



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

December 6, 2010

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

FROM: Bruce D. Greenstein   
DHH Secretary

RE: Annual Management and Program Analysis Report (AMPAR)

In accordance with Louisiana Revised Statutes 36:8, the Department of Health and Hospitals is submitting its Annual Management and Program Analysis Report (AMPAR) for the 2009-2010 fiscal year. These reports summarize the activities of each office relating to management and program analysis, outstanding accomplishments, areas where we are making significant progress and specific management/operational issues that exist within the agency.

Although the last few years have marked challenging times for the Department and the State of Louisiana, our Department continues to make improvements, reforms, and bring fresh ideas and insights in our efforts to make quality health care a reality for the citizens of our state.

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

# Department of Health & Hospitals

## Agency List

09-300	—	<b>Jefferson Parish Human Services Authority</b> Michael Teague (504) 838-5215
09-301	—	<b>Florida Parishes Human Services Authority</b> Melanie Watkins (985) 748-2220
09-302	—	<b>Capital Area Human Services District</b> Dr. Jan Kasofsky (225) 922-2700
09-303	—	<b>Developmental Disabilities Council</b> Sandee Winchell (225) 342-6804
09-304	—	<b>Metropolitan Human Services District</b> Judge Calvin Johnson (504) 568-3130
09-305 & 306	—	<b>Bureau of Health Services Financing – (Medical Vendor Administration &amp; Medical Vendor Payments)</b> Don Gregory (225) 342-6726
09-307	—	<b>Office of the Secretary</b> Jerry Phillips (225) 342-6726
09-320	—	<b>Office of Aging and Adult Services (OAAS)</b> Hugh Eley (225) 219-0223
09-324	—	<b>Louisiana Emergency Response Network (LERN)</b> Coletta C. Barrett, (Acting Director) (225) 756-3440
09-326	—	<b>Office of Public Health (OPH)</b> Clayton W. Williams (225) 342-8093
09-330	—	<b>Office of Mental Health (OMH) – Areas A, B &amp; C</b> Kathy Kliebert, Office of Behavioral Health (225) 342-2540
09-340	—	<b>Office for Citizens with Developmental Disabilities (OCDD)</b> Julia Kenney (225) 342-0095
09-351	—	<b>Office for Addictive Disorders (OAD)</b> Rochelle Head-Dunham (225) 342-6717

# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

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

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips, Undersecretary

**Agency Head:** Michael E. Teague, Executive Director

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

For each accomplishment, please discuss and explain:

#### Electronic Health Record

##### A. What was achieved?

Jefferson Parish Human Services Authority (JPHSA) continued expansion of its fully integrated Electronic Health Record (EHR) throughout FY 2009-2010. The Adult Community Support Division was included as a “unit” within the EHR, and five programs (“subunits”) began to document within the system. All appropriate in-house staff and staff of specific contractors received intensive training. (Documentation is included in ongoing quality control monitoring.) The Project Manager completed due diligence, and developed an implementation plan and training schedule with the Developmental Disabilities Community Services Division. Monitoring and decision-support functions were also expanded, e.g. concurrent documentation of service delivery, direct/indirect service time (productivity), appointments kept/ cancelled by provider/cancelled by recipient/no show, client engagement, no contact 180 days, etc., and were used for benchmarking and trending as well as for performance and process improvement. The billing component of the EHR was completed during FY 2009-2010, and 100% of billable services were billed via the system before the close of the Fiscal Year. Performance standards for billing were put in place including timelines for validation of billing data and release of billing as well as for denial rates, i.e. clean bill rate.

B. Why is this success significant?

JPHSA is the first Local Governing Entity (LGE) to implement a fully integrated Electronic Health Record and is on the leading edge among Behavioral Health and Developmental Disabilities service providers in Louisiana with implementation of its system. Further, JPHSA is ahead of task to meet the national goal of modernizing health care by making all records electronic by the year 2014.

Continued advancement of the EHR has enabled the significant enhancement (in terms of sophistication and depth/breadth) of JPHSA's infrastructure for decision support and performance and quality improvement functions. Of particular note is concurrent documentation of service delivery, which encourages client engagement, promotes information sharing among members of the treatment team on a real-time basis, enables more timely monitoring for compliance and quality, supports improved productivity, i.e. direct service time among service providers, and enables more efficient validation of services for billing.

C. Who benefits and how?

The individuals served by JPHSA and the Authority itself benefit from the ongoing expansion of the EHR. The system: provides a real time and holistic view of individuals receiving services; facilitates concurrent documentation that stimulates improved client involvement in service plan development and implementation, i.e. ongoing treatment; supports performance and process improvement including monitoring of outcomes; enhances communication and collaboration across programs and facilities; reduces the incidence of medical errors by increasing accuracy and clarity; improves the defense of protected health information via a multi-layered security system; improves and reduces the cost of compliance and utilization management monitoring; improves the billing process in terms of both speed and accuracy; and, enhances the generation of revenue from billable services.

D. How was the accomplishment achieved?

A Project Manger and the chartered System Transition Steering Committee (STSC) are accountable for the ongoing expansion and management of the JPHSA Electronic Health Record. The Project Manager chairs the multi-disciplinary, cross-divisional STSC, which currently meets on a biweekly basis, more frequently if needed. He is also responsible for change management documentation. Continued implementation of the EHR is regarded as significant cultural change within JPHSA, which requires top-down visible and consistent support, bottom-up communication, and horizontal coordination among participating Divisions.

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

As stated in the FY 2008-2009 AMPAR, expansion and advancement of the JPHSA Electronic Health Record supports the Authority's Strategic Plan. The EHR is a foundation tool for ongoing performance and quality improvement; facilitates concurrent documentation of service delivery; streamlines operations; enhances productivity; enables ongoing daily monitoring for quality assurance, medical necessity, and treatment/service outcomes; and, maximizes reimbursement opportunities to support service delivery and the sustainability of the Authority. Therefore, it may be concluded that the EHR has a positive impact on achieving the Goals set forth in JPHSA'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?  
JPHSA shared its due diligence process in selecting an Electronic Health Record system as well as its implementation and change management plan with the former Office of Mental Health. Further, the Authority played an active role in the Electronic Behavioral Health Record Stakeholder Group, also operating out of the former office of Mental Health. Currently, JPHSA is providing demonstrations and decision support to other Local Governing Entities considering implementation of an EHR.

### **Performance & Process Improvement**

- A. What was achieved?  
Jefferson Parish Human Services Authority (JPHSA) formalized a multi-dimensional, Authority-wide Performance and Quality Improvement (PQI) process to 1) assure effective and efficient use of available resources to meet the needs of internal and external customers and 2) position the Authority for long-term sustainability. The PQI process put into place assures ongoing critical assessment, evaluation, and continuous improvement of every aspect of JPHSA administrative and service delivery functions...in a structured, continuous, and highly visible manner. (Analysis based on experience, continuous monitoring, and outcome data were utilized to develop the supporting document – JPHSA Performance & Quality Improvement Plan – in September 2010.)
- B. Why is this success significant?  
Performance and Quality Improvement is part of the JPHSA culture that values service quality, positive outcomes for individuals served, prudent use of resources, efficient and streamlined service delivery, as well as the achievement of Mission and Strategic Plan Goals. Every employee has an identified role with expectations set and communicated with accountability clearly identified. JPHSA has, in effect, “walked the walk.”

C. Who benefits and how?

The individuals and families served by JPHSA and the Jefferson Parish community at large benefit from the Authority's commitment to Performance & Quality Improvement. PQI assures a highly performing, productive, efficiently operated, organization that is focused on achieving positive outcomes through the most effective treatment/service regimens within the context of available resources now and in the future.

D. How was the accomplishment achieved?

The JPHSA Executive Director and Executive Management Team have overall responsibility for the continued enhancement and implementation of the Authority's Performance & Quality Improvement Plan (process) including the development of strategies needed to effectively remove barriers to ongoing successful execution of the plan. The foundation of the plan/process is rooted in the National Council for Community Behavioral Health Care endorsed "Accountable Care" Model and is supported by the Authority's robust decision support and monitoring functions and by consistent and ongoing communication with internal and external stakeholders. PQI is part of the daily fabric of JPHSA operations.

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

Performance & Quality Improvement supports the JPHSA Strategic Plan. All components of the Authority's PQI process are geared to assure 1) focus on achieving and/or exceeding Strategic Plan Goals, Objectives, and Performance Indicators, and 2) decisive and coordinated action based on data when corrective action or improvement is needed.

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

A Performance & Quality Improvement Plan, adopted as part of an organization's culture, is critical to that organization's continued viability and ongoing success. Although JPHSA is pleased to share its plan, any agency or department making the commitment to implement a PQI plan should develop one that is specific to that entity's strategic goals and needed outcomes.

## 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.

Overall, Jefferson Parish Human Services Authority (JPHSA) remained on target with

progress toward achieving Strategic Plan Goals and Objectives. The Authority consistently utilized **all** strategies outlined in its Strategic Plan to effectively demonstrate performance and quality improvement on a continuous basis.

In addition to Strategic Plan Goals and Objectives, implementation of strategies also produced positive results in the areas of client engagement (solid “kept appointment” rates rivaled benchmarks set by the Accountable Care Model), documentation of clinical treatment (significant improvement in concurrent documentation due to use of the Electronic Health Record and continuous monitoring), 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 (turnover remained below 2%).

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

During FY 2009-2010, Jefferson Parish Human Services Authority (JPHSA) demonstrated progress on each of the three goals included within its Strategic Plan:

**Goal 1:**

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

**Goal 2:**

To improve personal outcomes through effective implementation of best practices and data-driven decision-making.

**Goal 3:**

To retain an adequate workforce to fulfill the Mission and Priorities of Jefferson Parish Human Services Authority.

As stated previously, JPHSA utilized all Strategic Plan strategies with increased focus on utilization management, monitoring and related follow-up activities, client engagement, and positive outcomes.

a. To what do you attribute this success?

Success may be attributed to the following: 1) continued adherence to the Accountable Care Model; 2) renewed emphasis on performance and continuous quality improvement throughout every area of JPHSA operations; 3) continued focus on horizontally integrated and holistic service delivery; 4) expansion of the

Electronic Health Record; and, 5) clearly defined performance expectations for all employees supported by monitoring, consistent supervision, and ongoing coaching.

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

JPHSA intends to strive for continued progress toward achieving Strategic Goals and Objectives in support of the Authority's Mission: "To minimize the existence and disabling effects of mental illness, substance abuse, and developmental disabilities and to maximize opportunities for individuals and families affected by those conditions to achieve a better quality of life and to participate more fully within our community."

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

JPHSA experienced **no** lack of progress in achieving its Strategic Goals and Objectives during FY 2009-2010. However, Standards set for Performance Indicators related to employment for both Behavioral Health and Developmental Disabilities proved to be difficult to achieve. Success was negatively impacted due to the external factors of an economic downturn, coupled with higher unemployment and increased competition for jobs; and to the internal factors caused by budget reductions. JPHSA still met or exceeded national benchmarks for employment of individuals with Behavioral Health (specific to mental illness) issues and/or Developmental Disabilities.

♦ **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?

JPHSA's revised Strategic Plan retained Goal 1 and Goal 2 (see above) with Objectives developed to coincide with Authority functions identified during the FY 2010-2011 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/service delivery; increased access to social support systems; increased monitoring; increased technical assistance to contractors; and, pervasive performance and quality improvement activities. All Strategies were geared to assure sustainability, increase capacity, and continue the delivery of high quality effective services and supports. The Authority also honed Performance Indicators, retaining some trending data with the bulk of the attention on true outcome measures.

No. If not, why not?

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

JPHSA, a Local Governing Entity, adheres to the Carver Policy Governance Model. The Board of Directors establishes the Authority's Mission 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 Strategic Plan Goals and Objectives.

As an organization that has adopted and actively practices both Accountable Care and Performance and Quality Improvement models/philosophies, JPHSA 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 employees).

Each Division Director within the Authority is required to develop an annual division-specific business plan in support of the JPHSA Strategic Plan. Each Director is also required to provide quarterly progress reports to the Executive Director and other members of the Executive Management Team. Additionally, the Executive Management Team develops, adopts, and implements cross-divisional annual Performance & Quality Improvement Initiatives (PQI) to further insure JPHSA will meet and/or exceed Strategic Plan Goals and Objectives and to support the successful sustainability of the Authority. As with the business plans, quarterly progress reports are delivered, in this case by the full Executive Management Team.

JPHSA informs employees about Strategic Plan Goals, Objective, and Performance Indicators via its electronic newsletter, *Have You Heard*; and, Directors involve staff in data collection, analysis, and reporting of Performance Indicator outcomes. Directors also lead discussion about their Division business plans during Division-wide meetings (held on no less than a quarterly basis), reporting progress, obtaining staff input, and emphasizing accountability for reaching goals and objectives. Performance & Quality Improvement Initiatives are reported to staff in the *Have You Heard*; and, PQI Teams (representing various Divisions and levels of staff) are formed to focus on specific components of the array of initiatives.

The Executive Director schedules two all-staff meetings each Fiscal Year. Performance and quality improvement are routine parts of the agenda. Further, the Executive Director bases a significant portion of the Division Directors' annual performance reviews on their contributions to the JPHSA Strategic Plan and Performance & Quality Improvement

Initiatives as well as on their degree of success in accomplishing business plan goals and objectives.

Weekly Executive Management Team meetings and occasional planning retreats are used as both group supervision and as forums for discussion of progress on meeting/exceeding Goals and for development of corrective action and/or performance improvement plans. The Executive Director holds the Executive Management Team accountable on both an individual and group basis for the successful implementation of the JPHSA Strategic Plan, Division-specific Business Plans, and PQI Initiatives.

Each JPHSA 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 JPHSA's Staff Development and Supervision Guidelines (weekly for new employees, monthly for established employees, and as needed for employees in need of performance improvement) to review and discuss progress toward meeting expectations. Continued and open discussion is encouraged.

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

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

#### **Reductions in Funding**

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

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

During FY 2009-2010, Jefferson Parish Human Services Authority (JPHSA) experienced a **reduced level in** State General Funds (SGFs). Added to this is the hiring freeze of FY 2009-2010 and the "non-T.O." Executive Order of June 30, 2010, which reduced the number of funded positions. Vacant positions in service areas are, of course, the priority to fill. JPHSA was a recipient of Primary Care Access Stabilization Grant (PCASG) funding, which ended September 30, 2010.

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

Yes. JPHSA revised its Strategic Plan goal and amended its strategic plan objectives.

3. What organizational unit in the department is experiencing the problem or issue?  
Every activity of Jefferson Parish Human Services Authority, i.e. Behavioral Health Services, Developmental Disabilities Community Services, and, Administration (which includes utilization management, monitoring, and billing functions) is experiencing the problem/issue.
  
4. Who else is affected by the problem?
  - Individuals Served
  - Residents of Jefferson Parish
  - Every employee (all areas and all levels)
  - Contractors and their employees
  - Community Partners such as the Jefferson Parish President and Council, Jefferson Parish Sheriff's Office, Jefferson Parish Coroner's Office, Jefferson Parish Public School System, the District Attorney's Office, Juvenile Judges, and local not-for-profit community hospitals
  
5. How long has the problem or issue existed?  
The negative effect of reduced funding was noted in FY 2008-2009, although PCASG did offer limited (restrictions on use of dollars) and temporary relief.
  
6. What are the causes of the problem or issue? How do you know?  
Causes are a reduced State budget; a depressed economy; and, reductions in Federal funding.
  
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?  
JPHSA must address all impacts and potential impacts of decreased funding with urgency and must utilize effective and flexible strategies/tactics to continuously improve performance and quality AND to identify and capture alternate revenue streams.

#### B. Corrective Actions

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

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

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

JPHSA will:

- Continue execution of the Performance & Quality Improvement Plan to assure best use of limited resources, streamlined operations and service delivery, high levels of productivity, open capacity, and high quality outcomes for individuals receiving services and supports.
- Continue implementation of the JPHSA Utilization Management Plan.
- Continue to explore and seek relationships with private payors to open new streams of revenue. (The initial application and contract are awaiting approval, and a second private insurer is targeted for FY 2010-2011.)
- Participate fully in the 1115 Waiver. (The Authority is already a credentialed provider.)
- Support, encourage, and seek Medicaid funding for evidence-based practices offered in the home and community.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?  
Reductions in funding were addressed in the AMPAR submitted for FY 2008-2009.

4. 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 JPHSA for continued success with the dramatic changes anticipated with the full implementation of Healthcare Reform in 2014.

5. Do corrective actions carry a cost?

- No.  
 Yes.

Corrective actions are viewed as business and service delivery processes woven into the fabric of JPHSA's daily operations. Primary responsibility for setting expectations and monitoring progress rests with the Executive Director; primary responsibility for execution of corrective actions rests with the members of the Executive Management Team. Resources needed to successfully carry out these processes are Human Resources; related duties and responsibilities are included in

each Executive Management Team member's position description and in each employees performance planning and rating documents. Executive Management Team members are expected to manage priorities with flexibility and to LEAD their respective staffs to assure processes are ongoing and expectations are met or exceeded.

## **Expansion of Medicaid Revenue**

### A. Problem/Issue Description

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

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

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

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

Yes. Please refer to Section III, Reductions in Funding. Without expansion of this revenue stream to counter balance the reduction or elimination of State General Funds (SGFs) and federal dollars (e.g. Primary Care Access Stabilization Grant), JPHSA 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 Jefferson Parish Human Services Authority, i.e. Behavioral Health Services, Developmental Disabilities Community Services, and, Administration (which includes utilization management, monitoring, and billing functions).

#### 4. Who else is affected by the problem?

- Individuals Served
- Residents of Jefferson Parish

5. How long has the problem or issue existed?  
The services referenced in this section of AMPAR have never been eligible for reimbursement. The cap placed on the number of services allowed to be billed per visit has been in place since the formation of JPHSA; and the cap of \$100 on the amount allowed to bill has been in place since FY 2006-2007.
  
6. What are the causes of the problem or issue? How do you know?  
The array of services eligible for reimbursement and the rates of reimbursement are identified in Title 48 of the Louisiana Administrative Code and in the Louisiana Medicaid Program Mental Health Clinics Provider Manual.
  
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?  
As previously stated, JPHSA must expand alternate revenue streams to mitigate the consequences of diminishing State General Fund and loss of Primary Access Stabilization Grant funding with a sense of urgency. In tandem, the Authority must utilize effective and flexible strategies/tactics to continuously improve performance and quality.

#### B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?  
  
 No. If not, skip questions 2-5 below.  
 Yes. If so, complete questions 2-5 below.
  
2. What corrective actions do you recommend to alleviate or resolve the problem or issue?  
Once the proposed Medicaid State Plan is finalized and approved for implementation, JPHSA will 1) make necessary adjustments to its staffing patterns to assure providers delivering services are eligible to bill and 2) modify its charge master and the billing component of its Electronic Health Record (EHR) to assure all allowable services are billed.
  
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?  
Medicaid funding for evidence-based practices offered in the home and community was discussed in JPHSA's FY 2008-2009 AMPAR.

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

JPHSA's Executive Director and Behavioral Health Clinical Division Directors have completed an assessment and analysis of JPHSA's current staffing patterns. Adjustments have already been instituted within the Authority's Access function to assure licensed clinicians who can diagnose and bill manage the intake and initial assessment processes. Additional actions with regard to staffing patterns will not be taken until the proposed Medicaid State Plan Amendment is in final form and released for implementation. Procedures for modification of the JPSHA charge master and the billing component of its EHR are in place but will not be initiated until the Amended State Plan is in hand.

## 5. Do corrective actions carry a cost?

- No.  
 Yes.

JPHSA has the in-house expertise to carry out all components of these identified corrective actions.

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

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

- Internal audit  
 JPHSA's Management Services Division provides ongoing monitoring of clinical and administrative functions. Audit tools, with identified criteria and targets are utilized; results are reported; and, appropriate process improvement and/or corrective actions are executed. Further, JPHSA formed three Process Improvement Teams – Service Delivery Area, Environment of Care, Administrative and Management – to audit Authority performance using benchmarks set forth in Council On Accreditation standards and to implement process improvement and/or corrective action as needed. A member of the Management Services Division serves on each of the three teams to assure there is no duplication of effort.
- External audits (Example: audits by the Office of the Legislative Auditor)  
 JPHSA is audited on an annual basis through the Office of the Legislative Auditor as well as by the Department of Health & Hospitals Office of Behavioral Health (former Office of Mental Health and Office for Addictive Disorders) licensing function and the Louisiana Department of State Civil Service. Additionally, the Authority was periodically audited by the Louisiana Public Health Institute (LPHI) due to funding received from the Primary Care

Access Stabilization Grant and by other entities for federally funded programs.

- Policy, research, planning, and/or quality assurance functions in-house  
JPHSA's Executive Management Team and the Management Services Division provide this function.
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff  
Performance is monitored on an ongoing basis utilizing the JPHSA Strategic Plan, Operational Plan, Division-specific Business Plans, Performance & Quality Improvement Initiatives, Utilization Management Plan, and position-specific performance expectations. All have clearly stated expectations and performance targets. The Executive Director, Executive Management Team, Supervisory Staff, and the Management Services Division share responsibility. Outcomes are reported on no less than a quarterly basis.
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)  
JPHSA collects data, 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. JPHSA 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 for Citizens with Developmental Disabilities on an ongoing basis.
- In-house performance accountability system or process  
JPHSA utilizes: the National Council for Community Behavioral Healthcare endorsed Accountable Care Model; the Council On Accreditation Standards and Performance & Process 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; and, ongoing data mining and analysis via the JPHSA Electronic Health Record.
- Benchmarking for Best Management Practices  
JPHSA has an active and robust decision-support function supported by the availability of live data from its leading edge Electronic Health Record 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. JPHSA also utilizes benchmarks set forth in the Accountable Care Model and Council On Accreditation Standards for ongoing performance and quality

improvement initiatives.

- Performance-based contracting (including contract monitoring)  
All JPHSA 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  
JPHSA's three Process Improvement Teams – Service Delivery Area, Environment of Care, Administrative and Management – all use peer review as part of the ongoing performance and quality improvement initiative. The Authority's Medical Director leads comprehensive multi-disciplinary peer review in cases of client suicide or death not associated with a physical disease or chronic condition. He is also initiating ongoing peer review during regular meetings of the Medical Staff.
- Accreditation review  
JPHSA is implementing an Authority-wide plan for accreditation readiness with the Council on Accreditation (COA). Communication between the Authority and COA is ongoing and formal application was filed. As stated previously, JPHSA has three active Process Improvement Teams that are focusing on meeting and/or exceeding requirements set forth in COA Standards.
- Customer/stakeholder feedback  
JPHSA participates in satisfaction surveys sponsored by the Office of Behavioral Health and the Office for Citizens with Developmental Disabilities. Additionally, JPHSA fields a proprietary survey within its Behavioral Health Clinics on an annual basis to gain additional information for the identification of opportunities for improvement. The Authority's Adult Community Support Division conducts satisfaction surveys for all contractors as part of standard contractual requirements. JPHSA also partners with the Office of Behavioral Health to hold an annual community forum for the residents of Jefferson Parish. The members of the Board of Directors, per the Carver Policy Governance Model, actively engage in "community linkages" and report the results of these interactions with community stakeholders during monthly Board meetings.
- Other (please specify):

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

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

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

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

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

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

# Annual Management and Program Analysis Report

## Fiscal Year 2009 – 2010

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

**Department Head:** Bruce Greenstein  
Title: Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Melanie Watkins  
Title: Executive Director

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

#### **Increased Mental Health Services**

FPHSA increased the number of clients served through its Community Mental Health Centers from 7,241 (FY 09) to 7,887 (FY 10). The increase was due primarily to the agency's response to increased population and demand for services. This success is significant as it represents FPHSA's response to increasing community mental health needs. All residents of FPHSA's catchment area benefit as these services meet a critical need that impacts many lives directly or indirectly.

#### **Increased Addictive Disorder Services**

FPHSA increased the number of clients enrolled in addictive disorders prevention services from 4,898 (FY 09) to 6,807 (FY 10). This success is significant as it allows FPHSA's to serve more individuals at a young age, reaching them prior to the development of any substance abuse issues. All residents of FPHSA's catchment area benefit as these services meet a critical need that impacts many lives directly or indirectly.

#### **Increased PSH Services**

FPHSA continued the Permanent Supportive Housing (PSH) program and increased the number of individuals served from 35 (FY 2009) to 154 (FY 10). PSH is a major policy objective of Louisiana's "Road Home Program" and funded through a Community Development Block Grant. FPHSA hired additional staff to assist with this initiative. PSH combines permanent affordable rental housing with flexible support services to help eligible individuals attain and maintain stable housing. Services are tailored to each participant's needs and goals through an Individual Service Plan. Services are flexible and responsive to the needs of the individual and their family and are

geared toward assisting the individual to maintain tenancy thereby avoiding homelessness and/or inappropriate institutionalization. This program benefits homeless individuals (including those displaced by Hurricane Katrina) as well as low-income individuals/families with long-term disabilities.

## **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 overall effectiveness of FPHSA strategies is positive. Strategies are working as expected and proceeding as scheduled. Although the agency is making significant progress at meeting its objectives, the demand for services continues to far outweigh capacity due to growth in the number of individuals presenting for services. Most of FPHSA's anticipated outcomes (goals and objectives) are being attained as expected.

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

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

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

FPHSA has made progress toward meeting this goal. The agency has made efforts to move toward treatment of co-occurring disorders. A Co-Sig grant facilitated progress toward a more holistic treatment approach by allowing the agency to provide Motivational Enhancement Therapy (MET) training to all staff. MET training is an annual event. This training enhances management's goal of promoting a culture of service within the agency.

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

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

FPHSA is meeting this goal in several ways. Major educational initiatives include the

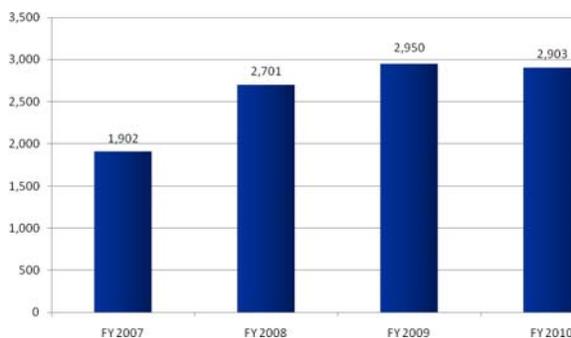
OAD-funded Addictive Disorders Services Prevention program and the CDBG-funded Permanent Supportive Housing program. FPHSA staff of each of the agency's service areas participate in numerous coalitions across the five-parish area including St. Helena Social Services Network, Tangipahoa Social Services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

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

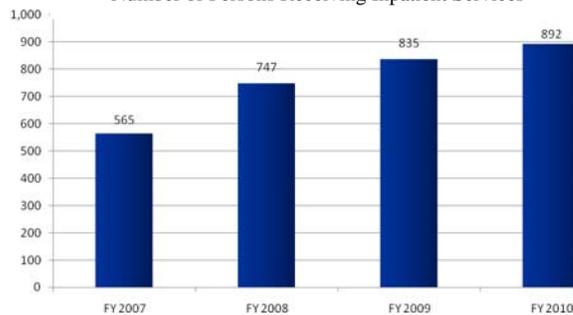
FPHSA is successfully meeting its objective related to individuals with addictive disorders. The objective is to provide treatment services to individuals with addictive disorders. The total number of people with addictive disorders served increased 53 percent (from 1,902 to 2,903—see chart below) between FY 2007 and FY 2010.

The number of people receiving inpatient treatment increased from 565 in FY 2007 to 892 in FY 2010—a 58 percent increase (see chart below). The per-day average cost for inpatient services decreased from \$169 in FY 2007 to \$128 in FY 2010, representing a decrease of 24 percent (see chart below).

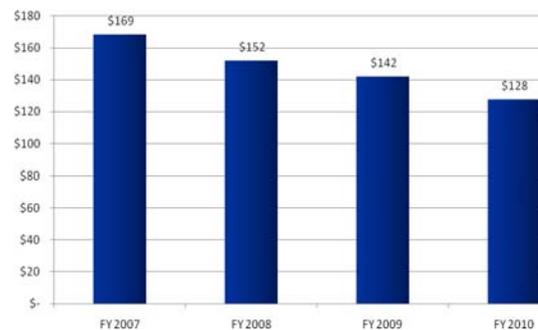
Addictive Disorders Treatment Services: Total Served



Addictive Disorders Services:  
Number of Persons Receiving Inpatient Services

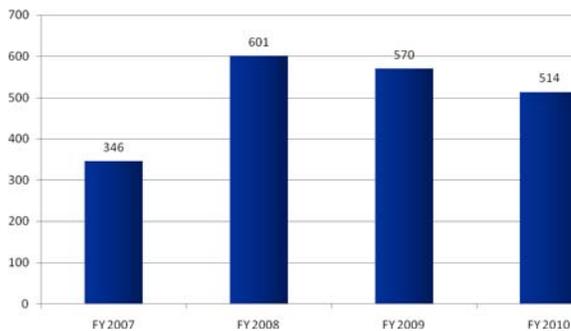


Addictive Disorders Services: Cost per Client Day

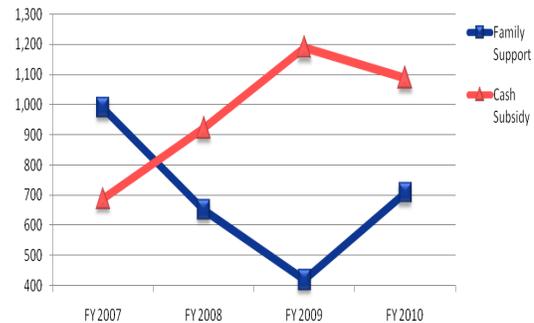


FPHSA is successfully meeting its objective relating to people with developmental disabilities. The objective is to provide services that emphasize person-centered individual and family supports. The total number of people served annually increased 49 percent (from 346 to 514-see chart below) between FY 2007 and FY 2010. The number of clients with developmental disabilities waiting for Family Support services remained below its FY 2007 level of 988. There were 706 individuals on the waiting list for Family Support at FYE 2010 (see chart below). The waiting list for Cash Subsidy services remained above its FY 2007 level of 690. There were 1,088 individuals on this waiting list for Cash Subsidy at FYE 2010. A partial reason for this increase was a decrease in the number of Cash Subsidy “slots” allocated for FPHSA’s catchment area. In FY 2009, the Office for Citizens with Developmental Disabilities, which manages the statewide allocation for Cash Subsidy, reduced FPHSA’s Cash Subsidy slots from 218 to 174.

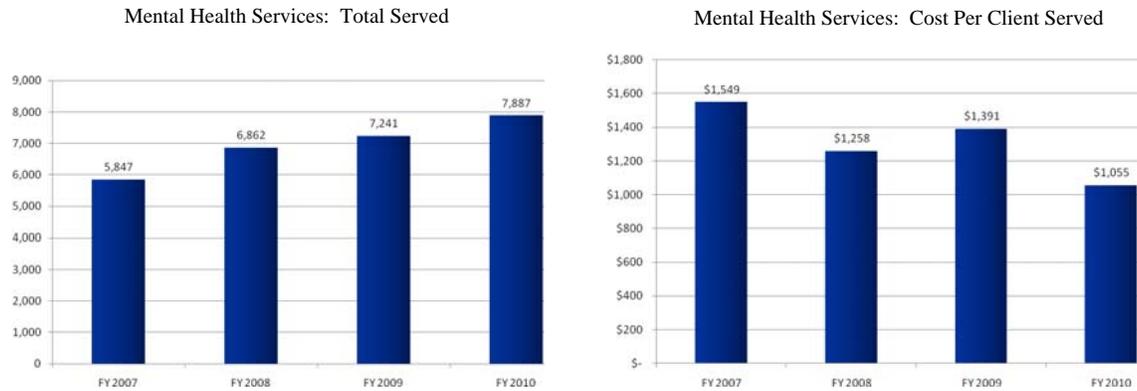
Developmental Disabilities Services: Total Served



Developmental Disabilities Services: Individuals Waiting for Services



FPHSA is successfully meeting its objective related to people with mental illness. The objective is to provide services emphasizing recovery for adults and resiliency for youth for those diagnosed with mental illness. The total number of people served in FPHSA’s Community Mental Health Centers increased 35 percent (from 5,847 to 7,887-see chart below) between FY 2007 and FY 2010. That same period, the number of adults receiving services increased from 4,564 to 6,053 (33 percent) and the number of children receiving services increased from 1,279 to 1,830 (43 percent). The average cost per person served saw a reduction from \$1,549 in FY 2007 to \$1,055 in FY 2010 (see chart below), representing a decrease of 32 percent. The primary reason for this reduction was implementation of a more restrictive formulary which resulted in reduced expenditures for pharmaceuticals. During this period, FPHSA enhanced its focus on and expanded pharmaceuticals provided through patient assistance programs (PAPs).



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

Social Detoxification services, which were provided through a contracted service provider, had ceased since Katrina. They were revived during the third quarter of 2008 with 346 clients receiving services in FY 2009. However these services were discontinued in FY 10 after 182 individuals were served.

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

◆ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** FPHSA has monthly meetings with its Board of Directors and conducts routine (weekly) Management Team meetings. The supervisors of each service area hold regular meetings with their staff at which information related to the agency's overall plan and strategies is discussed. Community stakeholders' meetings are held throughout the 5 parishes served by FPHSA.

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

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

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

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

#### A. Problem/Issue Description

Recruitment and retention issues have negatively impacted services across the agency—both those provided by staff directly and those provided by contract providers. The problem has been acutely critical in the case of psychiatrists and clinical staff. While psychiatric coverage issues primarily impacted MHS, the staffing crisis was pervasive across all service areas.

#### 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?

(Investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies, for example.) 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 (Office of the Legislative Auditor; LPAA)
- 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.Louisiana Performance Accountability System (LaPAS)
  - b.Legislative Audit
2. Date completed
    - a.October 2010
    - b.April 2010
  3. Subject or purpose and reason for initiation of the analysis or evaluation
    - a.Legislative requirement
    - b.Legislative requirement
  4. Methodology used for analysis or evaluation
    - a.DOA-required methodology; performance indicators developed by FPHSA and approved by DOA
    - b.Methodology is specific to the Legislative Audit
  5. Cost (allocation of in-house resources or purchase price)
    - a.Not calculated
    - b.\$25,476
  6. Major Findings and Conclusions
    - a.None; minor variances from targets
    - b.None
  7. Major Recommendations
    - a.None
    - b.None
  8. Action taken in response to the report or evaluation
    - a.None
    - b.None
  9. Availability (hard copy, electronic file, website)
    - a.[www.doa.louisiana.gov/opb/lapas/lapas.htm](http://www.doa.louisiana.gov/opb/lapas/lapas.htm)
    - b.<http://www.la.state.la.us/>
  10. Contact person for more information:

Name: Melanie Watkins, Executive Director; E-mail: [melanie.watkins@la.gov](mailto:melanie.watkins@la.gov)

Name: Trent Myers, Administrative Director; E-mail: [trent.myers@la.gov](mailto:trent.myers@la.gov)

Agency & Program: Florida Parishes Human Services Authority

Telephone: 985.748.2220

# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

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

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Jan Kasofsky, PhD  
Title: Executive Director

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

### CAHSD Restructures Its Residential Facility to Accommodate Budget Reductions

Determined to bring down the cost of its residential facility, and to maintain the number of beds and level of services for men needing this residential drug treatment facility, maintaining services at Capital Area Recovery Program (CARP), required a restructuring of its staff. Keeping within the licensing standards, CAHSD reassigned several employees to fill other needed positions within the agency and will share clinicians from their outpatient clinic. Outpatient staff will now work in the evenings at CARP to conduct group and family therapy and nursing shift changes alleviated the need for additional contract staff.

### Intermediate Level of Care for Long Term Clients Transitioning to Community-Based Services

\$2.3M has been added to CAHSD's 2011 budget to provide a new level of community-based, intermediate care services and supports focused on people being discharged from state mental health hospitals. This new level of care was designed both for non-forensic individuals who will be discharged from these hospital beds to the community and to provide a step up level of care to stabilize individuals in the community to avoid hospitalization. These new funds will be specifically for mobile, intensive treatment teams and additional funding will provide intensive case management. Funding will be maintained at the Office of Behavioral Health for housing needs across the state.

To best manage the transition of long term, hospital discharges, CAHSD formed a multidisciplinary team called a Continuity of Care (COC) team which will review all discharge plans developed by hospital staff, and ensure the plans match with available mental health, addiction recovery, developmental disability and physical health services in the community. Video-conferencing is being used in this region so that hospital patients can see and interact with the COC team before discharge.

### Maintaining a Community Specific Plan to Address the Needs of Increasing Numbers of People in Behavioral Health Crisis in the Greater Baton Rouge Area in Louisiana in the Midst of Continued Funding Reductions

Although there was an increase in funding for Intermediate Level of care for individuals being discharged from the Department's Inpatient Mental Health Facilities, the CAHSD suffered a more than \$2 Million State General fund reduction to its existing behavioral health and developmental disabilities services due to budget reductions and mandated increases that have to be covered with existing funds.

In spite of decreased funding, the greater Baton Rouge region's behavioral health system continues to be seriously impacted due to a sustained increase of 57% in new SMI-clients with a three-fold increase in acuity level entering the public mental health clinics, a greater than six-fold increase in the number of patients discharged from public psychiatric hospitals statewide into the region, double that seen currently in New Orleans, and a steadily increasing number of people calling local law enforcement or entering the local hospital emergency departments in behavioral health crisis. Additionally, there is another two-fold increase in discharges from the local private psychiatric acute hospitals into this region as well. The large number of acute hospital discharges places an enormous burden on our mental health clinics due to their required scheduled clinic appointment occurring within two weeks of discharge.

We do not have a static population of people living in this community with SMI. In recent years, we have used SSBG/Stat Ded/SGF as far as possible to increase capacity to serve this increasing number of people in need. The numbers of PECs and OPCs have also continued to increase in this region and the numbers of people still accessing the local EDs have increased by nearly 100 per month. We have worked more closely with law enforcement and our relationships with all local hospital ED staff and discharge planners to identify ways to decrease recidivism experienced by our least stable clients. Carefully we have implemented best practices regarding delivery of clinic and community-based treatment and wrap-around approaches within our community and taught many others within the state across the nation, and even internationally with regard to our emergency preparedness and continuity of operations experience. While many of these achievements can be maintained should a cut be implemented, our ability to reach those in need would be curtailed and there would be an immediate increase in clinic wait times, crises requiring more first responder interventions and a return to longer waits within the local EDs.

This region cannot afford to lose any more capacity. We have worked especially hard to ensure appropriate and efficient use of all of our funding sources while looking for ways to improve efficiency and discontinuing funding for services that do not prove their value based on

outcomes and access analysis.

For years there has been national concern over the pressure on hospital emergency departments due to non-emergent or inappropriate use. While this had long been an issue in this community, the loss and disruption of the housing stock, emergency departments and inpatient psychiatric beds in the greater New Orleans area due to the hurricanes of 2005, greatly exacerbated and continues to contribute to the increased numbers of adults presenting in psychiatric crisis to local emergency departments.

The development of a region-wide, multi-sector collaborative and the 10 component continuum they developed and implemented includes: 1. standardized screening and assessment tools and training for use; 2. clinic based and telephonic rapid screening/ assessment/treatment or referral process; 3. interagency services coordination process for multi-sector individualized plan development; 4.\*law enforcement run/CAHSD trained, Crisis Intervention Teams for engagement/assessment/ de-escalation and referral or transport; 5. mobile and Assertive Community Treatment Teams to provide preventive and treatment interventions/ongoing treatment at alternative settings; 6. \*\*Mental Health Emergency Room Extension (MHERE) constructed on the grounds of EKL to serve as a specialized emergency department is scheduled to open in August 2010; 7. medical case management routing clients to appropriate medical providers, CAHSD to establish on-site physical health care in collaboration with local private providers; 8. regional call center for triage/assessment and referral, or emergency intervention; 9. housing coordination, support and placement and; 10. Community Advisory Board for oversight and continuous quality improvement process.

***\*Fifth Crisis Intervention Team Training for the Capital Region Law Enforcement Officers:***

In the fifth institute offered by CAHSD, thirty law enforcement agents completed a 40-hour course in emergency behavioral health crisis (mental health, addictive disorders and other behavioral disorders) intervention and were certified Friday, November 5th as Capital Region Crisis Intervention Team (CIT) members to serve in Region II. The CIT program is based on successful program models in Memphis and Atlanta. The training was developed and presented by the CAHSD as a component of a ten part comprehensive continuum to respond to the increased behavioral health crises experienced by individuals with mental illness, addictive disorders and/or developmental disabilities that often brings this population to the emergency departments. 85% of the law enforcement agents surveyed stated that they would apply what they learned in CIT on their job. Law enforcement from seven parishes was invited to participate. "This training experience increases the agent's de-escalation skills in handling individuals that may be in behavioral health crisis," said Jan Kasofsky, Ph.D., CAHSD Executive Director.

Capital Area Human Services District designed the course in cooperation with Northwestern State University's Department of Criminal Justice. The officers, who complete the training, receive college credit upon enrollment and passage of a challenge exam. A special graduation ceremony honoring the 30 law enforcement agents was held at the East Baton Rouge Sheriff's Office Training Facility. A total of 139 CIT agents have now been trained in this region by CAHSD.

***One Day Crisis Intervention Team (CIT) Training Course Offered to Statewide Law Enforcement***

CAHSD has been an innovator in its approach to working with local first responders to better manage people in behavioral health (BH) crises through training and establishing a continuum of crisis services through the Behavioral Health Emergency Services Collaborative. One piece of the continuum focuses on training first responders in identification and de-escalation of people in a BH crisis is called Crisis Intervention Team (CIT). CIT training consists of 40 hours of training. A new one day training condenses it into an eight hour primer, to begin to meet the needs of the rural parishes that typically have part-time officers enrolled in the Capital Area Regional Training Association (CARTA), rural law enforcement and new cadet training. Also the Louisiana Probation and Parole Office added the one day "CIT" training as a P.O.S.T. (Peace Officer Standards and Training Council) Certification requirement for all new Probation and Parole Officers, and now fire chiefs are currently considering this introductory course for fire fighters as well.

***"Very informative class. Should be mandatory for all law enforcement."***

Although this one day training cannot provide the level of detail provided in the week long CIT course, it is designed to increase understanding of the impact of people with behavioral health problems on police procedure; the effect of limited community resources on individuals that may interface with the criminal justice system; recognize the signs and symptoms of behavioral health and developmental disabilities problems; learn intervention strategies to achieve safe outcomes; familiarize responders with community resources for treatment; and to familiarize them with communication and de-escalation techniques. To date, 154 law enforcement officers have attended this eight hour course.

***\*\*Mental Health Emergency Room Extension Opens***

Capital Area Human Services District (CAHSD) is pleased to announce the opening of the new Mental Health Emergency Room Extension (MHERE). This new 20-bed unit is a resource for people who are in behavioral health (BH) crises (mental health and/or addictive disorders). The unit serves as a specialized emergency department (ED) where staff provide a high level of screening and assessment to accurately determine the appropriate level of care needed and connect patients to either acute or ongoing community-based treatment. It is a "portal" to ongoing care for people with BH needs. Prior to admission to the MHERE, people will receive triage and medical clearance in the ED.

***This unit will serve 8,400 patients annually.***

The idea and design of this facility was developed by the Emergency Services Collaborative as a post-Katrina response to overutilization of the EDs and as a piece of a prevention, and early intervention continuum to address BH needs and crises in this area. CAHSD collaborated with EKL staff to develop clinical processes and outcomes as well as a process to determine how well the unit and overall continuum is working across the District's seven parishes. Ensuring MHERE funding has been a priority for Governor Jindal, DHH officials, local legislators and Congressman Cassidy.

The MHERE is located on the grounds of Earl K. Long Medical Center (EKL) behind the hospital's ED. Physicians, nurses and social workers will provide patients referral or linkage to ongoing care to limit cycles of crises.

*Interior of MHERE*



### Unique Collaborative Approaches to an integrated, Community-Based, Public System of Care, Through Specialty Behavioral Health Centers and Rural Public Health Units

The urgent need for physical healthcare access for SMI clients seen in public behavioral health settings is well documented. The majority of early deaths in this population have been attributed to the lack of access to physical healthcare for chronic diseases and lifestyle choices. In the public system there is little collaboration between behavioral health specialists and physical health providers, and care is provided within the silo in which it is funded. Typically, the SMI population is engaged in treatment only within the behavioral health specialty setting.

Similarly, clients seen in Public Health Units who access preventive or primary care for physical health needs, often times experience limited health outcomes which can be attributed to the absence of a cohesive approach to care management and access to behavioral health professionals who could provide brief interventions to address what is commonly termed “non-compliance” and assist with follow-up with appointments or treatment regime adherence.

To begin to address their SMI client's physical health needs, Capital Area Human Services District (CAHSD), the mental health, addictive disorders and developmental disabilities public authority, implemented a smoke free campus policy in 2009 and provided a low barrier smoking cessation program, and a physical health screening policy, tool and referral process. Weekly access to scheduled primary care delivered through an on-site mobile unit and access to local Federally Qualified Health Centers with administrative fee waivers and vouchers for low cost physical health care prescription medications for indigent clients was also established.

Un/underinsured adults who do not meet the criteria for SMI which is required for admission into the public mental health centers can access integrated care through a collaboration in the

rural public health units in this service district. The system of care incorporates physical health screening and referral to medical social workers who facilitate access to services. These referrals are made by clinicians working in traditional public health programs, such as Family Planning, and Sexually Transmitted Disease Clinics. The services provided by the medical social workers include care coordination, brief counseling, disease specific health education, and referral to community resources.

CAHSD is focusing on recasting the role of the behavioral health provider in the specialty setting to one with responsibility for clients who are known to typically lack connections to a medical provider, or medical home. This includes policy development/implementation, staff training, and the implementation of a more integrated care approach in a public behavioral health setting. Data of physical health findings, health outcomes and success of linkages to a medical home through a community-wide collaboration with local physical health providers, hospitals and local emergency departments is being collected.

CAHSD has implemented a physical health screening process and referral criteria in all of its behavioral health clinics and supportive prevention services are provided by medical social workers in the Public Health Unit. People with mental illness treated in the public system die on average 25 years earlier than their age cohorts due to preventable and treatable chronic illnesses. CAHSD clients are medically screened and referred with follow-up to a medical home from the mental health and addictive disorders clinics. For the last fiscal year, there has been 211 unduplicated clients seen by primary care providers in the OLOL Mobile Medical Clinic, located on site at the Center for Adult Behavioral Health, and Baton Rouge General's Family Health Center located at 3801 North Boulevard. The leading reasons for referral to primary care include high blood pressure (63%), elevated lipids (30%), elevated blood sugar (26%) and pain (17%). Referrals for physical exams and well woman's check-ups are completed on clients who have not seen a primary care provider for at least a year. This 5 part program is designed to address the increasing cost of care and poor health outcomes for persons with mental illness resulting from a direct lack of physical healthcare. It consists of a behavioral health referral and assessment; a primary and dental health care assessment; laboratory testing, prescription medication assistance and health education and training (i.e. tobacco cessation; disease prevention, etc.). The District, in collaboration with public health units, the Generals' Family Health Center and the OLOL mobile medical clinic provide for treatment and preventative health care for those individuals served in the mental health and addictive disorders clinics within the seven parishes which make up the District.

The development process of a local system of integrated care which included initiating the collaborative, a series of "town hall" meetings and public client surveys conducted in the local communities has been completed. As a result, integrated care plans with parish specific initiatives were created, shared with each parish president/local governing body and implemented. Medical social work services are now available to support client health outcomes, access to community resources, self-management of disease, and fewer visits to the emergency room for non-emergent care. Two parishes hired permanent social workers to work in their Public Health Unit, supervised by CAHSD. All parishes now offer free Tobacco Cessation programs and screening for blood sugar, blood pressure and cholesterol is being established in weekly clinics.

***Thank you to OLOL and BRG***

The CAHSD physical health integration initiative began six years ago to assist clinic clients to access needed medical care. Over these years the agency has formed important partnerships to deliver care to our indigent clients through a referral processes with local providers which at times was funded by grant dollars, but for many years our partners, particularly, Our Lady of the Lake Regional Medical Center (OLOL), provided this care for free. They, along with the local Federally Qualified Health Centers received some funding for these referrals from a grant with the National American Red Cross for a year, but this funding ended about a year ago. CAHSD would like the broader community to know that both OLOL and the Baton Rouge General Medical Center Family Health Center have agreed to provide free medical care to CAHSD's indigent clients until the end of this calendar year. CAHSD has applied for a Kaiser Foundation grant to provide funding for these referrals; awardees will be notified by late fall. Should this grant be received, we are planning to include additional providers into our referral network.

***Health/Primary Care Integration Program Client Survey:*** The purpose of the survey was to assist in evaluating the impact of the Behavioral Health / Primary Care Integration Program from the client's perspective. **53%** were not being seen by a physician because of no money; followed by **35%** who stated that they had fear or worry about their illness. **77%** stated that the services which helped them keep their appointment with the doctor was help by the nurse or social worker; followed by **37%** who needed assistance with transportation. **61%** said that the service that helped them most understand or manage your health problem was education about their condition/medication; followed by **56%** who said support and follow-up by staff helped. **47%** said that they strongly agree that they felt better; followed by **35%** stating that they agree that they felt better; overall **82%** felt that their health had improved. When asked to rate the extent to which you feel better **65%** said they strongly agree that they felt better. **Note:** Experience showed clients kept their appointments 77% of the time.

**News Release****For Immediate Release**

Capital Area Human Services District  
4615 Government Street, Building 2  
Baton Rouge, Louisiana 70806

Contact: Jan Kasofsky  
Phone: 225-922-2700  
[Jan.Kasofsky@LA.gov](mailto:Jan.Kasofsky@LA.gov)  
[www.cahsd.org](http://www.cahsd.org)

*Note to editors: Classes will start on various dates, depending on enrollment. Therefore, no dates are listed on page 2.*

**Capital Area Human Services District and Parish Governments****Kick-Off Tobacco Cessation Programs in 7 Parishes**

Working with the local parish governments, the Capital Area Human Services District (CAHSD) announced today a joint effort to kick-off a Tobacco Cessation program in the greater Baton Rouge area. Beginning in October, CAHSD will hold tobacco cessation groups in the parishes of Ascension, East and West Baton Rouge, East and West Feliciana, Iberville, and Pointe Coupee. There is no cost to participate. Approximately 50% of the smokers surveyed by CAHSD in these parishes stated a desire for smoking cessation assistance. Groups will meet weekly and participants will receive cessation education, strategies for quitting, and self-help material from a trained clinician. Participants will be offered the nicotine patch. Tobacco cessation group details regarding time and place is provided in this press release and can also be found on the CAHSD website at [www.cahsd.org](http://www.cahsd.org) using the Addictive Disorders link. Increasing awareness and knowledge of the benefits of tobacco cessation is a top priority for CASHD. According to the

American Cancer Society, thirty percent of all cancer deaths in Louisiana are directly attributed to tobacco use. Cigarette smoking is the leading preventable cause of death in the United States. On average, tobacco users die 13 to 14 years earlier than non-smokers. For every person who dies of a tobacco-related disease, 20 more people suffer with at least one serious illness from tobacco. People who stop tobacco use greatly reduce their risk of dying prematurely. Recent research shows that tobacco cessation not only reduces the risk of lung cancer but also reduces the risks of coronary heart disease, stroke, peripheral vascular disease, and other types of cancer. You can quit today; log onto [www.cahsd.org](http://www.cahsd.org) to find a tobacco cessation group in your community.

The sessions and contact information is listed below.

<b><u>Parish/ Provider/ Phone Number</u></b>	<b><u>Location/Day/Time</u></b>
Ascension-Jackie Powell (225) 621-5775	Ascension Counseling Center 1112 S. E. Ascension Complex Ave., Gonzales Tuesdays, 4-5 pm
East Baton Rouge-Shirley Joseph-Davisam (225) 925-1906	Family Road of Greater Baton Rouge 323 E. Airport Ave., Baton Rouge Mondays, 4-5pm
East Feliciana-Annita Bergman (225) 683-3874	Public Health Unit 12080 Marston St., Clinton Thursdays, 5-6 pm
Iberville-Bert Allain (225) 687-5889	Public Health Unit 24705 Plaza Drive, Plaquemine Thursdays, 6-7 pm
Pointe Coupee-Donna Hammond (225) 638-7663	Pointe Coupee Home Health Office 350 Hospital Rd., New Roads Thursdays, 5-6 pm
West Baton Rouge-Karen Berthelot (225)342-7525	Public Health Unit 685 Louisiana Ave., Port Allen Thursdays, 6-7 pm
West Feliciana-Ollie Perkins (225) 635-6707	Public Health Unit 5154 Burnett Rd., St. Francisville Wednesdays, 4:30-5:30 pm

###

*Capital Area Human Services District (CAHSD) is the quasi-governmental agency responsible for providing developmental disabilities, addiction recovery and mental health services in the parishes of East and West Baton Rouge, East and West Feliciana, Iberville, Ascension, and Pointe Coupee. For more information on CAHSD services, please call 922-2700 or go to [www.cahsd.org](http://www.cahsd.org).*

## CAHSD Program Touted in 2009 Public Mental Health Care in Louisiana Report 2009

CAHSD is seen as a model to remedy Louisiana's "fragmented system of care" in the 2009 *Public Mental Health Care in Louisiana* (PAR) report published by the Public Affairs Research Council of Louisiana. Co-authored by David W. Hood, the report focuses on the public mental health care delivery system and recommends pragmatic solutions that are within current reach of policymakers and unyielding budgets. The report highlights CAHSD's Behavioral Health Emergency Services Collaborative which is a part of a ten component continuum of health care.

***An excerpt from the report is as follows:***

A promising pilot project in Capital Area Human Services District (CAHSD) could be replicated to serve as a short-term solution to the problem of poor coordination of care.

Collaboration among area agencies has produced highly effective innovative services; crisis intervention teams with specially trained law enforcement personnel; specialized emergency rooms in local hospitals with mental health professional trained to handle behavioral crisis situations; medical case managers to help the mentally ill keep appointments and take medication; and mobile health clinics for those who lack access to primary medical care services.

The collaborative model brings together an array of services vital to the behavioral and physical health of persons with mental illness. A cost-effective system can be achieved by developing strong referral networks and emphasizing case management to ensure patient compliance. In addition to mental health and addiction specialists, hospitals and medical providers, other community collaborators would typically include law enforcement personnel, local jails, mental health advocates and attorneys, emergency transportation, emergency call centers and housing specialists.

The coordination of care that is possible in a system like the one developed by CAHSD would be instrumental in reducing excess emergency room usage by persons with mental illness. Use of case managers to provide referrals and follow-up could reduce emergency room visits significantly.

For the full report, log onto [www.la-par.org](http://www.la-par.org)

### Message from the Executive Director

Dear CAHSD Staff,

January 22, 1997 was my first day of state service. This was 13 years ago when I was hired as the first, and so far only, executive director of CAHSD. It amazes and amuses me to think that almost a quarter of my life has been spent here, but as my mom would always say, "Never a dull moment". How true. None of us could say we are bored! I like to tell people I spend my time with smart, committed people who are great at building and rebuilding a better "mouse trap", no matter how great the challenge may be. I really enjoy my job and I hope that you feel the same way, at least most of the time. Together we have weathered (more than) our share of storms, both literally and figuratively, and done the most fulfilling and frustrating work anyone could ever

imagine. I have had the privilege of seeing many of your babies born, graduated, married and having their own kids. I have shared in your wins of graduations, promotions, new homes, vacations, and grandchildren being born. I've also shared in your losses of parents and spouses and we have come to work together in sickness and in health. I have spent more time with you than with my son who was 3 when I started and is now 16, driving and looking at colleges and my husband, who reminds me that my BlackBerry needs to be used only when at work. There are so many unbelievably wonderful things we have accomplished together, and many of them have led to changes across the state. Even if folks don't recall where new ideas were tried and proven, we at least know that our work and ingenuity has helped in our region and beyond. Though talk of the budget (cuts) can easily invade all of our conversations and vaporize our optimism, as an optimist, I am lucky to have people like you to work with who I know will continue to efficiently deliver our needed services in a respectful and kind manner. Knowing this keeps me enthusiastic about the years ahead, even in the face of anticipated challenges. Many thanks for making this initially created pilot agency, a permanent and replicated model, credible and respected statewide and beyond. ~ Dr. Jan

### Effective Crisis Intervention – Hospitals and Emergency Departments Crisis Prevention Team within a Comprehensive Behavioral Health System of Care

The community collaborative efforts convened by Capital Area Human Services District (CAHSD) have led to useful discussion and planning by all the community partners involved. CAHSD appreciates the interest and effort shown by all the participants. An element emerging as important in our collaborative meetings is the need for emergency departments to have a contact person at CAHSD to ensure continuity of care for those patients who have presented to emergency departments with psychiatric complaints, do not require hospital admission for their symptoms, are not engaged in treatment with any behavioral health entity, and are in urgent need of outpatient care.

In an effort to assist emergency departments with these patients, CAHSD has assembled a crisis prevention team of two social workers and two mental health technicians to expedite treatment in our mental health centers. The emergency departments may contact the crisis prevention team to refer individuals who are not in treatment with a psychiatrist or other mental health service and who require early intervention following discharge from an emergency department in order to avoid the escalation of a problem to crisis levels. The crisis prevention team social worker will be available between 8:00 AM and 4:30 PM Monday through Friday to screen requests by emergency departments for mental health admission criteria exhibited by the patients and for level of urgency. This social worker may arrange follow-up within three days for patients who are deemed to be in urgent need of mental health intake at our Center for Adult Behavioral Health, Margaret Dumas Mental Health Center, or Gonzales Mental Health Center.

The telephone number for the service is (225) 205-8149. Messages left after hours will be returned the following business day. CAHSD serves residents of the parishes of East Baton Rouge, West Baton Rouge, Ascension, Iberville, Point Coupee, East Feliciana, and West Feliciana. Patients with schizophrenia, schizoaffective disorder, other psychotic disorders, bipolar disorder, major depression, significant anxiety disorders, and co-occurring disorders meet the diagnostic criteria for admission to the mental health services of CAHSD.

Emergency departments should also be aware of the ability to refer patients suffering from substance abuse for outpatient evaluation at CAHSD Addiction Recovery Services at (225)925-1906. There are, also, detoxification programs in Baton Rouge as follows:

Baton Rouge Area Alcohol and Drug Center (Baton Rouge Detox) –  
Social Detox Beds  
1819 Florida Blvd.  
Baton Rouge, LA 70802  
(225) 389-3325  
Louisiana Health and Rehabilitation Options, Inc. (LHRO Detox) –  
Social Detox and Medically Supported Detox Beds  
4914 McClelland St.  
Baton Rouge, LA 70805  
(225) 354-8325

### It's a Child's World: CAHSD Community School Based Mental Health Services

In 1991, the CAHSD school-based therapy program was developed to provide behavioral health services to children and adolescents. At conception, the school based therapy program existed in three schools and now has grown to twenty seven schools. The program provides weekly individual, family, and group counseling as needed to students in a school environment. An enrichment program is held to provide continuity of care during the summer months. The treatment team consists of master's level clinicians, a child psychiatrist, a pediatrician, a family practitioner, two social service counselors, and five Licensed Clinical Social Work supervisors. The program provides linkage to various community resources including family preservation, Child and Adolescent Response Team (CART), substance abuse counseling, Respite, housing and consumer support, Interagency Service Coordination (ISC), and Police Mentors. Community outreach is achieved through Behavioral Health Workshops, parent support groups, and teacher support groups. Various diagnostic and treatment tools utilized in treatment were developed and implemented. For the third year, the East Ascension Hospital Board has provided funding for four Social Workers to provide clinical services in select schools in Ascension Parish.

454 workshops focusing on mental health education and awareness were conducted in order to reach members of the community. These mental health workshops included topics such as bullying, social skills, conflict resolution, and self-esteem, behavioral health education to parents and teachers, and special education rights for students. 7,659 members of the community were reached through these workshops.

During the 2009-10 school year, data was collected from each school. 761 clients received school based behavioral health services totaling 25,235 units of service. 69 students were up for expulsion and 30 were not expelled because they were receiving behavioral health services from the school based therapy program. 43% were allowed a second chance in part because they are engaged in treatment. The students in the program demonstrated reduced school absenteeism by 25%, which improved overall academic achievement; 42% showed reduced suspensions.

## Judicial Behavioral Health Services

CAHSD's has expanded treatment services into the parish Juvenile Courts to provide assessment and treatment to adolescents participating in Juvenile Drug Court and FINS programs. This program allows the FINS programs and judges in these areas to refer to CAHSD social workers when children/adolescents are in need of mental health, substance abuse and/or co-occurring disorder services. The social workers coordinate with the family and other agencies as needed to get the child the appropriate services to prevent further problem behaviors or as an alternative to incarceration. The program helps to assure timely access to services upon release/reentry to the community and potentially reduce recidivism among this population. CAHSD plans to expand these services to include adults and all seven parishes in its catchment area. This expansion will increase public safety by facilitating collaboration among the criminal justice system and CAHSD's behavioral health treatment services to increase access to these services for individuals with behavioral health problems. Intercepting individuals with mental health, addictions or co-occurring disorders with misdemeanors or nonviolent offenses in the criminal justice system at the earliest point possible and engaging/reengaging in treatment is essential to reducing reincarceration. Appropriate screening, assessment and discharge planning is important to successful reentry into the community.

## CAHSD Permanent Supportive Housing (PSH)

CAHSD is designated as the PSH Local Lead Agency for the Louisiana Parishes of Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana. One hundred and ninety-five (195) Section 8 vouchers have been allocated for CAHSD's service area over a five (5) year period, and CAHSD provides supportive services to those households through the use of CAHSD staff as well as a contract provider that assists with PSH Housing Support Services by providing crisis prevention/intervention planning/response, non-emergency transportation services, and by serving as the fiscal agent for the CAHSD PSH Housing Establishment & Preservation System (HE&PS). In FY 2009-2010, CAHSD PSH staff served 96 unduplicated client households. During the open application period, CAHSD received more than 500 applications for PSH housing. CAHSD also began receiving PSH applications from patients being deinstitutionalized from the civil intermediate beds at the three state mental hospitals.

## Infant Mental Health

Capital Area Human Services launched the Infant, Child, and Family Center (ICFC) services August 28, 2007. The Center provides assessment and treatment services for children birth to 6 years of age who are in foster care or who have been prenatally exposed to alcohol or other drugs. Children referred to the Center receive comprehensive assessments that may include medical, psychological, infant mental health, and developmental evaluations. The Center also provides infant mental health services which are designed to strengthen the parent-child relationship. The team works collaboratively with a variety of systems affecting the lives of infants and toddlers, including child welfare, legal, educational, health care, and mental health systems. ICFC's goal is to improve the child's development, enhance the child/caregiver relationship, reduce the chance of further maltreatment, and ameliorate disturbances in early

childhood.

During FY2009-2010, ICFC received 154 referrals, of which 115 (75%) became active cases receiving assessment and/or treatment services. For the last fiscal year, there were a total of 529 services provided for a total of 131 active cases. The top diagnoses were Parent-Child Relational Problems, Intrauterine Alcohol and/or Drug Exposure, Language Disorder, and Developmental Delays.

Collaborating partners with CAHSD include the Department of Social Services Department of Children and Family Services, Our Lady of the Lake Regional Medical Center, and The ARC Baton Rouge. This model of care provides families with “one-stop” access to multidisciplinary services specializing in young children’s development and emotional well-being. The focus of services is on early intervention to prevent high-risk children from developing serious behavioral and mental health problems that can lead to school failure, trouble with the law, and social problems long term.

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

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

The 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?**

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. We have been successful in consistently attaining our performance targets with minimal variance.

## Ends Policy: Internal Accountability/Management

### Effectiveness/Resource Utilization and Optimization, Goal 1

Adopted 09/14/09

The purpose of Internal Accountability is to support effective/efficient districts that serve the needs of the target population and the communities in which they live and are accountable to their boards and funders.

Objectives	Action Steps	Final Status
<ol style="list-style-type: none"> <li>1. Prioritize achieving a fully commissioned CAHSD board.</li> <li>2. Re-establish bi-annual client satisfaction survey and submit results to the Board.</li> <li>3. Develop a UM Model utilizing district-wide data, monthly reports to establish ongoing management /oversight of services and effective utilization. Provide monthly reports to EMT for all services.</li> <li>4. Develop and provide presentations to parishes regarding CCYS results and/or behavioral health/primary care integration.</li> <li>5. Develop communication plan using existing parish specific resources.</li> </ol>	<ol style="list-style-type: none"> <li>1. A total of 17 positions will be commissioned 2009.</li> <li>2. The 2008 survey report will be completed and presented to the Board August 2009.</li> <li>3. The UM Plan for clinic-based services will be completed in 2009. Monthly access and UM reports will be developed consistent with DHH and reported to EMT 2009. Access and UM reports will be provided semi-annually to the board through standard agenda process beginning 2009 (months of December and June). Identify performance indicators to be presented to the board 2009.</li> <li>4. Presentations to each of 7 parishes to be made annually.</li> <li>5. Parish specific communications plan specific to initiatives to be completed 2009.</li> </ol>	<ol style="list-style-type: none"> <li>1. All but one Board position has been filled. 16 of the 17 members have been confirmed.</li> <li>2. Executed contract with consultant and research assistant to assist with the coordination, implementation and compiling of client satisfaction survey results.                         <ul style="list-style-type: none"> <li>• Established timeline of all steps/tasks to complete survey.</li> <li>• Established target date to implement survey as of 2/1/10.</li> <li>• Established target date of survey completion as 5/1/10.</li> <li>• Established target date of compilation of survey results as 6/1/10.</li> </ul> </li> <li>3. Submitted UM Model Draft to EMT.                         <ul style="list-style-type: none"> <li>• UM Draft is in process of being reviewed and approved by EMT.</li> <li>• UM reports re-designed to encompass more accurate UM data compiled from SPQM data base on physician/clinician direct billable time and Show Rates. Report data to EMT monthly.</li> <li>• Established UM Work Group with Medical Director and Managers to pilot new access and clinical practices to improve access, reduce waiting times, increase show rates and physician/clinician billable hours.</li> </ul> </li> <li>4. CCYS parish data has been compiled for presentations.</li> <li>5. Established local parish contact person for coordinating implementing activities and marketing.</li> </ol>

## Ends Policy: Clinic-Based/Satellite Services to Facilitate Optimal Functioning, Goal 2

Adopted 09/14/09

The purpose of Clinic-Based/Satellite Services is to address geographic barriers, especially in rural settings/ primary care services integration.

Objectives	Action Steps	Final Status
<ol style="list-style-type: none"> <li>1. Develop, disseminate and assist to implement a local Behavioral Health/Primary Care Integration Plan for the 7 parishes within the District.</li> <li>2. Permanently establish and expand the BHPC integration program initiated through American Red Cross throughout the District.</li> </ol>	<ol style="list-style-type: none"> <li>1. Complete 7 parish specific plans and present to parish presidents. Develop joint implementation plans in 2009.</li> <li>2. Identify and apply for sustained funding for the parish-based social workers for primary care linkage. Assist parishes in developing accessing funds to offer locally integrated access to behavioral health and primary care. Applied for SAMHSA grant.</li> </ol>	<ol style="list-style-type: none"> <li>1. Completed, distributed and presented.</li> <li>2. Permanently established and expanded behavioral health social worker coverage in the following regions:  <u>Ascension</u> – due to loss in sales tax revenues and a hiring freeze, the parish is unable to hire a social worker at this time. Plan to work with St. Elizabeth’s Hospital and explore potential funding sources for salary of social worker; <u>East Baton Rouge</u> – position paid for by CAHSD; <u>East Feliciana</u> – verbal commitment from RKM FQHC to hire a part-time social worker (they have been unable to locate one); <u>Iberville</u> and <u>West Baton Rouge</u> – position paid for by the parish; <u>Pointe Coupee</u> – working with Hospital District Board and Innis Medical Center FQHC to hire social worker; <u>West Feliciana</u> – wrote for a Pennington grant to fund part-time social worker (will be notified of award status in December)</li> </ol>

Ends Policy: Community Supports and Services

## That Support Optimal Functioning, Goal 3a

Adopted 09/14/09

The purpose of Community Supports and Services is to create Community Collaborations.

Objectives	Action Steps	Final Status
<ol style="list-style-type: none"> <li>1. Fully operationalize the ten components of the Emergency Services Behavioral Health Crisis Continuum. (Dr. K &amp; Becky)</li> <li>2. Ensure ES components provide supports and services for DD clients. (Becky &amp; Carole Anne)</li> <li>3. Establish local prevention planning models for each parish within the District to continually assess the needs and resources within the parishes.</li> <li>4. Develop capacity in the community for Behavioral Supports and medical services for people with DD in this region.</li> </ol>	<ol style="list-style-type: none"> <li>1. Establish the Community Advisory Board and assist in the establishment of the MHERE services. Building (MHERE) completed.</li> <li>2. Provide training for all local ED staff for assessing needs and providing linkage for DD clients who access ED services in 2009.</li> <li>3. Perform in-house contract review audit to ensure performance standards are met and that programs are meeting each of the community's needs 2009.</li> <li>4. Establish 2 permanent psychology positions to provide Behavioral Supports in DD Division. Establish linkage with LSU-NO to provide training and advocacy for DD clients to access medical services.</li> </ol>	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3. The District has implemented the following needs assessment methodology to determine needs and resources related to prevention:                             <ul style="list-style-type: none"> <li>• Public forums held in all parishes where residents have prioritized needs such as nutrition, physical exercise, tobacco cessation, and health screening. Community resources were also identified.</li> <li>• Community surveys in the public health units and mental health clinics served by each parish to identify specific needs and preferences related health and wellness topics.</li> <li>• Secondary data analysis that has provided information regarding health indicator trends that has been used to prioritize issues to address</li> <li>• Interviews with key parish agencies and other community leaders to establish a resource inventory and potential partners in strategic planning</li> <li>• Parish Health plans were developed based on the needs assessment and resource inventory that incorporate priority prevention topics for the region. Implementation of the health plans is in progress. A tobacco cessation program for the general public was initiated Nov. 2009 in each of the parishes. A health screening program has been piloted at one parish site and is in process of expansion. A key area of focus for current planning is obesity.</li> </ul> </li> <li>4. The Northlake Supports and Services Center Psychiatric and Behavioral Resource Center will provide training opportunities advertised and hosted by CAHSD at the following proposed venues during the upcoming year:                             <ul style="list-style-type: none"> <li>• CAHSD regular CEU training schedule</li> <li>• Woman's Hospital CME's quarterly luncheon</li> <li>• Louisiana Public Health Association conference: Consider training on use of psychotropics and psychiatric treatment</li> <li>• Professional Conferences (e.g., AMA, American Nursing Conference)</li> <li>• Emergency Services Collaborative: Using the regular CAHSD collaborative with ER physicians and nurses as a training venue</li> <li>• EKL staff via Grand Rounds</li> <li>• OLOL via their regular breakfast or lunch meetings for all pediatricians in the Baton Rouge area</li> <li>• Consider training all CAHSD staff at annual CAHSD Employee Meeting in a break out session ½ day tailored especially for physician</li> </ul> </li> </ol>

## Ends Policy: Community Supports and Services That Support Optimal Functioning, Goal 3b

Adopted 09/14/09

The purpose of Housing and Employment is....

Objectives	Action Steps	Final Status
<ol style="list-style-type: none"> <li>1. Determine amount of housing needed for clients and establish standard rate and program description for contract housing.</li> <li>2. Will implement Permanent Supportive Housing initiative to serve 171 households (based on funding).</li> </ol>	<ol style="list-style-type: none"> <li>1. Approximately 50 licensed residential beds are needed for CAHSD clients, and \$45 per diem is established as the standard rate.</li> <li>2. CAHSD PSH staff will serve 171 client households by 6-30-2010. CAHSD Housing Support Team (HST) staff will serve 400 CAHSD clients by 6-30-2010. CAHSD Employment Coordinator will serve 60 CAHSD clients by 6-30-2010.</li> </ol>	<ol style="list-style-type: none"> <li>1. FY 09-10: One housing contract was eliminated in February 2010, thereby reducing the number of CAHSD contract beds. CAHSD had approximately 14 contract beds remaining at licensed facilities for clients/potential clients, \$45 per diem is the standard rate (8 male beds at Maison Des Ami), and \$62 per diem is the rate where additional services are provided onsite (6 at female beds WCRC). Housing contracts served 129 unduplicated clients.</li> <li>2. FY09-10: CAHSD PSH served 96 unduplicated client households (based on funding). CAHSD HST served 361 unduplicated clients despite staffing shortage (social worker position eliminated). CAHSD Employment Coordinator served 69 unduplicated clients despite staffing shortage (position eliminated). LA HIRE contract served 39 unduplicated clients (6 youth and 33 adults).</li> </ol>

## Ends Policy: Community Supports and Services That Support Optimal Functioning, Goal 3c

Adopted 09/14/09

The purpose of Reentry Linkage to Treatment is to connect incarcerated individuals to services prior to discharge.

Objectives	Action Steps	Final Status
<ol style="list-style-type: none"> <li>1. Collaborate with parish jails to identify and establish process of screening, assessing and discharge planning for CAHSD clients to assure timely access to services upon release/reentry to the community with priority given to CAHSD clients.</li> <li>2. Collaborate with parish jails to identify and establish process of screening, assessing and discharge planning to assure timely access to services upon release/reentry to the community with expansion to individuals who are incarcerated who meet criteria of CAHSD services, but were not previous clients of the District.</li> </ol>	<ol style="list-style-type: none"> <li>1. Formal referral process will be established for 4 of 7 parishes 2009. Identify performance indicators to be presented to board 2009.</li> <li>2. Formal screening and referral process will be established for 4 of 7 parishes 2009. Identify performance indicators to be presented to board 2009.</li> </ol>	<ol style="list-style-type: none"> <li>1. Established referral process for CAHSD clients in East Baton Rouge, East and West Feliciana and Ascension Parishes. The following indicators will be tracked: Monitor number of referrals made to CAHSD. Percentage of referrals keeping initial appointment. Chain of communication/referral process is working effectively.</li> <li>2. Established referral process in East Baton Rouge, East and West Feliciana Parishes for non-CAHSD clients. Ascension is in final developmental stage and should be completed by December. The following indicators will be tracked: Monitor the number of referrals made to CAHSD. Percentage of referrals keeping initial appointment. Chain of communication/referral process is working effectively.</li> </ol>

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

DHH Plan: None

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

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

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

No. If not, why not? Management does not feel that revisions are needed at this time. The only area with a significant lack of progress is the accreditation process which management is currently underway to accomplish.

- ♦ **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 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.

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

Agency is faced with reduced funding levels and task of creating better efficiencies.

### **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): State Licensure (BHS and Public Health-Department of Health and Hospitals)

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

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

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

1. Title of Report or Program Evaluation  
Louisiana Performance Accountability System (LaPas)  
Louisiana Legislative Auditor Procedural Report
2. Date completed  
LaPas: October 2010  
Audit: June 20, 2009
3. Subject or purpose and reason for initiation of the analysis or evaluation  
Legislative requirement
4. Methodology used for analysis or evaluation  
LaPas: Standard methodology required by the DOA; actual performance indicators developed in conjunction with program offices and approved by the DOA.  
  
Audit: Review of internal controls, tests of financial transactions, tests of

adherence to applicable laws, regulations, policies and procedures governing financial activities and review of compliance with prior report recommendations.

5. Cost (allocation of in-house resources or purchase price)  
LaPas: Cost has never been calculated  
Audit: \$41,205
6. Major Findings and Conclusions  
LaPas: None-minor variances from targets  
Audit: 1. Payroll Internal Control Weakness  
Major Recommendations  
LaPas: None  
Audit: 1. Management should monitor compliance with existing policies and procedures to ensure proper approvals are documented and valid data are entered correctly.
7. Action taken in response to the report or evaluation  
LaPas: None  
Audit: Corrective Action Plan was implemented which included the development of a procedure to ensure that recommendations were applied.
8. Availability (hard copy, electronic file, website)  
LaPas: [www.louisiana.gov/opb/lapas/lapas.htm](http://www.louisiana.gov/opb/lapas/lapas.htm)  
Audit: [www.lla.state.la.us](http://www.lla.state.la.us)
9. Contact person for more information, including  
Name: Jan Kasofsky, PhD  
Title: Executive Director  
Agency & Program: Capital Area Human Services District  
Telephone: 225-922-2700  
E-mail: [Jan.Kasofsky@la.gov](mailto:Jan.Kasofsky@la.gov)  
  
Name: Carol Nacoste  
Title: Deputy Director  
Agency & Program: Capital Area Human Services District  
Telephone: 225-922-2708  
E-mail: [Carol.Nacoste@la.gov](mailto:Carol.Nacoste@la.gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

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

**Department Head:** Bruce D. Greenstein  
Title: Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Sandee Winchell, Executive Director

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

#### **Community Supports and Services**

The Council provides technical support and funding to Louisiana Citizens for Action Now (LaCAN), a statewide, grassroots, family-directed advocacy network. LaCAN has long advocated for the closure and downsizing of the state's institutions and the increase of home and community based services. This year legislators:

- Made significant positive reforms to the system serving people with developmental disabilities including the closure of Northeast Supports and Services Center and the downsizing by 20% of the remaining centers. Louisiana has historically over-relied on institutions serving more individuals in ICFs/DD per capita than any other state – almost four times the national average. These changes move Louisiana toward a model that supports all people living in their own homes and communities.
- Appropriated funds for an additional 150 New Opportunities Waiver slots and 425 Children's Choice waiver slots to address the more than 9,000 individuals with developmental disabilities who wait eight years for waiver services.
- Appropriated \$4.2 million from the Community and Family Support Fund (from the sale of the Metropolitan Developmental Center) to speed up the processing of NOW slots and on one-time expenditures for individuals with developmental disabilities and their families.

These accomplishments directly relate to the vision, mission, philosophy and direction of the Council's strategic plan. It also relates to Goal 1 of our strategic plan, to obtain federal funds through the Developmental Disabilities Assistance and Bill of Rights Grant. A requirement of maintaining grant funds is to demonstrate facilitation of advocacy, capacity building and systemic change.

### ***Early Intervention Program***

As a result of Council funding a model for providing early intensive intervention for children with autism and their families was developed. This model is being expanded and incorporated into EarlySteps and other programs to serve more children with autism and their families. These achievements support the vision; mission, philosophy and direction of the Council strategic plan and supports Act 1078 (Human Resources Policies Beneficial to Women and Families).

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

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

The Council's continuing efforts fulfill the responsibilities required under the federal enabling legislation and more funds are expended on plan activities than is required by federal law. The Council also continues to draw down the largest allotment possible in federal funds for Louisiana to provide individuals with disabilities and their families the maximum benefit in advocacy, capacity building and systemic change supports. All actions and efforts undertaken by the Developmental Disabilities Council continue to be directed to affect real and meaningful reform of Louisiana's system of services and supports to individuals with disabilities and their families.

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

The Council made significant progress this year on the objectives to provide Information and Referral, Peer to Peer Support to individuals with disabilities and parents/family members, and the number of individuals trained in each region of Louisiana. Performance greatly exceeded targeted goals for the number of information and referral services provided and the

number of people receiving peer to peer support. The increased need for support is attributed to increased need for supports due to the impact on the economy on many individuals' lives and changes to some services previously provided. Peer-to-Peer supports are expected to continue producing high levels of participation.

1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
    - Other? Please specify.
  2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?
- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

The Council was below target on the performance indicator goal of the number of training sessions. The reduction in meeting the targeted number of training sessions is attributed to a change in the definition of a training session. Only training sessions with sign-in sheets and evaluations are included in the number of trainings sessions reported. There are numerous other information sessions and presentations not counted due to being held in conjunction with a conference that does not lend itself to producing the required supporting documentation to be classified as a training session. There has also been a significant shift in how people are accessing information with higher numbers of individuals preferring more individualized peer-to-peer support rather than formal training sessions. When the performance of the number of individuals receiving services is considered it reveals that services are still being provided and that the overall outcome is achieved.

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

2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?
- ◆ **Has your department revised its strategic plan to build on your successes and address shortfalls?**
    - Yes. If so, what adjustments have been made and how will they address the situation?
    - No. If not, why not?

Objectives were added to the 2009-2010 Strategic and Operational Plans to develop an association of Families Helping Families Resource Centers to develop a formal mechanism of collaboration and support between these regionally based centers. Although this could provide a mechanism of support to reduce duplication of resources and enhance their operations and quality of resources available to parents in every region many Centers indicate that travel, dues and other aspects of participation in the Association is cost prohibitive.

- ◆ **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.

**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.)

All of our goals and objectives are reliant on federal and state appropriations. The Council consistently takes all actions possible to ensure continued allocations. One significant issue is the economy. The Council's federal funds

are not currently in jeopardy. , but State General Funds have been reduced. These Centers play a critical role in connecting, informing and supporting individuals with developmental disabilities and their family members. Unfortunately large portions of the individuals served live in rural areas and have limited use of computers. Considering the capacity to provide support in a lot of Louisiana's rural areas is contingent on travel, we have had to revamp the way services and outreach activities are provided to individuals who can not travel into large metropolitan areas.

**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?

Provide increased funding levels to support the core functions of 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)?

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?

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 SFY 09 level is needed for the Families Helping Families Resource Centers to meet the demand in their regions at a cost of \$126,943.

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract

- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

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

As required by federal law, the Council submitted a Program Performance Report (PPR) to the federal Department of Health and Human Services, Administration on Developmental Disabilities in December of 2009 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 2009-2010. A report covering the remainder of the state fiscal year will be submitted to the federal government in December of 2010.

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). ADD staff offered commendations for the Council's success with its Child Care program.

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

**For more information contact:**

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# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

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

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Judge Calvin Johnson, Executive Director

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

#### Care Center Implementation

*During FY2009-2010, Metropolitan Human Services District (MHSD) implemented the Care Center to integrate and manage the Single Point of Entry (SPOE) process of the community-based behavioral health service system. This integration has resulted in continuity of care across the mental health community and hospital treatment setting for mental health and addictive disorder services in Orleans, Plaquemines and St. Bernard parishes. In addition to service integration, the Care Center has as its goals better utilization of resources, the identification and elimination of gaps in service, and the provision of exemplary client-centered care. The Care Center team provides telephonic care coordination, as well as crisis triage. The Care Center applies standardized guidelines to ensure individuals receive services appropriate to their needs.*

*This accomplishment primarily contributes to Goal IV of MHSD's FY2009-2013 strategic plan – To deliver a seamless, integrated, and comprehensive system of services that is responsive to consumer strengths, needs, interests, and choices. The implementation of the Care Center moves MHSD closer to becoming a Stage Four health care system as identified by the Committee on the Quality of Health Care in America in "Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century." In a Stage Four health care system, services are coordinated across practices, settings, and patient conditions over time.*

### **Local Management and Expansion of ACT/FACT Services**

*Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT) is an evidence based practice, shown to be effective for individuals diagnosed as having a chronic mental illness and for whom traditional services have been ineffective. ACT/FACT is a multidisciplinary team approach with staff organized as a mobile mental health team, who function interchangeably in their roles to provide time unlimited treatment, rehabilitation and support services necessary to keep people with mental illness living in the community. Research findings support that ACT/FACT leads to reduced hospital stays, higher levels of housing stability, improved symptoms and social functioning, and higher quality of life. The New Orleans Police Department has reported fewer calls for service related to individuals once they have been admitted to ACT/FACT teams.*

*Prior to FY2009-2010, the State Office of Mental Health managed the contracts for the ACT/ FACT teams serving MHSD clients. The management of these contracts has now been transitioned to MHSD. Local control of these services means that they can be more effectively and efficiently managed.*

*ACT/FACT services were also expanded. There are currently two ACT teams serving MHSD clients in Orleans, St. Bernard, and Plaquemines parishes. A FACT team provides services to individuals residing in the MHSD and Jefferson Parish Human Services Authority catchment areas. These three teams afford MHSD the capacity to serve up to 300 clients.*

*This accomplishment primarily contributes to Goal II of MHSD's five-year strategic plan – To develop meaningful innovative research-based activities and programs directed toward the self-actualization of individuals and families throughout the community. It also supports MHSD's overall goal to provide research-based programs that are responsive to consumer and community identified strengths and needs within a structured measurable and outcomes-based integrated system.*

### **Expanded Service Continuum**

*In addition to the expansion of ACT/FACT services described earlier, MHSD also expanded the capacity of its transitional housing and intensive case management (ICM) services during FY2009-2010. Transitional housing is a 90 day program that helps to stabilize clients by transitioning individuals from an unstable housing situation to permanent housing. MHSD expanded its transitional housing from 19 beds to 40 beds. ICM teams provide around the clock care for clients and their families directly in the community. The ICM team not only provides case management, but also ensures that clients are in the appropriate treatment settings and ensure smooth transitions among levels of care. MHSD is now able to support over 100 clients through ICM. Additionally, the restructuring of contracted services described above has ensured that the availability of these services is guaranteed for MHSD clients. This accomplishment supports Goal II of MHSD's strategic plan – To deliver high quality cost efficient community based prevention, early intervention, treatment, recovery supports, individual and family supports that will*

*equip and strengthen individuals, children, youth, and elderly to be maintained in the community.*

### **Developmental Disability Services**

*MHSD has continued to increase service delivery and access to community based services to support individuals with developmental disabilities and their families to remain living in the community and to prevent institutionalization and recurring psychiatric hospitalizations. MHSD has expanded psychological services by hiring an in-house psychologist to provide positive behavioral support services to individuals with developmental disabilities who exhibit significant behavioral challenges and whose behaviors pose a danger to them or put them at risk for abuse, neglect, mistreatment, and the risk of losing their life in the community, at home, and in school.*

*MHSD is working to increase access for individuals participating in supported employment and other vocational options by systematically addressing vocational and employment options at support meetings. In addition, MHSD is working to restore services in St. Bernard parish through a unique partnership with ARC.*

*MHSD improved the ability of individuals with low income to remain living in their homes and in the community by partnering and collaborating with the Office of Aging and Adult Services and the Housing Authority of New Orleans (HANO) to obtain housing vouchers, including signing an MOU with HANO that provides 100 housing slots dedicated to MHSD clients.*

*MHSD has also been actively involved in the negotiations related to the transfer of the waiver program to local control.*

*These accomplishments support Goal I of MHSD's strategic plan – To identify, strengthen and link relevant resources that will foster community collaboration resulting in a dynamic and comprehensive system of service delivery for citizens of Orleans, St. Bernard, and Plaquemines parishes.*

### **Pharmacy Software**

*In December 2009, MHSD implemented the PRISM pharmacy software. The main intent of this implementation was to enhance and expedite medication delivery. PRISM allows the pharmacy to effectively track and dispense medications. The new system allows MHSD to track client medications received from Patient Assistance programs (PAP) or third party sources. The PRISM system interfaces with the PAP software (M & D Cares) eliminating the need for manual tracking and therefore reducing the likelihood for error. Another feature implemented was the use of barcode scanners at all clinics which allow physicians and nurses to submit all medications orders to the pharmacy electronically. Electronic submission of medication orders and the use of barcode scanners permit pharmacy staff to readily associate every prescription order dispensed with the prescribing physician. This accomplishment primarily supports Goal V of the MHSD 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.*

### **Redesign of Drug Court Intake**

*MHSD currently provides services to Drug Court clients. MHSD began an exploration of effectiveness of the current practices in place; from those findings the Intake/assessment procedure has been redesigned and plans are in place to implement practices to improve treatment delivery. This accomplishment supports Goal I of MHSD's five year strategic plan – To identify, strengthen and link relevant resources that will foster community collaboration resulting in a dynamic and comprehensive system of service delivery for citizens of Orleans, St. Bernard, and Plaquemines parishes.*

### **Increased Access to Services**

*The MHSD Mobile Unit provides outreach services to clients and their families in St. Bernard and Plaquemines parishes. The unit is staffed with a social worker and a psychiatrist, with nursing services available. Mobile services are provided in strategic areas so that citizens need not travel far for specialty behavioral health services. Additionally mobile services are located in key areas to provide services for those affected by the recent Gulf oil spill disaster. This accomplishment contributes to MHSD's strategic goal to ensure access to care. During FY2009-2010, Mobile Unit operations were expanded from two days to five days a week, thus improving access and utilization.*

*The Transportation Unit supports the overall mission of MHSD by providing regular vehicular transportation assistance to MHSD clients free of charge. This service removes transportation barriers for clients who require access to medication management, therapy or group counseling sessions and supports stabilization over time. The service also establishes and maintains a relationship between the District and its clients in a way that encourages continuity of care. MHSD also provides transportation tokens to clients unable to attend treatment sessions due to lack of transportation.*

*These services support Goal V of MHSD's 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.*

### **Behavioral Health Center Remodel**

*During FY2009-2010, MHSD remodeled its two largest behavioral health centers to create a more client-centered environment and increase the efficiency of service delivery. The changes at the Central City and Chartres-Pontchartrain Behavioral Health Centers included opening up the reception areas to allow more client interaction with staff and facilitate the admissions process. These changes were highlighted by the removal of the physical barriers (i.e., Plexiglas and iron partitions) that separated clients from staff.*

*The renovations also included the addition of private areas where clients can meet and exchange personal, financial information with the billing and other staff during PAP and Medicaid enrollment. The expansion of the waiting area capacity at the Central City Behavioral Health Center has allowed clients to be more comfortable while waiting, and the removal of the wall to wall carpet at Chartres has made the group rooms more aesthetically pleasing. Other improvements such as lighting and painting the clinics with colors that are more calming than the previous bright color scheme also had a positive effect on both clients and staff. The Chartres-Pontchartrain Behavioral Health Center was also upgraded with a generator to allow this facility to be used as an emergency preparedness site for MHSD. This accomplishment aligns with MHSD's overall strategic plan to move toward a client-centered approach to care that is responsive and respectful.*

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

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

*MHSD is steadily progressing toward achieving the goals outlined in the five-year strategic plan. MHSD has made significant progress in identifying and articulating its mission, values, and 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 resources to support a seamless, integrated, and comprehensive system of services. The MHSD Executive Team has thoroughly committed to research-based program and service development and a systematic, structured decision-making 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?

*The organizational changes MHSD is undergoing are phased. The first phase focused on mental health services. The second phase is focusing on integrating mental health and addictive disorder services. The third phase will be to integrate developmental disability services.*

- ◆ **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?

*In June 2009, MHSD began planning meetings at multiple staff levels to better define the direction of MHSD in terms of implementing the desired activities. During this process, MHSD depended primarily on literature searches as well as utilized data from the behavioral health systems to inform the process. MHSD has revised its strategic plan to reflect a focus on care coordination, service integration, and person-centered and information-driven service delivery.*

No. If not, why not?

- ◆ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department,**

**regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

*MHSD's executive staff and management team assure consistency of the District's goals with those of DHH 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 inadequate and inefficient information systems. A 21<sup>st</sup> century health system is one in which knowledge is shared and information flows freely. A strong information systems infrastructure is essential to support service delivery, quality measurement and improvement, and public accountability.*

**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 will undergo a thorough review of the existing information systems to assess their capacity as well as the quality of the information currently contained within them. The goal of the assessment will be to drive the establishment of real-time, information-driven decision supports and reporting capacities within MHSD.*

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

*No, this will be the first time MHSD has executed a coordinated plan for improving its information systems.*

4. Are corrective actions underway?

*Yes.*

- a. If so:

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

*The assessment of the existing information systems began in August 2010. It is anticipated that the assessment will be completed by the end of the calendar year. Once the assessment is completed an information quality implementation plan will be developed to address the gap between current and desired information capabilities. It will outline the action steps to improve the infrastructure of the existing information systems and the quality of the information they produce.*

- 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?

*It is extremely likely that the corrective actions will carry a cost, but the cost is unknown until the assessment has been completed and the extent of the problem is fully outlined.*

#### **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)

*MHSD is audited on a biennial basis through the Office of the Legislative Auditor.*

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

*MHSD is a learning organization. Organizational changes and programmatic decisions are based on available performance information and a thorough review of extant research literature and practices that are most likely to produce the desired results.*

- 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)

*MHSD collects and reports data into LaPAS on a quarterly basis. Performance standards are reviewed and adjusted on an annual basis during the budgeting process according to service level projections.*

- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)

*All MHSD contracts contain explicit performance expectations and reporting requirements.*

- 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 2009-2010

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

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Don Gregory, Medicaid Director

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

#### **Health Standards Section – Crisis Receiving Centers-**

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

Published in the La. Register an administrative rule for the licensing of crisis receiving centers.

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

This effort is aimed to improve access to better behavioral health in the state.

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

Residents of the state

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

Through legislation giving the authority to the Department to write licensing rules.

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

N/A

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

Unknown

### **Health Standards Section – Assisted living facilities, personal care homes and shelter care homes**

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

The transfer of the licensing of assisted living facilities, personal care homes and shelter care homes July 1, 2010

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

This brings the regulatory authority over these entities to DHH instead of DSS or the now named Department of Children and Family Services. These entities will now be licensed as Adult Residential Care Providers.

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

Residents of these licensed providers benefit in that they have some level of assurance that they are residing in a facility that has certain state compliance regulations that they must meet.

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

Through legislation giving the authority to the Department to transfer the facilities to DHH and license them as Adult Residential Care Providers (ARPCs) and revise the existing licensing rules that DSS promulgated and the currently existing ARCP rule and merge into one rule to govern all of these facilities as ARCPs.

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

N/A

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

Unknown

### **Work @Home-**

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

In SFY10, the Health Standards Section piloted the Work @ Home program that allows employees to work from home or an alternate location for part of their regular work week. Work @ Home is a management option where the arrangement supports the agency's strategic goals, objectives and business needs. Telework in Health Standards was made possible because of the Health Standards survey staff having tablet PCs for use in documenting health survey activities. The HSS pilot began in February with 15 survey staff.

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

Development of the Work @ Home program was instituted as a cost savings measure and as a tool to retain trained staff that would ordinarily have to come into the office to write lengthy survey reports. Work @ Home has demonstrated reduction of time spent in travel allowing for more productive report writing time.

**C. Who benefits and how?**

Work@Home offers considerable benefits to agency, employees, customers and communities. Listed below are many such benefits:

- Provides flexibility in meeting changing business needs
- Decreases administrative costs
- Increases productivity
- Reduces absenteeism
- Enhances the ability to recruit and retain talented people
- Reduces turnover and training costs
- Provides employees flexibility in managing work and family responsibilities
- Decreases work-related expenses for employees
- Affords greater employee satisfaction and improves morale
- Promotes Green Government

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

The Work @ Home program was pioneered by participants in DHH's eligibility section and has DHH Executive Management support. Due to the nature of the surveyors work site alternating between the healthcare provider's premises to carry out the survey process and a Health Standards Section office in order to formulate the report of the survey, HSS was an ideal environment in which to initiate the Work @ Home program.

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

Yes, telework directly and indirectly contributes to the success of the agency's strategic plan, as explained above.

**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 agency has had significant interest from outside entities in its Work@Home program. By request, the agency has presented on the program in state to the State Civil Service Commission and the State Human Resources Managers Association, and out of state at the 2009 annual conference of the National Association of State Personnel Executives. It was also featured in January 26, 2009 issue of Federal Computer Week magazine. In response to public demand for program information, program policy, procedures, evaluation and related information are posted on the Department website. Recently, the agency developed a Telework Toolkit intended for use as a guide to other State agencies seeking to implement a successful telework program.

**II. Is your department five-year strategic plan on time and on target for accomplishment?** Not Applicable**III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?**

The Health Standards Section (HSS) of the Department is the division of the Department that has the responsibility of licensing all healthcare facilities in the state that are subject to licensing statutes. HSS also has a federal contract with the Centers for Medicare and Medicaid Services (CMS) to conduct certification surveys and complaint surveys in programs that are Medicare and /or Medicaid certified. There are currently over 35 various providers and/or healthcare facility types that HSS licenses, certifies or in some format regulates.

The workload of HSS has had and continues to have continued consistent and steady growth in facilities and provider types under the HSS umbrella. In October of 2005, while still reeling from the devastating hurricanes of 2005, HSS acquired 1600 new providers with a transfer of these programs from the La. Department of Social Services.

Prior to the receipt of these 1600 providers, HSS had approximately **150** surveyors to conduct surveys of approximately **3,500 providers/facilities** statewide. The influx of these 1600 providers was a **46% increase** in the number of facilities/providers to regulate! In 2006 HSS was appropriated 13 surveyor positions to assist in conducting the licensing survey workload of this additional 1600 providers. This amount was far short of the amount needed to survey these facilities. Additionally, the number of these providers and the accompanying work involved in assessing and reviewing files, establishing the licensing processes for these programs, establishing the review process for the surveys conducted of these programs and answering the hundreds of communications and inquiries about these providers has been an enormous undertaking. Subsequent to legislation of these programs have required initial changes to the licensing requirements to be drafted and filed then subsequent revisions into a final all inclusive regulatory manual for these programs. There has been an immense amount of adverse action work in these programs because of the numbers of non-compliant providers we are citing on survey. Many of these providers were not surveyed for a few years and we have encountered serious deficient practice or no practice at all and the provider is essentially not operational.

Further, in the last couple of years we have also had to take on the regulation of new healthcare provider types or the transfer of providers from one state department to DHH and then undertaking the task of writing licensing regulations for these new healthcare provider types on short notice. Some of these include pediatric day healthcare facilities, crisis receiving centers, forensic supervised transitional facilities and adult residential care.

#### **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): CMS state agency performance review

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:

**External audits (Example: audits by the Office of the Legislative Auditor) - HSS has annual audits by the state legislative auditors.**

**Policy, research, planning, and/or quality assurance functions in-house** – HSS offers an informal dispute resolution (IDR) hearing process for all healthcare providers that have been cited for violations of federal or state regulation. This opportunity allows the healthcare provider to dispute any deficiencies that the provider thinks was written in error. The results of the IDRs are used as an internal quality assessment/quality improvement tool for our agency.

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: Erin Rabalais, RN  
Title: Section Chief

Agency & Program: Health Standards Section  
Telephone: 225-342-4997  
E-mail: rabalais@la.gov

## **Program Operations - ClaimCheck**

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

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

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

Implemented May 25, 2010, "ClaimCheck" is a nationally recognized comprehensive procedure code auditing solution that assists Louisiana Medicaid with proper physician reimbursement by automatically evaluating physician claims via sophisticated clinically-based "logic" before reimbursement. Drawing on the latest industry benchmarks and national clinical standards of care, ClaimCheck addresses Medicaid claims coding issues by identifying services billed incorrectly and educating providers as to the reason for denials. Additionally, this product decreases the amount of manual intervention required to maintain national coding compliance. The systematically updated ClaimCheck product is integrated with the current claims processing system and increases payment accuracy and consistency based on national clinical guidelines and specifically incorporated Louisiana Medicaid policy where appropriate. Savings are an expected result of implementing correct coding practices and policy through an effective editing tool such as ClaimCheck. The approximate initial savings seen in SFY 09/10 was \$2.9 million for six weeks, based on the implementation date of May 25, 2010.

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

When ClaimCheck is integrated with the claims processing system, in addition to the increased payment accuracy and consistency, coupled with overall savings of Medicaid dollars; the incorporation of this editing product brings Louisiana Medicaid processing more in line with national benchmarks and standards.

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

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

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

Working on a compressed timeline, Louisiana Medicaid collaborated with the fiscal intermediary and its subcontractor, McKesson Corporation, to integrate McKesson's ClaimCheck editing tool into the Medicaid claims processing system, as well as assessed and incorporated appropriate Louisiana Medicaid policies into the final product. This collaboration involved both the technical aspect of the implementation and integration and the assessment and modification of medical policy where indicated, to align with national

standards.

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

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

- ◆ **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?
- ◆ **Where are you making significant progress?** Significant progress has been slowed due to the delay of implementation.

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?
- ◆ **Where are you experiencing a significant lack of progress?** Program Operations is experiencing a significant lack of progress because of the delay in implementing efficiencies.

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

- The delay in implementing efficiencies is attributed to the unexpected lengthy review and approval process at both the state and federal levels.

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?

- This delay is due to the exhausting review and approval process at all levels of government. To remedy this, significant review/approval policies and procedures would have to be reviewed for their practicability.

♦ **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?

Further assessment of impact is needed after implementation.

♦ **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?**

Departmental notification of needed review is sent to appropriate staff.

**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?

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

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

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

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

Program Operations

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

Both internal and external customers were affected by the lack of human resources and the increase in responsibility to successfully manage these programs and initiatives, which led to the ultimate delay in implementation of cost-savings initiatives.

5. How long has the problem or issue existed?

Due to four (4) successive hiring freezes, the issue has been in existence for almost three (3) years and program progress has suffered.

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

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

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

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

#### B. Corrective Actions

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

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

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

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

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

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

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

#### **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:

## **Program Operations – InterQual Phase 1**

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

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

**A. What was achieved?**

Authorized acute inpatient hospital length of stay (LOS) was reduced by 0.425 days.

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

This success is significant because a decrease in LOS results in a decrease in expenditures paid for acute inpatient hospitalizations. It is also significant because authorizations are based on nationally recognized medical necessity criteria and the clinical knowledge of experienced physicians at the Fiscal Intermediary (FI).

**C. Who benefits and how?**

Using the combination of nationally recognized medical necessity criteria and the expertise of the physicians at the FI benefits the recipients of Louisiana Medicaid benefit. This process helps Louisiana Medicaid to manage care processes and resources in a way that fosters evidence-based practice and ensures patient safety while controlling medically unnecessary care.

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

In November of 2009 Program Operations implemented InterQual Phase One. The goal of this project was to increase the appropriateness of Inpatient Acute Care extension certification reviews and create efficiencies for the precertification department by automating specific manual review processes. The FI deployed CareEnhance Review Manager Enterprise (CERMe) with custom integration services to include Acute Adult & Pediatric Criteria and Procedures Criteria. This product enables health care case reviews using InterQual Criteria and provides consistent, reproducible reviews. Prior to implementation of Phase 1 this was a manual process, outdated medical necessity criteria was used and there was not 100% application of the medical necessity criteria to the LOS extension reviews.

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

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

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

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

- ♦ **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?
- ♦ **Where are you making significant progress?** Significant progress has been slowed due to the delay of implementation.

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?
- ♦ **Where are you experiencing a significant lack of progress?** Program Operations is experiencing a significant lack of progress because of the delay in implementing efficiencies.
- a. To what do you attribute this lack of progress?
    - The delay in implementing efficiencies is attributed to the unexpected lengthy review and approval process at both the state and federal levels.
  - b. 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?
    - This delay is due to the exhausting review and approval process at all levels of government. To remedy this, significant review/approval policies and procedures would have to be reviewed for their practicability.
- ♦ **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?  
Further assessment of impact is needed after implementation.
- ♦ **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?**

Departmental notification of needed review is sent to appropriate staff.

**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?  
Limited resources and an increase in state initiatives have caused a delay in implementation of these new initiatives.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)  
Although this issue has the potential to impact the strategic plan, the Department, although delayed, has implemented this major initiative and it will help fulfill the Department’s mission and goals.
3. What organizational unit in the department is experiencing the problem or issue?  
Program Operations
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)  
Both internal and external customers were affected by the lack of human resources and the increase in responsibility to successfully manage these programs and initiatives, which led to the ultimate delay in implementation of cost-savings initiatives.
5. How long has the problem or issue existed?  
Due to four (4) successive hiring freezes, the issue has been in existence for almost three (3) years and program progress has suffered.
6. What are the causes of the problem or issue? How do you know?  
The lack of resources due to the hiring freezes has limited our ability to hire

qualified staff to institute new programs in a timely fashion. Although new programs aimed at providing better services to the public and cutting cost to the state are finally becoming a reality, they have been delayed in many cases because of the multiple hiring freezes.

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

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

#### B. Corrective Actions

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

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

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

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

4. Are corrective actions underway?

a. If so:

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

b. If not:

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

5. Do corrective actions carry a cost?

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

Please discuss the following:

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
- b. How much has been expended so far?
- c. Can this investment be managed within your existing budget? If so,

does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

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

#### **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
  - Alternate Cost Savings Report
2. Date completed
  - Monthly report with 60 day lag
3. Subject or purpose and reason for initiation of the analysis or evaluation

- To evaluate the effectiveness of Phase 1
- 4. Methodology used for analysis or evaluation
  - Month to month comparison of all approved inpatient acute hospital LOS and expenditures paid pre and post implementation
- 5. Cost (allocation of in-house resources or purchase price)
  - None, the reporting was part of the SOW/Contract Amendment
- 6. Major Findings and Conclusions
  - Decrease in LOS of 0.425 days over 8 months for a total decrease in expenditures paid for acute inpatient hospitalization of \$80 million. (This does not include any payments made for authorizations approved via the appeal process)
- 7. Major Recommendations
  - None, continue with the program.
- 8. Action taken in response to the report or evaluation
  - None
- 9. Availability (hard copy, electronic file, website)
  - Electronic File
- 10. Contact person for more information, including
  - Name: Paige Hargrove
  - Title: Medicaid Program Manager 1-B
  - Agency & Program: DHH/MVA/Program Operations
  - Telephone: (225)342-5691
  - E-mail: [paige.hargrove@la.gov](mailto:paige.hargrove@la.gov)

## **Program Operations – P4P Initiative**

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

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

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

In 2007, Louisiana Medicaid's immunization pay-for-performance (P4P) initiative, which includes supplemental payments to providers, was recognized by the Centers for Medicare and Medicaid Services (CMS) as a Medicaid Promising Practice. This initiative was implemented to promote up-to-date immunizations of Louisiana Medicaid eligible children and to increase the number of providers utilizing the Louisiana Immunization Network for Kids Statewide (LINKS) immunization registry. Eligible providers are required to be CommunityCARE PCPs utilizing the Vaccines for Children Program and the LINKS immunization registry. The 2008 National Immunization Survey (NIS) ranked Louisiana second in the nation, up from 28th in 2007, for 19-35 month old children up-to-date with all recommended immunizations (81.9%). The 2009 NIS now reports on a higher (tougher) benchmark as the base for measurement and Louisiana again ranks as second best in the nation (53.7%) for children of this age being up to date with immunizations (US National rate reported at 44.3%).

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

The P4P initiative encourages providers to ensure Medicaid children in their practice are up to date with recommended childhood vaccines ensuring optimal health outcomes for Louisiana children. In collaboration with the Office of Public Health (OPH) Immunization Program, immunization rates increased in 2007 by 9.76%; 264 providers received payments; and, of those 264 providers, 62% saw an increase in the percentage of 24-month old recipients. In 2008, immunization rates among providers increased by 14.37%; 317 registered providers received payments; and, 57% of the 317 providers saw an increase in the percentage of 24-month old recipients. In 2009, immunization rates for participating providers that received P4P payments increased by 12.82% from July 2008 to June 2009. Payments were made to 332 providers, a 25% increase from 2007 and a 4.7% increase from 2008. Future plans are to restructure this initiative as necessary related to healthcare and Medicaid reform initiatives and hopefully expand the initiative to include an adolescent measure to incentivize providers in improving immunization rates of the adolescent population, dependent on funding availability.

**C. Who benefits and how?**

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

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

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

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

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

Financial Considerations

## Medical Homes

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

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

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

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

- ♦ **Please provide a brief analysis of the overall status of your strategic progress.**  
What is your general assessment of overall timeliness and progress toward

accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

♦ **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?

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

1. To what do you attribute this lack of progress?
2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

♦ **Has your department revised its strategic plan 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?  
Further assessment of impact is needed after implementation.

**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?**

Departmental notification of needed review is sent to appropriate staff.

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

#### B. Corrective Actions

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

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

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

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

No. If not, please explain.

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

Please discuss the following:

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

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

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

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

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

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

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

1. Title of Report or Program Evaluation

- U.S. Department of Health and Human Services Centers of Medicare & Medicaid Services, Region VI Louisiana EPSDT Review Report Dental Services

2. Date completed

- July 18, 2008

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

- The Centers for Medicare & Medicaid Services (CMS) conducted 16 State dental reviews to obtain information on dental services provided to Medicaid beneficiaries to further enhance national initiatives to improve oral health care in the United States. The review examined several variables on dental care provided to Medicaid beneficiaries under the age of 21. The reviews surveyed States' efforts to address the rate of children's dental utilization, to identify potential issues with adherence to Federal Medicaid statute or regulations, and to identify promising practices States have implemented to improve the delivery of oral health services to Medicaid eligible children

4. Methodology used for analysis or evaluation

- CMS conducted onsite reviews of children's dental services in 16 States. States with reported dental utilization rates of 30 percent or

less were selected for review. CMS established review teams consisting of regional and central office staff with health care and Medicaid policy expertise. The dental review protocol included standard questions to be addressed at each interview and focused on key areas. The dental review teams spent an average of three days in each State and interviewed a wide range of individuals. In order to supplement information from the onsite interviews, the CMS review teams requested supporting documentation.

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

- There was no cost to the State for this review

6. Major Findings and Conclusions

- Major findings consisted of: failing to ensure that medically necessary services were provided to EPSDT eligibles, not being in compliance with the requirement that States develop a separate dental periodicity schedule, and neglecting to maintain and monitor a network of appropriate providers.
- CMS determined the states area of improvements to be: recipients not adequately informed about the availability and importance of dental services, dental provider not updated on a daily basis, and transportation assistance

7. Major Recommendations

- Establish regular communication for dental providers, formalize provisions allowing medically necessary dental services and a dental periodicity schedule, periodically update provider information, and perform a quarterly review of support services with a focus of transportation.

8. Action taken in response to the report or evaluation

- The state has formalized a policy allowing medically necessary dental services, created focused communication for dental providers through a "Newsletter," created a link specifically for dental providers on our state Medicaid website, now closing dental providers enrollment if no claim has been processed in 18 months, implemented a dental periodicity schedule, conducting a review of the transportation program, and revised the annual EPSDT informing notice which informs recipients of available dental services

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

- a. LA EPSDT Draft 7-18-08
- b. 2008 National Dental Summary

10. Contact person for more information, including

Name: Cordelia Clay

Title: Medicaid Program Monitor

Agency & Program: Bureau of Health Services Financing

Telephone: 225-342-4182  
FAX: 225-242-0470  
E-mail: cordelia.clay@la.gov

## **Program Operations – Radiology Utilization Management (RUM) Program**

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

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

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

- Louisiana Medicaid implemented the Radiology Utilization Management (RUM) program in February of 2010.

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

- This program was implemented and is significant because it promotes the health of Medicaid recipients by ensuring appropriate utilization of Department-defined high-tech imaging studies by Medicaid providers and recipients

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

- The Medicaid recipients benefit. Louisiana Medicaid's goal is to assure patient-centered outcomes and to eliminate unnecessary and potentially harmful treatment. Unmanaged diagnostic imaging exposes patients to a host of clinical quality issues.

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

- Medicaid partnered with MedSolutions Inc. (MSI), to provide prior authorization, monitoring and management of medical imaging services. Through this program primary care and specialty care providers are required to request prior authorization for non-emergency outpatient Magnetic Resonance (MR), Computed Tomography (CT), and Nuclear Cardiac imaging. MSI's unique process of combining patient-specific information, evidence-based clinical criteria, and medically relevant decisions ensures that the right treatment is given at the right time in the diagnostic and treatment cycle.

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

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

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

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

- ♦ **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?
- ♦ **Where are you making significant progress?**  
Significant progress has been slowed due to the delay of implementation.

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

1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department’s contribution to the joint success?
    - Other? Please specify.
  2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?
- ♦ **Where are you experiencing a significant lack of progress?** Program Operations is experiencing a significant lack of progress because of the delay in implementing efficiencies.
    - a.1. To what do you attribute this lack of progress?
      - The delay in implementing efficiencies is attributed to the unexpected lengthy review and approval process at both the state and federal levels.
    - b. 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?
      - This delay is due to the exhausting review and approval process at all levels of government. To remedy this, significant review/approval policies and procedures would have to be reviewed for their practicability.

♦ **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?

Further assessment of impact is needed after implementation.

**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?** Departmental notification of needed review is sent to appropriate staff.

**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**

**Problem/Issue Description**

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

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

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

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

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

Program Operations

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

Both internal and external customers were affected by the lack of human resources and the increase in responsibility to successfully manage these programs and initiatives, which led to the ultimate delay in implementation of cost-savings initiatives.

5. How long has the problem or issue existed?

Due to four (4) successive hiring freezes, the issue has been in existence for almost three (3) years and program progress has suffered.

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

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

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

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

#### B. Corrective Actions

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

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

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

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

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

4. Are corrective actions underway?

a. If so:

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

b. If not:

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

## 5. Do corrective actions carry a cost?

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

Please discuss the following:

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

**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:

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

For each accomplishment, please discuss and explain:

### Eligibility Division – Achieved Increased Efficiency

#### A. What was achieved?

To continue to provide excellent customer service to applicants and enrollees during a time of staff reductions, it was necessary for the Eligibility Division to develop and implement automated processes to reduce burdensome paper processes and reduce the amount of time it takes for staff to perform their work. Specifically, the Eligibility Division implemented Express Lane Eligibility, incorporated a Social Security Administration citizenship data match, developed a Long Term Care Facility Notification System, and automated the Medicare Savings Program application process for Low Income Subsidy referrals.

- **Express Lane Eligibility**

The Eligibility Division has streamlined enrollment and retention processes by utilizing options made available through the Children's Health Insurance Program Reauthorization Act. Express Lane Eligibility (ELE) allows DHH to use the eligibility findings of approved agencies to enroll children in LaCHIP or Medicaid. Currently DHH receives Supplemental Nutrition Assistance Program (SNAP)

information from Louisiana's Department of Children and Family Services and enrolls eligible children automatically.

- **Social Security Administration Citizenship Data Match**

To confirm citizenship for Medicaid and LaCHIP applicants, DHH submits identifying information for newly enrolled Medicaid recipients through an existing automated State Income Eligibility Verification System process managed by Louisiana's Department of Children and Family Services. The Social Security Administrations returns information either confirming citizenship or providing a reason for any discrepancy in data. This information is used to automatically update the eligibility system or sends a message to the Medicaid Analyst if additional investigation is needed.

- **Long Term Care Facility Notification System**

The new notification system was developed to replace a manual, paper-driven process. It is a secure, internet accessible web application which allows facilities to submit information to DHH, as well as retrieve information that is relevant to them. Admission, Discharge, Transfer, Status Change and Patient Income Information entered into the system is immediately transferred to the appropriate parish office for processing. The new system allows DHH staff to determine eligibility and patient liability more quickly because information is available to them immediately and is displayed in a worker queue for further processing. The system helps to ensure prompt, accurate payments to providers.

- **Low Income Subsidy Referral Process**

Beginning in January 2010, with the consent of applicants, the Social Security Administration (SSA) began transmitting data about Low Income Subsidy (LIS) applicants to state Medicaid Programs through an interface (file transfer). Through collaboration with the Social Security Administration, and other DHH personnel Medicaid developed an automated process that initiates an application for a Medicare Savings Program (MSP). The data is used to either pend, approve or deny the application based on income and resource data provided.

Medicaid achieved maximum use of the SSA LIS data transmittals to automate the required processing of LIS data for MSP eligibility determination, with the least amount of Medicaid staff contact. The state also aligned MSP and LIS resource eligibility more closely to reduce administrative burden on Medicaid eligibility staff.

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

Every component of this accomplishment was achieved by collaborative work among all members of the Eligibility Division and with external partners. This involved working to develop project specifications, working with systems programmers to make the proposed changes, testing the proposed changes training users and pilot testing prior

to implementation.

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

The success of these systems improvements is significant because DHH staff can work more efficiently with fewer resources. In addition, these changes support relationships with stakeholders and providers who are integral to the work done by the Medicaid agency. These efficiencies make the eligibility process transparent to applicants/enrollees.

**D. Who benefits and how?**

In all instances, staff, applicants, enrollees, and stakeholders benefit due to the increased access to electronic information, faster case processing and transparency of state government. In the instance of the LIS referral process, it increased enrollment of eligible citizens into Medicare Savings Program (MSP) and reduced the administrative burden for the applicant and the Medicaid eligibility determination staff. Louisiana Medicaid also aligned Medicare Savings Program eligibility more closely with the Medicare Part D Low Income Subsidy eligibility. The Facility Notification System allows multiple DHH Agencies to use a common shared system to report, monitor and track changes in nursing facility applicants/enrollees. This action is being taken to promote the health and welfare of elderly and disabled citizens who could derive benefits through the Medicaid program.

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

The specific automation initiatives could not benefit other executive branch departments due to the Medicaid-specific nature of the projects; however, all executive branches could benefit from the commitment to improve efficiency demonstrated by the Eligibility Division, especially during difficult budgetary times.

**Outstanding Children's Coverage Retention-**

**A. What was achieved?**

Due to policy and procedure simplifications implemented by the Medicaid Eligibility division during SFY10, employees closed fewer than 1% of children's cases at annual renewal for procedural reasons, such as failing to return a renewal form.

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

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

**C. Who benefits and how?**

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

Where information is needed beyond what can be found on electronic systems, it is most often obtained by telephone interview. Phone interviews allow for improved rates and speeds customer contact (the rate and speed of customer reply on renewal mailings are consistently poor, by contrast), better quality information, and more timely renewal processing. Today, less than 5% of all renewals are completed from a paper form, meaning less printing, scanning and shredding for employees and less paper cost and waste for the agency. In addition, continuous coverage reduces the amount of uncompensated care payments by the State for hospital services provided to children eligible for but unenrolled in Medicaid/LaCHIP.

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

The Medicaid/LaCHIP Eligibility division has streamlined the annual renewal process by eliminating the requirement for a signed renewal form, instituting telephone interviews, and allowing administrative renewals for cases identified as having a low risk of ineligibility. Eligibility caseworkers are pro-active and make aggressive attempts to locate families when mail is returned by the United States Postal Service as “Undeliverable.” This has required a fundamental change in the culture of eligibility. The number of closures for procedural reasons is monitored at the state, regional, local office, and individual staff member level and is a key factor in performance measurement.

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

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

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

Yes, this achievement has generated great interest and we were asked to share information through presentations to the following states and national entities in the past year: Indiana, Iowa, Colorado, California, Ohio, Kansas, National CHIPRA Grant Summit, the National Academy for State Health Policy and the National SNAP Directors’ Conference. We believe that the lessons learned are transferrable to other departments and agencies within Louisiana.

**LaCHIP Affordable Plan-****A. What was achieved?**

Enrollment in the LaCHIP Affordable Plan has continued to grow, thereby reducing the number of uninsured children in Louisiana and increasing access to quality health care. There were 3,230 children enrolled in the LaCHIP Affordable Plan as of June 30, 2010, which represents an increase of 840 children during SFY10.

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

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

**C. Who benefits and how?**

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

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

Enrollment was increased due to aggressive outreach to the target population.

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

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

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

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

**Work@Home-****A. What was achieved?**

Initially piloted in SFY09, the Medicaid Eligibility division's Work@Home initiative continues to be successful. This program allows employees to work from home or an alternate location for all or part of their regular work week. By the end of SFY10, 275 Eligibility employees (34% of the workforce) worked at home on a part- or full-time basis.

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

Continuation of the Work@Home initiative has continued to produce increased morale and work performance. The primary gains have been in the transformation of paper work

processes to paperless (electronic) ones, including application assignment, workload tracking, payroll, and performance measurement. These transformations quickly spread from Work@Home pilot participants to employees in the office, and resulted in administrative cost savings, such as paper, printers, toner and postage. Expanded telework participation also paved the way for facility cost savings (downsized or closed offices) in SFY10. The success of the program demonstrates to other State departments and agencies the power of telework when implemented as generally accessible rather than an infrequent “special” accommodation.

**C. Who benefits and how?**

Work@Home offers considerable benefits to agency, employees, customers and communities. Listed below are many such benefits:

- Provides flexibility in meeting changing business needs
- Decreases administrative costs
- Increases productivity
- Reduces absenteeism
- Enhances the ability to recruit and retain talented people
- Reduces turnover and training costs
- Provides employees flexibility in managing work and family responsibilities
- Decreases work-related expenses for employees
- Affords greater employee satisfaction and improves morale
- Promotes Green Government

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

The Work@Home program was pioneered by participants in the agency’s eligibility process improvement program, *WorkSmart!* Impetus for Work@Home came from a local office team of frontline workers and supervisors who developed a paperless application assignment process and proposed telework as the next improvement.

The FY2010 introduction and widespread deployment of thin-client devices to field staff as replacement for their traditional computers allowed for centralized management of their computer experience. This advancement provided consistency between the Work@Home experience and the in-office experience. Due to the fact that a worker’s computer is centrally managed and virtual, ultimate flexibility is achieved with regard to the worker’s physical location. Staff members are able to move between locations and even thin-client devices without any changes to their user experience. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes, telework directly and indirectly contributes to the success of the agency’s strategic plan, as explained above.

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

Yes. The agency has had significant interest from outside entities in its Work@Home program. By request, the agency has presented on the program in state to the State Civil Service Commission and the State Human Resources Managers Association, and out of state at the 2009 annual conference of the National Association of State Personnel

Executives. Recently, the agency developed a Telework Toolkit intended for use as a guide to other State agencies seeking to implement a successful telework program. The guide was recently presented to the Department of Children and Family Services.

**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.

**Eligibility Section**

**Achieved Increased Efficiency**

- ♦ **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 mission of the Medical Vendor Administration is to administer the Medicaid program and ensure that operations are in accordance with federal and state statutes, rules and regulations. The agency's objective of administering the Medicaid program within federal regulations and process up to 98.5% of applications in a timely manner continues to be reached through the use of technology and increased efficiencies. Streamlining work processes and increasing productivity are the result of the agency's investment in technology, process improvements and overall culture change amongst staff in the Medicaid Eligibility Division. The increased efficiency of processes accomplished by the Eligibility Division supports the ability of the agency to continue to meet this objective with fewer staff members.

- ♦ **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.

By maximizing technology, the progress is the result of collaborative work among all members of the Eligibility Division and with external partners such as systems contractors, long term care providers, the Social Security Administration, and the Louisiana Department of Children and Family Services. The successes would not have been achieved without these collaborations.

- ◆ **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.

N/A

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

N/A

- ◆ **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?

Current policies in place have been extremely successful towards achieving this goal. While Eligibility division will continue to explore new ways to further improve efficiency of processes, the goal of the strategic plan to simplify the renewal process has not changed.

- ◆ **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 levels of the Department of Health and Hospitals are devoted to streamlining and providing quality health insurance to uninsured children. The increase in efficiency of processes is directly tied to the department's goal of improving health outcomes by decreasing the number of uninsured children.

### **Outstanding Children's Coverage Retention-**

- ♦ **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 Medicaid/LaCHIP Eligibility Division's goal of reducing the percentage of children's cases that are closed at annual renewal due to paperwork reasons has been reached, as this percentage has been dramatically reduced since 2000. This goal has been achieved because of the multiple renewal simplification changes mentioned above. The Eligibility division is now working to maintain this low percentage and further reduce it through new options made available to states by the 2009 CHIP Reauthorization Act.

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

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

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

The Medicaid/LaCHIP Eligibility division has made significant progress towards reducing the percentage of children's cases that are closed at annual renewal due to paperwork reasons. This success can largely be attributed to policies implemented within the agency that simplified this process for the client.

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

Since this measure is now below 1%, another significant decrease cannot be expected, but the Eligibility Division will continue its work to further reduce this percentage.

- ♦ **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.

N/A

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

N/A

- ♦ **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?

Current policies in place have been extremely successful towards achieving this goal. While Eligibility division will continue to explore new ways to further reduce this percentage, the goal of the strategic plan to simplify the renewal process has not changed.

- ♦ **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 levels of the Department of Health and Hospitals are devoted to streamlining and providing quality health insurance to uninsured children. The low percentage of children lost at renewal is directly tied to the number of uninsured children throughout the state. By achieving this goal, the Eligibility Division also contributes to the department’s “green government” initiatives.

**LaCHIP Affordable Plan-**

- ♦ **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?

Through continued targeted outreach, enrollment in the LaCHIP Affordable Plan (LAP) has been steadily growing over the past fiscal year. 3,230 children were enrolled at the end of SFY10.

- ♦ **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.

Success in achieving the increase in enrollment of children into LaCHIP Affordable Plan can be attributed to coordinated and targeted outreach initiatives.

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

The increase of 840 children in SFY10 is not a one-time gain and the program is expected to grow to 3,728 children by the end of SFY11. According to the results of the 2009 Louisiana Health Insurance Survey, 4.6% of children in the LaCHIP Affordable Plan range of 201-250% of the federal poverty level are uninsured, so there is still work to be done. This same report also shows that the level of awareness surrounding LaCHIP has dramatically increased, proving that outreach initiatives have been effective.

- ♦ **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.

While the growth in the LaCHIP Affordable Plan has not been as high as initially projected, more children become enrolled each month and the program is expected to continue to grow.

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?

Efforts to educate enrollees about the auto-draft option for premium payment are underway and have been effective in reducing the number children lost due to failure to pay the monthly premium associated with this program.

- ♦ **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?

Current strategies of increasing enrollment through outreach and awareness have not changed as they relate to this goal of increasing the number of children enrolled in the LaCHIP Affordable Plan.

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

Increasing the number of children enrolled in the LaCHIP Affordable Plan contributes to providing quality health insurance to uninsured children, which is a goal at all levels of the Department of Health and Hospitals. To further the department's streamlining initiative, it was determined to be more efficient to have this program run by a third-party administrator, the Office of Group Benefits, instead of spending government resources to set up a new system. The Eligibility Division is also working towards the department's "green government" initiative by encouraging online applications and offering an auto-draft option for premium payments.

**Work@Home-**

- ♦ **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?

Work@Home has exceeded expectations with its contributions to the accomplishment of agency goals and objectives. It was instrumental in advancing efforts to transform paper work processes to electronic, which resulted in administrative efficiencies and desired performance enrollment and retention outcomes. Telework increased the division's ability to recruit, and more importantly during a hiring freeze, retain skilled employees. Increased retention is helping the division weather the workload storm of a hiring freeze (due to declining state revenues) and rising unemployment (driving more and more people to public assistance, including Medicaid). Work@Home increased productivity of telework employees by removing the distractions of the office.

- ♦ **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.

The Work@Home program contributes significantly to the success of the Eligibility Division for the reasons identified above. It required investment from all Eligibility Division sections, from policy to systems to field operations. The greatest investment was employee time, effort and expertise. Resources were also allocated for IT needs.

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

We continue to see continued gains from the Work@Home program particularly as offices are closed to meet budgetary constraints.

- ♦ **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.

N/A

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

N/A

- ♦ **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?

Work@Home has been very successful due to thorough pre-pilot planning and ongoing incremental adjustments. Fall 2009 revisions to the program policy and procedures to include non-Eligibility divisions of the agency are expected to build on earlier success.

- ♦ **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.

Eligibility division management routinely and actively participates in agency and department strategic planning processes, communication its needs and plans to be considered by management in decision making and resource allocation.

### **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.

N/A

### **Eligibility Section**

#### **Achieved Increased Efficiency**

#### **Outstanding Children’s Coverage Retention**

#### **LaCHIP Affordable Plan**

#### **Work@Home**

#### 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?**

##### **Eligibility Section**

##### **Achieved Increased Efficiency**

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:

### **Outstanding Children's Coverage Retention-**

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

Maximizing Enrollment in Louisiana: Results from a Diagnostic Assessment of the State's Enrollment and Retention Systems for Kids

2. Date completed

February 2010

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

Louisiana was awarded a \$1 million grant by the Robert Wood Johnson Foundation to use for the enrollment of uninsured children. A requirement for all Maximizing Enrollment for Kids state grantees was that each state undergoes a diagnostic assessment protocol. The purpose of this protocol was to complete an assessment of the strengths, weaknesses and potential opportunities associated with Louisiana's LaCHIP and Medicaid enrollment and retention systems, as well as the policies, procedures and external environment in which they operate.

4. Methodology used for analysis or evaluation

The diagnostic assessment centered on six areas: enrollment and renewal simplification and retention policies; coordination between Medicaid and LaCHIP and other state agencies; analytic capacity for program management and decision-making; client-centered organizational culture; non-governmental partnerships and outreach; and state leadership. Information was provided to researchers by the state in advance of onsite interviews. This included progress reports on Medicaid and LaCHIP, trend data, number of uninsured children, policy, procedure and process information, and contracts and agreements between DHH and other state agencies or private entities relating to enrollment, retention or call centers. Additional information was provided by way of an extensive questionnaire. During a two-day visit to Louisiana, researchers interviewed state program staff as well as people outside the program whose views would help identify current strengths of the program and new opportunities to cover more children.

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

N/A

6. Major Findings and Conclusions

Louisiana has leveraged both technological and policy solutions to create customer-oriented, simplified enrollment and renewal processes. An integrated culture of sustained commitment to continuous quality improvement has helped Louisiana repeatedly simplify the steps families and workers follow in enrolling and renewing coverage. Louisiana has made children's health insurance programs and their management seamless, reducing complexity for families and aligning workers under a single set of goals. Consistent bipartisan commitment to covering children has been a contributing factor in supporting Louisiana's Department of Health and Hospitals eligibility over the years.

7. Major Recommendations

Remaining pockets of uninsured children throughout the state will require targeted strategies to find and enroll. Interagency collaborations are in their early stages, and may not progress without leadership and/or funding.

8. Action taken in response to the report or evaluation

DHH Medicaid applied for and was granted funding from the Children's Health Insurance Program Reauthorization Act to provide targeted outreach and enrollment assistance to underserved populations including those in Hispanic or migrant families, those whose families were impacted by Hurricanes Katrina, Rita and Gustav and those in rural areas of the state. Further work to identify pockets of uninsured children has been enhanced by the 2009 Louisiana Health Insurance Survey published by the LSU Public Policy Research Lab in collaboration with DHH. DHH continues to seek opportunities to partner with other state agencies. In early 2010 DHH Medicaid implemented Express Lane Eligibility, an automated system to enroll eligible children in Medicaid, using data provided by the Department of Children and Family Services, Office of Family Support.

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

An electronic copy may be obtained at

<http://www.maxenroll.org/files/maxenroll/file/MaxEnroll%20Louisiana%20-%20FINAL%20-%20for%20posting.pdf>

10. Contact person for more information, including

Name: Katie Baudouin

Title: MaxEnroll Project Manager

Agency & Program: MVA/Eligibility Supports

Telephone: (225) 342-0456

E-mail: [katie.baudouin@la.gov](mailto:katie.baudouin@la.gov)

**LaCHIP Affordable Plan-**

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
11. Cost (allocation of in-house resources or purchase price)
12. Major Findings and Conclusions
13. Major Recommendations
14. Action taken in response to the report or evaluation
15. Availability (hard copy, electronic file, website)
16. Contact person for more information, including
  - Name:
  - Title:
  - Agency & Program:
  - Telephone:
  - E-mail:

**Work@Home-**

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  
An Evaluation of the DHH Telecommuting Pilot Program
2. Date completed  
February 2009
3. Subject or purpose and reason for initiation of the analysis or evaluation  
To determine the effectiveness of the Work@Home program to inform management decision making on whether to continue, expand or terminate the program.
4. Methodology used for analysis or evaluation  
The following components are included in the evaluation:
  - An environmental scan and literature review
  - Analysis of pilot participant and non participant survey data
  - Analysis of performance data as provided by Work@Home participants
  - A summary report of focus groups of stakeholders in the Work@Home project evaluation
5. Cost (allocation of in-house resources or purchase price)  
N/A

6. Major Findings and Conclusions

“The overwhelming positive results of the program support not only the continuation of the pilot but an expansion of the program within MVA, DHH (for appropriate programs), and an implementation of similar programs throughout other State agencies where feasible.”

7. Major Recommendations

“Teleworking must be viewed as a business tool. It can be used to reduce costs, increase productivity, recruit and retain employees and enhance the image of State government as a preferred employer. Adequate staff must be assigned to implement the program. If the State invests in teleworking, a centralized team approach recommended by this report ensures success. The State of Louisiana should proceed with implementing a statewide teleworking program. The State can realize energy savings and reduction in building if it considers teleworking in its construction planning and office rental processes. Existing Information Technology Systems should be reviewed to determine if they could be redesigned to enable teleworking. When designing new computer applications and computer systems, the State should consider teleworking to enable as much of the work to be done off site as possible.”

8. Action taken in response to the report or evaluation

The Work@Home program was continued and expanded within the Agency, and experience shared with other government agencies for purposes of spreading the use of this business tool.

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

The document may be accessed using the following link:

<http://www.dhh.louisiana.gov/offices/reports.asp?ID=92&Detail=635>

10. Contact person for more information, including

Name: Jen Steele

Title: Acting Section Chief

Agency & Program: Medicaid Reform

Telephone: (337) 233-9627

E-mail: [jen.steele@la.gov](mailto:jen.steele@la.gov)

**I. What outstanding accomplishments did your department achieve during**

## the previous fiscal year?

For each accomplishment, please discuss and explain:

### PHARMACY BENEFITS MANAGEMENT

A. What was achieved?

*The Pharmacy program has achieved over \$438 million in saving in a fiscal year, and decreases expenditures in other Medicaid programs*

B. Why is this success significant?

**COB**-This process eliminates duplicate payment from multiple payors, allowing other payors to be billed first. Savings: >\$20 million/year

**ProDUR**-This process alerts pharmacists of duplications, early refills and pregnancy precautions. Savings: ~\$50 million/year

**RetroDUR**-Savings: ~\$2.6 million/year not including potential savings in other programs (hospitalization or physician visits)

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

**Generic utilization rate** in the Medicaid pharmacy program: 73.94% (Above the national generic utilization rates for PBMs.

**Pharmacy Provider Compliance Audits and Rebate Resolution**-Improper billing by providers may result in a payment disallowance and/or administrative sanctions by Medicaid and/or the Board of Pharmacy. Pharmacy staff works closely with Medicaid Program Integrity and the Attorney General's staff on potential fraud cases. Audits have encouraged provider compliance resulting in \$300k audit recovery as well as savings of \$1.2 million in rebate resolution totaling \$1.5 million in total savings

**Provider Fees** – Louisiana Medicaid charges a \$0.10 per prescription provider fee on all prescriptions dispensed in the state. This fee is applied toward the state general fund match requirements for financing the cost of the Medicaid program. PBM collected \$8 million stemming from prescription drugs.

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

**Synagis–Savings:** ~\$37 million/year (due to new reimbursement criteria and edits regarding the use of Palivizumab) October 1, 2009 was the effective policy change.

**The Pharmacy Rebate program-** Staffed under contract by University of New Orleans personnel, this process generates quarterly rebate invoices, reconciles payments and resolves disputes with manufacturers and identifies and recovers mis-billed claims from providers (\$332,766,234 collected for FY2010).

C. Who benefits and how?

*The pharmacy program has implemented numerous efficiencies in securing cost savings while continuing to provide necessary medication to Medicaid recipients. The pharmacy program is highly monitored by State and Federal auditors as many facets of this program are statutorily required and must comply with the Board of Pharmacy rules and regulations. While the Pharmacy program is one of the largest in services and expenditures, pharmacy services improve health status, reduce cost and promote a healthier population by providing drug therapies.*

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

**Behavioral Health Section:**

**A. What was achieved?**

The Mental Health Rehabilitation (MHR) program experienced significant achievements throughout FY09/10 within all five of the service center modules, which include Service Access and Authorization, Quality Management, Administration, Member Services and Network Services. Overall, the program has experienced a significant increase in the number of recipients served (40% over FY08/09), while realizing a decrease in the average cost of services per recipient (12% less than FY08/09).

Our recipient transition plan has been improved over the last fiscal year in an effort to ensure access to mental health services in the event that a provider ceases operation. Additionally, for the first time, expenditures for community based services as a whole now account for more of Medicaid's costs for behavioral health than those paid out for hospital-based services.

There have been multiple collaborative efforts between the Medicaid Behavioral Health Section and the Office of Juvenile Justice, the Department of Children and Family Services, Adult Protective Services as well as the Attorney General's office. These

efforts have resulted in achievements such as an increase in communication and ongoing training for OJJ and DCFS staffs in reference to Medicaid covered MH services so as to increase access to MH services for expanded populations. Coordination with the AG's office to eliminate fraudulent practices amongst providers, has also enabled MBHS staff to incorporate into provider training more comprehensive educational tools in an effort to reduce inappropriate actions on the part of our providers which results in cost savings to Medicaid. Coordination with Adult Protective Services has allowed for the education of our staff so that we have been able to train providers on their responsibilities in reference to the rights and safety of recipients. Furthermore, a series of dashboards on all Medicaid covered behavioral health services has been developed so that quarterly data is readily available to share with interested parties.

Numerous technological advances have been designed, expanded or implemented within the past fiscal year, inclusive of the further development of our Provider Performance Indicator tool (PPI) which is a new monitoring tool aimed at enhancing our QM unit's ability to evaluate provider performance and address problem areas on a greater scale and in a more timely and efficient manner. We have developed a centralized provider profile tool to track and trend data, as well as a complaints, grievances and events (CGE) electronic tool to collect, trend and follow up on these cases. Additionally, the streamlining of our SAA unit was begun in order to reduce workflow and administrative costs on the provider's part as well as in an effort to simplify the processes required for prior authorization. Our unit has also increased access and reduced the costs associated with training by making available webinar based sessions to providers.

The Multi-Systemic Therapy program which provides services to youth at risk of out of home placement due to severe behavior problems experienced a 100% increase in providers and a 775% increase in recipients served from FY08/09 to FY 09/10. Medicaid has established a collaborative consultative agreement with the national firm, MST Services, Inc. to assist in ensuring MST services are provided consistent with the national evidence-based model. Where indicated, MST, Inc. provides additional training and technical assistance to providers through in-state MST "Experts". Prior authorization of services which exceed the average number of units required to complete an MST treatment episode is now required.

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

These achievements are significant in that they show aggressive efforts and measurable successes in regards to cost savings, program monitoring, interagency collaboration and administrative streamlining. All of which support the effectiveness and efficiency of the Medicaid program.

**C. Who benefits and how?** Recipients benefit due to providers being held to higher standards because of quality management advances, and because of the increased

interagency coordination which results in greater access to a larger population of clients. Providers benefit from advances in training methodologies as well as stream lining efforts which reduce their overhead costs. The State also benefits because of improved methods for provider monitoring, which will result in a reduction in fraudulent or inappropriate reimbursements, as well as cost savings realized on a per recipient basis and by the increase in the utilization of community based versus hospital-based services

- D. How was the accomplishment achieved?** These accomplishments were achieved through interagency collaboration, utilization management efforts, programming upgrades via our software maintenance contracts and through the overall efforts of the MBHS staff and through consultation with the National Council on Community Behavioral Health.
- E. Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) Yes. These accomplishments contribute to the goals expressed in our strategic plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes. Collaboration between state offices and agencies is a best practice and this collaboration and our expanded use of technology are both streamlining recommendations.

**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.

### Behavioral Health Section

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

MBHS is making progress towards the goals set forth in the MVA strategic plan. We have increased access as witnessed by the increased number of recipients served, as well as decreased the cost per recipient by implementing strategies focused on utilization management. In addition, technological advances are proving to have an effect on the program and staff's efficiency and effectiveness.

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

1. To what do you attribute this success? For example:
  - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
  - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improved 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.
3. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

MBHS has made significant strides towards streamlining work processes and increasing productivity through technology by expanding the utilization of electronic tools for both the providers and the Medicaid administrative staff. MBHS has directed staff time and fiscal resources to the development of electronic tools used to promote efficiency within our programs. Technological advances have been made to improve the ease with which our providers can operate their programs in a less costly and less time consuming manner. We have made advances in the way in which we can collect, trend and follow up on authorized services data, as well as complaints received. These streamlining efforts will increase efficiency for staff and providers, as well as promote cost savings through increased monitoring capabilities.

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

The expansion of services to recipients with a lower level of need has made minimal progress. An increase in the utilization of Evidence Based Practices, beyond our MST program has not progressed over the last fiscal year due to a lack of resources.

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

Funding limitations have impacted all of our expansion efforts, including that of increased EBPs, which generally require increased provider compensation to stimulate growth. Further expansion of programs and services would be ill-advised without a significant increase in resources for oversight and utilization management.

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?

Unless the covered services are expanded and covered provider types are funded, possibly through the Coordinated System of Care (CSoc) project, the problem of limited access to these groups will continue.

♦ **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?

Further assessment of impact is needed after implementation.

**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?** Departmental notification of needed review is sent to appropriate staff.

### **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?

MBHS staffing issues had an impact on the progress toward strategic plan objectives and hampered efforts to streamline and expand utilization management and tracking methods.

#### 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:

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

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

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

- A. What was achieved?** As of September 30, 2010, the Money Follows the Person Demonstration program (MFP) has helped 71 persons move out of institutions (nursing homes, hospitals, group homes) into the community.
- B. Why is this success significant?** The MFP is a national initiative by Centers for Medicare & Medicaid Services (CMS) to assist states in rebalancing their long term care systems toward community living. These transitions are part of that nationwide effort to remove barriers to community living for people of all ages with disabilities or chronic illnesses. This is significant progress toward transition targets that are a CMS requirement of the MFP funding award. Additionally, the demonstration provides a means by which the state may address provisions in the Olmstead decision.
- C. Who benefits and how?** Firstly, the MFP participant, whose quality of life is most often enriched by moving out of an institution and reconnecting with the community. CMS requires MFP states to assure continued provision of home and community-based long-term care services (HCBS, or waivers) to these individuals as well as ensuring that procedures are in place to provide quality assurance and to provide for continuous quality improvement in such services.
- D. How was the accomplishment achieved?** A cooperative effort between Medicaid, OAAS and OCDD, focused on coordination with existing programs and resources at the state and regional level as well as with the state's ongoing strategies to address housing as a primary barrier to transition. Medicaid, OCDD, and OAAS have worked very well together in a team format to implement the demonstration successfully across the disability populations. The collaboration stems from joint work in systems change initiatives throughout the past decade.
- E. Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) The state effort to rebalance its long-term care system (LTC) benefits in three ways: (1) through an enhanced FMAP for services delivered to individuals during their 365-day participation in the program, (2) savings realized from moving the individual out of institutionalized care, and (3) 100% federal funding for 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? Given the barriers and challenges mentioned previously, the MFP is making progress, though at a slower rate. The barriers and challenges to the MFP program’s transition targets are being addressed through utilization of 100% federal administrative funding toward meeting our goals, specifically with the continued development of housing contacts and the training of families and support and transition coordinators.
- ♦ **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 our waiver services was cited by CMS in their March 2010 site visit as superior to those observed in other MFP states, giving them confidence that Louisiana would see positive outcomes and sustained transitions.
    - 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?) 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.
    - 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? Joint cooperation between Medicaid, OAAS, and OCDD is directly attributable to the success of the MFP to date.
    - Other? Please specify. N/A
  2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

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

None.

1. To what do you attribute this lack of progress? For example:
  - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area? No.
  - Is the lack of progress due to budget or other constraint? No.
  - Is the lack of progress related to an internal or external problem or issue? No. If so, please describe the problem and any recommended corrective actions in Section III below.
  - Other? Please specify. The program offices have identified the following problem areas: access to housing, access to qualified state plan providers (primary care, specialists) and case managers, and delayed timelines for service initiation post waiver offer. OAAS and newly formed OBH face similar challenges.
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? No.

- ♦ **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 should have a significant impact on the problem issues identified. OCDD is working to expedite supplemental administrative funding elements tied to pre-move funding, provider training, housing relocation assistance, and post-move direct services in order to support the 20% downsizing of public supports and services centers occurring this fiscal year. OAAS recently implemented My Place Louisiana in DHH Regions 2 and 9, with the training of Ombudsmen and the Support Coordination Agencies serving the regions. Accordingly, OAAS anticipates an increase in the number of referrals. OAAS has also dedicated their Housing Monitor to work with the My Place Louisiana staff in assisting participants with housing resources and applications. In addition, In 2010, Louisiana DHH received an award from the Louisiana Housing Finance Agency for Tenant Based Rental Assistance dedicated to institutional transitions through the demonstration.

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. Regular monthly conference calls with CMS project office staff, technical assistance contractors, and regional CMS support staff are conducted to report on progress and barriers identified. Program office and Medicaid staff regularly discuss MFP progress internally. Quarterly meetings of executive office staff are also conducted to review progress and ensure effective utilization of resources and funding to meet program expectations.

### **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? Primary issues for MFP are as follows: OCDD has taken considerable steps to reduce institutional utilization and increase waiver capacity. However, barriers to these initiatives remain, including access to housing, access to qualified state plan providers (primary care, specialists) and case managers, and delayed timelines for service initiation post waiver offer. OAAS and newly formed OBH face similar challenges.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) These issues directly affect the state’s ability to successfully transition individuals into the community and meet the transition benchmarks agreed upon with CMS.
3. What organizational unit in the department is experiencing the problem or issue? Medicaid, OAAS and OCDD.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) Individuals assessed for MFP enrollment may be affected by these issues since service coordination, housing, etc., are key

factors affecting the date of transition into the community.

5. How long has the problem or issue existed? These problems are not new but have been highlighted over the past two years as the MFP has gotten underway.
6. What are the causes of the problem or issue? How do you know? While some issues are systemic in nature, problems with affordable and available housing are larger issues beyond the MFP.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? As stated above, some of these issues affect transitions, which impact our ability to meet the transition benchmarks.

#### 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? Based on the observations of the CMS site visit team in March 2010 (and nation-wide recognition of similar issues in the other 29 MFP states), we were given the opportunity to request 100% administrative funding to support our program as we seek to address these issues. Louisiana received approval in August for a \$14.4 million package designed to address specific challenges relative to developing housing, training for families, direct service workers, and transition teams --- all identified as areas in need of support. This funding requires no state match. Medicaid, OAAS, and OCDD are moving forward to utilize the funding as soon as possible.
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? Although no specific time-frame has been set by CMS, through monthly conference calls with the CMS Project Officer for MFP, the state MFP team will report on progress with the issues identified above. Medicaid and Program offices meet regularly internally to assess progress as well.
    - How much progress has been made and how much additional progress is needed? The current economic crisis affecting state agencies has had some impact on the hiring component of the funding package, but progress is being made by the program offices toward realizing the training initiatives.
  - b. If not:
    - Why has no action been taken regarding this recommendation?

- What are the obstacles preventing or delaying corrective actions?
- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

No. If not, please explain. Upon approval of the above-referenced administrative funding package, all MFP administrative operations are 100% federally-funded, which includes the elements that were added to operations in order to address corrective actions.

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

Please discuss the following:

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

#### 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 The MFP project team provide the MFP coordinating committee a quarterly report on progress, issues and barriers, and to solicit involvement in addressing these problems.
- 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.

11. Title of Report or Program Evaluation
12. Date completed
13. Subject or purpose and reason for initiation of the analysis or evaluation
14. Methodology used for analysis or evaluation
15. Cost (allocation of in-house resources or purchase price)
16. Major Findings and Conclusions
17. Major Recommendations
18. Action taken in response to the report or evaluation
19. Availability (hard copy, electronic file, website)
100. Contact person for more information, including
  - Name:
  - Title:
  - Agency & Program:
  - Telephone:
  - E-mail:

# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

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

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips

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

#### **Governor Jindal and DHH Launched "Consumer's Right to Know" Initiative**

Governor Bobby Jindal and Louisiana Department of Health and Hospitals (DHH) Secretary Alan Levine launched <http://www.healthfinderla.gov>, which will give residents across the state easy access to detailed, accurate information on the cost, quality and performance of health care facilities such as hospitals and nursing homes, as well as health plans and prescription drugs. The Governor and Secretary were joined by State Senator Willie Mount, and other state and health care officials at Willis-Knighton Medical Center in Shreveport.

With HealthFinderLA.gov, consumers – including children - will be able to access educational materials on living healthier lives, find the usual and customary charges for the Top 100 most commonly prescribed medications, and access information comparing various quality and patient safety measures in Louisiana hospitals, nursing homes and health plans. The site will provide key performance data on health care facilities and health plans, including death rates, readmission rates, dozens of nationally accepted quality and performance measures for health plans, and complication rates for procedures.

Louisiana Health Finder provides an increased level of transparency for Louisiana's health care consumers, helping them ensure the best use of their health care dollars. The site contains data from 113 of the state's 131 acute care/critical access hospitals, 285 of the 292 nursing homes in the state, nine private health plans, the state's Medicaid program, and more than 1,000 pharmacies statewide.

The Web site is a product of the Consumer's Right to Know Act, created by Act 537 of the 2008 Regular Legislative Session, which was part of the Governor's legislative package and was authored by Senator Willie Mount. The Act authorizes DHH to collect a broad range of health care information and publish it on the Internet.

To create the new site, DHH worked with a health data panel of technology experts, physicians, nursing homes, health plans, pharmacy and hospital administrators and consumer advocates, and federal representatives to bring together publicly available data. Data sources for the site include CMS Hospital Compare and Nursing Home Compare, the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set measures, and hospital inpatient discharge data.

DHH has also actively engaged providers across the state to make them aware of this reporting initiative. All hospitals, nursing homes, health plans and pharmacies were provided reports to review and identify any calculation errors in their data. DHH staff worked diligently with hospital administrators to explain and review hospital detail reports and results. The department's priority is to assure the community that these results have been calculated correctly.

In the future, the site is expected to become an interactive information portal where consumers will be able to create their own scorecard based on the measures and metrics that matter most to them. Additionally, researchers will be able to run custom, web-based reports to dive into a detailed analysis of the results displayed on these pages.

### **Governor Jindal and DHH Announce Grants to Fight Breast Cancer and Diabetes in Rural Areas throughout the State**

Governor Bobby Jindal and DHH Secretary Alan Levine announced eight community-based rural health grants that will aid rural communities throughout the state in the fight against breast cancer, diabetes, and other health needs. Governor Jindal and Secretary Levine made the announcement at the Winn Parish Medical Center in Winnfield.

The Governor emphasized the importance of these grants given the proposed federal changes to disproportionate share hospital (DSH) funding that could limit funds to many hospitals in rural areas.

Based on the latest audit, Louisiana faces a federal rule change that could cost the state \$197.5 million per year in DSH funds, which are available to hospitals to help cover the costs of uncompensated care to Medicaid recipients and the uninsured.

The grants total \$597,282, with approximately \$75,000 each going to the St. James Parish Hospital, the Health Enrichment Network in Allen Parish, the Central Louisiana Area Health Education Center, the Pointe Coupee Homebound Health Hospice, Pointe Coupee Better Access Community Health, the St. Charles Community Health Center, the Southwest Louisiana Center for Health Services, and the David Raines Community Health Center in Bossier Parish.

Funding for five of the grants, totaling \$372,282, was made available for the community-based and rural health program through an annual state legislative appropriation to provide financial assistance to rural and/or underserved areas. Funds are used to maintain, enhance or expand access to community-based primary and preventive health care services.

Three grant applicants -- the St. Charles Community Health Center, the Southwest Louisiana Center for Health Services, and the David Raines Community Health Center in Bossier Parish -- fit the requirements for both community-based rural health grant dollars and federal Social Services Block Grant (SSBG) dollars, allowing the state to fund these grants without using state general funds. DHH has also begun accepting applications for a new round of SSBG grants this week, which can also be used for rural health needs.

Each year the community-based rural health grant guidance is revised to reflect current priorities and initiatives of the Department. For the 2009-2010 grant year, funding was prioritized for those projects that demonstrate development or implementation of the medical home model of care. Grant recipients demonstrated they will use the funding to add or enhance one or more of the components of the medical home model of care, such as evidenced-based practices, accepted standards of care, quality initiatives, cost effectiveness, and strong medical management.

Recipients also demonstrated community support for their projects as well as data that identifies the community's health status, as well as defining their project objectives and strategies. All grantees receive technical assistance, as needed, from the DHH Bureau of Primary Care and Rural Health to assure the funded projects are fully implemented and are positioned for long-term community benefit.

### **DHH Launched Haiti Volunteer Resource Website**

The Louisiana Department of Health and Hospitals launched Health Care Assist. Louisiana, ([www.HealthCareAssistLA.org](http://www.HealthCareAssistLA.org)), as a resource for those in the health care community wishing to provide aid to Haiti. The site serves as a single point of reference for health care workers, nonprofits and corporations throughout Louisiana who may wish to donate time, money, supplies or other resources via national and international relief organizations following the earthquake and related health crisis in Haiti.

Health Care Assist Louisiana provides the health care community a list of agencies, organizations and corporations accepting financial and material donations, and volunteers for the recovery work in Haiti. Some of the resources include the U.S. Chamber of Commerce Business Civic Leadership Center, the Center for International Disaster Information and the Clinton Foundation.

Health Care Assist Louisiana also includes a news section, which will be updated with the latest information on how the state is helping the recovery effort. A "Who's Helping" page provides an ongoing list of individuals, companies, agencies and nonprofits already engaged in the volunteer efforts who have reported their work to the state.

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

The Governor's Council on Physical Fitness and Sports (GCPFS) added new physical activities and sporting events totaling 55 across the state-up from 53 events, and introduced a new program called, S.O.M.E. (So Others May Exercise).

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

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

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

### **Division of Health Economics**

Through excellence in its economic, statistical analyses and research, the Division of Health Economics (DHE) maintained a high accuracy on the Monthly Medicaid Expenditures Forecast Report, which is mandated by the Louisiana Legislature (HB1), and provided appropriate and innovative recommendations/ideas through analytical support that helped the department's executives make proper data driven policies in order to maintain the appropriated budget.

A State Fiscal Year (SFY) Medicaid Expenditures Forecast Report provides advanced information, enabling the executives/legislatures to see the direction the budget is heading throughout the SFY so they can make appropriate budget adjustments/plans for the future 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 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

The Division of Health Economics is able to achieve these accomplishments (high accuracy rate and other) due to highly efficient health economists, supporting staff and cooperation from Medicaid and other program staff. DHE employs appropriate statistical/forecast models developed in-house, suitable specifically for the Louisiana Medicaid Program.

This accomplishment contributes to the success of your strategic plan, as we are able to provide the Department's executives and senior managers with accurate and timely analyses. This accomplishment also represents a Best Management Practice that should be shared with other executive branch departments or agencies. With subject to appropriate resources we could apply these models/approaches with appropriate modifications to fit each department's needs/requirements.

### **DHH Information Technology**

- Sep 2009 – Implemented EMSTAT data and reporting system for nursing home emergency event preparedness which is a key component of the DHH IT Strategic plan. This is a key system for real-time information capture and reporting in the event of an emergency for the Louisiana public, especially those in nursing homes or long term care facilities, and it is integrated with GOHSEP. This system was developed by the DHH IT staff.
- Oct 2009 – Implemented DHH's First IT Governance structure including an Information Management Steering Committee and a Portfolio & Project Management Steering Committee. This new structure helps the DHH Offices and Bureaus better prioritize and allocate all IT purchases and projects. This was implemented with the DHH IT Leadership team with support from DHH Business Leadership and the new structure is a foundation that supports all IT efforts in the future and is therefore vital to the success of the DHH IT Strategy. The DHH IT Governance structure is a Best Practice and should be shared with other departments and agencies.
- Nov 2009 – Achieved Public Health Information Network (PHIN) compliance. As we improve the Health Information Technology (HIT) for DHH and Louisiana (a key component of the DHH IT Strategy), this is a major step to 'certify' DHH with the federal Public Health Information Network (PHIN). The reportable disease programs in OPH are the key beneficiaries, but all providers who are required to report diseases benefit from this. DHH IT and OPH worked closely together to achieve this milestone. While this is a Best Practice in the industry, this function is relatively specific to Public Health.
- Dec 2009 – Implemented Radiology Utilization Management improvement project for Medicaid. This reduced the abuse of radiology visits by Medicaid recipients saving thousands of dollars previously paid for unnecessary radiology visits. This is a key component to the DHH IT Strategic Plan to reduce waste, fraud and abuse. This was accomplished by Medicaid Program staff working closely with an IT vendor. While this is a Best Practice in the industry, this function is relatively specific to Medicaid.

- Jan 2010 – Implemented HealthFinderLa.com site to provide and improve consumer health choices. This solution was developed by DHH IT staff working with an IT vendor in response to the Consumer’s Right to Know legislation enacted in 2008. This contributes to the ‘Transparency’/Information component of the IT Strategic Plan. Although the information on the website is DHH/Healthcare specific, concepts of this solution are Best Practices that should be shared with other departments and agencies.
- Mar 2010 – Federal ARRA HIT Grants (~\$16M) awarded to DHH through the Louisiana Health Care Quality Forum (Louisiana Health Information Exchange-LaHIE and the Louisiana Health Information Technology Resources Center-LaHIT). This is ‘seed’ funding to facilitate the increase of electronic healthcare information exchange to improve patient care, health outcomes, and overall population health. Public and private stakeholders across Louisiana worked for 2+ years to collaborate and plan for this award. This is a core component of the DHH IT Strategic plan to implement and increase Health Information Technology (HIT). While this is a Best Practice in the industry (all states are going through the same process at the same time), this function is relatively specific to DHH.
- Feb 2010 – Implemented the Medicaid Express Lane Eligibility system. Over 10,000 Medicaid eligible recipients were processed in a short period of time which is a dramatic increase in throughput for Medicaid. With the new National Healthcare Reform, this type of throughput will be required to bring on approximately 300 thousand new Medicaid recipients. This was accomplished by the Medicaid Program staff working closely with an IT vendor. While this is a Best Practice in the industry (all states are going through the same process at the same time), this function is relatively specific to DHH.
- Jun 2010 – Implemented DHH’s first North Louisiana Business Continuity/Disaster Recovery data center at Louisiana Tech (LaTech). This supports emergency event preparedness which is a key component of the DHH IT Strategic plan. This environment/data center was implemented by the DHH IT staff working closely with the LaTech staff and is a Best Practice that should be shared with other departments and agencies.

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

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

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

The Department’s strategic planning efforts have improved over the past few years. The Office of the Secretary has recognized and identified the need for improved performance

information. Without increased management attention to setting priorities and developing overall goals that can be used to assess its performance, the Department will be limited in its ability to make significant progress. Considerable progress has been made in hiring, assigning, and training personnel. Our new 5-year strategic plan provides (1) a general picture of intended performance across the agency, (2) a general discussion of strategies and resources the agency will use to achieve its goals, and (3) general confidence that agency performance information will be credible. For example, most performance indicators in the plan include baseline or trend data and projections against which to assess performance.

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

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

Elementary Fitness Testing and Competition:	217,822 (up from 185,196 in 2009)
Governor's Games	27,150 (up from 18,600 in 2009)
Lighten Up Louisiana	26,000 (down from 38,000 in 2008)
Weightlifting Development Center	345 (up from 150 in 2009)
Project S.O.M.E. (So Others May Exercise)	350
Total Number of Participants	271,686
Number of Youth receiving Tobacco Control Materials	12,000
Number of Youth receiving Physical exams before the preliminary and state Fitness Meet	400
Number of Youth Signed up with LaChip	50
Amount of Accumulated Steps and Mileage for the Lighten Up Louisiana Youth Challenge Steps:	372,822,990 (175,528 Miles)
Amount of Accumulated Steps and Mileage for the Lighten Up Louisiana Kids (K-6) Challenge Steps:	59,306,676 (27,922 Miles)
Amount of Accumulated Steps and Mileage for the Lighten Up Louisiana Adults Challenge Steps:	240,645,188 (226,596 Miles)

**DHH Information Technology**

In the last FY, the DHH IT Strategy has focused on the following for the next 3-5 years:

1. Maintaining and advancing the current business needs/strategies
2. Enterprise Information Strategy
3. Enterprise Applications Strategy
4. Disaster Recovery/Business Continuity Strategy
5. Health Information Technology (HIT) Strategy
6. IT Process and Structure Strategy

As noted in the Accomplishments section, tremendous progress was made in all of these areas. While each of the areas in the IT Strategy have 3-5 year timeframes, each of the ‘first year’ goals were achieved in the last FY and immediate progress has been made so far in this FY. These strategies are still aligned with the business strategies and remain the focus.

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

**Governor’s Council on Physical Fitness and Sports**

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

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

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

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

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

### **DHH Information Technology**

Significant progress is being made in all areas of the DHH IT Strategic areas noted below:

- Maintaining and advancing the current business needs/strategies
  - Enterprise Information Strategy
  - Enterprise Applications Strategy
  - Disaster Recovery/Business Continuity Strategy
  - Health Information Technology (HIT) Strategy
  - IT Process and Structure Strategy
- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state “None.” However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well.

No section/activity within the Office of the Secretary reported experiencing any lack of progress.

- ♦ **Has your department revised its strategic plan to build on your successes and address shortfalls?**
- Yes. If so, what adjustments have been made and how will they address the situation?
- No. If not, why not?

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

Our 5-year strategic plan also provides a general picture of intended performance across the agency, a general discussion of strategies and resources the agency will use to achieve its goals.

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

The strategic plan was adjusted by making sure that the GCPFS would be a working Council. All appointed Council members must be able to coordinate physical activities and events, raise funds and solicit volunteers. In addition, all Council members must

support other members' activities or sporting events.

### **DHH Information Technology**

To account for budget and other market challenges, DHH has developed a new business plan to ensure the major priorities are the focus. Thankfully, the IT process and structure improvements made in the last year have prepared DHH IT for these. However, the DHH IT Strategy will not change, but several new initiatives to accomplish certain strategies will begin to manage the budget and resource reductions.

- ♦ **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?**

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.

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

GCPFS stresses that its strategic plan be coordinated throughout organizational and management levels of DHH, by collaborating with each agency that has similar goals and objectives.

### **DHH Information Technology**

The new DHH Leadership has involved the entire Executive Team in developing the New DHH Business Plan. As a result, DHH IT has tightly aligned the IT Strategy with this new plan. The new IT Governance Structure will maintain, monitor and tweak the IT Strategy on a regular basis.

## **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

**Governor’s Council on Physical Fitness and Sports** has a great formula for success. However, grants, foundations and corporate sponsors eventually dry up. Receiving additional State funding and investment in more prevention activities and programs would really bring significant returns on their investment.

**DHH Information Technology**

Currently, DHH IT is performed by multiple ‘teams’. This structure is not the most effective with duplicate processes being performed by multiple teams. This is a result of historical IT decentralization. This has been improved in the last 3 years, but additional progress needs to be made. As a result, one of the key initiatives for FY11 is to analyze inefficiencies, suggest and implement improvements. These steps may be performed largely with internal leadership resources.

IT Process and Structure improvements phase 1 was implemented in FY10. Phase 2 is expected to continue in FY11 and in future FY’s.

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 Bureau of Internal Audit role is to increase the assurance that the Department's assets are safeguarded against loss from unauthorized use or disposition. This section ensures that transactions are executed according to management's authority and recorded properly, to allow for the preparation of financial statements; that operating efficiency is promoted; and that compliance is maintained with prescribed federal and state laws and regulations and management policies.

**External audits**

The Louisiana Office of the Legislative Auditor conducts performance audits,

program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

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

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

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

**Program evaluation by in-house staff**

Program evaluation by contract

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

**In-house performance accountability system or process**

Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the DHH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each DHH agency. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies and programs review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, as well as agency and program management department-wide.

**Benchmarking for Best Management Practices**

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

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

Contracts are required to contain a description of the work to be performed including

goals and objectives, deliverables, performance measures and a monitoring plan.

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

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

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

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

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information:  
Name: Elizabeth Davis, Program Manager 2  
Agency & Program: Office of the Secretary, Division of Planning & Budget  
Telephone: 225-342-4302 E-mail: [Liz.Davis@La.Gov](mailto:Liz.Davis@La.Gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

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

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips

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

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

- Dismissal of the *Barthelemy* Settlement Agreement
- Successful Implementation of Service Hours Allocation of Resources (SHARe)
- Expansion of Home and Community Based Services (HCBS) Consumer Satisfaction Survey
- Legislation strengthening nursing home residents rights
- Legislation to define sexual abuse of adults with disabilities
- Implementation of legislation requiring Alzheimer's training for staff of nursing homes and assisted living facilities
- Compliance with federal laws regarding pre-admission screening of nursing facility residents

#### A. What was achieved?

**Dismissal of the *Barthelemy* Class Action Suit.** Effective December 31, 2009, the *Barthelemy* lawsuit was dismissed. Dismissal occurred pursuant to the terms of the Second Supplemental Settlement Agreement with the plaintiffs, negotiated by OAAS in 2008. *Barthelemy* was a class action lawsuit brought in 2000 by the Advocacy Center that alleged that the state violated the rights of the elderly and persons with disabilities by not allowing them to live in the least-restrictive environment possible. Louisiana entered into the original settlement agreement in 2001, which outlined steps the state would take in providing more community and home-based care options.

**Completed Implementation of Service Hours Allocation of Resources.** In March 2009, OAAS implemented SHARe (Service Hour Allocation of Resources), a standardized, evidence-based method for allocation of in-home services for participants receiving Elderly and Disabled Adult (EDA) Waiver

services and Long Term Personal Care Services (LTPCS). With SHARe, service hour allocations and service budgets are directly related to the recipient's condition as identified by the assessment tool used (Minimum Data Set for Home Care [MDS-HC]). By June 30, 2010, with the exception of a few outstanding cases being appealed, OAAS had completed implementation of SHARe for 15,799 recipients of services.

**Consumer Satisfaction Survey.** OAAS extended face-to-face satisfaction surveys, begun the previous year with Elderly and Disabled Adult (EDA) Waiver participants, to recipients of Adult Day Health Care (ADHC) Waiver and Long-Term Personal Care Services. Surveys are with a statewide, statistically valid sample of program participants. Contingent upon the ongoing availability of state match, surveys will be ongoing and completed for each Medicaid-funded OAAS program every two years.

**Nursing Home Residents Rights Legislation.** Legislation was passed in the 2010 Regular Session that updated the nursing home residents right statutes to bring them into compliance with federal law and to extend new rights to persons who lived in "licensed-only" facilities.

**Legislation to define sexual abuse of adults with disabilities.** During the 2010 legislative session, R.S. 15:1503 (2) was amended and reenacted and R.S. 15:1503 (13) was enacted to amend the definition of "abuse" and to provide for a definition of "sexual abuse." The purpose of the amendment was to protect adults lacking capacity to consent against being forced, threatened, or otherwise coerced into sexual activity, including involuntary exposure to sexually explicit materials, language, activity, or contact. OAAS Adult Protective Services (APS) investigates such complaints of abuse.

**Implementation of legislation requiring Alzheimer's training for staff of nursing homes and assisted living facilities.** Rules were promulgated to require training of staff in nursing homes and assisted living facilities, with a higher level of training being required for staff working on special care units for people with Alzheimer's disease. OAAS also put the necessary resources and procedures in place so that providers could obtain the mandated training and meet requirements.

**Compliance with federal laws regarding pre-admission screening of nursing facility residents.** OAAS worked with DHH offices for mental health and for development disabilities and with Medicaid to implement corrective actions and procedures to comply with federal Pre-Admission Screening and Resident Review (PASRR) requirements for nursing home admissions. OAAS also streamlined its own business processes associated with nursing facility admissions.

B. Why is this success significant?

**Dismissal of the Barthelemy Class Action Suit.** This ends almost ten years of DHH provision of home and community based services to the elderly and adults with disabilities being subject to the terms of this settlement. The Second Supplement Agreement allowed OAAS to make needed changes in the EDA and LTPCS programs to address cost-effectiveness issues and removed certain requirements in the previous settlement. Dismissal further allows OAAS and DHH to implement changes in the programs consistent with best practice and to ensure sustainability of the services.

**Completed Implementation of Service Hours Allocation of Resources.** Originally developed to

provide participants and providers more flexibility in scheduling weekly care, SHARe was the key tool used to restore compliance with CMS cost-neutrality rules to the Elderly and Disabled Adult Waiver. The waiver regained cost-neutrality. In addition, during a time of budget reductions, SHARe enabled OAAS to continue to offer waiver slots and to serve an additional 2000 persons in LTPCS, while lowering total spending by \$5 million on LTPCS and \$14 million in the EDA waiver. It also helped avoid some rate cuts to HCBS providers. Most importantly, participant outcomes remained stable during implementation. There was no change in the percentage of persons transitioning from the community to nursing facilities, no change in percentage of deaths in the waiver, and not discharges due to health and welfare concerns following a reduction in services. On average SHARe reduced EDA care plan costs by 21% and LTPCS care plans by 14%.

**Consumer Satisfaction Survey.** The CMS-developed Personal Experience Survey (PES) is the foundation for the consumer satisfaction survey tool. The use of the PES allows OAAS to benchmark consumer satisfaction with community services against data from other states using the PES instrument. Information from the survey is important to improving the quality of waiver services and to planning the redesign of our Home and Community Based Services (HCBS) system. Data from the survey will also be used to meet the CMS required waiver assurances that are a condition of continued federal funding.

**Nursing Home Residents Rights Legislation.** The new act recognizes in state law rights previously extended under federal law, including basic rights such as being able to rise and retire when one chooses, being informed about medical conditions, and others. It also extends these rights to residents of facilities that are “private pay” only and not, therefore, subject to the federal law. The changes help promote “culture change” to make nursing homes more resident-centered.

**Legislation to define sexual abuse of adults with disabilities.** OAAS Adult Protective Services (APS) is responsible for investigating cases of sexual abuse and referring them to local law enforcement, who may seek prosecution if appropriate. This legislation provides clarity to mandated reporters on what to report as sexual abuse.

**Implementation of legislation requiring Alzheimer’s training for staff of nursing homes and assisted living facilities.** Improved knowledge and skills on the part of facility staff should improve quality of care and quality of life for facility residents.

**Compliance with federal laws regarding pre-admission screening of nursing facility residents.** Compliance with federal law is significant in that it prevents federal disallowance of Medicaid payments made for nursing facility care. Related improvements to the OAAS nursing facility admissions process are significant in that the time for processing applications to determine medical eligibility and level of care for applicants was decreased from an average of 5 to 7 days to less than 24 hours.

### C. Who benefits and how?

**Dismissal of the *Barthelemy* Class Action Suit.** DHH benefits by having the freedom to make programmatic changes in this area without having to consider how it impacts the Settlement Agreement. In the long run, recipients home and community based services will benefit as OAAS makes programmatic changes necessary to maintain cost-effectiveness and sustainability of home and community based services.

**Completed Implementation of Service Hours Allocation of Resources.** Although many recipients experienced a reduction in services, some received additional services based on their assessed acuity. Recipients benefitted because 1) the EDA waiver is no longer threatened due to non-compliance with CMS rules and 2) the SHARe savings allowed services to continue and more people to be served despite budget reductions. Providers benefitted by avoiding additional rate cuts. The state benefits from savings and cost avoidance attributable to SHARe. Long term, this method helps preserve Medicaid Home and Community Based Services (HCBS) by moving average costs closer to national norms and ensuring sustainability.

**Consumer Satisfaction Survey.** Program participants are the primary beneficiaries since the data will be used to improve services and assure continued federal funding. Having data on participant satisfaction and preferences will also be of help to managers charged with improving and planning redesign of HCBS services. For instance, survey findings regarding underuse of cost-effective assistive devices and technology contributed to planning for a new HCBS waiver to be implemented by OAAS in SFY 2011.

**Nursing Home Residents Rights Legislation.** These changes in the legislation provide additional rights to persons residing in nursing facilities.

**Legislation to define sexual abuse of adults with disabilities.** Adults with disabilities in Louisiana who are unable to escape unwanted sexual activity due to their disabling condition are the primary beneficiaries. Families in which abuse may be occurring may be expected to be strengthened as a result of protection of adults who are vulnerable to sexual abuse.

**Implementation of legislation requiring Alzheimer's training for staff of nursing homes and assisted living facilities.** Nursing home and assisted living residents, both those with Alzheimer's and related dementias and those without, benefit from staff having better knowledge and skills for handling behavioral and other issues associated with dementia. Staff will also benefit from improved knowledge and ability to provide better care, as will the family members of residents.

**Compliance with federal laws regarding pre-admission screening of nursing facility residents.** Individuals in need of 24 hour care in a nursing home benefit from faster processing of admissions. DHH and the Medicaid program benefit by eliminating the risk of federal sanctions. Hospitals benefit from improvements in the admissions process because they are able to discharge patients more quickly.

D. How was the accomplishment achieved?

**Dismissal of the Barthelemy Class Action Suit.** OAAS and DHH Legal staff spent several months in negotiations with the plaintiffs to convince them of the need to make changes due to the cost-effectiveness issues with the EDA waiver and to develop the terms of the new agreement. Those changes included dismissal of the suit, although the plaintiffs could have raised other issues prior to dismissal. Successful implementation of Service Hours Allocation of Resources was also a key.

**Completed Implementation of Service Hours Allocation of Resources.** OAAS trained all assessors and support coordinators in the new process prior to beginning implementation and conducted a "trial run" with a sample of cases. Once implementation began, the OAAS SHARe Workgroup met weekly to troubleshoot issues, review and revise procedures as needed, and monitor implementation. The major

issue that arose was the huge increase the number of appeals filed as services were reduced. OAAS staff put in overtime to try to keep up with the number. A backlog did develop but was eventually worked through. Recipients outcomes were monitored closely. Outliers and other cases of concern were reviewed to determine where the methodology needed to be revised and/or exceptions needed to be made for specific recipients. It is fair to say that implementation of SHARe in one year for over 15,000 participants took up the majority of time of OAAS staff during fiscal year 2009-2010.

**Consumer Satisfaction Survey.** Funds from the federal Systems Transformation Grant were used to pay for consultants who assisted OAAS Quality Management staff in seeking stakeholder input, adapting the PES for Louisiana, determining the necessary sample size, and developing reports based on survey data. CMS contracted technical assistance providers trained surveyors on data-collection using the PES. OAAS contracted with an independent researcher, Dr. Gifford and Associates, to conduct data-collection. An OAAS staff person whose salary is paid in part under the Systems Transformation Grant conducted the data-analysis. Data from the survey was entered in the database for analysis using Select Survey software.

**Nursing Home Residents Right Legislation.** DHH was approached by advocates seeking this change. After discussion, the bill was include in DHH's package. Support from other stakeholders was obtained early in the process. The legislation was supported by provider and advocacy groups.

**Legislation to define sexual abuse of adults with disabilities.** OAAS/APS worked with multi agency committee to help draft legislation. In SFY 11, OAAS will promulgate administrative rules to adopt the changes included in Act 342.

**Implementation of legislation requiring Alzheimer's training for staff of nursing homes and assisted living facilities.** OAAS worked with an advisory group that included external stakeholders to identify curriculum requirements and issue a Request for Information from organizations qualified to review and approve curricula. Our Lady of the Lake Health Care Institute was selected for this purpose. OAAS promulgated rules to implement the requirements and disseminated information about meeting requirements to nursing home and assisted living providers.

**Compliance with federal laws regarding pre-admission screening of nursing facility residents.** OAAS worked with the Louisiana Nursing Home Association, Gulf State Nursing Home Association, Louisiana Hospital Association, DHH Office of Mental Health and Office for Citizens with Developmental Disabilities, Medicaid, and DHH legal staff to implement corrective actions. To improve its own nursing facility admissions procedures, OAAS eliminated unnecessary paper work, consolidated functions into two regional OAAS offices, and implemented electronic processing of applications.

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

**Dismissal of the *Barthelemy* Class Action Lawsuit.** The changes DHH /OAAS were able to implement as a result of the Second Supplement Settlement enabled the continued provision of services and even the expansion of home and community-based services during a time of budget reductions, by

lowering average per person cost and by changing targeting criteria for waiver slots to focus on persons not currently receiving any services. Further such changes will be possible in the future.

**Completed Implementation of Service Hours Allocation of Resources.** Resource allocation is key to expansion of home and community based services. Lowering per person average cost closer to national norms is critical as more persons are to be served and waiting lists reduced. This provides a rational means to achieve that. SHARe allowed the number of persons receiving HCBS services to grow, even as spending was reduced. This supports the goal to expand HCBS services.

**Consumer Satisfaction Survey.** This accomplishment contributes to the strategic goal “To administer and manage patient care programs in long-term, acute care, and nursing facilities in a manner that ensures compliance with applicable standards of care.” It is also consistent with the agency vision and mission.

**Nursing Home Residents Rights Legislation** - This does not have direct impact on strategic plan goals and objectives but is consistent with the role, vision, and mission of OAAS.

**Legislation to define sexual abuse of adults with disabilities.** Act 342 enables APS to investigate all reported instances of sexual abuse of adults with disabilities and positively impacts strategic plan objectives and indicators for the Adult Protective Services activity. It is also consistent with the agency vision and mission.

**Implementation of legislation requiring Alzheimer’s training for staff of nursing homes and assisted living facilities.** This does not have direct impact on strategic plan goals and objectives but is consistent with the role, vision, and mission of OAAS.

**Compliance with federal laws regarding pre-admission screening of nursing facility residents.** This accomplishment does contribute positively to strategic plan objectives and indicators for the nursing facility admissions activity.

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

**Dismissal of the *Barthelemy* Class Action Suit.** Not applicable.

**Completed Implementation of Service Hours Allocation of Resources.** Yes. Use of an assessment-driven, evidence-based “case-mix” system to allocate resources or set payment levels in home and community based long term care services is relatively new. A number of states are moving in this direction but Louisiana, though OAAS and a similar effort in OCDD, is at the front of this trend. OAAS presented some information on SHARe at a recent national conference on HCBS Services and a number of other states expressed interest.

**Consumer Satisfaction Survey.** Yes. Implementation of a consumer satisfaction survey using the PES is a best-practice in assuring the quality and consumer-centeredness in long term supports

and services. OAAS's survey was conducted in conjunction with OCDD's implementation of the National Core Indicators consumer satisfaction survey for DD service recipients. Both survey efforts employed consulting and data-analysis resources available through the Systems Transformation Grant; so this practice was shared between the two relevant program offices. Results of the survey will be shared with service recipients and the general public when the report is finalized, and will likely receive broader circulation as DHH moves forward with its transparency initiatives.

**Nursing Home Residents Right Legislation.** Not applicable.

**Legislation to define sexual abuse of adults with disabilities.** Not applicable.

**Implementation of legislation requiring Alzheimer's training for staff of nursing homes and assisted living facilities.** Not applicable.

**Compliance with federal laws regarding pre-admission screening of nursing facility residents.** Not applicable.

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

Yes. OAAS has accomplished or seen progress towards all of the goals and all 17 objectives described in the five-year strategic plan.

- ◆ **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?

OAAS has made progress on all goals and objectives of its five-year strategic plan. 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. Implementation of SHARe has been key to expanding access to services within existing budget constraints, and has allowed OAAS to serve more people while controlling and reducing both overall and per-person expenditures. Progress in developing further community-based alternatives has also been made and will come to fruition in SFY 11, when OAAS will offer at least one new waiver with a much broader array of services to replace the current Elderly and Disabled Adult Waiver. OAAS has also made progress on objectives related to developing an integrated Information Technology (IT) system and a comprehensive, data-driven quality management system, though work remains to complete both those systems. OAAS has

achieved the objective of “facilitating timely access to nursing facility services for eligible applicants,” with nearly all admission applications being completed by OAAS staff within 24 hours. OAAS continues to meet and exceed its performance measures for objectives related to Adult Protective Services, John J. Hainkel Home and Rehabilitation Center, and Villa Feliciana Medical Center.

OAAS has also achieved internal objectives of operating and providing access to Medicaid programs that provide over a billion dollars in direct services to people. In SFY 10, OAAS costs for administering and operating these programs constituted less than 2% of the cost of services delivered.

- ♦ **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:

Implementation of SHARe and improvements to nursing facility admissions processes have both produced results that exceeded expectations.

1. To what do you attribute this success?

SHARe has been a success because OAAS had earlier made the decision to use a very well-researched and recognized comprehensive assessment tool as the basis for all assessment and care-planning for individuals in OAAS HCBS programs; and because OAAS worked closely with the authors of that instrument to plan, project, measure, and monitor implementation. This assessment tool, the MDS-HC, allows individuals to be grouped in “Resource Utilization Groups” that are predictive of actual service need and usage. People with higher relative needs are approved for more services. This provides an equitable way to allocate limited resources, but it also serves to assure better outcomes for individuals. In implementing SHARe, OAAS has seen no increase in admissions to nursing facilities, no increases in discharges from community-based waiver services for health and safety, and no declines on health and quality outcome measures. Savings from SHARe have been greater than anticipated and, as a result, more people have had access to non-institutional alternatives.

OAAS has been successful in bringing nursing facility admissions processes into compliance with federal law and in improving the speed and efficiency of those processes because of sound analysis and decisions regarding the elimination of unnecessary paperwork, automation of work processes, and consolidation of the review process.

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

SHARe has realized program savings, as well as cost-avoidance, in SFY 10. SHARe related savings are projected in SFY 11 as well. Once initial savings, which are considerable, are realized, SHARe will still contribute to cost-avoidance in the face of growing demand for services due to population aging. It also provides OAAS with an equitable, evidence-based means of allocating limited resources based on objective assessment of individual needs. The ability to allocate resources based on actual needs is important, on an ongoing basis, to achieving the best possible outcomes for program participants.

Efficiency realized in the nursing facility admissions process will continue through SFY 11, however that process is proposed for privatization in SFY 12, with the expectation that a private contractor will perform the work with the same or greater degree of efficiency than is currently being realized.

- ◆ **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:

There are no areas in which OAAS is experiencing a significant lack of progress.

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

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

For SFY 11, goals, strategies, and performance indicators have been updated, both to better reflect the current functions and activities of OAAS and as a result of new budget and performance measurement guidelines from the Division of Administration. While major strategic goals have remained the same, strategies have been updated and performance indicators improved to focus on outcomes and efficiency rather than outputs.

- ◆ **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.

OAAS ensures the coordination of the strategic plan among all programs, facilities, and

levels of management. Reporting on performance indicators is a joint responsibility of OAAS finance division and OAAS program divisions, and is performed multiple times a year as part of the budget process. OAAS strategic priorities are set during annual staff retreat. Progress towards strategic goals and objectives is reviewed during monthly staff meetings and at weekly meetings of executive management and division directors. Reordering of priorities and resource decisions is the responsibility of executive management, and may occur and/or be communicated during these weekly meetings. These decisions are reflected in annual updates to the OAAS Strategic and Operational Plans.

For JJ Hainkel and Villa, progress in fulfilling the strategic plan is met through the ongoing evaluation and coordination of administrative and managerial functions at the facility. Progress toward set goals and objectives is periodically evaluated, measured, and internally communicated. Adjustments including resource allocation are made based on specific objectives necessary to achieve the overall strategic plan.

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

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

**Information Technology (IT).** When created as an office in 2006, OAAS inherited many inefficient processes that were not supported with appropriate information technology, including many processes that were still performed on paper. In SFY 11, OAAS will complete IT initiatives that go a long way towards addressing these inefficiencies, including implementation of an automated participant tracking system for all OAAS programs. Once that system is in place, the remaining significant IT need for OAAS will be for an electronic plan of care. Development of an electronic plan of care is critical to OAAS making further progress on its strategic plan and to realizing efficiencies and related budget targets for SFY 12. OAAS internal and external customers have long been affected by the lack of an electronic care plan. Paper processes associated with completion and approval of plans of care result in service delays for consumers and add administrative costs and complexity for providers. This has been an issue since the

inception of programs currently operated by OAAS.

**Provider Capacity.** Rate adjustments to home and community-based providers in SFY 10 may impact OAAS goals and objectives related to offering high quality alternatives to institutionally-based care and “right-balancing” of institutional versus community-based spending. Provider performance also needs to be improved, though outcome indicators tracked by OAAS do indicate that HCBS services are producing better outcomes overall than nursing facility care. Service recipients are impacted by inefficiency in the support coordination (i.e., “case-management”) system. Worker turnover and pay are issues, as well as training, licensing/certification requirements, and payment structures for support-coordination and direct services. These issues were identified as early as 2004 in consultant and legislative auditor reports, and pre-date those reports.

**Internal Administrative Processes.** Federal, State and Departmental processes for contracts, human resources, and policy implementation are complex, multi-layered, and administratively burdensome. The documents that must be created to accomplish work in these areas and to implement change, and the guidelines for creating and evaluating those documents, are frequently complex in themselves. Change documents are then subject to multiple layers of review both within the Department and at the level of State and Federal bureaucracies. The complexity and administrative burden of internally processes prevents improvements and efficiencies from being implemented with optimal speed and certainly slows the pace at which strategic change can be realized. This has real impact on agency ability to execute strategic plans, and on providers and recipients who may wait years for policy improvements to be finalized or contracted services/systems to be implemented.

#### 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?

**Information Technology (IT).** OAAS recommends that development of an electronic plan of care for home and community-based services operated by OAAS, and by OCDD, be a priority among DHH IT initiatives. OAAS will work closely with OCDD, Medicaid, and DHH IT to identify and pursue the most efficient approach to accomplishing this task.

**Provider Capacity.** OAAS, alone and in partnership with other DHH entities, will continue to work on and will accomplish several initiatives to improve provider quality

and capacity. These include, but are not limited to: (1) working with providers, advocates, and DHH Health Standards Section to finalize new licensing requirements for providers of home and community-based services; (2) implementation of comprehensive training and certification of support coordinators; (3) execution of performance-based agreements with support coordination agencies; (4) comprehensive annual monitoring of support coordination agencies; (5) exploration of incentive-based payment approaches and service delivery options.

**Internal Administrative Processes.** OAAS has sought to streamline its own work processes and has simplified many procedures for providers and consumers. OAAS has also made recommendations within the Department and will work other departmental entities towards improvements.

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

IT issues were noted in the FY 08-09 and 09-10 reports.

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?

OAAS anticipates that nearly all of the corrective actions identified above that are related to provider capacity will be completed in SFY 11. Ability to change payment incentives may be impacted by budgetary decisions outside of OAAS.

Corrective actions in the other two areas are more difficult to predict because they are intra- and inter-departmental in nature.

Implementation of an electronic plan of care is critical to OAAS's ability to meet strategic and budgetary goals in SFY 12 and thereafter.

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

Revised licensing regulations for HCBS providers have been drafted and will be promulgated in SFY 11. OAAS has begun contracting for development and delivery of comprehensive training curricula and certification of support coordinators, with training to be delivered by OAAS staff in SFY 11. OAAS has begun revising performance-based agreements, and agreements will be executed with all support

coordination agencies. Under the federally-funded Systems Transformation Grant, OAAS has developed the support coordination monitoring tool and will have that tool fully automated in SFY 11. OAAS regional operations staff will be trained in the performance of support coordination monitoring and will begin monitoring in SFY 11.

OAAS has also made revisions to its plan of care requirements and approval process in anticipation of an electronic plan of care being developed.

- 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? (Investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies, for example.) 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?

Almost all costs associated with corrective actions in the area of support coordination will be covered through 100% federal funds available through the Systems Transformation Grant, Person Centered Planning Grant, and Money Follows the Person Demonstration. These funds were included in department budget requests.

Corrective action related to development of an electronic plan of care could

potentially be accomplished under existing contracts without additional funding, or may require new funding. The cost of purchasing or developing an electronic plan of care have not yet been determined.

#### 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:

**SHARe Evaluation Report** – This report is completed quarterly and is used to monitor the impact of SHARe resource allocation on OAAS program and recipient outcomes. It is produced in-house. Major findings have been that SHARe has effectively lowered per person costs in the EDA waiver and LTPCS without negative impact on participant outcomes. On the basis of this evaluation, OAAS has proceeded with implementation of SHARe. Copies of the report are available upon request.

**HCR 190 Evaluation of Adult Day Health Care (ADHC) Services and Reimbursement** – This report was completed in February, 2010, in compliance with HCR 190 of the 2009 Regular Session. The report was produced in-house and included data collected by independent contractors, including data from OAAS's biennial survey of ADHC waiver participants and an

electronic survey of ADHC providers. The study found considerable variation in ADHC services and resulted in recommendations to change ADHC licensing and payment to allow for two or more “tiers” of ADHC services. OAAS is in the process of working with ADHC providers and other stakeholders to implement the recommendations contained in the report. The report is available on the DHH website.

OAAS staff also produce regular reports examining program performance on Health and Quality Outcome Indicators, and reports on the results of consumer satisfaction surveys. Those reports are used for federal quality assurance and to implement quality improvement initiatives. Though currently used internally, OAAS is in the process of having these reports approved for external distribution.

The contact person for more information on any of these reports is:

Name: Robin Wagner, Deputy Assistant Secretary  
Agency & Program: Office of Aging and Adult Services  
Telephone: (225) 219-0223 E-mail: robin.wagner@la.gov

# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

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

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Coletta C. Barrett, RN, MHA (Acting Director)

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

#### **What was achieved?**

- Based upon the American College of Surgeons Trauma System development consultative visit June 2009, LERN introduced and passed Act 934 (House Bill 985) in the 2010 Regular Session of the Louisiana Legislature.
- Identified and contracted with Dr. Robert L. Coscia, LERN Medical Director
- Contracted with Wright-Feigley Communications to develop communications plan
- Contracted with Robert Rose & Associates, a firm that specializes in identifying and applying for sustainable funding sources
- Sponsored, through contracts with LSUHSC-Shreveport, students to attend Advanced Trauma Life Support (ATLS) courses and rural hospitals to attend Rural Trauma Team Development Course (RTTDC)
- Through a contract with The Louisiana Ambulance Alliance, sponsored the training of 60 EMT and Paramedic healthcare providers in Pre-Hospital Trauma Life Support (PHTLS)
- Facilitated the movement of greater than 10,000 patients to definitive care.

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

The passage of Act 985 is very significant in that it establishes the Louisiana Emergency Response Network as the lead agency to govern, develop, and manage a comprehensive statewide trauma system that would address trauma and time-sensitive illness. This Act, most importantly, provides for the requirements for trauma centers, provides for a statewide trauma registry, provides for the confidentiality requirements for the statewide trauma registry, provides the authority to develop stroke and STEMI systems, creates a LERN fund in the State Treasury and provides from public records exceptions as its key elements. Additionally, it modifies and adds expertise to the structure of the LERN Board and provides authority for LERN to publish and distribute information. As LERN continues to develop a statewide system of trauma care, it is crucial to have the expertise in system development that Dr. Robert Coscia brings to the agency. Dr. Coscia is a nationally recognized expert in the field of trauma system development and is a member of the American College of Surgeon's Committee on Trauma on the national level. Through this affiliation, Dr. Coscia has participated in many site visits across the country evaluating and recommending next steps for other states that are in the process of trauma system development. With this expertise on board, LERN has acquired a significant resource to aid in its mission to develop a statewide trauma system. As the system develops, it is important that the citizens and stakeholders in the state recognize the value and the need for such a system of care. Through the use of the communications plan being developed by Wright-Feigley, LERN will be able to communicate in an organized fashion the importance of this program statewide. Equally important, is the ability of LERN to identify and secure sustainable funding for the future. It is the role of Robert Rose & Associates to assist LERN in this very important next step in its growth. Recognizing that resources throughout the state are at a premium, LERN realizes that education is an important part of a successful trauma system. In FY10, LERN sponsored education programs through LSUHSC-Shreveport for rural hospitals and for physicians and through a contract with the Louisiana Ambulance Alliance was able to train 60 addition pre-hospital providers in trauma care. This will be an on-going endeavor and LERN will utilize every opportunity to educate healthcare providers to increase the standard of trauma care available in all areas of the state. The movement of greater than 10,000 patients to definitive care assures that these patients are connected to appropriate resources that have the potential to impact morbidity & mortality.

**B. Who benefits and how?**

As LERN continues to grow the statewide trauma system of care, it is the citizens of the state that benefit. With only two Level I trauma centers in Louisiana (located in New Orleans and Shreveport), there is a significant lack of trauma care available in a majority of the state. The bridge to this gap is the development of the trauma network which will bring together the sparse resources of the state into a coordinated system of care. The elements that are necessary for this process to continue are centered on the

expertise that Dr. Coscia will contribute from a national perspective and from the best practices shown in other states, public awareness of the value of such a system and the need for a coordinated effort, sustainable funding so that as the resources of the state dwindle, the ability of LERN to continue the development of the network does not, and education greater numbers of healthcare providers in trauma care so that when a Level trauma center is not available, the expertise of the provider is there.

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

This success was achieved through the leadership of the LERN Board, in coordination with the LERN Staff, the LERN Regional Commissions, local hospitals and EMS providers and state agencies to collaborate, cooperate and implement the program plan. Additional support was received through the use of expert contractual deliverables such as provided by SSA Consultants, Wright-Feigley Communications, Robert Rose & Associates and the Louisiana Ambulance Alliance.

**D. Does this accomplishment contribute to the success of your strategic plan? (See**

Section II below.)

These accomplishments directly address the FY 2012-2016 Strategic Plan as well as the legislative mission and the needs of the regions served by the Network.

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

With the significant cut in personnel that LERN has experienced, the use of contract expertise has allowed LERN to continue in its legislative mission to develop a statewide system of trauma care. This use of contracts is a practice that is being seen in more state agencies and allows for a better use of state dollars in obtaining the services needed.

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

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

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

The next phase of development for FY10 was influenced by the Best Practice research offered by SSA Consultants and the American College of Surgeons

Consultative Visit held in 2009. The Best Practice Research showed specifics of the methodology of other states with successful trauma systems. The Consultative Visit done by the American College of Surgeons set the methodology for this next phase of Trauma System development. It outlined the steps needed to design and implement a true Trauma System based on the expertise of the College and the experiences seen by the College in other states. These recommendations specifically addressed Goal I and II of the Five Year Strategic Plan which calls for a decrease in risk adjusted trauma-related deaths and incidents of morbidity and mortality due to trauma and to ensure that all citizens gain access to the statewide trauma network for both trauma and time sensitive related illnesses. The accomplishments realized in FY10 put LERN on a continued path to realizing these goals within the timeframe of the Strategic Plan.

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

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

- Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?

Progress has been possible due to many external factors. For FY10, the primary factor has been the inclusion of subject matter experts into the resource pool of the agency through the use of contractual arrangements. A secondary external factor would include the successful collaboration created between the many local, regional and state level stakeholders who voluntarily participated in the creation and operations of the Network.

- **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?)

As a state agency the support of the Department of Health and Hospitals has been crucial in the continued development of LERN. The results to date would have not have been possible without specific department action. Included in this success is the support of the Governor’s Office, the guidance of the Division of Administration, the expertise of DHH personnel in Contracts and Procurement Support, the Division of Planning and Budget and the Fiscal Office, as well as the guidance of the Office of State

Purchasing, the Office of Information Technology, and the Governor's Office of Homeland Security.

- **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 the LERN. Examples include the following:

- Assistance of DHH personnel in RFP development for Management Consulting and Call Center Staffing
- Assistance from the Department of Health and Hospital and the Division of Administration for guidance on budget and funding
- Assistance from the Office of State Purchasing in the acquisition of necessary contracts, purchases and equipment to meet state requirements

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

The significant achievements of FY10 are the building blocks of future trauma system development. The Best Practices Research done by the SSA Consultants and the recommendations of the American College of Surgeons have been incorporated in the LERN Board's Five Year Plan which identify the milestones in this development. Progress will continue according to the timelines established by the Board.

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

The budget cuts LERN experienced in FY10 had its greatest impact on the number of personnel available. In FY10, LERN experienced a 30% reduction in T.O. with a corresponding reduction in budget dollars to fund these positions.

- ♦ **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?

In order to address budget shortfalls first experienced in FY10, LERN has streamlined its Communication Center operations to be the most efficient as possible. Additionally, LERN has sought out and engaged subject matter experts to assist LERN in continuing its mission to develop a statewide system of trauma care. While addressing the anticipated budget shortfalls, LERN will continue to address the milestones of its current Strategic Plan.

No. If not, why not?

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

The strategic plans for the Network are created by the LERN Board with facilitation from SSA Consultants, based on LERN's Legislation, Best Practices Research and the recommendations received from the ACS Consultative Visit. A discussion of the progress of this plan is a regular agenda item at the LERN Board Meetings with regular updates provided by the LERN Chair and relative consultants. It is shared with the Regional Commissions via the LERN Administrative Director and the Tri-Regional Nurse Coordinators in each DHH Region.

**III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?** ("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, condition of the state fisc, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

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

None.

**A. Problem/Issue Description**

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

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

B. Corrective Actions

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

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

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

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

Please discuss the following:

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

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract  
A continual review of literature and other best practices from other states is performed by staff and consultants and is used as guidance for development of the System as commissioned by the LERN Board through SSA Consultants.
- Program evaluation by in-house staff
- Program evaluation by contract  
Contracted service for Communication Center staffing provides input of data into the ImageTrend software owned by LERN. This software provides data on calls, time to definitive treatment, mechanism of injury, transport time
- Performance Progress Reports (Louisiana Performance Accountability System)  
LERN reports Performance Indicators quarterly through the LaPAS system.
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)  
Contracts have deliverables and a monitoring plan to include reports that are reviewed by the LERN Chair. The Chair provides status reports on all contract activities to the LERN Board.
- 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:

LERN Annual Report to the Legislature submitted March 2010 in compliance with LERN Enabling legislation

Monthly Fiscal Reports submitted to LERN Chair and LERN Treasurer and discussed at LERN Board Meetings

Contact person for more information:

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Agency & Program: Louisiana Emergency Response Network

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# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

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

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips, Undersecretary

**Agency Head:** Clayton W. Williams, Assistant Secretary

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

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

#### **#1 Response to the British Petroleum (BP) Deepwater Horizon Oil Spill**

A. What was achieved?

The DHH OPH Health Environmental Health Services staff were effective in their response to the BP Deepwater Horizon Oil Spill event by:

- collecting water and oyster meat/seafood samples in all affected harvest areas along the Louisiana coast,
- establishing a surveillance system for health care providers to report illnesses related to the spill, and coordinating with local, state and federal agencies to evaluate health and environmental data and advise the concerned public

B. Why is this success significant?

The Environmental Health Services staff was able to mobilize quickly and establish mechanisms to collect and report information relative to this public health emergency event. This ongoing successful effort is significant because it is a major component of the public confidence campaign for the safety of Louisiana seafood.

### C. Who benefits and how?

This effort benefits Louisiana's residents, visitors, and workers in areas impacted by the spill, seafood consumers at the local, state, national and international levels, the seafood industry and the agency. This effort provides a level of confidence that Louisiana seafood was and continues to be sampled and tested for any indication of contamination resulting from the BP Deepwater Horizon Oil Spill. The ongoing collection of samples contributes to the nation's confidence that Louisiana seafood was and continues to be sampled and tested for any indication of contamination resulting from the BP Deepwater Horizon Oil Spill.

### D. How was the accomplishment achieved?

This effort has been a collaborative effort between Department of Health and Hospitals, Department of Wildlife and Fisheries, and Department of Environmental Quality. The Molluscan Shellfish, Commercial Seafood, and Environmental Epidemiology and Toxicology Programs tirelessly worked to collect samples and monitor and evaluate health and environmental data as requested. The ongoing success of this effort is attributed to the dedication and experience of the program staff and the agency response actions.

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

Yes. Environmental Health Services contributes to the agency's plan by accomplishing the following: Educating and empowering citizens regarding their health; creating a solid infrastructure attractive to businesses and thriving families; providing protection and confidence in the water we use to bathe, drink, cook or wash in daily, the milk they drink, the food they eat, and safe sewage disposal; and enabling communities and families to return to their homes and businesses after emergency events.

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

Yes. This effort took a great deal of coordination and cooperation between local, state and federal agencies. The program has learned how to better manage its resources, personnel and equipment during disasters and for continuity of operations.

## **#2 Pandemic Flu Planning and Response**

### A. What was achieved?

The DHH OPH response to the H1N1 influenza pandemic was successful, efficient and highly effective as a result of staff efforts throughout public health. OPH staff executed its disaster response, influenza pandemic, and continuity of operations plans

for this effort resulting in phenomenal outcomes for state public health preparedness and response. In preparation for the pandemic, antiviral medications and H1N1 vaccines were distributed to healthcare providers statewide. As documented by the DHH OPH Center for Community Preparedness, Pandemic Influenza Program, more than 500,000 H1N1 vaccinations were administered in Louisiana in response to the pandemic. Through the use of the Louisiana Immunization Registry for Kids Statewide or LINKS, OPH immunization staff were able to register, profile, qualify, and document provider participants for the H1N1 influenza vaccination campaign and count the number of vaccines administered. In real-time, LINKS enables staff to monitor supply and demand needs statewide for medications. Immunization staff are also able to track patients who have had adverse reactions to medications. (see more on LINKS on page 9).

Public health staff at the state, regional, and parish levels worked to distribute antiviral medications and H1N1 vaccines to healthcare providers with guidance for dispensing. Staff also developed sound communications programs and techniques for a variety of key partners and the public; developed and implemented a sound vaccination campaign approach, effectively utilized an existing registry for patient and physician information; and performed epidemiological surveillance and laboratory testing and reporting quickly and effectively under significant constraints of time and resources.

Louisiana's H1N1 response was consistent with various sources of federal guidance on combating pandemic influenza, as well as international and national recommendations for identification, prophylaxis and treatment of disease through frameworks provided by the U. S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA), and the World Health Organization.

Through its Center for Community Preparedness, OPH conducted an after action review and administered a survey to 881 stakeholders to evaluate public health's response to the H1N1 pandemic. Results from the survey show collectively, more than 80 percent of respondents agreed or strongly agreed that DHH OPH was effective in its response efforts, communications, vaccine administration and distribution, outreach and education, and pre-emergency preparedness planning. The results from the after action reviews and the survey are being used by public health to improve its disaster response and continuity of operations plans. Lessons learned from the H1N1 response will be incorporated into all facets of pandemic influenza and all-hazards preparedness planning.

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

The Louisiana's vaccination initiative was the largest public health response to H1N1 in the history of the CDC and in Louisiana; and was developed and operated within a very short planning period. The pandemic presented the significant challenge of response to an emerging infection of unknown potential, and affected residents statewide. The vaccination campaign encountered challenges in the

allocation of scarce resources, and later a reluctance for vaccination even when easily accessible. This success was also significant because OPH was able to augment its LINKS system to allow electronic reporting of H1N1 vaccine doses administered as required by the CDC. LINKS was modified to create an H1N1 registration module for both existing and new providers of vaccinations. LINKS was then used to “profile” providers and categorize them into their patient and employee populations. Finally, once vaccine was available, these profiles were used to allocate appropriate and available vaccine to appropriate providers.

C. Who benefits and how?

All persons in Louisiana benefited from the efficient response of the DHH OPH, response partners and stakeholders as well as the effective use of resources through preplanning and during H1N1 response. The severity of the H1N1 pandemic was a critical factor, but Louisiana did not experience critical infrastructure or health system failure in response to H1N1. The H1N1 response has also improved Louisiana’s all hazards planning.

D. How was the accomplishment achieved?

Effective and efficient H1N1 response was achieved through a multiyear planning process under the guidance and evaluation of Federal agencies such as HHS and CDC, as well as building upon the responses, partnerships, and emergency structure set up for hurricane response in Louisiana. The cornerstone of this accomplishment is the medical intelligence, epidemiological and laboratory expertise and capabilities, the guidance, allocation, distribution and dispensing of medical countermeasures such as antiviral medications and H1N1 specific vaccine, and the sound communications programs and techniques of DHH OPH. This accomplishment was achieved with significant constraints of time and resources. The investment by the DHH/OPH in preplanning and resilient relationships with response partners and stakeholders was critical to the success of the H1N1 response.

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

The Louisiana DHH OPH pandemic preparedness accomplishment contributes to the success of strategic planning and also its disaster preparedness and continuity of operations planning; by incorporating H1N1 improvements into pandemic planning as well as strengthening the commitment to all hazards planning.

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

Executive state government, branch departments, and agencies (state, regional and parish levels) have been involved in pandemic influenza preparedness activities and all participated in the State’s response to the H1N1 influenza pandemic. Louisiana has tested its readiness for a flu pandemic in two previous highly successful mass

vaccination campaigns. Its most recent exercise resulted in over 26,000 residents receiving a flu shot. CDC requires at least 200 people per hour to be vaccinated during a mass vaccination campaign. Louisiana averaged 550 people receiving shots per hour. The emergency operational structure that was used can certainly be seen as a “best practice” for the State response to any emerging infectious disease threat or future pandemic.

### **#3 Tobacco Control & Prevention**

#### A. What was achieved?

The 100% Tobacco-Free Schools program is being national recognized as a model program and has received an increase in funding in order to support local school districts. Thus far, 24 out of the 70 Louisiana school districts have 100% Tobacco-Free School policies that protect Louisiana’s youth from the exposure of tobacco-use and prevent their initiation of tobacco products. Following the CDC Guidelines for School Health Programs to Prevent Tobacco Use, the LA Tobacco Control Program has designed and began its implementation of the 100% Tobacco-Free Schools Program since 2007.

In 2009, the LA Tobacco Control Program was one of three state programs awarded a Technical Assistance Grant from the National School Boards Association’s Tobacco Consortium to assist with implementation of LTCP’s 100% Tobacco-Free Schools Program. This Louisiana program is being used as a model for the National School Board Association to develop a training and technical assistant manual for other states.

The LA Tobacco Control Program has recently received federal funding through the American Recovery and Reinvestment Act to partner with the LA School Boards Association, the LA Department of Education’s Health and Wellness Services Unit, and the Obesity Council to assist 27 additional school districts with developing their School Health Advisory Councils and implement Comprehensive School Wellness Policies to implement 100% Tobacco-Free School policies and promote physical fitness and healthy eating.

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

This success is significant because for the first time the LA School Boards Association is addressing Tobacco Prevention and Obesity Prevention (School Wellness) as a priority. By doing so, school districts across the state are provided with information and resources to improve the health of Louisiana youth in order to improve their academic performance.

C. Who benefits and how?

Louisiana youth benefit by learning in an environment not susceptible to the influence of the tobacco industry's targeting and an environment free from tobacco smoke. In addition to preventing youth initiation of tobacco-use and starting a lifetime of dependence, the program is linked to the Coordinated School Health model that serves school staff and faculty. By promoting cessation among those teachers and staff members who use tobacco, the health improvements could lead to lower healthcare costs for the school district.

D. How was the accomplishment achieved?

This achievement was accomplished by having program design based on CDC Best Practices and the efforts of the LTCP to develop and maintain strong state and local partnerships to provide guidance to local school districts. LTCP has developed a partnership with the Louisiana School Boards Association that has led to a greater coordination on the Louisiana Tobacco-Free Schools Initiative and allowed educational outreach to school board members and administrators across the state.

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

This accomplishment contributes to the strategic plan's success, specifically the program's Goal One – to decrease the initiation of tobacco by Louisiana's youth.

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

The accomplishment is based on strong partnership development and management practices.

#### **#4 Louisiana Volunteers in Action**

A. What was achieved?

Louisiana Volunteers in Action (LAVA) is Louisiana's approach to the federally mandated ESAR-VHP Program, serves as an online, state-based registry of medical and non-medical volunteers. It was designed to provide a systematic way of coordinating volunteer efforts during an emergency with a special emphasis on advanced credential verification and deployment based on skill set.

B. Why is this success significant?

The system provides 24/7/365 volunteer registration capabilities, assigns volunteers to one of four credential levels as outlined in Guidelines and identifies volunteers willing to participate in Federally coordinated emergency response. The State is able to search

for volunteers via queries. The system has the ability to verify credentials prior to a disaster. It enhances resources available to the state and community-at-large for disaster response and recovery.

C. Who benefits and how?

Considering, the workforce shortage, citizens of the State of Louisiana having volunteers to assist them during natural/man-made disasters and provide support to relief efforts. Volunteers provide valuable cost-effective resources to the community.

D. How was the accomplishment achieved?

The Department of Health and Human Services initially allocated funds as a supplement to the state's funding to develop a functional volunteer system. The intent was not to cover the full cost of the system, but supplement to help meet the specific governmental mandate. In 2007, Louisiana launched LAVA as a tool and recruitment mechanism for its emergency volunteers. Since that time period, the state has recruited nearly 4,300 volunteers.

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

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. Louisiana's LAVA system has been celebrated for its recruitment and retention efforts. The LAVA system has contributed to the state's 10 out of 10 ranking in the 2008 *Ready or Not: Trust for America's Health Report* and the state's A- ranking in disaster preparedness for the National Health Report Card.

### **#5 Louisiana Health Shortage Areas**

A. What was achieved?

Since November 2009, Louisiana has increased the number of health care professionals serving Medicare, Medicaid and the uninsured from 47 to 110 and increased the eligible service sites by 75.

B. Why is this success significant?

The National Health Service Corps providers service a minimum of 2-year service commitments in a health professional shortage area (HPSA) in return for \$50,000 in educational loan repayment incentives from the NHSC. In addition to the 2-year service, the associated clinics are required to see all patients regardless of their ability to pay. It is estimated that state-wide, NHSC providers treat 165,000 patients annually.

C. Who benefits and how?

Residents of HSPAs are provided access to community-based primary care, mental and dental professionals that treat all patients regardless of their ability to pay. The majority of providers commit to serve in federally qualified health centers, rural health clinics and state health facilities.

D. How was the accomplishment achieved?

The Bureau of Primary Care and Rural Health (BPCRHR) is awarded \$164,742 annually for the State Primary Care Office and also received an additional \$52,925 for the American Recovery and Reinvestment Action (ARRA) State Primary Care Office Grant to support increased participation by Louisiana in the federal NHSC program. The ARRA funds provided for a part-time contracted health professional specialist, NHSC Ambassador meeting funds, and travel expenses for site visits in monitoring and approval of service sites and providers. To increase awareness, the BPCRHR conducted an informational campaign to Med Job Louisiana, partner organizations, and medical training programs to increase awareness of the incentive opportunity.

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

The mission of the BPCRHR is to increase access to primary health services to Louisiana's medically underserved populations. The Bureau now has 226 health providers serving in the NHSC, State Loan Repayment and Conrad 30 programs.

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

This program demonstrates Louisiana's return on investment in maximizing a federal program which does not require a state match or state funding to serve Louisiana's most needy populations.

**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's strategic plan focuses its efforts toward those initiatives which assure accountability and drive program goals, objectives, and strategies that target the health care needs of the state. The offices major strategic goals focus on reducing illness,

disability, and premature death; elevating the health status of Louisiana's population; protecting the quality of Louisiana's physical environment; and improving the social and health care environment in Louisiana. OPH has made progress towards attaining these goals and focuses efforts through three major program areas including: Vital Records and Statistics, Personal Health Services, and Environmental Health.

OPH is making great advancements in vital records and statistics to improve efficiency measures in its operation of the office's vital event registry and vital statistics analysis. The program is continuing to develop the Louisiana Electronic Event Registration System (see page 10), that will allow for the electronic registration of many vital services. The program has over 10 million original records stored in archives, comprising over 70,000 volumes of records. This vast improvement through LEERS will yield greater efficiencies in vital records operations for which staff collect, transcribe, compile, and analyze reports, preserve, amend, and issue vital records including birth, death, fetal death, abortion, marriage, and divorce certificates.

Within personal health services OPH has seen continuous improvements in immunization rates, maternal and child health services, nutrition, laboratory, emergency preparedness, and health-care associated infection planning. Specifically the program has seen continuous improvement in pregnancy related visits for low income women, preventive child health visits from 143,105 in state fiscal year 2006 to 317,668 at the end of state fiscal year 2010; from 95 percent in SFY 2006 to 99 percent in 2010 of children fully immunized at kindergarten entry; 100 percent of bioterrorism lab tests completed within 72 hours; and increases in women receiving family planning services while seeing decreasing cost over time for these services. The program is part of a state-wide effort to improve birth outcomes for moms and babies in Louisiana. The Louisiana Birth Outcomes Action Team held its inaugural meeting November 17, 2010, bringing together community stakeholders in the healthcare, governments, private citizens, and not-for-profit community-based groups. The priorities of the birth outcomes action team are performance measurement, coordination of pre- and inter-conception care, patient safety and quality of care, health disparities in birth outcomes, and behavioral health.

Environmental health services has seen continuous improvements in its efforts to assure compliance with the *State Public Health Sanitary Code*. The program permitted 28,537 retail food establishments last year, monitors 8,000,000 in acreage for shellfish, 1422 public water systems, performs inspections on tens of thousands permitted establishments, places of public accommodations, and private premises that may be detrimental to the community. These inspections can occur in daycares, restaurants, tanning facilities, water systems, dairies, beaches, school cafeterias, etc. The program also monitors rivers, lakes and other water bodies to assure that they are safe for swimming and fishing, educates the public about mold, and performs many studies on environmental conditions for short- and long-term health impact over time. The program is focusing efforts to improve its sanitary code standards and for greater public access to information about retail food establishments.

Public health's infrastructure is built upon unique public-private partnerships that are strategically linked to influence positive health outcomes. These partnerships exist between State and local departments of health, university systems, through collaborations with community-based organizations, the executive branch of state government and through broad relationships with federal agencies. It is the agency's priority to ensure that developing objectives and strategies would lead toward the fulfillment of the agency and department mission and goals for Louisiana's residents and visitors.

***Louisiana Electronic Event Registration System (LEERS)***

The DHH OPH Center for Records and Statistics is continuing with the development and implementation of LEERS to allow for the electronic registration of birth, death, fetal death, induced termination of pregnancy, marriage, and divorce records. LEERS will also include an integrated business system and the imaging of approximately ten million records archived by the vital records 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:

***Louisiana Immunization Registry for Kids Statewide (LINKS)***

The DHH OPH Immunization Program used the Louisiana Immunization Registry for Kids Statewide (LINKS) to register, profile, qualify and document provider participants for the H1N1 influenza vaccination campaign. Electronic reporting of H1N1 vaccine doses administered was required by the Centers for Disease Control (CDC). Using our existing infrastructure and ability allowed our vaccination campaign to focus on the campaign itself, rather than on creating new or temporary technology.

The LINKS registry was used as the cornerstone for the H1N1 vaccination campaign. The registry first was modified to create an H1N1 registration module for both existing and new providers of vaccinations. LINKS was then used to "profile" providers and categorize them into their patient and employee populations. Finally, once vaccine was available, these profiles were used to allocate appropriate and available vaccine to appropriate providers. The upgrades and support of the LINKS system can now be applied to routine vaccinations for all. For example, because of the use of LINKS in the H1N1 campaign, we now have all vaccinating pharmacists on the LINKS system. These pharmacists can now use LINKS to document flu shots given at these pharmacies across the state yearly. As always, the modification of an existing technology that is routinely and successfully used can lead to lasting benefits.

***Louisiana Electronic Event Registration System (LEERS)***

The DHH OPH Center for Records and Statistics is continuing with the development and implementation of LEERS to allow for the electronic

registration of birth, death, fetal death, induced termination of pregnancy, marriage, and divorce records. LEERS will also include an integrated business system and the imaging of approximately ten million records archived by the vital records registry.

LEERS will allow external stakeholders to electronically register vital events with the Louisiana Vital Records Registry. Electronic registration will provide the Center for Records and Statistics and its data partners with almost real-time reporting of these events. This project will bring this state in line with the national movement to modernize vital event registration and reporting systems.

The birth registration module of LEERS will be implemented on December 6, 2010. Birthing hospitals around the state will begin to electronically report births in their facilities at this time.

### ***Heart Disease and Stroke***

The Heart Disease and Stroke Prevention Program was able to expand a private hospital's telestroke system to other hospitals in southeast Louisiana. Two major factors led to the success of the ASSERT initiative: funding and partners. The \$200,000 provided to the HDSP Program by CDC is necessary for the implementation and sustainability of the telestroke system. This system can cost a hospital \$22,000 initially and over \$40,000 annually. The CDC funds are offsetting these costs for those smaller hospitals that otherwise would not be able to afford to participate in a telestroke system. Our partnerships with Ochsner Medical Center and the American Heart Association have been crucial to the success of ASSERT. Ochsner has the expertise and experience with telestroke, while the American Heart Association has expertise in guidelines for stroke care.

Grant funding ends in June 2012. The HDSP Program has committed to expanding the network to three hospitals in FY10-11 and three in FY11-12. To assist these hospitals in sustainability, the grant funds are only paying for a portion of the costs. The amount paid by the grant decreases each year so that hospitals are better able to integrate the expenses into their budget. It is the intent of the HDSP Program to apply for additional funds in 2012 to expand ASSERT to additional hospitals.

### ***Asthma Prevention***

The DHH OPH Louisiana Asthma Management and Prevention (LAMP) Program has made significant strides under the CDC cooperative agreement in year one. The program exceeded its goals of establishing asthma coalitions at the regional level in the timeline, providing evidence based educational trainings to healthcare providers on the diagnosis and management of asthma, and establishing partnerships with school districts to increase their ability to properly care for children with asthma. The results would not have been generated without the funding received from the CDC as well as without the guidance of the LASC. The LASC has been facilitated by the LAMP Program Manager since 2007 and without his leadership; the program and LASC's efforts would have lack the support from the CDC. Due to the collaboration, the state is

benefiting from the 2009 Louisiana Act 145 child asthma medication law which decreases the time it takes for Louisiana children to have access to prescribed emergency asthma medications while in the care of the school. The program and its partners continue to implement evidence based strategies in years two through five and attempt to implement policies that will reduce the burden of asthma on the state from a cost and health standpoint.

Overall, the success is due to a strong internal asthma program lead by knowledgeable asthma professionals, internal stakeholders and experts within the Department of Health and Hospitals, and external partners to the agency that enhances the state's ability to reach patients, caregivers, and institutions that will be significant in the state's attempt to decrease the burden of asthma. The progress is expected to continue through cooperative agreement with the CDC and beyond.

***Implementation of the Laboratory Information Management System (StarLIMS)***

StarLIMS (*Laboratory Information Management System*) went live for the entire state allowing all health units and a large number of STD clinics to log in tests for samples remotely to sent to the lab with a barcode instead of a lab slip. In addition, this allowed all results to be securely viewed online for each submitter. In addition, the reports could be faxed which sped up the turnaround time for reporting. StarLIMS currently allows all health units to order Syphilis, HIV, CT/GC, Hepatitis A, B and C panels, TB Sputum, and clinical chemistry tests online. StarLIMS also tracks and reports for the Influenza assay. This system significantly reduced the time required to order labs and the turnaround time for results. Clients served by programs utilizing the lab benefit by receiving their results in a timely fashion and reducing the risk for unnecessary tests and/or medications. The Centers for Disease Control Emergency Preparedness Grant funds were utilized to develop the system and staff worked closely with clinic staff to train them and implement the program.

***Environmental Epidemiology & Toxicology***

At the request of the Governor, the Louisiana Department of Health & Hospitals, Office of Public Health, Section of Environmental Epidemiology and Toxicology (SEET) is conducting an investigation into suspected Chinese drywall that has been placed in newly built or renovated homes since 2002. In March 2009, SEET initiated a multi-state collaboration between several federal agencies including the Consumer Product Safety Commission (CPSC), the Environmental Protection Agency (EPA) and the Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry (CDC/ATSDR). In June 2009, SEET collaborated with health professionals from CDC/ATSDR to release an imported drywall guide for healthcare providers to educate and assist physicians in the treatment of patients presenting symptoms related to sulfur gas exposures. The guide was mailed to all Louisiana residents in SEET's survey database (433 households at release date of August 4, 2009), who were encouraged to share the guide with their physician as part of their healthcare treatment.

In August 2009, SEET organized a state interagency workgroup to share information regarding foreign drywall as related to specific state agency duties. In March 2010, SEET joined with the Louisiana Department of Insurance and the Louisiana State

Licensing Board for Contractors to prepare a response requested by the Louisiana State Legislature to assess the nature and scope of health, insurance and safety of Chinese drywall building materials. As of July 30, 2010, SEET's Indoor Air Quality (IAQ) hotline has received 1,010 phone calls from Louisiana residents concerned about foreign drywall. A phone survey was administered to 532 Louisiana households, with responses compiled to document the types of health complaints and home conditions reported by people living in affected homes. SEET has analyzed the survey data compiled and has updated a summary report of this information, which is available on the SEET website.

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

None

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

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

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

It is the agency's priority to ensure that developing objectives and strategies would lead toward the fulfillment of the agency's mission and goals. In the plan, there are short-term and long-term goals in alignment with the Governor's Health Care Reform which have been linked to the ten Essential Public Health Services. The agency is seeing vast improvements.

- ♦ **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 agency's Center for Health Policy, Information and Promotion, Policy Planning and Evaluation Section serves as a leadership/resource arm that facilitates programs in a strategic planning process. The process encompasses planning sessions and strategic direction setting activities to ensure that no duplication of effort is present and to further ensure that objectives and strategies established complement each other in the fulfillment of the overall program goals. These strategic direction-setting activities are supported by DHH/OPH administration and are required for overall program efficiency and effectiveness.

**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?

**Improving performance on key public health imperatives including vital records, and food and water regulatory operations.**

The DHH Office of Public Health is concerned with the protection and promotion of the health of the community as a whole. It is more important than ever that we focus on improving our use of state and federal resources to strengthen performance on *public health imperatives* (e.g., safe food and water, vital records) in terms of quality and efficiency. Improvement of performance on public health imperatives will initially focus on three challenges:

**Quality improvement and efficiency of food safety and safe drinking water regulatory operations.** While Louisiana has historically maintained adequate performance in the basics of Sanitary Code enforcement, there is much room for improvement by implementing a systematic quality control program. Updating the Sanitary Code and improving enforcement statewide will result in clearer, more consistent guidelines for businesses and other stakeholders, and more robust protections of the public's health.

**Outdated and inefficient processes in Vital Records and Statistics.**

Louisiana Vital Records and Statistics currently operates using paper-based and often inefficient processes that compromise our ability to provide timely access to records and data for citizens and other stakeholders.

**Transparency of retail food establishment sanitation information.**

While Sanitation Services personnel perform 300-point inspections on nearly 64,000 retail food establishments on an annual basis, this information is not readily accessible by the public. Other states have shown that improvements in sanitary conditions can be driven by publicly posting (e.g., on the Internet) sanitary conditions in restaurants and other retail food establishments. According to the Centers for Disease Control and Prevention, about half of all reported food borne disease outbreaks are attributed to restaurants.

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

Public health will see greater improvements in vital records, and food and water regulatory operations including better performance outcomes. The agencies strategic plan will be updated to reflect this course of action for improvement.

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

The DHH OPH centers for Records and Statistics and Environmental Health Services (Food and Drug Control, Retail Food, Safe Drinking Water) and Center for Community Health (State laboratory) are mainly impacted.

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

Records and Statistics: Internal customers that will be affected are those program areas that rely on vital records data to develop policy and target strategies to improve health outcomes such as maternal and child health and injury research and prevention. External customers that will be affected include Louisiana residents and visitors, native Louisianans who now reside outside of the state, local registrars, hospitals, funeral homes,

medical certifiers, and clerks of courts.

Food Safety and Safe Drinking Water: Residents and visitors, large industry including retail food and public utilities.

5. How long has the problem or issue existed?

These problem unfortunately have existed for too long, but now have viable solutions that are being developed to bring about resolution to these problems.

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

Records and statistics has depended on an antiquated system to carry out vital operations for its customers across the following areas:

- **Birth Registration Process:**

- DOS-based Genesis EBC system

- 90% of hospitals transmit data via modem

- Main computer located in Metairie

- Hospitals send original birth certificate to Central Office

- All birth certificates require some type of data entry by Registry staff

- **Death Registration Process:**

- Manual registration process

- Funeral homes submit to Local Registrar

- Local Registrar submits to Central Office

Food and drug/safe drinking water have seen challenges in codes and standards, education, plan reviews, and transparency of retail food establishments sanitation information.

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

These problems will continue to have an impact on some of the most important aspects for individual's quality of life for safe food and drinking water. Residents will continue to have slow access to vital records that are needed for school registration, driving privileges, travel, etc.

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?

DHH solution will address all three of the identified challenges.

**Quality improvement and efficiency of food safety and safe drinking water regulatory operations** will be improved by addressing the following three areas:

- **Codes and standards:** Sections of the Code that are particularly problematic will be revised through a comprehensive and transparent process that includes all major stakeholders. In addition, the Code can be more uniformly applied by making memos of previous decisions or conclusions universally accessible by state and local enforcement officials through an OPH Web Portal.
- **Education:** Implement a focused internal and external education campaign using technology to reach priority audiences.
- **Peer review:** Conduct an objective analysis of plan reviews and food establishment inspections to assess quality and consistency, and develop interventions to address shortfalls. In addition, letters of intent to modify the code will be subject to more comprehensive peer review and stakeholder input.

**Outdated and inefficient processes in Vital Records and Statistics:** Industrial engineering experts will assess our current processes and design a preferred future state that will yield greater efficiency and improve performance on key indicators. The solution includes implementation of an electronic system called LEERS, starting with birth records.

**Transparency of retail food establishment sanitation information:** This includes online posting of sanitary conditions for restaurants and other retail food establishments.

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

This recommendation has been made previously, however additional funding to begin the reengineering was not available. Through state allocations and other in-kind resources, public health is developing and solution that will vastly improve the current problems identified

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?

**FY 11 Progress Benchmarks:**

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

5. Do corrective actions carry a cost?

No. If not, please explain.

The Legislature and in-kind resources have already been allocated for the development and implementation of LEERS.

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

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

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:
  - (Fax)
  - E-mail:

# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

**Department:** Department of Health and Hospitals  
09-330 Office of Mental Health (Central Office)

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Philips

**Agency Head:** Kathy Kliebert, Assistant Secretary

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

#### **Organization of the Office of Behavioral Health**

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

Planning of the Organization of the Office of Behavioral Health (OBH) was a significant accomplishment of the fiscal year, accomplished together with the Office of Addictive Disorders, under the guidance of an OBH Implementation Advisory Committee. Act 384 of the 2009 Regular Session of the Louisiana Legislature created an Implementation Advisory Committee and provided that it shall recommend to the Secretary of the Louisiana Department of Health and Hospitals (DHH) a specific plan for implementation of the consolidated administrative functions of the Office of Behavioral Health (OBH), merging the organizational functions of the formerly separate Office of Addictive Disorders and Office of Mental Health. The DHH Secretary presented a comprehensive implementation plan to the Joint Health and Welfare Committee in January, 2010, and OBH was initiated July 1, 2010.

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

The goal of this merger was to consolidate the administrative and planning functions of

the two agencies in order to create an integrated, comprehensive behavioral health care system better serving persons with mental illness, substance abuse, or both (co-occurring) disorders. It has been determined that as much as 50% of the clients of each agency need both mental health and addictive disorders services. Implementation of an integrated agency is in keeping with a national trend to merge the service delivery to better serve this population in need, and so they are not “shuttled” between agencies. Integration also enables OBH to maximize available state, federal and grant funding for the provision of behavioral health services and to improve the pursuit of best practices and maximize available professionals to provide services in accordance with their respective licensing statutes. Moreover, this integration reduces the barriers and burden to the now five Local Governing Entities (integrated human service authorities) which have already consolidated and integrated their mental health and addictive disorders services.

C. Who benefits and how?

All citizens of Louisiana benefit from this consolidation of mental health and addictive disorders services from an efficiency and cost savings standpoint. Those persons with mental illness and addictive disorders will benefit most directly from the quality of an integrated service delivery program.

Through this integrated service delivery approach, all persons with behavioral health service needs are welcomed through a “no wrong door” access point, which prevents individuals being “shuttled” between separate agencies or “falling through the cracks”. Treatment addresses the person as a whole, with both disorders viewed as primary, rather than as a person with a primary mental illness or primary addictive disorder. This is in keeping with national best treatment practices.

D. How was the accomplishment achieved?

The implementation committee created by the legislature was as a multi-stakeholder group representing a balance of professionals, providers, and advocates with interests in addictive and mental health services. The committee conducted its work through six implementation workgroups, each focusing on an aspect of organization and implementation: Infrastructure; Performance Measures and Outcomes; Access to Care; Licensing, Training, and Workforce Development; Funding Strategies; Local, State, and Federal Coordination. A total of 84 specific recommendations were formulated by the workgroups, many of which focused on strategies for the integration of the agencies and many others on implementation of best practices for behavioral health services. The Implementation Advisory Committee also developed a vision, mission, and guiding principles for the new Office of Behavioral Health and also recommended procedures and timelines for implementing this consolidation. It was recommended that the office be lead by one Assistant Secretary, one Medical Director, and three Deputy Directors, each of whom have authority over both mental health and addictive disorders services. An organizational framework along the lines of a functional matrix

was proposed. A first step recommended was to combine the agency budgets and human resources under one organization.

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

Yes. Merger and integration of the Office of Addictive Disorders and Office of Mental Health is Goal I of the Mental Health 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?

This accomplishment represents a best management practice by enabling an organization to provide integrated behavioral health services, which is a national evidenced-based practice.

### **Implementation of Consumer Peer Support Services**

- A. What was achieved?

Since 2008, Louisiana has systematically undertaken a comprehensive person-centered, recovery-focused training and education program targeted to individuals diagnosed with a mental health and/or substance abuse disorder. The purpose of the training program was to provide mental health/substance abuse consumers with the tools, skills and knowledge to support consumers in the community as they begin their recovery journey. These programs are referred to Wellness Recovery Action Plan and Peer Support Specialist.

The Peer Support Specialist program is a 72 hour, two week training which uses a curriculum as developed by Recovery Innovations who was contracted to provide services. Essentially, peer support is as the name implies it is peers (mental health consumers) supporting peers and in doing so incorporates the concepts of hope, mutuality and empowerment. As a result of receiving this nationally recognized trainings peers are employed in a variety of settings throughout Louisiana; including, intermediate care facilities, community mental health centers and mental health drop-in-centers. Day-to-day activities may include serving as bridge to services for clients new to the system of care, providing information on community resources and connecting to those resources, moderating support groups and working with peers in one-to-one private sessions. As it is always emphasized in training and employment, peers enhance the quality of services provided. Since 2008, OMH has hosted six Peer Support Specialists, successfully trained 105 and employed 53 in every region/district and authority. Peer services and peer employees have been funded through a variety of mechanisms including state general funds, and the federal mental health block grant. The last Peer Support training was held in February 2010 and additional trainings are scheduled for November 2010 and

February 2011. The training is an intensive two week learning experience that challenges peers to expand in ways never before asked or expected. Future initiatives to be accomplished by June 2011, for the Peer Support Specialist program will include the implementation of a state certification and testing program, a Peer Support/WRAP Conference, and a continuing education curriculum.

In conjunction with the Peer Support Specialist Program, the Office of Behavioral Health also has trained peers in Wellness Recovery Action Plan (WRAP). WRAP as developed by The Copeland Center is a person-centered recovery oriented plan of care that provides a structured process for peers to successfully map out their plan for wellness and recovery. It aids in the identification of triggers, early warning signs and crisis and is essentially a toolkit for life. The original training program was funded through a Person-Centered Planning Grant through the Center for Medicaid Services in 2008 and is currently in the no-cost extension phase to expire in September 2011. To date, 98 individuals have been trained and certified as WRAP Facilitators in the weeklong training which has been provided six times. WRAP Facilitators go on to lead an 8-12 week education class that teaches peers how to develop their own WRAP plans. The last training was held November 2010. As these programs enhance and support one another an emphasis has been placed on cross-training mental health consumers in Peer Support and WRAP. As a result, the majority of Peer Support Specialists conduct WRAP classes as part of their job duties. Although, the evidence on WRAP is primarily anecdotal due to its emphasis on voluntary participation it is estimated that over 300 WRAP plans have been created as a result of this program.

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

The incorporation of Peer Support and WRAP is significant in the overall system of care for a variety of reasons including the following:

- Peers are empowered to take personal responsibility for their own wellness and recovery and subsequently are able to self-advocate for services that will aid in the betterment of their basic needs and overall level of recovery. This process lessens dependence on an overburdened system of care and as a result cost savings are realized.
- Once successfully certified, peers are employed in a variety of capacities and setting. The majority of individuals, who have been employed, at one point dependent on the public system such as SSI/SSDI and now are fully self-sufficient and contributing to society.
- There is now the expectation that peers can successfully and with success complete intensive trainings as provided through the Office of Behavioral Health. Subsequently, peers are now challenged to expand beyond previous boundaries.

As Peer Support and WRAP trainings continue to be hosted throughout the state and

peers are now employed in a variety of settings more individuals are willing to self-identify and speak to the impact of having a mental health/substance abuse disorder. Thus, stigma of mental illness is reduced.

C. Who benefits and how?

Everyone can benefit as a result of the implementation of these programs. For example, the community benefits through the employment of peers who with an income will be able to buy services and products in their local area. Service providers and community mental health centers benefit because peers through the process of shared experience, mutuality and hope are able to encourage peers to talk about matters never before discussed. Thereby, enhancing the quality of services received. The Office of Behavioral Health/Department of Health and Hospitals benefits because individuals are now able to self-advocate for their needs thus shaping services provided. Lastly, the peers themselves benefit because they now have the tools and resources to take personal responsibility for their own wellness and recovery.

D. How was the accomplishment achieved?

The Peer Support Specialist training component was completed through the use of Mental Health Block Grant Dollars in the amount of \$150,000. Within the Peer Support training contract dollars are also set aside for continuing education and an annual conference to be held in late 2011. The actual employment of Peer Support Specialists is dependent on regions and funding mechanisms used include state general funds and mental health block grant. The WRAP training program was funded through a Center for Medicaid Services grant to expire in September 2011. Funding for WRAP training will be rolled over into the current Peer Support training contract.

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

Yes, because in a system of care driven by the recovery modality peers must be at the forefront of the conversation and must actively contribute and play a role in how those services are developed and implemented.

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

Yes, Peer Support is an emerging national best practice model that can easily be adapted to multiple venues and populations because it is based on the principle of shared experiences as peers support peers. Already, it is being incorporated into services for Veteran's Affairs to address Post-Traumatic Stress and Addictive Disorders which has a similar peer mentor program through the advent of 12 Steps.

### **Implementation of Community Mental Health Redesign**

#### A. What was achieved?

A convergence of factors within and outside of OMH (now OBH) required OMH to embark on a major redesign of its service delivery system. These factors included a change in the overall mission of the agency, decreasing budget due to shortfalls in SGFs supporting both hospital and community based care, a need to shift resources from hospital to community-based care, decreasing staff due to retirement and inability to hire new staff due to hiring freezes, demand for demonstrable outcomes, and an emphasis on application of evidence based or best practices. As a result of these factors OMH accomplished a complete re-design of the community mental health service delivery system in order to provide a more efficient and effective means of accessing service and to provide levels of service that are more in keeping with client's level of need, rather than a "one-size-fits-all" approach. This effort is in keeping with an Accountable Care Utilization Management approach and organizing services to be more recovery-oriented. OMH central office staff developed a model for the organization of community clinic-based services that was based on available research and an historical review of the most frequently delivered services by OMH clinics. This model involved an integrated system of care that utilized 3 core functional components: 1-An access to service process; 2-A medication management service; and 3-A Specialty Recovery Services component. The Access unit provides the single point of entry for the clinic-based services and involves the functions of screening/assessment and a determination of level of need that is used to determine the proper assignment of services to individuals. Crisis services are included as part of the available service packages for those persons who present with a level of need that is considered a psychiatric emergency. The medication management component allows individuals who only need medication monitoring to have their clinical status evaluated quickly and have their medications renewed without need for ongoing counseling or having to see a counselor before being able to get their medications. The individuals who would qualify for medication management only usually have a low level of need but need medication to maintain their level of community functioning and symptom management. Finally, the Specialty Recovery services component provides contemporary, evidenced based treatment services, such as Assertive Community Treatment, Supported Housing, Intensive Case Management, and Multi-systemic Family Therapy, for persons needing that level of need. Peer support services are also provided. Level of need is established through use of a standardized assessment instrument, the Level of Care Utilization System (LOCUS). In addition, the LOCUS total score and key domain scores are used to determine how quickly someone needs to be seen for evaluation and entry to treatment and also determines how frequently someone needs to be seen for ongoing treatment. The algorithm for this determination is part of the utilization management protocols that have been implemented by the community clinics. The model allows for ongoing assessment of an individual's needs and as their service need changes, the service level and package of services can also be

changed. For example, individuals who are receiving medication management only services may at some point display behaviors that indicate that some form of evidence based therapy may be needed. These individuals can be routed to the access service to determine their level of need and what types of specialty recovery services would be needed and for how long. These services would then be assigned and individuals would then not only continue receiving medication management services but would now receive additional therapeutic services. This effort to redesign and realign community services is being implemented in concert with a parallel initiative to provide opportunities to increase the numbers of individuals who can be discharged from intermediate care facilities and reduce the number of beds in these hospitals. This is in keeping with the OMH goal to reduce utilization of institutional care and to better develop community based care to maintain persons in need in their communities.

B. Why is this success significant?

This effort has been successful in streamlining and achieving a service delivery system that is more efficient given the needs of the service population and addresses the limited amount treatment resources that are available. Monitoring of the implementation has indicated that based on the implementation of these 3 components, clinics have reported increased staff productivity, increased efficiency of clinical process, and increased consumer satisfaction.

C. Who benefits and how?

All consumers statewide benefit from the improved service delivery system that is better organized to address individual level of service need. The agency benefits from the implementation of a more efficient service delivery that makes better use of the financial and staffing resources leading to increased access and increased productivity.

D. How was the accomplishment achieved?

OMH leadership made this initiative an agency priority and dedicated central office and community staff to plan and implement the re-design. The agency held weekly video conferences between central office staff and regional managers and their staff to provide education, guidance, and monitoring of the planning and implementation.

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

Yes. A major goal of the strategic plan is to increase access to community based services and to divert persons from more intensive hospital-based services.

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

Yes. This approach demonstrates an effective transformation and realignment of resources and services in keeping with more efficient and contemporary community-based service delivery utilizing a utilization management approach.

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

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

*The Goals of the OMH Strategic Plan are to:*

1. Consolidate and integrate administrative functions of OMH and OAD into an effective and efficient Office of Behavioral Health
2. Reduce reliance on expensive inpatient psychiatric hospitalization while concurrently increasing the availability and access to contemporary community-based care and hospital diversion services
3. Increase preventative, treatment, and support services available to children, youth, and families, especially young children who have traditionally been underserved
4. Continuously improve the quality, effectiveness, and public accountability of services provided through ongoing utilization management, performance improvement, and outcome monitoring that will result in data-based decision-making with respect to the financing and delivery of services

Some of the outstanding accomplishments pertaining to these goals this past fiscal year are listed above. OMH's great strides towards the goals of its Strategic Plan was indicated by meeting the targeted level of outcome/ performance on 84% (16) of the 19 LAPAS key performance indicators set and monitored.

The OMH Strategic Plan goals were accomplished through the objectives and strategies in each of the three major program areas: Administration and Support, Community Based Treatment Services, and Hospital Based and Community Based Services and in each of the three major service area of the state; i.e., Area A (south-east); B (south-central); and C (north). (Note: Each state Area has also submitted an AMPAR for their respective hospital and community based programs).

The FY09-10 OMH Administration and Support objective was to improve client behavioral health outcomes throughout the state as indicated by client's positive ratings of the access, quality, and outcome of care received. This was accomplished through the following strategies: Implement comprehensive, integrated, person-centered and evidenced based services throughout the state; Provide a competent treatment workforce

through provision of workforce development activities and standards of care; Implement and monitor service performance/accountability measures and corrective action plans for improved service quality and outcomes. LAPAS indicators indicated that OMH successfully met the annual targets.

The FY09-10 OMH Community-based Treatment objective was to increase the ratio of community to hospital public funds; increase number of persons served in community-based settings, and increase access to prevention and early intervention for children ages. This was accomplished by implementing the following strategies: Increase funding for contemporary, evidenced-based community treatment services by re-alignment of the service dollars; Implement services to divert clients from hospital care and maintain them in their community (e.g., crisis programs; assertive and evidenced –based treatment services); Operate/expand Early Childhood Supports and Services statewide (ECSS for children ages 0 – 5).

OMH made good progress on the above objectives as indicated by approaching the targets for the Annual percentage of total state mental health agency expenditures allocated to community based services as compared to the Annual percentage of total state mental health agency expenditures allocated to inpatient services. OMH successfully achieved the anticipated community utilization rate per 1000 population and the targeted Number of youth receiving early childhood mental health services (through ECSS).

The FY09-10 Community Based Treatment objectives for each service Area A, B, and C was to increase the community service penetration rate (increasing towards a targeted community utilization rate) and to reduce reliance on hospitalization with provision of local crisis services (decreasing to a targeted hospital utilization rate) with rates in keeping with national standards. The objectives for Hospital Based Treatment for each service Areas were to improve behavioral health outcomes of intermediate inpatient care and to insure that the targeted number of discharge-ready patients are identified and have community living plans developed at the time of discharge.

The objectives for Community Based Treatment were accomplished through the following strategies: 1. Re-design community-based care by implementing improved access-to-care processes, establishing evidenced based specialty services (e.g., Assertive Community Treatment; Intensive Case Management; improved Housing and support options), and by augmenting the regional crisis response systems; 2. Increase resources for community-based service programs to serve more persons in their community and reduce reliance on more expensive hospital-level care.

The objectives for Hospital-based Treatment were accomplished through the following strategies: 1. Augment the hospital discharge planning process through implementing improved policies and procedures and a statewide continuity-of-care process utilizing integrated teams of hospital and community clinical and support staff; 2. Implement a standard discharge readiness and community living needs assessment process and a community living plan document to facilitate effective discharge planning and continuity

of care; 3. Improve outcomes of intermediate care through implementation of contemporary best practices and standards of care (e.g., The Joint Commission); 4. Investigate the feasibility of privatization of intermediate civil and forensic inpatient services.

OMH made significant progress on these objectives as indicated by the percentage of adults discharged from a state hospital and readmitted within 30 days of discharge (statewide); The Number of discharge-ready patients identified and with community living plans developed; the Community utilization rate per 1000 population; and the State hospital utilization rate per 1000 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?

As indicated above, OMH, in coordination with its sister agency the Office of Addictive Disorders, and through the guidance of the Implementation Advisory committee made outstanding progress in planning and organizing the merger of the two offices into the Office of Behavioral Health. This effort was facilitated by the two agencies previously participating together in the five-year federal Co-Occurring State Incentive Grant (COSIG) which enabled the two agencies to together focus on the needs of persons with dual diagnoses of mental illness and substance abuse. The grant helped the agencies to focus on the benefits of integrated screening/ assessment and treatment and the use of evidenced based treatment for persons dually diagnosed. Whereas this effort laid an important foundation for the merger, it was the concerted effort of the staff of both agencies and stakeholders participating in the workgroups that contributed to the successful implementation planning. Implementation progress is expected to continue at an accelerated pace under the new leadership of the Office of Behavioral Health.

The agency has also progressed in advancing the provider workforce and making services more person and consumer centered through the implementation of Peer Support Services. This was accomplished by setting this program as a priority of the agency and allocating a significant amount of the federal block grant dollars to implement the program. The leadership of the Director of the Office of Client Affairs, working closely with field managers and consumers, provided the guidance to a successful implementation of the program statewide.

Finally, great progress was made in transforming the community mental health service delivery system into an efficient, contemporary system of care based on accountable care principles through the Community Mental Health Re-design initiative. This progress was facilitated by the work of previous years in progressively establishing utilization management principles in community care through an effective working partnership of regional and central office staff.

- ♦ **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 primary issue that exists in the continued implementation and expansion of the Peer Support Specialist program is the long term sustainability of the Peer Specialist positions as they are primarily funded through contracts/state general funds which are vulnerable to budget cuts. A suggested corrective action is the conversion of Peer Support Specialist positions to Medicaid Reimbursable services. Guidelines for Medicaid Reimbursable Peer Support was detailed in a 2007 letter from the Center of Medicaid Services to State Medicaid Directors and today 25 states have Medicaid reimbursable peer services. As a result of the conversion, these valuable and innovative services would become self-sustaining.

Additionally, there is a need to develop and standardize Peer Support Specialist positions in terms of pay and expectations through the State of Louisiana permanent

classification system. Currently, the majorities of positions are allocated through contracts and are thus subject to fluctuations and potential reductions. As a state classified employee, Peers would receive leave and benefits entitled to all employees and would be recognized as a viable employment opportunity.

In terms of the WRAP program, the major operational barrier is the incorporation of WRAP in overall treatment planning. Although WRAP is a voluntary program, clinicians could suggest that those they serve actively seek out and enroll in a WRAP education program. In doing so, clinicians and other front line staff would need to receive information which would present an overview of the WRAP program and how is beneficial to a patient's wellness and recovery.

Within the general realm of service delivery, fiscal and workforce constraints have created a situation where there is demand for services beyond what the system is able to supply, despite the agencies best efforts to re-design the system. The per-capita expenditure for services remains well below the national average despite exceptional efforts on the part of stakeholders to provide more sufficient funding levels for mental health programs. Efforts to ease the fiscal needs of the system require a continuously adapting and flexible workforce. Although certainly not yet widespread, and in itself an area of need, the implementation of evidence-based practice provides a framework for the future and a direction for the training of healthcare providers.

A major concern continues to be the challenge of recruiting and maintaining a provider workforce that is skilled in contemporary mental health service delivery in sufficient numbers to meet the service demand. Budget adjustments over the past few years have significantly impacted the available workforce. Many seasoned mental health clinicians are retiring and there remain few resources for ongoing staff development. The need for community-based services far outstrips the current available workforce, both public and private.

However, it is noteworthy that OMH has begun to intensify efforts in this area, including provision of training in evidenced based practices and extending the workforce by incorporating peer support specialists and using technology such as tele-psychiatry and implementing web-based learning management system operating statewide.

Additional steps are being taken to increase access to qualified prescribers in the community mental health system, such as Medical Psychologists (MPs) and Nurse Practitioners (NPs) who can prescribe psychotropic medications, to ease the burden on the limited number of psychiatrists who are available in the state, particularly in the more rural areas that have found it difficult if not impossible to recruit and retain these medical specialists.

A continuing challenge has also been the coordination and integration of service delivery into a seamless, consumer/family-centered plan of care across agencies.

There is a need for the continued implementation of more contemporary services such as Assertive Community Treatment (ACT) for adults and Multi-systemic Treatment (MST) for Adolescents. Establishing an effective, statewide crisis response system continues to pose a challenge, especially addressing the increased number of persons presenting with mental health needs in emergency rooms around the state. Service delivery for forensically involved consumers continues to be a challenge as the agency tries to meet the demands of the justice system. And although there have been significant strides made in the implementation of a continuum of care for children and youth that is based on best-practices and evidence-based programs, the population of child/youth with serious emotional/behavioral disorder remains substantially underserved. OMH capacity to serve this population is seriously under-funded and inadequate to meet the continually growing mental health and substance abuse needs.

Finally, as the state is making a transition to integrated local human service districts, serving persons with mental illness, substance abuse, and developmental disabilities, the Office continues to be challenged to re-organize and assume a new role as a policy and standards setting, monitoring and technical assistance entity, moving away from the traditional direct mental health service delivery role. Implementation of the Office of Behavioral Health will greatly benefit this transition. This past fiscal year, OMH began re-organizing the central office operations to be in keeping with contemporary service delivery needs. During this transition period of a mixed OMH region and human service delivery system of Local Governing Entities (LGEs), OMH continues to be challenged to execute its role, responsibility, and authority as the State Mental Health Authority while also supporting efforts of the successful statewide transition to LGEs. This issue is being addressed as a goal within the framework of DHH Implementation and Accountability Plan for local districts, and through the coordinating efforts of the state Human Services Interagency Council.

♦ **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?

OMH was not revised or updated the Strategic Plan this past year given that imminent merger of OMH and Office of Addictive Disorders into Office of Behavioral Health, which will require the a new Strategic Plan for OBH.

However, the Implementation Advisory Committee did identify the OBH strategic plan vision, mission, and guiding principles for the new office as follows:

**VISION:** The Office of Behavioral Health ensures care and support that improves

quality of life for those who are impacted by behavioral health challenges.

**MISSION:** The mission of the Office of Behavioral Health is to promote recovery and resiliency through services and supports in the community that are preventive, accessible, comprehensive and dynamic.

**GUIDING PRINCIPLES:**

- We can and will make a difference in the lives of children and adults in the state of Louisiana.
- People recover from both mental illness and addiction when given the proper care and a supportive environment.
- The services of the system will respond to the needs of individuals, families and communities, including culturally and linguistically diverse services.
- Individuals, families and communities will be welcomed into the system of services and supports with a “no wrong door” approach.
- We respect the dignity of individuals, families, communities and the workforce that serves them.
- Through a cooperative spirit of partnerships and collaborations, the needs of individuals, families and communities will be met by a workforce that is ethical, competent and committed to the welfare of the people it serves.
- We will utilize the unique skills of professionals with appropriate competencies, credentials and certifications.
- Mental illness and addiction are health care issues and must be seamlessly integrated into a comprehensive physical and behavioral health care system that includes primary care settings.
- Many people we serve suffer from both mental illness and addiction. As we provide care, we must understand, identify and treat both illnesses as primary conditions.
- The system of care will be easily accessible and comprehensive and will fully integrate a continuum of prevention and treatment services to all age groups. It will be designed to be evidence-based, responsive to changing needs, and built on a foundation of continuous quality improvement.
- We will measure our results to demonstrate both improved outcomes for the people we serve and fiscal responsibility to our funders.

- We will prioritize de-stigmatizing historical biases and prejudices against those with mental illness and substance use disorders, and those who provide services, through efforts to increase access to treatment. We will do this by reducing financial barriers, addressing provider bias, integrating care and increasing the willingness and ability of individuals to seek and receive treatment.
- ♦ **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 OMH Strategic Plan process is managed through the OMH Division of Planning, Information Management, and Performance Accountability, which has been the central office entity responsible for overall office planning and monitoring efforts, both strategic and operational, and including oversight of the regional and hospital processes. This effort is complimented by the Divisions of Policy, Standards, and Quality Assurance, and the Division of Research, Evaluation, and Fiscal Integrity. These Divisions operate in a functional matrix to plan, organize, implement, monitor, and evaluate programs and services statewide.

The Bureau of Strategic Planning and Grants Development is responsible for support of the State Mental Health Planning Council of state stakeholders and the federal Block Grant for Community Services Development Plan for comprehensive mental health system development. These stakeholders provide ongoing input into planning, resource allocation, and priority setting.

Division staff provides ongoing technical assistance, consultation, training, and oversight in the development and use of the Office strategic planning.

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

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

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

**A. Problem/Issue Description – Outdated Pharmacy System**

1. What is the nature of the problem or issue? The regional outpatient pharmacies were operating with an outdated pharmacy software package which had been retro-fitted to meet their needs 15 years prior. The OBH team gathered to determine a process for addressing current and future software needs as well as the data requirements to continue current and anticipated reporting levels. The team negotiated a standard contract for regional implementation with the single software vendor; identified the regional software and hardware needs for a successful implementation; and scheduled the implementation timelines to accommodate specific regional needs.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) This problem is associated with Goal 4 of the Strategic Plan, which addresses data based decision making, in that the pharmacy data are critical to operations of the office.
3. What organizational unit in the department is experiencing the problem or issue? Six existing outpatient regional pharmacies and 2 newly Board of Pharmacy licensed facilities serving secure forensic populations.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) The outdated pharmacy software couldn't accommodate current reporting needs mandated by the Louisiana Board of Pharmacy.
5. How long has the problem or issue existed? The existing software had been in use over 15 years.
6. What are the causes of the problem or issue? How do you know? Although the software addressed the needs 15 years ago, changes in technology and pharmacy regulations over time required adaptations which were no longer supported by the existing vendor. Pharmacy operations changed over the last 15 years as a result of federal and state laws & emphasis on patient health and safety.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? The existing software did not comply with the electronic record keeping and prescription monitoring requirements published by the LA Board of Pharmacy. The existing vendor no longer supported the product. Software updates were necessary to comply with existing LA mandates and to avoid sanctions.

**B. Corrective Actions**

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

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

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

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

No. If not, please explain.

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

Please discuss the following:

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

**A. Problem/Issue Description – Slow Processing of Contracts**

1. What is the nature of the problem or issue? The significant time required to get a contract approved hinders the provision of services.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) This problem interferes with our ability to provide services effectively and efficiently. In some cases, as with grants, the grant is nearly over before the

contract is approved.

3. What organizational unit in the department is experiencing the problem or issue?  
OBH contracts division as well as DHH contracts division.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) Customers and providers are affected by the delay in contract approval.
5. How long has the problem or issue existed? Unknown
6. What are the causes of the problem or issue? How do you know? In the OBH contracts division, there are too few staff members to complete the work in a timely manner. The same problem probably exists in the DHH contracts division.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? We will continue to wait months for approval of contracts to providers who would otherwise be able to provide services.

#### B. Corrective Actions

6. 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.

7. What corrective actions do you recommend to alleviate or resolve the problem or issue? Evaluation the flow, paperwork, and authorizations required in the process, and identify means of streamlining it, including adding automation, where possible. Review how the LGEs have streamlined their contracting process. Change DHH contract policy and procedures where indicated.
8. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? No
9. Are corrective actions underway? No
  - 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?
10. 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?

It is recommended that an efficiency consultant be contracted with to analyze the current system and make recommendations for improvements.

#### **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 2009-2010

**Department:** Department of Health and Hospitals  
09-330 Office of Mental Health (Area A)

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Philips

**Agency Head:** Kathy Kliebert, Assistant Secretary

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

#### **Southeast Louisiana Hospital (SELH) Item 1**

- A. What was achieved? Completed consolidation of New Orleans Adolescent Hospital and Southeast Louisiana Hospital.
- B. Why is this success significant? The consolidation of these two programs allowed for the closure of a costly, outdated, and oversized facility in New Orleans while using previously unused spaces at the Southeast Louisiana Hospital Facility. This allowed for a savings of approximately \$9.1 million by allowing for more efficient use of limited resources. This move also allowed for a greater investment in community resources for youth in the New Orleans area.
- C. Who benefits and how? Taxpayers of Louisiana as well as individuals utilizing mental health services and their families by maximizing the use of available resources to operate more efficiently.
- D. How was the accomplishment achieved? Through careful analysis and planning this consolidation, and the related savings, were able to be accomplished without any reduction in services.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, this action allowed for a reduction in operating costs with no reduction in services on the inpatient side while actually allowing for increased investment in outpatient services at the same time.

- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes, in the sense that an alternative plan for delivering the same services was devised which also resulted in a more efficient use of resources.

### **SELH Item 2**

- A. What was achieved? Repairs to hospital plumbing and HVAC systems.
- B. Why is this success significant? These repairs have resulted in several hundred thousand dollars in savings that will continue to be realized in coming years.
- C. Who benefits and how? Taxpayers of Louisiana as well as individuals who require mental health treatment. These repairs allowed for a reduction in operating expense. The funds that would have otherwise been required to operate the facility at the same level of services were able to be reduced from the operating budget without a reduction in services.
- D. How was the accomplishment achieved? Investments made to replace an antiquated boiler and to repair several underground leaks across the campus have resulted in several hundred thousand dollars in savings in utilities and chemical additives.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, this investment in repairs allowed us to operate more efficiently and reduce expenses.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes, although these improvements required initial investments which could have been deferred due to their cost, it was in the agency's interest to identify funding to make the repairs as the ongoing savings would quickly repay the initial investment.

### **Region 3 Item 1**

- A. What was achieved? DHH Region 3 very successfully met all requirements of the Readiness Assessment to be designated as the South Central Louisiana Human Services Authority beginning July 1, 2010.
- B. Why is this success significant? Three agencies previously under separate state leadership merged together to work in concert to achieve the necessary criteria for the formation of the authority. This action has brought all agencies to better understand the services of each agency and to offer more seamless referral for services and to jointly work toward achievement of successful discharges for persons leaving long term hospitalization and those seeking services with complex behavioral health needs.
- C. Who benefits and how? Joint meetings and planning sessions for all staff have created better insight to all programmatic issues and services. Each agency has worked closer with the other agency to eliminate barriers to services for the clients to have more timely access and better coordination of needed services. The resources of the agencies now are seen as a sum total rather than resources for each agency.
- D. How was the accomplishment achieved? Involvement of all staff, especially the leadership of the existing agencies along with the advocacy and leadership of the executive director and the program manager, being assigned projects and following through with goals to

achieve the readiness criteria.

- 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?  
Legislation has been passed for the enactment of other human services authorities throughout the state.

**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.

1. The Office of Mental Health has identified the following priorities for FY 09-10:

- a) Serving youth, adults and families affected by serious mental health and co-occurring disorders with Best Practices and Evidence Based Practices;
- b) Improving access to care through an integrated health care system;
- c) Reducing stigma
- d) Using Utilization Management to ensure people receive the right care;
- e) Increasing Cultural and Linguistic Competency;
- f) Competency in coordinating care for high end users;
- g) Ensuring the use of valid and reliable data in decision making;
- h) Provision of training, skills assessment, retraining, monitoring and outcome/quality measures;
- i) Manualization of Practices; and
- j) Focusing on Prevention and Early Intervention

- ♦ **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? In addition to the above priorities, the Office of Mental Health began a Mental Health Redesign project which included reducing the number

inpatient beds in the system while expanding community resources. SELH has been involved in this process throughout and participates in weekly meetings to monitor the progress.

- ♦ **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: Refocusing efforts on discharging planning has allowed for our successful participation in the Mental Health Redesign project.

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

This progress can be attributed to the Office’s commitment to seeing the plans outlined in the Mental Health Redesign project accomplished and to the commitment of leadership to facilitate this endeavor

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? This improvement should be sustainable and allow for resources to be placed where they are most needed. Efforts to discharge clients to the least restrictive setting will always be one of the key aspects of treatment planning at SELH.

- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state “None.” However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each: The increasing regularity of court ordered youth in DHH custody are significantly affecting the programming of youth services units at SELH. Clients who are court ordered without recognizable or treatable mental health conditions are draining resources which should be devoted to youth who require mental health treatment.

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

The scarcity of services to serve these types of clients statewide leave few options for the courts.

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? Unless units or programs are developed specifically to deal with this population this problem will continue to grow.

- ♦ **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?

OMH was not revised or updated the Strategic Plan this past year given that imminent merger of OMH and Office of Addictive Disorders into Office of Behavioral Health, which will require the a new Strategic Plan for OBH.

However, the Implementation Advisory Committee did identify the OBH strategic plan vision, mission, and guiding principles for the new office.

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

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

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

#### **SELH Item 1**

##### A. Problem/Issue Description

1. What is the nature of the problem or issue? Staffing - Staffing, particularly nursing and psychiatry, continues to be a challenge.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) Constant struggles for adequate staffing consume considerable energy and resources.
3. What organizational unit in the department is experiencing the problem or issue? Nursing services and medical services primarily
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) Clients served can be impacted if staffing is inadequate. Staffing has not remained adequate but the energy expended to maintain staffing could be otherwise directed to program improvements etc.
5. How long has the problem or issue existed? Staffing issues are problematic in healthcare organizations nationwide. Locally, these were most acute following

Hurricane Katrina and have alleviated somewhat during the recent economic downturn as less competition exists for employees currently.

6. What are the causes of the problem or issue? How do you know? A lack of trained and available applicants. Compensation structure of Civil Service can be an obstacle as well as the State's financial predicament.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Continuity of patient care is impacted by staff shortages. Overtime and agency staffing is more costly than core staffing

#### 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? Compensation structures should continue to be evaluated to ensure that trained professional staff can be recruited.
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? Yes, current financial climate makes pay level increases difficult.
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. This would depend upon the strategy chosen to solve the problem
- b. How much has been expended so far? N/A

- 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? Not in the current budget, but improvements in the current year may result in savings in following years.
- 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. Would depend upon strategy chosen
  - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests? N/A

#### 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:

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# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

**Department:** Department of Health and Hospitals  
09-330 Office of Mental Health (Area B)

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Kathy Kliebert, Assistant Secretary

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

#### **East Louisiana Mental Health System (ELMS):**

1. ELMHS maintained Joint Commission accreditation, CMS certification, and State licensure on 635 licensed inpatient adult intermediate, acute, and forensic mental health beds, 16 ICF-MR residential beds, 10 OCS girls residential beds, 44 chairs for PHP partial hospitalization day program children/adolescents, and provided outpatient/aftercare forensic services.
  - a. ELMHS maintained Joint Commission accreditation, CMS certification, and State licensing, which represents all major accomplishments. In November 2009, full CMS survey was conducted on certified units and ELMHS passed upon addressing deficiencies.
  - b. This is significant because it shows we are meeting so many national standards and requires us to: monitor performance and progress, meet state and licensing standards, meet CMS standards, meet life safety and Risk Management standards, comply with best practices and good management on state and national issues, institute performance improvement projects and collect data to ensure feasibility and efficiency, be compliant with patient safety goals, and meet stringent Environment of Care standards.
  - c. Patients, Staff, Public, Risk Management, Budget, and Families all benefit. Accreditation and constant review of performance activities ensures we strive for a clean, safe, secure, quality environment. It also ensures that we conduct planning and budgeting to provide for the physical plant and

- clinical services.
- d. Continuous evaluation of required standards, updating budgets to ensure proper staffing, proper funding of programs, and continuous performance improvement helped us to achieve results. Met all standards required by the Joint Commission, CMS, and licensing.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan because the Standards require us to meet various chapter requirements such as leadership, fiscal management, human resources, meeting the needs of consumers, ensuring quality patient care, security and continuous improvement in a safe environment.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies. The standards that are set forth by the Joint Commission and CMS are based on best practices. Meeting those standards is a requirement of all State Inpatient Psychiatric hospitals and should be shared with clinics and community services.
2. ELMHS provided Acute, Intermediate, Forensic, Community, and Outpatient services to the Mentally ill throughout the State.
- a. ELMHS served 2,048 patients in the inpatient setting for the past fiscal year. In addition, ELMHS provided services for 84 outpatient clients (2800 visits) through the Forensic Aftercare in New Orleans, diverted 42 patients in the jail and community from entering into the Forensic system, tracked 312 conditionally released forensic patients, operated three ICF-MR community group homes, and operated a 10 bed OCS girls residential group home.
  - b. The number is significant because it shows the flow through the System and the need for all aspects of Mental Health Services. ELMHS continues to work with Community Services to discharge into appropriate community transitional and community homes. Efforts were placed on reducing the forensic waiting list and providing more services in outpatient settings.
  - c. Patients, Staff, Public, and Families needing mental health treatment are benefited by the ability to admit patients that are waiting for services.
  - d. Accomplishments were achieved through a more expedient return to jails based on clinical readiness, Louisiana Act 648b which requires civil commitment hearings in a timely manner, a push by clinical staff on fast track/competency restoration units to restore clients to competency, and through extensive work by District Forensic Staff.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan, because the needs of consumers are met.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies as it expedites services to Mental Health clients.

3. ELMHS eliminated admission to Civil Intermediate Care beds in the Hospital while still introducing strategies to comply with a Federal summons for the reduction in the forensic competency waiting list.
  - a. In February of 2010, ELMHS halted admissions to the civil intermediate care beds and began temporarily holding acute care bed admissions in order to reduce inpatient Mental Health services as outlined in the Redesign plan. In addition, preparations were made to admit patients off the Forensic competency restoration waiting list in anticipation of a ruling from the Federal summons to appear before the Federal Judge in the Eastern District U.S. Court.
  - b. The significance of these actions was to reduce the number of inpatient civil beds in the State, with emphasis placed on outpatient services.
  - c. The benefit of these actions was for patients that are capable of receiving treatment in an outpatient setting.
  - d. These actions were achieved by reducing and/or halting admissions, except where mandated by the need of Forensically involved patients and other emergent needs.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies. Yes.

#### **REGION 4:**

1. Region IV maintained and further developed several substantial mental health social service contracts.
  - a. Contracted services included adult Intensive Case Management, Consumer Care Resources, Supported Independent Living, Day Treatment, and Assertive Community Treatment, as well as a Child and Adolescent Response Team. Region IV's Assertive Community Treatment team achieved a score of 3.96 out of 5 on the Dartmouth ACT Fidelity Scale.
  - b. Continued operation and development of Region IV's contracted mental health services is highly significant in light of the ongoing state hospital closures and client discharges. Through its contractors, Region IV is able to provide clients with the necessary supports and services to achieve and maintain productive community-based living. The contract programs further enhance Continuity of Care. Although Assertive Community Treatment is not currently Medicaid-billable in the State of Louisiana, fidelity to the ACT model will be required when it is. Region IV's 3.96 score demonstrates high fidelity to the model.
  - c. The primary beneficiaries of Region IV's mental health contract programs are Region IV clients and their families. Benefits include increased satisfaction and success in community living and decreased hospitalization rates, incarceration

- rates, and out-of-school/home placements.
  - d. State General Funds and Block Grant Funds.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
2. Region IV maintained a contracted Crisis Intervention Team (CIT) program with the St. Martin Parish Sheriff's Department.
- a. Continued operation of an innovative first-responder model of police-based crisis intervention for incidents involving persons with mental health issues.
  - b. The success of the CIT program was significant in opening communication and promoting cooperation between multiple agencies involved in the handling and treatment of psychiatric clients.
  - c. All persons involved with law enforcement as a result of mental health crisis benefit from the CIT program. Benefits include, where appropriate, diversion from arrest of psychiatric clients.
  - d. State General Funds and collaboration with the St. Martin Parish Sheriff's Department.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
3. Region IV continues to work to identify all clients with Medicare benefits and assist them in obtaining the program appropriate to their medical needs (for example, Medicare Part D).
- a. Region IV continues to screen clients for Medicare benefits, new clients at the time of admission and existing clients at the time of the annual review of financial status or as any change is reported by the client. As per state policy, clients with Medicare are required to complete an Extra Help Application to determine eligibility for extra help, or low income subsidy.
  - b. Region IV's identification of all clients with Medicare benefits has helped to decrease Region IV's use of OMH funds for purchase of medications.
  - c. Region IV's efforts to identify all clients with Medicare benefits assisted them in becoming eligible for varying degrees of subsidy and possible additional benefits.
  - d. Region IV was able to assist clients with Medicare benefits through training on Medicare Part D, which was provided to Region IV staff.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.

4. Region IV identified a Continuity of Care team to coordinate with state hospitals providing intermediate care to transfer long-term patients from the hospitals into the community.
  - a. Region IV successfully reintegrated 3 patients into the community between Jan 1 - June 30.
  - b. The OMH Redesign plan calls for transferring resources and patients from inpatient services to wrap-around services within the community. This is not only less costly but more sensitive to the recovery needs of the affected individuals.
  - c. The patients benefit by becoming part of the community and enhancing their recovery. The state benefits by providing more cost effective treatment options.
  - d. By creating a well coordinated regional COC team and working closely with the hospital COC team as well as utilizing our Intensive Case Management contract and our Assertive Community Treatment team contract. The presence of Peaceful Village, a transitional housing program (contract) also greatly enhanced the success of this initiative.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
  
5. Region IV continues to implement direct care productivity expectations and to measure productivity in all Centers.
  - a. All direct care staff have productivity expectations included in their Performance, Planning and Review and supervisors monitor compliance.
  - b. This increases time spent in direct care with clients, provides more effective treatment for larger numbers of clients, ultimately providing more responsible management of public fiscal resources.
  - c. Clients receive more frequent routine care, alleviating symptoms and facilitating more rapid recovery, as well as improved chance of preventing relapse. This ultimately allows more clients to be discharged from our system, making room for treatment of additional clients.
  - d. Productivity expectations were included in PPRs and by utilizing Centralized Scheduling, SPQM, Microsoft Outlook, and other relevant data sources.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
  
6. Region IV established Wellness Clinics for appropriate clients within all 5 of the region's mental health centers.
  - a. Wellness Clinics provide care to clients who are stable in their recovery yet require periodic checks and medication management.
  - b. Moving appropriate clients into Wellness Clinics increases staff time for

accepting new clients or serving existing clients with greater psychotherapy needs than those in Wellness Clinics.

- c. Stable clients benefit by having an appropriate level of care that is not available elsewhere in the community. Other clients benefits by greater staff availability.
  - d. By utilizing medical and nursing staff and scheduling specific Wellness Clinic days. Criteria for transfer to Wellness Clinic are determined using the client's current LOCUS level of care.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
7. Region IV establishment of Access Unit/Function in all 5 of the region's mental health centers.
- a. The number of clients admitted to Region IV clinics, who meet routine admission criteria according to the LOCUS, has been increased, while maintaining service to all urgent and emergent clients.
  - b. Establishment of Access functions has resulted in fewer barriers to entering treatment, has decreased wait times, and has improved the percentage of clients in our target population who receive mental health services.
  - c. Clients benefit from quicker alleviation of symptoms, quicker resolution of treatment issues, which also statistically decreases the percentage and severity of relapse.
  - d. By bundling scheduled slots for first-time client appointments, each clinic has been able to determine whether all of the allotted time will be utilized. Upon determination that scheduled slots will not be utilized, client slots have been backfilled from the wait list, shortening the wait list/wait time.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
8. Region IV continues to maintain pharmacy cost savings measures through non-budgetary sources: the Patient Assistance Program (PAP) and dispensing of samples and vouchers.
- a. Region IV has experienced significant pharmacy cost savings through the continuation of the Patient Assistance Program, samples, vouchers, and dispensing medication.
  - b. Region IV implementation of the Patient Assistance, samples, and voucher programs have resulted in significant savings, thereby allowing us to meet the needs of a greater number of clients served.
  - c. Implementation of pharmacy cost savings through Pharmacy Assistance, samples, and voucher programs benefits the Clients, their family members, and the Community at large.
  - d. Region IV experienced a pharmacy cost savings through Patient Assistance

Program, samples, and vouchers by making PAP a priority as well as employing PAP Specialists either through job appointment or contracts as well as a concerted effort by the entire treatment team to educate and assist the clients in obtaining medication through the alternative sources.

- e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies..
9. The Acadiana Area Human Services District (AAHSD) Board has been approved and seated.
- a. The AAHSD Board has met monthly since January. They have elected permanent officers, attended governance training, and written policies.
  - b. This brings the AAHSD closer to submitting a letter of intent to hire an Executive Director and enter the next phase of readiness to become a fully functional LGE.
  - c. Citizens of Region IV benefit by moving toward increased autonomy and local authority.
  - d. The Board members have been dedicated to the task and worked diligently at meetings and between meetings.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
10. Region IV Acute Unit enhanced recovery oriented services.
- a. UMC Psychiatric Unit has added group topics which provide patient education on illness recognition, medication, and treatment compliance. Patients are referred to VOA or Addictive Disorders Clinics to aid in transitioning back into the community. Psychiatric Aides and Recreational Therapists are provided with cross training to become actively involved in patient care.
  - b. These actions contribute to improved recovery and increased reintegration into the community.
  - c. The patients served by the Acute Unit and citizens of Region IV.
  - d. Through an increased training and utilization of community resources.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies..

**REGION 5:**

1. Increased number of persons served using Evidenced-based Therapies/best practices throughout the Region.
  - a. Evidenced-based therapies implemented in Region 5 include Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), and Interpersonal Psychotherapy (IPT). Other evidence-based practices implemented in Region 5 include LOCUS/CALOCUS (Level of Care Utilization System for adult and child) measurement instruments, and Bio-feedback therapy.
  - b. Provide best outcomes for mental health clients.
  - c. Mental health clients benefit, as they can be treated effectively and appropriately by competent clinicians who are offering a greater array of evidence-based treatment services.
  - d. Clinicians trained and certification received or in process in DBT, CBT, IPT, LOCUS/ CALOCUS, and Bio-feedback.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
  
2. Continued implementation of Cornerstone Utilization Management Plan.
  - a. Implementation of additional UM Goals, including: centralized scheduling throughout the region; centralized regional Access Unit providing telephonic and walk-in screening services and assessment services, which increased access by 30%; implementation of Medical Management Clinic services with nearly 80% show rate; 10% increase in show-rate with 24-hr appointment reminder calls; implementation of SPQM process for further implementing data-based decision-making in the UM process; increased hours of operation with periodic Saturday clinics.
  - b. Improved access to care by 30%, efficiency, and effectiveness of mental health service delivery, utilization and motivation of staff, costs, and client outcomes.
  - c. Mental Health clients, staff, and system benefit from improved operations.
  - d. Regional UM Team meets one time per week to discuss, strategize, plan, implement, and monitor UM Goals.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
  
3. Movement toward Electronic Behavioral Health Record.

- a. Improved efficiency and accuracy in documentation and record keeping for clinic and contracted services.
  - b. Helps to improve time management and increase productivity.
  - c. Staff, clients, and system.
  - d. Implementation and monitoring of use of newly developed UM forms within OMH-IIS Electronic Data System, including Screening Form, Assessment Form, and Progress Note.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
4. Community Partnership implementation of Bristol-Myer Squibb Program Grant to provide treatment and support services for women with depression.
- a. OBH/MH and AD, NAMI, and Family And Youth Counseling Agency, Inc. continue in a community partnership to provide Southwest Louisiana women suffering from depression during and after pregnancy with treatment and tools needed to regain their lives.
  - b. The Bristol-Myer Squibb program provides MH services for women and mothers who may not be eligible for CMHC services and this should benefit their children. Lake Charles Mental Health Peer Support Specialists (PSS) are involved by administering the Beck Depression Scale (BDS) Short Form at the Region 5 Office of Public Health Women, Infant and Children (WIC) clinic on those women who score positive on the SBIRT and provide CMHC or WRAP group referrals for those who screen positive on the BDS. The PSS in partnership with NAMI SWLA also facilitate Women and Depression Support Groups utilizing the Wellness Recovery Action Plan (WRAP).
  - c. Women and Children in the community as a whole.
  - d. Grant awarded from Bristol-Myer Squibb Foundation and community partnership.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
5. Collaborated with Office of Juvenile Justice Services (OJJS) to develop a “one stop shop” resource center for families. This resource center is similar to the Neighborhood Place concept.
- a. In Spring 2010, the Next Step Academy II (NSA II) as well as the Evening Reporting Center (ERC) became operational. NSA II is an alternative school site for youth that have been unsuccessful in both their home school and the parish alternative school. Youth that are enrolled in the ERC participate in this program from 3:00pm until 8:00pm. During this time they complete homework, and participate in study skills and recreational activities. Transportation is provided by OJJS to bring the youth home in the evening. The Multi Agency Resource

Center (MARC) building is currently undergoing its final phases of construction and is expected to fully open in early 2011.

- b. The NSA II program is successful in keeping youth enrolled in school that might otherwise have been suspended or expelled. The ERC has been successful as an alternative to youth spending time in juvenile detention.
  - c. These programs are designed to benefit youth of Calcasieu parish that have some level of involvement with the OJJS.
  - d. This project is partially funded through a grant from the MacArthur Foundation. The development of the program is with the collaboration of state and non-profit agencies as well as local law enforcement. The core team continues to meet on a regular basis for implementation purposes. Members of the team have gone on site visits to tour other resource centers in the state.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
6. Implemented a regional Crisis Response Partnership (CRP) to address crisis needs of people in Region 5.
- a. The Crisis Response Partnership launched a community wide commitment to crisis response within Region 5. The Partnership (CRP) includes representatives from public and private sector behavioral health providers, mental health advocates, law enforcement, school systems, faith based entities, and governmental entities. CRP implemented an Interagency Service Coordination process for adults with serious and persistent mental illness who are served by multiple agencies yet not progressing in recovery. CRP is sponsoring the first Behavioral Health Resource Fair for professionals and consumers in Region 5.
  - b. Communities working together to address a common problem will aid individuals in behavioral health crisis in getting better and more timely services, reduce the impact on human and fiscal resources for service providers, and foster inter-agency and inter-disciplinary service coordination.
  - c. Individuals and family members of individuals in behavioral health crisis benefit from receipt of appropriate and timely crisis response. Behavioral health providers, emergency response personnel, etc. benefit from this partnership through increased coordination with other agencies and entities. Communities benefit from this partnership through decreased incidents of unresolved crises and inadequate crisis response.
  - d. Legislative Act 447 called for the development of a community crisis response plan. Representatives from Region 5 Offices of Mental Health, Addictive Disorders and Citizens with Developmental Disabilities developed a Core Team with a primary goal of engaging community stakeholders in the development of a partnership to address crisis response. The Crisis Response Partnership has a comprehensive plan to address behavioral health crises, and the team is moving forward with implementation of a variety of programs and coordination of services.

- e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
7. Utilization of Peer Support Services (PSS) in the community.
- a. Six peer support specialists offer Peer Support Services for the CMHC clients and partner with community providers to offer support groups and Wellness Recovery Action Plan (WRAP) to mental health clients and to the general mental health community. Two new PSS staff persons received the 3-week Peer Employment Training (PET) certification course and the one-week WRAP course. Also, one PSS became a one of 2 state-wide certified train the trainers in the WRAP program and another PSS was named one of two persons in the state to become a train – the-trainer for the Peer Employment Training certification program.
  - b. Peer Support Specialists are able to educate other providers and peers about the concept of recovery. They provide services at the three CMHCs, the W.O. Moss Acute Psychiatric Care Unit, Lake Charles Memorial Hospital, Martin De Porres Nursing Home, Volunteers of America of Southwest Louisiana, Lake Charles Addictive Disorders Clinic, NAMI SWLA, and NAMI Maison des Amis apartments.
  - c. The community is able to benefit from Peer Support Services.
  - d. Partnership with the various community agencies.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.
8. Partnered with DOC and State Intermediate Care (IC) Hospitals to facilitate re-entry of persons from institutional care into the community.
- a. Implemented process for assessing and facilitating a person's re-entry into the community from DOC or intermediate MH care facility.
  - b. Reducing the number of persons served in 24-hour facilities will reduce costs and improve individuals' self-sufficiency and quality of life.
  - c. The individual, the state, and the community benefit from persons living more independently in their community.
  - d. DOC, OBH/MH and AD, OCDD, DHH and VOA all partner to develop the process and to facilitate re-entry into the community. The local receiving team meets weekly and individuals visited the hospitals to complete patient interviews and assessments to assist persons' re-entry into the community.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.

9. Continued to implement permanent supportive housing (PSH) program, using the Housing Supports and Services best practice model, in Regions IV and V, also working to house persons being discharged from IC Facilities.
- a. Working to fill 309 units of subsidized housing with supports for disabled people with low and very low incomes, and persons who are homeless or affected by the hurricanes of 2005.
  - b. This is significant because of the housing shortage and the number of people with little or no income due to the downturn in the economy. It also allows people with disabilities who may have never had a home to receive supports to learn to live independently and become productive members of society.
  - c. People in Regions IV and V with a variety of disabilities who have low or very low incomes who may be homeless or affected by the hurricanes and who are in need of permanent supportive housing.
  - d. With funding from CDBG, technical assistance from TAC, federal housing subsidies, and cooperation of DHH, OCD, and local lead agencies. These agencies are also working to sustain the program through Medicaid funding.
  - e. Yes, this accomplishment does contribute to the success of our strategic plan.
  - f. Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies.

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

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

Area B has continued to adjust the priorities to implement parts of the Strategic plan and has continued to provide necessary services to patients and clients.

- ♦ **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:

Area B has demonstrated progress in improving operational efficiency directed toward performance improvement.

- ♦ **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:

One of Area B’s biggest issues has been recruitment and retention of professional clinical staff. Not only are professional clinical staff hard to locate and recruit, but the recruitment and retention issue has been in part due to the redesign process and the uncertainty of stable employment.

- ♦ **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?

Area B, both regions and hospital, are currently reviewing their goals and objectives and updating their strategic plans. The Region’s Plan is part of the OBH/MH Community Redesign plan to offer more outpatient opportunities to clients. The Hospital’s Plan is based on improved inpatient quality of care based on best practices and remains stable as described below. The economic environment and redesign has limited funds and staff, but quality of care has not diminished. Both the Regions and the Hospital must creatively initiate new management strategies to deal with shortfalls.

- ♦ **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.

Area B ensures the operations of the Regions and the Hospital are in conjunction with the Strategic Plan through continuous oversight by the Office of Behavioral Health/Mental Health.

For Area B, Region 4 and Region 5 are part of the Community operations for the continued treatment of the mentally ill. OBH/MH Redesign plans for community placement opportunities for our clients is an ongoing and active initiative in the state. The provision of efficient and effective treatment depends on the resources available to the Community programs and the management of budget dollars and staff. Strategic planning is an on-going activity in providing good care.

Currently the ELMHS strategic plan includes items such as 1. A system of quality care that responds to the changing needs of the community; increasing patient beds in both the Forensic and Acute settings; developing training programs 2. Provide a therapeutic atmosphere for safe quality care; decreasing complaints, compliance with National Patient safety goals, decreasing seclusion and restraints, better treatment planning 3. Provide an organizational environment that is conducive to retention and recruitment of quality staff 4. Provide resource management for efficient and effective treatment of the mentally ill; Budget, EOC, HR and Management of Information. We are currently on track with the plan – making significant progress in areas that do not require additional budget dollars and or recruitment of professional staff that are in extreme shortage categories. Lack of progress can be attributed to issues pertaining to upgrading equipment, raising salaries for recruitment along with capital outlay and major repairs. Strategic planning is on-going to ensure we are a progressive and prepared organization. We discuss in our System Executive Board and update as need through Quality Management. The provision of efficient and effective treatment of the numbers served depends on the resources available and the management of budget dollars and staff. Strategic planning is an on-going activity in providing good care.

**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?**

- a. Adequate TO positions continues to create issues of quantity and quality care, access to care, inefficiencies in clinical operations, etc. for the provision of minimal inpatient coverage and for sufficient clinical outpatient program staff; for the community and regional programs, and

for the hospital operations.

- b. Infrastructure issues in the community/regions and at the hospital create ongoing issues for the staff and those served; e.g., age of facilities, air and heating issues, size/space issues, etc. One major accomplishment during FY10 was the start of a capital outlay HVAC project for the 88 bed forensic unit ITU, and the project will be completed in October 2010 during FY11.
- c. The decrease in civil beds due to an increased demand for forensic beds has been an ongoing problem.
- d. Ability to recruit professional clinical staff such as nurses, social workers, psychologists, and psychiatrists.
- e. Forensic waiting list, compliance with new laws pertaining to the waiting list, and civil commitments.
- f. Ability to expeditiously admit patients to Acute beds.
- g. Ability to step down Forensic patients to Civil Intermediate beds.

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

- a. With the waiting list, we are constantly recommending more community placement opportunities for discharges to ensure more movement in the system and thus a decrease in the waiting list at an economical rate. The new laws will also affect the waiting list and the insufficient placement opportunities. Part of the Strategic plan is to develop a better therapeutic environment that is more energy efficient, allows for better staff utilization and conducive to the recovery of the patient – this is difficult without capital dollars.
- b. Having accommodated these problems/issues for so long, strategic planning efforts are directed toward developing goals, objectives and timeframes which can reasonably be accomplished despite the problems/issues. Over time, this approach has resulted in an organization that in general has accepted constraints and limited growth/innovation. The strategic plan is to develop a better therapeutic environment that is more energy efficient, allows for better staff utilization, and conducive to the recovery of the patient; but we need capital dollars.
- c. With the forensic waiting list, we are constantly recommending more community placement opportunities for discharges to ensure more movement in the system and thus a decrease in the waiting list at an economical rate. The new laws will also affect the waiting list and the insufficient placement opportunities.

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

The problems are experienced by Area B as a whole. Both the outpatient services and the inpatient programs face challenging times.

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

The issues outlined create problems of access and limitations on quality of care, negatively impacting those in need of services; including courts, prisons, hospital emergency rooms, families, patients, outpatient programs, inpatient programs, etc.

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

The problems have been ongoing; to the systems credit, they have for the most part adapted to the problems to provide care to as many individuals as could be served despite the limitations; both in the regions and in the hospital.

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

- a. The restrictions placed by budgets and state guidelines have caused difficulty in recruiting clinical positions. Both Region staff and Hospital staff have adapted and are able to work within the constraints to provide services to meet the needs of our patients/clients.
- b. We are constantly working on the waiting list issues – problems include insufficient staff to divert patients, lack of diversion placement community resources, various personalities of courts and judges, lack of community placements or secure transition placements. The new law Act 861 648b may create revolving door for patients and initially decrease list but eventually rise to current level.
- c. The struggles of old buildings and infrastructures are ongoing issues.

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

- a. The consequences of not resolving these issues are that the organization continues to have difficulty maintaining clinical operations, providing quality care, training/maintaining/recruiting staff, which directly impacts the outcomes for those served. Over the past few years, operational/clinical attention has increasingly become more and more crisis oriented due to many of these issues, which will continue to require functioning in a crisis mode. These crisis services are often at a higher cost and do not alleviate or prevent the increasing need for inpatient care.
- b. The increased waiting list and the potential for lawsuits delays treatment for those in the jails.
- c. Aging buildings causes increased expenditures for maintaining patient care services.

**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?**

Create more placement opportunities in the community, more in-jail treatment, more District Forensic Coordinators to track and divert patients, and provide more education of Courts.

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

Yes, governing body and budget recommendations/request.

4. **Are corrective actions underway?**

a. If so:

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

Yes, through agency requests to OBH/OMH and DHH.

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?

Due to budget adjustments, we have been unable to correct all issues. If budget was available, problems could be corrected within 2 years through new programs, which would create positive data.

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.

Yes, for current budget request, items to address the above issues include – new programs, \$5.2 million annually and a new facility at \$180 million.

b. **How much has been expended so far?** None

c. **Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?** No

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. **See above**
- Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests? Yes

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

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

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

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

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

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

Area B provided the following primary reports, in addition to any additional requested reports: quarterly TQM reports, monthly financial reports and human resource reports, annual financial and budget reports, hospital governing body reports, Joint Commission PPR reports, and other in-house reports as requested by OBH/MH/DHH/DOA.

**Contact person for more information:**

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# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

**Department:** Department of Health and Hospitals  
09-330 Office of Mental Health (Area C)

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Kathy Kliebert, Assistant Secretary

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

A. What was achieved?

#### **Central Louisiana State Hospital:**

- (1) We continue to plan for a new hospital which was included in the Capital Outlay Budget in Fiscal Year 2007-2008. We have been working with Facility Planning as well as with the assigned architect firm of Barron, Heinberg & Brocato. There have been numerous meetings with Barron, Heinberg & Brocato and a final meeting for bid documents. The anticipated ground breaking is early 2011. The new hospital will accommodate up to 92 beds and will have the capability to serve both adults and/or adolescents.
- (2) The Joint Commission granted Central Louisiana State Hospital an accreditation decision of Accredited for all services surveyed under the Comprehensive Accreditation Manual for Hospitals. This accreditation cycle became effective beginning December 4, 2009 and is customarily valid for up to 39 months. Also, as a result of the July 15, 2010 Medicare survey by the Louisiana Department of Health and Hospitals, Central Louisiana State Hospital was found in compliance with all the applicable hospital Medicare requirements based upon accreditation by The Joint Commission.

**Region 6:**

- (1) **CRISIS INTERVENTION TEAM (CIT) FOR JUVENILES: National Participation as Presenters by CIT Program to the first annual International Conference on CIT.** Continued participation in the advanced training for CIT Law Enforcement Officers in the region on **Juvenile Mental Health Issues.**
- (2) **SUPPORTED EMPLOYMENT:** Employment Development contract program was established as a contract that provided resources for the development of Peer Support staff as well as WRAP Facilitator Training. This Program allows for the training of these staff to provide experience and support while learning to utilize developing skills. The program also supports persons who have a mental illness in seeking positions for competitive employment.
- (3) **WORKFORCE DEVELOPMENT AND IMPLEMENTATION OF EVIDENCED BASED PRACTICE:** Provided a number of trainings in order for OMH staff to provide Dialectical Behavior Therapy. Also provided were trainings to refresh and encourage staff to utilize Cognitive Behavior Therapy to person with whom they work. Contracted programs were updated to enhance and promote the use of Evidenced Based Practices within the social services contracts.
- (4) **IMPROVEMENT OF COMMUNITY SYSTEM OF CARE FOR PEOPLE WITH PSYCHIATRIC IMPAIRMENTS:** 1) Participation with Ninth Judicial District Court Staff in MacArthur Foundation activities to promote coordination between community agencies 2) Facilitation of the Crisis System Planning Coalition 3) Participated with the Christus Cabrini Strategic Community Health Planning for Central Louisiana.
- (5) **CONTINUED DEVELOPMENT OF COMMUNITY BASED CRISIS RESPONSE SYSTEM:** Actively participated with multi-agency and community coalition on the development of a Crisis System Description and Business Plan. The plan has been supported by the Rapides Foundation.
- (6) **COMPLETE RE-DESIGN OF THE DELIVERY SYSTEM OF CARE FOR THE REGION 6 COMMUNITY SERVICES CLINIC PROGRAMS:** The re-design included the development of 3 separate clinic functions as follows: Access to Care Clinic, Recovery Clinic, and Wellness Clinics (Medication Management Clinic).
- (7) **IMPROVED ACCESS TO CARE:** After implementation of the Access to Care Clinic within the Region 6 Community Services program a decrease in the wait time for access to outpatient services was realized as evidenced by a wait time of 3-4 months to a wait time of 2 weeks for first appointments.
- (8) **IMPLEMENTATION OF A CENTRALIZED ACCESS TO CARE CLINIC:** A centralized access to care clinic that utilized a singular phone access number was initiated with the Region 6 Community services program.

- (9) **IMPLEMENTATION OF WELLNESS CLINICS:** Wellness Clinics offer specialized services to those person who have chronic mental illness who have stabilized their psychiatric symptoms and are in need of medication to maintain wellness. The clients served do not require specialized therapy to remediate acute psychiatric symptoms.
- (10) **IMPLEMENTATION OF RECOVERY CLINICS:** Recovery Clinics offer intensive clinic treatment that includes medication education, pharmacotherapy, individual therapy, DBT, CBT, Casemanagement, supportive housing, Peer Support, and FFT.
- (11) **IMPROVED UTILIZATION MANAGEMENT AND USE OF EVIDENCED BASED PRACTICE:** Continued implementation of the use of the LOCUS assessment tool for all admissions to adult programs was implemented. Initiation of the TOMS as an outcome measure for the Region VI.
- (12) **DEVELOPMENT OF RECOVERY AND RESILLIENCY PHILOSOPHY:** Advancement in the WRAP and Peer Support with up to 6 consumers employed to provide support to clients in Welcoming Centers for each of the new Clinic programs. The WRAP/Peer Support Staff developed informational brochures to be utilized within each of these new Clinic options including Access to Care Clinic, Recovery Clinic, and Wellness Clinic.
- (13) **INCREASED USE OF EVIDENCED BASED PRACTICE IN CLINICAL MILIEU:** Implementation by clinical staff process region-wide for **Dialectical Behavior Therapy Services, Cognitive Behavioral Therapy, and Functional Family Therapy.**
- (14) **SUCCESSFUL RISK MANAGEMENT AUDIT SURVEY**
- (15) **SUCCESSFUL INITIATION OF A HUMAN SERVICE DISTRICT BOARD** with the selection of the Board Members by each of the Parish Police Jury's in the region.
- (16) **REDESIGN OF REGION VI CONTRACTED SERVICES:** Region VI contracted services were examined and improved to include Evidenced Based Practices and improve contract Statements of Work to better define outcome measures for the expected program benefits.

### **Region 7:**

- (1) **Mental Health Redesign** – In an effort to meet the state's timelines for achieving implementation of the Mental Health Redesign (Access Units, Wellness Clinics and Recovery Center services) by July 1, 2010, Region VII conducted a system analysis of staffing resources, existing infrastructure, existing system challenges and gaps. The achievement was a fully developed implementation plan and intensive training for all staff on the design elements and full implementation of the Redesign by the target date of July 1, 2010.

- (2) Continued Promotion of a Mental Health Recovery Environment –
  - A. Region VII continued to implement Recovery Strategic Plan which included conducting weekly Recovery Chats that all staff participated in to promote the Recovery Philosophy
  - B. Peer Services provided direct support, advocacy, and educational services on a broader basis in our service system through the Wellness Clinics throughout the region. This was found to be a more effective venue for service provision than had been used before. Peer Specialists were responsible for conducting TOMS assessments. Peer Specialists served in crisis support, housing and resource center programs. All Peer Specialists employed in the clinics and by contract completed an online course in Advanced Peer Practices to enhance personal development, further develop recovery coaching skills, and deliver a wide range of advanced peer services.
  - C. The Wellness Recovery Action Plan classes were taught in clinics and community facilities around the region to mental health and addictive disorder clientele. In addition to eight regular facilitators, we have an Advanced Level facilitator who is certified to train people to teach WRAP classes.
- (3) Continued work to becoming Co-occurring Treatment Capable – The region developed a monitoring tool for our strategic plan (based on the DDCAT) which we monitor every six months: alternating with internal monitoring and interagency monitoring.
- (4) Workforce Development
  - A. The Region developed a systematic training process for incoming direct care staff that it provided by current staff in their areas of expertise.
  - B. Certified trainer for Applied Suicide Intervention Skills Training provided 5 trainings during the course of the fiscal year to 122 participants.
  - C. Regionally sponsored trainings on clinical documentation/performance improvement (progress notes, treatment planning, crisis assessments)
    - 1. In August 2009, all adult providers attended a LOCUS refresher and participated in inter-rater reliability testing.
    - 2. In November 2009, staff received refresher training CALOCUS refreshers and participated in inter-reliability testing. Adult providers participated in Gambling Addiction training.
    - 3. In February 2010, staff received training on documentation (i.e. concurrent documentation, progress notes, treatment planning and practiced these techniques.) Additionally, during this time, 40 staff received training on Rational Emotive Behavioral Therapy.
    - 4. In May 2010, all direct care staff within the Region were provided with trainings on Medication Education and Diagnoses specific to either children/adolescents or adults.

- D. Implemented DBT – Sept 2009. – Approx 30 clients completing at least one (8 week) Module - 5 Clinical Staff attended Parts I – III training.
- E. 2 Staff became Crisis Prevention Supportive Intervention (CPSI) certified trainers.
- (5) Patient Assistance Program - Overall savings from Patient assistance rose to \$1,511,013 in FY10. The outcome was a 97% utilization of Patient Assistance for all medication dispensed making the region number one in the state for SGF pharmacy savings.
- (6) Implementation of TOMS (Telesage Outcome Measurement System). TOMS is a client self assessment is taken a few times a year to assess treatment progress towards recovery.
- (7) Community Partnerships - Development of community referral resource in Natchitoches: Natchitoches Outpatient Medical Center (FQHC)
- Trained their 3 physicians in psychiatric diagnosis, medication management, reviewed referral procedures
  - Physicians increased in confidence in treating psychiatric illness and more likely to take MHC step-down referrals
  - July 09 – Sept 09
- (8) Continued focus on Performance Improvement / Quality Assurance
- A. Developed / Implemented Weekly Program Manager Audits covering Clinical / Operational areas
- B. Active use of SPQM resources to review monthly data and identify areas for continuous performance improvement.

### **Region 8:**

- (1) Region VIII MH began using the new Performance Planning and Review process which required all supervisors to be trained. In conjunction with this effort, it was decided that all plans would be reviewed by Regional Director for consistency and adherence to the guidelines with a common requirement for rating attendance.
- (2) Increased doctor coverage by usage of tele-medicine.
- (3) All clinical staff trained in Cognitive Behavioral Therapy
- (4) Telesage Outcome Measurement System (TOMS) was implemented.
- (5) Risk Assessment Training and Increased Awareness with all clinical staff (added to orientation checklist and to the initial assessment).

- (6) Successful safety audit.
- (7) Region VIII MH implemented a redesign of clinic services that included the development of an Access Unit, Medication Management Clinics and Specialty Clinics.
- (8) New lab monitoring guidelines were implemented.
- (9) All staff trained in Crisis Prevention Supportive Intervention (CPSI).
- (10) Region VIII has conducted 6 Wellness Recovery Action Plan (WRAP) groups with 20 participants graduating.
- (11) Region VIII has Peer Support Specialist that has been chosen by the Copeland Foundation to be PSS Trainers.

B. Why is this success significant?

**Central Louisiana State Hospital:**

- (1) Our physical structure is outdated and not ADA compliant. Building a new up-to-date hospital will assure that we are in compliance with all existing standards in that Maintenance demands on the new hospital would be minimal.
- (2) The accreditation of these two organizations assures our hospital receives the funding necessary to continuously provide safe, high-quality care, treatment, and services.

**Region 6:**

- (1) **CIT FOR JUVENILES:** Advances the respect and dignity of Junvenile's in acute behavioral crisis. Enhances Law Enforcement knowledge and skills while dealing with the families and the Juvenile who become involved with Law Enforcement while having a behavioral health crisis. **National Recognition** brings not only Louisiana to the forefront in the advancement of Streamlined and respectful treatment of those persons who have behavioral health issues. The Activity also benefits those who have a mental illness by decreases stigma and increasing support while **diverting them from jails, detention facilities, and court systems.**
- (2) **SUPPORTED EMPLOYMENT:** Peer Support and WRAP are activities that enhance a person's ability to improve their satisfaction and functioning in their daily lives. In order to teach these skills it is necessary for Peers to provide hope by actively role modeling to their peers methods for overcoming the challenges of having a behavioral health illness.

The program also facilitates the gainful employment as a means for health and recovery from mental illness.

- (3) **WORKFORCE DEVELOPMENT AND IMPLEMENTATION OF EVIDENCED BASED PRACTICE:** Evidenced based practices are practices that have associated scientific support as methods of treatment that are proven to successfully remediate problems that result as a product of having a behavioral health issue. Behaviors that result from behavioral health disorders cause increased legal involvement, crime rates, violent acting out, family problems, school problems, work problems, and other social dysfunction.
- (4) **IMPROVEMENT OF COMMUNITY SYSTEM OF CARE FOR PEOPLE WITH PSYCHIATRIC IMPAIRMENTS:** The System of Care for Behavioral Health provides for the Access and facilitation of Care for persons with Behavioral Health issues to access treatment options in a way that remediates and decreased the impact of related behaviors to that consumer and to the community system as a whole. Without adequate and streamlined access to care for emergency services as well as non-emergent health conditions, persons with behavioral health disorders struggle with finding appropriate treatment and providers that meet their needs at the level of care that matches their needs. One specific area of need targeted in the Region VI area is the Access to treatment/Care for persons with a behavioral health crisis/emergency.
- (5) **CONTINUED DEVELOPMENT OF COMMUNITY BASED CRISIS RESPONSE SYSTEM:** The crisis response system provides the Access to care for those persons most in need of immediate service delivery. Without a streamlined, efficient, and coordinated effort a person in crisis spends many hours, even days in an effort to receive much needed services. And as such, the access system is disjointed, in that persons who are in crisis do not have a centralized and defined system of evaluation and referral. Each agency has individualized and various protocols and processes for managing behavioral health crises. The uncoordinated system gives rise to increase costs to the community and ultimately does not serve the person in crisis well.
- (6) **COMPLETE RE-DESIGN OF THE DELIVERY SYSTEM OF CARE FOR THE REGION 6 COMMUNITY SERVICES CLINIC PROGRAMS:** The re-design of the delivery of care implemented a Utilization Management Plan to increase productivity and streamline the delivery of services to those persons being served in the Region 6 Community Services Programs. The Re-design resulted in increased staff productivity as well as a significant decrease in wait times for initial appointments being requested by a consumer. Therefore, service provision has been delivered to the individuals in needs in a more timely fashion. The re-design also allowed a framework for clinic services to function within a managed care environment.
- (7) **IMPROVED ACCESS TO CARE:** As a part of the re-design process, Access to Care Clinics were established. In the Access Clinic, individual wait time for Psychiatric Assessment and evaluation decreased from approximately 3 month period to a 2 week period. Emergency outpatient clinic appointments, as well as urgent appointments were

built in to the Access Clinic system as available for the same day or next day appointments. The prioritization of appointments according to urgency, builds a capacity of outpatient clinic services to treat persons in a crisis as an outpatient rather than result in an emergency hospitalization for the safety of an individual. The hospitalization is a more costly method of service delivery.

- (8) **IMPLEMENTATION OF A CENTRALIZED ACCESS TO CARE CLINIC:** Centralizing the Access to Clinic allowed for one phone number to be arranged for all callers interested in services at the Region 6 Community Services Offices. The result simplified the process for callers in that it reduced confusion on how and where to obtain support and services. The Centralized Process also reduced the number of staff hours dedicated to the evaluation of clients new to the system. The Centralized evaluation process allowed for improved specialty of Clinician training and skill development and reduced clinician bias.
- (9) **IMPLEMENTATION OF WELLNESS CLINICS:** Wellness clinics established an option for the provision of care that promoted focused service delivery eliminating the inefficiency of providing unnecessary high end services to those persons who were in need primarily of medication management for the management of their chronic illness. The establishment of Wellness Clinics also streamlined the time of Professionals in order to align discipline specific care and increase the time available to provide high end therapy to those who are more acutely ill.
- (10) **IMPLEMENTATION OF RECOVERY CLINICS:** The Recovery Clinics are designed to provide persons who are in acute distress from a behavioral health issue with intense therapeutic services that are focused to alleviate symptoms and expedite stability, healthy behavior, and functioning within the community. In quickly stabilizing persons acutely distressed, referral to less expensive high end service is accomplished with improved cost/ savings and improved consumer satisfaction.
- (11) **IMPROVED UTILIZATION MANAGEMENT AND USE OF EVIDENCED BASED PRACTICES:** Standardized assessments to measure the level of functioning (LOCUS) of clients facilitates the appropriate use of clinical resources to eliminate wasteful use of high end resources unnecessarily. Standardized Outcome Measures (TOMS) promotes the examination of the effectiveness of the resources and Practices Utilized for the intervention of the presenting behavioral concerns.
- (12) **DEVELOPMENT OF RECOVERY AND RESILLIENCY PHILOSOPHY:** Principles of Recovery and Resiliency promotes personal accountability and responsibility for the development of a plan of recovery for the challenges of someone with a behavioral health disorder. The plan promotes the growth and personal development of plans that are step wise in creating a lifestyle and living situation that are desired by the person in recovery. Reliance on peers who are successfully overcoming their own personal challenges as role models and examples of success are key in implementing and establishing this philosophy amongst consumers and professionals in Region 6.

- (13) **INCREASED USE OF EVIDENCED BASED PRACTICE IN CLINICAL MILIEU:** Use of Evidenced based practices results in improved clinical outcomes, reduces unnecessary staff time in ineffective interventions, improves client satisfaction by improving clinical outcomes, and reduces overall program costs by improving use of staff resource and reducing length of stay in high end treatment. Ultimately, effective intervention of behavioral health issues reduces overall expense to the community by promoting diversion from judicial system, law enforcement, and hospital emergency departments for behavioral health crisis intervention.
- (14) **SUCCESSFUL RISK MANAGEMENT AUDIT SURVEY:** Implementation of the necessary aspects of Risk Management assist Region 6 in providing a safe and therapeutic environment in which to operate our programs. The Audit also assist the Regional Administration in reducing the costs associated with injuries and insurance.
- (15) **SUCCESSFUL INITIATION OF A HUMAN SERVICE DISTRICT BOARD:** The development of a Human Service District would allow for a Region to gain local/regional input regarding financing and decisions for the area for which it would be accountable. The Regionalization of Management would promote local interest in the supports needed to provide for persons with behavioral health needs.
- (16) **RE-DESIGN OF REGION VI CONTRACTED SERVICES:** The re-design of Region 6 Contracted services was necessary to align the contracts with the newly designed processes and requirements of the Core Community Services Programs. The re-design of the programs allowed for the Regional Office to include and support the use of Evidenced Based Practices by other providers in the community. The Practices selected have support that indicate improved outcomes. Therefore, the re-design of contracts shall lead to improved utilization of funding by improved outcomes/ results of those contracted programs.

### **Region 7:**

- (1) Redesign of the service system allows for quicker access to care and service tracks designed to meet individual client need/choice. Redesign also allowed for optimal use of limited state personnel resources and staffing enhancements through the partnership with a community social service contract provider for clinic based services in three of the CMHC's in the region.
- (2) Continued training/programmatic enhancements and environmental enhancements focused on Recovery ensure agency progress toward meeting the agency's Vision/Mission.
- (3) With the expectation that our target population is at a greater risk for co-occurring disorders

- than the general population, need for developing the capacity for co-occurring treatment is essential to meet the needs of those we serve and meet the agency's Vision/Mission.
- (4) Training and implementation of clinical best practices is essential to ensure quality outcomes.
  - (5) Ensures access for eligible clients to available prescription programs and reduces the reliance on SGF resources
  - (6) TOMS allows for a treating clinician and doctor to see a clients progress over time. It also allows the organization to measure outcome data by clinic, region and statewide.
  - (7) Developing referral networks in the community assures client flow through the system which increases access to care.
  - (8) Monitoring ensures that the policies/procedures in place are meeting the system and clients needs. Reviewing data and performance measure allows for identification of opportunities to improve all processes.

**Region 8:**

- (1) Region VIII MH has never had a consistent, uniform method for rating attendance. This gives more credibility to the evaluation process.
- (2) Consumers were unable to see a physician in a timely fashion especially in the rural clinics. When we were able to secure a contract with Tulane for the Tele-medicine, time of doctors traveling from Monroe to the other clinics was saved. The Monroe MHC was able to increase doctor presence and the other clinics were able to increase the coverage.
- (3) All clinical staff being trained in an evidence-based treatment increases the potential for competency and quality of product.
- (4) Measuring the effectiveness of services enhances the system in that this is an important advancement in our performance improvement program. Obtaining direct feedback of progress and satisfaction from consumers has also been demonstrated to be a critical element of effective treatment, as well.
- (5) Risk is always an issue in behavioral health. Having periodic training and awareness to assessing for client risk enhances the ability of the clinical staff to make early interventions designed to preserve life and quality of life.

- (6) New guidelines and format were required which demanded extensive work involving the re-writing.
- (7) The clinic redesign provides for easier access to services and more appropriately tailored services to client need. Region VIII MH now has “open access” which means that people are able to be seen on a walk-in basis.
- (8) This development moved us farther along the path of excellence in that the clinic is now providing increased attention to medical issues generally. In light of mental health consumers dying some 25 years in advance of the general population, this serves as a way for early detection of other physical problems that may need to be addressed.
- (9) Limits the risk by increasing the ability of staff to manage mental health crises.
- (10) Indicates the progression of Peer Provided Services in the region.
- (11) Indicates the development of the PSS program in Region VIII and these trainers will be able to further the development in other regions as they train additional PSSs.

C. Who benefits and how?

**Central Louisiana State Hospital:**

- (1) Everyone benefits: the clients, OBH family, CLSH staff; and entire State of Louisiana charged with providing such continuing care to the clients, care which could not be accomplished without adequate facilities for clients and for the attending staff.
- (2) The patients and their families, OBH, CLSH staff, and the entire state of Louisiana who is charges with providing continuing care which could not be accomplished without the safe, high-quality care, treatment, and services we provide.

**Region 6:**

- (1) **CIT FOR JUVENILES:** Most importantly, Children and Youth benefit from the increased expertise of those persons who respond to their behavioral health needs. Also, families benefit by the increase level of support and understanding of those people who are assisting them in dealing with their loved ones. The Judicial System, jails, and law enforcement benefit as a result of the increased safety that is achieved, the reduction of the inappropriate incarceration of Children/Youth, and the reduction of rate of penetration of those youth into the Judicial/Court system.
- (2) **SUPPORTED EMPLOYMENT:** Primarily Consumers who have a significant behavioral health diagnosis and who have had difficulties sustaining or obtaining employment as a result of the symptoms of their illness. One of the benefits of gainful employment is improved

emotional health and feelings of accomplishment, achievement, success, and meaningful life experiences. Employment, therefore, supports wellness which is the object of the services the Region provides. Employment also empowers individuals to become self sufficient and self sustaining.

- (3) **WORKFORCE DEVELOPMENT AND IMPLEMENTATION OF EVIDENCED BASED PRACTICE:** Developing and enhancing the skills of direct service providers to provide Evidenced Based Practices encourages the use of effective interventions that expedite the recovery of those persons who are struggling with symptoms of their illness. In implementing the approaches to provision of care, the consumer benefits by the improvement of their overall condition and level of functioning/productivity within their community.
- (4) **IMPROVEMENT OF COMMUNITY SYSTEM OF CARE FOR PEOPLE WITH PSYCHIATRIC IMPAIRMENTS:** Everyone benefits from improved processes and streamlined access to behavioral health services within the Region. Improved access benefits consumers by providing services in a more timely manner, decreased use of emergency services are realized when ease of access to outpatient services is accomplished. Also, for the community are fiscal savings in various service systems including emergency departments, law enforcement agencies, and Judicial Courts.
- (5) **CONTINUED DEVELOPMENT OF COMMUNITY BASED CRISIS RESPONSE SYSTEM:** During this time of transition of Mental Health System Delivery as well as the events of the recent past it has become increasingly important to have a Crisis Response system that is supportive to those persons in a crisis. Since there are numerous agencies that provide services to persons in a behavioral health crisis, there is a heightened probability that coordination between the agencies can be compromised with any increase in the volume of referrals. This System again is important for everyone in the community (ie persons served, family members, neighbors, government and private health care providers).
- (6) **COMPLETE RE-DESIGN OF THE DELIVERY SYSTEM OF CARE FOR THE REGION 6 COMMUNITY SERVICES CLINIC PROGRAMS:** Most importantly, the persons being served by the system are most impacted by the improvement of the delivery of care. The system re-design was implemented utilizing the most current principals of utilization management for the outpatient mental health services. The principals were used to increase productive use of staff resources as well as contracted services to deliver the appropriate level of care while maximizing the use of staff time. The principals included the movement toward discipline specific care as well as the implementation of the use of Evidenced based practices for contracted and core service programs.
- (7) **IMPROVED ACCESS TO CARE:** Everyone benefits from the improvement in access for Mental Health services. Highest on the list of those benefiting are the consumers and families who are seeking service as they were able to obtain a first appointment within 2 weeks as opposed to 2-3 months. Also benefiting are law enforcement and emergency departments, as access to outpatient services is decreased, emergencies would decrease as a product of earlier intervention and support.

- (8) **IMPLEMENTATION OF A CENTRALIZED ACCESS TO CARE CLINIC:** The implementation of a one phone number contact for access to care promotes the ease of access for all persons who are seeking services in the Region 6, Community services program. The caller would not then have to call more than one place to receive an initial appointment. Also, fiscal savings are realized in a domino effect way as follows: The increase in the support staff ability to centralize work function arranged duties to allow increased ability of support staff to Clinical Staff needed clerical support (Thus, the clerical support allowing clinical staff to provide strictly clinical services and less clerical like duties).
- (9) **IMPLEMENTATION OF WELLNESS CLINICS:** Best serves the clients at the level of care suited to the identified need for wellness maintenance. Also, the implementation of wellness clinics maximized the discipline specific care that medical staff are trained to provide as well as allowed the other Clinical providers to admit those waiting for acute service delivery. Some clinical staff (LMHP) were then able to implement evidenced based mearsure such as use of the LOCUS, CBT, and DBT.
- (10) **IMPLEMENTATION OF RECOVERY CLINICS:** Although the recovery clinics were initiated, staff were being trained and encouraged to deliver several evidenced based practices. Plans last fiscal year were to develop and encourage the use of the new skills while adding and researching other upcoming best practices as part of the staff developent. Case load sized remain quite large as a result of the increase in access to the needed services. Clients would most benefit by the improvement of this service delivery and would be realized in the outcomes of the treatment being provided.
- (11) **IMPROVED UTILIZATION MANAGEMENT AND USE OF EVIDENCED BASED PRACTICES:** Evidenced based and promising practices have demonstrated effectiveness for consumers. These practices best support persons who are in need of change in order to recover from a Mental Illness or other behavioral health issue. Utilization Management (UM) maximized the use of staff competencies and training as well as promotes productivity. Thus, UM increase the capacity of the system to serve the public.
- (12) **DEVELOPMENT OF RECOVERY AND RESILLIENCY PHILOSOPHY:** The promotion of respect and dignity for consumers as part of the philosophy of care benefites persons served by the system. Also, the philosophy support accountability and rights of a person to self determine care for deciding what is best for them. This philosophy encourages individuals to strive for recovery rather than wait to have others fix their problems with dissapointment and discouragement. The Best Practice philosophy is good for everyone, especially the persons being served.
- (13) **INCREASED USE OF EVIDENCED BASED PRACTICE IN CLINICAL MILIEU:** Evidenced based and promising practices have demonstrated effectiveness for consumers. These practices best support persons who are in need of change in order to recover from a Mental Illness or other behavioral health issue.

- (14) **SUCCESSFUL RISK MANAGEMENT AUDIT SURVEY:** Risk Management Audit promote the Region to provide a safe environment for those being served as well as visitors to the Clinics. The Risk Management Office Audit support also increased the Regions ability to provide a secure setting for assets of the region to decrease theft and lossess. These acitivities decrease the likelihood of injuries and other losses that have a fiscal impact. The public is served well by the successful compliance with the recommended policies and procedures.
- (15) **SUCCESSFUL INITIATION OF A HUMAN SERVICE DISTRICT BOARD:** The local public and persons served would benefit from a Human Service Distrct in that the District would allow for more local control of resources. The local control would promote local interest and support, provide for special concerns for the disctrict, and provide support for it's local constituents with understanding of the limitations locally. Also, this the implementation would simplify some of the processes of the governemnt functions (such as contracting process) making the service implementation more expediate.
- (16) **RE-DESIGN OF REGION VI CONTRACTED SERVICES:** The re-design of contracts allows for services provided within the contracts to better compliment service received by persons who attend core services in the Behavioral Health System of care. This improvement allowed also for the implemetation of some best practices with the hope of improving outcomes for persons being served.

### **Region 7:**

- (1) The primary beneficiaries are the clients we serve. The redesign will enable us to best reach the goal of receiving the right services, level, intensity duration, frequency and outcomes based on their choice and preferences and improve access to care.
- (2) Recovery benefits both the people we serve and us as workers. Nothing is more invigorating as seeing a client succeed, even greater than we imagined. Also OMH is viewed as an office where people progress through treatment instead of remaining chronically mentally ill.
- (3) The primary beneficiaries are the clients we serve but staff also benefit by increasing their confidence in treating those with a co-occurring substance use disorder.
- (4) The primary beneficiaries are the clients we serve when our workforce is trained and competent to meet the unique needs of individuals with behavioral health challenges. Staff also benefit by increasing their confidence in treating clients with complex behavioral health needs. With regard to the ASIST training, the beneficiaries are the over 360,000 residents of Region VII benefit from exposure and skills from the cross representation of individuals already trained in throughout the Region.
- (5) The primary beneficiaries are the clients and families we serve.

- (6) The primary beneficiaries are the clients and families we serve.
- (7) Enhancing the competency and comfort of community providers to serve individuals with behavioral health challenges that no longer need an intensive level of care increase access throughout the region.
- (8) The primary beneficiaries are the clients and families we serve.

**Region 8:**

- (1) The overall morale of staff. Staff awareness of importance of attendance.
- (2) Primarily the consumers, but this additional doctor time has made it beneficial for staff in that they are able to access a physician much more quickly.
- (3) Primarily the consumers, but the staff are able to have greater confidence and satisfaction in their work, as well.
- (4) Primarily the consumers, but the program benefits by being able to measure effectiveness which allows for adjustments to be made in the delivery of services on a programmatic basis and an individual basis.
- (5) Primarily the consumers, but when there is a suicide or attempt by one of the consumers, this is difficult for staff, too.
- (6) The department benefits by having lower liability fees.
- (7) Consumers benefit by having services that better meets their assessed needs. The department benefits by having a more efficient operation.
- (8) Consumers, as stated above.
- (9) This training is designed to limit the risk of harm to both consumer and staff.
- (10) All individuals involved benefit as these are lifelong skills that can be used to obtain and maintain an improved quality of life.
- (11) The individuals themselves, as this is a major recovery accomplishment, but other consumers will be able to benefit from their expertise.

D. How was the accomplishment achieved?

**Central Louisiana State Hospital:**

- (1) Accomplished through submission to the Capital Outlay process. The need for a new hospital was recognized by local legislators and they helped to move this forward to its present approval state.
- (2) This was accomplished through a hospital-wide effort with the support of our Periodic Performance Review Teams and Hospital Administration.

**Region 6:**

Intensive Planning and hard work of the Management team as well as improved methods of communicating were utilized to accomplish the changes and improvements implemented. These accomplishments were achieved through weekly Regional Management team meetings to negotiate concerns and problems solve any issues that would arise. Quarterly in-service Trainings were also utilized to train staff on new procedures and philosophies of the approach being implemented. Individual Training was provided to specific staff as needed to improved and resolve unexpected problems that arise when implementing new /changed policy and procedures. Peer support staff and other contracted services were maximized and used to provide ancillary supports to the core service programs offered by the Mental Health System Clinics.

**Region 7:**

- (1) Critical review of data and significant allocation of staff time for the planning of the redesign as well as staff time for training on the redesign.
- (2) Establishing the promotion of Recovery as a priority throughout the region though the allocation of staff and state general fund resources.
- (3) Accomplished through a close coordinated effort of between Region VII OMH and OAD staff.
- (4) Establishing the development of staff competency as a priority throughout the region/state though the allocation of staff and fiscal resources.
- (5) Allocation of staff and state general fund resources to hire PAP staff.
- (6) Allocation of staff time.
- (7) Accomplished through a close coordinated effort between Region VII OMH and community

providers.

- (8) Considering performance improvement and quality assurance a priority and dedication of necessary resources and time.

**Region 8:**

- (1) Directive.
  - (2) Negotiation with Tulane Department of Psychiatry.
  - (3) The Regional Advisory Council generally hold an annual conference for the public, but this year they supported the training of staff in an effort to improve the service being delivered to the consumers.
  - (4) Department initiative.
  - (5) Unfortunately, this initiative was prompted by a critical incident. The performance improvement process worked, however. The training was completed and a checklist prompt was added to the assessment to ensure that all consumers were assessed upon intake with consideration to risk factors and protective factors and a specific safety plan, when indicated.
  - (6) Staff attended Risk Management Trainings and worked diligently to meet the expectations.
  - (7) This began as a department initiative, but the local staff were instrumental in making the redesign work in Region VIII.
  - (8) This was an aspect of the redesign initiated by the department, but the Region VIII Medical Director developed an efficient process for the monitoring.
  - (9) The department trained two Region VIII staff as trainers who held several trainings (8 hours each) to accommodate all staff members (8-10 per class).
  - (10) Region VIII supported this effort via social services contract.
  - (11) Region VIII has simply supported the effort started a few years ago and these individuals have taken great initiative.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes for all accomplishments.

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

Yes for all accomplishments.

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

Yes, we are on target for accomplishing the goals of our Strategic Plan especially in the area of Client Services where our mission is to provide a comprehensive, integrated, continuum of diagnostic/evaluation, treatment, and support services addressing the unique and challenging mental health needs of adults, adolescents, children, and families within the area.

- ◆ **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?

We feel that we are making adequate progress in accomplishing the various goals and objectives in our strategic plan. We take the accomplishment of those particular goals that we have outlined for ourselves very seriously and pride ourselves with every forward step we make.

Communication, collaboration, and continuity have improved within and across our service programs making our work efforts more congruent with our stated philosophy of care. Data will have to be gathered on key performance indicators to determine if our anticipated long term returns on our investment are returned. Our initial effort directed toward data management and indicator review has shown improved continuity of care, increased focus and attention to direct service delivery, and more efficient determination of eligibility/access to care.

- ◆ **Where are you making significant progress?** If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
  1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same

results have been generated without specific department action?

- Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improved service delivery?)
- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
- Other? Please specify.

We have demonstrated progress in improving operational efficiency directed toward performance improvement. The success we have achieved and our ongoing success is highly dependent on improved channels of communication, exposure to successes on a local level or even client level, experience in making things happen with limited resources resulting in creative thinking and problem solving. The organizational culture is being challenged through many of these activities and changing toward a learning culture working toward continuous quality improvement.

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

We expect the progress we have made in meeting our goals to continue at a steady pace.

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

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

The barriers we experience in meeting our goals/objectives are reviewed, discussed, and either solved, reframed, or worked around. As we continue to expand our core leadership groups and enhance our ability to improve our performance, we anticipate continued success in meeting our organizational goals.

As we move toward achieving these goals, we also recognize that critical to our success will be the integration of services, funding, technical assistance from other State Agencies, Child Welfare, Corrections, Rehabilitation, Developmental Disabilities, etc.

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

The lack of progress will continue without management intervention or problem resolution

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

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

We have revised our strategic plan to refine it more to the needs of the Area. We expect that our plan will be flexible enough to allow changes to address shortfalls

- 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.

Updates to the plan are coordinated through the Office of Behavioral Health.

### **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?

**Region 6:**

- a. Region 6 Community Services has had significant fiscal and operational resource issues that resulted from economic struggles. During the fiscal year monies for operational costs were minimal with no allowances for capital outlay or major repair budget categories. The fiscal limitation delayed the regional ability to make needed repairs. Administrative support was diminished as a result of the retirement of the Regional Manager with increased demands for Administration to implement system changes. Changes in the Organizational structure resulted in confusion of staff in the new roles of those in positions of authority. This confusion affected staff ability to perform expected functions at a maximum level of efficiency. The System's ability to effectively keep up with the implementation of new initiatives while in addition to the changes in organizational structure has been somewhat overwhelming and stressful to staff. Coordination problems arose in particular between Region 6 Community Services and Central Louisiana State Hospital where some resources were thus share. As the resources changed within the facilities, the capacity of the shared resources changed as well.

Challenges include the management of limited human resources when implementing the Strategic Plan that includes the Human Service Districts and those goals that specifically address the Utilization Management Objectives that have been established. The lack of additional funding related to the training and implementation of Evidenced Based Practices is largely a barrier in allowing the sustainability for maintaining trained staff to implement the Practices within the system. The transition for provision of care to implement new evidenced based, therapeutic models while simultaneously continuing to care for clients who are not eligible or recommended for the new therapy without increased clinical support is a real challenge. Private providers continue to express reluctance and discomfort in caring for individuals who are stabilized and being prepared to be referred to local community providers

- b. Currently, the maintenance of a paper record and a partially developed electronic record is a challenge and creates a burden on time for clinicians providing direct service.
- c. Infrastructure issues in the community create ongoing issues for both staff and those served, e.g., age of facilities, a/c and heating issues, size/space issues, etc.
- d. Inadequate Information Technology infrastructure that results in inconsistent internet access, which creates barriers to implementation of and access to the current limited

electronic medical record, as well as barriers to seamless operation of centralized scheduling processes.

- e. Critical Incidents that occurred at the end of the fiscal year have impacted staffing and system resources. Management of the remaining resources is fragile.
  - f. The staff-to-client ratio in the Recovery clinics is cumbersome. Caseloads remain high. The staff-to-client ratio inhibits the clinician's ability to provide adequately planned and thoughtful interventions due to the time frames that they are allowed to provide services within.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)

Yes, the problems impact the rate at which progress can be made and extend the time frames within which we are able to accomplish the goals.

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

**Region 6**

All clinics and the LIFT program were impacted by the rate of change as the work load of supervisors increased dramatically during the Re-design transition period.

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

**Region 6**

Employees of the Office are impacted by issues, both directly as a result of trying to do more with less and attend to quality care and indirectly due to how this impacts their desire to provide quality care, impacting their own sense of professionalism. The employees stress levels increased with the changes expected and some confusion due to communication issues in understanding what is explained to them and in the execution of the new procedures and policies. The UM guidelines provided for the new Wellness Clinic (Medication Management did need adjustments to meet more realistic goals for the provision and completion of each needed service.

5. How long has the problem or issue existed?

**Region 6**

OMH Region VI has continued to provide services to the community while attempting to improve develop the quality of services provided to the community.

Program re-design included thoughtful implementation of the staff resources to maximize the use of all available time of the clinicians time. Productivity of the staff has been examined with a focus of increasing staff productivity levels. Although these productivity levels have improved, the infrastructure issues relevant to the electronic health record, partial medical records maintained by hand, geographic challenges, phone technology systems that are inadequate have limited the ability of the staff to meet the national benchmarks for their services. Problems with human resources and fiscal resources dedicated to workforce development have existed for many years.

The Providers of care need credit for maintaining a focus on the people they serve. Adaptations have been implemented to work towards resolution of those problems in order to provide care to as many individuals possible. These efforts to served despite the limitations, which conversely also resulted in these issues appearing the problems were less of an issue than they actually were. Some of the problems such as inadequate T.O. and recruitment/retention issues are on-going. They have existed for many years.

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

### **Region 6**

The reduction of the fiscal resources reduced structures that were developed to support the progress toward the implementation of the Plans for system improvement and change (e.g. Retirement of staff that resulted in overload of remaining staff assuming duties diminishes time needed for implementing innovative changes; the training offered for best practices requires travel, money for trainers, staff time, etc.)

Organizational processes seem incapable of dealing with issues in “real time” or lack the flexibility to address issues in more creative or responsive manner. Hiring process is restrictive, purchasing process is not timely, implementing work requiring a bid is lengthy and slow, workforce development is costly and rapidly deteriorating physical plant with minimal resources to improve or repair. The increase in the staff direct service time (productivity) limits time spent on training and encouraging use of best practices/evidenced based practices.

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

### **Region 6**

Limited fiscal and Human resources results in delays in implementation of changes needed, delays in the assessment of the outcome of the changes implemented, failure to implement correction of physical plant maintenance in a timely manner, a reduction of the system’s ability to provide evidenced based programs, delays in the ability of management to implement cost saving structures. Reduction of workforce

results in increased duties and diminishes the ability of the staff to provide attention to detail and follow up as provided prior to the change.

Consequences of not resolving these issues are that the organization continues to have difficulty maintaining clinical operations, providing quality care, training / maintaining / recruiting staff, directly impacting outcomes for those served. Delayed maintenance results in increased cost of maintenance and repairs.

#### B. Corrective Actions

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

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

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

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

Quarterly Quality Performance Management Reports, C'est Bon, and LaFete – 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
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:**

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# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

**Department:** Louisiana Department of Health and Hospitals  
09-340 Office for Citizens with Developmental Disabilities

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips

**Agency Head:** Julia Kenny, Assistant Secretary

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

#### Implementation of Resource Allocation System for New Opportunities Waiver (NOW)

- A. **What was achieved?** Consistent with the Office for Citizens with Developmental Disabilities (OCDD) *Guidelines for Support Planning*, the Office implemented the Resource Allocation System which uses planning and needs-based assessment to better allocate resources to support individuals. All support coordinators and regional office staff members have been trained on the Resource Allocation System. Family and provider informational sessions are offered by each regional office.
- B. **Why is this success significant?** Better allocation of resources results in greater sustainability of home and community-based supports and offers the opportunity to support more individuals who continue to wait significant periods of time for needed services. By using a person-centered philosophy and needs-based assessments, the resources are allocated to ensure all needed supports are in place in a manner that also supports the individual's preferences and goals. This is expected to result in significant cost savings while still ensuring overall improvement in the quality of plans. Prior to this initiative, plans were either not adequate to meet the individual's needs or provided an abundance of supports in the absence of real identified needs.

- C. **Who benefits and how?** All current and future NOW recipients will benefit. This includes about 8,000 people in the next year. The current recipients are receiving improved planning which will result in better services and outcomes. Using the *Guidelines for Support Planning* in conjunction with the Resource Allocation system will allow OCDD to increase the number of individuals who can receive supports within the current resources available.
- D. **How was the accomplishment achieved?** The Resource Allocation System was developed through a collaborative effort between OCDD, regional staff, support coordinators, providers, and other stakeholders and with guidance from national consultants who work with many states to implement similar systems.
- E. **Does this accomplishment contribute to the success of your strategic plan?** Yes, OCDD has specific goals in the Strategic Plan relative to increasing the use of needs-based assessments for planning and serving more individuals while decreasing waiting time for needed services.
- F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes, the approach OCDD has taken is consistent with nationally recognized needs-based assessment and Resource Allocation methodologies.

### **Implementation of Residential Options Waiver (ROW)**

A. **What was achieved?**

OCDD received approval from the Center for Medicare and Medicaid Services (CMS) for the new Residential Options Waiver (ROW) on 10/1/09; and the waiver was implemented on 7/1/10. However, funding was not available in FY 10 to fully implement this new waiver.

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

The ROW is a new and innovative waiver which contributes to rebalancing the Developmental Disabilities Services System by focusing resources formerly used for more restrictive institutional care to serving people with developmental disabilities in community settings utilizing less costly Home and Community-Based Services (HCBS) Waivers. This success is significant because of the level of complexity involved in developing this innovative waiver and acquiring CMS approval after many questions, clarifications, and revisions; three years of work were involved in accomplishing approval/implementation of this waiver.

C. **Who benefits and how?**

The ROW was designed to be a flexible, cost-effective alternative to the New Opportunities Waiver (NOW) which would focus on rebalancing the Developmental Disabilities Services System through specific target groups: by converting private Intermediate Care Facilities for People with Developmental Disabilities (ICFs/DD) (up

to 8 beds) into shared living waiver homes; by offering current residents of private ICFs/DD who are waiting for NOW services a sooner alternative; by transitioning adults and children residing in nursing homes into community waiver options; and by providing community alternatives to individuals in crisis whose only choice has been institutionalization. In addition, the ROW allows the funding to follow the person instead of being tied to the provider and offers new, innovative residential models and additional waiver services (i.e., Occupational Therapy, Physical Therapy, Speech Therapy, and dental services) which have been long requested by stakeholders. Therefore, all persons seeking waiver services and waiting on the NOW Request for Services Registry (RFSR), especially those living in private ICFs/DD who want to move into less restrictive community services via waiver-funding; adults and children living in nursing homes who are able to live in the community; persons who would otherwise have to be institutionalized for care during a crisis; and those in other waivers needing never before offered services (i.e., Occupational Therapy, Physical Therapy, Speech Therapy, and dental services) will benefit from this waiver.

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

Development and implementation of the ROW were achieved with considerable statewide stakeholder input from the developmental disabilities community involving waiver recipients and families, waiver providers, waiver support coordinators, and advocacy organizations. The ROW was also developed after studying models from other states as well as their successes and failures and after sharing information with other state waiver managers at national waiver conferences. Finally, because this was a new and innovative waiver with some new services and models, never before seen in Louisiana, extensive negotiation and compromise had to occur within several sections of DHH under the Medicaid/Bureau of Health Services Financing (BHSF) and with the Center for Medicare and Medicaid Services (CMS).

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

Yes, there are specific goals in the Strategic Plan related to rebalancing the Developmental Disabilities Services System and increasing less-costly waiver services while decreasing institutional-based care. This also meets the DHH goal of maximizing state-funded dollars towards waiver services using a 70%/30% federal/state match.

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

The goal of downsizing institutions, reducing their costs and increasing services to individuals in HCBS waivers while using state funds to maximize federal dollars is a nationally recognized, best practices trend and is strongly promoted by the Center for Medicare and Medicaid Services (CMS) and by the Department of Justice. OCDD has been involved in this process for several years and is now refining and implementing it with less difficulty and more timely than other DHH Program Offices.

### **Downsizing of Supports and Services Centers**

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

During the FY ending 2010, ninety-three percent of the targets for Transition outlined in the OCDD *Plan for Transformation of Public Developmental Centers to Supports and Services Centers* were met throughout the state-operated supports and services centers. One of the many goals was to have fewer people served in large facilities and more people living and working in integrated, community settings of their choice. The Office is committed to supporting appropriate moves from centers to communities and to working with the private sector to maximize the quality of their service offerings. Through the successful and aggressive implementation of the plan each supports and services center achieved tremendous success with regard to transition goals. The successful transition of people from centers to less restrictive community options has been a focus for several years; ninety-six people with developmental disabilities transitioned during the past year from a supports and services center to a community living option. The continued emphasis each center placed on meeting each target in the plan provided for successful implementation and yielded positive outcomes.

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

This accomplishment is first and foremost significant in that people are choosing where and with whom to live and successfully transitioning to less restrictive living options while continuing to receive the necessary services. As services have become more easily accessible to people with developmental disabilities, successful downsizing of facilities has increased. Downsizing the supports and services centers not only results in increased choice and satisfaction of those individuals moving into community options, it also improved the entire system from a fiscal standpoint. Reducing the censuses of the centers results in a more efficient way of managing the state budget as the costs associated with living at a state-operated center are not necessarily as cost efficient as living in the community. The trend represented in this past year has been one of increasing community capacity while continuing to provide an array of necessary services to each person who continues to reside in a center. This trend allows for a more sustainable future for both private providers as well as state-operated services.

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

People with intellectual and/or developmental disabilities who have transitioned to a less restrictive community living option will benefit the most as they now have a different array of residential options. The service providers and private providers are also positively impacted as the trend to increase community capacity has been an Office focus throughout this process. The state also benefits as there are cost savings associated with downsizing.

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

The downsizing efforts and successful transition of people to community options was accomplished through a variety of efforts that play hand in hand with one another. Supports and service centers, private providers, and resource centers shared a renewed focus on person-centered planning, which resulted in greater continuity of care for people who could handle and benefit from community life. Individuals' plans for

provision of services and supports have been designed to support people to remain in their communities or locations of choice, to achieve valued outcomes, to develop meaningful relationships and to attain quality of life as defined by the person. By implementing a person/family-driven services system, supports and services are determined based on the person's needs and preferences. By allowing the person to drive the plan, transition to community life has been successful as the services and supports needed are being provided through a cost-effective allocation of resources. In addition to transitioning people from centers to the community, the state has followed the processes put in place for diverting admissions. Diversion of admissions has been a key element in maintaining lower center populations in support of the downsizing initiative. OCDD implemented a policy requiring that all referrals to supports and services centers be routed through an extensive process to locate an appropriate community residential option in lieu of placement at a supports and services center. Only when this process fails to locate an appropriate alternative residential option is the referral made to the state office for consideration of admission to a supports and services center; this referral/approval is required for any new or re-admission to a supports and services center. By increasing provider capacity; providing clearer expectations for transition staff, interdisciplinary teams and support coordinators; and implementing services offered through waiver services, a more efficient and comprehensive network of supports and services for people with developmental disabilities and their families has ensued. Service delivery is coordinated in a more unified manner and public sector expertise has been utilized to strengthen community capacity. By using resources from the centers to support community options we have successfully increased community capacity in many ways; one is the development and growth of resource centers. These centers are designed not only to develop and supply information, training and services in specific areas on a statewide basis but also to increase community provider capacity through the provision of opportunities for training, technical assistance, and consultation based on the identified needs of people with developmental disabilities. Adoption and implementation of the Supports Intensity Scale/Louisiana Plus (SIS/LAPlus) as the state's needs-based assessment for people with developmental disabilities has provided a sound objective approach in determining which supports would be necessary to help each person achieve specific goals and perform specific tasks necessary for daily living. As such, it is very compatible with the current planning literature. The SIS/LAPlus needs-based assessment has provided assistance to individuals to make choices about where to live and available service options through careful assessment of each service domain.

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

Yes, this accomplishment is in direct support of the strategic plan particularly with regards to census reduction, utilization of the SIS/LAPlus assessment tool and focus on the continued implementation of a person-centered planning method. The Department of Health and Hospitals and the OCDD have provided many opportunities for people with developmental disabilities and their families to provide input regarding their preferences for supports and services, as well as information and educational opportunities.

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

Yes

**Transition of State-operated Community Residential Services (Extended Family Living, Supported Independent Living, and 30 community homes) to Private Providers**

**A. What was achieved?**

As part of a statewide effort to reduce direct state-funded costs for developmental disability services and maximize the use of Medicaid funds to operate same, OCDD downsized and/or privatize 30 of its state-operated community homes, transitioned 41 recipients of supported independent living services/supports to private community waiver providers, and transitioned 54 recipients of extended family living (aka substitute family care) services into pure waiver funding using private providers. Twelve of the 30 residents of the state-operated community homes remained in their same residences (homes) without disruption while their facility operations were assumed by private Intermediate Care Facilities for People with Developmental Disabilities (ICFs/DD) providers at an overall cost savings to the state. The remaining residents either moved into less restrictive Home and Community-based Services (HCBS) waivers using the New Opportunities Waiver (NOW) or transitioned to existing privately-operated ICF/DD community homes around the state. The majority of the 41 individuals residing in supported independent living settings did not have to change their community residences but changed their waiver providers. All of the 54 individuals participating in the extended family living program kept the same families they had been living with for many years. They were provided the option of remaining in the NOW with the same services or transferring to the ROW which offered new, innovative service models and unique, previously unavailable services.

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

This initiative has saved the state money by eliminating the 30 state-operated community homes which all required higher Medicaid rates than privately-operated community homes. It also allowed for further downsizing of the public ICFs/DD and cost savings to the state by eliminating the leases for those community homes as well as the administrative and direct support staff salaries which typically are higher than in the public sector. The transition of recipients of supported independent living and extended family living services to 100% waiver funding eliminated any state-funded contracts which the state had been paying for these services or supplementing for these individuals' care. It also eliminated the need for state employees to provide any of the direct support or administrative oversight for these two services, thus saving additional costs.

**C. Who benefits and how?**

- The residents and service recipients who now have greater long-term/stable Medicaid funding streams as opposed to dwindling state appropriated funds. In

addition, this initiative has benefitted residents and service recipients by providing cost effective, efficient and safe options for accessing community services as an alternative to institutional services while maximizing choice.

- The taxpayers through increased cost savings and efficiency to the state budget and existing shortfall.
- The state through the provision of more cost-effective and higher quality community-based health care, thus decreasing reliance on more expensive institutionalization.

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

This initiative was accomplished within a short timeframe given the magnitude of the task. It was accomplished through coordination, communication and collaboration between supports and services centers' staff, regional waiver staff, waiver support coordinators, waiver providers and private ICF/DD providers; the initiative was managed, monitored and guided with provision of ongoing technical assistance from management staff at OCDD Central Office. The implementation of this initiative had to be preceded by advanced notice to recipients/residents and their families, stakeholder and advocacy groups, legislators, and the Governor's Office so that incorrect information would not cause confusion and unnecessary concern.

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

Yes, there are specific goals in the Strategic Plan related to rebalancing the Developmental Disabilities Services System and increasing less-costly waiver services while decreasing institutional-based care.

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

Yes, the goals of rebalancing the Developmental Disabilities Services System, downsizing institutions, reducing their costs and increasing care to individuals in HCBS waivers while using state funds to maximize federal dollars and maintain individual choice is a nationally recognized, best practices trend and is strongly endorsed by the Center for Medicare and Medicaid Services (CMS) and by the Department of Justice. OCDD has been involved in this process for several years and is now refining it and implementing it much easier and more expeditiously than other DHH Program Offices.

**Implementation of Supports and Services Centers' Quality Review Process**

**A. What was achieved?**

Four of the public supports and services centers received comprehensive reviews of facility processes and outcomes in the areas of administrative services, protection from harm programs, Interdisciplinary Team processes, psychological services, protective measures and supports, psychiatry services, medical and dental services, nursing services, therapy services, and transition services. The reviews were conducted by state and national experts in the various areas of expertise and were based on a

comprehensive set of performance measures. Each facility received a written report of reviewer findings and recommendations and subsequently developed and implemented a corrective action plan to improve compliance with the process- and outcome-based performance measures.

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

The Quality Review provided OCDD with a baseline assessment of the status of the four involved supports and services centers relative to a uniform and comprehensive set of process- and outcome-based performance indicators. The Quality Review framework provides an objective set of standards for the centers to strive to achieve thus introducing a degree of uniformity into the public supports and services center service system which has not previously existed.

**C. Who benefits and how?**

The focus of the Quality Review is on improving the quality of facility processes in the interest of improving individual and aggregate resident outcomes. The individuals served in the public supports and services centers therefore benefit from the Quality Review process. Additionally, the staff at the supports and services centers benefit from the Quality Review process in terms of professional development.

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

The services of nationally recognized experts in the fields of protection from harm, psychiatry services, medical services, nursing services, and therapy services were secured via contracts with the various experts. The services of experts employed by OCDD but not directly associated with the supports and services centers reviewed, in the fields of administrative services, psychology services, Interdisciplinary Team function, protective supports, and transition services were secured via special assignment by the OCDD Executive Management Team. OCDD, in conjunction with the experts used to conduct the reviews, developed and refined the performance measures used during the Quality Review process.

**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 Quality Review served as an external peer review process for the four facilities that participated. Participation in and response to the findings of external peer reviews is a best management practice for service provision-oriented Offices.

**Implementation of Quality Partnership with Regional Offices and Human Services Districts and Authorities: Reporting and Verification of Performance Measures and Quality Management Initiatives**

- A. **What was achieved?** The Human Services Accountability & Implementation Plan requires a Quality Partnership between the Office for Citizens with Developmental Disabilities (OCDD) and the regional offices and human services districts and authorities. Each quarter, regional offices and human services districts and authorities are required to report performance on twenty-three mutually agreed upon performance indicators. Regional offices and human services districts and authorities are required to develop and implement corrective action plans for each performance indicator for which the target was not achieved. Statewide annual performance targets were met for nineteen of the twenty-three performance indicators. In addition, OCDD conducts a validation visit to each regional office and human services district and authority during the fiscal year. During the validation visit, documentation verifying the numbers reported for the quarterly performance indicators and improvement strategies are reviewed and technical assistance is provided.
- B. **Why is this success significant?** This is significant because regional offices and human services districts and authorities are involved in reviewing their own performance on a quarterly basis and implementing improvement strategies, as needed. Performance indicators cover all major regional functions, including system entry, nursing home and ICF/DD admissions, administration of the Cash Subsidy and Individual & Family Support programs, DHH custody, and consumer outcomes in the areas of satisfaction, choice, and community employment.
- C. **Who benefits and how?** People with developmental disabilities, their families and providers benefit because regional offices and human services districts and authorities strive to achieve performance and quality outcomes.
- D. **How was the accomplishment achieved?** In 2008, pilots in two regions and two districts/authorities were conducted to test procedures and draft indicators. During the first six months of 2009, a workgroup modified the process and indicators based on the results of the pilots. Operational instructions and indicators were presented to the Human Services Interagency Council for its review and approval. The process was implemented July 1, 2009.
- E. **Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) Yes, a LaPAS indicator was developed related to conducting validation visits to each regional office and human services district and authority. As well, two La PAS indicators relate to customer satisfaction and choice.
- F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes.

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

- ◆ **Please provide a brief analysis of the overall status of your strategic progress.** OCDD is making progress in its five-year strategic planning process particularly with those initiatives that support the following strategic plan goals: *1) To provide a developmental disabilities services system which affords people with information about what services and supports are available and how to access the services system; timely completion of the system entry process; and timely access to the start of services and supports, with access and service delivery based on a needs-based assessment. 2) To provide a person-centered planning process which focuses on the person's goals and desires; addresses quality of life; affords choice; responds to a person's changing needs; supports the person to learn and be independent; identifies and mitigates risks; and meets the person's needs. 3) To increase the capacity of the Developmental Disabilities Services System through the development of a coordinated process to identify promising practices and other capacity building initiatives and implementation of strategies to address identified state-wide system needs. 4) To implement an integrated, full-scale data-driven quality enhancement system that provides structure and processes in defining the role of data analysis including: feedback from all stakeholders and review of the provision of developmental disabilities services/programs.* Implementation of the *Guidelines for Support Planning for New Opportunity Waiver (NOW) recipients; implementation of Resource Allocation; continued downsizing of state-operated Supports and Services Centers; transition of state-operated community residential services; and implementation of two quality management initiatives (Supports and Services Centers Quality Review Process and Quality Partnership with Regional Offices and Human Services Districts/Authorities)* have been key initiatives in the development and expansion of individualized supports and services for people with developmental disabilities and the provision of quality supports and services. The success of these initiatives has moved the Office toward goals outlined five-year strategic plan.
  
- ◆ **Where are you making significant progress?**

### **Program A**

#### **Objective I**

**Performance Indicator:** Percentage of Individual Support Plans (ISPs) completed by OCDD utilizing Support Intensity Scale/ Louisiana Plus (SIS/LAPlus) Assessments (Target: 98%/Actual: 100%)

1. **To what do you attribute this success?** Success is attributed to implementation of the OCDD Strategic Plan. The endeavor was supported by statewide training efforts and certification efforts of support coordinators in utilization of the SIS and new planning guidelines. OCDD also undertook extensive training with regional staff in review and incorporation of the assessment information into the planning process.
  
2. **Is this significant progress the result of a one-time gain?** Or is progress

expected to continue at an accelerated pace? The standardized needs-based assessment (SIS/LAPlus) and the improved planning guidelines have become permanent components of all newly approved New Opportunities Waiver (NOW) services. Full implementation is nearing completion for all NOW waiver recipients. Progress is expected to continue at an accelerated pace with the needs-based assessments being completed at routine intervals as part of the planning process.

### **Objective III**

**Performance Indicator:** Percentage of people supported who have an Individual Support Plan that contains all elements of the OCDD Planning Framework (Target: 90%/Actual: 100%)

1. **To what do you attribute this success?** Success is attributed to implementation of the OCDD Strategic Plan. Endeavor was supported by statewide training efforts and certification efforts of support coordinators in utilization of the SIS/LAPlus and new planning guidelines. OCDD also undertook extensive training with regional staff in review and incorporation of the assessment information into the planning process.
2. **Is this significant progress the result of a one-time gain?** Or is progress expected to continue at an accelerated pace? The implementation of a standardized needs-based assessment and the improved planning guidelines has become permanent components of all newly approved New Opportunities Waiver (NOW) services. Full implementation is nearing completion for all NOW waiver recipients. Progress is expected to continue at an accelerated pace with the needs-based assessments being completed at routine intervals as part of the planning process.

### **Program B**

#### **Objective 1**

**Performance Indicator:** Percentage of system entry requests completed within established Single Point of Entry timelines. (Target: 86%/Actual: 89.4%)

1. **To what do you attribute this success?** With the implementation of a new protocol for determination of eligibility and intensive training initiatives, system entry practitioners have developed an increased proficiency and efficiency in making system entry decisions.
2. **Is this significant progress the result of a one-time gain?** Or is progress expected to continue at an accelerated pace? This significant progress is the result of an office-wide concerted effort to develop proficiency and efficiency among practitioners which has been achieved. The goal for system entry at this point is to maintain this level of excellence in performance and eliminate

significant delays in making eligibility decisions for applicants for developmental disability services.

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

**Program A**

**Objective II**

Performance Indicator: Number of people on the Request for Services Registry (RFSR) – Supports Waiver (SW) (Target: 50/Actual: 226)

1. **To what do you attribute this lack of progress?** Due to a budgetary freeze effective December 2009 through the remainder of the fiscal year, no new waiver offers were made and attrition opportunities (slots) accumulated. Additionally, there are approximately 175 individuals added to this RFSR each quarter.
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?** This was due to budgetary constraints in FYE 10.

Performance Indicator: Percentage of reduction of time on the Request for Services Registry (RFSR) – Children’s Choice waiver (CC) (Target: -15.25%/Actual: +14.00%)

1. **To what do you attribute this lack of progress?** With the increased number of New Opportunities Waiver (NOW) opportunities being offered, individuals on the NOW RFSR who were eligible for CC opportunities were choosing not to accept a CC offer and wait for a NOW offer since the offer dates for the different waivers were compressing. Also, due to budgetary constraints experienced during FYE 10, offers were held for the last 6 months of the year. During FYE 10, there was actually an increase in the amount of waiting time by 14.00%.
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?** Since the offer date for NOW opportunities (slots) has met and passed the offer date for the CC waiver opportunities, individuals will receive a NOW offer. In the event that fewer NOW opportunities are available and the NOW offer date is again later than the CC offer date, the amount of time waiting for CC offer will continue to increase. An increase in the number of CC waiver opportunities and approval of the associated funding would increase participation in the CC waiver and reduce the amount of waiting time on the RFSR for CC waiver services.

Performance Indicator: Percentage of reduction of time on the Request for Services

Registry (RFSR) – Supports Waiver (SW) (Target: -92.67%/Actual: -29.17%)

1. **To what do you attribute this lack of progress?** Typically the data contractor releases all available SW opportunities (slots) at the beginning of each month and those opportunities are filled by the end of each month. Due to budgetary freeze effective December 2009 through the remainder of the fiscal year, no new offers were made and attrition slots accumulated.
  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?** This was due to budgetary constraints in FYE 10.
- ♦ **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? OCDD Strategic Plan was updated for FY 2012-2016. Plan update includes revisions to program goals, objectives and strategies to better reflect Office direction and to build on successes and provide strategies for areas where success has not been as substantial.
    - 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?** Objectives are assigned to individuals within the Office who manage and oversee the accomplishment of each objective and report to the Office Executive Management Team regarding progress made and support needed in order to achieve the assigned objective. Strategic planning is completed with input of stakeholders including the OCDD State Advisory Committee.

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

Lack of Adequately Trained Professionals and Direct Support Staff to Deliver Needed Behavioral Services in Community Settings, including Qualified Persons to Deliver Applied Behavior Analytic Therapies to People with Autism

#### A. Problem/Issue Description

1. **What is the nature of the problem or issue?** There continues to be a lack of adequately trained professionals and direct support staff to deliver needed behavioral services in community settings. This includes lack of qualified persons to deliver applied behavior analytic therapies to persons with autism - therapies which can be very effective and significantly alter the course of autism for many individuals.

2. **Is the problem or issue affecting the progress of your strategic plan?** Yes, lack of these professionals in community settings has continued to be the primary contributor to new admissions to supports and service centers, with requests for admissions resulting when community providers are unable to meet behavioral and psychiatric needs of people whom they are serving in community settings. Lack of trained autism professionals negatively impacts ability to develop new autism services which can prevent more severe negative developmental outcomes. Inability to adequately teach functional behavioral skills detracts from community participation objectives (that individuals with disabilities are participating fully in their communities).
3. **What organizational unit in the department is experiencing the problem or issue?** OCDD and Human Services Districts/Authorities are impacted by this.
4. **Who else is affected by the problem?** Individuals supported and their families, support coordinators, and private providers who serve persons with developmental disabilities in community homes, family homes, and supported independent living settings are impacted by this problem.
5. **How long has the problem or issue existed?** The problem is longstanding.
6. **What are the causes of the problem or issue? How do you know?** A multitude of factors contribute to the problem beginning with a historic lack of training by universities of persons equipped to deliver these services. Many Ph.D. psychologist programs, for example, offer no training in developmental disabilities. Medical school psychiatry programs typically offer almost no training in psychiatric needs of persons with developmental disabilities. The increasing number of persons with developmental disabilities now being served in the community and the downsizing of institutional services, generally considered to be positive and progressive developments in developmental disabilities services, has contributed to increased need for behavioral and psychiatric supports in the community. Some services which could be provided by non-terminal degreed practitioners [e.g., persons with a master's degree in psychology and expertise in this field, Board Certified Behavior Analysts (BCBA) with a master's degree] under the supervision of a licensed professional do not have a funding source. Also, private Supported Independent Living (SIL) providers serving persons in waiver settings and private community home providers generally conduct and are required to conduct very little training with direct support staff on positive behavior supports.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?** Consequences include a significant number of people with developmental disabilities not having needs met, continued needs for costly institutional admissions in supports and service centers, and inadequate practitioners to positively impact the developmental trajectories of children with

autism leading to snowballing service costs over the course of their lifespan.

B. Corrective Actions

1. **Does the problem or issue identified above require a corrective action by your department?** Yes.
2. **What corrective actions do you recommend to alleviate or resolve the problem or issue?** The following are recommended actions to alleviate the problem:
  - Continue recruitment of qualified professionals into state services;
  - Solicit support of university programs that provide training resulting in additional needed professionals, growing the service provider pool;
  - Explore funding sources that will pay for service delivery by less expensive, qualified professionals;
  - Create additional community technical assistance resources that offer training in behavior supports; and
  - Provide additional access to needed training for direct support workers.
3. **Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?** Yes, recommendation included in annual report last year.
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? Some corrective actions have already been implemented; however, it is anticipated that it will take a number of years to “grow” the skills and expertise needed.
    - How much progress has been made and how much additional progress is needed? A number of actions are underway:
      - OCDD is currently recruiting additional professionals with expertise in these areas. Additional staff responsible for behavioral training continued to be added in key positions in OCDD in the past year. However, resources are still inadequate.
      - OCDD is realigning its resource centers to offer technical assistance and training statewide. OCDD recently completed development of a Positive Behavior Support training curricula

for direct support workers. Plans are underway to offer the curricula to private providers and to partner with other providers and universities to further spread the training offerings.

- OCDD supports the development of a new university-affiliated training program for master's level practitioners.
- OCDD has partnered with other community organizations to begin offering continuing education options for individuals with BCBA certification to attract individuals with such certification and support their continued education and development.
- Supports and service centers continue to divert resources to community behavioral services.
- OCDD continues to operate small existing community service teams in each region of the state.
- OCDD is negotiating a partnership with a national consulting agency to assist in partnering with and developing the capacity within some provider agencies to support individuals with significant challenging behaviors.
- OCDD is participating in the State Comprehensive System of Care initiative to partner with sister agencies in serving youth with co-occurring conditions.

**5. Do corrective actions carry a cost?**

Most of these actions do not carry a cost, although partnering with the national consulting agency will. This cost will be incorporated into the Money Follows the Person Grant and will focus on assisting in the transition of individuals from state-operated institutional services into community-based living situations. While other corrective actions could carry a cost in so far as additional clinicians and/or technical assistance staff are recruited into state service systems, they do not carry a cost in so far as most new positions in OCDD are existing positions diverted from institutional services. They do not incur a cost when the focus is on community, non-public capacity building. Costs are in all probability offset by failure to implement corrective actions as: 1) failure to intervene at the community level can result in extensive additional institutional treatment costs and 2) failure to intervene with persons with autism at an early age does results in extensive lifelong service costs judged to be over a million dollars per person which are incurred by families and the taxpayer.

Lack of community capacity for serving people who require environmental modifications and/or adaptive equipment

A. Problem/Issue Description

1. **What is the nature of the problem or issue?** As the state-operated supports and services centers continue to downsize, people who are transitioning to community settings and require environmental modifications and/or adaptive equipment are facing barriers as the community (i.e., landlords, employers, etc.) is not always knowledgeable about and receptive to the need for such modifications.
2. **Is the problem or issue affecting the progress of your strategic plan?** Yes, the strategic plan goals for downsizing centers are impacted by this issue.
3. **What organizational unit in the department is experiencing the problem or issue?** This problem is being experienced by the supports and services centers who are preparing people for transitioning into the community.
4. **Who else is affected by the problem?** The problem impacts people who are currently living and working in the community who are in need of such modifications/adaptations.
5. **How long has the problem or issue existed?** The problem was identified in FY 2009-10.
6. **What are the causes of the problem or issue?** The problem is caused by an inability of families/private providers/employers/other community resources to accommodate the needs of individuals who require environmental modifications/adaptive equipment to reside successfully in the community. Such modifications/adaptations include, but are not limited to, wheelchairs, kitchen/bathroom modifications, lifts, adaptive furniture, communication boards, computer equipment, and specialized vans. These are essential in order for many individuals to communicate, move about their homes, and accomplish daily living skill without total assistance.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?** Consequences could result in people continuing to rely on services provided by support and services centers and other residential settings which do not afford maximum independence and community integration. This impacts the transition process and the budget.

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?** Provide information, training, and technical assistance to

private providers and families regarding capacity building as it related to service provision for individuals who require modifications/adaptations.

3. **Has this recommendation been made in previous management and program analysis reports?** No
4. **Are corrective actions underway?** Yes. The Office is working to develop community capacity and provide related information in a number of ways including the provision of training, consultation, and technical assistance to staff, providers and families.
  - Training and consultation are being provided relative to skill development in providing care and supports to individuals who utilize communication equipment and environmental modifications.
  - Individual needs are being address and planned for through needs-based assessments and a person-centered planning process.
  - Providers and families are receiving information regarding physical/ environmental accommodations and adaptive equipment, and transitions teams are available to assist with these areas prior to, during, and following transition.
  - Information is being provided regarding the possible use of home and community-based services waivers as a funding source for securing these accommodations/adaptive equipment.
  - Training is also being provided by a national consulting agency to supports and services center and regional office/human services district/authority staff regarding person-center thinking.

It is anticipated that these actions and information campaign will require time as in most cases planning and follow-up must occur on an individual basis. Providers and family members must develop confidence in their skills and ability to provide needed supports.

5. **Do corrective actions carry a cost?** Most of these actions do not carry a cost as existing resources are being utilized. However, partnering with the national consulting agency to provide training in person-centered thinking will require funding. This cost will be incorporated into the Money Follows the Person Grant and will focus on assisting in the transition of individuals from state-operated institutional services into community-based living situations.

Maintenance of property associated with facilities in which the campuses have been vacated

A. Problem/Issue Description

1. **What is the nature of the problem or issue?** As the supports and services

centers downsize, the need to vacate certain campuses has resulted in OCDD being left to maintain vacated premises of Bayou Region, Northeast and Acadiana Region Supports and Services Centers. Operations have ceased yet it is mandatory that OCDD provide resources to maintain components of each facility, many of which bring about unforeseen costs related to a cost savings endeavor.

2. **Is the problem or issue affecting the progress of your strategic plan?** Yes, although indirectly. As campuses are vacated, the opportunity to utilize state-owned property as revenue-generating property has been explored; however, there are current legislative rules in direct opposition to this method of planning.
  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 fulfill 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 2009-10.
  6. **What are the causes of the problem or issue?** The problem was caused by a lack of knowledge regarding mandatory duties related to state-owned property insured by ORM. The past fiscal year (FYE 10) is the first year OCDD has implemented either closure or privatization of a large facility's campus.
  7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?** Continuing to allocate resources without a means by which to increase revenue will likely result in shortfalls next fiscal year and in the years to come.
- B. Corrective Actions
1. **Does the problem or issue identified above require a corrective action by your department?** Yes
  2. **What corrective actions do you recommend to alleviate or resolve the problem or issue?** OCDD should seek permission and/or an exception to the Legislative rules and regulations to utilize state-owned property as revenue generating property or amend existing legislation.
  3. **Has this recommendation been made in previous management and program analysis reports?** No
  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. It is anticipated that it will take until the next regular legislative session to amend current law. Additionally, the Office is also working to identify potential buyers.

5. **Do corrective actions carry a cost?** No. There would be no direct costs related to researching and developing amendments to existing legislation as these actions would be completed by existing staff. However, as mentioned above failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings/facilities.

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

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

- Internal audit
- External audits (External audits by the Office of the Legislative Auditor, Health Standards, Fire Marshal, and Licensing)
- Policy, research, planning, and/or quality assurance functions in-house (The Office has a Clinical Review Committee that provides professional/quality oversight to a number of clinical areas; the Core Morality Review Committee, which is a subgroup of the Clinical Review Committee, that reviews all deaths of waiver participants; and a Performance Review Committee that oversees state-wide quality enhancement activities. Central Office has a Quality Enhancement Unit that coordinates state-wide quality initiatives. Additionally, each supports and services center, regional office, and human services district and authority completes in-house quality assurance/enhancement plans and conducts quality assurance/enhancement activities.)
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff (In-house staff have completed evaluations of some of the supports and services centers.)
- Program evaluation by contract (Consultants have been utilized for project planning, program evaluations, technical assistance and training.)
- Performance Progress Reports (Louisiana Performance Accountability System; Annual Performance Report for the Individuals with Disabilities Education Act (IDEA) - Part C submitted annually to the US Department of Education from EarlySteps and through the State Interagency Coordinating Council to the Governor)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring) (Support Coordination contracts)
- Peer review
- Accreditation review (All state-operated supports and services centers are

- currently accredited by The Council on Quality & Leadership.)
- Customer/stakeholder feedback (A state-wide community services customer satisfaction survey is completed annually)
- 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.

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

**National Core Indicators Project** - During FY 2008-09, the Louisiana Office for Citizens with Developmental Disabilities (OCDD) participated in the National Core Indicators (NCI) Project, along with 27 other states. The purpose of NCI Project is to identify and measure core indicators of performance of state developmental disabilities services systems. The NCI Project is co-sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). Through this project, three family surveys were sent to the families of people with developmental disabilities participating in various developmental disability programs. A number of reports were prepared to summarize the results of this project.

1. Title of Report or Program Evaluation:

Reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services:

- *National Core Indicators Consumer Outcomes, Phase XI Final Report 2008-2009 Data* - This report delivered results of interviews with adults receiving developmental disability services. The National Core Indicators Project includes three family surveys (one for families of children receiving services who live with family, one for families of adults receiving services who live with family, and one for families of children and adults receiving services who do not live with family) and interviews with adults receiving services, all of which Louisiana conducted during FY 2008-2009.
- *National Core Indicators Family Guardian Survey Final Report 2008-2009* – This report provides a summary of the survey which was administered to individuals having an adult family member with disabilities living outside of the family’s home. This report provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Adult Family Survey Final Report – 2008-2009* - This report provides a summary of the survey which was administered to

adults receiving developmental disability services who reside with their families.

- *National Core Indicators Child Family Survey Final Report - 2008-2009* - This report provides a summary of the survey which was sent to families of children living and receiving services in the family home.
2. Date completed: Final reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services were published in June 2010. (Surveys and interviews were completed between January and June 2009.)
  3. Subject or purpose and reason for initiation of the analysis or evaluation: Surveys and interviews were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. Survey and interview questions concerned satisfaction, quality of care, and quality of life. Analyses compared Louisiana statewide results with results of other states participating in the National Core Indicators Project.
  4. Methodology used for analysis or evaluation: The primary tools used for this evaluation were family surveys and consumer interview questions. Analyses reported number and percentage of responses to each question. Comparisons were reported among participating states.
  5. Cost (allocation of in-house resources or purchase price): Initial cost to conduct 325 interviews and input responses into the database was approximately \$45,000. Cost for mailing over 4,500 family surveys and inputting responses into the database was approximately \$30,000. Additionally, approximately 20 hours of staff time per region and per supports and services center was needed to set up interviews and obtain information from the person's case record concerning demographic information, health information, services, etc. Approximately 120 hours of Central Office staff time was needed to develop and monitor the contracts for the interviews and surveys, select random samples for each survey, obtain mailing addresses for families who will be asked to complete surveys, obtain current addresses and phone numbers for adults who will be asked to be interviewed, and coordinate activities among regions and supports and services centers.
  6. Major Findings and Conclusions: Overall, Louisiana was among the top ranking states in the *Child Family Survey* and the *Adult Family Survey* and within the average range for *Family Guardian Survey*. The majority of responses were "Within Average Range" with a substantial number falling 5 or more percent above average. However, there were a few areas that were 5 or more percent below average; more specifically responses regarding family participation in planning for adults who do not live with family and access to dental services for adults with developmental disabilities.
  7. Major Recommendations: Acquire information/explanations/causes related to

areas that fell below average and develop/implement strategies to improve/correct problems/issues identified.

8. Action taken in response to the report or evaluation: Efforts have been initiated through quality processes/questionnaires to gain additional information related to areas that fell below average.
9. Availability (hard copy, electronic file, and website): Available in hard copy and electronic file available on OCDD website.
10. Contact person for more information, including
  - Name: Dena Vogel
  - Title: Program Manager 3
  - Agency & Program: Office for Citizens with Developmental Disabilities, Quality Management Section
  - Telephone: 225-342-9251
  - E-mail: Dena.Vogel@LA.GOV

**Quality Review Reports for Supports and Services Centers** - During FY 2009-10, the Office for Citizens with Developmental Disabilities (OCDD) conducted comprehensive reviews of facility processes and outcomes at the four state-operated supports and services centers in order to establish a base-line in a number of areas related to administration, facility processes, and service delivery.

1. Title(s) of Report(s) or Program Evaluation:
  - Quality Review Report for Acadiana Region Supports and Services Centers (ARSSC)
  - Quality Review Report for North Lake Supports and Services Center (NLSSC)
  - Quality Review Report for Northwest Supports and Services Center (NWSSC)
  - Quality Review Report for Pinecrest Supports and Services Center (PSSC)
2. Date completed:
  - ARSSC: February 2010
  - NLSSC: March 2010
  - NWSSC: April 2010
  - PSSC: May 2010
3. Subject or purpose and reason for initiation of the analysis or evaluation: Four of the public supports and services centers received comprehensive reviews of facility processes and outcomes in the areas of administrative services, protection from harm programs, Interdisciplinary Team processes, psychological services, protective measures and supports, psychiatry services, medical and dental services, nursing services, therapy services, and transition services. The Quality Review provided OCDD with a baseline assessment of

the status of the four involved supports and services centers. The Quality Review framework provides an objective set of standards for the centers to strive to achieve thus introducing a degree of uniformity into the public residential services system which has not previously existed. Each facility received a written report of reviewer findings and recommendations and subsequently developed and implemented a corrective action plan to improve compliance with the process- and outcome-based performance measures.

4. Methodology used for analysis or evaluation: The reviews were conducted by state and national experts in the various areas of expertise using a uniform and comprehensive set of process- and outcome-based performance indicators.
5. Cost (allocation of in-house resources or purchase price): OCDD utilized some in-house professional/expert staff at no additional cost and allocated in-house resources to contract services in the amount of \$130,540.
6. Major Findings and Conclusions: The four supports and services centers, which underwent the Quality Reviews, were found to be at varying degrees of compliance with the objective standards reviewed. Each facility received a written report of findings.
7. Major Recommendations: The major recommendations, which were made through the Quality Review reports, were related to improving facility-specific and Office-wide processes in the interest of producing positive outcomes for the individuals supported by the facilities.
8. Action taken in response to the report or evaluation: Each facility generated and implemented an Action Plan in response to its particular Quality Review Report. The action plans are responsive to the reviewers' specific and general recommendations.
9. Availability (hard copy, electronic file, website): Reports are available in hard copy and electronic formats.
10. Contact person for more information, including

Name: Greg Andrus  
Title: Deputy Assistant Secretary 2  
Agency & Program: OCDD Central Office  
Telephone: (225) 342-0095  
E-mail: Greg.Andrus@LA.GOV

# Annual Management and Program Analysis Report

## Fiscal Year 2009-2010

**Department:** Department of Health and Hospitals  
09-351 Office for Addictive Disorders

**Department Head:** Bruce D. Greenstein, Secretary

**Undersecretary:** Jerry Phillips, Undersecretary

**Agency Head:** Dr. Rochelle Head-Dunham, Assistant Secretary

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

#### **Implementation of the Office of Behavioral Health (OBH)**

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

In accordance with ACT 384 of the 2009 Regular Session, the administrative offices of the DHH Offices of Mental Health and Addictive Disorders were to be merged into the Office of Behavioral Health on July 1, 2010. The purpose of the merge is to streamline existing resources, for planning, technical assistance and monitoring of service needs for the addictive disordered, mentally ill and co-occurring populations. Additionally, the OBH creates an infrastructure that better relates to the needs of the local governing entities, the districts and authorities, whose task is the provision of services at the local level.

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

The success of the merger of the two Offices (OMH and OAD) represents the first of many steps leading toward consolidation of managerial and clinical functions resulting in a reduction of duplication of effort, which will ultimately improve service delivery for both addictive and mental health populations.

**C. Who benefits and how**

Addictive disorders and mental health clients should see an increase in the coordination, quality and scope of services. The co-occurring disorder population will be identified and served in a more expedited manner.

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

To ensure that the OBH merger occurred as scheduled, an OBH Transition Team was organized in February 2010 with participants from all entities/offices within DHH whose input was necessary to make certain that the Offices of Mental Health and Addictive Disorders had successfully merged by July 1, 2010.

Effective July 1, 2010, the appropriation units of OMH and OAD were consolidated into OBH. With the assistance of state agencies external to DHH, over 2,600 T.O. positions were effectively merged into the newly created Office of Behavioral Health, and the first payroll check-write of the new fiscal year occurred without errors. Preliminary performance indicators were also created and inserted into the appropriation bill. Medicaid has also updated all provider files to accurately reflect the new agency name. All OAD and OMH policies, procedures and plans continue to be revised to reflect OBH and streamlining of policies, procedures and plans will occur when possible.

Four (4) of the five person executive leadership of OBH have been appointed to their positions. Ms. Kathy Kliebert has been appointed as OBH Assistant Secretary; Rochelle Head-Dunham, M.D. has been appointed as OBH Medical Director; Anthony Speier, Ph.D. has been appointed as OBH Deputy Assistant Secretary for Development; and Pete Calamari has been appointed as OBH Deputy Assistant Secretary for Systems of Care. The Deputy Assistant Secretary for Administration has yet to be announced.

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

The merger should facilitate the the goals and objectives set forth in the Strategic Plan. By enhancing resources and strengthening collaborative efforts, as one agency, the treatment and prevention gaps should be reduced and the continuum of care strengthened.

**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 model, after implementation, should be evaluated for possible replication in State Government. During the course of the next one-and-a-half to two years, the formation of OBH will continue to develop and be organized into a complete and comprehensive program office to address the behavioral health needs of Louisiana

citizens. The lessons learned during this period would serve as a platform for future decision making.

## **Block Grant Policy Manual and E-Learning**

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

The SAPT Block Grant's annual allocation of \$26 million dollars to Louisiana serves as the cornerstone of Louisiana's public funding for substance abuse services. In 2009-2010 the Office for Addictive Disorders (OAD) began development and completed a first draft of the Substance Abuse Prevention and Treatment (SAPT) Block Grant Policy and Procedure Manual.

Planned, but not executed, is an e-learning targeted to block grant funded substance abuse providers statewide. This block grant e-learning will orient staff to the mandates of the block grant at the provider level. After vetting of the OAD SAPT Block Grant Manual is completed in 2010-2011, work on the block grant e-learning training will begin.

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

This manual provides OAD's first comprehensive overview of the policies and procedures followed by the staff of the OAD in managing the SAPT Federal Block Grant awarded to the State by the Substance Abuse and Mental Health Services Administration [SAMHSA] Center for Substance Abuse Treatment [CSAT]. As OAD moves away from state operated service delivery and toward privatization of services, it becomes increasingly necessary to employ policy and monitoring as the primary functions used to meet strategic goals.

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

The OAD SAPT Block Grant Manual serves several purposes. It serves as a guide for staff who prepares the annual SAPT Block Grant Application and serves as primary evidence of this agency's compliance with block grant regulations. In turn, it is a training and reference manual for staff who plan, monitor, document and report on block grant activities and for programs who receive SAPT Federal Block Grant funds to offer treatment and prevention services throughout the state.

The e-learning for SAPT Block Grant providers will orient block grant funded providers statewide, effectively and inexpensively, to block grant mandates and it will support provider compliance with these mandates.

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

OAD utilized consultation and OAD staff to develop this policy manual and will utilize DHH Essential Learning and consultation to complete the block grant e-learning in 2010-2011.

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

This accomplishment directly supports Goal I: To provide efficient and effective direction (policy development and planning, management information system, clinical and programmatic development, and financial and human resource management) to the programs and services provided by OAD.

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

All agencies should have in place a policy and procedure manual that provides clear direction regarding funding mandates for the delivery of services. Effective management requires that staff who plan and authorize services as well as those who deliver services understand the requirements, authority and responsibility delegated to carry out assigned tasks and initiatives.

**Strategic Prevention Framework - State Incentive Grant****A. What was achieved?**

The State of Louisiana was awarded an \$11.75 Million SPF-SIG Grant. The SPF-SIG or the Governor's Initiative to Build a Healthy Louisiana is developing a system that will coordinate planning, funding, and evaluation for substance abuse prevention at the state, regional, parish and community level. SPF-SIG supports the implementation of evidence based, culturally appropriate and cost effective prevention services. Ten (10) parishes were identified and received funding to develop coalitions to address alcohol-related problems, with the target population of 12-29 year olds. SPF-SIG implementation continued throughout SFY2009-2010.

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

Implementation of the SPF-SIG engages the Governor's Office in a collaborative effort with OAD and provides a state framework for funding and evaluation of substance abuse prevention in Louisiana. Under the SPF-SIG, two standing Advisory Committees were created by the Louisiana Drug Policy Board. The State Epidemiological Workgroup was developed to analyze substance abuse prevalence and incidence data. The Prevention Systems Committees was developed to advise on evidence-based prevention programs, policies, and practices and make policy recommendations.

**C. Who benefits and how**

A comprehensive and coordinated effort lends itself to maximizing resources and eliminating duplication of services. Ten (10) parishes have been identified and receive funding to develop coalitions to address alcohol-related problems in their respective parish with the target population of 12-29 year olds. These target parishes are building a Prevention infrastructure that coordinates, plans, and implements prevention services.

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

Through a federal grant and the braiding of existing state resources to develop a system to coordinate planning, funding and evaluation for substance abuse prevention in the state. The grant is sustained in continued partnership with the Governor's Office.

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

Yes. It encompasses Goal IV: Improvement of quality and effectiveness of treatment and prevention initiatives through the implementation of best practices.

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

This initiative is being implemented through a federal grant, meeting the grant requirement of sound strategic prevention planning. As such, it is a model worthy to be replicated.

**Community Based Prevention Programs-Evidence-Based Requirement and Increase in Services****A. What was achieved?**

OBH has implemented a policy that all Community Based Prevention Programs are required to implement evidence-based programs, policies and practices. OBH Prevention has a total of 65 providers to include 55 Community-Based Prevention Providers and 10 Synar Projects. The 55 Community-Based Prevention Providers provided a total of 26 different evidence-based programs. 100% of all programs funded by SAPT Block Grant were evidence-based. During SFY 2009-2010 (July 1, 2009 – June 30, 2010). Prevention Services provided evidence based services to 72,095 enrollees. This is 26% increase in the number of enrollees served during SFY 2010 vs. SFY 2009 (57,342).

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

In requiring evidence-based programs, the agency is ensuring the most effective and efficient delivery system. This increase in service delivery is due to OBH's partnership with the Department of Education, the mobile service delivery model and cost bands for universal and selective programs. This partnership allows us to provide services directly to the youth population while utilizing the Department of Education's infrastructure. This reduces our infrastructure cost and allows those resources to be moved to direct services. The cost band for universal and selective programs helps us keep our cost down based on the actual cost of service delivery for specific programs. Universal programs target the general population, while selective programs target individuals that are at highest risk for developing substance abuse behaviors. This is based upon the program developer's information on training cost, curriculum cost, labor cost, evaluation cost and incentive cost per enrollee. These improvements allow Regions, Human Services Districts or Human Services Authorities to reduce their cost per service while

providing quality evidence-based prevention services to more students, in more parishes, without additional resources.

**C. Who benefits and how?**

As a result of the implementation of evidenced-based programs, policies, and practices and the braiding of resources with the Department of Education, OBH is providing higher quality programs to more individuals. The impact of increasing the number and quality of prevention services benefits the entire Louisiana population.

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

OBH has implemented and adheres to a policy that only evidence-based prevention programs will be funded. Prevention Contracts stipulate that providers will adhere to this policy as a condition of contract approval.

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

Yes. It encompasses Goal IV: Improvement of quality and effectiveness of treatment and prevention initiatives through the implementation of best practices.

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

Yes. Implementation of evidence-based programs, policies, and practices is a national “Best Practice”. In addition, mobilization of services, the application of cost bands per type of service, and the use of existing infrastructure allow for quality evidence-based prevention services to be made available to more individuals, in more parishes, without additional resources.

## **Underage Access to Tobacco – Synar**

**A. What was achieved?**

OBH funds a Synar Contractor (since 1997) in each of the ten regions/districts. Each contractor provides merchant education to 400 tobacco merchants regarding the sale of tobacco products to minors through unconsummated compliance checks. In addition, OBH continues its partnership with the Office of Alcohol and Tobacco Control. As a requirement of the Synar Amendment, OBH coordinates an annual study of the rate of tobacco sales to minors. The current rate of tobacco sales to minors in FFY 2010 is 4.3%. Louisiana's rate has consistently been one of the lowest in the nation. The model that Louisiana has utilized is being considered as a model program by the Center for Substance Abuse Prevention.

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

Louisiana's achievement to maintain the rate of underage access to tobacco among the lowest in the nation has an impact on health care costs associated with tobacco-

related illnesses and youth tobacco consumption rates. Compliance with the Synar Amendment requirements prevents OBH from suffering a 40% decrease in SAPT Block Grant funds.

**C. Who benefits and how?**

The youth of the state and anyone who has a vested interest in their health and welfare.

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

OBH continued to fund a Synar Contractor in each region of the State in an effort to maintain no more than a 10% sale rate of tobacco products to minors. Contractors actively scanned their respective communities and regions to identify and collaborate with other agencies and organizations (i.e., Coalition for Tobacco Free Living, Students Against Destructive Decisions, American Lung Association, etc.) to implement comprehensive environmental strategies that address youth access, use rates, and tobacco-related health consequences.

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

Yes. This initiative impacts the quality and effectiveness of prevention initiatives through the implementation of best practices and by collaborating with other agencies and community-based organizations, it enhances evidence-based prevention programming in the state.

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

Yes. Prevention services has the additional responsibility of the Synar Initiative, a community development and educational program designed to comply with the federal and state laws regarding tobacco sales to individuals under the age of 18 years. The December 1996 baseline found 72.7% of retailers to be non-compliant. OBH implemented programs to educate tobacco vendors regarding tobacco sales to minors. Enforcement efforts are conducted via compliance checks by the Office for Alcohol and Tobacco Control through a contractual agreement with OBH. The federal mandate was to reduce the illegal sales of tobacco to minors from 75% to 20% over a five-year period. Louisiana met the federal goal in 18 months. Louisiana's program is a national model and should be shared with other executive branch departments and agencies.

### **TANF Women and Children's Treatment Program**

**A. What was achieved?**

For 2009-2010, OAD continued its collaboration and 4.1 million dollar contract with the Department of Children and Family Services (DCFS), formerly Department of Social Services, to provide addiction services to families applying for Temporary Assistance for Needy Families (TANF) or families that had become involved with the Child Welfare system. This initiative provides easy access to treatment for

TANF eligible women throughout the state (at least one site per region/district). This is the eight consecutive year of this successful collaboration.

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

This project represents collaboration between multi-agencies serving women with dependent children, with a focus of reducing duplication of effort, improving access to treatment and outcomes, and preserving family unity. Besides providing a mechanism for *quick access* to addiction services for women, the project helps preserve family unity and prevents children from entering the state's foster care system. Women who enter intensive outpatient treatment can remain in their community and maintain their apartments/ households, while women and families who require a higher level of care, such as residential treatment, have the option of having their children accompany them to treatment, thus avoiding family disruption. Lastly, both treatment and prevention efforts are strengthened by this contract.

**C. Who benefits and how?**

It directly benefits pregnant women and the unborn child, as well as women with dependent children served by OAD and DCFS, by providing easy access to treatment at all levels of care. This collaboration has resulted in service expansion of 108 TANF residential beds throughout the state. Five gender specific intensive outpatient services, and quick and easy assessments and entry to outpatient clinics.

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

OBH-AD entered into a Memorandum of Understanding initially with its sister agency, DCFS. The MOU has now been replaced with a contractual agreement.

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

This accomplishment directly supports Goal III: To close existing Treatment and Prevention gaps and provide a seamless system of care through a comprehensive array of community-based treatment and prevention services, for individuals with addictive disorders and those at risk for developing addictions. This contract provides for expansion of treatment services, easy access to treatment for women remaining in the community, and reduction in waiting time to access residential services for women and dependent children.

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

Yes Collaboration among agencies is an encouraged practice to avoid duplication of effort and promote cost effectiveness. Also, clinicians who provide assessments and treatment utilize the ASI, the Achenbach and the Ages and Stages Developmental assessments for children, and the Seeking Safety Curriculum to address trauma in residential facilities.

## Adolescent Intensive Outpatient Expansion

### A. What was achieved?

Every Region/District except Region VII and Florida Parishes Human Services Authority, (FPHSA), has an Intensive Outpatient (IOP) Adolescent Program. Region VIII (Monroe Region) has 4 IOP Programs and was able to receive funding from the Children's Cabinet in that area. Due to this expansion, OAD was able to address treatment gaps related to adolescent treatment needs and services at the IOP level of care.

### B. Why is this success significant?

Adolescents are now able to receive treatment services within the least restrictive level of care for those who do not require acute inpatient care. Family and school life is not interrupted because services are provided after school hours. The majority of adolescents show improvement while receiving IOP services.

### C. Who benefits and how?

This program directly impacts the adolescent and his/her family by providing community based, cost effective services without disruption to the family unit or the adolescent's education. It is also a cost effective measure as IOP services can be provided at a significantly lower cost than inpatient services.

### D. How was the accomplishment achieved?

Based on identified needs from the regions and public forums, OAD received State General funding to expand capacity for this target population.

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

Yes. Goal III postulates OBH's commitment to close the treatment and prevention gaps and provide a seamless system of care for individuals with addictive disorders and those at risk for developing addictions. Also, by intervening early, OBH aims to stop the progression of this disease.

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

OAD contracted with Kathi Meyers, PhD, author of the Comprehensive Adolescent Service Index (CASI) to identify required program components for adolescent IOP. Besides using the CASI to assess adolescents in these programs, the regions/districts are required to use the protocols developed by Dr. Meyers as a guide for IOP implementation, and most regions/districts have also incorporated researched based treatment curriculums into their service delivery.

## Screening, Brief Intervention, Referral and Treatment (SBIRT)

### A. What was achieved?

OAD and the Office of Public Health, Maternal and Child Health (OPH- MCH), Office of Mental Health (OMH), and the Tobacco Quit Line continued the SBIRT initiative which screens pregnant women for substance use, tobacco use, depression and domestic violence. One of the rationales for this initiative was directly correlated to Louisiana's consistently high infant mortality rate. In 2004, Louisiana was second only to Mississippi in high infant mortality rates (10.4 infant deaths per 1000 live births). The SBIRT committee selected the 4 P's Plus, developed by Dr. Ira Chasnoff, as the screening instrument. This instrument was developed specifically for use with pregnant women. SBIRT stands for Screening, Brief Intervention and Referral to Treatment. The collaboration decided on the 4P's Plus due to high reliability and validity scores. In 2007, SBIRT was implemented in CAHSD, Monroe, Alexandria and Florida Parish Human Services Authority. In 2008-09, SBIRT was expanded to the Lafayette Region and Metropolitan Human Services Authority. In 2009-10, SBIRT was identified as a health priority by the Secretary of DHH. The initiative is currently in revision, and a new state plan is being developed that will address improvement in birth outcomes across several areas. OAD will continue to be a partner in this initiative.

The project emphasis has been to provide education and screenings to pregnant women via implementation of SBIRT in the offices of private physicians. Additionally, screenings are also being provided in select WIC clinics throughout the state. More than 20,000 women have been screened by end of state fiscal year 2009-2010. We have noted some improvement in infant mortality rates in 2005, 2006, and 2007 State infant mortality rates, based on infant deaths per 1000 live births, have declined during these years to 10.1, 9.95, and 9.0 respectively.

### B. Why is this success significant?

This project implements early intervention strategies to prevent maternal alcohol and substance use during pregnancy, and to address depression and domestic violence issues as these have been associated with poor maternal and infant bonding. SBIRT's focus is to improve overall health outcomes for both mother and child. Low birth weight and preterm births have been associated with tobacco and other substance use, and pre-term births have been correlated with high infant mortality rates (Center for Disease Control or CDC). Also, approximately 2/3 of infant deliveries in Louisiana are funded through Medicaid. Infants born with low birth weight and/or Fetal Alcohol Spectrum Disorder (FASD) have substantially more health needs, and rehabilitative services are very costly (Chasnoff). Conservative estimates of the cost of care for one child with FASD have been estimated at 1.4 million (FASD Center for Excellence). Additionally, many of the premature infants spend considerable time in NIC units, increasing health care costs that are frequently reimbursed with Medicaid funds.

**C. Who benefits and how?**

Pregnant females and their unborn children who are at risk are directly impacted. Additionally, the community at large benefits via a reduction in health care costs. OAD's goal is to reduce FASD, mental retardation, preterm deliveries, and improve the health of the mother and fetus during pregnancy.

There are also indirect gains to the community. Some anticipated societal gains are fewer children entering the foster care system (as parents received alcohol and drug treatment), **fewer behavior and neurological problems are expected with healthy births**, and fewer families need respite care.

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

OAD entered into a Memorandum of Understanding with the Office of Public Health and the Office of Mental Health to accomplish this. The Office of the Secretary is also in the process of elevating SBIRT to a health care priority for Louisiana.

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

Yes. Goal III postulates OAD's commitment to close the treatment and prevention gaps and provide a seamless system of care for individuals with addictive disorders and those at risk for developing addictions. OAD also realizes that quality medical care should address the potential of substance use and domestic violence, and OAD has been on the forth front to accomplish the goal of primary care becoming more active in screening for behavioral health issues.

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

Yes. This initiative should be shared with other executive branches since it impacts quality and cost indicators for public health, education, criminal justice, children's mental health, child welfare, social security and public assistance, etc. SBIRT is considered a best practice and there is a "push" by governmental agencies to establish SBIRT screenings in primary care and obstetrical care so as to reduce stigma and provide holistic care.

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

OAD has consistently met and or exceeded the majority of its Strategic Plan administrative and program objectives, including the percentage of key indicators met or exceeded by the Agency. Overall, we have been able to make progress on agency goals and objectives, but some resources have been diverted to address the privatization of state services and the decrease in state revenues. These issues were not anticipated nor included in the state plan. We have remained on course regarding Block Grant implementation, Quality Improvement Initiatives, and Training Initiatives.

♦ **Where are you making significant progress**

OAD Prevention's implementation of evidence-based programs, policies, and practices is a national "Best Practice". OAD excels in the attainment of collaborative effort between multi-agencies to enhance resources and facilitate clients' transition within a continuum of care.

Region 8 has been able to offer 4 adolescent IOP Programs. This expansion is aimed to minimize the treatment gaps related to adolescent treatment needs and services.

OAD continues to aggressively pursue additional federal funding to expand treatment and prevention services and to support the development of the infrastructure to track outcomes, client data and to appropriately assess clients on waiting lists and to assist in determining the appropriate level of care for all clients.

Employees and state and contract providers have benefited by the agency's training initiatives that propelled implementation of best practices. Implementation of best practices both in treatment and prevention has resulted in consistently meeting standards/targets for key indicators.

1. **To what do you attribute this success?** In requiring evidence-based programs for Prevention Services, the agency is ensuring the most effective and efficient delivery system. OAD has increased service delivery due to OAD's partnership with the Department of Education (DOE), the mobile service delivery model and cost bands for universal and selective programs. This partnership allows OAD to provide services directly to the youth population while utilizing the Department of Education's infrastructure. This reduces our infrastructure cost and allows those resources to be moved to direct services. The cost band for universal and selective programs helps us keep cost down based on the actual cost of service delivery for specific programs. Even with budget adjustments to OAD and DOE, the number of services has not been impacted; instead, there has been an increase in services.
2. As long as collaboration between agencies continues, we are expecting the gains to remain and even increase.

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

The economic crisis impacting Louisiana has resulted in budget adjustments that affect both staff and programmatic resources spanning across treatment modalities.

♦ **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?  
Standards and targets were revised based on the SFY 2009 LAPAS outcome performance.
- 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?**

Strategic Plan goals and objectives are disseminated statewide and Treatment and Prevention Directors monitor outcome indicators of performance. An electronic Report Card is generated given a glance of the performance indicators outcomes. OAD Executive Leadership ensures that plan revisions are timely and reflect current agency directions

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

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

1. What is the nature of the problem or issue? Obtaining additional funding for prevention and treatment services continues to be of primary concern. Needs assessment studies conducted through funding from the SAMHSA (Substance Abuse Mental Health Services Administration) reveal that with the current level of funding, OAD is only able to treat 10% of the identified need for treatment for adults and adolescents. The national average is 21%. A 2003 study by Loren Scott and Associates, Inc. estimated that for each dollar the state spends into an alcohol and drug abuse treatment program, society enjoys a reduction in future crime and medical care
2. There is an estimated cost-savings between \$3.69 to \$5.19 per dollar spent. Because Louisiana has one of the highest HIV infection rates in the country, as well as the highest incarceration rate, it is reasonable to assume that the medical care and crime cost-savings from alcohol and drug abuse treatment programs will be greater. Finally, it should be noted that the estimated cost savings would be greater if the effects of alcohol and drug abuse treatment programs on education, public assistance, and lost productivity were included in the analysis.
3. Is the problem or issue affecting the progress of your strategic plan?

Serving the total population in need is the agency's on-going goal. Waiting list figures and utilization percentages indicate a treatment gap. OAD has successfully met key indicators and continuously pursues creative strategies, e.g., inter-agency collaborations.

4. What organizational unit in the department is experiencing the problem or issue?  
Office for Addictive Disorders and other agencies that serve indigent clients.
5. How long has the problem or issue existed? This has been an ongoing problem as needs exceed resources.
6. What are the causes of the problem or issue? How do you know? The need for additional funding. Because we know from our needs assessment studies the number of individuals that are identified who need treatment and compare that to the number of individuals treated each year.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? There continues to be an impact on society and individuals suffering from addiction. Addiction also impacts all aspects of society. Approximately 80 % of the inmates in prisons are there because of alcohol and drug problems. The same holds true for children in foster care where it is estimated that 75% of the families of children in care are there because of alcohol and drug related problems.

#### 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.

The current financial situation is beyond the Administration's control. Therefore, no request for additional funding was submitted.

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 (audits by DHH Internal Audit Division)
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house  
Forms developed for QA
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluations by contract Forms developed are program specific.
- Performance Progress Reports  
(Louisiana Performance Accountability System)LAPAS
- In-house performance accountability system or process
- Benchmarking for Best Management Practices Customer Service
- Performance-based contracting (including contract monitoring)
- Peer review Peer Review Instrument developed for Block Grant compliance.
- Accreditation review
- Customer/stakeholder feedback Block Grant Public Forums
- Other (please specify): Synar Report FFY 2010: Youth Access to Tobacco in

Louisiana; Office for Addictive Disorders – Prevention Services (Quarterly and Annual)

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

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

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

1. Synar Report FFY 2010: Youth Access to Tobacco in Louisiana

2. Data collection completed: July – August 2009

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

The State of Louisiana Department of Health and Hospitals Office for Addictive Disorders conducts this Annual Synar Report to examine the current level of accessibility of tobacco products to minors as a requirement of the Federal Government. An amended Synar Regulation, was issued by the Substance Abuse and Mental Health Services Administration in January 1996,

and requires each state receiving federal grant money to conduct annual random, unannounced inspections of retail outlets to assess the extent of sales to minors.

4. Methodology used for analysis or evaluation:

The study design is a cross-sectional survey of Compliance, with compliance defined as the refusal to sell tobacco to minors and the prevention of entry of a minor to outlets restricted to youth. A stratified random sample of outlets are identified and surveyed by a team of one youth operative and two adult agents. The youth operative attempts to purchase tobacco from unrestricted outlets and tests the access of restricted outlets. The adult agents record characteristics of outlets, inspection events, and outcomes, and cite non-compliant outlets and clerks. Information about outlets, inspectors, and the inspection event are entered into an electronic data system via laptop at the time of inspection.

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

OAD contracted with Southern University to complete the 2010 Annual Synar Report at a cost of \$45,000. Data was analyzed and a written report was provided to OAD. OAD also contracted with the Office of Alcohol and Tobacco Control (OATC) to conduct the random, unannounced inspections of tobacco outlets identified by the random sample at a cost of \$110,500 (\$65.00 per

compliance check x 1,700 checks). The total cost for the Report was \$ 155,500.00.

6. Major Findings and Conclusions:

The objective of this study was to estimate the non-compliance rate for tobacco sales in Louisiana among youth under age 18. It is important to note that Louisiana had the highest non-compliance rate in the nation at baseline (72.7%) at the inception of this report. Annual targets were established to decrease the state's non-compliance rate to 20% by FFY 2002. However, Louisiana achieved 20.3% non-compliance in FFY 1999, only two years after the start of the Louisiana Synar Initiative, and 3 years ahead of the scheduled target date. The current rate of tobacco sales to minors in FFY 2010 is 4.3%. Louisiana's rate has consistently been one of the lowest in the nation. The model that Louisiana has utilized is being considered as a model program by the Center for Substance Abuse Prevention.

7. OAD complied with all major recommendations made by the Center for Substance Abuse Prevention for the SFY 2010 report and will adhere to any future recommendations, as warranted.

8. Louisiana is ranked among the top states in compliance. Our goal is to continue implementing current strategies since they proven to be successful.

9. Availability (hard copy, electronic file, website) The report is available by hardcopy (limited number of color copies) as well as on OAD's website at <http://www.dhh.louisiana.gov/offices/reports.asp?ID=23&Detail=721>

10. Contact Person:

Dr. Leslie Brougham Freeman  
Director of Prevention Services  
LA Department of Health and Hospitals  
Office of Behavioral Health - Addictive Disorders

Office for Addictive Disorders – Prevention Services (Quarterly and Annual)

1. Data collection completed: July 1, 2009 – June 30, 2010

2. Subject / purpose and reason for initiation of the analysis or evaluation:

The Office for Addictive Disorders (OAD) is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OAD Prevention Services has developed this report to capture prevention services provided through funds of the Prevention Portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT Block Grant is the primary funding stream for prevention services in our state. It requires twenty (20%) of the Block Grant be set aside for primary

prevention services.

An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report is a continuing process to measure the number of services we provide and the populations that are served.

3. Methodology used for analysis or evaluation:

The data in this report is from the Prevention Management Information System (PMIS). PMIS is the primary reporting system for the SAPT Block Grant for prevention services.

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

There is no cost associated with this report. This report is generated in-house. OAD Program Staff utilize data from the Prevention Management Information System (PMIS) to generate this document. Data is entered into PMIS by OAD Regional and Headquarter Staff and Prevention Contract Providers statewide.

5. Major Findings and Conclusions:

During State Fiscal Year 2010 (July 1, 2009-June 30, 2010) Prevention Services provided Evidence-Based services to 72,095 enrollees. This represents a 26% increase over SFY 2009 (57,342).

Through State Fiscal Year 2010 block grant funded one-time services provided to the general population reached 194,798 participants. This number included the combined services provided by Prevention Staff and Prevention Contract Providers. This is a 21% increase over SFY 2009 (160,938).

6. The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.

7. No actions (other than the recommended (above) were pertinent.

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

9. The report is distributed via e-mail and is available by hard copy upon request.

10. Contact Person:

Dr. Leslie Brougham Freeman  
Director of Prevention Services  
LA Department of Health and Hospitals  
Office of Behavioral Health – Addictive Disorders