

# LA-DOJ Subject Matter Expert (SME) Report

COVERING THE PERIOD OF 1/1/2020 THROUGH 6/30/2020  
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## I. 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.

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 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 Louisiana Department of Health (LDH) compliance, including recommendations, if any, to facilitate or sustain compliance. This is the third SME report for the period of 1/1/2020 through 6/30/2020.

The State is required to create an Implementation Plan that describes the actions it will take to fulfill its obligations under the Settlement Agreement, and establishes annual goals and targets for achieving the outcomes specified in the Agreement and Plan. In December 2019, the State submitted an Implementation Plan for Calendar Year (CY) 2020.<sup>1</sup> In this plan, the State set forth various tasks that LDH was to accomplish during this period. The plan is divided into six subsections, which contain the associated goals: (1) Transition/Post-transition Activities, (2) Work Flow and Tracking System Development, (3) Diversion Activities, (4) Community Support Services Development, (5) Quality Assurance and Continuous Improvement, and (6) Stakeholder Engagement, Outreach, and In-Reach.

While there were many tasks for the State to complete during this reporting period, several key tasks are worth noting. Those tasks, and the current status, are summarized below. During the initial months of this reporting period (January and February), the State was able to get traction on a number of these activities. However, beginning in early March and continuing through the remainder of the reporting period these efforts were hampered by the COVID-19 pandemic. While the State did not put all tasks on hold, several major tasks were impacted by the pandemic. Below is a summary of activities the State was to complete during the reporting period, the activities the State undertook and activities for the next reporting period:

- **(1) Transition / Post- Transition Activities:**
  - The State was responsible for enhancing efforts to increase the number of individuals in the Target Population who are successfully transitioned from NFs, based on the targets set forth in the 2020 Implementation Plan. During this period, the State was supposed to:
    - Transition an additional 100 individuals from NFs in FY 2020;

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<sup>1</sup> Available at: <http://www.ldh.la.gov/assets/docs/MyChoice/AnnualImplementationPlan.pdf>

- Continue efforts to identify and remove transition barriers through a cross-agency process designed to identify and address systemic barriers that impede or prevent transitions;
  - Implement an interim case management strategy to ensure that individuals remain in the community and receive the services and supports necessary to successfully achieve the goals in their Individualized Transition Plans (ITPs);
  - Finalize an implementation strategy for the provision of case management services (following the interim process), including identifying a Medicaid authority to support the new case management model and developing a plan for implementing this strategy with specific timeframes; and
  - Revise the transition planning and transition monitoring tools and provide the necessary training to the Transition Coordinators (TCs) and others who will be using these tools.
- Since the last report, the State has made progress in these areas despite the pandemic. This includes:
  - Implemented the interim case management strategy to ensure that individuals remain in the community and receive the services and supports necessary to successfully achieve the goals in their Individualized Transition Plans (ITPs);
  - The State was able to transition five individuals from these facilities over the past few months but not at a rate consistent with the annual targets in the CY 2020 Plan. The COVID-9 Pandemic impacted transitions. Transition Coordinators (TCs), who are instrumental to the transition process, were unable to visit members of the Target Population in NFs due to COVID-19.
  - The State revised the transition planning and transition monitoring tools and provided the necessary training to the TCs and others who will be using these tools.
  - The State developed a monthly transition log for Transitions Coordinators to complete while performing their interim case management functions. This protocol will provide LDH with necessary information to develop and track measures required as part of the State's quality assurance efforts.
  - The State worked to develop a real time tracking system for individuals who had been transitioned from NFs to monitor and address any issues that occurred during the COVID-19 pandemic.
- Significant areas of focus for the next 6 months and beyond include:
  - Revising transition and diversion targets for CY 2020 after evaluating the challenges presented by COVID-19 to LDH and to NF residents;
  - Developing a strategy for enhanced transition efforts over the next six months to meet those targets;
  - Developing a methodology for projecting the number of individuals who will be transitioned and diverted in CY 2021 (The methodology should reflect efforts to increase the number of individuals in the Target Population who are successfully transitioned from NFs, based on the targets set forth in the 2020 Implementation Plan);
  - Continuing efforts to identify and remove transition barriers through the Service Review Panel (SRP) in order to identify and address systemic barriers that impede or prevent transitions;

- Continuing the interim case management strategy to ensure that individuals remain in the community and receive the services and supports necessary to successfully achieve the goals in their Individual Transition Plans (ITPs); and
  - Finalizing a strategy for the provision of case management services (following the interim process), including identifying a Medicaid authority to support the new case management model and developing a plan for implementing this strategy with specific timeframes.
  
- **(2) Work Flow and Tracking System:**
  - The State was to finalize the necessary documents for the vendors that will create the longer-term tracking system, including specifications for tracking members of the Target Population who are diverted from NFs. Some of the work was also interrupted given staff instrumental to this work were also redirected to responsibilities to address the pandemic.
  - Since the last report, most of the work was interrupted due to the pandemic.
  - Significant areas of focus for the next 6 months and beyond should include:
    - Finalizing the necessary documents for the vendors that will create the longer-term tracking system, including specifications for tracking members of the Target Population that are diverted from NFs.
    - Testing and going live with the My Choice tracking module that was created in the LDH Office of Aging and Adult Services (OAAS) Participant Tracking System (OPTS) that collects enhanced information on transitions.
    - Refining existing and creating new reports in OPTS for quality assurances purposes.
  
- **(3) Diversion Activities**
  - The State was to undertake various tasks in to implement diversion activities specific to the Agreement, including:
    - Finalizing and operationalizing the Diversion Plan with clear responsibilities for the State, Managed Care Organizations (MCOs), and providers to assist individuals who have been diverted from a NF;
    - Developing a data-use plan to help the State determine if the changes in the Pre-Admission Screening and Resident Review (PASRR) process over the past two years are effective and continue to make changes to the PASRR process based on data gathered and other relevant information;
    - Modifying PASRR data systems as needed, as well as enabling the ability to capture items identified in the data-use plan;
    - Continuing initial and annual PASRR Level II evaluations (As required by federal law, the State is required to perform a PASRR Level II evaluation when an individual is identified at admission of having a Serious Mental Illness (SMI). As required by the Agreement, the State is to perform a PASRR Level II annually for those individuals who are members of the Target Population. PASRR Level IIs were also impacted by COVID-19, and the State received permission from the Centers for Medicare & Medicaid Services (CMS) to delay initial and annual PASRR Level II reviews (Level I and Level II) during the pandemic. However, the State continued to provide Level II reviews for individuals currently in NFs when an

existing authorization was expiring or when a resident review was needed. The Level II authorities ensured evaluations were rendered using HIPAA compliant telehealth methodologies.

- Developing a data analytics plan to help the State determine if the changes in the PASRR process over the past two years are effective;
  - Continuing to make changes to the PASRR process based on data gathered and other relevant information as well as modifying PASRR data systems as needed;
  - Enabling the capture items identified in the data analytics plan; and
  - Enhancing in-reach efforts to include peers working with TCs during the engagement and transition process. One position was included in the FY 2021 budget set forth by the Governor, with additional positions throughout the State funded by Mental Health Block Grant funds. Whether or not the state can proceed with the position included in the FY 2021 budget is contingent in legislative approval of the budget.
- Since the last report, the State has made progress in this area including:
    - Implementing an interim case management strategy using Transition Coordinators, to ensure that individuals remain in the community and receive the services and supports necessary to successfully achieve the goals in their individualized transition plans;
    - Beginning work with the MCOs to develop a case management model for individuals who were diverted or transitioned from NFs. This includes planning with the MCOs to develop a diversion strategy and making proposed changes in the MCO contract that delineates more specific case management requirements for these individuals.
  - Significant areas of focus for the next 6 months and beyond should include:
    - Operationalizing the Diversion Plan with clear responsibilities for the State, Managed Care Organizations (MCOs), and providers to assist individuals who have been diverted from a NF;
    - Developing a data-use plan to help the State determine if the changes in the PASRR process over the past two years are effective;
    - Continuing to make changes to the PASRR process based on data gathered and other relevant information; and
    - Modifying PASRR data systems as needed, as well as enabling the ability to capture items identified in the data-use plan.
- **(4) Community Support Services Development:**
    - The State was to undertake various tasks to develop the array of services that were specified in the Agreement. This included:
      - Implementing the initial activities necessary to complete the gaps analysis included in the implementation plan, including data collection regarding the needs of the Target Population and other individuals with SMI;
      - Improving the quality of services provided by Assertive Community Treatment (ACT) providers by finalizing a set of measures that will be used to profile each ACT team and determine whether these teams are achieving the goals set forth for the service;
      - Completing the framework for peer services and undertaking the necessary steps to roll out these services, including the development of a training regarding the

- new peer support service and possible changes in the process to credential/certify individuals who will provide this service;
    - Finalizing an implementation strategy for the provision of case management services (following the interim process), including identifying a Medicaid authority to support the new case management model and developing a plan for implementing this strategy with specific timeframes; and
    - Developing a specific training schedule for critical services, including crisis services, employment services, and peer support.
  - Since the last report the State has made progress in these areas:
    - Initial work on developing an implementation strategy for the provision of case management (this work was interrupted, as staff and leadership who were key to these discussions were diverted to responsibilities to address the COVID-19 pandemic);
    - Beginning to house members of the Target Population using U.S. Department of Housing and Urban Development (HUD) mainstream vouchers for Non-Elderly Disabled (NED) individuals (these were applied for and obtained as part of the State's effort to comply with housing requirements in the Agreement);
    - Developing and implementing a specific training schedule for critical services, including crisis services, employment services, and peer support;
    - Beginning development of training for TCs, MCO Case managers, and behavioral health providers regarding person-centered planning approaches specific to individuals with SMI;
    - Implementing an interim case management strategy using TCs to ensure that individuals remain in the community and receive the services and supports necessary to successfully achieve the goals in their ITPs;
    - Implementing initial activities necessary to complete the gaps analysis included in the implementation plan, including data collection regarding the needs of the Target Population and other individuals with SMI;
    - Completing the framework for peer services and undertaking the necessary steps to roll out the service, including the development of a Request For Information (RFI) that would collect input regarding a modernized process to credential/certify individuals who will provide this service;
  - Significant areas of focus for the next 6 months and beyond include:
    - Finalizing the gaps analysis included in the implementation plan, including data collection regarding the needs of the Target Population and other individuals with SMI;
    - Continuing to implement the quality monitoring efforts provided by ACT providers; and
    - Developing the necessary Medicaid authorities for peer services and undertaking the necessary steps to roll out the service; and
    - Developing a training regarding the new peer support service and possible changes in the process to credential/certify individuals who will provide this service based on information from the RFI responses.
    - Dedicating more time and resources (including funding) for developing and implementing integrated day activities for the Target Population.

- **(5) Quality Assurance and Continuous Improvement**

- The State was to undertake various tasks in to develop and implement a quality assurance and continuous improvement strategy for the Target Population. This included:
  - Finalizing the quality assurance/improvement strategy, and developing public-facing reports on the measures that are currently available;
  - Revising and implementing changes to develop a more robust mortality review process;
  - Creating a formal external process improvement strategy to begin gathering qualitative information about the experiences of individuals who have transitioned from NFs, which will provide important lessons to improve the transition experience for individuals in the future;
- Since the last report the State has made progress in these areas:
  - Finalizing the Quality Assurance indicators and the data sources needed to support these indicators, including developing additional data sources and data collection strategies for a number of these measures;
  - Creating a more robust set of reports for many Quality Assurance indicators;
  - Implementing a process for improving the quality of services provided by ACT providers which included finalizing a set of measures that will be used to profile each ACT team and determining whether these teams are achieving the goals set forth for the service;
  - Working with State leadership and MCOs to finalize these measures and the processes that MCOs would use to collect, analyze, and use this information with ACT teams; and
  - Revising and developing changes to develop a more robust mortality review process, including developing a draft protocol for reporting deaths of Target Population members to the SME and DOJ as well as seeking the necessary statutory authority for Office of Behavioral Health (OBH) to obtain critical and timely information from medical providers regarding the cause of death.
- Significant areas of focus for the next 6 months and beyond include:
  - Developing a quality assurance/improvement strategy that will include the indicators identified for the Agreement;
  - Continuing to create the reports on measures from the quality matrix and developing and posting public-facing reports on the LDH website; and
  - Implementing changes to the OBH mortality review process given their new statutory authority to collect pertinent information that will provide better root cause analysis.
- **(6) Stakeholder Engagement, Outreach, and In-Reach:**
  - There were several activities the State had proposed to undertake during this reporting period, including:
    - Changing the format of the My Choice Stakeholder Advisory Group <sup>2</sup>to improve the value of these meetings and broaden the participation of the committee members; and
    - Enhancing the in-reach efforts to include peers working with TCs during the engagement and transition process.
  - Since the last report, the State has made progress by:

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<sup>2</sup> The MyChoice Advisory Committee is a stakeholder committee specifically created to provide guidance to the State regarding the implementation of the DOJ Agreement.



- Changing the format of the My Choice Advisory Group to improve the value of these meetings and broaden the participation of the Advisory Committee.
- Developing of a training for Transition Coordinators, MCO Case managers and behavioral health providers regarding person-centered planning approaches specific to individuals with serious mental illness.
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- Significant areas of focus for the next 6 months and beyond include:
  - Developing a concrete strategy for peer in-reach efforts that includes a timeframe for involving peers in the in-reach process;
  - Developing another strategy for in-reach efforts to individuals on the Master List that includes peers working with TCs during the engagement and transition process; and
  - Developing a specific training schedule for providers for critical service set forth in the Agreement, including a master training schedule of topics across LDH and the MCO for providers that are service members of the Target Population.
  - Creating and implementing a semi-annual communication plan for constituency groups beginning this next period.

There are several areas of significant focus for the State over the next 6 months and beyond, including continuation of work in some of the areas previously listed. The priority areas will be:

- Continuing to assess the impact of COVID-19 for individuals in the target population to ensure their health, safety and well-being. This should include LDH's efforts to have Transition Coordinators continue to engage individuals on a regular basis through telehealth or when necessary face to face. In addition, LDH should continue to track on a weekly basis the impact of COVID-19 on individuals who are on the Transition Coordinators caseloads and who have transitioned from the nursing facility. This includes whether individuals that have COVID-19 or had a COVID-19 test administered. This should also include information on whether these individuals visited the Emergency Department, were admitted to an inpatient facility (all cause) or readmitted into a nursing facility. In addition, LDH should also continue their efforts to assess the systemic impact on their service delivery system, including the number of providers (behavioral health and Community Choices Waiver) that have been adversely impacted and withdrew from the provider network do to COVID-19. Finally, the State should continue their efforts to provide guidance to behavioral health and long term care service providers regarding some of the temporary changes they developed to respond to the pandemic.
- Continue its efforts to develop the services that are set forth in the Agreement. Specifically, the State should finalize its overall strategy for covering case management services for individuals in the Target Population. As stated in this report and previous reports, the use of TCs should not be a long-term case management strategy. In addition, the State will need to revisit the Crisis Plan developed in December 2019 and determine how to begin implementation of a statewide crisis line and mobile crisis services consistent with the Agreement. Finally, the State should finalize its strategies for Medicaid authorities for other community-based services that are needed by the Target Population inclusive of behavioral health and long-term services and supports.
- Develop a sound methodology for projecting the number of individuals who will be transitioned from NFs for calendar Year 2021 - The State has identified many individuals in these facilities that have indicated interest in moving. Given concerns regarding COVID-19 and NFs, these individuals

may be more interested and motivated to move in the next eighteen months. The approach will also need to account for enhanced in-reach efforts by the State to discuss transition opportunities for individuals who are on the Master List.

- Develop and begin to implement a quality assurance process for reviewing the data that is being generated on quality indicators that have been finalized during this reporting period - There is rich data being generated on these indicators as well as the weekly COVID-19 tracking the State has undertaken over the past several months that should be used to inform quality improvement efforts.

The following report provides an overview of the State's progress in each area of the Settlement Agreement. The report is organized using the language of the Agreement as a framework, with paragraphs from critical areas of the Agreement (by number) included in italics followed by descriptions of progress of the State in these areas. The report also includes recommendations by the SME for the State to address in the next reporting period.

### III. Target Population

24. *The Target Population comprises (a) Medicaid-eligible individuals over age 18 with SMI currently residing in nursing facilities; (b) individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement during the course of this Agreement, or have been referred within two years prior to the effective date of this Agreement; and (c) excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis.*

25. *Members of the Target Population shall be identified through the Level II process of the Pre-Admission Screening and Resident Review (PASRR), 42 C.F.R. 483.100-138. LDH shall perform additional analysis of the assessment information contained in the Minimum Data Set (MDS) of information reported to the Centers for Medicare and Medicaid Services (CMS), to identify individuals who may have required a Level II screen but did not receive one.*

26. *The State will develop and maintain a Target Population priority list of individuals who meet the criteria described in paragraphs 24 and 25.*

One of the initial activities was to create a Master List of individuals in NFs who are members of the Target Population. The State analyzed and reviewed data from the MDS and PASRR Level II reviews on individuals who were residing in NFs to create this Master List. The MDS is part of a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process involves a comprehensive, standardized assessment of each resident's functional capabilities and health needs. There were individuals who the MDS identified had a SMI, but no PASRR Level II screening was performed to determine if they a member of the Target Population. The State matched MDS data to PASRR Level II data to identify individuals who may have required a Level II screening but did not receive one. Based on these efforts, the State developed a referral system and prioritization to complete Level II screenings. The SME has reviewed the criteria the State has developed to determine how an individual is identified to be included in the Master List. The criteria that has been developed list various pathways which an individual is determined to meet the Target Population criteria including: Medicaid enrollment, confirmed presence of an SMI through the PASRR Level II evaluation and ruling out if the individual has dementia. The criteria and pathways for determining eligibility for the Target Population, in the SME's opinion, provides a reasonable strategy for identifying individuals for the Agreement.

Initially, 3,122 individuals were included in the Master List. As of last report, 2,994 individuals are on the Master List. An additional 936 individuals are on the active caseload list. Individuals on the active caseload list have been assigned to a Transition Coordinator who will begin the engagement process.

27. *People in the State who have SMI but are not in the Target Population may request services described in Section VI of this Agreement or, with their informed consent, may be referred for such services by a provider, family member, guardian, advocate, officer of the court, or State agency staff. Once LDH receives a request or referral, the person with SMI will be referred for services in accordance with the State's eligibility and priority requirements, and provided notice of the State's eligibility determination and their right to appeal that determination.*

The SME is requesting information from the State regarding activities that have been completed to meet the requirements of this paragraph for the next reporting period.

## IV. Diversion and Pre-Admission Screening

29. *The State shall 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 State's plan shall include, but not be limited to, development of services identified in Section VI [of the Settlement Agreement].*

In December 2019, the State submitted a diversion plan to outline the steps LDH is taking to promptly identify individuals in the Target Population seeking admission to NFs and provide intervention and services to prevent unnecessary institutionalization. The plan set forth definitions for individuals who would be considered diverted from NFs and individuals who are at high-risk for NF placement. The plan initially focuses on the following populations:

- Persons with SMI who seek admission to a NF placement who meet NF Level of Care (LOC) criteria and for whom a PASRR Level II review recommends placement in the community;
- Persons with SMI who are admitted to a NF on a temporary basis and could be transitioned into the community within a short period (90 days); and
- Persons with serious mental illness (SMI) who are at risk of avoidable hospitalizations, which will then place them at risk for subsequent nursing facility admission. This included individuals that were homeless and with serious mental illness (including individuals with co-occurring substance use disorders (SUD)<sup>3</sup>.

To monitor the performance of the diversion strategies described in this plan, LDH is required to establish measurable targets for the diversion of the Target Population members. Specifically, the Agreement requires LDH to establish annual *targets* for the diversion of Target Population members. For Calendar Year 2020, LDH has developed the following *projections* for the number of individuals who meet the criteria in #1 and #2 above. This was the first year that LDH developed these projections. These projections are based on the State's data and experience with identifying these populations over the preceding year. Specifically, the State identified the number of individuals from January 2019 through December 2019 that were in both populations and determined to use this as a baseline for CY 2020.

<b>Population</b>	<b>Projected Diversions</b>
#1 Short Term Nursing Stays	6
#2 PASRR II Recommendation	120
Total	126

LDH, in cooperation with the SME, has developed an interim case management strategy for these individuals (discussed in Section V of this report). The strategy will be implemented by either the CCW Support Coordinator (if individuals qualify and agree to participate in the CCW) or by the case managers at one of five Managed Care Organizations (MCOs) if the individual does not qualify or agree to participate in the CCW. This interim strategy will be in effect until LDH implements the proposed community case management approach.

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<sup>3</sup> <http://ldh.la.gov/assets/docs/MyChoice/DiversionPlan.pdf>, p. 10

The Agreement's Target Population is not currently included as a group of MCO beneficiaries with Special Health Care Needs (SHCN). The SHCN population is defined as individuals of any age with a behavioral health disability, physical disability, developmental disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. During this report period, the State, in cooperation with the SME, developed proposed language in a revised MCO contract that would include the DOJ Target Population as a SHCN population. If these changes are accepted, the MCOs, as a contractual SHCN requirement, must offer members of the Target Population case management consistent with these requirements. This includes the traditional case management activities of assessment, development of care plan, referral, and ongoing monitoring.

In addition, LDH is analyzing data regarding the services needed and used by individuals who met the diversion definition in CY 2019 to inform their discussions with MCOs. This will include:

- Individuals who received their case management through CCW Support Coordinators
- Individuals who were offered case management by MCOs and the number of these individuals who have an assessment, a care plan, and are active in the MCOs case management program.
- Services and supports that were rendered to this population
- Services that were identified through PASRR II screening.

LDH, in cooperation with the SME, has developed an interim strategy for offering case management to individuals who are diverted from NFs based on the PASRR Level II criteria discussed above. As indicated, the State is proposing contract changes to MCOs. These changes will provide more specificity regarding the process MCOs will use for engaging members who are diverted from NFs to offer them case management. This should occur immediately after the individual is identified through the MCO's PASRR II process. The interim strategy also includes timeframes for MCOs to offer case management services, perform the initial assessment, and develop a plan of care. The strategy also included reporting requirements for MCOs to report their case management activities (including closures) to LDH. Many of these requirements have been included in draft contract language for the MCOs that will be executed in FY 2021.

LDH had planned to complete the initial analysis of data for the members of the Target Population that were diverted from NFs (using the PASRR Level II criteria) and to have preliminary discussion with the MCOs for implementing the interim case management strategy in March and April. These efforts were delayed by 60 days due to disruptions because of COVID-19. In May LDH has received data from the first 90 days of this calendar year regarding the number of individuals in the Target Population that were engaged in case management. This data will provide a baseline for MCOs regarding their engagement and initiation of the diverted population. The SME's review of this data indicated high variability across MCOs in the number of individuals who were diverted, offered case management, and actually received case management. This information should be used in discussions with the MCOs to improve their processes for engaging individuals in MCO provided case management. LDH should continue to receive this information on a quarterly basis from MCOs.

In addition, the State is developing a reporting process that provides more detail regarding the MCOs efforts to perform various case management functions (assessment and planning) as well as tracking whether individuals are receiving services identified through the PASRR Level II evaluation. This will enhance LDHs efforts to more closely monitor the MCOs endeavors to not only provide case management—but ensure that services identified in the PASRR Level II evaluation are included in the service plan and provided to individuals who were diverted from NFs.

In the 2020 Implementation Plan, by June, the State was to finalize its definition of the at-risk population and develop projections regarding the number of individuals who were in the at-risk group. One of the at-risk populations are individuals with a serious mental illness that were experiencing homelessness. LDH has developed a target of 30 individuals [will be diverted through use of PSH](#). Due to COVID-19, the work necessary to finalize additional definitions for at risk and develop additional projections was delayed by 60 days. The State has re-engaged on this effort and will have this definition by July 2020.

The SME believes that the proposed strategy developed by LDH in cooperation with the SME should create a reasonably effective interim case management strategy for the diversion population. The SME anticipates that there will be individuals diverted from NFs that will choose not to participate in the CCW or receive case management services from the MCOs.

It is recommended that the State and MCOs the data collection and analytics discussed in this section to assess the efficacy of the MCOs case management strategy for the diversion population. If the data indicates that, there are significant numbers of individuals who are not engaged in case management, the State and the MCO will need to identify the root cause of these engagement problems and improve these strategies. For these individuals, LDH should create an alternative outreach strategy requesting MHR and other behavioral health providers to engage these individuals in services in cooperation with the MCOs. This may include ACT teams that the MCO could authorize for a time-limited basis to provide outreach in an effort to engage these individuals in treatment. Alternatively, the MCO may be able to identify other local behavioral health providers, including LGEs, to assist in the outreach program through crisis intervention or community support services.

*30. LDH will therefore develop and implement an evidence-based system that seeks to divert persons with SMI from the avoidable hospitalizations that place them at risk for subsequent nursing facility admission.*

As indicated in response to paragraph 29, LDH will develop a strategy to divert persons with a SMI from avoidable hospitalizations, which place them at risk for subsequent NF admission. This will include individuals who were homeless and with SMI (including individuals with co-occurring SUD).

As part of the 2020 Implementation Plan, LDH intends to undertake several steps to work with hospitals to develop and implement diversion efforts for individuals who have been hospitalized and are at higher risk for NF placement. These include:

- Evaluating options to conduct outreach with hospitals regarding diversion efforts (February 2020);
- Meeting with stakeholders to discuss strategies for working with major referral sources (May 2020);
- Meeting with leadership from these referral sources to identify potential diversion strategies (May 2020); and
- Developing and implementing diversion strategies (October 2020).

To date LDH has not developed nor implemented a system to identify and divert individuals with avoidable hospitalizations. While working with hospitals is an important strategy, it is the SME's opinion that LDH's initial effort would be better spent on working with MCOs to prevent avoidable hospitalizations. Various strategies have been put in place at the MCO and provider level to prevent avoidable hospitalizations. For instance, many states SHCN strategies have established robust processes for ensuring that individuals who are at higher risk for multiple hospitalizations are identified and triaged using a multidisciplinary team

that identifies and addresses prevailing medical and behavioral conditions for their SHCN population. In addition, some states have developed health homes and primary care medical homes at the provider level to improve care coordination for individuals who have been identified as high-need/high-risk population. These efforts include intensive care coordination, health promotion, and individual and family support to provide education regarding various conditions and preventive measures individuals and their support systems can implement to prevent emergency and inpatient hospital admissions. LDH should work with MCOs this year to develop triage strategies for these individuals to best address their health care needs in the community.

It is the SMEs opinion that MCOs have the fiscal incentive to identify these individuals and develop strategies that prevent admission or readmissions for individuals with significant co-morbid conditions and SMI. Hospitals do not have the same incentives. Rather, hospitals have more of an incentive to discharge individuals in a timely manner and therefore have little incentive to initiate a discharge process that may require days, if not weeks, to locate the necessary housing and supports prior to discharge. However, it would be helpful for LDH to identify hospitals that have higher rates of potential avoidable hospitalizations (leading to NF referrals) and discuss strategies with the MCO and these hospital providers to reduce avoidable hospitalizations.

The State and the SME, during this reporting period, have reviewed the current managed care contract and proposed changes to the contract that would include the Target Population in the SHCN definition and additional language regarding the expectations of the plans to provide care coordination to individuals who may be at-risk for the definition of the Target Population.

*31. LDH shall also implement improvements to its existing processes for screening individuals prior to approving nursing facility placement.*

LDH is in the process of implementing a number of strategies to improve the PASRR Level I screenings and Level II evaluations to achieve diversion of individuals with SMI seeking admission to NFs. These strategies to improve PASRR processes and criteria include:

- Improving the identification of individuals with SMI through PASRR Level I screening;
- Improving the content of the PASRR Level II evaluations including revisions to the PASRR Level II screen;
- Enhancing efforts to identify individuals who must have a PASRR Level II where none have been previously done;
- Continuing to ensure that any individuals identified through the PASRR Level I process receives a PASRR Level II prior to admission to a NF;
- Requiring anyone who is seeking a continued stay in a NF to have a PASRR Level II;
- Performing PASRR Level II evaluations promptly to ensure continued compliance with federal standards regarding the timeliness of PASRR Level II determinations;
- Revising PASRR Level II forms to include more information regarding mental health services in the community;
- Providing additional training to ensure that PASRR Level II evaluators are familiar with the complete array of Home and Community-Based Services (HCBS) available; and
- Strengthening documentation requirements used to establish a primary diagnosis of dementia relative to the PASRR screening process.

*32. The State will ensure that all individuals applying for nursing facility services are provided with information about community options.*

According to the State, individuals who receive a PASRR Level II are asked about their interest in, need for community services, and are provided information about community options at the time of the screening. The SME has not reviewed the specific strategies and processes that the independent evaluator uses to discuss these options. The SME is requesting information from the State regarding their efforts to ensure that the evaluators offer community options in a meaningful way. The SME believes the State's oversight and evaluation of these strategies are important. The SME has reviewed the most recent list of community options. It has many resources that would be available to the individual—however it is a daunting list and the SME imagines that individuals will need assistance in understanding and accessing these options. The SME will review the practices MCO PASRR Level II evaluators use when implementing this requirement. In addition, it may be helpful for the State to provide information to the MCO PASRR Level II evaluators on community options developed by the TCs. The TCs may likely have more up to date and robust information on these services and supports. The SME will also request information from PTAC and other states that have operationalized good process for informing individuals of their community options before and during the PASRR Level II process.

*33. All screenings and evaluations shall begin with the presumption that individuals can live in community-based residences. For any individual for whom a nursing facility placement is contemplated, the PASRR Level I screening will be conducted by a qualified professional prior to nursing facility admission to determine whether the individual may have a mental illness. To improve identification of persons with mental illness through the PASRR Level I screening, LDH shall develop and implement standardized training and require that all personnel who complete any part of the Level I screening, excepting physicians, receive this training.*

LDH has taken several steps to change the PASRR Level I screening process to better identify individuals with SMI who are referred to NFs. These included modifying the Level I screening instrument, developing and implementing standardized training for personnel (except physicians) who complete any part of the PASRR Level I screening process, and specifying the credentials of individuals deemed qualified to complete the PASRR Level I Screen.

According to LDH, The PASRR Level I screening instrument was modified in June 2018 to incorporate several changes designed to better identify individuals with SMI for diverting them from NF admissions.<sup>4</sup> LDH revised the form in response to the PASRR Technical Assistance Center's (PTAC) findings that listed Louisiana among the states where too many individuals were identified as having a mental health diagnosis after nursing home admission, suggesting that the pre-admission form may not have been sensitive enough. LDH incorporated best practices from other states in the revision, especially from those states that PTAC found to have better pre-admission identification.

LDH provided training opportunities for NF and hospital staff to introduce the revised PASRR Level I screening tool. Specifically, OAAS held in-person trainings in Bossier City, Lafayette, and Metairie, which were attended by 106 individuals. In addition, OAAS held a series of 10 webinars twice a day for five consecutive days, which were attended by 382 individuals. The webinar training and an instruction guide

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<sup>4</sup> <http://ldh.la.gov/assets/docs/OAAS/PASRR/NFA-Level1-PASRR.pdf>



for completing the Level I Screen, including the list of individuals deemed qualified to provide the screening, are maintained on the LDH OAAS website.

The SME was not involved in the 2018 revisions to the PASRR Level I, nor participated in the training opportunity to implement the new screening tool. The SME is very familiar with PTAC and believes LDH took the appropriate steps to have initiated a third party review and revise this tool. The SME recommends that LDH begin by performing the necessary data analytics to determine if there was a change in the number of individuals that were identified as having a mental health diagnosis through this screening to determine if the changes recommended by PTAC had the desired effect. In addition, the SME would recommend LDH continue their training efforts for PASRR Level I reviewers. In addition, the State is proposing to continue their training efforts for PASRR Level I reviewers once changes are finalized for the tracking vendor. The State reports that the tracking vendor will need to train staff that complete LOCETs and PASRR Level I once changes to the tracking system are complete.

*34. For each individual identified through the Level I screen, LDH will promptly provide a comprehensive PASRR Level II evaluation that complies with federal requirements. It shall be conducted by an evaluator independent of the proposed nursing facility and the State. This evaluation will confirm whether the individual has SMI and will detail with specificity the services and supports necessary to live successfully in the community. It shall address options for where the individual might live in the community. LDH shall provide additional training to ensure that PASRR Level II evaluators are familiar with the complete array of home and community-based services available to provide and maintain community-integration, and shall revise Level II forms to include more extensive and detailed information regarding services in the community.*

PASRR Level II reviews are performed by the Medicaid MCOs' Level II Evaluator, a Licensed Mental Health Professional who operates independent of the NF and the State. LDH has implemented policies and incorporated specific requirements within its Medicaid managed care contracts to ensure sufficient timeliness of evaluation completion. LDH also issued a legal memorandum in December 2017 to providers to clarify their responsibilities to submit required documentation to OBH and Medicaid MCOs within a timely manner for the purposes of PASRR Level II evaluations.<sup>5</sup> This memo identifies the minimum data to be submitted as part of a PASRR Level II request and the required timeframes for providers sending requested records and information to the Medicaid MCO's PASRR Level II evaluators. The memo also clarifies that disclosure of Medicaid enrollee information by a Medicaid provider to a Medicaid MCO is permitted without enrollee authorization for the purposes of PASRR Level II evaluations. The most recent data provided to the SME indicates that Medicaid MCOs are completing PASRR Level II evaluations within four business days of referral from OBH, consistent with State requirements.

In 2019, LDH revised the PASRR Level II evaluation forms to better convey the availability of community-based mental health services that may be appropriate for NF residents with SMI. The MCO PASRR Level II evaluators were trained on the new evaluation form. The MCO PASRR Level II evaluators were trained on the new evaluation form. These revisions are intended to provide consumers and PASRR Level II evaluators more information regarding the continuum of services that are available in the community.

The SME was involved in the review of the revisions to the PASRR Level II evaluations and enlisted the support of PTAC in his review. We found the revised PASRR Level II form to include the services and

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<sup>5</sup> LDH Legal Memorandum "Provision of Required Documentation for the Purposes of PASRR", 12/4/2017. Included as Attachment C.

supports that were needed (at that time) for members of the target population. The SME review did recommend additional changes to be included in the evaluation including: greater specificity of available outpatient services, addition of questions regarding the ability/insight to self-administer medication, capturing history of homelessness/housing instability, including information regarding the type of housing voucher needed/recommended, and capturing involvement with the Louisiana Vocational Rehabilitation Program. The State incorporated the changes into the PASRR Level II screen currently in use.

LDH also updated the OBH PASRR Level II Evaluation Summary and Determination Notice, which is submitted, along with the final authorization, to the individual seeking NF placement at the completion of the determination. The determination forms are intended to better convey information about community-based mental health services and supports.

LDH has implemented changes to the PASRR Level II evaluation form and processes. The current PASRR Level II includes:

- Information that confirms the individual has SMI and the principle diagnosis established by the PASRR Level II evaluator;
- The specific behavioral health needs of the individual, including the array of Medicaid behavioral health services including:
  - Crisis intervention,
  - ACT,
  - Psychosocial rehabilitation,
  - Community support, SUD services (each level of care),
  - Outpatient counseling,
  - Medication assessments, and
  - Prescribing;
- The health and housing needs for the individual, including the type of housing (home, independent living, supportive housing) as well as the additional services and supports that will assist the person to live independently such as:
  - Training in ADLs and independent living skills,
  - Assistance in obtaining medical appliances/devices,
  - Services for individuals with visual/hearing impairments,
  - Structured leisure activities, and
  - Audio, dental, and vision services;
- Recommendations for specific rehabilitative, behavioral, and medical services needed by the individual.

According to LDH, and as set forth in the current MCO contract, the Medicaid MCOs are offering trainings to their affiliates and representatives that perform PASRR Level II evaluations. LDH has also developed directories for community-based resources available to individuals referred for PASRR evaluations, including mental health and SUD services, Medicaid MCOs, local housing authorities, disability and public benefits offices, Local Governing Entities, crisis hotlines, transportation, and other relevant programs. These directories will be maintained and updated with current listings of available services within the behavioral health service array. The SME is requesting the most recent PASRR Level II training materials for review in the next reporting period and will meet with PASRR Level II evaluators to discuss their approach for confirming individual have a SMI and their approach for identifying housing options and necessary services and supports.

Due to the COVID-19 pandemic, the State suspended PASRR processes for new admissions to nursing facilities in late March. LDH was granted permission by CMS to suspend these reviews. This waiver included the PASRR Level I process as well as the Level II initial assessment in late March. LDH has developed a process for tracking individuals (through the continued stay process discussed later in this report) that were admitted to nursing facilities that were recommended for a PASRR Level II evaluation. The SME has requested information regarding the number of individuals on LDH tracking list and the process to ensure these evaluations are performed on a timely basis. The Waiver was lifted as of June 15<sup>th</sup>.

LDH should continue to track and provide information on a regular basis to ensure these evaluations are performed within the required timeframes. LDH should also ensure the process is working for providing PASRR Level II review information immediately to the MCO's case management unit for those individuals for which the PASRR Level II does not recommend NF placement. This should also include resources identified by the TCs. LDH reports that they currently send the MCOs the Level II Form and email let them know that the person was denied nursing home placement and to connect that person to the recommended services.

*35. LDH shall refer all persons screened as having suspected SMI but also suspected of having a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, for PASRR Level II evaluation, including those aged 65 or older. LDH shall strengthen documentation requirements used to establish a primary diagnosis of dementia relative to the PASRR screening process. For individuals without sufficient documentation to establish the validity of a primary dementia diagnosis, LDH shall provide an additional professional evaluation to ensure appropriate diagnosis and differentiation. The evaluation shall rule out external causes of the symptoms of dementia such as overmedication and neglect. Individuals with a primary diagnosis of dementia shall be provided with information regarding community-based service options, but shall not be included within the Target Population for the purposes of this Agreement.*

According to LDH, steps were taken in 2018 to strengthen the application and criteria of PASRR Level II evaluations to ensure appropriate identification of dementia as a primary diagnosis. Strengthening these documentation requirements was meant to ensure that residents presenting with symptoms that could indicate dementia but might also be caused by overmedication and neglect are not improperly diagnosed with dementia and accordingly excluded from the Target Population.

In May 2018, LDH issued a legal memorandum clarifying the new documentation requirements to verify dementia diagnoses for the purpose of PASRR Level II evaluation.<sup>6</sup>

LDH contracted with an independent psychiatrist in 2017 to review all PASRR Level II requests that include dementia and Alzheimer's diagnoses. In addition, LDH revised the PASRR Level II evaluation form to include an addendum that clearly delineates the documentation required for requests with a dementia diagnosis. In addition, the State reported that PASRR Level II Evaluators, MCO staff, OBH determination staff, nursing facilities and hospitals participated in trainings regarding this new addendum. The SME is requesting information regarding the findings of these reviews to determine the prevalence of individuals that have been identified by this psychiatrist to determine if these findings may be within what may be considered norms in other states.

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<sup>6</sup> See attached LDH Legal Memorandum "Required documentation to verify dementia diagnoses for the purposes of PASRR through OBH Level II Authority", 5/30/2018.

LDH has implemented training on the new dementia diagnosis verification policy. The SME reviewed the training and provided additional content language. The SME indicated that for some individuals the symptoms of dementia may subside if a physical health condition or other stressor is addressed, which might trigger their eligibility for the Target Population. The SME recommended that individuals with dementia and physical health issues should be assessed with some frequency to determine if their dementia symptoms decrease and not just ruled out because they have an initial dementia diagnosis. The SME recommendations were included in the dementia diagnosis verification policy. The SME is requesting information regarding LDH's efforts to evaluate the effectiveness of the new training and whether the State reassesses individuals with physical health issues and dementia.

Finally, LDH has been tracking in real time the number of individuals that have transitioned and have been readmitted to nursing facilities. In discussions with the SME and DOJ the State will be reviewing these readmissions to identify what services and interventions could have been pursued that would have prevented the admission. This will provide valuable information regarding service gaps and individual's need to support the array of services available for the Target Population.

The SME is requesting data analytics for the next review period concerning additional assessments that are done on individuals who have a co-morbid physical health and dementia diagnosis to determine if individuals with these conditions continue to experience dementia.

*36. LDH will implement changes to its Level of Care determination process to assure that individuals meeting on a temporary pathway eligibility for nursing facility services receive only temporary approval and must reapply for a continued stay. Within 18 months of the execution of this agreement, LDH will eliminate the behavioral pathway as an eligibility pathway for new admissions to nursing facilities.*

In 2018, LDH eliminated the behavior eligibility pathway. The behavior pathway provided an avenue for individuals with SMI to be admitted to NFs without having met other LOC criteria for NF placement. NF residents who were admitted per the behavior pathway had no other qualifying condition to meet NF LOC other than SMI.

The behavior pathway was included among other medical eligibility pathways in the Level of Care Eligibility Tool, an initial screening tool used as part of Louisiana's NF application process, and the MDS 3.0 and the MDS for Home Care (MDS-HC), instruments used as part of the NF level of care assessment process.

LDH implemented new regulations to make changes to the behavior pathway effective May 2018.<sup>7</sup> LDH and DOJ agreed that admission to a NF primarily for a behavioral health condition was not an appropriate admission. The Behavior pathway was eliminated as a medical eligibility pathway for NF placement for new admissions. The rule included a "grandfather" clause: NF residents who were admitted prior to the implementation of the new rule were (and are) deemed to meet NF LOC as long as they continue to meet only on the Behavior pathway eligibility criteria. Residents lose their "grandfathered" status if they no longer meet on the behavior pathway, are discharged from the facility, or meet on an eligibility pathway other than the Behavior pathway.

LDH undertook steps to provide education and implementation support to providers as part of the elimination of the behavior pathway. LDH developed presentations and training materials for the State trade group, the Louisiana Nursing Home Association.

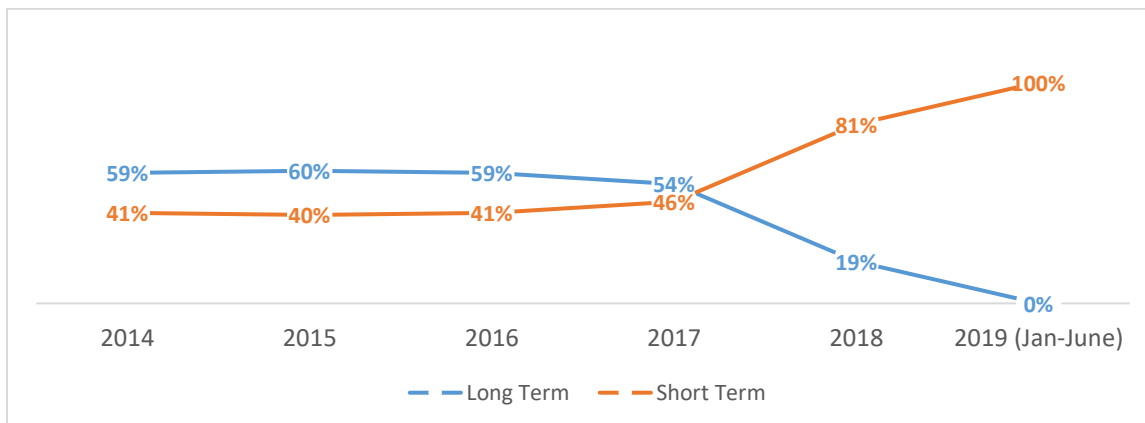
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<sup>7</sup> Louisiana Administrative Code. Title 50, Part II, Subchapter G. Section 10156(l)(1)-(2).

The SME is requesting information from LDH to determine if individuals with a sole diagnosis related to BH have been admitted to NFs since 2018. This would include information from the PASRR Level I and II evaluations and completed MDS.

*37. LDH, following approval of a Level II determination that in accordance with 42 CFR 483.132(a)(1) includes assessment of whether the individual's total needs are such that they can be met in an appropriate community setting, will initially approve nursing facility stays for no more than 90 days (or 100 days for persons approved for convalescent care by LDH) for an individual in the Target Population. If nursing facility admission for a limited period is approved by LDH, the approval shall specify the intended duration of the nursing facility admission, the reasons the individual should be in a nursing facility for that duration, the need for specialized behavioral health services, and the barriers that prevent the individual from receiving community-based services at that time.*

LDH has implemented changes to the screening process for NF admissions for all individuals, including members of the Target Population and individuals who would be members of the Target Population were they admitted to a NF. In general, LDH is now authorizing temporary stays rather than long-term “permanent” stays. This allows the State to review the ongoing need for NF services in a shorter period of time and allows the TCs to work with these individuals earlier in their NF stay toward a possible transition. The OBH has formally standardized the utilization of temporary authorizations for all individuals where the PASRR Level II confirms that they have a SMI. For pre-admission PASRR Level II requests, authorization requests do not exceed 90 days (or 100 days for persons approved for convalescent care by LDH). Subsequent re-reviews will not exceed one year, or 365 days. This change in process has resulted in 100% of authorizations issued by the OBH PASRR Level II authority being short-term and requiring continued stay requests thereafter. If granted a continued stay, a PASRR Level II will be completed. The table below provides information regarding time-limited initial authorizations.



*38. For the Target Population, LDH shall require that the MDS responses used to establish level of care for stays beyond 90 days (or 100 days for persons approved for convalescent care by LDH), be verified by a qualified party unaffiliated with the nursing facility.*

NFs are required to submit continued stay requests to OAAS at least fifteen days before the authorized temporary admission ends. LDH has created policies and criteria for individuals who will be provided a continued stay post the initial 90 or 100 days. The criteria provides a list of conditions and circumstances when a continued stay will be approved. Attachment A sets for the medical conditions will likely not

improve and would necessitate ongoing NF care (e.g. terminal illness, severe physical illness and dementia). The attachment also sets forth the review process the State is currently implementing to grant an extended stay.

LDH has implemented a process to have OAAS staff review medical records from the NF for these continued stay requests. Information OAAS uses for reviewing these continued stay include ADL documentation, nursing notes, physician orders, etc., in conjunction with the most recent MDS 3.0 available at the time of the submission. If there are questions about documentation provided by a NF, OAAS Regional Staff visit the facility for an onsite review. All individuals requesting a continued stay review receive a PASRR Level II (regardless of whether they meet level of care). The PASRR Level II evaluation process is similar to the pre-admission screening process. The SME has requested additional information regarding the process for engaging individuals where a continued stay request has been performed regardless of whether the individual continued to meet nursing facility level of care.

The SME recommends that LDH continue to collect and analyze data regarding the number and percent of individuals in the Target Population that have requested a continued stay and the percent of individuals who have an approved and a denied continued stay. The SME is requesting this data for the next reporting period. This will allow the State to determine if most individuals in the Target Population are approved for longer lengths of stay and/or how LDH can intervene earlier to effectuate a transition. In addition, LDH should collect information regarding the reasons for the continued stay approvals and denials and identified any trends in continued stay request by reason and facility. In addition, the SME is also requesting information from the State regarding the role that OAAS and OBH have in making continued stay recommendations. While it is clear that OAAS is responsible for these continued stay, the SME is interested in understanding if the PASRR Level II, as administered by OBH, provides timely and important information regarding a continued stay request. The SME has been provided and is reviewing initial information provided by the State regarding the CSR process and the roles of OBH and OAAS.

*39. In addition, LDH will ensure that each individual with SMI who has been admitted to a nursing facility receives a new PASRR Level II evaluation conducted by a qualified professional independent of the nursing facility and the State annually, and upon knowledge of any significant change in the resident's physical or mental condition, to determine whether the individual's needs can be met in a community-based setting. Examples of significant change that can occur subsequent to nursing facility admission include, but are not limited to: improvements or declines in physical or mental health; behavioral incidents triggering facility transfers or other change in an individual's living conditions; changes in mental health diagnosis or in dosage or type of psychotropic medication; and requests for community placement.*

As indicated in the response to paragraph 34, PASRR Level II reviews are performed by the Medicaid MCOs' Level II Evaluator, a Licensed Mental Health Professional who operates independent of the NF and the State. There are three scenarios when an individual receives a PASRR Level II:

- An initial PASRR is performed when the individual is seeking admission to a NF and the PASRR Level I indicates the individual has a SMI.
- A PASRR Level II is also performed by an independent reviewer when a provider requests a continued stay for an individual.
- Annual resident reviews, as required by the Agreement, are being performed on individuals in the Target Population that were admitted to a NF prior to 2018 and for individuals who were admitted after 2018 and who did not have a continued stay review during the year.
- A PASRR Level II is also done when a nursing facility request a Level II due to a significant change in an individual at their facility.

The SME has been provided information regarding the number of PASRR Level II annual resident reviews for the six-month period between 9/2019 through 2/2020. The number of annual resident reviews has gradually increased each month September (237 annual resident reviews) through February (386 annual resident reviews).

The SME is requesting information on how LDH identified individuals who have any significant change in the resident's physical or mental condition, which would prompt the need for a PASRR Level II request.

The SME also requests that LDH provide information on the number of individuals who are in the Target Population that have received an annual resident review for FY 2019 and FY 2020 (to date) and were admitted to a NF prior to 2018. This information will be helpful to determine if each member of the Target Population has received a PASRR Level II annually and if not, to develop a strategy for completing the PASRR Level II in a timely manner.

## V. Transition and Rapid Reintegration

### A. Comprehensive Transition Planning

*40. LDH will offer comprehensive transition planning services to all individuals in the Target Population who are admitted to a nursing facility in Louisiana. LDH's approach to transition planning shall address two distinct situations: (1) the need to identify and transition members of the Target Population already in nursing facilities at the effective date of this agreement, and (2) the need to identify and transition members of the Target Population admitted to nursing facilities after the effective date of this agreement.*

*41. If the State becomes aware of an individual in a nursing facility who should have received a PASRR Level II evaluation, but did not, the State will refer the individual to the Level II authority for evaluation.*

As indicated in Section III, the State has developed and continues to maintain a Master List of individuals who are members of the Target Population already in NFs at the effective date of this agreement. The State has a process in place to identify and transition members of the Target Population admitted to NFs after the effective date of this agreement.

In addition, the SME's service review will also begin to evaluate the transition process. The Agreement required the SME to assess the quality of community-based services for members of the Target Population. As a part of this quality assessment, the SME is responsible for reviewing a representative sample of individuals in the target population. The SME review will capture information about individual experiences with transitions from NFs, participation in care planning, safety of placements, physical and mental wellbeing, crises and acute health episodes, stability of housing, employment or other integrated day choices, choice and self-determination, integration in the community and community inclusion, barriers to community integration, and access to and utilization of services.

#### Transition Teams

*42. LDH shall form transition teams composed of transition coordinators from the LDH Office of Aging and Adult Services, the LDH Office of Behavioral Health, and the LDH Office for Citizens with Developmental Disabilities. The relative number of transition coordinators hired or otherwise provided by each of these LDH offices will be based upon an analysis of the characteristics of the Target Population residing in Louisiana nursing facilities as well as trends in nursing facility admissions relative to the Target Population. This approach builds upon the State's experiences and success within its existing Money Follows the Person program that transitions roughly 300 people per year from nursing facilities. The addition of OBH transition coordinators to the State's existing transition framework is to assure that the comprehensive transition plan fully identifies and addresses behavioral health needs. OBH transition coordinators shall facilitate medically necessary community behavioral health services for members of the Target Population whose behavioral health services are covered under Medicaid. Similarly, OAAS transition coordinators shall assess, plan for, and facilitate access to home and community-based services (HCBS) overseen by OAAS, such as long-term personal care services (LTPCS), Community Choices Waivers, and Permanent Supportive Housing. OCDD transition coordinators shall provide this same assistance for members of the Target Population who have a co-occurring developmental disability.*



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 NFs to the community. As indicated in the Agreement, the State had significant experience with this work through a federal demonstration program titled Money Follows the Person (MFP). 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 processes and protocols further on an ongoing basis.

The State has established positions for 18 positions to assist with transitions. The State has recruited, hired, and trained all Transition Coordinators. Each of the nine LDH regions has OAAS and OBH coordinators, in addition to two Project Managers who oversee the Transition Coordinators. OAAS is also seeking two additional transition coordinators; however, the COVID-19 pandemic has delayed the hiring process. 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.

In the opinion of the SME, the State has created the required infrastructure needed to conduct the transition assessments and individualized transition plan and assist individuals with the transition process. As discussed above, the SME, in the next review period, will begin to evaluate the experience of members that were transitioned from NFs. This will include reviews of the transition plan and transition planning process, the services received by the individual, and the experience of the transition process (through interviews with individuals who transitioned out of NFs).

During this reporting period, the TCs continued to assume the role of community case managers for individuals who transitioned to the community. As indicated in this report, LDH is required to provide case management to individuals in the Target Population that transition or are diverted from nursing homes for a minimum of 12 months. The State has implemented an interim strategy that relies on the existing TCs to provide case management until a long-term strategy is implemented. The interim case management strategy is discussed in more detail in paragraph 59. In the SME's assessment, this interim strategy, as designed, should provide a consistent case management approach, but should not be used as a long-term solution. The TCs have other important functions that will be compromised if this is the long-term solution. The longer-term case management approach is discussed in paragraph 59-61.

In the previous SME report, it was recommended that the State enhance its efforts to increase the number of individuals in the Target Population who are successfully transitioned from NFs. The State did a laudable job during the first eighteen months to transition over 100 individuals from NFs and projected to transition an additional 100 this year. The State has made the assumption that the number of individuals transitioned in FY 2020 would be reflective of similar activity from the previous 18 months. The pandemic has hindered the State's efforts to meet the 2020 transition targets and the SME is concerned that the pace of transitions will not be sufficient to meet the terms of the Agreement on a timely basis. The SME recommends that the State revise the projections for CY 2020 and develop a

methodology and plan for CY2021 targets that will significantly enhance the number of transitions from NFs. The annual targets should be developed in conjunction with a longer term, aggressive plan for accomplishing “rapid reintegration,” consistent with the goals of this Agreement. LDH should set forth a timeline for allowing *everyone* who is able to and would like to transition to the community to do so – with sufficient transition, discharge planning, and community-based services to meet their needs – within a set amount of time. In addition, this plan should address the barriers identified in this report and enhancing in-reach efforts including better motivational interviewing strategies and use of peers to assist TCs with in-reach efforts. The State will need to enhance its efforts to identify community resources that are needed by the Target Population specific to their health needs, since many of these individuals have comorbid physical and behavioral health conditions.

### Transition Planning

*43. LDH’s transition teams as described in paragraph 42 above shall be responsible for developing an Individualized Transition Plan (ITP) for each member of the Target Population who is residing in a nursing facility. The ITP shall address the service needs identified through the PASRR Level II process as well as additional needs identified by transition team members.*

*44. Transition planning will begin with the presumption that with sufficient services and supports, individuals can live in the community. Transition planning will be developed and implemented through a person-centered planning process in which the individual has a primary role, and based on principles of self-determination and recovery. LDH shall ensure that the transition planning process includes opportunities for individuals to visit community settings.*

*45. The process of transition planning shall begin within three working days of admission to a nursing facility, and shall be an interactive process in which plans are updated to reflect changes in the individual’s status and/or goals and in the strategies or resources identified to achieve those goals. The State shall assign a transition coordinator who shall initiate contact with the individual within three working days of admission. A face-to-face meeting shall occur within 14 calendar days of admission for new admissions. The Implementation Plans described in Section X shall specify timeframes for transition planning for members of the Target Population residing in nursing facilities as of the Effective Date.*

*46. The transition plans will accurately reflect and include: (a) the individual’s strengths, preferences, needs, and desired outcomes; (b) a list of the services and supports the individual currently receives; (c) a description of how the services and supports the individual currently receives will be provided in the community; (d) any other specific supports and services that would allow the individual to transition successfully back to his or her home and to avoid unnecessary readmission to an institutionalized setting, regardless of whether those services are currently available; (e) Case Management services consistent with Section V.E. of this Agreement; (f) the specific Community Provider(s) who will provide the identified supports and services, and the needed frequency and intensity of services and supports; (g) resources that the individual will call on if she or he experiences crisis in the community; and (h) the date the transition will occur, as well as the timeframes for completion of needed steps to effect the transition.*

Paragraphs 43-46 are addressed together. Since the beginning of the Agreement, LDH has developed ITPs based on a standardized assessment that is completed prior to discharge. As indicated in the previous report, the State, in July of 2019, revised the assessment to be more person-centered, and gather additional information regarding individuals’ interests and desires about integrated day opportunities. This includes 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, etc.) and identification of the needed supports to accomplish these goals. The Assessment, as revised, provides more specificity regarding the housing options that are available in the community post-transition. The Assessment also includes much needed information regarding crisis triggers and crisis planning. In addition, the Assessment gathers information on an individual's history of co-occurring mental and substance use disorders as well as behavioral health supports, including the individual's perspective on treatment and those preventive and early intervention strategies that can be used in their transition plan. As of May, 2020 1,105 ITPs were developed for individuals in the Target Population (individuals in NFs and individuals transitioned from NFs).

During this reporting period, the State has also revised the Transition Plan to reflect the changes to the assessment tool. The SME was involved in reviewing the changes to the tool and is satisfied with the content and format of the ITP. In addition, the State reviewed the revised tool with a subcommittee of the My Choice Advisory Committee who provided feedback on the tool. The ITP was revised to include this feedback and TCs were trained on this new planning tool. During the next reporting period, the SME recommends that LDH consider changes to the assessment and planning document to identify and account for individual's co-morbid conditions.

The SME has reviewed the current training used to develop the ITP to determine if the approach is person-centered. Initially, the TCs were trained on the principles of Person Centered Planning. The SME reviewed the training material initially and believed it appropriate for the Target Population—including specific references to recovery principles into the overall planning approach. Earlier this period, LDH provided the SME with training materials regarding transition planning and discharge. The SME's review of this material identified issues with the language and approach set forth in these materials. In particular, the materials lacked a person-centered approach that identified the strengths and wishes of individuals during the assessment and planning process. The SME recommended significant revisions to this training material. With the assistance from the SME, LDH is revising this material. A revised draft of the training materials will be provided to LDH in July that includes presentations and train the trainer material on person-centered planning.

There are requirements in the paragraphs above that the State has yet to implement. For instance, the State does not currently have a real-time way to identify when they are admitted to a nursing facility. Therefore they are not able to meet the 3 and 14 days requirements in paragraph 45 (although the proposed changes to the tracking system will allow them to do this in the future). In addition, it will be helpful to understand if and how individuals in NFs are afforded opportunities to visit community settings.

*47. The transition teams shall interface with case managers for each transitioning individual to assure that all services necessary to transition the individual are provided at the appropriate time and that all persons transitioned have a community plan of care in place with necessary services authorized at the point of transition to the community.*

*48. The Implementation Plan, described in Section X, shall define the process for assigning case management responsibility to support individuals in the Target Population.*

*49. Transition teams and the LDH managerial staff who oversee their work will also conduct post-transition follow-up to assure that services in the community are initiated and delivered to individuals in a fashion that accomplishes the goals of the transition plan.*

For paragraphs 47-49, the State has developed an interim case management strategy for individuals in the Target Population that have been transitioned from NFs. This includes TCs completing weekly and monthly logs that review whether the individual is satisfied with the services they are receiving, whether the individual is receiving the services identified in the ITP, and if the individual has experienced a significant change in services. The SME is requesting information from the State regarding the protocol being used to develop the community plan of care (if different from the expectation of the future case management definition) and the form used for this plan of care. The SME will review the plan of care form and provide feedback in the next reporting period.

*50. Members of the Target Population who will lose Medicaid financial eligibility upon transition to the community shall be referred for services through safety net behavioral health providers such as the LGEs and Federally Qualified Health Care providers.*

Over the reporting period, there were 8 individuals LGE). It is recommended that LDH, in cooperation with the LGEs, evaluate whether there are service gaps for these individuals and if so, develop strategies to address those gaps.

*51. For members of the Target Population who are eligible to remain in the nursing facility and choose to do so, LDH will document the steps taken to identify and address barriers to community living, and document efforts to ensure that the individual's decision is meaningful and informed. This same procedure will also apply for members who choose to move to a setting that is not community based.*

In the previous report, the State provided the SME with information regarding the individuals who are awaiting transition—specifically, any transition barrier that the State has identified for these individuals. Many of these barriers continue to exist for these reporting periods. These barriers include:

- Availability of accessible housing, especially in rural areas of the State;
- Transportation assistance, both for transportation within region to view housing and when transitioning to another region;
- Legal barriers to transition (availability of housing for individuals with criminal backgrounds);
- Lack of natural supports that are willing and able to assist in meeting the individual's post-transition needs;
- Physical needs that do not rise to the threshold of meeting a NF LOC, which means that some individuals are not eligible for HCBS;
- Service needs for those who, upon transition into the community, will lose Medicaid eligibility;
- Physical, emotional, and cognitive health decline of individual's who may be interested in transitioning, but for whom transitioning poses a health and safety risk;
- Delays in obtaining identification documents or birth certificates, especially when such documents are needed to secure housing;
- Non-cooperation from the NF in supporting transition activities;
- Family concerns regarding the adverse consequences of the transition; and
- Ambivalence of individuals about leaving NFs and changing preferences about arrangements they want in the community.

The State has made a reasonable effort to identify barriers. What is less clear is the process the State uses to reconcile these barriers. Some of these activities would squarely fit into the Quality Assurance process for the Agreement described in Paragraph 93 once the State has met the requirements of that paragraph. In the meantime, the SME is requesting the State provide documentation how these barriers are being addressed either on an individual or systemic basis.

*52. To assist the State in determining whether Target Population members are offered the most integrated placement appropriate to their needs, the Subject Matter Expert (“Expert”) will review all transition plans that identify an assisted living facility, personal care home, group home, supervised living house or apartment, rooming house, or psychiatric facility as the individual’s residence, for the first two years of this Agreement. Thereafter, the State and the Expert will determine the appropriate scope of review as part of the State’s quality assurance efforts.*

In early 2019, the SME developed a protocol and process whereby LDH reported the following instances to the SME:

- Individuals made an informed decision to choose housing that is not considered integrated according to the Agreement;
- Guardians or curators did not allow an individual to transition to an integrated setting;
- The Transition Coordinator or community service provider recommended a housing setting that is not considered to be integrated; and
- The Nursing Home recommended a housing setting that is not considered to be integrated.

During this evaluation period, LDH reported that no member of the Target Population transitioned from a NF requested to be transitioned to a setting other than their family’s home or their own housing (single family home or apartment).

*53. LDH will develop procedures for addressing safety and choice for members of the Target Population who lack decision-making capacity.*

LDH has reported that Transition Coordinators during the early phase of transitions have identified individuals that may present issues relative to safety in the community (e.g. cognitive issues that may be difficult to address in the community). The Transition Coordinators will engage the Service Review Panel discussed in the report to review various documentation to determine if safety issues identified were valid. In addition, the Transition Coordinators will engage the individual’s MCO to obtain additional evaluations/assessments to identify or ameliorate concerns that may have been identified as a barrier to transition. The SME has requested information from the State to better understand how the provisions of this paragraph are operationalized.

## **B. Outreach and Transition for Target Population Members in Nursing Facilities**

*54. Within dates to be specified in the Implementation Plan, LDH will analyze MDS data to identify members of the Target Population residing in nursing facilities. LDH will begin outreach to these individuals according to timeframes to be specified in the Implementation Plan. Outreach shall consist of face-to-face assessment of the individuals by one or more members of the transition team using a process and protocols to be agreed upon by LDH and the United States.*

*55. Based upon information gained as a result of outreach, as well as other information available to LDH, LDH may develop a plan to prioritize individuals for transition based upon such factors as location or concentration of members of the Target Population in certain facilities or regions, likelihood of successful transition as measured by MDS-based tools, individual access to housing or availability of housing in the area in which the person wishes to reside, and other factors. The goal of such prioritization will be to effect multiple successful transitions within two years of the effective date, on a schedule specified in the Implementation Plan, and to incorporate lessons learned into the State's practices.*

*56. LDH will transition members of the Target Population according to timelines agreed upon by LDH and the United States and set forth in the Implementation Plan.*

*57. Members of the Target Population will be transitioned back to their previous community living situations whenever viable, or to another community living situation, according to the timeframes set forth in the Individual Transition Plan.*

As indicated in paragraph 25 and 26, LDH developed a Master List of individuals in the Target Population that resided in NFs at the beginning of the Agreement using the methodology established in paragraph 54. TCs began the outreach process in July of 2018 to identify a cohort of individuals who were more likely to experience a successful transition. For the next reporting period, the SME is requesting information regarding how LDH identifies individuals who were likely to have a successful transition and what specific lessons learned the State has obtained from these transitions. The SME is requesting information from LDH regarding the number of individuals on the Master List who have been contacted by a TC.

The State does not have an information systems or processes in place to meet the timelines for working with individuals at admission or having contact with the individual within 14 days of admission. The procurement discussed in this report will provide LDH much needed real time information regarding admissions. The SME will follow up with the State in the next period to determine when this system will be operational or to develop an interim approach to track the 14-day period.

The State has developed the processes in place to offer individuals through the Assessment process the opportunity to return to a living arrangement that was consistent with their previous living situation with some exceptions. Several members were not stably housed prior to their NF admission, other individuals were in shared living arrangements that the individual indicated was not preferable at discharge. The State reports that all transitioned members of the Target Population were provided a stable housing arrangement that was consistent with this Agreement.

### C. Transition Support Committee

*58. LDH will create a Transition Support Committee to assist in addressing and overcoming barriers to transition for individual members of the Target Population when transition team members working with service providers, the individual, and the individual's informal supports cannot successfully overcome those barriers. The Transition Support Committee will include personnel from OAAS and OBH, and ad hoc representation as needed to address particular barriers in individual cases as well as systemic barriers affecting multiple members of the Target Population. Additional members with experience and expertise in how to successfully resolve barriers to discharge may include OCDD, Assertive Community Treatment team members, Permanent Supportive Housing staff and/or providers, community physical and home health providers, representatives of agencies responsible for benefits determinations, Adult Protective*

*Services staff, LGEs, and certified peer specialists. A list of such ad hoc members shall be approved by the Expert.*

As indicated in previous reports, the State has developed procedures to fulfill the Agreement's requirement to facilitate a Transition Support Committee. Using OAAS's framework for its current service review panel, LDH has developed the My Choice Louisiana Service Review Panel (SRP), a cross-agency process that works to identify systemic barriers that impede or prevent transitions and work through individual case-related issues. The My Choice Louisiana SRP functions as the Transition Support Committee. Currently, there are seven members of the Transition Support Committee consisting of OASS and OBH staff consisting of health care professionals, TCs, as well as Central office and regional staff. The My Choice Louisiana SRP meets weekly to review cases for individuals identified as members of the Target Population in which barriers are hindering the individual's personal goals, or the transition itself. The SME is requesting information from LDH regarding the number of individuals that have been referred to the SRP and if the SRP was effective in addressing these barriers.

As indicated in the previous SME report, it will be important that the State continue to use this process to identify and address barriers to transitions. As recommended in the previous report, the State should consider additional members that can identify systemic barriers affecting multiple members of the Target Population and ad hoc representation to address particular barriers in individual cases. This would include adding members with experience and expertise related to successfully resolving barriers to discharge. Potential additional members include Office for Citizens with Developmental Disabilities staff, ACT team members, Permanent Supportive Housing staff and/or providers, community physical and home health providers, representatives of agencies responsible for benefits determinations, Adult Protective Services staff, LGE staff, and certified peer specialists.

#### **D. Post-Discharge Community Case Management**

*59. Ongoing case-management in the community shall be provided to members of the Target Population for a minimum of twelve months following discharge from the nursing facility.*

*60. The Implementation Plan shall describe LDH's plan to ensure case management services are provided to the Target Population. Case management services shall provide consistency, and continuity, both pre- and post-transition. Services will be of sufficient intensity to ensure case managers are able to identify and coordinate services and supports to help prevent reinstitutionalization and assist the individual to maintain community placement. This will include assuring access to all medically necessary services covered under the State's Medicaid program, including but not limited to assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), behavioral and physical health services, substance use disorder services, integrated day activities such as supported employment and education, and community connections. LDH shall ensure capacity to provide face-to-face engagement with individuals in the Target Population, through case management and/or through the appropriate behavioral health provider.*

*61. The case manager will assure that each member of the Target Population receiving Medicaid services has a person-centered plan that will assist the individual in achieving outcomes that promote individual's social, professional, and educational growth and independence in the most integrated settings.*

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. As stated in previous SME reports, there is

not an existing model of case management that will suffice for many of the individuals in the Target Population. For instance, most members of the Target Population who are transitioned from NFs 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 want to participate in or 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 was 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.

The State has developed, but has not implemented, a case management model that will be available to individuals who transition from NFs, as well as for individuals who will be diverted from these facilities. As drafted, the case management model is individualized, person-centered, and reflects the individual's unique strengths, needs, preferences, experiences, and cultural background. It allows individuals to participate in all decisions that affect their care and ensures they are provided options regarding their services and supports—including the option to refuse services. The model establishes key functions for the community case manager and sets forth clear expectations of the nature and frequency of contact before, during, and after transitions from the NFs. It also sets forth the requirements for the case manager and the entities that will employ these staff. The SME has reviewed the proposed case management model and recommends that implementation occur during FY 2022.

The SME recommended that the State continue its efforts to finalize a strategy for the provision of case management services (following the interim process) during this reporting period. Specifically, the State is to identify the Medicaid authority necessary to implement the new case management model and have a plan for implementing this strategy with specific timeframes. The plan should address critical activities, including: establishing reimbursement methodologies for the service, developing training modules for potential case management staff, and creating information for individuals in the Target Population regarding the role of the case managers prior to, during, and post transition. In addition, training will need to be developed for Support Coordination agencies, MCOs, and others who will have contact with newly created case managers. The State has made some traction on finalizing these strategies during this reporting period. In the first few months of this year, LDH staff met with leadership to discuss the case management model and activities necessary for implementation (including Medicaid authority options). However, these discussions were paused due to the State's response to the COVID pandemic and no specific decisions were made regarding Medicaid authority and specific implementation activities and timelines. The State has resumed these discussions this month (June). The SME recommends that the State finalize their decision early in the next reporting period and develop the necessary budget and Medicaid authorities to implement the case management strategy. The SME recommends that this strategy be implemented in early FY 2022. This should allow sufficient time to obtain approval from CMS and to finalize and begin to implement the roll out plan for this service.

Meanwhile, the State has created and implemented the interim case management strategy, which requires the Transition Coordinator provide ongoing case management services. The SME worked with LDH to develop this strategy during the last reporting period. The purpose of this interim strategy is an effort to assure that members of the target population have a primary point of contact post transition



who will be tasked with ensuring that the care plan is effectively implemented and updated and the needs of the individual are addressed, whether or not the individual is engaged in services. Additionally, the Transition Coordinator will advocate on behalf of the person to achieve goals established in the plan of care (POC) and coordinate with the individual, their chosen natural and/or other support network, care managers and/or other service providers to assure seamless coordination of services.

Each contact completed by the TC must be documented. The State has developed a Case Management Contact Documentation Log that includes information on the type of contact (telephonic versus face to face), the frequency of the contact, the services currently being received by the individual and gathers other information regarding any changes in the individual's health, services and housing status. It also identifies any issues with community inclusion and critical incidents that may have occurred since the last contact. The State has requested that the TCs report weekly on their contacts with members on their caseloads. TC Supervisors and LDH program staff collect, review, and analyze these logs to determine if there are any service delivery issues, critical incidents, and if changes in the Individuals POC are warranted.

LDH has developed protocols for the frequency of case management provided to individuals who have transitioned from NFs. The frequency of contacts are consistent with the community case management definition. While the number and type of contact is individualized, more frequent contacts occur in the earlier months post transition and the frequency of these contacts are revisited based on the individuals desires and needs.

The interim case management strategy was implemented for OBH in the previous reporting period and for OAAS in the first few weeks of January 2020. As indicated in the protocol, case management was provided face to face and telephonically. The TCs were trained on the interim strategy as well as training on addressing individuals social determinants of health as well as increased competencies on identifying and responding to individuals in crisis situations.

With the onset of the COVID 19 pandemic, the TCs provided most of their case management activities via the telephone. Fortunately, all members of the target Population that were active on the TCs caseloads have telephones and were able to be contacted frequently during the pandemic. Any in-person case management activities will be dependent on the State's plan for phase-in during the recovery period and must address the need for Personal Protective Equipment (PPE) and policies that protect both providers and service recipients.

The SME has worked closely with the State to develop the interim case management strategy and the development of the case management log. The log will provide important information regarding the status of the Target Population that has been transitioned and can be used for the State's quality assurance approach for the Agreement. LDH is currently collecting information from the case management logs to create important indicators on any change in status of these individual as well as some initial indicators to assess the quality of the services provided. The weekly logs provided LDH leadership with important information regarding the health and well-being of individuals who were transitioned. These logs were used to create the weekly COVID-19 tracking process mentioned earlier in this report. These logs have provided real time tracking of the status of individuals who have been transitioned and should be continued throughout the duration of the interim case management strategy and should be incorporated into the longer-term community case management strategy.

## E. Tracking

*62. By the date specified in the Implementation Plan, LDH 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 in order 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 address proactively any such gaps to reduce the risk of readmission or other negative outcomes. The monitoring system shall include both face-to-face meetings with individuals in the Target Population and tracking by service utilization and other data.*

At the encouragement of the DOJ and SME, the State has developed an initial tracking system for individuals who have been identified for transition from NFs. 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 ITPs, 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. In November of 2019, the interim tracking system was adversely impacted by an attempted cyber-attack on many State information systems. This impeded the ability of the State to access (and enter) data from the interim system. Specifically, information from assessments and ITPs were lost and therefore unavailable on many individuals who were transitioned from NFs over the previous 17 months. This disrupted the reporting process and impacted the ability for the State to garner information that would be helpful for tracking and analyzing necessary information for reporting and quality assurance purposes. Fortunately, the State has hard copies of the necessary information that are in the process of being re-entered into the interim system. The interim tracking system is operational again. The tracking system includes ongoing entry of critical information, including case management logs. This allows the State to create and analyze some of the necessary reports required under this Agreement.

The State continues its efforts to secure a longer term tracking system for the Agreement. The 2020 Implementation Plan sets forth activities for developing key components of the more formal long-term tracking system that will enable the State to track transitions and diversions from NFs for members of the Target Population. The State proposed the specifications for system requirements of the longer-term tracking system. In reviewing the specifications, the SME found that the proposed system requirements would support the State's needs for tracking individuals who are transitioned or diverted from NFs.

The State has established two phases for the development and implementation of a more robust tracking system. Phase 1 consists of developing the necessary program in order to track individuals that are on the Master List of individuals who have been identified as members of the Target Population. It will be necessary to track the status of these individuals, including initial contact, follow-up to discuss interest in transitioning to the community, the revised Transition Assessment, a basic Transition Plan, and notification of transition. The State has sent the necessary information and instructions to the vendor, who will be developing the longer term tracking system. The vendor has developed the tracking system and is currently in the process of testing its functionality.

Phase 2 will include programming of the Transition Assessment, Transition Plan, and post-transition monitoring efforts by the TCs into the system. For this phase, the State has provided the vendor with the necessary business requirement documents. Over the next several months, the State will review the programming and provide feedback to the vendor. This should enable the State to reduce the time and resources necessary to track individuals and produce the necessary reports. The State also developed a list of reports that will be needed for tracking and monitoring individuals who are transitioned or diverted from NFs. There are additional reports that the State will need to consider developing once the quality

indicators are finalized. These reports have been identified in the quality indicator matrix, which identifies whether the report is an internal management tool and which reports would be available to the public. In addition to these reports, the State should continue to provide more detailed information regarding the status of transitions and diversions as well as information regarding individuals post-transition.

In addition to the next iteration of the tracking system, the State has begun efforts to enter information from the TCs logs. As described in this report, the TCs are collecting information regarding the individual's experience regarding the service planning process, change in caregivers or living arrangement, change or providers, critical incidents as well as specific follow up that will be needed by the Transition Coordinator. The SME recommends that the State continue their efforts to develop reports regarding individuals that have been transitioned from NFs and develop a strategy for collecting similar information for individuals that are diverted from NFs.

Due to COVID-19, the procurement efforts for the longer term tracking system were delayed. During this period, the SME recommends that State develop the necessary procurement documents in order to solicit a vendor that will create the long-term tracking system. Specifically, the SME recommends that the State procure the vendor by September 2020 and perform the due diligence necessary to ensure successful implementation (e.g. readiness review) with full involvement of the parties, which are expected to have use of this system.

## VI. Community Support Services

### A. Crisis System

*63. LDH will develop and implement a plan for its crisis services system. LDH will ensure a crisis service 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, consistent with the principles outlined below. Crisis services shall be provided in the most integrated setting appropriate (including at the individual's residence whenever practicable), consistent with community-based crisis plans developed for individuals receiving services, or in a manner that develops such a plan as a result of a crisis situation, to prevent unnecessary hospitalization, incarceration, or institutionalization.*

In December 2019, LDH, with input from the SME, developed a plan for a statewide crisis response system, which included the services in the Agreement and additional crisis services used in other jurisdictions that have proven efficacy. The plan included the requirements in the Agreement, which included:

- The development of a toll-free crisis hotline in each community 24 hours a day, 7 days a week, that would be staffed by qualified providers and includes strategies for the call center to dispatch crisis teams;
- Call center with staff who will attempt to resolve the crisis over the phone, and if needed will provide assistance in accessing face-to-face intervention from mobile crisis teams or arranging an urgent outpatient appointment, providing phone consultation with a Licensed Mental Health Practitioner if a higher level of clinical skill is needed, or connecting the caller with peer support services or other community resources;
- Mobile crisis teams that will have the ability to respond to individuals in real time consistent with the timeframes set forth in the Agreement; and
- Mobile crisis response that will have the capacity to support resolution of the crisis in the most integrated setting and arrange for urgent outpatient appointments with local providers, and providing ongoing support services for up to 15 days after the initial call.

The State included an array of crisis services in the plan that are primarily delivered to individuals in their home or communities (e.g. urgent care). The plan did recognize the need for out-of-home short-term crisis stabilization services intended to divert individuals from higher levels of care.

As indicated in the plan, implementation and timelines hinge on dedicated State funding and CMS approval for new and revised services. The proposed timeframes in the plan provide a multi-year strategy for implementation.

LDH began implementation on January of 2020 with the initial focus of enhancing the competencies of TCs to identify and respond when members of the Target Population experience a crisis. LDH in cooperation with the SME developed and implemented some initial training for staff that were working with individuals as they transitioned from NFs. Specifically, the training focused on improving the acumen of the Transition Coordinator's approach to plan for and address crisis that may be experienced by the Target Population with an emphasis on using engagement and intervention techniques designed to relieve symptoms and reduce the need for higher level of care intervention. The training commenced in February.

Additional follow up training occurred in May. Despite the COVID-19 pandemic, these ongoing trainings were held virtually.

In addition, the State continued to work on the requirements that define the services listed above. The State is developing the draft service definitions. As proposed in the plan, the state will finalize rate setting for these services during the next reporting period.

While COVID-19 has yet to impact the initial steps outlines in the plan, it will no doubt have an impact on the scope and timing of the implementation. While no changes to the crisis plan has been made to reflect the impact of the pandemic during this reporting period, the SME will work with the State to review the feasibility of the initial plan given the affect the pandemic will likely have on the LDH budget for several years. Possible alternative strategies would include a rolling implementation of various crisis services with an initial focus on developing mobile crisis. The SME team has only begun these conversations with the State and will have a clearer strategy in the next reporting period.

*64. LDH will ensure that the Target Population has access to a toll-free crisis hotline in each community 24 hours a day, 7 days a week, staffed by qualified providers, with sufficient capacity to preclude the use of answering machines, third-party answering services, and voicemail. Crisis hotline staff will try to resolve the crisis over the phone, and if needed will provide assistance in accessing face-to-face intervention, arranging an urgent outpatient appointment, providing phone consultation with a Licensed Mental Health Practitioner if a higher level of clinical skill is needed, or connecting the caller with peer support services.*

There is a patchwork of toll free crisis and help lines that are currently available to assist individuals, including members of the Target Population, experiencing crisis. This includes crisis lines that are operated by MCOs, LGEs, and individual providers. There is not a coordinated statewide effort. To address this issue, the crisis plan, as proposed, would ensure that the Target Population and all Louisianans experiencing a behavioral health crisis would have access to a toll-free crisis line. Until the State implements this system, members of the Target Population will continue to seek crisis assistance through existing hotlines and warm lines which will not provide the sufficient support that is needed for these individuals and others experiencing crisis.

*65. LDH will, through the Implementation Plan, ensure that a face-to-face, mobile crisis response capacity is available statewide before termination of this agreement. Mobile crisis response shall have the capacity to respond to a crisis at the location in the community where the crisis arises with an average response time of one hour in urban areas and two hours in rural areas, 24 hours a day, and seven days a week. Mobile crisis response will have the capacity to support resolution of the crisis in the most integrated setting, including arranging urgent outpatient appointments with local providers, and providing ongoing support services for up to 15 days after the initial call.*

The State has not implemented the mobile crisis response capacity set forth in the crisis plan. The State is developing service definitions for mobile crisis that set forth the response times and other expectations for mobile response providers. As indicated in the previous paragraph, during the next reporting period, the SME will work with the State to review the proposed strategy for mobile crisis services and determine if changes in implementation will need to be made. The SME would request the State would develop a strategy for mobile crisis during the next reporting period.

*66. LDH will, through the Implementation Plan, ensure that a crisis receiving system is developed statewide with capacity to provide community-based de-escalation and recovery services to individuals experiencing*

*crisis. The State shall conduct a gap analysis and develop crisis receiving system components in community-based settings designed to serve as home-like alternatives to institutional care, such as walk-in centers and crisis or peer respite apartments, or other evidence-based practices. LDH shall discourage co-locating in an institutional setting any new crisis receiving services developed during the term of this Agreement. Crisis or peer respite apartments developed through the Implementation Plan will have no more than two beds per apartment, with peer staff on site and licensed clinical staff on call 24 hours per day, seven days per week.*

LDH, in cooperation with the SME, has designed and is implementing a comprehensive needs assessment that includes an analysis of all crisis services including the components of the home-like alternatives referenced above. It is anticipated that the findings and recommendations from the needs assessment will be complete during the next reporting period. The goal of this needs assessment is to conduct a rigorous, formal needs assessment consistent with the terms of the Agreement, which will serve as a foundation for planning and expediting an effective behavioral health system change project in order to establish priorities, identify stakeholder requirements and preferences, make resource allocation decisions, and differentiate between short-term and long-term goals. The needs assessment has several aims, including:

- Identifying what services and supports are required for the target population to be safely transitioned or diverted from the nursing home to a community setting.
- Assessing the adequacy of community-based services and supports for an “at risk” population—that is, persons with SMI in the community who fit the profile of the target population and therefore might be placed in a nursing home absent the necessary community services.
- Assessing the adequacy of services and supports more broadly for the population of people with SMI in Louisiana.
- Produce a set of actionable, measurable, prioritized recommendations for addressing gaps, and a road map for effectively implementing those recommendations.

*67. LDH is working to address the State’s opioid crisis and other co-occurring substance use disorders affecting the Target Population. As part of this effort, LDH shall ensure statewide network adequacy of detoxification, rehabilitation, and intensive outpatient substance use disorder (SUD) recovery services. SUD services shall have sufficient capacity to accept walk-ins and referrals for the Target Population from crisis services, emergency services, and law enforcement personnel. With the technical assistance and approval of the Expert, the State shall develop policies, procedures, and core competencies for substance use recovery, rehabilitation, and detoxification service providers.*

Since 2018, LDH was implementing significant changes to their SUD service system through a CMS 1115 Demonstration Waiver. This 1115 Waiver opportunity allowed states to make important changes to their SUD system and required participating States to meet six important milestones. One of these milestones focused on improving access to SUD services. Through participation in the SUD Waiver, the State agreed to continue to offer all levels of residential and outpatient care set forth by the American Society of Addiction Medicine (ASAM). The State, since 2012 had already created a continuum of services consistent with ASAM through the Louisiana Behavioral Health Partnership. In addition, one of the State’s milestone was to ensure network adequacy for the array of services in the 1115 Waiver. The State currently requests information on a quarterly basis from the MCOs that are responsible for managing these benefits. A review of these reports by the SME indicated that there were no network adequacy issues for the various SUD levels of care during this reporting period. In addition to the 1115, the State has also received funds

through the CARES and SUPPORT Act to address the continuing opioid epidemic. The State had used these funds to expand evidenced-based practices, such as Medication Assisted Treatment (MAT) as well as increasing the availability of recovery coaches in communities throughout Louisiana. In addition, the State has worked with the Pew Foundation to develop and implement policies that seek to improve access to OUD/SUD services, including additional Opioid Treatment Programs (OTPs). In the SME's opinion, Louisiana is taking the necessary steps to improve access to SUD services, including MAT and peer supports, two interventions that are well supported through ongoing evidence. In addition, it is the SMEs recommendation that the needs assessment include information regarding the SUD needs of individuals in the Target Population to ensure their treatment needs are identified and addressed.

*68. LDH will collaboratively work with law enforcement, dispatch call centers, and emergency services personnel to develop policies and protocols for responding to mental health crises in the community and will support development and training of Crisis Intervention Teams and other initiatives that increase the competency of officers and emergency services personnel when engaging individuals with mental illness or substance use disorders.*

The State has done some initial outreach to emergency medical services providers regarding possible approaches to identifying and resolving crisis in the community. The State has reported that LGEs in certain areas of the State have engaged law enforcement and developed and trained crisis intervention teams.

Given the current national focus on the role of policing, including calls to reduce police role in responding to people with MH disabilities, LDH may want to consider making outreach to law enforcement a priority for this next reporting period. The SME understands that this will be a challenge given the number of law enforcement agencies in the state, but LDH should be taking those steps now.

*69. The State shall develop policies, procedures, and core competencies for crisis services providers, which shall be developed with the technical assistance and approval of the Expert prior to implementation. The State shall also develop quality assurance measures for all Providers of community-based crisis services, including, at a minimum, tracking response times, and dispositions at the time of crisis and at post-crisis intervals of 7 and 30 days. The State shall consult with the Expert in selecting its quality assurance measures for providers of community crisis services.*

As indicated above, the State is currently in the process of developing the service requirements for each of the services set forth in the crisis plan. As indicated in the plan, the State will develop the necessary performance metrics and the CME will oversee the provider network against these performance metrics to increase the accountability and performance of all crisis providers.

## **B. Assertive Community Treatment**

*70. The State will expand Assertive Community Treatment ("ACT") services to ensure network adequacy and to meet the needs of the Target Population.*

Currently, there are over 45 ACT teams operating within Louisiana that are and will be serving individuals in the Target Population. The SME team has reviewed the adequacy of access to ACT by reviewing information on ACT team capacity and recent MCO network adequacy reports specific to ACT. Upon review, the SME has made an initial determination that the State has sufficient ACT capacity for serving members of the Target Population that are currently in the community. What is less known is the demand

for ACT services for individuals yet to be transitioned or diverted from nursing facilities. The needs assessment currently underway this period will have information regarding the demand of ACT services for future years. The SME will re-review the adequacy of the ACT network once this information is available

*71. Members of the Target Population who require the highest intensity of support will be provided with evidence-based ACT services if medically necessary. The State shall review its level of care or eligibility criteria for ACT services to remove any barriers to access identified by the State or the Expert resulting in inadequate access for the Target Population.*

In 2019, the SME reviewed the Louisiana's ACT level of care requirements. As part of its overall implementation plan, the SME reviewed Louisiana's level of care requirements for ACT against similar requirements in other jurisdictions. As constructed, the admission criteria for ACT are reasonably consistent with other states. In the previous report, the SME identified that the State does not have defined exit or stepdown criteria. The SME has provided examples of other states' exit/stepdown criteria. In addition, the outcome work that is being completed will provide insight into the extent to which members receiving ACT would be a good candidate for exiting ACT. An additional concern by the SME team is the adequacy of the behavioral health provider network to adequately address former ACT member's needs. LDH should continue to work with the MCOs to enhance provider's acumen to address the needs for former ACT members, which will generally have higher behavioral health needs than many of the MHR participants.

*72. ACT teams will operate with high fidelity to nationally recognized standards, developed with the technical assistance and approval of the Expert.*

As indicated in the previous SME report, the State, through its MCOs, conducts fidelity reviews of ACT providers on an ongoing basis. The SME examined these fidelity reviews for 2019 and identified that there were needed improvements for ACT; specifically, the employment area was weak. It is unclear whether the State or the MCOs have done to make the necessary improvements to address these weaknesses. The SME is requesting the State follow up with the ACT teams to make these improvements and report their findings back to the SME.

Through the encouragement of the SME team, the State has developed critical performance measures that are specific to ACT. The State has also drafted more stringent requirements for ACT teams regarding Fidelity thresholds. Teams must meet particular standards on overall scores and must submit plans of correction on individual scores falling below appropriate standards.

While fidelity reviews are critical for ensuring ACT is being delivered consistent with national standards, it is also equally important for the State to determine if ACT is accomplishing the overall goals for the program. The State has collaborated with MCOs to implement an outcome reporting form that will be consistent across teams. The report tracks a variety of domains, the outcome areas include hospitalization (physical and psych), ER use, criminal justice involvement, employment, housing status, SUD treatment, education activities, and a measure of client involvement and participation. This outcome tool will be submitted to each MCO monthly, and a composite report across MCOs will be provided to the State.



### *C. Intensive Community Support Services (ICSS)*

*73. In Louisiana, [Intensive Community Support Services (“ICSS”) are provided through a variety of community-based mental health rehabilitation services as described below. Managed Care Organizations (MCOs) manage Medicaid reimbursable services for the treatment of mental health and substance use disorders. LDH shall 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. LDH will take into account rates and billing structure for Community-Based Services to ensure that all members of the Target Population have access to ICSS of sufficient intensity to support their transition, recovery, and maintenance in the community.]*

The State continues to measure the availability and access of Intensive Community Support Services, which include services in the State’s current Medicaid behavioral health services on a quarterly basis. The State has provided the findings of MCO-generated reports on network adequacy to the SME. Based on the review of these reports for the last two quarters of 2019, there are no access issues for intensive community support services. While Intensive Community Support Services could be defined as inclusive of case management services, for the purposes of this report case management is being considered as a stand-alone service for which the State is developing a more tailored strategy. Similar to ACT, the current needs assessment will review the demand for these services by members of the Target Population that are transitioned or diverted from NFs. The SME will review the adequacy of the MHR network once this information is available. The SME is not recommending that the State perform an analysis of rates and billing structures for the MHR services yet. While rates can be an indicator of barriers to access, the needs assessment may provide other root-cause issues that prevent access and will need to be reviewed.

*74. LDH will continue to provide services comparable to the following services currently provided: (a) Community Psychiatric Support and Treatment (CPST) services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual’s individualized treatment plan; (b) Psychosocial rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and environmental barriers associated with his or her mental illness. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family and community with the least amount of ongoing professional intervention; and (c) Crisis intervention (CI) services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and ameliorate a crisis experience, via a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment.*

The State continues to offer and provide these services through the Mental Health Rehabilitation program. There are over 400 providers of MHR services throughout the State. There have been changes to this program during the reporting period. The biggest change is the expansive use of telehealth by these providers. The State developed policies at the onset of COVID-19 to allow providers the flexibility to use telehealth to deliver MHR services. In addition, the State has and continues to track the impact of COVID-19 on these providers. Specifically, the LDH is collecting information on the number of MHR agencies that have notified their intent to close programs over the past two months. As indicated in these reports, four MHR agencies notified the MCOs that they will or have ceased operations in March. No providers submitted closure notifications in April. The SME has requested additional information regarding these facility closures (size, location and whether a member of the Target Population was impacted). As

requested, the State provided the SME with monthly closures for the four months prior to COVID-19. On average, six MHR providers a month submitted closure notification to the MCOS. Therefore, the closures experienced during COVID-19 were generally less than the SME expected which is good news given that other states are experiencing higher than normal closures. In addition, the needs assessment will also provide the State with valuable information regarding the adequacy and availability of MHR services more broadly for individuals with a serious mental illness and enrolled in Medicaid

*75. LDH will seek necessary waivers and/or CMS approvals to ensure that individuals in the Target Population identified as needing assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are provided with services sufficient to meet their needs.*

Individuals in the CCW program have access to an array of services and supports to address IADLs including personal assistance and skilled maintenance therapies. Members that are the purview of OBH do not have access to similar services. Therefore, the State is considering Medicaid options that will include services that are currently not included or allowable under the state's existing Medicaid plan.

During the previous reporting period, the State, with the guidance from the SME, reviewed options for enhancing the benefit array for individuals in the Target Population, including services that provide assistance with IADLs. This included conducting an analysis of the individuals who have SMI participating in the CCW program to begin to identify the benefit package needed for these individuals. In addition, the needs assessment that will be completed this year will also provide information that will shape any additional Medicaid authorities.

The State has targeted FY 2022 for the implementation of these new services, many that will require additional Medicaid authorities. The SME recommends the State finalize the benefit package and approach for these authorities in this reporting period and begin the process of requesting the appropriate authority for this service.

The State's 2020 implementation plan also includes actions to seek the appropriate Medicaid authority for case management, peer services and crisis services. The plan indicated that the State would identify the appropriate Medicaid authority this past February for case management. In addition, the State would develop and submit the necessary authorities for peer services (June 2020) and would begin to develop the appropriate Medicaid authority for crisis services in November of 2020. During February, the State was in the process of finalizing the approach for case management and IADL services. These discussions and subsequent decisions were delayed due to the COVID-19 pandemic. The SME has requested that the State finalize its plans for these services by the end of this reporting period given that these decisions may need budgetary authority for FY 2022. The submission of the Medicaid authority for peer services is dependent on the passage of the FY 2021 budget, which is still pending. The SME recommends that the State should revisit the Medicaid authority timeframes for crisis towards the beginning of the next period if the crisis plan is revisited and changed.

*76. LDH, in partnership with stakeholders, will review and recommend improvements to existing provisions governing the fundamental, personal, and treatment rights of individuals receiving community-based mental health services.*

LDH has not performed structured activities that address this paragraph. The SME is unaware of engagement and subsequent discussions with stakeholders regarding a review and possible changes to these provisions. It is recommended that over the next six months, LDH develop an organized process to

engage stakeholders to review current provisions, make recommended changes, and develop the necessary policy guidance to address these rights.

*77. Staff for each of the services in VI A-C shall include credentialed peer support specialists as defined by LDH.*

Currently, the State, through the MHR program allows peer specialists to provide services. This includes ACT, CPST, PSR and Crisis Intervention. In addition, the initial Crisis Plan Peer referenced that peer services are simultaneously being developed and will be incorporated into the crisis continuum services as well as other services. As referenced in paragraph 67 and 79 the State is in the process of developing a freestanding peer support service that will complement not only the services in VI A-C but also other services such integrated say services discussed below.

#### *D. Integrated Day Activities*

*78. The State will 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. These activities shall: (a) offer integrated opportunities for people to work or to develop academic or functional skills; (b) provide individuals with opportunities to make connections in the community; and (c) be provided with high fidelity to evidence-based models. The Implementation Plan will provide for development of supported employment services in the amount, duration, and intensity necessary to give members of the Target Population the opportunity to seek and maintain competitive employment in integrated community settings consistent with their individual, person-centered plans.*

During the previous reporting period, the State commenced activities to identify, develop, or enhance services for individuals during the day. The State has defined a preliminary set of integrated day services for members of the Transition Population that include employment supports, drop-in centers, and adult day opportunities. During the previous period, the State implemented various activities to improve access to this array. During this period, the State was to undertake several actions. The status of those efforts are summarized below:

- Continue training regarding employment for a wide range of stakeholders, including Transition Coordinators, ACT team members, and MHR staff. Additional training regarding employment was provided in early February to the Transition Coordinators. Additional trainings are scheduled to occur in 2020 including an Employment Summit. It is unclear when this Summit will take place due to the pandemic. Additionally, there are plans in conjunction with the TAC-assigned SME to produce a webinar series for the following groups: Transition Coordinators; MHR Direct Care staff; Administration-level (non-direct/supervisory roles services) trainings for MCO, MHR, State-agency staff, and other groups that may be identified while as this work progresses. Note, there is an awareness and anticipation that modifications will be necessary during the phases of this implementation process. In addition, the State is planning a Behavioral Health Symposium for stakeholders that will include more up to date information and progress regarding the Agreement and include training regarding employment.
- Continue to gather information to supplement the LGE surveys to identify drop-in/low-demand social settings that could provide support and engagement to individuals transitioning from NFs

or being diverted from them. This information has been added to the resource guide for the Transition Coordinators. LDH continues to work with the Transition Coordinators to gather information about existing drop-in/low demand social setting resources in each of their regions. This will be necessary, given the impact of COVID-19. It is unclear the extent to which these providers have continued to offer assistance virtually and if they will remain financially viable

- Developed guidance, with the assistance of the SME team, stipulating that illness management and recovery supports in the domain of employment activities be within the scope of current funding methodologies. This document is being reviewed by state leadership and will then be presented to MCO and leadership for discussion and dissemination. Follow up training efforts for MHR providers regarding this topic is planned for Fall, depending on the guidance for such events. In lieu of an in-person meeting, LDH may hold this event virtually.
- Implement a training series (Webinar or in-person) to focus on employment as a Social Determinant of Health (SDOH) and how ACT, MHR and other providers, can effectively deliver employment supports. This training will include how to best leverage the relationships between and among other state agencies that have employment in mission, e.g. State Vocational Rehabilitation and Workforce Systems. Initial trainings have occurred with Transition Coordinators prior to the COVID-19 pandemic.

The State has applied and was granted a second Visionary Opportunities to Increase Competitive Integrated Employment (VOICE) initiative from the Office of Disability Employment Programs, Department of Labor (ODEP DOL) and EconSys. The overall purpose of the VOICE project is to facilitate policy and training in states to enable them to increase employment outcomes for people with disabilities, and in particular this year, people with mental health disabilities. In Louisiana, the project is addressing the need for greater inter-agency collaboration between the Louisiana Workforce Commission (LWC), Louisiana Rehabilitation Services (LRS), and OBH. The agencies are jointly pursuing this goal during the second phase at the regional level in two specific areas of the State, Regions 2 and 3 Baton Rouge and Houma, respectively.

The VOICE project will develop communication, joint training (including training on assessment and identification), as well as partnerships among the LGEs, the LRS local/regional offices, and the behavioral health providers in those locations/regions (ACT, MHRs, etc.) The project seeks to develop adequate practices to support referral of clients and provision of necessary supports to enable them to pursue gainful employment of their choice. As planned, members of the Target Population may benefit from this project, as some of them have been transitioned to community living in these areas of the State. The two projects would have run simultaneously from January through July 2020, but due to the COVID-19 pandemic, the projects have been interrupted. The State (like other states involved with the VOICE initiative) anticipates that it will be given a requested extension through the end of September 2020.

It should be noted that OBH is planning to utilize a portion of grant-funding to supplement employment work, specifically training the workforce development opportunities. While the SME has been identified internally, there have been no finalization of the individual (s), but the decision has been made to allocate funding specifically toward the employment initiatives Improvements in the current MHR program will be beneficial, as will additional efforts by LRC to address the employment needs of individuals with serious mental illness. There needs to be a concerted effort to develop and implement a clear strategy for increasing employment for the Target Population that has expressed an interest to work and other approaches (modernized drop in centers) that members may see as a valuable opportunity. This could include strategies to be able to develop and fund these services through various Medicaid authorities, not dissimilar for creating employment supports for other populations (e.g. ID/DD).

## *E. Peer Support Services*

*79. LDH shall ensure certified Peer Support Specialists will continue to be incorporated into its rehabilitation services, CPST, PSR, CI, ACT, Crisis Services, Residential Supports, Integrated Day, SUD Recovery, and Supported Employment systems. Peer support services will be provided with the frequency necessary to meet the needs and goals of the individual's person-centered plan. LDH shall ensure peer support services are available to all individuals with SMI transitioning from nursing facilities, both prior to and after transition to the community.*

Peer support is an evidence-based practice for individuals with mental health conditions or challenges. Both quantitative and qualitative evidence indicate that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services, increasing the use of outpatient services. Peer support improves quality of life, increases and improves engagement with services, and increases whole health and self-management. The Stat and the SME believe there is an interest to increase access to and involvement of peer support specialists. The State has taken significant steps to enhance peer support services. During this reporting period, the State continues to allow Peer Support Specialists to deliver various MHR services. There were no specific changes that impacted this policy during this reporting period. The State has finalized a Medicaid framework for Peer Support services. The vision of these services is to support individuals with SMI in a variety of settings. The State has worked with the SME to develop the service parameters and staff qualifications for this new service. The State did identify that the need to improve the process for training and recertifying peers. The current process is not sufficient to support the necessary changes and additions proposed by the State. The State, in cooperation with the SME team has developed a Request for Information (RFI) to solicit recommendations from stakeholders regarding strategies for improving the training and certification process. The RFI is to be released in July. In addition, the State is seeking budget authority for additional peer supports for FY 21. At the writing of this report, the Legislature has not acted on this request. If approved, the State is targeting December 2020 for the implementation of this new service. As indicated above, the State will need to develop the necessary Medicaid authority for this service if they receive the necessary budget authority from the Legislature.

## *F. Housing and Tenancy Supports*

*80. The State will 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 Program, which includes use of housing opportunities under the State's current 811 Project Rental Assistance (PRA) demonstration. Housing services will ensure that members of the Target Population can, like Louisianans without disabilities, live in their own homes, either alone, with family members, or with their choice of roommates.*

In the previous reporting period, the State, with the assistance of the SME, finalized a Housing Plan, as required under the Agreement. The plan sets forth specific actionable strategies with specific annual targets for the creation of additional affordable housing units and rental subsidies to be made available to members of the Target Population.<sup>8</sup>

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<sup>8</sup> <http://ldh.la.gov/assets/docs/MyChoice/MyChoiceHousingPlan.pdf>

*81. In the Implementation Plan, the State shall set annual targets for creation of additional housing units and rental subsidies to be made available to members of the Target Population, for a combined total of 1,000 additional units and rental subsidies before termination of the Agreement. Once targets are achieved, the State shall maintain the availability of units and/or subsidies at the achieved target level for the term of this Agreement. Mechanisms to accomplish these targets shall be specified in the State's Implementation Plan, and include, but are not limited to, the following: (a) the State shall use some portion of the existing capacity in its current Permanent Supportive Housing program to house members of the Target Population through the institutional preference that prioritizes access to PSH units for persons in institutions; (b) the State shall use tenant-based vouchers in conjunction with Tenancy Supports offered through the Louisiana Permanent Supportive Housing Program to create supported housing opportunities for members of the Target Population; a portion of 125 existing vouchers shall be used for members of the Target Population; (c) through its statutory relationship with Public Housing Authorities, the State may seek to make available additional tenant-based vouchers for the Target Population; (d) the State, through the Louisiana Housing Corporation (LHC), shall continue to use existing incentives in the Low Income Housing Tax Credit (LIHTC) Qualified Allocation Plan (QAP) to create new units for the State's Permanent Supportive Housing Program; (e) the State shall additionally 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 shall establish a minimum of 100 State-funded short-term rental subsidies to assist with initial transitions.*

The State, in its housing plan, set forth the annual targets for creating additional housing units or rental subsidies that would be available to the Target Population. The combined total of 1,000 additional units and subsidies were identified from a number of federal and State housing resources.

The State has implemented a 100 state-funded subsidy rental assistance program. This program is referred to as My Choice State Rental Assistance Program and is operated through the same partnership as Louisiana's PSH program with all participants being offered tenancy support services. One million dollars in State general funds were allocated to this purpose starting in State fiscal year 2018-2019. LDH began providing short-term rental assistance using these funds in August 2018, while it was working with the Louisiana Housing Authority (LHA) on long-term program policies and guidelines. LDH and LHA completed policies in spring, 2019 and LHA took over payment of long-term subsidies (i.e., rental assistance lasting more than 3 months) effective July 2019. To date, 5 members of the Target Population have received short-term rental assistance, 51 are receiving ongoing rental assistance (i.e. My Choice Voucher) paid through LHA, and 42 additional members are in the process of being housed with My Choice rental assistance.

The State has implemented funding for housing-related expenses such as security deposits and other necessities for making a new home. For members of the Target Population who qualify for and transition to the OAAS CCW, many expenses of establishing a home can be covered under Medicaid. These include home accessibility modification, basic furnishings and supplies, and rent and utility deposits. These expenses can also be paid under the state's Money Follows the Person program for members of the Target Population who transition to OAAS or Office for Citizens with Developmental Disabilities (OCDD) Medicaid HCBS programs. For members of the Target Population who do not qualify for these resources, State funding was established for housing related expenses starting in State fiscal year 2018-2019. Unlike Medicaid resources, these State funds can also be used to purchase basic food items needed for the initial days of occupancy. In addition, the HOME Investment Partnerships Program Tenant-Based Rental Assistance administered by LHA is currently being used for security and utility deposits for persons transitioning to 811 PRA Units.

The State has obtained additional tenant-based rental subsidy vouchers to assist members of the Target Population. In 2018, LDH and LHA applied for and LHA was awarded 50 NED tenant-based vouchers to be incorporated into its existing Mainstream Voucher program for PSH. LDH and LHA established program policies and procedures for using these vouchers in early 2019 and 12 members of the Target Population have been transitioned from NFs using this resource. Another 15 members have been assigned a voucher and are being assisted with housing search and leasing. The target is for 25 of the 50 NED vouchers to be used by members of the Target Population. In September, 2019, LDH and LHA applied for an additional 200 NED vouchers. In late 2019, LHA received an award of 38 Mainstream Vouchers. In May of 2020 as part of its COVID-19 response, HUD awarded LHA an additional 27 Mainstream Vouchers which constitutes a 30% increase from the two previous awards. Both these Mainstream Voucher Awards (totally 65 vouchers) will be used by members of the Target Population. Currently, 24 are receiving ongoing rental assistance through the Mainstream Program and an additional 29 members are in the process of being housed through the Mainstream Program. In early 2020, LHC in collaboration with LDH submitted a proposal to HUD for additional Section 811 Project Based Rental Assistance (Section 811 PRA) to be used in conjunction with both existing and new affordable multi-family projects. HUD expects to announce Section 811 PRA awards in the summer of 2020.

The State created new requirements in LIHTC program specific to PSH units for the Target Population. In June, 2019, the Board of the Louisiana Housing Corporation approved language that created new units for the Permanent Supportive Housing Program to house individuals transitioning from nursing homes or at risk of nursing home placement for addition to the 2019 Qualified Allocation Plan for the state's LIHTC program.

Independent of the Agreement, LHC added universal design requirements to the LIHTC program beginning with the 2018 LIHTC awards. This requirement continued as part of the 2019 QAP. This combined with LDH's ability to provide State and Medicaid-funded home modifications and assistive technology will improve the overall accessibility of new affordable housing built under the LIHTC program. This is significant given that the majority of Target Population members transitioned from nursing homes have physical as well as behavioral health-related disabilities and may need accessible housing. For the 2020 QAP, LHC and its Board elected to select multi-family housing proposals from the 2019 LIHTC competition rather than hold a new competitive process in 2020. As a result, LHC was unable to negotiate additional incentives within the 2020 QAP. However, the incentive for creating PSH for the Target Population and the universal design requirement remained for projects awarded LIHTC in the 2020 QAP round. In addition, in early 2020, LDH and the LA Office of Community Development (OCD) worked collaboratively to include PSH incentives within the PRIME Multi-Family Rental Housing Development Notice of Funding Availability (NOFA) which offered both CDBG capital funding by OCD and 4% LIHTC financing from LHC.

These accomplishments are part of LDH's successful efforts to further the specific strategies to create targeted PSH opportunities for Target Population members. In addition to the accomplishments discussed above, LDH in partnership with LHC have made significant progress to applying for new targeted, permanent rental assistance resources from both HUD's Mainstream Program and the Section 811 PRA with an award received for Mainstream. HUD is expected to announce Section 811 PRA awards to States in the July/August timeframe. In the fall (October/November timeframe), LDH and LHC will conduct a formal progress review of all aspects of the Housing Plan to assess which strategies were successful in meeting their production targets and which strategies have fallen short in reaching their annual target for CY 2020. LDH and LHC will use this review to refine strategies and implementation next steps as well as create new strategies to take advantage of emerging opportunities for the CY 2021 timeframe. This formal

review will also be an opportunity to conduct a deeper analysis on to develop a PSH delivery plan to synchronize when these PSH opportunities will be available or be ready for lease up with the planned transitions of Target Population member.

*82. Consistent with the State's current Permanent Supportive Housing Program: (a) tenancy supports shall be voluntary; refusal of tenancy supports shall not be grounds for denial of participation in the Permanent Supportive Housing Program or eviction; (b) individuals shall not be rejected categorically for participation in Louisiana Permanent Supportive Housing due to medical needs, physical or mental disabilities, criminal justice involvement, or substance use history; and (c) in order to satisfy the requirements of this Section E, housing shall be community integrated and scattered site. For purposes of this Agreement, to be considered scattered site housing, no more than two units or 25% of the total number of units in a building, whichever is greater, may be occupied by individuals with a disability referred by or provided supports through the State's permanent supportive housing program or individuals who are identified members of the Target Population under this Agreement. For purposes of this Agreement, and consistent with provisions of the State's existing permanent supported housing program, community-integrated housing shall not include licensed or unlicensed personal care, boarding, or "room and board" homes, provider-run group homes, or assisted living facilities. It may include monitored in-home care provided to individuals in the Target Population eligible for Medicaid waiver services.*

Based on the policies and incentives of the LA PSH Program established by LHC and LDH, all of the PSH for the Target Population meets the definition above and are integrated, scattered site PSH.

*83. The State shall employ Tenancy Supports Managers (TSMs) sufficient 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 supports providers during the leasing process, and address crises that pose a risk to continued tenancy. TSMs shall have demonstrated experience finding and securing integrated housing and providing Tenancy Supports to individuals with mental illness. The State shall take steps to assure the preservation of existing housing for members of the Target Population when a member of the Target Population is admitted to a hospital or nursing facility, or is known to be incarcerated in connection with a mental health crisis or behavioral incident.*

The State has engaged two additional TSMs in addition to the existing 4 TSMs and will provide statewide coverage to assist members of the Target Population transitioning from NFs. These TSMs perform the following functions:

- Meeting with the client to perform housing needs assessment;
- Assisting the client in finding appropriate rental housing;
- Performing the HUD quality standards inspection of the unit;
- Negotiating with the landlord on the client's behalf, including seeking reasonable accommodation under the Americans with Disabilities Act and Fair Housing laws;
- Assisting the client in gathering documents necessary for housing application and lease signing;
- Helping the client accomplish move-in, including working with team members and assisting individuals to obtain items needed for move-in;
- Working with the client to develop crisis action plans and eviction avoidance plans;
- Serving as point of contact for the property manager/landlord mediation;
- Addressing problems that may arise between the client and landlord;
- Assisting households with community referrals as needed;



- Implementing eviction avoidance plans and seeks to prevent housing instability and rehousing;
- Providing ongoing tenancy support and community-living skills training during lapses in Medicaid coverage or when the Medicaid provider is unable to successfully engage; and
- Maintaining files on all households and providing data as requested on households served.

The SME's opinion is that TSMs provide a valuable function on behalf of the Target Population and for landlords and local housing authorities. No specific recommendations are suggested for this function.

*84. The State shall seek funding to cover such expenses as security deposits and other necessities for making a new home. The State shall use HOME Tenancy Based Rental Assistance for security and utility deposits for members of the Target Population.*

The State is currently funding these expenses as discussed in paragraph 81 and has included this strategy in the housing plan developed in December, 2019. In addition, the State has developed the policies related to a Risk Mitigation Fund to cover damages to an apartment where a member of the Target Population resides which exceeds the amount covered by the traditional damage deposit. The State expects that this Fund will provide a valuable tool to support members in retaining their housing over the long-term.

*85. LDH may seek federal approval of an 1115 or other Medicaid waiver to provide comprehensive services to the Target Population. LDH shall ensure its Medicaid rates are adequate to achieve and sustain sufficient provider capacity to provide HCBS and mental health services to the Target Population.*

As indicated in paragraph 75 of the Agreement, the State has identified several services that will require additional Medicaid authorities. All of these services will be provided to individuals of the Target Population in their homes, including individuals in supportive housing arrangement developed under this Agreement.

## VII. Outreach, In-reach, and Provider Education and Training

### A. Outreach

*86. 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. Such outreach may include, but shall not be limited to, existing forums such as meetings of the Developmental Disabilities Council, Behavioral Health Advisory Council and regularly scheduled meetings between LDH, provider associations, and advocacy groups. LDH will conduct outreach specifically to individuals currently receiving mental health services for the purpose of sharing this information and collecting feedback on the service array.*

For the first eighteen months of the Agreement, the State made solid efforts to engage stakeholders. 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 initial and 2020 Implementation Plan, and the development of an Advisory Committee for the Agreement. The State has reported their efforts to inform the State's Behavioral Health Advisory Committee regarding their activities under this Agreement. Initially, the State reported individual meetings with the Local Governing Entities (LGEs) to introduce them to the TCs, 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. As part of their stakeholder engagement efforts, the State developed the My Choice Advisory Committee, representing consumers, LGEs, advocacy organizations and providers. Since its inception in fall of 2018, the State has held 10 Statewide Advisory Committee meetings. The Committee's meeting agenda generally consists of updates regarding the number of individuals who have been transitioned from the NFs to the community, and an overview of critical areas of work being done under the Agreement. The SME has attended several meetings, which were well-organized and provided important information in terms of the State's progress regarding the Agreement. The State has also created subcommittees for several areas, including statewide service plans (e.g., crisis and housing), identification of service gaps, and related network development activities. The SME has attended several of these subcommittees. These meetings have been helpful to the State in their efforts to get specific feedback on important areas and activities. The meetings are interactive and subcommittee members provide helpful comments for regarding the subjects of discussion. The State has developed a subcommittee regarding resource identification but the State has indicated the subcommittee does not meet regularly. The SME recommends that the State have regular meetings of this committee given the barrier discussed in the Transition Section of this report.

The State has also created other opportunities to solicit input into critical services and activities for the Target Population and for individuals with mental health conditions, in general. In 2019, the State has done two rounds of listening tours regarding the overall "state of the State behavioral health system." These meetings have been conducted on a regional basis. In each region, the State holds separate meeting for consumers and families, providers, and other stakeholders. In 2019, the first round of listening tours shared general information about the Agreement. The State conducted a second round of listening tours that provided updates and sought feedback specific to crisis. During these meetings, the State provided information on some of their efforts, but most of the meeting is an open forum where participants can respond with critical information to the State regarding gaps, barriers, and other concerns, many of which are directly related to services and other activities under the Agreement. The State was planning on similar tours this calendar year; however, these meetings may not occur and may be postponed to later reporting periods.

The State continues to hold regular meetings with the MCOs that include information and updates specific to the Agreement. In addition, the State has a regular schedule of meetings with MCOs regarding PASRR, the My Choice Louisiana Transition Coordination activities, ACT, and, more recently, activities that would support individuals being diverted from NFs.

The State continues to have monthly presentations to LGEs that provide updates to specific work under the Agreement on a variety of topics. The State reports that they have presented to other stakeholder groups (including the Louisiana Supported Living Network) regarding an overview of the Agreement, activities that have occurred since the Agreement was reached, shared information about individuals who have transitioned, and an overview of upcoming activities.

There were some outreach meetings held during this period prior to the COVID-19 pandemic. In January, OBH convened the ACT teams and MCOs to discuss improvement in the delivery of ACT services. During this meeting, the OBH provided general findings of the fidelity reviews and discuss the rollout of the new outcome reporting forms and processes for ACT teams. The meeting also solicited feedback from ACT providers regarding what they need for program growth. A SME's team member attended this meeting and felt that the meeting achieved its intended outcomes for initiating a more targeted process for improving the delivery of ACT services. In January and March, the State had a quarterly My Choice Advisory Committee meeting. Many proposed meetings for this reporting period were cancelled or deferred due to COVID-19. The State is beginning meetings of this Committee virtually this summer.

As the SME reported in previous periods, the overall level of engagement from the Committee participants continues to be challenging. In meetings attended by the SME, there are few questions or recommendations from Committee members. As indicated in previous reports, the lack of engagement may be due to the structure and size of these meetings as well as committee members may not having the experience and information needed on every area that is being presented by the State. The State did make some initial changes in 2020 to better engage the Advisory Committee. LDH solicits information from the Advisory Committee regarding the areas and topics they were interested in discussing several weeks before the meeting. Even with this proactive outreach, the State is receiving few suggestions for topics members are interested in discussing. The State provides important information to the Advisory Committee for their reaction, including the number of individuals who are awaiting transition and information on individuals transitioned. The State provides ample opportunity for the Committee to review products developed by the My Choice program (including annual implementation plans). Yet, the State receives little feedback regarding these products. The State has provided a structure (e.g. specific subcommittees) to address more granular issues. These subcommittees do provide valuable feedback. The State may want to consider an approach that focuses more time and resources on these subcommittees rather than bi-monthly meetings of the larger Advisory Committee.

The SME recommends that the State enhance it's My Choice Website. While the site provides valuable information to stakeholders, the site should include additional information such as: information on the Advisory Committee, agendas and materials presented at the Advisory Committee. It could also include presentations and materials regarding the MyChoice program offered to other stakeholder groups. It is recommended that the State also post information in the next period regarding data from the quality measures referenced in paragraph 99.

*87. Within six months of execution of this Agreement, LDH will develop and implement a strategy for ongoing communication with community providers, nursing facilities, and hospitals on issues related to implementation of this Agreement. This strategy will include engaging community providers, nursing facilities and hospitals so that LDH learns about challenges encountered in the implementation of this Agreement and can engage the providers in addressing such challenges. This will, when needed, include the provision of technical assistance related to State policies and procedures that affect compliance with the Agreement.*

The State developed an initial communication plan for community providers, NFs, hospitals, law enforcement, corrections, and the courts. The communication plan included initial engagement to learn about challenges encountered in the implementation of this Agreement and addressing those challenges and targeted outreach and education needed to implement the plan. The SME did not participate in the initial meetings with these stakeholders.

During the initial eighteen months of the Agreement, the State has reported to hold ongoing meetings related to the Agreement for the following groups:

- Monthly meetings with LGE Executives;
- Monthly meetings with PASRR team and the MCOs;
- Weekly joint calls between My Choice TCs and one of the 5 MCOs;
- Every six weeks, joint meetings including LDH and all 5 MCOs;
- Monthly meetings with the MCOs concerning ACT; and
- Every six to twelve weeks, meetings held with MCO Behavioral Health Medical Directors.

The SME has not participated in these meetings and has been provided information resulting from some of these meetings that are specific to the Agreement.

The State has not developed an ongoing organized communication plan for these stakeholders. The SME recommends that the State create and implement a semi-annual communication plan for these constituency groups beginning this next period.

*88. LDH will incorporate into its plan for pre-admission diversion (Section IV.C.) any targeted outreach and education needed to successfully implement that plan, including outreach to law enforcement, corrections and courts.*

As set forth in the diversion plan, the State initially worked with individuals with SMI who are seeking admission to a NF and for whom the PASRR level II indicated community placement versus a NF admission. These initial efforts include education to MCOs and community providers to identify these individuals and triage the services and supports to meet their immediate needs. During this reporting period, the State has begun to work with the MCOs to identify a process for better engagement and diversion of individuals who are being identified through the PASRR process. Specifically, the State is evaluating the MCOs case management approach to successfully engage these individuals in their case management efforts and to work with the MCO to improve these efforts. This includes:

- Reviewing MCO data regarding the initiation and engagement of individuals diverted from NFs into their case management efforts.

- Reviewing MCOs efforts to conduct a timely assessment and develop a service plan for these individuals as well as ongoing engagement into case management services provided by the MCO.
- Revise process and protocols for referrals for MCO case management based on this review.

The SME has provided significant input regarding the efforts to enhance the MCO case management efforts specific to individuals who may be at-risk for the Target Population. The SME has requested additional information regarding outreach efforts that are specific to law enforcement, corrections and courts for the next reporting period.

## B. In-Reach

*89. Within six months of execution of the Agreement, LDH will 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. In-reach will explain LDH's commitment to serving people with disabilities in the most integrated setting; provide information about Community-Based Services and supports that can be alternatives to nursing facility placement; provide information about the benefits of transitioning from a nursing facility; respond to questions or concerns from members of the Target Population residing in a nursing facility and their families about transition; and actively support the informed decision-making of individuals in the Target Population.*

In December 2018, LDH developed a plan for in-reach to members of the Target Population residing in a NF. 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 NFs;
- Hiring staff and developing training to prepare them for multiple new roles, in addition to:
  - 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 TCs and help to identify and engage with those members of the Target Population who will transition into the community; and
- Developing resource guides for members of the Target Population during the in-reach and transition process.

As written, the in-reach plan was comprehensive and reflected a solid initial effort to identify individuals who may be transitioned initially. It set forth the foundational workflows for TCs. 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 NFs. During this next reporting period, the SME will request a status update on the original in-reach plan. Given the pandemic, the interest of Target Population in the nursing facilities to transition may be greater and the State should revise the initial in-reach plan to account for this increased interest.

The SME recommends that the State continue to enhance its efforts to increase the number of individuals in the Target Population who are successfully transitioned from NFs. These activities should include additional efforts to engage Target Population members who continue to be ambivalent regarding moving into the community. This could include evaluating and enhancing motivational interviewing strategies and continued efforts to identify community resources that are needed by the Target Population specific to their health needs, since many of these individuals have comorbid physical and behavioral health conditions. In-reach efforts are not static—what may have been effective for individuals who were more interested in leaving may not be effective for individuals who are ambivalent or anxious about the transition process. It would be helpful for the State to review the previous in-reach plan and determine if it was effective and more importantly, what changes might be made to continue to engage individuals. It will be important for the State to make changes to the plan given the limited in-person presence of transition planners during the pandemic, but also making revisions to address individuals who want to leave a high-risk congregate setting.

In the previous reports, it was recommended that the State’s in-reach efforts begin to include individuals with lived experience (peers) to assist the TCs in having initial discussions with the Target Population about opportunities to transition to the community.

The State has agreed that this would be a very valuable addition to the in-reach process. It is recommended that the State develop a strategy and timeframe for including peers in the in-reach process. This strategy should address the requirements for peers to perform these activities, the reimbursement strategy for peer in-reach efforts, the development of training for potential peers and TCs regarding the importance of peers in these efforts, and a strategy for supervising these peers to support their efforts. For FY 2021, the State did seek, but was not provided, budget authority to specifically request funds specifically for peers to assist in the in-reach process. The State has yet to implement this recommendation. The SME will request information regarding options the State is considering for including peers in the in-reach process.

### C. Provider Training

*90. Training for services provided pursuant to this Agreement will be designed and implemented to ensure that Community Providers have the skills and knowledge necessary to deliver quality Community-Based Services consistent with this Agreement.*

There are various training opportunities for community providers. As indicated in the Section V, there has been training regarding crisis, employment supports, and social determinants of health during the reporting period. There is also ongoing training that OBH and the 5 MCOs have developed specific to the Agreement. As mentioned earlier, a webinar series is being developed to target three groups including providers, administrators/non-direct staff/supervisors of direct staff, and TCs. The State has reported to have drafted the materials for this Webinar and will finalize these materials with the input of the OBH Leadership & DOJ SMEs, and the SME. The State has indicated the following training was available to providers during the reporting period:

- Introduction to Crisis Intervention and the Role of Communication;
- Fundamentals of Cultural and Linguistic Competence in Recovery-Oriented Systems of Care;
- MH 101 - Overview of SMI/Emotional Behavioral Distress;

- Suicide/Homicide Precautions;
- Treatment Planning;
- Co-Occurring Disorders: Treatment and Support for Persons with MI and SUD;
- Trauma informed Care;
- Level of Care Utilization System (LOCUS); and
- Substance - Related and Addictive Disorders.

*91. With the technical assistance and approval of the Expert, LDH will establish a mandatory training policy, qualifications, and curriculum for Community Providers. The curriculum will include initial training and continuing training and coaching for Community Providers.*

As indicated in several sections of this report, the State (and its MCO partners) has developed various training efforts (several with the SMEs assistance) for TCs and community providers. While the availability of provider training is laudable, the State could benefit from a single organized training plan for providers that serve the Target Population. The SME recommends that the State develop a policies and curriculum required under this paragraph during FY 2021.

*92. The curriculum will emphasize person-centered service delivery, community integration, and cultural competency. The curriculum will incorporate the provisions of this Agreement where applicable. LDH will seek input from individuals receiving services regarding the training curriculum and will include such individuals in the training where appropriate.*

The State is developing curriculum that is specific to person centered service delivery. Specifically, the State, in cooperation with the SME team, has developed a draft curriculum for person centered planning training. The purpose of this training is to help practitioners enhance their sensitivity and learn skills that will support them to ensure that the planning and subsequent service delivery for each person they serve is driven by the hopes, dreams, aspirations and wishes of the person receiving the help. This training manual consists of at least three modules, each designed to consist of potentially 60- to 90-minute training sessions. As indicated above, the State could benefit from a single organized training plan for providers and others that serve the Target Population. The State is developing curriculum that is specific to person centered service delivery. Specifically, the State, in cooperation with the SME team, has developed a draft curriculum for person centered planning training. The purpose of this training is to help practitioners enhance their sensitivity and learn skills that will support them to ensure that the planning and subsequent service delivery for each person they serve is driven by the hopes, dreams, aspirations and wishes of the person receiving the help. The target audience is Transition Coordinators, Case Managers in Managed Care Organizations, all community providers who will be doing assessment, treatment plans, and/or treatment plan implementation. At a minimum, this should include MHR and LGE staff who under Louisiana practice acts or state standards can perform such assessments and develop treatment plans. LDH is currently reviewing these training modules and determining the best strategy for implementation, which will take into account the impact of COVID 19 and in-person trainings.

## VIII. Quality Assurance and Continuous Improvement

*93. Community-Based Services will be of sufficient quality to ensure individuals in the Target Population can successfully live in, transition to, and remain in the community, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships).*

*94. Accordingly, by December 2019, the State will develop and implement a quality assurance system consistent with the terms of this Section.*

The State did not meet the timeframe in the Agreement for the development and implementation of the quality assurance system. The development of a quality assurance/quality improvement approach has proven to be more challenging than anticipated. Individuals in the Target Population are served through multiple delivery systems that have different quality assurance processes. For instance, the CCW program, managed by OAAS, services the majority of individuals transitioned from NFs. The quality assurance system for the CCW program is driven by the requirements and guidance developed by CMS. The CCW quality assurance program must address compliance with the essential waiver assurances set forth by CMS. The assurances in the CCW address important dimensions of quality, including assuring that service plans are designed to meet the needs of CCW participants and that there are effective systems in place to monitor participant health and welfare. The quality service approach for the CCW includes identifying and tracking performance in achieving critical participant outcomes, assessing how effectively the waiver supports participants to direct their services, or improving the capabilities of waiver providers to effectively support participants.

Individuals transitioned or diverted from NFs to the OBH service system receive the majority of their physical health and behavioral health services through the State's Medicaid managed care program. Target Population members are often enrolled in one of the five Managed Care Organizations (MCO) and therefore subject to the MCOs quality assurance processes. Each MCO is required by CMS to establish and implement a Quality Assessment and Performance Improvement (QAPI) program<sup>9</sup>. The purpose of the QAPI program is to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved beneficiary outcomes through monitoring and evaluation activities. MCOs must perform several critical activities through the QAPI program. For instance, each MCO must increase the utilization of evidence-based practices within certain target rates specified by LDH. MCOs must detect and address underutilization and overutilization of services. The MCOs are to report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time to measure positive outcomes of service delivered. Each MCO is to develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services, including members of the target population. There are various strategies that each MCO may use to collect and analyze data under its QAPI program including use of performance measures, medical record audits and beneficiary and provider surveys.

Having six separate quality assurance strategies (CCW and the five MCOs) will continue to be a challenge for the State to meet the requirements of this paragraph. While the State has made good progress to identify, operationalize, and report specific measures for the target population (see paragraph 99), it has not developed a quality assurance process that is specific to the Agreement. The SME recommends that

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<sup>9</sup> 42 CFR §438.330(a)(1)



LDH create a quality assurance plan in the next six months that is specific to the Agreement. The plan should incorporate the work that has been done to collect and analyze data on the measures identified in paragraph 99 and the processes LDH will use to use this information to improve the experience of care for individuals transitioned from NFs as well as improve the quality of services that are offered to the Target Population. The State should develop a process that is similar to the CCW approach for all Target Population members whether they participate in CCW, have their care delivered through Medicaid MCOs, or participate in the Medicaid fee for service program. This will require a cross-agency effort to develop and implement this plan. In addition, the State should include a stakeholder feedback process as part of their overall quality assurance strategy for the Agreement.

*95. For individuals in the Target Population receiving services under this Agreement, the State's quality assurance and critical incident management system 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 will collect and evaluate data; and use the evaluation of data to identify and respond to trends to ensure continuous quality improvement.*

The State continues to make progress with regards to developing a critical incident report process that will be used by the both agencies (OAAS and OBH). However, these agencies have separate processes for reporting critical incidents. In October 2019, both program offices stated they have identified consistent elements and processes for reviewing and responding to critical incidents. The SME requested the critical incident definitions and reporting protocols for both agencies. While there continues to be good cross-office collaboration to develop a reporting process to consistently track these critical incidents in the Target Population there are still two definitions and processes for reporting critical incidents for the Target Population. The SME recommends that there are common definitions and consistent processes across the two agencies for reporting critical incidents and collecting and evaluating this data to ensure the health, safety and well-being of individuals in the Target Population.

As an initial combined reporting process, LDH developed a weekly tracking system for select critical incidents for the Target Population as a result of the COVID-19 pandemic. Specifically, LDH collected critical incident information on individuals who were transitioned from NFs and active on the TCs caseload. This included information on COVID-19 testing, members that tested positive for COVID-19, presentations at emergency department for any cause, hospitalization for any cause and readmission into NFs. In addition to this information, the State collected information regarding the impact that COVID-19 was having on providers (MHR and CCW providers). LDH collected information regarding the number of these providers that closed during the COVID-19 pandemic. In addition, LDH reported the number of NFs that have more than two or more individuals who tested positive for COVID-19. Finally, the weekly tracker provided information on LDH or other State policy that would directly impact members of the Target Population and included:

- Guidance to providers regarding service access (behavioral health and long term services and supports);
- Guidance to providers regarding telehealth; and
- General guidance to providers concerning personal protective equipment and other precautions necessary to ensure the health and safety of individuals and providers.

For the past six weeks (prior to 5/29), LDH reported that no individuals that were transitioned self-identified as having COVID-19. Several critical incidents occurred during this time including 9 presentations at emergency departments. In addition, there were 25 admissions (all cause) and 3

individuals were readmitted into nursing facilities. The State reported that these admissions were for short-term rehabilitative stays and all three individuals have returned home.

The SME is recommending that LDH develop a combined quarterly critical incident reports for all members of the Target Population that have been transitioned or diverted from nursing facilities. This will allow the State to monitor and address trends over time. The State should also review these reports and determine the root cause of these critical incidents in an effort to reduce the number of incidents.

*96. The State will require that professional Community Providers implement critical incident management and quality improvement processes that enable them to identify service gaps and to timely identify, address, and remediate harms, assess the effectiveness of corrective or remedial actions, and reduce risk of recurrent harm. The State will require that MCOs implement critical incident management and quality improvement processes that enable them to identify and address service gaps and to timely identify, address, and remediate harms, assess the effectiveness of corrective or remedial actions, and reduce risk of recurrent harm.*

The SME has not reviewed the processes, protocols or contractual language that may require community providers to implement critical incident management and quality improvement processes. The SME will request this information for review for the next report.

The SME has reviewed the MCO contract regarding critical incident management and quality improvement processes. Currently, MCOs are responsible for developing, submitting, and implementing critical reporting and management procedures for the behavioral health population at large (not specific to the Target Population). These procedures are subject to review and approval by LDH. These procedures are to describe how each MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents. The MCO contracts also define critical incidents consistent with Louisiana statutes and regulations. These include abuse, neglect, exploitation and death.

The MCOs are required by contract to submit reports to LDH concerning quality of care concerns and adverse incidents for all Medicaid beneficiaries (not specifically the Target Population). The SME has not had the opportunity to review these reports this period but will request and review these reports over the next six-month period. In addition, the SME will review the process LDH use to review these reports and follow up with the MCO regarding quality of care concerns and adverse incidents.

*97. The State will establish reporting and investigation protocols for significant incidents, including mortalities. The protocols will require a mortality review of deaths of individuals in the Target Population in specified circumstances, including 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. Mortality reviews will be conducted by multidisciplinary teams, and will have at least one member who neither is an employee of nor contracted with OAAS, OBH, the LGEs, MCOs, and Community Providers. The reporting and investigation protocols for significant incident and mortality reviews shall be developed with the technical assistance and approval of the Expert.*

OBH and OAAS have different mortality review process for collecting and reviewing information on deceased individuals in the Target Population that have transitioned from NFs. OAAS has a separate Mortality Review Committee that is charged to monitor and analyze deaths of OAAS waiver participants. Specifically, the mortality review process is designed to: (1) identify remediation activities associated with

provider individual cases; (2) generate recommendations for system level quality improvement; and (3) reduce future risk. The protocol used by the Mortality Review Committee includes: (1) the purpose, composition, and functions of the committee; (2) procedures for conducting audits of Critical Incident Reports; (3) procedures for individual case provider remediation; and (4) procedures for analysis of aggregate data and recommending system-level quality improvement interventions. The Mortality Review Committee collects and reviews information on each death. Information collected through the process includes information from medical providers that may have a significant role in the delivery of health care services to an individual as well as other source.

OBH has a separate review process. While their mortality review process is consistent with similar processes used by other agencies, OBH is limited in their ability to collect information needed from key informants to fully evaluate the circumstance prior to an individual's death. Unlike other State agencies, OBH does not have the statutory authority to collect privileged information from medical providers that may have a significant role in the delivery of health care services to an individual. This causes a significant information gap for the committee and hinders their ability to develop the necessary conclusions and/or take the necessary actions to remedy systemic issues.

Over this past period, LDH developed a protocol for immediately notifying the SME and DOJ on all deaths of the Target Population that have been transitioned to the community. This protocol requires TCs to notify via email their immediate supervisor and program office lead within their respective program offices within 24 hours of first knowledge that an individual identified as a transitioned member of the DOJ Target Population has died. The Transition Coordinator will provide various information to their supervisor including the date of death, cause of death, date of TCs last contact and whether other individuals were with the member when they died. The program office leads are to contact the DOJ Program Integration Coordinator who will provide information on each death to DOJ in the timeframes specified. The two parties have not finalized this protocol and the SME recommends that this occur immediately. It should be noted, there have been no deaths of the target population that has transitioned from a NF during this reporting period.

While this protocol is helpful to notify DOJ, regarding deaths of members of the Target Population there continue to be issues with the mortality review process. At a minimum, OBH needed statutory authority for collecting information from medical providers. Without this information, the OBH mortality review committee will not be able to determine the true cause of a death and therefore will not have the information necessary to develop strategies that could prevent some deaths. It is the SME's understanding that OBH has requested these legislatively and that the Legislature has passed the provision, but the Governor has yet to sign this important legislation.

*98. On a regular basis, and as needed based on adverse outcomes or data, the State will assess provider and MCO services, the amount, intensity, and availability of such services, and quality assurance processes, and will take corrective actions where appropriate to ensure sufficient quality, amount, and accessibility of services provided pursuant to this Agreement.*

*99. 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. The State will create protocols on collection and analysis of data to drive improvement in services, which shall be developed with the technical assistance and approval of the Expert prior to implementation. Data elements shall measure the following areas: (a) referral to, admission and readmission to, diversion from, and length of stay in, nursing facilities; (b) person-centered planning, transition planning, and transitions*

*from nursing facilities; (c) safety and freedom from harm (e.g., neglect and abuse, exploitation, injuries, critical incidents, and death; timely reporting, investigation, and resolution of incidents); (d) physical and mental health and wellbeing, and incidence of health crises (e.g., frequent use of crisis services, admissions to emergency rooms or hospitals, admissions to nursing facilities, or admissions to residential treatment facilities); (e) stability (e.g., maintenance of chosen living arrangement, change in providers, work or other day activity stability); (f) choice and self-determination (e.g., service plans are developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services); (g) community inclusion (e.g., community activities, integrated day and employment outcomes, integrated living options, relationships with non-paid individuals); (h) provider capacity (e.g., adherence to provider qualifications and requirements, access to services, sufficiency of provider types); (i) barriers to serving individuals in more integrated settings, including the barriers documented and any involvement of the Transition Support Committee as required by Section V.D.; and (j) access to and utilization of Community-Based Services.*

The State, with the assistance of the SME, has worked to develop a process for collecting and reporting on the information required in this paragraph and, in November 2019, finalized a matrix of quality measures. That matrix, provided in Attachment B, reflects the current strategy for measuring subsections (a)-(h) – the majority of this paragraph. The matrix identifies the:

- Data Measure;
- Methodology;
- Data Source; and
- Frequency of Reporting the Measure.

A copy of this matrix is provided in Attachment B.

The State is to be commended for its efforts to develop and implement strategies for reporting the measures in the matrix. Many of the data sources identified in the matrix will provide the State with reliable information (e.g. Medicaid claims or UTOPIA that provides PASRR information). Some of the newer measures are being collected through self-reporting processes. Specifically, information reported from Transition Coordinator monthly logs will provide information on the extent to which Target Population members that have been transitioned:

- Receive the services in their transition plan;
- Whether the plan addressed their needs;
- Are reporting good physical and mental health;
- Changes in medications;
- Reported Stability in housing and natural support networks; and
- Level of involvement in the community.

While self-reported information can serve as a good proxy when quantitative data is not available, the State will need to develop processes to offset any reliability concerns regarding this data. The SME would recommend the State to review this data carefully and develop processes that would verify information that is being self-reported. This could include having the Transition Coordinator's supervisor (or a third party) perform interviews with the Target Population member to verify the information being reported is accurate.

The State has developed a process to identify barriers to serving individuals in more integrated settings, including information from the Transition Support Committee. The process continues to identify the following barriers that affect transitions described in paragraph 51.

The State has not provided information on the utilization of Community-Based Services. However, the Needs Assessment that is being conducted by the Human Services Research Institute will provide a framework for the State to collect and analyze utilization for all members of the Target Population (individuals who were transitioned and diverted). LDH should use the methodology from the needs assessment to collect and analyze information on services used by the Target Population. While the information will not be real-time due to lags in timely claim submission, it is an important input for identifying potential underutilization of services and projecting the need of Target Population members who may need these services in subsequent years.

*100. The State will use all data collected under this Agreement to: (a) identify trends, patterns, strengths, and problems at the individual, provider, and systemic levels, including, but not limited to, screening and diversion from nursing facility admission, quality of services, service gaps, geographic and timely accessibility of services, individuals with significant or complex needs, physical accessibility, and the discharge and transition planning process; (b) develop and implement preventative, corrective, and improvement strategies to address identified problems and build on successes and positive outcomes; and (c) track the efficacy of preventative, corrective, and improvement strategies and revise strategies as needed.*

The State has begun to develop the reports for the measures identified in paragraph 99 for the purposes of meeting the requirements of this paragraph. The reports for the quarter ending on March 2020 is provided in Attachment B. While developing these reports are a necessary first step, LDH has not developed a clear process for how the reports will be reviewed and factored in to a larger quality assurance framework for the Agreement. The State should develop a robust quality assurance process, as recommended in paragraph 94, to meet the requirements of this Agreement.

*101. At least annually, the State will report publicly, through new or existing mechanisms, on the data collected pursuant to this Section, and on the availability and quality of Community-Based Services (including the number of people served in each type of Community-Based Service described in this Agreement) and gaps in services, and will include plans for improvement.*

The State has reported only a fraction of data publicly. Since January of 2019, LDH has provided information to the My Choice Statewide Advisory Committee on the number of individuals who have been assessed, offered to participate in the CCW, and have transitioned from NFs. The State should continue its efforts to develop the reports on the measures listed above. These efforts should be available to the public regarding the progress the State has made regarding this Agreement. In addition, the State could develop a set of dashboards that focus on:

- The transition activities that have been performed by the State for individuals on the Master List. This could include: assessments started and completed; offers of participation in CCW; and individuals transitioned.
- The number of individuals who receive a PASRR. This information should include initial PASRRs, annual PASRRs, referrals for a PASRR for individuals who are on the Master List, and PASRRs that are completed due to a change in an individual's status.

- The number of individuals who have been identified as requiring each specialized behavioral health service. The State should develop a measure to identify the percent of individuals who received a specialized service consistent with the PASRR recommendation and plan of care.
- The number of individuals who have been diverted from a NF consistent with the definitions set forth in the diversion report.
- Information on individuals who have been transitioned from NFs. This should initially include basic demographics, information on housing status, and transition barriers.

*102. The State will ensure that all relevant State agencies serving individuals in the Target Population have access to the data collected under this Agreement.*

The State has not developed a formal process for all relevant State agencies providing or accessing data. The State does work closely with some agencies (e.g. LHC) regarding specific topics and requests. The SME recommends that LDH develop the formal to process meet the requirements of by the Agreement.

*103. Beginning no later than the fourth year following the Effective Date, the State will, with the technical assistance of the Expert, begin to adopt and implement an assessment methodology so that the State will be able to continue to assess the quality and sufficiency of Community-Based Services and the processes required in this Agreement, following the Termination of this Agreement. The State will demonstrate that it has developed this capacity prior to the Termination of this Agreement.*

## Conclusion

Since the last SME report, the State has continued efforts in all areas of the Agreement. However, the COVID-19 pandemic has adversely impacted the State's efforts to move forward with activities that are integral to the Agreement. The inability to access members in the Target Population in NFs and limited ability to complete timely assessments and provide care coordination have delayed transitions and diversions. In the next six months, the State will need to develop aggressive strategies that will allow them to meet the projected number of transitions and diversions set forth for CY2020. In addition, several areas will need significant attention:

- The operationalization of the Diversion Plan with the MCOs;
- Amending or finalizing the various service strategies for case management, crisis, peer supports and supported employment; and
- Continuing to pursue their strategy sets forth in the Housing Plan.

The State must also develop a methodology for projecting the number of individuals who will be transitioning from NFs in 2021 and the strategies that will ensure greater transitions from these facilities. In addition, a critical activity that was placed on hold due to COVID-19 will need to be completed—the development of the transition tracking system referenced earlier in this report (Phases 1 and 2).

# **Attachment A**

## **PASRR OBH PASRR Level II Authorization Rubric**



Level II Not Required	Temporary (30 – 60 day auth)	Temporary (90 – 100 day auth)	Long Term (1-year auth)	Denial
<p>Characteristics of Referral:</p> <ul style="list-style-type: none"> <li>○ Do not meet criteria for SMI in regards to:                             <ul style="list-style-type: none"> <li>▪ Diagnosis</li> <li>▪ Duration</li> <li>▪ Disability</li> </ul> </li> </ul> <p><b>**do not use this category if individual is on a Judicial Commitment, unless proof of primary dementia. Be sure to include clear documentation of such within system. **</b></p>	<p>Characteristics of Referral:</p> <ul style="list-style-type: none"> <li>○ Have SMI which is immediately overshadowed by a condition which would qualify an individual for one of the following Categorical Determinations:                             <ul style="list-style-type: none"> <li>▪ Respite (30 days, no more than twice annually)</li> <li>▪ Delirium (30 days)</li> <li>▪ Emergency Situation (7 days)</li> </ul> </li> </ul> <p>Based on extension request and review of documentation, OBH PASRR may authorize:</p> <ul style="list-style-type: none"> <li>○ up to 90/100 days if:                             <ul style="list-style-type: none"> <li>▪ individual is still not stable</li> <li>▪ if need longer time to transition back into the community with proof of active discharge planning</li> </ul> </li> <li>○ one (1) year to allow for annualized review of status for those who have demonstrated the need for long term placement</li> </ul>	<p>Characteristics of Referral:</p> <p>90 day: Medicaid; 100 day: Convalescent Care</p> <ul style="list-style-type: none"> <li>○ New referral</li> <li>○ Have a SMI with complicating medical conditions as listed below:                             <ul style="list-style-type: none"> <li>▪ Medical condition may improve                                     <ul style="list-style-type: none"> <li>• Requires stabilization and/or skilled nursing</li> <li>• Can eventually be managed in the community with appropriate services   <ul style="list-style-type: none"> <li>○ Services are, or will be, available</li> </ul> </li> <li>• Authorization will allow time for additional testing to verify presence of dx and longer term placement</li> <li>• Meets criteria for the following Categorical Determination:   <ul style="list-style-type: none"> <li>○ Convalescent Care from an Acute Physical Illness (90 days)</li> </ul> </li> </ul> </li> </ul> </li> </ul> <p>Based on extension request and review of documentation, OBH PASRR may authorize:</p> <ul style="list-style-type: none"> <li>○ up to 90/100 days if:                             <ul style="list-style-type: none"> <li>▪ individual is still not stable</li> <li>▪ if need longer time to transition back into the community with proof of active discharge planning</li> </ul> </li> <li>○ one (1) year to allow for annualized review of status for those who have demonstrated the need for long term placement</li> </ul>	<p>Characteristics of Referral:</p> <ul style="list-style-type: none"> <li>○ Have been residing in the NF under a permanent authorization or have already been issued a 90 day authorization and still SMI which is overshadowed by complicated medical condition which warrants NF placement                             <ul style="list-style-type: none"> <li>▪ Medical condition is not expected to improve                                     <ul style="list-style-type: none"> <li>• Needs cannot be managed within the community even with services   <ul style="list-style-type: none"> <li>○ Services are not available</li> </ul> </li> <li>• Would (most likely) not benefit from specialized behavioral health services</li> <li>• Has SMI and meets criteria of one of the following Categorical Determinations:   <ul style="list-style-type: none"> <li>○ Terminal Illness with prognosis of less than 6 months to live (6 month authorization)</li> <li>○ Severe Physical Illness (ex: Huntington’s, ALS, Coma, Ventilator, severe/advanced COPD, Parkinson’s, and Congestive Heart Failure at a level to which the person could not be expected to benefit from specialized behavioral health services   <ul style="list-style-type: none"> <li>○ Primary Dementia (level II not needed)</li> </ul> </li> </ul> </li> </ul> </li> </ul> </li> </ul> <p>Based on extension request and review of documentation, OBH PASRR may authorize:</p> <ul style="list-style-type: none"> <li>○ another short-term authorization of up to 90/100 days if individual’s condition has improved and they need time to transition back to the community</li> <li>○ additional short term authorization of up to 6 months if individual still has documentation of Terminal Illness with prognosis of less than 6 months to live</li> <li>○ one (1) year to allow for annualized review of status for those who have demonstrated the need for long term placement</li> </ul>	<p>Characteristics of Referral:</p> <ul style="list-style-type: none"> <li>○ Have a SMI with little to no complicating medical conditions</li> <li>○ Functionally independent with limited support needed for ADLs, etc.</li> <li>○ Needs can be met within the community with appropriate services; consider if:                             <ul style="list-style-type: none"> <li>▪ Services are available</li> <li>▪ The person has a place to go</li> </ul> </li> <li>○ May need a level of care beyond that which a NF can provide (danger to others, not psychiatrically stable)</li> </ul>

**\*\*if individual is on a Judicial Commitment – please review the packet, determining whether or not authorization for NF placement is warranted, coordinating with Legal regarding length of authorization (if deviates from length of Judicial Commitment) and/or if the individual does not meet NF LOC and the case should be denied.\*\***

## Attachment B

### I. My Choice Quality Matrix 2020

#### MY CHOICE 2020 QUARTER 1 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	January 2020 <sup>1</sup>	February 2020 <sup>1</sup>	March 2020 <sup>2</sup>
98	1. The State will assess provider and MCO services, the amount, intensity and availability of such services and quality assurance processes and take corrective action where appropriate	1.a	Number of community based behavioral health providers available to provide services and accepting new Medicaid participants	# of providers accepting new Medicaid patients by level of care stratified by LDH region			
		1.b	Geographic and timely availability of services:  Number of community based behavioral health providers available to serve BH Medicaid beneficiaries stratified geographically by region	Report analysis # of providers accepting new Medicaid patients by level of care stratified by LDH region			
		1.c	Number and percent of specialized behavioral health providers meeting appointment availability standards. 1) Emergent: 1 hour; 2) Urgent: 48 hours (2 calendar days); Routine: 14 calendar days	Statistically significant random sample of providers to obtain next available appointment			
		1.d	Number and percent of transitioned members who report that they received all types of services specified in the transition plan	Self report- Interviews with TP members done by TCs:  # of transitioned members who report that they received all types of services specified in plan/total # of transitioned members interviewed.  Question from Case Management log: #4 Has the participant received services as written in the plan of care and/or treatment plan?	49/65 87.69%	55/60 91.67%	58/70 82.86%
		1.e	Number and percent of transitioned members who received services in the	SME review of representative sample of individuals transitioned from NFs <sup>3</sup>			

MY CHOICE 2020 QUARTER 1 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	January 2020 <sup>1</sup>	February 2020 <sup>1</sup>	March 2020 <sup>2</sup>
			amount, frequency and duration specified in the transition plan				
		1.f	Number and percent of transitioned members reporting they are receiving the services they need	Self report- Interviews with TP members done by TCs:  # of transitioned members reporting they are receiving the services they need/total # of transitioned members interviewed  Question from Case Management contact log: # 12 Has the participant had problems accessing non-waiver behavioral or health care services?	56/65 86.15%	54/60 90.00%	57/70 81.42%
99	2. Referrals to, admission and readmission to, diversion from, and length of stay in nursing facility	2.a	Referral to nursing homes- Nursing Facility Admission Request	Number of persons that request level 1 admission to Nursing Facility	4348	3490	2878
		2.b	Referral to Level II OBH (as per results of Level I PASRR)	Number of individual initial placement requests	294 6.7%	248 7.1%	145 5.0%
		2.c	PASRR Outcome Trends	Independent Evaluations vs. desk review	Indep Eval 402	Indep Eval 334	Indep Eval 223
					Total Level II Reviews 934	Total Level II Reviews 776	Total Level II Reviews 566
		2.d	PASRR Outcome Trends	Total Resident Reviews--# of Resident Reviews conducted	380	386	280
		2.e	NF Short Term Authorizations vs. Long Term Authorizations	Number of initial authorizations approved for short term stay(100 days or less)	294 100%	248 100%	145 100%
		2.f	PASRR Level II Service Recommendations	Percent of PASRR determinations that recommended referral to Specialized Behavioral Health Services	76%	73%	51%

MY CHOICE 2020 QUARTER 1 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	January 2020 <sup>1</sup>	February 2020 <sup>1</sup>	March 2020 <sup>2</sup>
		2.g	Services Provided	Number and percent of individuals receiving PASRR Level II Specialized Behavioral Health Services Recommended <sup>4</sup>			
		2.h	PASRR Level II Placement Recommendations	Percent of PASRR determinations that were denied	6%	3%	2%
	3. Person Centered Planning	3.a	Number and % of transitioned members who report having service plans that addressed their needs	Self report- Interviews with TP members done by TCs:  # of transitioned members who report that they understand their plan of care/treatment plan/total # of transitioned members interviewed.  Question from Case Management contact log: #1 Is the participant aware of and understand their plan of care and/or treatment plan?			53/65 81.54%
		3.b	Number and % of transitioned members who report that they participated in planning	Self report- Interviews with TP members done by TCs:  # of transitioned members who report that they participated in planning /total # of transitioned members interviewed.  Question from Case Management log: #2 Were you involved in planning and face to face meetings?			51/65 78.46%
		3.c	Number and % of transitioned members who report planning included	Self report- Interviews with TP members done by TCs:			52/65 80.0%

MY CHOICE 2020 QUARTER 1 DATA

Paragraph #	Requirement	Proposed Data Measure	Methodology	January 2020 <sup>1</sup>	February 2020 <sup>1</sup>	March 2020 <sup>2</sup>
		participation members of their chosen social network	# of transitioned members who report that planning included others of their choosing/total # of transitioned members interviewed.  Question from Case Management log: #3 Did you have the people that you wanted to support you at those planning and face to face meetings?			
		3.d Number and % of transitioned members who indicated their preferences are being respected	Self report- Interviews with TP members done by TCs:  # of transitioned members who report that their preferences are being respected /total # of transitioned members interviewed.  Question from Case Management contact log: # 6 Has the participant indicated their preferences are being respected?	61/65 93.85%	57/60 95.00%	61/70 87.14%
		3.e Number and percent of transitioned members whose plan of care addressed their needs	SME review of representative sample of individuals transitioned from NFs <sup>3</sup>			

MY CHOICE 2020 QUARTER 1 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	January 2020 <sup>1</sup>	February 2020 <sup>1</sup>	March 2020 <sup>2</sup>	
	4. Safety and Freedom from harm	4.a	Number of critical incidents, stratified by type of incident	Review and analysis of critical incident reports submitted by the TCs and using provider and member reported CI information	Total CIRs=14	Total CIRs=21	Total CIRs=15	
					Major Medical Event = 11	Major Medical Event = 18	Major Medical Event = 7	
					Falls = 3	Major Behavioral Incident = 1 Falls = 1 Arrest = 1	Major Behavioral Health Incident = 1 Falls = 5 Medication Event = 1 EPS = 1	
		4.b	Number and percent of referrals reported to protective service agency for abuse, neglect, and exploitation	Number of abuse, neglect, exploitation referrals made	0	0	1	
		4.c	Number and percent of death investigations that were completed	Number of death investigations that were completed/ Total number of death investigations	0	0	0	
		4.d	Number and percent of deaths that require a remediation plan	# of transitioned TP members deaths requiring remediation plan/total # of transitioned members interviewed	0	0	0	
		4.e	Number and percent of participants whose service plans had strategies that	SME review of representative sample of individuals transitioned from NFs <sup>3</sup>				

MY CHOICE 2020 QUARTER 1 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	January 2020 <sup>1</sup>	February 2020 <sup>1</sup>	March 2020 <sup>2</sup>
			addressed their health and safety risks as indicated in the assessment (s)				
		4.f	Number and percent of transitioned members reporting that they have not experienced any major incidents	Self report- Interviews with TP members done by TCs:  # of transitioned TP reporting no major incidents/total # of transitioned members interviewed  Question from Case Management log: # 17 Has the participant had falls, injuries, or hospitalization?			47/65 72.31%
		4.g	Number and percent of transitioned members reporting that they have been free from abuse, neglect, or exploitation	Self report- Interviews with TP members done by TCs:  # of transitioned TP reporting freedom from abuse, neglect, exploitation/total # of transitioned members interviewed  Question from Case Management log: # 18 Has the participant been a victim of verbal or physical abuse (including sexual), neglect or exploitation?			61/65 93.85%
	5. Physical and mental health wellbeing and incidence of health crisis	5.a	Number and percent of transitioned members reporting good physical and mental health	Self report- Interviews with TP members done by TCs:  # of transitioned TP members reporting good physical health and mental health/total # of transitioned members interviewed	52/65 80%	50/60 83.33%	66/70 94.29%

MY CHOICE 2020 QUARTER 1 DATA

Paragraph #	Requirement	Proposed Data Measure	Methodology	January 2020 <sup>1</sup>	February 2020 <sup>1</sup>	March 2020 <sup>2</sup>	
			Question from Case Management contact log: # 15 Has the participant had a substantial change in medical condition or mental health condition?				
		5.b	Number and percent of transitioned members reporting independence with taking care of themselves physically	Self report- Interviews with TP members done by TCs:  # of transitioned TP members reporting no change in ability to complete tasks for themselves/total # of transitioned members interviewed  Questions from Case Management contact log: # 11 Has the participant had a substantial change in the ability to do things for him/herself?	60/65 92.31%	56/60 93.33%	66/70 94.29%
		5.c	Number and percent of individuals that report that they had a change in medications/ treatments, or side effects from, and/or who gives them	Self report- Interviews with TP members done by TCs:  # of transitioned TP members reporting a change in medications/treatments, or side effects from and/or who gives them/total # of transitioned members interviewed  Question from Case Management contact log: # 16 Has the participant had a change in medications/treatments, or side effects from, and who gives them?			10/65 15.38%
		5.d	Number and percent of participants who utilized crisis services, ED presentations,				



MY CHOICE 2020 QUARTER 1 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	January 2020 <sup>1</sup>	February 2020 <sup>1</sup>	March 2020 <sup>2</sup>
			hospitalizations (as an overlay to see if a person was in crisis)				
6.	Stability	6.a	Number and percent of transitioned members reporting stability in housing	Self report- Interviews with TP members done by TCs:  # of transitioned members reporting stability in housing /total # of transitioned members interviewed  Question from Case Management contact log: # 9 Has the participant had problems maintaining housing?			65/70 92.86%
		6.b	Number and % of transitioned members reporting stability in natural supports network	Self report- Interviews with TP members done by TCs:  # of transitioned members reporting stability in natural support network/total # of transitioned members interviewed  Question from Case Management contact log: # 7 Has the participant had a change in non-paid caregivers?	57/65 87.69%	59/60 98.33%	61/65 93.85%
7.	Choice and Self Determination	7.a	Number and % of transitioned members reporting that they are able to make choices and exert control over their own life	SME review of representative sample of individuals transitioned from NFs <sup>3</sup>			
8.	Community Inclusion	8.a	Number and percent of transitioned members reporting that they are involved in the community to the extent they would like	Self report- Interviews with TP members done by TCs:  # of transitioned members reporting they are able to be involved in the			48/65 73.85%

MY CHOICE 2020 QUARTER 1 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	January 2020 <sup>1</sup>	February 2020 <sup>1</sup>	March 2020 <sup>2</sup>
				community to the extent that they would like/total # of transitioned members interviewed  Question from Case Management contact log: # 10 Has the participant engaged in social, recreational, educational, or vocational activities as desired?			

<sup>1</sup> During this quarter, the My Choice team finalized edits/revisions to the Transition Coordinator contact log. The new log was not implemented until March 2020. For this quarter the data used for January and February based on an earlier version of the TC log. As such, not all elements aligned completely with the matrix therefore there are several metrics that data was not collected on. Graphs of data included only for those items that all 3 months of data were present.

<sup>2</sup> March – full implementation of the new TC log; however, there were 5 instances in which the old log was used instead of the new log by the TC. Where data was able to be cross walked from the old log for a particular metric it was counted. For items where there was not a question that could be used it was not included in the total count for that metric. This is why for some items the total denominator for March is 65 and in other instances it is 70.

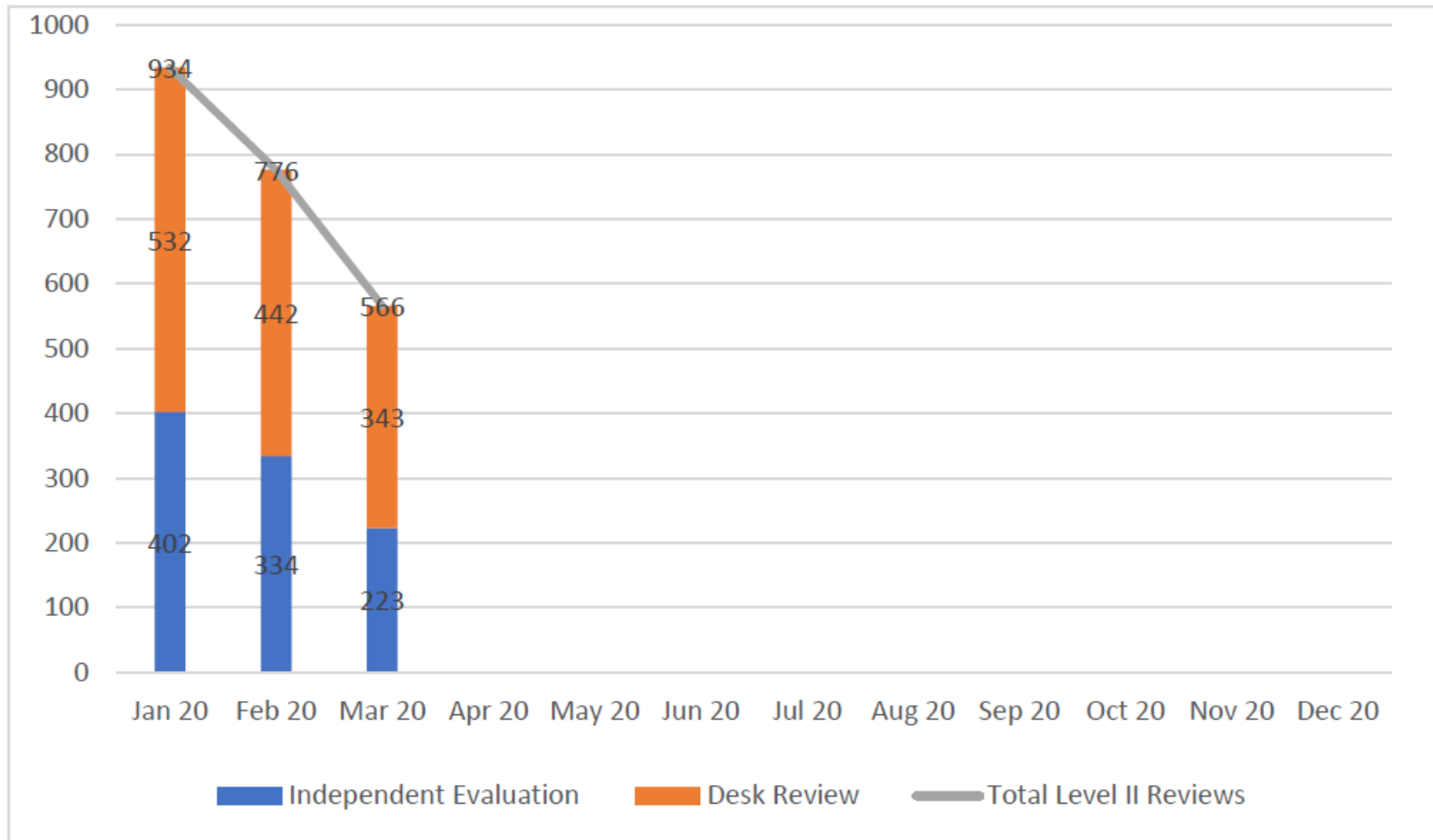
<sup>3</sup> For items that the methodology is noted as follows: ‘SME review of representative sample of individuals transitioned from NFs’, data not available during this reporting period as it is a measure that will be reported on a semi-annual basis.

<sup>4</sup> 2.g-OBH has identified changes needed to their system in order to be able to begin reporting this data. In the absence of those system changes the data is not able to be reported for this quarter.

II. PASRR Level II Data (2020 Quarter 1 Data by Month)

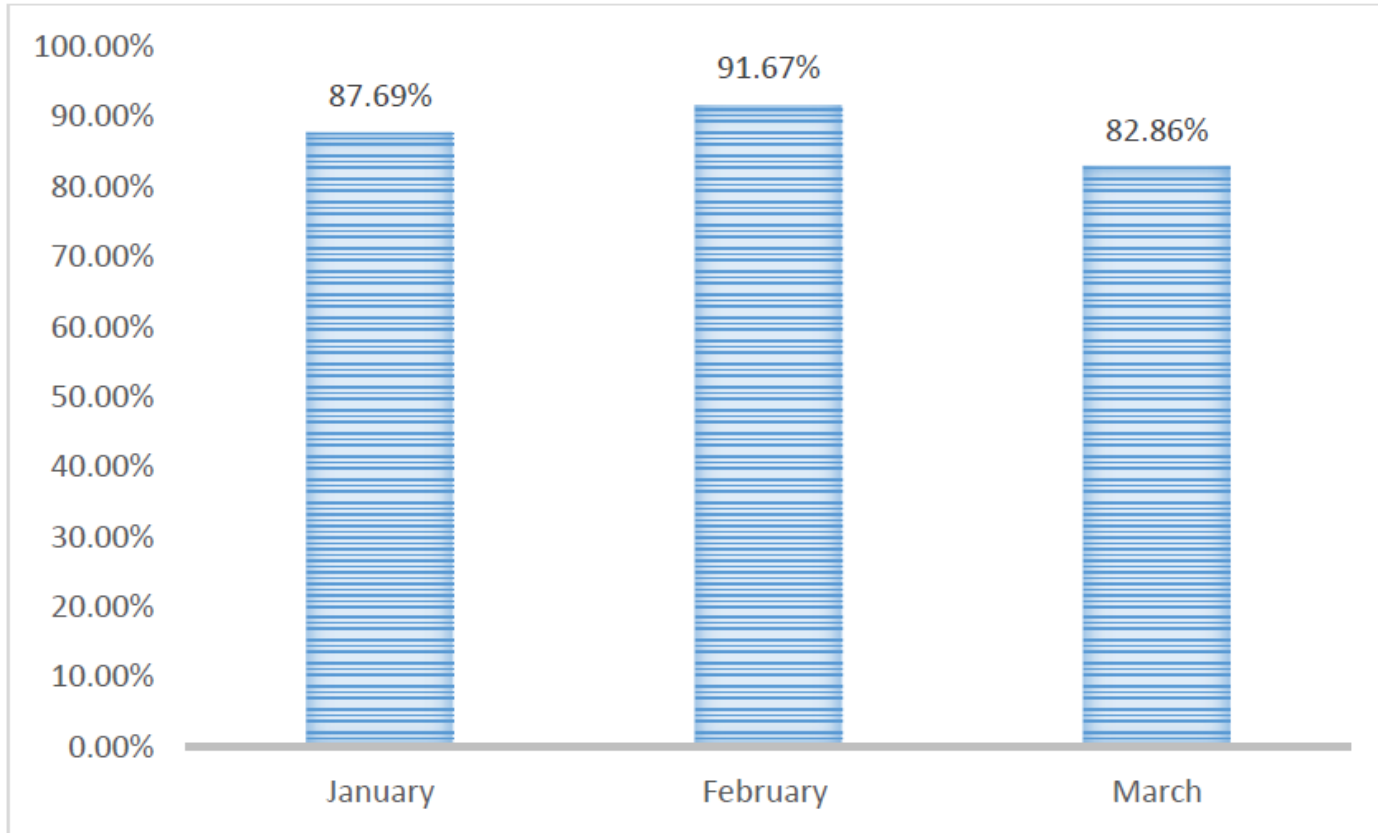
PASRR Outcome Trends – Total PASRR Level II Reviews Conducted by Method

Total # of all types PASRR Level II reviews broken down by those conducted by Independent Evaluation (face to face) verses Desk Review

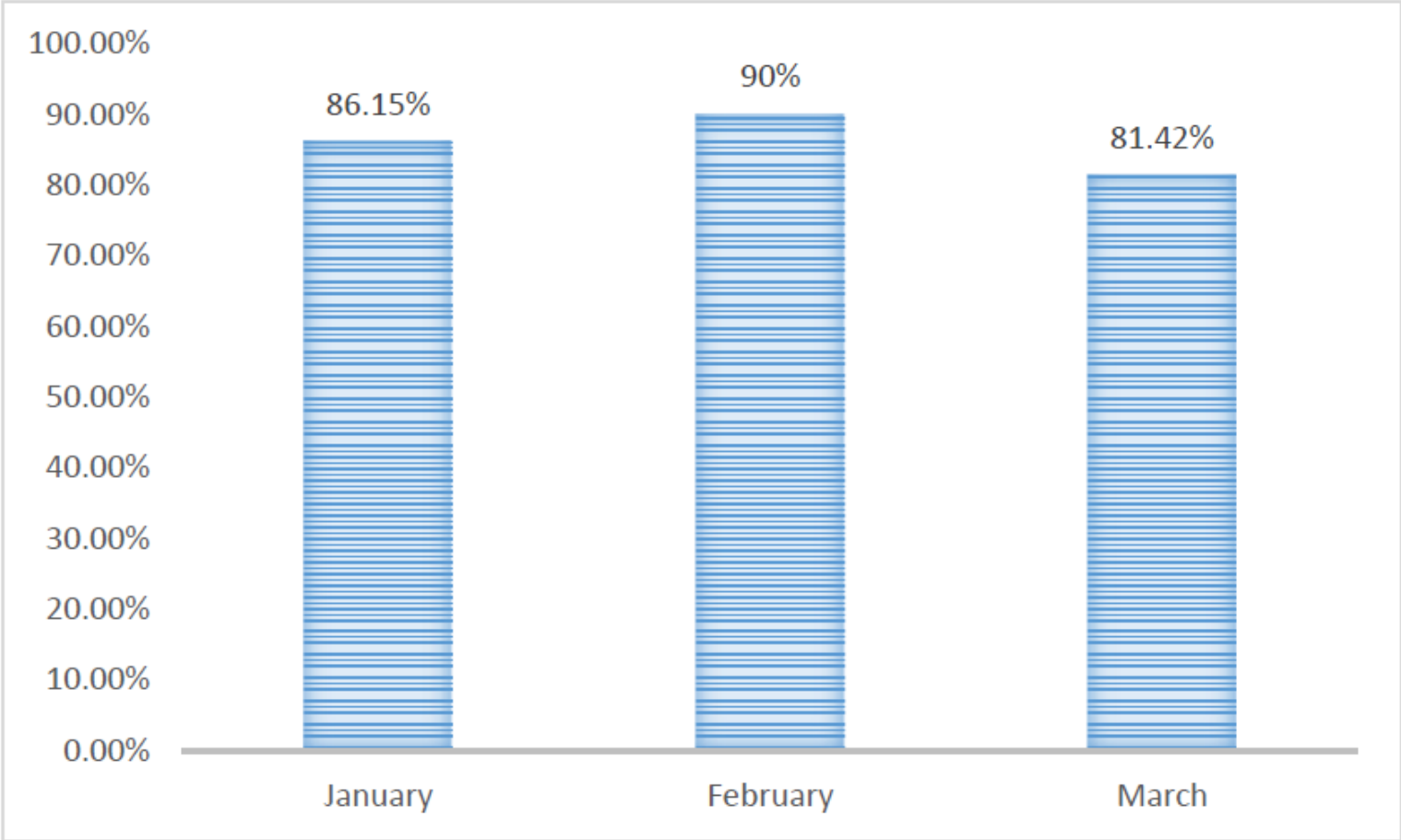


III. My Choice LA 2020 Quarter 1 Data

Percent of transitioned members who report that they received all types of services specified in the transition plan.

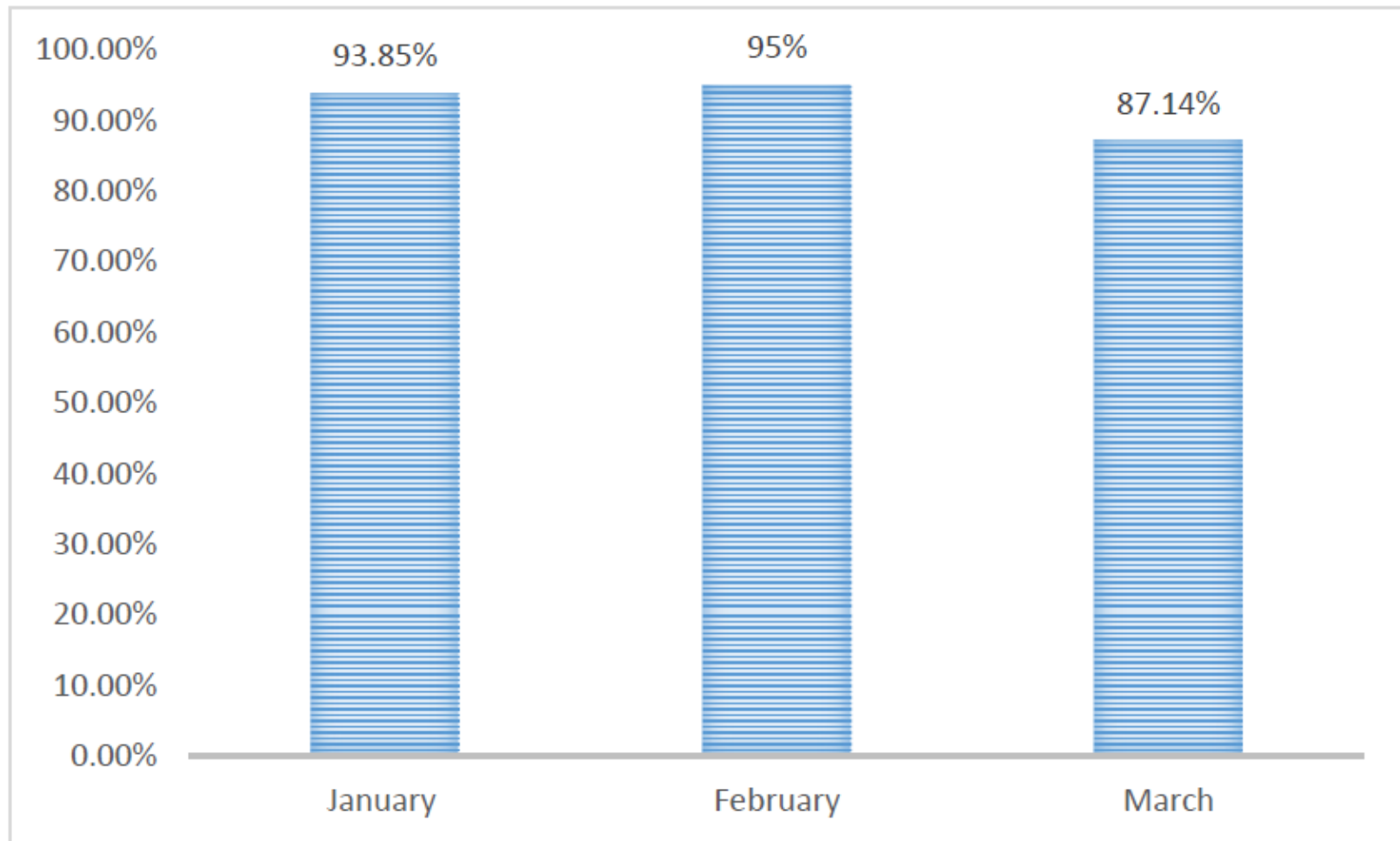


Percent of transitioned members reporting that they are receiving the services they need.



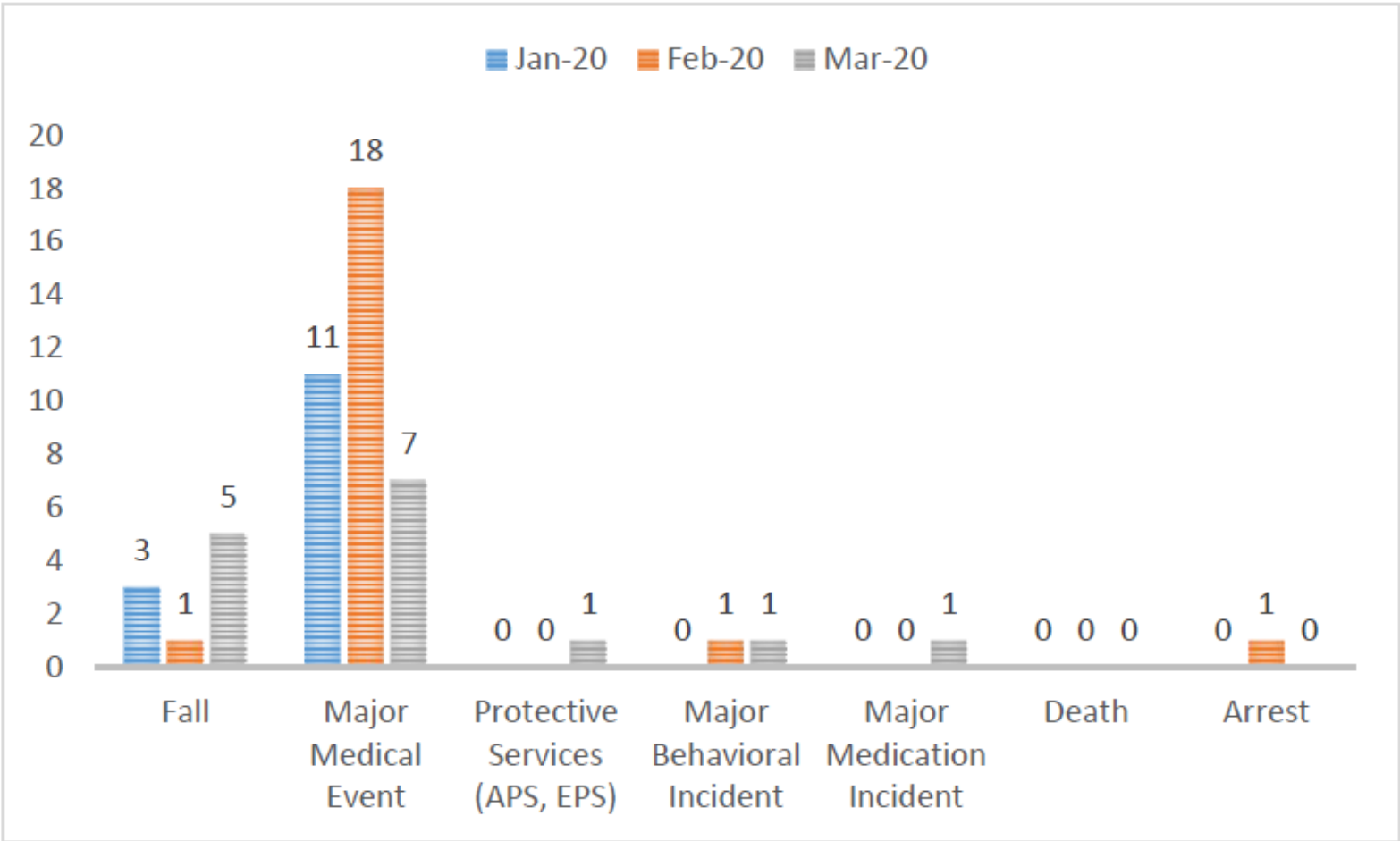
## Person Centered Planning

Percent of transitioned members who indicate their preferences are being respected.

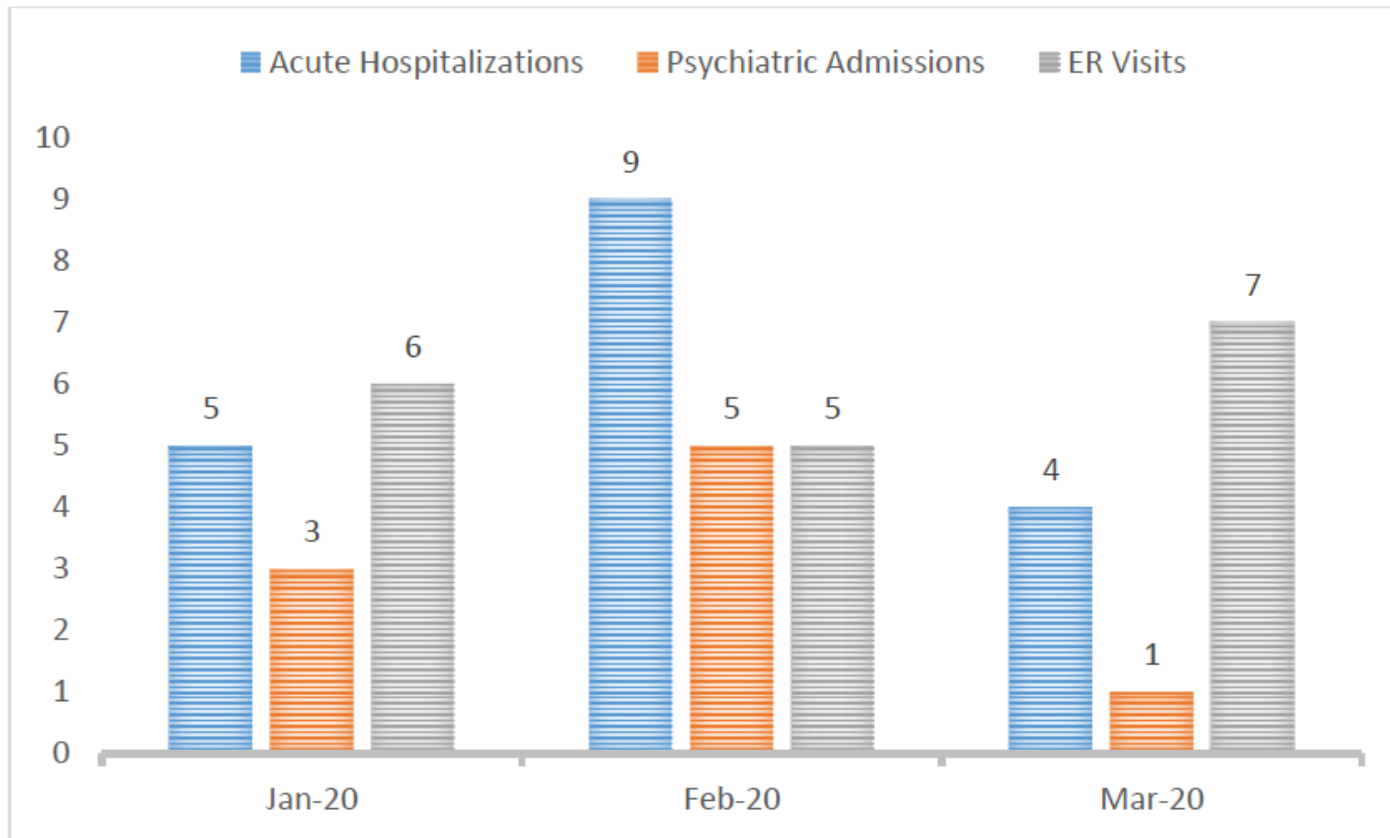


# Safety and Freedom from harm

Number of Critical Incidents, stratified by type of incident



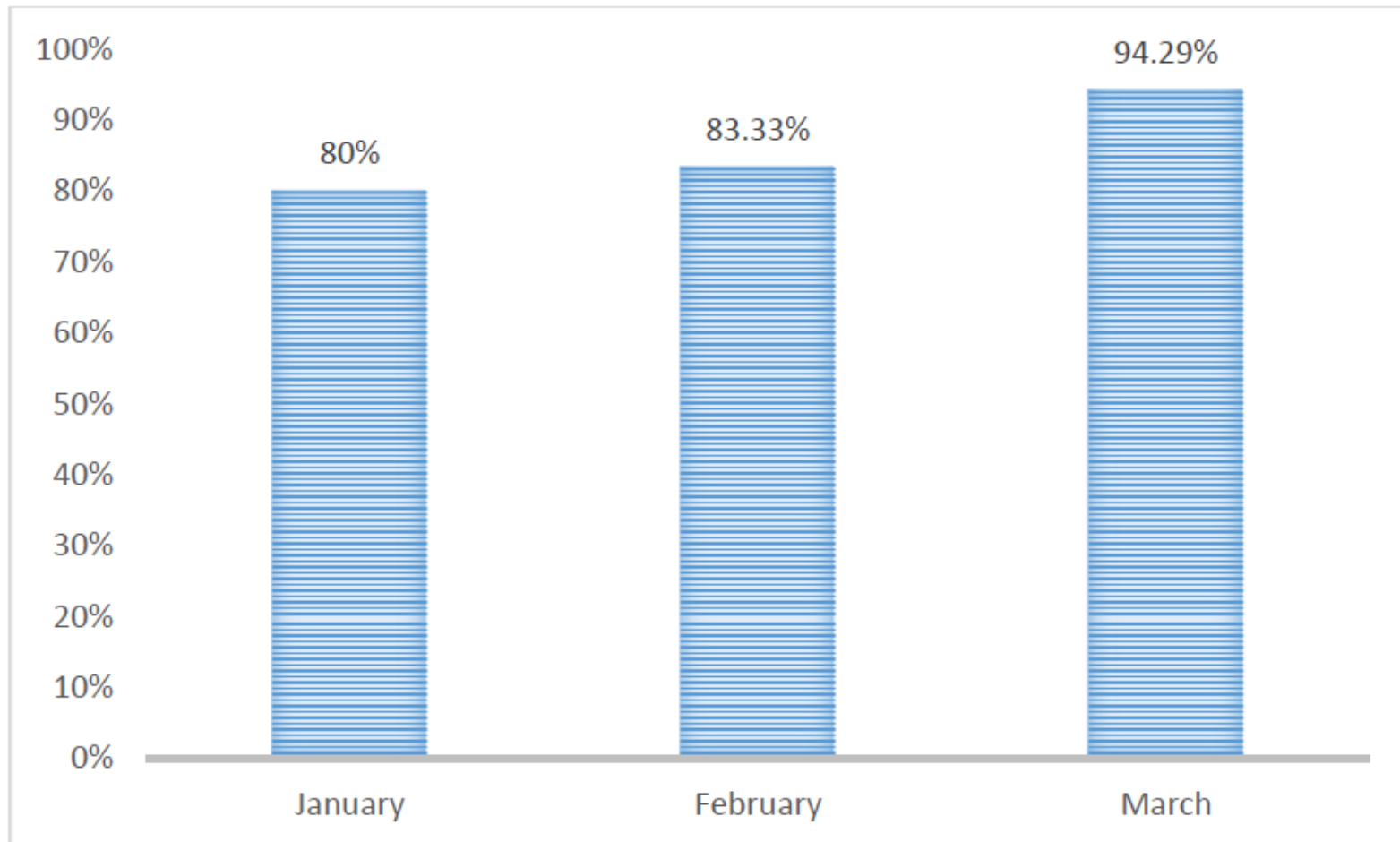
Of total CIRs noted above this graph represents a breakdown of acute hospitalizations, psychiatric admissions, and ER.



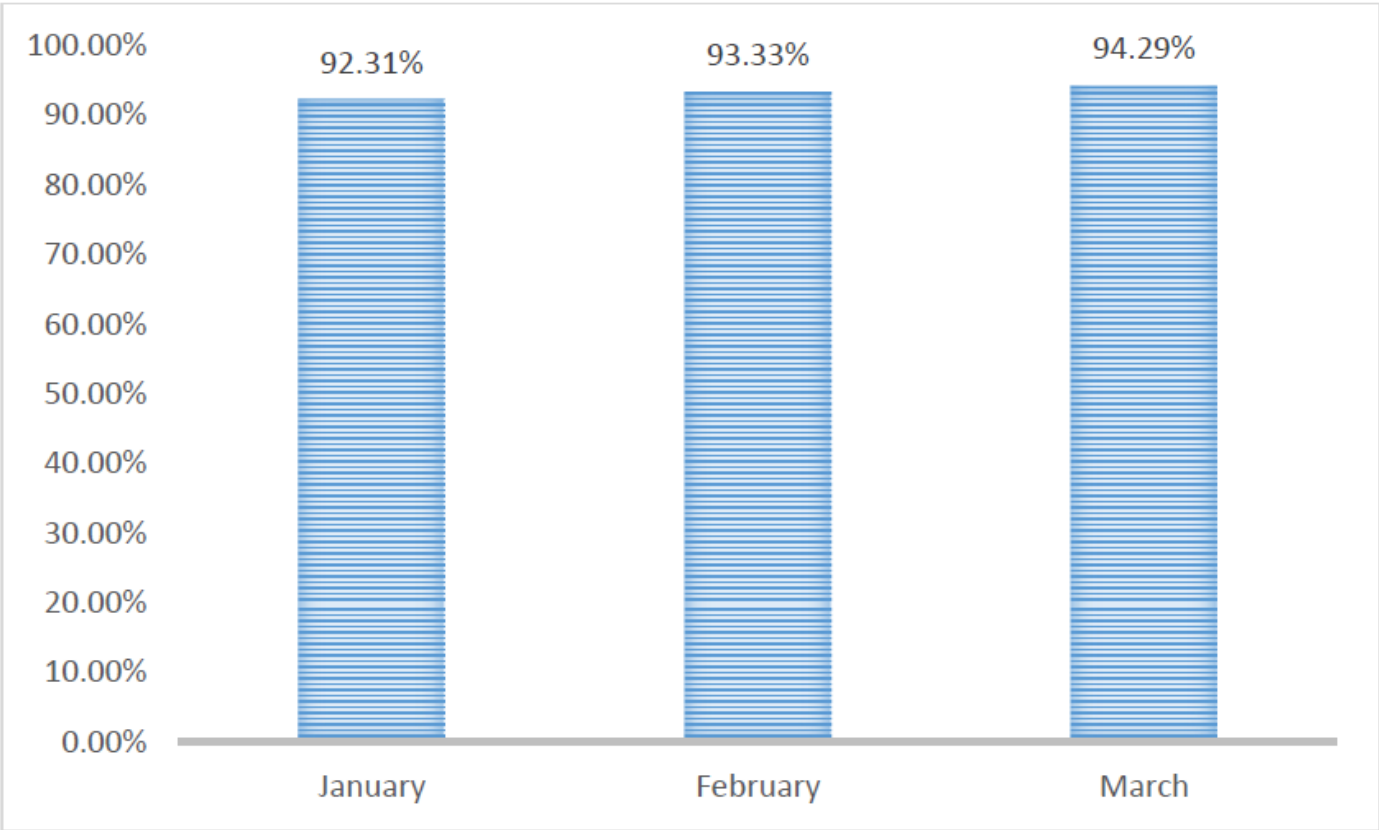


# Physical and mental health wellbeing and incidence of health crisis

Percent of transitioned members reporting good physical and mental health.



Percent of transitioned members reporting independence with taking care of themselves physically.



# Stability

Percent of transitioned members reporting stability in natural supports.

