

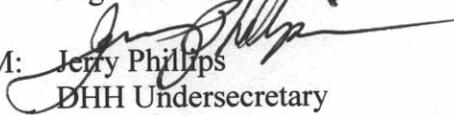
**Bobby Jindal**  
GOVERNOR



**Bruce D. Greenstein**  
SECRETARY

**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

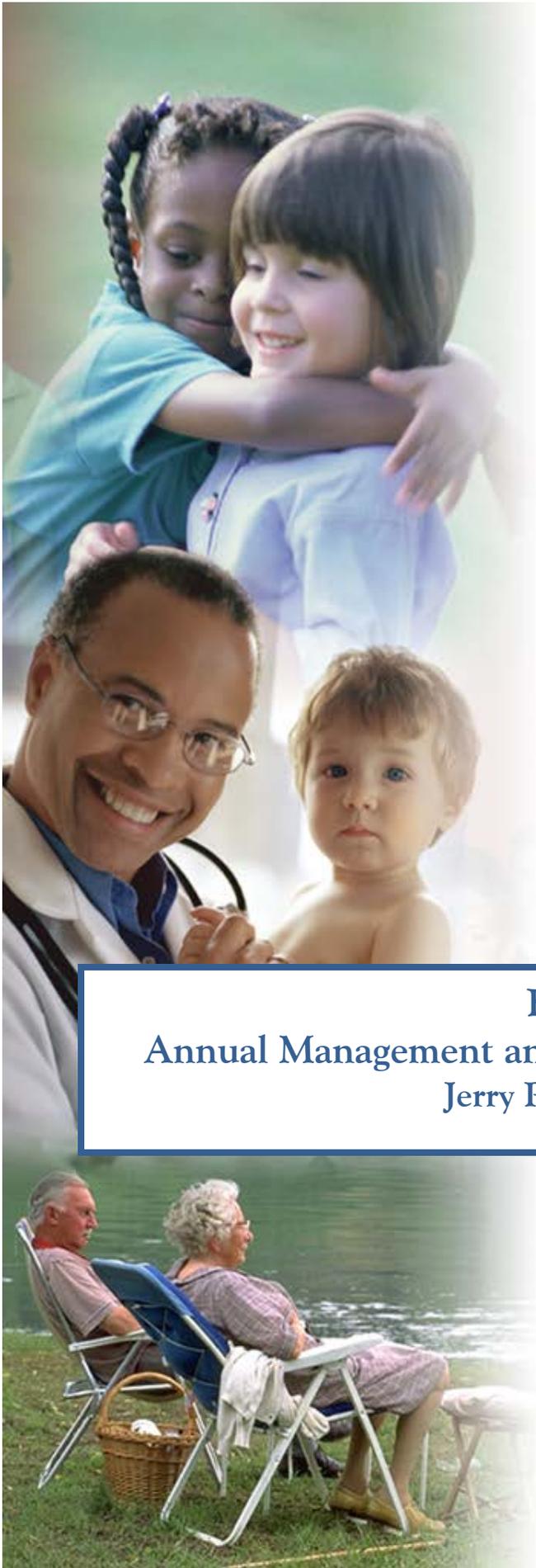
FROM:   
Jerry Phillips  
DHH Undersecretary

RE: FY 2012 Annual Management and Program Analysis Report (AMPAR)

DATE: December 5, 2012

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 2011-2012 fiscal year. These reports summarize the activities of each office relating to management and program analysis, outstanding accomplishments, areas where we are making significant progress and specific management/operational issues that exist within the agency.

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



**DEPARTMENT OF HEALTH  
AND HOSPITALS**

Bruce D. Greenstein, Secretary

**FY 2011 – 2012  
Annual Management and Program Analysis Report (AMPAR)  
Jerry Phillips, Undersecretary**

# Department of Health and Hospitals

09-300	—	<b>Jefferson Parish Human Services Authority</b> Lisa English Rhoden, Executive Director (504) 838-5215
09-301	—	<b>Florida Parishes Human Services Authority</b> Melanie Watkins, Executive Director (985) 748-2220
09-302	—	<b>Capital Area Human Services District</b> Jan Kasofsky, Executive Director (225) 922-2700
09-303	—	<b>Developmental Disabilities Council</b> Santee Winchell, Executive Director (225) 342-6804
09-304	—	<b>Metropolitan Human Services District</b> Judge Calvin Johnson (Ret.), Executive Director (504) 568-3130
09-305 & 306	—	<b>Bureau of Health Services Financing – (Medical Vendor Administration &amp; Medical Vendor Payments)</b> Ruth Kennedy, Medicaid Director (225) 342-6726
09-307	—	<b>Office of the Secretary</b> Jerry Phillips, Undersecretary (225) 342-6726
09-309	—	<b>South Central Louisiana Human Services Authority</b> Lisa Schilling, Executive Director (985) 858-2931
09-320	—	<b>Office of Aging and Adult Services (OAAS)</b> Hugh Eley, Assistant Secretary (225) 219-0223
09-324	—	<b>Louisiana Emergency Response Network (LERN)</b> Paige Hargrove, Executive Director (225) 756-3440
09-326	—	<b>Office of Public Health (OPH)</b> J.T. Lane, Assistant Secretary (225) 342-8093
09-330	—	<b>Office of Behavioral Health</b> Anthony H. Speier, Assistant Secretary (225) 342-2540
09-340	—	<b>Office for Citizens with Developmental Disabilities (OCDD)</b> Laura Brackin, Assistant Secretary (225) 342-0095

# Annual Management and Program Analysis Report

## Fiscal Year 2011-2012

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

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

**Undersecretary:** Jerry Phillips

**Executive Director:** Alicia English Rhoden

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

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

#### **Four-Year, Full-Authority Accreditation**

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

Jefferson Parish Human Services Authority (JPHSA) was awarded a four-year accreditation by the Council On Accreditation (COA), an international accrediting body, in February 2012.

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

JPHSA became the first and only Local Governing Entity to attain full-agency accreditation, i.e. all service delivery (behavioral health clinic **and** community-based services as well as developmental disabilities community-based services) and business functions of the Authority were included. By gaining accreditation, JPHSA met the requirement set forth by the State Office of Behavioral Health, the State Management Organization, and private Managed Care Organizations. Most important, JPHSA received validation of its high quality services, supports, and business practices.

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

The citizens of Jefferson Parish as well as the children, adolescents, adults, and families seeking and receiving services from JPHSA benefit. With this “gold seal of approval”

JPHSA is recognized as meeting a vast array of stringent standards that assure the provision of high quality services and supports that produce positive outcomes within an environment focused on continuous performance and quality improvement. Accreditation by COA attests that JPHSA meets the highest standards of best practice and establishes credibility that the Authority is effective and professionally sound. In addition, this accreditation provides assurance to all of JPHSA stakeholders that it is delivering needed services in the community, conducting its operations successfully, and managing its funds effectively.

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

JPHSA initiated the required intensive Self-Study in January 2011. The following standards were applied:

- Child and Family Development
- Counseling, Support, and Education
- Outpatient Mental Health Services
- Services for Individuals with Developmental Disabilities
- Services for Substance Abuse Conditions
- Supported Community Living Services
- Service Delivery Environment
- Behavior Support and Management
- Client Rights
- Training and Supervision
- Administration and Management
- Ethical Practice
- Financial Management
- Human Resources Management
- Performance and Quality Improvement
- Risk Prevention and Management

Governance and stakeholder involvement were also examined. Additionally, confidential surveys were fielded among all Board members and a wide array of stakeholders.

Every area of the Authority, all levels of employees, and the Board of Directors were engaged in completion of the Self-Study. Three work groups helped facilitated the process.

JPHSA completed all documentation for the Self-Study in November 2011 and COA scheduled the Site Visit by a Peer Review Team beginning January 30 and concluding February 1, 2012. **On February 29, 2012, JPHSA was awarded four-year accreditation on an expedited basis due to the high quality and expansive documentation provided in the Self-Study and completion of the Site Visit with no findings.**

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

The achievement of a four-year comprehensive accreditation by COA contributes to the sustainability of Jefferson Parish Human Services Authority and its Mission, and hence, to the success of the Strategic Plan. It also provides confirmation of JPHSA's strong position in achieving its Strategic Plan Goals.

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

All Local Governing Entities are required to achieve accreditation; however, JPHSA chose to obtain a full-agency accreditation rather than an accreditation that focuses solely on behavioral health clinics.

### **Management of Developmental Disabilities Waivers**

**A. What was achieved?**

On July 1, 2011, the State Office for Citizens with Developmental Disabilities transferred management and monitoring of the Medicaid Developmental Disabilities Home and Community-Based Services (HCBS) Waiver Program to Jefferson Parish Human Services Authority (JPHSA).

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

The significance of this action rests on the strong conviction that developmental disabilities services and supports are best managed and monitored at the local level. As the "Regional Authority" for the HCBS Waiver Program, JPHSA already has direct relationships, many long-standing, with the individuals and families using the Waiver, and is in a position to better determine needs and to be more responsible to those needs because of these relationships.

**C. Who benefits and how?**

The Jefferson Parish community benefits from the transfer of the HCBS Waiver Program to JPHSA. Individuals and families benefit from personal and closer relationships and increased attentiveness to needs and concerns. Providers also benefit. JPHSA has fostered provider relationships and is well positioned to be responsive to their concerns, particularly those relating to the prior authorization process, which impacts billing and sustainability. The Authority is also able to offer providers training and technical support to assure continuous quality improvement and more comprehensive services to individuals and their families. A quality assurance monitor works directly with the providers.

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

Transfer of the HCBS Waiver Program from the Louisiana Department of Health & Hospitals' Office for Citizens with Developmental Disabilities (OCDD) to JPHSA was a joint and collaborative initiative. The transfer of responsibility was accomplished through a Memorandum of Understanding. Communication and collaboration between JPHSA and OCDD are ongoing.

- E. **Does this accomplishment contribute to the success of your strategic plan?**  
Yes. Transfer of the HCBS Waiver Program to JPHSA helps promote quality of life, independence, and community participation on a more personal level with those individuals and families impacted by developmental disabilities in Jefferson Parish. Further, this action contributes to keeping individuals in their homes and avoiding institutionalization.
- F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**  
The transfer of the HCBS Waiver Program to Regional Authorities is a statewide plan.

### **Prescription Assistance Program**

- A. **What was achieved?**  
During FY 2011-2012, Jefferson Parish Human Services Authority (JPHSA) served over 1,000 individuals through its Prescription Assistance Program (PAP) and provided over **\$4 million of cost-free prescriptions** to these individuals.
- B. **Why is this success significant?**  
JPHSA's PAP produces a significant contribution to the Behavioral Health Service Centers' treatment of **indigent** adults through the provision of these very expensive medicines. Without this contribution, JPHSA's physicians would be greatly hindered in their ability to prescribe the most current medicines, and the Authority's shrinking budget would have to support the purchase of as much of these medicines as possible, i.e. the quality of treatment would experience a significant negative impact without PAP.
- C. **Who benefits and how?**  
Indigent adults receiving medication management services in a JPHSA Behavioral Health Service Center benefit. Without the PAP, the number of individuals receiving this critical service would be greatly reduced.
- D. **How was the accomplishment achieved?**  
Two full-time and very dedicated Social Service Counselors facilitate JPHSA's PAP. The Authority's Medical Director personally monitors and coaches these two employees. Their progress is reported on a quarterly basis.
- E. **Does this accomplishment contribute to the success of your strategic plan?**  
Yes. The success of JPHSA's PAP supports recovery and improves the quality of life for many more indigent individuals than would be possible without the access to cost-free medicines.

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

The State Office of Behavioral Health is promoting the establishment of Prescription Assistance Programs in all Regions and Local Governing Entities.

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

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

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 commitment to Performance & Quality Improvement.

Further, the award of a four-year accreditation by the Council On Accreditation (COA) provides reliable and valid evidence of progress toward achieving Strategic Plan Goals and Objectives.

It should be noted that data for eight (8) Behavioral Health Performance Indicators and two (2) Administrative Performance Indicators (out of a total of 21 Key indicators) could not be accessed for fourth quarter reporting and analysis. This was due to JPHSA's required switch from its former fully implemented electronic health record to the one provided by the State Management Organization. Analysis and reporting for these 10 Performance Indicators was based on third quarter data entered into the Authority's former electronic health record. It is hoped, with the continued assistance of the State Office of Behavioral Health, that the State Management Organization will provide the full array of data needed for reporting and continued Performance & Quality Improvement at some point in FY 2012-2013.

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

Based on available data, JPHSA reports continued progress on Strategic Plan Goals:

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

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

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: adherence to meeting and/or exceeding Council On Accreditation (COA) standards; adherence to the Accountable Care Model (endorsed by the National Council on Community Behavioral Health); ongoing commitment to and focus on Performance & Quality Improvement initiatives; integrated and holistic service delivery; communication of clearly defined performance expectations for all employees in compliance with the JPHSA Staff Development & Supervision Guidelines; and, the effort to utilize data for performance and quality monitoring and for decision support.

**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 & Quality Improvement (PQI) Initiatives as well as targeted PQI workgroups to assure progress.

♦ **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.

It should be noted that data is not available through the State Management Organization's electronic health record to monitor progress on eight out of 14 Key Performance Indicators for Behavioral Health activities. JPHSA is working closely with the State Office of Behavioral Health to resolve this issue.

Additionally, the reduction in State General Funds, the implementation of the Louisiana Behavioral Health Partnership by the State Management Organization, and continued suspension on merit increases create significant challenges for the Authority.

♦ **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?

Jefferson Parish Human Services Authority (JPHSA) updated its Strategic Plan in May 2012 (two months prior to the beginning of FY 2011-2012). Two Performance Indicators were eliminated. (The social detoxification unit closed July 1, 2010, and

the School Therapeutic Enhancement Program was slated to close July 1, 2012. Both closures were due to budget reductions and sustainability issues.) JPHSA regarded Strategic Plan Goals, Objectives, Strategies, and Performance Measures to be sound. The only potential barrier to progress is inaccessibility to data through the State Management Organization's electronic health record.

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

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

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

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

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

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

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

Weekly Executive Management Team (Division Directors) meetings are used as group supervision and as forums for discussion of progress o 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?**

#### **Barriers to Decision Support and Reimbursement**

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

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

Jefferson Parish Human Services Authority (JPHSA) had implemented an electronic health record prior to FY 2011-2012 which fully supported high level decision support and the revenue cycle. The move to the electronic health record required by the State Management Organization in March stymied decision support and presented barriers to billing for services.

2. Is the problem or issue affecting the progress of your strategic plan?  
There was no impact on progress toward achieving Goal I of JPHSA's strategic plan at the end of FY 2011-2012, as Self-Generated Funds were not part of the Authority's budget during this year.

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

Barriers to billing Medicaid and the inability to bill other third party payors, will add stressors to JPHSA's ability to retain current capacity and array of services and supports.

Progress toward achieving Goal II of JPHSA's strategic plan was impacted by the end of FY 2011-2012 as there was no data available to measure outcomes or to use for decision support.

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

The State Office of Behavioral Health is providing assistance to JPHSA in gaining access to full and current data from the State Management Organization.

3. What organizational unit in the department is experiencing the problem or issue?  
Although JPHSA's divisions providing adult and child/adolescent clinic-based behavioral health services are the users of the State Management Organization electronic health record, the impact is felt throughout the Authority.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)  
At year end, other Local Governing Entities, the State Office of Behavioral Health, and the State Management Organization are all affected by the problem as cohorts in the Louisiana Behavioral Health Partnership. Without resolution, individuals receiving services may experience impact as well.
5. How long has the problem or issue existed?  
JPHSA's Behavioral Health Services began using the State Management Organization electronic health record on March 15, 2012.
6. What are the causes of the problem or issue? How do you know?  
The electronic health record is an application still in development; however, with the assertive leadership provided by the Office of Behavioral Health, JPHSA is hopeful for timely resolution.
7. What are the consequences, including impacts on performance, of failure to

resolve the problem or issue?

The sustainability of JPHSA's current array of services and supports will be impacted from both a quality and capacity point of view. Additionally, JPHSA's ability to meet and demonstrate performance and quality improvement standards as well as fiscal standards set forth by the Authority's accrediting body, the Council On Accreditation (COA), will be placed in doubt.

#### 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?

## **Human Resources Management**

### A. Problem/Issue Description

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

As indicated in the FY 2010-2011 Annual Management and Program Analysis Report, the Louisiana Department of State Civil Service poses barriers to recruiting, hiring and retaining high quality and qualified staff and to the internal restructuring underway needed to build appropriate infrastructure for a managed care environment.

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

Yes, as a highly qualified and productive staff has direct impact on both capacity and quality of services and supports.

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

This issue impacts every division and all employees within Jefferson Parish Human Services Authority (JPHSA).

4. Who else is affected by the problem?

Individuals seeking and receiving services are impacted by this barrier. The quality of services and supports will not be compromised as JPHSA has an aggressive performance and quality improvement program in place; however, the timeliness of the eligibility process and delivery of behavioral health and developmental disabilities services is impacted when qualified service delivery employees are not in place.

5. How long has the problem or issue existed?

The Louisiana Department of State Civil Service has posed barriers that are regarded as significant since FY 2010-2011. The Rules inhibit JPHSA's ability to compete with private providers.

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

The Louisiana Department of State Civil Service does not have a mission that is supportive of the Local Governing Entities and State Offices operating as efficient businesses.

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

JPHSA will continue to work within the confines of the Louisiana Department of

State Civil Service and to utilize strategies and tactics that enable the Authority to compete for highly valuable human resources in a competitive environment. Ongoing and aggressive performance and quality improvement initiatives will be used to mitigate negative impact on current staff and service recipients as much as possible.

B. Corrective Actions

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

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

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

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

9. 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?

10. Do corrective actions carry a cost?

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

Please discuss the following:

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

- Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

#### **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, and administrative functions. 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.
- External audits (Example: audits by the Office of the Legislative Auditor)  
JPHSA is audited on an annual basis through the Office of the Legislative Auditor as well as by the Department of Health & Hospitals Office of Behavioral Health, Health Standards Section licensing function, the State Office for Citizens with Developmental Disabilities, and the Louisiana Department of State Civil Service.
- Policy, research, planning, and/or quality assurance functions in-house  
JPHSA's Management Services Division has overall responsibility for policy development and management, and for the Authority's quality assurance functions. The Executive Management Team, headed by the Executive Director, is responsible for short- and long-term planning; and, the Performance & Quality Improvement (PQI) Committee, chaired by the Management Services 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. All such studies are required to be consistent with the JPHSA Mission.
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff  
Performance is monitored on an ongoing basis utilizing the JPHSA Strategic Plan, Operational Plan, Division-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.

- 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 to the Department of Health & Hospitals' (DHH) Office for Citizens with Developmental Disabilities on an ongoing basis and as requested. The Authority had provided monthly data to the DHH Office of Behavioral Health; however, with the mandated use of the State Management Organization's Electronic Health Record data sharing in this manner ended in March 2012 as the new system does not allow access to or extraction of raw data. (A collaborative solution is currently under investigation.)
- 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 Development & Supervision Guidelines in conjunction with the Louisiana Department of State Civil Service Performance Evaluation System; ongoing internal monitoring with appropriate follow-up activity; and, ongoing data collection, mining, and analysis for decision support.
- Benchmarking for Best Management Practices JPHSA has a highly developed decision support function previously supported by the availability of data from the Electronic Health Record and Scheduler modalities of its Management Information System as well as other data warehouses. Since March, JPHSA has worked to retain the integrity of its decision support function through the State Management Organization's Electronic Health Record. Comprehensive data may still be extracted, analyzed, and reported from the Office for Citizens with Developmental Disabilities information system. Data analysis includes comparative studies to benchmark against national standards and internally set targets. Studies range from no-show rates for individuals with Serious Mental Illness to claims submitted vs. claims paid. JPHSA also utilizes benchmarks set forth in the Accountable Care Model and the Council On Accreditation Standards and Ratings System for ongoing performance and quality improvement initiatives. During FY 2011-2012, JPHSA completed a process flow analysis for business operations specific to its adult and child/adolescent behavioral health clinics,

using a multispecialty practice management model for points of comparison for efficiency, client throughput, and demographic/financial data collection. Execution of the implementation plan will occur throughout FY 2012-2013.

- Performance-based contracting (including contract monitoring)  
All JPHSA contracts have explicit performance requirements, i.e. plans of work with deliverables and include monitoring plans with timeframes, measures, and assigned 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 regular meetings of the Medical Staff. JPHSA participates in the Office of Behavioral Health annual peer review focusing on program or administrative functions with another Local Governing Entity.
- Accreditation review  
JPHSA achieved a four-year, full organization accreditation by the Council On Accreditation, an international accrediting body for human services organizations.
- Customer/stakeholder feedback  
JPHSA participates in annual satisfaction surveys sponsored by the Office of Behavioral Health and the Office for Citizens with Developmental Disabilities. Additionally, JPHSA fields a proprietary survey within its Behavioral Health Clinics on an annual basis to identify opportunities for improvement. Comment boxes are available in all Behavioral Health Clinics; and, JPHSA invites feedback via its internet site. The Authority's Adult Community Support Division conducts satisfaction surveys with service recipients of contractors as part of standard contractual requirement. JPSHA also 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 monthly Board meetings. Feedback is also obtained through active participation in the Jefferson Parish Mental Health Taskforce and community partners meetings held by the Developmental Disabilities Community Services Division. Regional Advisory Councils for Behavioral Health and Developmental Disabilities provide feedback as well.
- 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, and has a well developed decision-support function in place. Data is analyzed and discussions routinely occur in meetings of the Executive Management Team, Performance & Quality Improvement Committee, Business Process Committee, Utilization Review/Management Committee, and 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 executed as needed. Work Groups and Process Improvement Teams form to support execution of such plans.

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

Name: Gwen Doherty  
Title: Management Services Division Director  
Agency: Jefferson Parish Human Services Authority  
Telephone: 504-838-5215  
E-mail: [gdoherthy@jphsa.org](mailto:gdoherthy@jphsa.org)

# Annual Management and Program Analysis Report

## Fiscal Year 2011-2012

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

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

**Undersecretary:** Jerry Phillips

**Executive Director:** Melanie Watkins

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

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

**Continuation of Progress Towards Accreditation** – FPHSA has continued in its efforts to become accredited by Commission on Accreditation of Rehabilitation Facilities (CARF). FPHSA contracted with a consultant to assist in preparing for accreditation and has prepared policies and procedures that are required by CARF. Accreditation is required for participation in the Louisiana Behavioral Health Partnership (LBHP) and will help to ensure the agency’s long-time viability as a provider of community behavioral health. Individuals residing in FPHSA’s catchment area will benefit from the agency’s accreditation as it will help ensure a level of service that is consistent with national

standards. This accomplishment contributes to the DHH Business Plan theme of Building Foundational Change for Better Health Outcomes as it is required by the LBHP. The accomplishment also contributes to FPHSA's strategic plan as the consistency required for accreditation will improve the agency's ability to provide services that are comprehensive in nature and reflective of treatment modeled after best management practices.

**Implementation of Clinical Advisor** – FPHSA implemented the electronic behavioral health record of the Statewide Management Organization, Magellan, in March 2012. Implementation of Clinical Advisor is currently required to be eligible for reimbursement for services provided to clients who are Medicaid eligible. This accomplishment contributes to the DHH Business Plan theme of Building Foundational Change for Better Health Outcomes as it is required to participate in the LBHP. This accomplishment also contributes to the goals of FPHSA's strategic plan as the improved efficiencies provided by an electronic behavioral health record will enable staff to focus more on the efficacy of services provided and will greatly contribute to data-based decision making.

**Continuation of Increased Services Related to Permanent Supportive Housing** – FPHSA continued the Permanent Supportive Housing Services (PSHS) program and increased the number of families residing in permanent supportive housing from 190 (FYE 2011) to 198 (FYE 2012). PSHS is a major policy objective of Louisiana's "Road Home Program" and funded through a Community Development Block Grant. PSHS combines permanent affordable rental housing with flexible supportive services to help eligible individuals attain and maintain stable housing. Services are tailored to each participant's needs and goals through an Individual Service Plan. Services are flexible and responsive to the needs of the individual and their family and are geared toward assisting the individual to maintain tenancy thereby avoiding homelessness and/or inappropriate institutionalization. This program contributes to the DHH Business Plan theme of Promoting Independence through Community-Based Care as it strives to provide comprehensive services and supports to low-income individuals/families with long-term disabilities in an effort to avoid institutionalization. The accomplishment also contributes to FPHSA's strategic plan by allowing the agency to expand its provision of comprehensive services and supports which improve the quality of life and community participation for individuals with addictive disorders, developmental disabilities, and mental illness, as well as other disabilities of a long-term nature.

**Implementation of the Rural Health Care Pilot Program** – FPHSA prepared for the implementation of the Rural Health Care Pilot Program by ensuring proper technical requirements were met at each facility and all appropriate documentation relating to the associated federal grant was completed. The pilot program is scheduled to begin in FY 13. This accomplishment contributes to the DHH Business Plan theme of Managing Smarter for Better Performance as it strives towards making healthcare more accessible and efficient. The accomplishment also contributes to FPHSA's Strategic Plan by increasing technological capacity to improve the quality and effectiveness of services and treatment through the implementation of best practices and the use of data-based decision making.

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

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

The effectiveness of FPHSA's strategies in FY 12 has been hindered by the rapid evolution of outside circumstances and a workforce ill-equipped to adapt to such rapid statewide systematic transformation. The temporary closing of FPHSA's residential facilities due to repair work (Alcohol and Drug Unit and Fontainebleau Treatment Center), the implementation of the Magellan Clinical Advisor system, and the implementation of the LBHP have contributed to a reduction in the number of clients served and the cost per client served.

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

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

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

FPHSA has made progress toward implementation of data-based decision making. The agency has made headway toward treatment of co-occurring disorders. FPHSA continued progress toward co-housing Addictive Disorders Services and Mental Health Services staff this fiscal year. Clients with co-occurring disorders can see substance abuse and mental health professionals at FPHSA's Lurline Smith Mental Health Center/Northlake Addictive Disorders Clinic and FPHSA's Slidell Addictive Disorders Clinic. Soon, Addictive Disorders Services and Mental Health Services will be co-housed in Hammond as well.

Area Supervisors (Addictive Disorders Services, Developmental Disabilities Services, and Mental Health Services) met regularly with the Executive Director to discuss service and client data from various systems (LADDS, OARS, ITS, OBHIS, ARAMIS, etc.) and the transition to a single electronic behavioral health record.

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

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

FPHSA is meeting this goal in several ways. Major educational initiatives include the Addictive Disorders Services Prevention program. FPHSA staff of each of the agency's service areas participate in numerous coalitions across the five-parish area including St. Helena Social Services Network, Tangipahoa Social Services Council, St. Tammany Commission on Families, Washington Parish Human Services Coalition, Livingston Parish Human Services Coalition, Northlake Homeless Coalition, Families In Need of Services, Prevention and Reduction of Unhealthy Decisions, Tobacco and Cancer Control Coalition, etc. FPHSA also holds an annual public forum whereby information is presented and public input is received on the addictive disorders and mental health services provided by FPHSA.

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

FPHSA has met this objective as 57,159 individuals were served through addictive disorders treatment and prevention services.

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

FPHSA has seen success towards this objective. In FY 12, the percentage of Waiver participants discharged from program services due to the admission to an institution was below the targeted amount (the target was a maximum of 71 individuals or 5 percent with the actual being only 8 individuals or .56 percent). The percentage of individuals receiving Cash Subsidy and the percentage of individuals and families receiving family support who remain in the community versus being institutionalized were both 100 percent in FY 12. These results also promote the DHH Business Plan Goal for Promoting Independence through Community-Based Care with less individuals being institutionalized and more home- and community-based services.

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

**Washington.**

FPHSA has had success in the areas of property management, new employee training, and total number of individuals served by FPHSA (due to a surge in prevention outreach activity). Challenges lie in the payment of contract invoice delays, timeliness of IT work order closures, and the percentage of agency performance indicators within +/- 4.99%. These challenges are mainly due to increased demands on staff in preparation for CARF accreditation and the Clinical Advisor implementation.

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

As 2012 is the first year of this objective, the base line is \$1,093.23 for the average cost per individual served.

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

FPHSA has met this objective in FY 12 with 198 individuals/families residing in permanent supportive housing units with 211 individuals/families completing applications indicating a need for permanent supportive housing.

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

Although the number of merchants educated through Synar and the percentage of enrollees completing the evidence-based prevention program was down in FY 12, FPHSA surpassed its target in the area of individuals served in addictive disorders prevention. The total number of individuals served in prevention programs increased from 35,843 in FY 11 to 54,823 in FY 12 due to FPHSA's prevention providers being more active in the community than projected or planned.

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

**Data Reported** - With the implementation of Clinical Advisor and the issues it has presented, FPHSA has had difficulty in obtaining data required to determine accuracy of proximity to targets referenced in the five-year Strategic Plan. Most numbers had to be estimated from 3/1/12 through 6/30/12. It is anticipated that once the Clinical Advisor system has been fully developed and is 100 percent functional, this issue should be resolved.

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

authorization process increased the wait time for appointments for screenings and assessments. This, in turn, contributed to a decrease in the number of individuals admitted and an increase in the number of individuals screened but not admitted. The closing of the residential facilities from 6/16/11 through 8/25/11 due to required remediation and repair work also decreased the total number of clients served and increased the cost per client served.

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

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

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

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

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

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

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

Corrective Actions

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

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

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

4. Are corrective actions underway?

5. Do corrective actions carry a cost?

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue?

**Implementation of the “Managed Care” Model** – The requirements for the Statewide Management Organization’s authorization process increased the wait time for appointments for screenings and assessments. This, in turn, contributed to a decrease in the number of individuals admitted and an increase in the number of individuals screened but not admitted.

#### 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?

To be more aligned with the CARF “person-centered” model, FPHSA has enhanced its focus on client-centered services and has revamped its clinical workflow in an effort to become more “client centered.” Policies and procedures are being revised/written to ensure a “client-centered” theme.

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. Staff has been trained on the Clinical Advisor system whereby service documentation is centered around the individual (i.e., treatment plan, progress note, etc.). FPHSA is also in the process of becoming CARF accredited and is revising/writing policy and procedure to comply with CARF standards which are “person centered.”

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.)

FPHSA has experienced huge staff turnovers due to staff morale and confusion due to the implementation of the Clinical Advisor system. There has also been insufficient self-generated revenue to meet current year projected expenditures. FPHSA is requesting additional State General Funds in the amount of two million dollars for FY 14 to close the fiscal gap. Once the new workflow and the Clinical Advisor development is nearing completion, recently vacated positions will need to be filled.

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

#### Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?  
 No. If not, skip questions 2-5 below.  
 Yes. If so, complete questions 2-5 below.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
5. Do corrective actions carry a cost?  
 No. If not, please explain.  
 Yes. If so, what investment is required to resolve the problem or issue?

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

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

- Internal audit (Cash Receipts, Petty Cash)
- External audits (Louisiana Property Assistance Agency; Office of Risk Management, Louisiana Department of State Civil Service, Louisiana Legislative Auditor, Medicaid Integrity Contractor, Louisiana Department of Health and Hospitals Bureau of Health Services Financing)
- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify): Annual Financial Reports

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

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

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

1. Title of Report or Program Evaluation
  - a. Cash Receipts
  - b. Petty Cash
  - c. Louisiana Property Assistance Agency (LPAA) – Audit
  - d. Office of Risk Management (ORM) – ORM Compliance Review
  - e. Louisiana Department of State Civil Service – Human Resources Evaluation Report
  - f. Louisiana Legislative Auditor – Audit
  - g. Medicaid Integrity Contractor (IntegriGuard) – Medicaid Audit for LSMHC
  - h. Medicaid Integrity Contractor (IntegriGuard) – Medicaid Audit for RMHC
  - i. DHH Bureau of Health Services Financing – Educational Letter
  - j. Louisiana Performance Accountability System (LaPas)
  - k. Contract Monitoring

1. Annual Financial Reports
2. Date completed
  - a. Monthly
  - b. Quarterly
  - c. February 15, 2012
  - d. January 24, 2012
  - e. February 10, 2012
  - f. May 1, 2012
  - g. June 15, 2011
  - h. August 1, 2011
  - i. August 29, 2011
  - j. Last completed September 9, 2012 (FY 12)
  - k. Quarterly
  - l. Last completed September 4, 2012 by DHH/Fiscal Management (FY 12)
3. Subject or purpose and reason for initiation of the analysis or evaluation
  - a. FPHSA Accounting Policies and Procedures
  - b. FPHSA Accounting Policies and Procedures
  - c. Compliance with State Property Control Regulations
  - d. FPHSA Risk Management Policies and Procedures (ORM requirement)
  - e. Compliance to State Civil Service requirement
  - f. Accountability over public funds as required by State law
  - g. Compliance with applicable Federal and State laws and regulations relative to paid claims for Medicaid services provided under the Louisiana DHH
  - h. Compliance with applicable Federal and State laws and regulations relative to paid claims for Medicaid services provided under the Louisiana DHH
  - i. Compliance with Federal regulations regarding claims paid by the Medical Assistance Program
  - j. Compliance to LaPAS requirement
  - k. FPHSA Contract Regulations Policies and Procedures
  - l. Compliance to State requirement
4. Methodology used for analysis or evaluation
  - a. FPHSA Policies and Procedures 301-901 Cash Receipts
  - b. FPHSA Policies and Procedures 301-951 Petty Cash
  - c. Audit completed by LPAA, Program Compliance Officer
  - d. Compliance Review completed by ORM, LP Officer
  - e. Evaluation completed by State Civil Service, Program Accountability Division
  - f. Audit completed by the Louisiana Legislative Auditor
  - g. Audit completed by IntegriGuard on behalf of the Centers for Medicare & Medicaid Services
  - h. Audit completed by IntegriGuard on behalf of the Centers for Medicare &

## Medicaid Services

- i. Review completed on billings for more than one New Patient Office Visit within a three year period
  - j. DOA-required methodology; performance indicators developed by FPHSA and approved by DOA
  - k.FPHSA Contract Regulations Policies and Procedures
  - l. Policies and practices established by DOA or in accordance with Generally Accepted Accounting Principles as prescribed in the Governmental Accounting Standards Board
5. Cost (allocation of in-house resources or purchase price)
- a.\$17,552.27
  - b.\$5,851.93
  - c.Not calculated
  - d.Not calculated
  - e.Not calculated
  - f. \$25,632
  - g.Not calculated
  - h.Not calculated
  - i. Not calculated
  - j. Not calculated
  - k.Not calculated
  - l. Not calculated
6. Major Findings and Conclusions
- a.None
  - b.None
  - c.1.) Thirteen assets were not entered into the state's asset management system (AMS) within 60 days of receipt. Twelve of those assets were computers that FPHSA acquired as part of the transfer of the Developmental Disabilities Waiver Unit from DHH. FPHSA policy differs from state regulations as FPHSA requires the tagging of all computers no matter the cost and the entering of the computers into the AMS. The computers were manually tagged within the state required time frame, but due to the lack of purchasing information available to FPHSA for these assets, FPHSA was unable to input them into the AMS in a timely fashion. 2.) The agency is not submitting idle or surplus items in a timely manner. 3.) Three assets had an incorrect serial number in the AMS.
  - d.Agency was compliant, with a score of 99.28%. Under General Safety, one item was found to be deficient and recommendations were made.
  - e.One rule violation and two documentation violations were found.
  - f. No matters were found that required disclosure.
  - g.Findings were missing records and missing record specific service.
  - h.Findings were missing records and missing record specific service.
  - i. FPHSA billed and was paid for more than one new patient office visit

within a three year period.

- j. None
- k. None
- l. None

## 7. Major Recommendations

- a. None
- b. None
- c. 1.) The agency must ensure all pertinent information for qualifying items is entered into the states asset management system within 30 days of the date of the report. Future acquisitions must have all pertinent information entered into the state's asset management system within 60 days of receipt. 2.) The agency must complete a surplus transfer request for all property that is not presently in use within 30 days of the date of the report. According to the administrative code, the agency property manager shall submit surplus requests, within the week it becomes know that an item is no longer needed. 3.) The property manager must submit a change request in the state's asset management system to correct the serial number within 30 days of the report.
- d. Conduct documented employee training on bloodborne pathogens for all high risk employees at least once every year after the initial training.
- e. Agencies that have had a layoff within the past two years are required to maintain documentation of a Department Preferred List check dated within the two week period prior to a job offer being made.
- f. None
- g. 1.) Remit overpayment to DHH in the amount of \$10,800. 2.) Comply with all Federal and state, laws and regulations and billing instructions under the Medicaid program.
- h. 1.) Remit overpayment to DHH in the amount of \$10,100. 2.) Comply with all Federal and state, laws and regulations and billing instructions under the Medicaid program.
- i. 1.) Discuss the matter with billing staff to ensure that future claims are submitted correctly. 2.) Perform an internal audit on billing and refund any money to DHH that may be owed within sixty days of identification.
- j. None
- k. None
- l. None

## 8. Action taken in response to the report or evaluation

- a. Audit results are discussed at management team meetings and trouble shooting is done.
- b. Audit results are discussed at management team meetings and trouble shooting is done.
- c. FPHSA updated the purchase request form to include a check box on the

form to signify if an item is taggable prior to purchase in order to ensure that all taggable items are tagged in a timely manner. After the implementation of the electronic behavioral health record and the acquisition of the Early Child Supports and Services, FPHSA will surplus/dispose of any remaining inventory. FPHSA implemented a process for each Facility Property Manager to quarterly review and verify all asset information loaded into the asset management system to ensure that information entered is accurate.

- d.FPHSA scheduled all face-to-face instructor-led bloodborne pathogens training for all FPHSA staff considered to be “high risk.” The trainings were completed March 2012.
- e.No response required
- f. None
- g.Overpayment was remitted to DHH. FPHSA modified its workflow and documentation practices to ensure that proper documentation is available for all services billed.
- h.Overpayment was remitted to DHH. FPHSA modified its workflow and documentation practices to ensure that proper documentation is available for all services billed.
- i. Internal audit planned
- j. None
- k.None
- l. None

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

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

10. Contact person for more information, including

Name:	Melanie Watkins
Title:	Executive Director
Agency & Program:	Florida Parishes Human Services Authority
Telephone:	(985) 748-2220
E-mail:	<a href="mailto:melanie.watkins@la.gov">melanie.watkins@la.gov</a>

Name: Trent Myers  
Title: Administrative Director  
Agency & Program: Florida Parishes Human Services Authority  
Telephone: (985) 748-2220  
E-mail: [trent.myers@la.gov](mailto:trent.myers@la.gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2011-2012

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

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

**Undersecretary:** Jerry Phillips

**Executive Director:** Jan Kasofsky, PhD

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

#### ***CAHSD's School-Based Therapy Program Makes a Positive Difference in Area Schools***

The School-Based Therapy Program has made a difference for students, families, teachers, and principals. In the last three years alone, CAHSD professionals have:

- Provided therapy to 4,179 students
- Educated 42,391 students, parents, and teachers through workshops
- Averted 46 student suicides through interventions
- Avoided 112 student expulsions through mediation at hearings
- Contributed to a significant decrease in discipline referrals.

CAHSD is proud to work in approximately 30 schools in this region. Over the past 20 years, our school-based program has offered top-quality behavioral health counseling, therapeutic interventions and medication management. These; and other services, have won high praise from superintendents, principals, teachers, parents and students. They commend CAHSD for helping students improve their grades and stay in school through effectively addressing problematic behaviors, absenteeism, suspensions and expulsions.

Looking forward to the coming year, our staff continues to be the behavioral health provider of choice in area schools, serving with the utmost integrity. As a public entity, our focus has been and will always remain bringing the best professionals into schools to support students' success.

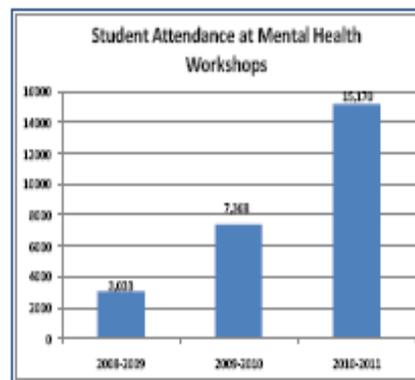
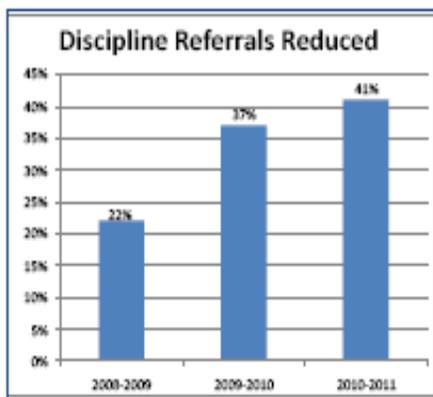
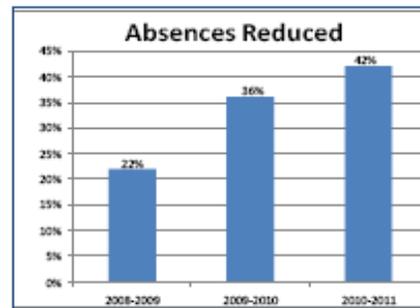
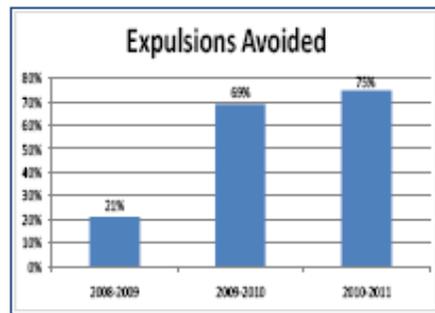
**School Staff and Families Participating in School-Based Programs Survey Reports:**

- 100% of principals indicated that the School-Based Therapy Programs provide quality services to students and their families.
- 91.3% of school administrators stated that students’ behavior had improved.
- 84.5 % of school administrators indicated that the overall progress made by students served by the School-Based Therapy Program had improved.
- 77.8% of school administrators indicated that students’ school attendance had improved.
- 95.1% of parents indicated that they were satisfied with the progress made by their child or family since seeing the school-based therapist.
- 98.5% of parents indicated that they were very satisfied with the amount of time the school-based therapist spent with them and/or their child.
- 97.4% of students indicated that they were very satisfied with the services they received through the School-Based Therapy Program.

In recent weeks, CAHSD representatives have visited with the Capital Area’s 8 school districts’ superintendents reviewing CAHSD services, to further gauge current satisfaction among the leadership in schools served.

Each June and July, the School-Based Therapy Program conducts summer enrichment programs in seven parishes at affiliate schools. This summer, there were 15 camps and a total of 150 students; 30 more than last year’s camp. The benefit of the summer enrichment program is to allow the opportunity for continuity of care for students during the summer months. Our school-based therapists facilitate group activities that focus on cooperation, increasing interpersonal skills, self-esteem and team building through structured adventure based counseling techniques.

**CAHSD Delivers:**



## ***CAHSD Partners with Department of Corrections to Help Prisoners Re-Entering the Community***

The Department of Public Safety and Corrections (DOC) has partnered with CAHSD through a signed Memorandum of Agreement (MOA) to create an Adult Re-entry Pilot Program for DOC offenders who are being released from prison in the CAHSD service area.

Officials of DOC and CAHSD say the program is designed to help adults access mental health and substance abuse treatment quickly upon release from prison. It ensures the referral and treatment of offenders released from state custody is expedited (including those housed in local facilities) for those with a serious mental illness and/or substance abuse problem. This process is the best way to prevent relapse into criminal behavior and/or re-incarceration. As part of the program, CAHSD will:

- Accept the individual who is released into treatment if he/she meets the clinic's eligibility criteria;
- Assist DOC in appropriate referrals and placement elsewhere for individuals that do not meet the clinic's eligibility criteria;
- Track the individual's progress and participation in treatment;
- Communicate with Probation and Parole regarding the individual's progress and needs.

*National statistics show that adults who are released from prison are more likely to remain free and become productive in society if they have access to quality behavioral health services, especially those that treat mental illness and substance abuse.*

The MOA between DOC and CAHSD is the first and only one of its kind in Louisiana and is intended to help prisoners who, upon release, meet the definition of having a serious mental illness or having a substance abuse problem. It will serve as the basis for additional regional MOAs across the state.

## ***Region 2 Selected as Phase 1 Implementer of the Statewide Coordinated System of Care***

The Capital region is one of four regions and one parish in the state to be selected to begin implementation, in March 2012, of the Coordinated System of Care (CSoC). CSoC is a statewide initiative to establish family and youth-driven care to serve children under the age of 22 with significant behavioral health challenges or co-occurring disorders and who are at risk of out of home placement. The CSoC project is an initiative of Governor Bobby Jindal and is being led by executives of the Office of Juvenile Justice, the Department of Children & Family Services, the Department of Health and Hospitals, and the Department of Education in partnership with regional agencies and families.

The new model of care includes Medicaid services management by a statewide organization and coordinating councils with representation by family members.

*The new system of care will provide community based intensive, individualized care planning and management along with additional supports and services through a coordinated and integrated network of service providers.*

CAHSD facilitated the planning process with family members, providers and other stakeholders to develop a regional plan to implement the CSoC. In the Capital Region, care planning and management services (called Wraparound services) will be provided by NHS Human Services while family support services will be provided by Families Helping Families of Greater Baton Rouge.

The CSoc involves collaboration across agencies, and includes families and youth to improve access to an expanded array of services that will promote better quality of life for families served. It will be available to 240 children/adolescents in this region per year.

### ***CAHSD Receives Federal Primary and Behavioral Health Care Integration Grant***

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

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

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

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

Since 2008, CAHSD has laid significant groundwork to continue addressing the physical health needs of persons with SMI through early regional partnerships with the Office of Public Health, the 7 local parish governments, local FQHCs, Our Lady of the Lake Regional Medical Center, the Baton Rouge General Family Health Center, St. Elizabeth Community Clinic, and the Earl K. Long Medical Center. CAHSD was also a national finalist for "Innovation in Government" in 2009 for its work on primary care and behavioral health integration from the Council of State Governments. "The CAHSD leadership and Board of Directors would like to thank these community partners for their service to clients and their support for the grant funding", said Jan Kasofsky, Ph.D., CAHSD Executive Director.

### ***CAHSD Partners with Crime Stoppers to Bring Message to 40,000 BR Area Residents***

CAHSD has contracted with Baton Rouge Crime Stoppers to focus substance abuse prevention and treatment efforts on the increased violence and crime-related issues in the Greater Baton Rouge area.

According to the data, Baton Rouge's violent crime rate is one of the highest in the nation compared to all communities of all sizes. To address the issue, 40,000 door hangers were printed with a substance abuse prevention message and information on where to get resources and treatment services. They were placed on the doors of homes and apartments in high crime areas. The door hangers will also be distributed at media events, speaking engagements and health fairs across our seven parishes.

CAHSD's logo will appear on eleven Crime Stopper billboards throughout the area and CAHSD will appear as a sponsor in Crime Stoppers' advertisements, which will air on networks such as BET and ESPN throughout the months of October and December.

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

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

The District operates under two separate five-year strategic plans. We, as part of the Department of Health and Hospitals, participate in the state-wide LaPas Performance Based Budgeting and Planning process which establishes common goals and objectives by specific programmatic disabilities with pre-set performance standards used to establish funding needs and efficient use of allocated resources. The District is on target with the expected accomplishments set forth in this plan.

The District's Internal Strategic Plan is a daily operations guide that establishes internal goals that are aimed at improving the quality of life for our clients and improving operational efficiencies. This plan has three major goals and the District has made significant progress on accomplishing many of the objectives covered under these goals. A few examples are listed below:

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

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

**CAHSD Plan:** Accreditation Preparation - The District is preparing its facilities and operations for CARF accreditation. Much progress has been made towards this initiative (i.e. Staff has been oriented to CARF Standards, Self-Assessments on CARF Standards have been completed and the Work Plan to achieve compliance on standards has been completed). CAHSD is scheduled to undergo accreditation review during the winter of 2012.

- ♦ **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:

N/A

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

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

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

No. If not, why not?

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

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

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

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

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

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

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

During the month of November 2011 as Magellan and the LA BHP jointly introduced the Clinical Advisor/Claim Track software, highlighted attributes included; a "Complete web based EHR" including E-prescribe, **On-line 3<sup>rd</sup> Party Payer Verification and Claim Submission (Clearing House) with 'Water Fall Billing'**, Accounts Receivable Management System, Lab Order Panel that will identify lab needs based on medications and diagnosis, Integrated BH Assessment, Treatment Plan, TOMS, NOMS, LOCUS, CANS and ASAM to be housed inside the CA, **Document Scan directly into the client file**, Automatic Appointment Reminder Calls and the 'Client File will Follow the Client'. All of these are component requirements for an EHR that is CCHIT and HL7 compliant with DHHS Healthcare Reform; and all were included in those softwares previously being used by or being developed for the LGEs at the time of this conversion.

Magellan provides a long list of clinical documentation requirements for complete and successful use of its CA treatment module, including Case Manager Progress Notes; Psychiatric Progress Notes; Nursing Progress Notes (including Lab Draws); **Comprehensive Assessment**; Treatment Plan (every six months); **Psychiatric Assessment (annual)**; At Risk Crisis Plan (ARCP as needed); Abnormal Involuntary Movement Scale (AIMS as needed); Medicaid Eligibility Screening (annual); Informed Consent (annual); PCP Communication Documentation (upon medication & diagnosis changes). Further documentation required for use of its Claim Track module (claims processing) include Client Intake Demographic Data; Client Insurance Coverage for Third Party, Medicare, and Medicaid payer information (as needed); EOB information from non-networked payers; Service encounter data (e.g. date of service, type of service, provider-at each encounter) and Provider data (provider ID, name, discipline, active status, etc.-kept updated).

However, the CA software system does not contain two major components of an electronic behavioral health record which are Comprehensive Assessment and Psychiatric Evaluations Tools. The system requires an Informed Consent be performed annually; however, the Informed Consent within the system has no means for electronic signature by the client. An alternative to having these tools included and functioning with the CA would be to allow for the electronic

scanning of a signed paper documents directly into the client's file, but this function of CA is not yet working. Furthermore, the CA system does not provide On-line 3<sup>rd</sup> Party Payer Verification and Claim Submission (Clearing House) with 'Water Fall Billing (supports only Medicaid billing) and there is no audit trail from scheduling to service to billing.

A number of limitations to our operations still exist as a result of the March, 2012 implementation of CA. The provision of clinical services was impacted by the need for each clinician to receive at least eight hours of training to make any reasonable use of the system. The billing module was not activated until sometime after April 1, 2012, and the training required for it was over and above the training needs previously mentioned. In addition, there continues to be no reasonable way of posting collections against billed services. The inability to edit patient information entered by a previous provider still prevents billing many services. And, as there remains no way of classifying clients as admitted, versus pre-admission or discharged, we are left with no means of accurately measuring caseloads, acuity, or other productivity indicators.

Aside from the increased time demands on clinical and billing staff, there were and remain increased time demands in order to obtain and maintain CARF accreditation and OBH and Magellan certification; all of which are requirements of the LA BHP and Magellan in order to participate in the SMO and receive reimbursement for behavioral health services provided to Medicaid and OBH clients.

In addition, there are the issues of increased Self-Generated/Medicaid Revenue Collections (CAHSD's portion increased 89% from \$2,248,000 to \$4,243,741) at the same time that Medicaid reimbursement rates were reduced (a [20-30 minute] medication check by a psychiatrist decreased 57% from \$100 to \$43 and psycho-therapy by a Licensed Social Worker decreased 66% from \$100 to \$33.85); individual clinicians who were previously reimbursed by Medicaid for providing psycho-therapy went from Master's Level Social Workers working toward licensure to only Licensed Clinical Social Workers. This change reduces our treatment staff pool by more than 24%.

#### 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 Clinical Advisor/Claim Track system needs to be fully functional and brought up to the standards as originally reported when the system was mandated for implementation. The Department needs to further evaluate the feasibility of allowing clinicians working toward licensure the ability to bill for professional treatment services provided under the proper level of supervision by Licensed

Clinical Social Workers, even if at a slightly reduced reimbursement rate, so that agencies are more likely to meet the revenue demand placed upon them during future fiscal years.

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

No, this system was just implemented during FY2012.

4. Are corrective actions underway?

a. If so: Yes

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

UNKNOWN

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

Little in some areas and none in others

b. If not:

- Why has no action been taken regarding this recommendation?

UNKNOWN

- What are the obstacles preventing or delaying corrective actions?

UNKNOWN

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

Corrective actions are beyond our control

5. Do corrective actions carry a cost? UNKNOWN

No. If not, please explain.

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

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
- b. How much has been expended so far?

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices (i.e. wait times study and MHERE clinic referrals kept)
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review: Magellan certification/review April 2012 (CARF accreditation scheduled for the winter of 2012)
- Customer/stakeholder feedback
- Other (please specify): State Licensure (BHS and Public Health-Department of Health and Hospitals)

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

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

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

1. Title of Report or Program Evaluation  
Louisiana Performance Accountability System (LaPas)  
Louisiana Legislative Auditor Procedural Report



Telephone: 225-922-2708

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

# Annual Management and Program Analysis Report

## Fiscal Year 2011-2012

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

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

**Undersecretary:** Jerry Phillips

**Executive Director:** Sandee Winchell

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

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

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

The Council provided leadership in advocacy, capacity building and systemic change activities that contributed to increased quantity and quality of community-based services for individuals with developmental 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 restoration of a million dollars for state funded community-based services that are the only option for many individuals with developmental disabilities and their family members; reaching agreement with the Department of Health and Hospitals (DHH) to pursue an additional NOW waiver slot for each 66,000 dollars

deposited into the NOW Fund with a minimum of 200 NOW slots requested per year; donations can be dedicated to the NOW Fund; numerous therapy treatment options were added for Children's Choice waiver recipients; Flexible Family Fund policy changes; DHH is pursuing the Money Follows the Person initiative to enable people in residential settings to transition into waiver services; insurance coverage for children with autism was expanded; and adult protective services merged into a single agency to reduce redundancies and increase capacity.

Educational policies influenced by the advocacy efforts of LaTEACH and the Council leadership include the Board of Elementary and Secondary Education adopting policies aligned with Council positions and based on Council and stakeholder input. BESE policy decisions impacted by the Council include rules changed to allow alternate assessment (LAA2) performance to be used in place of their respective End of Course (EOC) tests as a graduation requirement; reduction to the percentage of EOC test performance counting toward the final grade of LAA2 eligible students to five percent (compared to 15-30 percent); restructuring of the Special Education Advisory Council to allow greater flexibility and autonomy; and rules developed that reflect restraint and seclusion practices as indicated in Act 328 of 2011.

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

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

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

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

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

While many of the successes in policy and practice changes were a result of collaborations with other agencies, the successes realized are a direct result of targeted educational campaigns to policy makers, advocates and the general public conducted by the Council. The vast majority if not all of these changes would not have occurred without the specific actions taken by the Council. The Council has expanded its repertoire of strategies and tools to connect with the public and policy makers and has plans to continue to build its capacity to utilize social media networks and tools to conduct education campaigns and provide timely information to constituents.

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

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

- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:
  1. To what do you attribute this lack of progress? For example:
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
    - Is the lack of progress due to budget or other constraint?
    - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective

actions in Section III below.

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

None.

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

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

The Council's five year plan was ratified in July to address specific areas of emphasis to target and objectives for each goal area.

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

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

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

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

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

related directly to strategic plan lack of progress.)

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

**A. Problem/Issue Description**

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

All Council activities are dependent on federal and state appropriations. The Council consistently takes all actions possible to ensure continued allocations. One significant issue is the economy in general and Louisiana's capacity to maintain the contributions to supporting necessary programs in the future. The Council's federal funds are not currently in jeopardy, but the reductions to state general fund dollars have already created significant issues with the regional Families Helping Families Centers' capacity to provide their core functions. These Centers play a critical role in connecting, informing and supporting individuals with developmental disabilities and their family members. Unfortunately, large portions of the individuals served live in rural areas and have limited use of computers. Considering the capacity to provide support in a lot of Louisiana's rural areas is contingent on travel, the budget reductions have had a significant negative impact on the services and outreach provided to individuals who cannot travel into large metropolitan areas.

**B. Corrective Actions**

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

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

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

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

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

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

No. State revenue restrictions appear to prevent adequate funding levels to address the issue.

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

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

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

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

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

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

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

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

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

As required by federal law, the Council submitted a Program Performance

Report (PPR) to the federal Department of Health and Human Services, Administration on Developmental Disabilities in December of 2011 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 2011-2012. A report covering the remainder of the state fiscal year will be submitted to the federal government in December of 2012.

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](mailto:shawn.fleming@la.gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2011-2012

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

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

**Undersecretary:** Jerry Phillips

**Executive Director:** Calvin Johnson

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

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

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

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

*MHSD worked closely with its contract providers as the March 1 deadline approached and re-negotiated all the eligible contracts from cost reimbursement to fee for service to mimic the Magellan rates for the uninsured. MHSD created an internal training team to assist with implementing the new medical record as well as the new procedures under Magellan. MHSD re-configured its Access Center to become a Navigation Center so that MHSD could continue to assist individuals in finding services under the new Magellan system.*

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

### **Transition to an Electronic Health Record**

*During FY2011-2012, MHSD transitioned to an Electronic Health Record (CareLogic) on 12/1/12 and then transitioned to Magellan's medical record (Clinical Advisor) on 3/1/12 based on contract requirements previously unknown. The plan to transition to an electronic medical record was in response to significant gaps between the capacity of existing systems and the capacity needed to meet the agency's information needs. Once Clinical Advisor is fully implemented, the EHR will allow real-time documentation of MHSD service delivery, as well as allow more comprehensive information sharing across the agency.*

*This accomplishment primarily contributes to Goal V of MHSD's FY2009-2013 strategic plan: To ensure quick and easy access of consumers, family members and the community to an efficient system of care which addresses their addictive disorder, developmental disability and mental health needs.*

### **Implementation of Crisis Respite Beds**

*During FY2011-2012, MHSD completed its crisis continuum with the opening of five respite beds for adults by its contractor, Resources for Human Development (RHD). These beds are in addition to the 24/7 mobile crisis outreach unit (MCRT) in existence. The purpose of the crisis continuum is to prevent psychiatric hospitalizations and incarcerations by identifying less restrictive, appropriate interventions to address client issues/behaviors*

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

*This accomplishment primarily contributes to Goal V of MHSD's FY2009-2013 strategic plan: To ensure quick and easy access of consumers, family members and the community to an efficient system of care which addresses their addictive disorder, developmental disability and mental health needs.*

### **Enhanced Developmental Disability Services**

*Through a Memorandum of Understanding with the Department of Health and Hospitals (Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities) MHSD assumed responsibility for the direction, operation and management of the Home and Community Based Waiver Services for persons with developmental disabilities requiring an ICF/DD level of care. These services are designed to be an alternative to institutionalization and to promote independence, community inclusion and community participation for the waiver recipient through a provision of services such as*

*respite care, in-home personal care services, supported living services, employment /habilitation, environmental services, assistive technology and professional services.*

*The Home and Community Based Waiver Services utilizes the principles of self-determination as a foundation for supports and services to supplement the family and /or other community services that are available to maintain the person in the community. At the end of the 4<sup>th</sup> quarter of FY 11-12, MHSD currently had 788 total individuals receiving Home and Based Waiver Services in the following waiver programs:*

- 574 New Opportunity Waiver (NOW) recipients*
- 111 Support Waivers recipients*
- 96 Children's Choice recipients*

*People First is a national coalition of organizations for people with disabilities that supports individuals to become effective decision makers, to gain independence and to live as full contributing members in their communities. The local chapter of People First – People First of NOLA with leadership and support from MHSD continues to grow and serve as model for the State Chapters and was featured in a Times-Picayune article 8/30/12.*

*State General Fund - Individual/Family Support Budget - 94% individual/family support services budgeted for FY 11-12 was utilized on individuals with intellectual disabilities and their families through the provision of various services. The Human Services Accountability Performance Standard (HSAIP) for MHSD is 95% of Individual I/Family funds will be expended per fiscal year. As a result of this success, MHSD for the 1<sup>st</sup> time in 4 years has had to implement a waiting list for disability related services for individuals to access supports and services to meet their needs unless it is a documented emergency which would result in a health and safety risk.*

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

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

*MHSD management worked closely with OBH starting in September 2011 to transition Children's Services to MHSD effective June 25, 2012. Transitioning Children's Services under MHSD allows for the co-planning, operational efficiencies and sharing of resources that was not possible when these services were in OBH. For example, MHSD will be creating a combined child/adult clinic on the West bank in a new building currently under construction whereas currently there is a separate location for each. MHSD also combined child/adolescent and adult crisis response programs to create one number for the community to call.*

*This accomplishment primarily contributes to Goal III of MHSD's strategic plan: To deliver high quality cost efficient community based prevention, early intervention,*

*treatment, recovery supports, individual and family supports that will equip and strengthen individuals, children, youth and elderly to be maintained in the community.*

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

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

*MHSD is steadily progressing toward achieving the goals outlined in the five-year strategic plan. MHSD has made significant progress in refining its services to better address the needs of the service population.*

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

*MHSD has made significant progress in strengthening and linking internal and external resources to support a seamless, integrated, and comprehensive system of services.*

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

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

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

*None*

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

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

*The strategic plan was recently revised (June 2009).*

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

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

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

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

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

**A. Problem/Issue Description**

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

*MHSD continues to struggle with a lack of information to support planning and decision making. The transition to Magellan has been a challenge as information is not yet free-flowing.*

**B. Corrective Actions**

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

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

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

*MHSD expects that as the implementation is completed, the Magellan system will provide adequate information to support planning and decision-making*

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

*No.*

4. Are corrective actions underway?
  - a. If so:
    - What is the expected time frame for corrective actions to be implemented and improvements to occur?
    - How much progress has been made and how much additional progress is needed?

b. If not:

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

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

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)

- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

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

*No reports were created.*

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 2011-2012

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

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

**Undersecretary:** Jerry Phillips

**Assistant Secretary:** Ruth Kennedy

### BAYOU HEALTH

#### **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 statewide implementation of Louisiana Medicaid's managed care program, Bayou Health, and the transformation of service delivery for nearly 900,000 Medicaid and LaCHIP recipients.

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

The implementation of Bayou Health represents arguably the largest transformation in the delivery of services for the state of Louisiana. The move to managed care affects nearly 900,000 of the 1.2 million Medicaid and LaCHIP enrollees and their providers and is expected to achieve budget savings of \$135 million for SFY 12/13.

**C. Who benefits and how?**

First and foremost, Bayou Health was designed to provide improved access and quality of care for Medicaid and LaCHIP recipients, with a greater focus on preventive and primary care in the appropriate setting, coordination between care providers and interventions in the management of chronic illnesses. Through the more flexible managed care framework, recipients have access to incentives for healthy behaviors

and, in the case of the Prepaid Bayou Health Plans, the opportunity for increased benefits and guaranteed access to services.

Greater budget predictability and an emphasis on overall savings benefit the state of Louisiana and its taxpayers.

While the initial transition to Bayou Health includes some growing pains for providers, the end game is a system that supports and rewards them for quality patient care. Bayou Health ensures prompt pay to providers, provides administrative supports for coordinating the care of members and allows for physician incentives and the opportunity to share savings in the Shared Savings models.

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

The successful implementation of Bayou Health is the result of a multi-faceted effort by numerous players – including DHH staff from the executive level down, Medicaid providers, community stakeholders and a handful of contractors – dedicated to a smooth transition and a phased-in timeline.

The transition began with a major reorganization of the Louisiana Medicaid structure to include the pharmacy program, provide staffing for monitoring and management of all aspects of Bayou Health, and oversight for the bulk of state plan benefits and services for Medicaid.

Led by Bayou Health management and with the support from the Governor's office, the Division of Administration, DHH Contractual Review and Legal sections and the Office of Civil Service, the Bayou Health staff worked through administrative rulemaking, state plan amendment and CMS approvals, competitive review, drafting and awarding of contracts, the passage of readiness and systems reviews, the achievement of network adequacy and the launch of services statewide. With the assistance of state office and local eligibility staff, the DHH Bureau of Media and Communications and the outreach and education and enrollment broker contractors, DHH developed and implemented a massive outreach and education campaign that included over 500 member enrollment events, 79 provider education meetings, direct mailings to all eligible households and a multi-media education campaign that delivered an opportunity for choice to nearly 900,000 Medicaid and LaCHIP recipients. The Bayou Health staff supported this education and outreach effort during the transition by partnering with providers for rapid response, fielding a hotline for providers with issues during early implementation, the creation of informational bulletins for easy-to-access answers to provider and member concerns and daily provider calls.

**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?

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

- ◆ **Please provide a brief analysis of the overall status of your strategic progress.**
  - ◆ **Where are you making significant progress?**
    1. To what do you attribute this success?
      2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?
  - ◆ **Where are you experiencing a significant lack of progress?**
    1. To what do you attribute this lack of progress? For example:
    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? All new performance indicators have been developed and approved by the Division of Administration.
  - No. If not, why not?

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

Departmental notification of needed review is sent to appropriate staff.

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

Not applicable.

### 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?
  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:

Title:

Agency & Program:

Telephone:

E-mail:

### **BAYOU HEALTH: Pediatric Day Health Care Program**

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

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

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

Louisiana Medicaid has implemented the Pediatric Day Health Care Program; effective November 2011. There were two Pediatric Day Health Care centers ready to provide services in Baton Rouge beginning December 1, 2011. There are currently four providers altogether licensed to provide services since August, 2012; two in the Baton Rouge area, one in Zachary, LA and the fourth in Lafayette, LA.

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

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

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

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

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

This accomplishment was achieved through a cooperative effort with the Department and agencies that are experienced in operating similar facilities in other states and

various other stakeholders. The state licensing rule became a final rule published in the Louisiana Register in December 2009.

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

Yes

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

Yes

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

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

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

♦ **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.

DHH attributes the success of the launch of PDHC to the cooperation between the Department and stakeholders as well as providers who are experienced in providing these services.

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

The progress in the PDHC program is expected accelerate as more providers are

licensed and more families see the benefit of PDHC services for their children.

- ♦ **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? The lack of progress is due to external delays.
    - 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? PDHC is not specifically addressed in the strategic plan; however, it does align with the overall goal of expanding community based services in order to avoid institutionalization.
  
- ♦ **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. Departmental notification of needed review is sent to appropriate staff.

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

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

management, operations, and/or service delivery. “Problems or issues” may or may not be related directly to strategic plan lack of progress.) None.

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

A. Problem/Issue Description

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

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. N/A
- 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:

## **ELIGIBILITY SECTION**

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

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

### **ELIGIBILITY DIVISION: Children's Coverage Retention**

A. What was achieved?

Louisiana continues to lead the nation in the efforts to reduce churning, having less than 1.5% of children's cases closed for a procedural reason (failure to return a form or verification) at renewal. This accomplishment is only possible because of the policy and procedure simplifications implemented by the Medicaid Eligibility Division since the implementation of CHIP. Although these simplifications helped to negate the impact of the loss in staff within the division, there was still a slight increase in the percentage of procedural closures from last year's statistic of less than 1%.

B. Why is this success significant?

By keeping eligible children enrolled at renewal, stability of coverage is increased and administrative costs are reduced. Retention of eligible children at renewal has emerged as a key to further reducing the number of uninsured children, which is necessary to improve the health outcomes as determined by HEDIS measures.

C. Who benefits and how?

The high retention rate benefits not only eligible children and their parents, but the administrative streamlining and paperless processes that have been put in place improve customer service, reduce agency administrative costs, and promote “green government.”

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

D. How was the accomplishment achieved?

The Medicaid/LaChip Eligibility Division has streamlined the annual renewal process and implemented policies allowable under federal law, including using electronic Supplemental Nutrition Assistance Program (SNAP) eligibility data to determine Medicaid eligibility, elimination of the requirement for a signed renewal form, telephone interviews, and administrative renewals for cases identified as having a low risk of ineligibility.

With the full implementation of BAYOU HEALTH, the Medicaid Eligibility Division is obtaining more accurate and timely demographic updates from the health plans, as required by their contracts, improving the accuracy of contact information at renewal, thereby reducing the volume of mail returned as undeliverable by the U.S. Postal Service.

The Eligibility Division continues to use electronic SNAP eligibility data to determine eligibility for children in Medicaid and to determine ongoing eligibility for approximately 20% of cases that are up for renewal each month, as compared to the 4% that use a paper form. This initiative is another way that the Eligibility Division has reduced the amount of paper used to process a renewal and the level of effort required of the affected children’s parents or caretakers and staff members.

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

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

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

Yes, this achievement has generated great interest and we were asked to share information through presentations at national meetings in the past year including: Alaska Native Tribal Health Consortium; CMS Promising Enrollment Practices Symposium; Children’s Defense Fund; and Technical Advisory Group for evaluation of

Express Lane Eligibility mandated by CHIPRA. We believe that the lessons learned are transferrable to other departments and agencies within Louisiana.

**ELIGIBILITY DIVISION: Reduction in rate of Uninsured Children in Louisiana**

**A. What was achieved?**

According to the 2011 Louisiana Health Insurance Survey, 96.5% of Louisiana children under age 19 are insured, which demonstrates a continuing decline in the percent and number of uninsured children. The percent of uninsured Medicaid eligible children is less than 3%.

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

A reduction in the number of uninsured children in Louisiana serves to ensure that children have health coverage and access to needed medical care, contributing to improved health outcomes.

**C. Who benefits and how?**

Uninsured children in Louisiana families with household income between 0 - 250% of the federal poverty level benefit from the current Medicaid and CHIP programs by obtaining health care coverage otherwise not available or cost prohibitive.

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

Since the implementation of LaChip, awareness of the brand has grown significantly, demonstrating the effectiveness of marketing efforts undertaken by the Eligibility Division at the program's onset, outreach efforts taken to enroll uninsured but eligible children, and ongoing contact with parents/caretakers through public schools and doctors' offices.

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

Yes, this decrease in the number of uninsured children directly correlates with reducing the number of children who do not have health coverage.

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

The Eligibility Division has provided guidance and suggestions to other states on rebranding efforts employed with the implementation of LaChip, which could indeed be shared with other departments and agencies considering similar undertakings.

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

expected and whether your strategies are working as expected and proceeding on schedule.

### **ELIGIBILITY DIVISION: Children's Coverage Retention**

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

The Medicaid/LaChip Eligibility Division's has maintained its goal of keeping the percentage of children's cases that are closed at annual renewal due to paperwork reasons to a minimum, as this percentage has been dramatically reduced since 2000. This goal has been achieved because of the multiple renewal simplification changes mentioned above.

- ♦ **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.

None.

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

N/A

- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a

significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

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

N/A

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

N/A

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

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

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

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

**ELIGIBILITY DIVISION: Reduction in rate of Uninsured Children in Louisiana**

- ♦ **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?  
Through continued targeted outreach and awareness, the rate of children who are eligible for Medicaid but uninsured continues to decline.
- ♦ **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.  
NONE.
  2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?  
N/A
- ♦ **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.

NONE.

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

N/A

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

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

Current strategies to decrease the number of uninsured children through targeted outreach and enrollment and retention simplification measures have not changed as they relate to this goal.

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

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

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

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

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

listing of such reports and evaluations at the end of this form.

**ELIGIBILITY DIVISION: Children's Coverage Retention and Reduction in Rate of Uninsured Children in Louisiana**

A. Problem/Issue Description

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

The primary challenge that faced the Eligibility Division in SFY12 was the same as in SFY 11, an increase in workload without a corresponding increase in staffing. The exorbitant workload has contributed to an increase in turnover within the Eligibility Division which further compounds the problem when it takes up to 12 weeks to fill vacant positions, or those positions are caught in hiring freezes. Additionally, budget cuts necessitated the termination of the statewide Covering Kids and Families contractors who ensured that LaChip outreach efforts were ongoing and far reaching, where Division staff was not able to do so because of increased workloads.

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

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

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

This staff reduction is impacting all units in the Eligibility Division as reassignments are made to address the highest priorities.

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

The staff reduction affects applicants and enrollees because of the increased amount of time it takes for applications and coverage renewals to be processed.

5. How long has the problem or issue existed?

Staff reductions began in 2009.

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

State budgetary constraints

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

As indicated above, the staff reduction affects applicants and enrollees because of the increased amount of time it takes for applications and coverage renewals to be processed. It increases the volume of phone calls made by applicants to the Division requesting updates on their eligibility determinations, as well as to legislators when applicants request assistance in expediting their decision. It also impacts morale within the Eligibility Division and results in high staff turnover.

**B. Corrective Actions**

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

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

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

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

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

9. 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?

10. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

requests?

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

##### **ELIGIBILITY DIVISION: Children's Coverage Retention & Reduction in Rate of Uninsured Children in Louisiana**

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

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

##### Learning Management System

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

##### Medicaid Eligibility Quality Control

Louisiana is a pilot state for its Medicaid Eligibility Quality Control (MEQC) function. This means the Eligibility Division selects the specific eligibility criteria or program on which the MEQC reviewers will focus their efforts. Selection of the pilot area is a collaborative decision of management and MEQC staff. The pilot is based upon areas in which we suspect eligibility staff may be having problems and is also used to gauge

how well a new program, procedure, or eligibility requirement is being understood and executed. Each month MEQC staff review cases and report findings to eligibility staff and management. When a sufficient number of cases have been reviewed and error trends identified, MEQC reviewers and management meet to discuss corrective actions that will be implemented. Corrective actions range from training of eligibility staff to changing or modifying policy or procedure, to adding or clarifying recipient eligibility notices.

Each year, findings are summarized and a corrective action plan is provided to the Centers for Medicare and Medicaid Services. The MEQC function is audited by the state legislative auditor every year in order to determine cases are being reviewed timely and correctly.

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

- 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:

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

### **Medicaid Management Information System (MMIS) Section**

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

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

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

In SFY 2012, the Medicaid Management Information System (MMIS) Section began the Design, Development and Implementation phase for the Replacement MMIS, or Provider and Recipient Integrated System for Medicaid (PRISM). Issues are inevitable in such large and complex projects; however, issues that occurred have been addressed and PRISM is on track for an early deployment in Fall 2014. This meets and exceeds our strategic plan to implement the replacement system in three years, or 36 months. Meanwhile, operation and enhancement of the legacy LMMIS continued. Enhancements included federal mandates such as the HIPAA 5010 Transactions Project and the implementation of system modifications required for BYU and LBHP initiatives—attributing to the success of other Departmental initiatives listed in the DHH Business Plan. PRISM DDI is an enormous undertaking; however, MMIS accomplished its FY 12 tasks with a minimal increase of staff. LA Medicaid stakeholders will all benefit from PRISM as it controls increasing operational needs more efficiently, provides better reporting capabilities for more efficient administration of the programs and systems, and responds quickly to emergencies or new mandates. Sustenance of the legacy MMIS is significant, as there is a potential for loss of 25% of Federal Medicaid funding if the MMIS operation fails to meet the established Federal guidelines. The section's accomplishments were achieved by utilizing sound and effective planning, design and project management methodologies while working cooperatively with the new and current FI to identify opportunities for improvement, to develop an implementation strategy, and to monitor the initiatives to completion.

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

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

Overall, PRISM is on track for scheduled or early implementation. Project management strategies have been effective, but success will be dependent on continued SME and

stakeholder involvement.

- ♦ **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?

Progress was made through increased efficiencies, leveraging existing technologies, such as Microsoft SharePoint, where applicable. Contracts were scrutinized more carefully against performance standards and Contractors were held accountable for deficiencies. An increasing backlog of MMIS change requests (LIFTs) resulted in the assessment and prioritization of LIFTs. This process is ongoing, though progress is not expected to accelerate.

- ♦ **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. See Section III.

♦ **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? Already aligned with strategic plan.

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

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

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

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

A. Problem/Issue Description

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

Problem/Issue #1: MMIS organizational structure does not align with functional requirements, making it unclear to staff who exactly has the final responsibility for work performance and who

provides direction and oversight. This has a negative impact on operational efficiency.

#### B. Corrective Actions

11. 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.

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

To meet the increasing demands of the section, MMIS proposed a section-wide reorganization to reconcile the current organizational structure with the current and future needs of the section. This reorganization also includes the addition of one non-T.O. job appointment for assistance in the replacement project.

13. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? No.

14. Are corrective actions underway? Corrective action in progress. Reorganization proposal requires final Departmental and Civil Service approval.

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?

15. 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?

Will have a monetary cost for salaries and related benefits. However, a large percentage of salaries and related benefits receive enhanced federal funding, so the impact to State General Funds is insignificant.

#### A. Problem/Issue Description

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

Problem/Issue #2: Limited human resources (both internal and external) and an increase in state initiatives.

#### B. Corrective Actions

16. 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.

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

Contract language will be strengthened to reevaluate contractor staffing allocation and adjust as needed. SME involvement from other DHH offices must continue to be emphasized.

18. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? No.
19. Are corrective actions underway? In progress. Upcoming contract amendment will address recommended corrective actions.
  - 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?

20. Do corrective actions carry a cost? To be determined. Will be settled during contract negotiations, though contract is not expected to go over budgeted amount.

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:

21. Title of Report or Program Evaluation
22. Date completed
23. Subject or purpose and reason for initiation of the analysis or evaluation
24. Methodology used for analysis or evaluation
25. Cost (allocation of in-house resources or purchase price)
26. Major Findings and Conclusions
27. Major Recommendations
28. Action taken in response to the report or evaluation
29. Availability (hard copy, electronic file, website)
30. Contact person for more information, including
  - Name:
  - Title:
  - Agency & Program:
  - Telephone:
  - E-mail:

### **WAIVER ASSISTANCE AND COMPLIANCE SECTION**

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

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

**Waiver Assistance and Compliance Section**

**Greater New Orleans Community Health Connection (GNOCHC)**

- A. What was achieved? In SFY12, the GNOCHC Demonstration Waiver provided \$30M in funding to 18 participating organizations providing health care services to GNOCHC recipients (Medicaid eligible) at 41 locations throughout the Greater New Orleans area. As of July 31, 2012, 52,405 individuals were enrolled in GNOCHC.
- B. Why is this success significant? GNOCHC is a Section 1115 Medicaid Demonstration Waiver that provides primary, preventative, and behavioral health services to eligible low-income, uninsured residents of Jefferson, Orleans, Plaquemines, and St. Bernard parishes. GNOCHC enrollees are not eligible for full Medicaid benefits; without this program, their health care needs would go unmet or would likely be provided in emergency departments, outpatient clinics operated by the statewide public hospital system and FQHCs and RHCs. Additionally, GNOCHC provides financial support to the 18 provider participating provider organizations that form the community health safety-net in the Greater New Orleans area.
- C. Who benefits and how? GNOCHC enrollees receive primary, preventative, and behavioral health care services to which they might not otherwise have access, and the 18 participating provider organizations in the Greater New Orleans area receive financial support to help them develop the infrastructure to be competitive in the marketplace of the future. GNOCHC funding provides incentives to build a patient centered medical home and to invest in claims processing capabilities that are essential for clinics.
- D. How was the accomplishment achieved? All applicants for Medicaid are screened for possible participation in the GNOCHC Demonstration Waiver. Provider organizations who participated in the Primary Care Access and Stabilization Grant (PCASG) are eligible for participation in GNOCHC and receive reimbursement for patient encounters, as well as infrastructure investment awards and incentive payments based on recognition as a Patient Centered Medical Home (PCMH) by the National Committee on Quality Assurance (NCQA).
- 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, it is a federal/state/city/public-private partnership.

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

- ♦ **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized? The goals of the GNOCHC Demonstration are: 1) to preserve primary and behavioral health care access that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with PCASG funds; 2) to advance and sustain the medical home model begun under PCASG; and 3) to evolve the grant-funded model to a financially sustainable model over the long term that incorporates Medicaid, CHIP, and other private payer sources as the revenue base. As GNOCHC enters its third Demonstration Year, enrollment continues to grow at an average rate of 4% per month, and provider participation is stable.
  
- ♦ **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?

In SFY12, DHH accomplished its Phase 1 goals for GNOCHC, most notably:

- It enrolled tens of thousands of eligible, low-income uninsured adults into basic health care coverage.
- It transformed PCASG awardees into coverage model-driven health care providers with routine Medicaid enrollment and billing processes.
- It transitioned provider revenues from PCASG grant-like interim payments to Medicaid-like enrollee encounter rate payments while preserving health care access restored by and sustaining the medical home model begun under PCASG.
- Substantially completed program start up, paving the way for routine program operations in Demonstration Year 2.

Continued progress was made toward Phase 2 goals, including the development and

initial implementation of the waiver's approved evaluation design, and after lengthy negotiations with CMS, initial implementation of the Inter-Pregnancy Care Coordination pilot, which will provide pre- and inter-conception care for low-income, uninsured women who have had a prior adverse pregnancy outcome. DHH also secured final CMS approval of key waiver elements upon which program operations depend, including the Administrative Cost Claiming Protocol and the Audit and Accounting Protocol.

- ♦ **Where are you experiencing a significant lack of progress?** None. If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:
  1. To what do you attribute this lack of progress? For example:
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
    - Is the lack of progress due to budget or other constraint?
    - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
    - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?
  
- ♦ **Has your department revised its strategic plan/Business Plan to build on your successes and address shortfalls?**
  - Yes. If so, what adjustments have been made and how will they address the situation?
  - No. If not, why not? Regardless of operational issues surrounding provider reimbursement (see Section III below), the primary goals of the GNOCHC Demonstration remain the same: 1) preserve primary and behavioral health care access that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with PCASG funds; 2) advance and sustain the medical home model begun under PCASG; and 3) evolve the grant-funded model to a financially sustainable model over the long term that incorporates Medicaid, CHIP, and other payer sources as the revenue base.
  
- ♦ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

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

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

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

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

1. What is the nature of the problem or issue? GNOCHC clinics are primarily paid on a per-encounter basis. The GNOCHC enrollment and claims submission process highlighted variations in organizational infrastructure ability and capacity that created special challenges for the smaller, non-Federally Qualified Health Center (FQHC) clinics due to a lack of this ability and capacity. Clinics that were not accustomed to processing insurance claims and therefore did not have a robust infrastructure had difficulty training staff and establishing the necessary systems for enrolling patients into the GNOCHC program, thus limiting their reimbursements under the program so far.

While the total amount that can be allocated under GNOCHC is fixed at \$30 million per year, the current GNOCHC payment structure does not have a floor or ceiling for payments by provider, thus allowing a few providers with robust infrastructure investments to do extraordinarily well and others without the same administrative capacity or willingness to transfer to the new system to receive less. In addition, the reconciliation process is based on encounter payments thus continues the higher payments to organizations with a more sophisticated infrastructure in place. While participating clinics now have the capability to enroll patients and submit claims, this process has taken a while, and clinics could benefit from continued technical assistance and guidance to improve their process for billing and submitting claims.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) As a provider’s GNOCHC revenues are heavily dependent on claims volume, some smaller provider organization are experiencing limited cash flow throughout the fiscal year and receiving a large supplemental payment only after the Demonstration Year has ended. Lack of sufficient, predictable revenues throughout the fiscal year may jeopardize the sustainability of some of our smaller provider organizations.

3. What organizational unit in the department is experiencing the problem or issue?  
N/A
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) Participating GNOCHC provider organizations, especially smaller organizations for which GNOCHC is a significant payer source, are affected; should a provider organization find it necessary to scale-back or cease operations at one of its clinic, GNOCHC enrollees may also be affected. However, there is sufficient capacity in other clinics to continue the provision of services.
5. How long has the problem or issue existed? This issue has been recognized as a potential problem since the waiver's inception, as the payment methodology shifted from a grant-funded model under PCASG to an encounter-based reimbursement model under GNOCHC. One of the goals was to encourage all clinics to be competitive in the emerging competitive marketplace. Understanding and being able to process claims is a necessity.
6. What are the causes of the problem or issue? How do you know? Clinics expected to enroll more of their existing patient population previously served under PCASG in GNOCHC than they were able to because patients either resided outside the four parish area, did not meet citizenship requirements, , or their countable income was above 200% FPL, but uninsured and unable to afford care. While the clinics are still seeing those patients, they are not getting reimbursed for those services through the GNOCHC grant. The FQHCs receive financing for this population through their PHS 330 funding. It was never a part of the new GNOCHC waiver to pay for non-Medicaid eligible individuals. These clinics had opportunities for training and infrastructure grant investments in order to prepare for claims processing.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? We believe the clinics will improve their ability to process claims correctly, like any other Medicaid provider. In addition, the reconciliation process allows for additional funds to be paid out based on encounter payments.

#### B. Corrective Actions

21. 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.

22. What corrective actions do you recommend to alleviate or resolve the problem or issue?  
An amendment to the payment methodology is pending at CMS. In addition to encounter-based payments, the new methodology proposes new funding elements to help sustain provider operations and further incentivize the Primary Care Medical Home model. This would help to alleviate the cash-flow issue faced by smaller providers and provide for more equitable reimbursements amongst the provider organizations.

23. Has this recommendation been made in previous management and program

- analysis reports? If so, for how long (how many annual reports)? No.
24. 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? The payment methodology amendment is currently under review at CMS; implementation would begin early in Demonstration Year 3, which began on October 1, 2012.

25. Do corrective actions carry a cost?

No. If not, please explain. The proposed amendment is budget neutral; it simply provides other opportunities for providers to earn additional payments not allowable in previous demonstration years.

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: None.

31. Title of Report or Program Evaluation
32. Date completed
33. Subject or purpose and reason for initiation of the analysis or evaluation
34. Methodology used for analysis or evaluation
35. Cost (allocation of in-house resources or purchase price)
36. Major Findings and Conclusions
37. Major Recommendations
38. Action taken in response to the report or evaluation
39. Availability (hard copy, electronic file, website)
40. Contact person for more information, including
  - Name:
  - Title:
  - Agency & Program:
  - Telephone:
  - E-mail:

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

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

## **Waiver Assistance and Compliance Section**

### **Money Follows the Person Demonstration Program (MFP)**

- G. What was achieved? As of July 31, 2012, the Money Follows the Person Demonstration program (MFP) has helped over 360 persons move out of institutions (nursing homes, hospitals, group homes) into the community. We have also established specific training components, mentioned below, to further strengthen our transition infrastructure.
- H. Why is this success significant? The MFP is a national initiative by Centers for Medicare & Medicaid Services (CMS) to assist states in rebalancing their long term care systems toward community living. These transitions are part of that nationwide effort to remove barriers to community living for people of all ages with disabilities or chronic illnesses. This is significant progress toward transition targets that are a CMS requirement of the MFP funding award. Additionally, the demonstration provides a means by which the state may address provisions in the Olmstead decision.
- I. Who benefits and how? Firstly, the MFP participant, whose quality of life is enriched by moving out of an institution and reconnecting with the community. CMS requires MFP states to assure the continued provision of home and community-based long-term care services (HCBS, or waivers) to these individuals as well as ensuring that procedures are in place to provide quality assurance and to provide for continuous quality improvement in such services.
- J. How was the accomplishment achieved? A cooperative effort between Medicaid, OAAS and OCDD, focused on coordination with existing programs and resources at the state and regional level, to build on the state's ongoing strategies to address housing and other barriers to transition. Medicaid, OCDD, and OAAS have worked very well together in a team format to implement the demonstration successfully across the disability populations. The collaboration stems from joint work in systems change initiatives throughout the past decade. Additionally, we have partnered with the Office of Behavioral Health to add persons with Mental Illness to our target groups.
- K. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) The state effort to rebalance its long-term care system (LTC) benefits in three ways: (1) an enhanced FMAP for services delivered to individuals during their 365-day participation in the program, (2) savings realized from moving the individual out of institutionalized care, and (3) 100% federal funding for state MFP administrative operations.
- L. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. Collaboration between state office and agencies is a best practice and a streamlining recommendation.

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

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

What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized? This year we have seen more movement because the barriers and challenges to the MFP program's transition targets are being addressed through utilization of 100% federal administrative funding received last year toward meeting our goals, specifically with the continued development of housing contacts and the training of families and support and transition coordinators statewide.

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

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

- Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action? The strength of the operational systems of our waiver services is recognized by CMS as superior to those observed in other MFP states, giving them confidence that Louisiana will continue to see positive outcomes and sustained transitions. CMS has also recognized the department's commitment to systems change and flexibility in addressing barriers, during our technical assistance calls and national meetings.
- Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?) As vulnerabilities or other weaknesses in program policies or procedures are identified during MFP transition activities, changes are made to directly address them whenever possible. Some of the major activities are listed below:
  - Utilizing a full-time Housing Monitor to assist transition coordinators, nursing facility staff, and support coordination staff with identifying and linking demonstration participants to housing resources (Public Housing Authorities, Permanent Supportive Housing Program, and private housing resources) , as well as maintaining the current housing data base. The Housing Monitor conducts training for support coordination agencies, assists with the housing application process, and monitors the status of the application until housing is secured.
  - Regional transition/quality assurance coordinators assist with coordination, facilitation, and monitoring of demonstration participants; assist regional office staff, enrolled support coordination agencies, and providers in the process of transition from informed consent signing to the end of their participation in

- the demonstration (up to 24 months); collect and report quality outcomes for reporting on participants; provide training, dissemination of information, coordination of regional and statewide information-/resource-gathering; provide technical assistance to providers, and facilitate resolution of individual transition issues at both the regional and state program office level; report to the Housing Monitor identified housing needs and resources specific to their domiciled region so that MFP staff can address with Public Housing Authorities the need to secure housing resources in the specified region.
- Utilizing a Contracts Manager for Housing and Administrative Support to contract with realtors or property management companies across the state, assuring linkage of demonstration participants to the housing relocation contracts in the appropriate area and monitoring that supports are delivered in specified timelines. This person trains contractors for implementation statewide, compiles performance information for reporting, and identifies and implements sustainability measures. In addition, this position manages contracts and payments related to support activities and training not tied to the transition assistive supports contract manager.
  - Utilizing a Transition Assistive Supports Manager to engage in interagency agreements or contracts for transition assistive supports, including DSW training, facilitated family communications, community living training, family training in direct care responsibilities, community living training, and transition maintenance. This position develops the structure of the division of transition assistance among contractors to facilitate maximum access to expertise and timely response to requests; negotiates and monitors interagency agreements; trains support coordinators, providers, regional staff, and public facility transition staff on how to access transition assistive supports; coordinates access to transition assistive supports, including prior authorization, routing requests, monitoring, and post-authorization for payment; and remediates to improve the quality and performance of the program.
  - Facilitated Family Communication assists children with developmental disabilities in nursing homes that are the victims of a sudden accident or illness that resulted in disability. Families are not always emotionally equipped to face the immediate need for support provision and longer-term reality of planning for the family dynamic and future with a child with a disability. This program component assists caregivers and siblings living at home by discussing the impact of the move on the family and making appropriate adaptations.
  - Health Care Communication assists demonstration staff members,

- contractors, and related health care support staff who require assistance with interpretation and communication in order to inform persons of their transition options, enroll persons in the demonstration, validate eligibility, complete transition planning, successfully arrange for community supports, and complete post move monitoring, including administration of Quality of Life surveys.
- Physician Consultation funding assists Transition Coordinators working with nursing facility transitions to access additional medical expertise to support comprehensive planning and the successful completion of the transition process. In addition, Physician Consultation will also provide information to Support Coordinators about accessing local medical resources and provide information to the participant regarding medical/health management implications based on the proposed HCBS plan of care.
  - Legal Consultation funds assist Transition Coordinators and Support Coordinators who may require the assistance of an attorney or notary to complete necessary activities in support of the transition. Legal Consultation funding will support filing of affidavits related to legal status, marital status, etc. in order to assist participants to qualify for and/or acquire housing. Participants with developmental disabilities have been denied requests for vital records by the state office processing requests because they were deemed “not competent” to make the request and had no legal representative. Vital records are required for housing applications. An attorney will assist the participant and transition team to acquire vital records.
  - Community Living Training, delivered by Transition Coordinators in collaboration with the assigned Support Coordinator and transitioning participant. Roles and responsibilities include carrying identification, applying for and maintaining eligibility for local service programs, acquiring housing, paying deposits, managing a monthly budget and bills, appropriately furnishing and preparing a residence for occupancy (e.g., to pass the Pre-Certification Home Visit Review), use of transportation resources, etc. Transportation to/from location(s) for completion of training objectives will be provided as a part of the training program.
  - Family Training in Direct Care Responsibilities (pre-move and post-move) to prepare families acting as caregivers for the transition, build capacity to provide natural supports/complete delegated tasks, and reinforce pre-move training in the home setting after the participant moves.
  - Direct Support Workforce Training to offer to DSWs a specialization training program in the support of persons with intensive needs transitioning from institutions. It will allow

- multiple private agencies to access specialized training provided by a qualified training provider.
  - Support Coordination “Core Curriculum” Training for facility staff and residents who transition to community living. Provides a “Train the Trainer” course for regional level identified trainers, who directly train support coordinators at the local and sustainable level. Training targets Support Coordinators and Supervisors so they can effectively plan and coordinate services for the transition population, thus providing an avenue to continue the development of core competencies relative to planning, quality management and waiver assurances, but also expanding the knowledge base of support coordinators to provide linkages and support for transition needs.
  - The initiatives were all possible due to 100% administrative funding from CMS.
- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department’s contribution to the joint success? Joint cooperation between Medicaid, OAAS, and OCDD is directly attributable to the success of the MFP to date. In addition to built-in performance indicators for each component above, facilitated discussion groups—inclusive of training components—will be open to providers working with transitions and supporting waiver recipients to provide a forum for discussing barriers and sharing best practices.
- Other? Please specify. N/A
- 2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?
- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state “None.” However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:
  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? Not in the mean, however, there remains in the Medicaid MFP budget funding for an assistant project director, whose additional support would streamline and allow for division of labor within the Medicaid admin operation relative to budgets, analysis of programmatic data, travel to build working relationships with public housing authorities in the northern part of the state, and with coordinating the new addition of OBH/LBHP into the Operational Protocol.
    - Is the lack of progress due to budget or other constraint? No. We have

100% administrative funding from CMS to support this position, however, we have been told there are no positions available to which to apply this funding stream and subsequently fill the position.

- Is the lack of progress related to an internal or external problem or issue? Undetermined; this could be an inter-departmental decision, or one forced from the Division of Administration. If so, please describe the problem and any recommended corrective actions in Section III below.
- Other? Please specify. If were granted, at a minimum, a Program Manager 1-A position due to the complexity of this demonstration, it would allow Medicaid to respond faster and more effectively as we address unforeseen barriers to success in meeting demonstration goals. It is our concern that, should CMS discover this funding is unspent, we will lose the opportunity they provided us to enhance our operations.

2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution? No.
- ♦ **Has your department revised its strategic plan/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? Utilizing 100% administrative funding in support of the demonstration has had a significant impact on the problem issues identified. We expedited supplemental administrative funding elements tied to pre-move funding, provider training, housing relocation assistance, and post-move direct services in order to support the 20% downsizing of OCDD public supports and services centers. Also implemented was training of Ombudsmen and the Support Coordination Agencies serving the regions, which increased the number of referrals.

No. If not, why not?

- ♦ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully. Regular monthly conference calls with our CMS project office staff, technical assistance contractors, and regional CMS support staff are conducted to report on progress and barriers identified. Program office and Medicaid staff regularly discuss MFP progress internally. Monthly meetings of executive office staff are also conducted to review progress, ensure effective utilization of resources and funding to meet program expectations, and for strategic planning.

### **III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?** (“Problems or issues” may include internal concerns, such as organizational structure,

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

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

**A. Problem/Issue Description**

1. What is the nature of the problem or issue? Primary issues for MFP are as follows: Barriers to reducing institutional utilization and increasing waiver capacity remain, including access to housing, access to qualified state plan providers (primary care, specialists) and case managers, inadequate assistive technology aids, and a lack of a workforce development component to the demonstration.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) These issues impact our ability to transition individuals into the community and meet the transition benchmarks agreed upon with CMS, as well as providing the individuals we assist with opportunities to thrive in the community.
3. What organizational unit in the department is experiencing the problem or issue? Medicaid, OAAS and OCDD.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) Individuals assessed for MFP enrollment may be affected by these issues since service coordination, housing, etc., are key factors affecting the date of transition into the community.
5. How long has the problem or issue existed? These problems are not new but have been highlighted since the MFP demonstration has been underway.
6. What are the causes of the problem or issue? How do you know? While some issues are systemic in nature, problems with affordable and available housing are larger issues beyond the MFP, but we continue to partner with housing providers to strengthen collaboration. In addition, we partner with the Louisiana Housing Corporation as they apply for funding.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? As stated above, some of these issues affect transitions, which impact our ability to meet the transition benchmarks. CMS plan to evaluate progress in the demonstration nation-wide in 2012 to ensure adequate funding allocations.

**B. Corrective Actions**

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

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

2. What corrective actions do you recommend to alleviate or resolve the problem or issue? Using the 100% administrative funding to support our program to address these issues has helped. Approved and authorized through 2014, the \$14.4 million package is designed to address specific challenges relative to developing housing, training for families, direct service workers, and transition teams—all identified as areas in need of support. This funding requires no state match. Medicaid, OAAS, and OCDD are moving forward to implement the package. One barrier has been the hiring freeze. OAAS were able to hire their additional nine (9) staff, OCDD, their four (4), but Medicaid was unable to fill their one (1) 100%-funded position.
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? Unknown.
4. Are corrective actions underway?
- a. If so:
- What is the expected time frame for corrective actions to be implemented and improvements to occur? Although no specific time-frame has been set by CMS, they monitor our progress through monthly conference calls with the CMS Project Officer, wherein the state MFP team report on progress. Medicaid and Program offices meet regularly internally to assess progress as well.
  - How much progress has been made and how much additional progress is needed? The current economic crisis affecting state agencies has had some impact on the hiring component of the funding package, but progress is being made by the program offices toward realizing the other initiatives.
- b. If not:
- Why has no action been taken regarding this recommendation?
  - What are the obstacles preventing or delaying corrective actions?
  - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?
5. Do corrective actions carry a cost?
- No. If not, please explain. All MFP administrative operations are 100% federally-funded, which includes the elements that were added to operations in order to address corrective actions.
- Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.

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

#### 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: None.

41. Title of Report or Program Evaluation

42. Date completed

43. Subject or purpose and reason for initiation of the analysis or evaluation
44. Methodology used for analysis or evaluation
45. Cost (allocation of in-house resources or purchase price)
46. Major Findings and Conclusions
47. Major Recommendations
48. Action taken in response to the report or evaluation
49. Availability (hard copy, electronic file, website)
50. Contact person for more information, including
  - Name:
  - Title:
  - Agency & Program:
  - Telephone:
  - E-mail:

# Annual Management and Program Analysis Report

## Fiscal Year 2011-2012

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

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

**Undersecretary:** Jerry Phillips

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

**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?

### **State Efforts Lead to Rise in Louisiana's National Well-Being Rankings**

*Louisiana advanced to 36<sup>th</sup> among states in Gallup Healthways' annual index tracking well-being nationwide.*

The Gallup-Healthways Well-Being Index® is the first-ever daily assessment of U.S. residents' health and well-being. By interviewing at least 1,000 U.S. adults every day, the Well-Being Index provides real-time measurement and insights needed to improve health, increase productivity, and lower healthcare costs. Public and private sector leaders use data on life evaluation, physical health, emotional health, healthy behavior, work environment, and basic access to develop and prioritize strategies to help their communities thrive and grow. Journalists, academics, and medical experts benefit from this unprecedented resource of health statistics and behavioral economic data to inform their research and reporting.

Louisiana rose in all six indicators Gallup Healthways uses to measure well-being: life evaluation, emotional health, physical health, healthy behavior, work environment and basic access. Louisiana was ranked 42<sup>nd</sup> in last year's index. This year, Louisiana jumped from the fifth quintile of states to the fourth.

"These results confirm that Louisiana is on the rise," said Louisiana Department of Health and Hospitals Secretary Bruce D. Greenstein. "This is a reflection of a dedicated effort to improve every aspect of life in Louisiana - from our economy to education to health care. As we implement reforms like BAYOU HEALTH and the Louisiana Behavioral Health Partnership, I'm confident that we'll see this ranking and others continue to rise."

For the life evaluation indicator, which looks at how good respondents feel their current life situation is, and how well they expect to be doing in five years, Louisiana was ranked 11<sup>th</sup>. This places the State at the top of the second quintile nationwide for this measurement.

"We have a growing economy and a strong social support core. Our culture is rich and our people are resilient." Greenstein said. "Now we must focus on owning our own health and taking responsibility for improving our individual and community well-being. Let's keep getting better, together."

The Gallup Healthways Louisiana state report is available online. More information about this annual index is available at [www.well-beingindex.com](http://www.well-beingindex.com).

### **Medicaid Forecasting & Statistical Analysis/Research**

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

A State Fiscal Year (SFY) Medicaid Expenditures Forecast Report provides advanced information, enabling the executives/legislatures to see the direction the budget is heading throughout the SFY so they can make appropriate budget adjustments/plans without major surprises. DHE also provided innovative and appropriate ideas that helped the Department in making data supported/driven decisions that would impact the programs future and manage the budget within the appropriated levels.

The forecast benefits the State of Louisiana as a whole, Executives of the department, Division of Administration, Legislature, Governor's office, provider community (Hospitals, Nursing Homes, Physicians, etc), recipients and all other stakeholders who are directly or indirectly impacted by the Medicaid program, policies, etc.

These accomplishments (high accuracy rate and other) are achieved due to highly efficient health economists, supporting staff and cooperation from Medicaid and other program staff. DHE

employs appropriate analytical statistical/forecast models developed in-house, suitable specifically for the Louisiana Medicaid Program.

Through the forecasting process DHE is able to provide the Department's executives and senior managers with accurate and timely analyses during policy deliberations and decision making processes.

With subject to appropriate resources DHE could apply these models/approaches with suitable modifications to fit each department's needs/requirements.

### **Medicaid Annual Report**

Every State Fiscal Year (SFY) The Division of Health Economics (DHE) produces and publishes the Louisiana Medicaid Annual Report of the previously completed Fiscal year. This Louisiana Medicaid Annual Report provides a lot of quantitative (data/charts) and qualitative information about the Medicaid program and the occurrences of the previous SFY, which are very useful in decision making.

Medicaid Annual Report data/information enables the executives and legislatures, etc. to see how the Medicaid program progressed during the previous fiscal year so they can make proper data driven plans/decisions that impact the future of Medicaid.

This report benefits the State of Louisiana as a whole and other states. Importantly, Executives of the department, Legislatures, Division of Administration, Legislature, Governor's office, provider community (Hospitals, Nursing Homes, Physicians, etc.), recipients and all other community stakeholders who are directly or indirectly impacted by the Medicaid program, policies, etc.

DHE is able to produce this detailed report due to highly efficient health economists, supporting staff and cooperation from Medicaid and other program staff.

Through this report DHE is able to provide the Department's executives, senior managers and Legislatures' with accurate analyses during policy deliberations and decision making processes.

With subject to appropriate resources and data we could create annual reports for other programs.

### **Federal Medical Assistance Percentages (FMAP) Projections and Fiscal Impacts**

Through excellence and expertise in its economic analysis, the Division of Health Economics (DHE) develops the Federal Medical Assistance Percentages (FMAP) projections based on Louisiana state and national (US) Per Capita Personal Income data (PCPI) from the current Bureau of Economic Analysis. DHE's projected FMAP rates are within 99.9% of official CMS

rates each year. These projections are then used to project the fiscal impact of the changes in the FMAP rates.

Since these estimates are not available from any other source, particularly, five year FMAP projections are very useful in that they allow the Division of Administration (DOA) to make their five year long budget projections based off of DHE's estimations. Also, the projections are useful for DHH executives and state officials in the Medicaid budget development process (occurs September/October) since actual CMS's official published yearly FMAP rates are not released until November of each year.

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

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

With subject to appropriate resources and data DHE could make projections for other needed elements.

### **Provider Fee Projections**

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

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

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

The DHE is able to achieve these accomplishments (high accuracy rate and other) due to highly efficient health economists using appropriate data and econometric models.

Through these estimations DHE is able to provide the Department's executives, DOA & Governor's office with accurate and timely analyses for the budgeting process.

With subject to appropriate resources and data DHE could make projections for other needed elements.

### **DHH Teams up with Louisiana Emergency Response Network to help Prevent Concussions in Young Athletes**

The Louisiana Department of Health and Hospitals and the Louisiana Emergency Response Network (LERN) have joined forces to help protect young athletes from the dire consequences of head injuries and concussions.

Act 314, which was signed by Gov. Bobby Jindal on June 28, creates a uniform education, training and return-to-play protocol for private and public schools, private sports clubs, public recreation departments and other youth sports leagues intended to protect youth athletes. DHH and LERN are implementing Act 314 by giving coaches, administrators, parents and the athletes themselves new tools to know how to recognize concussions, follow proper return-to-play rules and prevent further injury.

"With the start of high school football season and youth soccer leagues, our children across the state will have great opportunities to exercise, build confidence and learn how to work well in a team environment," DHH Secretary Bruce D. Greenstein said. "At the same time, we want Louisiana's youth to safely enjoy physical activity - that's why this proactive movement to educate families and coaches about the serious dangers of head injuries like concussions is so critical."

State Sen. Sherri Smith Cheek authored SB 189, which became known as the Louisiana Youth Concussion Act, in the 2011 Regular Session of the Louisiana Legislature. It was approved unanimously by both chambers of the Legislature. Sen. Cheek said, "Our state's children are our greatest resource, and I am proud the governor, DHH and my fellow legislators recognized the importance of keeping their best interests at the forefront. The prevalence of concussions in youth athletes is on the rise, which makes this effort so important right now. Education brings empowerment, and these new tools will provide an extra layer of protection for our children as we work together to prevent the long-term and sometimes deadly effects of youth concussions."

The Louisiana Emergency Response Network was created in 2004 to build a statewide coordinated system to respond to the daily demands of traumatic injury. LERN works closely with DHH, but is governed by a 28-member governing board representing first responders, medical professionals and community leaders.

"The members of the Louisiana Emergency Response Network's governing board see firsthand the devastating effects of head trauma on a regular basis," said Coletta Barrett, RN, FACHE, chairman of LERN Board of Directors. "While not all concussions are avoidable, we have more evidence than ever that there are things we can do to reduce the overall number of concussions and improve the environment in which our children engage in sporting activities. We are thrilled Senator Cheek, a LERN Board member, sponsored this legislation. The LERN Board, staff and Regional Commissions stand ready to help implement this life saving program."

Anytime a concussion is not properly recognized, evaluated and treated, there is a tremendous risk of long-term, chronic cognitive, physical and emotional symptoms.

Dr. Gina Lagarde, medical director for DHH's Office of Public Health, said, "Young athletes often feel obligated to stay in the game, regardless of their injuries. Unfortunately, they don't always realize that a few extra minutes on the field following a concussion can have serious, sometimes life-threatening consequences. Therefore, it is imperative that young athletes, parents, and coaches are educated on the risks of concussions and other head trauma, and young athletes should be encouraged to speak up when they've been injured."

Under Act 314, the governing authority of each public and nonpublic elementary school, middle school, junior high school, and high school, as well as each private club or public recreation facility and each athletic league which sponsors youth athletic activities will:

1. Provide information to all coaches, officials, volunteers, youth athletes and their parents or legal guardian, prior to beginning of each athletic season, informing them of the nature and risk of concussion and head injury, including the risks associated with continuing to play after a concussion or head injury.
2. Require each coach and every official of a youth athletic activity that involves interscholastic play to complete an annual concussion recognition education course.
3. Require youth athletes and their parent or guardian to sign a concussion and head injury information sheet informing them of the statutory requirements for an athlete who has or is suspected to have suffered a concussion or head injury to return to play.

To help coaches and administrators comply with this law, DHH and LERN worked together to build an easy-to-access, one-stop-shop website for all the educational materials, training and forms developed by the Centers for Disease Control and Prevention that they need to educate themselves, their parents and their youth athletes on this critical public health issue.

To access these materials and learn more about the Louisiana Youth Concussion Act, go to [lern.la.gov/concussions](http://lern.la.gov/concussions). For specific questions call the LERN Central Office at (225) 756-3440.

### **Governor's Games Continues to Draw Record Number of Participants**

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

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

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

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

A general assessment of overall timeliness and progress is due to hard-working Council Members throughout the state developing new partnerships and identifying new funding sources.

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

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

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

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

The Office of the Secretary has recognized and identified the need for improved performance information. Without increased management attention to setting priorities and developing overall goals that can be used to assess its performance, the Department would be limited in its ability to make significant progress. Considerable progress has been made in hiring,

assigning, and training personnel. Our 5-year strategic plan provides (1) a general picture of intended performance across the agency, (2) a general discussion of strategies and resources the agency will use to achieve its goals, and (3) general confidence that agency performance information will be credible. For example, most performance indicators in the plan include baseline or trend data and projections against which to assess performance.

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

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

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

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

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

GCPF upcoming policies will make sure new sporting events and activities get the maximum amount of exposure as possible through local and statewide media outlets. An upgraded website with health and wellness tips, along with information and locations on all 55 sporting events

throughout the state and information on events and programs in other states has taken GCPFS to a higher level.

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

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

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

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

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

The Department updated its 5-Year Strategic Plan in July 2012. In the revised plan, agencies incorporated a section titled "Executive Summary" and have implemented new outcome performance indicators. In the Executive Summary, this addition to the strategic plan is intended to highlight the vision of the agency's assistant secretary. It contains a brief overview and information on where the agency is headed in the next five years, major goals,

recent accomplishments or important themes they hope to accomplish within this time frame. The new plan also incorporates charts and graphs of performance indicators. Our 5-year strategic plan also provides a general picture of intended performance across the agency, a general discussion of strategies and resources the agency will use to achieve its goals.

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

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

- Building Foundational Change for Better Health Outcomes
- Promoting Independence through Community-Based Care
- Managing Smarter for Better Performance
- ♦ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the DHH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for each DHH agency. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

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

**III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?**  
("Problems or issues" may include internal concerns, such as organizational structure,

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

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

**No significant operational problems or issues to report.**

A. Problem/Issue Description

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

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?  
 No. If not, skip questions 2-5 below.  
 Yes. If so, complete questions 2-5 below.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
  - a. If so:
    - What is the expected time frame for corrective actions to be implemented and improvements to occur?
    - How much progress has been made and how much additional progress is needed?

- b. If not:
- Why has no action been taken regarding this recommendation?
  - What are the obstacles preventing or delaying corrective actions?
  - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

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

Please discuss the following:

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

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

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

**Internal audit**

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

**External audits**

The Louisiana Office of the Legislative Auditor conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

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

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

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

 **Program evaluation by in-house staff**

Program evaluation by contract

 **Performance Progress Reports (Louisiana Performance Accountability System)**

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

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

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

 **Benchmarking for Best Management Practices**

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

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

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

Peer review

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

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

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

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

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 2011-2012**

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

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

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

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

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

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

**A. What was achieved?**

The South Central Louisiana Human Services Authority (SCLHSA) was awarded a Three-Year Accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) for the following programs: Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults, Children and Adolescents) and Outpatient Treatment: Mental Health (Adults, Children and Adolescents). The CARF is an independent, nonprofit accrediting body whose mission is to promote the quality, value, and optimal outcomes of services through a consultative accreditation process that centers on enhancing the lives of the persons served. Founded in 1966 as the Commission on Accreditation of Rehabilitation Facilities, and now known as CARF International, the accrediting body establishes consumer-focused standards to help organizations measure and improve the quality of their programs and services.

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

This accreditation decision represents the highest level of accreditation that can be awarded to an organization and shows the organization's substantial conformance to the CARF standards. An organization receiving a Three-Year Accreditation has put itself through a rigorous peer review process. It has demonstrated to a team of surveyors

during an on-site visit its commitment to offering programs and services that are measurable, accountable, and of the highest quality. Achieving national accreditation was cited as a goal in the SCLHSA's Strategic and Operational Plans. Payer sources such as the Statewide Management Organization (SMO) require accreditation; therefore SCLHSA will be able to maximize funding opportunities as a result of this success. It is also important to note that the SCLHSA Behavioral Health Clinics are the first clinic sites associated with the Department of Health and Hospital (DHH) to be accredited in the state of Louisiana.

C. Who benefits and how?

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

D. How was the accomplishment achieved?

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

standards, the agency earned a three year CARF accreditation which is the highest level of accreditation that can be achieved. The SCLHSA then had to submit a Quality Improvement Plan (QIP) to CARF to show how it was addressing any areas cited for improvement. Each year during the term of accreditation, the SCLHSA must submit a report to CARF documenting additional improvements it has made to its service array.

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

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

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

Payers whether a third-party funder, referral agency, insurance company, or governmental regulator looks for CARF-accredited service providers to lessen risk and provide greater accountability. Behavioral health payers prefer CARF International as an independent accrediting body of health and human service providers. Accredited providers have proven they have applied a comprehensive set of standards for quality to their business and service delivery practices. Because CARF accreditation signals a provider's demonstrated conformance to internationally accepted standards, it can significantly reduce governmental monitoring and help to streamline regulation processes. The value of CARF Accreditation is more than a certificate hanging on the wall. CARF Accreditation is evidence that an organization strives to improve efficiency, fiscal health, and service delivery -- creating a foundation for consumer satisfaction.

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

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

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

Overall, South Central Louisiana Human Services Authority (SCLHSA) remained on target with progress toward achieving our Strategic Plan Goals and Objectives. The Authority consistently utilized all strategies outlined in its Strategic Plan to effectively demonstrate performance and quality improvement on a continuous basis. In addition to Strategic Plan Goals and Objectives, implementation of efficiency strategies also produced positive results in the areas of client engagement, documentation of clinical treatment, client satisfaction (internal satisfaction survey results improved over previous survey and showed high marks for all clinicians, all support staff, and perceived positive outcomes), and staff retention.

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

During FY 2011-2012, South Central Louisiana Human Services Authority (SCLHSA) demonstrated progress on each of the three goals included within its Strategic Plan:

**Goal 1:**

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

**Goal 2:**

Integrate service provision among Behavioral Health Clinics.

**Goal 3:**

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

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

1. To what do you attribute this success? For example:
  - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
  - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you

initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

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

Other? Please specify.

Success may be attributed to the following:

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

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

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

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

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

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

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

- No. If not, why not?

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

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

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

Each Service Director assists the Authority developing an annual organizational specific business plan in support of the South Central Louisiana Human Services

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

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

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

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

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

South Central Louisiana Human Services Authority (SCLHSA) leadership approaches implementation of the Authority Strategic Plan as comprehensive and ongoing performance improvement that involves all Divisions (horizontal integration) and all

staff members (vertical integration) Monitoring and reporting are integral parts of the process as are compliance and process improvement activities.

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

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

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

#### **Reductions in Funding**

##### A. Problem/Issue Description

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

During FY 2011-2012, South Central Louisiana Human Services Authority (SCLHSA) experienced a reduced level in State General Finds (SGF’s). Added to this is the hiring freeze of FY 2011-2012 and the “non-T.O.” Executive Order, which reduced the number of funded positions. Vacant positions in service areas are, of course, the priority to fill.

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

Yes, South Central Louisiana Human Services Authority (SCLHSA) revised its Strategic Plan goal and amended its strategic plan objectives.

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

Every activity of South Central Louisiana Human Services Authority (SCLHSA), i.e. Behavioral Health Services, Developmental Disabilities Services, and Administration (which includes utilization management, monitoring, and billing functions) is experiencing the problem/issue.

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

- Individuals Served
- Residents of South Central Louisiana Human Services Authority (SCLHSA)-

Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne parishes.

- Every employee (all areas and all levels)
- Contractors and their employees
- Community Partners such as the Parish Presidents and Council/Jurors, Sheriff's Office, Coroner's Office, Public School Systems, District Attorney's Office, Juvenile Judges, and local not-for-profit community hospitals and social service organizations.

5. How long has the problem or issue existed?

The negative effect of reduced funding was noted beginning in FY 2010-2011, as we are a new local governing entity and has continued through the FY 2011-1012 Fiscal Year.

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

The problem is caused by a continual reduction to the State budget; loss in state revenues; a depressed economy; and reduction in Federal funding.

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

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

B. Corrective Actions

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

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

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

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

4. Are corrective actions underway?

a. If so:

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

progress is needed?

b. If not:

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

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

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

South Central Louisiana Human Services Authority (SCLHSA) will:

- Continue execution of the Performance Improvement Plan to assure best use of limited resources, streamlined operations and service delivery, high levels of productivity, open capacity, and high quality outcomes for individuals receiving services and supports.
- Work with the Statewide Management Organization to ensure Medicaid reimbursement is optimized for evidence-based practices offered by SCLHSA in the home and in the community.
- Continue implementation of the South Central Louisiana Human Services Authority (SCLHSA) Risk Management Plan.
- Research grant funding opportunities for expansion of new programs and/or to sustain existing programs.
- Explore opportunities to partner with pharmaceutical programs for research studies related to behavioral health and developmental disabilities.
- Integrate primary care into the SCLHSA behavioral health care service venue.
- Continue to explore and seek relationships with private payors to open new

streams of revenue.

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

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

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

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

9. Do corrective actions carry a cost?

- No  
 Yes

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

### **Expansion of Medical Revenues**

#### A. Problem/Issue Description

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

The behavioral health services reimbursement structure has changed to allow for multiple billable services to be delivered in a single day however the structure has limited billable services to a select few of licensed professionals, i.e. services rendered by nurses are no longer eligible for reimbursements. Additionally, we are challenged in that services delivered by unlicensed professionals are not

billable services in the outpatient clinic setting yet are in the community setting. The staffing of our agency relied heavily on nursing support to physicians/psychiatrists and the local private providers to deliver the community based services.

Implementing the Louisiana Behavioral Health Partnership, the Statewide Management Organization (SMO), charged the SCLHSA to restructure the entire behavioral health function and organize services to maximum the billing potential rather quickly and unfortunately caused major issues with service provision and billing compliance. There continues to be struggles with merging existing Medicaid beneficiaries into the SMO billing system that would allow for timely billing; there are issues in receiving pre-authorizations for services as identified in independent assessments that include but are not limited to non-response, care managers lack of understanding of identified needs, time lapse between requests and response; the contracted vendor for the La Behavioral Health Partnership is also responsible for billing the Medicare and third-party payors but unfortunately that component of the contract has not yet been implemented.

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

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

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

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

The inability to obtain reimbursement for the services described above negatively impacts every Activity of South Central Louisiana Human Services Authority (SCLHSA), i.e. Behavioral Health Services, Developmental Disabilities Services, and, Administration (which includes risk management, monitoring, and billing functions). The local private providers who have agreed to continue to serve the non-payor source client (those who are not beneficiaries of Medicaid, Medicare, third party or determined self-pay clients), that is the "true" indigent individual needing services), have also been challenged in delivering services at a contracted fee for service rate not to exceed the Medicaid determined rate as outlined in the La Behavioral Health Partnership instead of a cost reimbursement rate. This has resulted in private community based providers deciding not to continue services

which leave a gap in community resources available to the patient and staff involved in creating a plan of care for a client.

4. Who else is affected by the problem?

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

5. How long has the problem or issue existed?

The La Behavioral Health Partnership was implemented March, 2012. The challenges with re-organization, including staffing and billing began immediately. Through attrition, the agency is recruiting and replacing counselor vacancies with licensed billable staff; however there still remains staff with non-billable credentials employed. In billing challenges, the agency is working diligently with the SMO vendor to correct and update individual's basic demographic and guarantor information for successful transmission of billed claims; however this action addresses only the Medicaid component of billing, there still remains the unknown challenges that will surface when we implement the Medicare and third party payor billing with the SMO vendor. The implementation date of this component of the billing system is still unknown.

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

The array of services eligible for reimbursement and the rates of reimbursement are identified in Title 48 of the Louisiana Administrative Code and in the Louisiana Medicaid Program Mental Health Clinics Provider Manual and also by those determined by the Statewide Management Organization. Additionally, the delay in the full implementation of the SMO vendor's fiscal intermediary responsibilities and the structure/re-structure the agency components as needed to meet the services defined in the La Behavioral Health Partnership has affected SCLHSA's ability to predict its revenue potential.

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

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

## B. Corrective Actions

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

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

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

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

- 1) Continue to make necessary adjustments to its staffing patterns to assure providers delivering services are eligible to bill and/or contribute to the billing process.
  - 2) Modify its charge master and the billing component to assure all services performed meet the definitions of billable procedures approved by the Louisiana Behavioral Health Partnership and/or SMO are billed.
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

This is the second year that SCLHSA has submitted this recommendation and that Medicaid funding for evidence-based practices offered in the home and community has been targeted as a goal for the Department of Health & Hospitals Human Services Interagency Council (HSIC).

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

South Central Louisiana Human Services Authority's (SCLHSA) Executive Director, Deputy Director, Clinical Director, Human Resources Director and Chief Fiscal Officer have completed an assessment and analysis of South Central Louisiana Human Services Authority's (SCLHSA) current staffing patterns. A complete restructure of the behavioral health component was completed in February of 2012 to place licensed staff in the position to provide billable procedures in accordance with the SMO. Mental Health Clinics now operate as Treatment Centers to provide individual/group sessions, family/couple sessions, psychiatric evaluations, psychological testing, medication administration,

medication management, crisis stabilization, gambling counseling, breath tests, urine screens and referrals. Addictive Disorder Clinics now operated as Assessment Centers to provide screening, assessment, plan of care and level of need determination. The South Central Louisiana Human Services Authority (SCLHSA) charge master and billing component are aligned with the SMO and are continuously being changed to mirror the services that the state plan will approve for reimbursement.

5. Do corrective actions carry a cost?

- No  
 Yes

South Central Louisiana Human Services Authority (SCLHSA) has the in-house expertise to carry out all components of these identified corrective actions. The only cost associated with this process is the difference in salary to replace unlicensed staff with licensed staff should they choose to separate from the agency.

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

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

- Internal audit
- 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):
- 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. Outcomes are reported on no less than a quarterly basis.

- Performance Progress Reports (Louisiana Performance Accountability System)

South Central Louisiana Human Services Authority (SCLHSA) collects data, conducts statistical analysis, and reports outcomes into LaPAS on a quarterly basis. Detailed notes of explanation are provided for positive and negative variances and to outline any needed corrective action or process improvement activity. South Central Louisiana Human Services Authority (SCLHSA) also provides data to the Department of Health & Hospitals Office of Behavioral Health (Office of Mental Health and Office for Addictive Disorders) and the Office of Citizens with Developmental Disabilities on an ongoing basis. SCLHSA also provides annual documentation of conformance to CARF annually to comply with the standards of accreditation.

- In-house performance accountability system or process

South Central Louisiana Human Services Authority (SCLHSA) utilizes: the Department of Health & Hospitals Accountability and Implementation Plan, the

Commission on Accreditation of Rehabilitation Facilities (CARF) and Performance Improvement model; Staff Development and Supervision Guidelines in conjunction with the Louisiana Department of Civil Service Performance Planning and Review system; ongoing internal monitoring and auditing including corrective action and/or process improvement action plans with assigned accountability.

Benchmarking for Best Management Practices

South Central Louisiana Human Services Authority (SCLHSA) has an active and robust decision-support function supported by the availability of live data from state and other internal data warehouses. Data analysis includes comparative studies to benchmark against national statistics and internally set goals/targets. Studies range from individual service provider productivity to billing denial rates. South Central Louisiana Human Services Authority (SCLHSA) also utilizes benchmarks set forth in the Accountability Implementation Plan and Council on Accreditation of Rehabilitation Facilities (CARF) for ongoing performance and quality improvement initiatives.

Performance-based contracting (including contract monitoring)

All South Central Louisiana Human Services Authority (SCLHSA) contracts have explicit performance requirements and include mandatory reporting and development of corrective action and/or process improvement plans if the need is indicated.

Peer review

South Central Louisiana Human Services Authority's (SCLHSA) Performance Improvement Program uses peer review as part of the ongoing performance and quality improvement initiative. The Authority's Medical Director leads comprehensive multi-disciplinary peer review in cases. The Authority has initiated an ongoing peer review process to be conducted annually as part of the compliance standards implemented for the CARF accreditation process.

Accreditation review

South Central Louisiana Human Services Authority (SCLHSA) is implementing an Authority-wide plan for accreditation readiness with the Commission on Accreditation of Rehabilitation Facilities (CARF). Communication between the Authority and Commission on Accreditation of Rehabilitation Facilities (CARF) is ongoing and formal application was filed. As stated previously, South Central Louisiana Human Services Authority (SCLHSA) has active process improvement functions that focus on meeting and/or exceeding requirements set forth in the Commission on Accreditation of Rehabilitation Facilities (CARF) Standards, the Statewide Management Organization and the

Department of Health and Hospitals.

Customer/stakeholder feedback

South Central Louisiana Human Services Authority (SCLHSA) participates in satisfaction surveys sponsored by the Office of Behavioral Health and the Office of Citizens with Developmental Disabilities. Additionally, South Central Louisiana Human Services Authority (SCLHSA) fields a proprietary survey within its Behavioral Health Clinics on a quarterly basis to gain additional information for the identification of opportunities for improvement. The Authority has initiated satisfaction surveys for all contractors as part of standard contractual requirements. South Central Louisiana Human Services Authority (SCLHSA) also partners with the Office of Behavioral Health to hold an annual community forum for the residents of our seven parishes. The members of the Board of Directors, per the Carver Policy Governance Model, actively engage in “community linkages” and report the results of these interactions with community stakeholders during monthly Board meetings.

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

Yes. Proceed to Section C below.

No Skip Section C below.

Yes. Proceed to Section C below.

No Skip Section C below.

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

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

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

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

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

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

# Annual Management and Program Analysis Report

*Fiscal Year 2011-2012*

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

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

**Undersecretary:** Jerry Philips

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

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

1. *Implementation of Community Choices Waiver (CCW)*
2. *Transfer of management of and begin transition to sustainability of Permanent Supportive Housing (PSH)*
3. *Transformation of Waiver Quality Assurance System*
4. *Statewide implementation of Money Follows the Person (MFP)*
5. *Settlement of Pitts v Greenstein*
6. *ACT 299: Report and Implementing Work Plans*
7. *Traumatic Head Injury/Spinal Cord Injury Trust Fund Amendments*

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

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

## ***1. Implementation of Community Choices Waiver (CCW)***

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

OAAS began implementation of the Community Choices Waiver (CCW) on October 1, 2011 as a means to expand and develop additional, community-based services as an alternative to institutional care. The CCW afforded OAAS the opportunity to provide participants with a diverse and flexible array of cost-effective services to achieve quality outcomes and serve as many individuals as possible within available budgetary resources. Currently there are 4427 participants receiving CCW supports and services.

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

The previous Elderly and Disabled Adult (EDA) waiver provided a limited number of services, thus encouraging heavy reliance on one-on-one personal care delivered by a paid worker who goes to the participant's home. It proved to be a costly way to deliver care, and may have also resulted in unnecessary service dependency as opposed to promoting, improving, and maintaining independent functioning. The CCW provides a much broader array of services, including home delivered meals, in-home sensor monitoring, assistive devices/technology, and nursing and skilled maintenance therapies that can substitute for one-on-one care and can improve independence in the home. The CCW allows OAAS to deliver a fundamentally different approach to community-based services, and will also change the way that support coordination services are delivered and quality monitored in the waiver program.

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

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

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

Support coordination agency workers were trained with internal resources, on the array of services available to participants, as well as the new policies and procedures governing the waiver. At the same time, the regional office structure was changed to reflect new roles and responsibilities in providing training and technical assistance to support coordination agencies. A significant strength in implementing the CCW was the development a cadre of trainers. Of sixteen staff identified as trainers, four were ultimately selected to provide training in the regions on an ongoing basis.

OAAS worked with Molina to develop changes to their claims systems to support the new array of services in the CCW waiver. This remains a significant challenge as implementation continues due to Molina's antiquated MMIS system and lack of resources to make the necessary changes.

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

Implementation of the CCW is consistent with best practices used by states that have achieved a cost-effective “rebalancing” from institutional to community-based LTC (see, for instance, Mollica & Reinhard, Rebalancing State Long-Term Care Systems, National Academy for State Health Policy, October 2005). The program has been proven effective in preventing institutionalization, with only a small percentage of program participants ever transitioning to nursing home care.

The inclusion of assistive technology, sometimes known as gerontechnology, as a service in the CCW, is leading edge. Given the need for more healthcare options for the aging population; “there is a significant interest from industry and policy makers in developing these technologies” (Eriksson 2002).

OAAS shared our extensive research with The Office for Citizens with Disabilities (OCDD) to assist in incorporating similar technology into the New Opportunities Waiver.

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

This accomplishment contributes to the OAAS strategic goal, “To expand existing and develop additional community-based services as an alternative to institutional care.” It is a significant component of OAAS’s transformational initiative of “Redesigning the community-based long term care infrastructure” as described in the DHH Business Plan for SFY 13-14.

***2. Transfer of management and begin transition to the Statewide Management Organization (SMO) for sustainability of Permanent Supportive Housing (PSH)***

**A. What was achieved?**

Management of the PSH program was moved from the Office of the Secretary (OS) to OAAS. OAAS will provide programmatic oversight and monitoring. In addition, the PSH program is slated to begin its transition from CDBG, federal disaster recovery funded services to Medicaid funded services. The Statewide Management Organization (SMO) will begin transitioning current PSH households into its system in November and it is anticipated that the process will be complete by December 31st.

The CDBG funds are one time limited funds, so the transition of the program will create a sustainable source of funding for these housing support services. A source of funding for tenant services was developed through existing Medicaid authorities, including 1915 (c) waivers and the 1915(i) state plan service. Existing households that are not eligible for these services will continue to be funded through CDBG funds. Funding the eligible services through Medicaid will enable PSH to continue to support the non-eligible disabled households longer until another source for funding can be determined.

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

The transition to the Statewide Management System (SMO) manages costs through effective utilization of state, federal, and local resources and improves quality by establishing and measuring outcomes.

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

**C. Who benefits and how?**

The beneficiaries are current and potential participants of PSH. There are currently over 2300 persons in PSH. Because this is a cross-disability program, participants have a wide range of disabilities such as developmental disabilities, behavioral and addictive disorders, as well as aging-related disabilities.

Since the beginning of the program, 98% of participants housed in Region 1 retained stable community living, including people who had graduated from PSH to other independent living situations. Less than 2% of participants had faced negative outcomes such as eviction or incarceration

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

This accomplishment has been achieved through the joint effort of PSH program staff, consultants, and DHH PSH Executive Management Team, which includes the Office of Behavioral Health (OBH), OCDD, OS, and Medicaid. The necessary activities, including provider credentialing process and training, are in place to ensure an adequate infrastructure of providers in the community, both during and after the transition.

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

A preliminary review of the households served in PSH has reflected a decrease in Medicaid costs to those participants who have exited institutions or are high system users. The PSH transition is anticipated to not only stabilize disabled people in the community, but to save money in the Medicaid system.

Because of the scope and scale of Louisiana's program, the Robert Wood Johnson Foundation has funded the evaluation of Louisiana's PSH program, and the program has been presented at several national conferences.

Louisiana PSH is the only cross-disability program in the nation. The Centers for Medicaid and Medicare Services (CMS) has recognized the Louisiana PSH program as a model program for the nation and has encouraged other states to replicate the model.

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

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

**3. Transformation of Waiver Quality Assurance System (QIS)**

**A. What was achieved?**

In conjunction with implementation of the Community Choices Waiver, OAAS implemented a new waiver quality assurance system. This is the first implementation of the new system, which was developed jointly by OAAS, OCDD and Medicaid under a CMS Systems Transformation Grant. The system moves from a reliance on a one hundred percent review process in which OAAS waiver staff function as eligibility reviewers and approvers of care plans to a system that relies on valid sampling, a support coordination monitoring process, and a training and certification process for support coordination. It transforms the regional waiver staff role to that of monitors and trainers and provides objective data with which to evaluate waiver and provider outcomes.

A key part of the system is the electronic Support Coordination Monitoring (SCM) Database (LASCA). It will provide regional staff with a tool to enter and store data from their monitoring of support coordination agencies through an agency review tool, a coordinator interview tool, and a participant representative sample of record reviews and participant interviews. LASCA automatically calculates scores for each support coordination agency which identify unacceptable performance by agencies in plan of care development and participant monitoring. This data is reported on an individual participant level and on an aggregate level in order to facilitate remediation activities at both levels as required by CMS.

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

The monitoring results allow the Office of Aging and Adult Services to correct individual concerns as well as to implement systems improvement initiatives. The QIS will change the way that support coordination services are delivered and quality monitored in the waiver program.

The new processes which were implemented with the CCW waiver on 10/1/12 have dramatically streamlined waiver administrative processes through removal of the 100% plan review by OAAS Regional Office staff. This allows them to focus on increased monitoring of Support Coordination Agency assessments, plan development and client monitoring activities. DHH waiver specialists no longer duplicate the work of Support Coordination Agency supervisors and can offer a much greater service to participants.

**C. Who benefits and how?**

Primary beneficiaries are waiver participants. Recipients of the services benefit as system development enables protocols that enhance and strengthen the quality of care planning and health and welfare monitoring. The review elements have been cross-walked to collect the necessary data for the CMS performance measures as described in the waiver application. It is through the new robust and statistically sound SC monitoring processes that the discovery and remediation activities required by CMS will be accomplished.

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

The OAAS Division for Research and Quality did extensive preparatory research and developed the very critical Quality Improvement Strategy (QIS) that is a key component of the federal waiver application and approval process. The QIS provided to CMS was approved rapidly by federal authorities with minimal questions and requests for revision, indicating that the application was of high quality and well-prepared.

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

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

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

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

**4. Statewide implementation of Money Follows the Person (MFP)**

**A. What was achieved?**

The Deficit Reduction Act of 2005 enacted the Money Follows the Person program, designed to provide states with assistance to develop the systems needed to help move Medicaid-enrolled

individuals from institutions back into the community. \$6.9 million in supplemental administrative funding was instrumental in placing additional transition resources in the field, training and assisting support coordinators in facilitating transitions and improving overall performance.

This year, with funding from the approved supplemental budget request, OAAS was able to hire, train, and place a transition coordinator in each of the nine DHH regions. Funding also allowed OAAS to add a full-time intake coordinator/data manager as well as a part-time quality assurance coordinator to work with the "My Place Louisiana" program. With the additional staff added this year through the supplemental budget approval last year, "My Place" now employs fourteen staff dedicated to achieving transition benchmarks and quality outcomes as described in Louisiana's Operational Protocol for Implementation of the Money Follows the Person demonstration.

OAAS was also able to set up mechanisms for funding supportive services not otherwise funded through Medicaid long-term care waivers or services, but that were identified as presenting barriers to people transitioning during the first year of the program's implementation.

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

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

- Enhanced federal match rate for qualified Medicaid HCBS services that a participant receives for the first 365 days following transition back to the community.
- Ability to rebalance cost savings back into long term care programs, possibly providing for expansion of programs.
- Ability to create infrastructure that supports and sustains successful transitions by providing additional field resources and expanding training of OAAS staff and its contractors that provide direct services to Medicaid home and community-based services recipients.
- Development of Money Follows the Person Committee for the state to gain input from stakeholders in developing a long term care infrastructure that supports transitions from institutional settings to the community.

Funds will enable OAAS to exceed its benchmarks for number of individuals transitioned, with an average estimated savings to Medicaid of \$13,000 per year for each successful transition. MFP supplemental funds used for comprehensive training, competency-testing, and oversight of support coordinators also allows OAAS to strengthen its community-based services delivery system for all recipients.

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

Primary beneficiaries are nursing facility residents who are able to live in the community and who prefer to live in the community. Because 100% of individuals who transition to the

community under MFP are served at less cost to the state than if they remained in a nursing home, Louisiana's Medicaid program and taxpayers also benefit from this program. All waiver recipients benefit through the use of MFP funds for training and other initiatives that strengthen the HCBS system.

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

This accomplishment was achieved through supplemental funding provided through CMS. This accomplishment was facilitated by the creation of a supplemental budget request that outlined the established needs of the State to be able to successfully implement the Money Follows the Person demonstration and with the guidance of the Centers for Medicare and Medicaid.

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

Lessons learned on this accomplishment should be shared so that other offices or agencies can benefit from learning about barriers and/or success of the demonstration and to develop or promote "best practices" with institutional to community living transitions.

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

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

**5. Settlement of Pitts vs. Greenstein**

**A. What was achieved?**

On September 22, 2010, DHH was sued by four persons who received Long Term Personal Care Services (LT-PCS). Represented by the Advocacy Center, the Plaintiffs claimed a violation of Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12132 and the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("Section 504"). They sought to pursue a class action on behalf of themselves and other Louisiana Medicaid recipients who are eligible to receive LT-PCS. The lawsuit emanated from DHH limiting LT-PCS to a maximum of 32 hours per week (from 42 hours per week). Plaintiffs claimed that this reduction in services would force them into institutions to receive care, in violation of the Americans with Disabilities Act and the Rehabilitation Act. DHH claimed that the Plaintiffs' allegations do not state a claim of discrimination under the ADA and Rehabilitation Act as interpreted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999). The lawsuit was filed in Federal Court in the Middle District of Louisiana. The U. S. Dept. of Justice filed a statement of interest in the case.

DHH vigorously defended the suit and sought to have the lawsuit dismissed during several stages of the proceedings. Though unsuccessful in its efforts to have the lawsuit dismissed, DHH and

the plaintiffs were able to resolve and settle the lawsuit through a negotiated settlement agreement signed in January, 2012 that will result in the lawsuit being dismissed on December 31, 2012.

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

The settlement of the Pitts Lawsuit is significant because had DHH not prevailed, it very likely would have had to restore the 42 hour weekly cap, which would have had devastating budgetary consequences. Furthermore, any future decisions affecting the LT-PCS program would very likely had to have been considered and approved through a Special Master under the jurisdiction of the federal courts for quite some time, thereby thwarting programmatic innovation.

Instead, the settlement provides for a termination date and does not disrupt the State's comprehensive plan for providing home- and community-based services to a large, diverse, and growing population of individuals with disabilities. Prior to the settlement, DHH made some changes to one of its home- and community-based programs—the Community Choice Waiver—in order to provide new options for LT-PCS recipients who wanted more services than the LT-PCS program offered. Among those changes was a new policy that allows some LT-PCS recipients to request expedited access to the Community Choice Waiver. The settlement agreement carries forward the policy changes DHH already made to the Community Choice Waiver, allowing a larger group of LT-PCS recipients to apply for expedited access to the Community Choice Waiver until June 30. Additionally, the settlement agreement keeps in place the 32 hour weekly limitation and has an expiration date of December 31, 2012 at which time the lawsuit will be dismissed.

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

The state benefits from the agreement for the reasons set forth in B above. DHH can continue to impose the 32 hour cap limit in an efficient, equitable, and uniform manner. As DHH proved during the course of litigation, the 32 hour weekly limit did not force people unnecessarily into institutions (as the plaintiffs claimed) and struck the right balance between serving those persons who are the most acute versus those with lower acuity. By keeping this resource allocation methodology in place, current and future participants of OAAS services will benefit since expenditures in other programs will not have to be decreased.

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

During the course of litigation, DHH vigorously defended the lawsuit and tried at least twice during the proceedings to have the lawsuit dismissed. Recent jurisprudence in similar litigation as well as the Department of Justice entering the lawsuit on the side of the plaintiffs posed substantial obstacles for DHH in its efforts for dismissal.

However, by moving for dismissal, DHH was able to offer an abundance of evidence before the court that showed (among other things) that the 32 hour limit did not force people into institutions as the plaintiffs had claimed and that DHH had a comprehensive plan for providing home- and community-based services to a large, diverse, and growing population of individuals

with disabilities. Many of DHH's efforts were recognized and applauded by the presiding Judge. Given this, the Court requested that the parties explore settlement instead of protracted litigation. DHH's efforts in getting the lawsuit dismissed and the evidence presented therein provided a favorable backdrop for a negotiated settlement that while affording relief to the plaintiffs, was much less onerous than restoring the 42 hour cap limit.

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

Given that every class action lawsuit has to be judged and operated under its own set of facts, this accomplishment should be viewed as a positive outcome for this particular situation.

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

Yes. The settlement does not disrupt the State's comprehensive plan for providing home- and community-based services. OAAS' primary goal is to expand existing, and to develop additional community-based services as an alternative to institutional care. OAAS also strives to administer and operate its programs in a cost-effective manner while achieving high quality outcomes.

Had the 42 hour weekly cap been restored and the settlement not been entered, these goals could have been severely compromised. First, restoring the 42 hour weekly cap would have thwarted OAAS' efforts to expand the existing program since it would have caused a budgetary deficit. The 32 hour weekly cap strikes the right balance in achieving OAAS's goals because it allows for program growth. Second, the settlement's provisions allow OAAS to grant class relief in a cost-effective manner, while achieving high quality outcomes for all participants served by OAAS.

**6. ACT 299: Report and Implementing Work Plans**

**A. What was achieved?**

ACT 299 of the 2011 Legislative Session required that DHH, with the input of stakeholders, develop a comprehensive plan to include nine focus areas in order to address the delivery of quality services to individuals receiving home and community based services (HCBS) in the state. A report addressing the issues outlined in the legislation was submitted to the legislature in January 2012.

The plan addressed nine specific areas of focus:

- Accreditation
- Compliance
- Billing
- Cost reporting
- Support coordination
- Rate reimbursement

- Technology
- Medicaid enrollment
- Medicaid delivery options

With the research produced by the subcommittees, action steps, timelines, and resources have been identified for the implementation of the comprehensive plan required by Act 299.

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

Implementation of the initiatives detailed in this report will mark a step forward in addressing a number of issues regarding the home and community based services provided in the state. The focus of DHH is to continually improve quality of services and effectiveness for participants, to use available resources wisely to serve as many persons as possible, and to guard against fraud or billing errors.

**C. Who benefits and how?**

Potentially, all current and future participants of home and community based services will benefit from the implementation of ACT 299 initiatives.

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

Representatives from DHH's Office of Aging and Adult Services (OAAS) and Office for Citizens with Developmental Disabilities (OCDD) met with stakeholders and formed seven subcommittees to address the issues outlined in the legislation. As needed, these subcommittees will continue to meet and follow up on their respective focus areas.

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

The issues and subsequent initiatives of ACT 299 represent best management practices in the provision and delivery of long term care in home and community based services.

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

This accomplishment contributes to the OAAS strategic goal, "To expand existing and develop additional community-based services as an alternative to institutional care." It is a significant component of OAAS's transformational initiative of "Redesigning the community-based long term care infrastructure" as described in the DHH Business Plan for SFY 13-14.

## ***7. Traumatic Head Injury/Spinal Cord Injury Trust Fund Amendments***

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

Since taking over this program from Division of Children and Family Services (DCFS) on July 1, 2010, OAAS has reorganized and restructured the Traumatic Head and Spinal Cord Injury Trust Fund program (THI/SCI). In the 2012 Legislative session, ACT 269 effectively transferred the power, duties, functions, and responsibilities from the Advisory Board to DHH/OAAS. The Board will continue to function in an advisory capacity. Three outdated positions on the Advisory Board were replaced.

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

ACT 299 clarifies the management of the program, clarifies allowable uses of the funds, updates the Board membership, allows for money in the fund to be used to match available federal funding, and paves the way for revised policies to more effectively serve additional people within available levels of funding.

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

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

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

This accomplishment was achieved through working with the Board and other stakeholders to craft legislation that was passed during the 2012 Legislative Session.

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

The legislation brings the Louisiana program more in line with other states and allows the leveraging of funds to draw federal match and expand services.

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

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

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

Yes. Overall OAAS is making steady, and in some areas rapid, progress on all strategic goals and objectives.

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

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

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

In the case of Money Follows the Person (MFP), significant process has been made in transitioning people from nursing facilities back into the community.

The new Quality Improvement Strategy was implemented in January 2012. All support coordination agencies had an initial monitoring visit and results of the monitoring will be issued in October 2012.

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 12, 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. In SFY 12, OAAS began to pursue initiatives under federal health care reform (Affordable Care Act) that have the potential to increase federal match and serve more people without additional commitment of state general revenue.

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

There is one area where OAAS is experiencing a lack of progress.

This area is related to the strategic goal, “to expand existing and develop additional community-based services as an alternative to institutional care.” OAAS has requested approval from CMS to implement a 1915 (k) state plan Long Term Personal Care Services program. The external problem leading to this lack of progress appears to be an expansive CMS interpretation of program eligibility which would expand costs and would not be feasible. This is a position which OAAS regards as unjustified and untenable given that the CMS interpretation of program eligibility for waivers are more narrowly defined.

- **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?

Issues with the 195 (k) are not at the level of strategic or operational planning. They are, however, addressed in the DHH business plan.

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

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

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

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

**II. What corrective actions (if any) do you recommend?****A. Problem/Issue Description**

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

**B. Corrective Actions**

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

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

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

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

- b. If not:
- Why has no action been taken regarding this recommendation?
  - What are the obstacles preventing or delaying corrective actions?
  - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

- No. If not, please explain.
- Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
  - b. How much has been expended so far?
  - c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
  - d. Will additional personnel or funds be required to implement the recommended actions? If so:
    - Provide specific figures, including proposed means of financing for any additional funds.
    - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

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

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

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

Other (please specify):

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

Yes. Proceed to Section C below.

No Skip Section C below.

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

Contact person for more information:

Name: Robin Wagner

Title: Deputy Assistant Secretary

Agency & Program: Office of Aging and Adult Services

Telephone: (225) 342-3839

E-mail: [robin.wagner@la.gov](mailto:robin.wagner@la.gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2011-2012

**Department:** Department of Health and Hospitals  
09-324 Agency Name & Schedule Number

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

**Undersecretary:** Jerry Phillips

**Executive Director:** Paige Hargrove

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

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

**A. What was achieved?**

1. Started state Trauma registry.
2. Level II Trauma Center in Central Louisiana (Rapides Regional Medical Center – Alexandria, Louisiana)
3. Completed assessment and analysis of the current percent of Louisiana acute care hospitals capable of treating acute ST Elevated Myocardial Infarction (STEMI) patients and the assessment of the current percent of Louisiana pre-hospital (EMS) provider who have systems in place to provide early identification and appropriate triage of STEMI patients.
4. MOU with ESF-8 for LERN to serve as the primary coordinating entity for messaging and notifications regarding events and incidents as they occur.
5. In coordination with Louisiana Ambulance Alliance, we began implementation of the Rural Health Information Technology Network Development Grant.
6. Successfully collaborated with Region 1 hospitals to obtain 100% hospital participation with LERN.

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

1. Data is being entered and compiled regarding trauma care and four of the trauma centers in the state (three of which are verified by ACS). A registry is a

- necessary step towards the development of a trauma system for the state.
2. Prior to Rapides achieving Level II Trauma Center Designation there were only two verified trauma centers in the state – New Orleans and Shreveport with a huge gap in trauma care coverage. Rapides Regional Medical Center covers a major portion of the state including the I-49 corridor and allows for patients to travel a shorter distance for trauma care in a timely fashion. The services and requirements of a verified trauma center have a direct affect in decreasing mortality and morbidity of the injured. This also affects those most frequently injured (ages 1-44) and allows them to return to normal life activities and allows them to re-enter the workforce. Louisiana has the 6th highest mortality rate from injury in the nation. Trauma centers will help to change this statistic in a favorable manner.
  3. This assessment provided baseline data essential to reaching the outcome goal of developing a statewide system of STEMI care to improve outcomes for Louisiana citizens regardless of where they live in the state. STEMI is a time-critical illness resulting from complete closure of a majority coronary artery, and causes significant morbidity and mortality. Research shows that systems of care for treatment of STEMI decrease morbidity and mortality.
  4. Integration of LERN with ESF-8 is outlined in our enabling Legislation. As a 24 hour a day/365 day a year communications center resource, this MOU between LERN and ESF-8 obligates LERN to serve 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.
  5. EMS providers who participate in this grant are required to enter data into the State EMS Registry. The registry data, when fully developed; will serve to improve care and outcomes for patients afflicted with time sensitive illness (trauma, stroke, STEMI). This was the first step towards a comprehensive EMS registry.
  6. A functioning trauma system is an inclusive system that utilizes the resources of the most critical hospitals – adding the resource rich hospitals to the LERN network of participating providers moves us in the direction of an inclusive system.

#### C. Who benefits and how?

1. The citizens of the State of Louisiana and any visitors to the State because trauma centers and a trauma system have a direct correlation to improved care. The registry is the mechanism used to evaluate care provided and improve performance.
2. Anyone who sustains a significant injury within the state. The LERN Medical Director provided strategic oversight of the development of Rapides Regional Medical Center’s Trauma Program. This was accomplished via multiple conversations, multiple on sight visits and assistance with the requirements needed to meet trauma center designation/verification. These requirements include the development of a performance improvement program, physician call

coverage, activation levels, CME requirements and surgeon response to the ED. The LERN Medical Director is a reviewer for the American College of Surgeons trauma center verification program (VRC) and a past chairman of the VRC. Louisiana statute requires ACS verification for state designation as a trauma center. He performed a mock survey at Rapides Regional to enable them to be successful in their actual review. This mock survey identified areas where improvement was needed. By addressing the identified weaknesses prior to the ACS survey, Rapides was able to achieve trauma center verification. The LERN Medical Director continues to provide support, leadership and consultation as needed by their program.

3. 5% of all EMS calls for chest pain will be STEMI. LaHIDD data for hospital discharges in 2010 indicate 2,752 patients discharged with a diagnosis of STEMI with total charges of approximately \$202 million.
4. As LERN continues its development, it is the citizens of the state that benefit. Early notification in relation to disaster preparedness or in response to a mass causality event results in a coordinated response and better outcomes.
5. As LERN continues its development of the EMS Registry, it is the citizens of the state that benefit.
6. The citizens of Louisiana who live or visit the catchment area served by Region 1 hospitals.

D. How was the accomplishment achieved?

1. Multiple conversations with current verified trauma centers and potential trauma centers. Dialogue regarding the necessity of a trauma registry to achieve our legislative mandate to develop a trauma system. Verified trauma centers must submit data to the NTDB (National Trauma Data Bank). Louisiana's data dictionary was built to match the NTDB standard data dictionary.
2. Yes- The goal is for 9 trauma centers regionally dispersed across the state. This brings us one step closer our goal.
3. The successful assessment was achieved by distribution of a STEMI survey to all hospitals and EMS providers in the state. This was facilitated by the LERN Tri-Regional Coordinators through the cooperation of the 9 LERN Regional Commissions. Dr. Murtuza Ali led the state STEMI workgroup. Tri-Regional Coordinators compiled the data. Dr. Ali provided that analytics and STEMI report which outlined recommendations and next steps that Louisiana should take in its endeavor to build the state STEMI network.
4. Coordination between ESF-8 leadership and LERN leadership. Training of LERN staff with multiple mass causality regional drills to ensure competence.
5. Through collaboration between the Louisiana Rural Ambulance Alliance, LERN and EMS providers.
6. Collaboration and active listening to key stakeholders in Region One which resulted in negotiating alternative language in the LERN. Hospital Participation Agreements. These changes met the key objective of LERN and the Metropolitan Hospital District.

- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)  
Yes
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
1. Yes - In any system whereby you endeavor to improve performance you must have a data bank to benchmark performance.
  2. Yes
  3. Yes, It is a good example of engaging stakeholders to accomplish a defined goal.
  4. Yes- leveraging assets between DHH agencies provides efficiencies without duplication of service.
  5. Yes – Collaboration with agencies or groups who have common missions and objectives whether the agency/group is a private entity or part of state government can result in efficiencies without duplication of services.
  6. Yes

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

- ♦ **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?  
Utilizing the Best Practices Research conducted and the American College of Surgeons' Consultative visit recommendations strategic priorities were established by the LERN Board. A whitepaper outlining strategy for the development of an ideal trauma system for the state was developed. The trauma registry was started and now has over 7,000 patient records in the database. The Communications Center's continue to be a valuable asset for the State of La. LERN has continued to support the movement of patients to the most appropriate facility for definitive care with over 14,000 patients lives impacted fiscal year 2012. We are on target to route 15,810 patients to the definitive care resource for FY13.
- ♦ **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

1. To what do you attribute this success? For example:
  - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?  
Progress continues due to external factors. Contracting with subject matter experts continues to augment the effectiveness of the LERN staff. LERN continues to collaborate with local, regional and state level stakeholders to continue to build the Statewide trauma & time sensitive illness network. Subject matter experts in Trauma Data Systems and the development of the Trauma Registry were instrumental in making progress. The same results would not have been achieved without specific departmental action.
  - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new 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. Rapides Regional Medical Center openly reports that the LERN Medical Director's guidance and assistance in preparation for their site visit from the American College of Surgeons was critical to their successful verification as a level 2 trauma center. Changing the job description of the Administrative Director allowed for hiring of a staff member who could implement the state trauma registry. Formally signing an MOU with ESF-8 helped to clearly define LERN's role in disaster management – we allocated the communication center resources to this initiative. Aligning with ESF-8 improves service delivery for incident notification and ESF-8 application support. The STEMI workgroup survey, analysis and final report was completed by a group of volunteers led a LERN commission member and a LERN tri-regional coordinator. We initiated a new One Call policy for the Communication Centers which has resulted in increased EMS provider satisfaction and thus increase in call center volume.
  - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?  
Specific department actions have directly related to the success of LERN. Examples include: DHH Human Resources assistance with the hiring of an Executive Director and replacing the Administrative Director. ORM assisted LERN in obtaining a certificate of insurance which was required by a business associate prior to signing the BAA. This was instrumental in obtaining data for the trauma registry. Assistance from DHH and DoA with budget and funding challenges.
  - Other? Please specify.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

There continues to be forward progress with the Communications Center strategy. The implementation of the One Call process has significantly increased call volume but the increase has stabilized to a consistent pace. The trauma registry data was obtained from the four hospitals that currently have hospital trauma registries. Without legislation mandating submission of data I do not see additional hospitals submitting data to the registry. Trauma Network = Standing up trauma centers takes time. It requires a significant resource and infrastructure investment from hospitals. We are currently working with three hospitals to become trauma centers. We expect to have an additional level 2 trauma center in the state within the coming year.

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

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

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

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

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 the LERN management finds alternative funding.

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

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

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

No. If not, why not?

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

LERN hired a new Executive Director in December of 2011. The strategic plan has been re-evaluated and new strategic priorities adopted by the LERN Board of Directors. Progress towards these strategic priorities will be reviewed at each LERN Board meeting, and progress to goals reviewed. Each August the Board conducts a retreat where the Strategic Plan is reviewed and the fiscal operations plan is prioritized based on budget. LERN Board Chair and the LERN Executive Director provide routine updates. Regional Commissions are informed through the Tri-Regional Nurses and the LERN Administrative & Medical Directors.

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

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

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

#### A. Problem/Issue Description

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

#### B. Corrective Actions

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

department?

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

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

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

Please discuss the following:

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

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

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

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

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

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

# Annual Management and Program Analysis Report

## Fiscal Year 2011-2012

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

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

**Undersecretary:** Jerry Phillips

**Assistant Secretary:** J.T. Lane

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

The Department of Health and Hospitals, Office of Public Health has achieved many significant performance improvements related to targeted public health imperatives that are detailed in the 2012-2016 DHH, OPH Strategic Plan and the Department of Health and Hospitals, Office of Public Health (DHH OPH), 2012 Business Plan “Leading Transformation: Our FY2012 Priorities for a Healthier Louisiana”.

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

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

#### **Implementation of the Vaccine Management Ordering Systems (VOMS)**

A critical component of the Vaccine Management Business Improvement Project is the development and introduction of a new vaccine management technology system. The Immunization Program uses the Louisiana Immunization Registry for Kids Statewide (LINKS) Vaccine Ordering Management System (VOMS). VOMS is a vaccine tracking system similar to the one used by the CDC-VTrckS. VOMS is an enterprise system unique to LINKS that replaced several legacy systems used at the Centers for Diseases Control and Prevention (CDC) that all Grantees across the country use to track the vaccine inventory.

#### **Improvements to Nurse Home-Visiting Program**

The DHH Office of Public Health, Center for Community and Preventive Health, Maternal and Child Health (MCH) Program has achieved performance improvements related to targeted public health imperatives through building foundational change for

better health outcomes, promoting independence through community-based care and managing smarter for better performance. One of the programs provided by MCH, the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, Nurse-Family Partnership (NFP) served 3,530 first time mothers and their families in SFY 2012, an increase of 271 (8%) families over SFY 2011.

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

Sanitarian Services has initiated a Lean Six Sigma (LSS) project to evaluate processes within field operations. The specific areas addressed were the Retail Food, Onsite Wastewater, and Building & Premises programs. Lean Six Sigma is a customer focused improvement methodology that is designed to increase quality while reducing waste. A detailed evaluation of work load, activities, methods, and the goals of each program within Sanitarian Services field operations was completed. Problem areas were identified and a root cause analysis was conducted. Management tools and processes were developed to address the causes of the identified problems. The project is in the Implementation Phase. The management tools and processes have been implemented to pilot groups across the state. If a statistically relevant improvement is noted in the performance of the pilot groups, the management tools and processes will be implemented throughout all regions of the state.

**Center for Environmental Health-Creating transparency of retail food establishment sanitation information**

DHH OPH Sanitarian Services personnel perform 300-point inspections on approximately 34,000 retail food establishments annually. In August of 2011, DHH OPH launched a food safety website, [www.eatsafe.la.gov](http://www.eatsafe.la.gov), which provides the public with access to sanitary inspection reports on Louisiana retail food establishments. Enhancements have been made to the website throughout the year. These enhancements include making the food inspection website more informative and user friendly; decreasing the length of time required to post a re-inspection from 7 days to 1 day; adding search functions that list all establishments within a city, zip code or parish; and adding a predictive search field to make it easier for the viewing public to find establishments on the website.

**Tobacco Control Program**

Through the Schools Putting Prevention to Work (SPPW) program, comprehensive school wellness policies were implemented in 25 of the 70 school districts in LA. These 25 school districts are the first in Louisiana to have a comprehensive wellness policy that includes a tobacco policy. The comprehensive school wellness policy includes policies for healthy eating, increased physical activity, and a tobacco free campus. In addition, significant progress has been made in increasing the number of pregnant women who are current smokers that have called the Quitline. In SFY 2011-2012, the number of women utilizing the Quitline increased by over 100% resulting in over 150 pregnant women utilizing cessation services via the Louisiana Tobacco Quitline.

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

The DHH Center for Vital Records and Statistics implemented the Louisiana Electronic Event Registration System (LEERS). LEERS is a multi-year endeavor to re-engineer the issuance and registration processes of Louisiana Vital Records. LEERS streamlines the registration of vital events by replacing the inefficient and outdated DOS-based and manual system that relied on paper vital event records. The new application improves the data quality and the timeliness that vital event data is collected and accessible. The Induced Termination of Pregnancy (ITOP), Divorce, Marriage, Death and Fetal Death Modules of LEERS were implemented during Fiscal Year 2012. Implementation of these modules required thorough testing by Vital Records personnel as well as external users.

**Center for Community Preparedness-Strategic National Stockpile Program Perfect Score in Preparedness**

The Strategic National Stockpile (SNS) is a federal program that serves as the United States' national repository of medications, vaccines, medical supplies and equipment. In the event of a national emergency, the SNS has the capability to supplement and re-supply local health authorities that may be overwhelmed by the crisis, with a response time of as little as 12 hours. The SNS is jointly run by the Centers for Disease Control and Prevention (CDC) and the Department of Homeland Security. Annually, states are assessed on their ability to manage and receive SNS assets in an effort to ensure maximum preparedness for a public health event. Louisiana has scored a 100% for the past two (2) fiscal years on the assessment.

**Center for Community Preparedness- Louisiana Embarks on Project Public Health Ready Accreditation**

In September 2012, the Louisiana Office of Public Health (OPH) successfully completed a year-long process of developing state-sponsored applications to the National Association of County and City Health Officials (NACCHO) Project Public Health Ready (PPHR). This national competency-based training and recognition program assesses preparedness and assists health departments to respond to emergencies.

B. Why is this success significant?

**Implementation of the Vaccine Management Ordering Systems (VOMS)**

VOMS provides visibility of the vaccine inventories held at the individual provider level. It helps OPH understand how dollars associated with this program are being spent statewide as it provides OPH with management capabilities and assessment tools for the approximately \$80 million dollars associated with the Vaccines For Children (VFC) and Section 317 grantee funded programs.

**Improvements to Nurse Home-Visiting Program**

The NFP is recognized through rigorous research and meta-analysis (Home Visiting Evidence of Effectiveness Review, Executive Summary, October, 2011, ACF-OPRE, [http://homvee.acf.hhs.gov/HomVEE\\_ExecutiveSummary\\_Rev10-15-2011.pdf](http://homvee.acf.hhs.gov/HomVEE_ExecutiveSummary_Rev10-15-2011.pdf)) as the

most effective, evidence based early childhood home visiting program model, with major goals of improving pregnancy outcomes, child health and development and families' economic self-sufficiency. The positive outcomes of the program are being realized by more families and communities as NFP services are increased and expanded.

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

The LSS project has allowed Sanitarian Services to conduct a thorough analysis of the Field Sanitarian program and to identify areas for improvement. The Field Sanitarians maintain primary responsibility for the regulation of food safety and the application of the Sanitary Code. The LSS project has led to the development of management tools and processes that will assist Sanitarian Services in maximizing the number of inspections that can be provided in Louisiana. These tools and processes allow management to see what inspections need to be completed and assist with prioritizing the daily activities in each Parish. This will ultimately better protect the public by ensuring that more inspections are completed on an established routine basis.

#### **Creating transparency of retail food establishment sanitation information**

The EatSafe website provides access to retail food inspections in an easily accessible manner for the general public. The new food safety website provides information that enables residents to make informed decisions about where they eat.

#### **Louisiana Tobacco Control Program**

The 25 school districts that have adopted a comprehensive school wellness policy have set the standard for all other schools districts to make wellness a priority for their school districts. These districts understand the need for wellness policies to combat the obesity and smoking epidemics that are present in our state. According to the Pregnancy Risk Assessment Monitoring System (PRAMS) data, for the period 2000–2005, Louisiana showed increases in the prevalence of smoking before, during, and after pregnancy. During the study period, smoking during pregnancy (combined estimate) increased significantly for Louisiana from 13.7% to 18.9%, the percentage of smokers who quit smoking during pregnancy decreased significantly for Louisiana from 44.2% to 37.1% and the prevalence of smoking after delivery increased significantly for Louisiana from 18.7% to 23.4%. Also according to the CDC report on state-specific prevalence of smoking and attempts to quit among women of reproductive age, based on data from the 2006 Behavioral Risk Factor Surveillance System (BRFSS), Louisiana was ranked at the bottom with lowest percentage of women (26.8%) who were ever smokers and who had quit. The trend continues to be the same as evidenced by the 2008 Screening Brief Intervention and Referral to Treatment (SBIRT) statistics for Louisiana, where 19.2% of the women enrolled into the SBIRT program used cigarettes since they were known pregnant. In view of these alarming statistics the increase in pregnant women provided counseling through the Quitline is especially important as this intervention is especially cost-effective as it results in fewer low birth-weight babies and perinatal deaths; fewer physical, cognitive, and behavioral problems during infancy and childhood; and yields important health benefits for the mother.

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

The implementation of LEERS reduced duplicative data entry while creating an easy to use interface for Vital Records personnel and external stakeholders. LEERS has improved data quality and the timeliness with which birth data is accessible for dissemination, research and analysis.

**Center for Community Preparedness-Strategic National Stockpile Program Perfect Score in Preparedness**

Success in this area is significant because it serves as a federal benchmark of a state's overall readiness for public health emergencies. Louisiana's efforts in emergency preparedness are considered best practices and have been spotlighted in CDC's *Public Health Preparedness: Strengthening the Nation's Emergency Response State by State and Trust for America's: Ready or Not? Protecting the Public from Diseases, Disasters and Bioterrorism Report*.

**Center for Community Preparedness-Louisiana Embarks on Project Public Health Ready Accreditation**

The PPHR criteria include the most current federal preparedness initiatives which are divided into three goals: all-hazard preparedness planning, workforce capacity development, and demonstration of readiness through exercises or real world response. OPH Regions 1 and 6 diligently worked with subject matter experts throughout DHH from October 2011 through September 2012 to develop strong applications for NACCHO PPHR. Recognition status will be received in January 2013. If successful, Louisiana will be among 25 other state health departments to receive such an honor.

C. Who benefits and how?

**Implementation of the Vaccine Management Ordering Systems (VOMS)**

The entire population of Louisiana benefits from VOMS by ensuring that all VFC providers are accountable for all publically purchased vaccines that are provided to them.

**Improvements to Nurse Home-Visiting Program**

Through intense, standardized, yet flexible, home visitation and a trusting home visitor-family relationship, long-lasting, multi-generational change is accomplished-benefiting families, the community and the state. Nurse-Family Partnership is a voluntary program serving first-time, Medicaid eligible pregnant women and the program continues until the child's second birthday.

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

Residents and visitors benefit from the food safety website by having access to updated, online information regarding retail food establishment inspections that potentially

impact their lives on a daily basis. Individuals can make informed decisions about what they eat and also help to prevent foodborne illness.

### **Louisiana Tobacco Control Program**

The focused efforts of the Louisiana Tobacco Control Program (LTCP) in the school districts have had a direct benefit on the students, school faculty and staff, and visitors. As a result of this achievement, SPPW schools have been scheduling physical activity breaks into their academic day and after-school programming; they have been modifying cafeteria recipes/menus, vending selections, classroom snacks and fundraising activities; they have established tobacco free campuses and extended this to off-campus school events. SPPW has positioned school districts for long-term support of healthy behaviors. Students are motivated to select healthier food items and these options are now available at their school. Teachers and administrators are recognizing the value of time spent in physical activity and they are making the time for activities available for their students. Parents want more information on obesity prevention and are volunteering to help promote/maintain healthier campus environments. Tobacco is becoming less conventional at all school sponsored events. And each district has made plans for sustaining or increasing, over time, the improvements made to school environments.

Efforts of the LTCP have also targeted pregnant woman who smoke. Pregnant women who smoke were exposed to messages regarding the harmful effects that smoking has on their unborn child. These women were then empowered to call the Quitline to utilize the services offered to them. This media campaign also empowered the general population to call the Quitline for services as an increase in overall call volume was also experienced over this time period.

### **Improving outdated and inefficient processes in Vital Records and Statistics**

The implementation of LEERS benefits Louisiana residents and visitors, native Louisianans who now reside outside of the state, hospitals, Vital Records issuance offices and the Vital Records Main Office. Internal program areas and external stakeholders that rely on Vital Records birth data to develop policy and target strategies to improve health outcomes, such as Maternal and Child Health and Birth Outcomes, benefit from the implementation of these modules. Any consumer of data regarding marriage and ITOP cases is now able to access this data much more quickly and accurately. Local officials are able to submit statutorily-required marriage information more quickly and have been given the option to issue marriage licenses directly from LEERS.

### **Center for Community Preparedness**

The SNS program and the PPHR accreditation benefit the state's 4,574,836 citizens as well as visitors, businesses, and community partners. These efforts were geared to ensure the ultimate preparedness and resiliency of the entire state. Since Hurricanes Katrina and Rita, the state has made significant improvements in its preparedness and response efforts. As a result of these efforts, many Louisiana communities are more resilient and better prepared for emergency events.

D. How was the accomplishment achieved?

**Implementation of the Vaccine Management Ordering Systems (VOMS)**

The LINKS registry was used as the cornerstone for the VOMS implementation. This process began with a pilot back in June 2010, and was successfully rolled out and completed in December 2011 with all of OPH's active Vaccines for Children (VFC) provider practices. This represents training of approximately 700+ VFC sites and over 2,500 physicians, nurses, hospitals and other caregivers that are enrolled in the VFC Program. The VOMS training was conducted by nine (9) regional Immunization Consultants.

**Improvements to Nurse Home-Visiting Program**

The increase in number of families served was a function of at least two factors:

1. An increase in MIECHV program grant which was awarded to Louisiana in FFY 2010 allowed for expansion of NFP in at-risk parishes.
2. An internal programmatic system of communication of clear personnel and contract expectations and rigorous monitoring and feedback was instituted to help ensure optimal caseload and completed visit counts. These processes are components of the continuous quality assurance and improvement system that the Louisiana MIECHV leadership has implemented.

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

The LSS project required a thorough analysis of the activities occurring in Sanitarian Services. This analysis gave the Center for Environmental Health Leadership the opportunity to identify areas for improvement. After completing a thorough root cause analysis management tools and processes were developed and implemented to address the areas targeted for improvement.

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

The inspection process is an evaluation of the requirements addressed in Title 51, Public Health Sanitary Code, Part XXIII, Retail Food Establishments. Informing the public of the new website was accomplished through a DHH media event. Links to the website are provided on the DHH website as well as the Retail Food Program site, and DHH's Media and Communications sent out a news release for newspaper and television media. 56,966 people have logged on to the Eat Safe Website since the launch on August 8<sup>th</sup>, 2011 until June 30, 2012.

**Louisiana Tobacco Control Program**

In Louisiana, the ARRA/CPPW State and Territory Initiative's Statewide Policy and Environmental Change project took the form of School-Based Prevention under School Wellness Policies, and was renamed Schools Putting Prevention to Work (SPPW). This project was a partnership of the Louisiana Tobacco Control Program (LTCP), the Louisiana School Boards Association (LSBA), and the Department of Education,

designed to institutionalize healthy behaviors related to obesity control, nutrition, physical activity, and tobacco control and prevention. SPPW provided the technical assistance and a \$17,000 mini-grant to 27 of Louisiana's 69 school districts to draft, implement, and sustain a comprehensive district-wide school wellness policy that supports 100% tobacco-free schools, healthy eating, and active living/physical activity. LTCP has used a radio campaign targeted at pregnant women who smoke to increase awareness of the FREE Quitline services that are available to them. All pregnant women who smoke regardless of income are eligible for 10 FREE personalized counseling sessions with the Louisiana Tobacco Quitline. The media campaign consisted of a 60 second radio spot designed to educate pregnant women on the harmful effects of smoking during pregnancy, and to refer them to the Quitline for support and help. Media campaign messages were developed through focus groups of pregnant women who presented at the SBIRT clinics statewide.

### **Vital Records and Statistics**

LEERS was implemented through rigorous testing and preparation of external stakeholders. Field representatives ensured that users were prepared for the launch of the new system, and were available for support in the months following launch.

### **Center for Community Preparedness**

The accomplishments of the Center for Community Preparedness were achieved through collaboration with agency officials, community partners and stakeholders. Partners include, but are not limited to, the Hospital Community, Louisiana State Police, Louisiana National Guard, Louisiana Department of Agriculture, Louisiana Governor's Office of Homeland Security and Emergency Preparedness, Department of Transportation, Emergency Medical Services, Regional/Local Fire Departments, volunteers, faith-based community, etc. The state relies heavy on these relationships to leverage emergency preparedness resources.

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

Yes. The activities engaged in by the Office of Public Health support the strategic priorities and objectives of the agency.

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

Public Health has used technology to improve service delivery, streamline processes, and replace outdated and inefficient systems in the Center for Vital Records and Statistics. 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).

### **Implementation of the Vaccine Management Ordering Systems (VOMS)**

One of the primary goals of VOMS is to allow OPH to independently and uniquely manage providers. At the provider level, VOMS bridges a necessary gap by providing vaccine ordering and order status capabilities. As such, it requires all VFC providers to place their orders using LINKS. Orders are approved based on their usage and inventories on hand.

### **Improvements to Nurse Home-Visiting Program**

The MCH-MIECHV leadership team and staff use systematic continuous quality assurance and improvement (CQI) approaches identified by the American Society of Quality, the Institute of Healthcare Improvement, and the quality aims listed by the Institute of Medicine and the U.S. Public Health Quality Forum to guide its clinical work and business operations. Using data to identify priority areas, drivers are identified; intervention strategies are developed and presented; and outcomes are tracked and trended. Louisiana utilizes the Plan, Do, Study, Act (PDSA) technique within its overall CQI, allowing rapid change, as needed. The PDSA (aka, The Shewhart Cycle - The Deming Wheel) includes the following basic steps:

- **Plan:** Develop a plan for improving quality of a process;
- **Do:** Execute the plan, first on a small scale;
- **Study:** Evaluate feedback to confirm or adjust the plan;
- **Act:** Make the plan permanent or study the adjustments.

The MIECHV CQI plan focuses on client interactions, program implementation and outcome achievement; developing a standardized plan model; and using internal OPH-MCH tools and reports to assist in determining the quality improvement needs.

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

Lean Six Sigma is an established improvement methodology that has been used in many industries including production, manufacturing, and healthcare.

### **Louisiana Tobacco Control Program**

The SPPW approach has created a promising practice for future work with school districts. As designed and implemented, SPPW is effective. The SPPW approach is relevant and appropriate for use by all Louisiana's public school districts. The SPPW model can likely be successfully applied to public school districts throughout the country.

The radio campaign and approach to cessation is now being explored by the Birth Outcomes Initiative within the Office of the Secretary for further expansion. LTCP is partnering with BOI to discuss possible reruns of this campaign in the future due to the high success rate.

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

Electronic processing of data represents the elimination of redundant, labor intensive data entry while increasing the quality and reliability of the data.

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

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

As outlined in the DHH Business Plan, “Leading Transformation: Our FY2012 Priorities for a Healthier Louisiana”, OPH is “focused on building foundational change for better health outcomes” through efforts aimed at integrating public health and primary care, and “managing smarter for better performance” through the implementation of the Louisiana Electronic Event Registration System (LEERS) and the implementation of Eat Safe Louisiana.

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

OPH has continued to make great strides in meeting the goals and objectives outlined in the OPH Strategic Plan and the DHH 2011-2012 Business Plan and in establishing the foundation for improving health outcomes for the citizens of Louisiana. Some of the highlights include:

- Eat Safe Louisiana was implemented in August of 2011
- Provider agreements have been executed with the Coordinated Care Networks
- A healthcare access resource assessment was completed in 36 parishes
- The LEERS ITOP, Divorce, Marriage, Fetal Death and Death Modules have been implemented

- ♦ **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.
  -

#### **Implementation of the Vaccine Management Ordering Systems (VOMS)**

The LINKS VOMS application is operated by the State of Louisiana Immunization Program. Without program involvement, this success would not have been achieved. OPH continues to support not only the LINKS system, but all of its applications in order to ensure that better management of publicly-funded vaccine orders and distribution are conducted more effectively. The modifications and upgrades to the LINKS system ensure vaccine accountability. The administrative and management processes that followed were the result of the dedication and efforts of the Immunization Program staff. The benefits of using the LINKS VOMS application are long lasting because it provides the Louisiana Immunization Program a better method to manage publicly funded vaccine orders and its distribution. It also demonstrates the versatility and expanded capabilities of a statewide system.

#### **Improvements to Nurse Home-Visiting Program**

The successful implementation and progress of the MIECHV-NFP program is largely related to CQI activities. Rigorous CQI activities have been instituted to assure that the program is providing safe, timely, effective, equitable, efficient and patient-centered care (Institute of Medicine (2001), *Crossing the quality chasm*. Washington, DC: National Academies Press. Retrieved January 17, 2010, from [http://www.nap.edu/openbook.php?record\\_id=10027&page=40](http://www.nap.edu/openbook.php?record_id=10027&page=40)).

- The additional resources garnered for MIECHV grant program have begun the process of careful study of the business operations of the program. Local clerical staff additions have allowed home visitors and supervisors to concentrate on the business of home visiting and reflective supervision—all components of the OPH strategic plan. Use of technology via DHH SharePoint for internal monthly reporting and for sharing of policies and

procedures has increased efficiency for the direct service personnel and leadership team. In addition, efficiencies are being realized through use of webinars and “virtual” team meetings.

- The gains in program reach, efficiency and quality will continue at a manageable, planful pace. The MIECHV 2011 expansion grant will offer an opportunity for OPH-MCH to continue with collaborative efforts to expand, strengthen, enhance and sustain effective prenatal and early childhood home visiting services in areas of the state that are at-risk in terms of health and social problems. Additional low income, first time pregnant women, their children and families will benefit from NFP, with the plans to increase capacity of NFP to 20% of eligible women. The grant will fund resources for further collaboration with Louisiana’s designated State Advisory Council on Early Childhood Education and Care to study the feasibility of and make recommendations for use of evidence-based home visitation programs to complement NFP in Louisiana, including the study of necessary infrastructure for the complementary home visitation model(s). The additional, complimentary model(s) and associated infrastructure will increase the reach of effective early childhood home visiting services to even more of Louisiana’s families. The grant program will support and evaluate the Infant Mental Health (IMH) Consultant augmentation and the Community Relations/Outreach augmentation of the NFP model and allow for expansion of the IMH and community relations/outreach components to more NFP teams, pending evaluation results. The expansion grant will also allow for increased OPH-MCH epidemiological capacity for performance measurement, programmatic implementation and quality improvement. The professional development of all personnel within Louisiana’s systems that serve early childhood population will be fostered by grant activities as well. Business operations will be improved by conducting a business operations assessment that will focus on the contracting structure, efficiency of program operations, optimal reimbursement, and maximal use of home visiting national service office resources. OPH-MCH has begun the exploration of additional Medicaid reimbursement and funding via private/public partnerships for MIECHV and effective augmentation(s).

### **Center for Community Preparedness**

Louisiana’s emergency preparedness efforts contribute to the overall success of the agency’s core function of emergency preparedness. Louisiana’s efforts in emergency preparedness are considered best practices and have been spotlighted in CDC’s *Public Health Preparedness: Strengthening the Nation’s Emergency Response State by State and Trust for America’s: Ready or Not? Protecting the Public from Diseases, Disasters and Bioterrorism Report*. The department’s all-hazards preparedness approach to disasters has been tested through many exercises and real-world events. Once tested, the agency reviews, reevaluates and updates plans according to those lessons learned and national standards. This process has proven effective in moving the state towards being a leader in emergency preparedness planning and response.

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

The success of this project is due to the use of an established improvement methodology, a very dedicated team of individuals, and leadership support. The full benefits of this project will be realized when it is completed. The proven management tools and processes will be implemented throughout the state.

### **Louisiana Tobacco Control Program**

OPH is continuing to build and strengthen the partnership between the Louisiana Tobacco Control Program (LTCP) and the Birth Outcomes Initiative (BOI). This success is due to common goals shared, great leadership, dedicated staff, and a need to address this disparity for the state of Louisiana. Pregnant women who smoke are a priority population for the LTCP and also BIO. Statistics show the high smoking prevalence among this population and in order to impact this group a partnership between these two programs was a must. The Louisiana Health Assessment Referral and Treatment (LaHart) tool will be the vehicle of change to address smoking status among pregnant women. Progress has already been made to connect physicians who engage with this population to connect the smoking pregnant woman with the FREE resources that the Quitline offers them. An electronic referral system is being tested currently with the LaHart tool which will allow participating providers to be electronically connected to the Quitline via an FTP process. This will enable the patients to be proactively contacted by the Quitline to begin setting up their personalized counseling sessions. This partnership will continue to grow stronger with plans to run a joint media campaign targeted at pregnant women and to develop education materials with input from both organizations. In order for Louisiana to move out of the top 3 list for smoking during pregnancy this partnership will have to continue to prosper. Both programs have been engaged in searching for other grant opportunities in order to enhance cessation services to pregnant women.

### **Vital Records and Statistics**

Vital Records is on target with completing the objectives identified in the 2012 Business Plan. In SFY 2011-2012 the ITOP, Divorce, Marriage, Fetal Death and Death Modules were implemented. Partners have adapted to the new system, and input was gathered to improve the system via a system upgrade early in FY13.

- ◆ **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?

OPH is not currently experiencing a significant lack of progress on the objectives identified in the SFY 2012-2016 OPH Strategic Plan or the SFY 2012 DHH Business Transformation Plan.

### **Improvements to Nurse Home-Visiting Program**

OPH-MCH is not experiencing significant lack of progress with MIECHV. However, key infrastructure positions are needed to sustain and continue the quality of the implementation (i.e. state nurse consultant) and overall executive hiring freezes are delaying the hiring/replacement of key vacancies. In addition, Center leadership is recognizing that a clearer line structure of MIECHV staff from the Program Leadership to the direct staff may be more efficient in terms of accountability, responsibility and authority. A standardized contracting structure (as mentioned above) will add to business efficiency, as well.

- ♦ **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.

The OPH Strategic Plan is reviewed and updated on an annual basis. The plan is evaluated to ensure that it reflects the current strategic management imperatives. DHH Offices are required to develop a business plan that contributes to the department mission to improve and protect the health of Louisianans. Each plan is evaluated by the Secretary at mid-year and year-end to track and assess each office's progress in meeting the identified goals and objectives. Offices provide information on their respective plans including their successes, challenges, and provide recommended solutions to overcome

any issues that have been identified. Corrective actions from mid-year and year-end evaluations are incorporated into the Offices plans.

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

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

**A. Problem/Issue Description**

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

Although the Office of Public Health has continued to make progress toward meeting the agency’s goals and objectives, there are issues that prohibit the agency from completing the required activities in an efficient and timely manner. Some programs are using outdated information technology systems that lead to challenges with accessing and utilizing data and providing user friendly interfaces. The process for contracting can be lengthy and cumbersome and result in a delay in executing the contract. Moving toward electronic submissions rather than paper based could improve efficiencies. The Office notes that greater collaboration between DHH Human Resources (HR) and Louisiana Civil Services could result in improved HR processes. An adequate inventory/property control system would allow for better tracking of property resulting in less financial loss.

**B. Corrective Actions**

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

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

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

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

Please discuss the following:

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

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

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

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

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

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

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

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

# **Annual Management and Program Analysis Report**

## **Fiscal Year 2011-2012**

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

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

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

**Assistant Secretary:** **Anthony Speier**

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

The Office of Behavioral Health (OBH), in adherence to the OBH Business Plan, achieved three major accomplishments during the fiscal year under review: (1) implementation of the Louisiana Behavioral Health Partnership (LBHP), (2) implementation of the Coordinated System of Care (CSoC) within the LBHP, and (3) integrating behavioral health business practices and treatment approaches in transforming the state's behavioral health care system. Additionally, OBH Strategic Plan specifically develop the Hospital-based alternative and successfully completed two additional strategies: Consolidation of Services, and maintaining substantial compliance with the requirements of the federal consent decree relative to the Eastern Louisiana Mental Health System. All of these successful actions were part of the OBH strategic plan that incorporated Secretary Bruce D. Greenstein's business plan priorities. The goals of the strategic plan were accomplished through a systematic approach to implementing the administrative and programmatic goals established for the year by the Department of Health and Hospitals.

#### **Accomplishment #1: Implementation of the Louisiana Behavioral Health Partnership (LBHP)**

**A.** What was achieved?

OBH successfully launched both the Louisiana Behavioral Health Partnership (LBHP) and the Coordinated System of Care (CSoC) programs on March 1, 2012.

Launch of the Behavioral Health Partnership (LBHP) and the Coordinated System of Care (CSoC) programs, March 1<sup>st</sup>, 2012. These programs were created under the auspices of 1915(b) of the federal SSA – umbrella waiver /Act 384 of the 2009 Legislative Session implementing the LBHP as well as an amendment to R.S. 40:2017(B) to permit the state to establish an ASO for all behavioral health services; and 1915(c) of the federal SSA / Order BJ 2011 - 5. CSoC services for children.

A request for proposals (RFP) was advertised for the services a Statewide Management Organization (SMO) for most state-provided behavioral health services (to include both mental health and substance use disorder treatment). A review of all submitted proposals occurred and a successful contractor was selected. A contract was signed with Magellan Health Services, Inc., in November of 2011. On March 1, 2012, Magellan Health Services, Inc. began providing services as the SMO for the Louisiana Behavioral Health Partnership. It serves as the managed care entity (MCE) for all public Medicaid and non-Medicaid inpatient and outpatient behavioral health services in the state. Implementation of the LBHP through the SMO allowed for a single access point for a broader array of behavioral health care services.

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

Implementation of the LBHP represents the first time in the history of the state that all behavioral health services for both children and adults were organized under one MCE. It creates a comprehensive continuum of care for adults with severe mental illness (SMI) and children/adolescents with severe emotional disorders (SED). The LBHP includes a specialized set of services dedicated to those children/adolescents who are or most at risk of imminent out-of-home placement. These services are provided through the Coordinated System of Care (CSoC). It involves the use of multiple Medicaid waivers that increased the numbers and types of services that can be provided and also increased the number of provider types who can provide services within the LBHP. The CSoC program allows the state to leverage additional Medicaid funding through combining state resources from those agencies that typically provide services to this population. It will also allow for the management of resources to prevent over utilization of expense inpatient services, and expand the use of more cost-effective outpatient, community-based services. Finally, having a single MCE allows the state to collect data across all settings, and the ability to better monitor the effectiveness of behavioral health services.

**C. Who benefits and how?**

All persons served by the LBHP will benefit. Both adults and children/youth

with behavioral health needs will have increased access to an expanded array of services that include legacy rehabilitation services; services by licensed clinicians; crisis services; residential services for children/adolescents; inpatient services; and substance abuse services, including residential levels of care for members with substance abuse needs. In addition, the LBHP will expand the number and type array of service providers to include psychiatrists, psychologists, medical psychologists, advanced practice nurses, licensed social workers, licensed professional counselors, licensed marriage and family therapists, and licensed addiction counselors. Managed care is designed to provide members with both timely and appropriate care based on their individual behavioral health needs. It is designed to minimize the use of more restrictive and costly services such as emergency department care; hospitalizations, and provide greater access to community-based services that may be more convenient for member.. The managed care system implemented by the state is further intended to offer more robust support for children/adolescents in the community and greater participation from both member families and support services.

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

This accomplishment was achieved through the collaborative effort between multiple state agencies, stakeholder groups and the employ of national consultants experienced in the implementation of managed health care. In particular, the coordinated efforts of staff within the Bureau of Health Services Financing (BHSF), national consultant Mercer, and state agencies including the Office of Behavioral Health (OBH), the Department of Children and Family Services (DCFS), the Office of Juvenile Justice ( OJJ) and the Department of Education (DOE). All parties contributed to the development of the RFP solicitation for a statewide management organization, the plan for implementation of CSoC, review of proposals, constructing the final contract; and fostering the necessary collaboration between OBH, BHSF, OJJ, DCFS, DOE, and the selected statewide management organization, Magellan Health Services, Inc. Oversight of the implementation of LBHP was provided by multiple agencies including BHSF, the aforementioned partner state agencies, and the OBH executive management and contract monitor staff. The process continues with ongoing collaboration among all the partners in LBHP.

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

Yes. The strategic plan provides for the provision of high quality behavioral health services while maximizing state resources to assure that the greatest number of members are served through employment of evidence-based practices across the spectrum of care.

**F. Does this accomplishment or its methodology represent a Best Management**

Practice that should be shared with other executive branch departments or agencies?

Yes.

## **Accomplishment #2: Implementation of the Coordinated System of Care (CSoC) for children and youth services**

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

- *The Coordinated System of Care (CSoC)* was implemented on March 1, 2012, in five regions of the state, as the start-up phase of the program. As of June 30, 2012, there are 414 children and youth were enrolled in CSoC. There is no set date for Phase II (statewide implementation, but when fully implemented CSoC, will serve 2,400 children statewide).

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

The CSoC implementation results from a multi-year collaborative planning effort between the Department of Health and Hospitals (DHH) the Department of Children and Family Services (DCFS), the Office of Juvenile Justice ( OJJ) and the Department of Education (DOE). The 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 and their families in the community. 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.

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

CSoC serves children and youth, under age 22, with either significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out-of-home placement. Children and youth with behavioral health challenges and their families will benefit from a coordinated approach to care. New behavioral health services are now available as part of the State Plan Amendments and Waivers through CSoC that were not offered under the previously fragmented systems of care. These new services include an organized planning process for young people with significant emotional and behavioral challenges, called Wraparound, that 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.

**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 goal to improve health outcomes and reduce out-of-home placements among children and youth with significant behavioral health challenges. During the planning phase, eighteen (18) stakeholder workgroups participated in designing the initial system of coordinated care. Subsequently, Governor Bobby Jindal issued Executive Order BJ-2001-5, on March 3, 2011, to formally established a policy-level Governance Board with members including leadership of DHH, DCFS, OJJ and DOE, a representative of the Governor's office, two family representatives, an advocate representative, and a youth representative. This board is charged with providing oversight to the development and implementation of the Coordinated System of Care (CSoC). Each of the four collaborating agencies (DHH, DCFS, OJJ and DOE) also assigned staff to form a unified CSoC team, housed at the headquarters building of the Office of Behavioral Health, to participate in development of the Medicaid State Plan Amendments and waivers necessary to support service development, enhancement, and support and guidance for CSoC implementation. A Request for Applications (RFA) was issued as the first step towards statewide implementation. The RFA identified five regions in Louisiana that were ready to participate in the first phase of implementation. These regions were identified based on a demonstrated strong history of service delivery, and the knowledge and skills necessary to be successful. Louisiana's implementation will launch statewide FY13.

***During FY2012:***

- The Monroe, Shreveport, Alexandria and Baton Rouge regions and Jefferson Parish were selected to participate in Phase I.
- Contracts were developed with Wraparound Agencies and a Family Support Agencies to serve the regions. Wraparound Agencies ensure that youth with complex needs benefit from a coordinated care planning process that produces a single plan of care involves all agencies and providers in providing care for the individual and family.
- An Implementation Institute was held with leadership from the selected organizations during October 2011.
- The agencies acquired space, developed policies and procedures, hired staff and contacted with the Statewide Management Organization.
- The CSoC team provided guidance and technical assistance to the WAAs and FSOs providing services in order to ensure that the appropriate certification and training requirements were completed.
- A contractual agreement with the University of Maryland, Center for Innovation and Implementation was developed to provide training and technical assistance on the implementation of the wraparound process, in accordance with standards established by the National Wraparound Initiative (NWI)

- Quarterly meetings of the CSoC Governance Board were held to review progress, provide guidance, and establish policy as needed.
- Independent assessors were trained, and over 800 children residing in out-of-home placements were assessed during February and March 2012.
- A Family Lead OBH position was added to the CSoC Team. This position
- is charged with leading efforts to promote family and youth input and voice into service design and delivery as well as advising on policy-making.
- A quality assurance process was developed in collaboration with the University of Maryland and the Wraparound Evaluation and Research Team at the University of Washington.

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

Yes, the CSoC initiative was included in the OBH Business Plan as a top priority.

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

Yes. There are several aspects of the Coordinated System of Care initiative that represent best practices from a national perspective:

1. The formation of the Governance board represents a significant accomplishment. Across the country, there are very few states that have a Governor-endorsed and -supported Coordinated System of Care initiative and policy-making Board.
2. Detailing of staff from across child-serving agencies to a unified CSoC Team represents a true innovation in the system of care field.
3. Developing a Medicaid state plan amendment 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.

### **Accomplishment #3: Integrating Behavioral Health Business Practices and Treatment Approaches**

**A.** What was achieved?

- *Funding mandates for state operated services were identified and made accessible to clinics*  
These two steps, identifying and disseminating funding mandates, were critical to implementing the new business model. Funding mandates indicate what services are required in order to receive funding for state operated services. It

was critical to understand what services were vital to receiving funding before employing changes to the business model. Included in this process of identification was the preservation of compliance with the existing mandates, e.g., block grant, Medicaid, so that existing funding streams were not impacted.

OBH engaged in the following significant actions during the fiscal year toward the accomplishment of this goal:

- State operated facilities were prepared to obtain Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation;
- All state operated facilities applied for and received Medicaid Application Center designations;
- A Request for Proposals (RFP) was completed in order to obtain a consultant to assist with adapting the business processes of OBH-operated clinics;
- Designed a list of approved evidence-based practices (EBPs) for implementation by provider organizations;
- Developed a non-Medicaid services manual that defined services not currently identified in the existing Medicaid services manual; and
- Identified protocols to integrate primary care within the current managed care delivery system.

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

The identified successes allowed for publically operated facilities to begin making the transition from government supported to self-supporting through the use of self-generated revenue.

**C. Who benefits and how?**

Consumers ultimately benefit from the changes to the new service delivery system. Public facilities are moving towards better ways of containing costs and improving operating efficiencies to improve the quality of care provided. Funding streams are more appropriately utilized through assuring that client needs are specifically matched to services. More efficient use of existing funding streams is achieved through identifying benefits through Medicaid that would have otherwise been provided care through the use of SGF resources. This action represents a significant accomplishment by expanding care to children and youth using available funding streams. An expansion of available services is designed to both target and improve individual care for those served by the program.

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

These accomplishments were achieved through introducing managed care concepts into the publically operated delivery system. The publically operated

delivery system has begun the steps necessary to transition into the new business environment.

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

Yes, a large component of OBH's strategic and business plan is creation of a managed care network in which a maximum number of provider agencies would participate. Regional and local governing entities (LGE) clinics provide a substantial portion of services to behavioral health clients. It was necessary to prepare these public clinics for a new business model adapted to managed care delivery.

**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 managed care concepts to oversee clinical delivery of services is an industry-wide standard used within other agencies. Executive departments should continuously identify the best way to effectively manage care in order to create governmental efficiencies and improve quality of services.

**Accomplishment # 4: Consolidation of Services: Developing financial efficiency while optimizing treatment.**

**A. What was achieved?**

- ***OBH consolidated the ELMHS Acute Unit on Jackson Campus/Closure of Greenwell Springs Campus . Resource re-allocation*** from institutional-based services to potential resource funding of community-based programs.

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

This action allowed the Office of Behavioral Health to provide the same amount of services by reducing administrative and physical plant expenses. The relocation of these services resulted in a reduction of 42 positions and an estimated savings of \$607,000 for fiscal year 2012 and projected savings of \$2.5m for fiscal year 2013.

**C. Who benefits and how?**

Citizens of Louisiana benefit through increased efficiency in the provision of services. Costs savings realized through this consolidation effort did not impact availability of services, but has reduced the overall cost of providing services.

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

This was achieved by conducting a cost-benefit analysis that considered the impact of consolidating existing services onto one campus with an emphasis on patient care and recovery. It was determined that excess capacity at one location could be absorbed by the relocating these services to a single location.

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

Yes. This accomplishment is consistent with the Office of Behavioral Health's goal to ensure that behavioral health services are made available to the citizens of Louisiana an efficient and responsible manner.

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

Yes. The reallocation of resources directed towards institutional settings allows for greater resources to be used in community settings.

**Accomplishment # 5: Accountability Standards-Maintaining substantial compliance with the consent decree: Best Practices****A. What was achieved?**

East Louisiana Mental Health System achieved 99.5% compliance with Federal Consent Decree (Doc 185)

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

A federal lawsuit regarding patient care was resolved by consent decree that established specific timeframes within which competency restoration activities must be completed for individuals referred from the judicial system. Competency refers to the issue of whether or not someone charged with a crime understands the court proceedings and whether or not they can participate in their own defense. Competency restoration is the process by which the hospital staff treats and/or educates the clients so that they meet requirements to be considered competent.

The successful implementation of the requirements of the consent decree by OBH is significant in that it allowed OBH to substantially improve the timeliness of competency restoration services.

**C. Who benefits and how?**

Individuals ordered to receive competency restoration services in the state forensic hospital are no longer required to remain in jail for extended periods of time awaiting placement. Currently, the time has decreased to no more than 30 days from the date of the signed court order now whereas in the past people have, on occasion, waited longer than one year.

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

Competency restoration programming and processes were reevaluated following the adoption of the consent decree, and additional resources were devoted as necessary. The changes in processes, procedures, and addition of resources has allowed for a system with increased throughput for continued compliance with the order.

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

Yes. This accomplishment is consistent with the Office of Behavioral Health's goal to provide for the timely provision of the appropriate level of care. It specifically abides by the goal and objective to provide for services to individuals involved with the court system in compliance with the consent decree ruling.

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

Not Applicable. This action is a specific corrective strategy.

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

Significant progress has been experienced in all actions outlined in the OBH Business Plan. One of the major initiatives is the Louisiana Behavioral Health Partnership. Although implementation began in the last latter part of the fiscal year, beginning March 1, 2012, there are preliminary indications from the SMO and management analysis that the project will meet strategic objectives. During a recent disaster, the SMO was able to both maintain operations and provide services for members without interruption.

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

***Louisiana Behavioral Health Partnership (LBHP)***

**Where are you making significant progress?**

Progress is being made toward the goal of providing services for 100,000 adults and 50,000 children/adolescents. From 3.1.12 to 6.30.12, Magellan reported that 54,113 members have been served.

1. To what do you attribute this success?

The results are due to the collaboration between Magellan Health Services, Inc. and all of the identified state agencies. The results would not have been realized in the current time frame without significant collaboration between all agencies.

▪ Is progress directly related to specific department actions?

Specific agency actions included reorganizing the staffing structure of the OBH central office staff to form designated implementation teams that mirrored the teams established by the SMO. These teams included CSoC, Care Management/Utilization Management, Quality Management, Member Services, Provider Services, Fiscal, IT, and Communications. These teams now form the basis for the monitoring teams necessary to audit activities of the SMO are required by the existing contract. In addition, the OBH has enlisted the services of national consultants to provide guidance on this process. In addition, the OBH is building a process for supporting the Quality Management Strategy (QMS) required by the Medicaid waivers. This includes the development of an OBH Quality Assurance Committee and an Interagency Monitoring Team (IMT).

▪ 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?

Progress towards this initiative results from the efforts of multiple agencies within DHH and other partner state agencies. Although OBH is the lead agency responsible for monitoring the contract with the SMO, OBH collaborates with BHSF, DCFS, OJJ, and DOE, as well as the national consultants, to maintain focus on the goals of the project and monitor contract deliverables. Also, the IMT comprises representatives of all of the participating state agencies and member representatives. The successful implementation of this initiative is the

result of the combined efforts of all partner agencies.

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

Since there are significant indicators of progress toward objectives since the launch of managed care on March 1, 2012, it is expected that progress will be both ongoing and evident during the term of the 3-year contract.

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

Although several areas of the project have not reached complete implementation, OBH has identified no area where a significant lack of progress can be established. In all areas where lack of immediate progress have been identified, both OBH and Magellan Health Services, Inc. have worked to establish a plan of action to address identified barriers to implementation progress.

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

***Coordinated System of Care (CSoC)***

Significant progress has been made on the implementation of the Coordinated System of Care (CSoC) which began on March 1, 2012 in five regions of the state and represents the coordinated effort of DHH, DCFS, OJJ and DOE.

1. To what do you attribute this success?

OBH was able to implement the CSoC initiative in Louisiana through Medicaid 1915(b) and (c) waivers. These waivers are available to states through the federal Center for Medicare and Medicaid Services, and allow for the provision of care in both home and community-based settings. OBH and BHSF collaborated to develop these Waivers and the accompanying Medicaid State Plan Amendments, which allowed for implementation of both CSoC and the broader Louisiana Behavioral Health Partnership. These efforts would not have been realized without the willingness of CMS to consider home and community-based options and the actions of BHSF and OBH.

- 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 who 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 implementation team and partner with the CSoC

Team at the Statewide Management Organization to ensure progress. As part of the implementation, we have offered regular training to the Wraparound Agencies (WAA) and Family Support Organizations (FSO) and provided regular technical assistance and support through scheduled conference calls including monthly WAA calls, monthly FSO calls, monthly joint (WAA and FSO calls) and bi-weekly regional calls between individual CSoC staff and representatives from each of the five implementing regions. 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 the services young people and families are referred to are those that they most need.

- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?  
Yes. As the lead for implementation of the CSoC, OBH is able to gauge success by the ability to enroll youth in the CSoC. Going forward, OBH will monitor the Quality Management Strategy which was developed as part of the b and c waivers to ensure all performance measures are met.

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

No, this is not a one-time gain development. As of June 30, 2012, a total of 414 children and youth were enrolled in CSoC. We anticipate that enrollment will continue in the five regions where CSoC is being implemented with a maximum of 1200 enrollees. In addition, a planning process has begun to inform the expansion of CSoC into the remaining areas of the state based on learning from the initial implementing regions.

- ♦ **Where are you experiencing a significant lack of progress?**  
Not applicable

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

***Integrating Behavioral Health Business Practices and Treatment Approaches***

Significant progress is being made with goals gear at transforming public clinics into more viable business operations. Clinics are improving their capacities to receive reimbursement and embrace a larger volume of client services.

**1. To what do you attribute this success?**

Success is linked to staff commitments and changing work environments seem to be the reason for the most notable changes in care delivery. These actions were made possible through the intervention of OBH system of care staff. Some of the changes include the reformulating of behavioral health care delivery rules and policies as well as the introduction of managed care and electronic health care records.

**2. Is this significant progress the result of a one-time gain?**

No. Improvements made to clinic structures will likely impact the system for years to come. Improved efficiencies and new operational strategies will continue to heavily weigh on the quality and efficiency by which care is delivered.

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

Not Applicable

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

***Consolidation and reallocation of resources-Hospitals***

Consolidation of services based on utilization analysis have resulted in improved efficiency in delivery of services.

**1. To what do you attribute this success?**

Success is based on the application of behavioral health and managed care principles resulting from evaluating the possibility of changes to the system based on current capacity at existing locations.

**2. Is this significant progress the result of a one-time gain?**

No. The savings from the one-time change are continuing savings which will be realized in each future fiscal year as the ongoing costs for providing those services are reduced.

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

Not applicable

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

**Accomplishment #4: *Accountability Standards-Maintaining substantial compliance with the consent decree: Best Practices***

OBH continues to maintain a 99.5% compliance with the federal consent decree.

**1. To what do you attribute this success?**

Systems, processes, and policies were revised to increase throughput via the competency restoration program. By moving clients within the program at a faster rate, those clients awaiting services are able to be admitted in a timelier fashion, as the turnover of beds happens at a more efficient rate.

**2. Is this significant progress the result of a one-time gain?**

No. This compliance is an on-going requirement of the federal consent decree, as to the time, it is terminated. However, the learning process and the strategic planning will continue to benefit the provision of services for this population. The specific changes that allowed for a transformation of the competency restoration program were the result of a one-time gain. However, those processes continue to be refined and retooled with the expectation of continuous improvement.

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

Not Applicable

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

Yes. OBH conducted an in-depth review of its strategic plan to ensure that it reflects current environmental, programmatic and fiscal configurations. As a result of this review, the strategic plan was revised to reflect a new mission, vision and goals. The OBH strategic plan embraces DHH Secretary Bruce D. Greenstein's FY12 priorities and follows his lead toward the transformation of health care in Louisiana. The revised plan contemplates a integrate service provision, performance accountability, and partnership with private providers as a means to enhance treatment services while containing costs. To that end, OBH's new strategic plan incorporates safety net function, but primarily as monitor of SMO compliance with contract requirements. OBH will amend the contractual agreement to improve standards and performance outcomes, as necessary.

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

The formulation of the OBH strategic plan will adhere to management strategies implemented by the Executive Team (Health Plan Management, Administration, Adult, Child and Family Operations). These strategies, at a

minimum, will 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 level of the agency's functional areas. Focus groups are conducted with Team Leaders and participants representing functional areas essential to support agency priorities to generate a draft of the plan.
- **Communication:** Receiving and sending information at the central office and the regional and 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? What corrective actions (if any) do you recommend?**

There is no significant department management or operational problems/issues, identified at the present time. OBH is currently engaged in a dynamic process of developing and fostering the Louisiana Behavioral Health Partnership ((LBHP)).

### **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):

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 FFY 2012: Youth Access to Tobacco in Louisiana**

- a. Data collection completed: July – August 2011
- b. Subject / purpose and reason for initiation of the analysis or evaluation:  
OBH conducts this annual Synar Report to examine the current level of accessibility of tobacco products to minors as pursuant to Federal Government guidelines. The Substance Abuse and Mental Services Administration (SAMHSA) is the enforcing agency. An amended Synar Regulation, issued by the Substance Abuse and Mental Health Services Administration in January 1996, requires each state receiving federal grant funding to conduct annual random, unannounced inspections of retail outlets to assess the extent of tobacco sales to minors.
- c. Methodology used for analysis or evaluation:  
The study design is a cross-sectional survey of compliance, with compliance defined as the refusal to sell tobacco to minors and the prevention of entry of a minor to outlets restricted to youth. A stratified random sample of outlets are identified and surveyed by a team of one youth operative and two adult agents Office of Alcohol and Tobacco Control (OATC). The youth operative attempts to purchase tobacco from unrestricted outlets and tests the access of restricted outlets. The adult agents record characteristics of outlets, inspection events, and outcomes, and cite non-compliant outlets and clerks. Information about outlets, inspectors, and the inspection event are entered into an electronic data system via laptop at the time of inspection.
- d. Cost (allocation of in-house resources or purchase price):  
OBH contracted with the Office of Alcohol and Tobacco Control (OATC) to conduct the random, unannounced inspections of tobacco

outlets identified by the random sample at a cost of \$69,550.00 (\$65.00 per compliance check x 1,070 checks). The total cost for the report was \$69,550.00.

- 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 FFY 2002. However, Louisiana achieved 20.3% non-compliance in FFY 1999, only two years after the start of the Louisiana Synar Initiative, and 3 years ahead of the scheduled target date. The current rate of tobacco sales to minors in FFY 2012 is 4.1%. Louisiana's rate has consistently been one of the lowest in the nation. The model that Louisiana has utilized is being considered as a model program by the Center for Substance Abuse Prevention.
- f. Major Recommendations:  
OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2012 report and will adhere to any future recommendations, as warranted.
- g. Actions taken in response to the report or evaluation:  
An annual report is generated by SAMHSA including a Table listing the Synar Retailer Violations (RVRs). Louisiana is ranked among the top states in compliance, in the FY 2011 report (most recent on file). Our goal is to continue implementing current strategies since they proven to be successful.
- h. Availability (hard copy, electronic file, website):  
The report is available by hardcopy, and may be accessed online at <http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/publications/SYNARRpt2012.pdf>; or [obh.dhh.louisiana.gov](http://obh.dhh.louisiana.gov).
- 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, 2011 – June 30, 2012
- b. Subject / purpose and reason for initiation of the analysis or evaluation:  
OBH is committed to providing quality, cost-effective prevention and

treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT Block Grant is the primary funding source for prevention services. It requires 20% of the grant be set aside for primary prevention services. An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report is a continuing process to measure the number of services we provide and the populations that are served.

- c. Methodology used for analysis or evaluation:  
The data in this report is from the Prevention Management Information System (PMIS), the primary reporting system for the SAPT Block Grant for prevention services.
- d. Cost (allocation of in-house resources or purchase price):  
There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from the Prevention Management Information System (PMIS) to generate this document. Data is entered into PMIS by OBH regional and headquarter staff and prevention contract providers statewide.
- e. Major Findings and Conclusions:  
During FY12, Prevention Services provided evidence-based services to 77,078 enrollees.  
  
FY12 block grant funded one-time services provided to the general population reached 206,965 participants. This number included the combined services provided by Prevention Staff and Prevention Contract Providers.
- f. Major Recommendations:  
The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.
- g. Action taken in response to the report or evaluation:  
No actions (other than the recommended (above) were pertinent.
- h. Availability (hard copy, electronic file, website):  
The report is distributed via e-mail and is available by hard copy upon request.
- i. Contact Person:

Dr. Leslie Brougham Freeman  
Director of Prevention Services  
LA Department of Health and Hospitals  
Office of Behavioral Health

# Annual Management and Program Analysis Report

## Fiscal Year 2011-2012

**Department:** Department of Health and Hospitals  
09-340 Office for Citizens with Developmental Disabilities

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

**Undersecretary:** Jerry Phillips

**Assistant Secretary:** Laura Brackin

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

The following are accomplishments of the Office for Citizens with Developmental Disabilities (OCDD) achieved during fiscal year (FY) 2011-2012:

#### **Downsizing of Public Supports and Services Centers**

- A. What was achieved? The OCDD continued to work on the goal established for FY 2010-2011 to transition those persons who have lower acuity needs in the population of its three largest supports and services centers (SSCs) to privately operated service settings. In FY 2011-2012, OCDD discharged 113 people from the three remaining public SSCs to privately operated service settings. This accomplishment results in an annualized net savings of \$8,902,154.
- B. Why is this success significant? The individuals with developmental disabilities identified for transition as part of the 20% downsizing initiative are those with less intensive support needs who can handle and benefit from living and receiving services in the community. These individuals do not require the level and types of services and supports offered in a public SSC setting and therefore can receive more cost-effective services in a less restrictive setting. This success is also significant in that many of the service recipients identified for transition and their families were not initially in favor of the transition but engaged the transition process. They then selected privately operated living settings in response to the diligent and supportive efforts of OCDD and facility staff at all levels to promote acceptance of the initiative by various stakeholders.

- C. Who benefits and how? The individuals with developmental disabilities who transitioned from the public SSCs to privately operated service settings are benefitting from the enhanced sense of dignity and self-fulfillment associated with living in the community alongside people with and without disabilities.
- D. How was the accomplishment achieved? The successful transition of persons from public supports to private supports was achieved through the collaborative efforts of OCDD staff throughout the State, support coordination agencies, and providers as well as services participants and their family members, friends, and other advocates. The MFP Rebalancing Demonstration (My Place Louisiana) provided funding to support the transition process.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a specific goal in the Strategic Plan relative to rebalancing the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. The approach OCDD has taken in identifying service recipients for transition from public SSCs to privately operated service settings is consistent with nationally recognized needs-based assessment and resource allocation methodologies.

### **Privatization of State-Operated Supports and Services**

- A. What was achieved? Acadiana Region Supports and Services Center was privatized through a Cooperative Endeavor Agreement (CEA) with The Arc of Acadiana on July 1, 2011. Sixty-three (63) of the residents residing there on that date were transferred in place to the private provider. The CEA will continue for a period of five years on the grounds of the former Acadiana Region Supports and Services Center. Leesville Residential and Employment Services ceased operation and transferred the remaining eleven residents to Pinecrest Supports and Services Center where these individuals are receiving the same level of individualized therapeutic services designed to meet their needs. OCDD now operates three public supports and services centers (SSCs) (large ICFs/DD) with plans to privatize North Lake and Northwest Supports and Services Centers on October 1, 2012. A budget savings of \$13,481,980 was achieved in FY 2011-2012 related to this accomplishment. Additionally, the initiative results in an annualized net savings of \$6,557,459.
- B. Why is this success significant? The number of people with developmental disabilities receiving services from OCDD as their primary service provider decreased while the overall number of individuals with developmental disabilities receiving services with OCDD oversight increased. This accomplishment resulted in cost savings for the Department/Office as, by and large, the service recipients formerly served in the privatized or closed settings are now receiving more cost-effective services with private

provider agencies. The administrative costs associated with OCDD operating the now privatized or closed services have been eliminated almost entirely resulting in additional cost savings.

- C. Who benefits and how? The Department/Office benefits from this accomplishment both in terms of cost savings and in terms of reaching more people with developmental disabilities with cost-effective services. The State's citizens with developmental disabilities benefit from this accomplishment as more individuals are receiving needed services more cost-effectively.
- D. How was the accomplishment achieved? The privatization/closure of targeted state-operated supports and services was achieved through the collaborative efforts of OCDD staff throughout the State, support coordination agencies, and providers as well as services participants and their family members, friends, and other advocates.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a specific goal in the Strategic Plan relative to rebalancing the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. This initiative focused on achieving cost savings while maintaining individually needed levels of support through privatization and consolidation of publicly operated services.

**Use of Person-centered tools to assure satisfaction for individuals moving from Supports and Services Centers (SSCs)**

- A. What was achieved? Consistent with national standards, OCDD implemented person-centered tools to assist individuals to move from supports and services centers (SSCs) to community living options that maintain or improve their satisfaction and involvement in local communities. Training on all of the tools was completed with identified staff at the three remaining SSCs. Overall, seventy percent (70%) of individuals moving from the SSCs chose smaller living options. During the course of the fiscal year, OCDD maintained an overall 88% satisfaction rate of satisfaction with home, work, school, roommates, and staff support ranging from 92-100% and satisfaction with getting "what you need" and "feeling healthy" ranging from averaging at 88%. The areas of less satisfaction (68-84%) were visits with family and visits with friends and local community involvement, which were not significantly different from pre-move concerns. Only 6% of individuals who moved had a second move to a less integrated setting than the initial living situation due to difficulties.
- B. Why is this success significant? OCDD supported a large number of individuals to move from SSCs during the last two fiscal years. Moving into smaller and more community-based living situations is consistent with national trends and is supportive

of a community-based life and larger social support network for individuals with developmental disabilities. However, moving many individuals within a brief period of time carries risks associated with missed support needs and options as well as moving to a living situation that is less preferable for the individual than the current institutional one. Thus, a focus on tools to assist in a more person-focused and person-driven approach increased the ability of OCDD staff to assist individuals in locating flexible living and support options consistent with the life each individual wanted to move toward. Satisfaction and success increased based upon this approach.

- C. Who benefits and how? All individuals who have moved from and will be moving from SSCs, their families and friends, regional offices/ districts/ authorities, community providers, and support coordinators benefit from this effort. Individuals are supported to have a living situation consistent with their preferences and able to meet their support needs including connections to families and friends where possible. The planning process is geared to meet these preferences and needs as well. Satisfaction and success increase resulting in fewer challenges and failures that the individual and those supporting him or her in the community have to address.
- D. How was the accomplishment achieved? The person-centered tools and approach were designed by and through consultation with national experts in person-centered thinking approaches and systems development. Training was delivered by national consultants. Implementation of approaches was undertaken by SSC administrative and clinical staff in consultation with OCDD Clinical Services. The consultative services were funded by the MFP Rebalancing Demonstration (My Place Louisiana).
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has specific goals with regard to increased use of community-based resources and less reliance on institutional care, person-centered practices, and increasing the capacity of community providers to support individuals.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. The approach OCDD has taken is consistent with national standards and trends related to both reduce reliance on institutional care and use of person-centered tools to drive and support systems change.

**Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana)**

- A. What was achieved? The Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana) exceeded the transition benchmark and achieved positive outcomes for persons with most intensive needs served in Home and Community-Based Services (HCBS). The calendar year 2011 transition target was met at 117% (Target: 66 / Actual: 77). The program entered calendar year 2012 with 60 persons enrolled. The MFP Demonstration is transitioning a much more challenging population group than that represented by the general waiver population. As of June 2011, a large percentage of the program's transitions were individuals assessing as needing supports consistent with

Level 6 of the OCDD Resource Allocation System. (Level 6 represents complex, co-occurring psychiatric and behavioral support needs.) The MFP Demonstration rate (per 1000) of critical incidents in the New Opportunities Waiver (NOW) is three times higher than that of the NOW general population. The MFP Demonstration rate of behavior-related critical incidents is much higher in proportion (better than two times) that of the general waiver population, wherein medical critical incidents are more prevalent in the general population. Yet with these challenges, the program still maintains 91% of persons remaining in community placement through the demonstration period. Intensive training, financial supports for additional services and supports structures, and intensive follow-along have been applied with Demonstration funded resources to retain community placement. In addition, quality of life data indicates improvements in key areas post move years one and two, and cost comparison data of before/after move indicates cost effectiveness.

- B. Why is this success significant? The Demonstration first successfully transitioned children with the most intensive medical needs from nursing homes and hospitals (began 2009) and then transitioned and sustained outcomes for persons with the most intensive of psychiatric and behavioral support needs moving from supports services centers, private ICFs/DD, and psychiatric hospitals. The achievement of the Demonstration shows: (1) that these persons can be effectively supported in the community, rather than in an institution; (2) the structure required for such supports, thus facilitating systems planning for sustainability; and (3) the utilization trends and costs of persons in the high need groups.
- C. Who benefits and how? An immediate benefit is to the persons transitioned through this program. However, a much larger-scale benefit is impact on the entire services system, both current and future. The achievements of the Demonstration provide evidence of strategies to accomplish successful, sustainable rebalancing of both investment and capacity.
- D. How was the accomplishment achieved? This was accomplished through the day-to-day applied expertise of the OCDD Demonstration staff using the program's Operational Protocol, along with collaboration with supports and services centers' Transition Offices; Resource Centers (inclusive of Transition Support Teams); OCDD Regional Office/Human Services Authority and District staff; support coordination agencies; cooperating providers; Central Office program managers, crisis team, and Clinical Review Committee; and supporting stakeholders.
- E. Does the accomplishment contribute to the success of your strategic plan? Yes. OCDD has a specific goal in the Strategic Plan relative to rebalancing the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes.

Participation in the federal Demonstration has enabled OCDD to examine strategies that may produce the best outcomes for Louisiana's citizens with developmental disabilities and align OCDD practices with both national best practices and goals for long-term care system sustainability. The 103 Demonstration participants in the calendar year 2011 fiscal evaluation showed a cost efficiency of \$15,375,595. These 103 persons, when served in various institutional settings before transition incurred Medicaid costs of \$21,341,676, while these same persons were served post transition in HCBS for \$5,965,879.

**Increased Sustainability of Community-Based Services through continued successful implementation of Resource Allocation in New Opportunities Waiver**

- A. What was achieved? The Office continued implementation of the OCDD Resource Allocation process, which utilizes person-centered planning and needs-based assessment to better allocate resources to support individuals with additional cost savings.
- B. Why is this success significant? Since implementation in October 2009, Resource Allocation has resulted in a cumulative \$27.7 million in savings at the end of FY 2011-2012. Aligning allocation of resources with need results in greater sustainability of home and community-based supports and offers the opportunity to support more individuals who continue to wait significant periods for needed services. In FY 2011-2012 the NOW program grew in participation by 8.26% with an expenditure growth of .62%. By using a person-centered philosophy and needs-based assessments, the resources are allocated to ensure all needed supports are in place in a manner that also supports the individual's preferences and goals. As anticipated, this continues to result in significant cost savings while ensuring overall improvement in the quality of plans. Through this process, OCDD has worked with recipients to increase the percentage of individuals sharing supports (from 8.5% to 14%) which can be a more sustainable option for the recipients and the system.
- C. Who benefits and how? The entire Medicaid service delivery system benefits from the implementation of this process as the dollars saved lessen the budget shortfalls experienced by Medicaid and offset the need for provider rate cuts and the need to cut necessary services to waiver recipients and their families.
- D. How was the accomplishment achieved? This was accomplished through the continued refinement of plan processing to ensure the most efficient and effective processes. OCDD has further defined "outlier" categories to ensure that only individuals with unique needs and/or circumstances receive additional supports.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a specific goal in the Strategic Plan relative to rebalancing the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs.

- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. This process was implemented statewide using an individualized needs-based assessment and person-centered planning for everyone receiving services through the NOW.

**Utilization of all available self-direction opportunities**

- A. What was achieved? One-hundred percent (100%) of all opportunities available through the Fiscal Agent contract for accessing self-direction opportunities within the New Opportunities Waiver (NOW) were occupied by individuals participating or in process for approval.
- B. Why is this success significant? Until this fiscal year, there were 80 individuals participating in the self-direction option with 306 opportunities available.
- C. Who benefits and how? Those benefitting include the individuals participating in this option, the employees hired through the self-direction option, and Medicaid benefit. Individuals are able to recruit, hire, train and supervise the workers they choose to hire allowing them to make their own decisions. Employees can experience a higher rate of pay. The overall cost to Medicaid is reduced as the total of the cost to pay the worker at the higher rate and the costs associated with being an employer (taxes, unemployment insurance, administrative cost, etc.) is typically lower than the approved rate for which a traditional provider may bill for the same service. The Fiscal Agent contractor returns to Medicaid any unused portion of the difference between the actual cost and the billed amount.
- D. How was the accomplishment achieved? This was accomplished through statewide implementation of the self-direction option and statewide training to regional offices, support coordinators and families. OCDD also assigned each support coordination agency in each region a specific number of slots to fill by actively recruiting individuals for participation by June 30, 2012.
- 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.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. This practice is also being used by the Office of Aging and Adult Services, and it could be applicable to any other HCBS waiver program upon approval by Centers for Medicare & Medicaid Services.

**Employment First Foundation Building**

- A. What was achieved? In FY 2011-2012, OCDD successfully initiated the following steps to build a foundation for Louisiana's Employment First initiative:
- Released the official Employment First Position Statement along with the Guiding Principles
  - Trained providers, support coordinators and OCDD Regional Office/Human Services Authorities and District staff in all regions on Employment First
  - Completed "Listening Sessions" in every region to hear concerns around employment from families, individuals, providers and other stakeholders
  - Highlighted Employment Success Stories in every region
  - Participated in job fairs held in October 2011
  - Hosted an Employment First Summit with approximately 230 participants
  - Initiated collection of baseline data from vocational providers
  - Established an employment contact person in each OCDD Regional Office/Human Services Authority and District
  - Drafted the "Implementation Plan for Employment First" with assistance from the Employment First Work Group

These initiatives resulted in new community employment opportunities for 439 individuals with developmental disabilities in FY 2011- 2012.

- B. Why is this success significant? Employment has not been a major focus of OCDD in the past. Typically, individuals with developmental disabilities participate in Day Habilitation and Pre-Vocational Services and do not work in jobs in the community as those without disabilities. As employment is brought to the forefront and concerns about employment are alleviated through improvement of service delivery, more individuals with developmental disabilities can achieve and maintain employment thereby increasing their independence.
- C. Who benefits and how? Individuals with developmental disabilities who want to work and achieve employment will benefit from improving employment services as more individuals will go to work and increase their independence. The state of Louisiana will benefit as these individuals will be paying taxes and spending money which improves the economy. Families will benefit by the increased independence of their family members and by having decreased level of financial responsibility.
- D. How was the accomplishment achieved? This was achieved by including community employment as a focus for the Office and making a plan to improve employment services that are offered in the waivers, as well as highlighting the need for employment for individuals with developmental disabilities. Additionally, OCDD partnered with various stakeholders, such as Louisiana Rehabilitation Services, Louisiana Workforce Commission, Department of Education, The Developmental Disabilities Council, The Advocacy Center and various other agencies, related to this initiative. To continue this success, OCDD continues to participate in the Work Pay\$ Coalition, which is a group that works together to improve employment for individuals with disabilities.

- E. Does this accomplishment contribute to the success of your strategic plan? Yes. Employment First is included in OCDD's Strategic Plan and is one of the three broad focus areas of OCDD's Business Plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. This process will continue to be implemented over a five-year period in order to continue the outreach and education around employment. Changes will continue to be made within OCDD to increase the number of individuals in community employment. Employment should be a focus for all agencies that serves individuals with any type of disability, not just developmental disabilities. Employment First has been in the national spotlight for the last five years. The State Employment Leadership Network (SELN) brings together state developmental disability agencies for sharing, educating and providing guidance on practices and policies around employment to its members; OCDD has participated in the SELN since 2007. Louisiana is 1 of 24 states that participates in the SELN.

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

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

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) Employment First; 2) System Rebalancing; and 3) Sustainable Home and Community-Based Services. The success of the following initiatives in FY 2011-2012 has moved the Office toward goals outlined in both OCDD's Strategic Plan and Business Plan: downsize of public supports and services centers; privatization of state-operated supports and services; use of person-centered tools to assure satisfaction for individuals moving from supports and services centers; continued implementation of Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana); full implementation of resource allocation in the New Opportunities Waiver; filling of all available self-direction waiver opportunities,

and foundation building for Louisiana's Employment First initiative have moved the Office toward goals outlined five-year strategic plan.

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

**Program A, Objective 1 - Performance Indicator:** Percentage of Support Coordinators and Supervisors achieving and/or maintaining certification(s) as determined by OCDD (Target: 70% / Actual: 95%)

1. **To what do you attribute this success?** Success is attributed to implementation of the OCDD Strategic Plan. The endeavor was supported by statewide training efforts and certification efforts of support coordinators in utilization plan requirements and approval process. OCDD also undertook extensive training with regional staff in a streamlined and improved review process.
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 the review process being implemented statewide and ongoing certification and review of plan quality put into place.

**Program B, Objective 1 - Performance Indicator:** Percentage of waiver participants who have been discharged from their waiver due to admission to a more restrictive setting (Target: 5% / Actual: 0.47%)

1. **To what do you attribute this success?** OCDD has initiated multiple initiatives that have contributed to this success. From a proactive perspective, OCDD has implemented enhancement to its planning and approval processes to increase assurance that the plans of care for participants address all needs so that each participant is able to successfully receive supports within their waiver living setting. Additionally, OCDD has begun implementation of a risk management process that provides access to additional consultation and recommendations for those individuals with complex support needs and risk incidents. Finally, OCDD has streamlined and centralized its crisis referral process for individuals for whom waiver living situation may be in jeopardy. This process involves collaboration and coordination across local entities, OCDD Central Office, and OCDD resource center clinicians to assist community providers in modifying or initiating needed supports in an effort to preserve the waiver living situation.
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.

**Program A, Objective 1 - Performance Indicator:** Percentage of decrease in average cost per person for New Opportunities Waiver (NOW) services post implementation of resource allocation model (Target: 1.25% / Actual: 1.25%)

1. **To what do you attribute this success?** Implementation of the OCDD Resource Allocation System allows for assessing support needs and designing the plan of care to ensure that needs are met and that unnecessary supports are not provided. Through this implementation OCDD has been able to decrease average cost per person while ensuring each recipient has his/her support needs met and the waiver system remains sustainable. New recipients have also been able to receive services they were not previously able to access.
2. **Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?** While this year's projected performance is at the expected level, the success of the implementation of this system over the last few years has resulted in dramatic decrease in cost per person and has allowed for system sustainability and implementation of supports to new recipients. At this time, pace is expected to be maintained.

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

**Program A, Objective I - Performance Indicator:** Percentage of increase in people reporting an overall improvement in health and safety and/or quality of life post-implementation of the OCDD Guidelines for Planning, electronic Individual Support Plan (eISP), and Support Intensity Scale/Louisiana Plus needs-based assessment (Target: 5% / Actual: 0%)

1. **To what do you attribute the lack of progress?** OCDD's eISP was initially postponed due to budgetary/resource concerns. OCDD has undertaken evaluation of the work processes surrounding the planning process to generate more specific recommendations related to the portions of the process that best lend themselves to automation and to ensure that ineffective processes are not automated. Initial automation will not focus on the plan of care itself. OCDD attempted capturing data related to improvements in health/safety and/or quality of life through the support coordination monitoring tool, which remains in early stages of implementation; thus, data is not available at this time.
2. **Is this lack of progress due to a one-time event or set of circumstances?** The lack of progress is due to a set of circumstances. This indicator will be modified or replaced so that OCDD is able to report on performance related to services using data that is accessible/available.

**Program B, Objective 1 - Performance Indicator:** Percentage of adult individuals with waiver services who have paid work and/or activities as recommended by their support team as compared to those who have the goal in their plan (Target: 95% / Actual: 50%)

1. **To what do you attribute the lack of progress?** OCDD has just begun implementation of a large Employment First initiative. This FY was a foundation building year that focused on activities that will allow for Employment supports

to be a central feature of planning and supports for adults and for partnerships with community providers and organizations to increase opportunities to individuals receiving waiver supports. When new large scale initiatives are undertaken, progress is typically slower in the beginning years due to the need to put foundational operations, structures, and partnerships in place.

2. **Is this lack of progress due to a one-time event or set of circumstances?** Lack of progress is due to a set of circumstances. The existing service system has not had employment at the forefront; thus, many processes and supports needed to be modified or developed. Progress should begin to increase over the years of implementation for this initiative.

**Program B, Objective 1 – Performance Indicator:** Percentage of utilization of Residential Options Waiver (ROW) opportunities which become available through funding allocation or conversion of ICF/DD beds (Target: 20% / Actual: 13%)

1. **To what do you attribute the lack of progress?** Providers have not been interested in the conversion option offered due to concerns over fiscal sustainability as they move from shared ICF settings for up to six individuals to shared waiver settings that would perhaps be smaller and have less stability in terms of continued services. Differences in fiscal options and support from the ICF model to the waiver model have not allowed for direct conversion. Providers are concerned about converting and then being challenged in continuing to meet the needs of individuals whom they have successfully supported for many years.
  2. **Is this lack of progress due to a one-time event or set of circumstances?** Lack of progress is due to a set of circumstances. OCDD is actively working with providers to look at other options for providing more individuals with waiver supports. The objective and indicator will be modified as appropriate as new options are identified.
- ◆ **Has your department revised its strategic plan/Business Plan to build on your successes and address shortfalls?**
    - Yes. OCDD's Strategic Plan for FY 2012 through 2016 and its annual Business Plan have been updated. Updates to both plans include revisions to program objectives, strategies and indicators to reflect Office direction, to build on successes, to provide strategies in areas where success has not be as substantial or where changes in program direction indicate such, and to improve performance assessment.
  - ◆ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Objectives are assigned to staff 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 Office Executive Management Team. Performance data is also reported in LaPAS and is available for management review and stakeholder access.

### **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 - therapies that can be very effective and significantly alter the course of autism for many individuals. While specific OCDD initiatives have been implemented this fiscal year to continue addressing this barrier and improvements have occurred in some areas, the general problem continues; it is believed that a multi-faceted and multi-year approach will be required to resolve the problem.
2. **Is the problem or issue affecting the progress of your strategic plan?** Yes. Lack of these professionals in community settings has continued to be the primary contributor to new admissions to supports and service centers, with requests for admissions resulting when community providers are unable to meet behavioral and psychiatric needs of people whom they are serving in community settings. Lack of trained autism professionals negatively impacts the ability to develop new autism services, which can prevent more severe negative developmental outcomes. 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 are impacted by this.
4. **Who else is affected by the problem?** Individuals supported and their families, support coordinators, and private providers who serve persons with developmental disabilities in community homes, family homes, and supported independent living settings are impacted by this problem.

5. **How long has the problem or issue existed?** The problem is longstanding.
6. **What are the causes of the problem or issue? How do you know?** A multitude of factors contributes to the problem beginning with a historic lack of training by universities of persons equipped to deliver these services. Many Ph.D. psychologist programs, for example, offer no training in developmental disabilities. Medical school psychiatry programs typically offer almost no training in psychiatric needs of persons with developmental disabilities. The increasing number of persons with developmental disabilities now being served in the community and the downsizing of institutional services, generally considered to be positive and progressive developments in developmental disabilities services, has contributed to increased need for behavioral and psychiatric supports in the community. Some services, which could be provided by non-terminal degreed practitioners [e.g., persons with a master's degree in psychology and expertise in this field, Board Certified Behavior Analysts (BCBA) with a master's degree] under the supervision of a licensed professional, do not have a funding source. 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, continued need for costly institutional admissions in supports and service centers, and inadequate practitioners to positively impact the developmental trajectories of children with autism leading to increasing service costs over the course of their lifespan.

#### B. Corrective Actions

1. **Does the problem or issue identified above require a corrective action by your department?** Yes.
2. **What corrective actions do you recommend to alleviate or resolve the problem or issue?** The following are recommended actions to alleviate the problem:
  - Transform current OCDD Resource Centers into Centers of Innovation and Excellence including opportunities for partnering with university programs that provide training resulting in additional needed professionals, growing the service provider pool;
  - Explore funding sources that will pay for service delivery by less expensive, qualified professionals; and
  - Expand implementation of statewide access to training for direct support workers through the MFP Rebalancing Demonstration (My Place Louisiana) program.

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 developed a statewide Positive Behavioral Supports (PBS) curriculum for DSWs and completed a pilot with selected community provider organizations. Implementation through the MFP Rebalancing Demonstration (My Place Louisiana) has occurred; use of the curriculum is being expanded.
  - OCDD supports 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.
  - Supports and service centers continue to divert resources to community behavioral services.
  - OCDD continues to operate small existing community service teams in each region of the state.
  - OCDD is working collaboratively with OBH and Medicaid related to coordinating services for youth and on transition of persons of all ages from ICFs/DD and psychiatric hospitals to OCDD waivers partnered with the LBHP services.
  - Evaluation of barriers to provision of services has begun and an Office initiative directed at transforming the OCDD Resource Centers to Centers of Innovation and Excellence 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 in all probability offset by failure to implement corrective actions as: 1) failure to intervene at the community level can result in extensive additional institutional treatment costs and 2) failure to intervene with persons with autism at an early age does results in extensive lifelong service costs judged to be over a million dollars per person which are incurred by families and the taxpayer.

**Maintenance of property associated with facilities in which the campuses have been vacated**

## A. Problem/Issue Description

1. **What is the nature of the problem or issue?** As the supports and services centers downsize, the need has arisen to vacate certain campuses. OCDD continues to be responsible for the costs associated with maintaining the properties vacated when OCDD operations at those properties ceased including risk management fees, building and grounds maintenance, utilities, and loss prevention/security. OCDD will continue to be responsible for all of these costs as long as the properties belong to OCDD and will continue to be responsible for the risk management fees for two (2) years after the properties no longer belong to OCDD. The risk management fees for the vacated OCDD properties total \$2,968,149 million per year. Total other costs associated with maintaining the vacated OCDD properties was approximately \$902,721 in FY 2011-2012 and is anticipated to be approximately \$7,213,488 in FY 2012-2013.
2. **Is the problem or issue affecting the progress of your strategic plan?** Yes. Although indirectly, this problem is affecting OCDD's progress in implementing its strategic plan in that the fiscal resources required to maintain the vacated properties could be better utilized to further OCDD's progress toward any one or all of its strategic plan goals. In addition, the opportunity to utilize state-owned property as revenue-generating property as campuses are vacated has been explored; however, there are current legislative rules in direct opposition to this course of action.
3. **What organizational unit in the department is experiencing the problem or issue?** OCDD is managing the problem by continuing to allocate necessary resources to manage the costs associated with maintaining the properties and fulfilling Office of Risk Management (ORM) and other state requirements.
4. **Who else is affected by the problem?** The OCDD budget authority and the employees fulfilling the duties are affected by this problem.
5. **How long has the problem or issue existed?** The problem was identified in FY 2009-2010.
6. **What are the causes of the problem or issue? How do you know?** The problem was caused by a lack of knowledge regarding mandatory duties related to state-owned property insured by ORM. Also, though vacated, the properties remain the property of OCDD and efforts must be made to keep the physical plant in good condition and to prevent theft or destruction of State property.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?** The consequence of this issue is continued expenditure of OCDD funds to maintain properties that are no longer used by OCDD as service provision sites which will likely result in shortfalls next fiscal year and in the years to come.

**B. Corrective Actions**

1. **Does the problem or issue identified above require a corrective action by your department?** Yes.
2. **What corrective actions do you recommend to alleviate or resolve the problem or issue?** OCDD should seek permission and/or an exception to the Legislative rules and regulations to utilize state-owned property as revenue generating property or amend existing legislation.
3. **Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?** Yes. This recommendation was made in this annual report last year.
4. **Are corrective actions underway?** Yes. As current legislation prohibits the sale or lease of state property to a non-government entity, the Office is exploring the possibility of introducing legislation to change this restriction. Additionally, the Office is also working to identify potential buyers for the vacated properties.
5. **Do corrective actions carry a cost?** No. There would be no direct costs related to researching and developing amendments to existing legislation as these actions would be completed by existing staff. However, as mentioned above, failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings/facilities.

**Slow Progress of System Rebalancing****A. Problem/Issue**

1. **What is the nature of the problem or issue?** The System Rebalancing progress has slowed, with some significant barriers to accomplishing progress developing over the fiscal year. FY 2011-2012 ended with 48% of developmental disability services being provided through Home and Community-Based Services (HCBS) and 52% through institutional services. Past efforts in system rebalancing have primarily relied upon: (1) spending more in HCBS, (2) utilizing state resources for capacity-building supports, and (3) reducing supports and services center (SSC) capacity with little impact on private ICFs/DD. These actions require maximum effort from the state, with involvement but no cost to the private sector. The system has reached a point where there are no longer additional funds; state resources have been reduced; and SSC capacity is phasing down to one center in late 2012. In order to continue rebalancing, impact areas must move to changing use and delivery of HCBS (more effective, more efficient, more accessible); forming public/private partnerships that enhance private sector led capacity building; and affecting the utilization of private ICFs/DD. Efforts dedicated to the shift in impact areas have met with considerable opposition from stakeholders. In

areas where some consensus has developed, resource constraints and external factors have presented as barriers.

2. **Is the problem or issue affecting the progress of your strategic plan?** Yes. OCDD has a specific goal in the Strategic Plan relative to rebalancing the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs. If rebalancing progress slows or halts, strategic plan elements will not be met.
3. **What organizational unit in the department is experiencing the problem or issue?** OCDD Community Services Section (waiver authority, state general fund, regional authority, OCDD regional offices, and human services authorities/districts), SSCs, and Resource Centers are impacted, as well private ICF/DD operations in Medicaid. The MFP Rebalancing Demonstration (My Place Louisiana) has benchmarks for system rebalancing; failure to meet these benchmarks affects funding.
4. **Who else is affected by the problem?** Those affected include individuals supported and their families, providers of HCBS and ICF/DD services, support coordination agencies, and local/state advocacy groups.
5. **How long has the problem or issue existed?** Rebalancing work began in 2001. However, the current problem has reached a head as of FY 2011-2012.
6. **What are the causes of the problem or issue? How do you know?** The need for rebalancing arose from a combination of federal Medicaid's initial institutional bias with: (1) the growing demand for home and community-based services, (2) the realities of system sustainability (HCBS are generally more cost-effective), and (3) mandates for provision of services in integrated settings appropriate to need. The current problem of slowing of OCDD's progress in system rebalancing is caused by the exhaustion of state resources, leading to the need for aggressively focusing on changes that more heavily impact the private sector and that must be carried out cooperatively by the private sector.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?** Consequences include continuing to invest heavily in ICFs/DD; retaining a long waiting list for waiver services; funding inefficient HCBS; failing to achieve outcomes in HCBS inclusive of continued crisis referrals for SSC admission; and having persons left unserved due to finite system funding. Long-term an unbalanced service system may not be sustainable, with persons served in higher cost/lower quality options and high percentages of persons underserved or unserved.

**B. Corrective Action**

1. **Does the problem or issue identified above require a corrective action by your department? Yes.**
2. **What corrective actions do you recommend to alleviate or resolve the problem or issue?** The following corrective actions are recommended:
  - Evaluate barriers to continued rebalancing; map past efforts and responses/results; identify stakeholder partners to include in planning and implementation; calculate risk/benefits related to each barrier; prioritize barriers; and develop a strategy to move forward.
  - Incorporate information on identified barriers, prioritization, and strategy in the Community System Transformation Plan currently under development.
  - Solicit support of state, regional, and local stakeholders through education of past rebalancing efforts and the barriers to moving forward.
  - Transform Resource Centers into Centers of Innovation and Excellence that have a broad impact on the Developmental Disabilities Services System and Louisiana local communities. (This would include developing a Resource Center structure that identifies the needs of community providers and professionals, and develops activities/ interventions/products that improve their ability to achieve good outcomes for recipients.)
  - Explore external and/or creative funding sources to support capacity-building activities necessary for rebalancing and the increased involvement and investment of private sector partners.
3. **Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?** Components of the proposed corrective actions have been discussed in previous management reports throughout fiscal year 2011-2012.
4. **Are corrective actions underway?** Yes. The following corrective actions are underway:
  - The Community System Transformation planning group has identified a number of barriers to rebalancing and has incorporated rebalancing planning into the large-scale effort. Additional details work is required; stakeholder input is required.
  - Problem solving related to ROW conversion continues. Information has been gathered from the Lewin Group (MFP Demonstration Technical Assistance) and other MFP Demo states that use a similar Shared Living definition and payment process. Direct comparison of rates and services expectations is ongoing to resolve provider concern over feasibility.
  - Planning and implementation of the transformation of Resource Centers to Centers of Innovation and Excellence is under way.
  - OCDD and the MFP Demonstration have worked to develop a sustainable administrative structure for continuation of the Permanent Supportive Housing

(PSH) program past the expiration of Community Development Block Grant (CDBG) funding. In addition, OCDD collaborated with Department of Health and Hospitals partners and the Louisiana Housing Corporation to apply for the 2012 Department of Housing and Urban Development (HUD) Notice of Funding Availability (NOFA) for the Section 811 Project Rental Assistance Demonstration (PRA Demo) Program, requesting \$8,254,097 of PRA Demo funds representing 200 units. This will be used to expand the PSH program statewide. Affordable housing is a core requirement for rebalancing.

- A Shared Supports Workgroup has developed a marketing plan and strategic approach to enhancing use of shared supports in waiver services, which is an efficient, effective manner of providing HCBS.
5. **Do corrective actions carry a cost?** Yes. Rebalancing efforts traditionally require an up-front investment to recognize savings later. These savings are often significant and sustainable. Investment may be in service dollars (i.e., more waiver slots, expansion of services offerings, rate adjustments, increased administrative funding) or in state general fund dollars for capacity building or one-time non-Medicaid costs. A suggested source of funding is the MFP Rebalancing Demonstration's "Rebalancing Fund," which for OCDD is estimated at over \$700,000 ending FY 2011-2012. Savings recognized from the enhanced Federal Medical Assistance Percentages (FMAP) through the Demonstration, per the award, are intended for reinvestment in system rebalancing strategies.

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

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

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

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

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

during the fiscal year covered by this report.

**National Core Indicators Project** – Since FY 2008-2009, the Louisiana Office for Citizens with Developmental Disabilities (OCDD) has participated in the National Core Indicators (NCI) Project. Currently, approximately 35 states participate in the NCI Project. The purpose of NCI Project is to identify and measure core indicators of performance of state developmental disabilities services systems. The NCI Project is co-sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). Annually, three family surveys are sent to the families of people with developmental disabilities participating in various developmental disability programs and adults with developmental disabilities are interviewed. A number of reports are prepared to summarize the results of this project.

**1. Title of Report or Program Evaluation:**

Reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services:

- *National Core Indicators Consumer Outcomes Final Report 2010-2011 Data:* This report provides a summary of the results of interviews with adults receiving developmental disability services and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Family Guardian Survey Final Report 2010-2011:* This report provides a summary of the survey which was mailed to family members of adult with disabilities living outside of the family's home and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Adult Family Survey Final Report – 2010-2011:* This report provides a summary of the survey which was mailed to families of adults receiving developmental disability services who reside with their families and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Child Family Survey Final Report - 2010-2011:* This report provides a summary of the survey which was mailed to families of children living and receiving services in the family home and provides comparisons between Louisiana and the national average of other participating states.

- 2. Date completed:** Final reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services were published in July 2012. (Surveys and interviews were completed between January and June 2011.)

3. **Subject or purpose and reason for initiation of the analysis or evaluation:** Surveys and interviews were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. Survey and interview questions concerned satisfaction, quality of care, and quality of life. Analyses compared Louisiana statewide results with results of other states participating in the National Core Indicators Project.
4. **Methodology used for analysis or evaluation:** The primary tools used for this evaluation were family surveys and consumer interview questions. Analyses reported number and percentage of responses to each question. Comparisons were reported among participating states.
5. **Cost (allocation of in-house resources or purchase price):** The family mail-out surveys were printed and mailed through a purchase order for approximately \$6,000. All other activities were performed in-house. Obtaining and verifying information for families for the mail-out samples and consumers for the interview sample took approximately 272 hours of staff time. Scheduling interviews, completing background information, and interviewing consumers took approximately 1400 hours of staff time. Entering family survey data and consumer interview data into the NCI database took approximately 184 hours of staff time. Postage costs for a Business Reply Permit and return postage costs were approximately \$2,200. Finally, travel costs to conduct 400 interviews were approximately \$6,000.
6. **Major Findings and Conclusions:** Overall, Louisiana was ranked within the average range for the *Child Family Survey*, *Adult Family Survey*, *Family Guardian Survey*, and *Consumer Outcomes Interviews*. The majority of responses were “Within Average Range” with a substantial number falling five or more percent above average. However, there were a few areas that were five or more percent below average.
7. **Major Recommendations:** Acquire information/explanations/causes related to areas that fell below average and develop/implement strategies to improve issues identified.
8. **Action taken in response to the report or evaluation:** OCDD’s quality improvement process includes review of NCI data as well as data from other sources such as: data on regional performance indicators as part of the Human Services Accountability and Implementation Plan and data from EarlySteps and 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 hard copy and electronic file on the National Core Indicators website:

[www.nationalcoreindicators.org](http://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