

**Agreement to Resolve the Department of Justice Investigation**

**Report by Subject Matter Expert**

**May 2019**

## Section 1--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. Specifically, the complaint alleges that the State relies on providing services to these individuals in institutional settings, specifically nursing facilities, rather than the community. Under this Agreement, the State is required to create and implement a plan that will 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.

The Agreement sets forth the requirement for a Subject Matter Expert (SME). The SME is to provide technical assistance to help the State comply with its obligations under the Agreement. The SME has various responsibilities including analyzing and reporting data on the State's progress in complying with all sections of this Agreement. In addition, the SME is responsible for assessing the quality of community-based services for members of the Target Population (defined in the Agreement). The State engaged the Technical Assistance Collaborative (TAC) in August of 2018 to perform the SME responsibilities. Every six months, the SME will draft and submit to the Parties a comprehensive public report on LDH's compliance including recommendations, if any, to facilitate or sustain compliance. This is the initial SME report.

Since the Agreement was signed, the State has made progress in various areas that are worth noting. Many of these areas are fundamental to the success of the State's efforts under the Agreement. This includes:

- Finalizing the Implementation Plan
- Developing initial transition protocols and processes for individuals in the Target Population transitioned from nursing facilities
- Developing an In-reach and Outreach Plan
- Recruiting, hiring, and training Transition Coordinators
- Transitioning an initial cohort of members of the Target Population from nursing facilities
- Implementing initial stakeholder engagement strategies
- Initiating efforts to identify quality indicators and related data sources
- Initiating service planning activities regarding crisis and supportive housing

There are several areas of significant focus for the State over the next six months and beyond. Some of these areas are continued work in the areas discussed above. However, the priority areas will be:

- Continuing efforts to transition members of the Target Population from nursing facilities
- Developing a community case management model for individuals who are diverted or transitioned from nursing facilities
- Finalizing the draft indicators and data sources needed to support these indicators
- Initial drafts of the crisis and housing service plans
- Revising critical protocols and processes such as the Assessment and Transition Plan
- Continued efforts to implement the in-reach plan, including the use of peer specialists to assist with transitions from nursing facilities

- Developing an operational definition for the members of the Target Population who will be diverted from nursing facilities into community-based services
- Increasing stakeholder engagement through the use of key subcommittees of the Advisory Committee
- Reviewing the impact that revisions to Level of Care and Pre-admission Screening and Annual Resident Review had on reducing inappropriate nursing home admissions

## **Section 2--Finalizing the Implementation Plan**

### *Overview*

The Agreement required the State to develop an Initial Implementation Plan (the Plan), which would focus on the first 18 months of implementation. The Plan was to focus primarily on the obligations of the State to put the necessary building blocks in place to ensure smooth transitions from nursing facilities and timely and appropriate diversions from those facilities. The Agreement identified various areas the Plan was expected to address, including:

- Identifying and transitioning individuals who had the fewest barriers to transition
- Assessing and beginning efforts to build the capacity for the community-based system
- Developing and implementing training to the State, providers, and managed care organizations (MCOs) regarding the Agreement
- Identifying and addressing barriers to the provision of community-based services for the Target Population
- Developing targets for individuals who will be diverted or transitioned from nursing facilities

In addition, LDH was required to seek input from stakeholders including the Louisiana Housing Corporation (LHC), local housing authorities, Local Governing Entities (LGEs), Community Providers, members of the Target Population and their families and advocates, healthcare providers, and the Advocacy Center. LDH engaged LHC in the drafting of key sections of the Plan, with a particular focus on the development of the sections directly related to housing. For the LGEs, LDH discussed the Agreement during monthly meetings of the LGE executive directors and held several resident council meetings in order to gather feedback directly from nursing facility residents regarding barriers that should be addressed in the Plan.

### *Assessment*

In September of 2018, the State developed and submitted the first draft of the Plan to the DOJ and the SME. The Draft Plan was submitted to these parties within the timeframes set forth in the Agreement. Upon initial review, the Draft Plan addressed all eight required areas of the Plan and provided specificity regarding the activities in each of the Plan's areas, owner(s) of the task/activity, and the target completion date. The DOJ and the SME provided comments with recommended changes regarding this Draft Plan, which were incorporated into a subsequent draft.

In November of 2018, the State disseminated the Draft Plan to the members of its Advisory Group meeting, asking the Group to provide comments to LDH to identify goals, concerns, and recommendations regarding the Plan and the proposed implementation. The State provided 30 days for

stakeholders to review and recommend changes to the Draft Plan. The State received a limited number of comments from stakeholders, which focused on several key areas, including:

- Developing targeted training efforts for state staff and service providers regarding the Agreement
- Addressing the needs of individuals who are transitioned from nursing facilities and may lose their Medicaid eligibility
- Creating network development activities to address service gaps identified by the State
- Developing a Medicaid Waiver specific to the Target Population
- Improving access to behavioral health services for individuals who are admitted to nursing facilities
- Incorporating Person-Centered Planning and Values in key implementation activities (e.g., training)
- More independence in the PASSR Screening process

The State incorporated some of these comments in the final Plan. The state identified that it would require additional time to develop potential strategies (that were relevant for future documents or processes undertaken by the State) for addressing some of the comments.

The final Plan, as written, provides a high-level roadmap for the State through December of 2019 to continue to build the foundation necessary to be successful in their implementation efforts.

#### *Recommendation*

The State is entering into an intense period of work—moving from committing activities to paper to performing those activities. The Plan has over 100 specific tasks or activities that the state staff will need to complete within the next ten months. In most instances, staff that are responsible for implementation activities are also performing other activities that are not related to the Agreement. Therefore, State leadership will need to pay particularly close attention to staff's bandwidth as critical milestones are looming. In addition, stakeholder interest and participation will increase (which is positive). Staff will also need to make sure that these stakeholder efforts are well organized, information to stakeholders is timely, and the process continues to provide effective engagement in the Plan's rollout. As key deliverables are developed, the State should seek input from the SME, Department of Justice, and stakeholders. This input is critical in the State's efforts to be transparent and improve the buy-in and quality of these deliverables.

## **2.1: Workflow and Tracking System Development – Phase 1**

### *Overview*

By December 2019, the State will develop and implement a system to identify and monitor individuals in the Target Population who remain in Louisiana Medicaid after their transition from a nursing facility. This will allow the State to: ensure health and safety in the community; assess whether supports identified in the individual's discharge plan are in place and achieving the goals of integration; identify any gaps in care; and proactively address any such gaps to reduce the risk of readmission or other negative outcomes.

### *Assessment*

The State has assessed the existing information systems (including the interim SharePoint system, OPTS, and Utopia) that support components of the Agreement. Per this review, the State determined that the existing systems would not meet all aspects of the Agreement. Therefore, the State will need to develop a new system to assist in their efforts to track and monitor individuals who are transitioned or diverted from nursing facilities under the Agreement. They will also create a system that will facilitate and track many of the tasks that are required under the agreement.

At the encouragement of the DOJ and the SME, the State has developed an initial tracking system for individuals who have been identified for transition from nursing facilities. While the long-term plan is to have a more sophisticated approach to tracking, state staff have developed an interim system that captures critical information regarding outreach, the assessment and development of transition plans, and services requested by the individual—including specific information on preferences regarding housing. The interim system also tracks the progress of the individuals who have transitioned to the community. Information and data reports from this interim system are easily accessible and useable to state staff and will provide a good foundation for a longer-term tracking system post 2019.

### *Recommendations*

The Implementation Plan sets forth a pathway for developing key components of a more formal tracking system that will allow the State to track transitions and diversions from nursing facilities for members of the Target Population. There are several important activities and decisions that will need to be finalized over the next several months. For instance, the State will need to finalize the specifications for system requirements for tracking. In addition, it is recommended that the State also develop an initial data-use plan for warehouses, which can be used in ongoing performance improvement efforts. Finally, the State will need to make a decision as to whether they will be able to develop the necessary infrastructure internally or engage a vendor that will be able to assist the State in developing this more formal tracking system.

## **2.2: Medicaid Managed Care Organization (MCO), LDH Employee, and Provider Training**

### *Overview*

The Agreement requires the State to develop training for services to ensure that community providers have the skills and knowledge necessary to deliver quality community-based services consistent with this Agreement. The State is to establish a mandatory training policy, qualifications, and curriculum for community providers. The curriculum will include initial and continued training and coaching for community providers, and will emphasize person-centered service delivery, community integration, and cultural competency.

### *Assessment*

The State has taken various steps to meet the requirements of the Agreement. However, given that the State must first develop new services requirements, it is premature to have developed and implemented a robust provider training or managed care training initiative. Therefore, there are no specific training recommendations for MCOs or providers for the next several months. There are several training recommendations embedded in recommendations in other sections of the report regarding Transition Coordinators.

## **Section 2.3 Transition System Development**

### *Overview*

One of the overarching goals of this Agreement is to identify and transition all members of the Target Population who have been admitted to nursing facilities, but are able to and would like to receive services in the community. During the first 18 months of implementation, the State is required to identify nursing facility residents in the Target Population who have the fewest barriers to transition, and begin to transition those residents to the community using transition planning and community-based services sufficient to meet their needs. The State is also required to establish annual targets for transition of Target Population members from nursing facilities to successful placements in the community.

The Agreement requires the State to identify all members of the Target Population residing in nursing facilities, and offer comprehensive transition planning services. The State must develop transition teams composed of Transition Coordinators. The Transition Coordinators are responsible for conducting the assessment and developing an Individualized Transition Plan (ITP) for each member of the Target Population who is residing in a nursing facility. The ITP should be developed through a person-centered planning process in which the individual has a primary role; it should address the identified service needs and be based on principles of self-determination and recovery. In addition, the State must develop a plan for ongoing “in-reach” to every member of the Target Population residing in a nursing facility (discussed in more detail in Section 2.7). This will include providing information about the benefits of transition and about the community-based services and supports that can be alternatives to nursing facilities. For members of the Target Population who choose to remain in a nursing facility, or move to a setting that is not community-based, the State must document steps taken to identify and address barriers to community living, and efforts to ensure the individual’s decision is meaningful and informed. For those who transition, the Transition Coordinators will conduct post-transition follow-up to ensure that services in the community are initiated and delivered to individuals in a fashion that

accomplishes the goals of the transition plan. Finally, the State is required to develop a Transition Support Committee to assist in addressing and overcoming barriers to transition for individual members of the Target Population when those barriers cannot be successfully overcome by transition team members working with service providers, the individual, and the individual's informal supports.

The State is also required to provide ongoing case management in the community to members of the Target Population for a minimum of 12 months following discharge from the nursing facility. The Implementation Plan shall describe LDH's plan to ensure case management services. The case management approach shall ensure capacity to provide face-to-face engagement with individuals in the Target Population. The case management approach developed by the State must ensure that each member of the Target Population has a person-centered plan that will assist them in achieving outcomes that promote their social, professional, and educational growth and independence in the most integrated settings.

### *Assessment*

Prior to finalizing the Agreement, the State embarked on a process to develop the protocols and processes for transitioning individuals in the Target Population from nursing facilities to the community. The State had significant experience with this work through a federal demonstration program titled Money Follows the Person (MFP). MFP is designed to help people move or "transition" from an institution into home- and community-based living settings, such as a home or apartment. The Louisiana MFP program is known as the My Place program and has successfully transitioned 2,400 individuals (mostly individuals who were elderly and had a physical disability and/or an intellectual/developmental disability) from institutional settings to integrated community settings. The My Place program developed protocols for conducting in-reach to individuals to inform them of opportunities to transition to the community, assessing the individual's transition and ongoing service and support needs, developing a plan for the transition, and providing individualized support during and after the transition process. This positioned the State to modify the existing MFP protocols and processes for the Agreement's Target Population rather than recreating these protocols and processes. This allowed the State to launch its efforts to identify and begin transitions sooner because it did not need to undertake significant development of these protocols and processes during the initial planning phase. The State did modify these protocols and processes for the Target Population for members under the Agreement and will be reviewing and modifying these protocols and processes further during the initial implementation phase.

The State has established positions for 18 Transition Coordinators. Over the past year, the State has recruited, hired, and trained all 18 Transition Coordinators. Each of the nine LDH regions has OAAS and OBH Coordinators, in addition to two Project Managers who oversee the Transition Coordinators. Two Transition Coordinator vacancies have occurred since the original hiring; the State is actively recruiting and is hoping to have these positions filled in early- or mid-spring. The role of these Transition Coordinators is similar to Transition Coordinators deployed through the My Place program. These Transition Coordinators are responsible for in-reach and education to members of the Target Population in nursing facilities. They are also responsible for assessing the community-based needs (including behavioral health needs) of individuals who have expressed interest in transitioning to the community

and working with the individual to develop a transition plan. They are responsible for facilitating referrals for individuals who are transitioning from nursing facilities to community-based services.

The State has developed a multi-day training program for the Transition Coordinators. The training materials reviewed were comprehensive and seem to provide a good base for enhancing the competencies of the Transition Coordinator. Each Transition Coordinator receives training on their role, the referral process from nursing facilities, transition assessments and service planning tools, supportive housing, using person-first language, strategies for individuals who may experience more difficulties during the transition, and other areas. Additional training included: motivational interviewing, advocating for reasonable accommodations, person-centered planning, self-determination, recovery principles, and information on behavioral health services and making referrals to such services.

Over the past year, the State has begun the process of identifying members of the Target Population who may be initial candidates for transitioning from nursing facilities to community-based services. This included reviewing MDS data and information from PASRR Level II screens. Assessments have been started and completed and individuals have been offered the opportunity to transition from nursing facilities through the OAAS Home and Community-Based Waiver Programs and/or to OBH community-based services and supports. As of 12/31/2018, the State has undertaken the following activities towards transition:

- 274 Assessment in process
- 222 Assessments completed
- 68 individuals offered participation in the State's Home- and Community-Based Services Engagement
- 24 individuals in the Target Population transitioned

The State is commended for its efforts to transition individuals from nursing facilities. It is the SME's understanding that the individuals offered participation in the HCBS program are awaiting the final paperwork regarding the appropriate housing voucher and some members of the Target Population awaiting HCBS participation are continuing to review specific apartments/living arrangements that they find satisfactory prior to transition.

As indicated above, there is an expectation (per the Agreement) that case management is available to members in the Target Population pre- and post-transition. In addition, the Agreement requires case management services to be of sufficient intensity to ensure case managers are able to identify and coordinate services and supports to help prevent reinstitutionalization. In short, the case management model will be pivotal to the success of the Agreement. Members of the Target Population will rely heavily on these individuals to ensure a smooth transition, minimize initial (and ongoing) crises, answer day-to-day questions regarding their new life in the community, and assist them in maintaining community tenure. In addition, the State will need to ensure that there is a single point of accountability for this member in the community. The case management model should be a consistent experience, no matter what community option the member selects.

State staff are refining their case management approach for individuals in the Target Population. Most members of the Target Population who are transitioned from nursing facilities are eligible to participate in the State's home- and Community-Based Waiver program, administered by OAAS, and are receiving

community case management through the Waiver's Support Coordinators. However, some individuals will not desire or will not be eligible for the Waiver and will be served by OBH or through MCOs and their care coordination/case management efforts. For individuals who will be served by OBH, an OBH Transition Coordinator will work with them to identify and facilitate access to the supports and services needed during and post-transition. However, there is no OBH case management model in place post-transition. While community support services offered by Mental Health Rehabilitation (MHR) providers may be available for these individuals and may provide critical activities, the intensity of the case management activities might not be enough to ensure individuals have the necessary supports and services to be successful in transitioning to the community and sustaining their tenure.

Therefore, there is not an existing model of case management that will suffice for many of the individuals in the Target Population. Some, but not all, of these functions are provided in existing approaches (e.g., Assertive Community Treatment, Support Coordination, MHR Community Psychiatric Support workers, Permanent Supportive Housing staff, and Transition Coordinators). In addition, the intensity of contact that will be requested/needed for individuals in the Target Population is not available through many of these options. Lack of a consistent and intensive approach may lead to longer transition periods and/or threaten an individual's tenure in the community, and may also violate the requirements of the Agreement.

### *Recommendations*

While the initial efforts by the State to identify and transition individuals from nursing facilities have been laudable, the State will need to amplify its transition efforts over the next six months. This will include setting targets for successful transitions for the balance of the year, and developing annual targets for subsequent years. The targets will be driven by a number of factors including the availability of intensive community support services, integrated and meaningful day opportunities, crisis services, and peer supports. The State should also provide the SME with information regarding the individuals that are awaiting transition—specifically any transition barrier that the State has identified for these individuals. In addition, the State will need to finalize and operationalize its approach to case management in order to continue to ensure smooth and successful transitions. Finally, the targets developed in the housing plan will also drive the State's development of annual targets for the number of individuals transitioned from nursing facilities.

The SME has also reviewed the Assessment and Transition Planning documents used by the Transition Coordinators during the initial transition process. Based on an initial review of these protocols, the SME recommends considering the following changes:

- Reframing the assessment tool and process to be more person-centered
- Gathering information during the assessment process regarding integrated day opportunities, crisis planning, and treatment and service opportunities for individuals. The Assessment and Transition Plan should include information from discussions with the members regarding how they want to spend their days in the community—e.g., employment, volunteer work, or general daytime activities, and identification of the needed supports for these
- Providing more specificity in the tools and processes regarding the housing options that are available in the community post-transition
- Adding more information in the Assessment and Transition Plan regarding crisis triggers and crisis planning

- Identifying individuals who have extensive histories of co-occurring mental health and substance use disorders and including preventive and early intervention strategies in their transition plan
- Creating clearer protocols regarding the participation of community providers in the transition process

In addition to changes in these protocols, the State's in-reach efforts should be implemented over the next six months to include individuals with lived experience (peers) to assist the Transition Coordinators in having initial discussions with the Target Population about opportunities to transition to the community.

It is also recommended that the current protocols and training materials for assessment and planning be reviewed by the Transition Coordinators, providers, and MCOs, along with individuals from the recovery community and other stakeholders. The review could provide improvements to ensure that the protocols and processes are both person-centered and recovery-oriented. Once the next generation of the Assessment and Transition Plan are developed, the State should provide training to the Transition Coordinators regarding these new protocols and processes.

Over the next six months, the State should finalize the design of the case management model. This model should incorporate the principles of self-direction and recovery. In addition, the State should develop a strategy for operationalizing the case management models. Specifically, this strategy should address the process for identifying agencies that have the competencies (or are good candidates for developing such competencies) to implement case management consistent with the State's vision. This will require the State to identify the necessary Medicaid authorities. In addition, the strategy will include clarification of the role of the MCOs in the model. Specifically, the case management model will need to clearly delineate the responsibilities of the MCO care managers and the community case managers.

## **2.4 Diversion System Development**

### *Overview*

Another overarching goal of this Agreement is to divert members of the Target Population away from inappropriate nursing facility placements. The Agreement requires the State to develop and implement a plan for a diversion system that has the capability to promptly identify individuals in the Target Population seeking admission to nursing facilities and provide intervention and services to prevent unnecessary institutionalization. The plan must include the development of community support services required by the Agreement. According to the State's Implementation Plan, this diversion plan will be completed within the next six months. The State is also required to implement improvements to its process for screening and evaluating individuals referred to nursing facilities, in order to prevent unnecessary admission. In brief, the Pre-admission Screening and Annual Resident Review (PASRR) process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have a serious mental illness (SMI). This is called a "Level I screen." Those individuals who test positive at Level I are then evaluated in depth, called "Level II" PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.

The State is required to implement improvements to its existing processes for screening individuals prior to approving nursing facility placement and ensure that all individuals applying for nursing facility services are provided with information about community options. The State is required to develop and implement standardized training required for all personnel who complete any part of the Level I screenings (with the exception of physicians). The State is to provide additional training to ensure that evaluators who are completing the Level II PASRR are familiar with the complete array of home- and community-based services available to provide and maintain community integration. The State is also required to revise Level II forms to include more extensive and detailed information regarding services in the community. In addition, the state must ensure that each individual in the Target Population who has been admitted to a nursing facility receives a new PASRR Level II annually, and upon knowledge of a significant change in the resident's condition, to determine whether his or her needs can be met in a community-based setting. The evaluation must be conducted by a qualified professional independent of the nursing facility and the State.

During the first 18 months of implementation, the State is required to establish annual targets for diversion of Target Population members from nursing facilities to successful placements in the community. In addition, it must establish annual targets and strategies for decreasing referrals for individuals with serious mental illness to nursing facilities.

#### *Assessment*

The State has undertaken various changes to the process for screening individuals prior to placement in a nursing facility. The State has implemented changes to the initial level of care determination process to ensure appropriate use of temporary stays and continued stays. The State has also modified approval standards for PASRR Level II to include initial authorizations of no more than 90 – 100 days in a nursing facility. The State has implemented improvements to processes to ensure that individuals applying for NF services receive information about community options. The State has developed and implemented standardized training to improve identification of persons with SMI during PASRR Level I and improve knowledge of community services for staff who are completing Level II screens. The State has also eliminated the behavioral pathway as an eligibility pathway for new NF admissions. Additionally, the State has put in place improved protocols and processes for each individual who received an initial Level II and was admitted to a NF to ensure they receive a new PASRR Level II annually. The State has included in its PASSR evaluations: the intended duration, reason for duration, the need for specialized behavioral health (BH) services, and barriers to community placement at time of temporary admission. Finally, the State has improved processes to refer all persons screened who are suspected of having SMI with dementia to Level II for evaluation, including those 65 and older. While the State has indicated that these activities are completed, the SME has not had an opportunity to review these deliverables.

A key element of the implementation plan is a definition of the diversion population. The definition will allow the State, MCOs, and providers to identify individuals with significant mental health conditions who may be most at risk of placement in a nursing facility. The State is undertaking initial efforts, directed by the SME, to define the population using claims and other administrative data for members of the Target Population who have been recently admitted to a nursing facility. This data may allow the State to identify trends in risk factors that can identify and predict the most likely candidates to be admitted into nursing facilities, which could assist with their definition of the diversion population.

#### *Recommendations*

The State has made progress in making the necessary changes to determining if individuals meet the nursing facility level of care and are better screened through the PASRR process. Over the next six months, the SME will review these documents. In addition, the State should review data and other information to determine if these changes have made a measurable difference in the number of individuals with SMI who are admitted to a nursing facility. At a minimum, this should include a multi-year review of admissions and diversions of individuals with SMI. This would include developing baseline information for LOC screenings, PASRR Levels I and II (for both individuals who were seeking admission into nursing facilities and for annual resident reviews for individuals with SMI that were previously admitted to nursing facilities).

The State is scheduled to have a definition of the diversion population within the next several months. The definition can serve several purposes, including helping the State to establish annual targets for decreasing referrals for individuals with SMI to nursing facilities. Once the State develops an initial definition, they should work with their MCOs and community providers regarding strategies to identify the population, have MCOs develop the necessary care management strategies (similar to strategies employed for similar high risk/high need populations), and implement the preferred case management strategy. In addition, the State will also need to establish annual targets for the diversion of Target Population members from nursing facilities to successful placements in the community and annual targets and strategies for decreasing referrals for individuals with serious mental illness to these facilities.

This case management strategy should specifically identify a single point of accountability for engaging individuals into services and identifying and coordinating the necessary services and supports to improve community integration, enhance recovery, and reduce unnecessary emergency department and hospital admissions, which are the most significant gateway to nursing facilities. Similar to internal and external process improvement strategies for transition activities, the State should incorporate “lessons learned” from their early diversion efforts.

## **2.5 Community Support Services Development**

### *Overview*

The Agreement requires the State to undertake an analysis of the adequacy of the network to offer key services that will be needed for transition and diversion activities. The Agreement requires the State to develop and implement a plan for its crisis services system that provides timely and accessible services and supports to individuals with SMI experiencing a behavioral health crisis within their local community. The services shall include a mobile crisis response capacity, crisis intervention services, and crisis telephone lines. The State shall develop policies, procedures, and core competencies for crisis services providers. In addition, the Agreement requires the State to expand Assertive Community Treatment (ACT) services to ensure network adequacy and to meet the needs of the Target Population. ACT teams will operate with high fidelity to nationally recognized standards. In addition, the State is to monitor the MCOs, LGEs, and Medicaid provider network to ensure the number and quality of community mental health service providers are sufficient to enable individuals in the Target Population to transition to and live in the community with needed community-based services. The State will also develop and implement a plan to ensure that all individuals in the Target Population have access to an array of day activities in integrated settings. Integrated day activities shall include access to supported employment and rehabilitation services, which may include but are not limited to competitive work,

community volunteer activities, community learning, recreational opportunities, and other non-congregate, integrated day activities.

The State is also required to develop a plan to provide access to affordable, community-integrated housing for members of the Target Population. This includes but is not limited to expansion of the State's current permanent supportive housing (PSH) program. The State must set annual targets for creation of additional housing units and rental subsidies to be made available to members of the Target Population. The State is also required to establish state-funded short- or long-term rental subsidies as needed to meet the requirements of this Agreement. Within 18 months of the execution of this Agreement, the State is to establish a minimum of 100 state-funded short-term rental subsidies to assist with initial transitions. In addition, the State is to employ a sufficient number of Tenancy Support Managers (TSMs) to conduct landlord outreach, provide tenancy supports when Medicaid-enrolled providers are unable to do so, provide technical assistance and support to landlords and/or tenancy support providers during the leasing process, and address crises that pose a risk to continued tenancy.

### *Assessment*

The State has made progress on initial planning efforts in two key areas identified in the Agreement: crisis and housing. Over the past several months, the State has begun internal efforts to frame the vision and content for developing the plans required under the Agreement.

The State has embarked on a strategy for developing a Crisis Plan that includes a public engagement process through a Request for Information (RFI). The purpose of the RFI is to seek input from a broad range of stakeholders to assist in the development of a vision for a modern and comprehensive crisis system of care. As written, this RFI should provide valuable information to the Crisis Plan. Information obtained from the RFI process should assist the State in their efforts to develop a crisis continuum of care as required per the Agreement.

The State is in the process of developing a housing plan that sets forth specific annual targets for creation of additional housing units and rental subsidies to be made available to members of the Target Population. State staff are working with the SME's team members to assist with these internal efforts. The State has started to engage stakeholders in identifying current efforts to offer various crisis services throughout the State and to develop a more formal method (e.g., Request for Information) to obtain information and recommendations from stakeholders for statewide and/or more regional crisis efforts.

The State, through its Managed Care Organizations (MCOs), has also conducted fidelity reviews of Assertive Community Treatment (ACT) providers. These reviews, done by an independent reviewer, were generally very positive—providers were offering these services consistent with national fidelity tools.

State staff have been working on efforts to establish state-funded short- and long-term rental subsidies as needed to meet the requirements of this Agreement. In cooperation with Louisiana Housing Corporation (LHC), and with the assistance of the SME team, LDH is developing policies and procedures to guide its management and oversight of the My Choice State Rental Assistance Program (RAP). In addition, the State is beginning its efforts to develop a housing plan that will be completed by the end of the year. The State has engaged two additional Tenancy Support Managers to augment existing TSMs and provide statewide coverage to assist members of the Target Population transitioning from nursing facilities. The State also plans to take advantage of the Mainstream Vouchers, recently awarded to the

LHC, to provide affordable housing opportunities and to work with the LHC and other public housing agencies to apply for additional voucher funding when it becomes available from the U.S. Department of Housing and Urban Development this summer.

The State is using several tools to measure availability and access of MHR and other behavioral health services. The State currently requires managed care plans to report, on a quarterly basis, whether Medicaid beneficiaries have access to services consistent with access requirements set forth in the MCO contracts. The MCOs do report quarterly on both ACT and MHR services and whether there are access issues that represent service gaps. In addition, the MCOs have to identify whether providers are accepting new referrals—a good proxy to determine if there may be a gap in capacity even if there is not a gap in access.

However, an initial scan of the Louisiana mental health system indicates that there are limited options and therefore limited availability of integrated day services that would support an individual's recovery. While there are some "pockets" of these services, it is not clear how available they are throughout most communities.

### *Recommendation*

The State should use the next several months to undertake activities to identify, develop, or enhance services for individuals during the day. Initially, the State should define a continuum of integrated day services for members of the Transition Population (which may have larger positive implications for the population of adults with significant mental health needs). This continuum should be age-appropriate and should include information from the preferences of the individuals who were the first to transition. It should also capture information from the Assessment and Transition Plan for those individuals who are awaiting transition. The Agreement sets forth examples of integrated day activities including competitive work, community volunteer activities, community learning, and recreational opportunities. The Agreement also sets forth an expectation that the focus of these integrated day activities be person-centered and include supported employment opportunities. It is recommended that the State review other state's integrated day activities that are offered by peer-run organizations—which could include drop-in centers. Drop-in centers (in particular, peer-operated drop-in centers) are becoming strong centers for advocacy and have evolved into environments where people learn about recovery, access resources, develop self-esteem and leadership skills, and obtain employment. Some common activities at drop-in centers include, but are not limited to: self-help group meetings, group meals, weekly or monthly socials or parties, social/recreational excursions, consumer speakers' bureau, individual advocacy, systems advocacy, referral bank for mental health services, computer access and training, employment services, guest speakers/workshops, assistance with basic needs, consumer-run businesses, political events, and outreach programs. It is suggested that the State work with one of the Advisory Committees to define this continuum of integrated day services. The State is developing subcommittee structures to the Advisory to assist them in the planning and implementation efforts. Having a subcommittee for defining and identifying the continuum of day services would enhance the work of the State in this area.

For crisis services, the RFI should not be the only process used as an input for the Plan. It is recommended that the State consider additional processes for obtaining input on the development of an array of crisis services. Specifically, the State should draft an initial Crisis Plan document within the next six months and review the Plan with a subcommittee of the Advisory Committee and with consumers, families, and critical stakeholders including representatives from LGEs, behavioral health

advocates, behavioral health representatives, law enforcement, and health systems that provide urgent and emergency services.

Several needed improvements were identified for ACT. The fidelity reviews recommended additional staff to improve staff-to-member ratios and referrals and provide better engagement for some teams. In some instances, ACT teams were operating under capacity and a higher than expected percent of individuals had shorter than expected tenure with ACT services.

There are also various steps that the State will need to undertake as part of their planning and implementation efforts regarding housing. Specifically, the State will need to:

- Finalize the Rental Assistance Program design and begin implementation, including potentially establishing a pool of funds to purchase new move-in kits
- Work with LDH and LHC to transition some members of the Target Population onto the PSH Project-Based Voucher Program and to tenant-based Mainstream Vouchers
- Work with LDH and LHC to apply for additional Mainstream Voucher funding from the U.S. Department of Housing and Urban Development, including identifying incentives for PHA participation

In addition, the State will need to develop a first draft of the statewide housing plan for the Target Population. While obtaining public input into this housing plan will be critical, it will be important for LDH and LHC to develop and implement a strategy to inform the affordable housing industry of the State's responsibilities under the Agreement and its planned efforts to create the necessary supply of supportive housing for the Target Population.

Finally, for existing Medicaid-covered behavioral health benefits (available through the Mental Health Rehabilitation program and other Medicaid programs), it is recommended that the State provide the findings of MCO-generated reports on network adequacy to the SME and the Advisory Committee (or related subcommittee) highlighting potential access issues regarding these services and a strategy for network development that will address these gaps. In addition, it will be helpful to consider other data analytics regarding access and engagement (e.g., whether individuals continue to engage in services within 30-60 days from an initial appointment).

## **2.6 Quality Assurance and Continued Quality Improvement**

### *Overview*

By December 2019, the State will develop and implement a quality assurance system consistent with the terms of the Agreement. The State will collect and evaluate data and use the results to identify and respond to trends at the individual, provider, and systemic levels. The State will collect and analyze consistent, reliable data to improve the availability, accessibility, and quality of services to achieve positive outcomes for individuals in the Target Population. In addition, this quality assurance system will include a critical incident management system and will identify and take steps to reduce risks of harm and ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings, consistent with principles of self-determination. The State is also responsible for establishing reporting and investigation protocols for significant incidents, including mortalities. At least annually, the State must report publicly on a range of a data elements collected pursuant to the Agreement, and

on the availability and quality of community-based services and gaps in services, and plans for improvement.

### *Assessment*

The State has undertaken a variety of activities that will well position it for initial and ongoing quality assurance and quality improvement efforts. Staff that are leading the quality assurance efforts have begun work on several important areas set forth in the Agreement, including:

- **Critical Incident Reporting**—the Agreement requires the State to track several important factors specific to safety and freedom from harm (e.g., neglect and abuse, exploitation, injuries, critical incidents and deaths, timely reporting, investigation, and resolution of incidents). Soon after the Agreement was finalized, staff began work on creating processes for critical incidents. This included reviewing existing regulations and requirements of existing program (e.g., existing home- and community-based services programs) to determine how well they adhered to the Agreement. In addition, staff reviewed information provided by the DOJ regarding approaches used by other states to report and resolve critical incidents.
- **Mortality Review Committee**—the Agreement requires the State, as part of its critical incident review process, to review deaths of members in the Target Population who have transitioned from these facilities, including any unexplained death and any death within 60 days of discharge from a Nursing Facility. Staff have begun efforts to design the mortality review process, taking into account existing processes within the State and other states' processes for similar populations.
- **Identification and Initial Operationalization of Key Indicators**—under the Agreement, the State is required to collect and analyze consistent, reliable data to improve the availability, accessibility, and quality of services to achieve positive outcomes for members in the Target Population. There are specific areas for measurement set forth in the Agreement, including: referral to, admission and readmission to, diversion from, and length of stay in, nursing facilities; person-centered planning, transition planning, and transitions from nursing facilities; incidence of health crises; choice and self-determination; and community inclusion and barriers to serving individuals in more integrated settings. The State has begun efforts to operationalize these areas by identifying potential indicators and ensuring there is a data source for populating these measures, the latter being key since some measures may not have an existing data source and the State will have to plan for alternative methods for reporting and analyzing the data.

### *Recommendation*

The State should continue its quality assurance and quality improvement efforts under the Agreement. Specifically, in this next period the State should identify the potential indicators that will be finalized later in 2019. The State should continue its efforts to crosswalk these indicators to all relevant data sources and identify which indicators may have no data source (and therefore the State may need to develop a source in the future). While there are key indicators identified in the Agreement that the State should continue to operationalize, there are interim measures that the State may want to consider. An important interim measure should focus on network development activities. The State will develop new services and create additional capacity for existing services. While it will be important to measure the quality of these services, an initial step would be to track the number of providers

interested in offering new services (or new providers offering existing services), the number of providers that eventually become a network provider, and initial training these providers received on the model(s) for these new services. The State should consider indicators related to network development, identify the data source for these indicators (MCOs or the State), and develop a “dashboard” for stakeholders to review progress of network development activities.

The State should formalize efforts for external process improvement strategies to garner information from the experience of individuals initially transitioned from nursing facilities. This process is in addition to the Transition Support Committee that the State must create to assist in addressing and overcoming barriers to transition for individual members of the Target Population. Specifically, the State should develop a formal external process to begin to gather qualitative information that will provide important lessons learned to make the necessary changes to improve the transition experience for the future. It is recommended that this be an ongoing effort, since the members of the Target Population who were initially transitioned may have fewer barriers than individuals who will be subsequently transitioned. External inputs into this process include information from members of the Target Population (and, when appropriate, their families and support network) who have been transitioned, Transition Coordinators, Tenancy Support Managers, community case managers (including support coordinators), providers (including nursing facility and community providers), and other key informants who will prove invaluable to ongoing improvements in the transition process.

These external discussions will identify barriers that are impacting transitions (both the number and timing of transitions). While some of these barriers may be directly related to the availability of services, it is quite possible that service coverage and other policy issues may be identified that the State will need to address through formal and informal policy changes. The State is proposing to have a subcommittee of the Advisory Group to assist with the identification of resources for individuals who may be more challenging to transition. While this is definitely a good use of stakeholder input, it is recommended that the State continue to use the Advisory Committee process for obtaining feedback regarding the State’s approach for transitioning members of the Target Population from nursing facilities. As indicated above, the process should include individuals who have direct experience with initial transitions and who will provide invaluable information on successful and less successful transition efforts to improve the transition process. Information from both internal and external process improvement efforts should also be conveyed to the Advisory Committee for their discussion and recommendations.

## **2.7 Stakeholder Engagement, Outreach and In-reach**

### *Overview*

LDH shall conduct broad stakeholder outreach to create awareness of the provisions of this Agreement and actions taken by LDH to accomplish the goals of the Agreement. In addition, the State LDH is required to develop and implement a strategy for ongoing communication with community providers, nursing facilities, and hospitals on issues related to implementation of this Agreement. The State is also required to develop a plan for ongoing in-reach to every member of the Target Population residing in a nursing facility, regular presentations in the community in addition to onsite at nursing facilities, and inclusion of peers from the Target Population in in-reach efforts.

### *Assessment*

The State has made solid efforts to initially engage stakeholders over the past year. This engagement has consisted of different strategies: education regarding the Agreement, development of a website that has information regarding the Agreement and the Plan, outreach to stakeholders while drafting the Plan, and the development of an Advisory Committee for the Agreement, referenced above. The State has also reported their efforts under this Agreement to the State’s Behavioral Health Advisory Committee. In addition, the State has held individual meetings with the Local Governing Entities (LGEs) to introduce them to the Transition Coordinators, explain the overall approach to the Agreement and the transition process, and offer clarification or information requested by the LGEs. The State has also presented at various statewide conferences including the Louisiana Nursing Home Association and Ombudsman Conference. Initially, in person stakeholder engagement and participation seemed challenging—which is natural given the large-scale transformation set forth in the Agreement. Stakeholders seemed cautious and skeptical about the State’s proposed efforts to meet the terms of the Agreement.

In December, LDH developed a plan for in-reach to members of the Target Population residing in a nursing facility. The in-reach plan set forth various activities that the State was undertaking in this area, including:

- Creating and implementing the necessary processes, procedures, tools, and tracking systems necessary to begin identifying, assessing, and transitioning individual members of the Target Population currently residing in nursing facilities
- Hiring staff and developing training to prepare them for multiple new roles; developing workflows and processes that integrate new and existing tasks across multiple LDH offices and functions at both the state and regional levels; developing transition assessment, planning, and monitoring tools and trainings; and developing interim systems and analytics to support workflows, data collection, monitoring, and process improvement
- Locating peers throughout the State to work with Transition Coordinators and help to identify and engage with those members of the Target Population who will transition into the community
- Developing resource guides for members of the Target Population during the in-reach and transition process

As written, the in-reach plan is comprehensive and reflects a solid initial effort to identify individuals who may be transitioned. It also sets forth the foundational workflows for Transition Coordinators. In addition, the use of peers for in-reach is a best practice. What is lacking is information on which in-reach activities will be statewide and which activities the State may be initiating in specific regions that may have the community resources more immediately available to members in the Target Population who are transitioning from nursing facilities.

### *Recommendation*

Critical to the success of their ongoing implementation efforts will be the meaningful participation of stakeholders throughout the tenure of the Agreement. The State will have to build off of its initial efforts to strengthen its stakeholder engagement process. Over the next six months, the State has several Advisory Committee meetings planned. In addition, the State should immediately identify and recruit members of subcommittees who can provide valuable feedback in several areas, including:

statewide service plans (e.g., crisis and housing), resource identification (in process), identification of service gaps, and related network development activities.

The State should focus on improving stakeholder relationships by including them in discussions that will provide important feedback in key areas as well as increase the transparency of the planning and implementation process. The State can address this by including such stakeholders in discussions regarding specific changes in services, processes, regulations (or sub-regulatory guidance) that will be developed in more detail than set forth in the Plan.

Finally, it would be helpful for the State to be clearer regarding which future in-reach strategies will continue to be statewide for the next six months and which efforts may be more regionally based.

### **Section 3--Conclusion**

Over the past six months, the State has made solid efforts to create an initial infrastructure and develop plans for the major areas set forth in the Agreement. Having the experience with MFP provided the State with a foundation for implementation efforts. In addition, the State has developed internal cross agency teams to implement the Plan over the next year. In addition, as indicated in this report, the next six months will continue to provide valuable lessons learned from transitions. The State will need to be nimble in its efforts to take these early lessons learned and make the necessary changes in policies, protocols, and processes before they become too entrenched in transition processes. The next six months will be a critical time for the State regarding the implementation of the Agreement. Various processes and deliverables will need to be developed or refined to meet the timeframes set forth in the Plan. There are several areas that will require the State to focus their resources to develop these processes and deliverables. Of critical importance are continued transition efforts, developing strategies for diverting individuals from nursing facilities, development of statewide service plans, and continued and meaningful engagement of stakeholders throughout the year.