

# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

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

**Department Head:** **Kathy Kliebert, Secretary**

**Undersecretary:** **Jerry Phillips**

**Executive Director:** **Alicia English Rhoden**

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

**For each accomplishment, please discuss and explain:**

**Integrated Primary and Behavioral Healthcare Services**

**A. What was achieved?**

Jefferson Parish Human Services Authority (JPHSA) initiated the provision of integrated primary and behavioral healthcare services on November 30, 2012. JPHSA's West Jefferson Health Center provides services to individuals residing on the west bank of Jefferson Parish. The provision of primary care services was initially implemented at this Health Center, and a total of 109 unduplicated individuals were seen by a nurse practitioner for primary care needs during FY 2012-2013. (Note: Integrated services will expand to children/adolescents at this Health Center during FY 2013-2014.)

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

The provision of primary care services allows JPHSA to integrate the delivery of primary care services with behavioral health services thereby providing a centralized location for individuals to address their healthcare needs.

The results of national research indicate individuals with a behavioral health disorder experience a significant decrease in their life expectancy. This decrease has been

measured to be on average 25 years or more compared to individuals who do not have a behavioral health disorder. Internal mortality statistics maintained by JPHSA's Medical Director also reflected this disparity in life expectancy.

C. Who benefits and how?

Individuals who receive integrated primary and behavioral health care services experience improved access to needed services, a reduction in the incidence of serious and acute physical illness, an improvement in overall health, and a reduction in the early mortality. These individuals have often neglected their primary care needs due to their mental illness exacerbated by the unavailability or lack of access to primary care providers. During FY 2012-2013, JPHSA served nearly 7,000 adults in Jefferson Parish for their behavioral health needs. Of those, 109 were seen for their primary care needs through internal referral by behavioral health staff or by a self-request for these services.

D. How was the accomplishment achieved?

JPHSA researched the integration of primary and healthcare and studied existing models prior to applying for a grant funded by the New Orleans Charitable Health Fund (NOCHF). The grant was created to support integrated behavioral health and primary healthcare as well as referrals to social services over a three-year grant period (July 2012 – June 2015). JPHSA was one of only six (6) organizations selected for this grant. It is administered through the Louisiana Public Health Institute (LPHI), an organization that provides technical assistance on all aspects of implementing an integrated healthcare model. Funding from the grant has allowed JPHSA to hire or contract with family practice physicians and nurse practitioners, to purchase materials and supplies to equip examination rooms, and to purchase an electronic health record to document services. The use of this electronic health record will be explored to eventually document all services provided in a single product. Supports for integrated services were developed in consultation with outside experts, also funded by the NOCHF grant; and, exploration of new access point application for Federally Qualified Health Center funding was initiated. Additionally, work was initiated to cultivate and execute cooperative endeavor agreements with other healthcare providers, e.g. West Jefferson Medical Center and EXELth, an FQHC. Finally, adults in active treatment at JPHSA's West Jefferson Health Center and who did not have a primary care physician were identified and offered primary care services.

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

Yes. JPHSA's Vision Statement is: *Jefferson Parish Human Services Authority envisions a Jefferson Parish in which individuals and families affected by mental illness, addictive disorders or developmental disabilities will live full, independent and productive lives to the greatest extent possible with available resources.* The integration of services affords individuals with mental illness or addictive disorders access to primary care services for treatment of chronic and acute illnesses, resulting in fuller and more productive lives.

Goal I of JPHSA's Strategic Plan is: *Provide coordinated services and supports which*

*improve the quality of life and community participation for persons in crisis and 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.* The integration of primary care and behavioral health care delivery within the West Jefferson Health Center resulted in improved coordination and access to care, treatment of physical illnesses previously neglected, and an improvement in the quality of life for these individuals served by JPHSA.

- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?  
JPHSA shared this accomplishment and the methods undertaken to achieve it with the Department of Health and Hospitals, the Office of Behavioral Health, and three other Local Governing Entities.

## II. Is your department five-year strategic plan on time and on target for accomplishment?

- ◆ **Please provide a brief analysis of the overall status of your strategic progress.**  
Jefferson Parish Human Services Authority (JPHSA) remains on target toward achieving Strategic Plan Goals and Objectives. Strategies outlined in the current Strategic Plan continue to be effective and continue to be enhanced by the Authority's aggressive and ongoing commitment to Performance and Quality Improvement.
- ◆ **Where are you making significant progress?**  
Based on available data, including survey research and access to comparative data, JPHSA reports continued progress on Strategic Plan Goals.

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

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

All strategies are utilized along with an ongoing emphasis on continuous performance and quality improvement in both service delivery and business processes.

1. To what do you attribute this success?  
JPHSA attributes its success to the following: ongoing compliance with Council On Accreditation (COA) standards; adherence to the Accountable Care Model (endorsed by the National Council on Community Behavioral Health); ongoing commitment to and assertive focus on performance and quality improvement

initiatives; integrated and holistic service delivery; communication of clearly defined performance expectations for all employees and adherence to the JPHSA Staff Development and Supervision Guidelines; and, the effort to utilize data for performance and quality monitoring as well as for decision support.

JPHSA, with the full support of its Board of Directors, has taken its destiny into its own hands, and has moved forward with aggressive strategies and tactics to assure sustainability and significantly decrease dependence on state funding. For example, the Authority is positioning clinic-based behavioral health services to operate as a Federally Qualified Health Center (FQHC) or a “Look Alike” FQHC; has taken an aggressive stance with acquiring private insurance contracts; and, continues to restructure operations for effective delivery of services in the most efficient manner.

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

Progress is not the result of a one-time gain; rather it is continuous. JPHSA utilizes division-specific annual plans and annual Authority-wide Performance and Quality Improvement (PQI) Initiatives as well as targeted PQI workgroups to assure progress. Support from the JPHSA Board of Directors is essential and ongoing.

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

Jefferson Parish Human Services Authority (JPHSA) continues to progress toward achieving Strategic Plan Goals and Objectives.

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

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

The Jefferson Parish Human Services Authority Board of Directors revised the Mission Statement to include the integration of primary and behavioral healthcare services:

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

This revision builds on JPHSA’s successes and becomes active with the Strategic Plan effective July 1, 2014.

- 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?**

Jefferson Parish Human Services Authority (JPHSA), a Local Governing Entity, adheres to the Policy Governance Model. The Board of Directors establishes the Mission and Priorities, and selects an Executive Director to provide ongoing leadership and operational management of the 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 (over many years) Accountable Care and Performance & Quality models/philosophies, JPHSA continuously communicates, monitors, reports, and implements corrective actions and/or performance and quality improvement activities with regard to Strategic Plan Goals, Objectives, and Performance Indicators. A broad range of venues are utilized: individual supervision, work groups, divisional staff meetings, all-staff meetings, the employee electronic newsletter, the employee intranet site, accessible data reports, etc.

Each Division Director is required to develop and implement an annual division-specific plan in support of the JPHSA Strategic Plan. Each Director is also required to provide quarterly progress reports to the Executive Director and to share these reports within his/her own division and to post them on the shared drive of the JPHSA computer network.

Additionally, the Performance & Quality Improvement Committee develops, adopts, and implements annual cross-divisional Performance & Quality Improvement Initiatives to further ensure JPHSA meets and/or exceeds Strategic Plan Goals and Objectives and to support the Authority's Mission and Priorities. Quarterly progress reports are delivered during a meeting of the full Performance & Quality Improvement Committee and reported in the employee electronic newsletter.

JPHSA uses its employee newsletter – *Have You Heard* – as a key tool for communicating with employees about Strategic Plan Goals, Objectives, and Performance Indicators as well as about daily Authority operations. The electronic newsletter is published a minimum of two times each week via the JPHSA email system with special editions provided on an as-needed basis.

Division Directors involve their employees in data collection, analysis, and reporting of Performance Indicator outcomes and in work groups formed to enhance performance and quality improvement. The Executive Director schedules three all-staff meetings each Fiscal Year. Performance and quality improvement is a routine part of the interactive agenda.

Bi-weekly Executive Management Team (Division Directors) meetings are used as group supervision and as forums for discussion of progress on meeting/exceeding goals

and for collaborative development of corrective action and/or performance and quality improvement plans. The Executive Director holds the Executive Management Team accountable on both an individual and group basis for successful implementation of the JPHSA Strategic Plan, Annual Division Plans, and the Annual Performance & Quality Improvement Initiatives. The Executive Director gauges a significant portion of the Management Team Members' performance reviews on their contributions to the Strategic Plan and Performance & Quality Improvement Initiatives as well as on their degree of success in accomplishing 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 required to meet with their subordinates as outlined in JPHSA's Staff Development & Supervision Guidelines (weekly for new employee, 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. (Every employee needs to vigorously row in the right direction and to adjust his/her course as needed to achieve JPHSA's Mission, Strategic Plan, Goals, and Objectives.)

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.

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

#### **The Louisiana Department of State Civil Service**

##### **A. Problem/Issue Description**

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

As indicated in the FY 2010-2011 and in the FY 2011-2012 Annual Management and Program Analysis Report, the Louisiana Department of State Civil Service continues to pose barriers to recruiting, hiring and retaining high quality and qualified staff and to the internal restructuring underway that is mission critical to the ongoing success of Jefferson Parish Human Services Authority (JPHSA).

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

Yes, as a highly qualified and productive staff has direct impact on both capacity and quality of services and supports. Although a favorable outcome may be achieved in the majority of Human Resources actions, the amount of time that must be invested on the part of both JPHSA Human Resources staff and upper level management AND the timelines for response and/or resolution are excessive. To survive in a competitive environment, organizations must be flexible and

nimble. Civil Service supports neither.

3. What organizational unit in the department is experiencing the problem or issue?  
This issue impacts every area and all employees of JPHSA.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)  
The recruitment AND retention of qualified service delivery staff for both Behavioral Health and Developmental Disabilities services and supports have a direct impact on individuals seeking and receiving services as do the ability to adjust staffing as needs present and to quickly resolve performance and productivity issues.
5. How long has the problem or issue existed?  
The Louisiana Department of State Civil Service has posed barriers regarded as significant and harmful to JPHSA operations since FY 2010-2011. Civil Service inhibits JPHSA's ability to effectively compete with private providers.
6. What are the causes of the problem or issue? How do you know?  
The Louisiana Department of State Civil Service does not have a mission that is supportive of the Local Governing Entities and State Offices operating as efficient and high performing businesses. The system is antiquated.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?  
JPHSA will continue to work within the confines of the Louisiana Department of State Civil Service and to utilize strategies and tactics that enable the Authority to compete in a competitive environment. Ongoing and aggressive performance and quality improvement initiatives will continue to be used to mitigate negative impact on the organization, its employees, and the individuals the Authority serves as much as is possible.

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

4. Are corrective actions underway? NA
- 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? NA

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?

## **Louisiana Behavioral Health Partnership**

### A. Problem/Issue Description

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

Jefferson Parish Human Services Authority (JPHSA), as reported in the FY 2011-2012 Annual Management and Program Analysis Report, utilized a fully functional Electronic Health Record prior to the State Management Organization for the Louisiana Behavioral Health Partnership, i.e. Magellan, and the Office of Behavioral requiring use of Clinical Advisor. Throughout FY 2012-2013, performance of Clinical Advisor did not meet the standards of an Electronic Health Record as basic functions could not be performed with the software, decision support was not feasible, and billing any payor other than Medicaid was

impossible. Additionally, the process put forth for prior authorizations for services was rife with problems and inefficiencies, e.g. requests lost and resubmitted a multitude of times, approval given then rescinded leading to recoupment of payments, poor customer service, etc.

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

There was an impact on progress toward achieving Goal I of JPHSA's strategic plan at the end of FY 2012-2013 as Self-Generated Funds were part of the Authority's budget during this year (\$4.36 million in revenue to be produced by billing Magellan).

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

The inability to bill Medicare, GNOCHC (Greater New Orleans Community Health Connection), and private insurance through Clinical Advisor required double entry into JPHSA's former Electronic Health Record, Anasazi. Further, it was impossible to identify GNOCHC from Medicaid within Clinical Advisor, leading to another billing slowdown and resulting in re-filing of GNOCHC claims. To put it simply, it required a Herculean effort to bill and to collect payment for services. The increased demand on human resources was costly. Further, ongoing snafus with prior authorization and eligibility determination for services led to several instances with monies being recouped after services were provided. These issues added stressors to JPHSA's ability to retain capacity and its array of services and supports.

Progress toward achieving Goal II of JPHSA's strategic plan was seriously impacted during FY 2012-2013 as there was little to no data available to measure outcomes or to use for decision support. (Note the number of Performance Indicators that could not be reported in the Louisiana Public Accountability System, i.e. LaPAS.)

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

Simply put, JPHSA's outcome measurement and decision support efforts, after years of high-end analysis and reporting, performance and quality improvement activities were seriously hampered. Through months of requests to both Magellan and the Office of Behavioral Health, JPHSA received its first "dump" of live data out of Clinical Advisor near the end of the Fiscal Year. Although far from meeting the standards and expectations set with JPHSA's former Electronic Health Record, the Authority made and is making best use of the data it can

access.

3. What organizational unit in the department is experiencing the problem or issue?  
Although JPHSA's adult and child/adolescent Behavioral Health clinic-based services are the users of Clinical Advisor, the Management Services Division worked with the software to extract billing data and also supported the prior authorization processes with Magellan. In terms of timely and full reimbursement for Louisiana Behavioral Health Partnership services and for services covered by other payors, impact is felt throughout the Authority. At this time, both Magellan and the Office of Behavioral Health state that use of Clinical Advisor is not mandatory. JPHSA is taking steps to suspend use of this software.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)  
The other Local Governing Entities are all affected by both Clinical Advisor and problems with the Magellan prior authorization process.
5. How long has the problem or issue existed?  
These issues have existed since March 15, 2012.
6. What are the causes of the problem or issue? How do you know?  
Clinical Advisor was rolled out for use before the application was fully developed. This can be stated with certainty as JPHSA has worked with both Anasazi and Success EHS software, two fully functional Electronic Health Records. Additionally, all other Local Governing Entities can confirm the same experiences with the software. As far as prior authorization and eligibility determination processes, JPHSA worked and works with several private insurers and is able to navigate the requirements with ease and without having payments recouped.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?  
The sustainability of JPHSA's current array of services and supports would be impacted from both a quality and capacity point of view. Additionally, the Authority's ability to meet and demonstrate performance and quality improvement standards as well as fiscal standards set forth by its accrediting body, the Council On Accreditation (COA) would be placed in doubt. However, JPHSA made the decision to move off Clinical Advisor and is in the process of developing a transition plan. The goal is to be fully functioning with another Electronic Health Record by the end of the first quarter of FY 2014-2015. Additionally, JPHSA made the decision to devote a full-time equivalent to manage and track the prior authorization process. This resource was put in place early in FY 2013-2014.

## 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? NA

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

4. Are corrective actions underway? NA

5. Do corrective actions carry a cost? NA

- 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, service delivery, business, and administrative functions as well as staff

development and supervision activities. Audit tools with identified criteria and standards are utilized; results are reported; and, appropriate performance and quality improvement and/or corrective actions are implemented. Further, the Management Services Division audits Authority performance using benchmarks set forth in Council On Accreditation standards. Improvement plans are developed and executed as needed. The Division monitors progress on improvement and corrective action plans as well.

- 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 and Hospitals Office of Behavioral Health, the Department of Health and Hospitals Office for Citizens with Developmental Disabilities, Health Standards, the Louisiana Department of State Civil Service, and Peer Monitoring in conjunction with another Local Governing Entity (Block Grant requirement).
- Policy, research, planning, and/or quality assurance functions in-house JPHSA's Management Services Division has overall accountability for policy development and management as well as for the Authority's quality assurance functions. With regard to policy development and amendment, the Management Services Division Director consults with the Jefferson Parish Attorney on an as-needed basis. The Executive Management Team, headed by the Executive Director, is responsible for short- and long-term planning. She seeks the consult of the JPHSA Board of Directors as appropriate according to Board policies. The Performance & Quality Improvement (PQI) Committee, chaired by the Management Services Division Director, is responsible for the review and update of JPHSA's PQI Plan and for the collaborative development and ongoing monitoring of annual PQI Initiatives. The Research Committee, chaired by the Authority's Medical Director, has overall responsibility for review and approval of research studies involving service recipients. Any and all such studies are required to be consistent with the JPHSA Mission and Priorities.
- Policy, research, planning, and/or quality assurance functions by contract The MST Network, of which JPHSA is a member, provides technical assistance as requested by the Authority's Multi-Systemic Therapy Teams.
- Program evaluation by in-house staff Performance is monitored on an ongoing basis utilizing the JPHSA Strategic Plan, Operational Plan, Division-Specific Annual Plans, Annual Performance & Quality Improvement Initiatives, Utilization Management Plan, Staff Development & Supervision Guidelines, and position-specific expectations. All have clearly stated goals/objectives and performance targets. The Executive Director, Executive Management Team, Supervisory Staff, and the Management Services Division share responsibility. The Executive Director is also required to submit ongoing monitoring reports to the JPHSA Board of Directors as defined by Board policy.

- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)  
JPHSA collects data, performs statistical analysis, 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 quarterly Performance Indicator targets. Each note outlines any needed corrective action or process improvement activities. JPHSA also provides data or makes data available to the Department of Health & Hospitals' (DHH) Office for Citizens with Developmental Disabilities (OCDD) and Office of Behavioral Health (OBH) on an ongoing basis and as requested. JPHSA is compliant with the DHH Human Services Accountability and Implementation Plan, which contains an extensive array of outcome measures, many of which OCDD and OBH utilize in compiling data for their own LaPAS reports.
- In-house performance accountability system or process  
JPHSA utilizes the following to model its performance accountability process: The National Council for Community Behavioral Health endorsed Accountable Care Model; the Council On Accreditation Standards and Rating System; the JPHSA Staff Develop & Supervision Guidelines in conjunction with the Louisiana Department of State Civil Service Performance Evaluation System; JPHSA's Performance & Quality Improvement Initiatives; fidelity models for Evidence-based Practices; ongoing internal monitoring with appropriate follow-up activity; and, ongoing data collection, mining, and analysis for decision support.
- Benchmarking for Best Management Practices  
JPHSA's decision support function is grossly impacted by Clinical Advisor, the software mandated for use as part of the Louisiana Behavioral Health Partnership. The Office of Behavioral Health, within the last few months, has agreed to provide raw data to JPHSA so the Authority may continue to mine and analyze data; however, data is not provided on a regular schedule. Although some double entry is required, JPHSA continues to use Anasazi, its former electronic health record, to supplement decision support. Developmental Disabilities Services data is obtained through the Office of Citizens with Developmental Disabilities software. Comparative studies are enabled through other Local Governing Entities reporting into the LaPAS system as well as through benchmarking against national standards for Evidence-based and Best Practices. JPHSA's Financial System, Great Plains, is a highly sophisticated system that allows detailed budget reporting, enabling the measurement of performance against quarterly targets and annual goals as well as identification of trends. JPHSA also uses benchmarks set forth in the Accountable Care Model and the Council On Accreditation Standards and Ratings System for ongoing measurement and performance monitoring.

- Performance-based contracting (including contract monitoring)  
All JPHSA contracts have explicit and detailed performance requirements, i.e. Statements of Work with all deliverables, program requirements, performance measures (both process and outcome), required administrative oversight, and reporting mandates clearly spelled out. Further, monitoring plans all include timeframes, measures, and assigned clinical/service delivery and financial monitors.
- Peer review  
The JPHSA Medical Director leads comprehensive multi-disciplinary peer review in cases of service recipient suicide or death not associated with a physical disease or chronic condition. He also schedules peer reviews during quarterly meetings of the Medical Staff. JPHSA participates in the Office of Behavioral Health annual peer review with a sister Local Governing Entity. These reviews alternately focus on program or administrative functions. The Office of Behavioral Health and Office for Citizens with Developmental Disabilities also conduct annual on-site reviews with peers from other Local Governing Entities as participants.
- Accreditation review  
JPHSA completed year two of a four-year full organization by the Council On Accreditation, an international accrediting body for human services organizations. Further, JPHSA successfully completed the second year maintenance of accreditation review with no recommendations or findings.
- Customer/stakeholder feedback  
JPHSA participates in annual satisfaction surveys sponsored by the Office of Behavioral Health and the Office for Citizens with Developmental Disabilities. Additionally, JPHSA fields a proprietary survey within its integrated health centers on an annual basis in order to identify opportunities for improvement. Comment boxes are available in all Health Centers; and, JPHSA invites feedback via its internet site. The Authority conducts satisfaction with service recipients of contractors delivering community-based Behavioral Health Services as part of standard contractual requirements. JPHSA partners with the Office of Behavioral Health to hold an annual addictive disorders community forum for the citizens of Jefferson Parish. The members of the Board of Directors, per the Policy Governance Model, actively engage in “community linkages” and report the outcomes of these interactions with community stakeholders during Board meetings. Additional feedback is obtained through active participation in the monthly Jefferson Parish Behavioral Health Taskforce meetings and the quarterly community partners meetings held by the Developmental Disabilities Community Services Division. Regional Advisory Councils for Behavioral Health and Developmental Disabilities provide feedback as well. The Division Director for JPHSA’s Developmental Disabilities Community Services Division now attends Developmental Disabilities Council quarterly meetings and interacts

on an ongoing basis with the Advocacy Center. The Executive Director and the Executive Assistant make regular calls on local and state elected officials as well as community leaders.

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:

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

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

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# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

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

**Department Head:** Kathy Kliebert, Secretary

**Undersecretary:** Jerry Phillips

**Executive Director:** Melanie Watkins

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

**Continuation of Co-location of Services** – Corresponding to DHH’s Business Plan theme of Building Foundational Change for Better Health Outcomes, FPHSA continued to co-locate/relocate staff and services to combine the provision of services and to reduce operating expenditures. Developmental Disabilities Services was the first to relocate to the newly leased facility located on Pride Drive in Hammond. FPHSA’s has also co-located/relocated Hammond Addictive Disorders Clinic, Rosenblum Mental Health Center for Adults (August 2013), and Mental Health Administration. FPHSA’s Executive Administration will move to the Pride Drive location in December 2013. Combining these facilities is estimated to save FPHSA approximately \$150,000 annually once all facilities have been co-located/relocated in December 2013. FPHSA clients will benefit from this accomplishment as multiple services will be located in one facility and the coordination of services for multiple disorders will be more readily accessible and care more integrated. This accomplishment also contributes to FPHSA’s goal of improving efficiency of services using data-based decision making.

**Continuation of Progress Towards Accreditation** – FPHSA has continued in its efforts to become accredited by Commission on Accreditation of Rehabilitation Facilities (CARF). FPHSA contracted with a consultant to assist in preparing for accreditation and has prepared policies and procedures that are required by CARF. Accreditation is required for participation in the 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 help ensure a level of service that is consistent with national standards. This accomplishment contributes to the DHH Business Plan theme of Building

Foundational Change for Better Health Outcomes as it is required by the LBHP. The accomplishment also contributes 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. FPHSA is planning to have the CARF survey completed in January/February 2014.

## **II. Is your department five-year strategic plan on time and on target for accomplishment?**

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

The effectiveness of FPHSA's strategies in FY 13 has been hindered by the rapid evolution of outside circumstances and a workforce ill-equipped to adapt to such rapid statewide systematic transformation. The implementation of the Magellan Clinical Advisor system and the implementation of the LBHP have contributed to a reduction in the number of clients served and an increase in the cost per client served.

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

FPHSA's past progress toward meeting this goal has been dampened. Although the agency continues to provide direct clinical services and coordinates an array of services designed to provide treatment on an outpatient basis as well as a 28-day residential treatment program for addictive disorders, staff direct care time with clients has been impacted by the mandated transition to the Statewide Management Organization and the limitations to the Clinical Advisor system.

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

FPHSA has made progress toward implementation of data-based decision making. The agency has made headway toward treatment of co-occurring disorders. FPHSA continued progress toward co-housing Addictive Disorders Services and Mental Health Services staff this fiscal year. Clients with co-occurring disorders can 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. In August 2013, FPHSA also combined Rosenblum Mental Health Clinic for Adults and Hammond Addictive Disorders in Hammond.

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, ITS, Clinical Advisor, etc.) and the transition to a single electronic behavioral health record (Clinical Advisor).

The agency continued preparation for accreditation which will enhance quality and effectiveness of services as well as prepare the agency and staff for the ongoing evolution of health care.

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

FPHSA is meeting this goal in several ways. Major educational initiatives include the Addictive Disorders Services Prevention program. FPHSA Prevention Services promotes healthier lifestyle throughout the community by supporting participation in healthy initiatives such as Red Ribbon Week, Wellness Week, Recovery Month, Alcohol Awareness, Suicide Prevention Awareness, Regional Child Mortality Death Review, etc. Prevention Services also bring training to the communities to empower individuals and groups to learn about the issues in the community (driven by data) strategic ways to address those issues to promote healthier communities. Such training includes ASIST (Applied Suicide Intervention Skills Training), SafeTalk (a suicide awareness program), Strategic Planning Framework (training in a process to strategically assess and address community issues), Cultural Diversity, Preventing Behavioral, Mental, and Substance Use Disorders in Young People, etc.

FPHSA staff of each of the agency's service areas participates in numerous coalitions across the five-parish area including St. Helena Human Services Coalition, Tangipahoa Social Services Coalition, St. Tammany Commission on Families, Washington Parish Commission on Human Services, Livingston Parish Human Services Coalition, Northlake Homeless Coalition, Families In Need of Services, Prevention and Reduction of Unhealthy Decisions, Healthy Community Coalition, TRACC (Tangipahoa Reshaping Attitudes for Community Change), etc. FPHSA also holds an annual public forum whereby information is presented and public input is received on the addictive disorders and mental health services provided by FPHSA.

**Objective 1: Each year through June 30, 2016, Florida Parishes Human Services Authority/Addictive Disorders Services will provide treatment services to individuals with addictive disorders and prevention services to four percent of the population within its catchment area.**

FPHSA has met this objective in FY 13 as 29,540 individuals were served through addictive disorders treatment and prevention services, which is five percent of the population of FPHSA's catchment area.

**Objective 2: Each year through June 30, 2016, Florida Parishes Human Services Authority/Developmental Disabilities Services will provide services that emphasize person-centered individual and family supports to people with developmental disabilities. Delivery of services will result in an increased percentage of people within the FPHSA catchment area that remain in the community rather than**

**being institutionalized.**

FPHSA has seen success towards this objective. In FY 13, the percentage of individuals receiving Flexible Family Funds/Cash Subsidy and the percentage of individuals and families receiving family support who remain in the community versus being institutionalized were both 100 percent again in FY 13. The percentage of Waiver participants with a current Statement of Approval was 100 percent in FY 13. These results also promote the DHH Business Plan Goal for Promoting Independence through Community-Based Care with less individuals being institutionalized and more home- and community-based services.

**Objective 3: Each year through June 30, 2016, Florida Parishes Human Services Authority/Executive Administration will increase the efficiency of the operation and management of public, community-based services related to addictive disorders, developmental disabilities, mental health, and permanent supportive housing in the parishes of Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington.**

FPHSA has had success in the areas of property management, new employee training, and Executive Administration percentage as percentage of agency budget. Challenges lie in the payment of contract invoice delays, timeliness of IT work order closures, and the percentage of agency performance indicators within +/- 4.99%. These challenges are mainly due to increased demands on staff in preparation for CARF accreditation and the Clinical Advisor implementation.

**Objective 4: Florida Parishes Human Services Authority/Mental Health Services will manage community-based mental health services such that quality services will be provided in a cost-effective manner in 2016 compared to 2012.'**

In FY 13, the average cost per person served was higher than FY 12. Since the transition to the LBHP and the use of Clinical Advisor, the calculation methodology for the number of persons served has changed which has contributed to a decrease in the number served.

**Objective 5: Florida Parishes Human Services Authority/Permanent Supportive Housing Services will maintain tenancy of and provide support services to 198 apartments/housing units designated for individuals/families with a variety of long-term disabilities.**

The more stringent criteria for the PSH program has resulted in fewer applicants on the waiting list meeting eligibility criteria. In some cases this has resulted in no applicants on waiting lists for some apartments. In other cases it has taken more time going through applicants on the waiting list before finding an applicant who meets eligibility criteria for a vacant apartment. In some cases this delay has resulted in the landlord renting the apartment to a non-PSH tenant. Not having apartments filled with PSH tenants has therefore resulted in a lower number served.

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

FPHSA has made progress in the number of Waiver participants having a current Statement of Approval (SOA). The percentage has increased to 100 percent from the previous fiscal year of 91.13 percent.

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

**Data Reported** – Due to the continued issues with Clinical Advisor, FPHSA has had difficulty in obtaining data required to determine accuracy of proximity to targets referenced in the five-year Strategic Plan for the second year. It is anticipated that once the Clinical Advisor system has been fully developed and is 100 percent functional, this issue should be resolved.

**Clients Served** - With the statewide implementation of Clinical Advisor and the participation in the LBHP, FPHSA developed and implemented a new clinical workflow which required staff to be reoriented and retrained regarding the client's journey through the treatment process. The requirements for the Statewide Management Organization's authorization process increased the wait time for appointments for screenings and assessments.

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

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

FPHSA changed the five-year Strategic Plan in FY 13 to be in compliance with DOA requirements.

♦ **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.**

FPHSA has monthly meetings with its Board of Directors and conducts routine 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.

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

**Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and**

discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

**Accounting for all Payor Sources** – FPHSA has had difficulty with collections from all pay sources. In part due to the complexity of the implementation of Clinical Advisor and the frequently revised procedures associated with Clinical Advisor, facility billing staff did not consistently obtain complete insurance and client information at admission and did not bill private insurance and self-pay clients in a timely manner. Collections have also been hampered by the implementation of Clinical Advisor. Since 3/1/12, FPHSA has not been able to bill private insurance companies, Medicare, or self-pay clients due to the lack of development of the Clinical Advisor system. This has led to a reduction in the funds collected by FPHSA.

#### 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?
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.)

**Continued Issues with the Implementation of Clinical Advisor** – Since implementation of the Clinical Advisor system on 3/1/12, FPHSA has had numerous challenges in entering data, billing for services, posting payments for services, and reporting.

#### 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?
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?

#### **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, Property, HR)
- External audits (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. Property
  - d. HR
  - e. Office of Risk Management (ORM) – Audit
  - f. Louisiana Department of State Civil Service – Compliance with Civil Service Rules and Directives
  - g. Louisiana Performance Accountability System (LaPAS)
  - h. Contract Monitoring
  - i. Annual Financial Reports
  
2. Date completed
  - a. Monthly from July through April
  - b. Monthly from July through April
  - c. Quarterly from July through March
  - d. Annually for each facility
  - e. February 15, 2013
  - f. May 23, 2013
  - g. Last completed September 3, 2013
  - h. Quarterly
  - i. October 17, 2013
  
3. Subject or purpose and reason for initiation of the analysis or evaluation
  - a. FPHSA Procedure 150.10 Cash Receipts
  - b. FPHSA Procedure 150.9 Petty Cash
  - c. FPHSA Procedure 150.16 Moveable Property
  - d. FPHSA Procedure 540.1 Time Administration
  - e. FPHSA Risk Management Policy 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 Procedure 150.10 Cash Receipts
  - b. FPHSA Procedure 150.9 Petty Cash
  - c. FPHSA Procedure 150.16 Moveable Property
  - d. FPHSA Procedure 540.1 Time Administration Policy
  - e. Audit completed by ORM, LP Officer
  - f. Evaluation completed 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. \$17,552.27
- b. \$5,851.93
- c. \$5,851.93
- d. \$4,676.67
- e. Not calculated
- f. Not calculated
- g. Not calculated
- h. Not calculated
- i. Not calculated

6. Major Findings and Conclusions

- a. None
- b. None
- c. None
- d. None
- e. Agency was deemed compliant, with a score of 98.68%. Under Incident/Accident Investigations and Emergency Preparedness Plan, one item was found in each to be deficient and recommendations were made.
- f. Agency was commended for being 100% compliant in 19 of the 23 categories reviewed. The audit showed that there were no areas of concern at this time. One rule violation, five documentation violations, and one directive violation were found.
- g. None
- h. None
- i. None

7. Major Recommendations

- a. None
- b. None
- c. None
- d. None
- e. 1.) Agency must use the DA2000/DA3000 or other equivalent form to report any accident/incident; and 2.) Agency must write an emergency preparedness program that should address proximity threats.
- f. 1.) Agency must ensure that rejected applicants who do not meet the

minimum qualifications are notified of the action taken; 2.) Agency must maintain documentation of minimum qualifications and preferred qualifications for each of its appointments, promotions, reallocations, and details to special duty that require such documentation; 3.) Agency must maintain official position descriptions for all positions within the agency; and 4.) Agency must ensure that DPRL checks are performed in accordance with Civil Service directives contained in the HR Handbook, Layoff Issues.

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

8. Action taken in response to the report or evaluation

- a. Audit results are discussed at management team meetings and trouble shooting is done.
- b. Audit results are discussed at management team meetings and trouble shooting is done.
- c. Audit results are discussed at management team meetings and trouble shooting is done.
- d. Audit results are discussed at management team meetings and trouble shooting is done.
- e. 1.) Agency notified staff that effective immediately staff will complete the investigation portion of the form when reporting an accident/incident. 2.) Each agency site conducted specific proximity threat assessments related to the location and developed emergency preparedness plans specific to their locale.
- f. Agency created and implemented various checklists to ensure all necessary tasks are completed, to ensure that all minimum/preferred qualifications are met for employees appointed, promoted, reallocated or detailed to special duty, and to ensure the task of checking the DPRL. Agency also incorporated the verification of the last date a position was updated prior to the appointing authority granting permission to announce the vacancy to fill the position.

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

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

- a. Electronic files
- b. Electronic files
- c. Electronic files
- d. Electronic files
- e. Hard copy
- f. Hard copy

- g. [www.doa.louisiana.gov/opb/lapas/lapas.htm](http://www.doa.louisiana.gov/opb/lapas/lapas.htm)
- h. Hard copy
- i. Hard copy

10. Contact person for more information, including

Name:	Melanie Watkins
Title:	Executive Director
Agency & Program:	Florida Parishes Human Services Authority
Telephone:	(985) 748-2220
E-mail:	Melanie.watkins@la.gov

# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

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

**Department Head:** Kathy H. Kliebert, Secretary

**Undersecretary:** Jerry Phillips

**Executive Director:** Jan Kasofsky, PhD

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

#### ***CAHSD Obtains 3 Year CARF Accreditation***

In November 2012, CAHSD attained a three year CARF Accreditation. This would not have been attainable, especially in light of all the other responsibilities tugging at us, if we had not come together as a team to tackle the numerous tasks to prepare for the survey over the last two years. CAHSD only received 20 recommendations which are considered deficiencies to correct. This is remarkable in light of the several hundred CARF standards that met compliance.

The CAHSD corrective action plan on all recommendations has been submitted and accepted by CARF. At the time of the next CARF survey in 2015, the survey team will review the deficiencies of the last survey to ensure those areas are in compliance. Most of the deficiencies have already been corrected or are in the process of being corrected through revision of policies, procedures and the client orientation handbook. Correction of some deficiencies related to the CARF record requirements (i.e. the development of person centered treatment plans, transition plans and completion of integrated summaries) will be addressed through quarterly quality record reviews. In order to improve compliance with the CARF client record requirements, a more detailed chart audit tool has been developed and implemented. Each facility performance improvement team has begun the process of using the tool to conduct quarterly chart audits to ensure CARF record compliance. Charts out of compliance will be addressed with each responsible clinician through the supervisory process.

As CAHSD continues to develop a service delivery model that promotes quality, productivity, and efficiency, maintaining CARF accreditation will be essential to our continued success in providing needed services to our community. Now that we have achieved our goal of CARF

Accreditation, we are preparing for the next survey by integrating the application of CARF standards into our daily activities.

### ***Practice Management Comes to CAHSD***

CAHSD hired its first Practice Manager of Clinic Based Services, and likely the first practice manager within the Department. The role of this individual is to help bridge the communication gap that sometimes occurs between clinical and administrative functions when you have an organization as large as CAHSD. Change can come swiftly in the healthcare industry, and we all have to be prepared for that change. This individual is preparing CAHSD for this inevitable change and to meet the challenge head.

She has rapidly established a Central Billing Office (CBO) in order to help transition CAHSD to a more traditional private billing model. This office processes claims for payment, work denials, perform claim follow-up, and is responsible for collecting our self-generated revenue. This team approach to billing will enable us to become more efficient and knowledgeable on how to keep our revenue cycle moving. Several new positions and staff have been added to create this office including a Billing Supervisor, Billing Specialists and a Credentialing and Contracting Specialist.

She is also working hard providing training sessions for the Social Workers and Psychiatrists on billing appropriate “Psychiatric Diagnostic Evaluations & Treatment” and “Evaluation & Management Coding for Optimal Reimbursement.”

### ***CAHSD Hosts Public Symposium with State Senator Broome and Representative Cassidy***

“Roots of Violence” was co-hosted by State Senator Broome and Representative Bill Cassidy to create a dialog on community violence. The forum was well attended and included presentations from the Sheriff; the Coroner; BRAVE Representatives; CAHSD’s own Medical Director, Dr. Udofa; and others. The event was well covered by television and newspaper reporters. As a result of this forum, legislation was prepared by Senator Broome and became law during the 2013 Legislative Session to create MH Courts. Senator Broome will utilize the BH Collaborative structure for further community work on behavioral health topics. [http://theadvocate.com/news/5240597-123/community-leaders-discuss-links-between.](http://theadvocate.com/news/5240597-123/community-leaders-discuss-links-between)

### ***CAHSD Partners with the EBR Law Enforcement Initiative-BRAVE***

Twenty two community leaders from the 70805 and 70802 zip codes participated in a 16 hour Mental Health First Aid training co-sponsored by The Capital Area Human Services District (CAHSD) and Magellan Health Services. The training informs non-mental health professions on how to identify and approach or make interventions with individuals showing signs and symptoms of mental health challenges. This training was provided in collaboration with the local EBR/Law Enforcement initiative, BRAVE, to address violence in Baton Rouge focusing on the two zip codes. CAHSD is also a recipient of BRAVE funding for the provision of treatment

services through the Mayor's office. <http://theadvocate.com/home/5250636-125/brave-program-extending-to-broader>.

### ***HIV Screenings Offered at CAHSD***

After years of wanting to offer co-located HIV testing for CAHSD clients, we were able to execute a contract with Baton Rouge Black Alcoholism Council/Metro Health. Their services will be offered at our Center for Adult Behavioral Health on Wednesdays for all CAHSD clients and include:

- Conducts HIV screening to CAHSD clients utilizing a rapid HIV test, so that clients will receive their test results during the visit and allow those clients who have a preliminary HIV positive test result to be immediately linked into clinical and prevention services.
- Draws blood specimens or conducts Rapid Testing for HIV in appropriate testing areas, secures and packages specimens and ships them to the appropriate laboratory when applicable.
- Provides pre-test/post-test counseling to consumers who will be tested for HIV.
- Provides HIV/AIDS education for CAHSD consumers and staff including individual and group educational sessions on reduction of high risk behavior related to HIV/STD infection.
- Refers consumers testing positive for HIV to the Office of Public Health, a local medical physician or primary care facility for further testing and/or care regarding infection.
- Follows all guidelines regarding confidentiality of records.

### ***CAHSD Increases Access to Psychiatrists through Tele-Psychiatry***

CAHSD was able to expand prescriber hours through telemedicine by adding 32 hours/week of psychiatry coverage to the child/adolescent and adult clinics. Not only did we pull together the technology and policies, our facility managers, working with our Medical Director, are making sure to trade hours to increase capacity as needed across the clinics.

### ***CAHSD Receives DHH LA Adolescent Treatment Enhancement & Dissemination (LASAT-ED) Grant Initiative Funding***

In November 2012, CAHSD's Children's Behavioral Health Services and School-Based Therapy Program were selected to participate in the LASAT-Ed as one of two learning collaborative sites (CAHSD Children's Behavioral Health Services and CAHSD Gonzales MHC Children's Behavioral Services) that will enhance access to assessment and treatment for youth with substance use disorders.

CAHSD plans to provide evidence-based practices using the Global Appraisal of Individual Needs (GAIN) and treatment consisting of 90 days of outpatient Adolescent Community Reinforcement Approach (A-CRA) followed by 90 days of community based Assertive Continuing Care (ACC). A-CRA is a behavioral therapy that utilizes social, recreational, familial, educational or vocational reinforcement and skills training so that non-substance using

behaviors are rewarded and can replace substance abuse behavior. ACC follows on with the emphasis on case management and service delivery in the home and community including at 10 middle and high schools in the Capital Area. Case management includes linkage and transportation services to engage youth in recovery activities such as 12-step groups, vocational/job searches and pro-social/recreational activities.

CAHSD anticipates that through the two learning collaborative sites, Louisiana will be able to make improvements in substance abuse assessment and treatment services for adolescents and their families that can be applied throughout the state.

### ***CAHSD Implements Dental Services through the Federal Primary and Behavioral Health Care Integration Grant***

In FY2012, CAHSD was awarded a \$1.9 million, four year grant, as part of a national initiative to find the best ways to improve the health status and increase the life expectancy of persons with serious mental illness (SMI) and substance abuse conditions. During the program, more than 7,500 persons with SMI in the Baton Rouge region are expected to be helped.

CAHSD is the only Louisiana program chosen and is one of 64 nationally awarded sites for the Primary and Behavioral Health Care Integration grant project, funded by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA).

The mentally ill experience early deaths due to the same chronic illnesses, such as diabetes, hypertension, and lung diseases, identified and typically treated much earlier in the general public. This lack of access to preventive and ongoing care results in disability, early death and disproportionately costly care commonly accessed at a late stage of the illness and in an emergency setting.

To date, SAMSHA grant funding has allowed CAHSD:

- To serve 769 patients
- To provide care coordination and wellness activities including nutrition and fitness classes, tobacco cessation referrals, Peer Support services through group and one-on-one sessions
- To provide on-site primary care medical services to 16 clients per month who are either un-insured/under-insured

These services were offered through larger clinics and rural satellites with local partners including the LSU-Mid City and North Baton Rouge Clinics in Baton Rouge, St. Elizabeth's Community Clinic in Gonzales, several local Federally Qualified Health Centers (FQHC) and private primary care clinics and offices. The LSU Department of Social Work will provide the evaluation component of the grant.

In addition, CAHSD partnered with the Baton Rouge Community Clinic to provide dental services to indigent patients. Our dental initiative was very successful and allowed CAHSD to provide comprehensive dental services to 45 patients. Each patient received a treatment plan which consisted of numerous visits for multiple procedures. An interesting outcome was of all

the visits that these 45 patients had, only 2 were missed. At the end of the contract, each patient was contacted to confirm services were provided and to obtain customer satisfaction with the program and provider. The patients expressed high levels of satisfaction with customer service provided by dental staff and the dental treatments received.

The following information demonstrates the importance of referring clients into the program to address their physical health needs. Baseline health indicators recorded for THP participants include blood pressure, body mass index (BMI-height and weight), waist circumference and lab values for glucose and lipids. The scores indicated that the mean (average) scores for BMI, Waist Circumference, and Blood Glucose are considered at risk. The mean Systolic Blood Pressure score is only 9/10 less than the recommended score of 130. The lab work scores for roughly one third of THP participants are considered at risk (Blood Glucose=31.3%, Lipid Total =35.8%, HDL=34.8%, LDL=30.7%, TRI=30.4%). The Systolic Blood Pressure scores for almost half of all THP participants (48.4%) are considered at risk. The Diastolic Blood Pressure and BMI scores for almost two thirds of THP participants are considered at risk (64.8% and 63.6%, respectively). The baseline Waist Circumference measurement places over half of the men (52.7%) and well over three fourths of the women (80.0%) in the THP program at risk. The above health indicators (waist was excluded) was computed for all THP participants, and results showed that only 2.7% had no at-risk scores, and that the majority (70.8%) had at-risk scores for between 1 and 4 health indicators. Just over one fourth (26.5%) had at-risk scores for between 5 and 8 of the health indicators. Significant differences emerged between men and women on two health indicators. Women showed significantly higher BMI and lipid HDL scores than men.

**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.

CAHSD Plan: Accreditation – In November 2012, the District met its goal of becoming CARF accredited. The District continues to make great strides toward meeting its goal of implementing a fully functional and DHHS-HIT approved electronic health record and reforming its internal clinical and billing practices to that of a Practice Management model.

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

None

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

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

The strategic planning process is managed by the Executive Management Team under

the direction of the Executive Director. This team monitors the implementation and success of the plan on an on-going basis through monthly meetings, bi-monthly meetings with senior management staff and supervisor weekly meetings with staff.

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

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

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

#### ***MHERE Closes***

Despite many attempts to prevent a full shut down and to create another licensed facility known as a Crisis Receiving Center, the Mental Health Emergency Room Extension, better known as MHERE stopped admitting patients and fully closed its doors on April 15, 2013 with the closure of the EKL Hospital by LSU. CAHSD continues to be available to local ERs to assist them through rapid referral to CAHSD mobile treatment teams or clinic appointments.

<http://theadvocate.com/home/4709803-125/district-focused-on-mental-patient>

The closure leave individuals in behavioral health crisis with no option other than Emergency Room or Mental Health Inpatient treatment for many episodes which could have been handled in a less restrictive and less costly treatment module had the MHERE remained operational or had another alternative treatment facility have been developed (i.e. Crisis Receiving Center or Crisis Respite Beds).

#### ***Electronic Health Record (EHR) Implementation***

While most LGEs (Local Governing Entities-Districts/Authorities) around the State were gearing up for Healthcare Reform and Managed Care implementation; either using or finding themselves in the midst of implementing an electronic health record that meets DHHS-HIT requirements; the Department announced a state-wide mandate requiring all providers of Medicaid reimbursed services to use the electronic health record (Clinical Advisor/Claim Track-CA) owned and operated by the State’s new SMO (Statewide Management Organization) Magellan Health Services. With Magellan’s implementation of SMO services effective March 01, 2012 also came the statewide implementation of the CA. Magellan justifies their CA mandate by stating, “Specific clinical documentation and data are required for Louisiana Behavioral Health Partnership (LA BHP) outcomes, performance analysis, and claims processing. In this light, Magellan at the March 01, 2012 “go live” is requiring all contracted providers to use the Clinical

Advisor/Claim Tract software application to ensure that all relevant data will be gathered consistently and completely across the statewide system of care.”

16 months later, the mandate was lifted and we are moving forward with the purchase of a true DHHS-HIT certified electronic behavioral health record with a functional EHR/scheduler/billing system to be implemented in the Winter of 2013. Staff were invited/included to ‘test drive’ several records and with their input, we selected and will implement a much more efficient and functional EHR system. The desire by staff to be included in this process was heard and followed.

The problems which plagued the LGEs as a result of the implementation and mandated use of the Magellan CA can be found in the Louisiana Legislative Audit Report of the DEPARTMENT OF HEALTH AND HOSPITALS OFFICE OF BEHAVIORAL HEALTH LOUISIANA BEHAVIORAL HEALTH PARTNERSHIP for FY2013:  
[http://app1.la.state.la.us/PublicReports.nsf/0757339DD165F29F86257BC6004F91F0/\\$FILE/00034771.pdf](http://app1.la.state.la.us/PublicReports.nsf/0757339DD165F29F86257BC6004F91F0/$FILE/00034771.pdf)

#### B. Corrective Actions

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

- No. MHERE If not, skip questions 2-5 below.  
 Yes. Electronic Health Record Implementation  
 If so, complete questions 2-5 below.

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

While the closure of the MHERE does not require a corrective action by the CAHSD, we are working with the DHH, a private BH Hospital and LCS to establish beds for indigent individuals who have no means of accessing Medicaid or Private Hospital Beds for BH Crisis which require short-time stabilization and re-entry into outpatient community BH treatment.

By the end of 2013, CAHSD will implement the ICANotes electronic health record which will eliminate the need for the Clinical Advisor/Claim Track System. ICANotes will offer greater flexibility to clinical staff to track medical services provided and will allow for billing staff to efficiently bill Magellan and all other payers for services rendered.

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

No, this system will be implemented during FY 2014.

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?

November/December 2013

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

The new system has been identified, purchased and is currently under customization. Staff is currently being trained as super users and all staff will be trained prior to implementation.

b. If not:

- Why has no action been taken regarding this recommendation?

N/A

- What are the obstacles preventing or delaying corrective actions?

N/A

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

N/A

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.

\$250,000 for Medicaid match through LINCCA for 2 Crisis Stabilization Beds and an Adult Night Crisis Mobile Team

\$95,422 software customization, training, go-live and user fees

- b. How much has been expended so far?

\$0 for BH Crisis

\$30,255 for EHR Customization & Training

- c. Can this investment be managed within your existing budget? Yes

If so, does this require reallocation of existing resources?

Yes-funding initially allocated for payment of psychiatric services in the MHERE are being diverted to provide the Medicaid matching funds for the BH Crisis Services.

No-by implementing this EHR system, collection of self-generated revenue is projected to increase by more than 20% from prior year, which will more than pay for all costs of implementation and continued annual user fees.

If so, how will this reallocation affect other department efforts?

There will be no impact on other departments as a result of this reallocation. The BH Crisis Services will, however, assist in reducing the burden upon private hospital emergency departments and inpatient beds for the medically indigent.

Implementation of the new EHR system will once again make the CAHSD eligible for Electronic Health Record incentive payments from the Federal Government which it lost once mandated to use the Magellan Clinical Advisor system.

- d. Will additional personnel or funds be required to implement the recommended actions? No 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 studies)
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review: Magellan annual certification/review and CARF accreditation annual reporting and re-certification scheduled for 2015

- Customer/stakeholder feedback  
 Other (please specify): State Licensure (BHS and Public Health-Department of Health and Hospitals)

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

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

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

1. Title of Report or Program Evaluation  
Louisiana Legislative Auditor Procedural Report FY2012-2013  
Louisiana Performance Accountability System (LaPAS)
2. Date completed  
Audit-August 21, 2013  
Quarterly July 01, 2012 through June 30, 2013
3. Subject or purpose and reason for initiation of the analysis or evaluation:  
Legislative requirement
4. Methodology used for analysis or evaluation  
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.  
  
LaPAS: Standard methodology required by the DOA; actual performance indicators developed in conjunction with program offices and approved by the DOA.
5. Cost (allocation of in-house resources or purchase price)  
Audit: \$25,172 (Audits conducted every 2 years/FY2013 cost)  
LaPAS: Cost uncalculated
6. Major Findings and Conclusions  
Audit: None  
LaPAS: None
7. Major Recommendations  
Audit: None  
LaPAS: None
8. Action taken in response to the report or evaluation  
Audit: None  
LaPAS: None

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

Audit: [www.la.state.la.us](http://www.la.state.la.us)

LaPAS: [www.louisiana.gov/opb/lapas/lapas.htm](http://www.louisiana.gov/opb/lapas/lapas.htm)

10. Contact person for more information, including Agency & Program:

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Agency & Program: Capital Area Human Services District

Telephone: 225-922-2700

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Title: Deputy Director

Agency & Program: Capital Area Human Services District

Telephone: 225-922-2708

E-mail: [Carol.Nacoste@la.gov](mailto:Carol.Nacoste@la.gov)

Name: Adina Collins

Title: Accountant Administrator

Agency & Program: Capital Area Human Services District

Telephone: 225-922-0004

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# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

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

**Department Head:** Kathy Kliebert, Secretary

**Undersecretary:** Jerry Phillips

**Executive Director:** Sandee Winchell

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

**For each accomplishment, please discuss and explain:**

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

The Council provided leadership in advocacy, capacity building and systemic change activities that contributed to increased awareness of the need for community-based services for individuals with developmental disabilities and the impact of educational policies and practices on students with disabilities. Through the Council's technical assistance provided to two grassroots advocacy networks, Louisiana Citizens for Action Now (LaCAN) and Louisiana Together Educating All Children (LaTEACH) numerous policies were changed to improve and/or increase community services. Significant policy and practice changes influenced by LaCAN and Council advocacy related to community-based services include the Department of Health and Hospitals agreeing to add an additional New Opportunity Waiver (NOW) slot for each \$66,000 in the NOW fund. Advocacy efforts were successful with increasing Legislators awareness and support for increased funding for additional NOW slots, the Individual and Family Support

Program, and Families Helping Families Centers; and, restoring funding for Children Special Health Services clinics that were slated for closure; and rejecting proposed changes to the education funding formula. However, Governor Jindal vetoed the additional funding for these programs due to reductions to Medicaid utilization or lack of identified funding sources.

Educational policies influenced by the advocacy efforts of LaTEACH and the Council leadership include avoiding changes to the Minimum Foundation Program (MFP) that would have left inequities in funding across school structures intact; were likely to result in students with disabilities being placed in more segregated environments; and produced incentives for schools and programs to avoid serving students with disabilities, particularly those with more significant disabilities. Advocacy efforts have continued providing information and parental input to the MFP Task Force. Advocacy efforts were influential in establishing a requirement that students with disabilities who are not pursuing a diploma will not have to take tests associated with the Louisiana Education Assessment Program (LEAP) or the American College Test (ACT) unless it is indicated on their Individual Education Program (IEP). Advocates strongly opposed any proposal related to private segregated schools designed exclusively for students with disabilities. LaTEACH members' voices and concerns were heard resulting in the proposal being withdrawn.

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

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

Collectively the policy changes described under 'outstanding accomplishments' 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 networks and family support agencies over the past twenty years. It is expected that there will continue to be an increase in the influence the Council and the self advocates and family members of individuals with developmental disabilities have on decisions by policy makers. The Council's capacity to educate the general public and policy makers about needed changes to existing policies and/or the impact of pending decisions is well established and growing.

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

The Council was successful with educating policy makers for the need for increased quality and quantity of home and community-based services. Unfortunately, state budget constraints resulted in funding needed for these critical services and programs

to be ultimately vetoed from the budget.

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

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

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

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

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

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

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

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

**Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question.** If the problem or issue was identified and

discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description

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

All Council activities are dependent on federal and state appropriations. The Council consistently takes all actions possible to ensure continued allocations. One significant issue is the economy in general and Louisiana's capacity to maintain the contributions to supporting necessary programs in the future. The Council's federal funds are not currently in jeopardy, but the allocation was reduced as a result of the federal sequestration. 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 many of Louisiana's rural areas is contingent on travel, the budget reductions have had a significant negative 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 adequate 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. The Council has consistently shared with the Administration the need for adequate financial support to maintain Families Helping Families Regional Resource Centers.

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 restrictions appear to prevent adequate 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 an additional \$170,000.

#### 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 2012 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 2012-2013. A report covering the remainder of the state fiscal year will be submitted to the federal government in December 2013.

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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Deputy Director  
Developmental Disabilities Council  
(225) 342-6804 (phone)  
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# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

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

**Department Head:** Kathy Kliebert, Secretary

**Undersecretary:** Jerry Phillips

**Executive Director:** Calvin Johnson

### **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?

#### **Transition to Magellan and Managed Care**

*MHSD continued to adjust its systems to be responsive to the new managed care environment. It hired a practice manager to begin the process of transforming the adult clinics to an environment more focused on productivity as well as appropriate medical necessity documentation. MHSD worked with its contracted providers to ensure they were sustainable during the first full year of the Medicaid managed care transition and provided technical assistance as needed around documentation issues. MHSD re-configured its Access Center to become a Navigation Center so that MHSD could continue to assist individuals in finding services under the new Magellan system.*

*This effort contributes to Goal IV of MHSD's FY2012-2016 strategic plan: To deliver a*

*seamless, integrated, and comprehensive system of services that is responsive to consumer strengths, needs, interests, and choices.*

### **Continued implementation of Crisis Continuum**

*During FY2012-2013, MHSD worked closely with its crisis continuum contractor, Resources for Human Development (RHD) and Magellan to make its five respite beds billable under Medicaid. Once these services become billable, it will allow the unit to expand from five to eight beds and will be available for a broader geographic area (including Jefferson Parish).*

*MHSD launched a grass roots marketing campaign targeted at increasing the use of the crisis continuum in lieu of calling 911. The “We’re Here for You” theme was targeted to the true first responders – families and friends and the main distribution channels were churches and neighborhood groups. MHSD also created business card sized crisis cards and posters for distribution through our clinics and contracted providers as well as through natural networks like libraries.*

*MHSD is currently contracting with Children’s Bureau of New Orleans to run the Louisiana Behavioral and Emotional Support Team (LABEST). The LABEST program is designed to have a team of behavioral health professionals ready to respond to a disaster, but also provides resources to address other behavioral health concerns in the community. More specifically, LABEST is part of Mayor Landrieu’s NOLA for Life initiative through participation on the New Orleans Police Department’s Rapid Engagement Support Enforcement Team (RESET) pilot program. LABEST staff members accompany other RESET team members in conducting door to door outreach in designated RESET areas, offering resource linkage and counseling support to families that reside in proximity to where recent homicides have occurred. LABEST also provides grief and trauma crisis response counseling support to children and adults following a traumatic event such as the homicide and/or sudden death of a classmate or faculty member, and witnessing community violence, including crisis response services in schools.*

*MHSD now has one phone number 826-2675 that can be used for all crisis – from an individual needing assistance to a school overcome with grief over the murder of a classmate. Once the number is called, the call is either routed to the mobile crisis team or to the LABEST team.*

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

### **Enhanced Developmental Disability Services**

*In terms of education and capacity building, MHSD was involved in numerous activities. MHSD conducted its 1<sup>st</sup> annual Individual/Family Support Seminar for individuals and families utilizing and receiving family support services. MHSD also served as a pilot site*

*for Collaborative Work with OCDD Greater New Orleans Resource Center – to increase capacity to serve individuals with significant challenging behaviors in Metropolitan New Orleans including (1) triaging cases to minimize waiting list for Clinical Services; (2) crisis response for individuals at risk for losing community and home life and; (3) acting as a Local Oversight Team Review for individuals with history of nonconsensual sexual behavior who pose public safety risk. MHSD also started a Private Provider Support Initiative which focused on training for direct support workers to generalize competencies to sever individuals with challenging behaviors. And finally, MHSD facilitated an Annual Forum focused on increasing capacity and knowledge of community on behalf of individuals living with Intellectual/Developmental Disabilities and Behavioral Health Disabilities.*

*MHSD also focused internally on improving efficiency and integrating services within developmental disabilities services as well as with behavioral health. Some of the activities include developing a screening tool for entry unit staff to increase efficiencies with intake applications; developing and training the Mobile Crisis Response evaluators to support integration of crisis calls from individuals and families with Intellectual/Developmental Disabilities. And finally, MHSD integrated the service coordination for 12 children who are receiving Flexible Family Fund and Individual/Family Support Services with one DD staff (Support Coordinator) to coordinate and manage their DD services.*

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

### **Transition of Children's Services**

*MHSD took over the management of Children's Services on June 25, 2012. Transitioning Children's Services under MHSD allows for the co-planning, operational efficiencies and sharing of resources that was not possible when these services were in OBH. MHSD spent most of the FY in a process of discovery and redesign including reviewing its own programs relative to the local market. MHSD identified a few gaps in Medicaid eligible programming and spent the spring of 2013 developing programs to fill the gaps. More specifically, MHSD developed contracts to seed a Family Functional Therapy (FFT) program, a Triple P Parenting program and a Father Mentoring program starting July 1, 2013. All these services are Medicaid billable and so the model is one that provides start up monies over the time it takes to reach a breakeven point. As part of MHSD's discovery, it became apparent how one of the biggest challenges in children's services is not only availability but also access in the MHSD area. More specifically, given the high number of CPST/PSR competing providers and the lack of a standardized assessment tool, there are few effective referral networks. This means that clients may not always end up in the correct level of care as they are generally being recruited by providers rather than managed based on acuity, a reality that can only be changed with a move to a managed care environment. Given this reality, MHSD also began to develop relationships with the hospitals to begin to design an aftercare process that will assist clients as they leave the*

*hospital to transition successfully into an appropriate outpatient setting.*

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

**II. Is your department five-year Strategic Plan/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 2013).*

- ♦ **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. The transition to Magellan had been expected to result in more consistent and available information, however, the transition has been less than smooth and MHSD continues to struggle with getting 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?

*MHSD is now moving back to its own electronic health record to ensure its ability to create consistent information to support planning and decision-making.*

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 re-implementing its own EHR. It is anticipated that the EHR will be operational by April 2014.*

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 re-implementation of the EHR will have additional costs of approximately \$80,000. 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 & Program:
  - Telephone:
  - E-mail:

**No reports were created.**

# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

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

**Department Head:** Kathy Kliebert, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Ruth J. Kennedy, Medicaid Director

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

**For each accomplishment, please discuss and explain:**

**Accomplishment #1: - Bayou Health**

**The Bureau of Health Servicing Finances (BHSF) completed first year and made ongoing enhancements to Bayou Health.**

**A. What was achieved?**

The Bureau of Health Services Financing (BHSF) completed a highly successful first year Bayou Health—the new Medicaid delivery system implemented in February 2012 and made multiple enhancements to the program: 1) immediate auto-assignment of pregnant women to a Health Plan to assure pre-natal care at the earliest possible point, 2) inclusion of pharmacy in the benefit package, and 3) addition of the population enrolled in the LaCHIP Affordable Plan Program.

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

Bayou Health is the Department's Medicaid reform initiative intended to improve quality of care, improve health outcomes and control costs. Successful implementation puts the Department of Health and Hospitals on track to realize these goals. Continuous improvement is important in order to better coordinate care.

**C. Who benefits and how?**

Bayou Health first and foremost benefits the approximately 900,000 Medicaid and the

Louisiana Children's Health Insurance Program (LaCHIP) enrollees who received health care through the program during SFY 13. Thousands of Medicaid enrollees received active case management for a chronic condition that would not have been available in the legacy Medicaid program. DHH benefits through greater budget predictability and partners in working toward quality improvement goals. Taxpayers benefit from lower costs than would have been incurred in the legacy Medicaid program.

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

Successful implementation of Bayou Health during the period 7/1/12 through 6/30/13 was the result of many factors, including:

- Daily, then weekly calls with providers and stakeholders to address issues and concerns
- Monthly "All Health Plan" meetings
- Individual weekly meetings between the Medicaid Director and CEO/Executive Director of each of the five Bayou Health Plans
- Formal quarterly Business Reviews with each of the five Bayou Health Plans attended by DHH Secretary, Medicaid Director, Medicaid Medical Director, Medicaid Behavioral Health Medical Director, and key Medicaid staff
- Immediate investigation and resolution of complaints

**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?**

Both the standing stakeholder conference calls and the quarterly Business Reviews used in monitoring contracts are methods that we have found to be highly effective.

**Accomplishment #2: Birth Outcomes Initiatives**

**A. What was achieved?**

The Birth Outcomes Initiative (BOI) is a partnership between LA DHH, the Louisiana State Medical Society, the Louisiana Hospital Association, and the Louisiana Chapter of the American College of Obstetricians and Gynecologists (ACOG) to improve the outcomes of Louisiana's births. Primary among these efforts is the focus on ending non-medically indicated deliveries prior to 39 weeks gestation in Louisiana's birthing hospitals. There is ample medical evidence that births prior to 39 weeks lead to higher admissions to the neonatal intensive care unit and multiple complications for these babies. Louisiana Medicaid data indicate that early elective deliveries decreased on average from approximately 20% of all early deliveries to less than 1% on average in hospitals participating in a data collection effort. The data also show that the proportion of deliveries between 37 and 38 weeks gestation decreased as a result of these efforts from (34.8% to 30.1%) while gestations between

39 and 41 weeks continue to increase (52.8% to 58.2%) from FY 2012 to FY2013. This shift represents how many fewer deliveries were performed before 39 weeks, due to intensive education efforts among providers and hospitals. Finally and most importantly, there was an approximately 6,300 day decrease in the number of NICU days between 2010 and 2012.

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

The goals of BOI are to create a culture of continuous quality improvement and safety in Louisiana's birthing hospitals; to improve birth outcomes and reduce Louisiana's Medicaid costs by fostering a population of healthier Louisiana women; to assess and improve the behavioral health of Louisiana's pregnant women and increase Louisiana Department of Health and Hospitals (LA DHH) data capacity and performance measurement of maternity care.

**C. Who benefits and how?**

The BOI is designed to improve the health of Louisiana's moms and babies by making positive impacts on women's health, infant health and hospital-based women and infant care. 70% of Louisiana's moms are in Medicaid, so our efforts to improve Medicaid have a great impact on total births in the state.

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

The Louisiana Birth Outcomes Initiative goals are continuously advanced through assessment, collection and monitoring of 39-Week Elective Delivery, gestational age, Neonatal Intensive Care Unit (NICU) average length of stay and preterm birth data.

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

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

Yes, the collaborative approach that collected stakeholder input prior to action (outlined in multiple DHH interviews/reports, attached) leads to greater buy in and cross sector involvement.

**Accomplishment #3: Centralized Appeals Unit (CAU) - Eligibility**

**A. What was achieved?**

The Bureau of Health Services Financing (BHSF) completed an expansion of the existing contract with the University of New Orleans to augment existing BHSF centralized appeals staff.

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

Providing additional support for the Centralized Appeals Unit ensures that federal regulations related to appeal rights are met and that the state does not risk the loss of federal dollars or a lawsuit for failing to do so.

**C. Who benefits and how?**

Appellants benefit by having due process related to adverse and negative decisions on case actions. Access to benefits and services pending timely appeal decisions ensures that health outcomes are not negatively impacted because of administrative functions.

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

Successful implementation of the CAU staff augmentation was achieved through an expanded statement of work for the professional services contract with the University of New Orleans (UNO). UNO's ability to recruit former staff both from Medicaid eligibility and Division of Administrative Law provided a knowledge base that facilitated an immediate impact on the division of workload.

**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, streamlining functions into central locations provides centers of excellence, benefitting stakeholders and the agency alike. Expanding existing contracts with state entities maximizes the state's return on investment of State General Funds (SGF).**Accomplishment #4 Medicaid Management Information Systems (MMIS) Request Monitoring****A. What was achieved?**

The MMIS Section, in October 2012, created a request monitoring process, in which each Department, under the observation of an MMIS/MARS (Management Administrative Reporting Subsystem) staff member are required to rank all of their outstanding system requests, or "LIFTs" (Louisiana Information From Tracking). From the aforementioned Department ranking listings, the MMIS/MARS manager creates a Monthly Priority Listing which is a subset of all outstanding LIFTs. This monthly listing is passed onto the Fiscal Intermediary (FI) and is to be considered the priority LIFTs in which the FI is expected to work on during that month. Due dates and completion dates are closely monitored and communication is a key component in order for this process to be successful. Due dates can only be altered when agreed upon by the Originator of the LIFT, MMIS and the FI. When the FI does not meet a due date, a penalty of \$200/business day is calculated for each business day in which the deliverable is late. Weekly, the FI and DHH staff is provided with updated Priority Listings (as priorities can change throughout the month).

In October of 2012 there were over 225 outstanding LIFTs. As of today, we have been able to reduce that number down to 116. On May 31, 2013, we had a low water mark of 100 outstanding LIFTs. Of these 116 outstanding LIFTs, 5 are ongoing requests and 5

LIFTs are related to the Provider Recipient Integrated System for Medicaid (PRISM) Project which MMIS has been directed to leave “On Hold”.

MMIS has averaged 32 LIFTs completed monthly.

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

This is significant because it allowed MMIS to reduce its LIFTs starting in October of 2012 from 225 outstanding LIFTs down to 116.

**C. Who benefits and how?**

In general – the public and the service providers benefits with the reduced time for integration of new technology and compliance issues.

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

MMIS accomplishments were achieved by Monthly Staff meetings and weekly staff meeting accompanied with clear communication from MMIS director.

**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?**

MMIS’s standing stakeholder meetings used in monitoring contracts are methods that we have found to be highly effective.

**Accomplishment #5: Electronic Health Records (EHR) & Health Information Technology (HIT)**

**A. What was achieved?**

Since its launch in January 2011, the EHR Incentive Program has issued nearly \$190 million in incentive payments to over 2,000 qualifying providers and hospitals. Of the 2,000 providers/hospitals, 30% have achieved meaningful use (MU) of certified EHR technology. The national average for achievement of MU is between 10% and 12%.

A web-based portal was designed and launched to enhance the attestation experience for providers and hospitals seeking an EHR incentive payment.

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

Louisiana’s MU rate of 30% is 3 times that of the national average (10-12%).

The system was launched successfully, allowing providers to complete their attestations via the web portal. In addition to efficiency and convenience for providers, the portal allows for the electronic collection and storage of attestation data which facilitates reporting and analytics.

**C. Who benefits and how?**

Louisiana Medicaid recipients and providers are reaping the benefits of the adoption and meaningful use of EHR technology. Benefits of EHR systems include reduction of medical errors; safer care; more effective diagnoses; more reliable prescribing; complete, legible records; reduced costs of paperwork; and improved provider workflow.

Louisiana Medicaid (DHH), providers, recipients, and Centers for Medicaid and Medicare Services (CMS) are beneficiaries of the portal. The system offers an efficient, convenient tool for provider attestation. The system collects attestation data – which includes Clinical Quality Measures (CQMs) – which are used to track the quality of healthcare services being offered to Medicaid recipients.

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

EHR/HIT accomplishments were achieved by Monthly Staff meetings and weekly staff meeting accompanied with clear communication from MMIS director.

Louisiana Medicaid launched the EHR Incentive Program in January 2011. Providers were offered incentive payments of up to \$63,750 for a 6-year period for professionals and incentive payments starting at \$2 million for a 4-year period for hospitals. Outreach and education activities have been offered to increase awareness among providers.

The system was developed by Molina Healthcare Services with oversight from Medicaid EHR staff.

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

Yes

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

The EHR Incentive Program was designed in accordance with regulations and guidance provided by CMS. Louisiana's program has received authorization to operate from CMS via approval of its State Medicaid Health Information Technology Plan and Implementation Advanced Planning Documents.

The EHR Incentive Program and web-based portal was designed in accordance with regulations and guidance provided by CMS. Louisiana's program has received authorization to operate from CMS via approval of its State Medicaid Health Information Technology Plan and Implementation Advanced Planning Documents.

**Accomplishment #6: Money Follows the Person (MFP) Demonstration Program - Waiver Assistance and Compliance)****A. What was achieved?**

- As of July 31, 2013, the Money Follows the Person Demonstration program (MFP) has helped over 726 persons move out of institutions (nursing homes,

hospitals, group homes) into the community. Specific training components developed in the previous year have been utilized to further strengthen the 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. MFP services that are utilized to assist individuals transitioning from institutional services to home and community based services are a key part of the 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?**

- Individuals participating in the MFP program benefit by increasing their personal quality of life. Participants' lives are enriched within the community which includes increased personal choice, reconnecting more closely with family, and connecting 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 participants 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, OAAS, and OCDD have worked collaboratively in a team effort to implement the demonstration successfully across the disability populations. The basis of this collaborative effort stems from the joint work in systems change initiatives that have occurred throughout the past decade. In the upcoming year, a goal is to incorporate the Office of Behavioral Health into the program which will result in the opportunity for individuals diagnosed with mental illness the same opportunities available in the program with OAAS and OCDD populations.

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

- The state's effort to rebalance its long-term care system (LTC) benefits in three ways: (1) an enhanced Federal Medical Assistance Percentages (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 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?

- MFP benchmarks indicate a consistent increase in the number of individuals being served in home and community bases services and an increase in home and community based spending. In addition the number of transitions has increased beginning with four (4) individuals the first year of the program to a total of 726 as of July 31, 2013. MFP is meeting or exceeding all program benchmarks.

- ♦ **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?
  - The strength of the operational systems of waiver services is recognized by CMS as superior to those observed in other MFP states, giving them confidence that Louisiana will continue to see positive outcomes and sustained transitions. CMS has also recognized the department’s commitment to systems change and flexibility in addressing barriers, during technical assistance calls and national meetings.
- **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 vulnerabilities or other weaknesses in program policies or procedures are identified during MFP transition activities, changes are made to directly address them whenever possible. Some of the major activities are listed below:
  - Integration with (Permanent Supportive Housing) PSH via the institutional preference process
  - Integration with the Minimum Data Set – Section Q ( MDS Q) for transition referrals
  - Aging and Disability Resource Center (ADRC) pilot to expand their involvement
- 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.
  - 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.

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

Progress is expected to continue.

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

In the area of modernizing our Medicaid Management Information System—the system that pays claims for the legacy Medicaid program and supports other Medicaid business processes—we have seen significant slippage as a result of the March 2013 cancellation of the replacement MMIS contract.

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

1. To what do you attribute this lack of progress? For example:
  - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?

The delay is related to the management decision to terminate the contract to build and implement a replacement MMIS. At this point we are working closely with CMS and the Division of Administration (DOA) in considering multiple options through which we can achieve our systems modernization goals and decide on the strategy.

- 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?**

DOA has been actively providing ongoing advice and assistance since April 2013.

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

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

- Utilizing 100% administrative funding in support of the demonstration has had a significant impact on progress toward rebalancing.

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?**

- ♦ BHSF works closely with Program Offices (Office of Public Health -OPH, Office of Behavioral Health-OBH, and Office of Aging and Adult Services - OAAS) in developing Activities, Objectives, and Strategies. Drafts are provided and comments and feedback are solicited and incorporated. BHSF considers the strategic plan to be a dynamic document and has incorporated a quarterly review of the plan into administrative operations.

Conference calls with the CMS project office staff, technical assistance contractors, and regional CMS support staff are conducted. Program office and Medicaid staff 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, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. “Problems or issues” may or may not be related directly to strategic plan lack of progress.)

Toward the end of SFY 13, BHSF identified the need for administrative realignment around “function” in order to eliminate some redundancies and improve efficiency and productivity.

**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?**

BHSF Central Office operations could be better aligned. For example, the Eligibility and Enrollment Systems Section and the MMIS Systems Section were totally separate and reported to different Medicaid Deputy Directors. Policy operations were fragmented with eligibility policy, waiver policy, and other Medicaid policy sections each reporting to a different Deputy Director. And there appeared to be little, if any, coordination. The Financial Operations Section was not optimized as it could be with Contracts concentrated in that Section.

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

Without realignment and with the net loss of ten TO's effective SFY 14, it would have begun to affect the progress of the strategic plan.

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

Bureau of Health Services Financing

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

Both internal and external customers and stakeholders are affected by sub-optimal administrative operations.

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

In retrospect, the redundancy in systems and policy functions has existed since at least 1992 when Medicaid eligibility was transferred from the Department of Social Services (DSS) to DHH. Other issues in need of correction date from the creation of the Bayou Health Section within Medicaid in 2012.

- 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?**

Less than optimal performance

## **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?**

Realignment of BHSF Central Office

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

No

- 4. Are corrective actions underway?**

Yes

a. If so:

- **What is the expected time frame for corrective actions to be implemented and improvements to occur?**

The Medicaid Reorganization Plan was submitted to Civil Service in early September and is awaiting approval.

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

Approximately 85%; Upon approval of the Plan by Civil Service, some reporting relationships will change, updated Performance Plans will be required and some employees will be physically relocated.

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.**

Hundreds of total man hours were spent in developing the BHSF Realignment; at this point the work is largely complete. While some positions are being reallocated downward, no positions are being eliminated and no employee will see a reduction in pay.

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 Island Peer Review Organization (IPRO) is contracted through External Quality Review Organization to perform CMS required reviews of Medicaid Managed Care Plans for compliance with Medicaid managed care requirements and review of their Performance Improvement Projects and reported quality measures.

Several weeks prior to the onsite portion of the compliance audit, IPRO requests an extensive list of policy documents from the plans for documentation/demonstration of how the plan is compliant with the contractual requirements of the health plan by the Department. Each plan uploads these documents to a secure File Transfer Protocol (FTP) site for IPRO's review. IPRO conducts an onsite audit with each of the plans to further document the plan's compliance level with requirements of the contract. Results reflect the plan's compliance levels overall in the following terms:

Full Compliance:	Health plan has met or exceeded requirements
Substantial Compliance:	Health plan has met all critical requirements and most non-critical requirements but has minor deficiencies in a small number of non-critical areas
Minimal Compliance:	Health plan has met most critical requirements and all or some non-critical requirements but has significant deficiencies requiring corrective action
Non-Compliance:	Health plan has not met most critical requirements
N/A:	Not applicable

IPRO also provides detailed audit findings reflective of each category of requirements listed in the contract. The plan's subject matter experts are present for the onsite audit to answer any questions IPRO may have relative to the plan's processes. Once the onsite audits are complete, IPRO issues a preliminary report for each plan. The reports are reviewed by the Department and each plan. Plans are then given the opportunity to respond to IPRO's findings and changes may be made based on the plan's response. After the response/comment period is complete, IPRO issues individual reports for each plan as well as a roll up report to the Department.

- Program evaluation by in-house staff  
MFP has established benchmarks that are reported semi-annually to CMS. These benchmarks are an indication of maintenance of effort from program baseline, rebalancing, and success of program efforts regarding transition progress. The benchmark status is reviewed as a monthly program evaluation by the MFP Demo administrative structure (Medicaid, the Office of Aging and Adult Services (OAAS), and the Office for Citizens with Developmental Disabilities (OCDD) Program managers) to evaluate progress toward semi-annual reporting requirements and formulate corrective actions. Data is gathered from Molina and the MFP Demo transition data set maintained by OAAS/SRI (Strategic Resources, Inc.), and OCDD. Corrective actions include implementing policy changes within program offices or Medicaid, involving partners more closely in transition process issues, engaging stakeholder partners in key areas of needed capacity development, and seeking adjustments to current or planned departmental budget.

The MFP Rebalancing Demonstration is a performance-based award, with funding only continuing if the state meets or exceeds these benchmarks. As a result, the ongoing in-house evaluation is essential to program management.

- 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)  
Each of the five Bayou Health Plans has performance measures in their contracts that are directly tied to a portion of the capitation payment or their share of savings. BHSF contracts with the University of Louisiana at Monroe for assistance in establishing baselines, benchmarks and actual performance.
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):  
BHSF's contracted actuary, Mercer Health & Benefits, develops: actuarially-sound rate ranges for capitated Managed Care Organizations (Bayou Health Prepaid Plans); enhanced care case management fees and actuarially sound benchmarks for Primary Care Case Management (PCCM) entities (Bayou Health Shared Savings Plans); and, savings determinations for each Shared Savings Plan.

BHSF contracts with Myers and Stauffer (M&S) to analyze Bayou Health encounter data submitted by Prepaid Plans to Molina and complete a comparison of the encounters to cash disbursement journals provided by each Prepaid Plan. Encounter data are claims paid by the plans or subcontractor vendors to health care providers for services provided to members enrolled in

the plans. M&S estimates each plan's encounter claims as a percentage of its cash disbursements. Plans are contractually required to meet a minimum of 95 percent.

Over \$19,500,000 was identified as over claimed cost in the Nursing Home (NH), Program, Intermediate Care Facility (ICF) Program, and the Adult Day Health Care (ADHC) Program. DHH benefits because we insure the integrity of the rate setting methodology as well as the general compliance of providers in these programs. Because these audits insure that money designated as Care Related actually goes to providing hands-on care to recipients they benefit by receiving a higher quality of care service. Taxpayers benefit from lower costs than would have been incurred if these over claimed cost were not identified. Through the Rate and Audit Section of Medicaid and our contracted CPA firm DHH performed agreed upon procedures (AUP) and/or desk reviews on 801 total providers. A breakdown of these procedures is below:

- Adult Day Health Care 2012 AUPs – 29
- ADHC 2012 Desk reviews - 5
- NH 2011 AUPs 108 (73 full and 35 limited)
- NH 2011 Desk reviews -161
- ICF 2011 AUPs – 180 (120 full and 60 limited)
- ICF 2011 Desk reviews – 318

AUPs are performed on-site at the providers facility are an in-depth review/audit of their financial and programmatic documents. Desk reviews are performed in house from documents provided by the provider and our request. Auditors assure that cost reported is accurate and compliant with Medicaid and Medicare guidelines.

These audits allow us to protect the integrity of the Medicaid payment methodology as well as insure Care Related funds are being used appropriately to enhance quality.

**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: **Children's Health Insurance Program (CHIP) Annual Report FFY12**
2. Date completed: 1/31/13
3. Subject or purpose and reason for initiation of the analysis or evaluation:

This annual report is required by CMS to be completed using the template provided by them.

4. Methodology used for analysis or evaluation:
    - (1) Input from program staff, (2) Enrollment and expenditure data extract from the Medicaid Management Information System via the MARS Data Warehouse, (3) Contract payments and administrative costs extracted from ISIS, (4) Healthcare Effectiveness Data and Information Set (HEDIS) performance measures calculated by University of Louisiana @ Monroe (ULM), and (5) the 2011 Louisiana Health Insurance Survey.
  5. Cost (allocation of in-house resources or purchase price): Not calculated
  6. Major Findings and Conclusions:
 

During FFY12, there were no changes to the LaCHIP eligibility requirements however, dental services became available to the LaCHIP Affordable Plan enrollees effective 1/1/12. Additionally, In February 2012, Louisiana began transitioning a large portion of Medicaid enrollees, including those enrolled in LaCHIP Phases I, II, III, and IV, into the new Bayou Health managed care delivery model. Five HEDIS measures were also reported which showed consistent rates related to well-child visits and access to care as compared to the previous year. The results of the 2011 Louisiana Health Insurance Survey showed a further decrease in the percentage of uninsured children to 3.5%.
  7. Major Recommendations: None at this time
  8. Action taken in response to the report or evaluation: None at this time
  9. Availability (hard copy, electronic file, website): Report is available online at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2324>
  10. Contact person for more information, including
 

Name: Kerri Lea  
 Title: Medicaid Program Manager  
 Agency & Program: BHSF-Medicaid  
 Telephone: 225-910-8832  
 E-mail: [kerri.lea@la.gov](mailto:kerri.lea@la.gov)
1. Title of Report or Program Evaluation: **LaCHIP Annual Report for the Legislature (SFY12)**
  2. Date completed: September 2012
  3. Subject or purpose and reason for initiation of the analysis or evaluation:
 

This annual report is sent to the Louisiana Legislature to provide an overview of program enrollment and cost.
  4. Methodology used for analysis or evaluation:
 

Enrollment and expenditure data extract from the Medicaid Management Information System via the MARS Data Warehouse as well as input from program staff.
  5. Cost (allocation of in-house resources or purchase price): Not calculated
  6. Major Findings and Conclusions:
 

Program eligibility requirements have not been changed and enrollment and expenditures have remained relatively constant.
  7. Major Recommendations: None at this time

8. Action taken in response to the report or evaluation: None at this time
  9. Availability (hard copy, electronic file, website): Report is available online at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2238>
  10. Contact person for more information, including
    - Name: Kerri Lea
    - Title: Medicaid Program Manager
    - Agency & Program: BHSF-Medicaid
    - Telephone: 225-910-8832
    - E-mail: [kerri.lea@la.gov](mailto:kerri.lea@la.gov)
  
    - Name: Edward Fowler
    - Title: Medicaid Program Manager
    - Agency & Program: BHSF-Medicaid
    - Telephone: 225-342-7242
    - E-mail: [edward.fowler@la.gov](mailto:edward.fowler@la.gov)
1. Title of Report or Program Evaluation: **Medicaid Purchase Plan Annual Report for the Legislature (SFY12)**
  2. Date completed: July 25, 2012
  3. Subject or purpose and reason for initiation of the analysis or evaluation:
    - This annual report is sent to the Louisiana Legislature to provide an overview of program enrollment and cost.
  4. Methodology used for analysis or evaluation:
    - Enrollment and expenditure data extract from the Medicaid Management Information System via the MARS Data Warehouse as well as input from program staff.
  5. Cost (allocation of in-house resources or purchase price): Not calculated
  6. Major Findings and Conclusions:
    - Program eligibility requirements have not changed and enrollment and expenditures have remained relatively constant as well as enrollee tax contribution and premium payments.
  7. Major Recommendations: None at this time
  8. Action taken in response to the report or evaluation: None at this time
  9. Availability (hard copy, electronic file, website): Report is available online at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2893>
  10. Contact person for more information, including
    - Name: Kerri Lea
    - Title: Medicaid Program Manager
    - Agency & Program: BHSF-Medicaid
    - Telephone: 225-910-8832
    - E-mail: [kerri.lea@la.gov](mailto:kerri.lea@la.gov)
  
    - Name: Edward Fowler
    - Title: Medicaid Program Manager
    - Agency & Program: BHSF-Medicaid
    - Telephone: 225-342-7242

E-mail: [edward.fowler@la.gov](mailto:edward.fowler@la.gov)

1. Title of Report or Program Evaluation: **2011 Louisiana Health Insurance Survey (LHIS) -Parish Level Update**
2. Date completed: December 2012
3. Subject or purpose and reason for initiation of the analysis or evaluation:  
To measure the number of uninsured persons in Louisiana, including divisions by geographical area and demographic groups
4. Methodology used for analysis or evaluation:  
Results will be based on telephone surveys of 9,000 Louisiana households chosen using stratified random sampling, where strata are chosen to ensure that our results measure the number of uninsured in all demographic groups, and on 2,000 randomly selected cell phone interviews. The analysis portion of this project will estimate the Medicaid bias in LHIS based on 500 randomly selected Medicaid recipients and construct a forecasting model to incorporate LHIS, Current Population Survey (CPS), Medicaid enrollment data and economic data. The forecasting model will be updated semi-annually. Overall, 11,500 interviews will be conducted.
5. Cost (allocation of in-house resources or purchase price): \$60,396.38
6. Major Findings and Conclusions: This report predicts a slight increase in the uninsured children population and a decrease in the number of uninsured Louisiana adults. The change in the adult population made a greater impact, resulting in an overall decrease in the number of uninsured Louisianans, by a little over 1,500 people.
7. Major Recommendations: None at this time
8. Action taken in response to the report or evaluation: None at this time
9. Availability (hard copy, electronic file, website): Report is available online at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1586>
10. Contact person for more information, including  
Name: Kerri Lea  
Title: Medicaid Program Manager  
Agency & Program: BHSF-Medicaid  
Telephone: 225-910-8832  
E-mail: [kerri.lea@la.gov](mailto:kerri.lea@la.gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

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

**Department Head:** Kathy H. Kliebert, Secretary

**Undersecretary:** Jerry Phillips

### 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?

### **Louisiana Moves Up in National Rankings for Overall Child Well-Being**

The Annie E. Casey Foundation released its annual KIDS COUNT Data Book, which ranks states on a series of child well-being indicators, and Louisiana has moved up two places to its highest-ever ranking.

The state moved to 47th place in the 2012 KIDS COUNT Data Book, after being ranked in 49th place for the previous 10 editions. KIDS COUNT measures child well-being in each state using 16 data indicators, which are grouped into four categories: Health, Education, Family and Community, and Economic Well-Being.

Louisiana improved on 11 of the 16 indicators, and received its highest state ranking - 39th place - in the Health category, reflecting major gains in children's health outcomes and access to health care services.

For health indicators, KIDS COUNT considers the percentage of low birth weight babies born in the state, children's health insurance coverage, teen alcohol and drug abuse and the number of child and teen deaths. Louisiana improved on each of these indicators and outperformed the national average on the percentage of children who have some form of health care coverage and teens who abuse alcohol or drugs.

The KIDS COUNT rankings show Louisiana improving on all of the health indicators at a faster rate than the national average, which is a trend that should lead to higher overall rankings in the future.

Regarding education, KIDS COUNT considers the percentage of children not attending preschool, reading and math proficiency and high school students not graduating on time. Louisiana improved in all four areas, and outperformed the national trend on the percentage of children percentage of children not attending preschool. According to The National Institute for Early Education Research's 2011 Preschool Yearbook, Louisiana ranked 13th in the nation in terms of ensuring access to preschool for 4-year-olds.

When evaluating family and community, KIDS COUNT considers the percentage of children in single-parent families, children in families where the household head lacks a high school diploma, children living in high-poverty areas and the number of teen births. Louisiana improved in two of the four indicators; most notably, the percentage of children living in high-poverty areas decreased by 23 percent.

In terms of economic well-being, KIDS COUNT considers the percentage of children in poverty, children whose parents lack secure employment, children living in households with a high housing cost burden, and teens not in school and not working. Louisiana showed improvement in the percentage of children in poverty.

### **DHH Applauds the Successful Transition of Health Care Services in Baton Rouge from LSU to the Lake**

The Department of Health and Hospitals marked the successful transition of regional safety net health care services from Louisiana State University to Our Lady of the Lake hospital as operations phased down at the Earl K. Long hospital.

This shift marks the culmination of years of hard work and planning between leaders at DHH, LSU and the Lake. More importantly, it kicks off the beginning of an important new era of delivering high quality health care and medical training at a better value for Louisiana taxpayers.

According Department Secretary Kathy Kliebert, "Individuals who previously relied on Earl K. Long are no longer confined to a separate tier of health care and can now access the high quality services offered by the Lake, not only through the hospital facility, but through the new 24-hours, 7-day-a-week urgent care clinic in North Baton Rouge."

## **Implementation of Provider Online Processing System**

The implementation of a Provider Online Processing System for all provider types will allow for more uniform tracking of providers. Features of the new system include online license renewal and payments, and a reports feature for data collection.

The Health Standards Section has been involved in multiple face-to-face training sessions with multiple provider types across the state, such as hospitals, nursing homes, Non-Emergency Medical Transportation providers, home health agencies, and hospice providers. These training sessions regarding process and regulatory guidance have reached hundreds of providers.

Finalized guidelines were developed with the Louisiana State Board of Nursing for didactic training and establishment of competency of direct service workers in medication administration and non-complex tasks. Hundreds of Home and Community Based Service providers were trained on these regulations which become effective Dec 2013.

The Health Standards Section has also engaged in the revision of multiple sets of regulations: Nursing Homes, Adult Residential Care Providers, abortion rule, alternative birthing centers, The Office of Behavioral Health service provider one license rule, Notice of Intent for Non-Emergency Medical Transportation, and sanction rules.

## **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 polices 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.

### **Provider Fee Projections**

Through excellence and expertise in its economic analysis, the Division of Health Economics (DHE) develops the fiscal year Provider Fee projections. DHE's Provider Fee projections are within 99.9% of the actual year end collected amount. These projections are then used to estimate the impact on the budget.

Since these estimates are not available from any other source, these Provider Fee projections are very useful in that they allow the Division of Administration (DOA) to make 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).

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 and econometric 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.

### **Department of Health and Hospitals Launches Living Well in Louisiana**

*Statewide physical activity, nutrition challenge includes activities for adults and youth*

Just in time for the 2012-2013 new school year, the Louisiana Department of Health and Hospitals is introducing a fun, easy-to-do health challenge that empowers Louisiana families to own their own health and enjoy the benefits of exercising, eating healthy foods and overall living well.

The Department, through the Governor's Council on Physical Fitness and Sports, is launching Living Well in Louisiana, a three-month wellness challenge in which participants earn points for physical activity and healthy eating, compete on teams or individually and track their progress at [www.livingwellinlouisiana.org](http://www.livingwellinlouisiana.org).

Louisiana is the fifth-most overweight state in the country and has the fourth-highest rate of childhood obesity, according to the 2011 "F is for Fat" report by the Robert Wood Johnson Foundation. Being overweight and out of shape leads to many chronic diseases, and also causes decreased quality of life.

Living Well in Louisiana is designed to help people combat obesity and its related chronic illnesses by taking small but effective steps to eat right and exercise daily.

There is no cost to participate. The first 1,000 participants will receive a pedometer to help them track their progress. Each week, participants will have the chance to win fitness prizes as they complete their wellness milestones. As in past competitions, Living Well in Louisiana will offer fitness-focused prizes like pedometers, towels, water bottles and more to motivate participants. All prizes are provided through wellness grant funding and sponsorships.

The Living Well in Louisiana website is a complete online wellness center that features healthy living tips, video clips from doctors, dieticians, athletes and other health experts, a worksite wellness resource guide and much more. In addition to diet and exercise guidance, the website offers resources to help people quit smoking, focus on their mental health, and access preventive health screenings.

Living Well in Louisiana features four sets of challenges, each hosted by a celebrity: ***Healthy Workplace Challenge (Les Miles Award)*** - is an exciting "Get Fit Crime Mystery Challenge," where participants earn miles equal to a race around London searching for clues to solve a case.

***Family Challenge (Gov. Bobby Jindal Award)*** - is designed to incorporate one activity with your family from the family challenge list and track its progress. Families can choose from an indoor, outdoor and/or social activity.

***Fit Schools Challenge (Malcolm Jenkins Award)*** -- challenges kids to track their miles as a race charting legendary explorers Lewis and Clark's trip to the Pacific and back!

***Community Weight Loss Challenge (Shaquille O'Neal Award)*** -- allows you to watch yourself virtually fly over the horizon in a hot air balloon as you track your fruits and veggie intake, shed pounds and get lighter by the week. This challenge encourages healthy, sustainable weight loss (one to two pounds per week).

Adults competing in *Living Well in Louisiana* are encouraged to form teams of two to 10 people and take one of the challenges, but they may also compete as individual participants. If you want to create customized challenge for your workplace, exercise group or other team, contact the Living Well in Louisiana Office at 1-866-562-9015.

Participants earn points by achieving milestones in accumulated activity; losing weight through a healthy, appropriate diet and physical activity; and by increasing their fruit and vegetable consumption. Participants can track their daily/weekly exercise activities-from jogging and swimming to walking and mowing the lawn- online by entering these into their profile. The online tool automatically converts activities into "steps," which is how the challenge is measured.

The site also features specific information that encourages healthy eating and physical activity.

With just a few clicks, participants can easily track their daily fruit, vegetable and water intake, body mass index and weight loss progress; print healthy recipes; send motivational e-cards; or create their own fitness challenges. The online tool allows individual and teams to create walking routes using Google Maps that log their distances and number of steps. These routes could be in nearby parks, on trails, around the participant's office or in his/her neighborhood.

The *Living Well in Louisiana* challenge is also available as a free mobile app that participants can use to track their progress on their smartphones.

## **Governor's Games, Council on Physical Fitness and Sports Continues to Draw Record Number of Participants**

*Promoting Physical Activity and Wellness Throughout the State of Louisiana*

During this State Fiscal Year (SFY) 2012/13, the Louisiana Governor's Council on Physical Fitness and Sports and Bureau of Minority Health Access strengthened its efforts in maximizing new initiatives that increased physical activities in underserved populations, and improved quality and sustainable access to health care for racial and ethnic populations. Notably during this SFY, Governor's Fitness Council implemented new initiatives such as Inner City soccer for at-risk youth, and the *Louisiana/Mississippi Partnership: Pearl River County Shelter Project* that is designed to assist low-income communities on the gulf coast with establishing their own community emergency preparedness plan in the event of a natural disaster or pan flu outbreak.

### **Inner City Soccer**

Youth Soccer clubs throughout the state are very expensive to join, and kids who come from low-income backgrounds cannot afford to pay for soccer shoes, shirts or even cleats. So the Governor's Fitness Council introduced a new Olympic-style soccer event free of charge for kids that love to play soccer but could afford it in the New Orleans inner city area. More than 200 kids showed up for the first-time event, and even more impressive was the number of volunteers that signed on to help. Approximately seventy-five volunteers gave up their Saturday afternoon to work the soccer tourney for the kids.

### **Louisiana/Mississippi Partnership: Pearl River County Shelter Project**

The Bureau of Minority Health Access partnered with the Chahta Native American tribe to expand an emergency preparedness program called, Community Preparedness Response Network (CPRN) to the state of Mississippi that is designed to assist low-income communities with establishing their own community emergency preparedness plan in the event of a natural disaster or pandemic flu outbreak.

The expansion was called, *Louisiana/Mississippi "Partnership: Pearl River County Shelter Project"* that provide hard-to-reach populations in Louisiana and Mississippi a point of contact during natural disasters or pan flu outbreak, and make available resources to assist them with relief and recovery efforts specific for their communities. By partnering and establishing a CPRN Resource Center in Mississippi, Louisiana's members will have an additional evacuation point in our neighboring state along with Arkansas and state-run shelters. This partnership will give Louisianan and Mississippi members of the CPRN another shelter location that will be closer to

their homes, hotels, service stations, grocery and hardware stores and shopping centers in the event of a natural disaster. This Pearl River Shelter will be part of FEMA's diversity program to ensure that low-income populations will receive assistance in a timely manner during and after a natural disaster.

### **Men's Health Month**

The purpose of National Men's Health Month is to heighten the awareness of preventable health problems and encourage early detection and treatment of disease among men and boys. This month gives health care providers, public policy makers, the media, and individuals an opportunity to encourage men and boys to seek regular medical advice and early treatment for disease and injury. During this 30-day period, community groups, faith-based organizations, regional and local health departments and other public and private entities conducted activities which included health screenings, educational events, health fairs and/or assessments. Our partner, Louisiana Primary Care Association served as Area Coordinator to oversee the coordination and implementation of activities throughout the state.

### **Louisiana Governor's Games**

The Governor's Games (LGG) is Louisiana's premier amateur sporting event, where sports enthusiasts from around the state participate in a variety of athletic competitions. With more than 50 sporting events, LGG 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 seven-month statewide set of sporting events involve every recreation department in the state. Experienced sports commissioners were chosen to run the events professionally and ensure that they have an Olympic-style atmosphere. Louisianans are encouraged to sign up through local recreation departments, sports leagues, or advertisements and public service announcements run via media partners. In addition, children can sign up through local schools and physical education teachers. Registration began in January, and the events took place through June. Results were tracked and posted on the Louisiana Governor's Games Web site for the remainder of the year. Six of the fifty-eight events were televised through Cox Cable channels in 14 Acadiana parishes and twelve northern Louisiana parishes on Comcast Cable channels.

### **Tour deFitness**

Provides training, teaching strategies, authentic assessment and best practice information to K-12 teachers in the areas of health and physical education. The primary purpose of this project is to in-service and equip teachers with developmentally appropriate information regarding smoking cessation, the dangers of tobacco (smokeless and smoking), techniques to make their physical education lessons more physically active, and assessment opportunities to measure physical fitness. This project allows clinicians to conduct a series of workshops throughout the state. While annual LAHPERD convention provides health and physical education teachers with numerous programs to improve the health status and physical education programs in school and recreational settings, many teachers are unable to attend this annual function. Taking the

message to teachers where travel, money and release time is not an issue, will impact the entire state.

The Workshops were conducted in various areas of the state and participants did not have to worry about barriers that normally prevent them from participating in a professional workshop. Each workshop contained breakout sessions that addressed the prevention of tobacco use, an orientation to the sponsored website [lagovernorsgames.org](http://lagovernorsgames.org) that promotes physical activity, information regarding parish and state physical fitness meets, lessons that address the state mandated physical education and health standards and assessment information appropriate for measuring the health related components of physical fitness, including BMI information.

The opportunity to train 500 teachers in these areas has the potential to impact thousands of students. The long term benefit of teaching children how to take ownership for their health behaviors and enjoy physical activity in a school setting impacts what they do in their leisure time. The more physical activity they experience during the day the less they tend to be overweight, have lower blood pressure, reduce the incidence of diabetes and cardiovascular disease.

### **Elementary Fitness Meet**

The Governor's Council on Physical Fitness and Sports has seen a significant increase in the physical fitness levels of elementary school children in the last three years from the 25 parishes that participate in the Fitness Meet program. More than 200,000 Students train for the event at the beginning of each school year and preliminary meets start in the spring. The top two boys and girls from each parish must survive their initial competition from their schools and compete against other kids in their parish before they reach the championship.

Strategy: Students perform the identical fitness tests acquired from the President's Challenge. Tests consisted of: the 50-yard Dash, Sit and Reach, Pull-ups, the Shuttle Run, Curl-ups (sit-ups), Standing Long Jump, and the 600-Yard Run. Instructions on how to execute each test properly are included in the Elementary Fitness Meet Guidelines packet that is distributed to each parish annually. The top scores from two boys and girls qualified them for the Elementary Championship Fitness Meet held in Baton Rouge at LSU's Bernie Moore Track Stadium. Elementary school children competed against other parishes from around the state. The Governor's Fitness Council sponsors this Olympic-style event in the spring of each year at LSU in Baton Rouge.

### **Weightlifting Development Center**

The Governor's Council on Fitness along with LSU-Shreveport and the city of Shreveport successfully operates the state's first weightlifting development center that trains future Olympians. Dr. Kyle Pierce manages the day-to-day operations. The Center produced its first Olympian, Kendrick Farris out of Shreveport.

**Legislative Fitness Day**

The Governor's Council on Fitness, Louisiana Association of Health, Physical Education, Recreation and Dance (LAHPERD) sponsored Legislative Fitness Day (each year in May). Each year during the legislative session, lawmakers are given fitness assessments when the session comes to a break. This year 125 lawmakers took part in the program.

**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 continue to improve over the past few years. Although the FY 2011 business plan was the first of its kind for DHH, its publication was the first step in an effort to introduce a predictable rhythm into the business cycle of the department. DHH leadership has used it as a guide and accountability tool to ensure that the day-to-day work is aligned with the priorities set forth.

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 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 FY 2012 business plan, goals carried forward from the FY 2011 plan include a continued effort to streamline operations, improve services, measure outcomes, ensure efficient spending and implement community-based expansion. From these themes emerged Transformational Priorities that represent those priorities with the highest potential impact.

- ◆ **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?

### **Governor's Council on Physical Fitness and Sports**

The Governor's Council on Physical Fitness and Sports continues to be one of the largest fitness councils in the country with 267,000 participants, 58 Olympic-style sporting events covering thirty-four parishes with thirty-two cities as partners and more than two hundred schools involved in various fitness events sponsored and cosponsored by the Fitness Council. In addition, the Bureau of Minority Health Access continues to meet the needs in uninsured and underinsured populations by responding to Louisiana's diverse racial and ethnic communities to provide access to quality of care, and eliminate health disparities that will ultimately improve health outcomes.

During the State Fiscal Year 2012/13, the Louisiana Governor's Council on Physical Fitness and Sports directed much of its efforts to expand existing physical activities and sports in parishes that did not have them, along with identifying kids and their parents who are eligible for La Chip. Another strategy that was utilized to influence policy was through the Governor's Games, which promote physical fitness and health while educating thousands through its competitive sporting events about the dangers of tobacco and tobacco-related products. The Bureau of Minority Health Access with its focus on eliminating health disparities among racial and ethnic populations, launched investigations as to causes for health disparities by exploring social determinants of health that are the economic and social conditions – and their distribution among the population – that influence individual and group differences in health status.

Some of the notable initiatives are the Louisiana Governor's Games, Tour deFitness, Living Well In Louisiana, Community Preparedness Response Network (CPRN), diabetes and obesity initiative in the Asian/Pacific Islander Community and the Weightlifting Development Center. We have already seen improvements in access to care in underserved, racial /ethnic populations and children are starting to be more physically active. We look forward to seeing continued improvements from these initiatives and the impact it will have on our population's health outcomes in coming years.

### **Health Standards Section**

The Health Standards Section is making significant progress toward the revision of multiple regulations sets. This is on track with current goals. The Provider Online Processing System (POPS) for online licensing has encountered setbacks, which have delayed the implementation process.

- ♦ **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?

### **Health Standards Section**

The current workload and related processes have impeded the ability of the Health Standards Section to schedule routine licensing surveys on multiple facility types, especially those such as Home and Community Based Services and Adult Residential Care Providers. Currently, only complaint investigations are scheduled (except for those situations involving egregious/cyclical non-compliance issues).

Health Standards Section is also experiencing the same type workload/resource issues as others within DHH. The number of providers to survey and the availability of resources are extremely unparalleled. The additional workload experienced in Adult Protective Services in July 2013 has severely impeded this process. As a result, approximately seven staff members had to be pulled from available resources to address Adult Protective Services increased workload. Given the current workload and limited resources, the turnaround time for provider requests is longer, and additional assignments or a job study/analysis of position allocations may be needed to determine appropriate structuring.

- ♦ **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 revised its 5-Year Strategic Plan in July 2013. In the revised plan, agencies incorporated a section titled "Executive Summary" and have implemented new outcome performance indicators. 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.

The department's Business Plan, "*Leading Transformation: Our FY 2012 Priorities for a Healthier Louisiana*," 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 and resource allocation?** Use as much space as needed to explain fully.

Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the DHH Division of Planning and Budget. This section reviews 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 ensures 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:

**None completed.**

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 2012-2013

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

**Department Head:** **Kathy Kliebert, Secretary**

**Undersecretary:** **Jerry Phillips**

**Executive Director:** **Lisa Schilling**

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

**For each accomplishment, please discuss and explain:**

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

The South Central Louisiana Human Services Authority (SCLHSA) instituted new Specialty Programs for behavioral health patients in our seven parish catchment area giving them more options to choose from as part of their person centered treatment regimen. The programs are evidenced based and give SCLHSA an opportunity to diversify treatment to include fee for service options for the general public. The Specialty Programs instituted include:

##### **1. Social Security Disability Evaluation**

SCLHSA performs consultation and psychological assessment for the Social Security Disability Determination Office to assist in identifying disability eligibility. Fees associated with this service are paid for by the Social Security Disability Determination Office.

##### **2. Substance Abuse Professional Services**

SCLHSA'S certified SAP provides assessment and completion interviews for individuals in violation of the Department of Transportation (DOT) regulation 49 CFR Part 40. The DOT rule, 49 CFR Part 40, describes required procedures for conducting workplace drug and alcohol testing for the Federally regulated

transportation industry.

**3. Anger Management Program**

SCLHSA offers a 16-week evidenced based program for mandated clients. The program requires an assessment, 4 individual sessions and 12 group sessions to receive a certificate of completion. Fee schedules are available upon registration.

**4. Intensive Outpatient Treatment**

SCLHSA offers a structure treatment program for clients with substance abuse and co-occurring disorders aimed at providing education, recovery skills and support. IOP creates a seamless continuum of care for individuals needing more structure than traditional weekly outpatient treatment or as a step-down to inpatient or residential treatment.

The main reason behind adding these new programs was to increase affordable care options for our patient population. The underlying goals for the SCLHSA expansion were access, affordability, and addressing the needs of our patients and filling gaps in key program areas in our agency and in the community. All of these programs complement our existing treatment service array and give an individual options to choose to make their personal care plan more relevant and meaningful.

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

The addition of services to the SCLHSA program structure enhances the agency's work product and the quality service delivery provided to our clients on a daily basis. These service additions are also important because they were developed from input with other community providers in our catchment area that identified needs and approached our agency about ways to help fill identified service voids. Because of these additions, SCLHSA will also be able to better maximize reimbursement from payer sources such as the Statewide Management Organization (SMO, and other community partners such as the Sheriff's Office, Public School Systems, District Attorney's Office, and the Court system. Additionally, these new programs also afford SCLHSA the opportunity to initiate some fee for service programs for private pay that meet community needs in the school system and with the judicial system and address one of our new Strategic Goals to increase the fiscal integrity of our agency.

**C. Who benefits and how?**

The SCLHSA clients benefit by receiving outpatient services that are evidenced-based and represent best practices for treatment/services delivery, client satisfaction, and performance improvement. The particular service additions SCLHSA selected allow our agency to improve communication with persons served; create person-focused standards that emphasize an integrated and individualized approach to services and outcomes; provide accountability to funding sources, referral agencies, and the community; instill management techniques that are efficient, cost-effective, and based on outcomes and consumer satisfaction; supply evidence to federal, state, provincial,

and local governments of commitment to quality programs and services that receive government funding; and guidance for responsible management and allow for professional growth of personnel. .

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

The SCLHSA Board of Directors and staff committed to hold the agency to the performance improvement standards included in the Strategic Goals and Objectives focusing on the unique needs of each person the agency serves, and monitoring of the results of services we provide. SCLHSA began with an internal examination of its program and business practices. The examination consisted of the SCLHSA staff conducting an in-depth self-evaluation review of agency policies, procedures and documents and making improvements in protocols and procedures to improve service delivery from the point of entry to discharge and then follow-up in the community. The result was that the previous Goals and Objectives were accomplished one by one and staff began to identify new opportunities for improvement in performance.

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

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

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

Payers whether a third-party funder, referral agency, insurance company, or governmental regulator looks for CARF-accredited or evidenced based service providers to lessen risk and provide greater accountability. Accredited providers have proven they have applied a comprehensive set of standards for quality to their business

and service delivery practices. Because CARF accreditation signals a provider's demonstrated conformance to internationally accepted standards, it can significantly reduce governmental monitoring and help to streamline the regulation processes. The value of CARF Accreditation is evidenced by the organization's continual effort to improve efficiency, fiscal health, and service delivery -- creating a foundation for consumer satisfaction and the agency impetus to accomplish its existing Strategic Goals and Objectives and to implement new ones that push the organization to the next level of performance and compliance.

**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?

Overall, South Central Louisiana Human Services Authority (SCLHSA) remained on target with our Strategic Plan Goals and Objectives accomplishing them all. The Authority consistently utilized all strategies outlined in its Strategic Plan to effectively demonstrate performance and quality improvement on a continuous basis. In addition to Strategic Plan Goals and Objectives, implementation of efficiency strategies also produced positive results in the areas of client engagement, documentation of clinical treatment, client satisfaction (internal satisfaction survey results improved over previous survey and showed high marks for all clinicians, all support staff, and perceived positive outcomes), and staff retention. SCLHSA has implemented a new set of Strategic Plan Goals and Objectives that focus on the agency remaining viable in the ever changing healthcare environment locally, statewide and nationally.

**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:

During FY 2012-2013, South Central Louisiana Human Services Authority (SCLHSA) demonstrated compliance with each of the three goals included within its Strategic Plan which led to the creation of new Goals and Objectives for the 2013/2014 Fiscal Year. The new Strategic Goals were created with input from the SCLHSA Board of Directors, Local Providers and SCLHSA staff. The four following goals represent the community's perspective on where our agency needs to concentrate its efforts:

- Goal 1: Improve service outcomes by partnering with stakeholders to expand integrated service programs in the community.
- Goal 2: Increase staff accountability and fiscal integrity of the agency.
- Goal 3: Provide the infrastructure, information, and systems to help employees successfully complete their jobs.
- Goal 4: Maintain CARF Accreditation by committing to quality improvement, focusing on the unique needs of each person we serve, and monitoring the results of services we provide.

The South Central Louisiana Human Services Authority (SCLHSA) will continue to utilize all Strategic Plan strategies with continued focus on utilization management, monitoring and related follow-up activities, client engagement, and positive outcomes to achieve the Authority's goals and objectives.

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.

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?**

**None**

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?

♦ **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 all of its Strategic Plan Short Term Goals (see above) with Objectives developed to coincide with Authority functions identified during the FY 2012-2013 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 focused on the development of true and meaningful outcome measures.

No. If not, why not?

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

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 Service 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 Administrative Team. Additionally, the Executive Administrative Team develops, adopts, and implements cross-divisional annual Performance Improvement Initiatives (PI) to further insure South Central Louisiana Human Services Authority (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 Administrative 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 Videoconference meetings each year with the entire agency. Performance improvement is a routine part of the agenda. Further, the Executive Director bases a significant portion of the Division Directors'

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

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

### **Reductions in Funding**

#### A. Problem/Issue Description

8. What is the nature of the problem or issue?  
During FY 2012-2013, South Central Louisiana Human Services Authority (SCLHSA) experienced a reduced level in State General Finds (SGF's). Additionally, the hiring freeze of FY 2011-2012 and the "non-T.O." Executive Order contributed to a reduction in the number of funded positions. Vacant positions in service areas such as clinical services are, of course, the priority to fill.
9. 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 Goals and amended its Strategic Plan Objectives.
10. 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 (mental health and addictive disorders, Developmental Disabilities Services, and the Administration component (which includes utilization management, monitoring, and billing functions) is experiencing the same problem/issue.
11. Who else is affected by the problem?
  - Individuals Served
  - Residents of South Central Louisiana Human Services Authority (SCLHSA)-catchment area to include Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne parishes.
  - Every employee (all areas and at all levels)
  - Contractors and their employees
  - Community Partners such as the Parish Presidents and Council/Jurors, Sheriff's Office, Coroner's Office, Public School Systems, District Attorney's Office, Juvenile Judges, and local not-for-profit community hospitals and social service organizations.

## 12. How long has the problem or issue existed?

The negative effect of reduced funding was noted beginning in FY 2010-2011, as we were a new local governing entity and has continued through the FY 2012-1013 Fiscal Year.

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

The problem is caused by a continual reduction to the State budget; loss in state revenues; a depressed economy; and reduction in Federal funding and change to payments for services within the Managed Health Care System for behavioral health services

## 14. 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 of decreased funding with urgency and must utilize effective and flexible strategies/tactics to continuously improve performance, quality and to identify and capture alternative revenue streams.

## B. Corrective Actions

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

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

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

## 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?
6. 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.
  - Work with the Statewide Management Organization to ensure Medicaid reimbursement is optimized for evidence-based practices offered by SCLHSA in the home and in the community.
  - Continue implementation of the South Central Louisiana Human Services Authority (SCLHSA) Risk Management Plan.
  - Research grant funding opportunities for expansion of new programs and/or to sustain existing programs.
  - Explore opportunities to partner with pharmaceutical programs for research studies related to behavioral health and developmental disabilities.
  - Integrate primary care into the SCLHSA behavioral health care service venue.
  - Continue to explore and seek relationships with private payors to open new streams of revenue.
7. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

This is the second year that the SCLHSA participates in the budget and AMPAR process as a new local governing entity and the second time that these recommendations are submitted.

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

All corrective actions identified above are underway and will continue in the future with no end date established. 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 with addition of the new Statewide Management Organization (SMO) and the anticipated implementation of Healthcare Reform in 2014.

## 9. 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 Administrative Team. Resources needed to successfully carry out these processes are Human Resources; related duties and responsibilities are included in each Executive Administrative Team member's position description and in employees performance planning and rating documents. Executive Administrative Team members are expected to manage priorities with flexibility and their respective staff 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?

The behavioral health services reimbursement structure has changed to allow for multiple billable services to be delivered in a single day however the structure has limited billable services to a select few of licensed professionals, i.e. services rendered by nurses are no longer eligible for reimbursements. Additionally, we are challenged in that services delivered by unlicensed professionals are not billable services in the outpatient clinic setting yet are in the community setting. The staffing of our agency relied heavily on nursing support to physicians/psychiatrists and the local private providers to deliver the community based services.

Implementing the Louisiana Behavioral Health Partnership, the Statewide Management Organization (SMO), charged the SCLHSA to restructure the entire behavioral health function and organize services to maximum the billing potential rather quickly and unfortunately caused major issues with service provision and

billing compliance. There continues to be struggles with merging existing Medicaid beneficiaries into the SMO billing system that would allow for timely billing; there are issues in receiving pre-authorizations for services as identified in independent assessments that include but are not limited to non-response, care managers lack of understanding of identified needs, time lapse between requests and response; the contracted vendor for the La Behavioral Health Partnership is also responsible for billing the Medicare and third-party payors but unfortunately that component of the contract has not yet been implemented.

One asset to the SMO implementation is the initiation of one integrated client record for someone receiving behavioral health services although this has created significant challenges due to CFR 42 Part 2 and HIPAA. The SMO vendor has firewalls that limits a provider's access to a patient's information, including the ability of the service provider to update demographic and guarantor information that would allow for successful billing.

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). The local private providers who have agreed to continue to serve the non-payor source client (those who are not beneficiaries of Medicaid, Medicare, third party or determined self-pay clients), that is the "true" indigent individual needing services), have also been challenged in delivering services at a contracted fee for service rate not to exceed the Medicaid determined rate as outlined in the La Behavioral Health Partnership instead of a cost reimbursement rate. This has resulted in private community based providers deciding not to continue services which sometimes leave a gap in community resources available to the patient and staff involved in creating a plan of care for a client.

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 La Behavioral Health Partnership was implemented March, 2012. The challenges with re-organization, including staffing and billing began immediately. Through attrition, SCLHSA has recruited and replaced counselor vacancies with licensed billable staff; however there still remains staff with non-billable credentials employed. In billing challenges, the agency is working diligently with the SMO vendor to correct and update individual's basic demographic and guarantor information for successful transmission of billed claims; however this action addresses only the Medicaid component of billing, there still remains the unknown challenges that surface on a daily basis. SCLHSA has also implemented its own billing system for Medicare and third party payors to ensure that funds not recovered since the SMO implementation in March, 2012 can be recuperated. As of this date, the implementation date of this component of the SMO billing system is still unknown.

## 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 and also by those determined by the Statewide Management Organization. Additionally, the delay in the full implementation of the SMO vendor's fiscal intermediary responsibilities and the structure/re-structure the agency components as needed to meet the services defined in the La Behavioral Health Partnership has affected SCLHSA's ability to predict its revenue potential.

## 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 continue to 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. This includes the agency's employment of billable 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 action do you recommend to alleviate or resolve the problem or

issue?

The implementation of the Statewide Management Organization (SMO) forced SCLHSA to examine all areas of operation for improvement to processes and daily service functions. South Central Louisiana Human Services Authority (SCLHSA) underwent a complete restructure of the behavioral health component to place staff in the position to execute a billable procedure or to assist in the process of completing a billable procedure. Staff was moved among clinic sites to reflect the assessment and treatment options available for services. This restructure is still a work in progress that we tweak depending on changes by the SMO/DHH. To ensure this process is effective and efficient the SCLHSA will:

- 1) Continue to make necessary adjustments to its staffing patterns to assure providers delivering services are eligible to bill and/or contribute to the billing process.
  - 2) Modify its charge master and the billing component to assure all services performed meet the definitions of billable procedures approved by the Louisiana Behavioral Health Partnership and/or SMO are billed.
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 third year that SCLHSA has submitted this recommendation and that Medicaid funding for evidence-based practices offered in the home and community has been targeted as a goal for the Department of Health & Hospitals Human Services Interagency Council (HSIC).

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

South Central Louisiana Human Services Authority's (SCLHSA) Executive Director, Deputy Director, Clinical 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. A complete restructure of the behavioral health component was completed in February of 2012 to place licensed staff in the position to provide billable procedures in accordance with the SMO. Mental Health Clinics now operate as Treatment Centers to provide individual/group sessions, family/couple sessions, psychiatric evaluations, psychological testing, medication administration, medication management, crisis stabilization, gambling counseling, breath tests, urine screens and referrals. Addictive Disorder Clinics now operate as Assessment Centers to provide screening, assessment, plan of care and level of need determination. The South Central Louisiana Human Services Authority (SCLHSA) charge master and billing component are aligned with the SMO and are continuously being changed to mirror the services that the state plan will approve for reimbursement.

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. The only cost associated with this process is the difference in salary to replace unlicensed staff with licensed staff should they choose to separate from the agency.

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

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

- Internal audit**  
 South Central Louisiana Human Services Authority's (SCLHSA) Administrative Services Division provides ongoing monitoring of clinical and administrative functions. Audit tools, with identified criteria and targets are utilized; results are reported; and, appropriate process improvement and/or corrective actions are executed. Further, South Central Louisiana Human Services Authority (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 Administrative Services Division oversees each of these areas to assure there is no duplication of effort.
- External audits (Example: audits by the Office of the Legislative Auditor)**  
 South Central Louisiana Human Services Authority (SCLHSA) is audited on an Annual basis through the Office of the Legislative Auditor as well as by the Department of Health & Hospitals Office of Behavioral Health Licensing Standards and the Louisiana Department of State Civil Service.
- Policy, research, planning, and/or quality assurance functions in-house**  
 The South Central Louisiana Human Services Authority's (SCLHSA) Executive Administrative Team provides these functions with oversight from the SCLHSA Deputy Director.
- 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 Administrative 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. SCLHSA also provides annual documentation of conformance to CARF annually to comply with the standards of accreditation.
- 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 annually as part of the compliance standards implemented for the CARF accreditation process.
- 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, the Statewide Management Organization and the Department of Health and Hospitals.
- 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.
- 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:

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 Administrative Team meetings. Findings are shared during individual and group supervision and at all-staff meetings, as appropriate. Corrective action and/or process improvement plans are developed and executed as needed, and are monitored by the Administrative Team on a routine basis and by the Executive Director as determined to be necessary.

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

Lisa Schilling  
Executive Director  
South Central Louisiana Human Services Authority (SCLHSA)  
985-858-2931  
[lisa.schilling@la.gov](mailto:lisa.schilling@la.gov)

Kristin Bonner  
Deputy Director  
South Central Louisiana Human Services Authority (SCLHSA)  
985-858-2931  
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# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

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

**Department Head:** Kathy Kliebert, Secretary

**Undersecretary:** Jerry Philips

**Agency Head:** Hugh Eley, Assistant Secretary

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

1. *Consolidated management of Adult and Elderly Protective Services*
2. *Centralization, transition, and recognition of Permanent Supportive Housing (PSH)*
3. *Implementation and further development of Participant Tracking System (OPTS/CRM)*
4. *Money Follows the Person (MFP) benchmarks exceeded*
5. *Waitlist for Traumatic Head and Spinal Cord Injury (THSCI) Trust Fund reduced*
6. *Nursing home quality initiatives started*
7. *Improvement of compliance with Medicaid and Medicare participation requirements at Villa Feliciano Medical Complex (VFMC)*

**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?

## **1. Joint operation of Adult and Elderly Protective Services**

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

Effective July 1, 2012, HB 1 transferred operations of Elderly Protective Services from the Governor's Office of Elderly Affairs to the Department of Health and Hospitals' Office of Aging and Adult Services. As a result, Louisiana has joined 42 other states in operating a single Adult/Elder Protective Services program for all vulnerable adults age 18 and older. Considered best practice, this has enabled better use of resources and improved services.

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

The transfer of Elderly Protective Services to the OAAS has significantly improved the quality of services provided to vulnerable adults 60 and older and as a result, provided a reciprocal benefit to the under 60 population served as well.

- The OAAS provides a 24-hour abuse reporting hotline with after-hours crisis intervention for the first time ever for the senior population.
- Staff training has improved. For the first time in several years, All Staff Training was held in October 2012 and again in March/April 2013. Supervisor Training took place in April 2013.
- The EPS Investigator Training Material was updated for the first time since 1992. The new material is based on a national best-practice curriculum.
- DHH offers improved access to legal services for interventions to protect seniors by providing an agency attorney in every regional office.
- Improved communication with OAAS and OCDD waiver staff has led to better results for abused recipients over age 60 in the Community Choices and New Opportunity Waivers. Clients have been able to access emergency waiver slots and get services in less than one week.
- The quality and timeliness of investigations and service delivery for both programs improved with the implementation of a more refined policy and procedure manual. The policy/procedure manual was updated for the first time since 1992. The newly developed manual adopts best practices of both programs while utilizing national guidelines.
- DHH has saved the state money by consolidating office space and going to a work-from-home model.

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

All current and future victims of abuse, neglect and or exploitation, their families and caregivers will benefit from the consolidation of Elderly Protective Services with Adult

Protective Services. The state also benefits from the transfer of EPS to OAAS by reducing the cost associated with operating two separate programs that utilize that same legislative statute.

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

Effective July 1, 2012, HB 1 transferred operations of Elderly Protective Services from the Governor's Office of Elderly Affairs to the Department of Health and Hospitals' Office of Aging and Adult Services. The two agencies entered into a Memorandum of Understanding to effectuate the transfer and ongoing operations. After the transfer, OAAS evaluated the operation of both programs and also reviewed and implemented national standards of practice to improve services.

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

This accomplishment contributes to the success of OAAS Strategic goal "To expand existing and develop additional community-based services as an alternative to institutional Care." As the State seeks to advance better health through increased reliance on community-based services, there is a corresponding increased need for oversight and protection for those residing in settings that lack the degree of regulation associated with an institutional setting.

This accomplishment also contributes to the success of OAAS Strategic goal "To timely complete investigations of adult abuse, neglect, exploitation, and extortion in the community" by utilizing best practices and available resources, through the consolidation of Protective Services, OAAS is better able to fulfill its mission to serve adults with disabilities and to enable them to live free from harm due to abuse, neglect, exploitation, or extortion.

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

Yes. Adopting "Best Practices" for the agency's unique discipline, updating policies to implement more effective standards, consolidating space and resources, and training staff regularly can be beneficial to all departments and agencies.

**2. Centralization, transition, and recognition of Permanent Supportive Housing (PSH)**

**A. What was achieved?**

Last year, management of the PSH program was moved from the Office of the Secretary (OS) to OAAS. This year, the PSH office successfully managed the closing of 6 Local Lead Agency (LLA) offices and quickly developed and implemented a transition plan that was necessary as a result of contract delays related to transitioning of certain PSH program

functions to the Statewide Management Organization (SMO) contractor, Magellan of Louisiana.

The PSH program was slated to begin its transition from CDBG, federal disaster recovery funded services to Medicaid-funded services. The SMO was slated to begin transitioning current PSH households into its system in November with an anticipated completion date of December 31st. These transition dates were postponed several times and as a result the PSH office absorbed the tasks of the 6 regional offices that were shutdown. During this transition period the PSH office successfully executed emergency contracts for all current providers to prevent a lapse in services and payments. The office also managed the following throughout the regions served by PSH: outreach, monitoring, program inquiries, assistance with completing applications, PSH application processing, lease-up across all regions and processing of invoices for all regions.

In addition to centralization, the PSH program was one of 13 applicants nationwide to be selected for a Project Based Rental Assistance Demonstration Award (PRA-Demo) from Housing and Urban Development (HUD).

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

The successful interim plan allowed for a seamless transition from multiple LLAs to the SMO. It prevented a lapse in services for program participants, continued payments for providers, and allowed the program to continue functioning under a single centralized office.

The PRA-Demo award will allow Louisiana's PSH program to expand outside of the Louisiana Go Zone to serve all areas of the state. HUD has not yet executed the contract for this award, but implementation is expected to begin in SFY 2014.

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

The centralization of the PSH functions under one office was beneficial to program participants, service providers, subsidy administrators, and property managers.

Program participants were not impacted by this significant shift in management functions and services continued to be delivered under CDBG funding. The program was also able to continue to admit new participants and link them to service providers. Providers were able to continue to provide services and were able to continue to receive payments under the emergency contracts established by the PSH office. The office also served as a link between subsidy administrators and providers to ensure lease-up continued and re-certifications were submitted in a timely manner. Property managers were served by the centralized office and had any concerns or issues addressed in a timely manner.

The PRA-Demo award will allow more than 200 additional households to be served statewide.

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

This task was accomplished with significant support and assistance from the OAAS executive management. Current PSH staff members also took on a great deal of additional responsibilities. Staff's willingness and cooperation in quickly responding to this shift in duties was crucial in making this unexpected task a success.

Development of the application for the PRA-Demo award was a joint effort by the PSH program office, other DHH offices, and the Louisiana Housing Corporation.

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

In and of itself, centralization does not constitute a Best Management Practice, though it has improved program efficiency.

The PRA-Demo is a promising practice to create high quality, community-integrated affordable housing with supports for people with disabilities. This national demonstration is actually based on Louisiana's program model.

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

Both selection for the PRA-Demo and the ability to continue to manage and provide services under the centralized office contribute 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.

**3. Implementation and ongoing development of participant tracking system****A. What was achieved?**

OAAS made significant progress in revising and expanding the OAAS Participant Tracking System (OPTS), which will include the long-awaited electronic plan of care and incorporate the MDS-HC level of care determination and functional assessment tool. OPTS is designed to automate formerly manual and paper processes, track initial contacts, determine medical eligibility, perform and analyze functional assessments, plan services according to prescribed budget limits, and document service schedules. When completed, OPTS will serve as the sole case management tool utilized by OAAS to track program participants and administer programs. Thus far, the participant demographics functionality is tested and ready for

deployment. Call/contact tracking, initial determination of medical eligibility, and functional assessment modules are implemented and have undergone testing: these modules are currently undergoing software defect repair and updating. Plan of care functions are presently being implemented. OPTS is expected to be deployed and placed in production in December of 2013.

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

Completion and deployment of OPTS will introduce improvements and optimizations to several processes. The implementation of a single client record used across several formerly independent software modules and paper processes creates a single case management tool, eliminates duplication, and automates existing manual processes. Consolidation of client records, assessment tools, care planning, budgeting, and scheduling functions in a single software application permits the creation of workflows and exchange of information between software modules, providing a level of efficiency previously not possible. OPTS will make use of web services to allow authorized contractors to securely exchange information with OPTS, including plans of care which are currently submitted to the OAAS data management contractor via fax. The consolidation of case management functionality in OPTS will also provide a more comprehensive and uniform platform for reporting. Finally, the completion and deployment of OPTS will improve the OAAS standing on the MITA maturity scale.

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

Support coordinators benefit from the creation of a single client record and the implementation of electronic tools to automate care planning and service budgeting. Software edits help catch errors in care plans before they are submitted, while workflows allow support coordinators to route care plans to supervisors for approval. Faxing care plans to the OAAS data management contractor will no longer be required, since the contractor will exchange care plans with OPTS electronically.

The OAAS data management contractor currently employs persons to manually review and enter care plan information into a data system by hand. The completion of OPTS will allow the contractor to electronically receive error-checked care plans, thus freeing employees for other tasks. Benefits are also seen by persons enrolled in OAAS programs (LT-PCS, CCW, ADHC): these persons should benefit from a more efficient and comprehensive care planning process. OAAS benefits from more efficient processes, as well as a more comprehensive reporting platform.

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

The progress in revising and expanding OPTS required substantial internal support from the DHH Office of the Secretary, including DHH-IT. Development to date has also required

cooperation and significant work by contractors including ULL (software development and technical support), UNO (project management and user technical training), and Venyu (networking infrastructure implementation and support). Internally, OPTS has required substantial contributions by OAAS subject matter experts and technical experts.

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

The OPTS revision and expansion is being implemented using the Microsoft Dynamics platform. This platform was chosen by DHH as the basis for a future Department-wide case management framework, which would make use of a single, master client record. Microsoft Dynamics includes pre-fabricated modules for the implementation of workflows, a standardized set of user interface components, enterprise database functionality, and reporting. The OPTS development project, as a test case, will provide valuable information on the suitability of MS Dynamics as a Department-wide platform for case management.

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

By improving accuracy and efficiency and reducing the time that it takes to process both initial and routine service planning and authorization, this accomplishment advances the OAAS program goal of improving access and quality in long-term care programs and the strategic objective of expediting access to a flexible array of home and community-based services.

**4. Exceeded benchmarks for Money Follows the Person (MFP)**

**A. What was achieved?**

The Deficit Reduction Act of 2005 enacted the Money Follows the Person demonstration, designed to help states move Medicaid-enrolled individuals from institutions back into the community. In SFY 2010-2011, the Centers for Medicare and Medicaid Services approved additional federal funding for the operation of this program in Louisiana, and later extended the demonstration through calendar year 2020 with the last participant enrollment through September 30, 2016.

This year, OAAS was able to exceed the CMS proposed transition benchmark of 100 by 68, moving a total of 168 nursing facility residents back into their desired communities with community-based services.

**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. Continuing to meet or exceed

proposed transition benchmarks allows OAAS and Medicaid to continue to draw down the 100% federal funds for operation of transition activities. These funds also allow OAAS to build systems and infrastructure that strengthen the community-based services delivery system for all recipients and that support and sustain future transition efforts.

### **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 system improvements that strengthen the HCBS system as a whole. Meeting or exceeding benchmarks is a requirement for continued participation in the MFP demonstration.

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

Supplemental funding provided through CMS was used to hire transition coordinators in every DHH region. Transition coordinators and other OAAS MFP staff work closely with OAAS regional office staff, enrolled support coordination agencies, nursing facility discharge staff, local housing resources, and participants to achieve successful transition from institutional care to home and community based care in the community. MFP has also worked with the Permanent Supportive Housing program on several successful transitions.

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

Lessons learned are shared with other offices within DHH that are charged with transitioning individuals from institutional to community settings. Louisiana's implementation of Money Follows the Person has also been shared with other states at national conferences and meetings.

### **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. Reduction of waiting list for Traumatic Head and Spinal Cord Injury (THSCI) Trust Fund**

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

The Traumatic Head and Spinal Cord Injury Trust Fund (THSCI) began SFY 13 with 314 individuals on the waiting list for trust fund services. The program was able to reduce the waiting list by 143 individuals and end SFY 13 with 171 individuals on the waiting list.

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

When the program was transferred to OAAS from Department of Children and Family Services in 2010, there were individuals who have been on the THSCI waiting list since 2005. Approximately 60% of the individuals were not eligible for other services and were without any assistance.

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

The individuals waiting for services, especially those ineligible for other services, benefit from the reduction of the wait list. The program has now been able to open cases for those who applied as recently as 2010.

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

In the 2012 legislative session, OAAS sought, and legislation was passed, that clarified management of the program and allowable uses of the funds, updated the board membership, allowed for money in the fund to be used to match available federal funding, and paved the way for revised policies to more effectively serve additional people within available levels of funding.

Once this groundwork was accomplished through the passage of Act 269, the first step in addressing the waiting list was to ensure that everyone on the list meet the criteria for the program. Approximately 3% were found ineligible. Validation forms were sent out to all individuals on the waiting list to ensure they were reachable for services and still interested in the program. This process reduced the waiting list by approximately 50%.

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

Waiting list validation is common practice for other home and community-based services and one that OAAS routinely performed for its other programs. However, prior to its transfer to OAAS, validation was not routinely performed for this program.

**F. Does the 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,” and the program objective to maintain independence and improve quality of life for survivors of traumatic head and/or spinal cord injury who receive services through the Trust Fund.

**6. Launched nursing home quality innovation grants****A. What was achieved?**

The Nursing Home Quality Innovations Grants Program offers a limited number of small grants of up to \$19,500 each to fund quality improvement projects that will make nursing homes better places to live, work and visit. This year is a pilot year for the program where we are learning about the processes and methods for announcing the program, selecting projects and awarding funds. We received forty-five (45) applications and were able to offer twelve (12) grants.

The grants are funded using civil money penalties collected from nursing homes for regulatory infractions and held in a restricted use fund. Federal law requires that the funds be used for activities that benefit nursing home residents.

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

While funds from the restricted fund have been used for other projects, those projects have been unsolicited requests to the Department. This is the Department’s first attempt to solicit projects paid for by the funds, and the first attempt to provide funds directly to nursing homes. All other grant recipients have been other governmental units or not for profit associations and the projects have largely been educational. These projects will have a more direct impact on the residents.

**C. Who benefits and how?**

The most immediate beneficiaries of the projects are the residents who reside in the nursing homes that were awarded grants. More than half of the homes are investing in an interactive computer system shown to promote cognitive and physical well-being and to improve interactions between staff and residents by providing a means through which critical information about residents can be shared. Other projects seek to improve nutrition and socialization and resident satisfaction.

As a condition of participation, the selected nursing homes have agreed to provide quarterly reports on the impact of the program on resident and staff satisfaction and on costs. This information will be used to promote change in nursing homes beyond the grant recipients.

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

OAAS sought permission from CMS to use funds to hire a temporary employee who helped to shape and implement the program.

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

When fully developed, this program could serve as model for other states who are seeking ways to use civil money penalties effectively.

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

Part of OAAS's mission is to "provide for a system of long-term care services and supports whereby individuals who require long-term care can be assured of a safe and healthy environment and quality services. " While most of OAAS activity is devoted to providing community services, institutional care and the quality of that care remains a concern that OAAS is seeking to address. This program is one means of improving quality.

**7. Improvement of compliance with Medicaid and Medicare participation requirements at Villa Feliciana Medical Complex (VFMC)****A. What was achieved?**

Substantial compliance is the minimally expected outcome of surveys conducted by Health Standards on behalf of CMS. However, VFMC was unable to achieve this outcome on two consecutive surveys conducted in May 2012 and in December 2012. Aside from the impact of the quality of care residents at the facility received, the consequences of the failure to achieve substantial compliance meant that the facility was faced with termination from the Medicare and Medicaid programs, a prohibition on the admission of new residents, and significant civil money penalties.

In June of 2013, Health Standards determined that VFMC was in substantial compliance.

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

Aside from averting the negative consequences that follow from a poor survey, VFMC staff showed themselves capable of making significant improvement in a short time. The achievement builds confidence in VFMC's ability to continue to progress.

**C. Who benefits and how?**

Clearly the residents are the first and most important beneficiaries of the improvements made at VFMC. Care has improved in the critical areas of infection control and pressure ulcer prevention and treatment. The second group to have benefitted is the staff at VFMC whose job satisfaction and teamwork skills have also substantially improved.

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

The improvements at VFMC could not have taken place without the dedicated and sustained efforts of the staff at VFMC. However, the most impactful change was the change in leadership. The Assistant Administrator stepped up to the challenge of filling the vacancy left by the previous administrator and brought with him the skills to systematically address areas of long-standing concern. Trained in hospital quality improvement methods, he led the staff through root cause analyses and in crafting solutions tailored to specific needs. He has brought in talented individuals to work with him in the positions of Director of Nurses and Safety Officer.

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

No. This is an achievement specific to the circumstances of VFMC.

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

This accomplishment is fundamental to success of the strategic plan. Without this achievement, VFMC would not be able to meet any of the goals or objectives.

**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 and reduction of waiting lists for state-funded programs. 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?**

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

Since achieving full staffing, Money Follows the Person is exceeding benchmarks for transitioning individuals from nursing homes to the community. Going forward, MFP will be making new use of data to target individuals with greatest potential for success post-transition. OAAS is also focusing effort on improving discharge planning capacity in nursing homes through training and level of care reviews, and is addressing some of the key barriers to transition, namely the availability of housing and of mental health services. The Permanent Supportive Housing program and its statewide expansion in the coming year are but the keystone to a multi-faceted housing strategy. OAAS is working closely with the Office of Behavioral Health and Magellan of Louisiana to improve timely access to community-based behavioral health services for individuals with mental illness seeking to return to the community from nursing homes.

A new Quality Improvement Strategy was implemented for Medicaid-funded HCBS waiver programs in January 2012 and was reported in last year's AMPAR report. The approach is more data-driven and outcome focused and shifts OAAS field operations towards training, technical assistance, sampling-based oversight, and performance management. The office has just completed its second round of data-collection using the new monitoring protocols and is able to see and report measurable improvements on all federally-reported performance measures. This work is also allowing the office to develop provider profiles from multiple data sources that provide a snapshot of individual provider business patterns and performance. Additional data for program management will become available with implementation of the OPTs participant tracking and plan of care system; a system that will also improve the efficiency of OAAS business processes.

Looking forward to SFY 14, the Office will be implementing several initiatives to assure program integrity in nursing facility and community-based programs. Techniques will include data-mining, access system audits, and reviews of continuing eligibility.

Overall, OAAS continues to meet internal objectives of operating and providing access to Medicaid long term care programs that provide over a billion dollars in direct services to people. In SFY 13, OAAS costs for administering and operating

these programs constituted less than 3% of the cost of services delivered.

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

Though average per person cost of community-based services may stabilize, cost-avoidance will continue and improve the state's ability to respond to ever growing demand for services to the older adult population. OAAS in concert with other offices within DHH has applied for and received initial approval to participate in the federal Balancing Incentives Program (BIP). BIP provides an enhanced match rate on community-based services to states that can demonstrate a shift in funding towards 50/50 spending on community versus institutional services. Anticipated implementation of BIP in SFY 14, OAAS, depending on federal interpretation of program rules, should 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?**

With respect to the strategic goal, "to expand existing and develop additional community-based services as an alternative to institutional care"; OAAS had requested approval from CMS to implement the new 1915 (k) state plan option as a replacement for the Long Term Personal Care Services program. This option provided a higher match rate. Due to an expansive CMS interpretation of program eligibility, OAAS and Medicaid determined this would actually increase state costs and would not be feasible. The decision was made to withdraw this request. OAAS and DHH are exploring other options such as the Balancing Incentive Program and managed long term support and services instead.

There is also less than expected progress with respect to two information technology issues that impact the program goal of "improving access and quality in long-term care programs". OAAS has been working to develop a web-based assessment and care planning system which would make the process of accessing and enrolling in community-based services more efficient and improving the ability to conduct real-time monitoring of participant plans of care. Implementation of this system was delayed by a DHH decision to make it the pilot case for a new software platform. At this point implementation is expected in early 2014.

Another technology issue was the inability to implement an electronic visit verification (EVV) system for OAAS/Medicaid home and community-based services. This system, which helps reduce billing errors and monitor for fraudulent billing, was to be part of the new Medicaid Management Information System (MMIS). However, the proposed EVV solution had significant shortcomings. With the subsequent cancellation of the new MMIS contract, implementation of EVV has been delayed.

• **Has your department revised its strategic plan/Business Plan to build on your successes and address shortfalls?**

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

Our successes are consistent with our current plan.

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

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

The vision that OAAS maintains on increasing access to home and community-based services as a sustainable, cost-effective alternative to nursing home care, in addition to improving access, efficiency, and quality in all OAAS programs, is key to integration of the OAAS strategic plan in other departmental processes such as budget and business plan development. Whether it takes the form of AMPAR reporting, LAPAS performance indicators, “transformative” business objectives, or budget explanations/justifications, OAAS strategic goals and objectives are clear, consistent over time and administrative changes, and understood by all OAAS staff. OAAS has been fortunate in having access to data that allows management and staff to monitor program outcomes, often against national goals and benchmarks. This allows OAAS to adjust strategies as needed to obtain office objectives. Because OAAS administers Medicaid funded programs, OAAS works very closely with that agency and with other offices in DHH to assure strategies and goals are aligned, even going as far as to share and report joint performance indicators with the Medicaid program.

**I. What significant department management or operational problems or issues exist?**

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

**II. What corrective actions (if any) do you recommend?**

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

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

### **B. Corrective Actions**

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

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

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

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
  - a. If so:
    - What is the expected time frame for corrective actions to be implemented and improvements to occur?
    - How much progress has been made and how much additional progress is needed?
  - b. If not:
    - Why has no action been taken regarding this recommendation?
    - What are the obstacles preventing or delaying corrective actions?
    - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?
5. Do corrective actions carry a cost?
  - No. If not, please explain.
  - Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

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

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

Contact person for more information:

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# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

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

**Department Head:** Kathy Kliebert, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Paige Hargrove, 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?

1. Started State EMS Registry.
2. An addition of a Level II Trauma Center Region 2 (Our Lady of the Lake Regional Medical Center – Baton Rouge)
3. The Louisiana Emergency Response Network (LERN) Board of Directors approved requirements for STEMI Receiving Centers, and the LERN Level 1, 2, 3, and 4 Stroke Centers. These requirements are based on national best practice and were recommended to the Board by the two state-wide stakeholder workgroups for stroke and STEMI.
4. The LERN Board of Directors approved: STEMI Triage Guideline for Pre-Hospital Providers, STEMI Guideline for patients self-presenting to STEMI Referral Centers, STEMI care process flow chart, Thrombolysis guidelines for STEMI Referral Centers, and LERN Stroke Care guidelines.
5. Supported disaster planning activities in each region across the state.
6. Achieved an agency best of 97.4% hospital participation with LERN.
7. LERN taught 32 Trauma Nursing Core Curriculum (TNCC) courses in 2012 with a total of 290 nurses obtaining certification in the core curriculum.

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

1. An EMS registry is a necessary step towards the development of a trauma system for the state.

2. Prior to Our Lady of the Lake achieving Level II Trauma Center Designation, there were only two verified trauma centers in the state – LSU New Orleans and Rapides Regional Medical Center in Shreveport with a huge gap in trauma care coverage. The services and requirements of a verified trauma center have a direct affect in decreasing mortality and morbidity of the injured. This also affects those most frequently injured (ages 1-44), allowing them to return to normal life activities and allows those capable to re-enter the workforce. Louisiana has the 8th highest mortality rate from injury in the nation. In the previous report, Louisiana had the 6th highest mortality rate from injury. Trauma centers have helped to change this statistic in a favorable manner.
3. STEMI and Stroke are both major health problems in Louisiana. STEMI is a time-critical illness resulting from complete closure of a major coronary artery, and causes significant morbidity and mortality. Stroke is the fourth highest killer of Louisiana residents. Research shows that systems of care for treatment of STEMI and stroke decrease morbidity and mortality. Establishing requirements for hospitals that treat these disease processes brings us one step closer to creating an inclusive system of care for patients afflicted with a stroke or STEMI.
4. These systems of care are significant because they provide direction/action steps for EMS and hospitals regarding how to achieve the best outcomes for STEMI and stroke patients.
5. Integration of LERN with ESF-8 is outlined in our enabling Legislation. As the 24 hour a day/365 day a year communications center resource, LERN serves as the “early warning” receptor of mass casualty events. When the LERN Communications Center is notified of a mass casualty that reaches ESF-8 trigger, LERN notifies the region(s) stakeholders and DHH leadership, allowing for mass casualty preparations. LERN participated in multiple table top exercises that proved effective when faced with the following live events: Military paratrooper live jump at Fort Polk, Williams-Olefins Explosion, CF-Industries explosion and multiple large mass casualty events at the regional level.
6. A functioning trauma system is an inclusive system that utilizes the resources of the most critical hospitals – adding the Willis-Knighton Health System to the LERN network of participating providers moves us in the direction of an inclusive system.
7. Trauma nursing as a discipline refers to the process and content of all the different roles nurses have in the care of the trauma patient. Knowledge is the core of any discipline. The purpose of TNCC is to present core-level knowledge, refine skills, and build a firm foundation in trauma nursing.

C. Who benefits and how?

1. The citizens of the State of Louisiana and any visitors to the State benefit because trauma centers and a trauma system have a direct correlation to improved care. The registry is the mechanism used to evaluate care provided and improve performance.
2. Anyone who sustains a significant injury within the state benefits from and

additional trauma center, especially those injured in Region 2. The LERN Medical Director provided strategic oversight for the development of Our Lady of the Lake's Trauma Program. This was accomplished via multiple conversations, multiple on sight visits and assistance with the requirements needed to meet trauma center designation/verification. These requirements include the development of a performance improvement program, physician call coverage, activation levels, CME requirements and surgeon response to the ED. Louisiana statute requires ACS verification for state designation as a trauma center. The LERN Medical Director is a reviewer for the American College of Surgeons trauma center Verification Review Committee (VRC) and a past chairman of the VRC. He performed a mock survey at Our Lady of the Lake (OLOL) to enable them to be successful in their actual review. This mock survey identified areas where improvement was needed. By addressing the identified weaknesses prior to the ACS survey, OLOL was able to achieve trauma center verification. The LERN Medical Director continues to provide support, leadership and consultation as needed for their program and for the other trauma centers in the state.

3. The citizens of Louisiana benefit when a system operates based on national best practice guidelines. Financially, everyone wins when patients are delivered to the right hospital, at the right time, for the right care.
4. The citizens of Louisiana benefit when a system operates based on national best practice guidelines. Financially, everyone wins when patients are delivered to the right hospital, at the right time, for the right care.
5. As LERN continues its development, it is the citizens of the state that benefit. Early notification in relation to disaster preparedness or in response to a mass causality event results in a coordinated response and better outcomes. Hospitals benefit from a coordinated response whereby patients are distributed evenly as not to overload facilities.
6. Severely injured trauma patients have greater inpatient survival in inclusive trauma systems even though they are no more likely to be hospitalized at a regional trauma center. Consideration should be given to continuing implementation of systems with an inclusive configuration, especially in light of other theoretical benefits of these systems, such as better dispersing of trauma care resources in the event of natural disasters or terrorist events.
7. Nurses providing the care and the recipients (injured patients) benefit from the TNCC outreach efforts. Offering these classes has resulted in a more confident and more skilled workforce in emergency rooms across the state.

D. How was the accomplishment achieved?

1. Achieved by including data sharing as a stipulation for EHRIT grant participants. For agencies who were not participating in the grant, we worked collaboratively with their software vendors to facilitate the export and import of their EMS data into the state EMS Registry.
2. Our Lady of the Lake made an extensive capital investment and human resource investment when deciding to pursue trauma center designation. LERN helped them achieve this via the support of our trauma Medical Director and via the

ongoing support of the LERN Communication Center.

3. Requirements for stroke and STEMI systems were achieved via the hard work of two groups: the STEMI state-wide stakeholder workgroup and stroke state-wide stakeholder work group. These groups were led by Dr. Murtuza “Zee” Ali and Dr. Kenneth Gaines, respectfully. Three tri-regional meetings consisting of physicians, nurses, administrators and EMS providers were held in Winnfield, New Orleans and Lafayette in order to educate regional stakeholders on the State systems for stroke and STEMI. The board approved plans were also communicated via the 9 LERN Regional Commissions.
  4. In addition to the actions taken in #3 above, LERN also developed a STEMI White Paper and a Stroke White Paper which has been a very successful tool to succinctly communicate our plan and the reasons why the state needs to develop these systems of care. These papers and all of the board approved documents can be found on the LERN website: [www.lern.la.gov](http://www.lern.la.gov).
  5. Support for disaster planning activities has been achieved via coordination between ESF-8 leadership and LERN leadership. We have also added disaster preparedness as a strategic priority. The tri-regional coordinators also worked closely with the Governor’s Office of Homeland Security and Emergency Preparedness (GHOSEP) rep on their commissions to embed LERN in more table top drills. Training of LERN staff with multiple mass causality regional drills to ensure competence.
  6. LERN increased hospital participation by keeping open lines of communication with our key stakeholders, being transparent in our intentions and reporting back outcomes related to our efforts.
  7. Teaching TNCC has been a “boots on the ground” effort. Many of the requests for the class originate from the regional commission members. These classes have made a big impact on our hospital participation (relates back to #6 accomplishment).
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)  
1-7 = Yes
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
1. Yes - In any system whereby you endeavor to improve performance you must have a data bank to benchmark performance.
  2. Yes
  3. Yes, it is a good example of engaging stakeholders to accomplish a defined goal.
  4. Yes, it is a good example of engaging stakeholders to accomplish a defined goal.
  5. Yes, leveraging assets between DHH agencies (LERN & ESF-8) and among law enforcement/industry provides efficiencies without duplication of service.
  6. Yes
  7. Yes

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

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

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

### 1. LERN Mission Sustainability

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

- Lessen or eliminate LERN's reliance on state general fund dollars
- Maximize LERN funding from recurring, dedicated source(s)

**Status:** Comparative research has been conducted for funding alternatives. 8 options identified. The Executive Committee determined that the best option is to add LERN to an Existing Statutory Dedication and Enhance the Revenue stream. Strategy: Possible legislation in 2014. LERN operations could be added into the intended purpose of the Traumatic Head and Spinal Cord Injury Trust Fund. Penalties in current law for various serious motor vehicle violations could be doubled with half the revenue funding LERN. We entered into a Low Income Needy Care Collaborative Agreement (LINCCA) for the Communication Center Staffing contract in order to leverage state general fund dollars.

### 2. Bureau of Emergency Medical Services (BEMS)

Investigate and explore potential opportunities for greater cooperation and integration between BEMS and LERN

- Identify and assess all major issues and challenges
- Define all potential benefits to a BEMS and LERN integration

**Status:** Via legislation in 2013, we pursued integrating LERN and BEMS. This was an unsuccessful effort. Since then we have continued to work collaboratively with BEMS and the EMS industry to achieve the best outcomes for the citizens we serve.

### 3. Statewide Trauma Center Network

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

- Leverage LERN's regional commissions and communications infrastructure
- Leverage Dr. Coscia's expertise and consulting support

- Strengthen partner relationships – LHA, LSMS, Health Standards/DHH, EMS, ESF-8/DHH, etc.

**Status:** Trauma White paper written and distributed to key stakeholders across the state. The LERN Website serves as a communication conduit and provides up to date information on the trauma system. We have a new Level 2 trauma center in Region 2. We have multiple education and injury prevention initiatives being implemented statewide via the region commission structure. Both injury prevention and education are key components of a trauma system. The LERN Medical Director is assisting North Oaks Medical Center in Hammond with becoming a Level 2 trauma center. Since 2012, 418 nurses have obtained certification in the Trauma Nursing Core Curriculum.

#### 4. STEMI Network

Develop a statewide system of STEMI care to improve outcomes for Louisiana citizens regardless of where they live in the state. System to include components recommended by LERN's STEMI Design the System workgroup:

- PCI Hospitals
- Non-PCI Hospitals – EMS

**Status:** Statewide dissemination of the STEMI plan has been completed. Attestation letters have been sent to all the hospital CEO's in the state and we have an 82% response rate, to date. The Louisiana Chapter of the American College of Surgeons has assigned a cardiologist to each of the 9 regional commissions to act as the STEMI champion for the region. The STEMI Whitepaper has been completed. The ESF-8 portal is near completion and we anticipate that we will assist in the routing of STEMI patients by 2014.

#### 5. Stroke Network

Develop a statewide system of stroke care to improve outcomes for Louisiana citizens regardless of where they live in the state. System to include final recommendations from the Stroke Design the System Workgroup relative to:

- Public recognition of stroke symptoms and community education
- Emergency/timely evaluation of all strokes
- EMS transfer protocols to facilitate timely administration of tPA
- 

**Status:** The state-wide stroke work group completed its recommendations for the development of a stroke system and these were adopted by the LERN Board of Directors. The plan has been disseminated to the state via three tri-regional meetings and via the 9 LERN Regional Commissions. Attestation letters have been sent to all the hospital CEO's in the state and we have an 82% response rate, to date. The Stroke Whitepaper has been completed and can be located on the LERN Website: [www.lern.la.gov](http://www.lern.la.gov). The system has the first comprehensive stroke center in the state – Ochsner Main, New Orleans.

## 6. State Registries for Trauma, Stroke, and STEMI

Establish statewide registries, consistent with national standards, for Trauma, Stroke, and STEMI. General purpose of these registries include:

- Facilitation of statewide and regional injury prevention efforts
- Facilitation of LERN performance improvement (Trauma System, Stroke System, and STEMI System – state level and regional)

### **Status:**

**Trauma Registry:** 4 hospitals are submitting data. The 2012 reports can viewed on the LERN website. LERN hosted a trauma registry course to educate registrars and encourage registry participation. We anticipate that there will be two additional hospitals submitting data by the end of 2014. There are currently over 13,000 patient records in the trauma registry. We must build on this in order to expand injury prevention and performance improvement efforts.

**EMS Registry:** Currently there are 4 agencies submitting data into the EMS registry: Baton Rouge EMS, Balentine, Caddo Fire District 1, and Bossier Parish EMS. We anticipate that by the end of 2014 we will have three additional agencies submitting data. LERN has a commitment from Acadian Ambulance which covers 60% of the state. Currently we have >100,000 patient records in the system. We plan to submit data to the National Emergency Medical Services Information System (NEMESIS) in 2014.

**STEMI Registry:** LERN has identified ACTION-GWTG as the preferred registry.

**Stroke Registry:** LERN is promoting GWTG as the preferred registry.

- ♦ **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. The same results would not have been achieved without specific departmental action.
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular

issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

Yes – Progress is directly related to specific department actions. The tri-regional coordinators work collaboratively with the 9 LERN Regional Commissions to further the trauma network and to build the networks for Stroke and STEMI. Our Lady of the Lake Regional Medical Center openly reports that the LERN Medical Director’s guidance and assistance in preparation for their site visit from the American College of Surgeons was critical to their successful verification as a Level 2 Trauma Center. The trauma registry and the EMS registry would not exist without LERN leading these efforts. The timely notification processes implemented to ensure key stakeholders are aware and responsive to regional events would not happen without the coordinated efforts of the LERN Communication Center and ESF-8 working together. Policies have been implemented and processes have been embedded into the LCC standard operating procedures. LERN has initiated, supported and implemented every aspect of the Stroke and STEMI system to date.

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

Specific department actions have directly related to the success of LERN. Examples include: DHH Health Standards Department has been integral in assisting with the development of rules and regulations for STEMI/Stroke, in answering questions related to EMTALA and providing general feedback on our efforts. Hugh Eley with Office of Aging and Adult Services has been helpful in research related to funding.

- 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?

Progress is expected to continue, but building systems takes time. It takes 2 years for a hospital to become a trauma center. We will continue to make incremental progress in trauma. We expect to see gains in Stroke and STEMI as well.

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

1. To what do you attribute this lack of progress? For example:
  - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in

another area?

- Is the lack of progress due to budget or other constraint?
- Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
- Other? Please specify.

We have made little progress lessening or eliminating LERN's reliance on state general fund dollars. While we have searched for grant opportunities we have not been successful in identifying available grant dollars that fit LERN's mission and strategy. Despite budget cuts, LERN has still made significant progress in the last year. We understand the funding alternatives utilized by other state trauma systems and we understand existing state dedications that could serve as practical alternative sources of recurring funding for LERN. It is not the right time politically to pursue those funding sources.

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

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

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

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

We contracted with a cardiologist to build the STEMI system. We entered into a LINCCA contract in order to leverage state general funds. We also added Disaster Preparedness as a new strategic priority.

No. If not, why not?

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

The Executive Director provides a report to the LERN Board of Directors (BOD) at least quarterly. This report includes progress to goals for each strategic priority. The strategic plan is completely re-evaluated annually by the LERN BOD. The LERN Regional Commissions are informed through the Tri-Regional Nurses and the LERN Administrative & Medical Directors.

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

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

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

#### A. Problem/Issue Description

1. What is the nature of the problem or issue?  
LERN operates on 100% State General Fund. This is problematic due to the fiscal condition of the state.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)  
To date, we have adjusted operations to absorb state funding cuts while still meeting our strategic priorities.
3. What organizational unit in the department is experiencing the problem or issue?  
Louisiana Emergency Response Network in the unit within the Department of Health and Hospitals. DHH has been very supportive and has worked with us in order to best prepare for budget adjustments.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)  
Fortunately, we have adjusted operations to prevent any cuts to the Communication Center and therefore continue to provide assistance to EMS and the ESF-8 network 24/7/365.
5. How long has the problem or issue existed?  
The state budget has been lean for the past 4 years.
6. What are the causes of the problem or issue? How do you know?  
Economic factors, big decrease in Federal Medicaid Match.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?  
Future cuts or changes to LINCCA will result in an inability to operate the communication center 24/7/365.

#### B. Corrective Actions

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

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

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

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

No. If not, please explain.

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

Please discuss the following:

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract  
Review of literature, other best practices, review of other state trauma programs, is performed by LERN staff and consultants, used to guide the implementation and continued development of the LERN Trauma and Time Sensitive Illness Network
- Program evaluation by in-house staff
- Program evaluation by contract  
Communications Center staffing provided by contract with AMR. Data is input to the Louisiana State owned ImageTrend system. This system software provides data on calls, time to definitive care, mechanism of injury and transport time.
- Performance Progress Reports (Louisiana Performance Accountability System)  
LERN reports Performance Indicators quarterly through the LaPas system
- In-house performance accountability system or process  
Monthly audits on Communications Center calls. Error statistics on data base with follow-up with each communicator.
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review  
The LERN Communicators are required to perform peer review audits on two calls per shift.
- Accreditation review
- Customer/stakeholder feedback  
Case review process
- 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. Name: Paige Hargrove, RN  
Title: Executive Director  
Agency & Program: Louisiana Emergency Response Network  
Telephone: (225)756-3440  
E-mail: [paige.hargrove@la.gov](mailto:paige.hargrove@la.gov)
  - a) LERN Annual Report to the Louisiana Legislature and the House and Senate Health and Welfare Committees – submitted in March in compliance with the 2004 LERN Enabling Legislation
  - b) Monthly Fiscal Reports submitted to LERN Treasurer, Chairman of the Board and discussed at LERN Board meetings.

# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

**Department:** Department of Health and Hospitals  
09-325 Acadiana Area Human Services District (AAHSD)

**Department Head:** Kathy Kliebert, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Brad Farmer, CEO

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

For each accomplishment, please discuss and explain:

**National Accreditation**

- A. What was achieved? **National accreditation – a 3 year award from CARF International, the highest level of accreditation possible.**
- B. Why is this success significant? **First, national accreditation is required by the SMO as Louisiana moves toward a managed system of care; secondly it demonstrates competence and commitment toward internationally recognized standards of practice; and it provides a foundation for AAHSD to operate more effectively and efficiently.**
- C. Who benefits and how? **Clients benefit as the organization increases the use of ‘best practices’ and also monitors significant clinical indicators to ensure the effectiveness of services. Additionally, AAHSD has implemented a quality improvement (QI) process and also monitors service access. The community at large and funders of services benefit as AAHSD demonstrates its competence in both administrative and clinical operations, along with the additional accountability of the accreditation review cycle.**
- D. How was the accomplishment achieved? **The development and implementation of an organizational Policy/Procedure manual and other supporting documentation, staff training, the designation and leadership of an ‘Accreditation Team’, and an on-site review by a CARF survey team.**

- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) **Yes**
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? **Yes**

### **Relocating Developmental Disabilities Office**

- A. What was achieved? **Relocating our Developmental Disabilities office/staff into the main AAHSD building.**
- B. Why is this success significant? **The financial savings to the organization is significant. Also, this move helps with the overall development of the District – it ‘operationalizes’ the two service units into one service delivery organization.**
- C. Who benefits and how? **Clients and the community at large benefit from the recurring savings as this allows AAHSD to expand services and better utilize the available resources. Staff benefit from the increased availability of training, cross-training, and enhanced communication.**
- D. How was the accomplishment achieved? **Cooperative efforts by management and staff. The Senior Management Team initiated the plan and then empowered the ‘chain of command’ to develop and implement the needed actions. This was supported by the Board of Directors and Executive Management.**
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) **Yes**
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? **Yes**

### **Implementation of Agency Website**

- A. What was achieved? **AAHSD website launch. (www.aahsd.org)**
- B. Why is this success significant? **This allows AAHSD to increase its availability and communication to the community we serve.**
- C. Who benefits and how? **Clients have 24 hour access to updated information regarding events, services, program locations, ... At this time the site is not ‘interactive’ but plans are underway to expand this system to allow for greater access to services as clients will be able to complete some preliminary intake information as a way to decrease waiting times and to help with ‘triaging’ services. Staff has 24 hour access to Policy/Procedure manual and other internal documents. Also posted for public view are Board announcements and minutes, management reports, strategic plans, and satisfaction survey information. This enhances our efforts to comply with the ‘Open Meetings Law’ and provides for transparency in our operations.**
- D. How was the accomplishment achieved? **A team comprised of senior managers and IT personnel were charged with the task of developing this site. Input was offered by program personnel as to specific content. A contract vendor was selected per bid process and assisted with technical aspects of this site.**
- 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**

### **Prevention**

- A. What was achieved? **AAHSD Prevention program staff, along with contractors, were able to make more Prevention contacts utilizing the same budget and contracts/ors as compared to the previous fiscal year.**
- B. Why is this success significant? **This is significant due to the overall impact of Prevention services in educating youths about the dangers of alcohol, drug, and tobacco use.**
- C. Who benefits and how? **The persons participating in the education activities, as well as their families, benefit from greater chance of not using substances that may lead to addiction.**
- D. How was the accomplishment achieved? **Contractors, under the direction of AAHSD Prevention staff, were able to coordinate with the local school systems to maximize their efforts and contact a greater numbers of students (75,122 contacts).**
- 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**

### **Pharmacy**

- A. What was achieved? **AAHSD's pharmacy generated over \$5M in Patient Assistance Program (PAP) medication for clients last fiscal year.**
- B. Why is this success significant? **The PAP program is designed to assist clients in obtaining their medications at little to no cost to the client or AAHSD.**
- C. Who benefits and how? **Clients benefit from this as they receive needed medications they otherwise may not be able to afford/obtain. AAHSD is able to utilize resources to provide medications to other clients who otherwise may not be able to afford/obtain medications and may not qualify for PAP medications.**
- D. How was the accomplishment achieved? **PAP staff works under the supervision of the AAHSD Pharmacy Director. The Pharmacy Director and Medical Director maintain close communication to ensure the success of this program.**
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) **Yes**
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? **Yes**

### **Local Governmental Entity (LGE) Readiness Criteria**

- A. What was achieved? **Successful completion of Phase II of the Local Governmental Entity (LGE) Readiness Criteria assessment process as developed by the Department of Health and Hospitals (DHH).**
- B. Why is this success significant? **This is a requirement of DHH in transitioning**

**administrative and programmatic operations from DHH to the LGE.**

- C. Who benefits and how? **Clients benefit as the organization is allowed to develop and implement programs/initiatives based upon local needs. The community at large also benefits as it is allowed to become more involved in the direction/vision/planning of local services.**
- D. How was the accomplishment achieved? **This accomplishment was achieved by the successful development/implementation of a Board Governance manual and Bylaws, the development/implementation of an operational Policy/Procedure manual, staff training, and an on-site review by a DHH assessment team.**
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) **Yes**
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? **Yes**

## **II. Is your department five-year strategic plan on time and on target for accomplishment?**

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

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

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

**AAHSD is progressing towards accomplishing goals and objectives, such as: developing clear policy objectives; providing behavioral health treatment services as part of the State’s continuum of care; improving accessibility; increasing stakeholders’ involvement; and, providing quality services and supports. These strategies are effective in ensuring persons served receive the highest quality care.**
- ♦ **Where are you making significant progress?** If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
  1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular

- areas? Have you initiated new 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?
- a. **AAHSD is on target for making the progress that was projected in the five-year Strategic Plan. Progress is due largely to reorganizing our internal structure, developing new policies and procedures, utilizing the expertise of the Governing Board, conducting staff training, and implementing a team structure and approach to management. We are continually working to improve policies/systems and making necessary changes to become more effective and efficient.**
  - b. **Progress is expected to continue on an 'on-target pace' as we conduct regular ongoing meetings of teams (Accreditation, Health/Safety, Quality Improvement, and Senior Management), participate in ongoing external reviews, and conduct ongoing internal reviews. Our efforts so far have not been 'one-time events' but the building of infrastructure and operating systems to ensure ongoing success.**
- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:
1. To what do you attribute this lack of progress? For example:
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
    - Is the lack of progress due to budget or other constraint?
    - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
    - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?  
**None**
- ♦ **Has your department revised its strategic plan to build on your successes and address shortfalls?**
- Yes. If so, what adjustments have been made and how will they address the situation?

No. If not, why not?

**The AAHSD five-year Strategic Plan gave a clear overview of goals and objectives to accomplish. The plan fully encompasses administrative and programmatic issues for ongoing review/improvement.**

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

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

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

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

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

#### **A. Problem/Issue Description**

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

## B. Corrective Actions

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

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

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

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

4. Are corrective actions underway?

a. If so:

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

b. If not:

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

5. Do corrective actions carry a cost?

- No. If not, please explain.  
 Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house  
**QI Team reviews client charts quarterly.**
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)  
**LAPAS Reports**
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)  
**Contract Monitoring**
- Peer review  
**Medical Doctors and OCDD peer review process**
- Accreditation review  
**CARF Accreditation—AAHSD received a 3-year accreditation**
- Customer/stakeholder feedback
- Other (please specify):  
**Human Services Accountability and Implementation Plan (AIP)  
monitoring visits by OBH and OCDD**

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

- Yes. Proceed to Section C below.

No Skip Section C below.

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

1. Title of Report or Program Evaluation **AAHSD Management Report**
- 2.
3. Date completed **June 2013**
4. Subject or purpose and reason for initiation of the analysis or evaluation  
**The AAHSD Management Report is offered as partial fulfillment of the standards set forth by CARF and is designed to summarize the results of the program plans; quality assessment; goals and objectives; the data collected in the areas of effectiveness, efficiency, service access, and consumer satisfaction; and from other operating systems and to provide a synopsis of 'significant events'.**
5. Methodology used for analysis or evaluation  
**Review of AAHSD systems including: Corporate Compliance, Health and Safety (including Accessibility), Human Resources, Information Management, Outcomes Management System, Quality Improvement, and Risk Management.**
6. Cost (allocation of in-house resources or purchase price) **In house resources**
7. Major Findings and Conclusions
  - **AAHSD Policy and Procedure Manual (operational) and Phase II requirements have been reviewed and approved by the Readiness Assessment Team.**
  - **AAHSD has signed MOUs with DHH for the operation of all programs previously operated by OBH and OCDD.**
  - **AAHSD's 2013/2014 budget has been developed and submitted per Division of Administration (DOA) requirements (*at the time of this report, the 2014/2015 budget has also been submitted*).**
  - **Contracts have been reviewed and developed, professional and service contracts have been transitioned to AAHSD.**
  - **A corporate compliance program has been initiated and the compliance officer has direct supervision of contract monitors.**
  - **New AAHSD policies have been approved by State Civil Service.**
  - **Employees have completed Civil Service PES as required.**
  - **The AAHSD Human Resource office has successfully completed a Civil Service audit.**
  - **AAHSD has received a 3 year CARF Accreditation.**
  - **AAHSD has been credentialed by the State SMO (Magellan).**
  - **AAHSD has conducted and/or participated in numerous public events, health fairs, community forums, and other professional forums.**
  - **AAHSD has assumed operation of services, including the provision of crisis services within our designated area.**

- **AAHSD participated in the development of a mental health court, with the intent of decreasing the need for crisis services to a subset of the service population.**
- **AAHSD has supported other organizations in their efforts to provide crisis services to the community – either through education/training opportunities, funding and/or referrals.**

**This report was made available to the Governing Board, all staff, and copies were available in all service locations for clients/visitors. A copy was sent to senior DHH officials as well as the entire ‘Acadiana Delegation’. Additionally, this report is posted on our website for public view.**

8. Major Recommendations **None**
9. Action taken in response to the report or evaluation **None**
10. Availability (hard copy, electronic file, website)  
**Located in the policy and procedure manual and website**
11. Contact person for more information, including  
**Name: Brad Farmer**  
**Title: CEO**  
**Agency & Program: AAHSD**  
**Telephone: 337-262-4190**  
**E-mail: Brad.Farmer@la.gov**

# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

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

**Department Head:** Kathy Kliebert, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** J.T. Lane, 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?

**Center for Environmental Health:**  
**Sanitarian Services Lean Six Sigma Project:**

Sanitarian Services has successfully implemented the Lean Six Sigma Project management tools and processes that were piloted the previous year. Lean Six Sigma is a customer-focused improvement methodology that is designed to increase quality while reducing waste. The tools used during the pilot have provided a method that allows Sanitarian Services to manage the inventory of over 33,000 active retail food and institutional permits statewide. The project also resulted in the development of a scheduling tool that ensures these permitted establishments are inspected according to their risk category (there are 4 risk categories). Each establishment is assigned a risk category which in turn dictates the minimum number of inspections that are required during a 12 month period.

**Sanitarian Services Reorganization**

The transfer of positions, creation of new positions, and consolidation of superfluous positions has been achieved. Efficiencies have been realized by eliminating three administrator positions whose duties will be performed by administrators of newly-

consolidated programs with closely related functions and creating a new command hierarchy consisting of a director and two subordinate chief sanitarians to oversee specialty and field operations for the programs.

Historically, Sanitarian Services has operated on a regional structure with Central Office staff exercising only limited direct supervision over sanitarian and clerical staff.

Approximately 200 sanitarians were broken up across the nine OPH regions and supervised fewer than nine distinct chains-of-command. This led to difficulties in implementing statewide policies and procedures and additional problems in ascertaining the appropriate steps when taking requisite enforcement actions.

### **Engineering Services' Response to Hurricane Isaac**

DHH OPH Engineering Services staff was highly effective in their response to the Hurricane Isaac Incident by:

- Collaborating with state and local officials to determine the areas and drinking water facilities impacted by the hurricane.
- Providing technical assistance to water system personnel to restore the operations of the drinking water facilities in order to provide safe drinking water to their customers.
- Conducting assessments of drinking water systems in the affected areas and collecting bacteriological samples from the distribution systems.
- Generating and issuing Safe to Drink and Not Safe to Drink Reports twice per day.
- Staffing the Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP) Emergency Support Function (ESF) 12 desk during day and night shifts.

### **Improvements to Technology:**

#### **Continued expansion of the Louisiana Health Information Exchange (LaHIE)**

From January to June of 2012, efforts made to achieve fully operational connectivity between LaHIE and OPH with respect to its ability to share information regarding immunizations, electronic lab reporting, and syndromic surveillance data were successful. In July 2013, LaHIE will have the ability to facilitate public health reporting in Louisiana by connecting providers with organizations such as the Office of Public Health and the Louisiana Immunization Network for Kids Statewide (LINKS) through its web portal.

#### **Consolidation of Software Programs in the Parish Health Units (PHU)**

For many years the 64 parish health units in every part of the state used an assortment of applications cobbled together to accommodate various needs by the programs that provide clinic services. These applications were completely standalone and primarily accommodated billing requirements for the various clinics. In collaboration with the Louisiana Health Care Quality Forum (LHCQF), OPH has begun the process of replacing these various non-integrated applications with a fully featured Electronic Health Record (EHR) that will not only replace these applications, but also give us practice management and billing capabilities OPH has not previously been able to take advantage of.

Requirements were gathered in collaboration with administrative, medical and health unit staff. A request for proposal was released and scored, demos were provided, and OPH is

in the final stages of providing details to allow the selected vendor to make a final cost proposal.

### **Technological Updates for Sanitarian Services**

Starting in FY2012, OPH embarked on a Lean Six Sigma Project (LSS) focusing on its Environmental Health Sanitarian Unit. One of the tools that the LSS determined was needed by the field sanitarians was a comprehensive, statewide inspection scheduler system. Detailed specifications were developed, including not only food inspections, but on-site wastewater and engineering as well. As of this report, the project was first attempted under sole source authority because there is only one vendor that provides all the functionality needed in a comprehensive package while remaining affordable. This was rejected, so a bid process has been initiated. The PST committee meeting expected to approve the bid documents will meet in November 2013.

### **Louisiana Public Health Information Exchange (LaPHIE)**

One important job for the Louisiana Office of Public Health (OPH) is ensuring that Louisianans with infectious diseases learn about their diagnosis and receive appropriate medical care. For certain conditions (including HIV, syphilis and tuberculosis), OPH works to fulfill this duty by sending staff to speak with newly diagnosed patients about the importance of undergoing proper treatment. However, such methods cannot reach every Louisiana patient with an infectious disease. Sometimes, OPH cannot locate patients after an initial diagnosis has been made. Other times, patients may drop out of care years after learning that they have an infectious illness. With the above challenges in mind, OPH partnered with seven Louisiana State University (LSU) Health Care Services Division hospitals to create the Louisiana Public Health Information Exchange (LaPHIE). The exchange uses OPH's surveillance data to alert LSU clinicians that a patient might have an untreated case of HIV, tuberculosis or syphilis requiring a doctor or nurse's attention. In the last year, not only has LaPHIE been maintained with the privatization of the LSU hospitals, but significant progress has been made with Our Lady of the Lake to expand this intervention to the private sector as well.

### **Center for Community and Preventive Health:**

#### **Implementation of the Louisiana Electronic Event Registration System (LEERS)**

##### **Modules**

Through a collaboration between Children & Youth with Special Health Care Needs Programs and Vital Records, LEERS modules were developed which perform the following: 1) supports the newborn screening component of the Genetic Diseases Program, 2) accomplishes the development and implementation of the Birth Defects Database LEERS Integrated Surveillance System which will interface with other Title V CYSHCN programs including HSV and Genetics and 3) utilizes a secured web-based tracking and surveillance system that will meet nationally endorsed health information interoperability standards developed for the LA Early Hearing Detection and Intervention (LA EHDI) Program. The LA EHDI information system (LA EHDI-IS) will be capable of generating comprehensive screening, follow-up and early intervention data reports for all birthing hospitals to accurately assess progress towards the national goals of screening by 1 month, diagnostics by 3 months and early intervention by 6 months. The system

allows for the collection of data that is unduplicated and individually identifiable throughout the entire EHDI process.

### **Transition of AIDS Drug Assistance Program Prescriptions from LSU Hospitals to OPH Pharmacy**

The Office of Public Health (OPH) completed the transition of Louisiana AIDS Drug Assistance Program (LA ADAP) prescription distributions from LSU hospitals to the Center for Community and Preventive Health Pharmacy Section due to the public-private partnerships that transitioned service from Louisiana's charity hospital system. The OPH Pharmacy began filling prescriptions for the LA ADAP clients in the Baton Rouge area within one month of initial notice of the merger. Clients were transitioned over a three month period as the hospitals merged. The transition was completed by June 30th.

### **Emergency Medical Services**

This year the Bureau of EMS (the Bureau) implemented the first phase of the new Education Standards and developed the Louisiana EMS transition toolkit documents. These toolkits have been adopted as the National EMS transition toolkit for the use of all 56 states and territories. The Bureau of EMS worked hard at maintaining the current levels of productivity with a continuously shrinking staff and budget authority. All EMS Professional Licensure requirements were met in a timely fashion and while there was a delay in conducting EMT Certification Exams, the Bureau of EMS was able to meet all of its demands with a less than adequate number of staff.

### **Moving towards Public Health Accreditation**

While activities towards bringing the Office of Public Health closer to the official stages of public health accreditation began in FY12, OPH saw an increased level of activity and participation in the process across all departments in FY 13. The National Public Health Improvement Initiative Grant (NPHII) is now in year three and one of the major goals is for the Louisiana Office of Public Health to obtain accreditation. OPH has received an initial readiness assessment and roadmap prepared by a consultant from the Missouri Institute for Community Health. Through the work performed by the consultant as well as OPH staff, gaps have been identified and efforts began to address the issues raised by this gap analysis. A Community Health Assessment was also developed and in FY14 will be broadened in scope to include more external stakeholders in the process of prioritizing health initiatives that will drive state health improvement processes.

B. Why is this success significant?

### **Center for Environmental Health Sanitarian Services-Lean Six Sigma Project**

The success of the Lean Six Sigma project has allowed Sanitarian Services to better manage the day to day activities and prioritize the needs of the public and the industry. There are many additional activities other than retail food and institutional inspections that are not predictable in scope or nature. These activities are conducted by Sanitarians on a daily basis. By efficiently managing those activities that are predictable, we now have the time to prioritize our response to the unpredictable events and the ability to

accomplish more work in a timely manner while providing better service to our customers.

Ultimately, this allows Sanitary Services more capability to protect the public by ensuring the correct number and type of inspections/activities are conducted in a given time period.

### **Sanitarian Services Reorganization**

The successful reorganization is significant as it provides a much needed continuity in services and flow of information. The newly-consolidated programs are functionally similar and will allow for cross-training which will improve the efficiency and effectiveness of staff.

### **Engineering Services' Response to Hurricane Isaac**

Engineering Services was able to determine which water systems were affected by the hurricane winds and floodwaters. Bacteriological samples were collected and analyzed in order to verify the quality of the drinking water that was being delivered to the public. The reports generated on a daily basis informed the public of whether the water they were receiving was safe or not safe to drink. The agency used press releases, social media, and other means of messaging to keep the public informed. This success was significant because safe drinking water is critical in protecting the health of everyone in Louisiana and a necessity for the recovery process after a storm.

### **Improvements to Technology**

#### **Continued expansion of the Louisiana Health Information Exchange (LaHIE)**

This is a significant step toward the advancement of improved health service delivery, more appropriate and individualized provision of care, and faster detection of public health emergencies. The end goal of this project is to provide the ability for information to be effortlessly shared between providers, and from providers directly to the appropriate state offices for processing.

#### **Consolidation of Software Programs in the Parish Health Units (PHU)**

Putting a more robust software program in the health units provides a more functional health record for a patient, regardless of which location they may visit. It also allows for enhanced billing capabilities, which will enable OPH to more fully recoup costs associated with providing many of the services that can be reimbursed.

#### **Status of Technological Updates for Sanitarian Services**

The scheduling system that has been requested will allow for seamless integration of licensing, inspections, enforcement, and laboratory functions in order to eliminate duplication of data entry. It will also automate the workflow and scheduling of inspections, leading to greater consistency and accuracy while allowing staff to conduct more inspections. While the procurement process has been particularly challenging, many OPH staff hours have been spent creating documentation that will lead to a solution with all the features needed to realize the expected benefits.

#### **Louisiana Public Health Information Exchange (LaPHIE)**

Louisiana was ranked 3<sup>rd</sup> in HIV case rates, 3<sup>rd</sup> for Chlamydia, 1<sup>st</sup> for gonorrhea and 1<sup>st</sup> for syphilis in 2011. These are critical diseases for Louisiana to target for direct intervention. Utilization of the LaPHIE system results in a high level of secure communication between public and private health partners regarding patients who are in need of testing and/or treatment. These interactions greatly increase the likelihood that a patient with untreated syphilis, tuberculosis, or HIV receives notification of and treatment for his or her infection(s) regardless of whether they are entering a public health facility or a partner facility participating with OPH to use the LaPHIE system.

### **Implementation of the Louisiana Electronic Event Registration System (LEERS)**

#### **Modules**

Louisiana is the first state to develop these three modules within its electronic vital records system. The application of the Genetics LEERS Module is significant because it will reduce the need for additional staff to enter demographic data manually since it will be obtained electronically directly from the hospital. This will also decrease the number of data entry errors.

The Birth Defects Database is significant because since mandated by law in 2001, Louisiana Birth Defects Monitoring Network (LBDMN) has never had an electronic database for the collection, processing, analysis and reporting of birth defects data. Manual processes for each phase of birth defects surveillance have been cumbersome which has directly affected the quality and timeliness of birth defects data. In 2010, LBDMN was awarded a CDC State Implementation Grant for the major purpose of creating a web-based surveillance system.

The LA EHDI-IS will improve the collection and reporting of complete, child-specific data for every birth through the three components of the EHDI process which include screening, diagnostics and early intervention. The web-based tracking and surveillance system will improve mechanisms for tracking, reporting, and linkage to follow-up services for children at risk for and/or identified with late onset or acquired hearing loss. The Information System will assure data linkage among child health programs and lead to improved follow-up and ensure that LA EHDI has access to all demographic data submitted to vital records, capturing data necessary for complete and accurate CDC reporting.

#### **Transition of AIDS Drug Assistance Program Prescriptions from LSU Hospitals to OPH Pharmacy**

If OPH Pharmacy had not assumed the transition of prescription distribution services, LA ADAP clients would have been without prescription access. The merger of the LSU hospital system with private entities voided the 340B contract pharmacy arrangement between LSU hospital pharmacies and the LA ADAP. As a result, the LSU pharmacies could no longer fill prescriptions for clients accessing medication services through LA ADAP. Due to HRSA 340B registration policy, it would have been six months before a new 340B contract pharmacy arrangement could be in place.

Without this successful collaboration, clients would have risked a gap in services and experienced an interruption in pharmaceutical treatment. Such an interruption could have

caused failure of virologic suppression or caused mutations in a person's HIV that would have been untreatable with current medications.

### **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 in one case and it has never been updated. This new process will eliminate out of date curriculums from being taught in the classroom.

The ability to obtain timely licensure is critical to the provision of state health services for the public. Without licensed EMT's and Paramedics, the citizens of the state will not be able to be transported and cared for in the pre-hospital setting and this, in turn, could cause levels of morbidity and mortality to rise.

### **Moving towards Public Health Accreditation**

Accreditation signifies that the best possible services are being offered to keep a community healthy and drives health departments to continuously improve the quality of their services. Having a public health structure consistent with the overall objectives of public health accreditation allows for future planning efforts to become and remain consistent with quality and performance improvement. These activities are and will continue to allow OPH to address gaps in infrastructure. By participating in the process of accreditation, health leaders can help demonstrate to external agencies their capacity to respond to public health threats.

## C. Who benefits and how?

### **Center for Environmental Health: Sanitarian Services Lean Six Sigma Project**

The 24 million citizens and visitors to the State of Louisiana are currently and will continue to benefit from the efficiencies and management tools put into place by Sanitarian Services. This benefit comes in the form of heightened confidence that basic public health elements such as safe food, proper sewage disposal, environmental complaints, and institutional facilities are being inspected and regulated using United States Food and Drug guidelines and that these guidelines have been adopted by the state. This will ensure continuity in the Sanitarian Services programs both now and in the future.

### **Sanitarian Services Reorganization**

The benefits realized from the reorganization are felt by the agency, the sanitarians, the industry and the public. The agency is improved through enhanced efficiency of information flow, reduction in operating expenses, and improved resource allocation and logistics. The sanitarians benefit by having a single chain of command for both

administrative and programmatic issues. They are supervised by other registered sanitarians that provide guidance and direction regarding the Louisiana State Sanitary Code regulations and interpretations. The industry benefits due to enhanced standardization of information and processes, while the public sees an improvement in sanitary services through the frequency and standardization with which inspections are performed across the state.

### **Engineering Services' Response to Hurricane Isaac**

Safe drinking water benefits all Louisiana residents. This particular effort directly benefits the residents of the areas that were impacted by Hurricane Isaac.

### **Improvements to Technology**

#### **Continued expansion of the Louisiana Health Information Exchange (LaHIE)**

There are many beneficiaries for this project. First, smaller providers that do not have the ability to create and manage their own electronic health records can become part of this exchange, achieve Meaningful Use (MU) incentives for meeting the practice management and public health reporting requirements, and share patient records under carefully controlled conditions between the other members of the exchange, ultimately joining with other state and federal exchanges. Patients who attend one or more of the facilities that are part of this exchange can reap the benefits of having their health information available to all the providers who may be seeing a given patient. Finally, this exchange will incorporate the consolidation project described below, further enhancing the information exchange and allowing our own health units to complete their public health reporting requirements in order to realize the MU incentives.

#### **Consolidation of Software Programs in the Parish Health Units (PHU)**

Both the patients and staff of the health units will benefit if the costs to operate can become more manageable through the use of proven technology. Many program areas that fund services in the health units will also be able to provide more services to more individuals if some of the costs are reimbursed properly. Patients who present at more than one location will not have duplicate tests and/or treatment.

#### **Status of Technological Updates for Sanitarian Services**

Sanitary Services staff will experience a significant increase in productivity as the new scheduler system decreases the need for manual entry of data, maintains all data in one location, and reduces paperwork for field staff. This will allow field sanitarians to spend more time and effort interacting with their partners and clients. Permits will be issued in a more timely way and inspections will be conducted on time, leading to better food and water safety for Louisiana.

#### **Louisiana Public Health Information Exchange (LaPHIE)**

Connecting individuals who are untreated for diseases that have diseases of high prevalence in Louisiana to treatment improves both individual and population health—especially in light of recent research which shows that persons taking HIV antiretroviral medications are less likely to transmit the disease. In addition, early identification of infection also minimizes the risk that an infection will be passed from mother to child

through vertical transmission. Any TB, HIV, or syphilis infection averted avoids significant costs of care to the public and private health system for both children and adults and eliminates subsequent possibilities of disease transmission.

### **Implementation of the Louisiana Electronic Event Registration System (LEERS) Modules**

The beneficiaries of the LEERS Genetics module include the following:

- OPH Laboratory – This will decrease the need for additional data entry staff and result in decreased data entry errors.
- Genetic Diseases Program – Having the legal name and additional pertinent information of an infant suspected of having a metabolic condition will help improve identification of the infant and subsequent follow-up.
- OPH Performance Measures – The LEERS Module will help identify infants who may not have had a newborn screening test sooner and to implement action to ensure that these infants obtain a test. This will help the Genetic Diseases Performance Measures remain at 99%.

Implementation of the Birth Defects Database in Year 4 of the 5 year CDC grant will not only demonstrate our ability to accomplish the goals of the grant, but will also allow us to process existing data and produce meaningful analysis and reporting in the final year of the grant. Financial benefits include meeting the criteria to qualify for additional CDC support. Stakeholder benefits include accurate and timely data for families, public and private health partners, diagnosis-related peer support organizations, and policymakers.

Physician and audiology providers will be able to submit follow-up service reports electronically. Additionally, physicians and audiologists will be able to access hearing screening and follow-up services for their patients through the web-based system. Hospital personnel will be able to access statistical reports to determine the success of their program and determine specific areas in need of improvement. Families will benefit from an efficient system that will reduce the number of infants lost to follow-up and save children critical developmental and language learning time.

The Hearing, Speech, and Vision Program is required to report annually to the CDC on extensive data that is compiled and analyzed by the CDC to determine differences among socioeconomic, race/ethnicity, gender and maternal characteristics. By acquiring and analyzing data within a timely and accurate information system, we will be able to determine the impact of hearing loss on children and their families and document improvements in infant and family outcomes. This will allow the program to identify gaps within and among different groups and compare our progress with other states and national trends. This required CDC data will also be included in national data analysis, which will allow Louisiana to be measured against our peers in other states.

### **Transition of AIDS Drug Assistance Program Prescriptions from LSU Hospitals to OPH Pharmacy**

The benefits of this successful transition is to the over 2,000 ADAP clients (low income

persons living with HIV) who would not have had access to prescriptions provided by the program. It is critical that these clients continue their medication regimen uninterrupted to avoid treatment failure and medication resistance. From a public health standpoint, patients who maintain their HIV medication regimen have a greatly reduced rate of viral transmission, thereby lowering the number of potential new cases of HIV transmission. This not only saves lives but also minimizes the burden on public health.

The OPH Pharmacy has also benefited by allowing staff to further their knowledge about HIV and the medications used for treatment. The addition of this program has also offered the opportunity to interact with new clients and providers and given OPH Pharmacy staff the satisfaction of providing a much needed service.

### **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 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 that were not updated on a regular basis. Loss of licensure could result in citizens of the state not being able to be transported to local hospitals in their time of need. This could also result in the closure of some local ambulance services due to their inability to bill for their services because of the non-availability of licensed personnel to staff their ambulances. Closure of ambulance services and/or loss of licensure could cause embarrassment to the state as a whole in that we would be seen as not being able to serve the citizens and meet their pre-hospital care and transportation needs.

### **Moving towards Public Health Accreditation**

When a public health agency obtains public health accreditation, the benefits immediately extend to internal and external partners, the agency itself, and the public. Accreditation creates a system of consistency among health departments so that communication can be more easily streamlined both in daily activities and in response to public health threats. By participating in the process to obtain accreditation, workforce development is improved through team building activities, training opportunities, and a proactive approach to emergency response. As programs work with one another during this collaborative approach towards accreditation, the process of applying for grants and programs also becomes more efficient and streamlined. Accreditation has also been shown to enhance recruitment and retention of high quality workforce through reputation and enhanced work environments. An agency that has achieved public health accreditation is one that can demonstrate to the public that it is capable of providing the highest level of services possible while constantly improving its level of efficiency, quality improvement, and performance management. During a time in which fiscal responsibility is paramount to an agency's reputation, the title of accreditation serves to ensure the citizens for whom it serves that it is taking full advantage of the funding appropriated to its programs.

D. How was the accomplishment achieved?

**Center for Environmental Health  
Sanitarian Services-Lean Six Sigma Project**

The LSS project required a thorough analysis of the activities occurring in Sanitarian Services. This analysis gave the Center for Environmental Health Leadership the opportunity to identify areas for improvement. After completing a thorough root cause analysis, tools and processes were developed and implemented to address the areas targeted for improvement. Implementation required methodical face-to-face training and coaching to all field operations sanitarians statewide. Frequent follow-up conversations and reporting are done to ensure the continuity and accuracy of the tools and management routines that have been put into place.

**Sanitarian Services Reorganization**

Successful completion was largely due to a high level of OPH Administration support. There were many plans of action submitted and ultimately approved by the Administration. This effort took a great deal of communication and coordination with Civil Service, DHH and OPH Human Resources, Operations and Support, and the Travel Office to process requests and paperwork changes.

**Engineering Services' Response to Hurricane Isaac**

The engineering team was able to mobilize quickly, determine the impacted water systems, collect and analyze water samples in the affected areas, and assess sample results to determine if water supplies were contaminated. This was possible due to both pre-planning efforts and strong collaboration within the team and between the team and its external partners.

**Improvements to Technology**

**Continued expansion of the Louisiana Health Information Exchange (LaHIE)**

The Louisiana Health Care Quality Forum (LHCQF) has led this project, in collaboration with OPH administrative and project management staff, including the Electronic Laboratory Reporting Coordinator, the Syndromic Surveillance Coordinator and the Immunizations staff.

**Consolidation of Software Programs in the Parish Health Units (PHU)**

This project is being completed under collaboration with the LHCQF, the agency managing LaHIE, and administration and project management staff from the Office of Public Health, along with the Department of Health and Hospitals' Information Technology section.

**Status of Technological Updates for Sanitarian Services**

Environmental Health, Onsite Wastewater, Engineering, and OPH Administrative staffs have worked many hours on creating the comprehensive specification documents, and OPH has worked closely with Contracts to route the appropriate paperwork.

**Louisiana Public Health Information Exchange (LaPHIE)**

This project has been funded through Special Projects of National Significance grants from HRSA, and implemented through a cooperative agreement with OPH, LSU HCSD, and recently, Our Lady of the Lake.

**Implementation of the Louisiana Electronic Event Registration System (LEERS)****Modules**

This accomplishment was achieved through the collaboration of the Genetic Diseases, Hearing, Speech & Vision and Birth Defects Monitoring Programs, OPH Vital Records Unit, and DBSysgraph (the developer of the module). Support from Executive Leadership within the Office of Public Health was also instrumental in making this accomplishment a reality. The teams and activities involved in accomplishing the creation and implementation of the BDDLSS included CDC funding; Center for Connected Health Policy (CCHP) executive support; DBSysgraph contract developers; DHH-IT deployment and maintenance; and the LBDMN Surveillance Team for program expertise.

**Transition of AIDS Drug Assistance Program Prescriptions from LSU Hospitals to OPH Pharmacy**

This accomplishment was the result of teamwork and collaboration of the STD/HIV Program, LA ADAP staff, OPH Pharmacy, Center for Community and Preventive Health (CCPH) Leadership, OPH Fiscal, and many external partners. To accommodate the filling of retail prescriptions for ADAP clients, major changes had to be made to the OPH Pharmacy daily operations, computer hardware and software, phone systems and staff assignments. This was done while maintaining pharmacy services to our current OPH programs and health units.

Additionally, a new prescription shipping and distribution network was developed with input from Community-based Organizations (CBOs) and clinics state wide. The distribution model was presented to the Louisiana Board of Pharmacy, which ultimately granted approval. Community partners (consumer groups, planning bodies and CBOs) were helpful in notifying persons who were accessing their LA ADAP medications through the LSU Medical Centers and assisting them in transitioning to the OPH Pharmacy services. Clients were also given a two months supply of medications so that there would be no lapse of treatment during the transition. Staff members from both programs continue to communicate and make adjustments on a regular basis as challenges arise.

**Emergency Medical Services**

The Bureau utilized its partnerships with the EMS community to implement the planned changes in the most effective way possible. The Bureau of EMS utilized its current staff after normal operating hours and on weekends to handle the workload and was also provided with volunteers from some EMS private and public providers.

**Moving towards Public Health Accreditation**

The continued efforts to move towards public health accreditation have been made possible through consistent collaboration between and among consultants, external partners, and intradepartmental staff. Subcommittees and workgroups were formed in order to break up the various steps towards accreditation into more manageable sections. These groups meet on a regular basis in order to discuss current activities and future steps to be taken in order to achieve established objectives. In the past year, a large number of state and local health staff met for a two-day quality improvement seminar as well as an accreditation seminar. In these seminars, discussion centered around the development of a foundation for successful progress towards accreditation. In order to ensure all staff members have a voice in the direction of OPH towards accreditation, post-meeting surveys are administered which help to provide meaningful feedback.

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

Yes. The activities engaged in by the Office of Public Health support the strategic priorities and objectives of the agency.

**Center for Environmental Health  
Sanitarian Services-Lean Six Sigma Project**

The lean six sigma program, due to its ability to increase levels of quality improvement while reducing waste, is directly supporting the goals of the OPH Strategic Plan.

**Sanitarian Services Reorganization**

Through the reorganization of personnel and their respective activities, Sanitarian Services is seeing an increase in its ability to provide high quality service across the state and in a more timely fashion. By improving the program's level of capability to serve the needs of the industry and the public, this reorganization supports the goals of the OPH Strategic Plan.

**Engineering Services' Response to Hurricane Isaac**

This accomplishment contributes to the success of the OPH Strategic Plan. Engineering Services, through its Public Health Engineering activities, provides a regulatory framework that assures that the public is not exposed to contaminated drinking water, or to raw sewage contact or inhalation, which can cause mass illness or deaths.

**Improvements to Technology**

These activities all directly support the goals of the OPH Strategic Plan.

**Center for Community and Preventive Health**

The LEERS modules within the Children and Youth with Special Healthcare Needs Unit will improve response times to follow-up for children with abnormal test results and enhance the interaction between hospitals, providers and the programs in accomplishing the best outcomes for the families of these children. The transition of ADAP

prescriptions from LSU Hospitals to OPH Pharmacy will help ensure those with HIV continue to have access to pharmaceutical treatment and medical care. These public health improvements are right in line with the success of the OPH Strategic Plan and directly support OPH's objectives.

### **Emergency Medical Services**

The activities performed by and services provided the Bureau of EMS directly supports the goals of the OPH Strategic Plan

### **Moving towards Public Health Accreditation**

Efforts to move OPH towards the goal of Public Health Accreditation are in line with the anticipated success of the OPH Strategic Plan. These activities are outlined in the National Public Health Improvement Initiative and seek to align federal funding support with key infrastructure objectives of Healthy People 2020.

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

### **Center for Environmental Health Sanitarian Services-Lean Six Sigma Project**

Lean Six Sigma is an established improvement methodology that has been used in many industries including production, manufacturing, and healthcare.

Our success with the Lean Six Sigma project has been shared with many other departments within OPH and DHH as well as outside agencies and organizations such as the Fire Marshall's Office. The OPH Deputy Assistant Secretary, Beth Scalco, has also presented our project to National Organizations.

### **Sanitarian Services Reorganization**

The Sanitarian reorganization demonstrates a best management practice. The original structure was disjointed and failed to provide continuity in communication, management, supervision and service to the public. The new structure serves all areas well.

### **Engineering Services' Response to Hurricane Isaac**

During fiscal year 2, these accomplishments and methodologies represented a Best Management Practice that was shared with other departments and agencies. This effort took coordination and cooperation between the local water system, and both Engineering Services and State Emergency Support Function (ESF) 12 desk at the Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP).

### **Improvements to Technology**

Public Health uses technology to improve service delivery, streamline processes, and replace outdated and inefficient systems. In addition to increasing transparency by publishing retail food inspections on a public website, the Center for Environmental Health initiated a Lean Six Sigma project aimed at increasing the productivity of Sanitarians, ensuring that all Retail Food Establishments are inspected per the

recommended USDA risk category schedule, and increasing standardization in training and the application of the Sanitary Code throughout the state. The Center for Community and Preventive Health and the Bureau of Primary Care and Rural Health have worked to integrate public health and primary care by collaborating with entities providing primary and preventive health services. The focus has been on avoiding duplication of services while maintaining a high level of service quality. Efforts have been made to transition essential public health services to the private sector in communities that have the infrastructure to sustain the services and provider agreements have been executed with Coordinated Care Networks (CCN's). OPH is focused on revenue generation through more effective use of technology and on statewide science-based health planning. LaPHIE is a nationally recognized novel intervention using data collected through a variety of surveillance mechanisms to reach out to individuals throughout the state for linkage to care.

### **Center for Community and Preventive Health**

The successful completion of the LEERS modules will utilize a secure web-based tracking and surveillance system that will meet nationally endorsed health information interoperability standards for the LA Early Hearing Detection and Intervention Program. The LA EHDI information system will be able to accurately assess progress towards the national goals of screening by 1 month, diagnostics by 3 months and early intervention by 6 months. This system will allow for the collection of data that is unduplicated and individually identifiable throughout the process. This will also result in a significant decrease in data entry errors as it will require fewer individuals to input the information. The ability of data linkages across child health programs will lead to improved follow-up and increase the accuracy of reporting.

The transition of prescription distribution services from LSU Hospitals (charity hospital system) to the OPH Pharmacy has allowed for HIV clients to have consistent access to pharmaceuticals and medical treatment. As a result, viral suppression in clients can continue and mutation of HIV is held to a minimum. When clients are required to begin an entirely new regimen of pharmaceuticals because of a discontinuation of treatment and subsequent mutation, the financial burden can become overwhelming. Thus, this transition to ensure that access to treatment continues will ultimately save lives while minimizing costs.

### **Emergency Medical Services**

Ideas for improved utilization of assets and resources will always be welcomed by all phases of the government. However, the actions outlined here by EMS were done more out of necessity for survival of the Bureau of EMS at a minimum level and not as a cost or manpower savings measure.

### **Moving towards Public Health Accreditation**

As stated by the National Association of County and City Health Officials (NACCHO), "The National Public Health Improvement Initiative (NPHII) is a program supported by the Office of State, Territorial, Local and Tribal Support at the U.S. Centers for Disease Control and Prevention that provides funding to state, local, territorial and Tribal public

health agencies to improve the delivery and impact of the public health services they provide by improving how they track the performance of their programs; fostering the identification, dissemination and adoption of public health's best and most promising practices; building a network of performance improvement managers across the country that share strategies for improving the public health system; and maximizing cohesion across states' and communities' public health systems to ensure seamless and coordinated services for residents.”

## **II. Is your department five-year strategic plan on time and on target for accomplishment?**

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

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

OPH has continued to make great strides in meeting the goals and objectives outlined in the OPH Strategic Plan and in establishing the foundation for improving health outcomes for the citizens of Louisiana. Some of the past year's highlights include:

- Lean Six Sigma project has been successfully implemented
- Completion of successful and sustainable reorganization of Sanitarian Services
- Louisiana EMS transition toolkits adopted as National EMS toolkits for use in all 56 states and territories
- Initial readiness assessment, gap analysis, and roadmap performed as first major step of the road to Public Health Accreditation.
- Engineering Services worked with media to produce twice-daily reports regarding water safety during emergency response to Hurricane Isaac
- LaPHIE continued to expand to include Our Lady of the Lake, thereby significantly increasing the network of providers that receive real time information on patients needing testing or treatment for certain conditions (HIV, syphilis, TB)
- ADAP prescription distribution was successfully transferred to OPH Pharmacy, ensuring that those with HIV continue to receive treatment
- Louisiana becomes the first state to develop Birth Defects, Genetics, and Hearing/Speech/Vision modules within its electronic vital records system, which greatly reduce the need for manual data entry and increase data accuracy
- OPH begins process of software program consolidation in the Parish Health Units in order to allow all PHUs to communicate in real time with one another and to increase the level of reimbursement for services provided

- ♦ **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.

**Center for Environmental Health**  
**Sanitarian Services-Lean Six Sigma Project**

The success of the Lean Six Sigma project is based on numerous factors and levels of personnel that worked together for the common goal of improved public health service to our customers.

Elements leading to the success include, but are not limited to:

- Strong and long term support of DHH/OPH Administration
- Experienced and proven Lean Six Sigma project managers
- Engaged and willing Sanitarian Services leadership team
- Dedication by sanitarians statewide to improve the efficiency and ability to manage their workload
- Limited technology used to the fullest and development of electronic methods to manage and report large amounts of data that needed to be analyzed in order to define the needs of the program (i.e., management tools and routines).

**Sanitarian Services Reorganization**

The successful reorganization of Sanitary Services activities was accomplished through multiple intradepartmental discussions examining ways in which services could be cross-cut across different teams in OPH in order to ensure that responsibilities for certain activities would be matched with the most appropriate subject matter experts. This has allowed for a more streamlined approach to all activities under Sanitary Services where sanitarians can better focus on those activities requiring their specific and unique set of skills.

The successful reorganization was based on numerous elements:

- Strong and long term support of DHH/OPH Administration
- Engaged and willing Sanitarian Services leadership team
- Sanitarians dedicated to improving the efficiency and ability to manage their workload
- Cooperation of the numerous agency and office departments that assisted with the transition

### **Engineering Services' Response to Hurricane Isaac**

The response to Hurricane Isaac by Engineering Services achieved a high level of success due to a strong collaboration between and among public health staff and through the program's ongoing positive relationship with media outlets that announced their findings and reports during times of emergency. The actions taken by Engineering Services would not have otherwise been performed due to the program's unique ability to provide such services. Engineering Services subsequently pushed for the adoption and primacy of new regulations and the revision of plumbing codes.

Engineering Services adopted and received primacy of three new EPA regulations for public water systems; the Final Rule was published in the September 20, 2012 La Register for the Stage2 D/DBR, LT2ESWTR and Lead/Copper Short Term Rules.

Engineering Services published the revised Louisiana State Plumbing Code in the November 20, 2012 Louisiana Register. The new federal low lead requirements for drinking water plumbing and piping were incorporated into the revision one year ahead of the federal requirements. Staff performed statewide presentations to notify stakeholders such as the plumbing industry and parish inspectors of the new changes.

### **Improvements to Technology**

Technological progress is succeeding per established goals and along the designated timeline.

### **Center for Community and Preventive Health**

The progress with the LEERS modules and the transition of prescription distribution services to the OPH Pharmacy continues to succeed per established goals and along the designated timelines.

### **Emergency Medical Services**

Progress in the EMS program is succeeding per established goals and along the designated timeline.

### **Moving towards Public Health Accreditation**

Progress towards accreditation is succeeding per established goals and along the designated timeline.

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

**Center for Environmental Health**

**Sanitarian Services-Lean Six Sigma Project**

The significant progress made is not a short term gain. The processes that are now in place are sustainable and will ensure continued success for Sanitarian Services.

**Sanitarian Services Reorganization**

The reorganization made significant progress in overhauling the Sanitarian Services programs. This is not a one-time gain but a sustainable, living change that allows for a statewide management approach that works

**Engineering Services' Response to Hurricane Isaac**

The significant progress experienced both with approved regulations and the plumbing code will experience continued progress rather than serving as one-time gains.

- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:
  1. To what do you attribute this lack of progress? For example:
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
    - Is the lack of progress due to budget or other constraint?
    - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
    - Other? Please specify.

**Center for Environmental Health**

**Sanitarian Services-Lean Six Sigma Project**

While the Sanitary Services program is not experiencing a lack of success, an additional level of success could be added through the procurement of a more comprehensive electronic system. An advanced electronic system would provide the ability to take the multiple individually-developed tracking and monitoring programs and combine them into one consolidated system. This system could communicate with all the various tracking needs and have the ability to further increase efficiency and reporting capability. The inability to acquire this new system is currently being addressed by OPH Administration.

**Sanitarian Services Reorganization**

There is no lack of significant progress

**Engineering Services**

During fiscal year 2013 the Engineering Services section experienced a significant lack of progress with regards to other rulemaking (i.e., Part XXIV-Public Swimming Pools) and development of process improvement tools and trainings due to efforts spent on higher priority tasks such as drinking water rulemaking, budget reduction processes (i.e., restructuring, program eliminations, and layoffs), and emergency response activities.

**Technology**

None

**Center for Community and Preventive Health**

None

**Emergency Medical Services**

The Bureau of EMS's progress is being delayed because of a loss of staff and budget authority. Some of the loss of staff has been due to normal attrition while some is attributed to loss of budget and required cutbacks. Another issue was related to the future placement of the Bureau of EMS and under which agency or department it would be placed; this issue was taken up in the legislature and the final outcome this past year was that the Bureau of EMS would remain under the Office of Public Health. Because this lack of progress is due to a potentially long-term issue, EMS will continue to seek out methods with which they can continue to meet annual goals despite losses in staff and budgetary cuts.

**Moving towards Public Health Accreditation**

None

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

**Center for Environmental Health****Sanitarian Services-Lean Six Sigma Project**

Lack of progress in the procurement of a more comprehensive and advanced software program is very likely a set of circumstances that will be resolved through successful funding in the near future.

**Engineering Services**

The lack of progress that Engineering Services has experienced this past year was due to particular rulemaking. Because rulemaking is a constantly evolving activity, this looks to be a one-time event subject to change.

**Emergency Medical Services**

Because this lack of progress is due to a potentially long-term issue, EMS will continue to seek out methods with which they can continue to meet annual goals despite losses in staff and budgetary cuts.

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

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

- ♦ **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 OPH Strategic Plan is reviewed and updated on an annual basis. The plan is evaluated to ensure that it reflects the current strategic management imperatives. 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 the identified goals and objectives. Offices provide information on their respective plans including their successes, challenges, and provide recommended solutions to overcome any issues that have been identified. Corrective actions from mid-year and year-end evaluations are incorporated into the Offices plans.

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

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

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

#### 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?

Although the Office of Public Health has continued to make progress toward meeting the agency's goals and objectives there are issues that prohibit the agency from completing the required activities in an efficient and timely manner. Some programs are using outdated information technology systems that lead to challenges with accessing and utilizing data and providing user friendly interfaces. The process for contracting can be lengthy and cumbersome and result in a delay in executing the contract. Moving toward electronic submissions rather than paper based could improve efficiencies. The Office notes that greater collaboration between DHH Human Resources (HR) and Louisiana Civil Services could result in improved HR processes. An adequate inventory/property control systems would allow for better tracking of property resulting in less financial loss.

#### 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 2012-2013

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

**Department Head:** Kathy Kliebert, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Dr. Rochelle Head-Dunham, Interim Asst. Secretary

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

Consistent with the Office of Behavioral Health (OBH) Business Plan, OBH achieved three major accomplishments during the fiscal year under review: (1) successfully transitioned OBH from the initial implementation phase of the Louisiana Behavioral Health Partnership (LBHP) to the monitoring and oversight role; (2) continued implementation and refinement in the Coordinated System of Care (CSoC) for children and youth; and (3) continuing transition of OBH roles and responsibilities from a regional service provision management model to monitoring, surveillance of, and technical assistance to local governing entities (LGEs). Additionally, the OBH Strategic Plan identified and successfully completed two additional strategies: 4) resource reallocation aimed at developing financial efficiency while optimizing treatment; and (5) maintaining substantial compliance with the consent decree as per OBH accountability standards. All of these successful actions were part of the OBH strategic plan and directly tied to DHH's business plan priorities.

#### **Accomplishment #1: Transitioned OBH from the initial implementation phase of the Louisiana Behavioral Health Partnership (LBHP) to monitoring and oversight role**

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

On March 1, 2012, OBH successfully implemented the LBHP to provide a

comprehensive system of behavioral health services within Louisiana. During FY 13, OBH's role shifted from implementation of the LBHP to one focused on monitoring of services and contract deliverables.

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

Through the LBHP, access to community-based services is enhanced, quality of care and health outcomes are improved, and utilization of more restrictive and crisis-driven services (emergency departments, hospitals, out-of-home placements) is reduced. As the model for behavioral health care continues to evolve, it is vitally important that OBH conduct regular monitoring of Statewide Management Organization (SMO) operations to ensure compliance with the performance measures and deliverables established in the contract for these services. These monitoring functions are used to assess the SMO's ability to perform its contractual responsibilities as the single behavioral health managed care entity in the state. This represents a significant shift in the business model for OBH, which was previously more involved with the direct provision and management of services, and now moves into a more clearly defined system oversight role.

**C. Who benefits and how?**

By integrating managed care into the service delivery model, OBH, through the SMO, has served and continues to provide quality care to over 150,000 Louisiana citizens since implementation in FY 12.

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

With the shift in focus from implementation to monitoring, OBH has employed different strategies to ensure appropriate oversight for these activities.

**Administrative:**

*Health Plan Management Team:*

In an effort to increase the effectiveness of monitoring of the LBHP and the SMO, OBH created the Health Plan Management Division. Positions were established specific to LBHP monitoring, and teams were reorganized. This newly created Division is charged with external monitoring of the LBHP through data analysis and information systems programming, as well as, internal OBH monitoring with more focused documentation of activities, stricter scrutiny of the contract and deliverables, and OBH and SMO staff accountability.

*Interdepartmental and External Review:*

In December 2012/January 2013, OBH established the Interdepartmental Monitoring Team (IMT) to facilitate monitoring of the LBHP waivers and state plan amendment performance measures outlined for the Centers for Medicare and Medicaid Services (CMS). The IMT is composed of representatives from

other state agencies, Medicaid, and different sections of OBH. The IMT meets regularly and has established a schedule for reporting and accountability with the SMO. The IMT has two subcommittees, one for adults and one for youth, that review the data pertaining to these populations and report to the IMT. The IMT and subcommittees receive reports, review and analyze the information, and provide feedback to the SMO. This structure was developed in late 2012 and began in earnest in 2013. The processes continue to be refined and streamlined.

In early 2013, OBH created a Request for Proposal (RFP) for an External Quality Review Organization to begin constant, independent, third-party evaluations of the CMS requirements. The contract was awarded to IPRO on July 30, 2013.

*Dashboard:*

In the spring/summer of 2013, the SMO, in partnership with OBH, revamped its dashboard to serve as a more effective monitoring document versus a project status update document. This dashboard is reviewed monthly by the OBH Executive Management Team (EMT) with the SMO.

*Communication:*

More emphasis has been placed on structured communication between OBH and the SMO. OBH EMT has bi-weekly meetings with the SMO's senior leadership team. The Bureau of Health Services Financing (BHSF) also facilitates a bi-weekly executive level management meeting with the SMO's senior leadership team. The SMO, in conjunction with representatives from OBH and BHSF, holds weekly and bi-weekly workgroups in specific areas including provider questions, provider billing, IT systems, and Clinical Advisor. Bi-weekly meetings are also held between the executive staff of OBH, OJJ, DCFS, and the SMO to facilitate interdepartmental communication.

*Data and Documentation:*

With the creation of the Health Plan Management Division within OBH, OBH and the SMO have standardized communication through a formal documentation process that includes action items and follow-up activities which serve to keep teams on task and hold them accountable for progress and completion of priority items. OBH works jointly with the SMO to perform quarterly chart and performance reviews that include comparing services approved in the plan of care to services actually provided, and review of issues regarding eligibility, documentation, family choice, needs and strengths, goals and objectives, and crisis plans.

Since implementation, OBH has continuously collected data on the populations served by the LBHP. Currently, OBH has hired a data warehouse analyst whose sole function is to review and validate Magellan's data and have the ability to create reports based on this information.

*Internal Staff Development:*

As OBH has transitioned to its new monitoring role, focus has been placed on developing the knowledge base and skill sets of staff. OBH has created a series of trainings focused on SMO monitoring to serve as both a refresher of responsibilities to experienced staff and an opportunity for new staff to learn and become familiar with expectations. Staff attending includes representatives from the analytics, informatics, child and adult programming, and fiscal divisions.

**Fiscal:**

OBH ensures the SMO maintains fiscal accountability by conducting several monitoring and assessment activities, including:

- Review Annual Statutory Audit Report
- Quarterly review of Financial Reporting package to assess revenue vs. expenditures and cash reserves (financial solvency);
- Monitoring timeliness of claims payments;
- Ensuring that non-risk payments stay within the upper payment limit (UPL) by using the fee-for-service (FFS) rate schedule and accounting for third-party liability and post eligibility treatment of income;
- Monitoring and reporting on 1915b waiver cost effectiveness;
- Conducting on-site financial reviews in conjunction with the Interdepartmental Monitoring Team (IMT) and the External Quality Review (EQR) Organization;
- Meeting monthly on financial reporting and budget items;
- Reviewing the Generally Accepted Accounting Principles (GAAP) Audit Report for material issues and financial viability;
- Reviewing any waiver-specific recoupments for waiver services provided without supporting documentation;
- Reviewing all proposed recoupments, maintaining access to the SMO prior authorization system, and conducting periodic reviews of prior authorization activities currently in place;
- Reviewing FFS invoices against encounters accepted into Medicaid's Database;
- Reviewing/approval of administrative payments for the Coordinated System of Care; and
- Monitoring payments and recoupments for individuals not enrolled with the SMO (excluded populations).

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

Yes. It is a significant step toward meeting the goal to serve children and adults with extensive behavioral health needs by leading the transition to the LBHP and ensuring full compliance and quality/outcomes of services provided for the duration of the SMO contract.

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

Yes. As other agencies within the department continue to utilize managed care or consider moving into a managed care system, OBH is in a position to help them to understand the LBHP implementation and monitoring successes and failures. This will assist with their transition as well.

## **Accomplishment #2: Continued implementation and refinement of the Coordinated System of Care (CSoC) for children and youth**

- A. What was achieved?

During FY 12-13, the Coordinated System of Care (CSoC) continued operations in five regions of the state. Throughout the course of the fiscal year, enrollment numbers continued to increase. In addition, OBH began preparing for the next round of implementation, with the intent to be statewide by the close of FY 14. As of June 30, 2013, 937 children and youth were enrolled in CSoC. In addition, refinements were made to entry processes and the CSoC service delivery model to ensure continued viability of this effort over time.

- B. Why is this success significant?

The CSoC implementation results from a multi-year collaborative planning effort between the Department of Health and Hospitals (DHH), the Department of Children and Family Services (DCFS), the Office of Juvenile Justice (OJJ) and the Department of Education (DOE). CSoC uses an evidence-informed approach to support young people with significant behavioral health challenges who are in or at risk of out-of-home placement to remain with their families, in the community, which research demonstrates results in more positive outcomes over time. It also makes better use of state resources, by leveraging additional Medicaid funding, to enhance available services for high-risk children and youth within the State of Louisiana. The successful implementation of CSoC is particularly significant because it represents true partnership across the child-serving state agencies to ensure that youth who are at highest risk and in greatest need, and their families, receive timely access to appropriate services and supports.

- C. Who benefits and how?

CSoC serves children and youth aged 0 through 21 with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out-of-home placement. Children and youth with complex behavioral health

challenges and their families benefit from a coordinated approach to care. New behavioral health services that were previously not part of the service array in Louisiana are now available as part of the Medicaid State Plan Amendments and Waivers that support CSoC and the broader Louisiana Behavioral Health Partnership. These new services include an organized planning process for young people with significant emotional and behavioral challenges, called Wraparound, which helps to ensure that individual and family needs are identified and addressed with an array of specialized services and supports. These efforts are proven to result in a reduced need for more costly out-of-home placement options. Families and young people also benefit from other specialized services which include: Parent Support and Training, Youth Support and Training, Crisis Stabilization, Independent Living/Skills Building and Short-term Respite.

D. How was the accomplishment achieved?

During 2009, DHH, DCFS, OJJ and DOE began collaboration on a multi-year planning process to develop a common vision and goals to improve behavioral health outcomes and reduce out-of-home placements among children and youth with significant mental health and/or substance use disorders. During the planning phase, eighteen (18) stakeholder workgroups participated in designing the initial coordinated system of care. Subsequently, Governor Bobby Jindal issued Executive Order BJ-2001-5 on March 3, 2011, to formally established a policy-level Governance Board with members including leadership of DHH, DCFS, OJJ and DOE, a representative of the Governor's office, two family representatives, an advocate representative, and a youth representative. This board is charged with providing oversight to the development and implementation of the Coordinated System of Care (CSoC). Each of the four collaborating agencies (DHH, DCFS, OJJ and DOE) also assigned staff to form a unified CSoC team, housed at the headquarters building of the Office of Behavioral Health, to participate in development of the Medicaid State Plan Amendments and Waivers necessary to support service development, enhancement, and support and guidance for CSoC implementation. OBH used a community driven process to select initial regions for statewide implementation.

To support the availability of CSoC in each region, a community process selected a Wraparound Agency that would serve as the locus for treatment and care coordination for every enrolled youth.

***During FY2013:***

- As of June 30, 2013 CSoC has served 1,974 youth and children, with a FY end enrollment of 937 children/youth. FY end enrollment ranges from 137 to 212 per region as follows: Monroe (211), Shreveport (212), Alexandria (137), Baton Rouge (180) and Greater New Orleans (197).
- Wraparound Agencies in each region ensure that youth with complex needs benefit from a coordinated care planning process that produces a single plan of care that is created with the youth, their family, natural supports and all agencies

and providers involved with the youth and family.

- The Family Support Organization (FSO) structure was reformatted from one agency per region to one statewide organization with local supervision and service provision. This change allowed for centralization of administrative functions, reduction in overhead costs, and resulted in standardization of policies and procedures across all regions.
- A new CSoC Director with over ten years of experience leading system of care efforts was hired to lead the initiative.
- The CSoC team is composed of employees of DCFS, DOE, OJJ, and Medicaid detailed to OBH in addition to three OBH employees including a Family Lead. The team provided guidance and technical assistance to the WAAs and FSO in each region in order to ensure that the appropriate certification and training requirements were completed.
- The University of Maryland, Institute for Innovation and Implementation provided training and technical assistance on the implementation of the wraparound process, in accordance with standards established by the National Wraparound Initiative (NWI) through a contractual agreement with OBH.
- The University of Maryland Institute for Innovation and Implementation provided training and technical assistance for the Family Support Organization in order to ensure members of the Family Support Organization had the knowledge and skills needed to support effective implementation of wraparound process.
- Quarterly meetings of the CSoC Governance Board were held to review progress, provide guidance, and establish policy as needed.
- The Statewide Coordinating Council (SCC) increased meeting frequency to every six weeks to monitor the transition to a Statewide FSO.
- OBH is collaborating with the University of Maryland and the Wraparound Evaluation and Research Team at the University of Washington to monitor fidelity to national wraparound standards. In addition, the CSoC Liaisons conduct ongoing training and outreach to stakeholders, state agency personnel, providers and community members.

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

Yes, the CSoC initiative was included in the OBH Business Plan and strategic plan as a top priority.

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

Yes. There are several aspects of the Coordinated System of Care initiative that represent best practices from a national perspective:

The formation of the Governance Board through Executive Order No. BJ 2011-5 represents a significant accomplishment. Across the country, there are very few

states that have a Governor endorsed and supported Coordinated System of Care initiative and policy-making Board. This collaboration and breaking down of historic silos between agencies has resulted in improved services for children and families and for enhanced collaboration across multiple efforts and initiatives.

Detailing of staff from across child-serving agencies to a unified CSoC Team represents a true innovation in the system of care field. Sharing staff from other departments under an integrated team design breeds increased understanding and familiarity of the mandates and requirements of each state agency and helps all members develop a deeper understanding and appreciation for the work of each child-serving agency.

Developing Medicaid state plan amendments and waivers and leveraging braided funding across child-serving state agencies to support service development and expansion is an example of best practices in the system of care field. This also represents a higher level of coordination across agencies which results in less fragmentation, duplication and redundancy.

### **Accomplishment #3: Continuing transition of OBH roles and responsibilities from regional service provision management to monitoring and surveillance of, and technical assistance to local governing entities (LGEs)**

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

As of July 1, 2012, there were five existing Local Governing Entities (LGEs), and the Acadiana Area Human Services District began its shadow year. During its shadow year, an LGE works toward becoming an independent umbrella agency for the administration of state-funded behavioral health and developmental disability services in an integrated system based on local control and authority. Throughout FY 13, OBH began preparations to transition the final four remaining regions into LGEs with independent budgets beginning in FY 14. This included developing guidance on the delivery of addictive disorders (AD), developmental disabilities (DD), and mental health (MH) services funded by appropriations from state general funds and block grant dollars and a systematic monitoring approach by OBH. Through coordination between the Department of Health and Hospitals (DHH) and the Human Services Interagency Council (HSIC), this plan grew into the Human Services Accountability and Implementation Plan (AIP).

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

With the impending transition of the final five regions into LGEs in FY 14, the role of OBH has begun to transition away from direct service delivery to one of providing resources and assistance that enable the LGEs to carry out service

delivery functions efficiently, effectively and independently. OBH is also responsible for providing assistance in setting policy, establishing minimum standards for the operation of the service system, establishing reasonable expectations for service utilization and outcomes, and developing mechanisms statewide for measuring these outcomes.

The AIP sets forth the criteria, process, timelines, and guidelines for planning, monitoring, and providing accountability in the delivery of mental health, developmental disabilities, and addictive disorders services. The AIP also sets forth the guidelines for the provision of technical assistance and training in the support of the delivery of services. The implementation of AIP monitoring will begin in FY 14 and allow for the ongoing analysis of LGE performance.

**C. Who benefits and how?**

By initiating a statewide managed care system for behavioral health, and completing the localization of behavioral health services, OBH positions itself to provide the necessary leadership, strategic support and oversight to build and provide a comprehensive, integrated, person-centered system of preventions and treatment services that promote recovery and resilience for all citizens of Louisiana.

AIP monitoring will have far reaching benefits. DHH, LGEs, and Louisiana's citizens with addictive disorders (AD), developmental disabilities (DD), and mental health (MH) diagnoses benefit from the analysis of AIP monitoring. AIP monitoring yields LGE performance data that can be utilized 1) in evidence based decision making, 2) to influence LGE performance targets that support federal and state funding requirements, and 3) in the analysis and improvement of service delivery.

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

The accomplishment was achieved through the transformation of the OBH business model with the introduction of the LBHP, including contracting with a Statewide Management Organization (SMO) and the transition of the traditional OBH regional model to the LGEs.

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

Yes. This accomplishment aligns with the Department of Health and Hospitals and the Office of Behavioral Health goals to provide quality service and promote health.

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

Yes. The use of monitoring to evaluate performance, promote the use of best practices, and make evidence-based decisions is a standard used within other agencies.

**Accomplishment #4: Resource reallocation aimed at developing financial efficiency while optimizing treatment.**

**A. What was achieved?**

Through privatization efforts at OBH, the state was able to save approximately \$3.6 million in FY 13 while maintaining core services and realizing efficiency in patient care. These efficiencies were achieved primarily through the privatization of the following services and populations in FY 13:

1. *Food Services Privatization* - Privatization of Facility Food Services on October 1, 2012, was undertaken at the OBH hospitals in order to facilitate the development of healthy menus, purchasing and storing of food and food ingredients, delivery of food to clients, hiring and training of staff, and providing nutritional supplements.
2. *Southeast Louisiana Hospital (SELH) Privatization* – Privatization of SELH included the transfer of 118 beds to other public and private service providers across the state. As a result of this privatization, 18 beds were returned to the New Orleans community and surrounding areas. These beds currently have an approximate utilization rate of 98%, which is the same level of utilization the state was experiencing prior to privatization.

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

The care for this population is still being provided while the cost to the state to provide the services has been greatly reduced.

**C. Who benefits and how?**

This has allowed the Office of Behavioral Health to adequately redistribute beds to other parts of the state in an effort to address the demand and need in those areas, while also meeting the budgetary demands of the Department.

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

By using private entities and other public hospitals that will still provide the same level of care but at a lower cost.

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

Yes. The state's goals have been achieved as the care for this population is still being provided while the cost to the state to provide the services has been greatly reduced.

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

This was a unique, one-time situation in order to meet the budgetary needs of the Department in FY 13.

**Accomplishment #5: Maintaining substantial compliance with the consent decree as per OBH accountability standards.**

- A. What was achieved?

East Louisiana Mental Health System achieved 98.4% compliance with Federal Consent Decree and has therefore remained in substantial compliance as per the terms of the Consent Decree.

- B. Why is this success significant?

A federal lawsuit regarding patient care was resolved by consent decree that established specific timeframes within which competency restoration activities must be completed for individuals referred from the judicial system. Competency refers to the issue of whether or not someone charged with a crime understands the court proceedings and whether or not they can participate in their own defense. Competency restoration is the process by which the hospital staff treats and/or educates the clients so that they meet requirements to be considered competent.

The successful implementation of the requirements of the consent decree by OBH is significant in that it allowed OBH to substantially improve the timeliness of competency restoration services.

- C. Who benefits and how?

Individuals ordered to receive competency restoration services in the state forensic hospital are no longer required to remain in jail for extended periods of time awaiting placement. Currently, the time has decreased to no more than 30 days from the date of the signed court order now whereas in the past people have, on occasion, waited longer than one year.

- D. How was the accomplishment achieved?

Competency restoration programming and processes were reevaluated following the adoption of the consent decree, and additional resources were devoted as necessary. The changes in processes, procedures, and addition of resources has allowed for a system with increased throughput for continued compliance with the order.

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

Yes. This accomplishment is consistent with the Office of Behavioral Health's goal to provide for the timely provision of the appropriate level of care. It specifically abides by the goal and objective to provide for services to individuals involved with the court system in compliance with the consent decree ruling.

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

Not Applicable. This action is a specific corrective strategy.

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

Significant progress has been experienced in all actions outlined in the OBH Business Plan. One of the major initiatives is the Louisiana Behavioral Health Partnership (LBHP). Although implementation began in the latter part of FY 12, there are preliminary indications from the SMO and management analysis that the project will meet strategic objectives.

### **LA Behavioral Health Partnership (LBHP)**

The Office of Behavioral Health oversees the LBHP, the statewide management contract for most behavioral health services, and delivers direct care through both hospital and community-based treatment programs.

**A. Where are you making significant progress?**

OBH successfully implemented the LBHP, effective March 1, 2012, to provide a comprehensive system of behavioral health services. The LBHP is intended to increase access to a more complete and effective array of behavioral health services and supports to meet the needs of both adults and children. Through the LBHP, access to community-based services is enhanced, quality of care and health outcomes are improved, and utilization of more restrictive and crisis-

driven services (emergency departments, hospitals, out-of-home placements) is reduced. By integrating managed care into the service delivery model, the SMO is currently servicing a membership of about 1.1 million Louisianans.

Upon the initial implementation of the program toward the end of FY 12, there appeared to be issues with the network of providers and low enrollment. However, in FY 13, OBH and the SMO made significant progress toward establishing a network of providers within the LBHP for the provision of necessary behavioral health services. As of June 2013, over 1,700 providers have been certified, credentialed, and contracted to provide services within the Louisiana Behavioral Health Partnership based on qualifications documented in the LBHP Service Definitions Manual. OBH continues to work with the SMO and local providers to ensure the delivery of services.

1. To what do you attribute this success?

Success can primarily be attributed to building the member and provider network within the SMO and making care more accessible statewide. Through the LBHP and in conjunction with OBH, the SMO is able to provide a single point of entry available 24/7/365 with two in-state call centers and maintain a contracted and credentialed network of some 1,700 providers at all levels of care. Additionally, the LBHP fosters transformation of the behavioral health system with programs that make behavioral healthcare more accessible and relatable to the public, including: cultural competency standards and training; recovery, resiliency and peer support; MyLIFE for youth (a peer-based support group); support for families; and liaisons specialized to DCFS, OJJ and DOE.

- Is progress directly related to specific department actions?

The department applied and received approval of a 1915(c) waiver and 1915i state plan amendment by the Centers for Medicare and Medicaid Services (CMS) for expanded and enhanced Medicaid services and eligibility groups, and the 1915(b) waiver to transition into a single managed care system. These actions allowed the LBHP to be established, which expanded services to additional populations. After implementation, OBH moved into the monitoring role for the partnership, and is continuously working to safeguard the interests of the state and its residents by ensuring the SMO meets its contractual obligations and maintains progress advancing the partnership.

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

The purpose of the LBHP, and in particular CSoC, was to involve multiple state departments including the Department of Education (DOE), Department of Children and Family Services (DCFS) and Office of Juvenile Justice (OJJ) in order to coordinate care across the system for the state's populations most in need. As the contract monitor, OBH has been the lead agency in many aspects of the partnership and continues to work closely with the other departments on the Interdepartmental Monitoring Team (IMT), through regular contract meetings to ensure continued progress. Additionally, Medicaid has worked closely with the SMO and OBH to enhance service provision management and payments as authorized under the 1915(b) and 1915(c) waivers and the 1915i state plan amendment.

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

Progress will continue at an accelerated pace as the SMO continues to enroll new members and providers, and OBH continues to enhance its abilities to effectively monitor the managed behavioral healthcare system. Also, the SMO continuously strives to improve behavioral health care through the implementation of performance improvement projects as per the terms of its contract with the state.

**B. Where are you experiencing a significant lack of progress?**

OBH has identified no area where a significant lack of progress can be established relative to the Louisiana Behavioral Health Partnership. In all areas where lack of immediate progress has been identified, both OBH and the SMO have worked to establish a plan of action to address identified barriers to implementation.

**Coordinated System of Care (CSoC)**

**A. Where are you making significant progress?**

Significant progress has been made on the implementation of the Coordinated System of Care (CSoC) which began on March 1, 2012, in five regions of the state and represents the coordinated effort of DHH, DCFS, OJJ and DOE.

1. To what do you attribute this success?

The success of CSoC can be attributed to several factors, including the collaboration of the four state agencies: Department of Health and Hospitals (DHH), Department of Child and Family Services (DCFS), Office of Juvenile Justice (OJJ) and Department of Education (DOE) deploying resources to create the State CSoC team who have been charged with the oversight of the Wraparound Agencies and the Statewide Family Support Organization. This

oversight includes assistance in the development of community teams in each region, outreach to their respective state agency personnel, providers and other stakeholders in each region, to provide training on the Wraparound process and CSoC referral and enrollment. The CSoC team also delivers regular support to the Wraparound agencies for guidance and technical assistance. The state CSoC Family Lead has been responsible for the oversight and provision of guidance and technical assistance to the Statewide Family Support Organization throughout this past year's transition. The state CSoC team also has important monitoring functions, which includes assessing adherence to practice fidelity, as well as monitoring the compliance with Waiver and RFP requirements.

- Is progress directly related to specific department actions?

Yes. The four collaborating agencies each allocated resources to leverage funding from Medicaid and form a dedicated staff housed at OBH headquarters. The primary goal is to improve outcomes for children/youth that are at risk for or in out-of-home placement. OBH serves as the lead agency for this effort and has worked to successfully mobilize the CSoC state team at OBH and partner with the CSoC team at the Statewide Management Organization to ensure progress. In addition, each state agency liaison housed at the OBH has done extensive outreach to their respective departments to ensure understanding of the new processes for referral and enrollment in CSoC, as well as the practice change associated with the move toward a system of care approach. Further, each department has developed policies for assessment and referral for behavioral health services to ensure that young people and families are referred to those services that they most need.

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

Yes. As the lead for implementation of the CSoC, OBH is able to gauge success by the ability to enroll youth in the CSoC. During this fiscal year 2013 OBH has begun to monitor the Quality Management Strategy which was developed as part of the b and c Waivers to ensure all performance measures are met.

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

No, this is not a one-time gain. From the start date of March 1, 2012, a total of 1,974 children and youth have been served in CSoC, with a current enrollment of 937 youth and children as of June 30, 2013. We anticipate that enrollment will continue in the five regions where CSoC has been implemented with a maximum of 1,200 enrollees at any given time. In addition, a planning process has begun to inform the expansion of CSoC into the remaining areas of the state, which will

increase maximum enrollment to 2,400 youth and children.

**A. Where are you experiencing a significant lack of progress?**

Although some areas of the project have not reached full implementation, OBH has identified no area where a significant lack of progress can be established. In all areas where lack of immediate progress has been identified, both OBH and the SMO have worked to establish a plan of action to address identified barriers to implementation.

**Transitioning OBH Roles and Responsibilities from Service Provision Management to Monitoring, Surveillance and Technical Assistance**

**A. Where are you making significant progress?**

Progress is being made toward the goal of transitioning from a direct-care service provider and operational manager of services to act primarily as an oversight agency through support and regular monitoring. Throughout FY 13, OBH began preparations to transition the final four remaining regions into LGEs beginning in FY 14. This included development of the Human Services Accountability and Implementation Plan (AIP) in conjunction with HSIC, which was subsequently implemented in FY 14. Included within this document are the processes for monitoring and review of LGE service delivery.

1. To what do you attribute this success?

Success is attributed to the coordinated effort to transform OBH's business model. Over the past several years, OBH has worked to reduce reliance on costly institutionalization to take a more community-based approach to the provision of services. These efforts are coupled with the move to managed care; transition of OBH operated regionally-based services to LGEs, and the new roles and responsibilities of the staff and operations of State Office.

- Is progress directly related to specific department actions?

Yes. Agency actions include monitoring of the SMO operations through regular meetings, review of documentation, and an array of compliance checks. OBH will monitor the SMO operations in the following areas: information technology, provider network, fiscal operations, clinical care, utilization management, quality management, and member services. OBH will ensure compliance with all state and federal requirements, including block grant activities. During the transition of adult and children & family services to the LGEs, OBH will provide oversight and monitoring through the Accountability and Implementation Plan. In partnership with the SMO, OBH programmatic staff will support the infusion of

best practice approaches into the service array, and provide technical assistance to the behavioral health service delivery system. OBH will continue to provide funding review for general psychiatric hospital-based services, forensic services and other 24-hour residential facilities through the continued stay review process and monitor Access to Recovery (ATR) and gambling/tobacco treatment services and funding, since these programs fall outside of the LBHP.

- Is progress related to the efforts to multiple departments or agencies?

Progress toward this initiative results from the efforts of multiple agencies within DHH including OBH, Medicaid, the existing LGEs, and the newly created LGEs.

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

No, this is not a one-time gain. During FY 2012 and FY 2013, OBH established transformational priorities that established a strong foundation for the transition to the new operational structure and associated roles and responsibilities. During FY 2014, OBH will enter the next phase of transformational activities under managed care and move away from direct community-based service provision with the transition of the four remaining OBH regions into LGEs. By initiating a statewide managed care system for behavioral health, and completing the localization of behavioral health services, OBH positions itself to provide the necessary leadership, strategic support and oversight to build and provide a comprehensive, integrated, person-centered system of prevention and treatment services that promote recovery and resilience for all citizens of Louisiana.

**B. Where are you experiencing a significant lack of progress?**

OBH has identified no area where a significant lack of progress can be established.

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

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

OBH did not revise its strategic plan in FY 13; however, OBH conducted an in-depth review of its business plan to ensure that it reflects current environmental, programmatic and fiscal configurations. As a result of this review, the business plan was revised to reflect a new mission and goals. The revised plan establishes integrated service provision, performance accountability, and partnership with private and public providers as a means to enhance treatment

services while containing costs. To that end, OBH's new business plan incorporates the safety net function, but focuses on OBH's role as monitor of SMO compliance with contract requirements.

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

The formulation of the OBH strategic plan adheres to management strategies implemented by the Executive Management Team (Health Plan Management, Administration, Adult, Child and Family Operations). These strategies, at a minimum, include:

- **Training:** Ongoing training is provided to ensure staff develops the necessary skills to understand and apply the concepts of the OBH strategic plan.
- **Input:** Gathering input from all levels of the agency's functional areas. Discussions are conducted with Team Leaders and participants representing functional areas essential to support agency priorities.
- **Communication:** Receiving and sending information at the central office and the district levels.
- **Coordination:** Using technology to enhance communication and participation (e.g., teleconferences, videos, electronic media, etc.).
- **Performance measurement:** Formulation of objectives that are specific, measurable, attainable, results oriented and time-bound. Performance indicators are formulated to ensure monitoring of progress in goal/objective attainment.
- **Evaluation:** The Strategic Plan will be revised, as warranted, to reflect fiscal, managerial and programmatic changes. These revisions will be conducted using the same strategies as the original plan, as warranted. Plan revisions will utilize strategies that are pertinent to the task at hand.

### **III. What significant department management or operational problems or issues exist?**

There are no significant departmental, management, or operational problems/issues identified at the present time. OBH is currently engaged in a dynamic process of developing and fostering the LBHP and continues to work toward its goal of providing quality behavioral health care to the citizens of Louisiana.

### **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.

**1. Synar Report: Youth Access to Tobacco in Louisiana**

- a. *Data collection completed:* July – September 2012
- b. *Subject / purpose and reason for initiation of the analysis or evaluation:*  
OBH conducts this annual Synar Report to examine the current level of accessibility of tobacco products to minors as pursuant to Federal Government guidelines. The Substance Abuse and Mental Services Administration (SAMHSA) is the enforcing agency. An amended Synar Regulation, issued by the Substance Abuse and Mental Health Services Administration in January 1996, requires each state receiving federal grant funding to conduct annual random, unannounced inspections of retail outlets to assess the extent of tobacco sales to minors.
- c. *Methodology used for analysis or evaluation:*  
The study design is a cross-sectional survey of compliance, with

compliance defined as the refusal to sell tobacco to minors and the prevention of entry of a minor to outlets restricted to youth. A stratified random sample of outlets are identified and surveyed by a team of one youth operative and two adult agents Office of Alcohol and Tobacco Control (OATC). The youth operative attempts to purchase tobacco from unrestricted outlets and tests the access of restricted outlets. The adult agents record characteristics of outlets, inspection events, and outcomes, and cite non-compliant outlets and clerks. Information about outlets, inspectors, and the inspection event are entered into an electronic data system via laptop at the time of inspection.

- d. *Cost (allocation of in-house resources or purchase price):*  
OBH contracted with 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 \$75,010 (\$65.00 per compliance check x 1154 checks). The total cost for the report was \$75,010.
- e. *Major Findings and Conclusions:*  
The objective of this study was to estimate the non-compliance rate for tobacco sales in Louisiana among youth under age 18. Annual targets were established to decrease the state's non-compliance rate to 20% by 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 2013 is 8.8%. 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:*  
OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2013 report and will adhere to any future recommendations, as warranted.
- g. *Actions taken in response to the report or evaluation:*  
An annual report is generated by SAMHSA including a Table listing the Synar Retailer Violations (RVRs). Louisiana is ranked among the top states in compliance, in the FY 2012 report (most recent on file). The SAMHSA report can be viewed at <http://store.samhsa.gov/shin/content//SYNAR-13/SYNAR-13.pdf> . Our goal is to continue implementing current strategies since they've proven to be successful.
- h. *Availability (hard copy, electronic file, website):*

The FY 2013 Annual Synar Report is available by hardcopy, and may be accessed online at

<http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/publications/FFY2013Synar.pdf>

- i. *Contact Person:*  
Dr. Leslie Brougham Freeman  
Director of Prevention Services  
LA Department of Health and Hospitals  
Office of Behavioral Health

## 2. **Office of Behavioral Health – Prevention Services (Quarterly and Annual)**

- a. *Data collection completed:* July 1, 2012 – June 30, 2013
- b. *Subject / purpose and reason for initiation of the analysis or evaluation:*  
OBH is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT Block Grant is the primary funding source for prevention services. It requires 20% of the grant be set aside for primary prevention services. An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report is a continuing process to measure the number of services we provide and the populations that are served.
- c. *Methodology used for analysis or evaluation:*  
The data in this report is from the Prevention Management Information System (PMIS), the primary reporting system for the SAPT Block Grant for prevention services.
- d. *Cost (allocation of in-house resources or purchase price):*  
There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from the Prevention Management Information System (PMIS) to generate this document. Data is entered into PMIS by the Local Governing Entity prevention staff, their contract providers statewide and OBH Central Office staff.
- e. *Major Findings and Conclusions:*  
During FY13, Prevention Services provided evidence-based services

to 88,030 enrollees.

FY12 block grant funded one-time services provided to the general population reached 324,784 participants. This number included the combined services provided by Prevention Staff and Prevention Contract Providers.

- f. *Major Recommendations:*  
The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.
- g. *Action taken in response to the report or evaluation:*  
No actions (other than the recommended (above) were pertinent.
- h. *Availability (hard copy, electronic file, website):*  
The report is distributed via e-mail and is available by hard copy upon request.
- i. *Contact Person:*  
Dr. Leslie Brougham Freeman  
Director of Prevention Services  
LA Department of Health and Hospitals  
Office of Behavioral Health

### **3. Substance Abuse Prevention and Treatment (SAPT)**

- a. *Data collection completed:* July 1, 2012 – June 30, 2013
- b. *Subject/purpose and reason for initiation of the analysis or evaluation:*  
OBH is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT Block Grant is the primary funding source for prevention services. It requires 20% of the grant be set aside for primary prevention services. An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report is a continuing process to measure the number of services we provide and the populations that are served.
- c. *Methodology used for analysis or evaluation:*  
The data in this report is from the Prevention Management Information System (PMIS), the primary reporting system for the

SAPT Block Grant for prevention services.

- d. Cost (allocation of in-house resources or purchase price):*  
There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from the Prevention Management Information System (PMIS) to generate this document. Data is entered into PMIS by OBH regional and headquarter staff and prevention contract providers statewide.
- e. Major Findings and Conclusions:*  
During FY13, Prevention Services provided evidence-based services to 88,030 enrollees. FY13 block grant funded one-time services provided to the general population reached 324,784 participants. This number included the combined services provided by Prevention Staff and Prevention Contract Providers.
- f. Major Recommendations:*  
The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.
- g. Action taken in response to the report or evaluation:*  
No actions (other than the recommended (above) were pertinent.
- h. Availability (hard copy, electronic file, website):*  
The report is distributed via e-mail and is available by hard copy upon request.
- i. Contact Person:*  
Dr. Leslie Brougham Freeman  
Director of Prevention Services  
LA Department of Health and Hospitals  
Office of Behavioral Health

#### **4. Response to Senate Resolution 119 of the 2011 Regular Session**

- a. Reports were submitted quarterly on the following dates:* October 31, 2012; January 31, 2013; April 30, 2013; July 31, 2013 (final report)
- b. Subject or purpose and reason for initiation of the analysis or evaluation:*  
This report was created in response to Senate Resolution 119 of the 2011 Regular Session, which urged and requested the Coordinated System of Care (CSoC) Governance Board and the Department of Health and Hospitals (DHH) to report to the Senate Committee on Health and Welfare and the Senate Committee on Finance the status of efforts to implement the CSoC in Louisiana.

- c. *Methodology used for analysis or evaluation:*  
Descriptive report
- d. *Cost (allocation of in-house resources or purchase price):*  
Minimal in-house resources were allocated to produce the report and the SMO contributed to data reporting as per the requirements and funding allocated through the SMO contract.
- e. *Major Findings and Conclusions:*  
Standard update on CSoC implementation
- f. *Major Recommendations:*  
Not applicable
- g. *Action taken in response to the report or evaluation:*  
Report distributed to all CSoC Governance Board members and posted to the DHH Legislative Reports website.
- h. *Availability (hard copy, electronic file, website):*  
Available by electronic file and on the DHH website  
(<http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2497>)
- i. *Contact Person:*  
Connie Goodson  
Coordinated System of Care (CSoC) Director  
LA Department of Health and Hospitals  
Office of Behavioral Health

# Annual Management and Program Analysis Report

## Fiscal Year 2012-2013

**Department:** **Department of Health and Hospitals**  
09-340 Office for Citizens with Developmental Disabilities

**Department Head:** **Kathy Kliebert, Secretary**

**Undersecretary:** **Jerry Phillips**

**Agency Head:** **Mark Thomas, Interim 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) achieved during fiscal year (FY) 2012-2013:

#### **System Transformation**

- A. What was achieved? OCDD completed a comprehensive system analysis in partnership with stakeholders to identify the priorities of system transformation and specific change areas for inclusion in a multi-year work plan. In addition, OCDD completed research and evaluated progress of efforts to implement managed care for persons with developmental disabilities in other states, as well as best practice recommendations, and developed an alignment strategy for system transformation and concurrent efforts by the Department of Health and Hospitals (DHH) to explore managed long-term supports and services.
- B. Why is this success significant? More than twenty states nationally are in some phase of developmental disabilities service system transformation, primarily due to the need for more efficient and effective systems components to address the ever-expanding demand for developmental disabilities services and challenge of rebalancing service provision away from institutional models to community-based supports. Technical assistance provided by the Centers for Medicare & Medicaid services policy experts Human Services Research Institute and Lewin Group have indicated that Louisiana DHH/OCDD's

transformational priorities and suggested system changes represent significant innovation and will serve as a national model.

- C. Who benefits and how? The community system transformation will improve access to, quality of, cost-effectiveness of, and efficiency of community services for persons with developmental disabilities utilizing state plan Medicaid, waiver, EarlySteps, and state general fund services. The transformation will also impact the access structures to public and private Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD), inclusive of better supporting persons served in ICFs/DD to utilize community-based supports as needs and preferences change. Identified improvements to the request for services registry (waiver waiting list) will enable more effective administrative processes and implement prioritization strategies that facilitate better access for persons in need. Administrative improvements system-wide will positively impact providers, support coordinators, families and persons seeking system entry, and local governmental entities.
- D. How was the accomplishment achieved? The successful completion of the system analysis, related planning, and managed care alignment strategy were achieved through the collaborative efforts of OCDD staff throughout the state, DHH program office staff partners (Medicaid, Office of Aging and Adult Services, and Office of Behavioral Health), local governing entities, support coordinators, providers, service recipients and their families, as well as other advocates.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. System Transformation components are aligned with all six goals of OCDD's strategic plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. The approach OCDD utilized to complete the comprehensive system analysis involving stakeholders and incorporation of national best practice recommendations are consistent with nationally recognized strategies for success in large-scale system transformation.

### **OCDD Resource Center Transformation**

- A. What was achieved? Working through an established workgroup, OCDD initiated strategies to transform the OCDD-operated resource centers into centers of innovation and hubs of expertise that have a broad impact in the developmental disabilities services system and to local communities. The Resource Center Transformation Workgroup both identified and initiated four pilot projects: 1) Triage of Referrals to the Resource Center; 2) Crisis/Diversion Referrals; 3) Oversight of Persons with High Risk Behavior (initial prioritization is on person with current and/or historical challenges related to non-consensual sexual behavior); and 4) Person-Centered Quality Enhancement Collaborative Consultation. Preliminary data from these pilot projects reveal that:
- In pilot triage cases where wait list is longest, 16% of persons did not need services; 4% were referred to community providers; and 39% were able to be resolved with consultation services only.
  - When resource center consultation was triggered by a local governing entity for crisis

cases in pilot areas that traditionally have larger number of crisis referrals, 12 of 15 referred remained in the community, 2 of 15 required admission to Pinecrest Supports and Services Center, and 1 of 15 went to jail.

- While the high risk consultation pilot process is still in process, preliminary anecdotal information suggests that providers are better positioned to address support gaps and can more effectively meet the needs of persons with high risk behavior.
- Anecdotal information from the pilot for Person-Centered Quality Enhancement Consultation suggests that a collaborative team approach to identifying root cause of systemic issues results in increased provider compliance with implementation of recommendations that target outcomes for individuals supported.

Additional activities that target improving health and behavioral health outcomes for recipients of developmental disabilities service; broadening the availability and access to local, natural support networks; increasing ability of community providers and professionals to support individuals with complex needs; using technology and innovative treatments that lead to improved support options and greater independence for recipients; and increasing local access to innovation and technical assistance were also identified. These additional activities will be prioritized for implementation in the upcoming fiscal year.

- B. Why is this success significant? Historically, the Resource Centers focused more on direct service provision or individual-specific capacity building efforts. Positive outcomes for individuals served through these more traditional OCDD Resource Center efforts included the following: 70-80% of those discharged from services met discharge criteria or needed less intensive services at time of discharge; only 4% of persons were referred for long-term placement; and a 71% diversion rate exists with resource center consultation compared to 48% diversion rate without consultation. Despite these positive outcomes, there was not an impact on overall service system delivery for people with concurrent developmental disabilities and complex medical and/or behavioral support needs and the number of individuals impacted remained relatively small. Initial data collected through pilot projects (provided in the above section) demonstrates that with the shift in service delivery model from direct services to consultative model, the resource centers will be able to serve a greater number of individuals/family/providers with greater impact on the service system.
- C. Who benefits and how? People with developmental disabilities, their families, and providers will benefit from the transformation of the services offered through the OCDD resource centers. The OCDD resource centers partner with community providers and professionals to offer quality supports inclusive of consultation, technical assistance, training, and targeted and time-limited primary services for persons with multi-complex needs, life-threatening conditions, or who pose a greater risk to public safety. The resource center transformation emphasizes building community capacity to support individuals with more complex needs and keeping the person connected to his/her community by working with the community services systems to assist in the provision of more evidence-based, effective, and person-centered services. The transformation also streamlines collaboration between the local governmental entity and the local resource center to

enhance accessibility and maximize coordination of services.

- D. How was the accomplishment achieved? The OCDD established a workgroup that included internal and external stakeholders across multi-disciplines. Workgroup members included OCDD clinical and administrative staff, resource center nursing, behavioral health, and allied health staff, human services district and authority designees, a provider designee, and support coordination designee. The workgroup reviewed existing data outlining historical and current successes and challenges within the developmental disabilities services delivery system, as well as considered national trends and innovative programs/services established in other states. This action led to brainstorming activities that identified pilot projects for immediate implementation and future activities that would impact the developmental disabilities services delivery system. (Note: These activities are summarized in Section A.)
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a specific goal in the Strategic Plan relative to supporting people with developmental disabilities to achieve improved outcomes, quality of life, and attain personal goals through the development and provision of capacity-building activities, partnerships, and collaborative relationships.
- F. Does this accomplishment or its methodology represent a best management practice that should be shared with other executive branch departments or agencies? Yes. This initiative focused on using existing data to identify gaps within the current developmental disabilities services delivery system in conjunction with a review of national trends and best practices, as well as input from internal and external stakeholders, to identify need for system changes.

#### **Privatization and Downsizing of Public Supports and Services Centers**

- A. What was achieved? In FY 2012-2013, OCDD discharged 25 people from the one remaining public supports and services center to privately-operated service settings with less intensive supports. Additionally, both North Lake Supports and Services Center (NLSSC) and Northwest Supports and Services Center (NWSSC) were privatized through two separate Cooperative Endeavor Agreements (CEAs) with private providers, effective October 1, 2012. On that date, three-hundred forty-three (343) people residing at those facilities were transferred-in-place to the private providers. The CEAs will continue for a period of five years on the grounds of the former supports and services centers (SSC). OCDD now operates only one public supports and services center (or large ICF/DD facility). The net annual state general funds savings achieved in FY 2012 - 2013 related to the privatization of North Lake Supports and Services Center was \$5,003,893 and of Northwest Supports and Services Center was \$1,901,433 for a total savings of \$6,905,326.

In order to ensure consistency of supports and services and monitor needs and satisfaction, OCDD uses person-centered tools to assist individuals and their providers following transition. Training on all tools was completed with identified staff. During the fiscal year, persons leaving SSCs or residing in facilities which were privatized in the fiscal year

maintained an overall 89% rate of satisfaction with home, work, school, roommates, and staff support. Only 4% 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? The number of people with developmental disabilities receiving services from OCDD as their primary service provider decreased while the number of individuals with developmental disabilities receiving services with OCDD oversight increased. This action has resulted in cost savings to OCDD. 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 also have been significantly reduced.
- C. Who benefits and how? The individuals with developmental disabilities who transitioned from the public SSCs to community living options are benefitting from an enhanced sense of dignity and self-fulfillment that is associated with living in the community alongside people with and without disabilities. OCDD also benefits both in terms of cost savings and in reaching more people with developmental disabilities due to transition of services. However, moving many individuals within a brief period of time carries risks associated with missed support needs. Thus, a focus on more person-focused and person-driven approach increased the ability of OCDD staff to assist individuals in locating support options consistent with the life each individual wanted to move toward. Satisfaction rates of persons transitioning from public SSCs to community living options (including SIL, CH, waiver with family, or no services) were 86% at baseline / prior to transition and 91% at one year post transition. Satisfaction rates of persons transitioning from public SSCs to privatized SSCs were 88% at baseline / prior to privatization and 89% at one year post transition.
- D. How was the accomplishment achieved? The successful transition of persons from public supports to private supports was achieved through the collaborative efforts of OCDD staff, support coordination agencies, and providers, as well as service participants and their family members, friends, and other advocates. The Money Follows the Person (MFP) Rebalancing Demonstration, also known as My Place Louisiana, provided funding to support the transition process. In addition, on-site Contract Monitors are present at the three privatized Supports and Services Center to ensure compliance with deliverables outlined in the Cooperative Endeavor Agreements.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a specific goal in the Strategic Plan relative to providing specialized residential services in a manner that supports the goal of returning or transitioning individuals to community-based options.
- 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 participants for transition from public SSCs to privately-operated service settings is consistent with nationally recognized needs-based

assessment and resource allocation methodologies. This initiative also focused on achieving cost savings while maintaining individually needed levels of support through privatization of publicly-operated services and use of person-centered tools to drive and support systems change.

**Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana)**

- A. What was achieved? While the Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana) did not meet its transition benchmark in FY 2012-2013, it achieved positive outcomes for persons with the most intensive needs that are served in Home and Community-Based Services (HCBS). This is an important achievement because the program has consistently demonstrated that persons with intensive support needs can be successfully served in home and community-based settings. The MFP Rebalancing Demonstration is transitioning a much more challenging population group than that represented by the general waiver population. During 2012, a large percentage of transitions (57%) were individuals assessed as needing supports consistent with Levels 5 and 6 of the OCDD Resource Allocation System. (Level 5 represents complex medical needs and 6 represents complex, co-occurring psychiatric and behavioral support needs.) The MFP rate (per 1000) of critical incidents in the New Opportunities Waiver (NOW) is three times higher than the NOW general population. The MFP Demonstration rate of behavior-related critical incidents is much higher in proportion (better than two times) than that of the general waiver population, wherein medical critical incidents are more prevalent. Yet with these challenges, 92% of persons remained in community placement through the demonstration period. Intensive training, financial supports for additional services and supports structures, and intensive follow-along have been applied with Demonstration funded resources to retain community placement. In addition, quality of life data indicates improvements in key areas in post-move years one and two, and cost comparison data of before/after move indicates cost effectiveness.
- B. Why is this success significant? The Demonstration first successfully transitioned children with the most intensive medical needs from nursing homes and hospitals (began 2009) and then transitioned and sustained outcomes for persons with the most intensive of psychiatric and behavioral support needs moving from supports services centers, private ICFs/DD, and psychiatric hospitals. The achievement of the Demonstration shows: (1) that these persons can be effectively supported in the community, rather than in an institution; (2) the structure required for such supports, thus facilitating systems planning for sustainability; and (3) the utilization trends and costs of persons in the high need groups. The Demonstration funded development, pilot, and implementation of direct support workforce training curriculum in Positive Behavior Supports (PBS) and Medical/Nursing/Physical Supports trainings. These training curricula are appropriate for both training of staff and natural supports and address capacity gaps consistently identified by OCDD and stakeholders. The curricula have been highly rated by direct service workers and employing provider agencies statewide. Louisiana OCDD MFP demo staffs have presented on this PBS curriculum in national Technical Assistance webinars and are releasing the curriculum for use in other states.

- C. Who benefits and how? An immediate, quality of life benefit is to persons transitioned to more integrated, community-based living options. However, a much larger-scale benefit is impact on the entire services system, both current and future. The achievements provide evidence of strategies to accomplish successful, sustainable rebalancing of both investment and capacity.
- D. How was the accomplishment achieved? This was accomplished through the efforts of MFP staff, using the program's operational protocol, along with collaboration with supports and services centers' Transition Offices; Resource Centers (inclusive of Transition Support Teams); OCDD Regional Office/Human Services Authority and District staff; support coordination agencies; cooperating providers; Central Office program managers and crisis team; and supporting stakeholders.
- E. Does the 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. Participation in the federal Demonstration has enabled OCDD to examine strategies that may produce the best outcomes for Louisiana's citizens with developmental disabilities and align OCDD practices with both national best practices and goals for long-term care system sustainability.

**Utilization of all available self-direction opportunities**

- A. What was achieved? Eighty-Two percent (82%) of all opportunities available (330) through the Fiscal Agent contract for accessing self-direction opportunities within the New Opportunities Waiver (NOW) were occupied by (270) individuals participating in the self-direction option. The aforementioned data only represents individuals who have completed all necessary preliminary requirements and have begun to use this option. Additional opportunities had already been encumbered and those individuals were in various stages of completing the preliminary requirements. Therefore, the actual number of participants would be closer to the target. OCDD also expanded the self-direction option to Family Support Services within the Children's Choice (CC) Waiver by receiving approval from the federal Center for Medicare & Medicaid Services (CMS). Subsequent to these successes, an additional 271 opportunities were made available by DHH Medicaid to accommodate the growth and expansion of self-directed options within both waiver programs.
- B. Why is this success significant? Both NOW and CC Waiver participants or their authorized representatives will be able to self-direct their Family Support Services by hiring, supervising and negotiating payment for their own direct support staff to deliver their quality support needs. This expansion to both waiver programs is consistent with

national best-practices in Home and Community-Based Services (HCBS) service-delivery.

- C. Who benefits and how? Those benefitting include the individuals participating in this option, the employees hired through the self-direction option, and Medicaid also benefits. Individuals are able to recruit, hire, train and supervise the workers they choose to hire allowing them to make their own decisions. Employees can experience a higher rate of pay. The overall cost to Medicaid is reduced as the cost to pay the worker at the higher rate and the costs associated with being an employer (taxes, unemployment insurance, administrative cost, etc.) is typically lower than the approved rate for which a traditional provider may bill for the same service. The Fiscal Agent returns to Medicaid any unused portion of the difference between the actual cost and the billed amount.
- D. How was the accomplishment achieved? The filling of the NOW opportunities was accomplished through statewide implementation of the self-direction option and statewide training to regional offices, support coordinators and families. OCDD also assigned each support coordination agency in each region a specific number of opportunities to fill by actively recruiting individuals for participation. Additional self-direction opportunities were obtained in collaboration with the BHSF/Waiver Compliance Section. The approval of the self-direction option in the CC Waiver required an amendment of the CC Waiver Application to be submitted to CMS by the OCDD Waiver Section with subsequent questions answered for CMS through the Request for Information (RFI) process.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a goal to manage the delivery of an array of community-based supports and services in a fiscally responsible way allowing people with developmental disabilities to achieve their person-centered or family-driven outcomes in the pursuit of quality of life, well-being, and meaningful relationships. A presentation by the Department of Health and Hospitals to the Joint Legislative Committee on the Budget, "Update on State Health Policy and Budget Priorities," concerning the trend to home and community-based and individualized services for people with developmental disabilities, specifically reported increased flexibility and self-direction in state supports for people with developmental disabilities living with their families.
- 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 practice also is used by the Office of Aging and Adult Services, and it could be applicable to any other HCBS waiver program upon approval by Centers for Medicare & Medicaid Services.

### **Continuation of Employment First Foundation Building**

- A. What was achieved? In FY 2012-2013, OCDD continued its efforts to build a foundation for Louisiana's Employment First initiative. The following successes were achieved:
- Trained providers, partner agencies and local governing entities' staff in all regions on Employment First.
  - Established referral procedures for Louisiana Rehabilitation Services (LRS).

- Participated in the 2<sup>nd</sup> Employment First Summit.
  - Collected baseline data from support coordinators on the number of individuals working in the community.
  - Provided Employment First training at the Transition Summit with Department of Education and Louisiana Rehabilitation Services.
  - Provided training on Employment First to consumers and families through Families Helping Families.
  - Participated in all nine regional job fairs.
  - Cross-trained with Louisiana Rehabilitation Services and other relevant agencies and support coordinators.
  - Provided training and employment tools and employment guidelines to support coordinators to facilitate the process.
  - Provided support coordinator agencies with a “success stories” video to be used to educate parents and consumers.
  - Established a data sub-group of the Employment First work group.
  - Established a rate sub-group of the Employment First work group.
  - Revised data collection tool establishing that there are approximately 530 individuals receiving an OCDD waiver who are working in the community and earning at least minimum wage.
- B. Why is this success significant? Community employment has become a major focus of OCDD with increased emphasis being placed on community-based employment opportunities for individuals with developmental disabilities. As employment is brought to the forefront and concerns about employment are alleviated through improvement of service delivery, more individuals with developmental disabilities can achieve and maintain employment thereby increasing their independence.
- C. Who benefits and how? Individuals with developmental disabilities who want to work and achieve employment will benefit from improving employment services as more individuals will increase their independence through employment. The state will benefit as these individuals will pay taxes and spend money, thereby improving the economy. Families benefit by the increased independence of their family members and through a decreased level of financial responsibility.
- D. How was the accomplishment achieved? This was achieved by including community employment as a focus and developing a plan to improve employment services that are offered in the waivers, as well as highlighting the need for employment for individuals with developmental disabilities. Additionally, OCDD partnered with various stakeholders, such as Louisiana Rehabilitation Services, Louisiana Workforce Commission, Department of Education, The Developmental Disabilities Council, The Advocacy Center and various other agencies, related to this initiative. To continue this success, OCDD continues to participate in the Work Pay\$ Coalition, a group that works together to improve employment for individuals with disabilities.

- E. Does this accomplishment contribute to the success of your strategic plan? Yes. Development of policies and procedures to provide pathways to community employment is a strategy in OCDD's current Strategic Plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. This process will continue to be implemented over a five-year period in order to continue the outreach and education around employment. Changes will continue to be made within OCDD to increase the number of individuals in community employment. Employment should be a focus for all agencies that serve individuals with any type of disability, not just developmental disabilities. Employment First has been in the national spotlight for the last five years. The State Employment Leadership Network (SELN) brings together state developmental disability agencies for sharing, educating and providing guidance on employment practices and policies to its members; OCDD, which has participated in the SELN since 2007, is one of twenty-four states that participate in the SELN.

### **EarlySteps Expenditure Reduction and Improved System Performance**

- A. What was achieved? The EarlySteps program achieved several significant accomplishments during FY 2012-2013:
- 1) Improved system performance on the fourteen US Department of Education (USDOE) Performance Indicators resulted in a "Meets Requirements" determination for EarlySteps issued by the USDOE/Office for Special Education Programs.
  - 2) Following the implementation of new Eligibility Criteria in May 2012, achieved program goal of a \$1.8 million reduction in expenditures for services.
  - 3) Achieved one of the primary program purposes in that forty percent of the children exiting EarlySteps improved in their development such that they were functioning at the level of their typical peers. (Note: This is a four percent gain in outcomes compared to the previous year.)
- B. Why is this success significant?
- 1) Since moving into OCDD in 2007, EarlySteps expenditures increased primarily due to a 30% increase in the number of enrolled children. A change in eligibility criteria decreased the number of eligible children in the program resulting in a reduction in expenditures and contributing to the sustainability of the program.
  - 2) The determination process has been in place since 2004. "Meets Requirements" is the highest performance result achievable and Louisiana has successfully achieved this determination for three years. This determination had never been reached prior to the administration of the program in OCDD in 2007.
  - 3) One of the stated purposes of the early intervention program is to minimize the potential for developmental delay in young children. This result indicates the benefit of early intervention through its impact on a child's development.
- C. Who benefits and how?
- 1) Effective service utilization benefits all children in the system by efficiently and effectively designing services, making services more available to everyone who is eligible,

and eliminating delivery of unnecessary services.

2) Achieving “Meets Requirements” means that EarlySteps is providing services that meet Federal requirements. Everyone benefits from the system when it is 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.

3) Families and children benefit through the successful development of their children. In addition, another stated purpose of early intervention is to minimize the need for future special education services for children. By attaining developmental milestones, this risk is minimized for a child.

D. How was the accomplishment achieved?

1) Staff compared eligibility criteria of other states to those used by EarlySteps prior to modifying program eligibility criteria. A more restrictive criterion of 1.5 standard deviations below the mean in two areas of development was selected and cost savings were projected based on the change.

2) EarlySteps uses a regional system of technical assistance and training provided through its nine regional coordinators. 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 which have focused on strategies to improve in targeted areas.

3) In 2011-12, training was conducted with regional provider teams on correctly identifying family needs regarding their child’s development and focusing on developing program plans designed to meet those needs. Service delivery, focused on these specifically identified needs, assists both providers and families in targeting activities with children.

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 eligibility change allowed EarlySteps to reduce costs for services.

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.

3) Yes, reaching and exceeding the targets set for this accomplishment demonstrate the benefit of the program.

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

1) Yes, EarlySteps used data on children enrolled in the system to project the cost savings: child outcome data at entry and the costs per child. Results of the calculations correctly predicted the cost savings.

2) Yes, the US Department of Education/Office of Special Education Programs provides technical assistance and resources to assist states in improving their performance results. The EarlySteps staff participated in the provided activities and recommendations, resulting in performance improvement.

3) The training model used for regional training was based on nationally available content, individualized for EarlySteps. The training included features of Implementation Science

which incorporates follow up activities to sustain changes in performance.

### **Expansion of Service Options with Home and Community-based Services**

A. What was achieved? During FY 2012-2013, a number of significant service opportunities were added to Home and Community-Based Services waivers affording participants an increased array of options:

1) Permanent Supportive Housing (PSH) services were added to the New Opportunities Waiver (NOW), Children's Choice (CC) Waiver, and Supports Waiver (SW) so that these waiver participants could subsidize their rent through housing vouchers and could continue to remain in their rental units through housing stabilization services. These services assist with aspects of managing a participant's needs, bills, food, clothing, child care, money management, etc. in order to keep him/her from losing the rental unit. (Note: The addition of PSH services to the ROW was delayed until last since its application renewal was being completed and since there were few participants expected to need PSH services. This effort is currently underway.)

2) Remote Monitoring was added to the NOW which allows a participant to have both video and audio oversight in his/her home from a remote location without having a direct support worker on sight. This allows for increased independence with a potential for a lower cost service, yet the press of a button can bring immediate assistance on the way since there is stand-by staff around the clock. Companion Care is another innovative service added to the NOW which allows a participant to live with his direct support worker and share the costs of an apartment or arrange for payment of the worker's share of the apartment by exchanging his/her services to the participant for his/her portion of the rent.

3) Medical Equipment and Supplies was added to the CC Waiver to fund these services which were formerly not available in the CC, if not already covered under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) or state plan services. Six Alternate Therapies (Applied Behavior Analysis; Aquatic Therapy; Art Therapy; Music Therapy; Sensory Integration; Hippo/Therapeutic Horseback Riding) were added to the CC because they were alternate types of therapies that were not included in EPSDT or state plan services, not traditionally included in 1915(c) waivers, yet proven to be beneficial to children and highly requested by parents of children in the CC waiver and members of the Louisiana Developmental Disabilities Council. They involve behavior modification, therapeutic techniques or other activities rendered by licensed or certified therapists, Occupational Therapists, Physical Therapists, Licensed Mental Health Professionals, etc. which improve the child's skills or functioning.

4) Related Rulemaking - The Notice of Intent (NOI) has been published for items #1 and #2, above but not the final rule; the final rule has been published for item #3, above which was effective on 9/20/2013.

B. Why is this success significant?

1) Permanent Supportive Housing (PSH) – For the first time, NOW, CC and SW participants can have PSH services which support them in paying/subsidizing their housing and in maintaining a stabilized housing unit for a longer period of time with an array of support services provided by specially trained case managers.

2) Remote Monitoring – It is a new and innovative technologically advanced service which will increase participant independence, maintain health/safety and possibly reduce cost. Companion Care – This represents a new, innovative and highly flexible service which allows participants and their direct support workers to live together and share rental expense either by dividing the actual cost or by bartering for services for their portion of the cost of rent, utilities, living expenses, etc.

3) Medical Equipment and Supplies – This adds an identical service to CC participants which was also available to NOW participants. This allows them access to medical equipment and supplies not otherwise covered by other funding sources. Six Alternate Therapies (Applied Behavior Analysis; Aquatic Therapy; Art Therapy; Music Therapy; Sensory Integration; Hippo/Therapeutic Horseback Riding) – These therapies fill gaps in services which are not available to children with developmental disabilities in Louisiana through state plan or EPSDT and fulfill the requests of parents and developmental disability stakeholders and developmental disability advocacy groups.

C. Who benefits and how? Those benefitting from all of the aforementioned expanded Home and Community-Based Services (HCBS) service options include: NOW and CC waiver participants; their parents and other family members; the providers, support coordinators and the Developmental Disabilities services system which plan for and use these expanded and innovative services to improve the care of and for persons with developmental disabilities, especially services which improve oversight and protect health and safety of waiver participants. Other services provide more flexibility, greater choice, increased independence more access to medical/therapeutic services and supports.

D. How was the accomplishment achieved?

Permanent Supportive Housing required extensive planning, meeting and collaboration with other DHH Program Offices (i.e., Office of Behavioral Health and Office of Aging and Adult Services) as well as DHH executive management before it could be implemented for the developmental disability population in the relative “Go Zones.” Subsequently, PSH services had to be added to the NOW, CC and SW Applications and approved by CMS before rulemaking could be accomplished.

Remote Monitoring and the Six Alternate Therapies required research from other states that were providing those services as well as refinement of the definitions and development of the rates, provider types and certification/licensing requirements for each professional. Remote monitoring also included a live demonstration from a company who was providing this service in other states.

The remaining expanded HCBS services had already been developed for our other waivers and simply required CMS approval for adding them to the NOW and CC waivers.

E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a goal to manage the delivery of an array of community-based supports and services in a fiscally responsible way allowing people with developmental disabilities achieve their person-centered or family-driven outcomes in the pursuit of quality of life, well-being, and meaningful relationships. Also, OCDD has the following Community Support Objective: To provide effective and efficient management, delivery, and expansion of

waiver and state funded community programs and to optimize the use of typical community resources in order to promote and maximize home and community life and prevent and reduce institutional care during FY 2012 through FY 2016.

- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. Several of the aforementioned innovative services, technologically advanced services and alternate therapies represent national best practices. The PSH service is also being used by the Office of Behavioral Health and the Office of Aging and Adult Services.

## II. Is your department five-year strategic plan on time and on target for accomplishment?

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

OCDD is making progress in its five-year Strategic Plan/Business Plan particularly with those initiatives that support the following strategic plan goals: 1) To provide a Developmental Disabilities Services System which affords people with information about what services and supports are available and how to access the services system; 2) To provide a person-centered planning process consistent with a needs-based assessment that focuses on the person's goals and desires and addresses quality of life; 3) To increase the capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings; 4) To increase the capacity of the Developmental Disabilities Services System to support people with complex behavioral, mental health, and/or medical needs in all service settings; 5) To implement an integrated, full-scale data-driven quality enhancement system; and 6) To rebalance the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs. These initiatives also support OCDD's Business Plan Priorities: 1) System Transformation, 2) Resource Center Transformation, and 3) Privatization. The success of the following initiatives in FY 2012-2013 has moved the Office toward goals/objectives outlined in both OCDD's Strategic Plan and Business Plan: transforming OCDD resource centers to centers of innovation and excellence; privatizing two of state-operated supports and services centers to private ICFs/DD through Cooperative Endeavor Agreements; assuring satisfaction for individuals moving from supports and services centers; downsizing remaining supports and services center; expanding service options within Home and Community-Based Services (HCBS); continuing implementation of Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana); utilizing all available self-direction waiver opportunities; and building foundation for Louisiana's Employment First initiative.

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

### **Program 1000 (Administration), Objective 2:**

**PI Code #24654 - Performance Indicator:** Percentage of human services districts/authorities receiving an annual validation visit (from a review of report of validation

visits) (Target: 95%/Actual: 100%)

1. To what do you attribute this success? Success is attributed to implementation of the OCDD Strategic Plan and issuance of operational instructions which include the procedures and schedule for the annual validation visits to each district and authority.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to be maintained at the current high rate.

**Program 2000 (Community-Based Supports), Objective 1:**

**PI Code #24660 - Performance Indicator:** Percentage of waiver participants who have been discharged from their waiver due to admission to a more restrictive setting (Target: 5%/Actual: 0.54%)

1. To what do you attribute this success? OCDD continues its multiple initiatives that have contributed to this success. OCDD continues enhancement and improvement to its planning and approval processes to increase assurance that the plans of care for participants address all needs so that each participant is able to successfully receive supports within their waiver living setting. Additionally, OCDD continues implementation of its risk management process that provides access to additional consultation and recommendations for those individuals with complex support needs and risk incidents. Finally, OCDD has centralized its crisis referral process for individuals for whom waiver living situation may be in jeopardy. This process involves collaboration and coordination between local entities and OCDD resource center clinicians to assist community providers in modifying or initiating needed supports in an effort to preserve the waiver living situation as outlined in OCDD Resource Center Transformation section. A new component is collaboration between OCDD, the Office of Behavioral Health and its managed care service provider (Magellan), so that behavioral health services to persons with developmental disabilities and mental illness may be adequately understood, diagnosed and treated properly.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at an accelerated pace with current OCDD initiatives focused on expanding the collaborative efforts between local entities and resource centers to increase preventive consultation and technical assistance to providers; as well as with OBH/Magellan to improve services to persons with co-occurring disorders.

**Program 2000 (Community-Based Supports), Objective 2:**

**PI Code # 24662 - Performance Indicator:** Percentage of EarlySteps providers that meet all training requirements (Target: 70%/Actual: 80%)

1. To what do you attribute this success? EarlySteps negotiated a contract with Essential Learning to hosts on-line training. Support provided through this contract allows the

regional offices to track completion of the modules and generate reports for follow up. In addition, an office policy was implemented which requires new providers to complete the modules prior to enrollment which ensures completion.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? With the policy which requires completion prior to enrollment, current performance level is expected to remain the same.

**Program 2000(Community-Based Supports), Objective 2:**

**PI Code # 24664 - Performance Indicator:** Percentage of Individual Family Services Plans (IFSPs) developed within 45 days of referral. (Target: 97%/Actual: 99%)

1. To what do you attribute this success? EarlySteps is able to generate reports from its data system and closely track timelines for completion of IFSPs by its entry offices. When performance is less than 100% monitoring is triggered to determine the reason for the delay. The system now tracks delays which are due to family reasons as compared to system or internal office reasons; if the delay is due to a system reason, a finding is issued and the entry office receives technical assistance in managing their timelines.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? A focus on improving performance for this indicator has been in place since 2008. Progress has been steady and is expected to continue.

**Program 2000(Community-Based Supports), Objective 2:**

**PI Code # 24665 - Performance Indicator:** Percentage of Individual Family Services Plans implemented within 30 days of parental consent on the Individual Family Services Plan. (Target: 92%/Actual: 92%)

1. To what do you attribute this success? Since 2007, EarlySteps has conducted provider recruitment and enrollment activities to increase the availability of providers around the state. Lack of provider availability is the main reason for a delay in meeting the 30-day timeline. In addition, support coordinators are required to have team meetings and contact the regional coordinator if there are problems with provider availability. With an increased number of providers in place and the addition of the follow up by the support coordinator, the performance standard has been met.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Since 2004 when EarlySteps began collecting data for this indicator, steady progress has been shown and expected to continue due to increased availability of providers.

**Program 6000(Residential Services), Objective 1:**

**PI Code #22522 - Performance Indicator:** Number of people transitioned to private provider community options according to assessment/support team recommendations (Target: 30/Actual: 40)

1. To what do you attribute this success? Success is due to joint efforts of Supports and Services Center staff, Regional Offices/Human Services Authorities and Districts, private providers, case management agencies, OCDD resource center clinicians, and Central Office to facilitate successful community transitions.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at current rate.

**Program 6000 (Community Resources/Resource Centers), Objective 1:**

**PI Code #24259 - Performance Indicator:** Percentage of individuals served by the resource center's Community Support Teams (CSTs) and Community Psychologists who remain in the community (Target: 85%/Actual: 99%)

1. To what do you attribute this success? OCDD resource centers employ clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral and medical support needs. The resource centers utilize a multi-disciplinary approach to providing consultation, training, and services that improve the ability of caregivers and providers to achieve positive outcomes for persons with complex needs.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at an accelerated pace for a greater number of individuals. With implementation of triage initiatives, the resource center staffs are able to provide services to a greater number of individuals and provider agencies. With implementation of crisis/diversion initiatives, the resource centers, in collaboration with the human services districts/authorities are able to initiate a consultation prior to escalation of a crisis situation such that one's community connection is maintained, or within a timeframe that increases the likelihood of diversion to the most integrated setting.

**Program 6000 (Community Resources/Resource Centers), Objective 1:**

**PI Code #24699 - Performance Indicator:** Percentage of individuals reporting satisfaction across the Partners in Quality (PIQ) assessed living situations (Target: 85%/Actual: 92%)

1. To what do you attribute this success? OCDD has utilized a person-centered approach and tools as individual's transition from a large ICF/DD setting into less restrictive community settings to ensure individuals support needs are met and to assist with improving quality of life in the less restrictive environment. The PIQ process allows ongoing oversight for a minimum of one year after transition from a large ICF/DD to ensure supports are met and the inter-disciplinary team is actively planning if issues are identified.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at an accelerated pace. OCDD will initiative activities to FY14 to further refine the oversight process

following transition from a large ICF/DD to ensure quality of life and support needs are met.

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

**Program 2000 (Community-Based Supports), Objective 1:**

**PI Code #25035 – Performance Indicator:** Number of persons in individual integrated employment (Target: 225/Actual: 0\*) [\*Note: Unable to measure this indicator as the electronic Plan of Care currently being developed is not on line, and this is the only means to secure accurate information.]

1. To what do you attribute the lack of progress? The Employment First initiative continued in a foundation building mode during FY 2012-2013. While OCDD is still not able to accurately track this objective, it is suspected that the actual number did not meet the target. Activities focused on employment supports being a central feature of planning and supports for adults and for partnerships with community providers and organizations to increase employment opportunities to individuals receiving waiver supports.
2. Is this lack of progress due to a one-time event or set of circumstances? When new large scale initiatives are undertaken, progress is typically slower in the beginning years due to the need to put foundational operations, structures, and partnerships in place. Many of the existing processes and supports are in need of modification and/or development. Progress should begin to increase over the years of implementation for this initiative.

**Program 2000 (Community-Based Supports), Objective 1:**

**PI Code #24648 - Performance Indicator:** Number of years and months on Request for Services Registry (RFSR) until offered a NOW opportunity (Target: 7.5/Actual: 8.9)

**PI Code #24649 - Performance Indicator:** Number of years and months on Request for Services Registry (RFSR) until offered a Children's Choice (CC) opportunity (Target: 6.5/Actual: 8.3)

**PI Code #24650 - Performance Indicator:** Number of years and months on Request for Services Registry (RFSR) until offered a Supports Waiver (SW) opportunity (Target: .3/Actual: 1.67)

1. To what do you attribute the lack of progress? Although OCDD had made significant progress in previous years in reducing the "wait time" for persons on the RFSR, this was due to the ongoing distribution of waiver opportunities which became available from a 1/3 legislative allocation of funding that was matched by a 2/3 federal Medicaid funding award. However, due to state budget constraints, no state appropriations for waiver opportunities have been funded by the Louisiana legislature for several years. Thus, as more persons request waiver services and are added to the RFSR without any new opportunities being offered, the natural trend is for more persons to wait longer and the overall average wait time for the RFSR to increase over time. This is the trend which is demonstrated in the data for the three performance

indicators presented above.

2. Is this lack of progress due to a one-time event or set of circumstances? A set of circumstances which are described in question number 1, above.
- ◆ **Has your department revised its strategic plan to build on your successes and address shortfalls?**
    - Yes. OCDD's Strategic Plan for FY 2012 through 2016 and its annual Business Plan have been updated. Updates to both plans include revisions to program objectives, strategies and indicators to reflect Office direction, to build on successes, to provide strategies in areas where success has not be as substantial or where changes in program direction indicate such, and to improve performance assessment.
  - ◆ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Objectives are assigned to staffs within the Office who are responsible for management and oversight of the accomplishment of each objective and related performance indicators. Additionally, a variety of management tools (i.e., databases, project charters, etc.) and task/initiative specific workgroups/committees are utilized to track, review, and provide feedback for utilization in decision making and resource allocation. Progress or lack of progress (along with support/resources needed in order to achieve the assigned objective) is reported to the OCDD Executive Management Team. Performance data is also reported in LaPAS and available for both management and stakeholder review.

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

**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 a lack of qualified persons to deliver applied behavior analytic therapies to persons with autism. These therapies can be very effective and significantly alter the course of autism for many individuals. While specific departmental and OCDD initiatives have been implemented this fiscal year to continue addressing this barrier and improvements have occurred in some areas, a general problem continues to exist. It is believed that a multi-faceted and multi-year approach may be required to resolve the problem.
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 the ability to develop new autism services, which can prevent more severe negative developmental outcomes. The inability to teach functional behavioral skills adequately detracts from community participation objectives (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 have been impacted by this problem for a number of years. The Office of Behavioral Health and the newly implemented Louisiana Behavioral Health Partnership (LBHP)/Coordinated System of Care (CSoc) is also likely experiencing some impact due to this problem.
4. Who else is affected by the problem? Individuals supported and their families, support coordinators, and private providers who serve persons with developmental disabilities in community homes, family homes, and supported independent living settings are impacted by this problem.
5. How long has the problem or issue existed? The problem is longstanding.
6. What are the causes of the problem or issue? How do you know? Many factors contribute to the problem beginning with a historic lack of training of persons equipped to deliver these services. Many Ph.D. psychology 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. Both the increasing number of persons with developmental disabilities now being served in the community and the downsizing of institutional services, generally considered to be positive and progressive developments in developmental disabilities services, has contributed to an 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. In addition, private Supported Independent Living (SIL) providers serving persons in waiver settings and private community home providers generally conduct and are required to conduct very little training with direct support staff on positive behavior supports.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Consequences include a significant number of people with developmental disabilities having unmet needs, a continued need for costly institutional admissions to the higher treatment cost supports and service center, and an inadequate number of practitioners to positively impact the developmental

trajectories of children with autism leading to increasing service costs over the course of their lifespan.

## B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue? The following are recommended actions to alleviate the problem:
  - Continue implementation of the newly developed plan to transform the OCDD resource centers into centers of innovation and excellence. This includes opportunities for partnering with university programs that provide training resulting in additional needed professionals, growing the service provider pool, including expansion of Operation House Call into the Shreveport area.
  - Continue expanded implementation of statewide access to training for direct support workers through the MFP Rebalancing Demonstration (My Place Louisiana) program.
  - Develop collaborative protocol and practices for OCDD interface with LBHP/CSoc to enhance coordination of needed services for individuals with developmental disabilities and behavioral health needs.
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? Yes. A recommendation has been included in this annual report for the last few years. Some recommendations have been implemented, while others remain and new recommendations are included.
4. Are corrective actions underway? Yes. A number of actions are underway:
  - OCDD's statewide Positive Behavioral Supports (PBS) curriculum for direct service workers has been expanded to include statewide certified trainers and is being incorporated into the resource center transformation as an ongoing option with local accessibility.
  - OCDD continues to support the development of a new university-affiliated training program for master's level practitioners.
  - OCDD continues to offer Board Certified Behavior Analysts (BCBA) continuing education opportunities as well as other behavioral and psychological continuing education options.
  - OCDD continues to operate small existing community service teams in each region of the state.
  - OCDD and OBH have established more formal/routine cross office collaborative efforts. Cross training related to services within each system has begun and will continue into next fiscal year. A formal collaborative protocol is in development.
  - A proposal for transformation of the OCDD resource centers into centers of innovation and excellence has been completed with input from key stakeholders

throughout the state. Data from initial pilots featuring local partnerships between local governing entities and resource centers supports positive outcomes for participants (see section on Resource Center Transformation in the accomplishments section).

- OCDD continues to work with Medicaid in regard to needed behavioral services for children with Autism. Act 351 of the 2012 Regular Session of the Legislature, which provides for licensure of behavior analysts, will allow for enrollment in Medicaid and is a first step in addressing some of the access issues for these individuals.
5. Do corrective actions carry a cost? Most of these actions do not carry a cost. Implementation of training and capacity building efforts approved in the MFP Rebalancing Demonstration (My Place Louisiana) Operational Protocol are funded with federal demonstration dollars through 2020. While other corrective actions could carry a cost in so far as additional clinicians and/or technical assistance staff are recruited into state service systems, they do not carry a cost 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 result in extensive lifelong service costs that are estimated at over one million dollars per person and 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 downsized/privatized/closed, 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. These costs may include acquisitions and major repairs, risk management fees, building and grounds maintenance, utilities, and loss prevention/security. In addition, OCDD remains responsible for risk management fees at three privatized facilities and for major repairs and identified maintenance costs per the Cooperative Endeavor Agreement for operation of the former Northlake Supports and Services Center facility. OCDD will continue to be responsible for all of these costs as long as the properties belong to 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 premiums for the vacated and privatized OCDD properties were \$5,590,920 in FY 2012-2013. Total other costs associated with maintaining the vacated and privatized OCDD properties was approximately \$7,139,134 in FY 2012-2013 and is anticipated to be approximately \$7,683,688 in FY 2013-2014.

2. Is the problem or issue affecting the progress of your strategic plan? Yes. Although indirectly, this problem is affecting OCDD's progress in implementing its strategic plan in that the fiscal resources required to maintain the vacated properties could be better utilized to further OCDD's progress toward any one or all of its strategic plan goals. In addition, the opportunity to utilize state-owned property as revenue-generating property as campuses are vacated has been explored; however, there are current legislative rules in direct opposition to this course of action.
3. What organizational unit in the department is experiencing the problem or issue? OCDD is managing the problem by continuing to allocate necessary resources to manage the costs associated with maintaining the properties and fulfilling Office of Risk Management (ORM) and other state requirements.
4. Who else is affected by the problem? The OCDD budget authority and the employees fulfilling the duties are affected by this problem.
5. How long has the problem or issue existed? The problem was identified in FY 2009-2010.
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 a continued expenditure of funds to maintain properties that are no longer used by OCDD. These expenditures may cause shortfalls in future fiscal years.

#### B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue? 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 to researching and developing amendments to existing legislation as these actions would be completed by existing staff. However, as mentioned above, failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings/facilities.

### **Slow Progress of System Rebalancing**

#### A. Problem/Issue

1. What is the nature of the problem or issue? The System Rebalancing progress has slowed, with some significant barriers to accomplishing progress developing over the fiscal year. FY 2012-2013 ended with 72% of developmental disability services being provided through Home and Community-Based Services (HCBS) and 28% through institutional services. Past efforts in system rebalancing have primarily relied upon: (1) spending more in HCBS, (2) utilizing state resources for capacity-building supports, and (3) reducing supports and services center (SSC) capacity with little impact on private ICFs/DD. The system has reached a point where fiscal sustainability is a concern; state resources have been reduced; and support and services center capacity has phased down to one center, Pincrest. In order to continue rebalancing, impact areas must move to changing use and delivery of HCBS (more effective, more efficient, more accessible); forming public/private partnerships that enhance private sector led capacity building; and affecting the utilization of private ICFs/DD. Efforts dedicated to the shift in impact areas have met with considerable opposition from stakeholders. In areas where some consensus has developed, resource constraints and external factors have presented as barriers.
2. Is the problem or issue affecting the progress 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. If rebalancing progress slows or halts, strategic plan elements will not be met.
3. What organizational unit in the department is experiencing the problem or issue? OCDD Community Services Section (waiver authority, state general fund, regional authority, and local governing entities), the supports and services center, and resource centers are impacted, as well private ICFs/DD operations in Medicaid. The MFP Rebalancing Demonstration (My Place Louisiana) has benchmarks for system rebalancing; failure to meet these benchmarks may affect our funding stream.

4. Who else is affected by the problem? Those affected include individuals supported and their families, providers of HCBS and ICF/DD services, support coordination agencies, and local/state advocacy groups.
5. How long has the problem or issue existed? Rebalancing work began in 2001. However, the current problem has reached a head as of FY 2011-2012 and continued through FY 2012-2013.
6. What are the causes of the problem or issue? How do you know? The need for rebalancing arose from a combination of federal Medicaid's initial institutional bias with: (1) the growing demand for HCBS, (2) the realities of system sustainability HCBS are generally more cost-effective, and (3) mandates for provision of services in integrated settings appropriate to need. The current problem of slowing of OCDD's progress in system rebalancing is caused by the decreased availability of state resources, leading to the need for an aggressive focusing on changes that more heavily impact the private sector and that must be carried out cooperatively by the private sector.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Consequences include continuing to invest heavily in ICFs/DD; retaining a long waiting list for waiver services; failing to achieve outcomes in HCBS inclusive of continued crisis referrals for SSC admission; and having persons left unserved due to finite system funding. Long-term an unbalanced service system may not be sustainable, with persons served in higher cost/lower quality options and high percentages of persons underserved or unserved.

#### B. Corrective Action

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? In FY 2012-2013 OCDD began a comprehensive system transformation. The system transformation will improve access to, quality of, cost-effectiveness of and efficiency of community services for persons with developmental disabilities utilizing state plan Medicaid, waiver, EarlySteps, and state general funds services. The services will also impact the access structures to public and private ICFs/DD. Over the course of a multi-year period, the system transformation activities should result in the following:
  - Serving more persons in Home and Community-Based Services (HCBS),
  - Achieving cost effectiveness and greater quality-of-life satisfaction among persons served through a greater focus on HCBS versus institutional options,
  - Reducing institutional reliance in both private and public settings,
  - Providing access to appropriate services based upon need, and
  - Increasing the use of appropriate natural and community supports.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? Components of the proposed corrective actions have been discussed in previous management reports throughout FY 2011-2012 and FY 2012-2013.
4. Are corrective actions underway? Yes. OCDD completed a comprehensive system analysis in partnership with stakeholders to identify priorities of system transformation and specific change areas for inclusion in a multi-year work plan. In addition, OCDD completed research and evaluation progress of efforts to implement managed care for persons with developmental disabilities in other states, as well as best practice recommendations and developed an alignment strategy for system transformation and concurrent efforts by DHH to explore managed long-term supports and services. Fiscal year 2013-2014 will see implementation of the system transformation work plan.
5. Do corrective actions carry a cost? Yes. Rebalancing efforts traditionally require an up-front investment to recognize future savings. These savings are often significant and sustainable. Investment may be in service dollars (i.e., more waiver opportunities, expansion of services offerings, rate adjustments, increased administrative funding) or in state general fund dollars for capacity building or one-time non-Medicaid costs.

#### **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:

**National Core Indicators Project** – Since FY 2008-2009, the Louisiana Office for Citizens with Developmental Disabilities (OCDD) has participated in the National Core Indicators (NCI) Project. Currently, 39 states participate in the NCI Project. The purpose of NCI Project is to identify and measure core indicators of performance of state developmental disabilities services systems. The NCI Project is co-sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). Annually, three family surveys are sent to the families of people with developmental disabilities participating in various developmental disability programs and adults with developmental disabilities are interviewed. A number of reports are prepared to summarize the results of this project.

1. Title of Report or Program Evaluation:

Reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services:

- *National Core Indicators Adult Consumer Survey 2011-12 Final Report*: This report provides a summary of the results of interviews with adults receiving developmental disability services and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Family Guardian Survey 2011-12 Final Report*: 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 2011-12 Final Report*: This report provides a summary of the survey which was mailed to families of adults receiving developmental disability services who reside with their families and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Child Family Survey 2011-12 Final Report*: This report provides a summary of the survey which was mailed to families of children living and receiving services in the family home and provides comparisons between Louisiana and the national average of other participating states.
- *NCI Adult Consumer Survey Outcomes, Louisiana Report 2011-2012 Data*: This report provides a short summary of Louisiana's adult consumer survey data as compared to the average data of all 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 July 2013. (Surveys and interviews were completed between January and June 2012.)
3. Subject or purpose and reason for initiation of the analysis or evaluation: Surveys and interviews were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. Interview questions concerned satisfaction, quality of care, and quality of life. Analyses compared Louisiana statewide results with results of other states participating in the National Core Indicators Project.
4. Methodology used for analysis or evaluation: The primary tools used for this evaluation were family surveys and consumer interview questions. Analyses reported both the number and percentage of responses to each question. Comparisons were reported among the participating states.
5. Cost (allocation of in-house resources or purchase price): The family mail-out surveys were printed and mailed through a purchase order for approximately \$6,000. All other activities were performed in-house. Obtaining and verifying information for families for the mail-out samples and consumers for the interview sample took approximately 272 hours of staff time. Scheduling interviews, completing background information, and interviewing consumers took approximately 1,400 hours of staff time. Entering family survey data and consumer interview data into the NCI database took approximately 184 hours of staff time. Postage costs for a Business Reply Permit and return postage costs were approximately \$2,200. Finally, travel costs to conduct 400 interviews were approximately \$6,000.
6. Major Findings and Conclusions: Overall, Louisiana was ranked within the average range for the *Child Family Survey*, *Adult Family Survey*, *Family Guardian Survey*, and *Consumer Outcomes Interviews*. The majority of responses were “Within Average Range” with a substantial number falling five or more percent above average. However, there were a few areas that were five or more percent below average.
7. Major Recommendations: Acquire information/explanations/causes related to areas that fell below average and develop/implement strategies to improve issues identified.
8. Action taken in response to the report or evaluation: OCDD’s quality improvement process includes review of NCI data as well as data from other sources such as: data on regional performance indicators as part of the Human Services Accountability and Implementation Plan and data from EarlySteps and Home and Community-Based Services (HCBS) waiver performance indicators. The data is

reviewed by the OCDD Performance Review Committee. When trends and patterns are noted, quality improvement projects are developed and implemented upon approval of the OCDD Assistant Secretary.

9. Availability (hard copy, electronic file, and website): Available in electronic file on the National Core Indicators website:

[www.nationalcoreindicators.org](http://www.nationalcoreindicators.org)

10. Contact person for more information, including:

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Title: Program Manager 3

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