



State of Louisiana

Department of Health and Hospitals
Office of Management and Finance

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

FROM: Jeff Reynolds
DHH Undersecretary

RE: FY2014 Annual Management and Program Analysis Report (AMPAR)

DATE: December 5, 2014

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 2013-2014 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 may exist within each agency.

If there are questions regarding these reports, you may contact Elizabeth Davis at 225-342-5608 (liz.davis@la.gov) or the contact person listed for each agency.

Department of Health and Hospitals

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09-301	—	Florida Parishes Human Services Authority Melanie Watkins, Executive Director (985) 748-2220
09-302	—	Capital Area Human Services District Jan Kasofsky, Executive Director (225) 922-2700
09-303	—	Louisiana Developmental Disabilities Council Sande Winchell, Executive Director (225) 342-6804
09-304	—	Metropolitan Human Services District Yolanda Webb, Executive Director (504) 568-3130
09-305 & 306	—	Medical Vendor Administration & Medical Vendor Payments Ruth Kennedy, Medicaid Director (225) 342-6726
09-307	—	Office of the Secretary Jeff Reynolds, Undersecretary (225) 342-6726
09-309	—	South Central Louisiana Human Services Authority Lisa Schilling, Executive Director (985) 858-2931
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09-320	—	Office of Aging and Adult Services (OAAS) Tara Leblanc, Interim Assistant Secretary (225) 342-5855
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09-330	—	Office of Behavioral Health (OBH) Rochelle Head Dunham, Assistant Secretary (225) 342-4760
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Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Alicia English Rhoden, Executive Director

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

For each accomplishment, please discuss and explain:

Health Resources and Services Administration (HRSA) New Access Point Grant

A. What was achieved?

Jefferson Parish Human Services Authority (JPHSA) was issued a New Access Point (NAP) Grant from the Health Resources and Services Administration on November 1, 2013. This grant designates JeffCare, a program of JPHSA, as a Federally Qualified Health Center (FQHC). The project sites include both the East Jefferson and West Jefferson Health Centers.

B. Why is this success significant?

This grant, and status as an FQHC, supports JPHSA's efforts to adhere to universal design principles for all individuals seeking services. In addition to fostering the integration of primary care services with behavioral health services, it also fosters integration with those individuals with developmental disabilities thereby providing a centralized location for all individuals served to address their healthcare needs.

C. Who benefits and how?

Individuals who receive integrated behavioral health care and/or developmental disabilities supports and services experience improved access to needed primary care services, a reduction in the incidence of serious and acute physical illness, an

improvement in overall health, and a reduction in the early mortality. These individuals have often neglected their primary care needs due to their mental illness and/or developmental disability and it is exacerbated by the unavailability or lack of access to primary care providers. Young adults who have intellectual or physical disabilities often continue seeing their pediatrician at an age when they should be receiving care from an internist or family practitioner. These pediatricians, while familiar with the individual are often inexperienced with treating adult health concerns such as high blood pressure, heart disease, thyroid disorders, or diabetes.

Health promotion and prevention activities seldom target people with disabilities. Individuals with intellectual disabilities and co-morbid medical conditions such as cataracts and obstructive sleep apnea (patients with Down Syndrome); chronic gastro-esophageal reflux disease (GERD); dysphagia or difficulty swallowing; constipation and subsequent impaction; and, weight gain and obesity due to sedentary lifestyles and medication side effects.

The results of national research indicate individuals with a behavioral health disorder experience a significant decrease in their life expectancy. This decrease has been measured to be on average 25 years or more compared to individuals who do not have a behavioral health disorder. Internal mortality statistics maintained by JPHSA's Medical Director also reflected this disparity in life expectancy.

During FY 2013-2014, JPHSA served over 10,000 individuals in Jefferson Parish for their behavioral health needs and over 2,000 individuals with developmental disabilities. Of those, 426 were seen for their primary care needs through internal referral or by a self-request for these services.

D. How was the accomplishment achieved?

JPHSA researched the integration of primary and healthcare and studied existing models prior to applying for the New Access Point grant. The grant was created to support integrated behavioral health and primary healthcare as well as referrals to social services over a two-year grant period (November 2013 through January 2015). JPHSA submitted the New Access Point grant as the applicant with JeffCare as the co-applicant. A reorganization of behavioral health service provision and oversight was developed and implemented to enhance service delivery, ease of access and continuity of care. Clinic- and community-based services were no longer aligned using age groups served. Clinic-based services integrated adult and child clinicians under a central director. Community-based services adopted this model as well.

Funding from the grant has allowed JPHSA to hire or contract with family practice physicians and nurse practitioners, to purchase materials and supplies to equip examination rooms, and to purchase an electronic health record to document services. This electronic health record will be used to document all clinic- and community-based services provided in a single product. Documenting developmental disability services will be explored. Supports for integrated services were developed in consultation with outside experts. Additionally, work was initiated to cultivate and execute cooperative

endeavor agreements with other healthcare providers, e.g. West Jefferson Medical Center and EXELth, an FQHC. Special examination tables were purchased to accommodate individuals with physical disabilities who are unable to position themselves on most commonly used examination tables. Finally, education was provided to primary care specialists on the needs of individuals with behavioral health needs and those with developmental disabilities.

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

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

Goal I of JPHSA's Strategic Plan is: *Provide coordinated services and supports which improve the quality of life and community participation for persons in crisis and/or with serious and persistent mental illness, emotional and behavioral disorders, addictive disorders and/or developmental disabilities, while providing appropriate and best practices to individuals with less severe needs.* The integration of primary care and behavioral health care delivery within the East and West Jefferson Health Centers resulted in improved coordination and access to care, treatment of physical illnesses previously neglected, and an improvement in the quality of life for these individuals served by JPHSA.

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

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

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

JPHSA reports continued progress on Strategic Plan Goals.

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

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

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

1. To what do you attribute this success?

JPHSA attributes its success to the following: ongoing compliance with Council On Accreditation (COA) standards; adherence to the Accountable Care Model (endorsed by the National Council on Community Behavioral Health); ongoing commitment to and assertive focus on performance and quality improvement initiatives; continuous utilization management activities; integrated and holistic service delivery; communication of clearly defined performance expectations for all employees and adherence to the JPHSA Staff Development and Supervision Guidelines; and, the effort to utilize data for performance and quality monitoring as well as for decision support.

JPHSA, with the full support of its Board of Directors, has taken its destiny into its own hands, and has moved forward with aggressive strategies and tactics to assure sustainability and significantly decrease dependence on state funding.

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

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

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

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

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

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

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

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

Activities were revised to reflect the organizational restructuring: Behavioral Health Community-based and Specialty Services; Integrated Primary Care and Behavioral Health Clinic-based Services; Developmental Disabilities Community Services; and, Business Management/Performance & Quality Improvement Services.

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

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

Jefferson Parish Human Services Authority (JPHSA), a Local Governing Entity, adheres to the Policy Governance Model. The Board of Directors establishes the Mission and Priorities, and selects an Executive Director to provide ongoing leadership and operational management of the Authority. The Executive Director presents the members of the Board with monthly updates and an annual Ends Policy Monitoring Report detailing progress toward achieving Strategic Plan Goals and Objectives.

As an organization that has adopted and acculturated (over many years) Accountable Care and Performance & Quality models/philosophies, JPHSA continuously communicates, monitors, reports, and implements corrective actions and/or performance and quality improvement activities with regard to Strategic Plan Goals, Objectives, and Performance Indicators. A broad range of venues are utilized: individual supervision, work groups, divisional staff meetings, all-staff meetings, the employee electronic newsletter, the employee intranet site, accessible data reports, etc.

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

Additionally, the Performance & Quality Improvement Committee develops, adopts, and implements annual cross-divisional Performance & Quality Improvement Initiatives to further ensure JPHSA meets and/or exceeds Strategic Plan Goals and Objectives and to support the Authority's Mission and Priorities. Quarterly progress

reports are delivered during a meeting of the full Performance & Quality Improvement Committee and reported in the employee electronic newsletter.

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

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

Bi-weekly Executive Management Team meetings are used as group supervision and as forums for discussion of progress on meeting/exceeding goals and for collaborative development of corrective action and/or performance and quality improvement plans. The Executive Director holds the Executive Management Team accountable on both an individual and group basis for successful implementation of the JPHSA Strategic Plan, Annual Division Plans, and the Annual Performance & Quality Improvement Initiatives. The Executive Director gauges a significant portion of the Management Team Members' performance reviews on their contributions to the Strategic Plan and Performance & Quality Improvement Initiatives as well as on their degree of success in accomplishing Annual Division Plan goals and objectives.

Each JPHSA employee has job-specific performance factors and expectations to support Authority goals included in his/her annual planning document. Supervisors are required to meet with their subordinates as outlined in JPHSA's Staff Development & Supervision Guidelines (weekly for new employee, monthly for established employees, and as needed for employees with performance deficits). The supervision meetings are used to review and discuss progress toward meeting expectations. Active participation and open discussion are encouraged. (Every employee needs to vigorously row in the right direction and to adjust his/her course as needed to achieve JPHSA's Mission, Strategic Plan, Goals, and Objectives.)

JPHSA leadership approaches implementation of the Authority's Strategic Plan as ongoing performance and quality improvement involving all Divisions and all staff members, i.e. horizontal and vertical integration. Monitoring and reporting are integral parts of the process.

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

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

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

- Internal audit
JPHSA's Management Services Division provides ongoing monitoring of clinical, service delivery, business, and administrative functions as well as staff development and supervision activities. Audit tools with identified criteria and standards are utilized; results are reported; and, appropriate performance and quality improvement and/or corrective actions are implemented. Further, the Management Services Division audits Authority performance using benchmarks set forth in Council On Accreditation standards. Improvement plans are developed and executed as needed. The Division monitors progress on improvement and corrective action plans as well.
- External audits (Example: audits by the Office of the Legislative Auditor)
JPHSA is audited on an annual basis through the Office of the Legislative Auditor as well as by the Department of Health and Hospitals Office of Behavioral Health, the Department of Health and Hospitals Office for Citizens with Developmental Disabilities, Health Standards, the Louisiana Department of State Civil Service, and Peer Monitoring in conjunction with another Local Governing Entity (Block Grant requirement).
- Policy, research, planning, and/or quality assurance functions in-house
JPHSA's Management Services Division has overall accountability for policy development and management as well as for the Authority's quality assurance functions. With regard to policy development and amendment, the Management Services Division Director consults with the Jefferson Parish Attorney on an as-needed basis. The Executive Management Team, headed by the Executive Director, is responsible for short- and long-term planning. She seeks the consult of the JPHSA Board of Directors as appropriate according to Board policies. The Performance & Quality Improvement (PQI) Committee, chaired by the Management Services Division Director, is responsible for the review and update of JPHSA's PQI Plan and for the collaborative development and ongoing monitoring of annual PQI Initiatives. The Research Committee, chaired by the Authority's Medical Director, has overall responsibility for review and approval of research studies involving service recipients. Any and all such studies are required to be consistent with the JPHSA Mission and Priorities.
- Policy, research, planning, and/or quality assurance functions by contract
The MST Network, of which JPHSA is a member, provides technical assistance as requested by the Authority's Multi-Systemic Therapy Teams.
- Program evaluation by in-house staff
Performance is monitored on an ongoing basis utilizing the JPHSA Strategic

Plan, Operational Plan, Division-Specific Annual Plans, Annual Performance & Quality Improvement Initiatives, Utilization Management Plan, Staff Development & Supervision Guidelines, and position-specific expectations. All have clearly stated goals/objectives and performance targets. The Executive Director, Executive Management Team, Supervisory Staff, and the Management Services Division share responsibility. The Executive Director is also required to submit ongoing monitoring reports to the JPHSA Board of Directors as defined by Board policy.

- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System) JPHSA collects data, performs statistical analysis, and reports outcomes into LaPAS on a quarterly basis. Detailed notes of explanation are provided for positive and negative variances of 5% or more from quarterly Performance Indicator targets. Each note outlines any needed corrective action or process improvement activities. JPHSA also provides data or makes data available to the Department of Health & Hospitals' (DHH) Office for Citizens with Developmental Disabilities (OCDD) and Office of Behavioral Health (OBH) on an ongoing basis and as requested. JPHSA is compliant with the DHH Human Services Accountability and Implementation Plan, which contains an extensive array of outcome measures, many of which OCDD and OBH utilize in compiling data for their own LaPAS reports.
- In-house performance accountability system or process JPHSA utilizes the following to model its performance accountability process: The National Council for Community Behavioral Health endorsed Accountable Care Model; the Council On Accreditation Standards and Rating System; the JPHSA Staff Develop & Supervision Guidelines in conjunction with the Louisiana Department of State Civil Service Performance Evaluation System; JPHSA's Performance & Quality Improvement Initiatives; fidelity models for Evidence-based Practices; ongoing internal monitoring with appropriate follow-up activity; and, ongoing data collection, mining, and analysis for decision support.
- Benchmarking for Best Management Practices Developmental Disabilities Services data is obtained through the Office of Citizens with Developmental Disabilities software. Comparative studies are enabled through other Local Governing Entities reporting into the LaPAS system as well as through benchmarking against national standards for Evidence-based and Best Practices. JPHSA's Financial System, Great Plains, is a highly sophisticated system that allows detailed budget reporting, enabling the measurement of performance against quarterly targets and annual goals as well as identification of trends. JPHSA also uses benchmarks set forth in the Accountable Care Model and the Council On Accreditation Standards and Ratings System for ongoing measurement and performance monitoring.

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

attends Developmental Disabilities Council quarterly meetings and interacts on an ongoing basis with the Advocacy Center. The Executive Director and the Executive Assistant make regular calls on local and state elected officials as well as community leaders.

Other (please specify):

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

Yes. Proceed to Section C below.

No Skip Section C below.

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

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

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

Name: Gwen Doherty
 Title: JPHSA Management Services Division Director
 Agency: Jefferson Parish Human Services Authority
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Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Melanie Watkins, Executive Director

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

Achieving Accreditation – FPHSA attained a three year accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) in January 2014. Accreditation is required for participation in the Louisiana Behavioral Health Partnership (LBHP) and will help to ensure the agency's long-time viability as a provider of community behavioral health. Individuals residing in FPHSA's catchment area will benefit from the agency's accreditation as it will help ensure a level of service that is consistent with national standards. The accomplishment contributes to FPHSA's strategic plan as the consistency required for accreditation will improve the agency's ability to provide services that are comprehensive in nature and reflective of treatment modeled after best management practices.

Expansion of Services in Addictive Disorders – FPHSA contracted with the 22nd Judicial Drug Court to provide services to individuals referred to FPHSA by the court in St. Tammany Parish. This cost reimbursement contract has expanded services to include individuals who were not previously served by FPHSA and provides an additional revenue source.

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

This expansion of services contributes to FPHSA's objective of providing treatment services to individuals with addictive disorders and prevention services to four percent of the population within its catchment area.

Participation in LINCCA- FPHSA transitioned a portion of our Developmental Disabilities funding to the Low-Income and Needy Care Collaboration Agreement (LINCCA) program in order for recipients to maintain the same service/funding levels (\$410,643) with a lesser cost (\$267,152) to the agency.

Finalization of Co-location of Services – Corresponding to DHH’s Business Plan theme of Building Foundational Change for Better Health Outcomes, FPHSA completed the co-location of staff and services to combine the provision of services and to reduce operating expenditures. Developmental Disabilities Services was the first to relocate to the newly leased facility located on Pride Drive in Hammond. FPHSA’s has also co-located/relocated Hammond Addictive Disorders Clinic, Rosenblum Mental Health Center for Adults, and Mental Health Administration. The relocation of FPHSA’s Executive Administration completed the merger with the move to the Pride Drive location in December 2013. Combining these facilities is estimated to save FPHSA approximately \$150,000 annually. FPHSA clients now benefit from this accomplishment as multiple services are now located in one facility and the coordination of services for multiple disorders is more readily accessible and care more integrated. This accomplishment contributes to FPHSA’s goal of improving efficiency of services and also the objective of to increase efficiency of the operation and management of the agency.

Same Day/Next Day Access- FPHSA began preparing for and meeting with the National Council for Behavioral Health in FY 2014 to plan for implementation of the Same Day/Next Day Access initiative in FY 2015. FPHSA will continue to work with National Council expert consultants to help persons seeking public mental health and addiction treatment to access services more effectively and in a timely manner. FPHSA will assess and redesign our intake and assessment processes to reduce client wait times. Improved access to care has been proven to reduce no-shows and cancellations and better engage persons in treatment and recovery.

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

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

FPHSA has continued to progress towards accomplishing the strategies and goals set forth in the Strategic Plan.

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

FPHSA has continued to strive to assure comprehensive services and supports to improve the quality of life of those individuals served. Progress has been made for individuals served through developmental disabilities waiver supports and services. In FY 14, 1288 individuals were served through wavier supports and services compared to 1255 in FY 13. The agency continues to provide direct clinical services and coordinates an array of services designed to provide treatment on an outpatient basis as well as an ASAM III.5 residential treatment program for addictive disorders.

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

FPHSA has made progress toward implementation of data-based decision making. Area Supervisors (Addictive Disorders Services, Developmental Disabilities Services, and Mental Health Services) met regularly with the Executive Director to discuss services and client data.

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

FPHSA attained a three year accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) in January 2014 which will enhance quality and effectiveness of services as well as prepare the agency and staff for the ongoing evolution of health care.

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

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

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

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

FPHSA met this objective in FY 14 as 40,178 individuals were served through addictive disorders treatment and prevention services, which is seven percent of the population of FPHSA's catchment area.

FPHSA expanded services in Addictive Disorders by contracting with the 22nd Judicial Drug Court to provide services to individuals referred to FPHSA by the court in St. Tammany Parish. This cost reimbursement contract has expanded services to include individuals who were not previously served by FPHSA and provides an additional revenue source.

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

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

FPHSA continues to have success towards this objective. The percentage of individuals receiving Flexible Family Funds/Cash Subsidy and the percentage of individuals and families receiving family support who remain in the community versus being institutionalized were both 100 percent again in FY 14. The percentage of Waiver participants with a current Statement of Approval was again 100 percent in FY 14. The total number of individuals served through waiver supports and services increased from 1255 in FY 13 to 1288 in FY 14.

Objective 3: Each year through June 30, 2016, Florida Parishes Human Services Authority/Executive Administration will increase the efficiency of the operation

and management of public, community-based services related to addictive disorders, developmental disabilities, mental health, and permanent supportive housing in the parishes of Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington.

FPHSA has met this objective by the continued co-location of facilities over the last few years. FPHSA completed the co-location of staff and services to combine the provision of services and to reduce operating expenditures. Developmental Disabilities Services was the first to relocate to the newly leased facility located on Pride Drive in Hammond. FPHSA's has also co-located/relocated Hammond Addictive Disorders Clinic, Rosenblum Mental Health Center for Adults, and Mental Health Administration. The relocation of FPHSA's Executive Administration completed the merger with the move to the Pride Drive location in December 2013. Combining these facilities is estimated to save FPHSA approximately \$150,000 annually. FPHSA clients now benefit from this accomplishment as multiple services are now located in one facility and the coordination of services for multiple disorders is more readily accessible and care more integrated. This accomplishment contributes to FPHSA's goal of improving efficiency of services using data-based decision making and also the objective of to increase efficiency of the operation and management of the agency.

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

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

FPHSA is still progressing to meet this objective by FY 2016.

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

FPHSA has continued to work to meet this objective.

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

FPHSA made significant progress in the last year. In January 2014, FPHSA met its goal of becoming CARF accredited. The agency began reorganizing our internal structure, developing policies and procedures, and conducting on-going staff trainings to continue this progress.

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

None

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

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

FPHSA's strategic plan has not changed; however, the agency's working business plan continues to evolve with the ever changing demands of the behavioral health and developmental disabilities fields.

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

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

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

FPHSA is working to strengthen their Accounts Receiving capabilities.

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.

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 (HR)
- External audits (Office of Risk Management; Louisiana Department of State Civil Service, Office of the Legislative Auditor, Magellan, Department of Health and Hospitals Accountability and Implementation Plan (AIP), etc.)
- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- 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

- a. Human Resources
- b. Office of Risk Management – Compliance Review
- c. Office of the Legislative Auditor
- d. Louisiana Department of State Civil Service
- e. Magellan Treatment Record Reviews
- f. Louisiana Performance Accountability System (LaPAS)
- g. Contract Monitoring
- h. DHH--The Human Services Accountability and Implementation Plan (AIP) Annual On-site Monitoring Final Report
- i. ADS Peer Review
- j. Accreditation received in January 2014—annual reporting and re-certification scheduled in 2017.

2. Date completed

- a. Annually for each facility
- b. February 18, 2014
- c. October 8, 2014
- d. September 3, 2013
- e. October 21, 2013 (Mandeville location), February 7, 2014 (Slidell location), May 2, 2014 (Hammond location)
- f. September 2014
- g. Quarterly
- h. March 27, 2014
- i. June 5, 2014

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

- a. FPHSA Procedure 540.1 Time Administration
- b. FPHSA Risk Management Policy and Procedure (ORM Requirement)
- c. Accountability over public funds as required by State law
- d. Compliance to State Civil Service requirements
- e. Requirement of the LBHP Partnership
- f. Compliance to LaPAS requirement
- g. FPHSA Contract Regulations and Procedures
- h. Compliance with MOU with DHH
- i. Block Grant requirement

4. Methodology used for analysis or evaluation

- a. FPHSA Procedure 540.1 Time Administration
- b. Compliance Review completed by ORM, LP Officer
- c. Audit completed by the Louisiana Legislative Auditor
- d. Civil Services policies and rules
- e. Review completed by Magellan
- f. DOA-required methodology; performance indicators developed by FPHSA and approved by DOA
- g. FPHSA Contract Regulations Policies and Procedures
- h. Accountability and Implementation Plan (AIP)
- i. Peer Review

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

- a. Not calculated
- b. Not calculated
- c. \$14,967
- d. Not calculated
- e. Not calculated
- f. Not calculated
- g. Not calculated
- h. Not calculated
- i. Not calculated

6. Major Findings and Conclusions

- a. None
- b. None
- c. None
- d. Civil Service Findings:
 - a. Agency must ensure that rejected applicants who do not meet the minimum qualifications are notified of the action taken.
 - b. Agency must maintain documentation of minimum qualifications and preferred qualifications for each of its appointments, promotions, reallocations, and details to special duty that require such documentation.
 - c. Agency must maintain official position descriptions for all positions within the agency.
 - d. Agency must ensure that DPRL checks are performed in accordance with Civil Service directives.
- e. None
- f. None
- g. None
- h. None
- i. None

7. Major Recommendations

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

8. Action taken in response to the report or evaluation

- a. Audit results are discussed at management team meetings and trouble shooting is done.
- b. None
- c. None
- d. Human Resources has recently implemented various “checklists” to assist the HR staff in ensuring all necessary tasks are completed
- e. None
- f. None
- g. None
- h. None

i. None

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

- a. Electronic files
- b. Hard copy
- c. <http://app1.la.state.la.us/PublicReports.nsf> Hard copy
- d. Hard copy
- e. Hard copy
- f. www.doa.louisiana.gov/opb/lapas/lapas.htm
- g. Hard copy
- h. Electronic Files
- i. Hard copy

10. Contact person for more information, including

Name:	Melanie Watkins
Title:	Executive Director
Agency & Program:	Florida Parishes Human Services Authority
Telephone:	(985) 543-4333
E-mail:	Melanie.watkins@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: Kathy H. Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Jan Kasofsky, PhD; Executive Director

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

CAHS Partners with East Baton Rouge Parish Prison to Reduce Recidivism

In spring of 2014, the East Baton Rouge Parish Prison approached Capital Area Human Services (CAHS) about partnering to provide additional clinical social work services to the incarcerated seriously mentally ill. Since May 5, 2014, Capital Area Human Services has provided licensed social workers to the East Baton Rouge Parish Prison Medical Services for a total of 20 hours per week. The goals of the partnership are to assess behavioral health needs in each referred individual and to establish ongoing linkages to care after release. Since May, a total of 263 persons with behavioral health needs have been assessed and linked with care while incarcerated and upon release. According to Warden Grimes, one positive outcome attributed to the program has been that of reduced behavioral problems in the prison environment. A key component of the program is the work of the CAHS Peer Support Specialist. The Peer Support Specialist makes weekly contacts both individually and in groups to provide encouragement and hope to those battling addictions. Magellan Behavioral Health Services provided the seed grant money for the Peer Support Specialist. The long term goal is to link individuals in need with appropriate care and to reduce recidivism.

CAHS Integrates Certified Peer Support Specialists into BH Services

In January 2014, Tonja Myles achieved certification as a Peer Support Specialist and has worked with CAHS clients through the Department of Corrections' Second Chance Act Co-occurring (Addictions & Mental Health) Grant, the Magellan Seed Grant for services at EBR Parish Prison, and the Mental Health Block Grant for community outreach. Tonja has been instrumental in connecting people to much-needed treatment services at CAHS in order to support the recovery process and decrease their chances of re-arrest or re-hospitalization. According to Substance Abuse and Mental Health Services (SAMHSA), "Recovery from Mental Disorders and/or

Substance Use Disorders: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” These professionals work hard to help people with life challenges follow John Wooden’s inspirational quote, "Do Not Let What You Cannot Do, Interfere With What You Can Do."

In four months, 263 persons were identified with behavioral health needs and seen by the CAHS social worker in the EBR Parish Prison, assessed and linked with care while incarcerated and upon release.

Of the 73 females seen in the jail by the Peer Support Specialist, 26 have been released and 77% are current/active CAHS outpatient clients.

Of the 168 males seen in the jail by the Peer Support Specialist, 62 have been released and 21% are current/active CAHS outpatient clients.

The Warden of the EBR Parish Prison attributed reduced behavioral problems in the prison environment to this program.

CAHS’s SBIRT Woman’s/LSU Collaborative for Prenatal Addiction & Women’s Specific Gender Programs Improve Treatment Outcomes and Retention

CAHS’ new SBIRT Woman’s/LSU collaborative for the Prenatal Addiction Program which began in May of 2014 allowed us the opportunity to provide brief screening and counseling services for expecting mothers with substance abuse, domestic violence issues, and depression. From May-Aug 2014, we screened 557 individuals of which 160 tested positive (29%); provided 52 clients with services, and made 66 community referrals.

The gender based addiction program began an evidence based program using Seeking Safety. CAHSD trained two clinicians on the program. We have tripled enrollment/retention in this program since the 3rd quarter of FY2014.

CAHS Continues to Diversify Services Through Credentialing & Contracting With Commercial Insurances and Private EAP Programs

As a result of bringing Practice Management Services to our organization during FY2013; the Credentialing and Contracting Department is currently contracting with over 12 health plans for over 93 providers at 12 different locations/programs. We are currently beginning our commercial EAP program which will enable us to contract with companies that provide counseling services to their employees, further diversifying the services at CAHSD. We are now in 2 private EAP networks.

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

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

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

The District operates under two separate five-year strategic plans. We, as part of the Department of Health and Hospitals, participate in the state-wide LaPAS Performance Based Budgeting and Planning process which establishes 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. Progress on meeting our annual goals is reported semi-annually to the CAHS Board.

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

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

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

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

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

None

1. To what do you attribute this lack of progress? For example:
 - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
 - Is the lack of progress due to budget or other constraint?
 - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
 - Other? Please specify.
 2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?
- ♦ **Has your department revised its strategic plan/business plan to build on your successes and address shortfalls?**
- Yes. If so, what adjustments have been made and how will they address the situation?
- No. If not, why not?

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

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

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

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

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

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

management, operations, and/or service delivery. “Problems or issues” may or may not be related directly to strategic plan lack of progress.)

Capital Area Human Services District (CAHSD) has created both fiscal and operational efficiencies when necessary to adjust for the changing environment.

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? Yes

a. If so:

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

Provided funding is approved by the Legislature during the FY2016 Budget process, services can be restored as quickly as the first quarter of FY2016 (July-September 2015).

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

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?

- b. How much has been expended so far?
- c. Can this investment be managed within your existing budget? No
If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
- d. Will additional personnel or funds be required to implement the recommended actions? If so:
 - Provide specific figures, including proposed means of financing for any additional funds.
 - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review: Magellan annual certification/review and CARF accreditation annual reporting and re-certification scheduled for 2015
- Customer/stakeholder feedback
- Other (please specify): State Licensure (BHS and Public Health-Department of Health and Hospitals)

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

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

C. List management reports and program evaluations completed or acquired by your office

during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
Louisiana Performance Accountability System (LaPAS)
2. Date completed
Quarterly July 01, 2013 through June 30, 2014
3. Subject or purpose and reason for initiation of the analysis or evaluation:
Legislative requirement
4. Methodology used for analysis or evaluation

LaPAS: Standard methodology required by the DOA; actual performance indicators developed in conjunction with program offices and approved by the DOA.
5. Cost (allocation of in-house resources or purchase price)
LaPAS: Cost uncalculated
6. Major Findings and Conclusions
LaPAS: None
7. Major Recommendations
LaPAS: None
8. Action taken in response to the report or evaluation
LaPAS: None
9. Availability (hard copy, electronic file, website)
LaPAS: www.louisiana.gov/opb/lapas/lapas.htm
10. Contact person for more information, including Agency & Program:

Name: Jan Kasofsky, PhD
Title: Executive Director
Agency & Program: Capital Area Human Services District
Telephone: 225-922-2700
E-mail: Jan.Kasofsky@swe.la.gov

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

Name: Adina Collins

Title: Accountant Administrator
Agency & Program: Capital Area Human Services District
Telephone: 225-922-0004
E-mail: Adina.Collins2@swe.la.gov

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Sandee Winchell, Executive Director

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

For each accomplishment, please discuss and explain:

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

The Council provided leadership in advocacy, capacity building and systemic change activities that contributed to increased awareness of the need for community-based services for individuals with developmental disabilities and the impact of educational policies and practices on students with disabilities. Through the Council's technical assistance provided to two grassroots advocacy networks, Louisiana Citizens for Action Now (LaCAN) and Louisiana Together Educating All Children (LaTEACH) numerous policies were changed to improve and/or increase community services. Significant policy and practice changes influenced by LaCAN and Council advocacy related to community-based services include the Department of Health and Hospitals increasing the array of therapies provided under Children's Choice waivers, increase in the community capacity in behavioral and medical interventions in the community, improvements to the Office of Behavioral Health Consumer Care Resources policy, implementation, and agreeing to add an additional New Opportunity Waiver (NOW) emergency waiver slots. Advocacy

efforts were successful with increasing Legislators awareness and support for increased funding for additional NOW slots, the Individual and Family Support Program, and Families Helping Families Centers; relaxing training requirements for direct support professionals in self-directed programs; and, the inclusion of people-first language across all applicable Louisiana statutes.

Educational policies influenced by the advocacy efforts of LaTEACH and the Council leadership include the creation of a pathway for certain students to be promoted to higher grade levels and graduate with a high school diploma; continued consideration of changes to the Minimum Foundation Program (MFP) to address inequities in funding across school structures relative to students with disabilities. Advocacy efforts have continued providing information and parental input to the MFP Task Force.

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

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

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

targeted educational campaigns to policy makers, advocates and the general public conducted by the Council. The vast majority if not all of these changes would not have occurred without the specific actions taken by the Council. The Council has expanded its repertoire of strategies and tools to connect with the public and policy makers and has plans to continue to build its capacity to utilize social media networks and tools to conduct education campaigns and provide timely information to constituents.

This progress is due to the Council having developed and supported large grassroots advocacy networks and family support agencies over the past twenty years. It is expected that there will continue to be an increase in the influence the Council and self-advocates and family members of individuals with developmental disabilities have on decisions by policy makers. The Council's capacity to educate the general public and policy makers about needed changes to existing policies and/or the impact of pending decisions is well established and growing.

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

None.

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

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

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

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

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

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

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

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

A. Problem/Issue Description

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

The Council's federal funds are not currently in jeopardy, but the allocation was reduced as a result of the federal sequestration and the Council will continue to monitor the Federal Budget.

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:

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 2013 on its performance in compliance with the federal Developmental Disabilities Assistance and Bill of Rights Act.

This report is based on the federal fiscal year – October 1 to September 30, and therefore covered the first quarter of state fiscal year 2013-2014. A report covering the remainder of the state fiscal year will be submitted to the federal government in December 2014.

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

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

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

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Yolanda Webb, Executive Director

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

For each accomplishment, please discuss and explain:

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

Care Management / Administration

Metropolitan Human Services District (MHSD) provides increased access, engagement and coordination of care for behavioral health and the developmental disabled populations in Orleans, Plaquemines and St. Bernard parishes in doing the following:

Single Point of Entry

MHSD continues to fulfill its statutory role as the planning body for behavioral health and developmental disability services for residents of Orleans, Plaquemines and St. Bernard

Parishes by developing a Single Point of Entry (Front Door) to services as the central point of intake and eligibility for services in our community. This is significant because all community stakeholders will now have better access to all services provided through MHSD.

Our SPOE (Single Point of Entry) strives to:

- *Improve the way clients/consumers/families and the community learn about MHSD and available service options.*
- *Better connect individuals to needed services.*
- *Gives people as many options as possible through Freedom of Choice.*

The 'front door' or SPOE (Single Point of Entry) is for any individual seeking services for the first time or for those currently in service who need additional or modified services.

Our SPOE guides people through eligibility, assessment, identification of service needs, service authorization and implementation. This is an essential part of helping us achieve the outcomes associated with our strategic plan.

We also consolidated our MCRT (Mobile Crisis Response Team) for adults and children provided through a community contract into our Single Point of Entry through one telephone number to access our crisis service system.

The SPOE meets Goal I 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, Plaquemines and St. Bernard parishes.

MHSD IT/Fiscal:

MHSD's fiscal spin-off from the Department of Health and Hospitals (DHH) was completed on July 1, 2014. MHSD is actively using its new accounting system and has implemented the various banking controls as well. Policies are being revised to include the payment function and to ensure appropriate segregation of duties are in place.

MHSD worked with DHH and DOA over the year to spin-off of the DHH network. The spin off is mostly complete and included establishing secure back up equipment and data location in Baton Rouge for emergency preparedness purposes.

Clinical Operations:

- *Created a new inclusive screening for DD, SA, MH.*
- *Created Nursing Public Health Screening tool.*

- *Received 3-year CARF Accreditation for agency in our CPST/PSR program for Child/Youth Services.*
- *Coordinated referral process with Juvenile Court for Court involved youth to be assessed through MHSD.*
- *Completed credentialing with BlueCross & BlueShield of Louisiana for all physicians and LCSW's*

Operations/ Compliance/Human Resources

- *Completed purchase on building on Orleans/St. Bernard parish line to renovate as a replacement facility for the one damaged during Katrina.*
- *Outsourced MHSD pharmacy to contract pharmacy with QoL in MHSD clinic.*
- *Completed successful ORM Audit with 100% compliance*
- *Conducted HIPPA audit*
- *FEMA training standards maintained 100%*
- *Completed annual Affirmative Action Plan*
- *Completed Business Reorganization to meet new business model under Managed Care.*
- *Drafted and processed more than 170 contracts and contract amendments with community providers for services for individuals in Mental Health, SA, Gambling, and Developmental Disabilities*
- *Hired a Training Program Manager to provide both internal and external training for all stakeholders.*
- *Continued our marketing / communications efforts to increase the use of our Crisis Continuum and Single Point of Entry.*

Developmental Disabilities

MHSD conducts targeted collaboration with consumers, family members and community partners to identify individuals who may be eligible for supports offered through MHSD in the following ways:

- *Created an Employment Division to focus on development of a comprehensive person-centered employment program designed to support both a supported employment structure or micro-enterprise initiatives to employ individuals with disabilities.*
- *Reduced the volume of late and expiring Comprehensive Plans of Care (CPOC) for Waiver recipients through consistent processes and accountability plans.*
- *Hired a FT (full time) Psychologist who has built capacity of community psychologist to provide clinical services (Positive Behavioral Support) to individuals and families dealing with behaviors that disrupt quality of life, through direct support and oversight, thereby reducing our waiting list.*

Children's Behavioral Health Services

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

- *Launched pilot program with providers in our children's program to develop sustainable programs missing from the children's continuum: FFT, Triple P, and NOLA Dads.*
- *Partnered with LSU and Tulane teaching programs to design and develop 'specialty programs' including 0-6 treatment.*
- *Created an independent assessment/resource coordination unit for child/adolescent services.*
- *Transitioned behavioral health flex funds program to DD to create one consolidated program.*
- *Held community forum with more than 100 individuals and families in attendance on prevention and integration of Mental Health and Substance Abuse Treatment available through MHSD. Positive outcomes achieved as parents presented at the forum on services through MST (Multi-Systemic Therapy) program.*
- *Developed and established two youth support programs at two alternative high schools in Orleans parish.*
- *Worked collaboratively with DD, OBH, Magellan, OCDD, DCFS to address co-occurring and placement needs of youth hospitalized at Interim Louisiana Hospital Emergency Room for 9 days.*
- *Prevention program contracted and monitored evidenced-based, substance abuse curriculum programming services for students in 50 different schools in the MHSD catchment area.*
- *Gambling prevention services were provided to 637 students and we completed 356 tobacco sales compliance checks.*

Adult Behavioral Health Services

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

- *MHSD has begun an employment division that will incorporate the supported employment needs of Adults and Children in transition from high school with behavioral health needs and integrate treatment into employment planning, will be based on consumer choice and will offer individualized follow-along supports to employers and clients.*
- *Held informational and working summits with providers in Housing, Addiction and Mental Health Services.*
- *Worked to have a more formalized and active Regional Advisory Council.*
- *Ongoing work with the Community Alternative Program (CAP) and the Mental Health*

Court Program through Municipal Court to develop a comprehensive working system with key stakeholders to include NAMI, MHSD, Court Personnel, and the City of New Orleans.

- *Implemented the new IA/CBCM unit effective June .*
- *Designed new Resource Linkage Coordination program to complement IA/CBCM process.*
- *Nursing supports added to transitional housing*
- *ACT team added*
- *Second transitional housing provider identified.*
- *Transitioned New Hope NOLA beds to Medicaid reimbursement*

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

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

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

- ♦ **Where are you making significant progress?** If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
 1. To what do you attribute this success? For example:
 - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
 - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new 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?

MHSD has made significant progress as evidenced by our Single Point of Entry and Resource Coordination linkage program and outcomes in our clinic, Adult, Children's and Development Disability programs.

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

MHSD is not currently experiencing a lack of progress.

- ♦ **Has your department revised its strategic plan/business plan to build on your successes and address shortfalls?**
 - Yes. If so, what adjustments have been made and how will they address the situation?
 - No. If not, why not?
- ♦ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

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

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

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

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

MHSD has created both fiscal and operational efficiencies when necessary to adjust to the changing environment around us. As a result of the managed care structure, MHSD has undergone a business reorganization and changing business model and the District will continue to work with the State Department of Civil Service.

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)?

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?
-

We will be meeting with CS to describe our organizations structure and potential new model in order to create positions that will help us serve individuals in more person-centered and recovery focused ways.

b. If not:

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

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

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

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

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

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

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

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

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

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

2. Date Completed: August, 31, 2014

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

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

5. Cost: None

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

7. Major Recommendations: None

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

9. Availability: Hard copy & electronic file.

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

2. Date Complete: Current/ongoing plan monitoring 12/15/2014

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

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

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

6. Major Findings: none to date

7. Major Recommendations: none to date

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

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

1. Title of Report: DHH Follow up on Transition to the LBHP as Experienced by Five Human Services Districts/Authorities – State of Louisiana / Informational Audit/Financial Audit Services

2. Date Completed: September 24, 2014

3. Subject/Purpose: Follow-up informational audit of the transition issues for the LBHP at the Department of Health and Hospitals (DHH) and the Office of Behavioral Health (OBH).

4. Methodology: The focus of the audit was the human services districts and DHH-OBH in the following areas through interviews, data analysis of HER (electronic health records), fiscal audits, accessing internal controls over payment processing, reconciliations of payment systems, management surveys

5. Cost: None

6. Major Findings: For MHSD no major findings

7. Major Recommendations: No recommendations for MHSD – DHH to ensure that contracts are monitored closely and that all contract requirements are met.

8. Action: MHSD has shared report with its Board and Leadership staff. MHSD will be performing its own accounting services, payment management and financial reporting as of July 1, 2014 and using our own HER exclusively.

10. Contact person for more information, including

Name: Yolanda Webb, PhD (Candidate)

Title: Executive Director

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

Telephone: 504-535-2909

E-mail: Yolanda.webb@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: J. Ruth Kennedy, Medicaid Director

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

For each accomplishment, please discuss and explain:

Accomplishment # 1: Expansion of Lymphedema Coverage

A. What was achieved?

DHH expanded coverage of Custom-fit compression garments and other supplies, such as compression pumps, in order to help mitigate the symptoms of individuals experiencing lymphedema. Lymphedema is a condition that can cause severe swelling and is commonly experienced by those who have undergone certain cancer treatments, with 30 to 40 percent of those that have had breast cancer experiencing the disease. The compression garments are also used to treat vascular insufficiencies or to decrease contractures related to burns, which could result in a physical functional loss.

B. Why is this success significant?

The expanded coverage for lymphedema supplies will help patients suffering from the disease to recover from cancer treatment in greater comfort and with fewer residual ailments.

C. Who benefits and how?

Recipients suffering from cancer, vascular insufficiencies or burns will now get the expanded supplies to help treat the swelling caused by lymphedema and will help recovering cancer patients return to their lives faster and more comfortably. Without compression patients cannot maintain their condition, and suffer needlessly from an increased incidence of serious infections, loss of mobility and/or function, and other

preventable complications (including possible death).

D. How was the accomplishment achieved?

Benefits and Services staff worked jointly on researching other state Medicaid and documented average billed charges for the supplies that need to be added, and successfully updated the fee schedule to place the codes into payment status.

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, the role of Senator Broome and providers in creating awareness of the gaps to the department leads to greater buy in and cross sector involvement.

Contact person for more information:

Name: Gail Williams

Title: Program Manager 4

Agency & Program: DHH/BHSF/MVA Benefits & Services

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E-mail: gail.b.williams@la.gov

Accomplishment #2: Applied Behavior Analysis

A. What was achieved?

The Department successfully launched an Applied Behavior Analysis (ABA) program, making Louisiana the first state to offer ABA services through an approved State Plan Amendment. The State Plan Amendment for ABA services was submitted to CMS on February 28, 2014. DHH received verbal approval from CMS and the Department began providing services under the State Plan Amendment on April 1, 2014. Written approval from CMS was received May 23, 2014 with an effective date retroactive to February 1, 2014. As of June 30, 2014, 31 licensed ABA providers are enrolled in the program and Louisiana Medicaid is providing ABA therapy to 84 children.

B. Why is this success significant?

This is significant as it provides a medically necessary service for children with Autism Spectrum Disorder (ASD) and other disorders that can correct or ameliorate behaviors associated with these disorders. Early intervention with ABA therapy potentially saves DHH in the long term cost of care for persons with ASD and related disorders.

C. Who benefits and how?

Persons who meet the following criteria will benefit from the services: 1) Under age 21, 2) Exhibit excesses and/or deficits of behaviors that significantly interfere with home or

community activities, 3) Diagnosed by qualified health care professional with condition for which ABA-based therapy services are recognized as therapeutically appropriate, including ASD. Although not successful for every child, many children who receive it may eventually function in the community with minimal to no deficits.

D. How was the accomplishment achieved?

DHH was under court order to provide these services, but was concerned the court's approach would not be approved by CMS and therefore would not qualify for federal matching funds. While the order was under appeal, DHH consulted with CMS as to other options for covering this service, and then negotiated with counsel to seek court approval to replace the original order with an agreed-upon approach. This meant DHH could withdraw the appeal. It was important to find a solution that was acceptable to CMS but that also implemented the services expeditiously. Accordingly, DHH temporarily provided the service through the Children's Choice Waiver and converted the program to a Section 1905(a) (6) "Other Licensed Practitioners" model once the State BCBA Licensing Board began issuing licenses for these providers.

The State Plan Amendment for ABA services was submitted to CMS on February 28, 2014. DHH received verbal approval from CMS and the Department began providing services under the State Plan Amendment on April 1, 2014. Written approval from CMS was received May 23, 2014, with an effective date retroactive to February 1, 2014.

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

Yes, adding this new service addresses Goal II of the strategic plan, which is to expand existing services and develop additional community-based services as an alternative to institutional care.

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

Not applicable.

Contact person for more information:

Name: Rene Huff
 Title: Program Manger 1-A
 Agency & Program: DHH/ BHSF
 Telephone: 225-342-3935
 E-mail: rene.huff@la.gov

Accomplishment # 3: Dental Managed Care

A. What was achieved?

The Louisiana Department of Health and Hospitals (DHH) entered into a competitive procurement process to choose a single Dental Benefit Manager (DBM) to provide

dental services to Louisiana Medicaid and LaCHIP recipients statewide. The request for proposals (RFP) was released on January 8, 2014, and a selection was made on March 21, 2014. There were four proposals submitted and Managed Care of North America (MCNA) was selected as the DBM.

B. Why is this success significant?

The awarding of this contract supports the Department's reform initiative intended to improve quality of care, improve health outcomes, and control costs. Incorporating dental into managed care will position the state of Louisiana in line with the recent Center for Medicare and Medicaid Services (CMS) Children's Oral Health Initiative to improve children's access to dental care, with an emphasis on prevention.

C. Who benefits and how?

The Dental Benefit Manager, MCNA, will provide benefits to approximately 1.2 million Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) enrollees who are eligible to receive dental benefits, whether they receive health care services through traditional fee-for-service Medicaid or a Bayou Health Plan. Medicaid recipients will have greater access to dental services through the DBM due to network adequacy requirements of the contract. DHH benefits through greater budget predictability and working toward quality improvement goals.

D. How was the accomplishment achieved?

Successful implementation of the Dental Benefit Manager (DBM) during the period of SFY 14 was the result of a plethora of factors including:

- A statewide forum held to gather feedback on enhancing Medicaid Fee-for-Service dental care;
- Weekly calls with providers and contracted dental plan to address issues and concerns prior to implementation;
- Weekly meetings between the Managed Care Medicaid Deputy Director and the contracted dental plan's executive management staff; and
- Tracking of dental plan complaints with immediate investigation and resolution.

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

Yes, strategic plan performance indicators include performance measures of the dental plan with annual increases.

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

The Department has found the following methods highly effective in monitoring contracts: standing provider conference calls held on a weekly basis with the DBM, internal complaint tracking, and recurring required status reports from the DBM.

Contact person for more information:

Name: Cordelia Clay

Title: Program Manager 1A

Agency & Program: DHH/BHSF/MVA Managed Care

Telephone: 225-342-4182

E-mail: cordelia.clay@la.gov

Accomplishment #4: Medicaid Reorganization

A. What was achieved?

In SFY 14, BHSF successfully completed a major realignment of Medicaid administrative operations around business functions. This was listed as a corrective action in the SFY 13 AMPAR.

B. Why is this success significant?

The driving forces behind the reorganization were: (1) the monumental shift in recent years from legacy Medicaid to a managed care model and (2) the elimination of nine T.O. positions due to budget cuts. These two factors provided functional and financial motivation to realign the organizational structure to efficiently and effectively administer the evolving Louisiana Medicaid Program.

C. Who benefits and how?

The agency was sensitive to the declining morale from previous personnel reductions and the lack of merit increases for several years. The loss of additional positions without a corresponding reduction of workload would have placed excessive burden on the remaining staff who would have inherited the workload, increasing the likelihood of less than optimal performance. The reorganization benefited remaining staff by reducing redundancies and achieving a more equitable distribution of work. The reorganization also benefited Louisiana Medicaid providers and recipients by avoiding any deterioration in quality or timeliness of service.

D. How was the accomplishment achieved?

The reorganization was achieved through the guidance and diligence of various stakeholders, including senior management, DHH Human Resources, and Civil Service. Reasons for change were communicated to staff, and options and recommendations were solicited from the senior management team. Interviews with administrative staff to match individuals with newly created positions were held between July to September 2013 prior to Civil Service approval and the assignment of existing staff within the newly created functional organization.

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

This accomplishment supports the strategic plan goal for business process improvement, enabling the most cost-effective use of health care resources, reducing and eliminating inefficiencies, duplication of resources, and non-optimal activities. It also incorporates the federal Medicaid Information Technology Architecture (MITA)

principles for Medicaid administrative business processes.

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

We believe all departments and agencies should reexamine their organizational structures on a regular basis to ensure that the organizational structure aligns with their business functions.

Contact person for more information:

Name: Ruth J. Kennedy

Title: Medicaid Director

Agency & Program: DHH/BHSF

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E-mail: ruth.kennedy@la.gov

Accomplishment # 5: Eligibility Determination System (MEDS) Upgrade

A. What was achieved?

The Affordable Care Act (ACA) mandates surrounding alignment of Medicaid eligibility determinations across all states for certain populations required a major overhaul of existing systems, policies, processes and procedures. The Medicaid Eligibility Determination System (MEDS) required significant changes in order to accommodate the new Modified Adjusted Gross Income (MAGI) methodology for determining income eligibility and to build in the capacity to exchange account information with the Federally Facilitated Marketplace. Eligibility staff received training on the new budgeting methodologies and system modifications as they were implemented.

B. Why is this success significant?

Compliance with the ACA provisions for determining Medicaid eligibility was mandatory in order for the state to continue receiving federal matching payments for Medicaid eligibility operations costs and medical claims. This successful implementation prevented an insurmountable budgetary deficit.

C. Who benefits and how?

Louisiana citizens benefit from the ACA implementation, as eligibility determinations become more streamlined with those across the state and provide consistency for anyone moving between states and needing assistance.

D. How was the accomplishment achieved?

The Eligibility Division collaborated with the Eligibility Systems Division on an ongoing basis in order to address all of the changes required. This collaboration involved multiple contractors and required daily coordination and strategic planning which is still occurring today.

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?**

This implementation was done at an accelerated pace due to the delayed federal guidance and would not be recommended for replication.

Contact person for more information:

Name: Diane Batts

Title: Medicaid Deputy Director

Agency & Program: DHH/BHSF/ Medicaid Eligibility

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Email: diane.batts@la.gov

Accomplishment #6: Modernization of Medicaid Systems

A. **What was achieved?**

The Bureau of Health Services Financing (BHSF) completed its first year of planning with regard to modernization of Medicaid systems and ongoing enhancement of current systems. In conjunction with CMS and DOA, we have developed a vision of moving forward with our modernization effort.

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

CMS, the primary funder for the implementation and operation of our traditional Medicaid Management Information System (MMIS), had advised us of the future of MMIS as states seek outcome-driven and meaningful ways to improve their Medicaid programs and manage costs and stressed that we must ensure that our efforts are in alignment with the Seven Standards & Conditions and the Medicaid Information Technology Architecture (MITA) framework. Additionally, this change was imperative from the State's perspective, as the introduction of Medicaid Managed Care has significantly changed the landscape of the systems necessary to support the Louisiana Medicaid Program.

C. **Who benefits and how?**

Louisiana as a whole benefits from the modernization of the Medicaid systems. It will reduce administrative costs, assist us in providing better customer service to our recipients, and allow us to better monitor the program—ultimately providing better quality of care.

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

Successful planning and development of our vision during the period 7/1/13 through 6/30/14 was the result of many factors, including:

- Weekly calls with DOA to address issues and concerns
- Weekly calls with CMS to address issues and concerns

- Issued a Request for Innovation (RFI) in December 2013
- Met with vendors who responded to the RFI
 - Lessons learned about procurement
 - What did the vendor have to offer
- Contacted and researched what other state Medicaid program were doing
 - Lessons learned about procurement
 - What was the State's vision for their MMIS

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 Request for Innovation (RFI) process and the meetings that were held with vendors were very insightful. The meetings weekly with both CMS and DOA were instrumental in the process. These meetings helped keep our vision on track and within the parameters of both parties.

Contact person for more information:

Name: Bill Perkins

Title: Medicaid Deputy Director

Agency & Program: DHH/BHSF/Medicaid Systems Division

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

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

In regards to ABA, we are meeting anticipated timelines relative to launching the program under State Plan, meeting Chisholm Court-Ordered implementation and reporting mandates, enrolling new ABA providers and authorizing/managing the ABA services benefits.

Since the ACA changes applied to over 75% of the Medicaid population, there has been a marked impact on performance goals and objectives. The strategies being employed

are designed to ensure the greatest return on investment.

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.

Significant progress is being made in terms of drafting and revising state plan, emergency rule and provider manual, enrolling new ABA providers, developing dashboard data, completing standardized and routine data reporting, etc.

1. To what do you attribute this success?

- Consultative working relationship with CMS regarding how to provide ABA through Medicaid.
- The licensure of BCBAs by the Louisiana Behavior Analyst Board allowed Medicaid to enroll BCBAs as “other licensed professionals”. Without this licensure, the service could only have been provided in a limited amount through a waiver.
- Rates for this service are set at 100% of the commercial rate to attract providers to enroll in the Medicaid program and serve the Medicaid population.
- Extensive outreach by DHH which has included emails, phone calls and enrollment webinars for potential Medicaid ABA providers.
- The Behavior Health Medicaid Medical Director is spearheading the ABA program and one full time staff person is handling the day to day operations for the ABA program, as well as answering the calls coming in to the toll free line that has been set up for this specific programs. Outreach was also done to Autism Related Societies and Groups.
- DHH staff is regularly fielding and answering questions from parents seeking ABA therapy for their children.

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

There has been significant progress in the first year of the program. As of June 31, 2014, Louisiana Medicaid was providing ABA therapy to 84 children. DHH went from zero enrolled Medicaid ABA providers to 31 enrolled Medicaid providers as of June 31, 2014. The progress is expected to continue as this is a new and growing field that is in high demand.

- ♦ **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?**

Prior to ACA implementation in other states, the Eligibility Division had transformed to specialized processing units as a mechanism to provide efficiencies and ensure accuracy and had deemed that decision to be a significant accomplishment. As a result of the vast changes to processes and procedures, this workload distribution is being reevaluated and may have to be revised. Once the ACA implementation efforts are completed and a new eligibility and enrollment system is rolled out, it is likely that the division of workload will again need realignment.

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

- Yes. If so, what adjustments have been made and how will they address the situation?
Performance indicators have been modified in order to more accurately reflect realistic expectations due federal ACA requirements and associated system defects.
- 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.

Program Management provides weekly updates to the Medicaid Director relative to achievement and issues rose each week. Monthly meetings are held to review data and quarterly dashboards are distributed throughout the Department.

The Eligibility Determination section works in conjunction with all four of the other Medicaid departments on a daily basis. Weekly meetings occur in order to identify areas of concern and impacts across the department. Having this level of collaboration and transparency ensures that goals and objectives of the entire Medicaid department are streamlined and clearly articulated.

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

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

A. Problem/Issue Description

1. **What is the nature of the problem or issue?**
 - A limited number of specialists in Louisiana qualified to perform Comprehensive Diagnostic Evaluations.
 - Access to BCBA’s is better in some areas of the State than in others.
 - Training and qualifications for registered line technicians.
2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)**
 - Although there is a limited number of specialists in Louisiana qualified to perform Comprehensive Diagnostic Evaluations, DHH has been able to ensure that children seeking ABA therapy receive an evaluation on a timetable comparable to the timetable for evaluations in the commercial market.
 - Although some areas of the State have more enrolled BCBA’s than other areas, Louisiana’s Medicaid program already has more enrolled BCBA’s than any commercial plan in the State.
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?

DHH is currently surveying all mental health professionals enrolled to provide services to Medicaid clients to determine if they are qualified to perform Comprehensive Diagnostic Evaluations. In addition, DHH is considering engaging an outside contractor to train additional providers to diagnose ASD (and related disorders) and perform Comprehensive Diagnostic Evaluations for Medicaid clients. DHH is also pursuing an Emergency Contract with managed care cooperation that would require the contractor to build a network of Qualified Health Care Professionals to perform Comprehensive Diagnostic Evaluations for Medicaid clients. DHH is pursuing options for possible credentialing of Registered Line Technicians through the National Behavior Analyst Certification Board to assure minimum training and competencies are met.

DHH continues to engage in provider outreach to increase the number of Medicaid-enrolled BCBAs, particularly in rural areas of the State where fewer BCBAs are available.

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

Yes, in the weekly reports and monthly meeting

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? Within the next twelve months.
- How much progress has been made and how much additional progress is needed? This is a new program and these corrective actions are ongoing. Preliminary research has been done and the National Behavior Analyst Certification Board has been contacted. A number of Qualified Health Professionals have been contacted to determine if they are willing to perform diagnostic evaluations, and a contract is being pursued with an outside entity which will help credential and expand the network of providers.

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

There will be administrative cost to pay for the entity that will handle the ABA benefit and for the proposed training of diagnostic evaluators. These costs are estimated to be between \$2 and \$ 3.7 million.

b. How much has been expended so far?

None. (The Emergency contract for the entity to take over the management of the program is under review.)

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

Yes. If so, does this require reallocation of existing resources? No. If so, how will this reallocation affect other department efforts? Not Applicable

d. Will additional personnel or funds be required to implement the recommended actions?

No, assuming we are successful with the emergency contract for the outside entity to manage the program.

If so:

- Provide specific figures, including proposed means of financing for any additional funds. Not Applicable.
- Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests? Yes.

A. Problem/Issue Description

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

Medicaid eligibility determinations have been impacted due to the federal ACA requirements. There has been an increase in application processing times, as well as a delay in determining ongoing Medicaid eligibility decisions required annually.

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

Yes.

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

Medicaid Eligibility Operations, Medicaid Systems, Medicaid Managed Care, Medicaid Financial Operations.

4. **Who else is affected by the problem?** (For example: internal or external customers and other stakeholders.)
External customers and stakeholders, as applicants are waiting longer for decisions and providers have an increase in the timeframe for receiving payment.
5. **How long has the problem or issue existed?**
This delay began in October 2013.
6. **What are the causes of the problem or issue? How do you know?**
ACA implementation. The system modifications and determination processing were drastically modified due to ACA. No other changes occurred during this period that could attribute to the issue.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
Failure to process applications according to federal guidelines puts the department at risk of losing federal match for the Medicaid programs. Performance indicators will not be met. There exists the potential for lawsuits.

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

1. Title of Report or Program Evaluation: **Children's Health Insurance Program (CHIP) Annual Report FFY13**
2. Date completed: 1/31/14
3. Subject or purpose and reason for initiation of the analysis or evaluation:
This annual report is required by CMS to be completed using the template provided by them.
4. Methodology used for analysis or evaluation:
(1) Input from program staff, (2) Enrollment and expenditure data extract

from the Medicaid Management Information System via the MARS Data Warehouse, (3) Contract payments and administrative costs extracted from ISIS, (4) Healthcare Effectiveness Data and Information Set (HEDIS) performance measures calculated by University of Louisiana at Monroe (ULM), and (5) the 2011 Louisiana Health Insurance Survey.

5. Cost (allocation of in-house resources or purchase price): Not calculated

6. Major Findings and Conclusions:

- From December of 2011 to June 2012, Louisiana enrolled recipients statewide into Bayou Health, a new patient-centered managed care framework that replaces Louisiana's outdated fee-for-service system. In January 2013, LaCHIP Phase V enrollees moved into Bayou Health, which offers five statewide health plans that give enrollees a choice in their healthcare delivery system. Implementation of Bayou Health will help to improve health outcomes, reduce strains on the state budget, fight fraud and abuse, and offer safe, accessible and sustainable health care for Medicaid recipients and low-income uninsured citizens.
- Louisiana eligibility caseworkers continued to close an extremely low percent (1.4% at the end of FFY13) of CHIP children at renewal for procedural reasons (failure to complete renewal process, unable to locate, etc.). This impacts not only overall enrollment numbers but stability and continuity of coverage for eligible children.
- Louisiana also continued its Maximizing Enrollment grant activities, which are funded by the Robert Wood Johnson Foundation. These grant funds provide support to eight state grantees for systems improvements to improve the enrollment and retention of children in public health coverage.
- Louisiana continued to utilize Express Lane Eligibility (ELE), authorized by Congress in 2009, to enroll children receiving benefits through the Supplemental Nutrition Assistance Program (SNAP). In addition to initial enrollment, Louisiana took advantage of the technological savings afforded by ELE to renew children's certifications. As of September 2013, approximately 38,447 children have been enrolled using ELE and an average of 14,930 cases per month were renewed via ELE during FFY13. This process provides a time savings to field eligibility staff.

7. Major Recommendations: None at this time

8. Action taken in response to the report or evaluation: None at this time

9. Availability (hard copy, electronic file, website): Report is available online at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2324>

10. Contact person for more information, including

Name: Dawn Love

Title: Medicaid Program Manager

Agency & Program: BHSF-Medicaid

Telephone: 225-342-6375

E-mail: dawn.love@la.gov

1. Title of Report or Program Evaluation: **LaCHIP Annual Report for the Legislature (SFY14)**
2. Date completed: August 2014
3. Subject or purpose and reason for initiation of the analysis or evaluation:
This annual report is sent to the Louisiana Legislature to provide an overview of program enrollment and cost.
4. Methodology used for analysis or evaluation:
Enrollment and expenditure data extract from the Medicaid Management Information System via the MARS Data Warehouse as well as input from program staff.
5. Cost (allocation of in-house resources or purchase price): Not calculated
6. Major Findings and Conclusions:
The Affordable Care Act mandated changes to program eligibility requirements that have minimal effects on eligibility findings. DHH expanded LaCHIP Phase IV to include citizen women who are pregnant. Enrollment and expenditures have increased.
7. Major Recommendations: None at this time
8. Action taken in response to the report or evaluation: None at this time
9. Availability (hard copy, electronic file, website): Report is available online at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2238>
10. Contact person for more information, including
Name: Edward Fowler
Title: Medicaid Program Manager
Agency & Program: BHSF-Medicaid
Telephone: 225-342-7242
E-mail: edward.fowler@la.gov

1. Title of Report or Program Evaluation: **Medicaid Purchase Plan Annual Report for the Legislature (SFY14)**
2. Date completed: July 31, 2014
3. Subject or purpose and reason for initiation of the analysis or evaluation:
This annual report is sent to the Louisiana Legislature to provide an overview of program enrollment and cost.
4. Methodology used for analysis or evaluation:
Enrollment and expenditure data extract from the Medicaid Management Information System via the MARS Data Warehouse as well as input from program staff.
5. Cost (allocation of in-house resources or purchase price): Not calculated
6. Major Findings and Conclusions:
Effective January 1, 2014, program eligibility requirements changed to decrease the income limits from 250% of the Federal Poverty Level (FPL) to 100% of the FPL. Enrollment and expenditures have decreased significantly.
7. Major Recommendations: None at this time
8. Action taken in response to the report or evaluation: None at this time
9. Availability (hard copy, electronic file, website): Report is available online at

<http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2893>

10. Contact person for more information, including
 - Name: Edward Fowler
 - Title: Medicaid Program Manager
 - Agency & Program: BHSF-Medicaid
 - Telephone: 225-342-7242
 - E-mail: edward.fowler@la.gov

1. Title of Report or Program Evaluation: **2013 Louisiana Health Insurance Survey (LHIS) – December 2013 Parish Level Estimates and June 2013 Parish Level Estimates**
2. Date completed: August 2014 and April 2014
3. Subject or purpose and reason for initiation of the analysis or evaluation:
 - To measure the number of uninsured persons in Louisiana, including divisions by geographical area and demographic groups
4. Methodology used for analysis or evaluation:
 - The 2013 Louisiana Health Insurance Survey (LHIS), a biennial survey designed to assess Louisiana's uninsured populations, received responses from over 8,600 households made up of over 23,000 Louisiana residents representing every parish in the state. This large sample size makes it possible to create detailed estimates for each DHH region and certain subpopulations, such as adults and children living under 200% of the poverty level. In addition, the estimates incorporate three different sample groups: landline phones, cellphones, and a sample of residents currently covered by Medicaid. The Medicaid subsample allows estimates of health insurance coverage to be adjusted to account for the Medicaid undercount present in other large health coverage estimations like the American Community Survey (ACS). These parish-level update reports are to present the uninsured rates for children and adults in each of Louisiana's 64 parishes. The basic approach is to use a small-area estimation model with micro-level data from the surveys, combined with administrative and census population data on key socioeconomic characteristics, to produce more robust estimates for low-population parishes.
5. Cost (allocation of in-house resources or purchase price): \$60,396.37 each
6. Major Findings and Conclusions:
 - Over the last decade, the Louisiana Health Insurance Survey found the uninsured rate of children declined from the highest uninsured rate since we began tracking the data (11.1% in 2003) to the lowest percent in 2011, 3.5% of children uninsured. The 2013 survey has seen a modest upswing in the percent and number of uninsured children across the state. In 2013, the percent of uninsured children is 4.4%, an overall increase of 9,976 more children uninsured than in 2011. For children who are eligible for Medicaid, the uninsured rate increased to 4.8%, an overall increase of 13,919 children since 2011. Even though the number of uninsured is

higher than in 2011, this year's findings are still lower than any other previous findings from the Louisiana Health Insurance Survey.

7. Major Recommendations: None at this time
8. Action taken in response to the report or evaluation: None at this time
9. Availability (hard copy, electronic file, website): Report is available online at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/3097>
10. Contact person for more information, including
 - Name: Katie Baudouin
 - Title: Medicaid Program Manager
 - Agency & Program: BHSF-Medicaid
 - Telephone: 504-568-3143
 - E-mail: katie.baudouin@la.gov

1. Title of Report or Program Evaluation: **ACT 212 Report**
2. Date completed: January 2014
3. Subject or purpose and reason for initiation of the analysis or evaluation: Act 212 of the 2013 Legislative Session calls for a high level of transparency in reporting, ensuring Medicaid managed care operates in the most efficient and sustainable method possible. The Act calls for 24 separate reports on Health Plan performance, many compared to pre-Bayou Health Medicaid data. This report outlines responses to the request made by the legislature in Act 212 relative to Bayou Health management and performance.
4. Methodology used for analysis or evaluation: Analysis of encounter data submitted to DHH by MCOs was performed by DHH employees. Information not captured on claims was obtained by referencing one of DHH's more than 50 required health plan reports. Information required by Act 212 but otherwise not reported was submitted by MCOs upon request.
5. Cost (allocation of in-house resources or purchase price): \$90,625 in-house resources
6. Major Findings and Conclusions: Over the course of the first year of implementation of the Bayou Health program, there were numerous noteworthy accomplishments, including:
 - Claims data indicates a significant reduction in statewide neonatal intensive care unit (NICU) days paid by Medicaid, meaning more babies were carried full-term.
 - The overall collective physician oversight for enrollees increased more than five-fold and new care management resources were offered to recipients.
 - More than 25,000 individuals received case management to help them better manage their chronic or high-risk health conditions.
 - Health Plans provided support for more than 63,000 members in their efforts to quit smoking, lose weight, gain access to dental and vision services and to purchase medical essentials such as prescription medications, health-related items for newborns and more.
 - Health plans are providing ongoing assistance to at least 111 practices in

- attaining Patient Centered Medical Home (PCMH) certification, with six having already obtained initial or higher level recognition.
7. Major Recommendations: An informational audit by the Louisiana Legislative Auditor found several areas for improvement including:
 - DHH should verify or audit the self-reported data.
 - DHH should ensure that it collects and verifies all encounter data timely since encounters are a primary tool to ensure accurate service delivery and payment information from the Health Plans.
 8. Action taken in response to the report or evaluation: DHH has increased its extensive internal validation process already in place. Additionally, DHH has taken steps to provide additional levels of verification to future reporting for Act 212 through its contract with Myers & Stauffer, beginning with the January 2015 submission. DHH will also contract with LSU to assist in report preparation to reduce the enormous burden this report places upon permanent staff. Also, DHH recognizes the complexities of the encounter collection task and the transition to a managed care environment, and remains dedicated to improving our collection and validation of encounter data. This is demonstrated by our contract with Myers & Stauffer as well as through internal controls put in place to improve collection. This includes the requirement that Prepaid Bayou Health Plans submit encounter data submission reports weekly for dedicated claims staff to monitor, analyze and validate the data and remediate any inconsistencies between the Health Plans and the Fiscal Intermediary.
 9. Availability (hard copy, electronic file, website): The Bayou Health Transparency Report can be found online at <http://new.dhh.louisiana.gov/index.cfm/page/1750>
 10. Contact person for more information, including
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 - Title: Medicaid Program Manager
 - Agency & Program: BHSF-Medicaid
 - Telephone: 225-342-6917
 - E-mail: joshua.hardy@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

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

For each accomplishment, please discuss and explain:

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

DHH Implements New Internal Audit Processes

The Department of Health and Hospitals (DHH) has made significant improvements to its internal audit division aimed at strengthening the programs and processes that serve to protect and promote health throughout the state. In July 2013, DHH started organizing its Internal Auditing Section to address immediate concerns and risk assessments by hiring a Compliance Officer to maintain an internal audit staff, as well as contract with an outside auditing firm to protect the department from waste, fraud and abuse.

One of the first steps DHH took to improve audits within the Department was the hiring of Bill Root, as the Department's Chief Compliance Officer to develop and implement a new internal audit function. The Department also hired two new auditors who will conduct risk assessment surveys and serve as part of a "strike team." Since then, this team has provided critical process

improvements. The Department is confident that these changes will help to deter and more quickly detect fraud and other concerns within the Department.

The key changes implemented within the new Internal Audit Division include:

1. New risk assessment surveys to identify potential vulnerabilities within the Department so that audits may be conducted and corrective action plans may be implemented;
2. The designation of an audit coordinator to serve as the single point of contact for all external audit agencies, including the Louisiana Legislative Auditor, will coordinate all results and responses, and assist in kick starting any process improvements that are found to be needed during the course of an audit.
3. The hiring of a new investigator who will serve as a critical member of the internal audit team; and
4. A "strike team" availability to assist Department leadership in quickly investigating and auditing any urgent issues that may arise.

Other changes include: incoming checks to the Department now go directly to bank-controlled lock boxes which removed DHH employees from the process of handling checks; training of employees on new policies for the receipt of checks and strict handling protocols; and the use of electronic funds transfers where available.

The Internal Audit Division also plans to contract with an external audit firm when the audit needs of the Department require additional resources.

Division of Health Economics Excels in Provider Fee Projections

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

Since these estimates are not available from any other source, these Provider Fee projections are very useful in that they allow the Division of Administration (DOA) to make budget projections based off of DHE's estimations. Also, the projections are useful for DHH executives and state officials in the Medicaid budget development process (occurs September/October).

These projections benefit the executives of the department, sister agencies, associations, Division of Administration, Legislature, and the Governor's office.

The DHE is able to achieve these accomplishments (high accuracy rate and other) due to highly efficient health economists using appropriate data and econometric models. Through these estimations DHE is able to provide the Department's executives, DOA & Governor's office with accurate and timely analyses for the budgeting process.

If appropriated additional resources and data, DHE could make projections for other needed elements as well.

Health Standards Section Exceeds Projected Workload

Health Standards Section (HSS) exceeded its planned workload in multiple areas and especially in the non-long term care arena. This accomplishment was achieved by assigning a supervisor who directly supervises the staff in the field and who is responsible for the direct scheduling of the workload.

Given this commitment, staff far exceeded projected workload and HSS was awarded additional monies from the Centers for Medicaid and Medicare Services (CMS) to schedule and complete additional workload. Being able to take on additional workloads, allows facilities to be inspected at an interval that is within the guidelines of the CMS Mission Priority Document. Taking on additional workloads ensures closer adherence to established standards and thus improves the quality of care delivered to recipients. This also resulted in additional CMS funding allocations.

Louisiana State Board of Nursing Approves HSS Pilot

The Health Standards Section (HSS) Home and Community Based Services (HCBS) staff facilitated a provider work group on medication administration and Registered Nurse (RN) delegation that resulted in a client assessment tool being developed to establish clear definition and assessment criteria that can be used consistently across waiver client populations. The tool will determine a client's capacity to self-administer their medications and to determine whether they would require a referral to an RN for delegation of medications and/or noncomplex tasks.

The LA State Board of Nursing approved this tool to be piloted for a 6 month period by providers who participated in the work group. The development of a client assessment tool was a result of SB 499 of the 2014 Regular Legislative Session, which provides that direct service workers may administer insulin subcutaneously, nasally, or via insulin pump for individuals subject to criteria to be developed, and rules and regulations promulgated by the Department of Health and Hospitals, in conjunction with the Louisiana State Board of Nursing.

DHH New Chief Compliance Officer Honored with HHS Career Achievement Award

The Department of Health and Hospitals (DHH) Chief Compliance Officer William Root was honored by the U.S. Department of Health and Human Services (HHS) for his dedicated service with the Career Achievement Award. Root retired from HHS earlier in 2013 as the Assistant Special Agent in Charge of the Office of Investigations before joining DHH to head up the Louisiana Medicaid Program Integrity Office.

The Career Achievement Award is given annually to five or fewer employees with 10 or more years at HHS for their dedication and loyalty to the Department; they must also have received an exceptional or equivalent performance rating within the last year before their nomination.

Root, a Baton Rouge native, began his career as an investigator for the Louisiana Medicaid Fraud Control Unit, in which he worked with DHH to investigate several fraudulent schemes. For the last 26 years, Root served as a special agent for the federal government investigating transportation companies, physicians, hospitals, and various inpatient and outpatient healthcare providers.

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

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

Strategic Plan: Yes, the strategic plan for the Department of Health and Hospitals is on time for accomplishment. Our 5-Year Strategic Plan provides (1) a general picture of intended performance across the agency, (2) a general discussion of strategies and resources the agency will use to achieve its goals, and (3) general confidence and reliability that agency performance information will be credible. The Department's strategic planning efforts continue to improve over the past few years. The Office of the Secretary has also recognized and identified the need for improved performance information. Without increased management attention to setting priorities and developing overall goals that can be used to assess its performance, the Department would be limited in its ability to make significant progress.

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

usual” in Louisiana. As we moved forward from that first business plan, we have worked tirelessly as an agency to transform the delivery of and access to health care and services in the state of Louisiana, challenging decades of old models for how things are done.

Our priorities as an agency now center on three themes: Building Foundational Change for Better Health Outcomes, Promoting Independence through Community-Based Care, and Managing Smarter for Better Performance. As we present the next iteration of our business planning process – our goals for fiscal year 2014 – we continue to use these themes to guide our efforts to improve the way we manage our programs and services for a healthier Louisiana.

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

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

- ♦ **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?

Currently, there are no areas experiencing a significant lack of progress.

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

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

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

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

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

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

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

In addition, 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, if needed.

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

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

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

A. Problem/Issue Description

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

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

In July 2013, DHH started organizing its Internal Auditing Section to address immediate concerns and risk assessments amid allegations of fraud. One of the first steps DHH took to protect the Department from waste, fraud or abuse was to hire a Chief Compliance Officer. The new Chief Compliance Officer will maintain an internal audit staff as well as contract with an outside auditing firm to protect the department from waste, fraud and abuse.

Four key changes to the internal audit process have already been implemented, including new risk assessment surveys, the designation of a single audit coordinator, the hiring of a new investigator and an audit "strike team" that will address urgent audit needs within the Department.

Other changes include: incoming checks to the Department now go directly to bank-controlled lock boxes which removed DHH employees from the process of handling checks; training of employees on new policies for the receipt of checks and strict handling protocols; and the use of electronic funds transfers where available.

The Department has submitted changes to its audit processes as an Internal Audit Charter to the Louisiana Legislative Auditor and the Inspector General for review in order to ensure the changes meet compliance requirements.

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?

Corrective actions have already been implemented by hiring a Chief Compliance Officer and supporting audit staff.

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?

The only cost these corrective actions carry are the salary and benefits for the Chief Compliance Officer and supporting audit staff.

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

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

- Internal audit**
The Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions. The internal audit function within DHH appraises activities within the department to safeguard the department against fraud, waste & abuse. This function also ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is

promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

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

The Louisiana Office of the Legislative Auditor conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities. In the coming fiscal years, the DHH Internal Audit Division plans to contract with an external audit firm if/when the audit needs of the Department require additional resources.

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

Performance Progress Reports (Louisiana Performance Accountability System)

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

In-house performance accountability system or process

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

Benchmarking for Best Management Practices

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

Secretary, if modifications or additions are needed.

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

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

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

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

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

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

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: **Kathy Kliebert, Secretary**

Undersecretary: **Jeff Reynolds**

Agency Head: **Lisa Schilling, Executive Director**

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

For each accomplishment, please discuss and explain:

A. What was achieved?

The South Central Louisiana Human Services Authority (SCLHSA) successfully integrated Primary Care into our Behavioral Health Care setting. The overall goal of this integration is to improve and promote overall health within the general population. SCLHSA recognizes the need for patients to take care of both their physical and behavioral health needs. The mind and the body cannot be separated; symptoms and illness in one impacts the health of the other. Both physical health and behavioral health benefit from prevention efforts, screening tests, routine check-ups, and treatment. Our philosophy of holistic care recognizes and respects the role of individuals and their families in the health care experience and we strive to provide our patients with person centered treatment that reflects their total mind and body needs.

B. Why is this success significant?

Traditionally, behavioral health has been sort of marginalized, and patients have been treated separately from those with physical health concerns. But we know mental health issues present commonly in primary care and complicate the care of patients with other medical conditions. So, trying to integrate behavioral health and primary care services makes sense. This new service is extremely significant to our agency because the integration of behavioral health services with primary care services offers a promising, viable, and efficient way of ensuring that our patients have access to much needed primary care services all under one roof. Additionally, the integration of primary and

behavioral health services can help to minimize stigma and discrimination, while increasing opportunities to improve overall health outcomes. SCLHSA feels that adding primary care to our service menu is an intentional, ongoing, and a committed coordination and collaboration between all providers treating the individual. Some of the benefits from Primary Care services being offered at our clinical sites include: Prevention Care, Disease Management, Acute illness Visits, Pediatric Care, Behavior Health Treatment and Counseling, Sexually Transmitted Disease Prevention and Treatment, Family Planning, and Sports and School Physicals and Laboratory testing.

C. Who benefits and how?

SCLHSA providers recognize and appreciate the interdependence they have with each other to positively impact healthcare outcomes. SCLHSA Behavioral Health Clinics, the Judicial System, local advocacy agencies, Education system, Office of Juvenile Justice, Dept. of Children and Family Services, Early Steps Program, Medical professionals, Louisiana Rehabilitative Services, family members and friends are all beneficiaries of the collaborative approach SCLHSA has created in our clinic settings with the addition of Primary Care to the treatment regimen. SCLHSA and our patients benefit from addressing behavioral health issues with a primary care provider by patients seeing better outcomes in their overall health through the collaboration of the two roles; reduced physician burnout by psychiatrists transferring medication management only clients to primary care for follow-up; and reduced costs of care improving patient outcomes through treating patients total health care needs. This total care concept will eventually lead to a reduction in emergency room visits and hospitalizations. One of the things we anticipate is there will be a positive return on investment, meaning the money we spend on this service will be far less than the savings that will be accrued by providing these services.

D. How was the accomplishment achieved?

The SCLHSA Board of Directors and staff committed to hold the agency to the performance improvement standards included in the Strategic Goals and Objectives focusing on the unique needs of each person the agency serves, and monitoring of the results of services we provide. SCLHSA began with an internal examination of its program and business practices. The examination consisted of the SCLHSA staff conducting an in-depth self-evaluation review of agency policies, procedures and documents and making improvements in protocols and procedures to improve service delivery from the point of entry to discharge and then follow-up in the community. The addition of primary care services to the SCLHSA treatment protocol serves to emphasize the agency mission statement “To promote overall health within the general population by increasing public awareness and access for individuals with behavioral health and developmental disabilities to integrated primary care and community based services while promoting wellness, recovery and independence through education and the choice of a broad range of programmatic and community resources.”

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

As a service provider, SCLHSA has the advantage of utilizing clearly defined and

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

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

Payers whether a third-party funder, referral agency, insurance company, or governmental regulator looks for CARF-accredited or evidenced based service providers to lessen risk and provide greater accountability. Accredited providers have proven they have applied a comprehensive set of standards for quality to their business and service delivery practices. Because CARF accreditation signals a provider's demonstrated conformance to internationally accepted standards, it can significantly reduce governmental monitoring and help to streamline the regulation processes. The value of CARF Accreditation is evidenced by the organization's continual effort to improve efficiency, fiscal health, and service delivery -- creating a foundation for consumer satisfaction and the agency impetus to accomplish its existing Strategic Goals and Objectives and to implement new ones that push the organization to the next level of performance and compliance

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

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

Overall, the South Central Louisiana Human Services Authority (SCLHSA) remained on target with our Strategic Plan Goals and Objectives. The Authority consistently

utilizes strategies outlined in its Strategic Plan to effectively demonstrate performance and quality improvement on a continuous basis. In addition to Strategic Plan Goals and Objectives, implementation of efficiency strategies also produced positive results in the areas of client engagement, documentation of clinical treatment, client satisfaction (internal satisfaction survey results improved over perceived positive outcomes), and staff retention. SCLHSA continues to work towards the accomplishment of its Strategic Plan Goals and Objectives that focus on the agency remaining viable in the ever changing healthcare environment locally, statewide and nationally.

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

During FY 2013-2014, South Central Louisiana Human Services Authority (SCLHSA) has made huge strides in demonstrating compliance with its Strategic Goals which were created with input from the SCLHSA Board of Directors, Local Providers and SCLHSA staff. The four following goals represent the community’s perspective on where our agency needs to continue to concentrate its efforts:

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

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

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

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

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

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?

The South Central Louisiana Human Services Authority (SCLHSA) strives for continued progress toward achieving Strategic Goals and Objectives in support of its Mission: To increase public awareness of and to provide access for individuals with behavioral health and developmental disabilities to integrated community based services while promoting wellness, recovery and independence through education and the choice of a broad range of programmatic and community resources.

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

We are not experiencing any significant lack of progress.

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

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

South Central Louisiana Human Services Authority's (SCLHSA) implemented additional Strategies were added specific to: expansion of eligibility criteria, strengthened collaboration with community partners/stakeholders; intensified focus on evidence-based and best practices for treatment/services delivery; increased access to

social support systems; increased monitoring; increased technical assistance to contractors; and, pervasive performance and quality improvement activities. All strategies were geared to assure sustainability, increase capacity, and continue the delivery of high quality effective services and supports. The Authority also honed Performance Indicators, retaining some trending data with the bulk of the attention focused on the development of true and meaningful outcome measures.

No. If not, why not?

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

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

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

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

South Central Louisiana Human Services Authority (SCLHSA) informs employees about Strategic Plan Goals, Objectives, and Performance Indicators via monthly Manager Meetings and, Directors involve staff in data collection, analysis, and reporting of Performance Indicator outcomes. Clinic Managers lead discussion about

the Performance Improvement Plan during staff meetings (held weekly), reporting progress, obtaining staff input, and emphasizing accountability for reaching goals and objectives.

The Executive Director schedules quarterly All-Staff Videoconference meetings each year with the entire agency. Performance improvement is a routine part of the agenda. Further, the Executive Director bases a significant portion of the Division Directors' annual performance reviews on their contributions to the South Central Louisiana Human Services Authority (SCLHSA) Strategic Plan and Performance Improvement Initiatives as well as on their degree of success in accomplishing organizational goals and objectives.

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

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

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

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

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

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

A. Problem/Issue Description

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

During FY 2013-2014, South Central Louisiana Human Services Authority (SCLHSA) had to actively manage its resources to ensure that the Authorities clinical services positions were filled with qualified staff.

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

Yes, the South Central Louisiana Human Services Authority (SCLHSA) continues to adapt to its goals and strategies to remain within funding levels and sustain viability in the provision of services to the community.

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

Every activity of South Central Louisiana Human Services Authority (SCLHSA), i.e. Behavioral Health Services (mental health and addictive disorders) Developmental Disabilities Services, and the Administration component (which includes utilization management, monitoring, and billing functions).

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

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

5. How long has the problem or issue existed?

FY 2010-2011 and has continued through the FY 2013-2014 Fiscal Year.

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

South Central Louisiana Human Services Authority (SCLHSA) will address all impacts and must utilize effective and flexible strategies/tactics to continuously improve performance, service quality and to identify and capture alternative revenue streams.

B. Corrective Actions

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

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

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

South Central Louisiana Human Services Authority (SCLHSA) will:

- Continue execution of the Performance Improvement Plan to assure best use of our resources, streamlined operations and service delivery, high levels of productivity, open capacity, and high quality outcomes for individuals receiving services and supports.
 - Work with the Statewide Management Organization to ensure Medicaid reimbursement is optimized for evidence-based practices offered by SCLHSA in the home and in the community.
 - Continue implementation of the South Central Louisiana Human Services Authority (SCLHSA) Risk Management Plan.
 - Research grant funding opportunities for expansion of new programs and/or to sustain existing programs.
 - Explore opportunities to partner with pharmaceutical programs for research studies related to behavioral health and developmental disabilities.
 - Continue to explore and seek relationships with private payors to open new streams of revenue.
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? This is the third year that the SCLHSA participates in the budget and AMPAR process as a local governing entity and the third time that these recommendations have been submitted.
 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.
 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:

Corrective Actions for the South Central Louisiana Human Services Authority (SCLHSA) are viewed as business and service delivery processes woven into the

fabric of SCLHSA's daily operations. Primary responsibility for setting expectations and monitoring progress rests with the Executive Director; primary responsibility for execution of corrective actions rests with members of the Executive Administrative Team. Resources needed to successfully carry out these processes are through the Human Resources component; related duties and responsibilities are included in each Executive Administrative Team member's position description and in employees performance planning and rating documents. Executive Administrative Team members are expected to manage priorities with flexibility and their respective staff are to assure processes are ongoing and expectations are met or exceeded.

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

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

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

performance targets. The Executive Director, Executive Administrative Team, and the Supervisory Staff share responsibility for oversight of these functions. Outcomes are reported on no less than a quarterly basis.

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

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

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

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

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

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

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

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

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

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

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Monteic Sizer, Ph.D., Executive Director

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

Summary of Accomplishments:

- Completion of Phases II and III of the Local Governmental Entity (LGE) Readiness Assessment Criteria
- The Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation
- Relocating Developmental Disabilities staff to Regional Office
- Launched New Website
- Memorandums Of Understanding Addressing Integration of Behavioral and Primary Health

For each accomplishment, please discuss and explain:

A. What was achieved?

Successful Completion of Phases II and III of the Local Governmental Entity (LGE) Readiness Assessment Criteria as developed and reviewed by the State of Louisiana Department of Health and Hospitals (DHH). This review encompassed the areas of clinical protocols, financial controls, human resources, legal resources, programmatic operations, purchasing and contracting.

B. Why is this success significant?

This means that Northeast Delta Human Services Authority (NDHSA) has demonstrated its ability to independently govern, manage, and operate the functions of the LGE and its programs and services in a manner that meets Legislative mandates and the Human Services Accountability and Implementation Plan (HSAIP).

C. Who benefits and how?

Successful completion benefits the consumers of NDHSA by allowing the LGE to function independently from DHH in program development and allocation of assets to match the specific needs of the citizens of northeast Louisiana.

D. How was the accomplishment achieved?

Through successful development and implementation of a Board Governance manual and bylaws, an Operational Policy and Procedures manual, staff training, and thorough review by a DHH assessment team.

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

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

A. What was achieved?

NDHSA was surveyed by CARF International in April of 2014, and was accredited for a period of three years (the highest level of accreditation) for the following five (5) clinical programs:

- Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)**
- Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)**
- Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents)**
- Outpatient Treatment: Mental Health (Adults)**
- Outpatient Treatment: Mental Health (Children and Adolescents)**

B. Why is this success significant?

This meets the requirements of the Statewide Management Organization (SMO) for reimbursement of Medicaid payments for services provided by the LGE, and demonstrates the commitment of the organization towards providing competent, quality care. It also provides a foundation for effective and efficient business operations.

C. Who benefits and how?

Clients benefit as accreditation increases the focus on the use of “best practices” and

provides a framework for continuous quality improvements. It also helps identify opportunities for us to improve clinical services.

D. How was the accomplishment achieved?

This was achieved through the development/implementation of a comprehensive policy and procedures manual; annual operational plans and an outcome measurement system; staff training in the provision of clinical “best practices,” and an intensive and educational on-site review by CARF International.

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

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

A. What was achieved?

NDHSA relocated the Developmental Disabilities staff members into the Regional office and the DD Entry Unit at the Women and Children’s Clinic.

B. Why is this success significant?

This facilitated the overall development of human services delivery by combining two service units into one operational organization. In addition, location of the Entry Unit at the Women and Children’s Clinic has improved the community linkage and cross-referral access to services for our consumers.

C. Who benefits and how?

Operational and financial benefits created by the relocation benefit the citizens of northeast Louisiana through more efficient and collaborative service provision.

D. How was the accomplishment achieved?

Through the cooperative efforts of management and staff.

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

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

A. What was achieved?

The development of a new website for the NDHSA (<http://www.nedeltahsa.org>) was launched on 03/27/14

B. Why is this success significant?

This addresses one of the three tenets guiding our operations, i.e. greater access to services, and allows NDHSA to increase its availability and dissemination of information regarding services to the citizens of northeast Louisiana.

C. Who benefits and how?

Clients and potential clients have 24-hour access to information updates about services, events, program locations/times, emergency closures, ancillary services, etc.

The site also provides transparency regarding agency operations through the posting of compliance reports, program achievements/accreditations, complaint processes, contacting Board members, and other quality-related issues. All of these related to providing excellent customer service, another tenet guiding the operations of NDHSA.

D. How was the accomplishment achieved?

A contracted vendor was obtained to develop the website in conjunction with design input from executive management.

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

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

A. What was achieved?

NDHSA formed new collaborative relationships with community health providers through Memorandums of Understanding (MOUs), moving towards integration of behavioral health and health systems for the citizens of northeast Louisiana.

B. Why is this success significant?

This achieves better customer service for our consumer in connecting them with needed health care and wraparound services.

C. Who benefits and how?

NDHSA consumers and their families benefit from collaboration between behavioral health and primary health professionals in the treatment of multi-faceted health concerns.

D. How was the accomplishment achieved?

Due to the statistics of serious primary health concerns associated with persons suffering from behavioral health issues, and the movement across the state for more integrated care, NDHSA executive management spearheaded efforts to join local clinic management and local primary health facilities to explore ways to assist consumers in accessing all needed services.

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

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

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

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

Northeast Delta Human Services Authority (NDHSA) has not yet developed a 5-year strategic plan. A plan will be developed next fiscal year.

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

1. To what do you attribute this success? For example: **N/A**
 - 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?

Northeast Delta HSA serves as a catalyst for individuals with mental health, developmental disabilities, and addictive disorders to realize their full human potential by offering quality, excellent care with greater accessibility.

The following three tenets guide our actions:

Greater access to services,
Excellent customer service, and
Quality, competent care

- ♦ **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?

We are not experiencing any significant lack of progress.

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

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

Northeast Delta Human Services Authority (NDHSA) has not yet developed a 5-year strategic plan. A plan will be developed next fiscal year.

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

Not Applicable.

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

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

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

A. Problem/Issue Description

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

Issues related to better collaboration between Addictive Disorders and Mental Health treatment within NDHSA clinics and competency-based training for NDHSA personnel.

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

Northeast Delta Human Services Authority (NDHSA) has not yet developed a 5-year strategic plan. A plan will be developed next fiscal year.

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

Since competent, quality care is of utmost concern to the organization, this affects the overall operations as NDHSA strives to provide progressive, outcome-oriented, and comprehensive services to its consumers. However, Clinical Services is the frontline unit experiencing this problem.

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

Clients are affected through implementation of “minimally” effective treatment planning and coordination between AD and MH treatment units. The overall goal for NDHSA is to treat the whole person who comes to us seeking services and to see that our consumers get better.

5. How long has the problem or issue existed?

This is an ongoing issue for behavioral health providers.

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

Problems in staff training have always existed. The move to managed care and the desire prompted by accreditation to achieve a higher standard of organizational accountability in the treatment of our clients has highlighted the need to make this a focus for NDHSA going forward.

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

Failure to resolve this issue will result in the continuation of systems that operate independently of each other and without the coordination of service provision.

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?

Corrective actions include the formulation of continuous quality improvement mechanisms, including development of Peer Review teams to monitor service delivery systems, which guides training and is supported by clinical supervision and accountability to executive management.

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

4. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur? **By the end of FY15.**
- How much progress has been made and how much additional progress is needed? **Infrastructure is in place and training has been initiated.**

b. If not:

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

5. Do corrective actions carry a cost?

No. If not, please explain.

All initiatives have been accomplished through the use of existing resources and personnel.

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

Please discuss the following:

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

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

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

- Internal audit
Corporate Compliance performs audits of each department within NDHSA
- External audits (Example: audits by the Office of the Legislative Auditor)
Audits are done by the State Management Organization, the Office of Risk Management, and Office of Legislative Auditor, etc.
- Policy, research, planning, and/or quality assurance functions in-house
Corporate Compliance manages policy issuance and ensure adherence to policy for any procedures initiated within NDHSA.
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
Evaluations of clinical services by Corporate Compliance staff using Treatment Record Review, Review of Consumer Complaints, Critical Incident Analysis, and TeleSage Outcomes Measurement System (TOMS)
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)
Corporate Compliance reports performance data in LaPAS
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
Contract monitoring and technical direction of contracts
- Peer review
- Accreditation review
CARF
- Customer/stakeholder feedback
Consumer Satisfaction Surveys/C'est Bon/La Fete
- 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 2013-2014

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

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Hugh Eley, Assistant Secretary

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

#1 Unified Structure and Improvements to Adult Protective Services

Previously operated as two separate programs, Elderly Protective Services (EPS) and Adult Protective Services (APS) have been operated under a single management structure with significant improvement to services in SFY 14. Currently, eight of nine regions in the state now operate as a single program, offering services to all vulnerable adults age 18 and older, resulting in the following improvements:

- Centralized Intake has been implemented statewide. This ensures uniformity in regards to acceptance and assignment of reports statewide. It has also resulted in a higher percentage of reports made for elderly individuals being given a higher priority for investigation.
- On-Call services were extended to include all vulnerable adults over the age of 18. 24/7 coverage was not previously available for adults over the age of 60. A communication tool was developed to expedite priority waiver slots for Protective Services clients who have been abused or neglected and are at a high risk of harm.
- Case-workers moved to a work from home model which has enhanced productivity and saved money for the state by combining office space and reducing the need for leased property.
- The implementation of a “unified structure” for protective services has reduced caseload sizes by 18%. In 2012, the average caseload was 172 cases per case-worker. Now the average caseload is 141 cases per worker per year. The caseload reduction resulted from: (1) a redistribution of the workload across job functions; (2) improved training; (3) reallocation of positions to high volume areas; and, (4) the addition of positions.

- The existing data management systems were enhanced to ensure uniformity of reports. A data management team was formed to develop critical reports to assist with management decisions and to improve productivity.
- The quality assurance process was restructured to ensure a comprehensive review of all aspects of case activity from intake to closure.
- Staff development improved with the implementation of best-practices training curriculum for all new employees, monthly webinar training for specialists and supervisors, serious incident investigation training, cross-training with the Office of Citizens with Developmental Disabilities and the Office of Behavioral Health, and training for evidence-based documentation.
- Louisiana has increased its participation with the National Adult Protective Services Association (NAPSA). NAPSA provides resources and technical assistance to state protective services agencies. Louisiana is now better able to stay abreast of current standards in the area of protective services.
- Legal Services were enhanced when the APS Director provided training to all DHH legal staff related to the needs of Adult Protective Services and by the collaborative effort with the Advocacy Center of Louisiana for the purpose of developing *pro bono* legal resources to represent victims of abuse.
- Public awareness was improved. APS provided over 33 community presentations to professionals who offer services to vulnerable adults, participated in 3 media events, met with state Aging and Disability Resource Center Directors and recognized World Elder Abuse and Awareness Day by organizing and participating in related events.

Clients and their families benefit from the enhancements to operations that improve the timeliness and the quality of services delivered to vulnerable adults. The local communities benefit by improving their access to services and the state benefits by having a quality program that meets the needs of its citizens.

#2 CATS

In state fiscal year 2014, OAAS created a Compliance and Audit Team (CAT) to conduct audits and targeted assessments in an effort to assure the quality and accuracy of the LTPCS assessment, eligibility, and resource allocation processes. In this role the team is also well positioned to discover potential fraud and abuse. The team is aided by strategic data-mining and analysis performed by the OAAS statistical team which discovers patterns that are used to focus CAT efforts and provides data for more complete profiling of participant and provider performance and behavior. The team in the field consists of seven members supervised by the Program Manager for LTPCS and covers the entire state. The CAT affords the State the opportunity to monitor service delivery, therefore adding another resource to the oversight and delivery of LTPCS.

These efforts have led to major improvements in the accuracy of LTPCS eligibility determinations and resource levels. Data and audit findings pointing to issues in the assessment contractor's performance were reported and used in the contractor's quality improvement efforts. CAT findings have led to several referrals to Medicaid Program Integrity and the Attorney General. Cost avoidance thus far has been \$16 million.

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

citizens and to ensure that those citizens most in need receive those services.

#3 Established a nursing facility level of care review process:

Nursing facilities are required to complete an assessment of residents within twenty-one days of admission and periodically thereafter or as triggered by a significant change in a resident's health. OAAS has implemented a process to routinely review these assessments in order to assure that recently admitted individuals continue to meet nursing facility level of care and are appropriate for continued services in a nursing facility.

As a result of this level of care review process, OAAS has been able to identify and distinguish among:

- individuals appropriate for return to the community;
- individuals who have a continuing need for nursing facility services; and
- individuals who need additional review by the Office of Behavioral Health and/or the Office of Developmental Disabilities.

This review process was coupled with discharge planning training to nursing homes (described below) and by improvements to federally-mandated processes designed to insure that nursing homes identify and refer residents who express a desire to return to the community. The level of care review process benefits the residents by ensuring that they do not become institutionalized beyond need. This process also supports OAAS commitment to developing a long-term care system that meets the needs of consumers and caregivers.

#4 Best Practices for Discharge Planning

OAAS staff in collaboration with DHH Health Standards Section (HHS) and the Office of Behavioral Health conducted a webinar on the need for and best practices in discharge planning, and later created a video for distribution to all nursing facilities in the state. Both the webinar and the video emphasized the availability of resources for housing and behavioral health. Contributions to the best practices also was provided by The Capital Area Agency on Aging by providing a description of the services available through the Aging and Disabilities Resource Centers, and successful nursing home discharge planners and transition coordinators shared best practices.

Discharge planning for some residents with complicated needs and a poor social network can be a very difficult process. The best practices documented in the webinar and video has created a pathway for new personnel in nursing homes to acquire the basic knowledge they would need to carry out this responsibility. The immediate beneficiaries of these new best practices are nursing facility residents who obtain improved discharge planning.

#5 Medication Administration and Non-Complex Tasks

On December 20, 2012, DHH in conjunction with the Louisiana State Board of Nursing published a final rule in the Louisiana Register, Vol. 38, No. 12, related to training of direct service workers (DSWs) in medication administration and non-complex tasks. The rule allowed twelve months from the date of the rule for providers to comply with the direct service worker (DSW) training requirements. This rule allowed registered nurses to delegate medication administration and other

non-complex tasks to direct service workers once the DSW has successfully completed the required training and is deemed competent by the RN. The final rule incorporates best practices to ensure the health and safety of recipient who rely on DSWs to receive their medications and non-complex tasks. The best practices include the following:

- The RN will provide person-specific training to the DSW after the RN assesses the participant's health status. This additional step ensures medication and tasks are administered in a safe, appropriate manner.
- The RN will routinely assess the participant's health status.
- The RN will perform an annual competency evaluation to determine if the DSW is competent to perform medication administration and non-complex tasks safely and appropriately.

DHH (OAAS, OCDD & Health Standards) meets regularly with the Louisiana State Board of Nursing to provide feedback, evaluate effectiveness, and address issues as they relate to the participants' needs.

#6 State Personal Assistance Services Program additional services

In 2014, Senate Bill 498 (Act 493) amended the State Personal Assistance Services (SPAS) statute to clarify eligibility requirements, add additional services and make other changes to improve the flexibility of the program for participants. The additional goods and services can be used in lieu of personal care services or to supplement personal care services in order to increase a participant's independence or substitute for dependence on human assistance.

The previous definition in the statute was defined as persons with significant disabilities between eighteen (18) and sixty years (60) of age. The eligibility requirement was changed to twenty-one (21) and older to align with other program eligibility requirements for OAAS programs. Individuals on the waiting list will have the opportunity to receive a broader range of services and those currently receiving services will be afforded the opportunity of additional services to increase independence and avoid institutionalization

#7 Increases in Permanent Supportive Housing Units in New Orleans

The Louisiana Permanent Supportive Housing program (PSH) links affordable rental housing with voluntary, flexible, and individualized services to people with severe and complex disabilities, enabling them to live successfully in the community. In July of 2013, the Dr. Everette and Melva William apartments opened for business in New Orleans. This newly renovated complex is a partnership between UNITY of Greater New Orleans, the Louisiana Housing Corporation, DHH and HRI Properties. The complex consists of 30 one bedroom units which are dedicated to PSH tenants under the Shelter Plus Care Program.

The development of this property enabled the PSH program to house 30 homeless individuals with disabilities, most of whom were chronically homeless, in safe, affordable, fully furnished units. Based on the Common Ground model, support services are provided on site. The on-site services model provides an option for households that may not be as successful in scattered site housing.

Under this program, the tenant's portion of rent is based on income with all utilities included. Move in costs are eliminated because the units are fully furnished, utilities are included and security deposits are covered under the subsidy administrator. The on-site services are convenient, individualized and are not a condition of tenancy. This program continues to enable individuals to live successfully in the community.

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

During State Fiscal Year 2012-2013, forty-one percent (41%) of Permanent Supportive Housing (PSH) households were transitioned from the temporary revenue source of Community Development Block Grant (CDBG) funded services to a more sustainable revenue source of Medicaid funded services. Initially, PSH services were funded through a CDBG award. This CDBG funding was a non-renewable source that required a sustainability plan to ensure services would continue for PSH participants. Medicaid services were identified as the sustainable source and have proved to be a cost-effective and efficient way to continue these vital services for PSH participants.

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

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

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

#9 Improvements in the Quality Assurance Process and the Environment of Care at Villa Feliciano Medical Complex (VFMC)

At Villa Feliciano Medical Complex (VFMC), significant improvements were made to the quality of care process. Also, the residential and work environments were enhanced.

VFMC leadership adopted the Quality Assurance /Performance Improvement (QAPI) process, a new initiative in the industry designed to significantly expand improvement activities in nursing homes. The QAPI process utilizes a PDSA model that incorporates: (1) PLAN - develop and plan improvements; (2) DO - initiate the plan; (3) STUDY - pilot and monitor; and (4) ACT - implement the improvement based upon the results of the study. Using this model, leadership sanctioned several major performance improvement (PI) projects, including "One Home at a Time."

The “One Home at a Time” project promotes positive health outcomes and improves the quality of life for the residents of VFMC through offering a homelike atmosphere, as well as active engagement between residents and hospital staff.

Results of the QAPI /One Home at a Time project include:

- Refurbishing the grounds and entry to the facility
- Painting and decorating rooms and common areas in accordance with resident’s preference
- Educating staff on processes to encourage resident engagement
- Building showers in tub rooms
- Replacing furniture for day rooms in accordance with the recommendations of the clinical staff and other hospital team members
- Acquiring new beds, wardrobes and night stands for resident rooms
- Creating a storage solution for resident’s clothing and property
- Refurbishing and de-institutionalizing the dining areas

The adoption of the new quality assurance (QA) process was achieved as a result of two convergent factors. First, an environmental scan identified potential requirements for nursing facilities around the adoption of the new QAPI process. Second, several changes in key leadership positions brought in staff familiar with more rigorous QA standards used in other settings. Leadership then developed a new QA plan which included a solid performance improvement process. Once approved, the QAPI sanctions were initiated, and the goals within the parameters of the PI project were submitted to executive staff for approval. Finally, the members of the QAPI team delegated assignments and completed tasks.

Improvement in the QA process has benefitted leadership, visitors and staff through a variety of successful projects and by ensuring quality care is provided. The results of the QAPI project has boosted staff and resident morale, created comfortable and inviting spaces, and created an atmosphere that assures dignity and respect.

#10 Effective Continuation of the Money Follows the Person Demonstration

The Deficit Reduction Act of 2005 (Section 6071) enacted the Money Follows the Person demonstration, designed to help states move Medicaid-enrolled individuals from institutions back into the community.

This year, OAAS was able to exceed its MFP calendar year benchmark of 220 by 77 transitions; moving a total of 297 nursing facility residents back to their desired communities with community-based services.

These efforts are significant because OAAS’s community-based programs serve people at a fraction of the nursing facility cost, and because many people currently living in nursing facilities can, and would prefer, to live in their own homes and communities. MFP Demonstration funds also allow OAAS to build systems and infrastructure that strengthen the community-based services delivery system for all recipients.

#11 Continuation of the Nursing Home Innovations Grants

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

In FY14, OAAS conducted monitoring visits for grants awarded in the 1st grant cycle and completed the application process for the 2nd grant cycle for projects that will be carried out in FY15. The monitoring visits have confirmed that the projects have been highly effective in improving the quality of life for residents in the individual nursing homes that received the grants.

The grants project was launched as a pilot program in the FY13. Monitoring carried out in FY14 monitoring has demonstrated clear achievement of intended results. Nursing homes used the funds as proposed and can point to quantifiable improvements in the quality of life for residents in those nursing homes. These results have more than justified the continuation of the program in FY15.

The most immediate beneficiaries of the projects are the residents who reside in the nursing homes that were awarded grants. All of the homes met proposed goals, most of which focused on improvement in cognitive and physical well-being. Other outcomes achieved through the grants include improved resident satisfaction and increased socialization.

OAAS is continuing to rely on the services of a temporary employee paid for, with CMS approval, with CMP funds.

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

Accomplishments 1-8, 10 and 11 noted above contribute to OAAS strategic goal of “To expand existing and develop additional community-based services as an alternative to institutional care.” As the State seeks to advance better health through increased reliance on community-based services, there is a corresponding increased need for oversight and protection for those residing in settings that lack the degree of regulation associated with an institutional setting.”

Accomplishment #1 APS also contributes to OAAS Strategic goal “To timely complete investigations of adult abuse, neglect, exploitation, and extortion in the community” by utilizing best practices and available resources, through the consolidation of Protective Services, OAAS is better able to fulfill its mission to serve adjust with disabilities and to enable them to live free form harm due to abuse, neglect, exploitation or extortion.

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

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

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

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

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

◆ Where are you making significant progress?

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

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

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

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

In SFY 14, OAAS hired staff with expert skills and knowledge to create a Compliance and Audit Team (CAT). CAT focused efforts on conducting audit and targeted assessments to control quality and conduct monitoring of the Long-Term Personal Care Services program (LTPCS). CAT has proven to be effective

by identifying persons who were incorrectly receiving services through LTCPS and persons who should have been receiving LTPCS services as well as identified potential fraud and abuse of billing of LTPCS Medicaid services. OAAS has also focused efforts on nursing facility level of care reviews to insure that persons meet nursing facility level of care and are appropriate for continued services in a nursing facility. This level of care review process benefits the residents by ensuring that they do not become institutionalized beyond need.

Looking forward to SFY 15, the Office will be implementing electronic visit verification (EVV) system for OAAS/Medicaid home and community-based services. EVV system will assist in reducing billing errors and monitor for fraudulent billing. This valuable tool can significantly improve accountability to assure that services are being delivered to care recipients when and where providers claim they are; thus, reducing billing errors or fraudulent billings.

Overall, OAAS continues to meet internal objectives of operating and providing access to Medicaid long term care programs that provide over a billion dollars in direct services to people. In SFY 14, OAAS costs for administering and operating these programs constituted less than 3% of the cost of services delivered.

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

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

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

OAAS is working to develop a web-based assessment and care planning system which would make the process of accessing and enrolling in community-based services more efficient and improving the ability to conduct real-time monitoring of participant plans of care. Implementation is currently projected to occur in early 2015.

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

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

Our successes are consistent with our current plan.

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

The vision that OAAS maintains on increasing access to home and community-based services as a sustainable, cost-effective alternative to nursing home care, in addition to improving access,

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

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

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

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

A. Problem/Issue Description

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

B. Corrective Actions

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

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

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

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

No. If not, please explain.

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

Please discuss the following:

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

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

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

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

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

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

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

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

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

Name: Tara LeBlanc

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Agency & Program: Office of Aging and Adult Services

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Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: **Kathy Kliebert, Secretary**

Undersecretary: **Jeff Reynolds**

Agency Head: **Paige Hargrove, Executive Director**

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

For each accomplishment, please discuss and explain:

A. What was achieved?

1. Additional Level 1 Trauma Center in the state. LSU Health Shreveport was verified as a Level 1 Trauma center. This is the first time that the state has had 4 trauma centers verified by the American College of Surgeons (ACS).
2. Commitment from the Hospital Board at North Oaks Medical Center in Region 9 to become a Level 2 trauma center. They should be reviewed by the ACS in 2015 and if successful, they will be the 5th trauma center in the state.
3. Commitment from the Hospital Board at Lafayette General Medical Center in Region 4 to become a Level 2 trauma center. They should be reviewed by the ACS in 2015 and if successful, they will be the 6th trauma center in the state.
4. CEO's from 113 out of 114 hospitals have attested which to LERN Stroke Level bests fits their facility.
5. CEO's from 113 out of 114 hospitals have attested either ST Elevated Myocardial Infarction (STEMI) Receiving or STEMI Referral Center Status.
6. Expansion of the stroke "Hub and Spoke model" by 12 spoke hospitals thus expanding access to stroke care in underserved, rural areas of the state.
7. LERN Communication Center is providing destination assistance for Stroke and STEMI patients.
8. Supported disaster planning activities in each region of the state.
9. Expanded EMS Registry.

10. LERN taught 19 trauma Nursing Core Curriculum courses in 2013 resulting in 233 nurses obtaining certification in TNCC.
11. Began rule making process for Stroke and STEMI systems. Rule should be promulgated by the December 2014.

B. Why is this success significant?

1. Prior to LSU Health Shreveport achieving Level 1 Trauma Center verification, only 44.1% of the population had access to a verified trauma center within 1 hour drive time – the “golden hour” which is crucial to positive outcomes for trauma patients. With the addition of LSU Health Shreveport, 57% of the population has access to a verified trauma center within the golden hour. It has long been known that the best chance for survival following a traumatic injury occurs when the injured person is seen and treated within an hour of the event. This hour is known as the "Golden Hour" and the chance of survival for the level one trauma patient decreases after an hour has passed. For a state trauma system to work, paramedics, ambulance services and other hospitals, from the largest metro hospital to the smallest community hospital, must be committed to getting the patient to the trauma center within the "golden hour." I
2. It is significant because the addition of trauma centers in Regions 9 and 4 will expand “golden hour” coverage to 67% of the population thus improving outcomes for trauma patients in Louisiana.
3. It is significant because the addition of trauma centers in Regions 9 and 4 will expand “golden hour” coverage to 67% of the population thus improving outcomes for trauma patients in Louisiana.
4. LERN developed 4 levels of stroke hospitals. LERN Level 1 = Joint Certified Commission Certified Comprehensive Stroke Center, Level 2 = Joint that can Commission Primary Stroke Center, Level 3 = LERN Board developed provide requirements, Level 4 = bypass hospital, they do not have the capability of life-treating stroke patients. 118 CEO’s attested to how they fit into the system. See LERN website, www.lern.la.gov for more information. 45 hospitals attested as a level 4 hospital, indicating that they cannot provide timely/appropriate care to a stroke patient. With stroke, time is brain. Two million brain cells die every minute during a stroke. The sooner patients get to a hospital capable of providing life-saving treatment, the better their outcomes will be. Stroke is the fourth highest killer of Louisiana residents. Research shows that systems of care for treatment of STEMI and stroke decrease morbidity and mortality.
5. A ST Elevated Myocardial Infarction occurs from complete blockage of the artery and is the deadliest form of heart attack. Immediate opening of the artery is crucial to survival. The ideal treatment is opening the artery by angioplasty. In order to identify hospitals capable of providing 24/7/365 cath lab availability, the LERN Board adopted requirements for STEMI Receiving Centers, which were developed by the state STEMI workgroup. 118 CEO’s across the state signed an affidavit attesting to their ability to meet these requirements. Now EMS knows where to bring patients afflicted with STEMI. In many areas of the, State EMS obtains the EKG in the field, transmits the

- reading to the hospital while in route, thus activating the cath lab team who is ready for the procedure when the patient enters the door of the hospital. EMS has been educated to bypass the STEMI Referral Centers if they are within a 60 minute drive time to a STEMI Receiving Center. This saves lives.
6. Since January 2013 we have 12 additional spoke hospitals in the state. A “spoke” is a hospital that has a partnership with a “hub” hospital to provide stroke expertise/consultation within 15 minutes of the patient’s arrival to the spoke facility. Access to definitive care no longer means the delivery of a patient directly to a Comprehensive or Primary Stroke Center. Using the “hub and spoke” model, where a hub Comprehensive or Primary Stroke Center links to spoke hospitals via telemedicine, more patients can receive life-saving access to care and treatment with tPA. In fact, a study published by the American Heart Association, Telemedic Pilot Project for Integrative Stroke Care (TEMPiS), concluded patients treated with tPA by spoke hospitals produced virtually the same outcomes as hub hospitals. In addition, the randomized STRoke DOC trial in the United States showed that hospitals with access to telemedicine for stroke care resulted in more accurate diagnosis and less variation from protocols. Due to these studies, LERN is promoting a system of transporting stroke patients to tPA capable centers, and with 8 additional spoke hospitals we are getting closer to achieving a stroke system of care in Louisiana.
 7. Stroke and STEMI are both time-sensitive illnesses. The longer the time to treatment, the worse the patient outcome. When EMS does not know the closest most appropriate hospital for their patients, they call the LERN Communication Center (LCC). LCC routes them the closest appropriate hospital, thus saving time and obtaining the definitive treatment as fast as possible. This saves lives.
 8. Integration of LERN with ESF-8 is outlined in our enabling Legislation. As the 24 hour a day/365 day a year communications center resource, LERN serves as the “early warning” receptor of mass casualty events. When the LERN Communications Center is notified of a mass casualty that reaches ESF-8 trigger, LERN notifies the region(s) stakeholders and DHH leadership, allowing for mass casualty preparations. LERN participated in multiple table top exercises that proved effective when faced with live events.
 9. An EMS registry is a necessary step towards the development of a trauma system for the state. We now have >150,000 patient records in the registry. Acadian Ambulance is now entering data.
 10. Trauma nursing as a discipline refers to the process and content of all the different roles nurses have in the care of the trauma patient. Knowledge is the core of any discipline. The purpose of TNCC is to present core-level knowledge, refine skills, and build a firm foundation in trauma nursing.
 11. Promulgating the structure of the stroke and STEMI system solidifies the state program.

C. Who benefits and how?

1. Anyone who sustains a significant injury within the state benefits from an additional trauma center, especially those injured in Region 7 and surrounding areas. The LERN Medical Director provided assistance to LSU Health Shreveport.
2. Any patient sustaining a significant injury in the state, especially those in regions 4 and 9 benefits from a hospital working towards trauma center designation. The level of care at the hospital is elevated during this process.
3. Any patient sustaining a significant injury in the state, especially those in regions 4 and 9 benefits from a hospital working towards trauma center designation. The level of care at the hospital is elevated during this process.
4. Any patient sustaining a stroke in the state. EMS benefits because they have direction regarding where they should bring stroke patients. Hospitals benefit because the hospitals that don't have the capability to treat these patients will no longer have to spend extended amounts of time trying to transfer these patients to a higher level of care. They can expend their resources on patients that are within their treatment capability.
5. Any patient experiencing a STEMI in the state. EMS benefits because they have direction or a map of hospitals that clearly indicates treatment capability. Hospitals also benefit by receiving only those patients that cannot be transported to a STEMI Receiving center within 60 minutes. Hospitals that do not meet STEMI Receiving Center Requirements are automatically deemed a "STEMI Referral Center". LERN is working with these providers to hard wire their fibrinolytic protocols. Administration of a fibrinolytic is the second best option to opening the artery in the cath lab.
6. Citizens and visitors to Louisiana benefit from the state building a stroke system and expanding access to care.
7. Patients, EMS and Hospitals all benefit from utilization of LCC. Patients get to the right place, at the right time, for the right care. Having the LCC available 24/7/365 benefits the entire state. By expanding our routing capability to include stroke and STEMI patients we can
8. The citizens of the state that benefit. Early notification in relation to disaster preparedness or in response to a mass causality event results in a coordinated response and better outcomes. Hospitals benefit from a coordinated response whereby patients are distributed evenly as not to overload facilities.
9. The citizens of the State of Louisiana and any visitors to the State benefit because trauma centers and a trauma system have a direct correlation to improved care. The registry is the mechanism used to evaluate care provided and improve performance.
10. Nurses providing the care and the recipients (injured patients) benefit from the TNCC outreach efforts. Offering these classes has resulted in a more confident and more skilled workforce in emergency rooms across the state.
11. The citizens of the state and anyone visiting the state benefits from a stroke and STEMI system of care. It also benefits the providers (hospital and EMS) by providing a structure to build from.

D. How was the accomplishment achieved?

1. This was accomplished via multiple conversations, multiple on sight visits and assistance with the requirements needed to meet trauma center designation/verification. The LERN Medical Director is a reviewer for the American College of Surgeons trauma center Verification Review Committee (VRC) and a past chairman of the VRC. He visited LSU Health Shreveport to review their program, offered suggestions for their PI Committee, reviewed and made recommendations for changes to their PRQ before they submitted it to the ACS and provided consultation as needed in order to enable them to be successful in their actual review. The LERN Medical Director continues to provide support, leadership and consultation as needed for their program and for the other trauma centers in the state.
2. This was achieved via multiple meetings and presentations to the administrative staff and medical executive committees at each hospital regarding the importance of establishing a trauma system for the state. The LERN Regional Commission structure also facilitated stakeholder buy in and elevated the importance of establishing a trauma center in each region on the state. The LERN Medical Director works one on one with the medical leadership at each of these hospitals to build their trauma programs.
3. This was achieved via multiple meetings and presentations to the administrative staff and medical executive committees at each hospital regarding the importance of establishing a trauma system for the state. The LERN Regional Commission structure also facilitated stakeholder buy in and elevated the importance of establishing a trauma center in each region on the state. The LERN Medical Director works one on one with the medical leadership at each of these hospitals to build their trauma programs.
4. This was accomplished via the state stroke workgroup developing the frame-work of the system, obtaining feedback from the 9 LERN Regional Commissions and submitting the model to the state board for adoption.
5. This was accomplished via the state STEMI workgroup developing the frame-work of the system, obtaining feedback from the 9 LERN Regional Commissions and submitting the model to the state board for adoption.
6. This was accomplished by identifying the number of hospitals that did not have access to stroke expertise (Level 4 centers). This information was shared with the “Hub” hospitals. The “Hub” hospitals targeted these level 4 centers and executed partnerships to provide neurological consultations.
7. This was accomplished by working with DHH to expand the Resource Management portal to include the information about Stroke and STEMI. We provided e tri-regional education days and on sight education for hospital and EMS providers to be sure that they understood the system.
8. Support for disaster planning activities has been achieved via coordination between ESF-8 leadership and LERN leadership. We have also added disaster preparedness as a strategic priority. The tri-regional coordinators also worked closely with the Governor’s Office of Homeland Security and Emergency Preparedness (GHOSEP) rep on their commissions to embed LERN in more table top drills. LERN has also provided on sight training at hospitals and EMS agencies across the state.

9. Achieved by including data sharing as a stipulation for EHRIT grant participants. For agencies who were not participating in the grant, we worked collaboratively with their software vendors to facilitate the export and import of their EMS data into the state EMS Registry. By working collaboratively with EMS over the years, we have built trusting relationships. This has served us well in building the registry.
 10. Teaching TNCC has been a “boots on the ground” effort. Many of the requests for the class originate from the regional commission members. These classes have made a big impact on our hospital participation. Due to feedback from the nurses across the state we will expand our education offerings to include Emergency Nursing Pediatric Course in 2015.
 11. Achieved by working with the language state stroke and STEMI workgroups to develop the language for the rule. Obtaining stakeholder buy in was vital to moving the rule through the promulgation process without any public push back.
- D. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
1-11 = YES
- E. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
1. Yes
 2. Yes, it is a good example of engaging stakeholders to accomplish a defined goal.
 3. Yes, it is a good example of engaging stakeholders to accomplish a defined goal.
 4. Yes, it is a good example of engaging stakeholders to accomplish a defined goal. It is also an example of fulfilling the intent of the LERN Legislation.
 5. Yes, it is a good example of engaging stakeholders to accomplish a defined goal.
It is also an example of fulfilling the intent of the LERN Legislation.
 6. Yes. By first identifying the gap in coverage we were able to identify hospitals that should be targeted by the “Hub” hospitals.
 7. Yes – With any change, communication is paramount. Meeting one on one as needed helped to reinforce the education.
 8. Yes, leveraging assets between DHH agencies (LERN & ESF-8) and among law enforcement/industry provides efficiencies without duplication of service.
 9. Yes - In any system whereby you endeavor to improve performance you must have a data bank to benchmark performance.
 10. Yes
 11. Yes

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

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

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

1. LERN Mission Sustainability

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

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

Status: Comparative research has been conducted for funding alternatives. 8 options identified. The Executive Committee determined that the best option is to add LERN to an Existing Statutory Dedication and Enhance the Revenue stream. Strategy: Possible legislation in 2015. LERN operations could be added into the intended purpose of the Traumatic Head and Spinal Cord Injury Trust Fund. Penalties in current law for various serious motor vehicle violations could be doubled with half the revenue funding LERN. We continue the Low Income Needy Care Collaborative Agreement (LINCCA) for the Communication Center Staffing contract in order to leverage state general fund dollars.

2. Statewide Trauma Center Network

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

- Develop priority prospects for new Level II or Level III trauma center designations in regions without a trauma center. Secure at least two new commitments from hospitals to pursue ACS Level II or Level III trauma center verification.
- Research and design a regional performance improvement pilot.

Status: Tremendous progress has been made. We have a new Level 1 Trauma Center in Region 7 (Shreveport) and a Level 2 trauma center re-verified for an additional 3 years in Alexandria, LA. We developed a new LERN Website in order to more effectively communicate with our stakeholders. We continue to publish the LERN newsletter. The LERN team: made multiple presentations to promote trauma network concepts, conducted 11 community presentations to educate the public about the trauma system, hosted booths at OLOL Trauma Symposium, LSU Health Shreveport Trauma Symposium and the Rapides Regional Medical Center Trauma Symposium. Staff spoke at the ENA Conference and at the LSU Health Shreveport Conference. For the first time in the state, we have 4 ACS Verified/State Designated Trauma centers and are working with 2 additional hospitals to become level 2 trauma centers. We partnered with the Regional Highway Safety Coalitions to promote our injury prevention efforts, we hosted two Trauma Care After Resuscitation classes, and multiple classes for TNCC, RTTDC, PHTLS. The LERN Communication Center routed 14,492 trauma patients in 2013.

The performance improvement pilot is a work in progress.

3. STEMI Network

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

- Map geographic distribution of STEMI resources statewide.
- Educate and inform stakeholders of their role in the STEMI System.
- Set up process to monitor compliance with STEMI receiving center requirements.

Status: Map of geographic distribution of STEMI resources completed. Education provided via the tri-regional coordinators at the regional commissions and various other venues, STEMI Physician Champions identified in each of the 9 DHH regions, the ESF-8 portal is updated with statewide STEMI resources and the LCC routes patients to definitive STEMI care as needed. Rule promulgation for the STEMI system is almost complete. Monitoring of the system is being done via the case review process. Monitoring is difficult due to lack of data collection.

4. Stroke Network

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

- Develop comprehensive communications and earned media campaign featuring local and statewide spokespersons.
- Develop education plan for public and providers.
- Design process to monitor compliance with LERN Stroke Hospital requirements.

Status: Stroke Hospital capability established across the state via LERN levels/CEO attestation. Stroke toolkits and stroke reference cards developed for the Level 3 stroke centers. We developed data collection tool for level 3 stroke centers to submit data in an effort to promote quality improvement. Compliance with stroke requirements will be achieved via the data collection process and the case review process. Stroke system education was included in the 11 community presentations. The LERN Communication Center (LCC) routes EMS to the definitive care hospital as needed. LCC has routed 396 stroke patients in 2014 (thru Sept).

5. MCI/Disaster Preparedness

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

- Develop comprehensive communications and earned media campaign featuring local and statewide spokespersons.
- Develop education plan for public and providers.
- Design process to monitor compliance with LERN Stroke Hospital requirements.

Status: Provided a LERN update at the state Designated Regional Coordinator meeting on November 14, 2013 and requested that each hospital and EMS regional coordinator include LERN in regional drills. LERN participated in an Exxon Tabletop drill in October 2013, participated in an MCI Drill/Training with Acadian Ambulance in December 2013, and LERN is on the planning committee for the statewide Chem Pack exercise scheduled for 2014. We attended several regional LEPC meetings to provide education about the LERN System. We signed a contract with the United States Coast Guard to provide direction to the definitive care hospital. So far in 2014 we have participated in the following:

- Region 2: Active Shooter Drills at Central Middle, Catholic High, LSU; Plane Crash

at Baton Rouge Airport; Terrorist Drill at River Bend Nuclear Plant

- Region 3: Active Shooter at RK Smith Middle
- Region 5: Hurricane Drill
- Region 6: MCI Drill at Cabrini Hospital, Regional Airport drill, Fort Polk night jump
- Region 8: Plane Crash Drill in Monroe
- Region 9: Active Shooter at Springfield Middle
- Statewide Hurricane Drill

6. State Registries for Trauma, Stroke and STEMI

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

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

Status: Trauma

- State Data Reports for 2011, 2012, and 2013
- 4 Hospitals submitting data
- Three more hospitals slated to submit data in 2014
- Hosted trauma registry education for state trauma registrars

EMS Registry

- 7 agencies submitting data to the registry
- 4 more slated to submit data within the next 6 months
- Data sharing with Highway Safety Research for crash/injury study

Stroke/STEMI

- Promoting ACTION as the preferred registry
 - Approximately 9 hospitals in Louisiana currently use ACTION
 - Developed registry for Level 3 Stroke Centers
 - 4 hospitals have submitted data – work in 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:

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

- Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
Progress continues in part due to external factors. Contracting with subject matter experts continues to augment the effectiveness of the LERN staff. LERN continues to collaborate with local, regional and state level stakeholders to continue to build the statewide trauma & time sensitive illness network. Subject matter experts in Trauma Data Systems and the development of the Trauma Registry were instrumental in making progress. The same results would not have been achieved without specific departmental action.
- Is progress directly related to specific department actions? (For example:

Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

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

- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department’s contribution to the joint success? Specific department actions have directly related to the success of LERN. Examples include: DHH Health Standards Department has been integral in assisting with the development of rules and regulations for STEMI/Stroke. They are also an integral part of designating trauma centers in a timely manner. The Office of Aging and Adult Services has been helpful in research related to funding. Ryan Bilbo has assisted in running LaHidd data as well as the office of the state epidemiologist. Obtaining LaHidd data and mortality data has provided a baseline to work from and compare to national rates.
 - Other? Please specify.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

Progress is expected to continue, but building systems takes time. It takes 2 years for a hospital to become a trauma center. We will continue to make incremental progress in trauma. We expect 1 additional Level 2 trauma center to be verified by the ACS within the next 12 months. We expect to see 2 additional Primary Stroke Centers certified by the Joint Commission within the next year and continued expansion of the Hub and Spoke model. We have also embedded ourselves in regional disaster response plans and will continue to facilitate drills at the regional level.

- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state “None.” However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall

significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

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

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

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

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

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

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

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

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

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

No. If not, why not?

♦ **How does your department ensure that your strategic plan is coordinated**

throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation? Use as much space as needed to explain fully.

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

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

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

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

A. Problem/Issue Description

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

resolve the problem or issue?

Future changes to LINCCA may result in an inability to operate the communication center 24/7/365.

B. Corrective Actions

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

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

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

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

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

4. Are corrective actions underway?

a. If so:

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

b. If not:

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

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

the upcoming fiscal year or in previous department budget requests?

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
Review of literature, other best practices, review of other state trauma programs, is performed by LERN staff and consultants, used to guide the implementation and continued development of the LERN Trauma and Time Sensitive Illness Network
- Program evaluation by in-house staff
- Program evaluation by contract
Communications Center staffing provided by contract with AMR. Data is input to the Louisiana State owned ImageTrend system. This system software provides data on calls, time to definitive care, mechanism of injury and transport time.
- Performance Progress Reports (Louisiana Performance Accountability System)
LERN reports Performance Indicators quarterly through the LaPas system
- In-house performance accountability system or process
Monthly audits on Communications Center calls. Error statistics on data base with follow-up with each communicator. % secondary transfer log.
- Benchmarking for Best Management Practices
Compare state trauma registry data with NTDB data.
- Performance-based contracting (including contract monitoring)
- Peer review
The LERN Communicators are required to perform peer review audits on two calls per shift.
- Accreditation review
- Customer/stakeholder feedback
Case review process
- Other (please specify):

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

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

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

1. Title of Report or Program Evaluation
Annual Report 2012-2013
2. Date completed
February 2014
3. Subject or purpose and reason for initiation of the analysis or evaluation
Required by LERN Legislation La.R.S.40:2845
4. Methodology used for analysis or evaluation
Data in report obtained from Call Center Data and Trauma Registry Data
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
Hard copy and website www.lern.la.gov
10. Contact person for more information, including
Name: Paige Hargrove
Title: Executive Director
Agency & Program: Louisiana Emergency Response Network
Telephone: (225)756-3440
E-mail: Paige.Hargrove@La.Gov

a) LERN Annual Report to the Louisiana Legislature and the House and Senate Health and Welfare Committees – submitted in March in compliance with the 2004 LERN Enabling Legislation

b) Monthly Fiscal Reports submitted to LERN Treasurer, Chairman of the Board and discussed at LERN Board meetings.

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

Department: Department of Health and Hospitals
09-325 Acadiana Area Human Services District

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Brad Farmer, Executive Director

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

For each accomplishment, please discuss and explain:

Pharmacy Generates Over \$5M in Patient Assistance Program (PAP)

- A. **What was achieved?** Acadiana Area Human Services District (AAHSD) pharmacy program generated over \$5.21M in Patient Assistance Program (PAP) medication for clients last fiscal year. AAHSD's SGF expenditures for pharmacy were less than 4% of total pharmacy expenditures for FY14.
- B. **Why is this success significant?** The PAP program is designed to assist clients in obtaining their medications at little to no cost to the client or AAHSD.
- C. **Who benefits and how?** Clients benefit from this as they receive needed medications they otherwise may not be able to afford/obtain. AAHSD is able to utilize resources to provide medications to other clients who otherwise may not be able to afford/obtain medications and may not qualify for PAP medications.
- D. **How was the accomplishment achieved?** PAP staff works under the supervision of the AAHSD Pharmacy Director. The Pharmacy Director and Medical Director maintain close communication to ensure the success of this program.
- E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)** Yes

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

AAHSD Hosts 1-day Prevention Conference

- A. **What was achieved?** AAHSD hosted a 1-day Prevention Conference
- B. **Why is this success significant?** This provided an opportunity to gather Prevention specialists from around the state for networking and continuing education.
- C. **Who benefits and how?** Prevention programs in AAHSD, as well as other LGEs, by allowing dialogue regarding current preferred practices as well as possible areas of expansion for Prevention initiatives.
- D. **How was the accomplishment achieved?** Via classroom-style instruction, small group discussion.
- 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

Substance Abuse Prevention & and Treatment Forum

- A. **What was achieved?** Substance Abuse Prevention and Treatment Block Grant Public Forum.
- B. **Why is this success significant?** This forum allowed AAHSD an opportunity to provide stakeholders with information regarding current services, numbers of persons served, special populations served, and also opportunity for stakeholders to ask questions and to voice community needs regarding prevention and addictive disorders treatment.
- C. **Who benefits and how?** AAHSD, all other LGEs due to receipt of SAPT Block Grant monies, the Office of Behavioral Health, and community stakeholders all benefit due to being able to meet one of the block grant requirements, thus continuing to be eligible to receive block grant monies. The public forum also provides an opportunity to answer stakeholder questions, poll stakeholders about needs and service requests, and an opportunity to present information on statewide initiatives regarding prevention and addictive disorders treatment.
- D. **How was the accomplishment achieved?** Via classroom-style seminar at the Clifton Chenier Center in Lafayette, with multiple question/answer sessions.

- 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

AASHD Hosts CARF 202 Training

- A. **What was achieved?** AASHD hosted The Commission on Accreditation of Rehabilitation Facilities (CARF) 202 training.
- B. **Why is this success significant?** This allowed members of AAHSD's CARF team, as well as managers from other LGEs and community agencies, an opportunity to have locally-presented training regarding changes in accreditation standards contained in the 2014 CARF Behavioral Health Standards Manual.
- C. **Who benefits and how?** AAHSD, other LGEs, community agencies, and ultimately, the clients we all serve, by facilitating improved quality of care via meeting accreditation standards.
- D. **How was the accomplishment achieved?** Classroom-style seminar presented by Michael Johnson, Managing Director for Behavioral Health for CARF. This event was sponsored by AAHSD and held at the Lafayette Parish Sheriff's Office Public Safety Complex.
- 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

AAHSD Invited to Join the Lafayette Parish Criminal Justice Coordination Council

- A. **What was achieved?** AAHSD was invited to join the Lafayette Parish Criminal Justice Coordination Council.
- B. **Why is this success significant?** This allows for agency coordination to address greater continuity of care to meet the behavioral health needs for persons involved with the legal system.
- C. **Who benefits and how?** Persons served benefit by reduction of wait times for services, coordination of services, and improved channels of communication between agencies.

- D. **How was the accomplishment achieved?** AAHSD received invitation to join in June 2014. Meeting format conducted every other month.
- 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

AAHSD Successfully Completes First Legislative Audit

- A. **What was achieved?** AAHSD participated in our first Legislative Audit.
- B. **Why is this success significant?** No significant deficiencies were reported.
- C. **Who benefits and how?** This finding confirms the results of AAHSD's district Readiness Assessment from 2013, along with CARF accreditation, and indicates that AAHSD is operating with fiscal responsibility while meeting DHH mandates according to contractual obligation. This benefits our persons-served by allowing us opportunity to continue to operate and to maintain financial stability necessary to achieve our strategic plan and to expand/adapt according to the needs of stakeholders.
- C. **How was the accomplishment achieved?** Through systematic application of adherence to governing-body standards (CARF, Bureau of Health Standards Licensing, DHH District Readiness) and corrective actions when found deficient.
- D. **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

AAHSD Hosts Behavioral Health Forum

- A. **What was achieved?** AAHSD hosted a 4-part behavioral health forum designed to gather feedback/questions/concerns/suggestions for the Acadiana Legislative Delegation.
- B. **Why is this success significant?** This allowed time/space for stakeholders, both providers and persons served, to voice local needs for behavioral health funding and services.

- C. **Who benefits and how?** Behavioral health clients benefit via group problem-solving regarding key issues such as continuity of care following hospital discharge.
- D. **How was the accomplishment achieved?** Via a moderated group discussion held at Dr. Joseph H. Tyler Jr. Behavioral Health Clinic, followed by compilation of questions/concerns/requests that were forwarded to legislators.
- 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

AAHSD Conducts Board Training

- A. **What was achieved?** AAHSD conducted 1-day training for our governing Board.
- B. **Why is this success significant?** This allowed Board members an in-depth opportunity to receive training on policy governance and board policies and procedures.
- C. **Who benefits and how?** Board members benefit by receiving training which allows for more efficient participation. Stakeholders/persons-served benefit from organizational efficiency in operation resulting from efficient/effective Board governance.
- D. **How was the accomplishment achieved?** Facilitated classroom instruction and group discussion. The presentation was videotaped and DVDs were produced to supply to future Board members as part of their training/introduction.
- E. **Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) Yes.
- F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes

- II. **Is your department Five-year Strategic Plan/Business Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.
AAHSD submitted our initial five-year Strategic Plan in June 2013. Thus far, our goals and objectives are being met and the plan is on target for successful completion.

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

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

- ♦ **Where are you making significant progress?** If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
 1. To what do you attribute this success? For example:
 - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
 - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
 - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department’s contribution to the joint success?
 - Other? Please specify.
 2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?
 - a. **AAHSD is on target for making the progress that was projected in the five-year Strategic Plan. Progress is due largely to reorganizing our internal structure, developing new policies and procedures, utilizing the expertise of the Governing Board, conducting staff training, and implementing a team structure and approach to management. We are continually working to improve policies/systems and making necessary changes to become more effective and efficient.**
 - b. **Progress is expected to continue on an ‘on-target pace’ as we conduct regular ongoing meetings of teams (Accreditation, Health/Safety, Quality Improvement, and Senior Management), participate in ongoing external reviews, and conduct ongoing internal reviews. Our efforts so far have not been ‘one-time events’ but the building of infrastructure and operating systems to ensure ongoing success.**

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

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

None

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

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

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

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

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

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

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

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

A. Problem/Issue Description

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

B. Corrective Actions

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

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

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

progress is needed?

b. If not:

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

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house**
 QI Team reviews client quarterly
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)**
- In-house performance accountability system or process
- Benchmarking for Best Management Practices

- Performance-based contracting (including contract monitoring)**
Contract Monitoring
- Peer review**
Medical Doctors and OCDD peer review process
- Accreditation review**
CARF Accreditation—AAHSD received a 3-year accreditation
- Customer/stakeholder feedback**
Stakeholder Survey
- Other (please specify):**
Human Services Accountability and Implementation Plan (AIP) monitoring visits by OBH and OCDD

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

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

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

1. **Title of Report or Program Evaluation:** AAHSD Management Report
2. **Date completed:** June 2014
3. **Subject or purpose and reason for initiation of the analysis or evaluation**
The AAHSD Management Report is offered as partial fulfillment of the standards set forth by CARF and is designed to summarize the results of the program plans; quality assessment; goals and objectives; the data collected in the areas of effectiveness, efficiency, service access, and consumer satisfaction; and from other operating systems and to provide a synopsis of ‘significant events’.
4. **Methodology used for analysis or evaluation**
Review of AAHSD systems including: Corporate Compliance, Health and Safety (including Accessibility), Human Resources, Information Management, Outcomes Management System, Quality Improvement, and Risk Management.
5. **Cost (allocation of in-house resources or purchase price):** In house resources
6. **Major Findings and Conclusions:**
 - AAHSD’s 2014/2015 budget has been developed and submitted per Division of Administration (DOA) requirements (*at the time of this report, the 2015/2016 budget has also been submitted*).
 - New AAHSD policies have been approved by State Civil Service.
 - Employees have completed Civil Service PES as required.

- The AAHSD Human Resource office has successfully completed a Civil Service audit.
- AAHSD has been credentialed by the State SMO (Magellan).
- AAHSD has conducted and/or participated in numerous public events, health fairs, community forums, and other professional forums.
- AAHSD has supported other organizations in their efforts to provide crisis services to the community – either through education/training opportunities, funding and/or referrals.

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

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

Name: Brad Farmer
Title: CEO
Agency & Program: AAHSD
Telephone: 337-262-4190
E-mail: Brad.Farmer@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: J.T. Lane, Assistant Secretary

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

For each accomplishment, please discuss and explain:

A. What was achieved?

CENTER FOR POPULATION HEALTH INFORMATICS • Improvements to Technology

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

From January to June of 2012, efforts made to achieve fully operational connectivity between LaHIE and OPH with respect to its ability to share information regarding immunizations, electronic lab reporting, and syndromic surveillance data were successful. During the last fiscal year, LaHIE achieved the ability to submit public health reporting in Louisiana by connecting participating providers with OPH for the three Meaningful Use measures of Electronic Laboratory Reporting, syndromic surveillance and immunizations transactions.

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

For many years the 64 parish health units in every part of the state used an assortment of applications cobbled together to accommodate various needs by the programs that provide clinic services. These applications were completely standalone and primarily accommodated billing requirements for the various clinics. In collaboration with the Louisiana Health Care Quality Forum (LHCQF), OPH has begun the process of replacing these various non-integrated

applications with a fully featured Electronic Health Record (EHR) that will not only replace these applications, but also give us practice management and billing capabilities OPH has not previously been able to take advantage of. Requirements were gathered in collaboration with administrative, medical and health unit staff. A request for proposal was released and scored, demos were provided, and OPH has obtained a final cost proposal. Work groups have been identified for the variety of stakeholder interests in the design and customization of the new system.

CENTER FOR ENVIRONMENTAL HEALTH • Sanitarian Services Lean Six Sigma • Digital Health Department • FDA - Manufactured Food Regulatory Program Standards • Engineering Services

Lean Six Sigma Improves Inspection of Permitted Retail Food Establishments

Lean Six Sigma project management improvements have been successfully sustained since implementation in 2013. The scheduling tools have been maintained and have become a permanent part of field sanitarian's daily activities providing guidance, accountability, individual management of inventory, and a feeling of successfully completing ones' assignments and responsibilities.

Lean Six Sigma is a customer-focused improvement methodology that is designed to increase quality while reducing waste. Sanitarian Services implemented Lean Six Sigma Project management tools and processes and piloted them in 2012. The tools used during the pilot provided a method to allow Sanitarian Services to manage the inventory of over 33,000 active retail food and institutional permits statewide. The project resulted in the development of a scheduling tool that ensures permitted establishments are inspected according to their risk category. There are four risk categories. Each establishment is assigned a risk category which in turn dictates the minimum number of inspections that are required during a 12 month period.

Digital Health Department

With continuing focus on the goals that our Lean Six Sigma Project set forth, the Office of Public Health pursued obtaining a new management software application to consolidate all of our databases in to one data library. This new application called Digital Health Department will allow Sanitarian Services to have one software application that will manage all functions and aspects of Sanitarian duties.

FDA - Manufactured Food Regulatory Program Standards

The Department of Health and Hospitals Manufactured Food Programs, Food & Drug and Seafood, has signed up with the Manufactured Food Regulatory Program Standards (MFRPS) as an elective with the Federal Food & Drug Administration; DHH food safety contract. This elective provides for the

Manufactured Food programs to conduct a self-assessment of the program according to 10 standards to identify resources and needs in accordance with the MFRPS. This self-assessment was completed and a five year strategic plan developed to achieve conformance with the 10 standards outlined in the MFRPS. Implementation of the five year strategic plan will be expected once the Sanitarian Services Manufactured Food Program signs up with the FDA cooperative agreement and funding is provided upon acceptance of the cooperative agreement by FDA.

The Manufactured Food Regulatory Program (MFRPS) was established by the U.S. Food and Drug Administration. These program standards establish a uniform foundation for the design and management of State programs responsible for the regulation of food plants. The MFRPS are intended to enhance food safety. Conformance with these program standards will help States better direct their regulatory activities at reducing food borne illness hazards in plants that manufacture, process, pack, or hold foods.

Engineering Services

DHH OPH Engineering Services staff was effective in their response to the 2013 Primary Amoebic Meningoencephalitis (PAM) death and subsequent 2013 *Naegleria fowleri* Amoeba Detections.

CENTER FOR COMMUNITY AND PREVENTIVE HEALTH • Bureau of Family Health • STD HIV • Immunization • Hearing, Speech and Vision

Bureau of Family Health

The DHH-OPH Bureau of Family Health has successfully contributed to the state increasing access to critical reproductive health services by: 1) securing two competitive awards for OPH-BFH to elevate the quality and availability of best-practice reproductive health services through OPH and in primary care settings statewide; 2) actively contributing to the development of plans to transition the limited benefit Take Charge family planning services to a more comprehensive model incorporated into the state plan; and 3) securing a competitive award to maximize enrollment in Medicaid reproductive health coverage options.

STD HIV

Implemented “LA Links”, an intervention that has five dedicated Linkage to Care Coordinators (LCCs) who use surveillance data to identify individuals who have fallen out of HIV medical care or who have never accessed HIV-related care. LCCs provide intensive, field-based counseling and navigation services until individuals are successfully linked to or reengaged with HIV care and treatment. Since LA Links’ implementation in October 2013, LCCs have contacted 680 individuals living with HIV who had fallen out or were never linked to HIV care, enrolled 239 persons, and **successfully linked or reengaged 187 of them in HIV care** (78% linkage rate) as of June 2014.

The Louisiana Department of Health and Hospitals Office of Public Health leadership supported efforts to change state legislation to include a requirement for prenatal care providers to conduct third trimester testing for HIV and syphilis for all pregnant women. This bill was passed by the state legislature in June 2014.

Immunization

The Immunization Program implemented a site visit quality assurance data collection on-line tool known as Provider – Education – Assessment – Reporting (PEAR) System which is used during Vaccines for Children (VFC) provider visits. The Immunization Program had 850 VFC enrolled sites during July 1, 2013 – June 30, 2014.

Hearing, Speech and Vision – Public/Private Partnership

The Hearing Speech and Vision program successfully transitioned all previous OPH audiology clinic services in the Lafayette region to a large provider in the community, continuing the emphasis of moving previous OPH-provided services into the private sector. In Lake Charles, a contract for audiology services was successfully negotiated with a community-based provider who will continue to provide services through CSHS to children in the community including those with Medicaid and Bayou Health.

CENTER FOR VITAL RECORDS AND STATISTICS • LEERS

Implementation of Louisiana Electronic Event Registration System (LEERS)

Modules

Through a collaboration between Children & Youth with Special Health Care Needs Programs and Vital Records, LEERS modules were implemented and perform the following: 1) supports the newborn screening component of the Genetic Diseases Program, 2) utilizes a secured web-based tracking and surveillance system that will meet nationally endorsed health information interoperability standards developed for the LA Early Hearing Detection and Intervention (LA EHDI) Program. The LA EHDI information system (LA EHDI-IS) is capable of generating comprehensive screening, follow-up and early intervention data reports for all birthing hospitals to accurately assess progress towards the national goals of screening by 1 month, diagnostics by 3 months and early intervention by 6 months. The system allows for the collection of data that is unduplicated and individually identifiable throughout the entire EHDI process.

HEALTH PROMOTION • Well-Ahead

In November 2013, the Health Promotion team was created in the Office of the Assistant Secretary for Public Health. In response to the prevalence of obesity and other chronic diseases in Louisiana, a high level team was formed with the following goals:

- From Nov. 2013-April 2014, the Health Promotion team conducted a strategic analysis of diabetes, heart disease, stroke prevention, nutrition, physical activity, obesity, and school health state level funding. Critical DHH funding streams for programs and interventions related to these conditions span the Centers for

Disease Control and Prevention, Health Resources and Services Administration, and U.S. Department of Agriculture. The result of this analysis was the development of the Well-Ahead Louisiana Initiative WellSpot criteria.

- In April 2014, Governor Jindal launched Louisiana's first statewide health promotion initiative, Well-Ahead Louisiana. Well-Ahead Louisiana is a campaign started by the Louisiana Department of Health and Hospitals Office of Public Health- Health Promotion team aimed at improving the health and wellness of Louisiana citizens. Well-Ahead Louisiana promotes and recognizes smart choices in the spaces and places we live and work every day that make it easier for us all to live healthier lives, from going tobacco-free to ensuring healthy lunch options or supporting workplace fitness programs.
- To date, 56 sites have been designated as WellSpots through the Well-Ahead Initiative (40 worksites, 5 colleges/universities, 5 restaurants, 3 hospitals, 2 child care centers, and 1 school).

BUREAU OF PRIMARY CARE AND RURAL HEALTH • Community and Rural Health Clinic Development

- The Bureau of Primary Care and Rural Health (BPCRH) provided hands-on technical assistance to 15 rural providers working towards development of 15 rural health clinics (RHCs). Three of those providers opened RHCs in 2013-2014. Since July 1, 2011 BPCRH provided technical assistance in the opening of 24 RHCs.
- The Adolescent School Health Program completed 17 Quality Assurance reviews with one site having 17 clinics.
- 63 school based health clinics are all connected to the Louisiana Health Information Exchange, with plans to flow data through their electronic health records.
- School Based Health Centers continue to provide primary medical and behavioral health services to children on site. A total of 115,000 students visited these centers last fiscal year.

B. Why is this success significant?

CENTER FOR POPULATION HEALTH INFORMATICS • Improvements to Technology Continued expansion of the Louisiana Health Information Exchange (LaHIE)

This is a significant step toward the advancement of improved health service delivery, more appropriate and individualized provision of care, and faster detection of public health emergencies. The end goal of this project continues to be the provision for information to be effortlessly shared between providers, and from providers directly to the appropriate state offices for processing. In the previous fiscal year, participants continue to be added to the exchange as expected. The financial condition of the exchange remains stable, and this positions LaHIE ahead of many state exchanges that have not found a sustainable model.

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

Putting a more robust software program in the health units provides a more

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

CENTER FOR ENVIRONMENTAL HEALTH • Sanitarian Services Lean Six Sigma • Digital Health Department • FDA - Manufactured Food Regulatory Program Standards • Engineering Services

Lean Six Sigma Improves Inspection of Permitted Retail Food Establishments

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

Digital Health Department

Previously, Sanitarian Services used up to 22 different software tools to track various aspects of daily functions. There were also many functions that were only tracked electronically with no electronic detail of actual findings. The Digital Health Department Software will give San Services the capability of having one location for all inventories, inspection findings, scheduling, enforcement tracking, permitting, invoicing, bulk printing, online collections and many other functions along with reports for all of those activities.

FDA - Manufactured Food Regulatory Program Standards

Conducting an internal program self-assessment according to the requirements of the FDA Manufactured Food Regulatory Program Standards will allow the Sanitarian Services Manufactured Food Programs improve its long term operations. The improvements include the following program areas: Regulatory Foundation, Training Program, Inspection Program, Inspection Audit Program, Food-related Illness and Outbreaks and Response, Compliance and Enforcement, Industry and Community Relations, Program Resources, Program Assessment and Laboratory Support.

The first two years of this FDA food safety contract elective have been attributed to the self-assessment. In the next year, our program intends to apply for the significant funding provided by the FDA-Cooperative Agreement in order to achieve compliance with the MFRPS. Our program will have five years to accomplish conformity with the ten Standards, thus overhauling and providing for long term improvements and efficiencies within the Sanitarian Services Manufactured Food regulatory programs; specifically Food & Drug and the

Seafood programs. FDA will use the program standards as a tool to improve contracts with the State. The program standards will assist both FDA and the State in fulfilling our regulatory obligations.

Engineering Services

Since 2011, there have been 3 deaths of Primary Amoebic Meningoencephalitis (PAM) associated with drinking water in the state. DHH was able to promulgate an emergency rule requiring public water systems to increase the level of chlorine in the drinking water to protect the public from *Naegleria fowleri* amoeba infections. The significance of this success will be the reduced risk that no other Louisiana resident or visitor dies of PAM associated with drinking water.

CENTER FOR COMMUNITY AND PREVENTIVE HEALTH • Bureau of Family Health • STD HIV • Immunization • Hearing, Speech and Vision

Bureau of Family Health

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

STD HIV

Although treatments for HIV are effective at extending life, reducing costly complications, and preventing onward transmission, approximately 31% of persons living with HIV in Louisiana are not engaged in medical care for their condition. This intervention is proving effective at reaching very vulnerable populations and successfully connecting them to HIV-related medical care.

Mother-to-child transmission of HIV is almost completely preventable if the mother knows her status and treatment is delivered: 1) to the mother during pregnancy, 2) to the mother during labor and delivery, and 3) to the infant shortly after birth. Similarly, mother-to-child transmission of syphilis can be prevented if the mother is tested and receives treatment at least 30 days before delivery. Third trimester testing ensures that mothers have every opportunity to learn of possible infection and prevent transmission.

Immunization

Assessing program performance is an essential organization practice that requires use of multiple evidence based data sources. PEAR allows staff to evaluate immunization best practices; assess vaccine storage & handling practices; review provider's vaccines temperature monitoring; and educate VFC providers. In addition to this new PEAR on-line tool the Immunization Program also used the Louisiana Immunization Network for Kids Statewide (LINKS) and the Comprehensive Clinic Assessment Application (COCASA) to ensure a comprehensive program performance assessment. PEAR provides us with

management capabilities/assessment tools for the approximately \$80 million dollars associated with the Vaccines for Children and Section 317 grantee funded programs.

Hearing, Speech and Vision

The transition of hearing services to the private sector, will allow HSV leadership to focus on infrastructure building services, including needs assessing, policy development, quality assurance and improvement, standards development, monitoring, training and strengthening information system.

CENTER FOR VITAL RECORDS AND STATISTICS • LEERS

Louisiana is the first state to develop these three modules within its electronic vital records system. The application of the Genetics LEERS Module is significant because it reduces the need for additional staff to enter demographic data manually since it will be obtained electronically directly from the hospital. This also decreases the number of data entry errors.

The Birth Defects Database is significant because since mandated by law in 2001, Louisiana Birth Defects Monitoring Network (LBDMN) has never had an electronic database for the collection, processing, analysis and reporting of birth defects data. Manual processes for each phase of birth defects surveillance have been cumbersome which has directly affected the quality and timeliness of birth defects data. In 2010, LBDMN was awarded a CDC State Implementation Grant for the major purpose of creating a web-based surveillance system.

The LA EHDI-IS improves the collection and reporting of complete, child-specific data for every birth through the three components of the EHDI process which include screening, diagnostics and early intervention. The web-based tracking and surveillance system improves mechanisms for tracking, reporting, and linkage to follow-up services for children at risk for and/or identified with late onset or acquired hearing loss. The Information System assures data linkage among child health programs and leads to improved follow-up and ensures that LA EHDI has access to all demographic data submitted to Vital Records, capturing data necessary for complete and accurate CDC reporting.

HEALTH PROMOTION • Well-Ahead

The Health Promotion Team receives limited state and federal funding. The success of the investment of these dollars requires programs designed to have statewide reach and clear policy priorities. Well-Ahead Louisiana provides a gateway for the public to access the expertise of the Health Promotion Team and other DHH experts. In addition, it creates a clear path toward community level wellness in the form of the carefully chosen WellSpot criteria. In effect, Well-Ahead Louisiana has democratized environmental health change.

Well-Ahead allows the Health Promotion Team to efficiently identify and assist organizations that want to implement health and wellness initiatives. For

example, the OPH 2014 business plan reflects a goal of identifying and collaborating with one business per quarter to increase worksite based nutrition and physical activity policies. Through the Well-Ahead Initiative, the Health Promotion Team has reached 40 worksites in 6 months. In other words, the team has accomplished in six months what it would have taken them ten years to accomplish without Well-Ahead.

BUREAU OF PRIMARY CARE AND RURAL HEALTH • Community and Rural Health Clinic Development • School-based Health Clinics

- Additional RHCs provide increased access to primary care services for Louisiana's rural and underserved residents and helps to assure a safety net of preventive health services.
- Quality Assurance reviews are important because they verify compliance with the OPH/LCS contract and the *Principles, Standards and Guidelines for School-Based Health Centers (SBHCs) in Louisiana* as well as identify best practices in SBHC quality of care, identify barriers to continuous quality improvements in SBHC care, assess the quality of clinical services and data management by examining the SBHCs progress toward achieving goals set for identified core sentinel conditions, recommend improvements to better serve the students in LA SBHCs and certify that the SBHC qualifies to continue operating under the auspices of OPH.
- LAHIE will allow data to be readily available from all of our school based health centers.
- The success of SBHCs is significant because it improves health care outcomes for students and families and aids in eliminating barriers to learning by providing healthcare to those who otherwise would have no access.

C. Who benefits and how?

CENTER FOR POPULATION HEALTH INFORMATICS • Improvements to Technology Continued expansion of the Louisiana Health Information Exchange (LaHIE)

There are many beneficiaries for this project. First, smaller providers that do not have the ability to create and manage their own electronic health records can become part of this exchange, achieve Meaningful Use (MU) incentives for meeting the practice management and public health reporting requirements, and share patient records under carefully controlled conditions between the other members of the exchange, ultimately joining with other state and federal exchanges. Patients who attend one or more of the facilities that are part of this exchange can reap the benefits of having their health information available to all the providers who may be seeing a given patient. Finally, this exchange is anticipated to incorporate the consolidation project described below, further enhancing the information exchange and allowing our own health units to complete their public health reporting requirements in order to realize the MU incentives.

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

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

CENTER FOR ENVIRONMENTAL HEALTH • Sanitarian Services Lean Six Sigma • Digital Health Department • FDA - Manufactured Food Regulatory Program Standards • Engineering Services

Lean Six Sigma Improves Inspection of Permitted Retail Food Establishments

The 24 million citizens and visitors to the State of Louisiana are currently and will continue to benefit from the efficiencies and management tools put into place by Sanitarian Services. This benefit comes in the form of heightened confidence that basic public health elements such as safe food, proper sewage disposal, environmental complaints, and institutional facilities are being inspected and regulated using United States Food and Drug guidelines and that these guidelines have been adopted by the state. This will ensure continuity in the Sanitarian Services programs both now and in the future.

Digital Health Department

Sanitarian inspectors benefit by having more data accessible to them for all functions of their duties in the field and by having that data organized in a way to help them better schedule their daily activities. Administration benefits from having all of the data in one location for reporting purposes and employee activity tracking. Our customers will benefit from the Sanitarian inspectors being able to offer more point of contact services for permitting and inspections and be able to update establishment information on the spot.

FDA - Manufactured Food Regulatory Program Standards

The long term benefits realized by implementation and conformance to the FDA Manufactured Food Regulatory Program Standards (MFRPS) will be felt by the state agency, the Specialty Operations Sanitarians, industry and the public. Program policies and directives will be developed and implemented for all ten program areas under the MFRPS cooperative agreement. This will allow for uniformity in the Food & Drug and Seafood Programs, establish long term efficiencies, provide for better flow of communication, and improve resource allocation and logistics.

The Specialty Operations Sanitarian will be held to a much higher standard for

conducting inspections through the minimum training requirements and auditing inspection processes for standardization. The industry benefits due to enhanced standardization of inspection processes and risk based categorization which provides for a more even distribution of inspections and expectations. The regulatory authority members, industry and public benefit as the MFRPS provides to support an integrated food safety system (IFSS), as directed by the Food Safety Modernization Act (FSMA) of the Federal Food & Drug Administration. In addition our federal and state relations and partnerships will be strengthened to further enhance the safety of the nation's food supply.

Engineering Services

Safe drinking water benefits all Louisiana residents and visitors. Since 2011, there have been 3 deaths of PAM associated with drinking water in the state. DHH was able to promulgate an emergency rule requiring public water systems to increase the level of chlorine in the drinking water to protect the public from *Naegleria fowleri* amoeba infections. The significance of this success will be the reduced risk that no other Louisiana resident or visitor dies of PAM associated with drinking water.

CENTER FOR COMMUNITY AND PREVENTIVE HEALTH • Bureau of Family Health • STD HIV • Immunization • Hearing, Speech and Vision

Bureau of Family Health

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

STD HIV

Benefits of linkage-to-care efforts accrue to the individuals with HIV and to populations at risk. Persons with HIV who get linked to care and on effective antiretroviral treatment will survive to lead healthier, more productive lives; populations at risk benefit because persons receiving effective antiretroviral treatment are much less likely to transmit HIV to partners.

Pregnant women, new mothers and their infants benefit from third trimester HIV and syphilis testing by preventing life-changing illnesses, birth defects, and stillbirths.

Immunization

The entire population of Louisiana benefits from PEAR by ensuring that all VFC providers are accountable for all publicly purchased vaccines that are provided to them. The systems in place help prevent fraud, waste, and abuse.

Hearing, Speech and Vision

The availability of local audiology services will strengthen service provision by keeping care community-based and appointments more timely, benefitting hearing impaired children and their families. Physicians and audiologists will be

able to access hearing screening and follow-up information for their patients through the web-based system. Hospital personnel will be able to access statistical reports to determine the success of their program and determine specific areas in need of improvement. Families will benefit from an efficient system that will reduce the number of infants lost to follow-up and save children critical developmental and language learning time, resulting in optimal developmental and educational outcomes

CENTER FOR VITAL RECORDS AND STATISTICS • LEERS

Physician and audiology providers are able to submit follow-up service reports electronically. Additionally, physicians and audiologists are able to access hearing screening and follow-up services for their patients through the web-based system. Hospital personnel are able to access statistical reports to determine the success of their program and determine specific areas in need of improvement. Families benefit from an efficient system that reduces the number of infants lost to follow-up and save children critical developmental and language learning time.

The Hearing, Speech, and Vision Program is required to report annually to the CDC on extensive data that is compiled and analyzed by the CDC to determine differences among socioeconomic, race/ethnicity, gender and maternal characteristics. By acquiring and analyzing data within a timely and accurate information system, we will be able to determine the impact of hearing loss on children and their families and document improvements in infant and family outcomes. This allows the program to identify gaps within and among different groups and compare our progress with other states and national trends. This required CDC data will also be included in national data analysis, which will allow Louisiana to be measured against our peers in other states.

HEALTH PROMOTION • Well-Ahead

All Louisiana residents benefit from Well-Ahead. When an organization is designated as a WellSpot, it means any of its employees or clients are now accessing a tobacco free and wellness focused environment.

BUREAU OF PRIMARY CARE AND RURAL HEALTH • Community and Rural Health Clinic Development • School-based Health Clinics

All residents living in rural and underserved areas of Louisiana of the students receiving service in the SBHCs benefit from the provision of quality care in the school based health centers. The Quality Assurance (QA) reviews assure that these services will be provided. Readily available SBHC data provides necessary information for all stakeholders and substantiate the need for SBHCs. Healthy children encourage healthy families. Louisiana benefits if our students are healthier, test scores improve. The overall health of all of our citizens improve as healthy life style choices are introduced in the homes via the SBHCs

D. How was the accomplishment achieved?

**CENTER FOR POPULATION HEALTH INFORMATICS • Improvements to Technology
Continued expansion of the Louisiana Health Information Exchange
(LaHIE)**

The Louisiana Health Care Quality Forum (LHCQF) has led this project, in collaboration with OPH administrative and project management staff, including the Electronic Laboratory Reporting Coordinator, the Syndromic Surveillance Coordinator and the Immunizations staff.

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

This project is being completed under collaboration with the LHCQF, the agency managing LaHIE, and administration and project management staff from the Office of Public Health, along with the Medicaid office.

**CENTER FOR ENVIRONMENTAL HEALTH • Sanitarian Services Lean Six Sigma •
Digital Health Department • FDA - Manufactured Food Regulatory Program
Standards • Engineering Services**

**Lean Six Sigma Improves Inspection of Permitted Retail Food
Establishments**

Frequent follow-up conversations, monitoring management reports and accountability to DHH administration are done to ensure the continuity and accuracy of the tools and management routines that have been put into place.

Digital Health Department

The Digital Health Department software acquisition was achieved by help and cooperation from several different employees within OPH, an implementation of permit fee increases and partial funding from NPHII grant money. The Retail Food Permit fee increase helped OPH acquire more funding beginning in FY 14. Carryover from the NPHII grant money also helped to supplement funds needed for software acquisition. OPH administration helped to develop documentation for the acquisition (IT10 document) as well as the Invitation to Bid process which secured the proper software for our needs at the correct costs.

FDA - Manufactured Food Regulatory Program Standards

The FDA Manufactured Food Regulatory Program Standards (MFRPS) required a self-assessment of the Manufactured Food Programs, specifically the Food & Drug and Seafood programs in accordance with ten standards. Once the self-assessment was completed this was turning into a five year strategic plan. The five year strategic plan was developed during the 2012-2013 FDA – LADHH food safety contract year, as an elective to the contract. In the 2013-2014 Food safety contract year the five year strategic plan was

reviewed and revised. The plan has yet to be implemented as the funding source has not yet been secured to provide for the work needed to work towards conformance with the ten standards.

Engineering

By employing multidisciplinary strategies combining agency resources and expertise with private sector flexibility, and drastically increasing staff overtime over an extended period of time, Engineering Services was able to mobilize quickly, collect samples, conduct workshops/trainings, determine corrective actions, and monitor public water systems.

CENTER FOR COMMUNITY AND PREVENTIVE HEALTH • Bureau of Family Health • STD HIV • Immunization • Nutrition Services • Genetics • Louisiana Birth Defects Monitoring Network •

Bureau of Family Health

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

STD HIV

The OPH STD/HIV Program successfully competed for specially earmarked federal HHS project funds administered through the Centers for Disease Control and Prevention in order to support the linkage-to-care initiative. The project has been successful due to Louisiana's strong and mature HIV surveillance program and a philosophy of using those data for informed public health action. Staff examine surveillance data to identify persons with HIV who are not in medical care and reach out to them in a confidential and compassionate manner, assisting them with a variety of challenges in order to get them established in care.

The OPH STD/HIV Program built support for third trimester HIV and syphilis testing legislation by educating stakeholders on the issue and presenting scientific data on the impact of third trimester testing.

Immunization

CDC issued the new on-line VFC PEAR quality assurance guidelines in mid-November 2013. We immediately enacted the new guidelines, developed a protocol tool kit guide, started training and immediately began process with pilot testing in January 2014 and successfully rolled in February 2014. This represents the training of our seven (7) Immunization Consultants that conduct the visits and follow-ups statewide.

Hearing, Speech and Vision

The transition of audiology services to a private provider and the implementation of contract audiology services were achieved through collaboration of all impacted parties: CSHS, HSV, regional administration and staff, and the local healthcare facility that were all a part of the decision making.

CENTER FOR VITAL RECORDS AND STATISTICS • LEERS

This accomplishment was achieved through the collaboration of the Genetic Diseases, Hearing, Speech & Vision and Birth Defects Monitoring Programs, OPH Vital Records, and DBSysgraph (the developer of the module). Support from Executive Leadership within the Office of Public Health was also instrumental in making this accomplishment a reality. The teams and activities involved in accomplishing the creation and implementation of the BDDLSS included CDC funding; Center for Connected Health Policy (CCHP) executive support; DBSysgraph contract developers; DHH-IT deployment and maintenance; and the LBDMN Surveillance Team for program expertise.

HEALTH PROMOTION • Well-Ahead

Well-Ahead was created in collaboration with program leaders at DHH and external stakeholders. Its implementation is led by the team members on the Health Promotion Team.

BUREAU OF PRIMARY CARE AND RURAL HEALTH • Community and Rural Health Clinic Development • School-based Health Clinics

- Hands on technical assistance. This was accomplished through many visits, phone calls, data support, emails, etc. Funding for this was accomplished through a combination of Federal Funds and state funding.
- The adolescent school health program has 2 program monitors, a QA consultant and a Behavioral health consultant, as well as peer reviewers to provide the QA services. LAHIE services are provided through a partnership with the Louisiana Healthcare Quality Forum.

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

CENTER FOR ENVIRONMENTAL HEALTH • Sanitarian Services Lean Six Sigma • Digital Health Department • FDA - Manufactured Food Regulatory Program Standards • Engineering Services

Lean Six Sigma Improves Inspection of Permitted Retail Food Establishments

Yes. The activities engaged in by the Office of Public Health support the strategic priorities and objectives of the agency. The lean six sigma program, due to its ability to increase levels of quality improvement while reducing waste, is directly supporting the goals of the OPH Strategic Plan.

Digital Health Department

One of the recommendations from our Lean Six Sigma project as well as our

State Legislative Audit was to have updated data management software for better management practices, reliable tracking and more accurate reporting of data. This software falls in line with those recommendations.

FDA - Manufactured Food Regulatory Program Standards

The five year strategic plan for the FDA Manufactured Food Regulatory Program Standards (MFRPS) supports the long term goals and initiatives of the department's five-year strategic plan. The MFRPS five year strategic plan is a standalone document that was developed to ensure progression of the manufactured food programs to achieve compliance with the 10 standards within a five year time frame, according to the deliverables in the FDA cooperative agreement. The 10 standards look to achieve efficiencies, along with standardization of the program in all 10 areas, which supports the department's long term goals and the OPH Strategic Plan.

Engineering Services

Yes. Engineering Services, through its Public Health Engineering activities, provides a regulatory framework which will reduce the risk that the public is not exposed to contaminated drinking water, which can cause illness or deaths.

CENTER FOR COMMUNITY AND PREVENTIVE HEALTH • Bureau of Family Health • STD HIV • Immunization • Hearing, Speech and Vision

Bureau of Family Health

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

STD HIV

Yes. While these activities are not directly related to the Program's key dashboard measures, they are related and a part of a successful strategic plan to reduce HIV and syphilis.

Immunization

Yes. One of the primary goals of PEAR is to allow us to independently and uniquely manage providers. At the provider level, PEAR quality assurance visits allow the provider to be aware of vaccine accountability, learn how they can store and maintain valuable vaccine; provides the opportunity to take ownership of their practice by knowing how well the children in their practice are immunized and provides as an opportunity to learn about current vaccine recommendations and policies,

Hearing, Speech and Vision

Both of HSV/LA EHDI major accomplishments, community-based audiology services and LA/EHDI-IS, will improve response times for appropriate management and follow-up for children with hearing loss and enhance the interaction between the community, providers and the program in accomplishing the best outcomes for the families of these children. These public health

improvements are right in line with the success of the OPH Strategic Plan and directly support OPH's objectives.

CENTER FOR VITAL RECORDS AND STATISTICS • LEERS

The LEERS modules within the Children and Youth with Special Healthcare Needs Unit improves response times to follow-up for children with abnormal test results and enhances the interaction between hospitals, providers and the programs in accomplishing the best outcomes for the families of these children. These public health improvements are in line with the success of the OPH Strategic Plan and directly support OPH's objectives.

HEALTH PROMOTION • Well-Ahead

Yes. Well-Ahead directly assists the Health Promotion Team in meeting and in some cases exceeding its strategic plan performance measures.

BUREAU OF PRIMARY CARE AND RURAL HEALTH • Community and Rural Health Clinic Development • School-based Health Clinics

The mission of the Bureau of Primary care and rural health is to increase access to primary health services to Louisiana's medically underserved population. Our programs accomplishments definitely contribute to this mission. Part of the BPCRHS strategic plan is to create sustainable, quality-driven access to healthcare to all citizens in Louisiana; and by increasing access to primary 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?

CENTER FOR POPULATION HEALTH INFORMATICS • Improvements to Technology

Public Health uses technology to improve service delivery, streamline processes, and replace outdated and inefficient systems. In addition to increasing transparency by publishing retail food inspections on a public website, the Center for Environmental Health initiated a Lean Six Sigma project aimed at increasing the productivity of Sanitarians, ensuring that all Retail Food Establishments are inspected per the recommended USDA risk category schedule, and increasing standardization in training and the application of the Sanitary Code throughout the state. The Center for Community and Preventive Health and the Bureau of Primary Care and Rural Health have worked to integrate public health and primary care by collaborating with entities providing primary and preventive health services. The focus has been on avoiding duplication of services while maintaining a high level of service quality. Efforts have been made to transition essential public health services to the private sector in communities that have the infrastructure to sustain the services and provider agreements have been executed with Coordinated Care Networks (CCN's). OPH is focused on revenue generation through more effective use of technology and on statewide science-based health planning. LaPHIE is a nationally recognized novel intervention using data collected through a variety of surveillance mechanisms to reach out to individuals throughout the state for linkage to care.

CENTER FOR ENVIRONMENTAL HEALTH • Sanitarian Services Lean Six Sigma • Digital Health Department • FDA - Manufactured Food Regulatory Program Standards • Engineering Services

Lean Six Sigma Improves Inspection of Permitted Retail Food Establishments

Yes. Lean Six Sigma is an established improvement methodology that has been used in many industries including production, manufacturing, and healthcare. Our success with the Lean Six Sigma project has been shared with many other departments within OPH and DHH as well as outside agencies and organizations such as the Fire Marshall's Office.

Digital Health Department

Yes. After completing the Lean Six Sigma project, one of the lessons learned was good data management is essential in management decisions. Having accurate data to support managerial decisions is essential in making appropriate choices.

FDA - Manufactured Food Regulatory Program Standards

The FDA Manufactured Food Regulatory Program Standards (MFRPS) five year strategic plan has yet to be implemented as current resources does not allow for dedication of time to work on the plan and the funding has not been applied for as of yet since we are still in the elective year under the FDA food safety contract. This funding opportunity, cooperative agreement, will be posted in early 2015 for application. The successes of implementation of the MFRPS five year strategic plan has yet to be realized. Once the work begins, program policies, procedures and directives will be provided for in with a standardized approach and will benefit other Sanitarian Services programs as best practices. Most specifically the Retail Program will be able to utilize what is developed as best practices as they are signed up with the Voluntary National Retail Food Program Standards (VNRFPS). Most of the ten standards in the VNRFPS align directly with the MFRPS. Over the long term as conformity with the MFRPS takes place opportunities will exist to further harmonize the other regulatory programs under Sanitarian Services, i.e. the Milk & Dairy and the Molluscan Shellfish programs.

Engineering Services

Yes. This effort took coordination and cooperation between the local officials, water systems, and both Engineering Services, State ESF 12 desk at GOHSEP, and the private sector.

CENTER FOR COMMUNITY AND PREVENTIVE HEALTH • Bureau of Family Health • STD HIV • Immunization • Hearing, Speech and Vision

Bureau of Family Health

The collaboration between DHH-OPH and DHH-Medicaid to develop the plans for expanded services has been a productive and valuable model of synergy between programs. In addition, the BFH RHP plan demonstrates the strength of aligning of public health programs with national standards for clinical quality

(HEDIS, CHIPRA, Healthy People 2020).

STD HIV

None

Immunization

Yes. The modification update and expanded use of existing technology to ensure vaccine accountability, vaccines best practices that are routinely and successfully used can lead to lasting benefits.

Hearing, Speech and Vision

The successful completion of the LA EHDI module will utilize a secure web-based tracking and surveillance system that will meet nationally endorsed health information interoperability standards for the LA EHDI. The LA EHDI information system will be able to accurately assess progress towards the national goals of screening by 1 month, diagnostics by 3 months and early intervention by 6 months. This system will allow for the collection of data that is unduplicated and individually identifiable throughout the process. This will also result in a significant decrease in data entry errors as it will require fewer individuals to input the information. The ability of data linkages across child health programs will lead to improved follow-up and increase the accuracy of reporting.

CENTER FOR VITAL RECORDS AND STATISTICS • LEERS

The successful implementation of the LEERS modules utilize a secure web-based tracking and surveillance system that meet nationally endorsed health information interoperability standards for the LA Early Hearing Detection and Intervention Program. The LA EHDI information system is able to accurately assess progress towards the national goals of screening by 1 month, diagnostics by 3 months and early intervention by 6 months. This system allows for the collection of data that is unduplicated and individually identifiable throughout the process. This will result in a significant decrease in data entry errors as it will require fewer individuals to input the information. The ability of data linkages across child health programs will lead to improved follow-up and increase the accuracy of reporting.

HEALTH PROMOTION • Well-Ahead

- Two elements of the Well-Ahead Initiative represent a best management practice:
 - Due to Well-Ahead, the Health Promotion Team now has a vehicle that allows the public to engage in improving the state's health outcomes.
 - The alignment of grant deliverables across federal and state agencies has resulted in increased collaboration within DHH.

II. Is your department Five-year Strategic Plan/Business Plan on time and

on target for accomplishment?

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

OPH oversees more than 50 programs and initiatives through six primary agencies: Center for Records and Statistics, Center for Environmental Health, Center for Community and Preventive Health, Center for Community Preparedness, Bureau of Primary Care and Rural Health and Bureau of Emergency Medical Services. OPH protects and promotes the general health of Louisiana residents and is centered on population-based health concerns. This includes implementation and enforcement of the sanitary code, provisions of personal and environmental health services in parish health units (PHUs), sewerage treatment and disposal, supplemental food programs, emergency preparedness and other functions affecting the health of the public. OPH also monitors the aspects of environmental quality and pollution control that apply to public health and which are specifically assigned to DHH.

OPH continuously evaluates the quality of customer service and program service delivery to its vast community of stakeholders and populations who receive its services. The Office has continued to make great strides in meeting the goals and objectives outlined in the DHH Business and Strategic plans by establishing the foundation for improving health outcomes for the citizens of Louisiana. Some of the past year's highlights include:

- Development of an office-wide strategic plan that includes goals, objectives and strategic issues focusing on.
 1. Health Information, Technology, Infrastructure, Integration and Utilization.
 2. Meaningful internal and external collaboration.
 3. Reducing Health Disparities.
 4. Improving Workforce Development.
 5. Increasing Financial Stability.
- Lean Six Sigma project expansion to other OPH programs; sharing information with Offices within DHH.
- Continuing efforts to attain national Public Health Accreditation.
- Continuous monitoring for Safe Drinking Water.
- Improving and integrating newborn data sharing capabilities.
- Implementing LaHIE modifications that will impact public health reporting.
- Consolidating technological programs.
- Technological updates in Sanitarian Services.
- Implementation of LaHIE Modifications that will positively impact public health reporting
- Improving efficiency of service delivery through the use of LaPHIE
- Maintaining and exploring new partnerships that are critical to OPHs ability to combat many public health issues that impact populations, statewide.
- Modifications to health care insurance and transition to ICD 10 coding.
- Establishing and inspection frequency model and implementing new

- management tools; cross training of all specialty sanitarians
- Implementing electronic health records system
- Progress with the LEERS modules continues to succeed per established goals.
- Beginning process of software program consolidation in the Parish Health Units in order to allow all PHUs to communicate in real time with one another and to increase the level of reimbursement for services provided
- Three main elements to the OPH-Bureau of Family Health Reproductive Health Program plan: 1) Maximize the quality, efficiency, and use of OPH clinical reproductive health services; 2) Launch a Reproductive Health Quality Collaborative to increase the capacity of community primary care settings (e.g. FQHCs) to implement quality reproductive health services; 3) Maximize enrollment in the state's coverage options for family planning services
- Successful linkage to care efforts in STD/HIV
- Appropriate follow-up and care for newborns

HEALTH PROMOTION • Well-Ahead

Since November 2013, three Health Promotion Team grants were either cut from the federal budget or ended. In addition, the team received two new funding sources through the increased allocation to the CDC Prevent block grant. These new funds have shifted the focus of the Health Promotion Team. Impediments to progress are typically associated with contracting delays and federal changes to grant programs. The Health Promotion Team recognizes Louisiana's intractable obesity epidemic does not adhere to federal funding allocation rules and regulations. As such, the team is actively working to create an identity and focus that is driven independently of federal funding. The design of the Well-Ahead is the first significant step toward that goal.

BUREAU OF PRIMARY CARE AND RURAL HEALTH • Community and Rural Health Clinic Development • School-based Health Clinics

The BPCRH provides a great deal of hands-on technical assistance from the beginning thoughts of practice development in rural areas to sustainability support for RHCs after they are developed. Typically RHC development takes one to one and a half years to develop in Louisiana. The BPCRH provides regulatory knowledge, connections to needed programs, and other services required during RHC development. Timeliness of these services depends on many factors including health standards staffing, CMS regulations, and follow through of providers.

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

CENTER FOR ENVIRONMENTAL HEALTH • Sanitarian Services Lean Six Sigma • Digital Health Department • FDA - Manufactured Food Regulatory Program Standards • Engineering Services

Lean Six Sigma Improves Inspection of Permitted Retail Food Establishments

The continuous success of the Lean Six Sigma project is based on numerous factors and levels of personnel that worked together for the common goal of improved public health service to our customers. Elements leading to the ongoing success include, but are not limited to:

1. Strong and long term Departmental and Office level support.
2. Experienced and proven Lean Six Sigma project managers.
3. Engaged and willing Sanitarian Services leadership team.
4. Dedication by sanitarians statewide to improve the efficiency and ability to manage their workload.
5. Limited technology used to the fullest and development of electronic methods to manage and report large amounts of data that needed to be analyzed in order to define the needs of the program (i.e., management tools and routines).

Digital Health Department

The Office is making significant progress on our goals of New Management Tools, Centralized & Standardized Reporting Process, and Performance Metrics and Evaluation with this one software management tool. The Digital Health Department software centralizes all data in all programs within Sanitarian Services and allows for more detailed performance reports. Management can better evaluate, from a central access point, individual performance, Parish workload and performance, Regional statistics and Total Statewide data reporting.

CENTER FOR COMMUNITY AND PREVENTIVE HEALTH • Bureau of Family Health • STD HIV • Immunization • Hearing, Speech and Vision

STD HIV

The STD/HIV Program is making substantial progress toward goals related to testing, linkage to HIV medical care, and viral suppression. The success of linkage-to-care efforts has been a result of successful competition for federal grant funds, the strong data collection management practices regarding HIV surveillance, and careful, compassionate engagement of persons with HIV who are out of care. If the project can be sustained (or even expanded), positive results should continue. The success of linkage-to-care efforts has been a result of successful competition for federal grant funds, the strong data collection management practices regarding HIV surveillance, and careful, compassionate engagement of persons with HIV who are out of care. If the project can be sustained (or even expanded), positive results should continue.

◆ Where are you experiencing a significant lack of progress?

Contract processing: Typically, it takes three to four months to write and execute a state contract. In order to ensure contract reviews are occurring on a timely schedule, the contract monitor must individually track the contract through the approval process. At times, this requires the contract monitor to email, call and stop by the office of the individual the contract is waiting on for a signature or review.

Changes in federal policy affecting rural health clinics could result in not only lack of progress, but result in a profoundly negative impact to the safety net infrastructure in rural areas of the state. The Federal Office of the Inspector General has recently requested CMS to reclassify or “decertify” RHCs that are no longer located in a rural or underserved area. If this is completed, it has the potential to decertify 29 current RHCs. This is over 23 percent of the RHCs in the State of Louisiana. Without state legislative intervention, this problem could decrease access to primary care for rural Louisiana.

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

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

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

The OPH Strategic Plan is reviewed annually and updated every three years in compliance with ACT 1465. The plan is evaluated to ensure that it reflects the current strategic management imperatives. DHH Offices are required to develop a business plan that contributes to the department mission to improve and protect the health of Louisianans. Each plan is evaluated by the Secretary at mid-year and year-end to track and assess each offices progress in meeting the identified goals and objectives. Offices provide information on their respective plans including their successes, challenges, and provide recommended solutions to overcome any issues that have been identified. Corrective actions from mid-year and year-end evaluations are incorporated into the Offices plans.

Currently, the Office of Public Health has engaged an office-wide strategic plan that includes revisions to its mission, vision, and values statements. The plan includes goals, objectives, and strategic issues developed around five key strategic issues including:

1. Health Information, Technology, Infrastructure, Integration and Utilization.
2. Meaningful internal and external collaboration.
3. Reducing Health Disparities.
4. Improving Workforce Development.
5. Increasing Financial Stability.

OPH program managers and directors have viable relationships with federal funding project officers and they keep abreast of all funding requirements and modify goals and objectives and make necessary changes to our strategic plans and spending plans to ensure achievement of those goals and objectives.

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

The Office of Public Health continues to make progress toward meeting the agency's goals and objectives. The implementation of the office-wide strategic plan will be used to address some of the system-wide issues that such as updating information technology systems that lead to improve access and data uses while providing user friendly interfaces.

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.**

Contract Execution

A. Problem/Issue Description

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

OPH is working to streamline the contract procurement process.

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

Yes, it is difficult to put resources in place in a timely manner.

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

There are multiple program areas affected by this issue.

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

The agency and its contractors.

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

This problem has continued for some time.

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

Unknown, as we continue to work to streamline the process.

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

Services are delayed, contractors risk delayed or lost payment, and the agency's reputation is lowered.

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.

Declassification of Rural Health Clinics in Louisiana

A. Problem/Issue Description

1. **What is the nature of the problem or issue?** CMS regulatory change
2. **Is the problem or issue affecting the progress of your strategic plan?** Changes in federal policy could result in not only lack of progress, but result in a profoundly negative impact to the safety net infrastructure in rural areas of the state. The Federal Office of the Inspector General (OIG) has recently requested CMS to reclassify or “decertify” RHCs that are no longer located in a rural or underserved area. If this is completed, it has the potential to decertify 29 current RHCs. This is over 23 percent of the RHCs in the State of Louisiana. Without state legislative intervention, this problem could decrease access to primary care for rural Louisiana.
3. **What organizational unit in the department is experiencing the problem or issue?** The State Office of Rural Health within OPH.
4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)** DHH and the citizens of rural Louisiana.
5. **How long has the problem or issue existed?** It is pending at this time
6. **What are the causes of the problem or issue? How do you know?** OIG recent report release.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?** Decertification of 29 RHCs. This decreases access to over 60,000 rural Louisiana citizens.

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.

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:

**CENTER FOR COMMUNITY AND PREVENTIVE HEALTH • Bureau of Family Health • STD
HIV •**

Bureau of Family Health

- 1. Targeted Chart Review**
2. Monthly audits with quarterly central office review
3. Chart reviews are a standard quality assurance practice in direct service
4. Review tool designed by program which is commensurate with industry standards
5. Staff costs – RN Nurse Consultant time and field staff time. No cost for the specific report
6. Top Opportunities for Improvement Noted:
 1. All documents which required signature and dates completed
 2. Visit Type documented
 3. Any required referral & follow-up documented
 4. Most current forms used
 5. Medicaid eligibility verification document available from date of visit (if appropriate)
7. Major Recommendations - All areas have implemented corrective actions to correct and monitor these activities. All indicators have demonstrated steady improvement each quarter.
8. Action taken in response to the report or evaluation - Nurse Consultant provided

regional technical assistance to all regions regarding results and corrective action plan.

9. Availability – hard copy and electronic version
10. Contact person for more information, including
 - Name: Gail Gibson
 - Title: OPH BFH Nurse Consultant
 - Agency & Program: OPH
 - Telephone: 504-568-3504
 - E-mail: gail.gibson@la.gov

1. Clinic Flow Analysis

2. Quarterly reports submitted to OPH BFH
3. Clinic flow analysis are a standard quality assurance practice in direct service and are a cornerstone of the program's goal to improve productivity
4. Review tool designed by program which is commensurate with industry standards
5. Staff costs – RN Nurse Consultant time and field staff time. No cost for the specific report
6. Top Opportunities for Improvement Noted: The data collected in the spring clinic analysis showed a crucial need to continue monitoring and improving our clinic flow. As demonstrated by the data collected in the spring our clients:
 1. Experience increased overall time within the clinic (120 - 160 minutes)
 2. Experience increased wait time (45 - 60 minutes)
7. Major Recommendations - The bottlenecks and opportunities for improvement included:
 1. Registration process
 2. Scheduling
 3. Staff utilization (esp. RN & support staff)
 4. Space utilization (includes both use and availability of space for clinic)
8. Action taken in response to the report or evaluation - Nurse Consultant provided regional technical assistance to all regions regarding results and corrective action plan.
9. Availability – hard copy and electronic version
10. Contact person for more information, including
 - Name: Gail Gibson
 - Title: BFH Nurse Consultant
 - Agency & Program: OPH
 - Telephone: 504-568-3504
 - E-mail: gail.gibson@la.gov

In addition to the reports above, an annual comprehensive site assessment is completed in the fall according to the federal Title X quality assurance tool.

STD HIV

1. Title of Report or Program Evaluation: Semi-Annual Evaluation Report: Addressing Louisiana Inequities in HIV and AIDS, CARE and Prevention in the United States (CAPUS) Demonstration Project
2. Date completed: February 2014 and June 2014 (revised report)
3. Subject or purpose and reason for initiation of the analysis or evaluation: The STD/HIV Program contracted with PRG to complete an evaluation of SHP's CAPUS project on a semi-annual basis. The reports provide formative feedback on the implementation of each of the six CAPUS strategies and progress towards meeting project objectives. CAPUS strategies aim to significantly impact HIV inequities and health disparities among racial and ethnic minorities in Louisiana, particularly African Americans and men who have sex with men who bear the greatest HIV burden in the state.
4. Methodology used for analysis or evaluation: PRG's semi-annual evaluation plan specifies program implementation and outcome objectives and their empirical measures. On a semi-annual basis, aggregate and client-level data collected by SHP are de-identified and submitted to PRG using a secure VPN protocol. PRG produces a report that presents descriptive information in tabular and graphic form on each of the indicators and describes progress made towards meeting the objectives of each of the six strategies. The six strategies are 1) implementation of a new Laboratory Information Management System (LIMS); 2) LA Links, which is a linkage/re-engagement to care and patient navigation intervention; 3) expanded routine opt-out HIV testing in emergency rooms and clinics; 4) Health Models; which is a pay-for-performance-based linkage/re-engagement to care and treatment adherence intervention in three community-based HIV specialty clinics; 5) social marketing campaigns to reduce HIV testing-related stigma and ensure people know where to access HIV testing services; and 6) capacity building strategy to increase awareness of and undo institutional racism and structural homophobia.
5. Cost (allocation of in-house resources or purchase price): \$14,000
6. Major Findings and Conclusions: The report highlighted several findings: 1) Although the LA Links intervention was not on target to meet the enrollment objectives, a high proportion of LA Links clients linked to medical care (85%) and received referrals to support services (86%). 2) Health Model enrollment numbers and the number of incentives distributed exceeded the targets; 82% of clients were retained in care, and 57% maintained viral suppression. 3) The expanded testing objectives were not met; however the report showed that most tests conducted were among the priority population (76%). 4) Social marketing objectives were met. Two social marketing campaigns were implemented and members of target communities were involved in the planning and implementation of the campaigns. 5) The report highlighted the success of the Undoing Racism workshops. Participant satisfaction scores were very high, and participant's knowledge of racial health disparities and self-efficacy to address institutional racism increased from pre to post-workshop assessments.
7. Major Recommendations: The report did not list recommendations.
8. Action taken in response to the report or evaluation: The enrollment targets for

LA Links were reduced, since many clients have multiple complex needs requiring more referrals and services than originally anticipated. The Linkage Care Coordinators have had to spend more time with each client in order to get them linked and retained in care. Because the testing objectives were not met and some testing sites took longer to implement testing than expected, additional community health centers were recruited for opt-out testing. These new sites have been very successful at testing African Americans and Latinos. Based on the success of the Undoing Racism workshops, steps have been taken to expand these workshops to additional programs. In addition, ongoing meetings have been held at SHP to continue addressing issues identified during the workshops.

9. Availability (hard copy, electronic file, website): hard copy or electronic file
10. Contact person for more information, including
 - Name: DeAnn Gruber
 - Title: STD/HIV Program Director
 - Agency & Program: Department of Health and Hospital's Office of Public Health, STD/HIV Program
 - Telephone: (504) 568-7474
 - E-mail: deann.gruber@la.gov

Engineering Services

1. Title of Report or Program Evaluation: EPA End-of-Year Review
2. Date completed 7/31/2014
3. Subject or purpose and reason for initiation of the analysis or evaluation: Required by primacy and federal grant funding.
4. Methodology used for analysis or evaluation: Onsite interview by EPA
Cost (allocation of in-house resources or purchase price) NA
5. Major Findings and Conclusions: Program has met the EPA primacy requirements.
6. Major Recommendations: EPA recommended that DHH continue to dedicate resources to ensure State adoption of the last promulgated drinking water rules, Ground Water Rule and Revised Total Coliform Rule.
7. Action taken in response to the report or evaluation: Program will continue to devote time to work on adopting and implementing new drinking water regulations
8. Availability (hard copy, electronic file, website) Hard copy.
9. Contact person for more information, including
 - Name: Jake Causey
 - Title: Chief Engineer
 - Agency & Program: DHH OPH Engineering Services
 - Telephone: 225-342-7499
 - E-mail: Jake.Causey@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

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

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Dr. Rochelle Head-Dunham, Assistant Secretary

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

Consistent with the Office of Behavioral Health (OBH) Business Plan, OBH achieved six major accomplishments during the fiscal year under review: (1) continued statewide implementation and refinement in the Coordinated System of Care (CSoC) for children and youth; (2) successful transition of adult, children, and family services to the local governing agencies (LGEs); (3) continuing to redefine OBH roles and responsibilities from service provision management to monitoring, surveillance, and technical assistance; (4) ongoing prevention and reduction of substance use and other high-risk behaviors in Louisiana's youth; (5) continued provision of addiction services to populations not served by the Louisiana Behavioral Health Partnership (LBHP); and (6) continued compliance with the Consent Decree. All of these successful actions were part of the OBH strategic plan and directly tied to the Department of Health and Hospital's (DHH) business plan priorities.

Accomplishment #1: Continued statewide implementation and refinement of the Coordinated System of Care for children and youth

A. What was achieved?

During FY 2014, CSoC continued operations in five regions of the state. Throughout the course of the fiscal year, enrollment numbers continued to increase. In addition, OBH continued to prepare for the next round of implementation, which was expected to occur by the close of FY 2014. Preparations included submission of a waiver amendment to CMS and selection

of Wraparound Agencies (WAA) in each of the four non-implemented regions. These preparations will allow for seamless statewide expansion of CSoC upon waiver amendment approval. As of June 27, 2014, 1,128 children and youth were enrolled in CSoC.

B. Why is this success significant?

The CSoC implementation results from a multi-year collaborative planning effort between DHH, the Department of Children and Family Services (DCFS), the Office of Juvenile Justice (OJJ) and the Department of Education (DOE). CSoC uses an evidence-informed approach to support young people with significant behavioral health challenges who are in or at risk of out-of-home placement to remain with their families, in the community, which research demonstrates results in more positive outcomes over time. It also makes better use of state resources, by leveraging additional Medicaid funding, to enhance available services for high-risk children and youth within the State of Louisiana. The successful implementation of CSoC is particularly significant because it represents true partnership across the child-serving state agencies to ensure that youth who are at highest risk and in greatest need, and their families, receive timely access to appropriate services and supports.

C. Who benefits and how?

CSoC serves children and youth aged 0 through 21 with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out-of-home placement. Children and youth with complex behavioral health challenges and their families benefit from a coordinated approach to care. New behavioral health services that were previously not part of the service array in Louisiana are now available as part of the Medicaid State Plan Amendments and Waivers that support CSoC and the broader LBHP. These new services include an organized planning process for young people with significant emotional and behavioral challenges, called Wraparound, which helps to ensure that individual and family needs are identified and addressed with an array of specialized services and supports. These efforts are proven to result in a reduced need for more costly out-of-home placement options. Families and young people also benefit from other specialized services which include: Parent Support and Training, Youth Support and Training, Crisis Stabilization, Independent Living/Skills Building and Short-term Respite.

D. How was the accomplishment achieved?

During 2009, DHH, DCFS, OJJ and DOE began collaboration on a multi-year planning process to develop a common vision and goals to improve behavioral health outcomes and reduce out-of-home placements among children and youth with significant mental health and/or substance use disorders. During the

planning phase, eighteen (18) stakeholder workgroups participated in designing the initial coordinated system of care. Subsequently, Governor Bobby Jindal issued Executive Order BJ-2001-5 on March 3, 2011, to formally establish a policy-level Governance Board with members including leadership of DHH, DCFS, OJJ and DOE, a representative of the Governor's office, two family representatives, an advocate representative, and a youth representative. This board is charged with providing oversight to the development and implementation of CSoC. Each of the four collaborating agencies (DHH, DCFS, OJJ and DOE) also assigned staff to form a unified CSoC team, housed at OBH headquarters, participate in development of the Medicaid State Plan Amendments and Waivers necessary to support service development, enhancement, and support and guidance for CSoC implementation. OBH used a community driven process to select initial regions for statewide implementation.

To support the availability of CSoC in each region, a community process selected a WAA that would serve as the locus for treatment and care coordination for every enrolled youth.

During FY2014:

- As of June 27, 2014 CSoC has served 3,211 youth and children, with the fiscal year end enrollment of 1,128 children/youth. Fiscal year end enrollment ranges from 170 to 260 per region as follows: Monroe (252), Shreveport (217), Alexandria (170), Baton Rouge (229) and Greater New Orleans (260).
- WAAs in each region ensured that youth with complex needs benefited from a coordinated care planning process that produced a single plan of care that was created with the youth, their family, natural supports and all agencies and providers involved with the youth and family.
- The Family Support Organization (FSO) operated with a statewide organizational structure with local supervision and service provision established in FY 2013. The centralized administrative functions reduced overhead costs, and resulted in standardization of policies and procedures across all regions.
- The FSO service delivery increased steadily over the year.
- The CSoC team is composed of a CSoC Director with over ten years of experience leading system of care efforts, a Family Lead and team members detailed from DCFS, DOE, OJJ, OBH and Medicaid. The team provided guidance and technical assistance to the WAAs and FSO in each region in order to ensure that the appropriate certification and training requirements were completed.
- The University of Maryland, Institute for Innovation and Implementation provided training and technical assistance on the implementation of the wraparound process, in accordance with standards established by the National Wraparound Initiative (NWI) through a contractual agreement with OBH.
- The CSoC Team and the University of Maryland Institute for Innovation and Implementation provided training and technical assistance for the FSO in order to ensure members of the FSO had the knowledge and skills needed to support

effective implementation of wraparound process.

- Quarterly meetings of the CSoC Governance Board were held to review progress, provide guidance, and establish policy as needed.
- The Statewide Coordinating Council (SCC) increased meeting frequency to every six weeks to monitor the transition to a Statewide FSO.
- OBH is collaborating with the University of Maryland and the Wraparound Evaluation and Research Team at the University of Washington to monitor fidelity to national wraparound standards. In addition, the CSoC Liaisons conduct ongoing training and outreach to stakeholders, state agency personnel, providers and community members.
- A waiver was submitted to CMS to allow for statewide expansion of CSoC. In preparation for expansion, WAAs were selected for each of the non-implemented regions using a community driven process.

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

Yes. The CSoC initiative was included in the OBH business and strategic plans as a top priority.

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

Yes. There are several aspects of the CSoC initiative that represent best practices from a national perspective:

The formation of the Governance Board through Executive Order No. BJ 2011-5 represents a significant accomplishment. Across the country, there are very few states that have a Governor endorsed and supported CSoC initiative and policy-making Board. This collaboration and breaking down of historic silos between agencies has resulted in improved services for children and families and for enhanced collaboration across multiple efforts and initiatives.

Detailing of staff from across child-serving agencies to a unified CSoC Team represents a true innovation in the system of care field. Sharing staff from other departments under an integrated team design breeds increased understanding and familiarity of the mandates and requirements of each state agency and helps all members develop a deeper understanding and appreciation for the work of each child-serving agency.

Developing Medicaid state plan amendments and waivers and leveraging braided funding across child-serving state agencies to support service development and expansion is an example of best practices in the system of care field. This also represents a higher level of coordination across agencies which results in less fragmentation, duplication and redundancy.

Accomplishment #2: Successful transition of adult, children, and family services to the local governing agencies

A. What was achieved?

As of July 1, 2013, there were six existing LGEs, and four LGEs that began their shadow year. The shadow year is when an LGE works toward becoming an independent umbrella agency for the administration of behavioral health and developmental disability services in an integrated system that is based on local control and authority. OBH began preparing to transition the final four remaining regions into LGEs with independent budgets beginning in FY 2014. This preparation included the development of guidance on the delivery of addictive disorders, developmental disabilities, and mental health services funded by appropriations from State General Funds and block grant dollars. OBH also implemented a systematic approach to monitoring the LGEs. Through collaboration and coordination between DHH and the Human Services Interagency Council (HSIC), this plan grew into the Human Services Accountability and Implementation Plan (AIP).

B. Why is this success significant?

With the transition of the final four regions into LGEs in FY 2014, the role of OBH transitioned away from direct service delivery to one of monitoring, surveillance and technical advisory, which enable the LGEs to carry out service delivery functions efficiently, effectively and independently. OBH maintains responsibility for providing assistance in setting policy, establishing minimum standards for the operation of the service system, establishing reasonable expectations for service utilization and outcomes, and developing mechanisms statewide for measuring these outcomes.

The implementation of AIP monitoring began in FY 2014 and allows for the ongoing analysis of LGE performance. The AIP sets forth the criteria, process, timelines, and guidelines for planning, monitoring, and providing accountability in the delivery of mental health, developmental disabilities, and addictive disorders services. The AIP also sets forth the guidelines for the provision of technical assistance and training in the support of the delivery of services.

C. Who benefits and how?

The statewide managed care system for behavioral health and the LGEs will ensure the provision of behavioral health services for clients within each district. OBH can now provide the necessary leadership, strategic support and oversight to develop and maintain a comprehensive, integrated, person-centered system of preventions and treatment services that promote recovery and resilience for all citizens of Louisiana.

AIP monitoring will have far-reaching benefits. DHH, LGEs, and Louisiana's citizens with addictive disorders, developmental disabilities, and mental health diagnoses all benefit from the analysis of AIP monitoring. AIP monitoring yields LGE performance data that can be utilized in evidence-based decision making, to influence LGE performance targets that support federal and state funding requirements, and in the analysis and improvement of service delivery.

D. How was the accomplishment achieved?

The accomplishment was achieved through the transformation of the OBH business model with the introduction of the LBHP, including contracting with a Statewide Management Organization (SMO) and the transition of the traditional OBH regional model to the LGEs.

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

Yes. This accomplishment aligns with the DHH and OBH goals to provide quality service and promote health.

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

Yes. The use of monitoring to evaluate performance, promote the use of best practices, and make evidence-based decisions is a standard used within other agencies.

Accomplishment #3: Continuing to redefine OBH roles and responsibilities from service provision management to monitoring, surveillance, and technical assistance

A. What was achieved?

On March 1, 2012, OBH successfully implemented the LBHP to provide a comprehensive system of behavioral health services within Louisiana. During FY 13, OBH's role shifted from implementation of the LBHP to one focused on monitoring of services and contract deliverables. In FY 14, OBH continued to evolve in its role as contract manager of the SMO and transition services and programs to the SMO's responsibilities.

B. Why is this success significant?

Through the LBHP, access to community-based services is enhanced, quality of care and health outcomes are improved, and utilization of more restrictive and crisis-driven services (emergency departments, hospitals, out-of-home

placements) is reduced. As the model for behavioral health care continues to evolve, it is vitally important that OBH conduct regular monitoring of Statewide Management Organization (SMO) operations to ensure compliance with the performance measures and deliverables established in the contract for these services. These monitoring functions are used to assess the SMO's ability to perform its contractual responsibilities as the single behavioral health managed care entity in the state. This represents a significant shift in the business model for OBH, which was previously more involved with the direct provision and management of services, and now moves into a more clearly defined system oversight role.

C. Who benefits and how?

By integrating managed care into the service delivery model, OBH, through the SMO, has served and continues to provide quality care to over 191,000 Louisiana citizens since implementation in FY 12.

D. How was the accomplishment achieved?

With the continued evolution of its monitoring role, OBH has employed different strategies to ensure appropriate oversight for SMO activities.

Administrative:

Health Plan Management Team:

In an effort to increase the effectiveness of monitoring of the LBHP and the SMO, OBH created the Health Plan Management Division. Positions were established specific to LBHP monitoring, and teams were reorganized. This newly created Division is charged with external monitoring of the LBHP through data analysis and information systems programming, as well as, internal OBH monitoring with more focused documentation of activities, stricter scrutiny of the contract and deliverables, and OBH and SMO staff accountability.

Interdepartmental and External Review:

In December 2012/January 2013, OBH established the Interdepartmental Monitoring Team (IMT) to facilitate monitoring of the LBHP waivers and state plan amendment performance measures outlined for the Centers for Medicare and Medicaid Services (CMS). The IMT is composed of representatives from other state agencies, Medicaid, and different sections of OBH. The IMT meets regularly and has established a schedule for reporting and accountability with the SMO. The IMT and subcommittees receive reports, review and analyze the information, and provide feedback to the SMO. This structure was developed in late 2012 and began in earnest in 2013. The processes continue to be refined and streamlined.

In early 2013, OBH created a Request for Proposal (RFP) for an External Quality Review Organization to begin on-going independent, third-party evaluations of

the SMO's performance of the CMS requirements. The contract was awarded to IPRO on July 30, 2013. During FY 2014, IRPO has completed its evaluation of several key elements of the SMO contract during its first year, including: performance measure validation, performance improvement project validation, compliance review validation, encounter data validation, consumer and provider survey validation, set groundwork for determining Medical Loss Ratio, and submitting the technical report.

Communication:

More emphasis has been placed on structured communication between OBH and the SMO. The OBH Executive Management Team (EMT) has bi-weekly meetings with the SMO's senior leadership team. The Bureau of Health Services Financing (BHSF) also facilitates a bi-weekly executive level management meeting with the SMO's senior leadership team. The SMO, in conjunction with representatives from OBH and BHSF, holds weekly and bi-weekly workgroups in specific areas including provider questions, provider billing, IT systems, and Clinical Advisor. Monthly meetings are also held between the executive staff of OBH, OJJ, DCFS, and the SMO to facilitate interdepartmental communication.

Data and Documentation:

With the creation of the Health Plan Management Division within OBH, OBH and the SMO have standardized communication through a formal documentation process that includes action items and follow-up activities which serve to keep teams on task and hold them accountable for progress and completion of priority items. OBH works jointly with the SMO to perform quarterly chart and performance reviews that include comparing services approved in the plan of care to services actually provided, and review of issues regarding eligibility, documentation, family choice, needs and strengths, goals and objectives, and crisis plans.

Since implementation, OBH has continuously collected data on the populations served by the LBHP. Currently, OBH has hired a data warehouse analyst whose sole function is to review and validate Magellan's data and have the ability to create reports based on this information.

Internal Staff Development:

As OBH has transitioned to its new monitoring role, focus has been placed on developing the knowledge base and skill sets of staff. OBH has created a series of trainings focused on SMO monitoring to serve as both a refresher of responsibilities to experienced staff and an opportunity for new staff to learn and become familiar with expectations. Staff attending includes representatives from the analytics, informatics, child and adult programming, and fiscal divisions.

Fiscal:

OBH ensures the SMO maintains fiscal accountability by conducting several monitoring and assessment activities, including:

- Review Annual Statutory Audit Report
- Quarterly review of Financial Reporting package to assess revenue vs. expenditures and cash reserves (financial solvency);
- Monitoring timeliness of claims payments;
- Ensuring that non-risk payments stay within the upper payment limit (UPL) by using the fee-for-service (FFS) rate schedule and accounting for third-party liability and post eligibility treatment of income;
- Monitoring and reporting on 1915b waiver cost effectiveness;
- Conducting on-site financial reviews in conjunction with the Interdepartmental Monitoring Team (IMT) and the External Quality Review (EQR) Organization;
- Meeting monthly on financial reporting and budget items;
- Reviewing the Generally Accepted Accounting Principles (GAAP) Audit Report for material issues and financial viability;
- Reviewing any waiver-specific recoupments for waiver services provided without supporting documentation;
- Reviewing all proposed recoupments, maintaining access to the SMO prior authorization system, and conducting periodic reviews of prior authorization activities currently in place;
- Reviewing FFS invoices against encounters accepted into Medicaid's Database;
- Reviewing/approval of administrative payments for the Coordinated System of Care; and
- Monitoring payments and recoupments for individuals not enrolled with the SMO (excluded populations).

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

Yes. It is a significant step toward meeting the goal to serve children and adults with extensive behavioral health needs by leading the transition to the LBHP and ensuring full compliance and quality/outcomes of services provided for the duration of the SMO contract.

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

Yes. As other agencies within the department continue to utilize managed care or consider moving into a managed care system, OBH is in a position to help them to understand the LBHP implementation and monitoring successes and failures. This will assist with their transition as well.

Accomplishment #4: Ongoing prevention and reduction of substance use and other high-risk behaviors in Louisiana's youth

A. What was achieved?

OBH continues to comply with a Substance Abuse and Mental Health Services Agency (SAMHSA) required policy that all community-based prevention programs implemented are evidence-based programs, policies and practices. OBH Prevention has a total of 57 providers that include 47 community-based prevention providers and 10 Synar projects. The 57 community-based prevention providers provided a total of 15 different evidence-based curriculum/programs. All curriculum programs funded by SAPT Block Grant were evidence-based. Since FY 2010, the state has been able to provide evidence-based prevention programming to over 70,000 individuals per year. During FY 2014, Prevention Services provided evidence-based services to 83,317 individuals. In addition to curriculum-based services, OBH provides activities (e.g. health fairs, PSAs, billboards) to increase public awareness. During FY 2014, 2,692,363 participants were impacted by awareness activities.

B. Why is this success significant?

In requiring evidence-based programs through partnerships and collaborations, the agency is ensuring the most effective and efficient delivery system. In addition, public awareness messaging allows the state and LGEs to support evidence-based programming.

C. Who benefits and how?

As a result of the implementation of evidenced-based programs, policies, and practices through partnerships and collaborations, 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 the OBH strategic plan goal to assure that effective and efficient prevention services are provided statewide in an effort to impact the citizens of Louisiana by promoting mental health wellness and delaying the

initiation of substance use disorders by increasing knowledge, awareness, and healthy behaviors.

- 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, partnerships and collaborations allow for quality evidence-based prevention services to be made available to more individuals, in more parishes, without additional resources.

Accomplishment #5: Continued provision of addiction services to Louisiana Citizens

- A.** What was achieved?

The Access to Recovery (ATR) section initiated the use of an enhanced monitoring tool and process that utilizes a numerical score based on desktop and on-site records reviews. Formal follow-up procedures and Corrective Action Plans (CAP) are based on the performance score, with additional OBH oversight for providers obtaining lower scores. The oversight includes more frequent monitoring for those agencies with the lowest scores and required training on ATR policies and procedures. Quarterly ATR provider conference calls are used to provide information and share updates with the ATR network.

- B.** Why is this success significant?

This enhanced process aids providers in developing internal QA procedures. The scores help OBH identify providers with the most challenges. The goal is to provide support through technical assistance so that provider scores will increase and providers will have the tools they need to develop and maintain appropriate documentation for the services they provide. Additionally, the scores give providers a quantitative indicator of performance related to clinical documentation and policy compliance.

The quarterly calls provide a uniform process for ongoing communication between OBH and providers about issues or concerns that may be impacting the network or consumers. This helps keep the network updated and facilitates a proactive approach to addressing questions and concerns.

- C.** Who benefits and how?

OBH will have solid data that can be used to target efforts to support providers who may be struggling. This in turn makes ATR providers more stable and thus

able to better serve people with substance use disorders.

D. How was the accomplishment achieved?

Utilizing OBH personnel with expertise in monitoring and data analysis, ATR staff revised the existing monitoring tool to include weighted scores for each monitoring category. A tiered system of corrective action was developed based on the scores. The system was launched and revisions made as needed to ensure the instrument provided reliable data that indicates if technical assistance is needed and in what categories.

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

OBH has a commitment to ensuring quality services. Using a planned and quantitative QA approach supports this goal, and also allows us to increase accountability. Ultimately the aim is to improve treatment outcomes. This fits with the OBH strategic plan.

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

Yes. Using quantitative data to track performance improvement and challenges with providers is a process that can be shared.

Accomplishment #6: Maintain substantial compliance with the consent decree as per OBH accountability standards

A. What was achieved?

East Louisiana Mental Health System achieved 97.71% compliance with the Federal Consent Decree and has therefore remained in substantial compliance as per the terms of the Consent Decree.

B. Why is this success significant?

A federal lawsuit regarding patient care was resolved by consent decree that established specific timeframes within which competency restoration activities must be completed for individuals referred from the judicial system. Competency refers to the issue of whether or not someone charged with a crime understands the court proceedings and whether or not they can participate in their own defense. Competency restoration is the process by which the hospital staff treats and/or educates the clients so that they meet requirements to be considered competent.

The successful implementation of the requirements of the consent decree by OBH is significant in that it allowed OBH to substantially improve the timeliness of competency restoration services.

The Federal Consent Decree expired on July 30, 2013; however, OBH and the hospital continued to report to the court for FY 2014 in a good faith effort to demonstrate that the state intends to continue with the consent decree requirements to ensure individuals remain in jail no longer than necessary.

C. Who benefits and how?

Individuals ordered to receive competency restoration services in the state forensic hospital are no longer required to remain in jail for extended periods of time awaiting placement. Currently, the time has decreased to no more than 30 days from the date of the signed court order now whereas in the past people have, on occasion, waited longer than one year.

D. How was the accomplishment achieved?

Competency restoration programming and processes were reevaluated following the adoption of the consent decree, and additional resources were devoted as necessary.

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

Yes. This accomplishment is consistent with the OBH goal to provide for the timely provision of the appropriate level of care. It specifically abides by the goal and objective to provide for services to individuals involved with the court system in compliance with the consent decree ruling.

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

Not Applicable. This action is a specific corrective strategy.

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

Significant progress has been experienced in all actions outlined in the OBH Business Plan, and specifically with regard to the transformational priorities established for FY 2014: statewide implementation of CSoC, successful transition of adult, children, and family services to LGEs, and continuing to redefine OBH roles and responsibilities from service provision management to monitoring, surveillance, and technical assistance.

Statewide implementation of the Coordinated System of Care (CSoC)

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

Significant progress has been made on the implementation of CSoC, which began on March 1, 2012, in five regions of the state and represents the coordinated effort of DHH, DCFS, OJJ and DOE.

1. To what do you attribute this success?

The success of CSoC can be attributed to several factors, including the collaboration of the four state agencies: DHH, DCFS, OJJ, and DOE deploying resources to create the State CSoC team who have been charged with the oversight of the WAAs and the Statewide FSO. This oversight includes assistance in the development of community teams in each region, outreach to their respective state agency personnel, providers and other stakeholders in each region, to provide training on the Wraparound process and CSoC referral and enrollment. The CSoC team also delivers regular support to the WAAs for guidance and technical assistance. The state CSoC Family Lead has been responsible for the oversight and provision of guidance and technical assistance to the Statewide FSO throughout this past year's transition. The state CSoC team also has important monitoring functions, which includes assessing adherence to practice fidelity, as well as monitoring the compliance with waiver and RFP requirements.

2. Is progress directly related to specific department actions?

Yes. The four collaborating agencies each allocated resources to leverage funding from Medicaid and form a dedicated staff housed at OBH headquarters. The primary goal is to improve outcomes for children/youth that are at risk for or in out-of-home placement. OBH serves as the lead agency for this effort and has worked to successfully mobilize the CSoC state team at OBH and partner with the CSoC team at the SMO to ensure progress. In addition, each state agency liaison housed at the OBH has done extensive outreach to their respective departments to ensure understanding of the new processes for referral and enrollment in CSoC, as well as the practice change associated with the move toward a system of care approach. Further, each department has developed policies for assessment and referral for behavioral health services to ensure that young people and families are referred to those services that they most need. During FY 2014 DHH submitted a waiver amendment to CMS. Upon approval of the amendment, CSoC will be expanded statewide.

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

Yes. As the lead for implementation of the CSoC, OBH is able to gauge success by the ability to enroll youth in the CSoC. During FY 2013 OBH began to monitor the Quality Management Strategy which was developed as part of the b. and c. waivers to ensure all performance measures are met.

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

No, this is not a one-time gain. From the start date of March 1, 2012, a total of 3,211 children and youth have been served in CSoC, with a current enrollment of 1128 youth and children as of June 27, 2014. We anticipate that enrollment will continue in the five regions where CSoC has been implemented with a maximum of 1,200 enrollees at any given time. In addition, CSoC will be expanded into the remaining areas of the state upon waiver amendment approval by CMS, which will increase maximum enrollment to 2,400 youth and children.

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

Although some areas of the project have not reached full implementation, OBH has identified no area where a significant lack of progress can be established. In all areas where lack of immediate progress has been identified, both OBH and the SMO have worked to establish a plan of action to address identified barriers to implementation.

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

Successful transition of adult, children, and family services to LGEs

The four remaining DHH regional offices successfully completed Phase III of LGE Readiness Review and became fully independent on July 1, 2014. These districts are Imperial Calcasieu Human Services Authority (Region 5), Central Louisiana Human Services District (Region 6), Northwest Louisiana Human Services District (Region 7) and Northeast Delta Human Services Authority (Region 8).

1. To what do you attribute this success?

The successful transition of the remaining regions to LGEs is attributed to the collaborative effort between the newly hired executive directors, their staff and the DHH Liaison and DHH Readiness Review Team. The team was composed of representatives from OBH, (OCDD, and the DHH Human Resources, Procurement, Fiscal, and Legal sections. The team also included an executive director from one of the existing LGEs.

2. Is progress directly related to specific department actions?

The progress achieved can be attributed to the DHH Office of the Secretary, OBH, and OCDD. In order to ensure a timely transition, the Office of the Secretary provided a liaison to the newly formed LGEs in order to facilitate a successful transition. Each of the offices provided subject matter experts in the areas of administration, human resources, procurement, fiscal, legal and clinical operations. The subject matter experts provided on-going reviews of the work completed by the executive director's and their staff and provided technical throughout the process.

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

The progress achieved can be contributed to multiple DHH offices. Several staff from OBH contributed to the process and served as the lead for the Readiness Reviews. The initiative was completed on time and with all remaining regions transitioned to LGEs prior to July 1, 2014.

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

The progress can be considered a one-time gain. All remaining regions have completed LGE Readiness Review process and have become LGEs.

A. Where are you making significant progress?

Continuing to redefine OBH roles and responsibilities from service provision management to monitoring, surveillance, and technical assistance

Progress is being made toward the goal of transitioning from a direct-care service provider and operational manager of services to act primarily as an oversight agency through support and regular monitoring. Throughout FY 2013, OBH began preparations to transition the final four remaining regions into LGEs beginning in FY 2014. This included development of the Human Services Accountability and Implementation Plan (AIP) in conjunction with HSIC, which was subsequently implemented in FY 2014. Included within this document are the processes for monitoring and review of LGE service delivery.

1. To what do you attribute this success?

Success is attributed to the coordinated effort to transform OBH's business model. Over the past several years, OBH has worked to reduce reliance on costly institutionalization to take a more community-based approach to the provision of

services. These efforts are coupled with the move to managed care; transition of OBH operated regionally-based services to LGEs, and the new roles and responsibilities of the staff and operations of State Office.

2. Is progress directly related to specific department actions?

Yes. Agency actions include monitoring of the SMO operations through regular meetings, review of documentation, and an array of compliance checks. OBH will monitor the SMO operations in the following areas: information technology, provider network, fiscal operations, clinical care, utilization management, quality management, and member services. OBH will ensure compliance with all state and federal requirements, including block grant activities. During the transition of adult and children & family services to the LGEs in FY 2014, OBH provided oversight and monitoring through the Accountability and Implementation Plan. In partnership with the SMO, OBH programmatic staff supported the infusion of best practice approaches into the service array, and provided technical assistance to the behavioral health service delivery system. Moving into FY 2015, OBH will continue to provide funding review for general psychiatric hospital-based services, forensic services and other 24-hour residential facilities through the continued stay review process and monitor Access to Recovery (ATR) and gambling/tobacco treatment services and funding, since these programs fall outside of the LBHP.

3. Is progress related to the efforts to multiple departments or agencies?

Progress toward this initiative results from the efforts of multiple agencies within DHH including OBH, Medicaid, the existing LGEs, and the newly created LGEs.

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

No, this is not a one-time gain. During FY 2012 and FY 2013, OBH established transformational priorities that established a strong foundation for the transition to the new operational structure and associated roles and responsibilities. During FY 2014, OBH entered the next phase of transformational activities under managed care and move away from direct community-based service provision with the transition of the four remaining OBH regions into LGEs. By initiating a statewide managed care system for behavioral health, and completing the localization of behavioral health services, OBH positions itself to provide the necessary leadership, strategic support and oversight to build and provide a comprehensive, integrated, person-centered system of prevention and treatment services that promote recovery and resilience for all citizens of Louisiana. The new contract for the SMO will be awarded in FY 2015 as a culmination of OBH monitoring activities and lessons learned.

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

OBH has identified no area where a significant lack of progress can be established.

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

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

OBH did not revise its strategic plan in FY 2014; however, OBH conducted an in-depth review of its business plan to ensure that it reflects current environmental, programmatic and fiscal configurations. As a result of this review, the business plan was revised for FY 2014 to reflect a new mission and goals. The revised plan establishes integrated service provision, performance accountability, and partnership with private and public providers as a means to enhance treatment services while containing costs. To that end, OBH's new business plan incorporates the safety net function, but focuses on OBH's role as monitor of SMO compliance with contract requirements.

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

The formulation of the OBH strategic plan adheres to management strategies implemented by the Executive Management Team (Health Plan Management, Administration, Adult, Child and Family Operations). These strategies, at a minimum, include:

- **Training:** Ongoing training is provided to ensure staff develops the necessary skills to understand and apply the concepts of the OBH strategic plan.
- **Input:** Gathering input from all levels of the agency's functional areas. Discussions are conducted with Team Leaders and participants representing functional areas essential to support agency priorities.
- **Communication:** Receiving and sending information at the central office and the district levels.
- **Coordination:** Using technology to enhance communication and participation (e.g., teleconferences, videos, electronic media, etc.).
- **Performance measurement:** Formulation of objectives that are specific,

measurable, attainable, results oriented and time-bound. Performance indicators are formulated to ensure monitoring of progress in goal/objective attainment.

- **Evaluation:** The Strategic Plan will be revised, as warranted, to reflect fiscal, managerial and programmatic changes. These revisions will be conducted using the same strategies as the original plan, as warranted. Plan revisions will utilize strategies that are pertinent to the task at hand.

III. What significant department management or operational problems or issues exist?

There were no significant departmental, management, or operational problems/issues identified. OBH is currently engaged in a dynamic process of developing and fostering the LBHP and continues to work toward its goal of providing quality behavioral health care to the citizens of Louisiana.

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

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

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

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

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

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

1. Synar Report: Youth Access to Tobacco in Louisiana

- a. *Data collection completed:* July 1, 2013 – June 30, 2014
- b. *Subject / purpose and reason for initiation of the analysis or evaluation:*

OBH conducts this annual Synar Report to examine the current level of accessibility of tobacco products to minors as pursuant to Federal Government guidelines. The Substance Abuse and Mental Services Administration (SAMHSA) is the enforcing agency. An amended Synar Regulation, issued by SAMHSA in January 1996, requires each state receiving federal grant funding to conduct annual random, unannounced inspections of retail outlets to assess the extent of tobacco sales to minors.
- c. *Methodology used for analysis or evaluation:*

The study design is a cross-sectional survey of compliance, with compliance defined as the refusal to sell tobacco to minors and the prevention of entry of a minor to outlets restricted to youth. A stratified random sample of outlets are identified and surveyed by a team of one youth operative and two adult agents Office of Alcohol and Tobacco Control (OATC). The youth operative attempts to purchase tobacco from unrestricted outlets and tests the access of restricted outlets. The adult agents record characteristics of outlets, inspection events, and outcomes, and cite non-compliant outlets and clerks. Information about outlets, inspectors, and the inspection event are entered into an electronic data system via laptop at the time of inspection.
- d. *Cost (allocation of in-house resources or purchase price):*

OBH contracted with OATC to conduct the random, unannounced inspections of tobacco outlets identified by the random sample at a cost of \$65,715 (\$65.00 per compliance check x 1101 checks). The total cost to prepare and complete the Annual Synar Report was \$70,000.00.
- e. *Major Findings and Conclusions:*

The objective of this study was to estimate the non-compliance rate for tobacco sales in Louisiana among youth under age 18. Annual targets were established to decrease the state's non-compliance rate to 20% by FY 2002. However, Louisiana achieved 20.3% non-compliance in FY 1999, only two years after the start of the Louisiana Synar Initiative, and three years ahead of the scheduled target date. The current rate of tobacco sales to minors in FY 2014 is 15.9%.
- f. *Major Recommendations:*

OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2014 report and will adhere to any future recommendations, as warranted.

- g. *Actions taken in response to the report or evaluation:*
An annual report is generated by SAMHSA including a Table listing the Synar Retailer Violations (RVRs). Louisiana was ranked among the top states in compliance, in the FY 2012 report (most recent on file). The SAMHSA report can be viewed at <http://beta.samhsa.gov/sites/default/files/synar-annual-report-2013.pdf>. Our goal is to continue implementing current strategies since they've proven to be successful.
- h. *Availability (hard copy, electronic file, website):*
The FY 2014 Annual Synar Report is available by hardcopy, and may be accessed online at <http://www.dhh.la.gov/index.cfm/newsroom/detail/1390>
- i. *Contact Person:*
Dr. Leslie Brougham Freeman
Director of Prevention Services
LA Department of Health and Hospitals
Office of Behavioral Health

2. Office of Behavioral Health – Prevention Services (Quarterly and Annual)

- a. *Data collection completed:* July 1, 2013 – June 30, 2014
- b. *Subject / purpose and reason for initiation of the analysis or evaluation:*
OBH is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT Block Grant is the primary funding source for prevention services. It requires 20% of the grant be set aside for primary prevention services. An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report is a continuing process to measure the number of services we provide and the populations that are served.
- c. *Methodology used for analysis or evaluation:*
The data in this report is from the Prevention Management

Information System (PMIS), the primary reporting system for the SAPT Block Grant for prevention services.

- d. *Cost (allocation of in-house resources or purchase price):*
There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from PMIS to generate this document. Data is entered into PMIS by the LGE prevention staff, their contract providers statewide and OBH staff.

- e. *Major Findings and Conclusions:*
During FY 2014, Prevention Services provided evidence-based services to 88,317 enrollees.

FY14 block grant funded one-time services provided to the general population reached 2,692,363 participants. This number reflects the number of individuals that are impacted by PSAs, billboards, and other media campaigns. This number included the combined services provided by Prevention Staff and Prevention Contract Providers.

- f. *Major Recommendations:*
The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.

- g. *Action taken in response to the report or evaluation:*
No actions other than the recommended (above) were pertinent.

- h. *Availability (hard copy, electronic file, website):*
The report is distributed via e-mail and is available by hard copy upon request.

- i. *Contact Person:*
Dr. Leslie Brougham Freeman
Director of Prevention Services
LA Department of Health and Hospitals
Office of Behavioral Health

3. Substance Abuse Prevention and Treatment (SAPT)

- a. *Data collection completed:* July 1, 2013 – June 30, 2014
- b. *Subject/purpose and reason for initiation of the analysis or evaluation:*
OBH is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion

of the SAPT Block Grant. The SAPT Block Grant is the primary funding source for prevention services. It requires 20% of the grant be set aside for primary prevention services. An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report is a continuing process to measure the number of services we provide and the populations that are served.

c. Methodology used for analysis or evaluation:

The data in this report is from PMIS, the primary reporting system for the SAPT Block Grant for prevention services.

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

There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from PMIS to generate this document. Data is entered into PMIS by OBH regional and headquarter staff and prevention contract providers statewide.

e. Major Findings and Conclusions:

During FY 2014, Prevention Services provided evidence-based services to 88,317 enrollees. FY 2014 block grant funded one-time services provided to the general population reached 2,692,363 participants. This number reflects the number of individuals that are impacted by PSAs, billboards, and other media campaigns. This number included the combined services provided by Prevention Staff and Prevention Contract Providers.

f. Major Recommendations:

The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.

g. Action taken in response to the report or evaluation:

No actions (other than the recommended (above) were pertinent.

h. Availability (hard copy, electronic file, website):

The report is distributed via e-mail and is available by hard copy upon request.

i. Contact Person:

Dr. Leslie Brougham Freeman
Director of Prevention Services
LA Department of Health and Hospitals
Office of Behavioral Health

4. LBHP Transparency Report (Act 212)

- a. *Date published:*
January 2, 2014
- b. *Subject or purpose and reason for initiation of the analysis or evaluation:*
Act 212 of the 2013 Regular Legislative Session requires DHH to provide transparency relative to Medicaid managed care programs on an annual basis. For FY 2014, this involves the OBH managed SMO contract with Magellan over the LBHP. The report outlined responses to the requests made by the legislature in Act 212 relative to Magellan's management of care within the LBHP and CSoC.
- c. *Methodology used for analysis or evaluation:*
Act 212 details the types of information and data elements that are to be included in the report. Data was collected using Magellan's electronic health records and claims systems and compiled and checked by OBH for the report.
- d. *Cost (allocation of in-house resources or purchase price):*
Minimal in-house resources were allocated to produce the report and the SMO contributed to data reporting as per the requirements and funding allocated through the SMO contract.
- e. *Major Findings and Conclusions:*
The measures included in the report were used to demonstrate that the following outcomes expressed in the legislation were achieved:
 - 1) Implementation of CSoC;
 - 2) Improved access, quality and efficiency of behavioral health services;
 - 3) Seamless coordination of behavioral health services with the comprehensive healthcare system without losing attention to the special skills of behavioral health professionals;
 - 4) Advancement of resiliency, recovery and a consumer-focused system of person-centered care; and
 - 5) Implementation of best practices and evidence-based practices that are effective and supported by data collected from measuring outcomes, quality and accountability.
- f. *Major Recommendations:*
Not applicable.
- g. *Action taken in response to the report or evaluation:*

Report distributed to the Senate and House Committees on Health and Welfare and posted to the DHH OBH website. In response, OBH also initiated a more robust independent data validation protocol for the next report.

- h. Availability (hard copy, electronic file, website):*
Available by electronic file and on the DHH OBH website
(<http://new.dhh.louisiana.gov/index.cfm/page/1749>)

- i. Contact Person:*
Jennifer Katzman
Director of Research
LA Department of Health and Hospitals
Office of Behavioral Health

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

Department: Department of Health and Hospitals
09-340 Office for Citizens with Developmental Disabilities

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Mark A. Thomas, Assistant Secretary

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

OCDD will list a number of accomplishments for FY 2013-2014 in this section; however, it should be noted that the overall effect of these accomplishments resulted in major positive changes in the service delivery system which had positive impacts on those supported by the system. This was validated by the most recent report from United Cerebral Palsy (UCP) “The Case for Inclusion 2014” which ranked Louisiana in 12th place among the 51 states (up 32 places from last ranking). As system components improve, major outcome areas for people with developmental disabilities (i.e., living and participating in the community; having satisfying lives and social roles; having access and control over supports; and being safe and healthy in the environment which they live) begin to align. The UPC report noted that Louisiana had a huge improvement in the portion of individuals (from 49 percent to 68 percent) and resources (from 41 percent to 79 percent) dedicated to community services over institutions, closed seven large state institutions and had a large drop in the portion of individuals served in large institutions (from 18 percent to 8 percent).

EarlySteps Expenditure Reduction and Improved System Performance

- A. What was achieved? The EarlySteps program achieved several significant accomplishments during FY 2013-2014:
1. Achieved one of the primary program purposes in that forty-three percent of the children exiting EarlySteps improved in their development such that they were functioning at the level of their typical peers. (Note: This is a seven percent gain in outcomes compared to the previous two years).

2. Continued system performance on the fourteen United States Department of Education (USDOE) Performance Indicators resulting in a “Meets Requirements” determination for EarlySteps issued by the USDOE/Office for Special Education Programs in June 2014.
3. Following the implementation of new Eligibility Criteria in May 2012, continued reduction in State General Fund dollars by \$1.29M in expenditures for services.
4. Successful implementation of family cost participation in EarlySteps services. Families with income above 300% of the Federal Poverty Level contribute to a portion of the cost for some services received. Estimated revenue projected for FY 2014-2015 is \$350,000.

B. Why is this success significant?

1. Since moving into OCDD in 2007, EarlySteps expenditures increased primarily due to a 30% increase in the number of enrolled children. A change in eligibility criteria decreased the number of eligible children in the program resulting in a reduction in expenditures and contributed to the sustainability of the program.
2. The determination process has been in place since 2004. “Meets Requirements” is the highest performance result achievable and Louisiana has successfully achieved this determination for four years. This determination had never been reached prior to the administration of the program in OCDD in 2007.
3. Implementation of cost participation will assist in the sustainability of the program.
4. One of the stated purposes of the early intervention program is to minimize the potential for developmental delay in young children. This result indicates the benefit of early intervention through its impact on a child’s development.

C. Who benefits and how?

1. Effective service utilization benefits all children in the system by efficiently and effectively designing services, making services more available to everyone who is eligible, and eliminating delivery of unnecessary services.
2. Achieving “Meets Requirements” means that EarlySteps is providing services that meet Federal requirements. Everyone benefits from the system when it is identifying eligible children, providing timely services, assisting families in meeting their child’s needs, and assisting children and families in accessing other services when children leave the program at age 3.
3. The early intervention system benefits overall in that stable revenue can continue to support the program without further cost containment measures.
4. Families and children benefit through the successful development of their children. In addition, another stated purpose of early intervention is to minimize the need for future special education services for children. By attaining developmental milestones, this risk is minimized for a child.

D. How was the accomplishment achieved?

1. Staff compared eligibility criteria of other states to those used by EarlySteps prior to modifying program eligibility criteria. A more restrictive criterion of 1.5 standard deviations below the mean in two areas of development was selected and cost savings were projected based on the change.
2. EarlySteps uses a regional system of technical assistance and training provided through its nine regional coordinators. Data is reviewed frequently and follow-up is conducted when targets are not met. In addition, several statewide training activities have occurred over the past 2-3 years which have focused on strategies to improve in targeted areas.
3. EarlySteps staff utilized the resources of its Central Finance Office (CFO) contractor to develop the cost participation system. The CFO has assisted other states in utilizing the process. Stakeholders were involved regularly in the implementation of the changes through regional meetings and regular updates. Materials were developed to assist in implementation.
4. In FY 2011-2012, training was conducted with regional provider teams on correctly identifying family needs regarding their child's development and focusing on developing program plans designed to meet those needs. Service delivery, focused on these specifically identified needs, assists both providers and families in targeting activities with children. These activities are continuing and have contributed to the ongoing successful implementation.

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

1. Yes, a major focus for EarlySteps is providing quality services and reducing costs. The eligibility change allowed EarlySteps to reduce costs for services.
2. Yes, reaching "Meets Requirements" means that EarlySteps staff can focus more on the quality of service delivery in the system in addition to meeting compliance of federal requirements.
3. Yes, additional revenue generated from cost participation will support program operations moving forward.
4. Yes, reaching and exceeding the targets set for this accomplishment demonstrate the benefit of the program.

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

1. Yes, EarlySteps used data on children enrolled in the system to project the cost savings: child outcome data at entry and the costs per child. Results of the calculations correctly predicted the cost savings.
2. Yes, the US Department of Education/Office of Special Education Programs (OSEP) provides technical assistance and resources to assist states in improving their performance results. The EarlySteps staff participated in the provided activities and recommendations, resulting in performance improvement.

3. Yes, EarlySteps used the model from other states and worked with OSEP to accomplish the development and implementation of cost participation.
4. The training model used for regional training was based on nationally available content, individualized for EarlySteps. The training included features of Implementation Science which incorporates follow-up activities to sustain changes in performance.

OCDD Resource Center Transformation

- A. What was achieved? OCDD continued state-wide implementation of strategies to transform the OCDD-operated resource centers into centers of innovation and hubs of expertise that have a broad impact in the developmental disabilities services system and to local communities. The Resource Center Transformation Workgroup completed pilot projects and monitored roll out of initiatives state-wide in the areas of triage of referrals to address waiting list for Resource Center services, crisis and diversion referrals, and oversight of persons with High Risk Behavior related to non-consensual sexual behavior.
1. In regards to the triage process, the pilot was completed and a formal process was implemented at Resource Centers state-wide such that all new Resource Center referrals received a triage consultation prior to initiation of services. A total of 353 triage consultations were provided which resulted in the following: 48% received consultation services; 16% received primary short-term services; 12% received primary long-term services; 16% required no services; and 7% were referred to community providers. In addition, the waiting list for services was reduced from 124 people in October 2013 to 68 people in June 2014, indicating there are fewer people waiting for Resource Center services.
 2. The OCDD crisis process was modified to require that the Local Governing Entities (LGE) make a referral for consultation to the Resource Center prior to submitting a referral to the Crisis Committee to ensure that all resources are available to assist with maintaining community placement. In addition, the LGE may refer to the Resource Center when community placement is at risk, and Resource Center will prioritize these individuals for consultation and not place them on the waiting list. A total of 51 crisis diversion consultations were provided state-wide in FY 2013-2014; of these 51 consults, 43 (84%) remained living in the community and 8 (16%) required a more restrictive environment. Of the eight who required alternate placement, 5 (63%) required admission to a psychiatric facility and 3 (38%) required admission to Pinecrest Supports and Services Center.
 3. Resource Center initiatives related to building community capacity for providers who support individuals with complex medical and behavioral needs have continued, with an emphasis on training and technical assistance. In FY 2013-2014, 750 training events and 183 technical assistance sessions were provided, and the Resource Centers worked with 343 providers state-wide.
 4. Efforts toward assuring that persons with a history of and/or current challenges related to non-consensual sexual behavior (NSB) have access to needed supports

were a priority in this reporting period. State-wide roll out of the NSB process was completed, with four of the ten Local Governing Entities (LGEs) completing the initial reviews. Case reviews within the remaining LGEs are underway. The following is a summary of initial outcome data related to this initiative:

- Improvements occurred in understanding of NSB and associated risk.
 - Better definition of NSB and risk ensures that those who are in need of greater support are correctly identified and plans are reviewed comprehensively and with clinical expertise to ensure needed supports are present (77 of the original 129 reviewed were identified with confirmed NSB and in need of ongoing review).
 - Those without ongoing NSB concerns or erroneously identified have their plans and documents updated to remove the previous “labels” and unnecessary risk identification with the added assurance of minimizing/removing “over support” and unnecessary “rights restrictions” (40% or 52 of the original 129 reviewed were noted as not having confirmed NSB).
- Positive outcomes and improved supports occurred for those identified with NSB and ongoing risk needs.
 - Some individuals were determined to have needs related to overall quality of life, and the review process provided opportunity for the person to get connected to these supports (e.g., recreational opportunities).
 - Some reviews afforded discussion of new support ideas that may not have been otherwise identified.
 - Only 4 of the original 129 reviewed had subsequent incidents following review; 2 out of these 4 individuals were placed in more restrictive settings (one person was incarcerated and one person was placed at a forensic hospital).
- Individuals with NSB can and are being supported successfully within community living situations (81% of those reviewed currently reside in community living situations with waiver supports).
 - This is consistent with the national approach toward deinstitutionalization and the recognition that persons with disabilities have the right to community living consistent with their life vision.
 - This process appears to underscore the need to engage in creative and comprehensive planning on an ongoing basis to ensure that persons with NSB have the opportunity to remain in the most integrated setting.
 - Custody is only required in a small number of instances (9%).
- Many individuals with identified NSB also have co-occurring Behavioral Health conditions. In some instances Behavioral Health conditions can trigger or exacerbate NSB; thus, the need for appropriate treatment for these conditions is a key component of positive outcomes (64% have a BH diagnosis and 14% have history of substance use).
 - The fact that more than half of these persons at some point have received some form of therapy (69%) supports the growing research acknowledging that individuals with intellectual/developmental disabilities and behavioral health needs can participate in and benefit from therapeutic approaches.

- The use of traditional therapy and other behavioral health supports (22%) in addition to more traditionally used behavior supports for individuals with intellectual/developmental disabilities (77%) highlight the need to consider a variety of supports and services to assure individualization, choice, and needs related to NSB and overall quality of life are addressed.
 - Additionally, given the potential for multiple providers to engage in service provision for the person, communication across all team members (including clinical providers) to assure continuity of supports and care remains critical.
- B. Why is this success significant? Historically, the Resource Centers focused more on direct service provision or individual-specific capacity building efforts. Positive outcomes for individuals served through these more traditional OCDD Resource Center efforts were noted with 97-99% of individuals served remaining in a community living setting. Despite these positive outcomes, there was not an impact on overall service system delivery for people with concurrent developmental disabilities and complex medical and/or behavioral support needs and the number of individuals impacted remained relatively small. Outcome data collected related to the Resource Center initiatives discussed above indicate that with the shift in service delivery model from direct services to consultative model, the resource centers are able to serve a greater number of individuals/family/providers with greater impact on the service system.
- C. Who benefits and how? People with developmental disabilities, their families, and providers will benefit from the transformation of the services offered through the OCDD resource centers. The OCDD resource centers partner with community providers and professionals to offer quality supports inclusive of consultation, technical assistance, training, and targeted and time-limited primary services for persons with multi-complex needs, life-threatening conditions, or who pose a greater risk to public safety. The resource center transformation emphasizes building community capacity to support individuals with more complex needs and keeping the person connected to his/her community by working with the community services systems to assist in the provision of more evidence-based, effective, and person-centered services. The transformation also streamlines collaboration between the local governmental entity and the local resource center to enhance accessibility and maximize coordination of services.
- D. How was the accomplishment achieved? The OCDD established a workgroup that included internal and external stakeholders across multi-disciplines. Workgroup members included OCDD clinical and administrative staff; resource center nursing, behavioral health, and allied health staff; human services district and authority designees; a provider designee; and support coordination designee. The workgroup reviewed existing data outlining historical and current successes and challenges within the developmental disabilities services delivery system, as well as considered national trends and innovative programs/services established in other states. The workgroup assisted with high level development and review of processes discussed in Section A.

- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a specific goal in the Strategic Plan relative to supporting people with developmental disabilities to achieve improved outcomes, quality of life, and attain personal goals through the development and provision of capacity-building activities, partnerships, and collaborative relationships.
- F. Does this accomplishment or its methodology represent a best management practice that should be shared with other executive branch departments or agencies? Yes. This initiative focused on using existing data to identify gaps within the current developmental disabilities services delivery system in conjunction with a review of national trends and best practices, as well as input from internal and external stakeholders, to identify need for system changes.

Continuation of Employment First Foundation Building

- A. What was achieved? In FY 2013-2014, OCDD continued its efforts to build a foundation for Louisiana's Employment First initiative. The following successes were achieved:
- Revised vocational definitions in the Supports Waiver to promote community employment
 - Included career planning as part of the Supports Waiver
 - Included time-limited prevocational services in the Supports Waiver
 - Added expectation that at least 5% of individuals supported by Support Coordination will become employed in the community
 - Established employment pilot in one region
 - Trained providers, partner agencies and local governing entities' staff in all regions on Employment First
 - Provided training on Employment First to consumers and families through Families Helping Families
 - Participated in regional job fairs
- B. Why is this success significant? Community employment has become a major focus of OCDD with increased emphasis being placed on community-based employment opportunities for individuals with developmental disabilities. As employment is brought to the forefront and concerns about employment are alleviated through improvement of service delivery, more individuals with developmental disabilities can achieve and maintain employment thereby increasing their independence.
- C. Who benefits and how? Individuals with developmental disabilities who want to work and achieve employment will benefit from improving employment services as they will increase their independence through employment. The state will benefit as these individuals will pay taxes and spend money, thereby improving the economy. Families benefit by the increased independence of their family members and through a decreased level of financial responsibility.

- D. How was the accomplishment achieved? This was achieved by including community employment as a major Office focus and developing a plan to improve employment services that are offered in the waivers, as well as highlighting the need for employment for individuals with developmental disabilities. Additionally, OCDD partnered with various stakeholders, such as Louisiana Rehabilitation Services, Louisiana Workforce Commission, Department of Education, The Developmental Disabilities Council, The Advocacy Center and various other agencies, related to this initiative. To maintain this success, OCDD continues to participate in the Work Pay\$ Coalition, a group working together to improve employment for individuals with disabilities.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. Development of policies and procedures to provide pathways to community employment is a strategy in OCDD's current Strategic Plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. This process will continue to be implemented over a five-year period in order to continue the outreach and education specific to employment. Changes will continue to be made within the OCDD to increase the number of individuals in community employment. Employment should be a focus for all agencies that serve individuals with any type of disability, not just developmental disabilities. Employment First has been in the national spotlight for the last eight years.

System Transformation

- A. What was achieved? Continuing the prior fiscal year activities in FY 2013-2014, OCDD completed research, design, and implementation activities in seven key areas of System Transformation:
- **Request for Services Registry (RFSR)** - OCDD Stakeholders identified the multi-year wait for waiver services and the high number of persons on the RFSR as urgent to be addressed and a driving factor for System Transformation. Actions undertaken aimed to improve the efficiency and effectiveness of RFSR administrative processes as well as facilitate shifting access to waiver services from first come, first served to more responsive practices. Validation procedures were improved, with policy and rule change following. RFSR validation was completed using these updated procedures, resulting in a more accurate registry. In addition, RFSR validation efforts were extended for persons currently served in facilities. A "future state" RFSR concept was developed, and discussion of important prioritization features was completed. The RFSR assessment, which concluded Phase I in FY 2013-2014 and continues in FY 2014-2015 with Phase II, is providing individual specific information about people on the RFSR that will be important in crafting the prioritization approach.
 - **Lifespan Planning** - OCDD Stakeholders hoped to reduce fragmentation of access and planning processes that create confusion, duplication and lack of continuity of care for people with disabilities and their caregivers. Actions undertaken worked to

propose improvements in both individual support planning and the support coordination process to span system-wide and translate into Managed Long-Term Supports and Services (MLTSS). A model for front-end support coordination was developed and transferred to MLTSS progress. Alignment of planning processes across OCDD waivers and programs, including EarlySteps was completed and prepared for use in MLTSS.

- **Supports Utilization & Transformed System Design** - OCDD Stakeholders requested common-sense changes to both services and administrative processes, including use of more innovative funding strategies, to accomplish the five transformational outcomes. Actions undertaken aimed to deliver a more streamlined system that will produce a seamless customer experience and will serve across the lifespan, offering supports and services consistent with an individual's assessed level of care and need. The work in this area translates strongly to development of the MLTSS service structure. Research was completed and policy recommendations made on improvements to a level of care/level of need process, as well as accompanying assessment instruments for consideration, as the OCDD system transitions to MLTSS and better aligns assessment and allocation processes across programs and ages.
- **Single Point of Entry/No Wrong Door (SPOE/NWD)** - OCDD Stakeholders identified areas for improvement in entry processes across programs and administrative entities. At the same time, DHH entered into the Balancing Incentive Payment Program, which requires better alignment of the Medicaid and the three long-term supports and services program offices' entry/no wrong door processes. SPOE/NWD work started with improvements to the accuracy and usability of information provided in print and on the web. FY 2013-2014 saw the redesign of OCDD print materials and a complete revamp of the OCDD web site, with the site now fully compliant with the Americans with Disabilities Act (ADA). In addition, OCDD completed a comprehensive evaluation of performance of the entry and eligibility process. Significant improvements were made in guidelines and requirements, with these being promulgated in policy and rule. Finally, improvements to the accuracy and timeliness of data entry tracking eligibility were made.
- **Increased Consumer Choice & Control** - Provider freedom of choice (FOC) was identified as an area for improvement. Stakeholders requested better delivery of information to support service participants making informed choices about their supports. Workgroup activities in FY 2013-2014 developed a provider questionnaire with response topics addressing provider operations areas most important to stakeholders in approaching provider selection. The freedom of choice information page, included in the OCDD web site, was improved for accuracy and ease of locating the information. Provider questionnaire responses will be included in the online FOC listing.
- **Current Services** - OCDD Stakeholders identified areas for improvement of current services, some ideas for new services that may help diversify the current service array, and some solutions to address service access barriers. Actions undertaken in FY 2013-2014 included implementation of new services (included in a later portion of this report), as well as program design of the service array for

MLTSS. Significant research and efforts were made to address service gaps identified by stakeholders as high priority in the mid and long range System Transformation/MLTSS design.

- **Stakeholder Engagement** - OCDD Stakeholders are an integral component of evaluating the current system, planning for needed changes and supporting implementation of these changes. Stakeholder involvement in all phases of System Transformation (ST) is necessary to achieve consensus toward the paradigm shift of the transformed system design. FY 2013-2014 saw regular actions undertaken to facilitate engagement of stakeholders throughout the ST process. A Core Stakeholder Advisory Committee was formed during a 07/19/13, large stakeholder meeting. Mark A. Thomas, OCDD Assistant Secretary, requested individuals with a high degree of interest in the OCDD ST to serve on a committee that would commit to meet monthly, for up to a full day if needed, and work with workgroups to discuss very detailed recommendations, provide feedback on options, and shape success/failure criteria for key decisions. Thirteen people responded to the call, the majority of which are family members or advocates, and a Core Advisory Stakeholder group was formed. This group met eleven times in FY 2013-2014. In addition to the Core Stakeholder Advisory Committee, OCDD has held large, statewide stakeholder meetings at least quarterly during FY 2013-2014. These meetings were broadcast online beginning November 2013. The meeting format supported discussing proposals from System Transformation workgroups and Core Advisory recommendations for final decision making and input from stakeholders before implementation. More than 400 people participated in this meeting series during FY 2013-2014.
- B. Why is this success significant? As noted in the FY 2012-2013 AMPAR, more than twenty states nationally are in some phase of developmental disabilities system improvement or redesign, with all working to address system efficiencies, growing demand for services, and the challenges of rebalancing. Louisiana DHH/OCDD's System Transformation plan was viewed as ambitious, innovative, and comprehensive. The hard discussions, decisions, and paradigm shifts that would need to occur to carry out the plan presented a large barrier to overcome. However, in FY 2013-2014, not only did OCDD accomplish significant system reforms, this was done with a level of transparency and stakeholder involvement that has resulted in strong consensus in both moving forward with System Transformation and some very sweeping changes as proposed in MLTSS.
- C. Who benefits and how? Actions of the OCDD System Transformation in FY 2013 - 2014 resulted in improving access to, quality of, cost-effectiveness of, and efficiency of community services for persons with developmental disabilities utilizing state plan Medicaid, waiver, EarlySteps, and state general fund services. The transformation will also impact the access structures to public and private Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD), first through improvements in the eligibility process, and later with efforts to better support persons served in ICFs/DD to utilize community-based supports as needs and preferences change. Identified improvements to the Request for Services Registry (waiver waiting list) has enabled

more effective administrative processes, and ongoing efforts to implement prioritization strategies will facilitate better access for persons in need. Administrative improvements designed and/or implemented in FY 2013-2014 system wide will positively impact providers, support coordinators, families and persons seeking system entry, and local governmental entities.

- D. How was the accomplishment achieved? The successful completion of System Transformation activities and MLTSS alignment were achieved through the collaborative efforts of OCDD staff throughout the state, DHH program office staff partners (Medicaid, Office of Aging and Adult Services, and Office of Behavioral Health), local governing entities, support coordinators, providers, service participants and their families, as well as other advocates.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. System Transformation components are aligned with all six goals of OCDD's strategic plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. The approach OCDD continues to utilize in tying a comprehensive system analysis to a multi-phase strategic action plan, as well as the approach to involving stakeholders and incorporation of national best practice recommendations is consistent with nationally recognized strategies for success in large-scale system transformation.

Expansion of Service Options with Home and Community-based Services, Including Permanent Supportive Housing

- A. What was achieved? During FY 2013-2014, a number of significant service opportunities were added to Home and Community-Based Services (HCBS) waivers affording participants an increased array of options:
1. Permanent Supportive Housing (PSH) services were added to the New Opportunities Waiver (NOW), Children's Choice (CC) Waiver, and Supports Waiver (SW) so that these waiver participants could subsidize their rent through housing vouchers and could continue to remain in their rental units through housing stabilization services. These services assist with aspects of managing a participant's needs, bills, food, clothing, child care, money management, etc. in order to keep him/her from losing the rental unit. (Note: The addition of PSH services to the ROW was approved by CMS in October 2014.) Additionally, sixty-five waiver participants' PSH services were moved from Community Development Block Grant (CDBG) to a billable service under each respective waiver. The implementation of PSH system selection was developed and has been tracked monthly for current waiver participants who previously requested PSH and their names have appeared at the top of the list for PSH services.
 2. Remote Monitoring was added to the NOW which allows a participant to have both video and audio oversight in his/her home from a remote location without having a direct support worker on sight. This allows for increased independence with a

potential for a lower cost service, yet the press of a button can bring immediate assistance on the way since there is stand-by staff around the clock. Companion Care is another innovative service added to the NOW which allows a participant to live with his direct support worker and share the costs of an apartment or arrange for payment of the worker's share of the apartment by exchanging his/her services to the participant for his/her portion of the rent.

3. Medical Equipment and Supplies service was added to the CC Waiver to fund these services which were formerly not available in the CC, if not already covered under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) or state plan services. Six Alternate Therapies (Applied Behavior Analysis; Aquatic Therapy; Art Therapy; Music Therapy; Sensory Integration; Hippo/Therapeutic Horseback Riding) were added to the CC because they were alternate types of therapies that were not included in EPSDT or state plan services, not traditionally included in 1915(c) waivers, yet proven to be beneficial to children and highly requested by parents of children in the CC waiver and members of the Louisiana Developmental Disabilities Council. They involve behavior modification, therapeutic techniques or other activities rendered by licensed or certified therapists, Occupational Therapists, Physical Therapists, Licensed Mental Health Professionals, etc. which improve the child's skills or functioning. Finally, the Self-Direction service delivery option was added to the Children's Choice (CC) waiver which allows participants/parents/legal guardians to exercise Employer Authority in the delivery of their Family Support services.
4. Related Rulemaking - The Notice of Intent (NOI) has been published for items #1 and #2, above but not the final rule; the final rule has been published for item #3, above which was effective on 9/20/2013.

B. Why is this success significant?

1. Permanent Supportive Housing (PSH) – For the first time, NOW, CC, ROW and SW participants can have PSH services which support them in paying/subsidizing their housing and in maintaining a stabilized housing unit for a longer period of time with an array of support services provided by specially trained case managers.
2. Remote Monitoring – It is a new and innovative technologically advanced service which will increase participant independence, maintain health/safety and possibly reduce cost. Companion Care – This represents a new, innovative and highly flexible service which allows participants and their direct support workers to live together and share rental expense either by dividing the actual cost or by bartering for services for their portion of the cost of rent, utilities, living expenses, etc.
3. Medical Equipment and Supplies – This adds an identical service to CC participants which was also available to NOW participants. This allows them access to medical equipment and supplies not otherwise covered by other funding sources. Six Alternate Therapies (Applied Behavior Analysis; Aquatic Therapy; Art Therapy; Music Therapy; Sensory Integration; Hippo/Therapeutic Horseback Riding) – These therapies fill gaps in services which are not available to children with developmental disabilities in Louisiana through state plan or EPSDT and fulfill the requests of parents and developmental disability stakeholders and developmental

disability advocacy groups.

- C. Who benefits and how? Those benefitting from all of the aforementioned expanded Home and Community-Based Services (HCBS) service options include: NOW, ROW and CC waiver participants; their parents and other family members; the providers, support coordinators and the Developmental Disabilities services system all of which plan for and use these expanded and innovative services to improve the care of and for persons with developmental disabilities, especially services which improve oversight and protect health and safety of waiver participants. Other services provide more flexibility, greater choice, increased independence, and greater access to medical/therapeutic services and supports.
- D. How was the accomplishment achieved?
Permanent Supportive Housing required extensive planning, meeting and collaboration with other DHH Program Offices (i.e., Office of Behavioral Health and Office of Aging and Adult Services) as well as DHH executive management before it could be implemented for the developmental disability population in the relative “Go Zones.” Subsequently, PSH services had to be added to the NOW, CC, ROW and SW Applications and approved by CMS before rulemaking could be accomplished.
Remote Monitoring and the Six Alternate Therapies required research from other states that were providing those services as well as refinement of the definitions and development of the rates, provider types and certification/licensing requirements for each professional. Remote monitoring also included a live demonstration from a company who was providing this service in other states.
 The remaining expanded HCBS services had already been developed for our other waivers and simply required CMS approval for adding them to the NOW, ROW and CC waivers.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a goal to manage the delivery of an array of community-based supports and services in a fiscally responsible way allowing people with developmental disabilities achieve their person-centered or family-driven outcomes in the pursuit of quality of life, well-being, and meaningful relationships. Also, OCDD has the following Community Support Objective: To provide effective and efficient management, delivery, and expansion of waiver and state-funded community programs and to optimize the use of typical community resources in order to promote and maximize home and community life and prevent and reduce institutional care during FY 2012 through FY 2016.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. Several of the aforementioned innovative services, technologically advanced services and alternate therapies represent national best practices. The PSH service is also being used by the Office of Behavioral Health and the Office of Aging and Adult Services.

II. Is your department Five-year Strategic Plan/Business Plan on time and

on target for accomplishment?

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

OCDD is making progress in its five-year Strategic Plan/Business Plan particularly with those initiatives that support the following strategic plan goals: 1) To provide a Developmental Disabilities Services System which affords people with information about what services and supports are available and how to access the services system; 2) To provide a person-centered planning process consistent with a needs-based assessment that focuses on the person's goals and desires and addresses quality of life; 3) To increase the capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings; 4) To increase the capacity of the Developmental Disabilities Services System to support people with complex behavioral, mental health, and/or medical needs in all service settings; 5) To implement an integrated, full-scale data-driven quality enhancement system; and 6) To rebalance the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs. These initiatives also support OCDD's Business Plan Priorities: 1) System Transformation, 2) Resource Center Transformation, and 3) Privatization. The success of the following initiatives in FY 2013-2014 has moved the Office toward goals/objectives outlined in both OCDD's Strategic Plan and Business Plan: transforming OCDD resource centers to centers of innovation and excellence; assuring satisfaction for individuals moving from supports and services centers; expanding service options within Home and Community-Based Services (HCBS); continuing implementation of Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana); utilizing self-direction waiver opportunities; and building foundation for Louisiana's Employment First initiative.

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

Program 2000 (Community-Based Supports), Objective 1:

PI Code #24660 - Performance Indicator: Percentage of waiver participants who have been discharged from their waiver due to admission to a more restrictive setting (Performance Standard: 5%; Actual: 0.62%)

1. To what do you attribute this success? OCDD continues to implement multiple initiatives that have contributed to this success. Continued enhancement and improvement to the planning and approval processes increase assurance that the plans of care for participants address all needs so that each participant is able to successfully receive supports within their waiver living setting. Additionally, OCDD continues implementation of its risk management process that provides access to additional consultation and recommendations for those individuals with complex support needs and risk incidents. Finally, OCDD has centralized its crisis referral process for individuals for whom waiver living situation may be in jeopardy. This process involves collaboration and coordination between local entities and OCDD resource center clinicians to assist community providers in modifying or initiating needed supports in an effort to preserve the waiver living

situation as outlined in OCDD Resource Center Transformation section. Collaboration between OCDD, the Office of Behavioral Health and its managed care service provider (Magellan), so that behavioral health services to persons with developmental disabilities and mental illness may be adequately understood, diagnosed and treated properly, continues to be a contributing factor to this success.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at an accelerated pace with current OCDD initiatives focused on expanding the collaborative efforts between local entities and resource centers to increase preventive consultation and technical assistance to providers; as well as with OBH/Magellan to improve services to persons with co-occurring disorders.

Program 2000 (Community-Based Supports), Objective 2:

PI Code # 24664 - Performance Indicator: Percentage of Individual Family Services Plans (IFSPs) developed within 45 days of referral. (Performance Standard: 97%; Actual: 98%)

1. To what do you attribute this success? EarlySteps is able to generate reports from its data system and closely track timelines for completion of IFSPs by its entry offices. When performance is less than 100%, monitoring is triggered to determine the reason for the delay. The system now tracks delays which are due to family reasons as compared to system or internal office reasons; if the delay is due to a system reason, a finding is issued and the entry office receives technical assistance in managing its timelines.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? A focus on improving performance for this indicator has been in place since 2008. Progress has been steady and is expected to continue.

Program 2000 (Community-Based Supports), Objective 2:

PI Code # 24665 - Performance Indicator: Percentage of Individual Family Services Plans implemented within 30 days of parental consent on the Individual Family Services Plan. (Performance Standard: 94%; Actual: 95%)

1. To what do you attribute this success? Since 2007, EarlySteps has conducted provider recruitment and enrollment activities to increase the availability of providers around the state. Lack of provider availability is the main reason for a delay in meeting the 30-day timeline. In addition, support coordinators are required to have team meetings and contact the regional coordinator if there are problems with provider availability. With an increased number of providers in place and the addition of the follow up by the support coordinator, the performance standard has been met.
2. Is this significant progress the result of a one-time gain? Or is progress expected to

continue at an accelerated pace? Since 2004 when EarlySteps began collecting data for this indicator, steady progress has been shown; it is expected to continue due to increased availability of providers.

Program 6000 (Community Resources/Resource Centers), Objective 1:

PI Code #24259 - Performance Indicator: Percentage of individuals served by the resource center's Community Support Teams (CSTs) and Community Psychologists who remain in the community (Performance Standard: 90%; Actual: 99%)

1. To what do you attribute this success? OCDD resource centers employ clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral and medical support needs. The resource centers utilize a multi-disciplinary approach to providing consultation, training, and services that improve the ability of caregivers and providers to achieve positive outcomes for persons with complex needs.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at an accelerated pace for a greater number of individuals. With implementation of triage initiatives, the resource center staffs are able to provide services to a greater number of individuals and provider agencies. With implementation of crisis/diversion initiatives, the resource centers in collaboration with the human services districts/authorities are able to initiate a consultation prior to escalation of a crisis situation such that one's community connection is maintained, or within a timeframe that increases the likelihood of diversion to the most integrated setting.

Program 6000 (Community Resources/Resource Centers), Objective 3:

PI Code #24699 - Performance Indicator: Percentage of individuals reporting satisfaction across the Partners in Quality (PIQ) assessed living situations (Performance Standard: 85%; Actual: 89%)

1. To what do you attribute this success? OCDD has utilized a person-centered approach and tools as individual's transition from a large ICF/DD setting into less restrictive community settings to ensure individuals' support needs are met and to assist with improving quality of life in the less restrictive environment. The PIQ process allows ongoing oversight for a minimum of one year after transition from a large ICF/DD to ensure supports are met and the inter-disciplinary team is actively planning if issues are identified.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at an accelerated pace. OCDD will continue to refine activities in FY 2014-2015 to further improve the oversight process following transition from a large ICF/DD to ensure quality of life and support needs are met.

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

Program 1000 (Administration), Objective 1:

PI Code #24648 - Performance Indicator: Number of years and months on Request for Services Registry (RFSR) until offered a NOW opportunity (Performance Standard: 7.5; Actual: 9.87)

PI Code #24649 - Performance Indicator: Number of years and months on Request for Services Registry (RFSR) until offered a Children's Choice (CC) opportunity (Performance Standard: 6.5; Actual: 9.33)

PI Code #24650 - Performance Indicator: Number of years and months on Request for Services Registry (RFSR) until offered a Supports Waiver (SW) opportunity (Performance Standard: 0.3; Actual: 2.67)

1. To what do you attribute the lack of progress? OCDD had made significant progress in previous years in reducing the "wait time" for persons on the RFSR due to the ongoing distribution of waiver opportunities which became available from a 1/3 legislative allocation of funding that was matched by a 2/3 federal Medicaid funding award. Thus, as more persons request waiver services and are added to the RFSR without any new opportunities being offered, the natural trend is for more persons to wait longer and the overall average wait time for the RFSR to increase over time. This is the trend which is demonstrated in the data for the three performance indicators presented above.
2. Is this lack of progress due to a one-time event or set of circumstances? A set of circumstances which are described in question number 1, above.

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

Yes. OCDD's Strategic Plan has been updated for FY 2015 through 2019 and its Business Plan is updated annually. Updates to both plans include revisions to program objectives, strategies and indicators to reflect Office direction, to build on successes, to provide strategies in areas where success has not be as substantial or where changes in program direction indicate such, and to improve performance assessment.

♦ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Objectives are assigned to staffs within the Office who are responsible for management and oversight of the accomplishment of each objective and related performance indicators. Additionally, a variety of management tools (i.e., databases, project charters, etc.) and task/initiative specific workgroups/committees are utilized to track, review, and provide feedback for utilization in decision making and resource allocation. Progress or lack of progress (along with support/resources needed

in order to achieve the assigned objective) is reported to the OCDD Executive Management Team. Performance data is also reported in LaPAS and available for both management and stakeholder review.

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

Lack of adequately trained professionals and direct support staff to deliver needed behavioral services in community settings, including qualified persons to deliver applied behavior analytic therapies to people with autism

A. Problem/Issue Description

1. What is the nature of the problem or issue? There continues to be a lack of adequately trained professionals and direct support staff to deliver needed behavioral services in community settings. This includes a lack of qualified persons to deliver applied behavior analytic therapies to persons with autism. These therapies can be very effective and significantly alter the course of autism for many individuals. While specific departmental and OCDD initiatives have been implemented this fiscal year to continue addressing this barrier and improvements have occurred in some areas, a general problem continues to exist. It is believed that a multi-faceted and multi-year approach may be required to resolve the problem.
2. Is the problem or issue affecting the progress of your strategic plan? Yes. Lack of these professionals in community settings has continued to be the primary contributor to admissions to the supports and service center and other more restrictive settings, with requests for admissions resulting when community providers are unable to meet behavioral and psychiatric needs of people whom they are serving in community settings. Lack of trained autism professionals negatively impacts the ability to develop new autism services, which can prevent more severe negative developmental outcomes. The inability to teach functional behavioral skills adequately detracts from community participation objectives (that individuals with disabilities are participating fully in communities).
3. What organizational unit in the department is experiencing the problem or issue? OCDD and human services districts/authorities have been impacted by this problem for a number of years. The Office of Behavioral Health and the implemented Louisiana Behavioral Health Partnership (LBHP)/Coordinated System of Care (CSoC) is also likely experiencing some impact due to this problem.
4. Who else is affected by the problem? Individuals supported and their families, support coordinators, and private providers who serve persons with

developmental disabilities in community homes, family homes, and supported independent living settings are impacted by this problem. Hospitals are impacted when individuals with co-occurring needs present at the emergency room due to difficulty accessing other needed services.

5. How long has the problem or issue existed? The problem is longstanding.
6. What are the causes of the problem or issue? How do you know? Many factors contribute to the problem beginning with a historic lack of training of persons equipped to deliver these services. Many Ph.D. psychology programs, for example, offer no training in developmental disabilities. Medical school psychiatry programs typically offer almost no training in psychiatric needs of persons with developmental disabilities. Recent national reports indicate that there is a general shortage of behavioral health professionals in many areas of the country with access for those with co-occurring intellectual/developmental disabilities and behavioral health needs even more challenging. Both the increasing number of persons with developmental disabilities now being served in the community and the downsizing of institutional services, generally considered to be positive and progressive developments in developmental disabilities services, has contributed to an increased need for behavioral and psychiatric supports in the community. In addition, private Supported Independent Living (SIL) providers serving persons in waiver settings and private community home providers generally conduct and are required to conduct very little training with direct support staff on positive behavior supports.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Consequences include a significant number of people with developmental disabilities having unmet needs, a continued need for costly institutional admissions to the higher treatment cost supports and service center, continued high utilization of high cost acute services, and an inadequate number of practitioners to positively impact the developmental trajectories of children with autism leading to increasing service costs over the course of their lifespan.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?
 - No. If not, skip questions 2-5 below.
 - Yes. If so, complete questions 2-5 below.
2. What corrective actions do you recommend to alleviate or resolve the problem or

issue? The following are recommended actions to alleviate the problem:

- Continue implementation of the newly developed plan to transform the OCDD resource centers into centers of innovation and excellence. This includes opportunities for partnering with university programs that provide training as well as individual clinicians resulting in additional needed professionals, growing the service provider pool.
 - Continue implementation of statewide access to training for direct support workers through the Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana) program with additional development of specialized/customized approaches for providers.
 - Develop specialty specific certifications for behavioral health professionals and specialized services to be included in the Managed Long Term Supports and Services (MLTSS) for intellectual/developmental disabilities.
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? Yes. A recommendation has been included in this annual report for the last few years. Some recommendations have been implemented, while others remain and new recommendations are included.
4. Are corrective actions underway? Yes. A number of actions are underway:
- OCDD's statewide Positive Behavioral Supports (PBS) curriculum for direct service workers has been expanded to include statewide certified trainers and has been incorporated into the resource center transformation as an ongoing option with local accessibility.
 - OCDD continues to support the development of a new university-affiliated training program for master's level practitioners.
 - OCDD continues to offer Board Certified Behavior Analysts (BCBA) continuing education opportunities as well as other behavioral and psychological continuing education options.
 - OCDD continues to operate small existing community service teams in each region of the state.
 - OCDD and OBH have established more formal/routine cross office collaborative efforts. A formal collaborative protocol has been developed.
 - Transformation of the OCDD resource centers into centers of innovation and excellence has continued throughout this year. Most initiatives are implemented with a final few in process. Diversion of admission to the remaining Supports and Services Center has had a significant positive impact with more in-depth and earlier involvement of resource centers clinicians (see section on Resource Center Transformation in the accomplishments section for more details).
 - OCDD worked with Medicaid to offer Applied Behavior Analysis (ABA) services via the Children's Choice Waiver on an interim basis while more longstanding changes to the State Plan were implemented. Licensure of Behavior Analysts began in January 2014 which then allowed offering ABA services to children with a diagnosis of Autism or other appropriate diagnosis

via the Other Licensed Professional option in the State Plan. OCDD collaborated with Medicaid in the development of assessment and prior authorization processes, and continued collaboration is ongoing to address needed continued expansion of service access. Additionally, inclusion of this service in MLTSS is in the planning stages to ensure continuity of service and access for those in need.

- Planning for an all-inclusive MLTSS program which will encompass Behavioral Health services is underway.
5. Do corrective actions carry a cost? Most of these actions do not carry a cost. Implementation of training and capacity building efforts approved in the MFP Rebalancing Demonstration (My Place Louisiana) Operational Protocol are funded with federal demonstration dollars through 2020. While other corrective actions could carry a cost in so far as additional clinicians and/or technical assistance staff are recruited into state service systems, they do not carry a cost in so far as most new positions in OCDD are existing positions diverted from institutional services. They do not incur a cost when the focus is on community, non-public capacity building. Costs are associated with new services such as ABA. Costs are in all probability offset by costs associated with failure to implement corrective actions as: 1) failure to intervene at the community level can result in extensive additional institutional treatment costs and 2) failure to intervene with persons with autism at an early age does result in extensive lifelong service costs that are estimated at over one million dollars per person and incurred by families and the taxpayer.

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? Over the past ten years, eight former supports and services centers have been privatized or closed, and OCDD continues to be responsible for costs associated with six of these eight facilities. These costs may include acquisitions and major repairs, risk management fees, building and grounds maintenance, utilities, and loss prevention/security. In addition, OCDD remains responsible for risk management fees at three privatized facilities and for major repairs and identified maintenance costs per the Cooperative Endeavor Agreement for operation of the former Northlake Supports and Services Center facility. OCDD will continue to be responsible for all of these costs as long as the properties belong to OCDD and will continue to be responsible for the risk management fees for two (2) years after the properties no longer belong to OCDD. The risk management premiums for the closed and privatized OCDD properties were \$6,264,341 in FY 2013-2014. Total costs associated with maintaining the closed and privatized OCDD properties, including risk management premiums was approximately \$11,104,749 in FY 2013-2014. (Note: Costs are anticipated to be approximately \$12,993,668 in FY 2014-2015.)

2. Is the problem or issue affecting the progress of your strategic plan? Yes. Although indirectly, this problem is affecting OCDD's progress in implementing its strategic plan in that the fiscal resources required to maintain the vacated properties could be better utilized to further OCDD's progress toward any one or all of its strategic plan goals. In addition, the opportunity to utilize state-owned property as revenue-generating property as campuses are vacated has been explored; however, there are current legislative rules in direct opposition to this course of action.
3. What organizational unit in the department is experiencing the problem or issue? OCDD is managing the problem by continuing to allocate necessary resources to manage the costs associated with maintaining the properties and fulfilling Office of Risk Management (ORM) and other state requirements.
4. Who else is affected by the problem? The OCDD budget authority and the employees fulfilling the duties are affected by this problem.
5. How long has the problem or issue existed? The problem was identified in FY 2009-2010.
6. What are the causes of the problem or issue? How do you know? The problem is caused by mandatory duties related to state-owned property insured by ORM. Also, though vacated, the properties remain the property of OCDD and efforts must be made to keep the physical plant in good condition and to prevent theft or destruction of State property.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? The consequence of this issue is a continued expenditure of funds to maintain properties that are no longer used by OCDD. These expenditures may cause shortfalls in future fiscal years.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?
 - 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/OCDD should seek permission and/or an exception to the Legislative rules and regulations to utilize state-owned property as revenue generating property or amend existing legislation.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? Yes. This recommendation was made in this annual report last year.
4. Are corrective actions underway? Yes. As current legislation prohibits the sale or lease of state property to a non-government entity, the Office is exploring the possibility of introducing legislation to change this restriction. Additionally, the Office is also working to identify potential buyers for the vacated properties.
5. Do corrective actions carry a cost? No. There would be no direct costs related to researching and developing amendments to existing legislation as these actions would be completed by existing staff. However, as mentioned above, failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings/facilities.

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

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

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

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

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

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

National Core Indicators Project – Since FY 2008-2009, the Louisiana Office for Citizens with Developmental Disabilities (OCDD) has participated in the National Core Indicators (NCI) Project. Currently, 40 states and the District of Columbia participate in the NCI Project. The purpose of NCI Project is to identify and measure core indicators of performance of state developmental disabilities services systems. The NCI Project is co-sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). Annually, three family surveys are sent to the families of people with developmental disabilities participating in various developmental disability programs and adults with developmental disabilities are interviewed. A number of reports are prepared to summarize the results of this project. Response rate for completed family surveys has decreased over the past five years (especially for the Family Guardian Survey), probably due to some people being selected in the random sample in multiple years. To increase the response rate, in the coming year, OCDD plans to send a follow-up reminder postcard approximately two weeks after mailing the family surveys, with a phone number to call if the family has any questions or needs another copy of the survey.

1. Title of Report or Program Evaluation:

Reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services:

- *National Core Indicators Adult Consumer Survey 2012-13 Final Report:* This report provides a summary of the results of interviews with adults receiving developmental disability services and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Family Guardian Survey 2012-13 Final Report:* This report provides a summary of the survey which was mailed to family members of adult with disabilities living outside of the family's home. Louisiana did not have enough completed surveys returned by families to be included in the national report. However, when the Louisiana state report is issued, Louisiana will be able to compare its results with the national average reported in the NCI Family Guardian Survey 2012-13 Final Report.
- *National Core Indicators Adult Family Survey 2012-13 Final Report:* This report provides a summary of the survey which was mailed to families of adults receiving developmental disability services who reside with their families and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Child Family Survey 2012-13 Final Report:* This report provides a summary of the survey which was mailed to families of children living and receiving services in the family home and provides comparisons between Louisiana and the national average of other participating states.

- *NCI Adult Consumer Survey Outcomes, Louisiana Report 2012-2013 Data:*
This report provides a short summary of Louisiana's adult consumer survey data as compared to the average data of all other participating states. The NCI Project has not yet released the 2012-13 state reports. The Louisiana state reports will include the results from the Louisiana surveys.
2. Date completed: Final reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services were published in July 2014. (Surveys and interviews were completed between January and June 2013.)
 3. Subject or purpose and reason for initiation of the analysis or evaluation: Surveys and interviews were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. Interview questions concerned satisfaction, quality of care, and quality of life. Analyses compared Louisiana statewide results with results of other states participating in the National Core Indicators Project.
 4. Methodology used for analysis or evaluation: The primary tools used for this evaluation were family surveys and consumer interview questions. Analyses reported both the number and percentage of responses to each question. Comparisons were reported among the participating states.
 5. Cost (allocation of in-house resources or purchase price): The family mail-out surveys were printed and mailed through a purchase order for \$6,770. All other activities were performed in-house. Obtaining and verifying information for families for the mail-out samples and consumers for the interview sample took approximately 272 hours of staff time. Scheduling interviews, completing background information, and interviewing consumers took approximately 1,400 hours of staff time. Entering family survey data and consumer interview data into the NCI database took approximately 184 hours of staff time. Postage costs for a Business Reply Permit and return postage costs were approximately \$2,200. Finally, travel costs to conduct 400 interviews were approximately \$6,000.
 6. Major Findings and Conclusions: Overall, Louisiana was ranked within the average range for the *Child Family Survey*, *Adult Family Survey*, and *Consumer Outcomes Interviews*. The majority of responses were "Within Average Range" with a substantial number falling five or more percent above average. However, there were a few areas that were five or more percent below average.
 7. Major Recommendations: Acquire information/explanations/causes related to areas that fell below average and develop/implement strategies to improve issues identified.

8. Action taken in response to the report or evaluation: OCDD's quality improvement process includes review of NCI data as well as data from other sources such as: data on regional performance indicators as part of the Human Services Accountability and Implementation Plan and data from EarlySteps and Home and Community-Based Services (HCBS) waiver performance indicators. The data is reviewed by the OCDD Performance Review Committee. When trends and patterns are noted, quality improvement projects are developed and implemented upon approval of the OCDD Assistant Secretary.

9. Availability (hard copy, electronic file, and website): Available in electronic file on the National Core Indicators website:

www.nationalcoreindicators.org

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

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

Department: **Department of Health and Hospitals**
09-375 Imperial Calcasieu Human Services Authority

Department Head: **Kathy Kliebert, Secretary**

Undersecretary: **Jeff Reynolds**

Agency Head: **Tanya M. McGee, Executive Director**

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

For each accomplishment, please discuss and explain:

Successful Establishment as a Local Governing Entity

A. What was achieved?

Imperial Calcasieu Human Services Authority was created under Act 373 of the 2008 Legislative Session but did not begin activities to become a Local Governing Entity until the first meeting of the Board of Directors in September 2010. For the last three years, Imperial Calcasieu Human Services Authority (ImCal) has successfully completed all three phases of the DHH Readiness Assessment Process with the last and most difficult phase occurring during the 2013-2014 Fiscal Year, establishing itself as an official LGE under DHH.

B. Why is this success significant?

This move is significant for a number of reasons. The move from the previously state-governed Region V Offices of Behavioral Health and Citizens with Developmental Disabilities to the now ImCal HSA greatly affected every level of administration, management and service delivery. ImCal assumed responsibility for all Fiscal, Operations and Human Resource functions for the previously state governed area. This included an overhaul in the development and revision of policies and procedures related to Budget, Contracts, Purchasing & Procurements, Information Technology, Property, Safety, Emergency Preparedness, Human Resources, Payroll, Workforce Development, and Community Services, just to name a few.

C. Who benefits and how?

This benefits all individuals served by ImCal HSA, as well as those staff persons who serve them. Decisions regarding programming and service delivery are made at the local level with input from community stakeholders to the local Board of Directors. By providing the local governing entities, such as ImCal, local authority over the management of Mental Health, Addictive Disorders and Developmental Disability Services, there is a significant reduction of “red tape” that must occur to better serve those in the community. The employees of ImCal were able to maintain their Civil Service positions, and are now able to have input in how services are provided.

D. How was the accomplishment achieved?

ImCal HSA went through the 3 Phases of DHH’s LGE Readiness Process to accomplish this goal. The process consisted of three distinct phases of preparation with a final phase requiring ongoing monitoring. Phase I which was completed in April 2012 included board appointments, the creation of bylaws and governing policies, and engaging the community to solicit feedback and input. Phase 2 included the appointment the Executive Director for ImCal HSA and the development of the Executive Management Team, organizational structure for the district and the beginning of policy and procedure development. Phase 3 occurred from July 1, 2013 to June 30, 2014 and was identified as the “shadow year.” During this year, ImCal had budget and appointing authority but operated under the jurisdiction of DHH/OBH/OCDD. All 3 Phases were successfully completed in FY 13/14.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Not Applicable.**F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes

Move from a public agency business model to a Practice Management Model within all Behavioral Health Clinics

A. What was achieved?

Imperial Calcasieu HSA implemented a Practice Management Model in the delivery of Mental Health and Addictive Disorder Services within its Behavioral Health Clinics. With the implementation of the Statewide Management Organization to manage behavioral healthcare services in Louisiana, as well as depleting State General Fund and Federal Block Grant dollars available for provision of behavioral healthcare services, it was imperative that ImCal reorganize its business operations in a manner that ensure it is viable in the future and can continue to provide, at minimum, core services for mental health and addictive disorders services.

B. Why is this success significant?

The move to a Practice Management Model resulted in a 65% increase in direct billable services provided; a decrease from 13 days to 4 days between initial contact & first clinical appointment, a 53% decrease in time from initial contact to first doctor appointment; and 3rd party billing increase of 100%.

C. Who benefits and how?

The clients being served and the community as a whole. Individuals are able to access more services, more efficiently.

D. How was the accomplishment achieved?**Clinic Staff reorganization & revision of job duties/job performance expectations**

1. Revised staffing patterns to increase “revenue generator positions” and reduce “cost centers positions”
2. Revised job duties/tasks/assignments removing admin tasks from clinical staff in order to allow an increase in direct billing time
3. Establishment of productivity standards within staff performance evaluations for direct care service staff based on billable services through Magellan and other 3rd party payers

Access & Service Enhancements

4. Implemented Walk-in clinics to expedite access and decrease no-show rates
5. Reduced number of “steps” & paperwork required to access treatment
6. Simplified screening and integrated Mental Health & Addiction Assessments

Created Billing Unit & Enhanced Billing processes

7. Hired Certified Billing Specialist from private sector
8. Implemented policy & procedures for claims management, revenue tracking, client scheduling according to payer source, client eligibility & authorizations, working denials, provider credentialing with 3rd party payers, etc

Implemented viable Electronic Health Record**E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Not Applicable****F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes****Business Re-organization with Executive Administrative Staff****A. What was achieved?**

- ❖ Created Practice Manager Position for BH Division - position focus on business operations and revenue generation of BH clinics which allows for Licensed Clinic Managers to focus on clinical services and increase number of billable clinical hours

- ❖ Dissolved BH Regional Manager Position & Created Program Monitor position – previous regional BH organizational structure too management heavy. Program monitor position focus on corporate compliance, data reporting, performance improvement, contract monitoring.
- ❖ Moved existing Admin Coordinator position to district office – previous regional DD organizational structure too admin staff heavy. In lieu of hiring new admin staff to assume Fiscal and HR functions now responsible for as a district, moved excess admin staff to district office to assume those functions.

B. Why is this success significant?

These changes within Executive Administrative Staff reduced the previously management heavy organizational structure and allowed for more direct staff hours providing services in the Behavioral Health Clinics.

C. Who benefits and how?

Direct line staff within the ImCal Divisions. By absorbing more administrative duties at the district office, it allows for more time to provide direct services to individuals in need within ImCal Behavioral Health Clinics and the Developmental Disabilities Division.

D. How was the accomplishment achieved?

Through consultation and guidance from the Department of Civil Service, ImCal completed a business re-organization, revised job descriptions and assigned staff best qualified and suited for the new roles.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Not Applicable

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

Partnership with QoL Meds for On-Site Pharmacy Services

A. What was achieved?

In May 2013, ImCal HSA contracted with Quality of Life (QoL) Meds to provide onsite pharmaceutical services within the Lake Charles BHC clinic.

B. Why is this success significant?

In 2011, while still under the direct authority of the Office of Behavioral Health, pharmacy services in all of the state-governed regions were centralized to a pharmacy in Alexandria. Approximately 90% of the medications for ImCal clients are filled by this centralized pharmacy and mailed to our clinics. With the centralized pharmacy process, clients had to wait from 3 to 10 days before receiving their medications and the

medication error rate increased from 3% to 22%. Even though the vast majority of medications were filled through the centralized pharmacy, ImCal was still required to house and dispense PAP meds and emergency medications. Due to this, by law we were mandated to maintain a full time Pharmacist on site. By outsourcing pharmaceutical services, ImCal once again has an onsite pharmacy in our main clinic where clients can get their medications filled on the same day as their appointment and a significant cost savings was realized in personnel expenses.

C. Who benefits and how?

Clients served by the ImCal Behavioral Health Division and the staff who serve them. By outsourcing our pharmaceutical services, ImCal has an onsite pharmacy in our main clinic where clients can get their medications filled on the same day as their appointment. Further enhancements and benefits of outsourcing pharmaceutical services include the provision of primary care medications in addition to behavioral health medications, specialized packaging, follow-up calls to clients regarding medications which assist with treatment compliance. In addition, the contracted company manages all medication prior authorization with third party payers, i.e. the Bayou Health companies and commercial insurers. Prior to this move, prior authorization consumed extensive productive time on the part of staff outside of the pharmacy, primarily nursing staff.

D. How was the accomplishment achieved?

Through a contractual agreement with QoL.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Not Applicable

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

***During FY 2013/14, Imperial Calcasieu HSA was in the Phase 3 “Shadow year” under DHH/OBH/OCDD and therefore did not have an agency specific Strategic Plan. Therefore, the answers to section II are all “N/A.” ImCal HSA will implement a Strategic Plan in 2015.*

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

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

- ♦ **Where are you making significant progress?** If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
 1. To what do you attribute this success? For example:
 - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
 - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new 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:
 1. To what do you attribute this lack of progress? For example:
 - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
 - Is the lack of progress due to budget or other constraint?
 - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
 - Other? Please specify.
 2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

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

During FY 2013/14, Imperial Calcasieu HSA was in the Phase 3 “Shadow year” under DHH/OBH/OCDD and therefore did not have an agency specific Strategic Plan. Therefore, the answers to section II are all “N/A.” ImCal HSA will implement a Strategic Plan in 2015.

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

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

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

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

A. Problem/Issue Description

Ways to Maximize Self-Generated Revenue

1. **What is the nature of the problem or issue?**
For FY 13/14, during the “shadow year” Imperial Calcasieu Human Services Authority’s budget was received through Interagency Transfers (IAT) with the Office of Behavioral Health and the Office for Citizens with Developmental Disabilities. Imperial Calcasieu Human Services Authority is working to strengthen its accounts receivable functions and maximize the self-generated revenue generated by the Authority.
2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)** Not Applicable
3. **What organizational unit in the department is experiencing the problem or issue?** All areas of ImCal HSA.

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? FY 13/14.**
6. **What are the causes of the problem or issue? How do you know?**
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue? ImCal HSA consolidated two rural clinics.**

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?

Recruitment and Retention of Professional and Qualified Staff Under a Civil Service System

A. Problem/Issue Description

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

ImCal HSA is working to improve recruitment and retention of licensed professional staff under the rules issued by Louisiana State Department of Civil Service. The requirements and rules regarding the posting and filling of positions, disciplinary actions, and any re-organization of staffing patterns or job duties creates challenges in hiring and sustaining high quality staff.

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

3. What organizational unit in the department is experiencing the problem or issue? All areas of ImCal HAS

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

5. How long has the problem or issue existed? Since ImCal's inception.

6. What are the causes of the problem or issue? How do you know? The rules of the LA Department of Civil Service.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? ImCal will continue to work to fill vacancies and provide needed services to the community.

B. Corrective Actions

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

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

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

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

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

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

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

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

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

During the FY 13/14 shadow year, while there were no formal audits from outside entities, ImCal worked to create a Performance Management and Improvement Program. This is accomplished through a data collection process which involves input from persons served and community stakeholders. The information collected is used to assess and address performance needs, while providing a framework for ongoing assessment of effectiveness and response to process and systems issues as they occur. The Performance Improvement Program is integrated into the daily operations of ImCal HSA divisions in order to support decision-making that is aligned with the mission and values of the organization.

The primary purpose of the ImCal HSA Performance Improvement Program is to improve business function and service delivery by analysis of data collected regarding finances, accessibility, resource allocation, corporate compliance, cultural diversity and competency, risk management, human resources, technology, health and safety, field trends, and service delivery. The Program Monitor is the Performance Management Coordinator and is responsible for performance monitoring activities. The Department Heads are responsible for performance improvement activities for their respective

departments.

The Program Monitor/Corporate Compliance Officer shall assure the completion of performance audits consisting of indicators that are quantitative in nature and look to compliance. Performance monitoring assures the departments are in compliance with CARF Standards, state licensing, CMS rules, LBHP regulations, AIP, and other business regulations.

The Department Heads are responsible for collecting qualitative data on selected performance indicators as determined by the committee and outlined in the performance improvement plans, (i.e., Accessibility Plan, the Workforce Development Plan, Stakeholder Input Plan, Competency Plan, and Cultural and Linguistic Competency Plan). The department heads, managers, and supervisors are responsible for conducting qualitative reviews and/or peer reviews each quarter specific to their unit, i.e., review interpretive summary, treatment plan, discharge summary content for accuracy and appropriateness.

Results of performance monitoring and performance improvement measurement are reported to the Performance Management (PM) Coordinator on at least a quarterly basis. The PM Coordinator shall compile the collected data and bring to the PM committee on a quarterly basis for further action.

Action plans to address areas of improvement will be reflected in PM Committee minutes. The PM Committee will provide technical assistance to the department heads when the results of the monitoring and PI interventions do not demonstrate expected change. All information flows from the departments through the Performance Management committee up to the Executive Management Team. The PM Coordinator will review PM outcomes with the Executive Management Team on a quarterly basis. EMT will provide feedback to the PM Committee as needed.

Contact person for more information or copies of any performance management/improvement activity:

Name: Susan Fry

Title: DHH Monitor, Corporate Compliance Officer

Agency & Program: ImCal HSA

Telephone: 337.475.3100

E-mail: susan.fry@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

Department: Department of Health and Hospitals
09-376 Central Louisiana Human Services District

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: John Egan Jones, LCSW, Executive Director

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

Administration

A. What was achieved?

Phase II and Phase III District Readiness Assessment was successfully completed

B. Why was this success significant?

Phase II of the assessment process evaluated the presence of policies that had been established which addressed the need for the LGE to operate in a manner that meets the Human Services Accountability and Implementation Plan standards and established clear limits of authority for the ED. Completion of Phase II Readiness Assessment indicates the positive progression of the District toward autonomous functioning. As an LGE, the Central Louisiana Human Services District (CLHSD) advanced to Phase III (the “shadow year”) involving a transitional operation from Region to becoming a fully operational LGE. CLHSD was granted Phase III compliance status, September 12, 2013. Phase III assessment was conducted April 10th, 2014. A letter of compliance certifying the successful completion of Phase III was received on May 15, 2014. CLHSD is now a fully operational District and has full authority to enter into contract agreements.

C. Who benefits and how?

The District and the people we serve will benefit from the strengthening of the administrative component of the agency. Policies and procedures governing service delivery ensure application of best practices and quality control that ultimately benefits the people we serve. The ability to independently enter into contract agreements facilitates and enforces CLHSD role as broker of best services for our clients.

D. How was this accomplishment achieved?

This accomplishment was a joint venture among the Administration, Fiscal, IT, Behavioral Health, Corporate Compliance and the Human Resource Departments. Collaboration with DHH/OBH was an intrinsic part of the process. Existing DHH forms were revised; reference manuals for Forms and Policies were compiled with an electronic “share” –K- drive to provide easy access to District policies for all District employees.

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

CLHSD, as a newly formed District, was given the prerogative not to submit a Strategic Plan to the DHH Office of Management and Finance, for the FY 2013-2014 year. A Strategic Plan is slated to be submitted during May 2015. However, this achievement is a key factor in developing and accomplishing current and future goals and objectives.

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

Not applicable.

A. What was achieved?

Obtain proper registration to qualify for grant applications with the federal government. As an independent entity, CLHSD now qualifies to conduct business with the federal government. CLHSD now has a DUNS¹ number (granted 3.18.2014) and a System for Award Management (SAM) number (granted 04.30.2014).

B. Why was this success significant

A D-U-N-S® Number remains with the company location to which it has been assigned even if it closes or goes out-of-business. The D-U-N-S® Number also "unlocks" a wealth of value-added data associated with that entity, including the business name, physical and mailing addresses, trade styles ("doing business as"), principal names, financial, payment experiences, industry classifications (SICs and NAICS), socio-economic status, government data and more. The D-U-N-S® Number also links members of corporate family trees worldwide. The D-U-N-S® Number is widely used by both commercial and federal entities and was adopted as the standard business identifier for federal electronic commerce in October 1994. The D-U-N-S Number® was also incorporated into the Federal Acquisition Regulation (FAR) in April 1998 as the Federal Government's contractor identification code for all procurement-related activities.

A System for Award Management number (SAM) is used by anyone interested in the business of the Federal Government, including entities (contractors, federal assistance recipients, and other potential award recipients) who need to register to do business with the government, look for opportunities or assistance programs, or report subcontract information; and Public User Capability. SAM registration affords public users searching for government business information, information at various sensitivity levels. Public data is available to search and view without having to login or register for a SAM account. Public users that want to save their searches or government users needing access to higher levels of sensitive data must register for a SAM user account.

¹ Created in 1962, the Data Universal Numbering System or D-U-N-S® Number is D&B's1 copyrighted, proprietary means of identifying business entities on a location-specific basis. Assigned and maintained solely by D&B, this unique nine-digit identification number has been assigned to over 100 million businesses worldwide.

C. How was this accomplishment achieved?

Applications for the DUNS and the SAM numbers required the completion of multiple steps necessary to obtain final approval. The process took approximately a month for setting up and creating the accounts and receiving verification of tax exemption status. After completing this step(s) a staff of the Business & Funding Development Division registers CLHSD with Grants.gov. This is the final requirement to fulfill grant eligibility requirements. Grants.gov must receive verification of registration from SAM electronically before an Authorized Organization Representative (AOR) can submit applications on Grants.gov.

D. Who benefits and how?

Under the President's Management Agenda, Grants.gov was chartered to deliver a system that provides a centralized location for grant seekers to find and apply for federal funding opportunities. Today, the Grants.gov system houses information on over 1,000 grant programs and vets grant applications for 26 federal grant-making agencies. As such, by qualifying the District enhances its capability for identifying and seeking available funding at the federal level through a more efficient system that allows applicants to determine what grants are available, what are the qualifications and the existing deadlines.

As a grant seeking tool/prospective funding, the entire district and the people we serve will benefit from the outcomes.

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

Not Applicable

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

Not applicable

Corporate Compliance**A. What was achieved?**

Baseline monitoring of District operated clinics and contractors to determine current performance and work with Management staff to remediate areas of concern.

B. Why was this success significant?

The goal of monitoring is twofold. It gives management a tool to determine what areas need improvement and also an opportunity to make positive changes that will result in improved performance. Baseline monitoring is used to generate a training curriculum and open communication channels for technical assistance and program support.

C. How was this accomplishment achieved?

Individual meetings were conducted with Division Directors to establish quality improvement and quality enhancement plans for their respective Divisions. Monitoring of District clinics and contract programs was conducted. Site visits included staff interviews, peer review, clinical and administrative auditing of charts.

D. Who benefits and how?

The success of the monitoring activity positively impacts all areas of services in the District. It gives management an understanding of how well services are provided and a goal for improving future performance. Persons serve benefit from changes resulting from identifying existing service gaps and implementation of quality control measures. Through training and program support clinic staff and providers acquire new skills and best practices.

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

CLHSD, as a newly formed District, was given the prerogative not to submit a Strategic Plan to the DHH Office of Management and Finance, for the FY 2013-2014 year. A Strategic Plan is slated to be submitted during May 2015. However, this achievement is a key factor in developing and accomplishing current and future goals and objectives.

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

Not Applicable.

Behavioral Health

Treatment

A. What was achieved?

A three (3) year CARF accreditation, one of the highest ranks of approval rate, was earned by CLHSD.

B. Why was this success significant?

Accreditation for the Commission on Accreditation of Rehabilitation Facilities (CARF) is a coveted prize for a business, professional entity and a community service provider. “The mission of CARF is to promote the quality, value, and optimal outcomes of services through a consultative accreditation process that centers on enhancing the lives of the persons serve. CARF accreditation signals a service provider's commitment to continually improving services, encouraging feedback, and serving the community. The value of accreditation goes beyond a competitive distinction for service providers and a framework for continuous quality improvement. Achieving accreditation requires a service provider to commit to quality improvement, focus on the unique needs of each person the provider serves, and monitor the results of services” (Source: www.carf.org). This accomplishment is a cornerstone in the District’s development. It indicates its readiness for growth and its posture for a leadership role in the community.

C. How was this accomplishment achieved?

This accomplishment was the result of a team effort that included the entire staff from management, to clinical, to budget stakeholders. Through top level leadership and participation at all levels of functioning, the necessary changes were made that culminated in being granted accreditation. The preparation for accreditation began in earnest in September 2012. To qualify for accreditation review, the agency needed a minimum of six (6) months track record. Leadership staff fast tracked writing and implementing policies compatible with the new district status and from April to June 2013, staff devoted countless hours to present a picture that

demonstrated our commitment to improving quality of care for clients and staff. Accreditation was granted in July 2013, for a period of three (3) years.

D. Who benefits and how?

Qualifying for accreditation requires a standard of excellence in service delivery. Thus, the entire customer population (persons serve, employees, and community) is positively impacted. Persons serve benefit from the accreditation process through the improvement of service delivery and streamlined procedures for admission/access to care. CARF resulted in heightened safety, added specialized training and improved working environment for clinics, contract staff and employees. For the community, CARF related activities resulted in greater access to care and improved service delivery. Increased access and quality of services strengthened the ability of persons serve to participate in the community as productive members. It potentially reduces the need for law enforcement response, and decrease overall cost to the community (justice, health care and educational systems).

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

A Strategic Plan is slated to be submitted during May 2015. However, this achievement is a key factor in developing and accomplishing current and future goals and objectives.

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

Not Applicable.

A. What was achieved?

The Caring Choices Clinic of Pineville redesigned the access to care admission process

B. Why was this success significant?

The change was aimed to maximize resources, eliminate waiting time and increase services/staff productivity.

C. How was this accomplishment achieved?

Clinic management designed and implemented no-scheduling “walk-in” process.

D. Who benefits and how?

This change was aimed to ensure the most efficient and cost effective service delivery. It benefits the District and the people we serve.

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

A Strategic Plan is slated to be submitted during May 2015. However, this achievement is a key factor in developing and accomplishing current and future goals and objectives.

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

This strategy is at onset stage. As the District matures, the operational processes will be streamlined and fomented.

Developmental Disabilities

A. What was achieved?

Increased outreach efforts to reach people that may be of need of DD services in rural areas

B. Why was this success significant?

The more people are aware of services available, the more people we can serve and meet their needs. Rural areas are especially high need services areas due to distance and cultural barriers.

C. How was this accomplishment achieved?

OCDD used multiple techniques to achieve this project. Educational approaches: Families and the community in rural areas participated in forums and quarterly presentations about DD services. Office staff has participated in several community forums regarding our services, several transition meetings with various school boards in our district. Initially, we were participating in Rapides and Avoyelles Parish special education forums. We have now added Grant and Catahoula parishes. We have been sharing handouts and resource materials regarding our services to the Grant Parish Tech Conference for Teachers, LSU-A special education class, schools, churches, day care centers, etc. Our handouts have been updated to reflect the transition from Region VI OCDD to Central Louisiana Human Services District (CLHSD) and a new brochure including all services of CLHSD was implemented August 2013. We have requested schools send out our resource materials to parents along with IEP's and parents' conference letters. Staff is now attending Coalition meetings in each parish in our service area with concentration in parishes with fewer participants receiving services/rural areas. This will be a resource for networking with other agencies and potential for future outreach opportunities in those parishes.

D. Who benefits and how?

People served in the rural areas that have developmental disabilities, their family and the community at large will benefit from outreach activities. Outreach efforts target hard to reach populations resulting in greater access to care. As people served are able to receive services, there is a greater probability their community functioning will improve and cost to society will decrease.

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

A Strategic Plan is slated to be submitted during May 2015. However, this achievement is a key factor in developing and accomplishing current and future goals and objectives.

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

Although this strategy aims to outreach people within the Office of Developmental Disabilities service area, the techniques used are applicable to all people in need of services, especially in the rural areas. As such, it represents a Best Practice that should be shared with others.

A. What was achieved?

Increased percentage of individuals receiving Individual & Family Support (FS) services and percentage of Individual & Family Support funds expended for individuals & families

B. Why was this success significant?

Individuals with developmental disabilities and their families were provided supports to maintain or establish quality of life and family integrity in a manner that respects both individual needs and aspirations and affirms the individual's ability to use supports in a responsible and accountable manner. It is a great accomplishment to finally have met the set target. We were able to provide services to more people with developmental disabilities than we did in the past.

C. How was this accomplishment achieved?

The set target (percentage) of budget to be expended was 95%. For FY 2011 we expended 69% of the budget on family support services. For FY 2012 the percentage of expenditures was 72.5% and in FY 2013 we exceeded the target and reported a 98.83% of the budget expended on family support services. We developed a spreadsheet to track expenditures that enabled management to easily know where we stood at any point in time, closely monitoring IFS agreements and amending them when necessary to ensure that obligated monies are being spent, and increased outreach efforts.

D. Who benefits and how?

People with developmental disabilities, especially in the rural areas, who were the recipient of more services benefited from this activity. More expenditures/more services translate into a higher probability of functioning in the community and should minimize family's stress and burnout risk. The increased cost of services will be offset by the decrease cost of medical, mental and criminal justice involvement for this population, which will be at a much higher price.

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

A Strategic Plan is slated to be submitted during May 2015. However, this achievement is a key factor in developing and accomplishing current and future goals and objectives.

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

Although this strategy aims to outreach people within the Office of Developmental Disabilities service area, the techniques used are applicable to all people in need of services, especially in the rural areas. As such, it represents a Best Practice that should be shared with others.

A. What was achieved?

Completion of client data entering /transferring into the new OCDD Participant database.

One of our biggest accomplishments in CLHSD-DD section was the completion of transferring/entering client data into the new OCDD Participant database. This was a huge task, and the time/effort put forth by the Entry and Family Support staff to enter data and update clients demographic and eligibility status is to be commended.

B. Why was this success significant?

With this system's update OCDD is now able to track more client information and have the capability to generate a number of reports that tracks data on the number of people being served, the type of services they are receiving, services budget information, eligibility status and number of other performance reports. Additionally, this achievement is helping us to better serve our clients by keeping more accurate data and expediting client service delivery.

C. How was this accomplishment achieved?

This was a huge task, and the time/effort put forth by the Entry and Family Support staff to enter data and update clients demographic and eligibility status is to be commended.

D. Who benefits and how?

It benefits both the District and the persons we serve. With this system's update we are now able to track more client information and have the capability to generate a number of reports that tracks data on the number of people being served, the type of services they are receiving, services budget information, eligibility status and number of other performance reports. Additionally, this achievement is helping us to better serve our clients by keeping more accurate data and expediting client service delivery.

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

A Strategic Plan is slated to be submitted during May 2015. However, this achievement is a key factor in developing and accomplishing current and future goals and objectives.

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

Not Applicable.

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

CLHSD, as a newly formed District, will develop and submit a Strategic Plan by May 2015.

◆ Where are you making significant progress?

Although there is no current official Strategic Plan, the District's current Business Plan and the FY 2015- 2016 Operational Plan set forth a strategic path for the Agency's operation. In this respect, we have made significant strides in the Agency goals to increase public awareness and to provide access to care for individuals and their families who are in need of behavioral health and developmental disabilities services. The District's Compliance Division conducts regular on site monitoring of programs to ensure that services provided are responsive to client needs, based on evidence-based best practices, and that programs afford the client a continuum of care taking into consideration cultural diversity and abide by District, Departmental, State and Federal guidelines. One of the primary focuses has been educating the community on the importance of prevention, early detection and intervention, and facilitating coalition building to address localized community problems.

1. To what do you attribute this success?

This success is attributed to the joint effort among the Administration, Fiscal, IT, Behavioral Health, Corporate Compliance, Business & Funding Development and the Human Resource Divisions. It is the result of top level leadership and participation at all levels of functioning. Each department undertook specific tasks aimed to comply with DHH external regulatory agencies' requirements. The successful transition from Region to District would not have been possible without the contribution of all District staff and the effective and rapid implementation of policies, procedures and practices to allow for this change and meet external deadlines.

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

None.

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

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

CLHSD, as a newly formed District, will develop and submit a Strategic Plan by May 2015.

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

The formulation of the CLHSD strategic plan will adhere to management strategies approved by the Executive Director. These strategies, at a minimum, will include:

- **Input:** At the *District level*, the initial steps consist of gathering input from all levels of the agency's functional areas. Meetings are conducted with CLHSD Executive Team and District and Contract program managers to share the leadership mission and vision and to obtain feedback for implementation of Agency goals and objectives.
At the community level, Community Awareness and Partnership Forums are conducted to gather information regarding the priority needs of the people we served in each Parish and this feedback will be incorporated in the development of the Strategic Plan Objectives. Stakeholders' surveys are conducted during these forums.
At the Executive level, the Executive Director exchanges ideas with the CLHSD Board and invites their input and feedback on monthly meetings. The Board will give review the plan and give an final approval
- **Communication:** The Strategic Plan will be available for review at all provider sites and posted in the Internet at the DHH website as part of a compilation of Strategic Plans for DHH: Office of Planning and Budget/DHH/Office of the Secretary.
Coordination: Using technology to enhance communication and participation, e.g., teleconferences, videos, electronic media, etc.
- **Training:** Ongoing training is provided to ensure all stakeholders become familiar and buy into the District's goals and objectives.
- **Performance measurement:** Formulation of objectives that are Specific, Measurable, Attainable, Results oriented and Time-bound. Performance indicators are formulated to ensure monitoring of progress in goal/objective attainment.
- **Evaluation:** The Strategic Plan will be revised, as warranted, to reflect fiscal, managerial and programmatic changes.

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

A. Problem/Issue Description

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

Movement of Central Louisiana State Hospital to its new building in Pineville. Central Louisiana State Hospital is a free-standing inpatient facility that provides acute, intermediate and long-term mental health care, treatment and rehabilitative services to adults in Central Louisiana. In 2012, DHH announced a two-phased plan to vacate the current Central State Hospital property and build a new facility on land adjacent to Pinecrest Supports and Services Center. In the second phase, DHH will build a new building on property it already owns and maintains adjacent to Pinecrest along with using already vacant buildings that will be refurbished for ancillary services. The new Central Louisiana State Hospital will remain separate and apart from Pinecrest. Construction on the new building is expected to last between a year and a year and a half, at which time the current Central property will be completely vacated.

Services located on the grounds of Central State Hospital serving more than 13,000 consumers annually include:

- Behavioral Health Clinic of Central La providing both mental health and addictive disorders services to the Alexandria/Pineville area
- Halfway House for men with Addictive Disorders
- Halfway House for women with Addictive Disorders
- Residential Treatment for Women with Dependent Children (TANF)
- Halfway House services for Homeless Veterans
- The Extra Mile, Region 6 including food pantry and clothes closet for those in need
- Residential Treatment for Adults with Addictive Disorders (Red River)
- Residential Treatment for Adolescents with Addictive Disorders (Gateway)
- Medically Supported Detox Unit
- Co-Occurring Disorders Unit for those with both Addictive Disorders and Mental Illness
- Adolescent Intensive Outpatient Services
- 9th JDC Adolescent Drug Court
- Compulsive Gambling Outpatient Services
- CLHSD Prevention Programming
- VOA Transitional Living Program
- CLHSD Administrative Offices

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

No.

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

The entire District and the providers currently on the grounds of Central will be impacted.

4. Who else is affected by the problem?

The people we serve and their families are members of the community, thus the entire community and stakeholders are ultimately impacted.

- 5. **How long has the problem or issue existed?**
- 6. **What are the causes of the problem or issue? What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**

B. Corrective Actions

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

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

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

The District will work with the State to ensure that the programs currently housed on the campus will continue.

- 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?**

Time frame and plans unknown.

- 5. **Do corrective actions carry a cost?**

- No. If not, please explain.
- Yes. If so, what investment is required to resolve the problem or

There are too many unknown variables to predict cost.

A. Problem/Issue Description

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

Migration off the DHH Network Agency, Impact and Cost

As a result of the former Region 6 becoming an independent district, CLHSD is transitioning to an independent computer network. This involves two different processes:

- 1. *Internet access and*
- 2. *Wide Area Network (WAN) connections.*

CLHSD IT staff initiated the migration process in July 2013 by seeking a service agreement with local consultant to help build and populate domain. Purchasing quotes (bids) were submitted in October of 2013 for Internet service and WAN circuits. Quotes were reviewed and a provider was chosen.

- 2. **Is the problem or issue affecting the progress of your strategic plan?**
The capability of accessing and using Internet and WAN structures is vital to the communication network of the District (Agency, providers and consumers).
- 3. **What organizational unit in the department is experiencing the problem or issue?**
Although CLHSD IT Division is the lead Division, the entire District is impacted. The bulk of the problem is centered on Internet Access. LAN connections are under construction and providers are absorbing the construction cost.
- 4. **Who else is affected by the problem?**
Along with District (Agency, providers and consumers), the community at large will be affected.
- 5. **How long has the problem or issue existed?**
Since FY2014.
- 6. **What are the causes of the problem or issue? What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
See 1 above.

B. Corrective Actions

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

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

- 2. **What corrective actions do you recommend to alleviate or resolve the problem or issue?**
The District will continue to work to transition to its independent computer network.
- 3. **Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?**

No.

4. **Are corrective actions underway?**

Yes.

5. **Do corrective actions carry a cost?**

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem?

Providers' fees for services are estimated to yield \$4,750 total cost per month.

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

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

Internal audit: CLHSD Division conducts regular monitoring and identifies /reviews any areas of concern.

External audits (Audits by the Office of the Legislative Auditor)
DHH Annual monitoring/MOU is conducted to ensure compliance with the Human Services Accountability and Implementation Plan (AIP). It includes on-site monitoring and corrective action plan, if warranted.
Licensing reviews is conducted annual by the DHH Health Standards staff to certify providers abide by established guidelines.
 CLHSD Board's reviews: The Board in conjunction with the Executive Director reviews the District operations and endorses Business and Strategic Plans.
OBH oversees Block Grant and TANF programs.

Policy, research, planning, and/or quality assurance functions in house:
 Performance Improvement and Critical Incident Review Committees, Continuous Quality Assurance (CQI) process is implemented by providers and reviewed by monitors, on an ongoing basis.

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

Program evaluation by in-house staff: CLHSD Division of Corporate Compliance conducts quarterly assessments of District and Contract Programs.

Program evaluation by contract

Performance Progress Reports: Louisiana Performance Accountability System (LAPAS)

In-house performance accountability system or process

Benchmarking for Best Management Practices

Performance-based contracting (including contract monitoring)

Peer review

Accreditation review: CARF Quality standards form the cornerstone of CARF accreditation. Conformance to quality standards is a way to identify areas for improvement and growth and help the service provider focus on improved service outcomes, satisfaction of the persons served, and quality service delivery. Accreditation was granted in July 2013, for a period of three (3) years.

Customer/stakeholder feedback (Stakeholders Surveys): Community Awareness and Partnership Forums are conducted at the community level to gather information regarding the priority needs of the people we serve in each Parish and this feedback is incorporated in the development of the Strategic Plan Objectives. Stakeholders' surveys are conducted during these forums.

Other (please specify): N/A

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

Yes. Proceed to Section C below.

No Skip Section C below.

Annual Management and Program Analysis Report

Fiscal Year 2013-2014

Department: Department of Health and Hospitals
09-377 Northwest Louisiana Human Services District

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Agency Head: Doug Efferson, Executive Director

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

For each accomplishment, please discuss and explain:

Phase II and Phase III Readiness Assessment

- A. **What was achieved?** Phase II and Phase III Readiness Assessment completed.
- B. **Why is this success significant?** These were performance metrics that had to be met in order to transition administrative and programmatic operations from the Department of Health and Hospitals (DHH) to the Local Governing Entity (LGE).
- C. **Who benefits and how?** The clients of the Northwest Louisiana Human Services District (NLHSD) service area benefit from having a local governing entity capable of implementing services that are focused on meeting local needs.
- D. **How was the accomplishment achieved?** By the development of a governing board, LGE leadership structure, policies and procedures specific to both the Board and the LGE, and transitioning responsibility for human resources, purchasing, contracting, etc. from the DHH to the LGE.
- 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

Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation

- A. **What was achieved?** NLHSD Behavioral Health Clinics obtained a three year Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation.
- B. **Why is this success significant?** National accreditation is required by the SMO as Louisiana moves toward a managed system of care. CARF accreditation reflects a level of service quality and ensures NLHSD's ability to generate Medicaid revenues.
- C. **Who benefits and how?** The primary beneficiaries are clients and families as the organization increases the use of 'best practices' and also monitors significant clinical indicators to ensure the effectiveness of services. NLHSD benefits financially in being able to continue to receive Medicaid reimbursements that can then be used to continue operations/services for those in need.
- D. **How was the accomplishment achieved?** Through the development and implementation of Policies/Procedures, provision of staff training and allocating staff time to ensure CARF requirements are documented and achieved.
- E. **Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) Yes
- F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes

Implementation of a New Electronic Health Record

- A. **What was achieved?** Implementation of a new electronic health record - ICANotes.
- B. **Why is this success significant?** ICANotes was implemented as NLHSD's Behavioral Health electronic health record to enhance delivery of patient care and services. This software is specifically designed for services being provided. It improves clinical documentation, enhances chart audit and supervision opportunities, enhances the ability to bill third-party insurance companies and allows more robust monitoring of revenue cycle processes.
- C. **How was the accomplishment achieved?** Allocating financial resources for the purchase of the EMR and staff time for comprehensive training on the software.

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

Consolidation of Non-Clinical Operations

- A. **What was achieved?** Consolidation of non-clinical operations into a single location.
- B. **Why is this success significant?** Locating all purchasing, contracts, human resource, and administrative functions in a single location allowed for consolidation of duties and improved efficiencies. This also created the opportunity to consolidate the Shreveport adult and child behavioral health services in one location.
- C. **How was the accomplishment achieved?** The Shreveport NLHSD non-clinical staff were relocated to the Knight Street leased space and the Shreveport Child/Adolescent services were relocated to the North Hearne Street building.
- D. **Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) Yes
- E. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes

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

NLHSD submitted an initial five-year Strategic Plan at the end of this fiscal year. Thus far, our goals and objectives are being met and the plan is on target for successful completion.

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

The NLHSD Five-year Strategic Plan was just implemented, so there has been very little time to progress or analyze results. Quick results include the filling of board

member vacancies, using ICANotes to streamline business process, and expanding third-party billing as a financial source.

- ♦ **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:

Due to the short time since implementation of the NLHSD Five-year Strategic Plan, there has not been time to make any significant progress on the goals and objectives.

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

Due to the short time since implementation of the NLHSD Five-year Strategic Plan, there has not been time to assess any significant lack of progress on the goals and objectives.

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

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

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

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

Due to the short time since implementation of the NLHSD Five-year Strategic Plan, there has not been a need to revise the plan.

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

The areas of focus for the strategic plan were developed based on stakeholder input and the creation of an End Statement by the NLHSD Board of Directors. The NLHSD Senior Leadership Team then developed the goals and objectives of the plan based on input from management staff. The final draft has been disseminated to staff via e-mail and posted on the NLHSD shared folder for all staff to reference when needed. Review of the plan is set to occur twice a year with a summary report to the Board of Directors for their review and input.

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

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

NLHSD is not experiencing any management or operational problems.

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

A. Problem/Issue Description

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

B. Corrective Actions

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

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

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

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

4. Are corrective actions underway?

a. If so:

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

b. If not:

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

5. Do corrective actions carry a cost?

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

Please discuss the following:

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
- b. How much has been expended so far?

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)**
Semi-Annual Legislative Audits and Annual Civil Service Audits
- Policy, research, planning, and/or quality assurance functions in-house**
Performance Improvement Committee reviews
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff**
Behavioral Health Services Annual Performance Analysis Report
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System):** LaPAS and C'est Bon Reports
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)**
Contract Monitoring
- Peer review**
Medical Staff Review and OCDD Peer Review process

- Accreditation review**
3-Year CARF Accreditation with annual conformance review
- Customer/stakeholder feedback**
Input solicited from surveys, during public forums, and requested during the NLHSD Board's annual strategic planning process
- Other (please specify):**
Annual Human Services Accountability and Implementation Plan (AIP) On-Site Monitoring by OBH and OCDD

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

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

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

1. **Title of Report or Program Evaluation:**
Northwest Louisiana Human Services District – Behavioral Health 2013-2014 Annual Performance Analysis Report
2. **Date completed**
August 11, 2014
3. **Subject or purpose and reason for initiation of the analysis or evaluation**
This report is generated to fulfill CARF accreditation standards. The report establishes specific, measurable goals and tracks the District's performance in an effort to determine the degree to which the District is achieving the desired service and business outcomes.
4. **Methodology used for analysis or evaluation**
A systematic annual review of Financial/Resource Allocation, Accessibility, Corporate Compliance, Cultural Competency and Diversity, Risk Management, Human Resources, Technology, Health and Safety, Strategic Planning, and Service Delivery Improvement.
5. **Cost (allocation of in-house resources or purchase price)**
No direct cost. Used in-house resources.
6. **Major Findings and Conclusions**
 - 3-Year CARF accreditation achieved
 - Purchasing, Contracting, and Human Resources duties successfully transferred from DHH to the District

- Centralized billing implemented
- Savings from Patient Assistance Program rose to \$3,168,337 due to 97% utilization of Patient Assistance for all medication dispensed.
- Human Resource annual retention rate has decreased
- Electronic Medical Record (EMR) implemented
- No-Show rate negatively impacting clinicians direct service time

7. Major Recommendations

- Implementation of credit/debit card processing in the clinics
- Construction of a handicap accessible bathroom on second floor of the Shreveport Behavioral Health Clinic
- Utilize employ satisfaction surveys and exit interviews to assess possible causes of annual retention rate decrease
- Promote services through the development of a District website and the use of social media
- Implement a shared folder system to replace SharePoint for electronic file sharing among behavioral health staff
- Develop a tracking system for the administration of the TOMS survey
- Implement an automated reminder call system to reduce no-shows

8. Action taken in response to the report or evaluation

- Credit/Debit card processing implemented
- Shared folder system implemented

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

Electronic file is available on the District's shared folder

10. Contact person for more information:

Name: Doug Efferson

Title: Executive Director

Agency & Program: Northwest Louisiana Human Services District

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E-mail: Douglas.Efferson@la.gov