My Choice Louisiana

Annual Mortality Review Report #3

Calendar Year 2023

Agreement to Resolve the Department of Justice Investigation

Louisiana Department of Health

Prepared by: Melissa Ledoux, Research and Quality/ Prog Mgr
Office of Aging and Adult Services
Louisiana Department of Health
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LOUISIANA DEPARTMENT OF HEALTH

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INTRODUCTION

In June of 2018, the State of Louisiana (the State) entered into an Agreement with the United States Department of Justice (DOJ) to resolve its lawsuit alleging the State violated the Americans with Disabilities Act (ADA) by failing to serve people with mental illness in the most integrated setting appropriate to their needs. The complaint alleges that the State relies on providing services to these individuals in institutional settings - specifically, Nursing Facilities (NFs) - rather than in the community. Under this Agreement, the State is required to create and implement a plan that will either transition or divert individuals with mental illness from these facilities by expanding the array of community-based services, including crisis services, case management, integrated day services, and supportive housing.

SCOPE AND STRUCTURE

In response to Louisiana's Agreement (LDH) with the U. S. Department of Justice (DOJ), Louisiana Department of Health (LDH) has created a Mortality Review Committee (The Committee) to establish reporting and investigation protocols for mortalities and significant incidents that exhibit a propensity for death. This committee completes a mortality review of the death of transitioned or diverted individuals in the Target Population in specified circumstances: any unexplained death (a sudden death that is unexpected or is unexplained at the date of death. This includes but not limited to suicide, car accident, drowning, and sudden natural causes such as heart attack or stroke), any death within 60 days of discharge from a Nursing Facility, and any death in which abuse, neglect, or exploitation is suspected within 12 months of the transition.

The mortality review process is designed to: (1) identify remediation activities associated with individual cases; (2) generate recommendations for system level Quality Improvement; (3) reduce future risk and (4) to better understand the causes and circumstances surrounding the deaths of certain target population members. The Committee will monitor the appropriate and timely implementation of identified remedial actions and systemic changes and reforms to reduce the risk of death and other adverse outcomes for individuals participating in the My Choice Program. The Committee will share and identified actions or outcomes with LDH Leadership (Health Standards Section (HSS), Office of Aging and Adult Services (OAAS), Office of Behavioral Health (OBH), Adult Protective Services (APS)) for their review, discussion and recommendations.

Mortality reviews are conducted by members of a multidisciplinary committee and examine the documentation of mortality cases involving members of the Target Population. LDH has formed a mortality review committee consisting of representatives from OAAS and OBH and includes Quality Management (QM), Policy and Operations staff, Health Standards (HSS), and Adult Protective Services (APS). APS's representation facilitates communication and collaboration in cases of suspected abuse, neglect, or exploitation, which leads to more efficient and timely investigations, interventions, and protections in these types of cases.

Required members of The Committee are:

OAAS Quality Manager	OAAS Policy Program Manager
OAAS Program Operations Manager	OBH Quality Program Manager
LDH Registered Nurse	OAAS Policy Program Manager
HSS Program Manager	

The Committee meets monthly or as needed based on case referrals. Committee meetings are rescheduled if all required members are not present or if a case referral is not presented for review.

HSS enforces regulatory compliance of health care facilities and provider types within the State of Louisiana. This is accomplished through periodic surveys/inspections of the providers which are licensed and/or certified to operate in Louisiana. HSS also investigates complaints received regarding allegations of abuse, neglect, exploitation, and extortion, and noncompliance with federal and/or state regulations, which fall under the purview of the state survey agency. Additional expertise (for instance: physicians, representatives of attorney general's office, pharmacists, etc.) may be sought for participation on this body when needed.

The My Choice Louisiana Mortality Review committee (described above) meets as referrals are received and as needed to perform strategic reviews, evaluation, and trend analysis on cases meeting the criteria, commensurate with a continuous quality improvement approach. The Committee will meet once per month, unless a MRC case requested documentation is not ready for review. The Committee will not hold a meeting unless the required members of The Committee are present.

The My Choice Louisiana Mortality Review process also includes a review team consisting of OAAS and OBH staff and are separate from the Committee members, aiding LDH in ensuring an impartial collection of records occurs. The My Choice Louisiana Mortality Review Committee makes a referral to the review team to collect, organize, review the documentation and provide a preliminary analysis of the individual's death. The review team provides the necessary documentation and preliminary analysis to the My Choice Mortality Review Committee for their review, discussion and recommendations.

Members of the My Choice Louisiana Mortality Review Committee are:

OAAS Quality Program Monitor	OBH Program Manager

Annually, LDH will release a My Choice Louisiana Mortality Report and made publicly available to ensure public transparency regarding the health, welfare, and safety of members of the Target Population. This is the third mortality review report from the Committee.

MY CHOICE MORTALITY REVIEWS

For Calendar Year (CY) 2023, twenty-seven (27) mortalities were reported and fifteen (15) mortalities were submitted to the Mortality Review Committee for review. Of these fifteen mortalities, eight (8) of the individuals were experiencing significant health issues and two (2) were receiving hospice care at the time of their passing or died in the hospital (and are not considered unexplained).

The remaining 12 mortalities were not unexplained, abuse/neglect/exploitation were not suspected, and it was not early in the transition process, therefore these individual cases were not referred to The Committee. The remaining fifteen cases were referred to the Committee based on the specified referral criteria. The Committee referred these individuals to the mortality review team who collected the following information (if referred to or enrolled) on all fifteen cases:

- The current plan of care for MCO Case Management and Waiver; MCL ITPs, CCM CPOCs, if applicable ;
- The current treatment plan from the behavioral health provider;
- Progress notes for 90 days preceding the individual's death for any Home and Community Based (HCBS) provider type, including but not limited to, behavioral health, support coordination, or direct service provider;
- Hospital and emergency department records including discharge summaries and all ancillary department records, from the past year;
- Medical records in the custody of health care providers from the past 6 months,
- Adverse incident reports from the past year;
- The death certificate; and
- Autopsy records.

After the applicable records were collected, the My Choice Mortality Review Team completed the Mortality Review form, which summarized all events leading up to and immediately preceding the individual's death. The My Choice Louisiana Mortality Review Committee convened throughout 2023 to perform a comprehensive review of the fifteen cases.

Of the fifteen referred cases:

- 13 cases were unexplained deaths;
- 6 cases occurred with 60 days of transition from a nursing facility discharge, however, the two participants were receiving hospice at the time of their death or died in the hospital (and are not considered unexplained);
- 8 cases required remediation with corrective action plans
- 5 referred to HSS for review
    - 2 accepted for HSS investigation
    - 3 did not meet criteria for HSS investigation
- 7 cases did not require remediation (Case #7,#9, #10, #11, #13, #14, and #15)

See Appendix A at the end of this report for a visual representation of these cases.

Five of the 15 reviewed cases (Cases #1, #2, #3, #4, and #5) were recommended for referral to LDH's HSS for further investigation of the direct service provider agencies and one nursing facility.

The below chart details the breakdown of the My Choice Target Population deaths in CY 2023. It describes the number of deaths, reviewed cases and cases pending review. Five cases were referred to HSS in which two required corrective action plans for the direct service provider agency. Additional corrective action were required for the transition coordinator, ACT provider, and support coordination agencies.

CY 2023 Mortality Review Committee							
Number of My Choice Reported deaths	**Number of My Choice deaths referred to The Committee**	**Number of reviewed cases**	**Number of cases pending review**	**Number of reviewed cases referred to HSS for review**	**Number of reviewed cases pending corrective action**	**Number of corrective action plans required and approved**	**Number of corrective action plans required and pending approval**
27	**15 (13-Transitioned 2-Diverted)**	**15**	**0**	**5**	**0**	**8**	**0**

REMEDIATION

Following DOJ Mortality Review HSS referral and investigation, HSS reports to the Committee the results of their investigation. Case #1 resulted in a substantiated allegations; one deficiency in the area of criminal background checks was cited for the DSW who had been assigned to work with the client. The DSW's criminal background check results revealed the DSW had convictions that barred employment. Case #2 received an on-site investigation with results indicating no deficiencies noted.

Case #3, #4 and #5 did not meet criteria for HSS investigation.

In addition to the HSS referrals, additional areas were noted for remediation for cases #5 and #6. These two cases required remediation training for transition coordinators (communication and documentation). Two cases (#5 and #12) required support coordination agency remediation on critical incident documentation and documentation follow up.

CHALLENGES AND NEXT STEPS

The Committee will continue to meet to review individual cases, pursue corrective action as needed, review aggregate data to identify trends in statewide, regional or provider-level performance, and recommend system level quality improvement as identified. The Committee will meet once per month, unless a MRC case requested documentation is not ready for review.

One instance of systemic improvement that was noted was the need for an updated self-neglect definition within the Office of Behavioral Health. APS provided training to the Managed Care Organizations and Community Case Management around proper identification and reporting. Implementation of this recommended systemic improvement went into effect August 2024.

In CYs 2020-2022, reviews challenges included lengthy waits to acquiring paperwork and documentation from local coroner's offices, direct service and healthcare providers. In CY 2023, The Committee experienced shorter processing time for investigations, which helped to review cases faster, and provide timely remediation to any identified corrective action. Average length of time to complete a full mortality review now averages 172 days (previously 254 days).

The Committee will continue to identify remediation activities associated with individual cases and address identified systemic issues to improve the quality of life and delivery of home and community based services for members of the Target Population. Additionally, The Committee continues to identify solutions to reduce risk and prevent adverse events for Louisiana citizens.

The next My Choice Annual Mortality Review Report covering CY 2024 will be made available in the third quarter of 2025.

APPENDIX A

Cause of Death	Unexplained Death	Within 60 days of NF Discharge	Remediation/ Corrective Action	HSS Referral	Accepted by HSS
Hypertensive Arteioscietotic Cardiovascular Disease, Diabetes	*				
Acute Coronary Syndrome	*		*	*	*
Cardiopulmonary Arrest	*	*			
Atherosclerotic Cardiovascular Disease	*		*	*	
Atherosclerotic Cardiovascular Disease, Hypertension	*		*	*	*
Coronary Artery Disease, Hypertension, Diabetes		*	*	*	
Gunshot Wound	*		*		
Gastrointestinal Hemorrhage due to Duodenal Ulcer, Clostridium Difficile Colitis, Chronic Kidney Disease, Diabetes	*				
Adenocarcinoma Colon	*				
Multiple Drug Toxicity	*	*			
Endometrial Cancer		*	*		
Cerebrovascular Vascular Disease	*	*	*		
Hepatic Encephalopathy	*				
Hypertensive Cardiovascular Disease, Chronic Obstructive Pulmonary Disease	*	*	*	*	
Sudden Cardiac Death	*				