My Choice Louisiana

Annual Mortality Review Report #2

Calendar Years 2020-2022

Agreement to Resolve the Department of Justice Investigation

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, 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 (HSS, OAAS, OBH, 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 Office of Aging and Adult Services (OAAS) and Office of Behavioral Health (OBH) and includes Quality Management (QM) staff, OBH Medical Director, OBH Chief Psychologist, and representatives from Health Standards (HSS), 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.

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 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.

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 second mortality review report from the Committee.

MY CHOICE MORTALITY REVIEWS

Between Calendar Year (CY) 2021 and CY 2022, there were nineteen mortalities reported for the My Choice population. Of these nineteen mortalities, eight of the individuals were experiencing significant health issues and were receiving hospice care at the time of their passing. As these mortalities were not unexplained, abuse/neglect/exploitation were not suspected, and it was not early in the transition process, these individual cases were not referred to The Committee. The remaining eleven cases were referred to the Committee based on the specified referral criteria. In addition to the eleven cases for CY 2021 and 2022, there was one pending review from CY 2020, thus a total of 12 cases that needed review during this timeframe. The Committee referred these individuals to the mortality review team who collected the following information (if referred to or enrolled) on all twelve 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 2022 and 2023 to perform a comprehensive review of the twelve cases.

Of the twelve referred cases:

- 10 cases were unexpected deaths;
- 2 cases occurred with 60 days of transition from a nursing facility discharge, however, the participants were receiving hospice at the time of their death (cases #3 and #5) and are not considered unexpected;
- 10 cases required remediation with corrective action plans
- 2 cases did not require remediation (Case #11 and #13)

Five of the 12 reviewed cases (Cases #1, #2, #5, #9, #10) required referral to LDH's HSS for further investigation of the direct service provider agencies.

The below chart details the breakdown of the My Choice Target Population deaths in CY 2020-2022. It describes the number of deaths, reviewed cases and cases pending review. Five cases were referred to HSS in which one required a corrective action plan for the direct service provider agency. Additional corrective action were required for the transition coordinator, ACT provider, OAAS regional office, and support coordination agencies.

CY 2020-2022 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 requiring HSS referral**	**Number of reviewed cases pending corrective action**	**Number of corrective action plans required and approved**	**Number of corrective action plans required and pending approval**
19	**12**	**12 (includes one carryover review from 2020)**	**0**	**5**	**3**	**7**	**0**

REMEDIATION

Following DOJ Mortality Review HSS referral and investigation, HSS reports back to the Committee the results of their investigation. Case #2 resulted in unsubstantiated allegations involving the direct service agency that did not require remediation or corrective action. HSS investigated the support coordination agency and found the allegations of quality of care/treatment and administration/personnel was substantiated for lack of critical incident entry and follow up. This required a corrective action plan which has been submitted by the providers and remediation is complete.

Case #10 required corrective action from the ACT provider due to lack of documentation regarding hallucinations and medication. Remediation and corrective action has been completed. HSS investigated and cited one deficiency related to case #10 not receiving all service hours by the direct service provider. Completion of corrective action in cases #1, #5, and #9 is pending at the time of this report. Corrective action will be completed by the next mortality report.

In Quarter 3 of 2023 (July through September), OAAS conducted a training to all direct service provider agencies and support coordination agencies on critical incident reporting policy and procedure. Agenda items included a review of critical incidents, reporting requirements, and roles. In 2023, there was an added on training on Transition Coordinator documentation and follow up actions.

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.

One instance of systemic improvement that was noted was the need for a Medicaid transportation representative on The Committee when a Medicaid transportation barrier is discovered during the review process. A representative from Medicaid transportation will attend only when Medicaid transportation has been identified as a barrier.

Challenges presented during the CY 2020-2022 reviews included lengthy waits to acquiring paperwork and documentation from local coroner's offices, direct service and healthcare providers. There is also a wait when a referral is made to HSS or APS divisions as these teams complete their investigation within their timelines. The Committee will convene to discuss possible methods to reduce timelines or adapt The Committee procedure to account for such delays.

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 2023 will be made available in the

fourth quarter of 2024.