaid to seek technical assistance and consulting regarding the ADHC rate structure. Staffing requirements under state licensing rules were changed to differentiate between the amount of staffing needed for a small or start-up center and the amount needed for higher census centers. OAAS implemented 15 minute rate increments. This allows providers to be paid for the time that they actually serve participants rather than the previous daily per diem payment which was based on a participant staying a minimum of 5 hours, with no payment for those who attended a shorter day and no additional payment for those who attended a longer day. Recognizing that transportation costs for ADHCs vary greatly depending upon size and location, the rate structure was also changed to calculate the transportation component separately for each center. Another significant change was to require that ADHC waiver participants attend the ADHC a minimum of 36 days per quarter. A significant number of participants appeared to be attending ADHC infrequently and

perhaps to merely maintain other Medicaid benefits. This made each center's census unpredictable, and was not an appropriate use of the waiver given the number of individuals on the waiting list.

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

No. These changes were very specific to this program.

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

This accomplishment contributes to the OAAS strategic goal "To expand existing and develop additional community-based services as an alternative to institutional care." It is a contributing component of OAAS's transformational initiative of "Redesigning the community-based long term care infrastructure" as described in the DHH Business Plan for SFY 12-13.

#4 Application for and receipt of supplemental funding for Money Follows the Person (MFP)

A. What was achieved?

The Deficit Reduction Act of 2005 enacted the Money Follows the Person program, designed to provide states with assistance to develop the systems needed to help move Medicaid-enrolled individuals from institutions back into the community. The program provided enhanced federal match for a person's initial year of services in the community. Six months into OAAS's implementation of MFP, multiple barriers to transitioning participants from institutions back into the community became apparent. Representatives of the federal Centers for Medicare and Medicaid Services (CMS) strongly encouraged Louisiana to develop a supplemental administrative funding request, available under the Affordable Care Act, for qualified items and activities to be paid with 100% federal funding, not the 50/50 match rate previously proposed for administrative activities. OAAS worked with Medicaid and the Office for Citizens with Developmental Disabilities to develop Louisiana's request and received notification on August 24, 2010 that the supplemental funding request of \$14.4 million was approved. Of this amount, OAAS was awarded \$6.9 million to place additional transition resources in the field, train and assist support coordinators in facilitating transitions and improving overall performance, and to address various legal and logistical barriers.

B. Why is this success significant?

It is significant because OAAS's community-based programs serve people at a fraction of nursing facility cost, and because many people currently living in nursing homes can, and would prefer, to live in their own homes and communities. Some of the benefits to Medicaid/OAAS from this supplemental funding include:

- Enhanced federal match rate for qualified Medicaid HCBS services that a participant receives for the first 365 days following transition back to the community.

- Ability to rebalance cost savings back into long term care programs, possibly providing for expansion of programs.
- Ability to create infrastructure that supports and sustains successful transitions by providing additional field resources and expanding training of OAAS staff and its contractors that provide direct services to Medicaid home and community-based services recipients.
- Development of Money Follows the Person (MFP) Committee for the state to gain input from stakeholders in developing a long term care infrastructure that supports transitions from institutional settings to the community.

The supplemental award to OAAS is \$6.9 million through calendar year 2014, with the possibility of additional funds carrying the demonstration to 2020. Funds will enable OAAS to exceed its benchmarks for number of individuals transitioned, with an average estimated savings to Medicaid of \$13,000 per year for each successful transition. MFP supplemental funds used for comprehensive training, competency-testing, and oversight of support coordinators also allows OAAS to strengthen its community-based services delivery system for all recipients.

C. Who benefits and how?

Primary beneficiaries are nursing facility residents who are able to live in the community and who prefer to live in the community. Because 100% of individuals who transition to the community under MFP are served at less cost to the state than if they remained in a nursing home, Louisiana's Medicaid program and taxpayers also benefit from this program. All waiver recipients benefit through the use of MFP funds for training and other initiatives that strengthen the HCBS system.

D. How was the accomplishment achieved?

Responding to guidance from CMS, OAAS worked with both internal and external stakeholders to develop and submit a successful request for supplemental funding.

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

This is a best practice, and the executive branch should be aware of the cost-savings and other benefits associated with successful implementation and expansion of MFP.

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

This accomplishment contributes to the OAAS strategic goal "To expand existing and develop additional community-based services as an alternative to institutional care." It is a significant component of OAAS's transformational initiative of "Right balancing institutional and community-based long term care for older adults and people with adult onset disabilities as described in the DHH Business Plan for SFY 12-13.

#5 Rent up and services to majority of Permanent Supportive Housing (PSH) unites in the Louisiana GO-ZONE

A. What was achieved?

In response to the 2005 hurricanes, the State of Louisiana made a commitment to create a comprehensive 3000 unit Permanent Supportive Housing (PSH) program for people with disabilities as part of the state's Katrina/Rita Road Home recovery plan. The Louisiana Housing Finance Agency (LHFA) and Office of Community Development (OCD) developed and administer the affordable housing component of this initiative while DHH, through the Office of Aging and Adult Services, places individuals with disabilities in available units and assures they receive the services necessary to sustain them in these community-integrated rental units. The PSH approach combines deeply affordable rental housing with voluntary, flexible, and individualized community-based services that assist people with severe and complex disabilities to live successfully in the community.

As of June 30, 2011, the PSH program as a whole was providing services to 3,502 households, 1,698 of which were in DHH Region 1, with community-based supportive services, including pre-tenancy services that help connect program applicants with benefits and community resources. As of June 30, 2011, there was 2,357 households actually housed in the program (1,237 in Region 1) and was receiving post tenancy housing supports.

Since the beginning of the program, 98% of participants that had been housed in Region 1 had retained stable community living, including people who had graduated from PSH to other independent living situations. Less than 2% of participants had faced negative outcomes such as eviction or incarceration. In addition, at least 9% of Region 1 program participants had obtained additional sources of income, either through employment or linkage to benefits.

B. Why is this success significant?

The successes of the program demonstrate that the PSH model of services and housing can stabilize even severely disabled people in a community setting. PSH program participants are low-income, face serious and complicated disabilities, and are institutionalized or homeless or at risk of homelessness or institutionalization. Despite these considerable obstacles, PSH has helped its participants become stable and successful in non-institutional settings, which is less costly to public resources and more desirable for the tenants themselves.

C. Who benefits and how?

Most obviously, the tenants themselves benefit by having an improved quality of life in their own homes. Research has indicated that this reduces institutional recidivism, and the housing stability of the PSH tenants is bearing this out. The local community benefits from the housing stability of this population because in many cases the individuals served in this program would have been, or have become, homeless on the streets at which point they can become a public nuisance requiring the involvement of law enforcement. Because the rental units are leased in the participant's name, the tenant pays their share of their rent, thereby resulting in no cost to the state for the person's housing. The state also benefits from savings in the reduction of institutional placement and institutional recidivism.

D. How was the accomplishment achieved?

This accomplishment was achieved through the successful partnership of a number of state and federal agencies as well as private service providers. CDBG funds through HUD and to Office of Community Development have provided the seed money for the development of the service piece of the program and for some of the housing development. The Low Income Housing Tax Credit program funded construction of affordable housing units. The appropriation of rental subsidies allowed the program to access housing via the existing rental market, and the creation of the Louisiana Housing Authority (LHA) within the OCD resulted in a rental subsidy program that is responsive to the challenges and needs of people with disabilities. It also results in the stability of the subsidy process by concentrating the subsidies within one Housing Authority, thereby avoiding the complexity of working with a multiplicity of small housing authorities who are not focused on the needs of a disabled population. The use of DHH for tenant selection, waiting list management and service provision enabled the program to directly outreach to people with disabilities; create a waiting list management system that is sensitive to the barriers that people with disabilities encounter in the housing market; and to create access to the service system that is vital to people successfully attaining and retaining their tenancy.

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

Yes. PSH is a “best practice” model of housing and services because it supports people within the community and within their own homes rather than in an institutional setting or a program based setting from which a person must leave and resettle whether they are successful or they fail. It is more desirable for participants to be able to remain in their own homes and improves their quality of life. Because of the scope and scale of Louisiana’s program, the Robert Wood Johnson Foundation has funded evaluation of Louisiana’s PSH program, and the program has been presented at several national conferences.

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

This accomplishment contributes to the OAAS strategic goal “To expand existing and develop additional community-based services as an alternative to institutional care.” It is a significant component of OAAS’s transformational initiative of “Right balancing institutional and community-based long term care for older adults and people with adult onset disabilities as described in the DHH Business Plan for SFY 12-13.

#6 Transfer of Independent Living Services from Division of Children and Family Services (DCFS) to OAAS and improvement of transferred programs**A. What was achieved?**

Since taking over these programs from Division of Children and Family Services (DCFS) on July 1, 2010, OAAS has reorganized, restructured and streamlined the Community and Family Supports program, State Personal Assistance program and the Traumatic Head and Spinal Cord Injury Trust Fund program. OAAS updated the waiting list to see if individuals interested in

these services were still interested and eligible. Regional waiting lists were consolidated to ensure individuals are provided services on a first come, first serve basis regardless of where they reside in the state. The application and approval process was streamlined. Duplication of services was eliminated. OAAS found that 212 individuals were receiving case management from these programs and also from Medicaid. It was determined that the Medicaid case managers should also encompass the trust fund program based on CMS' and DHH's definition of case management. OAAS eliminated a 9 month back log of approximately 300 requests for goods and services that existed at the time of the transfer of the TH/SCI program. Individuals/applicants who are eligible for Medicaid were identified and OAAS assisted them with applying for Medicaid services. Case Management contracts were revised to clearly define contractor responsibilities. A Resource Center has been set up for individuals with Traumatic Head and Spinal Cord Injuries, which will assist these individuals in identifying all available supports and services throughout the state of Louisiana.

B. Why is this success significant?

These strategies enabled OAAS to maximize available funds and serve more people. OAAS will be able to serve all the individuals currently on the TH/SCI waiting list, thus eliminating that list.

C. Who benefits and how?

Louisiana citizens can benefit from the programs immediately following a recent injury, at the time when supports are critically needed. Individual's will have qualified staff and/or case managers coordinating all care to ensure that participants are receiving a comprehensive array of services and supports in the most cost effective and efficient manner.

D. How was the accomplishment achieved?

Transfer of the program enabled OAAS to access data systems to identify individuals eligible for Medicaid and eliminate duplication of services. OAAS trained all contracted agencies on all available resources. Case managers are now more knowledgeable and have a better understanding of what is available and how to access those supports and services. OAAS revised procedures to follow the original intent of the laws and trained contracted agencies on appropriate and approvable goods and services.

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

Transfer of these programs was a recommendation of the Streamlining Commission. Transfer did enable the combining of state-funded and Medicaid-funded services to reduce cost and improve efficiency.

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

This accomplishment contributes to the OAAS strategic goal “To expand existing and develop additional community-based services as an alternative to institutional care.” It is a contributing component of OAAS’s transformational initiative of “Redesigning the community-based long term care infrastructure” as described in the DHH Business Plan for SFY 12-13.

#7 Award of contract for statewide single point of entry to Medicaid home and community-based services**A. What was achieved?**

Execution of an improved Single Point of Entry (SPOE) contract with clear and quantifiable performance measures. The new contract continues services previously delivered under contract, but does so at less cost and with more deliverables than the previous contract. The new contract, which resulted from an RFP for Long Term Care Access Services released in December, 2010, directly correlates payment with face to face assessments completed in a timely manner. The contractor serves as the SPOE for all Medicaid-funded long term care programs managed by OAAS, including both community-based services and nursing facility care. Under the terms of the new contract, the SPOE is paid for the number of assessments completed, and those that are not completed within the specified timeframes are paid at only 75% of the rate. The contract also includes retainage provisions requiring the contractor to comply with other performance measures.

B. Why is this success significant?

This is significant because of the large scale operations and services contained in this multi-million dollar statewide contract. It also decreased the amount of the previous monthly payment by \$200,000. In addition, services are now measured with a specific data monitoring tool that provides accurate data that is validated and accessible by OAAS, allowing the office to review contractor compliance with the performance measures.

C. Who benefits and how?

Recipients in OAAS programs benefit from the additional client monitoring required under the terms of the new contractor. The state and taxpayers benefit because the services provided to our clients are more efficient and cost savings have been realized through the terms of the RFP and performance-based payment structure. .

D. How was the accomplishment achieved?

This accomplishment was facilitated by the creation of a strong RFP that clearly outlined the expectations and performance measures. Department –wide collaboration was implemented to ensure that the performance measures that affected various areas were relevant, accurate, and significant to our overall mission. A data tool was also created to be able to independently

measure the contractor's compliance.

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

Yes. Lessons learned, and documents generated, in the RFP and contracting process are a model of effective performance-based contracting.

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

This accomplishment contributes to the OAAS strategic goal "To improve access and quality in long term care programs." It is a significant component of OAAS's transformational initiative of "Redesigning the community-based long term care infrastructure" as described in the DHH Business Plan for SFY 12-13.

#8 Consolidation and streamlining of nursing facility admissions

A. What was achieved?

OAAS program operations employees worked with multiple agencies to streamline and expedite the nursing facility admission process. OAAS successfully consolidated nursing facility admissions from nine regional offices to one regional office in April 2011.

B. Why is this success significant?

There was a significant reduction in number of employees needed to process applications for approximately 300 nursing facilities statewide. The actual time for processing applications to determine medical eligibility and level of care for nursing facility admissions has been reduced from days and sometimes weeks to less than 24 hours. Timeliness and customer service have promoted a improved working relationship with acute care, rehab care, hospice care providers, as well as long term care facilities and the Louisiana Nursing Home Association. The timeliness of the admission process, in most cases, avoids any unnecessary delay in more costly acute care settings.

C. Who benefits and how?

Louisiana citizens who need skilled care or rehabilitation care in a nursing facility. Hospitals also benefit because they are able to discharge patients' quicker ultimately reducing hospitalization cost.

D. How was the accomplishment achieved?

OAAS collaborated with the Louisiana Nursing Home Association, Gulf States Nursing Home

Association, Louisiana Hospital Association, other DHH offices, Medicaid, and the DHH Legal department to streamline processing.

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

This endeavor took a considerable amount of organization and collaboration between several state agencies and private organizations. We are administering our resources and or processes much more efficiently and effectively and cost has been considerably reduced.

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

This accomplishment contributes to the OAAS strategic goal to “Improve access and quality in long-term care programs.”

#9 Privatization of John J. Hainkle Nursing Home and Rehabilitation Center

A. What was achieved?

Pursuant to Act 933 of the 2010 Legislative Session, the DHH/OAAS facility the John J. Hainkel Jr. Home & Rehabilitation Center was privatized. This privatization occurred on April 18, 2011.

B. Why is this success significant?

The facility was privatized and moved from direct operation by DHH to operation by a private entity. The facility continues to serve the New Orleans area.

C. Who benefits and how?

Taxpayers. Long term Medicaid savings are estimated at \$1.1 million annually. This is due to shifting the facility from a cost reimbursement basis used for state facilities to the Case Mix Index reimbursement used for private nursing homes. Following a one year transitional rate, these savings will begin to accrue in April of 2012. The non-profit entity is paying quarterly rent that covers the majority of ongoing operating costs associated with the facility.

D. How was the accomplishment achieved?

A negotiating team was appointed in August, 2010 to explore and develop an agreement to lease the facility to the non-profit organization that has historically been affiliated with the facility. The lease agreement was finalized in early 2011. A transition team worked to identify each area that needed to be addressed to ensure a smooth transition, and a final readiness review was conducted prior to April 19th.

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

Yes. The accomplishment overcame red tape and challenges to leasing and privatization. The experience could be beneficial to other executive branch agencies undertaking similar efforts.

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

This accomplishment contributes to the OAAS strategic goal “To administer and manage patient care programs in OAAS long-term/acute care and nursing home facilities 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”.

#10 Completion of Phase 1 implementation of OAAS participant tracking IT system

A. What was achieved?

Development of an office-wide IT system for the Office of Aging and Adult Services. In 2011, the basic system for OAAS Participant Tracking System (OPTS) was created.

B. Why is this success significant?

The new system will facilitate OAAS business processes, access to data, and monitoring of services, providers, and contractors. The OPTS system provides the foundation for future modifications and enhancements including the development of an electronic plan of care for OAAS recipients.

C. Who benefits and how?

Through increased efficiency and elimination of paper-based processes, OAAS program staff, single point of entry contractor, and private sector support coordinators who are an integral part of the service delivery system for Medicaid home and community based services will benefit. Recipients of the services will also benefit as system development enables protocols that enhance and strengthen the quality of care planning.

D. How was the accomplishment achieved?

Development of contract with Center for Business Information Technology at the University of Louisiana in Lafayette, with work guided by a DHH development team composed of program and IT staff.

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

OAAS was formed in 2006. This information system represents a forward development in management of information on home and community based services provided by the office, and provides a foundation for electronic plan of care, and implementation of best practice protocols for care planning. System contract and design are being shared with other offices within DHH.

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

This accomplishment contributes to the OAAS strategic goal to “Improve access and quality in long-term care programs.”

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

Yes. Overall OAAS is making steady, and in some areas rapid, 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 a higher percentage of people, in the community than ever before, and at an average cost per person of about 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 facility admissions. This is consonant with the major strategic goal of OAAS is 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?**

As noted above and in other sections of this report, OAAS has improved timeliness and reduced costs in two key access systems: the nursing facility admissions process and the statewide single point of entry contract. Implementation of SHARE has been key to expanding access to services within existing budget constraints, and has allowed OAAS to serve more people while controlling and reducing both overall and per-person expenditures. Effective implementation of Permanent Supportive Housing and reform of programs transferred to OAAS from DCSF has made community based alternatives – in the case of PSH, a highly innovative alternative – available to thousands more.

OAAS has also made progress on objectives related to developing an integrated Information Technology (IT) system and a comprehensive, data-driven quality management system. The new Quality Improvement Strategy will become a reality with implementation of the Community Choices Waiver on October 1, 2011; and Phase 1 of OAAS’s integrated IT system is in process.

OAAS continues to meet internal objectives of operating and providing access to Medicaid programs that provide over a billion dollars in direct services to people. In SFY 11, OAAS costs for administering and operating these programs constituted less than 2% 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. Limited state funds available for outside consultation and technical assistance 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. In SFY 12, OAAS will also begin to pursue initiatives under federal health care reform (Affordable Care Act) that have the potential to increase federal match and serve more people without additional commitment of state general revenue.

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

There are two areas where OAAS is experiencing lack of progress.

The first is related to the strategic goal "To expand existing and develop additional community-based services as an alternative to institutional care." OAAS has requested approval from CMS to implement an Adult Residential Care waiver that would provide assisted living as a lower cost residential alternative to nursing home care. CMS has thus far failed to approve Louisiana's application. Since current OAAS programs cannot provide – nor is it affordable to provide – 24-hour care in the home, lack of this residential alternative means that many individuals remain in nursing homes who do not need 24 hour nursing care but who do need 24 hour access to supports and supervision of the type provide in assisted living. The external problem leading to this lack of progress appears to be CMS opposition to allowing nursing to convert excess capacity to assisted living, a position which OAAS and DHH regard as unjustified and untenable given that nursing home conversions would have to meet the same standard as purpose-built assisted living and given that consumers would have a choice of assisted living facilities.

OAAS is also seen a reversal in progress towards the strategic objective to "Optimize the use of community-based care while decreasing reliance on more expensive institutional care to meet or exceed national averages for institutional versus community-based spending by 2015." OAAS is optimizing the use of community-based care -- reducing per person costs, transitioning people out of nursing homes under Money Follows the Person, and serving a higher percentage of participants in the community. The percentage of spending going to nursing homes is continuing to increase. The nursing home reimbursement increase is due to annual nursing facility rebasing which results in a higher Medicaid per diem payment for nursing facility care. Louisiana Medicaid Nursing Home reimbursement

is still one of the lowest in the nation. In SFY 11, percentage of spending going to Medicaid community-based services versus nursing home care – a key performance indicator for OAAS – went down from 30% to 27%.

♦ **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?

OAAS will revise its Operational plan and strategies to address the problems identified above. These have also been addressed in the DHH Business Plan for SFY 13.

♦ **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 clear and coherent vision that OAAS maintains on increasing access to home and community-based services as a sustainable, cost-effective alternative to nursing home care; and on 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 development 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?

A. Problem/Issue Description

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

On September 22, 2010, DHH was sued by four persons who receive Long Term Personal Care Services (LT-PCS). They are represented by the Advocacy Center. The Plaintiffs claimed a violation of Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12132 and the Rehabilitation Act of 1973, 29 U.S.C. § 794 (“Section 504”).

They are seeking a class action on behalf of themselves and other Louisiana Medicaid recipients who are eligible to receive LT-PCS. The lawsuit emanates from DHH limiting LT-PCS to a maximum of 32 hours per week (reduced from 42 hours per week). Plaintiffs claim that this reduction in services will force them into institutions to receive care, in violation of the mandate of the Americans with Disabilities Act and the Rehabilitation Act. DHH claims that the Plaintiffs' allegations do not state a claim of discrimination under the ADA and Rehabilitation Act as interpreted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999). The lawsuit was filed in the Middle District of Louisiana and is before the Hon. James J. Brady.

DHH filed a motion to dismiss on October 21, 2010, under Fed. R. Civ. Pro. 12(b)(6) for failure to state a claim upon which relief can be granted as well as for the dismissal of all claims against DHH. On April 7, 2011, the United States Department of Justice (DOJ) filed a "Statement of Interest" in the lawsuit. The DOJ, urged the Court to deny DHH's motion, asserting that the Plaintiffs have properly asserted a cause of action. Oral argument was held April 20, 2011. On May 18, 2011, the Court denied DHH's motion. The Court also certified the class as:

"Louisiana residents with disabilities who have been receiving Medicaid-funded services through the LT-PCS program; who desire to reside in the community instead of a nursing facility; who require more than 32 hours of Medicaid-funded personal care services per week in order to avoid entering a nursing facility, and who do not have available (including through family supports, shared living arrangements, or enrollment in the ADHC waiver) other means of receiving personal care services."

It is anticipated that the Plaintiffs will file a Motion for Preliminary Injunction in the near future.

2. Is the problem or issue affecting the progress of your strategic plan?

This has not yet created a setback in terms of OAAS strategic objectives and outcomes on performance measures, however it has the potential to do so, and very immediately should plaintiffs be granted a preliminary injunction. Reduction in the LTPCS maximum from the original 56 hours per week is part of the reform that has allowed OAAS to provide 5,000 additional people with home and community-based services. Reversal of that reduction would mean far fewer people having access to services and could lead to elimination of the program altogether should costs become unsustainable.

The lawsuit further constrains OAAS decision-making, since operational strategies often must be weighed against potential impact on this lawsuit. This hinders innovation and policy-making based on best practice rather than impact on DHH's legal posture in the lawsuit, its potential class members, how it will be perceived by plaintiffs' counsel, etc.

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

OAAS, since it is charged with implementing the LT-PCS program; and Medicaid, since it provides the source of funding.

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

OAAS believes that failure to fully implement the 32 hour cap will drive up the average per person cost of LTPCS and negatively impact the state's ability to serve more people. Furthermore, and given the ever growing demand for LTPCS, the long term sustainability of the program is directly correlated to having a reasonable weekly cap limit that is in line with other state's LT-PCS programs to account for program growth.

5. How long has the problem or issue existed?

The problem has existed since September 22, 2010, the date the lawsuit was filed.

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

The lawsuit specifically states as its cause of action DHH's limitation of LT-PCS to a maximum of 32 hours per week (from 42 hours per week). This limitation began on September 5, 2010 and is currently being implemented across the board for all LT-PCS recipients. However, the reduction in the LTPCS weekly maximum is not, in itself, a problem, since contrary to plaintiff claims, OAAS has seen no increase in nursing facility admissions from LTPCS and thousands of people now receiving services have reaped the benefits of the reduction. The problem is the misplaced and highly problematic effort at judicial advocacy pursued by Louisiana's protection and advocacy organization, The Advocacy Center.

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

The reduction in the weekly cap equates to a \$4.8 million savings in FY 2010/11, which equates to a 1.6% savings to the overall spending on HCBS services. If DHH loses the lawsuit, it could be placed in a position where these savings, both current and prospective, would be severely compromised, thereby thwarting any initiatives to expand or sustain home and community based programs as explained in response to #4 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
- 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:

Service Hour Allocation of Resource Evaluation

Multi-method evaluation issued June 1, 2011 that assessed the impact of resource allocation (SHARe) in OAAS programs. Evaluation showed savings, cost-avoidance, and no increase in admissions to nursing facilities as a result of resource allocation. Report was produced internally. Findings have been used to adjust SHARe methodology and to inform internal and external stakeholders regarding the impact of resource allocation. It is available in hard copy or as PDF file.

2009 Consumer Survey – Adult Day Health Care (ADHC) Waiver

Reports analysis and finding of in-home, interview-based survey of a statistically valid sample of ADHC waiver participants. Report was issued 8/12/2010. Results showed overall high levels of satisfaction with service provided by ADHCs, but lack of assessment and services in certain areas, such as assistive technology and dental care. Findings have been used in reports and planning documents that compare institutional to community-based care. Broader circulation is pending approval of DHH Bureau of Media and Communications. Report is available in hard copy and PDF.

Contact person for more information:

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Annual Management and Program Analysis Report

Fiscal Year 2010-2011

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

Department Head: Bruce D. Greenstein, Secretary

Agency Head: Coletta C. Barrett, Chairman of the Board

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. Mass Casualty Incident Notification Algorithm developed with ESF-8 Partnership in draft.
2. Completed build out of ESF-8 Information system strategy. Purchased 3 software modules.
3. LERN website developed and implemented.
4. Trauma Registry inclusion criteria defined and data dictionary developed.
5. Statewide Trauma Destination protocol approved and promulgated moving from regional protocol to state wide protocol.
6. LERN Communications Protocol developed and implemented statewide for stakeholder communications with the LERN Communications Center.
7. Injury Prevention education moved from OPH to LERN.
8. Successfully collaborated on the Rural Health Information Technology Network Development Grant.
9. Implemented routing of trauma patients in Region 3 (Thibodaux)

B. Why is this success significant?

1. Integration of LERN with ESF-8 is outlined in our enabling Legislation. As a 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.

2. After Hurricanes Gustav and Ike, ESF-8 determined that EMResource was not able to meet the needs of ESF-8. An information systems strategy was executed that involved the eventual replacement of EMResource with a suite of applications (EMSTAT). LERN provided the funding for 3 modules (Security, Resource Management, Incident Management Module) that hastened the completion and build out for ESF-8.
3. The successful completion of the LERN website enables better communication about LERN and its mission to its stakeholders and public.
4. A successful Trauma System must rely on quality data that identifies system performance issues – Is the system working? The first step in developing such a tool is to determine inclusion criteria that identify the right kind of patient to be evaluated with standard definitions to consistently measure outcomes.
5. A standard system wide protocol allows for the movement of patients within and inter-regionally.
6. To address the communications between various EMS agencies, hospitals, and LERN, LERN developed a standard methodology involving Phone, HEAR radio system, and LWIN system (700 MHz radios)
7. A key component of a trauma and time sensitive illness network is injury prevention, education and outreach. Through the collaboration and restructuring within OPH, LERN has assumed the role as injury prevention educator.
8. LERN is committed to finding alternate methods of funding through partnerships.
9. With the addition of Region 3, Trauma patients have access to organized trauma care throughout the state.

C. Who benefits and how?

As LERN continues its development, it is the citizens of the state that benefit. Coordinated systems of care have proven to decrease morbidity and mortality in trauma and time sensitive illnesses.

D. How was the accomplishment achieved?

The success was achieved through the leadership of the LERN Board, the LERN staff, the LERN regional commissions and the stakeholders that cooperate, collaborate, and implement program plans.

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

Yes. These overall accomplishments contribute to the success of our strategic plan.

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

II. Is your department five-year Strategic Plan/Department 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?

Utilizing the HHS Model for Trauma System Development, the Best Practices Research conducted and the American College of Surgeons' Consultative visit recommendations – a draft State Plan for Trauma was developed this year. The Communications Center's continue to be a valuable asset for the State of La. LERN has continued to support the movement of patients to the most appropriate facility for definitive care with over 10,000 patients lives impacted this year.

- ♦ **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 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.
- **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?)**

As a state agency, LERN continues to benefit from the support of DHH. The Office of the Secretary – Emergency Preparedness was most helpful in collaborating in building out the EMSTAT system. While LERN supplied the funding from the FY 11 budget; the build out the system would not have happened without the collective assistance of DHH staff. Results to date would have been possible without the assistance of DHH Human Resources (hiring and assistance with voluntary terminations).

The assistance of the Department of Administration, DHH Contracts and Procurement Support were critical during the budget cut proposals. The Office of Planning and Budget, Fiscal Office, State Purchasing, and Information Technology were helpful with LERN operations and plans this past year. LERN continues to collaborate with the Governor's Office of Homeland Security on its ESF-8 mission.

- 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 Human Resources assistance with the hiring of a Tri-Regional Coordinator, assistance with documentation of disciplinary issues, and voluntary resignation of program manager position. LERN benefited from the assistance of DHH personnel in the development of an RFP, the awarding of the RFP for Management Consulting and the implementation of documentation of the review process. Assistance from DHH and DoA with budget and funding challenges.
- 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?

There continues to be forward progress with the Communications Center strategy – Region 3 is now organized and using the communications center. 8/9 DHH planning districts now use the LERN Communications Center. There are currently 2 additional hospitals pursuing ACS Trauma Center verification. If funding were available to support the added cost hospitals incur to become ACS verified Trauma Center's; there would be more institutions undertaking the review preparation process. LERN continues to progress in the implementation of its 5 year plan as outlined by the LERN Board of Directors. LERN assumed the primary function of Injury Prevention education from the Office of Public Health this FY. This was a one time program gain – without funding. Progress will be dependent on LERN ability to attract grants to support the further development of Injury Prevention programming.

- ♦ **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.

Budget constraints that LERN experienced in FY11 had its greatest impact on our ability to contract for services. We were not able to continue a contract for Communications support to assist with the development of communications templates and strategies for keeping commissions informed and engaged. We also were not able to continue a contract for Grant writing assistance to secure funding for Injury Prevention.

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?

In order to address budget shortfalls, LERN streamlined its operation – prioritized contracts based on direct impact to LERN goals. LERN will continue to prioritize budget with milestones of Strategic Plan.

No. If not, why not?

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

The strategic plan adopted by the LERN Board of Directors is reviewed at each LERN Board meeting, progress to goals reviewed, each August the Board conducts a retreat where the Strategic Plan is reviewed and the fiscal operations plan is prioritized based on budget. LERN Board Chair and SSA consultants provide routine updates. 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, condition of the state fisc, 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.

None.

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
- 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
- Program evaluation by contract
- Communications Center staffing provided by contract with AMR. Data is input to the La State owned ImageTrend system. This system software provides data on calls, time to definitive care, mechanism of injury and transport time
- Performance Progress Reports (Louisiana Performance Accountability System)
- LERN reports Performance Indicators quarterly through the LaPas system
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- LERN contracts have deliverables and a monitoring plan that includes reports

that are reviewed by the LERN Board Chair and contracts program manager. The Board Chair provides status updates to the LERN Board of Directors on all contract activities.

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

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Agency & Program: Louisiana Emergency Response Network

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- 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 2010-2011

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

Department Head: Bruce D. Greenstein, Secretary

Undersecretary: Jerry Phillips

Agency Head: Clayton Williams, Assistant Secretary

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 DHH Office of Public Health has achieved many significant performance improvements related to targeted public health imperatives as published in the DHH Business Plan, including:

- 1. Creating transparency of retail food establishment sanitation information**
Annually, DHH Sanitarian Services personnel perform 300-point inspections on nearly 34,000 retail food establishments. DHH launched a new food safety website www.eatsafe.la.gov, which provides the public access to sanitary inspection reports on Louisiana retail food establishments that DHH permits and inspects.
- 2. Improving outdated and inefficient processes in Vital Records and Statistics**
The DHH Center for Records and Statistics implemented the Louisiana Electronic Event Registration System (LEERS) Birth Module, followed by the Sales and Management (SAM) Module during state fiscal year 2011. LEERS is a multi-year endeavor to re-engineer the issuance and registration processes of Louisiana Vital Records. LEERS streamlines the registration of vital events by replacing the inefficient and outdated DOS-based and manual system that relies on paper vital event records. The new application improves the data quality and the timeliness that vital event data is collected and accessible. All birthing hospitals within the state

began to electronically register birth records beginning December 6, 2010. The Vital Records Main Office at New Orleans began using the SAM Module for case management, request tracking, issuance of certified copies of birth certificates and birth cards, printing of certified copies of newborn complimentary birth certificates, accounting and auditing on January 31, 2011. At the same time, all other Vital Records issuance offices began using the SAM Module for request tracking and the issuance of certified copies of birth certificates and birth cards. The ITOP, Divorce, Marriage, Death and Fetal Death Modules of LEERS will be implemented during Fiscal Year 2012. These modules require thorough testing by Vital Records staff as well as external users, and they must continuously be supported by Vital Records Field Consultants.

3. “Top Marks” Nationally for Public Health Preparedness by the CDC and Trust for America’s Health

Louisiana received top marks nationally for level of preparedness in general and for its chemical/biological laboratory and response readiness (communication) capabilities. The Centers for Disease Control and Prevention in a publication of its annual report *Public Health Preparedness: Strengthening the Nation’s Emergency Response State by State* (December 2010), rated Louisiana’s preparedness levels high across the board and on several measures, Louisiana achieved perfect scores.. Accomplishments highlighted in the report for Louisiana include:

- a. Louisiana has a laboratory that is capable of testing for specific biological agents. The state’s lab passed both of the CDC’s proficiency tests used to evaluate their abilities to receive, test and report on one or more suspected biological agents. The lab also met the CDC’s time requirements for submitting results to the PulseNet database 100 percent of the time.
- b. Louisiana has a laboratory with the ability to respond should the public be exposed to chemical agents. The state’s lab successfully demonstrated proficiency in four out of six core methods for rapidly detecting and measuring certain chemical agents that can cause severe health effects.
- c. The state has a 24/7 reporting capacity system that could receive urgent disease reports at any time; Louisiana responded to Health Alert Network’s (HAN) test message within the allotted time each time it was tested.
- d. On its ability to stage, distribute, and dispense medical assets received from CDC’s Strategic National Stockpile or other sources, Louisiana received a perfect score of 100%, improving 6 percentage points from the 2007-2008 evaluation.
- e. To improve its readiness to respond, Louisiana activated its public health emergency operations center (EOC) as part of an exercise or drill five times during the fiscal year, and staff reported to the EOC within the target time of 2.5 hours every time.

In December 2010, Trust for America released its eight annual *Ready or Not? Protecting the Public from Diseases, Disasters and Bioterrorism Report*.

Louisiana achieved nine out of 10 key indicators for public health emergency preparedness and achieved its highest ever scores for public health preparedness for:

1. Maintaining the state funding commitment for public health programs.
2. Sending and receiving electronic health information to health care providers and community health centers.
3. Having an electronic syndromic surveillance system that can report and exchange information.
4. Ability to acknowledge pre-identified staff for emergency exercises within one hour.
5. Activating the DHH Emergency Operations Center as part of a drill, exercise, or real incident a least twice in 2007-2008.
6. Developing at least two after-action report/improvement plans after an exercise or real incident in 2007-2008.
7. Rapidly identifying disease-causing E-coli O157:H7 and submitting the results by PulseNet within four working days 90% of the time.
8. Increasing laboratory response network for chemical treat (LRN-C) capability
9. Developing after action and improvement plans.

4. **Improving National Education Standards in Emergency Medical Services**

The DHH Bureau of Emergency Medical Services implemented the first phase of the new National Education Standards that “define the minimal entry-level educational competencies, clinical behaviors, and judgments that must be met by each level of EMS personnel as identified in the National EMS Scope of Practice Model.” The Standards as they are commonly called include four components:

1. Competency – Represents minimum competency required for entry-level personnel at each licensure level.
2. Knowledge Required to Achieve Competency - Represents an elaboration of the knowledge within each competency (when appropriate) that entry-level personnel would need to master in order to achieve competency.
3. Clinical Behaviors/Judgments - Describes the clinical behaviors and judgments essential for entry-level EMS personnel at each licensure level.
4. Educational infrastructure – Describes support standards necessary for conducting EMS training programs at each licensure level

EMS also developed the Louisiana EMS transition toolkit documents. The Louisiana EMS transition toolkits were subsequently adopted as the National EMS transition toolkit for the use of all 56 states and territories. The Bureau of EMS held 24 “town hall” stakeholder meetings throughout the state. These town hall meetings allowed the Bureau to distribute the information regarding the first major EMS education change in 15 years to the EMS community. The meetings were also a forum for the Bureau to gauge the level of support for this change along with the

ability to solicit input from the stakeholders in the creation, refinement and distribution of these new transition documents.

B. Why is this success significant? The success of the four public health performance improvements are significant for the following reasons:

1. **Creating transparency of retail food establishment sanitation information**

Health inspection reports have always been public record. Residents had to request copies from parish health units and then go into the facility to review the full report. These reports are now available to the public in a more accessible manner. The EatSafe website will give users details on violations found at each establishment and corrective actions taken. The new food safety website helps to empower residents to make informed decisions about where they eat and encourages them to become partners with DHH and restaurants to help prevent food-borne illness.

2. **Improving outdated and inefficient processes in Vital Records and Statistics**

The LEERS Birth and SAM Modules have allowed for a web-accessible, state-of-the-art electronic registration system for births and the issuance of certified copies of birth certificates and birth cards. The implementation reduced outdated and duplicative data entry and transmission of birth records while creating an easy to use interface for Vital Records and external stakeholders. The Birth Module has improved data quality and the timeliness that birth data is accessible for dissemination, research and analysis. The implementation of the LEERS Birth and SAM Modules has allowed Vital Records to reduce the amount of time between birth and registration from an average of 72 days to 17 days; reduce the amount of time between birth registration and mailing of the complimentary birth certificate from 60 days to less than 3 days; and provided built-in validations to ensure that mandatory fields are complete and that entries beyond normal ranges are verified by the user.

3. **“Top Marks” Nationally for Public Health Preparedness by the CDC and Trust for America’s Health**

Louisiana’s public health preparedness accomplishments reflect nearly ten years of progress that Louisiana has made to improve how the state prevents, identifies, and contains new disease outbreaks and bioterrorism threats and responds to the aftermath of natural disasters since hurricanes Katrina and Rita in 2005.

4. **Improving National Education Standards in Emergency Medical Services**

The new National Education Standards will allow the 20,000 existing and the future EMS professionals in Louisiana to maintain national EMS certification as well as national EMS education accreditation. The new standards will also allow the state to implement the new National EMS Scope of Practice which has been adopted by the Louisiana EMS Certification Commission. The existing EMS scope of practice is over 30 years old and it has never been updated. Adoption of the new standards will also allow the state to make changes to curriculums as soon as the standards are adopted. This new process will eliminate out of date curriculums from being taught

in the classroom.

C. Who benefits and how? Residents, visitors, government and private entities benefit from public health's performance improvements in these ways:

1. **Creating transparency of retail food establishment sanitation information**

Restaurants only account for 50 percent of the establishments monitored by DHH's Food Safety Certification Program. DHH is responsible for permitting and inspecting more than 8,800 markets - including meat and seafood markets - 4,700 bars, close to 2,500 daycare and residential facilities and a number of seasonal establishments like snowball stands in the summer and food carts found at festivals across the state. Residents and visitors benefit from the food safety website by having access to updated, online information about these and other retail food establishments that potentially impact their lives on a daily basis. Individuals can make informed decisions about what they eat and also help to prevent foodborne illness.

2. **Improving outdated and inefficient processes in Vital Records and Statistics**

The implementation of the LEERS Birth and SAM Modules benefit Louisiana residents and visitors, native Louisianans who now reside outside of the state, hospitals, Vital Records issuance offices and the Vital Records Main Office. Internal program areas and external stakeholders that rely on Vital Records birth data to develop policy and target strategies to improve health outcomes, such as Maternal and Child Health and Birth Outcomes, benefit from the implementation of these modules.

3. **"Top Marks" Nationally for Public Health Preparedness by the CDC and Trust for America's Health**

These national achievements show that Louisiana's public health preparedness personnel efforts have resulted in the state having an integrated network of health care, laboratory, and emergency response capacities. Since 2005 the state has progressively made improvements in the state's ability to rapidly identify and respond to biological, chemical, radiological, or naturally occurring public health threats. Residents and visitors have a resilient and dependable infrastructure that will quickly identify emerging health threats and respond swiftly to contain them; communicate electronic health information to healthcare providers and community health centers; and rapidly alert the public and provide them with credible information about what to do in an emergency event.

4. **Improving National Education Standards in Emergency Medical Services**

All persons in Louisiana benefit from EMS professionals who are nationally certified and educated at the most current nationally recognized standards. These new standards will allow new cutting edge technologies and new procedures and medications to be introduced in a timely manner. The old process required changes in strict national curriculums which were not updated on a regular basis. One curriculum is nearly 30 years old and has never been updated.

D. How was the accomplishment achieved? Public health performance improvements were achieved by:

1. **Creating transparency of retail food establishment sanitation information**

The inspection process is an evaluation of the requirements addressed in Title 51, Public Health Sanitary Code, Part XXIII, Retail Food Establishments. There are 17 categories that a retail food establishment is evaluated on. Violations in eight of these categories are considered critical and the remaining nine categories are considered non-critical violations.

The 8 Critical Violations include:

1. Food – Condition, Source, Labeling
2. Food – Time/Temperature
3. Personnel – Employee Health, Practices
4. Cross Contamination
5. Food contact Equipment/Utensils Construction and Sanitization
6. Toxic Chemicals
7. Water/Sewage
8. Insects/Rodents/Animals

The 9 non-critical violations include:

1. Labeling
2. Food protection
3. Utensils/Equipment/Single Service
4. Personnel, clothes, hair restraints
5. Toilets/Hand Wash facilities
6. Garbage/Refuse Disposal
7. Structural/Design/Maintenance/Plumbing
8. Permits/Plans/Food Safety Certificates
9. Miscellaneous (linen, wiping cloths, maintenance equipment, laundry facilities, water pressure)

Electronic inspection software is used when conducting the inspection. The program provides a drop down selection button in each category that allows the Sanitarian to immediately identify the specific applicable code reference and statement for each violation. The information can then be printed and immediately provided to the retail food establishment at the time of the inspection. The detailed report is a useful management tool for the establishment.

Public knowledge of the website was accomplished through a DHH media event. Links were provided on the current DHH website as well as the Retail Food Program site, and DHH's Media and Communications sent out a news release for the newspaper and television media. Based on experiences from the previous inspection web site, television media and word of mouth were extremely effective.

The results of at least one previous retail food inspection for each establishment were uploaded to the public website prior to the go live date in August 8, 2011. Since the launch of the website, all retail food establishment inspections are uploaded within seven days of the inspection being completed. In addition to inspection data, the site will also be used to educate the public on food safety (commercial and residential), emergency/disaster food and water safety, and other useful information such as recalls initiated by USFDA. The website will also allow consumers to contact DHH to issue a complaint or comment about restaurant sanitary conditions.

A reduction in the number of restaurant-attributable food borne disease outbreaks will be measured by a reduction in the number of food related complaints and a decrease in the number of re-inspections due to uncorrected violations. This will be measured and monitored on a quarterly basis. Increased transparency of retail food inspections is expected to decrease both of these measures progressively over a one year period to reach a total reduction of 10%.

2. Improving outdated and inefficient processes in Vital Records and Statistics

The LEERS Birth and SAM Modules were implemented through detailed design and development, collaboration with external stakeholders, rigorous testing and comprehensive training of Vital Records staff, internal stakeholders and external stakeholders. Vital Records Field Consultants ensured that users were prepared for the launch of the new Birth and SAM Modules and have been available for support since the modules went live.

3. Top Marks” Nationally for Public Health Preparedness by the CDC and Trust for America’s Health

DHH has developed all-hazards preparedness plans that have all been tested through discussion-based tabletop exercises and full-scale drills to target plan weaknesses for corrective action. Each year, plans are re-evaluated, updated and retested to assure that Louisiana is meeting national standards and its workforce remains well trained for emergency response. This accomplishment was achieved through ongoing state planning efforts with the Centers for Disease Control and Prevention, the Health Resources Services Administration and other national partners; through strong partnerships with the healthcare community, all state departments, volunteer organizations, and grass roots door-to-door public awareness and outreach.

4. Improving National Education Standards in Emergency Medical Services

EMS utilized its partnerships with the EMS community to distribute the planned changes in the most effective way possible. Staff members traveled throughout the state reducing the need for stakeholders to travel at their expense. This strategy allowed a much larger audience than the traditional education updates that were normally held at one location in 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?

Yes, public health has been able to use technology to improve service delivery, streamline processes, and replace an outdated and inefficient system for vital records; increase public access to retail establishment's inspections; and assure a competent and well-trained public health emergency preparedness and EMS workforce of paramedics, first responders, firemen, EMTs.

II. Is your department five-year Strategic Plan/Department 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.

As published in the DHH Business Plan *A Roadmap to a Healthier Louisiana* public health is concerned with

1. Transforming health systems by improving public health outcomes through coordinated care
2. Creating meaningful use of information technology and improving processes by improving performance on key public health imperatives including:
 - Quality improvement and efficiency of food safety and safe drinking water regulatory operations
 - Outdated and inefficient processes in Vital Records and Statistics
 - Transparency of retail food establishment sanitation information

Public health is making progress towards attaining its public health imperatives through its solution as follows:

Quality improvement and efficiency of food safety and safe drinking water regulatory operations are being improved by addressing:

1. **Codes and standards:** Sections of the Public Health Sanitary Code that are particularly problematic will be revised through a comprehensive and transparent process that includes all major stakeholders. In addition, the Code can be more uniformly applied by making memos of previous decisions or conclusions universally accessible by state and local enforcement officials through an OPH Web Portal.

During FY 11, DHH started the rulemaking process to revise Title 51, Part VII (Milk, Milk Products, and Manufactured Milk Products) and Part VIII (Frozen Desserts). These revisions are complete and the new code will be Title 51, Part

VII (Milk, Dairy Products and Manufacturing/Processing Regulations). The new title will be published in the September 20, 2011, issue of the Louisiana Register.

2. **Education:** Implement a focused internal and external education campaign using technology to reach priority audiences.
3. **Peer review:** Conduct an objective analysis of plan reviews and food establishment inspections to assess quality and consistency, and develop interventions to address shortfalls. In addition, letters of intent to modify the code will be subject to more comprehensive peer review and stakeholder input.

Outdated and inefficient processes in Vital Records and Statistics:

Industrial engineering experts have assessed public health's current processes and have determined that through the development and continued implementation of LEERS, the agency is on the right track to yield greater efficiency and improve performance on key indicators. The solution includes continued implementation of an electronic system called LEERS, that has already resulted in the implementation of the birth module and SAM Module for case management, request tracking, issuance of certified copies of birth certificates and birth cards, printing of certified copies of newborn complimentary birth certificates, accounting and auditing on January 31, 2011. At the same time, all other Vital Records issuance offices began using the SAM Module for request tracking and the issuance of certified copies of birth certificates and birth cards. The ITOP, Divorce, Marriage, Death and Fetal Death Modules of LEERS will be implemented during Fiscal Year 2012. These modules require thorough testing by Vital Records staff as well as external users, and they must continuously be supported by Vital Records Field Consultants.

Vital Records is already seeing improved performance that has the following benefits:

- Reduction in the amount of time it takes for birth certificates to be registered with Vital Records
- Improvements in the timeliness and quality of birth data available to other programs
- Improved efficiency and savings due to reductions in the amount of data entry required by Vital Records
- Improved access to certified copies of vital records for the public

Transparency of retail food establishment sanitation information:

This includes online posting of sanitary conditions for restaurants and other retail food establishments.

Public health has launched an online food safety website that places the results of inspections for approximately 34,000 retail establishments and corrective actions taken for those businesses found to be in violation of retail food codes. This initiative will enhance public confidence that rigorous food safety standards exist and are being assessed and enforced, and will give the public easy access to information about sanitary conditions in the state's food establishments. Improvement in this area is a

priority for the public, and could ultimately lead to fewer restaurant-attributable food borne disease outbreaks.

- ♦ **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?

Public health imperatives progress benchmarks already achieved include:

1. October 2010:
Complete vital records industrial engineering assessment and receive report and recommendations
 2. December 2010
Implement LEERS birth module
 3. January 2011
Engagement of expert(s) to conduct independent assessment of sanitation plan reviews and inspections
 4. March 2011
Complete Independent review with recommendations
 5. April 2011
Procure system to publicly post restaurant and other retail food establishment inspection results
- ♦ **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?

None.

- ♦ **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?

Public health is not experiencing a significant lack of progress on its imperatives as of this reporting.

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?

Public health is on target in meeting the benchmarks identified in the DHH business plan. The office has identified new benchmarks in the FY 12 business plan to continue improving its public health imperatives.

- ♦ **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.

DHH offices are required to develop a business plan that contributes to the department mission to improve and protect the health of Louisianans. Each plan is evaluated by the Secretary at mid-year and year-end to track and assess each offices progress in meeting

its benchmarks. Offices describe success, challenges, and provide recommended solutions to overcoming problems. Corrective actions resulting from the mid-year and year-end evaluations are incorporated into the offices plans. DHH has developed a monitoring tool on its sharepoint site to track agency progress, plan updates and solutions.

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, condition of the state fisc, 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?

Public health is seeing great improvements around its imperatives and does not report any issues as of this reporting.

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

Annual Management and Program Analysis Report

Fiscal Year 2010-2011

Department: Department of Health and Hospitals
09-330 Office of Behavioral Health

Department Head: Bruce D. Greenstein, Secretary

Undersecretary: Jerry Phillips

Agency Head: Anthony Speier, Deputy Assistant Secretary

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

Integration of Mental Health (MH) and Addictive Disorders (AD) in Central Office

A. What was achieved?

During FY 2010- 2011, the consolidation of the Offices of Mental Health (OMH) and Addictive Disorders (OAD) into the Office of Behavioral Health is 98% complete at the Central Office level. The only remaining item was the approval by Civil Service of the revised position descriptions submitted for each employee.

B. Why was this success significant?

The consolidation of the two offices was a requirement of Act 384 of the 2009 Regular Session and necessary for the efficient use of resources and the integration of assessment and treatment approaches for a population that has a high incidence of co-occurring disease.

C. Who benefits and how?

The consolidation of OAD and OMH benefits all the citizens of Louisiana by creating a more efficient behavioral health system resulting in a significant cost savings to the state and also benefits the people served by integrating their treatment needs when appropriate.

D. How was this accomplishment achieved?

Act 384 established an Implementation Advisory Committee to make recommendations on the consolidation. Central Office staff and community stakeholders participated in the development of the recommended strategy for consolidation. As a result of the committee's planning efforts, OBH was able to develop an efficient organizational structure with a new organizational chart to eliminate positions with duplicated functions and to select executive positions in a leadership role.

Three OBH divisions, consistent with the advisory group recommendations, were created to support integrated care. These divisions include:

- the administrative division (human resources, fiscal, operational);
- the system of care division, (mental health and addictive disorder prevention and treatment); and
- the development division, (research and design, integrated policy and planning, business intelligence/information technology, quality assurance).

Staff with respective addictive disorders and mental health specializations were assigned and redistributed throughout the organization. Previously non-integrated addictive disorder and mental health specialized tracks were completely merged within the three primary organizational areas (OBH Implementation Statues Report prepared in response to Act 384 of the 2009 regular session, June 2011-Executive Summary).

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

The current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). For the purpose of this report, the Business Plan that was submitted to the Secretary of the Department of Health and Hospitals will be referred to as "the OBH Strategic Plan", since it contains current information.

Yes, the integration of MH and AD in Central Office is Priority One in the OBH 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 restructuring and consolidation of two state offices into one more effective and efficient office is a significant accomplishment that would benefit other executive branch departments or agencies.

Integration of Mental Health (MH) and Addictive Disorders (AD) in the Regional Offices and Regional Clinics**A. What was achieved?**

During FY 2010-2011, OBH integrated former OMH and OAD regional offices and regional clinics to create one regional administrative structure and integrated behavioral

health clinics providing addictive disorders and mental health services. This process also fostered the creation of civil service titles which adequately reflect the administrative needs for management of the clinics.

B. Why was this success significant?

The consolidation of the two offices was a requirement of Act 384 of the 2009 Regular Session and necessary for the efficient use of resources.

C. Who benefits and how?

Consumers benefit by having mental health and addictive disorders services in the same location, this is especially significant in that over 50% of the clients served have co-occurring mental health and addictive disorders and receive treatment services for both disorders in the same location. Employees benefit as a result of the collaborative learning environments created by the merger.

D. How was this accomplishment achieved?

Re-organization at the regional levels resulted in a consolidated management structure with a single regional administrator for overall behavioral health operations in that locale. Fiscal functions, administrative support functions and clinical management functions were redesigned to build in efficiencies and eliminate duplications. Efforts to balance the needed expertise were made, in an effort to ensure continuity of operations in the midst of the massive system changes and to ensure a balance of representation between mental health and addictive disorders. Similar to the OBH central office, there were cost savings that provided for the elimination of 179 positions. (OBH Implementation Status Report prepared in response to Act 384 of the 2009 regular session, June 2011-Executive Summary).

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

The current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). For the purpose of this report, the Business Plan that was submitted to the Secretary of the Department of Health and Hospitals will be referred to as “the OBH Strategic Plan”, since it contains current information.

Yes, the integration of MH and AD in Central Office is Priority Two in the OBH Strategic Plan. Additionally, by maintaining existing services and reducing duplication in staffing and facilities this initiative enforces the goals of the existing 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 consolidation of the Office of Behavioral Health has positioned the State to take advantage of funding and program innovations which will result in better access to services and treatment. (Implementation Status Report prepared in response to act 384 of the 2009 regular session, June 2011-Conclusion).

Privatization of Addictive Disorders Services

A. What was achieved?

During FY 2010, 2011, OBH privatized six Addictive Disorders residential treatment programs that were previously operated and staffed by DHH/OBH employees these programs included Joseph Briscoe Treatment Center in Lake Charles, Red River Treatment Center and Red River Co-occurring Unit in Pineville, Pines Treatment Center in Shreveport, SOAR Treatment Center in West Monroe, and Springs of Recovery Adolescent Inpatient Center in Greenwell Springs.

B. Why was this success significant?

By privatization OBH was able to save \$2.5 million (OBH 2010-2011 Budget) in reduced cost for residential treatment services without a decrease in number of beds available.

C. Who benefits and how?

Consumers benefit by no reduction in number of residential treatment beds.

D. How was this accomplishment achieved?

Using the Request for Proposals (RFP) process OBH secured proposals from private providers and selected the best providers to assume operations of these established programs.

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

The current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). For the purpose of this report, the Business Plan that was submitted to the Secretary of the Department of Health and Hospitals will be referred to as “the OBH Strategic Plan”, since it contains current information.

Yes, the integration of MH and AD in Central Office is Priority Three in the OBH 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. By privatization OBH was able to save \$2.5 million (OBH Budget FY 2010-2011) in reduced cost for residential treatment services without a decrease in number of beds available and puts Louisiana Behavioral Services among those in the nation that maximize resources without incurring additional cost.

Sustaining the ATR Prototype

A. What was achieved?

During the previous fiscal year, the Access to Recovery (ATR) program served 4,371 people statewide (Data Source: LA-ATR Voucher Management System). ATR is a voucher-based program that provides both substance use clinical treatment and recovery support services to people with alcohol or drug abuse problems. The ATR program engages in agreements with community-based agencies to function as service providers. Community-based provider agencies include private, public, non-profit, for-profit, and faith-based agencies. 69% (of 3,537 clients discharged from ATR treatment services, 2,425 successfully completed treatment) of those being discharged from the program successfully completed treatment.

B. Why is this success significant?

ATR is a treatment model that works with people who may not typically be engaged in traditional treatment programs. Outreach and marketing efforts by non-traditional service providers, which include community-based and faith-based agencies, encourage individuals to become engaged in treatment activities and recovery support services.

C. Who benefits and how?

ATR continues to be a cost effective, efficient, and successful investment of State dollars into DHH programs and local communities.

ATR continues to provide clinical treatment and recovery support services to persons with substance use disorders through the voucher program, which is driven by consumer choice and services provided by community-based organizations. The outcome measures (see chart below) on abstinence, crime, education, stable housing and social connectedness show the benefit of the program to participants and the community at large.

LA-ATR Outcomes (SFY 2011)					
	Valid Cases	INTAKE		DISCHARGE	
Abstinence	2,406	774	32.2%	2,084	86.6%
Crime (no arrests in past 30 days)	2,422	2,242	92.7%	2,376	95.7%
Education/Employment	2,288	777	34.0%	1,350	59.0%
Stable Housing	2,309	1,553	67.3%	1,585	68.6%
Social Connectedness	2,237	1,966	87.9%	1,864	83.3%

Data Source: LA-ATR Voucher Management System

D. How was the accomplishment achieved?

Performance Based Budgeting - ATR provider annual review process is used to determine which provider agencies are performing well with good outcomes and are allowed to continue with the program.

The LA-ATR web-based voucher management system makes monitoring of provider activities, individual client vouchers, clinical records, services provided, and provider reimbursements possible through remote on-line monitoring; thus, reducing administrative costs of the program.

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

The current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). For the purpose of this report, the Business Plan that was submitted to the Secretary of the Department of Health and Hospitals will be referred to as “the OBH Strategic Plan”, since it contains current information.

Yes, the integration of MH and AD in Central Office is Priority Four in the OBH 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?

The ATR voucher program and web-based voucher management system has served as a prototype for the knowledge and movement of OBH into a managed care environment. The ATR program has served as a simulated administrative service organization overseeing the provision of substance use treatment and recovery support services by independent (non-State) provider agencies statewide since 2005 within OBH.

Right-Sizing State Psychiatric Hospitals

A. What was achieved?

DHH/OBH is balancing the hospital component of the service system. OBH/ELMHS opened a new eighty two (82) bed residential Secure Forensic Facility between August 31, 2010 and January 10, 2011. Occupancy rate for FY11 was 93%. Eighty-two residential beds are open at Eastern Louisiana Mental Health System (ELMHS) with a 93% occupancy and daily admissions; Forty (40) additional community based forensic residential beds were opened in Baton Rouge and another twenty-two (22) were opened in New Orleans creating less restrictive treatment alternatives in the community for the forensic population. Thirty-five (35) acute beds were closed between Southeast Louisiana Hospital (SELH) Acute Unit and ELMHS/East Acute Unit at Greenwell Springs Hospital. All 118 of the targeted 118 civil inpatient beds have been closed at ELMHS and fifty-six (56) forensic beds were closed at Central Louisiana State Hospital in Pineville with individuals being transitioned into community placements. Twelve (12) youth beds were relocated from Central Louisiana State Hospital to SELH to gain fiscal efficiencies through operations and reduced per diem rate.

B. Why was this success significant?

The Mental Health Redesign was created in an effort to manage the impact of the budget constrictions. OBH used this opportunity to shift funding from high cost institutional care to fund an array of supports and services in the community to permit more individuals to leave the restricted environments of institutional care. This shift allowed Louisiana to take a major step toward community based care and decrease its reliance on costly institutional care. Additionally, each of the state’s three (3) psychiatric facilities

have engaged in various measures to achieve increase efficiencies of the operations within the facilities, including outsourcing, combining and/or sharing resources, and improved management practices.

C. Who benefits and how?

OBH has been able to comply with the Federal Consent Decree by decreasing the waiting time for hospital based competency restoration from over one year to no more than 30 days.

Individuals receiving mental health supports and services through the DHH/OBH System of Care are the primary beneficiaries of the redesign. Individuals previously living in institutions are able to participate in community living and lead productive lives. Ultimately, Louisiana taxpayers will benefit, due to less reliance of costly inpatient care. Families and significant others benefit through additional supports and services for persons with mental illnesses and are afforded the opportunity to play a significant in the life and recovery of their loved one.

D. How was this accomplishment achieved?

This was accomplished by reducing reliance on inpatient care and increasing the array of community based supports and services. OBH retained a 3rd party evaluator to assist in determining the appropriate level of care for all hospitalized individuals. Central Office worked closely with the hospital and the communities to facilitate collaboration that promoted timely and well planned discharges from intermediate care beds. OBH staff effectively collaborated with the client, family, hospital, regions and Local Governing Entities (LGEs) to effect successful transitions from inpatient care. OBH collaborated with other intermediate care facilities to streamline and share resources.

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

The current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). For the purpose of this report, the Business Plan that was submitted to the Secretary of the Department of Health and Hospitals will be referred to as “the OBH Strategic Plan”, since it contains current information.

Yes, the integration of MH and AD in Central Office is Priority Five in the OBH 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?

The right-sizing of state psychiatric hospitals is a significant accomplishment and places Louisiana among other states following the national trend away from extended inpatient care for mental illness. Other agencies within the state would benefit from right-sizing departments within agencies.

Responding to the Forensic Lawsuit

A. What was achieved?

Federal lawsuit alleging excessive wait time for jail-based competency restoration clients awaiting admission was filed by the Louisiana Advocacy Center on April 12, 2010. DHH was able to successfully address the issues raised in the Federal suit. Through OBH, DHH developed a plan and expanded programming to ensure the timely restoration of competency and/or the provision of mental health assessment/treatment as indicated. The plan was acceptable to the Court and DHH/OBH received a letter of commendation from the Court following the filing of the consent decree in April 2011. The plan is fully implemented and report refinement has been completed.

B. Why was this success significant?

OBH has been able to comply with the Federal Consent Decree by decreasing the waiting time for hospital based competency restoration from over one year to no more than 30 days.

C. Who benefits and how?

Forensic clients benefit from having their mental health needs addressed in a more timely and efficient manner. The judicial system benefits by the increased emphasis placed on competency restoration and the decrease in time that it takes an individual to regain competency and proceed to trial. Local and parish jails benefit through a reduction in population, thus reducing overcrowding and costs.

D. How was this accomplishment achieved?

As soon as the original Federal lawsuit was filed by the Advocacy Center in August 2010, DHH/OBH made the forensics system a priority. OBH and East Louisiana Mental Health System (ELMHS) were able to increase the number of community and jail-based staff who provide competency restoration from nine to sixteen, allowing the clients to receive twice weekly restoration while in the jails and to be screened to determine level of need for hospitalization. OBH and ELMHS staff met regularly to review each individual case to determine the most appropriate placement. OBH contracted with the LSU Construction Management and Industrial Engineering Department to conduct a simulation-based assessment of the competency restoration process that was completed in January 2011. The results provided the number of beds needed for each of several different scenarios, allowing OBH to determine that a turnover of two beds per week is needed to ensure that OBH would be able to meet the 30-day timeline set by the consent decree. The addition of programmatically appropriate and cost-effective step-down treatment options for forensic patients allowed individuals to move to more appropriate treatment settings which allowed hospital beds to become available more frequently. A comprehensive database has been in development at ELMHS to document compliance with the Consent Decree. The database, completed in August 2011, allows the community forensics division to more accurately assess the status of clients and to provide the monthly report required by the court.

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

The current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). For the purpose of this report, the Business Plan that was submitted to the Secretary of the Department of Health and Hospitals will be referred to as “the OBH Strategic Plan”, since it contains current information.

Yes, the integration of MH and AD in Central Office is Priority Six in the OBH 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?

The effective implementation of appropriate cost-effective step-down treatment options would benefit other agencies providing long term inpatient or residential care. The methods used were well thought out and involved the collaboration and cooperation of numerous groups within OBH. Other agencies would benefit from following this methodology.

Developing and Implementing Civil Discharge Initiatives**A. What was achieved?**

During FY 2010-2011, OBH closed 118 ELMHS beds and discharged 200 patients from intermediate care facilities throughout the state.

B. Why was this success significant?

The 200 discharges and closure of 118 ELMHS beds allowed OBH to right-size the psychiatric hospitals. A follow-up tracking system indicates that 80% of discharges remain stable and most (65%) are living in independent settings, thus reducing their reliance on inpatient psychiatric care.

C. Who benefits and how?

The patients discharged from inpatient facilities will be able to have a higher quality of life, acquire skills and live in less restrictive settings. Families of the patients will be able to have more frequent contact with their loved ones which will enhance relationships. The state will benefit through reduced costs.

D. How was this accomplishment achieved?

Implementation strategies and infrastructure were developed that support and evaluate the discharge initiative. Other residential options and capacity building operations were developed and implemented. Inter-hospital transfers were coordinated; critical factors biographical data was reviewed; the Continuity of Care (CoC) Process and Plan was developed and followed; and a post discharge tracking system was developed.

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

The current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). For the purpose of this report, the Business Plan that was submitted to the Secretary of the Department of Health and Hospitals will be referred to as “the OBH Strategic Plan”, since it contains current information.

Yes, the integration of MH and AD in Central Office is Priority Seven in the OBH 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 forms a prototype logic model that other agencies may use for rebalancing initiatives.

Evidence-Based Community Support Programs**A. What was achieved?**

For Fiscal Year 2010-2011, the Office of Behavioral Health (OBH) contracted with qualified providers awarded through the Request for Proposal (RFP) process for Assertive Community Treatment (ACT) services which is an evidence based practice sanctioned by Substance Abuse and Mental Health Services Administration (SAMHSA). OBH contracted with qualified providers awarded through the Request for Proposal (RFP) process for Intensive Case Management services (ICM) which is a best practice service. OBH in collaboration with the Permanent Supportive Housing (PSH) initiative for the Go Zone actively pursued housing opportunities for persons eligible for the PSH program. The Go Zone is comprised of Metropolitan Human Service District (MHSD), Jefferson Parish Human Service Authority (JPHSA), Florida Parish Human Service Authority (FPHSA), Capital Area Human Service District (CAHSD), OBH Region 4 and OBH Region 5. OBH staff in collaboration with persons seeking PSH successfully completed the application process for project based safe and affordable housing for those person’s meeting the program criteria. Additionally, OBH issued funding to the community through the contract process to qualified providers for wraparound support services and bridge funding to assist persons discharging from intermediate hospitalization or at risk for re-hospitalization.

Wraparound support services could include accessing a personal care attendant (PCA) or a qualified Psychiatric Aide to provide supports to the person as they gained the skills to function in a community setting after discharge from intermediate hospital level of care. Bridge funding dollars were allocated through a central office process to allow for startup funding for persons moving into independent community residency.

B. Why was this success significant?

This initiative represents the efforts to move persons in a highly restrictive level of care to a least restrictive level of care. The redesign and realignment of service delivery for efficiency and effectiveness provided the State the opportunity to realign the behavioral health system of care to serve persons in the most appropriate level of care made possible by funding evidence based programs, promising practice programs and therapeutic residential housing supports. With these community based services in place, the initiative was successful for persons exiting intermediate hospital level of care to be supported in community residency.

C. Who benefits and how?

Adults discharged from intermediate hospital level of care. The discharge initiative benefited not only 118 persons from intermediate hospital level of care but also the additional 71 persons discharged in the hospital discharge initiative. By providing ACT, ICM, PSH and access to therapeutic residential housing supports, persons were discharged into the community of their choice and are being supported by these programs and housing supports to maintain community residency. OBH is maintaining a monitoring process at the Central Office level to allow for interagency intervention should the need arise to assist persons in maintaining community level of care.

D. How was this accomplishment achieved?

Evidence-Based Community Support Programs Based on person centered data and community capacity, Assertive Community Treatment (ACT) teams were located in Metropolitan Human Service District (MHSD), Capital Area Human Service District (CAHSD), Jefferson Parish Human Service Authority (JPHSA), and OBH regions 4, 5, 6, 7. The ACT service capacity was originally 1,200 persons. ACT capacity was reduced by 100 by CAHSD for a total capacity of 1,100. The Intensive Case Management (ICM) teams were located in MHSD, CAHSD, Florida Parish Human Service Authority (FPHSA), South Central Louisiana Human Services Authority (SCLHSA), and OBH regions 4, 5, 7, 8. The ICM service capacity was originally 1,725. ICM capacity was reduced by 100 by CAHSD for a total capacity of 1,625. The Permanent Supportive Housing (PSH) project based housing vouchers allowed 1,995 persons to be housed since the inception of the initiative. The PSH program allowed for 147 out of 200 persons across three DHH agencies (i.e., OBH, OCDD, OAAS) to be eligible for institutional super preference for available housing units. The therapeutic residential housing support funding allowed for additional service delivery for skill building to those persons discharged into the community as well as personal care supports and services. Additionally, this funding allowed for “bridge/startup” funding for persons residing independently within the community.

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

The current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). For

the purpose of this report, the Business Plan that was submitted to the Secretary of the Department of Health and Hospitals will be referred to as “the OBH Strategic Plan”, since it contains current information.

Yes, the integration of MH and AD in Central Office is Priority Eight in the OBH 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 initiative should be shared with other executive branches since it embraces the nationally recognized recovery and resiliency movement. This methodology can be utilized to assess and to provide an infrastructure for assisting persons in Louisiana to live a healthy, productive life in a community of choice reducing dependency on the state for costly higher levels of care primarily acute and intermediate hospitalization.

Implementing and Integrating Prevention Services

A. What was achieved?

OBH has continued the policy that all Community Based Prevention Programs are required to implement evidence-based programs, policies and practices. During SFY 2011, OBH Prevention contracted with a total of 62 providers to include 52 Community-Based Prevention Providers and 10 Synar Projects. The 52 Community-Based Prevention Providers provided a total of 20 different evidence-based programs. 100% of all programs funded by SAPT Block Grant were evidence-based. During SFY 2011 (July 1, 2010 – June 30, 2011). Prevention Services provided evidence based services to 77,171 enrollees. This is 7% increase in the number of enrollees served during SFY 2011 vs. SFY 2010 (72,095). In SFY 2011, the Louisiana Partnership for Youth Suicide Prevention (LPYSP) trained 25 individuals as ASIST Trainers (Applied Suicide Intervention Skills Training) across the state and 17 individuals as safeTALK Trainers. These trainers will be able to sustain these trainings in by 2012 when they become registered trainers. During SFY 2011, 641 individuals participated in ASIST, safeTALK and Suicide 101 trainings. Through its Media Campaign, over 10,000,000 individuals across the state were exposed to suicide prevention awareness messages.

B. Why was this success significant?

In requiring evidence-based programs, the agency is ensuring the most effective and efficient delivery system. This increase in service delivery is due to OBH’s partnership with the Department of Education, the mobile service delivery model and cost bands for universal and selective programs. This partnership allows us to provide services directly to the youth population while utilizing the Department of Education’s infrastructure. This reduces our infrastructure cost and allows those resources to be moved to direct services. The cost band for universal, selective, and indicated programs helps us keep our cost down based on the actual cost of service delivery for specific programs. Universal programs target the general population; selective programs target individuals that are at highest risk for developing substance use behaviors; and indicated programs

provide early intervention for individuals that are exhibiting high-risk behaviors. This is based upon the program developer's information on training cost, curriculum cost, labor cost, evaluation cost and incentive cost per enrollee. These improvements allow Local Governing Entities to reduce their cost per service while providing quality evidence-based prevention services to more students, in more parishes, without additional resources. The LPYSP has consistently built capacity to sustain awareness of youth suicide and training of gatekeepers who provide services to youth. In the last year, the number of trainers trained in suicide prevention services has doubled.

C. Who benefits and how

As a result of the implementation of evidenced-based programs, policies, and practices and the braiding of resources with the Department of Education, OBH is providing higher quality programs to more individuals. The impact of increasing the number and quality of prevention services benefits the entire Louisiana population. Services provided by the LPYSP benefit parents, survivors, clinicians, teachers, clergy, law enforcement, and others involved in early identification and referral of youth at risk for suicide.

D. How was this accomplishment achieved?

OBH has adhered to the policy that only evidence-based prevention programs will be funded. Prevention Contracts stipulate that providers will adhere to this policy as a condition of contract approval. Those trained by LPYSP are also trained in evidence-based suicide prevention programs.

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

The current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). For the purpose of this report, the Business Plan that was submitted to the Secretary of the Department of Health and Hospitals will be referred to as "the OBH Strategic Plan", since it contains current information.

Yes, the integration of MH and AD in Central Office is Priority Nine in the OBH 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. Implementation of evidence-based programs, policies, and practices is a national "Best Practice". In addition, mobilization of services, the application of cost bands per type of service, and the use of existing infrastructure allow for quality evidence-based prevention services to be made available to more individuals, in more parishes, without additional resources. In addition, prevention specialists will be trained in the delivery of evidenced-based suicide prevention services, further utilizing existing infrastructure in early identification and referral of youth at risk.

Developing and Implementing the Coordinated System of Care (CSoC)

A. What was achieved?

Governor Jindal issued Executive Order BJ-2011-5 on March 3, 2011. This formally established the mechanism for governance and policy level oversight of the development of the Coordinated System of Care (CSoC).

The specific CSoC accomplishments for the fiscal year include:

- Formation of the CSoC State Governance Board.
- Each of the partnering State departments assigned staff to a unified CSoC Team based at DHH.
- CSoC staff participated in the developed and submission of State Plan Amendments and 1915b and c waivers to support service development/enhancement to support future enrolled families.
- A Community Application (RFA) was released for the first phase of CSoC implementing regions and the initial cohort of communities was selected.
- A Director with significant national SOC experience was recruited and hired to lead the CSoC Team.

B. Why was this success significant?

The Executive Order that formally established the Governance Board establishes a mechanism for governance and policy level oversight of the development of the Coordinated System of Care. This Board will work to reduce legislative and policy barriers that interfere with Louisiana's ability to offer effective, individualized, family-driven, youth-guided & culturally competent care.

The redeployed staff from each of the partnering departments (Office of Juvenile Justice, Department of Children and Family Services, Office of Behavioral Health and Department of Education) was able to assume initial responsibilities for CSoC implementation including providing support to various workgroups and offering input on the Medicaid State Plan amendments and Waiver applications. This represents a significant accomplishment in that it represents a visible commitment of the partnering agencies to support the implementation of the CSoC. This team provides the necessary support to complete tasks identified in the OBH Business Plan to implement the CSoC.

The development of State Plan Amendments and Waivers allowed for the new service array to be defined that includes an array of community-based and specialized services for young people in or at-risk of out of home placement.

The Community Application and selection of an initial cohort of implementing regions is significant in that it represents the tangible first step toward operationalizing the goal of a coordinated statewide system of care.

In June 2011, OBH was able to secure a Director for the CSoC initiative who has worked

to successfully implement systems of care in New York and provided technical assistance and support across the country. Having a professional with demonstrated experience and success with system of care implementation will result in a more informed approach for implementation activities. Ultimately, with this expertise serving in a leadership position both with the CSoC Team and OBH, the likelihood for success is increased.

C. Who benefits and how?

As a result of these initial steps, ultimately, children and youth with behavioral health challenges and their families will benefit. The development of new services as a part of the State Plan Amendments and Waivers represent significant growth in the available complement of services available to young people who had previously been placed in out of home settings. Out of home care has been demonstrated to produce marginal outcomes (Burns et al., 1999 with costs ranging from \$80K-100K/year/youth).

D. How was this accomplishment achieved?

The development and implementation of CSoC was through the Executive Order. Effective April 2011, the Department of Children and Family Services (DCFS) deployed two full time employees (FTE), the Office of Juvenile Justice (OJJ) deployed one FTE and DOE deployed one FTE to become a part of a unified CSoC Team within OBH. Through the Partnership between Medicaid and OBH and the CSoC Team allowed for the completion and submission of a State Plan Amendment and Waiver submission to enhance the service array available to Louisiana residents. Through a competitive application process the implementing regions in Phase I were selected. By using professional national networks that were established during CSoC planning, OBH was able to identify potential candidates and recruit them to lead Louisiana's initiative.

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

The current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). For the purpose of this report, the Business Plan that was submitted to the Secretary of the Department of Health and Hospitals will be referred to as "the OBH Strategic Plan", since it contains current information.

Yes, the integration of MH and AD in Central Office is Priority Ten in the OBH 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 formation of the Governance Board represents a significant accomplishment from a national perspective. Across the country, there are very few states that have a Governor endorsed and supported Coordinated System of Care initiative. Further, the detailing of staff from across child-serving agencies to a unified CSoC Team represents a true innovation in the system of care field.

Reorganizing Central Louisiana State Hospital

A. What was achieved?

The achievements of reorganizing included outsourcing the dietary operations; beginning the process of closing Central Regional Laundry which included outsourcing laundry services; transferred adolescent patients to SELH and closing the adolescent unit; and developing aggressive treatment discharge plans.

B. Why is this success significant?

The outsourcing of the dietary operation allowed for a reduction in work force. This resulted in the reduction of meal cost and additional reduction in staffing costs over time as remaining dietary staff retiree or resign.

The closing and outsourcing of the Central Regional Laundry allowed for reduction in work force. The laundry is now processed at a comparable cost by an outside vendor and resulted in additional savings in utilities and maintenance repairs that were being provided by the hospital.

By transferring adolescent patients to SELH there was a reduction in work force. This allows for hospital management to concentrate provision of care to civil inpatient adults. This change helps to meet the overall goal of OBH in provision of care to all persons in need.

Through more aggressive treatment discharge, clients are discharged in a timelier manner and not remain at the hospital any longer than necessary.

C. Who benefits and how?

The clients and the hospital are the beneficiaries. They will have food and laundry services provided in an efficient and timely manner. Closing the existing unit and transferring patients to a unit that will focus strictly on adolescents, will afford them more effective treatment. Overall, hospital patients were provided aggressive treatment allowing them to be discharged to the community and not remain in the hospital for a long-term period. The hospital benefits by being able to provide services to more clients during each year.

D. How was the accomplishment achieved?

In outsourcing the dietary operations, the hospital worked with State Purchasing to award a purchase order to an outside vendor that would meet the needs of the hospital to provide meals and snacks that met hospital requirements and comply with Joint Commission and CMS standards.

The hospital worked with State Purchasing to award a purchase order to an outside vendor that would provide laundry services to both Central Louisiana State Hospital and Pinecrest Support Services in an efficient and timely manner for a minimum cost.

Adolescent clients were discharged to the community or transferred to another facility. Social Workers and other Administrators worked together and had various meetings to develop methods to be used to implement an aggressive discharge process.

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

While this accomplishment is not included in the Office of Behavioral Health Strategic Plan, the significance of this accomplishment in the implementation strategies and infrastructure development warranted that it be included in this report.

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 accomplishments allows for greater efficiency in the Dietary operations; greater efficiency in laundry services which created cost savings for the hospital in utilities and building maintenance; increased effectiveness for the specific care for adolescent clients by the consolidation of adolescent services to a single facility; and allows statewide discharge planning in order to take advantage of all resources available in the community and allows for an overall shorter length of stay in the hospital.

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

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

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- Integration of MH and AD in Central Office
- Integration of MH and AD in the Regional Offices and Clinics
- Privatization of Addictive Disorders Services
- Sustaining the ATR Prototype
- Right-Sizing State Psychiatric Hospitals
- Responding to Forensic Lawsuit
- Developing and Implementing Civil Discharge Initiative
- Implementing Community Evidence-Based Programs
- Implementing and Integrating Prevention Services
- Developing and Implementing Coordinated System of Care

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

- The Office of Behavioral Health set two FY 11 top priorities related to infrastructure: to consolidate the administrative structure within OBH central office and to consolidate local mental health and addictive disorders clinics in order to provide integrated, holistic, accessible care. At this juncture in the evolution of OBH, the Office has achieved all of its ambitious first year reorganization benchmarks at the state office level and at the Regional clinic level, while reducing spending by 20%. ((Implementation Status Report prepared in response to ACT 384 of the 2009 Regular Session, June 2011-Executive Summary).
- OBH is maintaining a monitoring process at the Central Office level to allow for interagency intervention should the need arise to assist persons in maintaining community level of care. OBH is maintaining a policy that all Community Based Prevention Programs are required to implement evidence-based programs, policies and practices.
- OBH has been able to comply with the Federal Consent Decree by decreasing the waiting time for hospital based competency restoration from over one year to no more than 30 days.
- The CSoC is progressing on time and according to schedule. The strategies employed to date have been effective in achieving the critical milestones of early implementation. At this point, the returns on investment are not yet apparent as in FY 10-11 we remained in early implementation.

1. To what do you attribute this success?

Through expert consultation and in conjunction with national guidance, OBH redesigned the central office administrative structure to eliminate duplication and align with the recommended functional areas that would support an integrated and co-occurring informed care model, while maintaining the unique features of mental health and addictive disorder stand-alone services. (Implementation Status Report prepared in response to ACT 384 of the 2009 Regular Session, June 2011-Report to the Legislature: Infrastructure). In addition to the external resources, OBH invested in staff training and internal re-structuring to support the newly created organization. Utilizing a framework including multiple disciplines' input (administration, clinical fiscal and information systems) ensured a knowledge base that minimized decision making errors. Ultimately, participation of stakeholders (state and private providers) contributed to the success of the enterprise.

- ◆ **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) 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 current OBH Strategic Plan is a transitional document that is slated to be revised in FY 2011-2012. It does not reflect the most recent developments as it pertains to the merging of the Offices and the resulting Office of Behavioral Health (OBH entity). A Business Plan that was submitted to the Secretary of the Department of Health and Hospitals June 2011. The Plan delineated 10 Top Priorities (Goals). The revised OBH FY 2012 Strategic Plan will address the progress of these goals and will set of course of action for the upcoming year.

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

The formulation of OBH strategic plan will adhere to management strategies implemented by the Executive Team (Administration, Development and System of Care). These strategies, at a minimum will include:

- **Input** (gathering input from all level of the Agency's functional areas),
- **Communication** (receiving and sending information at the Central Office and the Regional/District level,
- **Coordination** (using state of the art technology to enhance communication and participation, e.g., teleconferences, videos, electronic media, etc.
- **Performance evaluation** (formulation of goals that are Specific, Measurable, Attainable, Results oriented and Time-bound) and

- **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).

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, condition of the state fiscal, 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.

None.

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.

Each and all methods are utilized specific to the application of regulations and oversight agency requirements for each program..

- 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):

Quarterly Quality Performance Management Reports, C'est Bon, and LaFete - Reports can be found on Management Decision Support Web Site – <http://10.12.82.151/DSONline/index.asp>

- 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.

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

1. OBH Implementation Status Report

- a. Date completed: June 24, 2011
- b. Subject or purpose and reason for initiation of the analysis or evaluation:
 On July 1, 2011 Louisiana merged the Offices of Addictive Disorders and Mental Health to form the Office of Behavioral Health (OBH) under the authorization of Act 384 from the 2009 Regular Session. Pursuant to this legislation, an Office of Behavioral Health Implementation Advisory Committee was formed to report recommendations to the Joint Health and Welfare Committee of the Louisiana Legislature. This document satisfies the legislative requirement for a final implementation status report on the OBH implementation.
- c. Methodology used for analysis or evaluation:
 An Office of Behavioral Health Implementation Advisory Committee was formed, pursuant to Act 384 and included representatives from both the former mental health and addictive disorders agencies, the Department of Health and Hospitals Administration, the Human Services Districts, and consumers, providers and advocates of mental health and addiction services. The purpose of the Implementation Advisory Committee was to make recommendations upon which to build a successful merger of the Offices of Mental Health and Addictive Disorders. The Behavioral Health Implementation Advisory Committee Report to the legislature recommended the following areas of focus be addressed through the consolidation of the Office for Addictive Disorders and the Office of Mental Health: 1) Infrastructure; 2) Performance Measures and Outcomes, 3) Access; 4) Funding Strategies; 5) Licensing, Training and Workforce; and 6) Local, State and Federal Coordination . OBH has taken direction and guidance from the aforementioned recommendations to generate the legislatively mandated OBH

Implementation Status Report..

d. Cost:

There is no cost associated with this report. This report is generated in-house. OBH Program Staff utilized data from its management information systems.

e. Major Findings and Conclusions:

At this juncture in the evolution of OBH (FY 2011), the Office has achieved all of its ambitious first year reorganization benchmarks at the state office level and at the Regional clinic level, while reducing spending by 20%. Process improvement activities to increase client initiation, engagement and retention resulted in a 25% to 35% improvement in show rates for treatment appointments and approximately 30% decreases in drop-out rates in some OBH clinics. OBH at the central office level has entered into a new era of Medicaid reform that better leverages federal Medicaid funding and positions Louisiana to expand Medicaid reimbursement for addictive disorders, which will create a shared funding stream and broaden access. OBH has established a number of competency areas upon which to certify both licensed mental health professionals and provider agencies who will then be credentialed by the La-BHP Statewide Management Organization as enrolled providers.

f. Major Recommendations:

OBH achieved the most critical benchmark related to the powerful strategic driver behind the merge, the integration of the infrastructure of both mental health and addictive disorders, committing the Office to the provision of service delivery that is holistic and person-centered. This integration has reduced expenditures annually by 20% and readied the Office for a number of impending opportunities to leverage care, including health care reform, Medicaid reform and movement to an integrated managed care system (Office of Behavioral Health Implementation Status Report June 30, 2011).

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

The consolidation of the Office of Behavioral Health has positioned the State to take advantage of funding and program innovations which will result in better access to services and treatment. The newly developed overarching Louisiana Behavioral Health Partnership (La-BHP) leverages federal Medicaid funding to support integrated access to behavioral health care, inclusive of Medicaid reimbursement for substance abuse services. Conceptually, the La-BHP takes behavioral health services paid for by state general funds and makes these services a substantial part of the Medicaid funded integrated service delivery system. With reduced dollars spent, OBH can maintain and even expand, to some extent, an integrated service menu and still fund a “safety net” of service delivery not funded by insurance. (Office of Behavioral Health Implementation Status Report June, 30, 2011).

OBH continues to move forward with implementation in all 6 focus areas

addressed by both the Implementation Committee and the Status Report

- h. Availability (hard copy, electronic file, website)
The report is available by hardcopy as well as electronically at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2033>
- i. Contact person
Michele Beck
Program Manager 1-A
Department of Health and Office of Behavioral Health,
Telephone: 342-2623
Michele.Beck@la.gov

2. Synar Report FFY 2010: Youth Access to Tobacco in Louisiana

- a. Data collection completed: July – August 2009
- b. Subject / purpose and reason for initiation of the analysis or evaluation:
The State of Louisiana Department of Health and Hospitals Office for Addictive Disorders conducts this Annual Synar Report to examine the current level of accessibility of tobacco products to minors as a requirement of the Federal Government. An amended Synar Regulation, was issued by the Substance Abuse and Mental Health Services Administration in January 1996, and requires each state receiving federal grant money to conduct annual random, unannounced inspections of retail outlets to assess the extent of 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. 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):
OAD contracted with Southern University to complete the 2010 Annual Synar Report at a cost of \$45,000. Data was analyzed and a written report was provided to OAD. OAD also contracted with the Office of Alcohol and Tobacco Control (OATC) to conduct the random, unannounced inspections of tobacco outlets identified by the random sample at a cost of \$110,500 (\$65.00 per compliance check x 1,700 checks). The total cost for the Report was \$ 155,500.00.
- 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. It is important to note that Louisiana had the highest non-compliance rate in the nation at baseline (72.7%) at the inception of this report. Annual targets were established to decrease the state's non-compliance rate to 20% by FFY 2002. However, Louisiana achieved 20.3% non-compliance in FFY 1999, only two years after the start of the Louisiana Synar Initiative, and 3 years ahead of the scheduled target date. The current rate of tobacco sales to minors in FFY 2010 is 4.3%. Louisiana's rate has consistently been one of the lowest in the nation. The model that Louisiana has utilized is being considered as a model program by the Center for Substance Abuse Prevention.

- f. Major Recommendations:
OAD complied with all major recommendations made by the Center for Substance Abuse Prevention for the SFY 2010 report and will adhere to any future recommendations, as warranted.
- g. Actions taken in response to the report or evaluation:
Louisiana is ranked among the top states in compliance. Our goal is to continue implementing current strategies since they proven to be successful.
- h. Availability (hard copy, electronic file, website):
The report is available by hardcopy (limited number of color copies) as well as on OAD's website at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1390>
- i. Contact Person:
Dr. Leslie Brougham Freeman
Director of Prevention Services
LA Department of Health and Hospitals
Office of Behavioral Health

3. Office for Addictive Disorders – Prevention Services (Quarterly and Annual)

- a. Data collection completed: July 1, 2009 – June 30, 2010
- b. Subject / purpose and reason for initiation of the analysis or evaluation:
The Office for Addictive Disorders (OAD) is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OAD Prevention Services has developed this report to capture prevention services provided through funds of the Prevention Portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT Block Grant is the primary funding stream for prevention services in our state. It requires twenty (20%) of the Block 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). PMIS is 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. OAD Program Staff utilize data from the Prevention Management Information System (PMIS) to generate this document. Data is entered into PMIS by OAD Regional and Headquarter Staff and Prevention Contract Providers statewide.
- e. Major Findings and Conclusions:
During State Fiscal Year 2010 (July 1, 2009-June 30, 2010) Prevention Services provided Evidence-Based services to 72,095 enrollees. This represents a 26% increase over SFY 2009 (57,342).

Through State Fiscal Year 2010 block grant funded one-time services provided to the general population reached 194,798 participants. This number included the combined services provided by Prevention Staff and Prevention Contract Providers. This is a 21% increase over SFY 2009 (160,938).
- 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

Annual Management and Program Analysis Report

Fiscal Year 2010-2011

Department: Department of Health and Hospitals
09-340 Office for Citizens with Developmental Disabilities

Department Head: Bruce D. Greenstein

Undersecretary: Jerry Phillips

Agency Head: Julia Kenny, Assistant Secretary

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

The following are accomplishments of the Office for Citizens with Developmental Disabilities (OCDD) during FY 10/11:

Full implementation of resource allocation in New Opportunities Waiver

A. What was achieved? Ninety-five percent (95%) of all New Opportunities Waiver (NOW) recipients completed the Resource Allocation process, which utilizes person-centered planning and needs-based assessment to better allocate resources to support individuals.

B. Why is this success significant? Since implementation in October 2009, Resource Allocation has resulted in a cumulative \$27 million in savings at the end of FY 10/11. Aligning allocation of resources with need results in greater sustainability of home and community-based supports and offers the opportunity to support more individuals who continue to wait significant periods of time for needed services. In FY 10/11 the NOW program grew in participation by 8.5 percent with an expenditure growth of .42 percent. By using a person-centered philosophy and needs-based assessments, the resources are allocated to ensure all needed supports are in place in a manner that also supports the individual's preferences and goals. As anticipated, this has resulted in significant cost savings while ensuring overall improvement in the quality of plans.

C. Who benefits and how? The entire Medicaid service delivery system benefits from the

implementation of this process as the dollars saved lessen the budget shortfalls experienced by Medicaid and offset the need for provider rate cuts and the need to cut necessary services to waiver recipients and their families.

- D. How was the accomplishment achieved?** This was accomplished through the refinement of plan processing along with hiring of additional temporary staff for processing purposes.
- E. Does this accomplishment contribute to the success of your strategic plan?** Yes. OCDD has a specific goal in the Strategic Plan relative to rebalancing 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.
- 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 was implemented statewide using an individualized needs-based assessment and person-centered planning for everyone of the over 300 persons that have been through the Resource Allocation process. This has resulted in \$1 million over the expected cumulative savings of \$26 million at the end of FY 10/11 without compromising the health and safety or causing the institutionalization of any of the persons involved in the process.

Expansion of the Children's Choice (CC) Waiver to increase the number of children supported by 425

- A. What was achieved?** Between CMS (Centers for Medicare & Medicaid Services) approval of this initiative on 5/11/11 and the end of the fiscal year, OCDD expanded the number of children served in the Children's Choice (CC) waiver by maximizing its available/ allocated state funds to serve more children with developmental disabilities and by increasing the array of Medicaid-funded waiver services available to meet their support needs. During this short time frame, OCDD obtained CMS approval to fund and offer 425 new CC waiver opportunities resulting in 364 (85%) of the released slots being accepted, linked and/or certified. The office goal is for the remainder of these children will be certified for CC waiver services by 9/30/11.
- B. Why is this success significant?** Consistent with national trends and state priorities, OCDD utilized state funds allocated for developmental disabilities services as a 3:1 Medicaid/State match to maximize federal funding and increase waiver opportunities in order to more effectively and efficiently serve 425 additional children in the CC Waiver. Without this effort, these children would have had only access to a limited amount of ACT 378 state-funded Family Support services based on their priority and severity of needs and limited by funding availability, geographic distribution, and number of individuals waiting within each of the ten OCDD Regional Offices and Human Services Districts/Authorities (regional offices/ districts/ authorities) across the state.

- C. Who benefits and how?** (1) Children who were a high priority and waiting to receive limited, state-funded Family Supports to address a crisis, to avoid institutionalization or to provide some other unmet support needs were now able to access more comprehensive and ongoing waiver services more quickly. (2) Children who were waiting for several years on the waiver “Request for Services Registry” (RFSR) to access CC waiver services could now be served sooner as a result of the newly created 425 slots. (3) The distribution of these 425 CC waiver slots reduced the overall “wait time” for all persons on the RFSR.
- D. How was the accomplishment achieved?** This was achieved through (1) stakeholder buy-in and support, especially that of the Developmental Disabilities Council who advocated for the passage and has oversight of the implementation of ACT 378. The Family and Community Support System provides for state-funded supports and services in accordance with the ACT through yearly legislative appropriations and (2) CMS approval (which was attained by demonstrating that conversion of state funds to waiver opportunities would allow more children with high priority needs to access waiver services to better meet their needs).
- E. Does this accomplishment contribute to the success of your strategic plan?** Yes. This action brings to completion one of OCDD’s innovative rebalancing/restructuring activities by “focusing existing (state) funding towards achievement of quality outcomes targeted to individual needs” and by maximizing state funds into federal, Medicaid funds to allow more persons with developmental disabilities to access more comprehensive services, more quickly.
- 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 same strategy of using state-funds in a 3:1 Medicaid/State match to increase federal funds and serve more persons with more comprehensive services can continue to be used to increase ongoing waiver opportunities (slots) when State budgetary constraints prevent the legislature from allocating new slots within OCDD’s annual budget.

Downsizing of Public Supports and Services Centers

- A. What was achieved?** The OCDD established a goal for FY 10/11 to transition 20% of the population of its three largest Supports and Services Centers (or a total of 198 persons) to privately-operated service settings. OCDD exceeded the transition target overall and discharged 192 people from the targeted public Supports and Services Centers to privately-operated service settings. This accomplishment results in an annualized net savings of \$24,768,337.
- B. Why is this success significant?** The individuals with developmental disabilities identified for transition as part of the 20% downsizing initiative are those with less intensive support needs who can handle and benefit from living and receiving services

in the community. These individuals do not require the level and types of services and supports offered in a public Supports and Services Center setting and can, therefore, receive more cost-effective services in a less restrictive setting. This success is also significant in that many of the service recipients identified for transition and their families were not initially in favor of the transition but engaged the transition process and selected privately-operated living settings in response to the diligent and supportive efforts of OCDD and facility staff at all levels to promote acceptance of the initiative by various stakeholders.

- C. Who benefits and how?** The individuals with developmental disabilities who transitioned from the public Supports and Services Centers to privately-operated service settings are benefitting from the enhanced sense of dignity and self-fulfillment associated with living in the community alongside people with and without disabilities.
- D. How was the accomplishment achieved?** The 20% transition target (or 198 persons) was exceeded through the collaborative efforts of OCDD staff throughout the State, support coordination agencies, and providers as well as services participants and their family members, friends, and other advocates.
- E. Does this accomplishment contribute to the success of your strategic plan?** Yes. OCDD has a specific goal in the Strategic Plan relative to rebalancing 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.
- 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 has taken in identifying service recipients for transition from public Supports and Services Centers to privately-operated service settings is consistent with nationally recognized needs-based assessment and resource allocation methodologies.

Privatization of State-Operated Supports and Services

- A. What was achieved?** The OCDD established a goal for FY 10/11 to privatize all state-operated waiver and community home services and to privatize one and close two other of the remaining state-operated Supports and Services Centers (SSCs). OCDD achieved this goal by completing the privatizations and closures of 39 public community homes (ICFs/DD or Intermediate Care Facilities for Persons with Developmental Disabilities), the transitioning of 63 public New Opportunities Waiver (NOW) participants to private providers, the transitioning of 42 Extended Family Living (EFL) participants to private providers, the privatization of Acadiana Region SSC, and the closure of Northeast and Bayou Region SSCs. OCDD now operates three public SSCs (large ICFs/DD) and one group home. A budget savings of \$5,476,030 was achieved in FY 10/11 related to this accomplishment. This accomplishment results in an annualized net savings of \$12,927,398.

- B. Why is this success significant?** The number of people with developmental disabilities receiving services from OCDD as their primary service provider decreased while the overall number of individuals with developmental disabilities receiving services with OCDD oversight increased. This accomplishment resulted in cost savings for the Department/Office as, by and large, the service recipients formerly served in the privatized or closed settings are now receiving more cost-effective services with private provider agencies. The administrative costs associated with OCDD operating the now privatized or closed services have been almost entirely eliminated resulting in additional cost savings.
- C. Who benefits and how?** The Department/Office benefits from this accomplishment both in terms of cost savings and in terms of reaching more people with developmental disabilities with cost-effective services. The State's citizens with developmental disabilities benefit from this accomplishment as more individuals are receiving needed services more cost-effectively.
- D. How was the accomplishment achieved?** The privatization/closure of targeted state-operated supports and services was achieved through the collaborative efforts of OCDD staff throughout the State, support coordination agencies, and providers as well as services participants and their family members, friends, and other advocates.
- E. Does this accomplishment contribute to the success of your strategic plan?** Yes. OCDD has a specific goal in the Strategic Plan relative to rebalancing 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.
- 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 achieving cost savings while maintaining individually-needed levels of support through privatization and consolidation of publicly-operated services.

Use of Person-centered tools to assure satisfaction for individuals moving from SSCs

- A. What was achieved?** Consistent with national standards, OCDD implemented person-centered tools to assist individuals to move from Supports and Services Centers (SSCs) to community living options that maintain or improve their satisfaction and involvement in local communities. Training on all of the tools was completed with identified staff at the three remaining SSCs. Overall, sixty-seven percent (67%) of individuals moving from the SSCs chose smaller living options. Following the training, choice of waiver options (more person-driven and flexible) increased from 28% in December, 2010 to 65% in June, 2011. During the course of the moves, OCDD maintained an overall 89% satisfaction rate of satisfaction with home, work, school,

staff support, and local community involvement ranging from 92-94% and satisfaction with getting “what you need” and “feeling healthy” ranging from 96-98%. The areas of less satisfaction (65-70%) were visits with family and visits with friends which were not significantly different than pre-move concerns. Only 3% of individuals who moved had a second move to a less integrated setting than the initial living situation due to difficulties.

- B. Why is this success significant?** OCDD supported a large number of individuals to move from SSCs during the last two fiscal years. Moving into smaller and more community-based living situations is consistent with national trends and is supportive of a community-based life and larger social support network for individuals with developmental disabilities. However, moving many individuals within a brief period of time carries risks associated with missed support needs and options as well as moving to a living situation that is less preferable for the individual than the current institutional one. Thus, a focus on tools to assist in a more person-focused and drive approach increased the ability of OCDD staff to assist individuals in locating flexible living and support options consistent with the life each individual wanted to move toward. Satisfaction and success increased based upon this approach.
- C. Who benefits and how?** All individuals who have moved from and will be moving from SSCs, their families and friends, regional offices/ districts/ authorities, community providers, and support coordinators benefit from this effort. Individuals are supported to have a living situation consistent with their preferences and able to meet their support needs including connections to families and friends where possible. The planning process is geared to meet these preferences and needs as well. Satisfaction and success increase resulting in fewer challenges and failures that the individual and those supporting him or her in the community have to address.
- D. How was the accomplishment achieved?** The person-centered tools and approach were designed by and through consultation with national experts in person-centered thinking approaches and systems development. Training was delivered by national consultants. Implementation of approaches was undertaken by SSC administrative and clinical staff in consultation with OCDD Clinical Services.
- E. Does this accomplishment contribute to the success of your strategic plan?** Yes. OCDD has specific goals with regard to increased use of community-based resources and less reliance on institutional care, person-centered practices, and increasing the capacity of community providers to support individuals.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes. The approach OCDD has taken is consistent with national standards and trends related to both reduce reliance on institutional care and use of person-centered tools to drive and support systems change.

Improved Crisis Intervention and Diversion

- A. What was achieved?** OCDD implemented evidenced-based practices at the Stabilization Unit (SU) with a focus on portability back to the home settings to decrease Length of Stay and developed a statewide Positive Behavior Supports (PBS) curriculum for Direct Support Workers (DSWs) in waiver settings. Both efforts focused on improved crisis intervention and diversion with a longer term goal of increasing the capacity for individuals with challenging behaviors to successfully receive support in community living options. The efforts at the SU resulted in reduction in average length of stay of nine months to five months. The PBS curriculum has been piloted with twenty-three DSWs from three provider organizations. All but one staff passed the competency test following the training. Feedback from trainees was 100% positive with 83% of ratings strongly agreeing and 17% agreeing and an overall satisfaction rate of 93%. Specific suggestions were gathered and used to further improve the curriculum. Implementation as part of the My Place Louisiana initiative is proceeding into the coming fiscal year. While overall crisis referral requests increased this year, diversion rate improved from 50% to 58%. OCDD has been chosen to present at the NADD (The National Association for the Dually Diagnosed) with regard to Stabilization Unit services and at the national CMS (Centers for Medicare & Medicaid Services) conference with regard to its My Place Louisiana initiatives for DSWs inclusive of the PBS curriculum.
- B. Why is this success significant?** OCDD has continued to note challenges in supporting individuals with challenging behavior and mental health needs within community living situations. Improvements at the SU provide a short-term intensive treatment option that does not result in losing a community living option and are an alternative to long-term admission. Development of a statewide PBS curriculum provides a tool to assist DSWs in developing needed skills to better support these individuals on a day-by-day basis.
- C. Who benefits and how?** Individuals with significant challenging behaviors and mental health concerns, regional offices/ districts/ authorities, community providers, and support coordinators benefit from these initiatives. These efforts result in increased access to needed supports so that individuals with challenging behaviors and mental health needs can live in local communities and provide training, support, and technical assistance to regional offices/ districts/ authorities staff, providers, support coordinators and families. In addition, the overall Developmental Disabilities Services System benefits by reducing reliance on more costly institutional care for these individuals.
- D. How was the accomplishment achieved?** OCDD Stabilization Unit (SU) improvements occurred by evaluating program models for similar programs in other states and developing a comprehensive short-term intensive treatment model along with devoting specific clinical resources to the SU to support collaboration with community providers and transition back home for all individuals. The PBS curriculum was developed using OCDD Clinical resources and through partnership with community providers to pilot and revise the curriculum to best meet the needs of the DSWs in

waiver support settings.

- E. Does this accomplishment contribute to the success of your strategic plan?** Yes. OCDD has specific goals with regard to increased capacity to support individuals with challenging behaviors and mental health needs within community living situations.
- 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 improved SU practices are consistent with evidenced-based practices and the PBS curriculum is consistent with national standards.

Early Steps - Improved Efficiency and Service Performance

A. What was achieved?

1. Following the implementation of a Service Determination Protocol in February 2010 to structure a process for determining service utilization and decreasing service costs, a 7% savings in service costs was realized despite increased numbers of eligible children.
2. Additionally, improved system performance on the US Department of Education Performance Indicators (total of fourteen) resulted in a “Meets Requirements” determination for EarlySteps Program.

B. Why is this success significant?

1. EarlySteps has had increasing expenditures since moving into OCDD in 2007. Increased costs are primarily the result of a 100% increase in the number of children enrolled in the program since 2007. The increased number of children has impacted service expenditures, so implementing a successful process for making service decisions, will assist in cost containment despite more enrolled children in the system.
2. The determination process has been in place since 2004. “Meets Requirements” is the highest performance result achievable and the first time it has been achieved by the State.

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, and eliminating delivery of unnecessary services.
2. Achieving “Meets Requirements” means that EarlySteps is providing services that meet Federal requirements. Everyone benefits from the system when it is effectively and efficiently identifying eligible children, providing timely services, assisting families in meeting their child’s needs, and assisting children and families in accessing other services when children leave the program at age 3.

D. How was the accomplishment achieved?

1. Research was reviewed to confirm a “service package of 24 hours in 6 months” for

eligible children based on national data. A process based on collection of assessment data and medical/family history data was then developed. Eligibility teams are required to use this data to determine services levels for each child, above or below the “service package.”

2. EarlySteps uses a regional system of technical assistance and training provided through its OCDD regional coordinators. Through a significant amount of “hands on” work with providers, data is reviewed frequently and follow-up conducted when targets are not met. In addition, several statewide training activities have occurred over the past 2-3 years including ten training events for 229 support coordinators last year.

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

1. Yes. A major focus for EarlySteps is providing quality services and reducing costs. The Service Determinations Process has decreased the per child service costs.
2. Yes. Reaching “Meets Requirements” means that EarlySteps staff can focus more on the quality of service delivery in the system in addition to meeting compliance of federal requirements.

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. Research from the early intervention field was used to design the service determination process with input from stakeholders. Decisions are based on actual child and family data, therefore, highly individualized according to needs identified, rather than a “one size fits all” approach.
2. Yes. EarlySteps utilized the Technical Assistance resource center services funded by Office of Special Education Programs (OSEP) to analyze its service system, evaluate processes and make targeted changes to improve results.

Early Autism Screening

A. What was achieved? OCDD has implemented an early autism screening protocol through EarlySteps to increase early identification of individuals with autism spectrum disorders. Screenings are offered to individuals within the program at 18 months of age and later. To date 6,694 screenings have been offered. The program has a 54.1% acceptance rate of screens by families. Current efforts are aimed at identifying barriers to acceptance.

B. Why is this success significant? This initiative establishes Louisiana as a leader in early screening and identification for individuals with autism spectrum disorders. Early identification increases the likelihood of early intervention for these children which results in increased positive outcomes.

C. Who benefits and how? Children with autism spectrum disorders and their families benefit through early detection and opportunity for early intervention. Research

indicates that early intervention services can reduce symptom presentation and future support/service needs with increased positive outcomes for individuals receiving services. Additionally, the overall Developmental Disabilities Services System benefits by investing in early identification and services which reduce later needed services and associated costs.

- D. How was the accomplishment achieved?** OCDD partnered with a local university with national recognition for work related to supporting individuals with developmental disabilities and autism spectrum disorders. OCDD Clinical staff worked with EarlySteps staff to ensure training and implementation of the protocol for high risk children through Louisiana's Early Intervention program with no cost to families and minimal additional program costs as the screen is incorporated into the typical assessment protocol except in rare instances when it is deemed needed out of the assessment cycle.
- E. Does this accomplishment contribute to the success of your strategic plan?** Yes. OCDD has specific goals related to increasing access and supports for infants and toddlers to minimize developmental delay and future costs of services.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes. Early screening is consistent with national best practices and trends in state approaches to increasing early access to services for individuals with autism spectrum disorders.

Implementation of initiatives to facilitate ongoing quality enhancement across the developmental disabilities service delivery system

- A. What was achieved?** OCDD implemented processes to obtain information about agency performance and the quality of service and use the data to identify and implement strategies to improve performance. The processes implemented include: 1) Mortality Review, 2) Provider Quality Enhancement Review, 3) Human Services Accountability and Implementation Plan Quality Partnership, 4) National Core Indicators Project, and 5) Support Coordination Monitoring. In addition, during the fall of 2011, a new complaint management system will be implemented.
- B. Why is this success significant?** The Centers for Medicare and Medicaid (CMS) requires that states collect and report data on Home and Community-Based Services (HCBS) waiver programs and that the data be used to develop and implement quality improvement strategies. Without implementation of a comprehensive, data-driven quality management system, Louisiana's waiver programs for people with developmental disabilities would be jeopardized.
- C. Who benefits and how?** People with developmental disabilities and their families benefit because systemic problems can be identified and strategies implement to

improve agency responsiveness and the quality of services. The Department/Office benefit because decision-making can be driven by review of performance indicator data.

- D. How was the accomplishment achieved?** Louisiana has been the beneficiary of several CMS grants to develop the infrastructure needed to improve the quality of waiver services. At the regional level, each regional office/ district/ authority has a quality assurance monitor position to facilitate regional quality management activities. At the state level, OCDD has a quality management section that provides oversight of the regional quality management activities and facilitates statewide quality management activities.
- E. Does this accomplishment contribute to the success of your strategic plan?** Yes. OCDD's quality management activities enable the collection of strategic plan performance indicator data.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes.

Completed and began deployment of the Participant Services Database

- A. What was achieved?** The Participant Services Database is a web-based application supporting and tracking intellectual and developmental disabilities services in the regional offices/ districts/ authorities. It replaces an antiquated system that is no longer supported. The database is part of the OCDD data system that includes all system entry, state-funded services such as Family Support, and OCDD HCBS waiver programs.
- B. Why is this success significant?** The application supports consistent processes and reliable data across the state with each office handling developmental disabilities services. It allows better, more accurate data and performance management and reduces, if not eliminates inefficient paper records.
- C. Who benefits and how?** Applicants for services and people supported and their families benefit from the consistency and accuracy of the information. The more timely data tracking and the better decision making allow better and more efficient uses of resources to meet needs. State office management benefits with quick and reliable access to information necessary to manage the system. The direct state-wide access avoids multiple queries to local offices for current information. Anyone requesting data from the Office benefits from the improved speed and accuracy.
- D. How was the accomplishment achieved?** The project was accomplished through a combination of an outside contractor and internal resources. Development was informed by participation of field staffs in planning and testing.

E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a Strategic Plan objective related to implementation of an integrated Information Technology system that supports system processes.

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

II. Is your department five-year Strategic Plan/Department 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; timely completion of the system entry process; and timely access to the start of services and supports, with access and service delivery based on a needs-based assessment. 2) To provide a person-centered planning process which focuses on the person's goals and desires; addresses quality of life; affords choice; responds to a person's changing needs; supports the person to learn and be independent; identifies and mitigates risks; and meets the person's needs. 3) To increase the capacity of the Developmental Disabilities Services System through the development of a coordinated process to identify promising practices and other capacity building initiatives and implementation of strategies to address identified state-wide system needs. 4) To implement an integrated, full-scale data-driven quality enhancement system that provides structure and processes in defining the role of data analysis including: feedback from all stakeholders and review of the provision of developmental disabilities services/program. These initiatives also support OCDD's Business Plan Priorities: 1) Meeting the Needs of More Citizens with Developmental Disabilities in a High-Quality, Cost-Effective Manner; 2) Community Capacity Building for Citizens with Developmental Disabilities; 3) System Rebalancing – Promoting Sustainable, Community-Based Services. Full implementation of resource allocation in one of the developmental disabilities waivers; expansion of waiver opportunities in another waiver program ; downsizing of public supports and services centers; privatization of additional state-operated supports and services; utilization of person-centered thinking; improvement in crisis intervention and diversion; improvement in the efficiency and service performance of the EarlySteps program; further implementation of early autism screening; implementation of additional quality enhancement initiatives; and improvement in participant tracking information technology have been key initiatives in the development and expansion of individualized supports and services for people with developmental disabilities and the provision of quality supports and services. The success of these initiatives has moved the Office toward goals outlined five-year strategic plan.

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

Program A

Objective IV (Strategic Plan): To implement an integrated information technology system that supports system processes during FY 2009 through FY 2013.

1. **To what do you attribute this success?** The success results from a consistent effort by the Office to build and expand the OCDD Data System as part of the Strategic Plan. It would not have been accomplished except through that effort.
2. **Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?** Progress in developing and implementing the OCDD Data System is expected to continue.

Program B

Objective 1 - Performance Indicator: Number of people on the Request for Services Registry (Performance Standard/Target = 9,250; 4th Quarter Actual = 8,165)

Note: This data represented an 11.73% reduction [$8,165/9,250 = 88.27\%$; $100\% - 88.27\% = +11.73\%$] in the actual number of people on the Request for Services Registry (or waiting list) which meant there were fewer people waiting for waiver services and the average “wait time” for all individuals on the RFSR was overall reduced.

1. **To what do you attribute this success?** An 11.73% overall reduction in number on the RFSR as compared to the Performance Standard was the result of the release of the final 2,025 New Opportunities Waiver (NOW) unfilled waiver opportunities (slots), the release of all remaining NOW attrition slot offers, and the approval and release of the newly created 425 additional Children's Choice waiver slot offers during the last quarter.
2. **Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?** The number of persons on the RFSR and its corollary, average “wait time” on the registry, is impacted by several variables including: (a) the number of new persons who are requesting waiver services and newly added to the registry (or waiting list); (b) the number of new waiver slots funded each year through legislative appropriations, through maximizing state-funds to create new waiver slots, or through conversion of private ICF/DD beds to waiver slots via the Residential Options Waiver (ROW); (c) the number of attrition slots released when existing waiver recipients are institutionalized, expire, move out of state or lose their waivers; and (d) the number of persons who decline their Children’s Choice Waiver offers to wait longer for their offer/effective date to receive the more comprehensive NOW waiver. When additional waiver slots become available and are released to those

persons waiting on the registry, the total number of persons on the registry decreases and the overall average “wait time” on the registry decreases until new applicants for waiver services are put on the list. The aforementioned variables make it hard to accurately predict any continuous pace of progress in reducing the number of persons on the registry and average wait time. Therefore, it is more accurate to predict peaks and valleys in these indicators over the short term (equating to a single fiscal year) with an overall decreases more likely to occur over multiple fiscal years (based on our historical trending pattern). For example, there has been an overall decrease in average “wait time” on the RFSR by 5.33 years between 2007 and 2011 with it reaching the lowest wait times in FY 09/10 (8.54 years) and FY 10/11 (7.2 years). OCDD has also added 3,640 new NOW slots (representing a 42% increase) since July, 2006.

Objective 2 - Performance Indicator: Percentage of Individual Support Plans (ISPs) completed by OCDD utilizing Support Intensity Scale/ Louisiana Plus (SIS/LAPlus) Assessments (Target: 98%/Actual: 100%)

1. **To what do you attribute this success?** Success is attributed to implementation of the OCDD Strategic Plan. The endeavor was supported by statewide training efforts and certification efforts of support coordinators in utilization of the SIS and new planning guidelines. OCDD also undertook extensive training with regional staff in review and incorporation of the assessment information into the planning process.
2. **Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?** The standardized needs-based assessment (SIS/LAPlus) and the improved planning guidelines have become permanent components of all newly approved New Opportunities Waiver (NOW) services. Full implementation is nearing completion for all NOW waiver recipients. Progress is expected to continue at an accelerated pace with the needs-based assessments being completed at routine intervals as part of the planning process.

Indicator: Percentages of EarlySteps federally required compliance standards met

The EarlySteps system is designed to address fourteen federally-required compliance standards. Since 2007, EarlySteps has increased performance or achieved the 100% target for each applicable indicator.

- Federal Compliance Indicators 1,7,8,9,10,14: The state has increased performance for these targets which are set by the US Department of Education at 100% as follows:
 - Indicator 1 - Timely Services: 90.7%
 - Indicator 7 - Timely Evaluation and Eligibility: 99%
 - Indicator 8 - Successful Transition: 98.3%
 - Indicator 9 - General Supervision: 98.9%
 - Indicator 10 - Complaint Resolution: 100%

- Indicator 14 - Data Collection and Reporting: 96.3%
- Federal Results Indicators 2,3,4,5,6: EarlySteps has increased performance for these targets set by the State based on prior year baseline data collected by the State:
 - Indicator 2 - Services in Natural Environments: 99%
 - Indicator 3 - Children's Development improves: 37% exit at level of typical peers.
 - Indicator 4 - Families are helped by the system: 87.1%
 - Indicator 5 - Infants under age 1 identified: 1.56% of children under age 1 in Louisiana identified and in EarlySteps
 - Indicator 6 - Children under age 3 identified: 2.27% of children under age 3 in Louisiana identified and in EarlySteps

The following indicators clearly demonstrate the success of the program:

- Number of children identified in the program has increased each year.
- Number of providers enrolled to provide services has increased to make services more available to children and families.
- Number of families expressing satisfaction with the system and that it benefits their family.

1. **To what do you attribute this success?** When EarlySteps moved into OCDD in 2007, a management structure was redesigned to address system needs across OCDD and very deliberately design strategies which would improve system performance. These strategies included setting expectations for regional staff in technical assistance and training and hiring quality assurance staff to assist with monitoring and quality assurance.

Progress is most definitely the result of specific Office actions described above as well as:

- The issuance of contracts for training in targeted areas which would improve performance and making available on-line training for providers
- On-site and data monitoring of contractor performance to assure adherence to program standards
- Technical Assistance (TA) provided by regional staff to providers and contract agencies
- Participation at the State level in the resources of the national resource and TA Centers
- Community outreach to referral sources to increase referrals to EarlySteps
- Community outreach to providers to increase the number of providers in the system, making services more available statewide.
- Improving data collection processes through a contract for the Central Finance functions of the system.

EarlySteps works closely with Medicaid to address and prevent issues, both in Early and Periodic Screening and Diagnosis (EPSDT) and Waiver Compliance. Additionally, EarlySteps developed Memorandums of Understanding (MOU)

with the La. Department of Education and the La. Department of Children and Family Services to coordinate resources and eliminate duplication.

2. **Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?** Progress has resulted in the State's first-ever attainment of a "Meets Requirements" determination issued in June, 2011 by the US Department of Education, Office of Special Education Programs. EarlySteps intends to continue to meet program standards, increase performance to target where needed and address process quality in the system to improve beyond mere "compliance" to standards.

Programs D, E, and F

Objective 1 - Performance Indicator: Number of people transitioned from Northwest, North Lake, and Pinecrest Supports and Services Centers to private provider community options. (Target: 198/Actual: 206*)

*Different from number reported in LaPAS for end-of-year due to inaccurate count.

1. **To what do you attribute this success?** Progress is directly related to specific Office actions. A 20% transition target was set for each of the above-named Supports and Services Centers and objective needs assessments were conducted to identify those service recipients with less intensive support needs who could most readily handle and benefit from transition to private provider community options. Facility Transition Services staff work diligently with the service recipients identified for transition and their families as well as with private providers, support coordinators, and OCDD staff across the State to facilitate smooth transitions to private provider community options with the level and types of supports needed to enhance individuals' quality of life.
2. **Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?** The FY 11/12 target for number of people transitioning from the above-named Supports and Services Centers is lower than the FY 10/11 target but is still higher than prior year targets. The reason that the FY 11/12 transition target is lower than the FY 10/11 target is that the majority of service recipients identified as having lower intensity support needs than are provided in the Supports and Services Center settings transitioned to private provider community options in FY 10/11. By and large the service recipients who will be transitioning from these centers in FY 11/12 have more intensive support needs than those who transitioned in FY 10/11 and more intensive transition planning will be required to ensure that the transitions are successful.

Program F

Objective 3 - Performance Indicator: Percentage of youth discharged who do not return to therapeutic program and who are not incarcerated within six months of

discharge. (Target: 65%, Actual: 75%)

1. **To what do you attribute this success?** Progress is directly related to specific Office actions. Facility staff work diligently with the youth participating in the program who are identified for discharge as well as with members of the youths' natural support networks and with private providers, support coordinators, and OCDD staff across the State to facilitate the youths' smooth and successful transitions to community living settings. After discharge the youths and their providers receive transition follow-up and technical support for at least one year to help address and resolve any issues which would jeopardize the youth's community placement.
 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 at an accelerated pace. As the program continues to develop and grow, the success ratio is expected to improve.
- Where are you experiencing a significant lack of progress?**

Program A

Objective I - Performance Indicator: Percentage of providers of New Opportunities Waiver services trained on person-centered planning (Target: 75%/Actual: 4%)

1. **To what do you attribute the lack of progress?** The original projections for this indicator were based upon a strategy that more broadly targeted community providers for a one time person-centered training. OCDD has worked with national consultants to develop a more comprehensive approach to addressing implementation of a person-centered service delivery system. This new approach focuses on a multi-pronged approach including: implementation of person-centered tools to assist individuals to move from SSCs to community living situations that maintain or improve their satisfaction and involve them in local communities; completion of person-centered thinking training for support coordinators who are responsible for plan development and development of sustainable training and competencies for plan facilitation with these support coordinators; implementation of a pilot of a systematic 1-2 year person-centered organization process with one SSC and two community waiver providers to assess the added benefits of this organizational approach paired with specific training for direct support workers on supporting individuals with significant medical or mental health/behavioral challenges versus only focusing on direct support worker skills; and development of family support training and tools to effectively engage the planning process, choose providers who can meet their loved ones needs, and work collaboratively with providers to sustain needed supports. Actual progress was made in this area, but not as originally planned and not in a manner that can be captured with the current performance indicator. Data presented previously support the completion of person-centered thinking training with all designated SSC staff, increased choice of more person-focused and

flexible waiver options, and overall satisfaction post move. Support coordinator supervisors from all agencies throughout the state have completed the person-centered thinking training. OCDD has begun training with support coordinators. The next phase of implementation will focus on in-depth person-centered organization work and the development and implementation of the plan facilitation and family support training.

2. **Is this lack of progress due to a one-time event or set of circumstances?** The reported lack of progress is an artifact of the change in approach which necessitates a change in the performance indicator to appropriately capture the progress.

Program B

Objective I - Performance Indicator: Percentage of utilization of all waiver opportunities (slots) which become available through funding allocation or conversion of ICF/DD beds. (Performance Standard/Target = 95%; 4th Quarter Actual = 83%)

Note: This data represented all four OCDD Waivers: the New Opportunities Waiver (NOW); the Children's Choice (CC); the Supports Waiver (SW); and the Residential Options Waiver (ROW).

1. **To what do you attribute the lack of progress?** **NOW** – The delay in filling available slots was due to multiple reasons: (1) the increased number of slots offered with the NOW fund (2025) slots which required the SIS/LA Plus assessment and application of the new Guidelines for Planning which resulted in extending the time between NOW offer acceptance to certification in the waiver; (2) a slowdown of the number of NOW offers being released due to budgetary constraints; and (3) residents who transitioned from facilities who required more time to establish all necessary supports in the community. **Children's Choice** - Since the NOW offer date surpassed that of the CC waiver, children on the RFSR who were eligible for CC received an offer for NOW. **Supports Waiver** - Offers were continuously being made on a monthly basis but the number of requestors remained low probably because persons on the RFSR for the SW were typically also on the registry for the NOW and opted to either choose the NOW initially or accept a NOW offer after being certified in the SW. **ROW** - Funding for ROW was not available until 7/1/10 which delayed the enrollment process. ROW implementation is targeted to specific groups of individuals and in a specific order. One of the largest target groups involved conversion of private ICF/DD beds into waiver slots for the development of new and innovative “shared living conversion waiver homes.” Although this HCBS waiver model was designed to parallel the capped rate structure used for private ICFs/DD based on the recipient's ICAP (Inventory of Client and Agency Planning) score, two unexpected across-the-board budgetary rate cuts in the same fiscal year prevented several ICF/DD providers from implementing their planned ROW “conversions” involving upwards of fifty individuals which would have greatly improved utilization data in the ROW and

consequently, in this overall performance indicator.

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

Due to the State's continuing budget constraints, without management intervention, the low utilization within the ROW is likely to continue especially as it relates to the "shared living conversion waiver home" model. A proposed solution, whose implementation must include consultation with DHH/Medicaid, would be to selectively avoid future rate cuts to the ROW "shared living conversion" service and all related professional and nursing services within the ROW which support this model.

Objective I - Performance Indicator: Percentage of increase in people reporting an overall improvement in health and safety and/or quality of life post-implementation of the OCDD Guidelines for Planning, electronic Individual Support Plan, and Support Intensity Scale/Louisiana Plus needs-based assessment (Target: 5%/ Actual: 0%)

1. **To what do you attribute the lack of progress?** The ability to track this data and reach implementation was dependent on the development and implementation of the electronic Individual Support Plan (eISP). The development of the eISP has not been completed at this time, and OCDD is in the process of process mapping and evaluation of the components of the planning process and document in relation to benefits of automation as well as interface with other DHH plans with regard to electronic health records.
 2. **Is this lack of progress due to a one-time event or set of circumstances?** The lack of progress is due to a set of circumstances. Process mapping has occurred with regard to the ISP process and further review was undertaken of the plan content and format. OCDD is evaluating the analysis and workgroup recommendations with regard to process changes and opportunities for technological solutions. OCDD EMT will determine plan for moving forward after review of recommendations from workgroup and will reset indicator in upcoming operational plan in October, 2011.
- **Has your department revised its strategic plan/Business Plan to build on your successes and address shortfalls?** Yes. OCDD's five year Strategic Plan has been updated for FY 2012 through 2016 and its Business Plan has been updated for FY 11/12. Updates to both plans include revisions to program goals, objectives and strategies to better reflect Office direction and to build on successes and provide strategies in areas where success has not be as substantial or where changes in program direction indicate such.
 - **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 individuals within the Office who

manage and oversee the accomplishment of each objective and report to the Office Executive Management Team regarding progress made and support needed in order to achieve the assigned objective. Strategic planning is completed with input of stakeholders, including the OCDD State Advisory Committee.

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

Lack of Adequately Trained Professionals and Direct Support Staff to Deliver Needed Behavioral Services in Community Settings, including Qualified Persons to Deliver Applied Behavior Analytic Therapies to People with Autism

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 services in community settings. This includes lack of qualified persons to deliver applied behavior analytic therapies to persons with autism - therapies which can be very effective and significantly alter the course of autism for many individuals. While specific OCDD initiatives have been implemented this fiscal year to begin addressing this barrier and improvements have occurred in some areas, the general problem continues and will require a multi-faceted and multi-year approach.
- 2. Is the problem or issue affecting the progress of your strategic plan?** Yes. Lack of these professionals in community settings has continued to be the primary contributor to new admissions to supports and service centers, 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. Lack of trained autism professionals negatively impacts ability to develop new autism services which can prevent more severe negative developmental outcomes. Inability to adequately teach functional behavioral skills detracts from community participation objectives (that individuals with disabilities are participating fully in communities).
- 3. What organizational unit in the department is experiencing the problem or issue?** OCDD and Human Services Districts/Authorities are impacted by this.
- 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.
- 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?** A multitude

of factors contribute to the problem beginning with a historic lack of training by universities of persons equipped to deliver these services. Many Ph.D. psychologist programs, for example, offer no training in developmental disabilities. Medical school psychiatry programs typically offer almost no training in psychiatric needs of persons with developmental disabilities. 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, has contributed to increased need for behavioral and psychiatric supports in the community. Some services which could be provided by non-terminal degreed practitioners [e.g., persons with a master's degree in psychology and expertise in this field, Board Certified Behavior Analysts (BCBA) with a master's degree] under the supervision of a licensed professional do not have a funding source. Also, 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.

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, continued needs for costly institutional admissions in supports and service centers, and inadequate practitioners to positively impact the developmental trajectories of children with autism leading to snowballing 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:
 - Evaluate barriers to provision of services to individuals with developmental disabilities and behavioral/mental health needs by private practitioners and use results to develop future strategic actions/objectives;
 - Solicit support of university programs that provide training resulting in additional needed professionals, growing the service provider pool;
 - Explore funding sources that will pay for service delivery by less expensive, qualified professionals;
 - Implement statewide access to training for direct support workers through the My Place Louisiana program; and
 - Complete pilot of joint person-centered organization activities with direct support worker training to determine added benefit of organizational approaches.

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 two 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 developed a statewide PBS curriculum for DSWs and completed a pilot with selected community provider organizations. Implementation through My Place Louisiana will occur in the coming fiscal year.
 - OCDD supports the development of a new university-affiliated training program for master's level practitioners.
 - OCDD continues to offer BCBA continuing education opportunities as well as other behavioral and psychological continuing education options.
 - Supports and service centers continue to divert resources to community behavioral services.
 - OCDD continues to operate small existing community service teams in each region of the state.
 - OCDD has partnered with a national consulting agency to assist in partnering with and developing the capacity within some provider agencies to support individuals with significant challenging behaviors.
 - OCDD is participating in the State Comprehensive System of Care initiative to partner with sister agencies in serving youth with co-occurring conditions.
 - OCDD has implemented improvements within its SU to decrease length of stay which increases access to short-term intensive services for individuals with behavioral and mental health needs that increases the ability to remain living in their community.

The following are additional actions that the Office will consider:

- Further evaluation of barriers to provision of services to individuals with developmental disabilities and behavioral/ mental health needs by private practitioners and use of results to develop future strategic actions/objectives.
- Working with DHH/Medicaid, amend the NOW waiver to allow individual enrollment of all professionals, especially licensed psychologists as is done in the ROW, instead of linking them to Supported Independent Living (SIL) and/or Personal Care Attendants (PCA) providers.

- In regional offices/ districts /authorities where there is an extreme shortage in the availability of licensed psychologists who are enrolled as NOW professionals/providers, possibility of the OCDD Supports and Service Centers contracting with same to provide licensure linkage, billing of invoices and direct payment for services rendered (without administrative overhead), as a temporary solution to access immediate psychological services and avert potential crises.

5. Do corrective actions carry a cost?

Most of these actions do not carry a cost, although partnering with the national consulting agency does. This cost has been incorporated into the Money Follows the Person Grant and focuses on assisting in the transition of individuals from state-operated institutional services into community-based living situations. 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 in so far 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 in all probability offset by 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 results in extensive lifelong service costs judged to be over a million dollars per person which are incurred by families and the taxpayer.

Maintenance of property associated with facilities in which the campuses have been vacated

A. Problem/Issue Description

1. **What is the nature of the problem or issue?** As the Supports and Services Centers downsize, the need has arisen to vacate certain campuses. OCDD continues to be responsible for the costs associated with maintaining the properties vacated when OCDD operations at those properties ceased including risk management fees, building and grounds maintenance, utilities, and loss prevention/security. OCDD will continue to be responsible for all of these costs as long as the properties belong to OCDD and will continue to be responsible for the risk management fees for two (2) years after the properties no longer belong to OCDD. The risk management fees for the vacated OCDD properties total over \$2 million per year. Total other costs associated with maintaining the vacated OCDD properties was approximately \$300,000 in FY 10/11 and is anticipated to be approximately \$600,000 in FY 11/12.
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. Also, 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?** The problem was identified in FY 09/10.
 6. **What are the causes of the problem or issue? How do you know?** The problem was caused by a lack of knowledge regarding mandatory duties related to state-owned property insured by ORM. Also, though vacated, the properties remain the property of OCDD and efforts must be made to keep the physical plant in good condition and to prevent theft or destruction of State property.
 7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?** The consequence of this issue is continued expenditure of OCDD funds to maintain properties which are no longer used by OCDD as service provision sites which will likely result in shortfalls next fiscal year and in the years to come.
- 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?** OCDD should seek 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 last year.
 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

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.

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 08/09, the Louisiana Office for Citizens with Developmental Disabilities (OCDD) has participated in the National Core Indicators (NCI) Project, along with 27 other states. 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.

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 Consumer Outcomes, Phase XII Final Report

2009-2109 Data: 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 Family Guardian Survey Final Report 2009-2010: This report provides a summary of the survey which was mailed to family members of adult with disabilities living outside of the family's home and provides comparisons between Louisiana and the national average of other participating states.
 - National Core Indicators Adult Family Survey Final Report – 2009-2010: 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 Final Report - 2009-2010: 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 2011. (Surveys and interviews were completed between January and June 2010.)
 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. Survey and 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 number and percentage of responses to each question. Comparisons were reported among participating states.
 5. **Cost (allocation of in-house resources or purchase price):** Initial cost to conduct 325 interviews and input responses into the database was approximately \$45,000. Cost for mailing over 4,500 family surveys and inputting responses into the database was approximately \$30,000. Costs for scheduling and rescheduling interviews, confirming interviews, contacting individuals receiving services and services providers to clarify conflicting information, etc. were approximately \$15,000. Additionally, approximately 20

hours of staff time per region and per supports and services center was needed to obtain background information from the person's case record (concerning demographic information, health information, services, etc). Approximately 120 hours of Central Office staff time was needed to develop and monitor the contracts for the interviews and surveys, select random samples for each survey, obtain mailing addresses for families who will be asked to complete surveys, obtain current addresses and phone numbers for adults who will be asked to be interviewed, and coordinate activities among regions and supports and services centers.

6. **Major Findings and Conclusions:** Overall, Louisiana was among the top ranking states in the *Child Family Survey* and the *Adult Family Survey* and within the average range for *Family Guardian Survey* and the *Consumer Outcomes Interviews*. The majority of responses were "Within Average Range" with a substantial number falling 5 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/correct problems/issues identified.
8. **Action taken in response to the report or evaluation:** Efforts have been initiated through quality processes/questionnaires to gain additional information related to areas that fell below average.
9. **Availability (hard copy, electronic file, and website):** Available in hard copy and electronic file on the National Core Indicators website: <http://www2.hsri.org/nci/index.asp?id=reports>.
10. **Contact person for more information, including:**
 - Name: Dena Vogel
 - Title: Program Manager 3
 - Agency & Program: Office for Citizens with Developmental Disabilities, Quality Management Section
 - Telephone: 225-342-9251
 - E-mail: Dena.Vogel@LA.GOV