

LA-DOJ Fifth Subject Matter Expert (SME) Report

COVERING THE PERIOD OF 1/1/2021 THROUGH 6/30/2021
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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 fifth SME report, covering the period of 1/1/2021 through 6/30/2021.

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) 2021.¹ 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.

The Target Population for the Agreement is comprised of (a) Medicaid-eligible individuals over age 18 with serious mental illness (SMI) currently residing in nursing facilities; and (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 who have been referred within two years prior to the effective date of this Agreement. It excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis. In June 2018, there were 3,580 individuals in the Target Population in nursing facilities. As of 6/30/2021 there are 3,549 individuals in the Target Population in nursing facilities.

One of the State's initial activities was to create a Master List of individuals who are in Nursing Facilities who are members of the Target Population. The Master List includes individuals who have not expressed an interest in moving (either they declined to be transitioned or they had not yet been engaged by LDH to discuss an interest in moving). The State's process for developing and maintaining this list is discussed in Section III, Paragraph 26. There are 2,825 individuals on the Master List residing in nursing facilities (NFs).

¹ Available at: <https://ldh.la.gov/assets/docs/MyChoice/LA-LDH2021AnnualImplementationPlan.pdf>

Additionally, LDH had identified a number of individuals in the Target Population who expressed an interest in moving to the community. Utilizing information from the Minimum Data Set (MDS) and interviews with individuals in the Target Population, LDH identified individuals who were interested and likely candidates to transition. The MDS collects individuals' preferences for discharge to the community. These individuals were placed on an Active Caseload list that was separate from the Master List. Individuals on the Active Caseload list were and continue to be assigned to a Transition Coordinator who will begin the engagement and transition process. LDH has identified 724 individuals on the Active Caseload list. However, this number is evolving as LDH has implemented more assertive in-reach measures to identify individuals who have been on the Master List to determine their interest in transitioning to the community. This will add significant numbers to the Active List this calendar year.

The State is aiming to transition approximately 219 individuals (a 119% increase from the 2020 projections) in Calendar Year (CY) 2021. The State is also aiming to divert an additional 194 individuals from NFs in CY 2021. However, more diversions and transitions will need to be projected and occur in future years to meet the goals of this Agreement. As of June 2021, LDH has transitioned 168 individuals from nursing facilities since June 2018, when the implementation of this Agreement began. As of 6/30/2021, 25 had transitioned in CY 2021. In addition, there were 168 individuals who were diverted from nursing facilities in CY 2021 thus far. Thirty-six (36) individuals were seeking admission to a nursing facility and 127 were homeless with an SMI and were at high risk of NF admission.

There are several areas of significant focus for the State over the next 6 months and beyond. These priority areas have not changed significantly since the last SME report. The fundamental goals of the Agreement drive the SME's areas of focus. Specifically, diverting individuals with serious mental illness away from inappropriate nursing facility admissions and identifying people with serious mental illness who have been admitted to nursing facilities but are able to and would like to transition to the community, and providing them with transition and discharge planning and community-based services sufficient to meet their needs. Therefore, the SME recommends that LDH concentrate most of its efforts over the next reporting period on the following activities:

- Increasing the number of individuals to be transitioned from nursing facilities. As indicated in this report, LDH is aiming to transition 219 individuals in the Target Population in CY 2021. This represents a significant increase over both CY 2019 and CY 2020. The number of transitions this reporting period is only a fraction of what LDH projected and the State is not on track to meet their target for this calendar year. LDH will need to do much work in this next reporting period to meet the goals they set forth for transitions. The SME recommends that the State continue assessments and transition planning with members on the Active Caseload list and rapidly transition individuals who are being identified through the more assertive in-reach process. As indicated in paragraph 89, these in-reach efforts have the promise for identifying a significant number of individuals who were previously on the Master List and were not identified as being interested in transitioning. The State should develop a specific plan by the end of September for improving transitions similar to their efforts regarding in-reach. Specifically, LDH should undertake a number of strategies for inputs into this plan. This includes developing a list of individuals who can move immediately versus individuals that may need more time and resources to move. It should also include specific expectations for Transition Coordinators to assess, plan, and complete the transition. LDH should also develop a strategy for monitoring these expectations on a bi-weekly basis to determine if these transitions are occurring. In addition, 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.

- Continuing their efforts to implement a strategy to contact individuals on the Master List to gauge their interest in moving from NFs. As indicated above, there are almost 2,500 individuals currently on the Master List. LDH has implemented a revised in-reach plan that includes additional staff resources (regional medical certification specialists) and is in the process of hiring peer support specialists to perform some of this in-reach. The State has developed regional and staff specific targets for in-reach efforts and has developed the necessary initial reports to monitor in-reach activities and outcomes. They are also conducting frequent meetings with the medical certification specialists and Transition Coordinator (TC) supervisors to review and discuss each region's efforts to undertake in-reach and the results of these efforts (e.g., identifying the number of individuals who have indicated interest in transitioning). They are identifying individuals who may benefit from additional contacts with a peer specialist to assist with answering questions and addressing perceived barriers identified by individuals who may not be interested in moving. As with transitions, the State is not on track to meet the expectations set forth in their April projections. The SME is recommending the State revisit the projections for the balance of the year (until April 2022) and revise expectations for meeting the projections developed during this reporting period. In addition, the State is considering the use of peer specialists to perform in-reach versus assisting TCs and Medical Certification Specialists to perform in-reach efforts. The SME recommends the State implement this consideration immediately and develop targets/expectations for peer specialists to provide in-reach to individuals on the Master List. The SME is also suggesting LDH develop a strategy to identify barriers generally for individuals who are not expressing an interest in transitioning and develop initial strategies to address these barriers. LDH should continue to provide the SME with monthly (if not more frequent) status reports regarding in-reach efforts over the next reporting period. The SME is also recommending that LDH evaluate the quality of the in-reach engagements and identify future training needs of staff performing in-reach.
- Implementing the community case management benefit. The Agreement requires ongoing case management in the community to be provided to members of the Target Population for a minimum of twelve months following discharge from the nursing facility. The Department has developed and is undertaking initial implementation activities to prepare for the launch of this service (scheduled for November 2021). There are still various activities that will help prepare the State, managed care organizations (MCOs), and community providers for this launch, including: developing the assessment tool and plan of care template for community services, determining work flows for individuals in the diversion population, and developing training for the community case management agencies. A major activity for this area will be the identification, referral, and engagement of individuals who have been diverted from nursing facilities. While LDH has identified these individuals and some are receiving services (as indicated in the Needs Assessment), they do not benefit from the intensive case management provided by the TCs. Therefore, LDH will need to pay particular attention to the referral and engagement process for these individuals. Finally, the SME's service review set forth various longer-term recommendations (see Attachment A) that impact the roles and responsibilities of the community case manager. As found through these service reviews, there is not a comprehensive plan of care, process for sharing plans across other care coordinators (e.g., MCO case managers), or consistent communication strategy that addresses service gaps and duplication for individuals in the Target Population who have transitioned. In the short term, the SME is recommending that LDH finalize

an approach to a comprehensive and integrated community plan for use by the Community Case Managers in the next several months.

- Monitoring the MCOs' efforts regarding the at-risk population. As indicated in this report, LDH has finalized the at-risk definition and has met with the MCOs regarding the approximate number of individuals that meet this at-risk definition for each MCO. The State is implementing (August, 2021) a report that tracks the MCO's efforts to provide case management to these individuals. In addition, the MCOs were requested by LDH to provide specific plans on how to improve care coordination and hopefully reduce the number of individuals identified as at-risk for Emergency Department (ED) visits and all cause inpatient re-admissions. This will be significant since all of these individuals had six or more major medical events (ED and inpatient admissions) over the past two years. The MCOs were to provide these specific plans in August. LDH should monitor the effectiveness of these plans using claims and other information to determine if individuals who are at-risk are experiencing fewer ED visits and inpatient admissions. If possible, the SME recommends LDH track NF admissions for these individuals over the next reporting period. As indicated in the LDH Needs Assessment, these individuals do not receive many behavioral health services, unlike individuals who have been transitioned and diverted.
- Continuing efforts to measure the quality of community services for Target Population members. LDH has collected a year's worth of information on the quality matrix measures for CY 2020. There are several measures that continue to indicate potential systemic issues that the State's quality assurance workgroup should address, as discussed in paragraph 100. In addition, LDH has taken several steps to review the current measures to determine if they need to be modified (either the measure or the methodology), removed, or whether new measures should be added. LDH has met with stakeholders (a subcommittee of the My Choice Advisory Committee) on a monthly basis to review the existing process and measures and to solicit input regarding these and possible new measures. In addition, LDH has received input from DOJ and the SME and is in the process of amending the initial measures with a particular focus on improving measures specific to PASRR, stability and community integration. The SME is also recommending that LDH develop their Annual Quality Report. This will be the first such quality report for the My Choice Program. The State should provide this plan to the My Choice Advisory Committee during the next reporting period and present the plan to a larger stakeholder forum prior to posting the plan on the LDH website by November.
- Contracting for the necessary tracking systems to meet the requirements of the Agreement. In particular, the State should have the necessary systems to not only support their quality assurance efforts, but also, more importantly, identify individuals in the Target Population within three days after admission into an NF. The SME continues to be frustrated with the lack of progress in this area. As the Agreement enters its fourth year it will be very difficult to fulfill this requirement but more importantly identify and intervene early with individuals who are in the Target Population to offer and assist with transitions.
- Developing and implementing activities that will allow the new services to commence January 1, 2022. There are three crisis services, a statewide crisis hot line, employment supports, and personal care assistance, in addition to community case management (discussed above). The SME recognizes and commends the State in their efforts to develop a detailed workplan for its crisis services and crisis line rollout. They have also developed several weekly meetings to discuss and review implementation activities and progress. The State has also undertaken the necessary steps for the other services. They are in the process of meeting with Medicaid and other agencies in their efforts to finalize Medicaid authorities, reimbursement strategies, and MCO contracts that will include a network development strategy for a go-live date of January 2022.

- Developing and implementing recommendations set forth in the LDH Needs Assessment and the SME Service Reviews. LDH has begun to address several of the recommendations in the SME Service Review report, including developing the necessary forms (assessment and planning) for community case managers and messaging expectations to MCO case managers and service providers to circulate service or care plans among key providers and Transition Coordinators (initially and when a change occurs).

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 the State's progress in these areas. The report also includes recommendations by the SME for the State to address in the next reporting period. The report also assesses LDH's progress in completing activities in the CY 2021 Implementation Plan that can be found at <https://ldh.la.gov/assets/docs/MyChoice/LA-LDH2021AnnualImplementationPlan.pdf>. In addition, this fifth SME report includes findings from the LDH Needs Assessment and the SME's Service Review.

II. 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.

Paragraphs 24 through 26 are combined. As one of the initial activities, LDH created 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 whom the MDS identified as having an SMI, but no PASRR Level II screening was performed to determine if they are 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. During the reporting period ending 6/30/2021, the SME reviewed the criteria the State has developed to determine how an individual is identified to be included in the Master List. The criteria that have been developed list various pathways in 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, provide a reasonable strategy for identifying individuals for the Agreement.

In the previous SME report, 2,944 individuals were included in the Master List. As of June 2021, 2,825 individuals are on the Master List. An additional 724 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.

During this reporting period, the SME requested information from the State regarding activities that have been completed to meet the requirements of this paragraph. Per LDH, individuals who have SMI but are not in the Target Population may request and receive some existing and some new services that are set forth in the Agreement, including Mental Health Rehabilitation Services, outpatient mental health services, substance use disorders under the State's 1115 Demonstration Program, and, more recently, Peer Supports. Available services and processes to access these services are dependent on payer source. For instance, individuals with SMI who are enrolled in the Medicaid program may receive the current array of existing and new Medicaid services. These individuals must maintain Medicaid eligibility and meet the medical necessity criteria established by the State or their contracted Managed Care Organizations (MCOs) to receive these services. For services managed by LDH (e.g., services in the Community Choice Waiver), the individual must apply and be determined to meet eligibility criteria set forth by the State.

For individuals who seek behavioral health services, the MCO case manager or behavioral health provider seeks authorization (as necessary) from the MCO to determine if the individual meets medical necessity criteria. If an individual is denied participation in the Waiver or is denied services from their MCO, LDH has the required processes for the individual to appeal that decision. If an individual is not Medicaid eligible and has an SMI, the individual will be encouraged to enroll in the Medicaid program. If the individual is determined to be ineligible for the State's Medicaid program, LDH has the required processes to appeal that decision. If found ineligible, the Office of Behavioral Health (OBH) will refer the individual to a Local Governing Entity (LGE) for services and supports. The array of services and supports available to those individuals without Medicaid is dependent on the services offered by the LGE and the availability of funding for expanded services beyond that which they are mandated to provide.

III. 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 to 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 State's plan can be found at <https://ldh.la.gov/assets/docs/MyChoice/DiversionPlan.pdf>. The State's plan initially focuses on the following populations:

1. Persons with SMI who seek admission to an NF placement who meet NF Level of Care (LOC) criteria for whom a PASRR Level II review recommends placement in the community and therefore were not admitted to an NF
2. Persons with SMI who are admitted to an NF on a temporary basis and could be transitioned into the community within a short period (90 days)
3. 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 who were homeless and with serious mental illness (including individuals with co-occurring substance use disorders (SUD)).

LDH is making revisions to the 2019 Diversion Plan and considering whether to include the second population (persons admitted to an NF on a temporary basis) in the plan or include these individuals in the Transitioned Population. In addition, LDH is determining whether and how to accurately identify individuals who were homeless and had a serious mental illness.

As set forth in the CY 2021 implementation plan, the State was to develop a long-term diversion strategy "to increase the number of diversions," similar to the aggressive long-term transition strategy, and develop diversion targets consistent with that strategy. The State has taken some initial steps to develop this plan (e.g., reviewing PASRR Level II decisions and finalizing the definition of "at risk") and is scheduled to have this plan completed in the next reporting period.

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 and strategies for decreasing referrals for individuals with SMI to nursing facilities. For Calendar Year 2020, LDH projected 156 diversions. These projections were based on the State's data and experience with identifying populations 1 and 2, above, in CY 2019.

The State reported a total of 277 diversions in CY 2020, which was greater than projected. This increase was due to a significant increase in the number of individuals who were identified as experiencing homelessness and having an SMI (who are part of Population #3). This increase was also due to the pandemic and the State's efforts to test, triage, and aggressively house individuals who were homeless, preventing them from returning to congregate shelter settings. The State should be commended for these efforts. In order to evaluate whether these 277 individuals should be considered "diverted" for purposes

of this Agreement, the SME requested and received Medicaid claims information regarding these individuals to determine if they had characteristics that were comparable to individuals in the PASRR Level II diversion population, or the at-risk population discussed in paragraph 30 of the Agreement. The information provided by the State indicates that approximately 75% of the individuals who were homeless and had behavioral health conditions did not meet the State's most recent diversion or at-risk definition. For instance:

- Of those 252 who were identified as homeless, 241 could be matched to CY 2020 Medicaid eligibility records.
- Of those 241, there were 198 individuals with at least one behavioral condition.
- Of those 241, there were 66 with at least one physical condition.
- Of those 241, there were 86 who had at least six Emergency Department (ED)/Inpatient Hospital (IP) visits.

However, there was insufficient data to determine if these individuals had a co-morbid condition or met the threshold of having at least six ER visits or inpatient admissions (all cause). Many of these individuals were dually eligible for Medicaid and Medicare and therefore claims regarding their health and ED visits or inpatient admissions were not available to determine if they met the at-risk threshold. The SME recommends several steps for the next reporting period to more accurately count diversions and to identify individuals who would benefit from community case management:

- Reviewing Medicaid claims data to determine if some of these individuals were admitted to a nursing facility over the past three to five years (depending on whether data is available). Also, consider reviewing Medicaid claims information for individuals who are younger than 50 (this group represented about 40% of the individuals in the SMI homeless population).
- Consider information from the Louisiana Housing Corporation, Service Prioritization Decision Assistance Tool (SPDAT), which collects information from individuals on the same domains as the Agreement (physical health well-being, meaningful daily activities, self-care, and social relationships). This information could serve as a proxy to determine if these individuals would likely be at risk for the Target Population.
- Consider collecting information during the re-housing process to identify whether these individuals were at high risk for a nursing facility placement. While a look back at the SPDAT information may be helpful, LDH and LHC should develop a process for identifying these individuals at referral based on existing data collection.

During the third reporting period, LDH developed diversion projections for CY 2021 based on a similar methodology used for 2020. LDH identified the number of individuals who sought NF admission in CY 2020, but the PASRR Level II evaluation did not recommend NF placement. Given that PASRR Level IIs were completed for only 6 months this past year due to the pandemic, LDH had to annualize this number over a 12-month period for CY 2021.

LDH met internally to determine the number of individuals who had an SMI and who were experiencing homelessness. Original projections for 2020 were determined prior to the COVID pandemic, considering both the vouchers available and prior experience at the time with outreach. A target of 50 individuals was projected for 2021, consistent with the number of Non-Elderly Disabled (NED) vouchers that would be available for this population. As indicated in the previous report, the SME agrees with the methodology the State has set forth for these two groups. The following table provides the projected diversions and the actual diversions as of June 1, 2021.

Population	Projected Diversions for CY 2021	Actual Diversions (to date)
#1 PASRR II Recommendation	144	36
#2 Experiencing Homelessness	50	127
Total	194	163

The reported total diversions for this reporting period was 163 individuals. Thirty-six individuals were diverted based on PASRR recommendations, representing approximately 22% of the overall diversion. Individuals who had an SMI and were experiencing homelessness totaled 127 and represented 78% of the reported diversions. The percent of diversions based on PASRR Level II recommendations is 25% of what is projected for the calendar year. The SME is requesting LDH to provide information on the reason for lower diversions than projected and to provide a strategy for increasing the number of PASRR Level II diversions early in this reporting period. In addition, LDH is reviewing whether and how to identify individuals who are homeless and have an SMI as part of their diversion projections. The reported number far exceeds the projections for these individuals. While the SME applauds the State's efforts to house these individuals and provide them the necessary supports, the SME is concerned that many of these individuals may not have service needs that are consistent with the Target Population.

In the previous report, the SME recommended the State develop projections for the at-risk group (discussed in paragraph 30 of the Agreement) and track the number of individuals in CY 2021 who were admitted to an NF during the year. This will allow the State to develop a baseline to determine whether the MCO strategies that will be developed in CY 2021 for providing MCO case management for these individuals is effective in reducing the number of at-risk individuals being admitted to inpatient hospitals, which account for 80% of all NF referrals. The State developed projections for the at-risk population. These projections were based on the criteria developed by LDH to define the at-risk group. The criteria required the individual to have at least one physical health condition, at least one behavioral condition, and at least six ER visits or inpatient hospital (all cause) admissions within the last twelve months. The State projected there were 7,150 individuals that met the criteria in CY 2020. LDH met with the MCOs during this reporting period to discuss these projections and requested they provide information regarding the number of individuals at-risk receiving MCO case management. Specifically, LDH required each MCO to develop a plan for serving the at-risk population, including:

- Engaging members and linking them with an MCO case manager
- Assessing their needs and linking them with services/service providers to address those needs
- Ongoing monitoring and follow-up to ensure appropriate access to care, quality of care, and member health and safety
- Tracking members and member outcomes
- Reporting data in accordance with LDH-issued reporting templates.

The SME recommends LDH develop a strategy to evaluate the effectiveness of the MCOs' efforts to address the needs of individuals in the "at-risk" population. At a minimum, the State should review changes in the number of ED visits, inpatient admissions, and NF admissions or re-admissions.

As discussed in the previous SME report, during this reporting period, LDH was to implement an interim case management strategy for individuals who were diverted from NFs based on a PASRR Level II evaluation. The State opted to track the MCO case management efforts for this population while they

continued to design the longer-term community case management benefits for these individuals. These efforts are discussed below.

The State has developed the various strategies needed to provide case management for individuals who are diverted (based on PASRR Level II evaluations), are homeless and have an SMI, and who are at risk of becoming an individual in the Target Population. As indicated in the previous SME report, strategies undertaken in other jurisdictions put in place at the MCO and provider level prevented avoidable hospitalizations. This includes identifying and triaging these individuals using a multidisciplinary team that identifies and addresses prevailing medical and behavioral conditions for this population. States have also deployed other efforts to address these individuals' health and behavioral health needs, including intensive care coordination, health promotion, and individual and family support to provide education regarding various conditions and preventive measures that individuals and their support systems can implement to prevent emergency and inpatient hospital admissions. The State has undertaken the following actions during this reporting period:

- Finalized an approach to provide case management services for individuals who are diverted, defined as individuals where the PASRR Level II evaluation did not authorize nursing facility placement. The State will develop community case management services for these individuals that will be offered by community agencies (versus MCOs) in CY 2021. This approach is similar to the approach for the transitioned population discussed in Paragraph 61. As indicated above, the State is also reviewing the definition of other individuals in the diverted population (e.g., individuals with SMI who experience homelessness).
- Developed a Department of Justice Compliance Guide for MCOs that sets forth the expectations of the State for case management for the Target Population and individuals at risk of being in the Target Population. This Compliance Guide requires MCOs to offer case management to these individuals, especially individuals who are at risk for becoming members of the Target Population.
- Implemented reporting processes that provide more detail regarding the MCOs' efforts to perform various case management functions (assessment and planning) for the Target Population, specifically for individuals who have been transitioned and diverted. These reports are discussed in further detail in paragraph 88. These new reports should enhance LDH's efforts to more closely monitor the MCOs' endeavors to provide case management to individuals who are in the at-risk population. The State states that they review these reports to confirm that the information is correct (e.g., the individual has a behavioral health diagnosis), that assessments and plans of care are being completed on a timely basis, that cases are not continually open with no engagement. LDH requests clarification from the MCO regarding this data or takes any necessary action to ensure compliance. For the next reporting period, the SME is requesting these reports as well as any information LDH is reviewing to determine the effectiveness of the MCO's at-risk implementation efforts.
- Completed initial and ongoing analysis of data for the members of the Target Population who were diverted from NFs (using the PASRR Level II criteria). The SME assessment of this data from the LDH Needs Assessment is discussed later in this paragraph.
- Finalized the at-risk definition. As described in Paragraph 29 of the fourth SME report, this definition was developed based on an analysis of the members of the Target Population who were admitted to a nursing facility in CY 2018.

The SME believes the State's approach to providing case management services for individuals who are diverted (defined as individuals where the PASRR Level II evaluation did not authorize nursing facility placement) is consistent with other states' case management strategies, as well as LDH's strategy

developed earlier this year. In the previous SME report, it was recommended that the State have clearer referral processes for these individuals to ensure timely engagement with community case managers. Specifically, the SME recommended that a referral to case management should occur immediately after the individual is identified through the MCO's PASRR II process. Immediate engagement will improve the likelihood that an individual will receive the services they need to prevent possible future admissions but, more importantly, receive the services and supports they request and require to live successfully in the community. During this reporting period, the State has included in the Community Case Management (CCM) design a process to ensure that the individual is referred immediately from the PASRR Level II evaluation, even prior to OBH final determination.

As indicated in the last SME report, data provided to the SME from LDH for the members of the Target Population who were diverted from NFs (using the PASRR Level II recommendation) or other populations to be determined by the State indicated high variability across MCOs in the number of individuals who were diverted, were offered case management, and actually received case management. The variability of this approach did not allow the MCOs to report data to the LDH similar to information collected on individuals who had been transitioned from NFs (e.g., services received consistent with the individual's plan, participation in service planning meetings, etc.). The State has revised their reporting process to collect information on MCO case managers' activity on individuals who were transitioned from nursing facilities and individuals who were diverted from nursing facilities. As indicated in paragraph 88, there is still some variability regarding the level of engagement of these individuals in MCO case management. However, there are marked improvements with some plans' engagement efforts.

The SME has received and reviewed information from LDH regarding the MCO's case management effort. This is discussed in more detail in paragraphs 61 and 88. The SME recommends the State and MCOs continue the data collection and analytics discussed in this section to assess the efficacy of the MCOs' case management strategy that will be necessary for individuals who are at-risk of being in the Target 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. The SME is requesting information on any follow-up activities MCOs are requested to take based on LDH review of data provided on the diverted and at-risk population.

In the previous report, the SME recommended LDH continue to meet with the MCOs to assertively develop and implement the case management approach for the diversion and at-risk populations. Specifically, the SME recommended that LDH direct the MCOs to develop specific strategies by June 2021 to operationalize their case management strategy to address the chronic conditions for these individuals in the at-risk group. As indicated previously in this paragraph, the State met with the MCOs and provided specific guidance regarding their case management efforts for individuals in the at-risk group. The SME is requesting information from the State regarding the results of the MCOs' effort with this population in the next reporting period.

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 part of the 2020 Implementation Plan, LDH was to undertake several steps to work with referral sources, including 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)
- Developing and implementing diversion strategies (October 2020).

To date, LDH has not developed nor implemented a system to identify and divert individuals from 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 versus hospitals directly to prevent avoidable hospitalizations. These strategies were put on hold based on the SME's recommendation in the last report, in order to shift focus to avoidable hospitalizations.

The SME continues to believe 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. In the most recent SME report, the SME recommended LDH 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 has not undertaken an analysis of hospitals with higher rates of referrals and has not met with the MCOs and hospitals to review this data and to develop strategies to reduce these referrals. The SME recommends LDH complete these activities in the next reporting period.

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. The strategies the State identified to improve the PASRR screening process included changes to the PASRR Level I referral process that provided training to Level I screeners to improve the identification of individuals with SMI through the PASRR Level I screening, including reviewing in real time diagnosis information from the MDS. The State is reporting that improvements in screening will be included in the process that will be used to develop the tracking system for identifying individuals in the Target Population who were admitted into an NF within three days. However, the tracking system will not be operational until early CY 2022.

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 evaluation are asked about their interest in and need for community services, and are provided information about community options at the time of the screening. The SME has not yet reviewed the specific strategies and processes that the independent evaluator uses to discuss these options. The third and fourth SME reports requested 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 again deferred this request until the next reporting period as part of a broader strategy to review the whole PASRR Level II evaluation process.

In addition, 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 has met with the State to develop a process to review the practices of the MCO PASRR Level II evaluators use when implementing this requirement, including a possible oversight process to conduct an independent review of supporting documentation and admission decision using the PASRR Level II evaluation to support the admission decision. It is expected that this process will be finalized and commence implementation during the next reporting period.

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.² LDH revised the form in response to the PASRR Technical Assistance Center (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, the LDH Office of Aging and Adult Services (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 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 State is proposing to continue their training efforts for PASRR Level I reviewers this calendar year once changes are finalized for the tracking vendor. The State indicates the tracking vendor will need to train staff that complete Level of Care Eligibility Tool (LOCET) and PASRR Level I once changes to the tracking system are complete.

The SME was not involved in the 2018 revisions to the PASRR Level I and did not participate 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 initiate a third-party review and revise this tool. The SME continues to

² <http://ldh.la.gov/assets/docs/OAAS/PASRR/NFA-Level1-PASRR.pdf>

recommend that LDH perform the necessary data analytics to determine if there was a change in the number of individuals who were identified as having a mental health diagnosis through this screening and to determine if the changes recommended by PTAC had the desired effect. In the previous two SME reports, it was recommended that the State track information regarding the number and percent of individuals who are identified as having an SMI during the PASRR Level I evaluation. The State should compare this number and the percent of individuals identified as having an SMI through the PASRR Level I tool prior to the data from June of 2018 to determine if the change in the PASRR Level I screen and training were effective. The SME has not received this information from the State.

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 independently of the NF and the State. LDH has implemented policies and incorporated specific requirements within its Medicaid managed care contracts to ensure timeliness of the evaluations. 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.³ 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 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. 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. As indicated in the third report, the SME was involved in the review of the revisions to the PASRR Level II evaluations and enlisted the support of PTAC in the review. The SME made recommended changes and 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.

³ LDH Legal Memorandum "Provision of Required Documentation for the Purposes of PASRR", 12/4/2017, available at https://ldh.la.gov/assets/medicaid/hss/docs/ALL_Prgms/HIPAA_and_PASRR_120417.pdf.

According to LDH, and as set forth in the current MCO contract, the Medicaid MCOs continue to offer trainings to their affiliates and representatives that perform PASRR Level II evaluations. As indicated in the previous two SME reports, LDH has also developed directories for community-based resources available to individuals referred for PASRR evaluations. Ongoing efforts are made to ensure these directories are maintained and updated with current listings of available services within the behavioral health service array. The State also reports that during meetings with MCOs, LDH staff integrate discussions on available community resources. Of note, during the December meeting, a representative from OAAS participated and reviewed the array of services available through their network, including eligibility criteria and how they are accessed.

The SME requested and received the most recent PASRR Level II training materials during this reporting period. A review of the training material by the SME and the SME team found the presentation to be fairly process oriented and did not convey substantive information on how to best determine if an individual should be denied admission to a nursing facility. For instance, there is only one slide that discusses denials and there was limited resource information included in the training package. There was no reference to working specifically with Transition Coordinators for individuals who were residing in nursing facilities and who required a PASRR Level II for continued stay or for annual reviews. The SME recommends the training be revised to address some of these deficits. The training should also be revised based on findings from the process recommended in paragraph 32 (a review of current PASRR Level II evaluator practices).

In addition, the SME, as part of the PASRR Level II review process, will meet with PASRR Level II evaluators to discuss their approach for confirming that individuals have an SMI and their approach for identifying housing options and necessary services and supports. The SME also recommends that LDH develop an oversight process for the MCO PASRR Level II evaluators and the LDH PASRR Level II staff who make the final determination regarding an NF admission. This oversight process should include an independent review of supporting documentation and admission decision using the PASRR Level II evaluation to support the admission decision. The review should also include how the reviewer identifies the services and supports necessary to live successfully in the community and the options for where the individual might live in the community.

As indicated in the 6/30/2020 report, the State, due to the COVID-19 pandemic, suspended PASRR processes for new admissions to nursing facilities in late March 2020. The State must request a waiver from CMS to suspend PASRR screenings and evaluations. The State also requested a similar waiver several times during the last reporting period that extended into this reporting period. These waivers were requested due to CY 2020 hurricanes and increases in the number of individuals with COVID-19. LDH was granted permission by CMS to suspend these reviews. The last waiver was lifted as of March 2021. Due to these waivers, many individuals who were candidates for a PASRR Level II did not receive the Level II evaluation prior to admission to an NF. However, LDH continued to use a process for tracking individuals who were admitted to nursing facilities who did not receive a PASRR Level II evaluation during these waivers.

As indicated in paragraph 37, individuals admitted to a nursing facility are only provided a 90-100 day initial authorization. If/when an individual requested a continued stay at the end of the initial authorization period, OAAS refers these individuals to OBH for a subsequent PASRR Level II evaluation during the CSR process. Therefore, LDH would be able to identify individuals who were in the Target Population through this PASRR Level II evaluation rendered as part of the CSR process. During this reporting period, 16,601 individuals were admitted to a nursing facility and received a PASRR Level I. Of these individuals, 1,607 requested a continued stay. Of these 1,607 individuals, 697 individuals were

referred for a PASRR Level II evaluation to determine if they would be possibly included in the Target Population. Of these 697 individuals:

- 391 were determined not to need a PASRR Level II.
- 274 were approved for a continued stay and were added to the Target Population list.
- 1 was denied a continued stay and was considered for the Diverted Population.
- 31 individuals had no decision at the time of this report.

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 them to 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. These steps were documented in the fourth SME report (12/2020).

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. In the previous SME report, it was recommended that the State continue to request information regarding the findings of these reviews to determine the prevalence of individuals with dementia who have been identified by the psychiatrist, to determine if these findings may be within what are considered norms in other states. The State has new OBH leadership in the PASRR program and will be requesting this information from other states or from PTAC.

LDH has developed training on its dementia diagnosis verification policy. In 2019, the SME reviewed the training and provided additional content language. 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 if they should be included in the Target Population. The SME recommendations were included in the dementia diagnosis verification policy. In the last two SME reports, data was requested regarding 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. This request is being deferred to the next SME reporting period.

During this reporting period the SME met with the LDH psychiatrist who reviews all individuals who are in the Target Population, are admitted to a nursing facility, and have a dementia diagnosis. The psychiatrist verifies that a dementia diagnosis determines whether the individual would benefit from behavioral health services. While individuals are not re-reviewed for dementia, the psychiatrist did identify several conditions that may benefit from a review, including a substance use disorder (especially alcohol disorder) and other medical conditions. It was also discussed that individuals who have a dementia diagnosis need to be re-reviewed in a year. Therefore, the SME recommends that the LDH psychiatrist re-review individuals with dementia, who have certain physical and behavioral health conditions, on an annual basis. Over the next reporting period the SME requests that LDH develop an approach to these reviews.

Finally, LDH has been tracking in real time the number of individuals who have transitioned and have been readmitted to nursing facilities. In discussions with the SME and DOJ during the last reporting period, the State intended to begin 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 the individual's need, to support the array of services available for the Target Population. For this reporting period, the State reports that there were two long-term admissions into NFs. The SME is requesting information for LDH regarding these admissions and what information from these admissions LDH can use to learn from and apply to possible future long-term admissions.

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 level of care (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.

LDH implemented new regulations to make changes to the behavior pathway effective May 2018.⁴ LDH and DOJ agreed that admission to an 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 the behavior pathway eligibility criteria. Residents lose their "grandfathered" status if they no longer meet the behavior pathway, are discharged from the facility, or meet 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.

The SME requested information from LDH to determine if individuals with a sole diagnosis related to behavioral health (BH) have been admitted to NFs since 2018. Initially, the SME discussed with the State how information from the PASRR Level I and II evaluations and completed MDS could be used to identify whether an individual with an SMI was admitted to an NF with no underlying physical health condition.

⁴ Louisiana Administrative Code. Title 50, Part II, Subchapter G. Section 10156(I)(1)-(2).

This would be a proxy to determine if the elimination of the behavioral health pathway was implemented. Per these discussions, information from the PASRR Level I or II does not provide the information regarding other health conditions and was not a good source of information. The MDS does collect information on diagnosis, including behavioral health diagnosis. In the last reporting period, the SME requested information from MDS data to identify if anyone was admitted to an NF in CY 2020 who had only a BH diagnosis. The State reports that two individuals in CY 2020, with a sole diagnosis of behavioral health, were admitted to an NF. Both individuals discharged within two weeks of admitting. OAAS, due to quick discharge, is unable to obtain NF LOC information to determine which pathways were met post NF admit.

The State reports there are no individuals in CY 2021 with a sole diagnosis of behavioral health admitted to an NF.

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 evaluation process for NF admissions for all individuals, including members of the Target Population and individuals who would be members of the Target Population if they were admitted to an 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. OBH now requires a temporary authorization for all individuals where the PASRR Level II confirms that they have an 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). This timeframe does not exceed 365 days for those individuals who are already residing in an NF. As indicated in the last SME report, 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. The SME requested information regarding the percent of individuals in the Target Population admitted since January 2021 who received a short-term authorization request. The State has reported that 100% of authorizations issued for this reporting period do not exceed 90 days (or 100 days for persons approved for convalescent care). LDH should develop a strategy to evaluate the effectiveness of the CSR strategy. This next reporting period will mark the first year anniversary of this policy that should provide data to measure the effectiveness of this change.

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.

As indicated in the previous SME report, NFs are required to submit continued stay requests (CSRs) to OAAS at least fifteen days before the authorized temporary admission ends. LDH created policies and criteria for individuals who will be provided a continued stay past the initial 90 or 100 days.

The State's CSR process reviews activities of daily living (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 an NF, OAAS regional staff visit the facility for an onsite review. All individuals requesting a CSR 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. If the individual is evaluated through the PASRR Level II as being a member of the target Population, they are assigned a Transition Coordinator who undertakes in-reach and a Transition Assessment to determine interest and supports needed for an individual to move to the community. The SME requested and the State provided additional information regarding the process for TCs to engage individuals where a continued stay request has been performed, regardless of whether the individual continued to meet nursing facility level of care. This included information regarding the role that OAAS and OBH have in making continued stay recommendations.

The fourth SME report provided a description of the CSR process LDH has developed for individuals in the Target Population and delineates the role of OAAS and OBH.

In the previous report, the SME recommended that LDH continue to collect and analyze data regarding the number and percent of individuals in the Target Population who have requested a continued stay and the percent of individuals who have an approved and a denied continued stay. The table below reflects the dispositions of all Continued Stay Requests for the Target Population during the time period from January 1 to June 30, 2021.

Target Population Decisions	Count	Percent
Approved	274	39.3%
Denied	1	.1%
Level II Not Required	391	56.1%
No Decision	31	4.4%
Total⁵	697	100.00%

After reviewing this information, the SME met with LDH and expressed concern regarding the high approval rate and low denial rate. LDH did not share the same concern since LDH believed that many newly admitted individuals in the Target Population were discharged prior to the expiration of their initial 90 day authorization. The SME requested and received information for the next reporting period regarding the number of newly admitted individuals in the Target Population who were discharged prior to the expiration of their initial 90 day authorization. Data reviewed for the period 1/2021 through 6/2021 found that 91% of all newly admitted individuals in the Target Population were discharged prior to the expiration of their initial authorization. As indicated in paragraph 34, approximately 1,607 individuals (9%) requested a continued stay review. While this data did indicate a significant number of individuals who were discharged prior to 90 days, the SME still has concerns regarding the low denial of PASRR Level II individuals given denials for admission are between 6-8% of all individuals at admission. The SME recommends the Department continue to report this CSR information and discuss strategies for improving potential denials using the PASRR Level II during CSR requests.

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.

⁵ This is not an unduplicated count; individuals may have received more than one CSR.

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 several scenarios when an individual receives a PASRR Level II:

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

The SME, in the previous report, has requested information over the past year regarding the number of individuals in the Target Population who received a PASRR Level II based on each of these scenarios. In discussions with the State, information for several of these scenarios is not readily available in large part due to the lack of existing fields in the UTOPIA system used to collect PASRR Level II data. For instance, the State does collect information regarding the number of PASRR Level II that are performed upon an initial request for an NF admission. The State also collects information regarding PASRR Level II evaluations based on initial and subsequent continued stay requests or resident reviews. The data does not differentiate whether these reviews were annual resident reviews or reviews due to a significant change in an individual at a facility. The State is in the process of making changes to the UTOPIA system and, in discussions with the SME, is adding the necessary fields to collect data that differentiate between various resident reviews. Changes in the UTOPIA system in addition to information from the existing OPTS system and information from Medicaid claims will allow LDH to collect the following information:

- The number and percent of individuals who are admitted to Nursing Facilities who have a PASRR Level II upon admission.
- The number and percent of individuals in the Target Population who have a recent (within the past year) annual review.
- The number and percent of individuals in the Target Population who had a PASRR Level II (within the past year) due to a change in medical condition.
- The specialized services recommended by the PASRR Level II for:
 - New admissions (number and percentage for each service)
 - Ongoing stays (annual resident review--number and percentage for each service)
- The number and percent of individuals (new admissions and ongoing stays) who received each service.

The changes were not developed and tested in this reporting period. It is anticipated that these changes will occur later this summer. Once these changes have been implemented, the SME is requesting an analysis of the different scenarios for how and when an individual receives a PASRR Level II evaluation and the resulting disposition (e.g., discharge, provision of behavioral health services).

The SME requested and received information on the number of individuals who are in the Target Population who have received an annual resident review for FY 2019 and FY 2020 (to date) and were admitted to an NF prior to 2018. The State provided several analyses. The first analysis is the number and percent of individuals on the Master List who were admitted prior to the start of the Agreement and have received a PASRR Level II prior to August 2020 and before June 2021. The table below provides this information.

Received PASRR Level II	As of 8/1/2020	As of 6/1/2021
No	21.66%	6.01%
Yes	78.34%	93.99%
Total	100.00%	100.00%

As this table indicates, over 78% of the individuals on the Master list as of August 2020 had received a PASRR Level II. The State reported that the remaining 22% did not receive a PASRR as of last August (2020). In the fourth report, the SME requested a further analysis of this PASRR information by year for individuals on the Master List who were admitted prior to the beginning of the Agreement and who received a PASRR Level II. Information provided by the State indicated that approximately 94% of individuals admitted before the start of the Agreement received a PASRR Level II evaluation, a 20% increase from the last reporting period.

It is recommended that the State track whether these individuals received an annual review (versus an initial review) once the reporting system referenced in this report becomes operational. This will allow the State to meet the commitment to ensure that everyone in the Target Population receives an annual PASRR Level II and, more importantly, to identify the ongoing specialized behavioral health needs for these individuals. The annual PASRR Level II evaluation will also allow LDH to have an additional “touchpoint” with the individual regarding community alternatives and gauge possible interest in transitioning from the NF.

In the previous SME report, it was recommended that the State identify individuals who are on the Master List, who were admitted prior to the beginning of the Agreement and who did not receive a PASRR Level II. The PASRR Level II would identify whether the individual had an SMI and would be a trigger for starting the in-reach and transition process. The revised in-reach process will expedite the identification of individuals who are interested in transitioning rather than waiting for an individual to receive a PASRR. However, the new in-reach process does not negate the need for a PASRR Level II. The SME continues to recommend that these individuals receive a PASRR Level II to identify any specialized services and support the individual may request while they are currently residing in the NF as well as provide an additional touchpoint regarding community alternatives and interest in transitioning.

The State also provided the SME with information regarding the number and percent of individuals on the Master list admitted after the start of the Agreement who have received a PASRR Level II. Information regarding these individuals is provided in the following table.

Received PASRR Level II by Year of Admission					
Received PASRR Level II	Admit Year				
	2019		2020		2021 (to date)
	12/2020	6/2021	12/2020	6/2021	6/2021
No	14.21%	7.09%	23.28%	10.21%	13.7%
Yes	85.79%	92.91%	76.72%	89.79%	86.3%
Total	100%	100%	100%	100%	100.00%

As this table indicates, the number of PASRR Level II evaluations for individuals on the Master List admitted in 2019 and 2020 has increased by 8%. Seven (7) percent of individuals admitted to an NF in FY 2019 still did not receive a PASRR Level II evaluation. The percent of individuals receiving a PASRR Level II evaluation increased by 17% during this reporting period. The SME is encouraged that the State has increased its PASRR Level II evaluation efforts and recommends they continue these efforts to perform an initial PASRR Level II on individuals in NFs who have not been evaluated and continue efforts to perform annual PASRR Level II for individuals that have received at least an initial evaluation.

IV. 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.

Please refer to the discussion in paragraph 39 regarding the State's efforts in this area.

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 is evaluating 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 reviewing a representative sample of individuals in the Target Population. The SME review is gathering information about individual experiences with transitions from NFs, participation in care planning, safety of placements, physical and mental well-being, 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. The SME's initial report on the first round of reviews is provided in Attachment A.

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 through the My Place program funded 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 them. 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 them further on an ongoing basis.

The State initially established 18 positions to assist with transitions. The State recruited, hired, and trained all Transition Coordinators (TCs). Currently, there are a total of 25 TCs; OAAS has 16 TCs and OBH has 8 TCs (OBH currently has a vacancy and is in the process of hiring an additional TC). The role of these Transition Coordinators is similar to those 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 for 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.

At the beginning of the Agreement, LDH reviewed information regarding the number of individuals in the Target Population who had a co-occurring intellectual and/or developmental disability (ID/DD) to determine if additional TCs were necessary for the Office for Citizens with Developmental Disabilities (OCDD). There was a very small number of individuals with co-occurring SMI and ID/DD. The State decided not to have specific TCs for ID/DD and to coordinate with OCDD program staff for services potentially needed by these individuals. LDH has indicated that it would revisit the need for OCDD Transition Coordinators if the number of individuals with ID/DD and SMI increased.

In the opinion of the SME, the State has created the required infrastructure needed to conduct the transition assessments, develop individualized transition plans, and assist individuals with the transition process. The SME performed an initial evaluation of the experience of members who were transitioned from NFs. This includes reviews of transition plans and the 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). While the State has created the infrastructure needed to conduct assessments and develop transition plans, there are improvements the State should implement to improve the quality of transitions. For instance, the SME recommended that LDH:

- Provide training and technical assistance to Transition Coordinators to fulfill their interim responsibilities to provide Intensive Case Management focusing on important areas established in the Transition Assessment, including services and supports that will enhance community integration (including employment) and medication information and adherence.
- Have Transition Coordinators focus on having regular team meetings with the individual, relevant support system (e.g., family/friends), and the various care coordinators and service providers.
- Provide training to Transition Coordinators on medication reconciliation and adherence monitoring.

- Message an expectation to MCO case managers and service providers to circulate service or care plans among key providers and Transition Coordinators (initially and when a change occurs). This will provide all parties with a more comprehensive view of the individuals' goals, services the individual should be receiving to meet these goals, frequency of services, and parties responsible for providing each service.
- Ensure that services that have been identified in the Transition Plan are available immediately at the time of transition.

This initial evaluation is discussed in the SME Service Review in Attachment A.

During this reporting period, the TCs continued to assume the role of intensive 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 who 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. Depending on the month, the TCs were providing interim case management for approximately 55 individuals in the Target Population who had transitioned from NFs. As interim case managers, the TCs were required to make regular weekly contact with the individual, continue to assess service needs and supports, and develop a community plan for these individuals. The frequency of interim case management activities were as follows:

- First 180 days: Minimum of 2 contacts per week (8 per month), at least 2 of which are face to face
- Every 90 days, 1 face to face contact / team meeting with all community partners
- 181 – 365 days: Minimum of 1 contact per week, at least 1 of which is face to face

As indicated in the SME Service Review report, the Transition Coordinator logs indicated frequent contact with the individual and provided good information regarding the status, challenges, and strategies the Transition Coordinator deployed to address service barriers. In addition, the State required TCs to assess each individual to determine the need for continued case management services beyond the initial year.

During this reporting period the TCs continued to provide most of their case management activities via the telephone given the pandemic. The State reports that all members of the Target Population who were active on the TCs' caseloads continue to have telephones and were contacted frequently during the pandemic. Over this past reporting period, in-person case management activities were provided by TCs for some individuals. LDH reported they continue to secure the needed Personal Protective Equipment (PPE) to protect both TCs and service recipients. In addition, many TCs and individuals on their caseloads have been vaccinated, increasing the number of in-person meetings. The SME anticipates that the frequency of in-person meetings should increase over the next reporting period. The SME will request information for the next reporting period from the State to monitor changes in meeting modalities.

During the SME Service Review, the review team found few individuals who were assessed for case management services beyond the first year. While the Agreement only requires case management to be available for individuals one year post transition, there was some discussion with LDH that individuals may need ongoing case management services. During the next reporting period, the SME recommends the State finalize a policy on case management delivered after the first year.

In the third report, the SME's assessment of this interim strategy did indicate that the TCs provided intensive case management but it should not be used as a long-term solution. As indicated in this report, TCs have other important functions that will be compromised if this is the long-term solution. The longer-term case management approach discussed in paragraphs 59-61 should be implemented in the next reporting period. This will allow the TCs to focus more of their energy on in-reach, education, and transition efforts that will be needed to meet the State projections to increase the number of individuals who will be transitioned in this upcoming year.

In previous SME reports, 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 is required to establish annual targets for successful diversions and transitions of Target Population members to the community. In October 2020, the State revised their targets for CY 2021 to significantly enhance the number of transitions from NFs. Specifically, the State has developed targets for CY 2021 that were based on critical assumptions rather than historical projections. The assumptions for the targets include:

- The number of individuals in the Target Population who currently reside in a nursing facility and are on the Department's Active Caseload list. Individuals on this list have a confirmed SMI (as indicated by a PASRR Level II evaluation) and have met the numeric threshold of the MDS Q+, which indicates a strong interest in moving.
- The percent of individuals on the Active Case list whom either continue to meet or do not meet nursing facility (NF) level of care.
- The average caseloads for the Transition Coordinators, taking into account the multiple functions (including providing interim case management) for individuals who are on the Active Caseload list.
- The estimated percent of individuals on the Active Caseload list who continue to indicate a strong interest in transition.
- The estimated percent of individuals who have significant transition barriers, impacting the number of individuals who will move in a given year.
- Length of time from application for the CCW Program to transition, for individuals on the OAAS Active Caseload list.
- The percent of individuals on the OBH Active Caseload list who do not meet the level of care but who have been in a nursing facility for more than 30 months and have effectively been grandfathered eligible for ongoing NF placement.
- The percent of individuals on the OBH Active Caseload list who do not meet the level of care but who have been in a nursing facility for more than 30 months and have continued to express an interest in moving.

Based on these assumptions, the State is aiming to transition approximately 219 individuals in CY 2021 (136 transitions by OAAS and 83 by OBH), a 119% increase from the projections in 2020. The State is to be commended on establishing these more aggressive transition targets. These numbers were largely derived by several factors, including:

- Estimating the number of individuals a TC can actively work with to transition over the course of a year
- The percentage of those individuals who, based on historical assessments, the State expects will be interested and able to transition (84%)
- The time it takes to transition (4-6 months after initial contact).

The State developed a revised transition process for CY 2021 that provided specific expectations for the transitions by the Transition Coordinator. They have also developed the necessary reports that will allow them to track individual progress towards these expectations.

The State has also communicated with each nursing facility the expectation that TCs are allowed to make in-person visits to individuals in nursing facilities, including individuals in the Target Population who have expressed interest in moving back to the community. Each Transition Coordinator was also provided documentation to provide nursing facilities information that addressed outdated COVID-19 protocols used by some facilities to prevent TCs from accessing individuals on their caseloads.

During this reporting period, the State transitioned 20 individuals, which is very disappointing since it is far less than the number projected for CY 2021. Transitioning an additional 200 individuals is highly unlikely for the next reporting period. The State cites continued concerns regarding the impact of the pandemic on the number of transitions during the first five months of the reporting period. The SME does not recommend the State revise their CY 2021 projections. Revising these numbers would lessen the pressure on TCs, nursing facilities, and others to increase transitions. The SME does recommend that LDH set forth a plan to remedy the pace of these transitions. This could include:

- Setting specific monthly targets for TCs to transition individuals from NFs.
- Considering a combination of all TCs to perform transitions regardless of the population they were initially responsible for transitioning. Some OBH Transition Coordinators have low caseloads and may have additional capacity to complete transitions.
- Monitoring TC activity at the LDH supervisor level to identify regions or areas of the State that may have fewer transitions, which may indicate greater barriers to transition. Once these barriers are identified, LDH should develop a process for rapidly addressing these barriers and proceed with transitions.
- Recreating the Status Tracker that will provide LDH with critical information to identify where individuals are in the transition process. This would prove to be a very valuable management tool for LDH executive and management staff to determine the progress of transitions and any “bottlenecks” the State may be experiencing regarding transition activities.

As indicated in the second and third SME reports, 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. The State has included an activity in the 2021 Implementation Plan to complete a methodology to develop these longer term targets in the next reporting period. The SME anticipates that these longer-term multi-year projections will be significantly

more aggressive than the current transition efforts. These projections should be part of a longer term transition plan that takes into account the demand on TCs to identify and perform these transitions and how the State will address and rapidly address the barriers identified during these transitions. The initiation of community case managers will allow the TCs to return to their initial functions (e.g., in-reach and transitions). However, LDH should identify if additional resources are needed to increase the number of transitions projected long-term rather than projecting transitions based on current staffing capacity.

The plan should also include enhanced in-reach efforts, including better motivational interviewing strategies and use of peers to assist TCs with in-reach efforts. The State has developed a longer-term in-reach plan that takes into account in-reach and engagement with all members of the Target Population to determine their interest in transitioning to the community. The State has developed and is deploying a strategy that will contact the 2,500 individuals currently on the Master List. This strategy is discussed in more detail in paragraph 89.

This new in-reach strategy will provide up-to-date information regarding the number of individuals on the Master List who express an interest in moving. The SME understands this number will not be static (some individuals who may initially express no interest may express subsequent interest with additional information or time, thus necessitating continued engagement with all members of the Target Population). The revised in-reach plan accounts for this variation and includes strategies for continued in-reach for individuals who have not decided to transition or who have not expressed an interest in transitioning.

The State has renewed in-reach efforts, which will provide them updated information regarding the actual number of individuals on the current Active Caseload list who continue to express interest in moving to the community. This should allow the State to assess the capacity of the TCs to work with individuals who are on the Active Caseload list to transition. Specifically, this should include an assessment of whether the TC workforce is sufficient to engage, assess, plan, broker the community resources, and transition individuals at a reasonable pace. It is very likely that the number of individuals on the Active Caseload list will increase due to these in-reach efforts and LDH will need to have additional TCs in CY 2022 to address these transitions. This strategy should also account for the decrease in case management activity in FY 2022 due to the presence of community case managers to provide ongoing assessment, planning, care coordination, and monitoring of services provided to individuals who have been transitioned.

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 first SME report, in July 2019 the State revised the assessment to be more person-centered and to 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 June 2021, 965 individuals on the Active Caseload (including those individuals who were transitioned) received a Transition Assessment. Of these 965 individuals, approximately 158 Transition Plans have been completed.

The previous SME report recommended that the State consider changes to the assessment and planning document to identify and account for an individual's co-morbid conditions. In reviewing the transition assessment, the document does account for co-occurring physical health and substance use disorder (SUD) co-morbidities. The SME reviewed a sample of transition assessments as part of the SME Service Review process to determine whether co-morbid conditions are being identified in the assessment and are included in the Transition Plan. Of the assessments reviewed, all identified physical health co-morbid conditions. The number of co-morbid conditions ranged from 3 to 27, based on the documentation reviewed by the SME. Some of these conditions were acute (lasting less than a month); however, most of the co-morbid conditions were chronic health conditions (heart disease, COPD, etc.). While it is difficult to determine the accuracy of these conditions, the TCs, through the assessment process, are identifying and documenting co-morbid conditions and are including services to address some of these conditions.

As indicated in the report in Attachment A, all individuals who were included in the service review had transition assessments and transition plans. In addition, the Transition Coordinators provided frequent logs regarding the transition of these individuals from the nursing facilities. There were a few takeaways from this review. The assessment and planning process always included the individual or caregiver (when appropriate). In addition, the review generally found that a team planning process included the individual as well as Transition Coordinator, nursing facility staff, MCO case managers, CCW support coordinator, and other individuals. Individuals that needed housing post-transition were offered and provided housing and supports. In most instances, these individuals were able to return to their communities as requested during the transition planning process. However, some individuals experienced housing instability post transition. In addition, TCs have begun to identify that individuals with greater mobility issues during the transition would benefit from additional accessible housing, which may not be readily available.

However, the quality of the assessments and plans varied. While all plans included specific services and supports needed for the individual to transition to the community, there was little or no information in key areas, especially community integration. Information regarding interests and hobbies was not always indicated on the assessment and therefore not included in the transition plan. In addition, many individuals' interests in employment were not indicated on the assessment and no individual had employment as a goal in the transition plan. It should be noted that several individuals who participated in the review expressed an interest in discussing and possibly pursuing work. As recommended in the SME Service Review Report, the State should develop and deliver training regarding important areas established in the Transition Assessment including services and supports that will enhance community integration (including employment) and medication information and adherence.

Some of the variability in the transition plan was directly related to the design of the transition planning document. Initially, the State used a transition planning template that was similar to the My Place template. This initial template, as discussed in this report, was inadequate to reflect the needs of the Target Population. After the first year of the My Choice Program, the State used their experience to make important changes to the template to better reflect individuals in the Target Population. While the transition plan is an improvement, there are still additional improvements the State should consider. Specifically, the SME requests revising the existing transition planning process to include detailed information regarding scope, amount, and duration of community services and supports that will be provided to individuals post transition. This could be included in either the transition planning document or a community plan that will be developed by the Community Case Managers later this year. The SME understands that it may be difficult to anticipate exactly what the individual may need post transition, but this initial plan will provide the individual, team members, and community providers with clarity regarding the referrals necessary to support individuals for the first 30 days of their community tenure.

As indicated in the third SME report, the SME reviewed previous and planned training used to develop the ITP to determine if the approach is person-centered. 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 the content of the training. During the previous reporting period, the State, in collaboration with the SME's team, revised the training materials. These new training materials specifically reframed the approach for TCs, MCO case managers, and other providers for engaging the individual during the assessment process (focusing on strengths and needs versus diagnosis and barriers) and to develop a meaningful process for working collaboratively with the individual to develop a transition plan. Initially, the materials and training were piloted with the TCs. Feedback from this pilot was incorporated into a revised version of the training materials. The State is in

the process of implementing a “train the trainers” approach for rolling out this training. In the previous report, the SME recommended this approach be finalized and implemented early in CY 2021. The State, during this reporting period, finalized the approach and began to implement this approach in this reporting period by providing training to the MCO trainers. The MCOs have developed a schedule for training community providers from July-November 2021.

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 individuals are admitted to a nursing facility. In the past three reports, the SME recommended the State solicit applications for vendors that will create the longer-term tracking system, including specifications for tracking members of the Target Population who are diverted from NFs. In the most recent report (December 2020) the SME recommended that LDH test and go live with the My Choice tracking module during this reporting period. The tracking module was to be created in the LDH Office of Aging and Adult Services (OAAS) Participant Tracking System (OPTS) that collects enhanced information on transitions. This will include training for TCs and others regarding the new system. Therefore, the State is not able to meet the 3 day and 14 day requirements in paragraph 45. Based on work that the State has set forth in its implementation plan for CY 2021, the State was to have this much-needed functionality in place by October 2021. However, based on contract delays, LDH has stated the tracking system will not be operational until early CY 2022. The SME continues to be frustrated with the lack of progress in this area given the Agreement is entering its fourth year.

In addition, it will be helpful to understand if and how individuals in NFs are afforded opportunities to visit community settings. The new in-reach process that is discussed in paragraph 89 should include how the State will use existing or new strategies for offering individuals opportunities to “visualize” what their life could look like once they transitioned from the facility. The SME is requesting specific information in the next reporting period regarding the process the State deploys to allow individuals an opportunity to visit potential housing options and the surrounding community, to better envision their lives post transition.

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 implemented the interim intensive case management strategy for individuals in the Target Population who 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, as part of the service review process, requested community plans of care for a select group of individuals. During the service reviews, it was discovered that an overall plan of care was not available for individuals who were transitioned.

In follow-up conversations with the State, they indicated these community plans were not a required activity for Transition Coordinators. Rather, most individuals had multiple care or treatment plans but not an overall plan that integrated services and supports into a single document that reflected the individual needs and provided the TC with a tool to ensure better coordination of services. As described in Attachment A, the lack of an overall community plan for the individual that knits together the goals, overall desires, and needs of the individual is a major concern. For some individuals, there were multiple plans: Transition Plan, MCO plan of care, CCW plan of care, and a behavioral health provider treatment plan. The plans were often not developed collaboratively nor were they shared or reviewed as a team. Without an all-encompassing plan aimed at achieving a clear set of goals and aligning an array of services in pursuit of these goals, it is challenging to assess progress for individuals in the Target Population and the service system as a whole. It also makes it very difficult to refine services in response to crises or other unexpected events or to employ consistent, complementary approaches across providers.

There was rarely documented re-assessment of the individuals' needs post discharge that would typically lead to a modification of each individual's plan and would address any changes in living environment, integrated day supports, or social needs that would support community inclusion. Given that there was not an ongoing comprehensive plan, there was no regular updated assessment that would account for an individual's recovery or for ongoing issues such as critical incidents or possible gaps in care. The service review team would generally expect to see an updated assessment of a community plan when significant events (crisis, hospitalization, and critical events) occurred, which many of the individuals experienced post-discharge.

In the next reporting period, the SME recommends that the State develop the various tools and protocols that will address this planning gap, especially for community case management.

The SME understands that assessments and plans for individuals post transition may take several months to develop. The SME is requesting these tools be tested and be ready for use by the new community case managers by the end of the next reporting period. The SME recommends that the State seek input from stakeholders regarding these new tools. In addition, the State has required the MCOs to develop a training curriculum for new community case managers on these tools and protocols by July 1, 2021. Due to contract delays, it is unlikely the State will meet this contract date. In addition to the new assessment and community plan, the SME recommended in the last report that the State develop protocols for community case managers. The State has developed these protocols and included them in the DOJ Agreement Compliance Guide. These protocols include:

- How individuals who are transitioned (and diverted) will be offered case management and ensured that they have a choice of case managers
- How the case manager will perform various engagement efforts prior to the transition and within the timeframes established by LDH
- How the case manager will work in cooperation with the individual, TC, nursing facility staff, and MCO care manager (if appropriate) in developing and implementing the transition plan
- How and when the case manager will conduct assessments and develop plans of care that are consistent with the person-centered training developed by LDH
- How frequently community case managers will have contact with the individual
- Processes for reporting contacts, critical incidents, and other pertinent information, and related processes for effective MCO and LDH monitoring and oversight, that will allow LDH to ensure the quality of services provided to individuals in the Target Population who have been transitioned or diverted.

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, four individuals who transitioned into the community were at risk of losing Medicaid eligibility post transition. These individuals will continue to be enrolled in the Medicaid program until the end of the pandemic. Over the duration of the program, a total of 18 individuals through OBH have lost Medicaid. However, two individuals who were projected to lose Medicaid were referred and participated in the Medicaid Purchase Plan. The State reported the following information regarding these individuals:

- Six individuals were applied for and were found eligible for the Medicaid Purchase Plan.
- Two individuals moved and left no forwarding contact information.
- One individual relocated to another area of the state and opted to discontinue receiving behavioral health services.
- Several individuals receive Medicare and continue to receive services covered under Medicare.
- One individual was approved for Permanent Supportive Housing (PSH) prior to PSH rule changes and continued to receive tenancy support, Community Psychiatric Support and Treatment (CPST), and Psychosocial Rehabilitation (PSR) through the PSH provider.

Given the increase in this number of individuals during the reporting period, LDH should develop clear pathways for making referrals for these individuals to LGEs for follow-up services. The SME is requesting information on whether these 18 individuals were referred to LGEs and if available, any information regarding their engagement in services provided or coordinated by the LGE.

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 period covered by the second SME 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. These barriers have been identified by Transition Coordinators, Support Coordinators, and MCO case managers over the course of the past three years. Separate meetings with LDH leadership and these individuals have identified the barriers, and in some instances, possible solutions to address these barriers. In addition, the Needs Assessment confirmed or identified barriers. Barriers that were identified for this reporting period, including:

- Developing relationships with individuals in the Target Population given restricted access to NFs
- NF staffing shortages making virtual meetings difficult to arrange
- Availability of accessible housing
- Transportation assistance, both for transportation within the 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 willing and able to assist in meeting the individual's post-transition needs

- Physical needs that do not rise to the threshold of meeting an 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 individuals 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
- Local Social Security Administration offices being closed, adding difficulty to getting award letters
- Non-cooperation from the NF in supporting transition activities
- Family concerns regarding the adverse consequences of the transition
- Ambivalence of individuals about leaving NFs and changing preferences about arrangements they want in the community
- Access to physical health preventive and specialty services in a timely manner to prevent utilization or over-reliance on emergency departments
- Identifying barriers to treatment for substance use disorders for individuals who have been identified as having previous or current substance use/misuse issues.

The State has made a reasonable effort to identify barriers. They have also developed and implemented processes for addressing these barriers across OAAS, OBH, and MCOs. According to the State, MCO case managers and TCs have developed more frequent and better communication strategies, which has allowed MCO case managers to assist TCs to better identify resources in the community for members who have been transitioned from NFs. This cooperation was noted in the service reviews conducted by the SME. The TCs and the MCO case managers often had regular standing meetings (quarterly or more frequently, as necessary). Additionally, in some instances and as needed, the different organizations meet with service providers to discuss the situation with the member in an effort to overcome barriers. The SME is recommending that the State provide specific strategies and progress for addressing each of the barriers listed above during the next reporting period. Many of these barriers have been perennial issues that have been identified by the SME in previous reports. Measuring the progress of the State efforts to address these barriers will be important for subsequent transitions.

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
- The nursing home recommended a housing setting that is not considered to be integrated.

During this evaluation period, LDH reported that no members of the Target Population who were interested in transitioning from an 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 who 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 engaged 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. In the last report, the SME requested information from the State to better understand how the provisions of this paragraph are operationalized. While this continues to be a request, the State has focused efforts on other areas. The SME will work with the State to obtain and review this information in CY 2021. This request has been deferred until the next reporting period.

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.

Paragraphs 54 through 57 are addressed together. As indicated in paragraph 25 and 26, LDH developed a Master List of individuals in the Target Population who resided in NFs at the beginning of the Agreement, using the methodology established in paragraph 54. TCs began the outreach process in July 2018 to identify a cohort of individuals who were more likely to experience a successful transition. During the previous reporting period, the SME requested 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 State reports that individuals were initially identified using information gathered from the MDS Q+ index and follow-up conversations with the Transition Coordinators.

In the third report, the SME requested information from LDH regarding the number of individuals on the Master List who have been contacted by a TC. The State reported that few, if any, individuals from the Master List were contacted this reporting period. The State has developed a more robust in-reach strategy for these individuals and committed to contact all individuals on the Master List who were admitted to a nursing facility prior to October 2020, over a year's period starting April 2021. Individuals who were admitted after October 2020 and who seek stays beyond 90 days will receive an in-reach visit by TCs per the revised continued stay protocol discussed in paragraph 38. The State's progress with respect to in-reach is discussed in paragraph 89.

As indicated in the past two reports, the State lacks the information systems and processes to meet the timelines for working with individuals at admission or having a face-to-face 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 State relayed that the system changes necessary for accomplishing this goal will be operational in January 2022. The SME continues to be perplexed on this delayed effort. June 2021 marks the fourth year of the Agreement. The State has provided multiple updates and reasons for this delayed procurement. However, this ongoing lack of tracking admissions is discouraging and should be remedied in the next reporting period.

In the meantime, the LDH is using information from SharePoint to monitor the progress of individuals on the Active Caseload who will be transitioning this year. Specifically, the State is tracking the following information:

- The average number of days from assessment start to assessment completion (6 days)
- The average number of days from when an assessment was completed to when the transition plan was started (23 days)
- The average number of days from Transition Plan completion to transition date (40 days).

While these timeframes provide valuable information regarding critical assessment, planning, and transition dates, the State should collect the following information (by TC if possible):

- The length of time between the completed Transition Plan and proposed transition date
- The length of time between the proposed transition date and actual transition date.

The SME believes this information is necessary for senior staff within LDH and Transition Coordinators to identify any barriers that may create bottlenecks for transitioning individuals.

The State has developed the processes in place to offer individuals going through the assessment process the opportunity to return to a living arrangement that was consistent with their previous living situation with some exceptions. If members were determined by LDH to not be stably housed prior to their NF admission or were in shared living arrangements (e.g., group homes) or if the individuals indicated that returning home was not preferable at discharge, the State provided alternate supportive housing. The State continues to report that all transitioned members of the Target Population were provided a stable housing arrangement that was consistent with this Agreement. However, the SME Service Review did identify several individuals who experienced housing stability during their transition. One transition was

directly related to storms in the summer of 2020. However, this individual and another individual moved several times post-transition. These transitions, in the SME's opinion, may have been preventable.

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 OAAS and OBH staff, including health care professionals, TCs, and central office and regional staff. The My Choice Louisiana SRP meets weekly to review cases for individuals identified as members of the Target Population for which barriers are hindering the individual's personal goals or the transition itself. The SME requested information from LDH regarding the number of individuals who have been referred to the SRP and if the SRP was effective in addressing these barriers.

There are several barriers that have been identified by the SRP. This includes individuals interested in transitioning and require insulin to manage their diabetes. There is a lack of training resources that are available to these individuals while in the nursing facility. Nursing facility staff may be weary of an individual's ability to self-manage their insulin post discharge and are unwilling to provide information to assist individuals with insulin management. Once discharged, personal care staff cannot provide insulin directly to these individuals. LDH is working with the SME to identify alternative strategies for providing education prior to discharge and oversight processes that can be used to have individuals effectively manage their diabetes post discharge. In addition, there are individuals with cognitive issues that LDH indicated do not have natural or other non-paid supports to assist with caretaking post discharge. The SME is requesting that barriers identified by the SRP be included in the report requested in paragraph 51 and for the State to provide specific strategies and progress for addressing each of the barriers listed above during the next reporting period.

As indicated in previous SME reports, it will be important that the State continue to use this process to identify and address barriers to transitions. As recommended in the third SME report, the State should consider additional members who 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 (APS) staff, LGE staff, and certified peer specialists. During the fourth reporting period, OCDD and APS representatives were included in the SRP. The SME recommended additional members who are working on a daily basis with members who have been transitioned or diverted, especially ACT team members and MCO case managers who have been identified as coordinating additional supports needed by individuals who have transitioned. LDH has stated the SRP will extend an invitation to the MCO Case Manager or ACT representative to participate in SRP meetings when the MCO/ACT team is a member of the transition team for an individual.

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.

Paragraphs 59 through 61 are addressed together. 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 the third SME report, 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 some community case management through the waiver's support coordinators, but generally for services and supports offered under CCW.

The OAAS transition coordinators are currently tasked with intensive case management for individuals who are assigned to OAAS. Individuals who do not meet NF LOC are served by OBH and provided intensive case management by the OBH TCs. All individuals are also offered case management from their respective MCOs. Therefore, some but not all individuals have elected to receive MCO case management. Finally, some individuals are getting additional types of case management through other providers. For instance, individuals receiving ACT have an ongoing source of case management in addition to case management provided by TCs and MCOs (and a support coordinator if participating in CCW). These multiple approaches to case management were recognized by the State in the development of the Community Case management approach.

The State finalized a strategy for the provision of community case management services (following the interim TC process) during this reporting period. During the last reporting period, the State identified a strategy for implementing the new case management model inclusive of implementation timeframes. They finalized the vision for the case management program, the specific functions of the case manager, and the expected frequency of contact with the individual, and drafted contract language and shared with the MCOs to operationalize this effort. The MCOs will be responsible for contracting with community case management providers. LDH has been working with the MCOs during this reporting period to provide specific expectations regarding the contract between the MCO and community case management providers, including reports that will be included in the LDH My Choice Quality Matrix. In this reporting period they provided an overview of the community case management approach to the My Choice Advisory Group and the Quality Subcommittee.

This new case management model will be implemented in November 2021 and will be available for individuals who transition from NFs, as well as for individuals who will be diverted from these facilities. The case management model, as designed, 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 case management model will begin in November 2021. As indicated in the introduction, the State completed several critical activities, including the Medicaid authority for this service and development of reimbursement rate. They have also trained the MCOs in the new community case management model this reporting period. There are still several activities the State and the MCOs (who are responsible for implementing community case management) will need to address in the next reporting period:

- Reviewing the training modules developed by the MCOs and ensuring the MCOs train new case management staff in these community agencies
- Developing training for support coordination agencies, Program for All-inclusive Care for the Elderly (PACE), Long Term Personal Care Service providers, and others who will have contact with newly created case managers
- Continuing efforts to develop LDH monitoring and oversight processes to ensure the agencies' quality and sufficiency of case management services.

For the next reporting period, the State will continue its interim case management strategy, requiring Transition Coordinators to provide ongoing case management services. The SME recommends that the interim case management strategy continue past November 2021 to allow onboarding of the community case managers and ensure that individuals who are receiving case management from the TCs do not experience an interruption in their care. In order to support the TCs in their ability to fulfil this function, and enhance transitions, the State reports they have enrolled TCs in the Foundational and Advanced Care Excellence training offered through California State University. This online training series is designed to help teams who provide case management to populations with special and complex needs.

As indicated in the previous SME report, the State developed and implemented a Case Management Contact Documentation Log that includes information on the type of contact (telephonic versus face-to-

face), the frequency of the contact, and 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 or critical incidents, and if changes in the individual's POC are warranted.

LDH is using the information from the contact logs to be able to gather and analyze information for its Quality Assurance Strategy, creating important indicators on any change in status of these individuals 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 discussed in the third SME report. In addition, they 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. As recommended by the SME, the State has indicated that these logs will be incorporated into the longer-term community case management strategy. In July 2020, the State moved to a monthly rather than weekly tracking of key indicators, including critical incidents for individuals who have been transitioned. A review of these indicators is now embedded in LDH's My Choice Quality Assurance process. These indicators are reviewed jointly by OAAS and OBH leadership to identify individual and systemic issues. In addition, as discussed in paragraph 98 and 99, LDH has shared and discussed these indicators with a subset of their My Choice Advisory Committee.

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.

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.

Due to a cyber-attack in November 2019, information from assessments and ITPs was lost and therefore unavailable for 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 re-entered lost information into the interim system and 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. As indicated in paragraphs 54-57, the State tracks TC's planning and assessment efforts that include:

- Number of open and closed cases on the Master List
- Dates when Transition Assessments were started and completed
- Dates when Transition Plans were started and completed
- Dates of planned and actual transitions.

The SME recommends the State review this information on a regular basis against the baseline discussed in paragraphs 54-57 to determine whether the length of the transition process is appropriate or whether there was an increase in the transition timeframes. This may indicate issues and barriers that need to be addressed to have more timely transitions.

The State continues its efforts to secure a longer-term tracking system for the Agreement. The 2021 Implementation Plan set 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 reports that it will go live with this new tracking system in January of 2022. 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 who 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 has developed the longer-term 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. The State has identified the necessary programming changes and provided specifications 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 identifies 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.

The State continues their efforts to enter information from the TCs' logs. As described in the last SME report, the TCs are collecting information on the individual's experience regarding the service planning process, change in caregivers or living arrangement, change of providers, and critical incidents, as well as specific follow up that will be needed by the Transition Coordinator. LDH also uses information from these logs for reporting purposes as part of their larger Quality Assurance effort. This includes information to measure whether individuals were involved in the transition plan and community plan process, whether

the individual is receiving the services they have identified or requested, and their physical health and well-being.

In the third SME report, the SME recommended that the State continue their efforts to develop reports regarding individuals who have been transitioned from NFs. The State continues these efforts. The SME also recommended that LDH develop a strategy for collecting similar information for individuals who are diverted from NFs. Given that the interim diversion strategy was not implemented, the State has not developed or implemented this strategy as discussed in Section IV. Since community case management commences in November 2021, the SME recommends the State develop the necessary tracking protocols for the diversion population at that time. As indicated in paragraph 61, the SME is recommending that the State focus their energy on implementation of the ongoing case management program for individuals in the Target Population who are diverted from NFs rather than taking steps to implement the interim diversion efforts with the MCO's case managers. The SME requests that LDH develop a process that will capture information from the assessments, plans of care, and notes from the community case managers early in the next reporting period. This will allow LDH to have quick access to these assessments and plans and will provide continuity for reporting information on key outcome measures for the My Choice Program.

As indicated in the previous SME report, the procurement efforts for the longer-term tracking system were delayed due to COVID-19. The SME recommended 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 that are expected to have use of this system. The State was unable to meet that recommended benchmark. The State had proposed that they would release the RFP in early CY 2021 and have a contract with a vendor in spring 2021. This did not occur, and the procurement is delayed again, which continues to be a source of frustration for the SME.

V. 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 crisis services in the Agreement and additional crisis services used in other jurisdictions that have proven efficacy. This framework included the requirements in the Agreement and can be found at <https://ldh.la.gov/assets/docs/MyChoice/CrisisFramework.pdf>. There are four crisis services that LDH seeks to create for individuals enrolled in the Medicaid program: mobile crisis intervention, community brief crisis support, behavioral health urgent care, and crisis stabilization units. Since the release of this framework, LDH has undertaken the following activities:

- Developed an internal workplan for implementing crisis services (including the crisis call center) for FY 2022
- Developed and implemented initial training for staff who were working with individuals as they transitioned from NFs, described in the fourth SME report
- Finalized the requirements in the draft service definitions
- Requested and received funding in their budget for FY 2022 to implement several Mobile Crisis Intervention (MCI), Community Brief Crisis Support (CBCS), and Behavioral Health Urgent Care (BHUC) centers
- Is in the final stages of developing the rate setting process for crisis services.

The State is proposing a rolling implementation of various crisis services. The initial focus of these efforts will include standing up MCI, CBCS, and BHUC centers. Additional information regarding these crisis services can be found at <https://ldh.la.gov/assets/docs/MyChoice/CRISIS-PRESENTATION-032921.pdf>. As indicated above, the State has received the necessary funding for these services in FY 2021 with a likely implementation date of January 2022. The State has also reviewed their crisis service definitions to align with federal opportunities in the recently passed American Recovery Plan to garner additional federal funding for these new services.

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.

As discussed in previous SME reports, there is a patchwork of toll-free crisis and help lines that are currently available to assist individuals, including members of the Target Population, who are experiencing crisis. This includes crisis lines that are operated by MCOs, LGEs, and individual providers. However, there is no 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. The State is developing options for implementing a centralized statewide crisis line that will be able to triage and dispatch mobile crisis teams. The State is also developing plans to implement a state-specific 988 hotline for Louisianans in crisis to connect with crisis services and supports. Though the 988 implementation plan is in process, the State has had ongoing meetings between these two programs in order to ensure their implementation occurs in tandem, given that there will ultimately need to be interface between the LDH crisis hotline and 988.

In early CY 2021, the State received a federal grant to develop the necessary specifications of the statewide call-in center. Through this funding, LDH is assessing the competencies of current organizations that provide crisis hotlines (including MCOs that are contractually required to have a 24/7 behavioral health hotline) for their new system. Initially, LDH is seeking to enhance an existing vendor's capacity to fulfill this function. The LDH goal is to have a strategy for the call center developed by July 1, 2021 that will be operational in January 2022. In addition, LDH will assess and address the infrastructure needs of mobile crisis providers when they become operational in the next reporting period.

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 framework as indicated in paragraph 63. Three crisis services will be operational in early CY 2022. As indicated above, the State has developed service definitions for mobile crisis response that set forth the response times and other expectations for mobile response providers. In addition, the State is working with Louisiana State University (LSU) to develop network capacity for MCI, CBCS, and BHUC centers. LSU is developing a plan that will include recruiting and training providers who will offer these services. These services will be critical to reducing visits to emergency departments and hospital admissions, not only for behavioral health but also for all visits and admissions. As indicated in this report, inpatient hospitals are the referral source for 80% of admissions into nursing facilities. Reducing referrals from hospitals will be directly linked to the ability of the crisis system to reduce these visits and admissions. In order to achieve this goal, the State is exploring options for collaborations with community partners to assist with these activities. The SME recommends that this planning should continue during the next reporting period, with the understanding that implementation is dependent on funding.

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.

As indicated in paragraph 63, the State is developing a BH Urgent Care Service to address initial or emergent psychiatric crisis intervention response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis for adults.

In addition, LDH, in cooperation with the SME, completed a comprehensive needs assessment with an analysis of all crisis services, including the components of the home-like alternatives referenced above. The goal of this needs assessment was to conduct a rigorous, formal needs assessment consistent with the terms of the Agreement, which serves 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.
- Producing a set of actionable, measurable, prioritized recommendations for addressing gaps, and a road map for effectively implementing those recommendations.

The initial findings and recommendations from the needs assessment were helpful in shaping the FY 2022 budget request. LDH used the data from the initial analysis and developed budget assumptions regarding the potential need for each crisis service. LDH developed additional assumptions to project budget requests for FY 2022. This included identifying the potential demand for crisis services (based on ED visits and inpatient hospitalization for behavioral health) and reimbursement rates from other states that had established services similar to those proposed for Louisiana. It also incorporated service initiation dates (most were January 2022).

The final Needs Assessment (published in September 2021) provided additional recommendations for LDH to consider for developing crisis services in the future. Specifically, the Needs Assessment recommended expanding crisis service capacity and funding for individuals who are not enrolled in Medicaid but who experience significant behavioral health issues that often generate the need for a crisis response.

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 has been 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). Since 2012, the State has created a continuum of services consistent with ASAM through the Louisiana Behavioral Health Partnership. In addition, one of the State's milestones 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 for the fourth quarter of 2020 (October-December) 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 Waiver, the State has also received a federal block grant to address the continuing opioid epidemic and other substance use disorders. The State had used these funds to expand evidenced-based practices, such as Medication Assisted Treatment (MAT), as well as to increase 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 Opioid Use Disorder (OUD) and SUD services, including additional Opioid Treatment Programs (OTPs).

A finding from the needs assessment is the low penetration of SUD service utilization for members of the Target Population. As indicated in the needs assessment, less than 5% of individuals who transitioned or were diverted received an SUD service. While data was not available on all diagnoses in the Target Population, about 18% of all individuals with mental illness have a co-occurring SUD⁶. This percentage increases for individuals with serious mental illness; 48% of individuals with an SMI may have a substance use issue or disorder⁷. Some of these individuals should have their SUD needs assessed and addressed by the ACT teams (almost 30% of all individuals diverted from NFs were receiving ACT according to the Needs Assessment). ACT teams include a SUD practitioner that is responsible for providing SUD services for individuals with identified substance use or substance misuse issues. The SME's service review also found that over one-half of the individuals participating in the review had an SUD history. Several individuals were actively using (mostly alcohol) and did not want to seek or participate in treatment. While this is consistent with the SUD population in general, the State should identify and address barriers to individuals in the Target Population who have an SUD who may benefit from treatment and recovery services.

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 had done some initial outreach in early 2020 to emergency medical services (EMS) providers regarding possible approaches to identifying and resolving crisis in the community. The State was interested in EMS efforts to respond to behavioral health crisis to determine if and how they may be

⁶[https://pubmed.ncbi.nlm.nih.gov/19087479/#:~:text=Results%3A%20Overall%2C%20the%20prevalence%20of,with%20personality%20disorders%20\(34%25\).](https://pubmed.ncbi.nlm.nih.gov/19087479/#:~:text=Results%3A%20Overall%2C%20the%20prevalence%20of,with%20personality%20disorders%20(34%25).)

⁷ https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf

included in the crisis network. 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 ongoing national focus on the role of policing, including calls to reduce the police role in responding to people with MH disabilities, LDH is outreaching to law enforcement during this next reporting period. This was a SME recommendation in the third and fourth reports. LDH has plans to meet with leads for State and local police associations to provide an overview of the crisis services that will be implemented in early CY 2022. LDH reports that the intent of these initial meetings will be to provide information regarding these services and discuss the role of police to access and utilize these services rather than seeking involuntary admissions into inpatient hospitalizations. LDH reports that LSU (who is charged with training providers) will attend these meetings to identify potential training efforts that are focused on law enforcement.

It should be noted that LDH has provided TCs with training focused on improving their capability in planning for crisis and on engagement and intervention techniques to reduce the need for higher level of care intervention. As recommended in the Needs Assessment, this training should be incorporated into the training curriculum for ACT teams, MCO case managers, and the future community case managers. The SME supports this recommendation and requests that LDH identify when and how this training will occur.

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, in consultation with the SME, has developed the service requirements for each of the services set forth in the crisis plan. The State still needs to finalize the necessary performance metrics for the call center and crisis providers. The SME recommends that these metrics be finalized in this reporting period. The SME has provided information to the State regarding nationally recommended call center metrics. The State is in the process of reviewing these metrics for their call center; it is recommended that these metrics be finalized in the first 90 days of the next reporting period. In addition, the State will need to finalize how the MCOs 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.

As of June 2021, the State reports there are 46 ACT teams operating within Louisiana that are and will be serving individuals in the Target Population. In previous reports, the SME team has reviewed and reported on the adequacy of access 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 who are currently in the community. The needs assessment finalized this reporting period indicated that approximately 30% of individuals in the Target Population who transitioned from nursing facilities received ACT. Fifteen percent of individuals diverted from nursing facilities received ACT. The needs assessment projected that

approximately 136 individuals may need ACT services over the next fiscal year (assuming 400 individuals will be transitioned from nursing facilities by June 30, 2022). While the needs assessment did not specify where capacity was needed, historically the State has not experienced challenges with increasing ACT capacity. For instance, the ACT capacity increased by 300 individuals in FY 2020. During the next reporting period, LDH should review policies and other efforts to better identify individuals who will be or have been recently transitioned to determine if these individuals (based on their previous behavioral health ED and IP utilization) should be referred to ACT teams. LDH should report the number of these individuals who were or will be referred to ACT at their transition to the community.

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, as part of the 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 State continues its efforts to identify which ACT teams may be experiencing more challenges with existing/stepping down individuals from their team. For instance, there are individuals who have been in NFs receiving ACT for several years. It is unclear whether these individuals continue to need ACT or could benefit from other services such as CPST or psychosocial rehabilitation. The intensity of ACT may not always be appropriate for these individuals.

OBH, in cooperation with the SME and Medicaid, is collecting and analyzing data from the ACT Outcomes System. The ACT Outcome System provides information on:

- Homelessness status
- Incarceration status
- Emergency Department visits
- Behavioral health Inpatient admissions
- Physical health inpatient admissions
- Partial hospitalization participation
- Admission into an SUD detoxification facility
- Employment
- Average lengths of stay in ACT.

The ACT Outcomes System is in use by all ACT teams, but not all teams are technically proficient using this new system. Most teams are serving clients from multiple MCOs, and there are complexities in the reporting to assure clients are reported by MCO as well as the total team. The SME recommends the State and MCOs provide technical assistance to the ACT provider group in monthly MCO/LDH/ACT meetings. In addition, the SME recommends ACT teams be informed on how to use the outcome data they are collecting for quality improvement.

This analysis should be completed within the next reporting period to identify ACT teams that may have longer lengths of stays and that could benefit from targeted technical assistance to determine whether those stays are appropriate or whether step-down strategies are needed.

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

According to key informants in the Needs Assessment, there is considerable variability among ACT workers in their responsiveness to potential crises and engagement early in the response to a crisis and recommended training for ACT providers and MCOs to improve their capability in planning for crisis and engagement and intervention techniques to reduce the need for higher level of care intervention. As recommended in paragraph 68, LDH should include ACT teams and community case managers, who are often the locus of accountability for these individuals with training regarding new crisis services, and provide them with training regarding crisis de-escalation approaches.

As indicated in previous SME reports, the State, through its MCOs, conducts fidelity reviews of ACT providers on an ongoing basis. The SME examined these fidelity reviews for 2019 through 2020 and identified that there were needed improvements for ACT; specifically, the employment area was weak. Also noted were weaknesses in some teams in the areas of individualized treatment planning.

In the previous SME report, it was recommended that the State and/or the MCOs make the necessary improvements to address these weaknesses. The SME requested the State follow up with the ACT teams to make these improvements and report their findings back to the SME. The most recent oral report from Case Western (the entity performing the fidelity reviews) indicated improvements in some of these areas.

In the SME's opinion, with respect to the employment area, the ACT teams are singularly positioned to provide intensive supported employment services because the teams already include a dedicated employment specialist. As indicated above, the 2019 fidelity reviews did indicate some weakness in that area, specifically in training of employment specialists and lack of individualized treatment. The State is addressing these areas for ACT, in particular, in two ways:

- A training curriculum was developed and delivered to the ACT Employment Specialists and team leaders. This training was provided to two groups in March 2021. The training outlined expectations for the employment specialist and provided consistent information and technical assistance about providing supported employment in the context of ACT. The newly implemented Outcomes Measurement System records employment status monthly for every ACT member, further raising the profile of employment as a recovery tool. The OBH is consulting with the MCO partners about rollout of this training.
- As indicated in the previous SME report, a Person-Centered Planning training has been developed in cooperation with the SME team and piloted to several groups of Transition Coordinators, state staff, and MCO staff. The ACT teams are still expected to be the first group of providers to receive this training. It is expected that this information will increase the fidelity in providing individualized person-centered treatment plans and service delivery. Examples of employment goals, objectives, and interventions were included in this material. As indicated in paragraph 92, the MCOs have provided their training schedule regarding this training. Training will commence in July and be completed by November 2021.

Through the encouragement of the SME team, the State has developed critical performance measures that are specific to ACT. The purpose of these measures is to determine if high fidelity for an ACT team is associated with better outcomes and if lower fidelity is associated with poorer outcomes (e.g., low

intensity services or lack of individualized plans for individuals on an ACT team). The ACT Outcomes Systems in paragraph 71 will be instrumental in getting these performance standards. The SME recommends the State collect and populate these measures for the next reporting period.

The State has also developed and implemented 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.

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 utilizing network adequacy reports. For the purposes of this report, the SME has identified the following services to be intensive community supports:

- Community Psychiatric Services and Treatment
- Psycho-Social Rehabilitation
- Crisis Services (current crisis intervention services)
- Assertive Community Treatment
- Peer Supports
- Intensive Outpatient Programs
- Ambulatory Withdrawal Management with Extended On-Site Monitoring

The State provides the findings of MCO-generated reports on network adequacy quarterly to the SME. It is also included in the quarterly Quality Assurance matrix developed by LDH. Based on the review of these reports for the CY 2020 there are no obvious access issues for Intensive Community Support Services. Providers of CPST increased by 9% during this calendar year. 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. During this reporting period, LDH has made changes to the CPST service, to better differentiate the role of this service versus Psycho-Social Rehabilitation (PSR), which had overlapping service definitions. As proposed, CPST will provide more supportive counseling by certain practitioners with PSR continuing to focus on building skills and competencies for individuals participating in the program.

Similar to ACT, the current needs assessment reviewed the demand for ICSS services by members of the Target Population who are transitioned or diverted from NFs. Per this report, up to 250 additional individuals may need CPST. This is a relatively small number compared to the 18,000 individuals who utilized this service in CY 2019 and the current capacity in the network should be sufficient. 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 and review of the MCO's network adequacy report does not infer there are issues with accessing CPST.

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 over the past calendar year, including the biggest change, 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.

The State continues to track the impact of COVID-19 on these providers. Specifically, the OBH is collecting information from MCOs on the number of MHR agencies that have notified their intent to close programs. In the previous SME report, there were about the same number of program closures (3-4) pre and post COVID-19 onset. During this reporting period, there were four additional closures. Three of these closures were specific sites of providers that had multiple sites. One closure occurred due to the death of the director.

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.

The Needs Assessment found a high need for in-home personal care supports for individuals transitioning to the community and recommends maximizing access. According to the report, data suggest up to 75% of individuals transitioning to the community need some form of in-home personal care service. The Needs Assessment stated that dependencies for activities of daily living is “one of the strongest predictors [of NF placement], demonstrating the importance of these support services in maintaining people in the community.”⁸

There are several current pathways for individuals to receive in-home personal care through the Medicaid program. Some individuals may qualify for the CCW program and have access to an array of services and supports to address IADLs, including personal assistance and skilled maintenance therapies. In addition, individuals may receive personal care through a stand-alone Medicaid state plan service (Long Term Personal Care Services). Both of these pathways require the individual to meet nursing facility level of care.

⁸ [LouisianaNeedsAssessment-Final-Report.pdf \(la.gov\)](#)

Members who are under the purview of OBH do not have access to similar services since they do not currently meet the NF level of care. The State will target these benefits on individuals in the Target Population who resided in NFs, who need some level of personal care, and who currently do not meet the criteria for the CCW or LTPCS program. The State identified and is pursuing a Medicaid option during this reporting period for services currently not included or allowable under the state's existing Medicaid plan. The State has targeted FY 2022 (January 2022) for the implementation of these new services. The State, as recommended by the SME, finalized the initial benefit package and approach for these authorities in the last reporting period and has started the process of requesting the appropriate authority for this service. The initial benefit package will include personal care services and supported employment. LDH has requested and received funding for their services in their FY 2022 budget. The State will seek an amendment to its current 1915b Medicaid Waiver for personal care services. The State may use this Medicaid authority or a combination of state or block grant funds to pilot their supported employment efforts.

The Needs Assessment did identify several issues with the existing personal care services. The Assessment cited a concern about "churn" for these programs—specifically individuals improving their IADLs and no longer qualifying for these supports. Few individuals were re-referred for a subsequent evaluation for these benefits despite ongoing needs and sometimes deteriorating IADLs. LDH should develop processes to track individuals in the Target Population who no longer meet the NF level of care needed for the CCW or LTPCS program and make a follow-up referral for these programs or the new Medicaid option that offers personal care assistance to ensure ongoing personal care services.

The State submitted and obtained approval from CMS for peer services. This new service began in March of 2021 and is a benefit that is provided through LGEs. During the next reporting period, the SME will request information regarding the utilization of this new service for the Target Population.

Upon further review of the existing Medicaid state plan, LDH believes it has the current authority to cover the initial crisis services in the existing State Medicaid Plan.

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. In the previous report, the SME recommended 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. The State has not undertaken these activities. The SME is recommending the State initiate steps to meet the requirements of this paragraph during the next reporting period.

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, Community Psychiatric Supportive Treatment, Psychosocial Rehabilitation, and Crisis Intervention. In addition, the initial Crisis Framework 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 79, the State implemented a freestanding peer support service in March that complements not only the services in VI A-C but also other services such as integrated day services discussed below. For the next reporting period, the SME is requesting data regarding the number of individuals in the Target Population receiving this new peer support services.

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.

The State has undertaken activities to identify, develop, or enhance services for individuals during the day. In June 2019, the State defined a preliminary set of integrated day services for members of the Target Population that include employment supports, drop-in centers, and adult day opportunities. The State continued to implement various activities to improve access to this array, including training the MCOs on guidance that stipulates that illness management and recovery supports in the domain of employment activities be within the scope of current funding methodologies. This document has been reviewed by State leadership and was to be presented to MCO and leadership for discussion and dissemination. The meetings with the MCOs regarding this guidance have not occurred. The SME recommends that this be a priority conversation with the MCOs at the beginning of CY 2022. Without this information, MCOs will be unable to train MHR providers on this guidance.

In 2019, the State gathered 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. The information from the LGE surveys was added to the resource guide for the Transition Coordinators. Given that some of these programs have limited operations during the pandemic, the SME recommends the State identify which of these programs are still operational and update the resource guide for the next reporting period.

As indicated in the previous SME report, the State 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 was 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 was to address the need for greater inter-agency collaboration between the Louisiana Workforce Commission (LWC), Louisiana Rehabilitation Services (LRS), and OBH. Specific information regarding the VOICE project is included in the previous SME report.

During this reporting period, the State undertook several important activities. With the assistance of the VOICE coach, they had a statewide learning opportunity for MCOs, behavioral health providers, and other stakeholders regarding the importance of employment for individuals with mental health conditions and strategies that providers and others should consider to garner interests and enhance strategies for integrated employment. In addition, the State has engaged the assistance of Westat, a national consulting organization that provides technical assistance regarding Individual Placement and Support (IPS), a supported employment program that assists individuals with severe mental illness find competitive, community employment and provides ongoing, individualized services with a focus on employment. The State is seeking assistance from Westat to provide training and coaching for select sites that may be good candidates for implementing IPS. LDH is also seeking to participate in a national Learning Collaborative on IPS. The SME is very encouraged by the State's efforts in this area and requests the State to provide an update of these efforts during the next reporting period.

As indicated in this paragraph, OBH has developed guidance to providers regarding employment services, including individual placement and support, employment supports, and coaching through the MHR program. This includes developing a definition of employment service to include as a Medicaid authority, as well as training the MCOs and community providers regarding the messages that various employment supports can be reimbursed through existing Medicaid services (e.g., CPST and PSR).

While the State has developed strategies to expand the availability of services and supports that will enhance community integration, there are several issues that should be addressed. As indicated in the SME Service Review Report, Transition Assessments for individuals in the initial sample were less robust than the Transition Assessment forms used in subsequent samples. Information regarding interests, employment, and other information that would assist with developing goals regarding community integration was not included in the initial form. The transition plans and plans of care (when available) did not reflect either goals or interventions to address community integration. While the pandemic impacted their involvement, individuals participating in the service review did not seem to engage or were not actively encouraged to participate in activities of interest prior to the pandemic. The State should implement the recommendations in the Service Review, explicitly focusing on assessments and plans developed by TCs that did not have any information on recommended services and supports that would enhance community integration, determine why there was no recommended services and support, and re-train TCs on strategies to solicit information for the assessment and have actionable strategies developed in cooperation with the individual to identify and engage the individuals in these services and supports. This training should include a refresher on wellness and employment and a concrete process for TCs to identify resources in the community that will support integration.

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 and 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 State and the SME believe there is an interest in increasing access to and involvement of peer support specialists.

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. As indicated in the previous report, the State finalized a Medicaid framework for peer support services. The vision of these services is to support individuals with SMI in a variety of settings, including in-reach and transition assistance for individuals in the Target Population in NFs (as discussed in paragraph 89). The State has worked with the SME to develop the service parameters and staff qualifications for this new service. The State released an RFI in 2020 to solicit recommendations from stakeholders regarding strategies for improving the training and certification process. The previous SME report provides information on the responses received through this process.

As indicated in the previous SME report, the State identified the need to improve the process for training and recertifying peers, as the current process is not sufficient to support the necessary changes and additions proposed by the State. The State also identified the need for training of peer supervisors. During this reporting period, with the assistance of the SME team, LDH has developed and implemented an initial training for peer supervisors. Approximately 25 individuals attended the supervisor training in June of 2021. The SME recommends that this training occur with some frequency in the future and is requesting information from the State regarding the cadence of these trainings.

As indicated previously in this section, the State received budget authority for additional peer supports for FY 2021. The State submitted the State Plan Amendment and received approval from CMS to implement this service. This service was implemented in March 2021 as discussed in paragraph 75.

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.

The State has 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.⁹ LDH in coordination will be reviewing the Housing Plan to assess progress thus far and update the actionable strategies that comprise the plan. This deliberate review is expected to be completed by the end of CY 2021.

⁹ <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. As stated above, LDH in coordination with LHC will be conducting a review of progress made in reaching the annual targets thus far and updating the housing plan and accompanying strategies. The expectation is that the updated plan will be developed by the end of CY 2021.

The State has implemented a state-funded subsidy rental assistance program for 2020 and 2021 serving over 100 individuals. This program is referred to as the 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 continued to offer short-term rental assistance using these funds throughout 2020, utilizing established program policies and guidelines. In collaboration with LDH, the Louisiana Housing Authority continues to administer the rental assistance subsidies (i.e., rental assistance lasting more than 3 months). LHC and LHA have reached and expects to continue to maintain full utilization of the My Choice rental assistance program through the end of CY 2020. To date, 9 members of the Target Population have received short-term rental assistance (These are bridge type of housing subsidies for 2-3 months in order to bridge to a permanent rental assistance source/subsidy., 103 are receiving ongoing rental assistance (i.e., My Choice Voucher) paid through LHA, and 44 additional members (39 individuals are currently in Nursing Facilities) are in the process of being housed with My Choice rental assistance.

The State continues 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 2020, as part of the CARES Act, LDH and LHA applied for and LHA was awarded two awards of 27 (May award) and 75 (November award) NED tenant-based vouchers to be incorporated into its existing Mainstream Voucher program for PSH. Both these new Mainstream Voucher Awards (102 vouchers) will be used by members of the Target Population. LDH and LHA continued to utilize and refine their established program policies and procedures for using these vouchers throughout 2019-2020 and 53 members of the Target Population have been transitioned from NFs using this resource with an additional 26 members enrolled and currently in a housing search and 14 members identified for enrolment in NED.

LDH is currently working with members of the Target Population to utilize the subsidies awarded by HUD in May. LDH expects to start to utilize mainstream vouchers from the November award in March 2021. Overall, there are a total of 190 NED subsidies of which 109 subsidies are currently utilized with an additional 74 individuals in the pipeline (10 individuals with unit's approved, 4 individuals pending unit approval, 5 individuals with units identified, 58 individuals in active housing search. Of these 74 individuals, 17 are DOJ transition members. In August 2020, HUD awarded LHC additional Section 811 Project Based Rental Assistance (Section 811 PRA), which will be used in conjunction with both existing and new affordable multi-family projects. LHC expects this new Section 811 PRA award, totaling \$7 million, to support approximately 140 integrated permanent supportive housing units. During FY2021, there were significant delays in LHC receiving the grant agreement from HUD associated with this Section 811 PRA award. LHC recently received the draft cooperative agreement from HUD in late September of 2021. The HC is currently working to review documents associated with the grant agreement and expects to execute the agreement by November of 2021. As part of its Section 811 PRA proposal to HUD, LHC proposed to target the integrated PSH units' support, with Section 811 PRA assistance, to members of the Target Population. In August 2021, the LHC Board approved language for the 2022 Qualified Allocation Plan creating a requirement for all LIHTC applicants to commit up to 10% of the total units in the proposed project as Section 811 PRA assisted units. These commitments were in addition to the PSH unit set-asides created in 2019 discussed below.

The State sustained the existing requirements in the 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 as part of the 2019 Qualified Allocation Plan for the State's LIHTC program.

The State sustained the existing requirements in the 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 as part of the 2019 Qualified Allocation Plan for the State's LIHTC program.

In addition, in 2020, LDH and the LA Office of Community Development (OCD) successfully collaborated 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. This partnership resulted in 67 PSH set-aside units to Target Population members within 14 new multi-family rental housing developments to be created across Louisiana.

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, has made significant progress in 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. In the first quarter of CY 2021, 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 implement 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 to develop a PSH delivery plan to synchronize when these PSH opportunities will be available or ready for lease with the planned transitions of Target Population members.

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, through OAAS, has engaged six 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 applications 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, seeking 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
- 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 a supportive housing arrangement developed under this Agreement.

VI. 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 18 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, 2020, and 2021 Implementation Plans; 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 the fall of 2018, the State has held 15 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 all meetings this reporting period. These meetings continue to be well organized and provide important information in terms of the State's progress regarding the Agreement. The State has continued to meet with the following subcommittees:

- The Crisis Resource Group, to provide input/feedback and guidance regarding the development of the crisis system. In March of 2021, LDH met with this group and other stakeholders to provide important information and solicit feedback regarding the four new crisis services discussed in paragraph 39. The SME team attended this meeting. There was general support from stakeholders regarding these new services and the SME was encouraged by the State's plans to implement these services in FY 2022 (pending funding from the Legislature).
- The Community Service Development Resource Group assists with the development of community services and capacity building for the My Choice program. This group has provided input/feedback and guidance specific to the person centered training efforts developed and implemented by the Department.

The Community Transitions Resource Group did not meet this reporting period. The SME recommends the State convene and meet with this resource group during this reporting period to discuss the issues that have been identified by the Needs Assessment, TCs, and other individuals regarding barriers to transition, given the low number of individuals transitioned during this reporting period.

As indicated in paragraph 94, the State has developed a Quality Resource Group to solicit feedback regarding the measures for the Agreement and their approach to the development and implementation of their Quality Assurance Plan.

In the SME's opinion, these meetings have been helpful to the State in their efforts to get specific feedback on important areas and activities, as the meetings are interactive and subcommittee members provide helpful comments regarding the subjects of discussion. The State has developed a subcommittee regarding resource identification but has indicated that the subcommittee does not meet regularly. It did not meet during this reporting period. The SME recommended the State meet with this committee in early CY 2021, given the barriers discussed in the Transition Section of this report. The State has not met with this subcommittee. The SME is requesting information regarding the rationale for not holding these meetings given the barriers identified in paragraphs 51.

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. This included regional listening tours regarding the overall "state of the State behavioral health system" in 2019. During these meetings, the State provided information on some of their efforts, but most of the meeting format was an open forum where participants responded with critical information to the State regarding gaps, barriers, and other concerns, many of which were directly related to services and other activities under the Agreement. The State was planning on similar tours in CY 2020 and CY 2021; however, due to the pandemic, these meetings did not occur.

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 strategies for at risk individuals to divert them from potential NFs placements. The SME has not attended these meetings during the reporting period.

LDH continues to have outreach meetings with MCOs and providers. During this reporting period, OBH continued to convene ACT teams and MCOs to discuss improvement in the delivery of ACT services, as discussed in paragraph 72. The SME anticipates that these meetings will likely increase over the next reporting period as new services (crisis, personal care, employment, and case management) are scheduled to be implemented no later than the second half of FY 2022. These meetings will be essential to understanding the MCOs' approach in developing the network for these new services, including identifying, soliciting, and training providers to deliver these services.

The overall level of engagement from the My Choice Advisory Committee participants continues to be challenging. There continued to be few questions or recommendations from committee members. Even with proactive outreach, the State continues to receive very few suggestions for topics that 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.

However, in the SME's opinion, the subcommittee structure has produced more input and participation. As recommended in the previous report, the State developed an approach that focuses more time and resources on these subcommittees rather than bi-monthly meetings of the larger Advisory Committee.

The SME believes this structure is generally providing the information needed by the State to obtain input on critical areas for LDH to be successful with this Agreement.

In previous reports, the SME recommended that the State enhance its My Choice Website, specifically recommending that the site should include additional information such as information on the Advisory Committee and the agendas and materials presented at the Advisory Committee meetings. It should include presentations and materials regarding the My Choice program offered to other stakeholder groups. Other states with similar initiatives can be used as a model for the website changes. Specifically, the Rosie D. consent decree in Massachusetts has a well-developed website that the state maintains regularly. The State has not enhanced the My Choice website. The SME is requesting the State to take the necessary steps the next reporting period to improve the website.

In the previous report, the SME recommended that the State also post information in the next period regarding data from the quality measures referenced in paragraph 99 and required in paragraph 101. Posting this information is important to provide transparency regarding the State's progress on all performance measures. The previous SME report does provide information regarding the measures in paragraph 98 and 99. This report is placed on the My Choice Website when completed. While this is available for the general public, the State is developing an additional strategy to provide information regarding the My Choice Quality matrix for the next reporting period. As indicated in the previous report, the SME recommended the State delay posting this information during this period and publish in July 2021. The SME recommended the State develop a process for incorporating feedback from stakeholders regarding the changes in quality indicators as part of their overall Quality Improvement approach rather than simply posting this information on the website.

As of April 2021, LDH had a full year of data for the Advisory Committee and other stakeholders to review. The SME recommended and the State provided an orientation session in early CY 2021 for the Advisory Committee and other interested stakeholders regarding the overall quality improvement approach and used this as an opportunity to discuss additional measures for the Agreement. As indicated in paragraph 94, the State developed a Quality Resource Group to provide recommendations to the State regarding these measures. The State has received this feedback and is in the process of updating the measures and providing the Advisory Committee with the full year data (including changes by quarter) for review and discussion and making suggestions regarding strategies to move indicators in the right direction. The State did not meet the July 1, 2021, deadline for publishing the Quality Report and should consider publishing this report by November 1, 2021.

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, 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 18 months of the Agreement, the State has reported ongoing meetings related to the Agreement for the following groups:

- Monthly meetings with all LGE executives
- Monthly meetings with PASRR team and the MCOs
- Weekly joint calls between My Choice TCs and one of the five MCOs to discuss specific issues that arise related to transitions; these meetings are held as needed
- Every six weeks, joint meetings including LDH and all 5 MCOs
- Quarterly meetings with the Louisiana Behavioral Health Advisory Council
- Monthly meetings with the MCOs concerning ACT
- Every six to twelve weeks, meetings with MCO Behavioral Health Medical Directors
- Monthly meetings with OBH and the MCOs.

As indicated in the previous SME report, the State had not developed an ongoing organized communication plan for these stakeholders. The previous SME report recommended the State create and implement a semi-annual communication plan for these constituency groups beginning this next period. As of this reporting period, the State has not undertaken this activity. In the fourth report, the SME recommended and LDH agreed to develop a quarterly newsletter (or a similar communication effort) to keep stakeholders beyond the Advisory Group informed of the progress regarding the Agreement. This is particularly important given that the State has not re-established listening tours for this year and stakeholders could benefit from the progress and the work the State will continue to do this year. This did not occur during this reporting 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 an NF and for whom the PASRR Level II indicated community placement versus an NF admission. These initial efforts included education to MCOs and community providers to identify these individuals and triage the services and supports to meet their immediate needs. During the reporting period ending 12/2020, the State had 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 evaluated 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 included:

- Reviewing MCO data regarding the initiation and engagement of individuals diverted from NFs in 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 in case management services provided by the MCO.
- Revising processes and protocols for referrals for MCO case management based on this review.

In reviewing the MCO data, there was wide variability in these organization's efforts to engage individuals in MCO provided case management. For instance, some MCOs were successful in performing the initial assessment for case management services within the timeframe projected by the MCO. Individuals in

other MCOs were still pending their assessments, even 3-4 months after the MCO's projected timeframe. In addition, there was variability among plans regarding their case management status (open or engaged). Individuals that were engaged were receiving case management from the MCOs. Several plans indicated that individuals in the Target Population were engaged in case management. Other plans had many members open in case management but not actively engaged. Therefore, the SME recommended that MCOs not be the primary source of case management to meet the requirements for case management in the Agreement. Rather, LDH should develop and implement the case management approach as discussed in Section D of this report.

During this reporting period, the State continues to collect data regarding the MCOs' efforts to offer case management and engage individuals who have been transitioned and diverted from nursing facilities in their case management approach. The SME did not recommend LDH pursue a strategy for having MCO provide case management directly for transitioned or diverted individuals and provided the rationale in the last report. Rather, the SME recommended the community case managers that will be in place in FY 2022 provide case management to individuals in the Target Population diverted from nursing facility admissions. The SME continues to receive and review the reports from each MCO regarding their case management activities from each plan for the most recent reporting period (last quarter of CY 2020). These reports do indicate that some MCOs showed marked improvement in the engagement of individuals in the Target Population (transitioned and diverted) in case management. Several MCOs reported either no information or limited engagement in case management post initial assessment. While the State is planning to have a more comprehensive case management approach for the Target Population through their community case management strategy described in paragraph 56-61, LDH will rely on MCOs to engage the at-risk group more aggressively to reduce ED visits and inpatient hospital admissions (all cause).

In the previous two reports, the SME requested additional information regarding outreach efforts that are specific to law enforcement, corrections, and courts for the next reporting period. These outreach efforts have yet to occur. As stated in paragraph 68 of this report, the SME recommends that the State have a targeted outreach effort to law enforcement, especially given the intent regarding the development of crisis services.

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 an NF. The in-reach plan set forth various activities that the State was undertaking in this area and was described in the most recent SME report (paragraph 89).

As indicated in the last two SME reports, there were areas of the original in-reach plan that lacked specificity regarding more granular in-reach activities and timeframes and discussed challenges TCs experience to perform their in-reach functions due to the pandemic. The most recent SME report also described LDH's learnings from multiple states that implemented strategies to perform their in-reach efforts for individuals in NFs and long-term care facilities.

In the previous SME report, it was recommended that LDH enhance its efforts regarding virtual in-reach and revise the initial in-reach plan to enhance efforts for increasing the number of individuals in the Target Population who are successfully transitioned from NFs. The SME recommended several activities to better engage Target Population members who continue to be ambivalent regarding moving into the community and further 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.

During this reporting period, LDH made and is implementing major changes to its in-reach efforts. More specifically, the State has implemented strategies to improve their in-reach effort to specifically identify individuals in the Target Population (both on the Master List and Active Caseload List) who are interested in moving to the community. The SME is very encouraged by these new strategies, which include:

- Developing information to provide individuals during their in-reach visits. The SME has reviewed this information and believes it is a solid start in providing additional information to the Target Population in NFs.
- Developing regional teams of OAAS medical certification specialists (who perform initial and ongoing continued stay reviews) and TCs to perform in-reach strategies. The medical certification specialists have contact with many individuals in the Target Population as part of their daily activities and to some degree have an existing relationship with these members. Specifically, the State is considering having these staff members perform outreach to individuals on the Master List to discuss and engage their interest in transitioning.
- Continuing to have TCs perform in-reach strategies for individuals on the Master List, coordinating with the medical certification specialists.
- Hiring Peer Support Specialists (PSS) (termed Peer In-Reach Specialists (PIRS)) in each region to also provide in-reach and transition efforts for individuals in NFs. The State has hired four since the end of this reporting period and is in the process of hiring the full complement of individuals over the next several months. This strategy will provide additional engagement mechanisms, ensuring the PSSs will be able to use their personal experience, modeling recovery in action for the in-reach process. The Department is hopeful that all regional peer positions will be on-boarded by September 1, 2021.

As recommended in the previous report, the State is implementing several strategies to guide the regional in-reach teams' efforts including:

- Identifying and reconnecting with individuals on the existing Active Caseload to determine their continued interest in transitioning to the community.
- Identifying and connecting (or reconnecting) with individuals on the Master List for in-reach purposes.

- Setting specific targets for each region to contact each individual on the Master List over the course of a year. For planning purposes, LDH has identified the year as April 2021 through March 2022 and has developed monthly projections for each staff to perform in-reach.
- Developing and implementing training for medical certification specialists and TCs in March 2021 to improve their in-reach efforts.
- Increasing the number of PSSs for in-reach efforts for CY 2022 and subsequent years.
- Developing the management reports to track progress of each regional team's in-reach efforts.
- Having senior leadership at OAAS and OBH meet with the regional teams initially to implement the in-reach plan and to address concerns regional team members may have regarding in-reach.
- Develop in-reach strategies that ensure choice for members lacking decision-making capacity.

While the State is commended on its efforts to creatively fund an initial cadre of PSSs who will assist in in-reach and transition efforts, the SME believes these numbers will not be sufficient to assertively continue in-reach efforts for individuals on the Master List. In addition, having a single peer in each region is not recommended long term. Peers in similar situations have often experienced confusion regarding their roles, isolation, and higher turnover. The SME would suggest that the State have perhaps twice or three times the number of PSSs to supplement in-reach efforts by CY 2023.

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 Section V, there has been ongoing training on employment supports, ACT, and the general mental health provider community. The State has also worked with the MCOs to develop a schedule for person-centered planning for the next reporting period. Five initial trainings will occur throughout the State for behavioral health providers during the next reporting period. As mentioned earlier, the State designed and held a BH Symposium in September 2020 that included a major focus to improve knowledge regarding the overall Agreement and continued its efforts to train providers, administrators/non-direct, and staff/supervisors of direct staff on crisis and employment services. The State has indicated the following training continued to be 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)
- 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 recommended in the previous SME report, the State could benefit from a single organized training plan for providers who serve the Target Population. The SME recommended in the past four reports that the State develop policies and curriculum required under this paragraph during FY 2021. As of this reporting period, the State has not developed this training plan. Therefore, the State should use the balance of FY 2021 to develop this training plan, requesting the My Choice Advisory Committee to participate in the development of the plan and to recommend specific curricula.

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, with the assistance of the SME, developed and tested a curriculum that is specific to person-centered service delivery. The purpose of this training is to help practitioners enhance their sensitivity and learn skills that will support them in ensuring 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 three modules, each designed to consist of potentially 60- to 90-minute training sessions. Initially, this training was piloted with Transition Coordinators, who provided feedback regarding the content and delivery of the training. Based on this pilot, the training was amended to incorporate their recommendations.

LDH has done several “train the trainer” sessions for Managed Care Organizations trainers. These trainers will be responsible for training community providers, including community case management agencies and all other community providers who will be doing assessment, treatment plans, and/or treatment plan implementation. In addition, the previous SME report recommended the State review this training with members of the My Choice Advisory Committee to obtain and incorporate their feedback. The State met with a subcommittee of the My Choice Advisory Committee. The State provided both the presentation and training manual to the subcommittee for their review. The State received initial feedback from some committee members and the State is in the process of making revisions to respond to their recommendations.

VII. 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 timeframes set forth in this paragraph and therefore the SME continues to recommend that LDH create a quality assurance system, including a quality assurance plan, during this reporting period. The SME recommended the plan incorporate the work that has been done to collect and analyze data on measures identified in paragraph 99 and the processes LDH will put in place 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.

As indicated in the first SME report, OAAS and OBH had different quality assurance approaches. The SME recommended that the State develop a process that is similar to the CCW approach for all Target Population members. Finally, the SME recommended that the State include a stakeholder feedback process as part of their overall quality assurance strategy for the Agreement. The State developed its first iteration of a cross agency matrix of measures in CY 2020. As discussed below, the matrix contains preliminary measures designed to address requirements in paragraph 98 and 99 of the Agreement. The State intends to continue expanding and refining this matrix to capture all information required by those paragraphs. The State collects and reviews data on a monthly basis regarding these measures. They also report these measures on a quarterly basis. During this reporting period, the State reported the first full year of measures (January 1, 2020, through December 31, 2020). These preliminary matrix and performance data are reflected in the quality matrix provided in Attachment B.1-B.3. A number of measures are similar to measures used in the CCW program, specifically regarding service availability, person-centered planning, safety and freedom from harm, and choice and self-determination. Other measures are specific to the requirements of the Agreement (e.g., PASRR Level II, stability, and community integration).

During this reporting period, the State has continued to collect information on measures that were identified for Paragraph 99. During this reporting period, LDH continued their cross agency internal quality assurance workgroup that reviews the changes in the measures each quarter, identifies measures that seem to indicate there are individual or systemic issues, and discusses strategies for further analyzing and addressing these issues. The SME continues to participate in meetings of this workgroup and continued to be encouraged by the discussion. Prior to these discussions, staff review measures and are generally prepared to discuss areas that needed further review or discussed systemic issues that resulted from their review. Systemic issues that were discussed and identified for improvements are discussed in more detail in paragraph 100.

In the last report, the SME recommended this workgroup identify actionable items to address the systemic issues in subsequent meetings. The workgroup has focused on the root cause of the critical incidents that have been reported for individuals that have transitioned from NFs. As indicated in Attachment B.1,

approximately 50% of individuals experienced a critical incident in the last quarter of CY 2020. The percent of critical incidents gradually increased in CY 2020. Staff reviewed these critical incidents to identify if there were trends in the type of incidents and to determine what actions were taken or could be taken to prevent these incidents. This review identified that most of the critical incidents were related to major medical issues. While major behavioral health issues and falls were also experienced by individuals that transitioned from NFs, major medical issues were far more significant. These major medical issues often resulted in an ED visit to inpatient admission for physical health concerns. This is consistent with the findings from the SME Service Review where almost one half of the individuals in the review experienced a major medical issue. The review by the LDH staff quality committee and the SME review identified issues with access to specialty physical health providers during the pandemic. Individuals did not have access to non-emergency transportation during the pandemic and relied on EDs to treat their acute needs, many of which could have been treated in the community. The SME recommends the State monitor the availability of Non-Emergency Transportation and consider other opportunities to expand access to transportation to these specialty medical providers to reduce the critical incidents that are related to addressing their ongoing and sometimes chronic physical health conditions. In addition, the State should consider conducting a Quality Improvement analysis as proposed in the Needs Assessment to identify the causes of ER and inpatient admissions, and the extent to which these adverse events are the result of barriers to primary care preventive services as well as to identify strategies for reducing the frequency of these events.

The State continued to implement the design of the quality assurance system, setting forth the process that the State will use to collect, analyze, identify, and address individual and systemic issues that result from the process they have created over the past year. In the last report, the SME recommended a process to engage the My Choice Advisory Committee and other stakeholders in the quality assurance process. Over this reporting period, the State reviewed the overall quality assurance approach with the My Choice Advisory Committee to solicit feedback and recommendations. In addition, LDH created a subcommittee of the Advisory Committee, the Quality Resource Group, which has met monthly since February with LDH to provide feedback and recommendations regarding the measures in the matrix, the SME service reviews, and the State's overall quality assurance process. The SME participated on all Quality Resource Group calls. In the opinion of the SME, the State provided timely and valuable information to the members of this group regarding the measures, including the process for collecting the measures, and solicited feedback from the group on changes to the initial set of measures or additional measures to be considered for future efforts. The recommendations from the Quality Resource Group will be incorporated into the State's ongoing Quality Assurance efforts. The SME also recommends that LDH amend the initial measures (as recommended by DOJ and the SME) with a particular focus on improving measures specific to PASRR, stability and community integration.

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 has developed a critical incident report (CIR) process that is used by both agencies (OAAS and OBH). As indicated in the previous SME report, these agencies had separate processes for reporting critical incidents. As indicated in the third SME report, both program offices had different elements and processes for collecting this information. The SME recommended in previous reports that these definitions and processes should be made consistent across the two agencies and that LDH develop a combined quarterly

critical incident report for all members of the Target Population who have been transitioned or diverted from nursing facilities. The program offices have aligned definitions and processes for individuals transitioned from NFs. The OBH TCs are responsible for completing the CIRs, capturing the elements and measures that align with the definitions and formats used by OAAS. LDH then combines the critical incidents across program offices and provides aggregate information for the quality matrix.

The State has developed these similar definitions and processes and has been the focus of cross agency discussions and improvement strategies regarding these incidents as part of their overall Quality Assurance framework.

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 has not requested this information for review for this reporting period. The State reports that initial efforts to have community providers report critical incidents will occur with the community case managers in CY 2021. The State has included these requirements in the MCO contracts for this service. The SME is deferring this request to the next reporting period.

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, subject to review and approval by LDH, 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, including 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 uses 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.

In the previous reporting period, LDH developed an interim protocol for immediately notifying the SME and DOJ on all deaths of members of the Target Population who had 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 information to their supervisor, including the date of death, cause of death, date of TC's last contact, and whether other individuals were with the member when they died. The program office leads are to contact the LDH 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.

There have been no deaths of members of the Target Population who had transitioned from an NF during this reporting period.

As indicated in previous reports, OBH and OAAS had different mortality review processes for collecting and reviewing information on deceased individuals in the Target Population who had transitioned from NFs. OAAS had a separate Mortality Review Committee that is charged with monitoring and analyzing deaths of OAAS waiver participants. While their mortality review process was consistent with similar processes used by other agencies, OBH was limited in their ability to collect information needed from key informants to fully evaluate the circumstance prior to an individual's death; they did not have the statutory authority to collect privileged information from medical providers who may have had a role in the delivery of health care services to these individuals. Since the previous report, OBH has received the statutory authority to fully investigate deaths and the two agencies have developed a joint mortality review committee protocol for the My Choice Program. In the opinion of the SME, the new protocol is a vast improvement over the interim protocol developed during the previous reporting period. The new mortality review protocol includes:

- Description of the composition of the My Choice mortality review committee.
- Functions of the My Choice mortality review committee.
- Procedures for the mortality review committee.
- Creation of a My Choice Mortality Review Database.
- Development of an annual Mortality Review Report and process for sharing this report with stakeholders.

As part of this process, the State has developed a mortality review form for the My Choice Program and a mortality review committee documentation form that summarizes the assessment, findings, and recommendations regarding deaths. The State reports this process was used for deaths that occurred in CY 2020 for some individuals who transitioned from NFs. The SME has not had an opportunity to evaluate the effectiveness of this process.

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.

Paragraphs 98 and 99 are addressed together. The State, as part of its larger quality assurance framework, has developed a process for collecting and reporting on preliminary measures to address the requirements of this paragraph. These preliminary measures and performance data are reflected in the quality matrix provided in Attachment B.1-B.3. As noted above, the SME recommends that LDH amend the initial measures with a particular focus on improving measures specific to PASRR, stability and community integration.

The data sources identified in the matrix provide the State with reliable information (e.g., Medicaid claims or UTOPIA PASRR information). Other measures are being collected through self-reporting processes gathered from the Transition Coordinator monthly logs. This information includes whether:

- Individuals received the services in their transition plan
- The plan addressed their needs
- Individuals are reporting good physical and mental health
- There are changes in medications
- Individuals report stability in housing and natural support networks.

The information collected also attempts to gauge the individual's 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. In the previous SME report, the SME recommended the State develop a process that would verify information that is being self-reported. During this reporting period, the State has developed an initial process for independently collecting additional information or verifying existing information collected by the State. Specifically, the State is considering having the Transition Coordinators perform interviews with the Target Population member to verify that the information being reported is accurate. This process is being considered for implementation in CY 2022, when the Transition Coordinators will no longer be providing intensive case management for individuals who have been transitioned from nursing facilities and can collect and review information through a more independent review of the quality of services provided, assessing Target Population members' satisfaction of services, transition, and community tenure more generally.

In addition, the Service Reviews conducted by the SME this past year were also a source to verify information collected by TCs. Specifically, these Service Reviews reviewed information on the following measures:

- Number and percent of transitioned members who received services in the amount, frequency, and duration specified in the transition plan
- Number and percent of transitioned members whose plan of care addressed their needs
- Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessments
- Number and percent of transitioned members reporting that they were able to make choices and exert control over their own life.

As indicated in the Report in Attachment A, the SME Service Review Team obtained information through interviews and review of various documents to assess the quality and sufficiency of services provided to a representative group of individuals who were transitioned from nursing facilities over the past two years. The Team relied heavily on member interviews since the original transition plan format provided more detail regarding community services requested immediately prior to transition versus on an ongoing basis. Revised and subsequent Transition Assessment and Transition Planning documents provided more detailed information on post transition services. A review of documents and interviews did indicate almost all members transitioned from nursing facilities received the services in the transition plan. Unfortunately, the initial and current Transition Plans do not include the recommended amount, frequency, and duration of services, and therefore the Team was unable to answer that question specifically.

The next measure is the number and percent of transitioned members whose plan of care addressed their needs. As indicated in the Service Review Report, individuals in the review had multiple assessments and plans. These multiple assessments made it difficult to obtain a comprehensive perspective of the collective needs and desires of the individual and the extent to which plans addressed those needs. The lack of a comprehensive plan hindered the ability of the review team to ascertain whether individuals participating in the review were generally getting their needs met.

The third measure was the number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessments. The source of information for this measure was both Transition Plans and the presence (or absence) of a current crisis plan. In the review, only two individuals (25%) had clear documentation of a current crisis plan or stated they had and were familiar with their crisis plan. These plans are important tools for the individual, caregivers, their support network, and organizations involved with providing services to identify potential causes of crisis and strategies that can be deployed to address and prevent the crisis from escalating. It will also be helpful to guide the new crisis providers in their efforts to respond to a crisis.

The final measures, the number and percent of transitioned members reporting that they are able to make choices and exert control over their own life, was collected through interviews with the members. As indicated in the Service Review Report, the Team interviewed individuals on their transition experience and their overall experience of care post discharge from the nursing facility. Multiple questions were included in the interview to solicit a response to this question. All members (and in one instance, a caregiver) interviewed stated they were actively involved in the planning process, were provided choices regarding their services and supports, and generally felt they controlled their own life post transition. The

Team impressions of individuals' responses to these questions was supported by the strengths and resiliency of the individuals. These strengths included:

- A commitment to stay independent, generally positive or very positive about the transition
- Ability to advocate for themselves, often tenacious and self-directing
- Capability to articulate clear preferences (i.e., where to live, services, and supports)
- Goal oriented
- Self-sufficient in many areas, arranging their own appointments and using social network for critical activities (e.g., shopping, transportation).

In order to address the Team's initial findings regarding assessments and plans, the SME recommends LDH consider an assessment and more comprehensive plan that weaves together the holistic needs of the individual. The plan should consider:

- Specific services, formal and natural supports that are needed by the individual
- The initial proposed scope, amount, and duration of the Plan
- Organizations and individual practitioners that will render these services
- A crisis plan that includes potential causes and strategies for recognizing and addressing crisis (including physical and behavioral health)
- Sharing of this comprehensive plan with individuals, caregivers, and organizations delivering care
- Cross sharing of plans during regular team meetings with the individual and others identified by the individual who should participate in regular team meetings
- Updating the comprehensive and individual plans when a significant event or change in an individual's condition occurs.

The SME recommends these features be incorporated into the new community case management process that will be implemented during the next reporting period. Specifically, the SME is recommending LDH develop or have MCOs develop the assessment and comprehensive planning documents and seek input from stakeholders regarding the proposed process and components of these documents. In addition, the State should develop (or require the MCOs to jointly develop) protocols and training for community case managers responsible for conducting the assessments and coordinating the overall care planning process.

Currently, the State's matrix does not include data measures related to 99(i), which requires the State to collect and analyze data to measure "barriers to serving individuals in more integrated settings, including the barriers documented and any involvement of the Transition Support Committee." The State has developed a process to identify barriers to serving individuals in more integrated settings, including information from the Service Review Panel (SRP), as described in paragraph 58. The members of the SRP meet weekly and OBH and OAAS leads join 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 recent needs assessment provides information on the utilization of Community-Based Services for individuals who were in the Target Population. This needs assessment provides a framework for the State to collect and analyze utilization for all members of the Target Population (individuals who were transitioned and diverted). Specifically, the needs assessment provides information on:

- Services utilized by individuals who are currently in nursing facilities. LDH can use this information to review utilization against the number and percent of individuals whose PASRR Level II evaluation recommended specialized services.
- Services utilized by individuals who are transitioned from nursing facilities. LDH can use this information to determine if additional capacity is needed for existing services and if there are any changes in utilization over time that should be explored for potential gaps.
- Services utilized by individuals who are diverted from nursing facilities. Similar to individuals who were transitioned from nursing facilities, this information can provide some recognition on service gaps for this cohort of the Target Population.
- Services utilized by individuals who are at-risk for admission to a nursing facility. This information can provide a valuable barometer of the approaches the MCOs are undertaking to serve these individuals and diversion efforts from emergency departments and inpatient hospitalizations (all cause).

Information from the needs assessment was provided by LDH and therefore the State will have ready access (and a format) for ongoing review of services utilized, to identify potential gaps in services. The SME recommends that LDH develop and review this data on an annual basis (as required in paragraph 101) or more frequently if necessary. The SME recommends the State develop these same reports in the third quarter (April) of each year to review and determine if additional capacity is needed and whether additional budget requests will need to be made the following summer based on the State's budget cycle.

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 developed the reports for the measures identified in paragraph 99 for the purposes of meeting the requirements of this paragraph. The reports for the quarter and year ending in December 2020 are provided in Attachment B.1-B.3. In general, these reports indicate that measures have been more positive and are similar or greater than measure values since the beginning of CY 2020. There are several measures that continue to indicate potential systemic issues that the State's quality assurance workgroup should address, including:

- Number and percent of transitioned members who report that they received all types of services specified in the transition plan. One in four individuals continue to report they do not receive all types of services specified in the transition plan.
- Number and percent of transitioned members reporting they are receiving the services they need. Twenty-one percent of the individuals continue to report they do not receive the services they need.
- Approximately 80% of transitioned members report that they participated in planning.
- Thirty percent of transitioned members report that they have experienced any major incidents.
- Number and percent of individuals who report that they had a change in medications/ treatments, or side effects from, and/or in who gives them. While the percent of individuals have decreased

(on average 24% of individuals reported this change), this was a significant issue in the Service Review Report and should be addressed through better medication education and adherence strategies.

- Review and analysis of critical incident reports submitted by the TCs and using provider and member reported CI information indicated:
 - On average 14 individuals per month reported a critical incident.
 - These individuals averaged approximately 20 critical incidents in aggregate, with most of these incidents being major medical events (all cause admissions into hospital and emergency department presentations representing 75% of these events).
- Number and percent of transitioned members reporting that they are involved in the community to the extent that they would like is increasing but is still worth LDH exploring; on average 21% of individuals who have been transitioned reported they have not been involved in the community as much as they would like.

In the previous SME report, it was identified that LDH had not developed a clear process for how the reports will be reviewed and factored into a larger quality assurance framework for the Agreement. The State has yet to develop a quality assurance plan, as recommended and discussed in paragraph 94, to meet the requirements of this Agreement. The State is in the process of finalizing this plan during the beginning of the next reporting period.

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.

As indicated in Paragraph 99, LDH has completed the first needs assessment for individuals in the Target Population. LDH will be providing the finding of these needs assessment to the My Choice Advisory Committee and will post this information of the My Choice Website during the next reporting period. The State has the necessary templates and data to populate and analyze information from Transition Assessments, PASRR Level II evaluations, and Medicaid claims to be able to replicate the original needs assessment for subsequent years. The SME is requesting that LDH provide information regarding the approach and frequency for meeting the requirements of this Agreement on an annual basis as proposed in paragraph 99.

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 to access data collected under this Agreement. As recommended in the previous report, the State should consider including other State agency input as part of its larger quality assurance framework. Specifically, the State should have a parallel process for reviewing the measures, including changes in the measures, and specifically discuss implications for their systems and assistance that may be needed to improve the experience of individuals who have been transitioned or diverted that have implications for other systems (e.g., OCDD).

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 most areas of the Agreement. As the State emerges from the COVID-19 pandemic, it will be imperative for TCs to more aggressively perform their in-reach and transition efforts. While the in-reach effort seems to be off to a good start, transitions continue to lag significantly. The State has only achieved 10 percent of the proposed transitions projected for this calendar year during this reporting period.

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 CY 2021. In addition, several areas will need significant attention:

- Meeting the targets set forth regarding the number of individuals who will need to be transitioned in CY 2021.
- Continuing to implement and track the success of the more aggressive in-reach strategies to contact individuals on the Master List to gauge their interest in moving and to begin transition activities.
- Developing rapid referral and transition efforts for individuals identified through this new in-reach process who have expressed a desire to transition.
- Developing strategies to address the recommendations set forth in the SME Service Reviews and the Needs Assessment.
- Considering methods to develop projections and strategies for additional years of the Agreement.
- Continuing to develop the necessary infrastructure for the community case management benefit.
- Finalizing implementation strategies for services that were included in the FY 2022 budget, including crisis, employment, and personal care services.
- Continuing to pursue the strategy set forth in the Housing Plan.

LA-DOJ Subject Matter Expert (SME)

Service Review Report

6/30/2021

JOHN O'BRIEN, TECHNICAL ASSISTANCE COLLABORATIVE

Introduction

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

The Agreement sets forth the requirement for a Subject Matter Expert (SME). Among other duties, the SME is responsible for assessing the quality and sufficiency 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. This is the initial report by the SME regarding these service reviews. A summary of findings from this report indicate:

- Many individuals experienced positive changes in their overall well-being post transition and almost all expressed a strong desire to never return to the nursing facility.
- Critical services not available on a timely basis, such as specialty physical health services, in-home nursing, essential transportation to primary care and specialty care providers and personal care services.
- Lack of accessible housing for individuals with mobility issues and evidence of housing instability for some individuals in the review.
- Significant concerns with post discharge care coordination, including the absence of an overarching community plan post-transition and unevenness in care coordinate efforts especially for individuals with significant physical health issues.
- The absence of crisis plans to address behavioral health issues.
- Poor community engagement and an inadequate focus on community inclusion in the planning process.
- No individuals were employed despite work histories and expressed interest during the interviews.
- There was evidence that most people received services in transition plan, but transition plan does not establish amount frequency and duration of service.
- Lack of information or understanding regarding individuals' mental health conditions and related service needs.

This report provides information regarding the design of the service reviews, the process of conducting the reviews, the findings of these reviews, and recommendations that the State should consider to make improvements to the My Choice Program that serves individuals in the Target Population.

It should be noted that there were several factors that affected the individuals who participated in the service reviews and impacted the service review process. The COVID-19 pandemic had an impact on several domains including community integration and physical well-being. Goals and interests expressed by the individual that were specific to fuller integration into the community (e.g., church, integrated adult health centers) were not available to individuals during most of 2020. In addition, contact with friends and families who comprised the individual's support network was significantly curtailed. In addition, some health care services (primary and specialty care) were interrupted early in the pandemic and resulted in emergency department visits for care that would have been typically provided in an office-based setting.

The pandemic affected the service review process. Originally, the service review team was to begin their on-site efforts in Spring of 2020. Due to the pandemic, all records had to be collected and transmitted electronically. The pandemic hampered access to critical medical, behavioral health, and long-term services and support records. Almost all of these providers were not in-office, which had an impact on obtaining critical records (service plans and other documentation). In addition, all interviews were done virtually. While this worked well for most individuals reviewed, it did not always provide optimal engagement with the individual or other interviewee.

Another variable that affected the service reviews was the change in role of the transition coordinator. Prior to January 2020, the transition coordinator's role was to provide assistance with the transition and have an ongoing monitoring role. Transition coordinators were required to monitor the individual at certain timeframes post transition (e.g., 7, 30, 90, 180 and 365 days post discharge from the nursing facility). In CY 2020, the Louisiana Department of Health (LDH) modified the role of the transition coordinator to provide intensive case management. Transition coordinators were required to provide face-to-face and telephone contacts frequently to individuals who had transitioned. During the pandemic, LDH required contacts with these individuals on a more frequent basis (albeit almost all contacts were virtual). This role change generally had a positive impact on the service reviews. Transition coordinators completed contact logs more frequently which provided a rich source of information for the service reviews. In most instances, the transition coordinator was the identified care coordinator for the individual, leading team meetings across multiple care coordinators and service providers. It should be noted that in CY 2021, intensive case management services will be provided by community providers and the Transition Coordinators will return to their initial roles discussed above.

Focus of the Review

The Agreement did not provide specific parameters for assessing the quality of community-based services conducted through the service reviews. Therefore, the SME identified four domains for measuring the quality of the services. These domains are consistent with the areas that LDH used

for evaluating the overall quality of the My Choice Program and were based on paragraphs 98 and 99 of the DOJ Agreement. These domains include:

- **Physical health well-being**—Individuals in the Target Population had *one or more co-morbid physical health conditions*. The presence of co-morbid conditions is associated with adverse health outcomes, such as poor quality of life, disability, behavioral health issues, and increased mortality.
- **Behavioral health well-being**—Individuals in the Target Population *had a serious mental illness* and many needed an array of services to address their condition and symptoms. Untreated or undertreated mental health and substance use disorders are associated with premature mortality, productivity loss, high rates of disability, and increased risk for chronic disease.
- **Stability**—Individuals in the Target Population were at higher risk of adverse social determinants of health including *housing stability, income security, social support networks, education, employment, physical environments, and coping skills*.
- **Community Integration**—Individuals with serious mental illness experience isolation and lack opportunities to fulfill meaningful roles and activities in their communities. There is abundant evidence that participation in community life positively affects health and behavioral health.

In addition, the SME designed the service reviews to also focus on the *sufficiency of community-based services*. This required the service team to review assessments, service plans, and services received post transition. The reviews sought to answer the following questions:

- Did members who transitioned receive services in the amount, frequency, and duration specified in the transition plan?
- Did the plan of care address the individual's needs?
- Did the service plans include strategies that addressed their health and safety risks as indicated in the assessment(s)?
- Did individuals report they were able to make choices and exert control over their own lives?

These four questions are included in the State's overall quality framework for the My Choice Program (currently measures 1.e, 3.e, 4.e, and 7.a in Attachment B). The intent is for these Service Reviews to provide the data for those measures going forward.

Finally, the service review concentrated on the *outcome of the transition*. Specifically, the review highlighted the successful and less successful aspects of the member's transition and maintenance of tenure in the community. The focus on the outcome of the transition was to provide LDH with feedback regarding the design of the transition process and potential recommendations for improvement to this design, especially as LDH considers the implementation of the Community Case Management service.

Methodology

This section provides an overview of the methodology for completing the service reviews. The approach included the process for selecting a representative sample of individuals who would participate in the review. Once selected, applied a methodology that included a review of records, Medicaid claims analysis, and interviews. Interviewees included individuals, their caregivers (when requested by the member), Transition Coordinator, Managed Care Organization (MCO) case manager, Community Choice Waiver Support Coordinator, behavioral health provider (e.g., Assertive Community Treatment Team) and other persons recommended by the individual or support network. Based on a review of all of these sources, a summary was produced for each individual that provides an overview of the individual's overall strengths, scores in each of the domains described above, positive aspects and areas of improvement for each domain, and systemic findings. Each phase of the methodology is discussed below.

Reviewers

The review team is comprised of three licensed behavioral health clinicians and the Subject Matter Expert. All three members of the team were selected by the Subject Matter Expert because they have significant experience with individuals who represent the Target Population in different capacities. While these members have strong clinical backgrounds, they have also had other responsibilities in relevant areas such as care coordination, population health management, and quality improvement. Two of the team members had designed and implemented service reviews for populations with health and behavioral health needs in other locales. We specifically added a member of the team who was a nurse to assist with the team's efforts to identify physical health issues and potential strategies for identifying and addressing medication concerns and service gaps specific to health care.

Sample Selection

The samples for the reviews were drawn from the population of individuals who transitioned from nursing home placements into community-based services between 7/1/18 and 12/31/20. As explained below, there were two sets of reviews. An initial review was based on members from the Target Population who were transitioned between 7/1/18 through 12/31/2019. In March of 2020 when the first review started, there were approximately 92 individuals in this group. The State estimated that approximately 50 of these individuals meet criteria to receive home- and community-based services under an existing Medicaid 1915(c) waiver program. By participating in this program, these individuals should have access to a range of behavioral health services and established long-term services and supports. Individuals who do not meet criteria for the 1915(c) waiver program receive behavioral health services and other community supports which are in the process of being developed and improved by the State. We assumed the individuals might be at increased risk of service disconnection given they did not have a single source of care coordination. As a result, we oversampled individuals who are not participating in the 1915 (c) program and assigned to the Office of Behavioral Health for Transition Coordination.

We began the review with a sample of four Target Population members during the first record review. The purpose was to test the initial methodology for these reviews (discussed in more detail below) on a smaller sample of individuals. There were several steps to identify the sample. The first step was to request a complete list of the Target Population members who had transitioned and specific information on each individuals including:

- Age,
- Ethnicity
- Gender
- TC assignment
- Region of residence, and
- Participation in the 1915 (c) program.

The SME team used a random sample to select eight individuals who were generally representative of the Target Population. If the samples were not representative of the demographics listed above, we conducted additional random re-drawings until the sample was more representative of the total population that was transitioned. The initial sample of eight was representative of the target population that had been transitioned to date.

Outreach to these eight individuals occurred through the Transition Coordinator who contacted the individuals on behalf of LDH and the SME to request their participation in the service review. Four of the eight individuals agreed to participate in the review. Each member who agreed to participate signed a consent form specific to the service review process.

For the second sample, the SME followed the same protocol for selecting individuals in the Target Population to participate in the review process. For this sample, we included 38 individuals who transitioned from nursing facilities from 1/1/20 through 12/31/20. We requested and received demographic information on these individuals. Unlike the first nineteen months, an equal percent of individuals were participating in the State's 1915 (c) program as those individuals who did not meet criteria for the 1915 (c) waiver program. Ten individuals were selected to participate in the service reviews who represented members of the Target Population who had transitioned, across demographics, geography, and 1915 (c) waiver participation. Of these 10 individuals, four agreed to be part of the service review. Each member who agreed to participate signed a consent and an additional release of information form specific to the service review process.

Record Review

Once individuals participating in the review were identified, we submitted a formal request for records and other information to LDH in [date]. For the initial sample (four individuals who transitioned between June 2018 and December 2019), we had identified a robust set of records and other information that would be helpful to complete this review. The records focused on collecting information on basic demographic information, documentation of service needs and services provided (pre and post transition), emergency department and inpatient record (pre and post transition), assessment and evaluations (e.g., MDS, PASRR Level II, CCW Waiver), service

plans (transition plans, MCO plans and CCW Plans of Care), critical incidents, and other information.

One challenge experienced on the record collection effort for the initial sample was collecting timely and current records and other information. While certain records were immediately available (e.g., LDH-specific records such as PASRR level I and II, MDS, transition assessment and plans), other records requests were far more challenging to obtain. The ability to access records external to LDH was extremely limited due to COVID-19 pandemic since practitioners and providers were remote and did not have immediate access to these records. In other instances, there was a significant time lag between the request and receipt (or in some instances these requests went ignored) of these external records despite LDH's multiple requests to these providers. The inability to collect some external records on a timely basis affected the timeliness of the reviews (in some instances by weeks or months) and led to significant delays in the process. In addition, Transition Assessments for individuals in the initial sample were less robust than the Transition Assessment forms used in subsequent samples. Information regarding interests, employment and other information that would assist with developing goals regarding community integration was not included in the initial form.

The lessons learned from the initial sample informed our subsequent record request for the second sample. We limited the request to records and information that would be timely, current, and readily accessible. The SME second review was not able to collect medical and other physical health provider records that would have provided a more robust assessment of the conditions and the scope of services that may have been needed to address those conditions. This would allow the reviewers to conduct the record review on a timely basis and collect the information necessary for the next phase of the review—interviews with members and key individuals identified as having an important role in the individual's life and service provision. In addition, the Service Review team determined that MCO case managers were able to obtain additional information from community providers given their contractual relationship with these providers. While OBH requested information from these providers, they did not always have leverage for these requests. Attachment C also provides the recent list of records that were requested for the second sample.

Interviews

Interviews provided the most valuable source of information regarding the quality of the services provided to the individuals who were transitioned and the experience of the member, caregiver, and participants in the transition process. As previously indicated, interviews were requested and conducted with:

- Individual
- Caregiver or significant other (if requested by the individual)
- Transition Coordinators
- MCO Case Manager
- Support Coordinator (for individuals participating in the CCW)
- Direct service worker (personal care provider)
- Behavioral health provider (when available)

An interview guide was developed for different interviewees. For instance, there was a specific guide for individuals and caregivers, transition coordinators, and other service providers. These interview guides are included in Attachment D. These guides sought to solicit information on the key areas of focus: physical health well-being, behavioral health well-being, stability, community integration, and the outcome of the transition. Each individual was contacted and provided potential times (including weekends and evenings) for the interviews. Interviews commonly lasted about 60 minutes. The review team asked each individual if they would like to have someone present during the review. Many individuals requested their direct service worker or caregiver to be present during the interview. Given the pandemic, all interviews were conducted virtually. For the initial reviews, interviews occurred from August through October 2020. For the second cohort, interviews occurred from March through May 2021, it should be noted that reviewers were advised to raise issues immediately to the State if there were emergent situations that presented imminent risk to the individual.

Review of Claims

The review also included the collection and analysis of Medicaid claims data for several purposes. As previously indicated, the review examined whether services were delivered consistent with the transition plan and community plan of care. In addition, the claims are helpful for understanding whether the individual was receiving additional services that were not included in the record review or discussed in the interviews. The claims summary also allowed the reviewer to determine if there were gaps in treatment—especially prior to a critical incident (e.g., behavioral health inpatient admission). Medicaid claims were requested from LDH for each individual participating in the service review for the year prior to discharge and for the period post discharge to the review date. Unfortunately, over one-half of the individuals were dual eligible (Medicare and Medicaid). Medicare claims are not available to LDH and therefore data on critical services reimbursed by Medicare (e.g., physician services, inpatient hospital, and pharmacy) were lacking for these individuals, making it more challenging to draw conclusions about service adequacy and quality. The claims analysis format is provided in Attachment E.

Summary and Scoring

Information collected from the interviews, record reviews, and claims data was reviewed by a two-person team to develop the summary for each individual participating in the service review. A summary was completed for each individual that provided the following:

- General demographic information (i.e., gender, age, region, transition date)
- Member's strengths as identified by the review and other interviewees
- Community services received
- Care coordination/case management received
- Critical incidents
- Summary of records reviewed.

In addition, the two-person review team completed a summary of the strengths and areas for improvement for each of the following domains and areas:

- Physical well-being
- Behavioral health well-being
- Stability
- Assessment and Person Centered Planning
- Community Integration
- Transition Outcome.

Strengths and areas of improvement were identified from the interviews and records reviewed. The team identified the strengths and areas of improvement for each domain for each individual. The team discussed these strengths and areas of improvement to determine a score using a 5-point Likert scale for each of these domains and areas. Each reviewer used the evaluation criteria in Table 1 to assign a score. The scoring tool with instructions is provided in Attachment F.

Table 1. Evaluation Criteria Used for Scoring

Score	Definition
5	A significant number of strengths (individual and process) were identified. No areas of improvement were identified.
4	Some strengths were identified and there were areas of improvement identified.
3	Some strengths were identified and one area of improvement was identified.
2	Some strengths were identified but there were a number of areas of improvement.
1	No strengths were identified and there were many areas of improvement.

Each reviewer rendered a score independently to measure reliability. Once each reviewer provided a score, these scores were compared to identify and discuss differences. A consensus process addressed major scoring differentials to obtain a final score.

Finally, each review team was requested to identify potential systemic issues arising from the service review process. These issues included documentation issues (e.g., lack of or incomplete documentation), process issues (e.g., coordination of care), and service availability and access issues including barriers to receiving care.

Review of Plans

The review team was also tasked with reviewing assessment and plans to determine if the plan addressed the individual's needs as identified by the assessment and whether the individual received services in the amount, frequency, and duration specified in the transition plan. The reviewers also evaluated whether the plans include strategies that addressed their health and safety risks as indicated in the assessment. The team collected and reviewed the transition assessment, transition plan, and claims summaries to initially determine if the plans addressed the needs identified in the assessment and if the Medicaid claims identified whether these services were provided to individuals. In addition, the service review team also solicited information during the interviews to verify or supplement information regarding the services received by the individual.

Summary of Findings and Scores

This next section provides information from the service reviews. General demographic and other information is provided for the eight individuals participating in the service review for the past year. An overview of the individuals' strengths is also discussed below. This is followed by aggregate scores for each of the domains and areas scored by the reviewers as well as a summary of the strengths and areas of improvement for each domain and area.

Review Participants

Table 2 provides a snapshot of individuals who participated in the service reviews. As indicated in the sample selection section there was a wide age range for individuals participating in the service review (44-82). This range was slightly different from the overall percent of individuals who transitioned from nursing facilities with age ranges:

- Individuals under 49 represented 9% of transitions.
- Individuals between 50-64 represented 61% of transitions.
- Individuals 65 and over represented 30% of transitions.

Attachment A provides a comparison regarding the overall demographics of the transition population and the service review participants.

Of the participants, 75% were female and 25% were male. This is different from the overall population that transitioned (47% female and 53% male). The participants resided in five of the State's service regions. Several individuals resided in the same region.

Table 2. Demographics of Review Participants

INDIVIDUAL	AGE	GENDER	REGION	RACE/ETHNICITY
1	65	F	6	Black
2	73	M	4	Caucasian
3	52	M	1	Caucasian
4	67	F	4	Caucasian
5	44	F	5	Black
6	82	F	1	Black
7	44	F	2	Black
8	56	F	4	Black

Nursing Facility Length of Stay Prior to Transition

Individuals participating in the service reviews had variable lengths of stay. As Table 3 below illustrates, the length of stay ranged from 9 months to over 129 months (greater than 10 years). The average lengths of stay for all individuals in the Target Population's Active caseload list was 45 months. The average length of stay for individuals that were transitioned was 37 months.

Table 3. Nursing Facility Lengths of Stay

INDIVIDUAL	NF ADMIT	NF DISCHARGE	MONTHS
1	11/2018	3/2020	14

2	11/2016	8/2019	33
3	7/2016	9/2019	38
4	8/2018	5/2019	9
5	10/2008	7/2019	129
6	4/2019	12/2020	20
7	5/2017	2/2020	33
8	3/2019	12/2020	21
ALOS	37 months		

Community Tenure

All individuals who participated in the review continue to live in the community. Table 4 provides the length of community tenure, which varied as expected across service review participants. Individuals in the first phase of the reviews were transitioned from nursing facilities earlier than individuals in the second phase. It should be noted that none of the individuals were re-admitted to a nursing facility (which was consistent with all individuals transitioned from NFs during the same period).

Table 4. Lengths of Stay in the Community Post-Discharge

INDIVIDUAL	NF DISCHARGE DATE	MONTHS IN COMMUNITY
1	3/2/2020	14
2	8/6/2019	21
3	9/11/2019	20
4	5/2/2019	24
5	7/11/2019	22
6	12/18/2020	5
7	2/7/2020	15
8	12/16/2020	5
Average	15 months	

Strengths

The service review team interviews focused, at the beginning, on the strengths of the individual reviewed. In general, most individuals were able to advocate for themselves and were often tenacious and self-directing. In their interviews, they often had clear preferences (i.e., where to live, services, and supports). Most individuals exhibited remarkable resiliency and were goal oriented.

Generally, most individuals had good social skills, and were affable as reflected in the interviews. Several individuals interviewed had a good social support system (good family involvement or had made friends post transition). Others expressed an interest in seeking to improve their social

supports. Almost all individuals in the cohort expressed their desire to be socially engaged and rekindle family relationships or form new relationships.

Some individuals in the review were able to arrange appointments (physical, behavioral health, and transportation) on their own. In some instances, they relied on formal and informal supports to provide or arrange transportation. Several individuals exhibited good problem solving skills during their interview and many knew how to assertively access their various care coordinators (including transition coordinators) when needed.

All individuals interviewed were clearly committed to stay independent and were generally positive or very positive about the transition. Almost all expressed a strong desire to never return to the nursing facility. There were also several attributes worth noting. Several individuals had good work histories or expressed an interest in returning to work. In addition, several individuals continue to be in recovery from previous substance use or misuse.

It should be noted that many of these individuals were adversely impacted by the pandemic. For all individuals reviewed, social isolation cancelled or rescheduled healthcare and behavioral healthcare services, transportation, and general anxiety regarding the pandemic had an impact on their ability to remain positive and on their community tenure. Despite the pandemic and its impact on their ability to engage with others or to access needed health care services, these individuals remained astonishingly positive. While many of them experienced critical incidents (discussed below), most remained relatively happy and stable in the community.

Critical Incidents

The service review team received all Critical Incident Reports for individuals that participated in the service review. These standardized reports collect information on major medical and behavioral incidents, falls, deaths and protective services (e.g. abuse, neglect, and exploitation). These individuals varied in the number of critical incidents occurring post transition. Several individuals had no critical incidents recorded since their transition. Others had multiple critical incidents. The majority (85%) of these critical incidents were specific to emergency department visits and inpatient admissions (all cause admissions). None of these individuals was re-admitted to a nursing facility during the review period.

Scores

This section provides information regarding the individual and composite score for individuals who participated in the service reviews. As indicated in the methodology section, each member of the service review team provided a score for each individual for each domain and area. Table 5 below reflects these scores.

Table 5. Composite Scores

INDIVIDUAL	PHYSICAL WELL- BEING	BEHAVIORAL WELL-BEING	STABILITY	ASSESSMENT AND PERSON CENTERED PLANNING	COMMUNITY INTEGRATION	TRANSITION OUTCOME	OVERALL SCORE
1	2	2	2	3	3	4	2.67

2	2	3	3	2	2	3	2.50
3	3	3	4	3	2	3	3.00
4	4	4	4	2	3	4	3.50
5	4	5	2	3	4	4	3.67
6	2	2	3	2	1	2	2.00
7	2	2	3	2	1	2	2.00
8	2	4	3	2	3	3	2.83
AVG. SCORES	2.63	3.13	3.00	2.38	2.38	3.13	2.77

Scores varied by individual and by domain or area. Scores for individuals were reflective of both the strengths and challenges identified in the service reviews. Lower scores for individuals represented significant issues or barriers prior to but mostly immediately after the transition. As described in more detail below, these issues were often reflective of the initial lack of services and supports during the two weeks after transition. The lack of access to services was not an ongoing issue after the initial transition period. The TC often worked with the individual to find other providers that could provide consistent services if there was a lack of services provided in the first few weeks post transition. One of the individuals with an overall poor score was significantly older than the overall cohort, had significant medical issues that impacted their quality of life and had a limited support network. They were also considered high risk for COVID-19 and the family caregiver was appropriately cautious regarding outings and in-home visitors, which impacted their behavioral health and community integration activities. The other individual with a low score had multiple housing transitions therefore impacting both their behavioral health well-being, community integration and stability.

While the transition plan identified most, if not all the services and supports, they were not in place immediately after transition. Most of these services and supports were more directly related to health care services, personal care, medical equipment, and medications. Higher scores for individuals often reflected that good pre-discharge assessment, planning, services, and supports identified in the plan were immediately available post discharge. Some higher scores were also reflective of individuals that may have fewer service needs and therefore services and supports at transition were generally available (e.g., medication and behavioral health services). There was some variability in scores for some individuals due to the pandemic. Access to services and supports was often affected by COVID-19 with some individuals needing to seek new providers given organizational and practitioner shortages (mostly for physical health).

There was also wide variability in the scores for each domain or area. With the exception of the overall transition outcome (reviewing the successful and less successful aspects of the member's transition), most other domains were in the poor to good range with a score between two and 3 on the Likert scale discussed on page 7. While some of these domains (e.g., community integration) were adversely affected by the pandemic, other domains were impacted by other variables. Discussed below is each domain or area. For each domain or area, trends in overall strengths in the approach taken to support the member were identified. For instance, for physical well-being, the strengths that support the physical well-being of the member are listed,

identifying the individual's strengths in this area and things that have been done well by service providers as well as formal and informal supports. For transition outcome, the review highlighted the best or most successful aspect of the individual's transition and maintenance of tenure in the community.

As previously indicated, the review also identified areas for improvement. For each domain, the reviewers provided brief statements of issues and areas of improvement that could/should be addressed to better support the individual post transition to the community.

Physical Well-Being

All individuals reviewed had multiple chronic health conditions. In addition to these behavioral health conditions, most of the cohort had at least four chronic conditions and one individual had over twenty active medical issues. Chronic conditions identified in this cohort included:

- Hypertension
- Hypothyroidism
- Cardiovascular disease
- HIV
- Arthritis
- Chronic orthopedic injuries (back, hips) requiring durable medical equipment (DME)
- Chronic pain management
- Obesity and metabolic syndrome.

Some of these conditions are not surprising given the age cohort of individuals agreeing to participate in the review. However, in the next section, is a discussion of the impact these conditions had on physical well-being and stability, which generated a number of systemic issues that will need to be addressed by the State moving forward.

Some individuals had an understanding and/or awareness of physical health issues and self-care needs. Some individuals appeared to have become physically stronger since discharge from the nursing facility. All individuals had an identified Primary Care Practitioner (PCP). Some individuals were able to keep their appointments with their PCP and specialty care post discharge despite the pandemic.

As previously indicated some individuals were capable and willing to schedule and manage transportation to their medical appointments. Other individuals were able to seek assistance from family members to provide transportation to medical appointments (especially during the pandemic). Transition Coordinators and Assertive Community Treatment (ACT) Teams were generally the first responders when physical health issues arose and access to services were compromised.

There were many areas for improvement. As mentioned throughout the balance of this report, there was no overarching community plan post-transition to have an understanding of the individual goals, desired services and supports, providers, and scope, amount, and duration of services. For physical well-being, this affected all members but often for different reasons. For

instance, four members were dually eligible (Medicare and Medicaid). Transition Coordinators and MCO Case Managers were either unaware of these Medicare services or supports, or did not take the necessary steps or felt they did not have the necessary leverage to engage Medicare providers in the transition and ongoing care planning. The MCO Case Manager was only responsible for behavioral health and therefore, did not see physical health issues as being within their scope, nor did they have the necessary information available (e.g., Medicare claims data) to identify physical health issues such as inpatient physical health inpatient admissions or emergency department visits. The lack of this information also made it challenging to identify potential medication administration issues.

These Medicare services and supports varied; however, the most critical services not often received were home nursing and essential transportation to primary care and specialty care providers. The lack of these services often resulted in the individuals or caregiver delaying care. For some individuals this resulted in an unnecessary inpatient admission. For other individuals they sought to receive specialty health care at an emergency department.

Individuals continued to have physical health issues that were often a precipitant to their previous nursing facility admission. Several individuals need the assistance of a wheelchair or DME to assist with ambulation. As indicated in this report, DME was not in place before or immediately after transition. In addition, some individuals had services identified that could improve ambulation (e.g., physical therapy) but there was little or no follow through on these appointments. As indicated in the assessment and person centered planning section, there was a lack of attention or limited knowledge by care coordinators regarding services and supports that were available through Medicare for individuals who were dually eligible. Most care coordinators saw these supports outside the purview of their referral and monitoring efforts.

In addition, social isolation and the lack of community integration also contributed to individuals' reliance on DME. Individuals did not have a reason or could not visualize themselves participating in activities that would require better ambulation. It should also be noted that individuals who required DME to ambulate also required accessible housing. Individuals and care coordinators indicated the lack of accessible housing did present barriers to offering multiple housing options to individuals.

Most individuals could not manage routine medications and were not always well informed regarding medication (physical and behavioral health) purposes and adherence. The reviewers found an overall lack of training for individuals regarding the purpose of their medication, the intended benefit and schedule for taking their medication. Some individuals relied on their family members to assist with medication self-management; others were involved with ACT but refused assistance with medication. Another individual cited the need for assistance with medication, as she would often run out of medication before refilling the prescription.

Medication reconciliation was another area for improvement. This issue applied to medications to address physical health and behavioral health issues. Most individuals experienced polypharmacy issues given their co-morbid behavioral health and physical health conditions.

Some individuals were discharged from the nursing home without the necessary medications. In one instance, the medications provided were not for the individual transitioned. There was also limited medication education and information provided to the individual pre and post transition. There was rarely medication reconciliation upon discharge. There were also occasional gaps in medication refills. This was sometimes due to a missed medication management appointment (3-4 months for one member). Individuals interviewed often-cited transportation issues as a cause for these missed appointments. While the transition assessments indicated the needs for non-emergency transportation—the lack of transportation providers especially during the pandemic made it difficult to get reliable and timely transportation.

Transportation (medical and non-medical) was a major issue for many individuals. As previously indicated in this report, the pandemic did have an impact on service delivery including transportation. For one individual, the transportation vendor was unable to provide transit and suggested they call an ambulance provider to get to a routine medical appointment.

For some individuals, medical transportation was arranged but the transportation provider did not arrive at the scheduled time or did not arrive at all. This was further complicated by the lack of transportation for individuals that needed a lift or other assistance. The delay or lack of medical transportation led to missed medical appointments that had an impact on individuals' physical health well-being.

For some individuals, DME and other medical care supplies were not available to members at the time of moving into new living arrangements. In some instances, individuals and caregivers “made due” until the equipment arrived. While the necessary DME was identified in the transition plan, delays by the medical equipment providers impacted the access to these services.

Finally, a number of individuals continued to have issues with performing Instrumental Activities of Daily Living (IADL). These IADL were identified in the Transition Assessment and individuals were referred to the Community Choice Waiver (CCW) Program or Long Term Personal Care Services (LTPCS). However, not all individuals that needed assistance with IADLs met the level of care necessary to qualify for these programs. Few individuals were re-referred for a subsequent evaluation for these benefits despite ongoing needs and sometimes-deteriorating IADLs. One Transition Coordinator cited a concern about “churn” for these programs—specifically individuals improving their IADLs and no longer qualifying for these supports, which is understandable but should not be a reason to make a follow-up referral for these programs that offer personal care assistance.

Behavior Well-Being

Overall, this domain was generally rated good by the reviewers. Individuals varied in their previous behavioral health history and services and supports needed. Individuals interviewed and plans reviewed (when available) indicated they were engaged in behavioral health services on a regular basis (and when available consistent with the behavioral health specific plan of care). Behavioral health services received by these individuals often varied in the scope of amount and

duration. Some individuals had mild mental health needs and required psychotropic medications and outpatient counseling. Some individuals had more moderate mental health needs and were actively participating in daily-organized mental health programs. Individuals with more intensive mental health needs were engaged in ACT teams and have been successful in maintaining a high level of functioning and community tenure especially for individuals in rural areas. Another individual was receiving effective services from a Permanent Supportive Housing provider that assisted the individual to sustain their community tenure. In some instances, there was continuity of behavioral health services prior to and post transition. In addition, some individuals reviewed had a stable behavioral health provider since discharge despite the pandemic. Some individuals participating in the service review had not experienced a significant behavioral health crisis or had any mental health changes since returning to the community.

Despite this being a domain that was generally identified as “good” by the reviewers, there were several issues related to the individuals’ behavioral health well-being. For some members, behavioral health services were identified early in the transition planning process but providers either were not engaged at the time of actual transition or were not updated on the members’ needs and conditions that had evolved in the nursing facility after the original contact. In one instance, the member expressed interest in behavioral health services but during transition chose not to receive those services (individual had mild need for behavioral health services). In another instance, the provider did not engage with the individual on a timely basis post transition. This individual eventually received these services within a month after transition.

Similar to the discussion of medications for physical well-being, medication knowledge and adherence were uneven across review participants. For instance, one individual was hospitalized within several weeks after discharge from the nursing facility due to medication issues. The individual and others stated the individual had taken too much medication and may have been unclear regarding the proper dosage upon discharge. Another individual was hospitalized due to the lack of adherence to medication. While the Transition Coordinator and direct service worker had developed sensible strategies for checking adherence, the individual did not always follow the proposed medication regimen.

A third individual lost her pain management specialist upon transition from the NF and went to the emergency room twelve times in four months seeking pain relief. There was another individual who was prescribed opioids for pain and had medication issues. In these reviews, there was little discussion about alternative pain management strategies that might be suggested for these individuals in addition or in-lieu-of pain medication.

The presence of a behavioral health crisis plan was variable. Some members had a crisis plan, while others did not. The lack of a crisis plan may be due to the lack of an overall community plan for the My Choice program since a crisis plan would be a component of the plan.

Most individuals had a history of alcohol or other substance use. Some individuals had not used a substance for many years prior to their nursing facility admission and no obvious substance use or misuse issues were identified in the record review or interviews. However, over one-half of the cohort had identified substance use (prior to admission and post discharge from the nursing

facility). During the interviews these individuals expressed they were not interested or reluctant to participate in treatment.

Stability

As indicated earlier in this report, the service review team defined stability broadly. Initially the team was focusing on critical factors such as housing stability and employment. After the initial reviews, the team took a more comprehensive approach to stability, focusing on critical social determinants of health versus a narrower focus. As indicated by the review, this domain had a mid-point score between poor and good. On a positive note, most individuals did not experience income instability. While all individuals were receiving some income from government programs (e.g., SSI or SSDI), none of the individuals reviewed experience a disruption in these benefits. For all individuals reviewed, housing was identified in the transition plan and individuals were discharged to a housing option identified in transition plan. Some individuals were able to return to their home where they resided prior to their nursing facility admission. Most individuals reviewed remained in their initial house or apartment post transition. Some individuals were able to develop new or revisit previous social support networks (e.g., family).

While housing stability was generally good for six of the eight individuals reviewed, there were several instances worth noting. Several members had multiple moves post transition. One move was unpreventable (displacement due to a hurricane). Yet other moves were due to conflicts with neighbors and property owners. One individual was placed temporarily for two weeks in transitional housing because he was frustrated with the slowness of the move and then moved again to permanent supported housing. This individual temporarily left the My Choice Program (was unable to be located) and moved several hours away to be closer to his family. This individual's new housing initially did not have heat and was in a state of disrepair. On the positive side, the individual and sibling made their own repairs to make the dwelling habitable.

One individual experienced a disruption in health insurance coverage. This individual experienced a loss of Medicaid eligibility and food stamps for several months following their transition. The individual did not provide the information for ongoing eligibility to LDH on a timely basis and these benefits were terminated. The Transition Coordinator worked with this individual to retain these benefits.

Multiple emergency department visits and inpatient hospitalizations (all cause) created overall instability of their community tenure and affected their ability to pursue their goals. Specifically four of the eight individuals had ED visits or presentation. The majority of these (80%) were for physical health issues. One individual had 50% of critical incidents that resulted in an ED visit or hospitalization. For this individual, there were no specific changes in the care plans to address future medical or behavioral health issues. For two of these individuals, there was a lack of information or interventions that were specifically addressing medication management that resulted in the ED visit or ultimately an inpatient admission.

In addition, most individuals, despite their personal strengths, were not afforded the opportunity to be actively involved in the community. While most individuals had identified interest in their

transition plan, most were not involved in these activities with any regularity. The transition plans and plans of care (when available) did not reflect either goals or interventions to address community integration. While the pandemic impacted their involvement, the first cohort in the service review did not seem to engage or were not actively encouraged to participate in activities of interest prior to the pandemic.

In addition, no individuals in the cohort were employed, despite solid work histories and encouragement by some Transition Coordinators to pursue work. The Transition Plan and Plans of Care (when available) did not include employment goals or interventions for individuals identified in the Transition Assessment of having a history and/or interest to pursue employment post-transition. The reviewers' general sense was that care coordinators were not thinking broadly enough regarding employment possibilities and did not take into account the individual's previous work history during the planning process.

Assessment and Person Centered Planning

Per the Agreement, LDH hired transition coordinators who were responsible for conducting individualized assessment and developing transition plans for each individual transitioning from a nursing facility. Originally, the initial Transition Assessment and Plan were modeled after the My Home Program (the State's Money Follow the Person Program). The state modified these documents in 2019 to better reflect the experience and choices for the Target Population. 4 of the individuals reviewed had assessments and plans that were prior to this revision. The second cohort had assessments and plans that were more tailored to the My Choice Program. The second cohort of individuals participating in the review therefore had assessments had more information collected regarding community integration and employment interests.

Yet, despite these changes, this domain was consistently poor across all individuals participating in the review and across various providers that were delivering services. There is significant variability in the completeness of Transition Assessment and Plans. As indicated throughout this report, assessment often lacked information regarding community interests and social relationships. Some individuals had been assessed using the initial Transition Assessment that did not include this detailed information regarding interests post transition. However, the revised Transition Assessment included a specific section on interests and relationships. For some individual assessed using this new tool, information was not collected on these areas. In addition, when the individual expressed interests during the assessment process the Transition Plan did not always address these interests or relationships.

On a positive note, the Transition Plan was largely the bright spot of the planning process. All individuals indicated they participated in the transition planning process and other service planning processes (CCW Waiver and MHR programs). This was confirmed by the interviews with other planning team members. In the review of the transition plans, almost all identified the strengths of the individual and the transition plan reflected the wishes stated by the individual.

In addition, all individuals reported they are able to make choices and exert control over their own life when interviewed.

All individuals interviewed indicated they received the services requested and needed. One of the bright spots in the reviews was the role of the Transition Coordinator. Since January 2020, LDH has required the TCs to provide intensive case management in addition to their other responsibilities (e.g. in-reach, transition assessments and planning). This is a temporary strategy until the community case management service is put into place later in CY2021. This service will be provided by community-based providers that have experience with providing case management consistent with the standards developed by LDH. For most individuals, the Transition Coordinator made solid attempts to coordinate the care across multiple organizations and providers. The Transition Coordinators held team meetings with some regularity to discuss potential changes in services and supports, especially when there was a critical incident. Unfortunately, subsequent changes in plans due to these incidents were not identified in the documentation provided. In addition, there was also strong collaboration between the Transition Coordinator and MCO Care Coordinator. They generally worked in tandem during the transition process and were in frequent contact post-discharge.

A major concern is the lack of an overall community plan for the individual that knits together the goals, overall desires, and needs of the individual. MCO case managers, support coordinators, and behavioral health providers had assessments and plans for individuals. However, these documents were not always exchanged across care coordinators nor was a comprehensive community plan created for individuals who transitioned from nursing facilities.

There was rarely documented re-assessment of the individuals' needs post discharge that would typically lead to a modification of each individual's plan and would address any changes in living environment, integrated day supports, or social needs that would support community inclusion. Given that there was not an ongoing comprehensive plan, there was no regular updated assessment that would account for an individual's recovery or for ongoing issues such as critical incidents or possible gaps in care. The service review team would generally expect to see an updated assessment of a community plan when significant events (crisis, hospitalization, and critical events) occurred, which many of the individuals experienced post-discharge.

There were other aspects of the transition planning process that were lacking or absent. For instance, while the assessment generally identified individuals' interest in activities that would offer more community integration it was rarely addressed in the transition plan or any plans post discharge. While the pandemic is certainly a significant barrier to participate in some of these activities, there was no documentation in the plan or post-discharge documentation that addresses interests or activities (e.g., pursuing hobbies) that could have been done in-home. In very few of the assessment and transition plans, natural supports or other informal supports were rarely identified. This thread was also present in some of the post-discharge service plans reviewed.

The extent to which the individual had an active role in choosing where they would live post transition was also unclear. While some members did indicate they had choice, others had expressed their desire to live in another location that was closer to family and other informal

supports. Some living situations had landlords who were unfamiliar and/or intolerable of interacting with individuals who had symptoms of mental illness. This was an issue in non-Permanent Supportive Housing (PSH) residences.

None of the plans reviewed (transition and post discharge plans) included employment goals, which is a short coming in the current assessment process. This was not surprising since none of the assessments indicated the individuals' interest in employment. In addition, individuals on the ACT team were not engaged in pursuing employment. Each ACT team is required to have an employment specialist that should identify whether the individual is interested in pursuing employment and assist the individual with pursuing employment goals. It should be noted; several interviews with the service review team, and individuals did express an interest in returning to work.

It was difficult to assess whether the transition and other community planning efforts were person centered. While most individuals in the service review did have a pre-transition planning team that included the person, it was difficult to ascertain how person-centered the process was. Without being present during the transition planning process, the service review team had to rely on interviews and documentation to determine whether the approach was truly person-centered.

As indicated in the previous section, a major issue in the design of the My Choice Program was post discharge care coordination. While the Agreement requires the State to develop a case management service, it was not initiated during this service review process. As previously indicated, the Transition Coordinators were responsible for providing "light touch" care coordination initially for individuals for the first year post transition. They were not intended to provide the day-to-day care coordination the individual needed to arrange and ensure initial and ongoing access to physical health, behavioral health, long-term services and supports, and other formal and informal supports. This intensity of care coordination was necessary given the multiple goals and complex array of services needed for most members participating in the service review. In response to concerns raised by the SME and DOJ, LDH recognized this need and subsequently changed the role of the Transition Coordinators to address this gap in care coordination. Most members had multiple plans post discharge (MCO case management plans, specialty medical care plan, and behavioral health plans). Others had additional plans, especially those individuals who participated in the CCW program.

These plans, as designed, focus solely on the service and supports that can be delivered under the CCW program. As previously indicated in this report, a significant number of individuals who participated in the service reviews were dually eligible for Medicare and Medicaid. Benefits covered by Medicare were rarely on the care coordinator's radar screen. Several MCO case managers were aware that individuals were receiving Medicare benefits but stated it wasn't within their purview to coordinate or manage these benefits. While the service reviewers agree with this statement, MCO accrediting bodies require that MCOs look at the individuals' needs holistically and not only focus on benefits that are covered by the plans. In addition, several individuals who were dually eligible participated in Medicare Advantage plans and would likely have care coordinators for Medicare benefits. While the presence of yet another care

coordinator makes coordination even more challenging, there was no indication of communication with Medicare Advantage plan care coordinators.

Lastly, a major issue was sustaining care coordination efforts a year past discharge. The Agreement only requires individuals in the Target Population to receive case management for the first year post-discharge. LDH has messaged to Transition Coordinators that case management may be provided to individuals for longer than one year after discharge from the nursing facility. In addition, The MCOs are required to provide case management services to enrollees for a minimum of 12 months, or longer based on enrollee needs, unless the enrollee declines or dis-enrolls from case management. The MCOs are to develop a method and criteria to evaluate the enrollee's need for case management services beyond the 12-month period. From our interviews the criteria that TCs or MCO case managers were using to make a decision regarding ongoing case management was unclear. All individuals interviewed ceased case management provided by the TCs at the one-year mark. In interviews with individuals, many indicated their attachment to the Transition Coordinator and were generally chagrined that this care coordination was not going to be available on an ongoing basis.

The service review team was also tasked with reviewing the assessment and service plans to provide the following:

- Number and percent of transitioned members who received services in the amount, frequency, and duration specified in the transition plan
- Number and percent of transitioned members whose plan of care addressed their needs
- Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessments
- Number and percent of transitioned members reporting that they are able to make choices and exert control over their own life.

Transition plans were compared to post-discharge claims data to identify the Medicaid services provided to the individual including physical health, behavioral health, and long-term services and supports. The reviewers did not have access to Medicare claims data and therefore were unable to verify through this process whether services identified in the transition plan and reimbursed by Medicare were provided (medical services, medication). The reviewers had to rely on interviews with the individual and others to verify whether these services were provided.

A review of the claims data showed that the Medicaid services identified in the transition plan were received by individuals in the review. Claims data did identify additional services that were not included in the transition plan (e.g., personal care services, specialty medical services such as pain management). For services not identified in this data, interviews solicited information on the other services identified in the transition plan. Unfortunately, the initial and revised Transition Plan does not establish the amount, frequency, and duration of services post-transition. Therefore, the service review team was unable to draw any conclusions to answer that question.

To determine the number and percent of transitioned members who received services in the amount, frequency, and duration specified in the transition plan, the SME Service Review Team

obtained information through interviews and review of various documents to assess the quality and sufficiency of services provided to individuals. As discussed above, the Team relied heavily on member interviews since the original transition plan format provided more detail regarding community services requested immediately prior to transition versus on an ongoing basis. A revised and subsequent Transition Assessment and Transition Planning document provided more detailed information on post transition services. A review of documents and interviews did indicate almost all members transitioned from nursing facilities received the services in the transition plan.

The next measures included the number and percent of transitioned members whose plan of care addressed their needs. As indicated in the Service Review Report, individuals in the review had multiple assessment and plans. Multiple documents made it difficult to obtain a comprehensive perspective of the collective needs and desires of the individual and the extent to which plans addressed those needs. The lack of a comprehensive plan hindered the ability of the review team to ascertain whether individuals participating in the review were generally getting their needs met.

The third measure was the number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessments. The source of information for this measure was both Transition Plans and the presence (or absence) of a current crisis plan. In the review, only two individuals (25%) had clear documentation of a current crisis plan and stated they had and were familiar with their crisis plan. These plans are important tools for the individual, caregivers, their support network, and organizations involved with providing services to identify potential causes of crisis and strategies that can be deployed to address and prevent the crisis from escalating. It will also be helpful to guide the new crisis providers in their efforts to respond to a crisis.

The final measures, the number and percent of transitioned members reporting that they are able to make choices and exert control over their own life, was collected through interviews with the members. As indicated in the Service Review Report, the Team interviewed each individual on their transition experience and their overall experience of care post discharge from the nursing facility. Multiple questions were included in the interview to solicit a response to this question. All members (and in one instance, a caregiver) interviewed stated they were actively involved in the planning process, provided choices regarding their services and supports, and generally felt they controlled their own life post transition. The team impressions of individuals' responses to these questions was supported by the strengths and resiliency of the individuals.

The review process did find that services were not always provided on a timely basis. Some individuals experienced gaps in care for services identified in the Transition Plan. In these instances, the Transition Coordinator quickly identified the delay and attempted to find services as quickly as possible to address the service gap. Most of these service gaps were directly related to physical health (e.g. transportation to primary or specialty health care for their chronic conditions), in-home nursing care, and transportation. There were several reasons that delayed these critical services. The pandemic was cited as a reason that individuals were unable to receive these services. Practitioners were not returning calls to schedule or reschedule appointments. One provider indicated they were no longer accepting Medicaid patients. For another individual,

home nursing work force shortages resulted in a change of three providers within 30 days post transition. Another member lost her pain management specialist when she moved from the New Orleans area to a rural area and because she was dual eligible, the MCO could not help with network coverage remediation.

As indicated previously in the document, there was no overall community plan for any individual participating in the service review. While some plans of care existed, they were focused solely on one aspect of the individual's goals and needs. For instance, individuals participating in the CCW program had a plan of care addressing the long-term services and supports but not addressing the multiple physical health issues and behavioral health issues for these individuals. The service review team understands the CCW program as designed focuses more on the formal and informal supports offered or facilitated by the support coordinator. In addition, support coordinators in the review team's opinion, lacked information on approaches for providing services to individuals with mental health issues. Therefore, the lack of an overall community plan has serious implications for individuals to identify, request and receive necessary services. It also hampered the service review team efforts to determine if the plan of care addressed the individual's needs or if the service plans included strategies that addressed their health and safety risks that were identified in the assessment.

The last question, about whether individuals reported they are able to make choices and exert control over their own life, was discussed above. As indicated, all members interviewed responded affirmatively to this question and documentation reviewed did support that response when available.

Community Integration

Community integration was also an area that was general rated as poor. While many individuals appear to be sociable and open to community integration activities, there was little or no participation in these activities post-discharge. A major barrier to participating in these activities was the pandemic. Fortunately, most individuals had an established, sometimes limited social network post discharge. Interviews with individuals provided information regarding this network and the frequency with which they were able to access families and friends. Several members have boyfriends and girlfriends post discharge. Some individuals were able to meet family and friends outside with some frequency during the pandemic. In addition, several members self-initiated developing relationships with neighbors post transition, which provided them additional friends and had the added benefit of assisting them with some daily activities (e.g., food shopping, transportation).

It should be noted that several individuals had problematic family relations or were estranged from their family. This issue was self-identified as a goal for improvement during interviews with the individual. The impact of problematic or non-existent family relations often left the individual with no initial social connections post discharge. In some instances, the family members were involved and relied on to provide support. However, family members support was not always

reliable and created gaps in assistance with IADLs and transportation. The service review team understands that not all individuals have close family relationships or have limited or no contact with families. The service reviewers identified some unevenness in the care coordinators' knowledge and inclusion of family members for information and possible support. Several Transition Coordinators ensured active involvement of family members (when appropriate), while others did not include (or discuss) family involvement in planning, transition, and monitoring.

There was little or no evidence in the documentation or interviews of assessing the individual's strengths, preferences, or opportunities for community integration post-discharge. As discussed in the previous section, there were generally no goals identified in the transition plan for community integration and therefore there were no activities to address and enhance community integration. Besides the pandemic, one of the major barriers to community inclusion activities was transportation. Similar to access to transportation for physical health appointments, non-medical transportation was not always available to individuals. The lack of transportation affected individuals who lived in rural areas and had no public transportation. This limited an individual's ability to get groceries and other provisions and generally contributed to significant isolation.

Transportation to non-medical, social inclusion activities was not addressed in transition plans or post-discharge community plans. Transportation to these activities was universally identified as an issue by the individual and caregiver.

Transition Outcome

As indicated above the overall outcome of the transition was rated highest, as either good or very good. While the My Choice program has some design issues, the processes in place to support the individual during and after the transition were solidly in place. The success of the transitions was a balance of the individual's strengths and the support of the Transition Coordinator. Some of the success is derived from the individual's interest and strong commitment to remaining in the community and living independently. In addition, the individuals' personal strengths are a major driver to ensure that the transition was and continued to be successful. The stability of housing for several individuals also contributes to a successful transition outcome.

It was abundantly clear from the interviews and documentation that individuals participating in the service reviews formed a strong attachment with the Transition Coordinator. While these relationships produced short-term (1-year) outcomes, it is not a sustainable model long term. The service review team understands that individuals in the Target Population may need care coordination beyond one year; however, care coordination approaches lacked a focus on recovery and rehabilitation, which would educate and empower the individual to assume more responsibility for coordinating their care and accessing resources in the community.

Many individuals experienced positive changes in their overall well-being post transition. For instance, one individual stated they recovered some physical capabilities and were now able to maintain their home (cleaning), prepare their own food, and improve their personal appearance. Another individual's personal strengths, family support, and assistance provided by the ACT team

have resulted in him living where he chooses with most needed supports in place (given his location). Another individual leveraged previous relationships with a CCW support coordination agency to obtain the services from a staff member with whom they had a good working relationship and used her knowledge of a specific apartment complex to obtain the housing she desired. Another individual cited the successful support received by their CCW agency to improve ADLS/IADLS and address some mobility restrictions.

There were some issues identified with some transitions. One major take-away was the need to ensure all services and supports are engaged at time of transition. While some issues cannot be always anticipated, many individuals experienced service access issues immediately post transition. In addition, there seemed to be limited experience by long-term service and support providers for rendering services to individuals with significant mental health issues. In some instances, an individual's symptoms and related behaviors were misinterpreted as being challenging, obstinate, and uninterested in receiving services. As indicated throughout this report, transportation to non-medical appointment and services as well as other community services hindered many individuals in obtaining some goals related to community integration.

Systemic Issues

The services reviews identified a number of issues that were experienced by most individuals who participated in the process. Some of these issues were exacerbated by the pandemic; the ability for Transition Coordinators, other care coordinators, and service providers to perform their duties in-person truly was very challenging. The “unknowns” regarding the disease spread and effects associated with the COVID-19 pandemic impacted the workforce in being able to adequately carry out their responsibilities. However, there were a number of issues that were identified by the review team that were not always related to the impact of the pandemic. These issues include:

- The lack of a single plan guiding post-transition services and supports. For some individuals, there were multiple plans: Transition Plan, MCO plan of care, CCW plan of care, and a behavioral health provider treatment plan. The plans were often not developed collaboratively nor were they shared or reviewed as a team. Without an all-encompassing plan aimed at achieving a clear set of goals and aligning an array of services in pursuit of these goals, it is challenging to assess progress for individuals in the Target Population and the service system as a whole. It also makes it very difficult to refine services in response to crises or other unexpected events or to employ consistent, complementary approaches across providers.
- There is significant variability in the completeness of core assessment and plans, including transition and community plans.
- Employment aspirations and goals were not discussed or identified in any of the interviews or documentation despite that, when interviewed; some individuals expressed an interest in working.

- Though the Transition Coordinators were personally valued and frequently interacted, there was a heavy reliance on the Transition Coordinators to address and problem solve on all issues and barriers. Some Transition Coordinators were able to triage and delegate issues to appropriate providers, while others assumed the responsibility to “fix” every issued addressed.
- Messaging regarding time-limited care coordination. While the Agreement requires that ongoing case management is provided for at least one year following discharge from a Nursing Facility, the State has messaged that it may be provided for more than one year, based on the individual’s desires and needs. Yet, most Transition Coordinators were terminating care coordination at the one-year anniversary of transition.
- There was inadequate focus on community inclusion (social, recreation, employment, education, etc.) which is central to maintenance of community tenure and fulfillment of Olmstead obligations.

Recommendations

The individual and systemic issues identified in by the Service Review Team serve as the basis for the recommendations. The Team believes there are short term and longer-term strategies the State should consider for improving the quality and sufficiency of services provided to individuals in the Target Population. The Team understands that this next year will provide another important change in the care coordination approach for individuals that will be transitioned or diverted from nursing facilities. These initial findings will hopefully inform the implementation of LDH’s community case management approach as well as care coordination activities and other services provided to individuals in the Target Population.

Short-Term Recommendations

- Finalize an approach to a comprehensive and integrated community plan for use by the Community Case Managers in the next several months. LDH has developed requirements for this plan of care in their Compliance Guide for MCOs. It is LDH’s intent to have the MCOs work together to develop the plan by September 2021. LDH would review and approve the content of this planning document to ensure that it is consistent with the DOJ Compliance Guide and the person centered assessment and planning efforts to date by the Department. The compliance guide also specifies the criteria for updating the plan and information exchange needed to coordinate care. At a minimum this plan should include the services requested by individuals, identify the provider who will offer the service and indicate whether the service was received. In addition, the comprehensive plan should also include a copy of each plan developed by providers in the plan providing more detailed information on the frequency of service delivery.
- Provide training and technical assistance to Transition Coordinators to fulfill their interim responsibilities to provide Intensive Case Management. Specifically, the State should develop and deliver training regarding important areas established in the

Transition Assessment including services and supports that will enhance community integration (including employment) and medication information and adherence. In addition, the Transition Coordinator should focus on having regular team meetings with the individual, relevant support system (e.g. family/friends) and the various care coordinators and service providers. While this is the State's current expectation, there was variability on frequency of these team meetings.

- Develop a strategy for enhancing support coordinators and personal care staff's understanding and approaches for engaging and providing services to individuals with significant behavioral health needs. As indicated in this report, an individual's symptoms and related behaviors were misinterpreted as being challenging, obstinate, and uninterested in receiving services.
- Provide training to Transition Coordinators on medication reconciliation and adherence monitoring.
- Message an expectation to MCO case managers and service providers to circulate service or care plans among key providers and Transition Coordinators (initially and when a change occurs). This will provide all parties with a more comprehensive view of the individuals' goals, services the individual should be receiving to meet these goals, frequency of services, and parties responsible for providing each service.
- Develop and implement a crisis plan (including advanced directives) for each individual on the Transition Coordinators' Intensive Case Management Caseload. This seems doable given the relatively small number of individuals on each Transition Coordinator's ICM caseload (averaging two individuals per Transition Coordinator). While the presence of a crisis plan will not prevent a crisis, it will assist the individual and all parties (including caregivers) with important information regarding crisis precipitants and strategies to address the crisis in lieu of police engagement, visits to the emergency department or admissions to inpatient psychiatric facilities. Obviously, this should be done with the individual and shared with the relevant parties.
- Ensure that services that have been identified in the Transition Plan are available immediately at the time of transition. While the review identified transition issues that were not contemplated at or during the first week of transition, Transition Coordinators may want to follow-up with each service (including DME) a few working days before transition occurs. This will either confirm the availability of services or identify if there are immediate service issues that could adversely impact the transition.

Longer Term Recommendations

- Develop training and technical assistance for community case managers regarding care coordination approach, protocols, and materials to support this approach. The SME is aware that LDH is initiating efforts to identify the necessary assessments and service plan formats for this new care coordination approach (scheduled for implementation in FY 2022).
- In cooperation with MCOs, develop a new planning template for the community case manager. Specifically, the template should be a comprehensive plan driven by the

individual's goals and identify the services and providers and other individuals (e.g. MCO case managers) responsible for assisting the individual to meet their goals. This plan should identify when the referral was made and whether the individual is engaged with each service and support. In addition, the plan should include attachments for each individual plan developed by formal service and support providers that play a major role in the individual's care. The Service Review Team recognizes that individual providers will often have more detailed information regarding the scope, frequency and duration of services and supports. Similar to the short-term recommendation, the community case manager should collect and share this information with the individual (if they do not have these plans) and with relevant team members. In addition, the community case manager should identify and obtain updated plans on a quarterly basis or more frequently if there are circumstances that warrant a significant change to the individuals overall community plan.

- Develop training should to focus on the development and implementation of crisis plans for each individual. As indicated in this report, these plans were lacking or not updated. As LDH implements new crisis services in the next year, some of these crisis plans may include these services
- Develop a process and protocol in cooperation with the MCOs regarding community case manager's efforts to establish a process for initial and ongoing team meetings. As indicated in this report, individuals in the Transition Population have numerous providers rendering services and supports. Ongoing communication with individual and their team will be necessary to meet the goals in the community plan and make the necessary changes to the plan when the individual assessment indicates a change in the community plan or a critical incident or other event necessitates the review and possible changes to the plan.
- Require all community case managers and Transition Coordinators to participate in LDH's new Person Centered Assessment and Planning training. LDH is in the process of implementing this new training. The MCO trainers will be offering this training starting in July 2021. While participation in this training is voluntary for providers now, LDH plans to establish this training as a requirement for some provider types once MCO trainers have completed their train-the-trainer sessions and can operationalize collaborative training efforts. LDH should ensure that any contracts between MCOs and organizations providing CCM require this training initially and on an ongoing basis. While the assessment should attend to all goals and domains, particular attention should be provided to identifying, discussing, and developing supports and resources to ensure better community integration. As indicated throughout this report, this was an area that was not well identified in assessments and was rarely included in any individual's plans.
- Require all community case managers to receive LDH proposed training in CY 2022 on employment as a social determinant of health. This training discusses, identifies, and assists the individual to develop employment or educational-specific goals (when appropriate). While this aspect should be part of an overall training for identifying and assuring better community integration, the Team deemed that a separate focus on soliciting interest regarding education and employment was necessary given the fact that no assessment or plans identified these specific interests or goals.

- Implement the strategy discussed in short-term recommendations for enhancing support coordinators and personal care staff’s understanding and approaches for engaging and providing services to individuals with significant behavioral health needs. As indicated in this report, an individual’s symptoms and related behaviors were misinterpreted as being challenging, obstinate, and uninterested in receiving services.
- Develop a process to review the quality of the community plans for individuals in the Target Population. While training and ongoing technical assistance will be critical to support community case managers, there is a need for reviewing these plans to ensure they are being developed consistent with LDH’s expectation and, more importantly, that the overall care coordination approach is consistent with person centered planning principles—specifically that individual’s desires and needs are being solicited during the assessment process and reflected in the goals and that the services and supports in these plans reflect these goals. While MCOs may be most likely to develop and implement these quality review strategies, LDH should develop a “look behind” process to ensure quality as well.
- Provide training and support to assist transition coordinators and community case managers in improving their physical health acumen either through available on line programs or frequent training programs multiple times throughout the year.

MY CHOICE 2020 QUARTER 4 DATA

Requirement		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
1. Provider Capacity, Access to, and Utilization of Community Based Services	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	See attached reports			
	1.b	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.	54/65 83%	31/42 74%	34/49 70%	25/33 76%
	1.e	Number and percent of transitioned members who received services in the amount, frequency and duration specified in the transition plan	SME review of representative sample of individuals transitioned from NFs ¹				
	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	56/65 86%	33/42 79%	37/49 76%	26/33 79%
2. Referrals to, admission	2.a	Referral to nursing homes- Nursing Facility Admission Request	Number of persons that request level 1 admission to Nursing Facility	9432	5809	7807	7804

MY CHOICE 2020 QUARTER 4 DATA

Requirement		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
and readmission to, diversion from, and length of stay in nursing facility	2.b	Referral to Level II OBH (as per results of Level I PASRR) requested at admission	Number of individual initial placement requests (# initial placement requests)	687 7%	91 2%	403 5%	257 3%
	2.c	PASRR Outcome Trends	Independent Evaluations vs. desk review	Indep Eval 959	Indep Eval 633	Indep Eval 816	Indep Eval 960
				Total Level II Reviews 2276	Total Level II Reviews 1206	Total Level II Reviews 1514	Total Level II Reviews 1686
	2.d	PASRR Outcome Trends	Total Resident Reviews--# of Resident Reviews conducted (# resident reviews)	1046	688	602	798
	2.e	NF Short Term Authorizations vs. Long Term Authorizations	Number of initial authorizations approved for short term stay(100 days or less) (# short term authorizations)	687	91	788	84
	2.f	PASRR Level II Service Recommendations	Percent of PASRR determinations that recommended referral to Specialized Behavioral Health Services (# referred SS/# approved)	67%	73%	94%	77%
	2.g	Services Provided	Number and percent of individuals receiving PASRR Level II Specialized Behavioral Health Services Recommended ²				
	2.h	PASRR Level II Placement Recommendations	Number and Percent of PASRR determinations indicating that admission to NF is not recommended as it is not the least restrictive setting (#Level II determinations not recommending NF admission/#initial Level II referral requests for placement excluding cases identified as withdrawn)	4%	2%	23 6%	14 7%
3. Person Centered Planning, Transition Planning, and Transitions	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.	53/65 82%	37/42 88%	47/49 96%	31/33 94%

MY CHOICE 2020 QUARTER 4 DATA

Requirement		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
from Nursing Facilities	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.	51/65 78%	30/42 71%	38/49 78%	26/33 79%
	3.c	Number and % of transitioned members who report planning included participation members of their chosen social network	Self-report- Interviews with TP members done by TCs: # of transitioned members who report that planning included others of their choosing/total # of transitioned members interviewed.	52/65 80%	34/42 81%	46/49 94%	29/33 88%
	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.	60/65 92%	35/42 83%	42/49 86%	30/33 91%
	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 ¹				
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	# of people that had CIRs = 13 individuals <u>Categories:</u> Falls: 9 Maj Medical: 36 Maj Injury: 0 Maj Behavioral Incident: 2 Maj Medication Incident: 1 Protective Services: 1 Death: 0	# of people that had CIRs = 18 individuals <u>Categories:</u> Falls: 16 Maj Medical: 41 Maj Injury: 3 Maj Behavioral Incident: 7 Protective Services: 4 Death: 0 Other (legal involvement): 1	# of people that had CIRs = 20 individuals <u>Categories:</u> Falls: 17 Maj Medical: 44 Maj Injury: 0 Maj Behavioral Incident: 3 Protective Services: 4 Death: 3 Other: 3	# of people that had CIRs = 15 individuals <u>Categories:</u> Falls: 7 Maj Medical: 21 Maj Injury: 0 Maj Behavioral Incident: 2 Protective Services: 2 Death: 1 Other (loss of home): 2

MY CHOICE 2020 QUARTER 4 DATA

Requirement		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
				Other (legal involvement): 1			
				ER visits: 18 Hospitalization: 18 Psyc Admission: 9	ER visits: 31 Hospitalization: 17 Psyc Admission: 7	ER visits: 41 Hospitalization: 14 Psyc Admission: 6	ER visits: 14 Hospitalization: 10 Psyc Admission: 3
	4.b	Number and percent of referrals reported to protective service agency for abuse, neglect, and exploitation	Number of abuse, neglect, exploitation referrals made	1	4	4	2
	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	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				
	4.e	Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessment (s)	SME review of representative sample of individuals transitioned from NFs ³				
	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	47/65 72%	30/42 71%	30/49 62%	23/33 70%

MY CHOICE 2020 QUARTER 4 DATA

Requirement		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
			incidents/total # of transitioned members interviewed				
	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	61/65 94%	38/42 91%	46/49 94%	30/33 90%
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	56/65 86%	33/42 79%	38/49 78%	27/33 82%
	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	61/65 94%	36/42 86%	43/49 88%	30/33 91%
	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	10/65 15%	14/42 33%	14/49 29%	8/33 24%
	5.d	Number and percent of participants who utilized crisis services, ED presentations, 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	60/65 92%	36/42 86%	41/49 84%	30/33 91%

MY CHOICE 2020 QUARTER 4 DATA

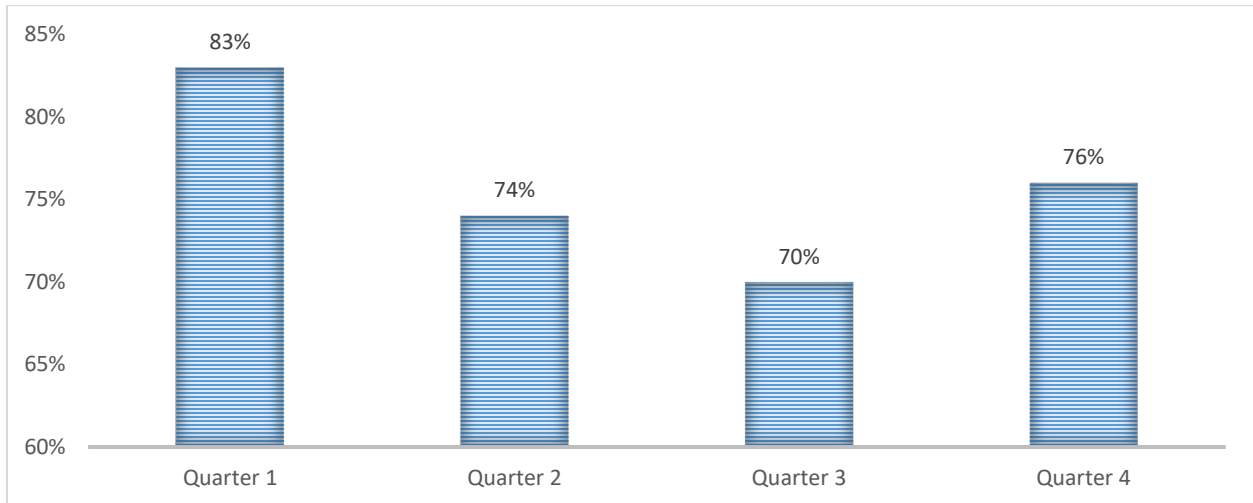
Requirement		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
			in housing /total # of transitioned members interviewed				
	6.b	Number and % of transitioned members reporting stability in natural supports network	Self-report- Interviews with TP members done by TCs: # of transitioned members reporting stability in natural support network/total # of transitioned members interviewed	59/65 91%	35/42 83%	46/49 94%	29/33 88%
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 ¹				
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 community to the extent that they would like/total # of transitioned members interviewed	48/65 74%	25/42 60%	32/49 65%	26/33 79%

¹ 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.

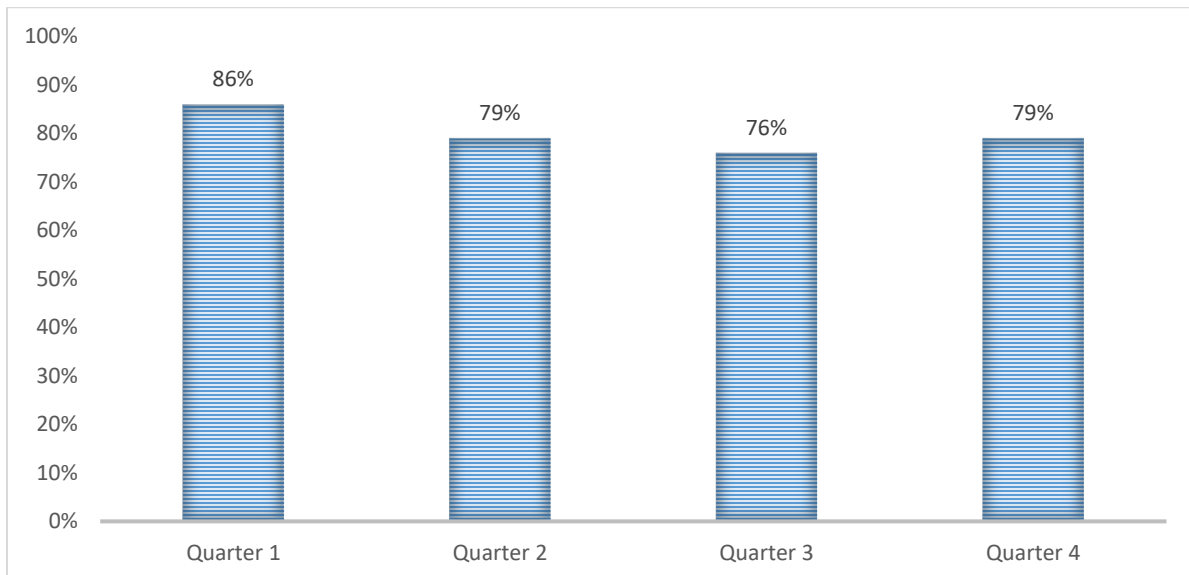
² 2.g-OBH has identified changes needed to their system in order to be able to begin reporting this data. In the absence of those system changes the data is not able to be reported for this quarter.

Provider Capacity, Access to, and Utilization of Community Based Services

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

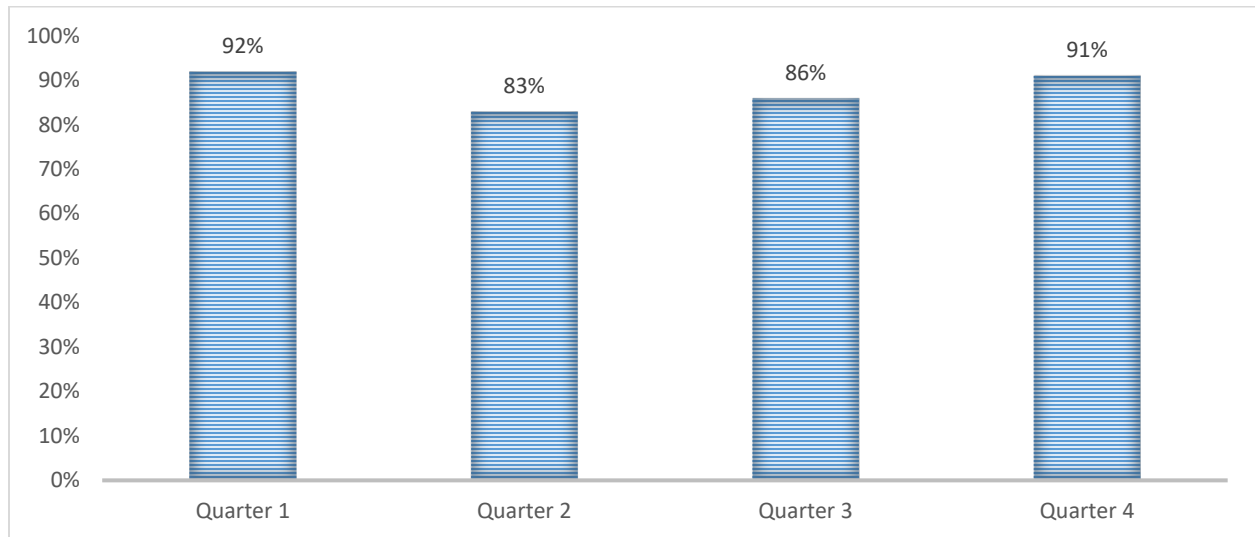


Percent of transitioned members reporting that they are receiving the services they need.



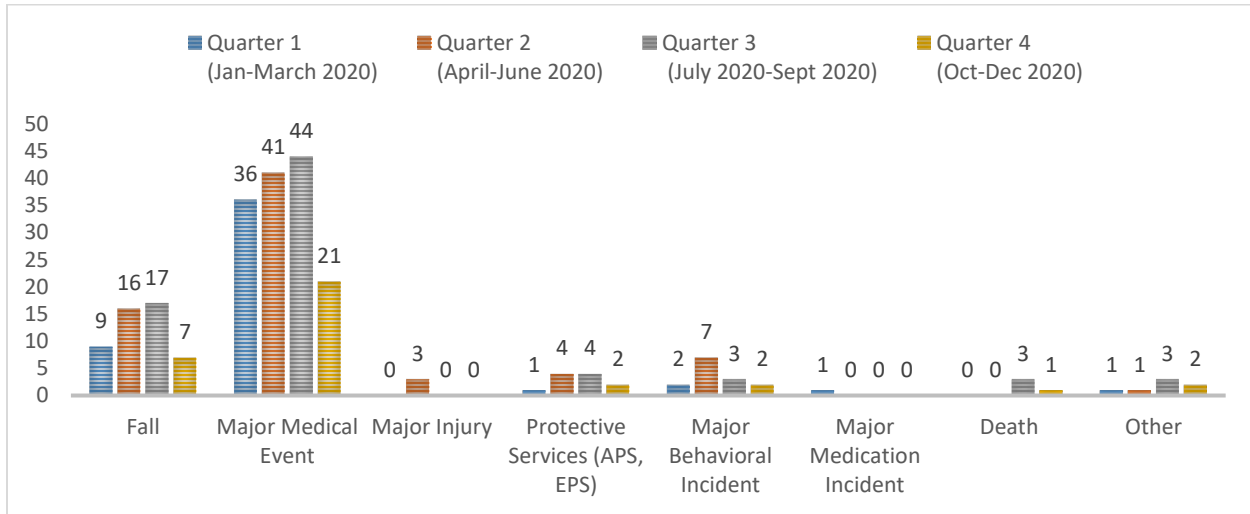
Person Centered Planning, Transition Planning, and Transitions from NF

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

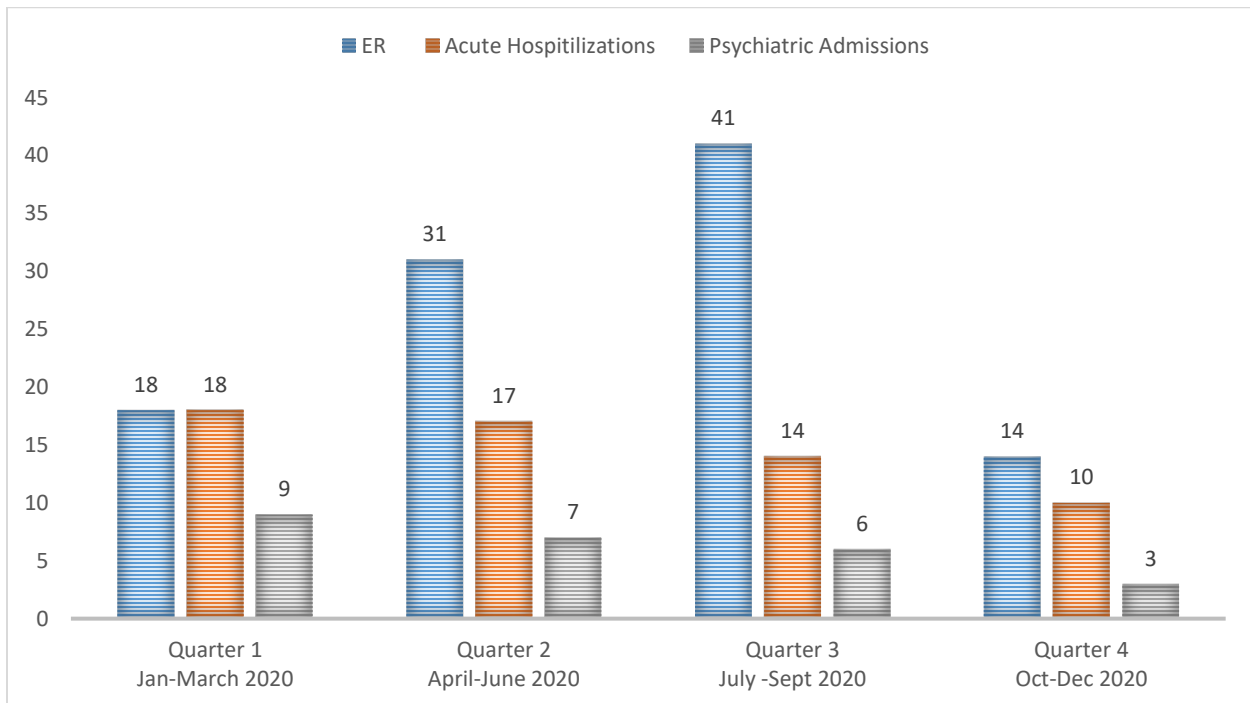


Safety and Freedom from harm

Number of Critical Incidents, stratified by type of incident

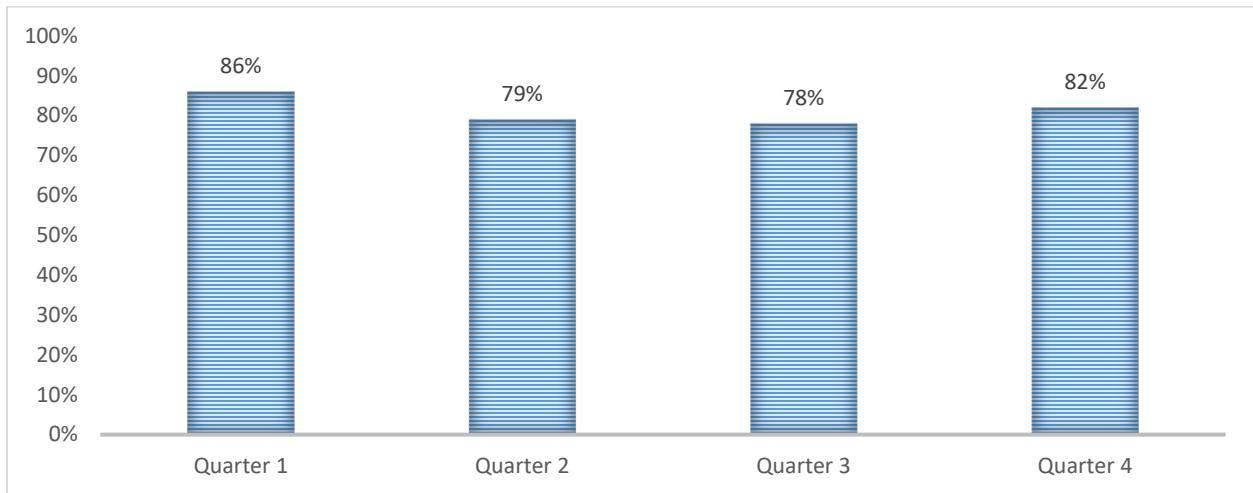


Of total CIRs noted above this graph represents a breakdown of acute hospitalizations, psychiatric admissions, and ER.

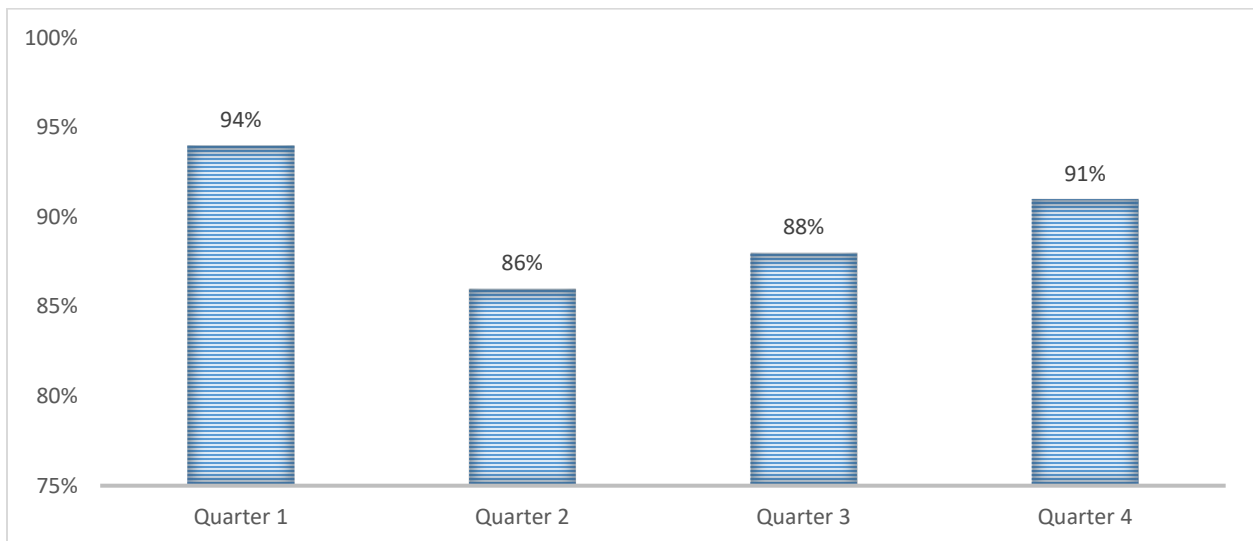


Physical and mental health wellbeing and incidence of health crisis

Percent of transitioned members reporting good physical and mental health.

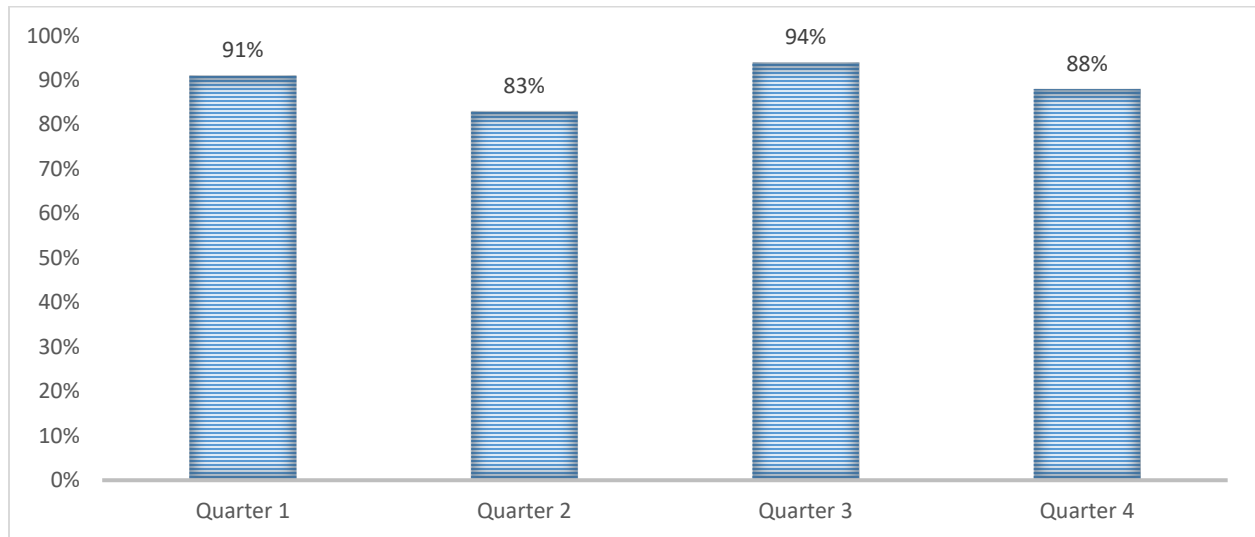


Percent of transitioned members reporting independence with taking care of themselves physically.



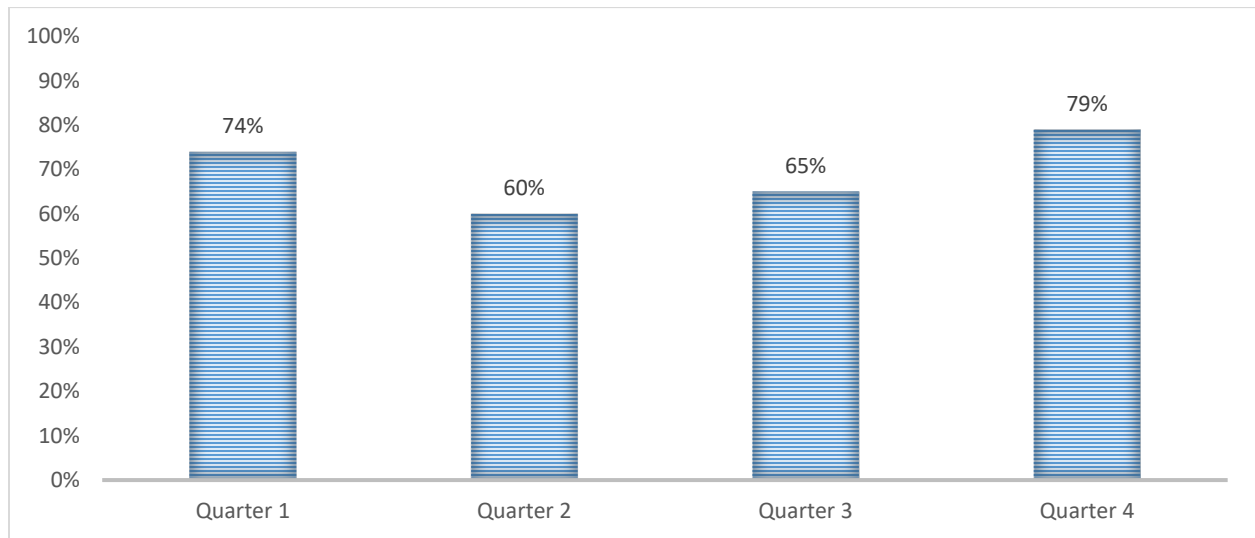
Stability

Percent of transitioned members reporting stability in natural supports.



Community Inclusion

Percent of transitioned members reporting that they are involved in the community to the extent they would like



Requirement: (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

Data Measure: (1a) Number of community based behavioral health providers available to provide services and accepting new Medicaid participants

Methodology: # of providers accepting new Medicaid patients by level of care

LEVEL OF CARE	Q1 Statewide Total	Q2 Statewide Total	Q3 Statewide Total	Q4 Statewide Total
Assertive Community Treatment (ACT)	45	43	42	48
Community Psychiatric Support and Treatment (CPST)	368	419	409	410
Crisis Intervention (CI)	318	396	402	399
Psychosocial Rehabilitation (PSR)	327	410	410	415
ASAM Level 1	146	136	134	145
ASAM Level 2.1	150	137	133	144
ASAM Level 2-WM	24	26	32	37
Psychiatric Outpatient (Agency/Facility) – Prescribers (Psychiatrist, Medical Psychologist, Nurse Practitioner (psychiatric specialty) and Clinical Nurse Specialist (psychiatric specialty)	784	763	779	813
Psychiatric Outpatient (Agency/Facility) – Non-Prescribers (LAC, LCSW, LMFT, LPC, Psychologist)	2219	2219	2258	2476
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	32	66	53	56
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	739	751	665	656
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	160	163	163	155
Psychiatric Outpatient Licensed Professional Counselor (LPC)	929	1004	943	948
Psychiatric Outpatient Medical Psychologist	34	36	30	28
Psychiatric Outpatient Psychologist	203	195	189	198
Psychiatric Outpatient Psychiatrist	382	375	376	392

Data Measure: (1b) Geographic availability of services: Number of community based behavioral health providers available to serve BH Medicaid beneficiaries stratified geographically by region

Methodology: Report analyses; # of providers accepting new Medicaid patients by level of care stratified by LDH region

LEVEL OF CARE Q4	LDH Region 1*	LDH Region 2	LDH Region 3	LDH Region 4	LDH Region 5	LDH Region 6	LDH Region 7	LDH Region 8	LDH Region 9
Assertive Community Treatment (ACT)	13	4	2	6	3	3	10	3	4
Community Psychiatric Support and Treatment (CPST)	96	69	17	37	15	28	64	56	27
Crisis Intervention (CI)	96	58	18	37	15	24	66	58	26
Psychosocial Rehabilitation (PSR)	134	18	33	15	24	69	57	29	36
ASAM Level 1	25	27	9	17	7	9	14	27	10
ASAM Level 2.1	21	28	8	19	7	8	11	31	11
ASAM Level 2-WM	4	9	4	6	0	1	6	3	4
Psychiatric Outpatient (Agency/Facility) – Prescriber (Psychiatrist, Medical Psychologist, Nurse Practitioner, Clinical Nurse Specialist)	440	214	133	136	117	105	153	95	183
Psychiatric Outpatient (Agency/Facility) – Non-Prescriber (LAC, LCSW, LMFT, LPC, Psychologist)	773	630	273	326	201	252	434	364	452
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	8	16	2	9	7	2	4	6	8
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	264	148	29	70	26	34	43	22	90
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	34	17	10	9	12	7	33	23	19
Psychiatric Outpatient Licensed Professional Counselor (LPC)	247	139	68	84	53	32	141	130	116
Psychiatric Outpatient Medical Psychologist	10	11	1	3	0	1	3	1	3
Psychiatric Outpatient Psychologist	112	28	5	14	4	8	14	8	22
Psychiatric Outpatient Psychiatrist	232	70	32	26	24	27	48	27	45

*LDH Region 1 includes provider counts for the following OBH regional areas: Metropolitan Human Services District (Orleans area) and Jefferson Parish Human Services Authority (Jefferson).

LEVEL OF CARE Q3	LDH Region 1*	LDH Region 2	LDH Region 3	LDH Region 4	LDH Region 5	LDH Region 6	LDH Region 7	LDH Region 8	LDH Region 9
Assertive Community Treatment (ACT)	10	5	2	5	2	3	9	2	3
Community Psychiatric Support and Treatment (CPST)	96	62	19	35	15	26	67	62	29
Crisis Intervention (CI)	95	65	21	32	15	26	64	60	24
Psychosocial Rehabilitation (PSR)	102	64	19	37	15	27	64	54	28
ASAM Level 1	21	22	8	15	7	8	13	27	13
ASAM Level 2.1	23	24	7	12	8	9	10	32	8
ASAM Level 2-WM	5	10	2	3	3	1	3	1	4
Psychiatric Outpatient (Agency/Facility) – Prescriber (Psychiatrist, Medical Psychologist, Nurse Practitioner, Clinical Nurse Specialist)	360	197	125	124	107	96	151	97	146
Psychiatric Outpatient (Agency/Facility) – Non-Prescriber (LAC, LCSW, LMFT, LPC, Psychologist)	786	573	243	303	175	225	374	344	418
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	6	14	2	9	7	3	6	6	8
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	253	139	31	68	27	43	47	23	95
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	41	20	10	9	12	7	38	21	18
Psychiatric Outpatient Licensed Professional Counselor (LPC)	265	127	64	76	50	39	152	130	111
Psychiatric Outpatient Medical Psychologist	14	9	0	3	0	2	3	1	4
Psychiatric Outpatient Psychologist	125	28	3	12	4	7	16	8	18
Psychiatric Outpatient Psychiatrist	207	66	30	26	24	27	46	26	41

*LDH Region 1 includes provider counts for the following OBH regional areas: Metropolitan Human Services District (Orleans area) and Jefferson Parish Human Services Authority (Jefferson).

LEVEL OF CARE Q2	LDH Region 1*	LDH Region 2	LDH Region 3	LDH Region 4	LDH Region 5	LDH Region 6	LDH Region 7	LDH Region 8	LDH Region 9
Assertive Community Treatment (ACT)	10	5	2	5	2	3	9	3	4
Community Psychiatric Support and Treatment (CPST)	105	74	17	31	13	25	69	58	27
Crisis Intervention (CI)	103	66	18	29	12	22	67	53	26
Psychosocial Rehabilitation (PSR)	100	73	18	33	11	24	66	58	27
ASAM Level 1	24	27	9	16	6	9	10	27	8
ASAM Level 2.1	16	31	9	18	7	8	12	28	8
ASAM Level 2-WM	2	7	1	6	2	4	1	2	2
Psychiatric Outpatient (Agency/Facility) – Prescriber (Psychiatrist, Medical Psychologist, Nurse Practitioner, Clinical Nurse Specialist)	369	191	121	139	97	82	151	95	153
Psychiatric Outpatient (Agency/Facility) – Non-Prescriber (LAC, LCSW, LMFT, LPC, Psychologist)	805	558	271	331	176	210	397	324	445
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	7	16	4	10	8	5	14	6	12
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	317	177	47	68	28	51	51	36	157
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	39	17	10	9	12	7	37	23	19
Psychiatric Outpatient Licensed Professional Counselor (LPC)	309	143	84	79	51	45	153	145	142
Psychiatric Outpatient Medical Psychologist	13	13	0	4	0	2	3	2	7
Psychiatric Outpatient Psychologist	129	25	3	11	4	9	18	8	20
Psychiatric Outpatient Psychiatrist	221	62	33	27	24	26	48	28	39

*LDH Region 1 includes provider counts for the following OBH regional areas: Metropolitan Human Services District (Orleans area) and Jefferson Parish Human Services Authority (Jefferson).

LEVEL OF CARE Q1	LDH Region 1*	LDH Region 2	LDH Region 3	LDH Region 4	LDH Region 5	LDH Region 6	LDH Region 7	LDH Region 8	LDH Region 9
Assertive Community Treatment (ACT)	11	5	2	5	3	3	9	3	4
Community Psychiatric Support and Treatment (CPST)	71	54	14	26	13	23	45	48	24
Crisis Intervention (CI)	123	55	19	30	15	24	61	49	26
Psychosocial Rehabilitation (PSR)	76	55	16	27	13	22	51	45	22
ASAM Level 1	25	28	10	16	7	11	11	30	8
ASAM Level 2.1	25	26	10	18	8	11	13	31	8
ASAM Level 2-WM	4	5	1	5	2	4	1	2	2
Psychiatric Outpatient (Agency/Facility) – Prescriber (Psychiatrist, Medical Psychologist, Nurse Practitioner, Clinical Nurse Specialist)	373	209	120	140	94	86	152	94	155
Psychiatric Outpatient (Agency/Facility) – Non-Prescriber (LAC, LCSW, LMFT, LPC, Psychologist)	816	541	272	322	173	200	397	318	430
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	3	8	1	6	1	2	6	4	7
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	313	178	46	69	25	48	52	33	148
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	40	15	10	10	12	7	37	22	17
Psychiatric Outpatient Licensed Professional Counselor (LPC)	284	134	77	71	48	37	135	136	134
Psychiatric Outpatient Medical Psychologist	15	14	0	4	0	2	4	3	8
Psychiatric Outpatient Psychologist	130	27	3	14	5	10	20	8	21
Psychiatric Outpatient Psychiatrist	227	66	37	29	24	25	48	29	42

*LDH Region 1 includes provider counts for the following OBH regional areas: Metropolitan Human Services District (Orleans area) and Jefferson Parish Human Services Authority (Jefferson).

Data Measure: (1c) Number and percent of specialized behavioral health providers meeting appointment availability standards.

Methodology: Random sample of behavioral health providers to obtain next available appointment

Appointment Availability Q4	Number	Percentage
Providers with appointment available within one hour for emergent care	723	87%
Providers with appointment available within 48 Hours (two calendar days) for urgent care	808	77%
Providers with appointment available within 14 calendar days for routine care	871	92%

Appointment Availability Q3	Number	Percentage
Providers with appointment available within one hour for emergent care	836	81%
Providers with appointment available within 48 Hours (two calendar days) for urgent care	870	76%
Providers with appointment available within 14 calendar days for routine care	1024	87%

Appointment Availability Q2	Number	Percentage
Providers with appointment available within one hour for emergent care	429	61%
Providers with appointment available within 48 Hours (two calendar days) for urgent care	535	73%
Providers with appointment available within 14 calendar days for routine care	620	82%

Appointment Availability Q1	Number	Percentage
Providers with appointment available within one hour for emergent care	480	79%
Providers with appointment available within 48 Hours (two calendar days) for urgent care	538	79%
Providers with appointment available within 14 calendar days for routine care	611	85%

LEVEL OF CARE DEFINITIONS

Assertive Community Treatment (ACT) services are therapeutic interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community. Interventions may address adaptive and recovery skill areas, such as supportive or other types of housing, school and training opportunities, daily activities, health and safety, medication support, harm reduction, money management, entitlements, service planning, and coordination. Services are provided in the community.

Community Psychiatric Support and Treatment (CPST) is a comprehensive service, which focuses on reducing the disability resulting from mental illness, restoring functional skills of daily living, building natural supports, and solution-oriented interventions intended to achieve identified goals or objectives as set forth in the individualized treatment plan. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. Most contacts occur in community locations where the person lives, works, attends school and/or socializes.

Crisis Intervention (CI) services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, through 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 goals of CIs are symptom reduction, stabilization and restoration to a previous level of functioning. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school and/or socializes.

Psychosocial Rehabilitation (PSR) is intended to restore the fullest possible integration of the individual as an active and productive member of his or her family, community and/or culture with the least amount of ongoing professional intervention using psycho-educational services associated with assisting individuals with skill-building, restoration and rehabilitation services. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. Most contacts occur in community locations where the person lives, works, attends school and/or socializes.

American Society of Addiction Medicine (ASAM) Level 1: Outpatient Treatment services are professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure. These services include, but are not limited to, individual, group, family counseling and psychoeducation on recovery and wellness. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but are fewer than nine contact hours per week for adults and fewer than six hours a week for adolescents.

American Society of Addiction Medicine (ASAM) Level 2.1: Intensive Outpatient Treatment is professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Intensive outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure. These services include, but are not limited to, individual, group, family counseling and psychoeducation on recovery, as well as monitoring of drug use, medication management, medical and psychiatric examinations, crisis intervention coverage and orientation to community-based support groups. Intensive outpatient program services shall include evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing and multidimensional family therapy. These programs offer comprehensive, coordinated and defined services that may vary in level of

intensity but must be a minimum of nine contact hours per week for adults, and a minimum of six hours per week for adolescents at a minimum of three days per week with a maximum of 19 hours per week. This level consists of a scheduled series of face-to-face sessions appropriate to the individual's plan of care.

American Society of Addiction Medicine (ASAM) Level 2-WM Ambulatory Withdrawal Management with Extended On-Site Monitoring is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility by trained clinicians, who provide medically supervised evaluation, withdrawal management and referral services. The care is delivered in an office/health care setting or BH treatment facility. These services are designed to treat the individual's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the individual's entry into ongoing treatment and recovery. Withdrawal management is conducted on an outpatient basis. It is important for medical and nursing personnel to be readily available to evaluate and confirm that withdrawal management in the less supervised setting is relatively safe. Counseling services may be available through the withdrawal management program or may be accessed through affiliation with entities providing outpatient services. Ambulatory withdrawal management is provided in conjunction with ASAM level 2.1 intensive outpatient treatment services.

Psychiatric Outpatient includes the following services: Outpatient psychotherapy (individual, family and group); Psychotherapy for crisis; Psychoanalysis; Biofeedback; Hypnotherapy; Screening, assessment, examination, and testing; Diagnostic evaluation; and Medication management. These services are provided by psychiatrists or licensed mental health professionals (LMHPs). LMHPs are individuals who are licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license.

Psychiatric Outpatient (Agency/Facility) – Prescribers – Psychiatric Outpatient services provided by licensed practitioners who are also employed by an agency or facility, with the ability to prescribe medication.

Psychiatric Outpatient (Agency/Facility) – Non-Prescribers - Psychiatric Outpatient services provided by non-prescribing licensed practitioners employed by an agency or facility.

Psychiatric Outpatient by Licensed Practitioners - Psychiatric Outpatient services provided by licensed practitioners practicing independently of an agency or facility.