2022-1

LA-DOJ Seventh Subject Matter Expert (SME) Report

COVERING THE PERIOD OF 1/1/2022 THROUGH 6/30/2022

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Contents

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 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.

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 seventh SME report, covering the period of 1/1/2022 through 6/30/2022.

While the goal of the agreement is to reduce the use of nursing facilities for people with serious mental illness, thus far, the number of people with serious mental illness living in nursing facilities has remained relatively constant. This is a result of new admissions exceeding transitions from NFs to integrated settings for much of the implementation period. In June 2018, there were 3,964 individuals in the Target Population in nursing facilities. As of 6/8/2022 there are 3,875 individuals in the Target Population in nursing facilities.

The following report is the first report that provides a compliance rating regarding 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. Each of these paragraphs is provided a compliance rating, followed by a discussion and analysis 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 SME used the following criteria for determining if LDH was in compliance with each paragraph:

Status	Criteria
Met	LDH has undertaken and completed the requirements of the paragraph--no further activity needed, or
	LDH has undertaken and completed the requirements of the paragraph--met with updates continuing to occur
Partially Met	LDH has developed deliverables (policies, procedures, training) that indicate the State is actively addressing the requirements of the paragraph,
	LDH has provided data that indicates the State is actively addressing the requirements of the paragraph,
	LDH has implemented activity and has yet to validate effectiveness, or
	LDH has begun but not completed implementation activities
Not Met	LDH has done little or no work to meet the requirement as set forth in the paragraph of the Agreement, or
	LDH has made little progress to meet the targets set forth in the Agreement, Implementation Plan, or other plans
Not Yet Rated	SME has not reviewed the provisions of the paragraph sufficient to determine compliance and will have a compliance rating in the future
Not Rated	The provision of the paragraph does not require a rating

Figure 1 illustrates the Subject Matter Expert's compliance determinations relative to each major section of the Agreement, aggregating to the total number of requirements falling within each compliance category. Within this report, there is a dedicated section for each of the compliance domains listed below, which includes the SME's rationale for each compliance assessment rating.

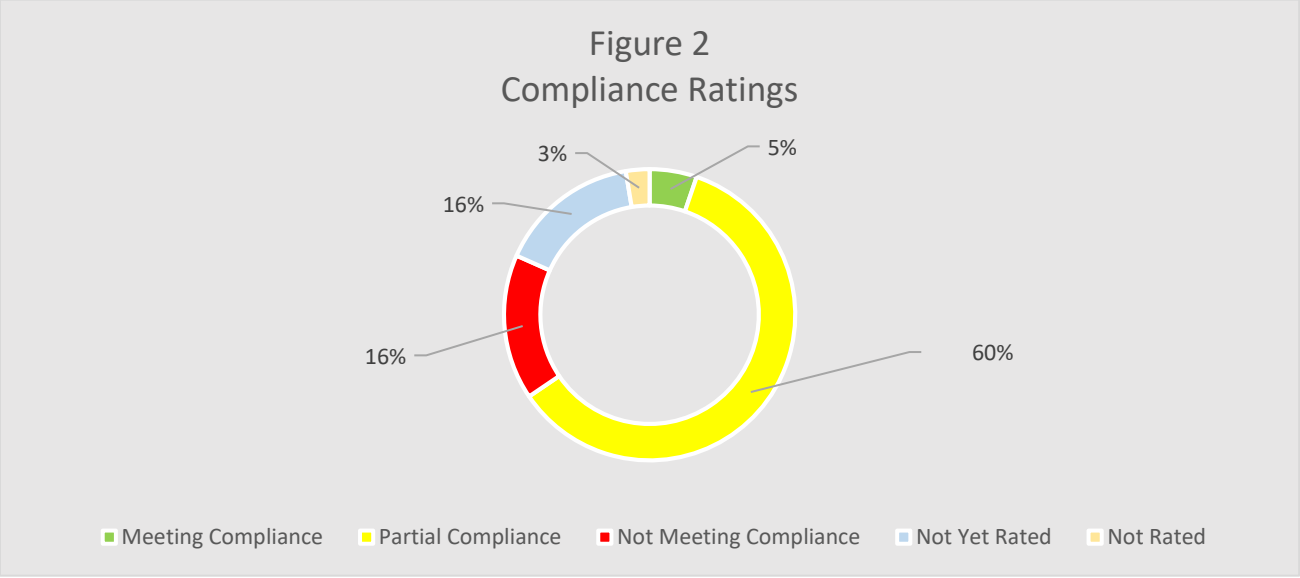
Figure 1:

Synopsis of Report & Compliance Assessment for the My Choice Program

Target Population (3)	**Meeting Compliance**	0	**Partial Compliance**	2	**Not Meeting Compliance**	0	**Not Yet Rated**	1	**Not Rated**	0
Diversion and Pre-Admission Screening (11)	**Meeting Compliance**	2	**Partial Compliance**	4	**Not Meeting Compliance**	3	**Not Yet Rated**	2	**Not Rated**	0
Transition and Rapid Reintegration (22)	**Meeting Compliance**	1	**Partial Compliance**	9	**Not Meeting Compliance**	5	**Not Yet Rated**	5	**Not Rated**	2
Community Support Services (23)	**Meeting Compliance**	1	**Partial Compliance**	17	**Not Meeting Compliance**	4	**Not Yet Rated**	1	**Not Rated**	0

Outreach, In reach and Provider Education and Training (7)	**Meeting Compliance**	0	**Partial Compliance**	6	**Not Meeting Compliance**	0	**Not Yet Rated**	1	**Not Rated**	0
Quality Assurance and Continuous Quality Improvement (11)	**Meeting Compliance**	0	**Partial Compliance**	8	**Not Meeting Compliance**	1	**Not Yet Rated**	2	**Not Rated**	0
Total		**4**		**46**		**13**		**12**		**2**

Figure 2 summarizes the Subject Matter Expert's compliance determinations relative to many of the paragraphs in the Agreement. There are 77 distinct paragraphs applicable to this reporting period. LDH is in compliance with 4 paragraphs (5%), in partial compliance with 46 paragraphs (60%), and not meeting compliance with 13 paragraphs (16%). There are 14 (19%) paragraphs that are either not rated or not yet rated.



The 60% of paragraphs in partial compliance reflects valuable, foundational work that LDH has undertaken to accomplish the requirements in this Agreement. This progress is the result of significant effort and commitment on the part of LDH staff, for which they should be commended. However, it is important to emphasize that significant work remains to achieve full compliance on the paragraphs rated in partial compliance.

The parties entered into this Agreement with a shared commitment to achieve compliance with Title II of the ADA. LDH was to accomplish this by transitioning and diverting people with serious mental illness away from unnecessary nursing facility placements, providing them the community-based services and

supports sufficient to meet their needs. After four years of implementation, a small proportion of those in the Target Population has benefited from the Agreement's ultimate purpose. As of June 2022, LDH has transitioned 317 individuals from nursing facilities since June 2018, when the implementation of this Agreement began. As of June 30th, 49 individuals were diverted from NFs based on the State's definition of the diversion population. More than 3800 remain in NFs. The pandemic, various storms, as well as workforce shortages for behavioral health and support services have created barriers for LDH to achieve some of the projected targets for transition and diversions. As the public health emergency eases, it is the SME's expectations that LDH will achieve important targets and milestones that will comply with this Agreement.

According to LDH's own projections, it will take three years to transition the more than 598 people who have already expressed a desire to transition and an additional 197 individuals who are on the Master List and are undecided. LDH continues to fall short of its transition projections. At the current pace, LDH is on track to accomplish just half of the 292 transitions it committed to complete in CY 2022. Consequently, hundreds of people who have already indicated they want to move will remain institutionalized unnecessarily.

Further, it is likely that many more individuals will express a desire to transition in the future – as LDH continues to admit new people to NFs, and as improved in-reach should uncover more people who want to move. As discussed in more detail below, significant improvements to LDH's diversion, in-reach, and transition practices are necessary in order to accommodate people's desire to live in their own homes and communities without undue delay. Greater oversight over the quality of community services will also be critical to ensuring positive outcomes for those who are diverted and transitioned from nursing facilities.

There are several areas of focus that the SME recommends for the next six months and beyond. These priority areas have not changed significantly since the last SME report. These priority areas include transitions, diversions, quality, and development of community services. 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 transitioned from nursing facilities. The State projects over 795 individuals in the current Target Population in NFs may be interested in moving in the near future. It is aiming to transition 292 of these individuals in CY 2022. This is approximately 37% of the individuals on the Active Caseload (those who have indicated an interest in moving or undecided and whom the State has prioritized for transition) and less than 8% of the overall Target Population in NFs.
- Identifying and addressing major barriers that impede transitions. There is not a consolidated approach to identify and report barriers for diverting or transitioning individuals from NFs.
- Completing initial efforts to contact individuals on the Master List to gauge their interest in moving from NFs and developing follow up in-reach. There are a number of individuals who were undecided through initial in-reach efforts conducted over the past year. There are also many individuals who have reportedly indicated they are not interested in moving or have difficulty in making decisions about moving. LDH is in the process of developing a process to prioritize additional in-reach efforts for these individuals. In addition, the SME continues to recommend LDH evaluate the quality of the in-reach engagements, consider additional in-reach strategies, and identify training needs of staff performing in-reach. These actions are necessary to ensure

that all members of the Target Population are offered a meaningful, informed choice about transition, consistent with the requirements of this Agreement.

- Re-engineering the process to divert individuals from NFs. LDH has embarked on a process to require the Managed Care Organizations (MCOs) to work with individuals with SMI who are at high risk of NF admissions. The SME believes that addressing the physical and behavioral health needs upstream of inpatient and emergency department visits should reduce the referrals to nursing facilities and therefore reduce the number of individuals who will potentially be included in the Target Population.
- Strengthening the current diversion process for people being considered for NF admission. The current PASRR Level II process is not creating additional diversions and therefore the number of individuals in the Target Population in NFs has not decreased. Increasing diversions, and coordinating the needs of individuals diverted from NFs, should be a major activity in the next reporting period. The referrals to Community Case Management (CCM) have just begun and it will be incumbent for LDH to ensure these individuals are identified, immediately referred to CCM, and that they have plans of care and receive services consistent with these plans.
- Supporting the MCOs' efforts regarding the at-risk population to ensure they are effective. The SME and LDH are performing independent reviews of the MCO at-risk efforts, and it is likely the State will need to monitor and provide concrete strategies to the MCO for ongoing engagement of at-risk members.
- Continuing efforts to measure the quality of community services for Target Population members. As noted above, effective oversight is critical to ensuring successful outcomes for people in the Target Population. As additional individuals are transitioned and diverted from nursing facilities, and new services are brought on-line, LDH's quality assurance activities will need to be expanded to oversee the implementation of the new services and specifically to ensure that MCOs and the Community Case Management agencies are engaging individuals in case management in a timely manner, conducting the necessary assessments and developing person-centered plans of care. LDH should also develop a process to ensure that individuals are linked effectively to the services identified in the plan of care.
- Contracting for the necessary tracking systems to meet the requirements of the Agreement. The State should have the necessary system to support their quality assurance efforts. The State also needs a system to identify individuals in the Target Population within three days after admission into an NF so that they can be quickly engaged and transitioned, where appropriate. The State solicited proposals from vendors this past reporting period and reports that a contract will be awarded in early CY 2022.
- Ensuring that new community-based services are implemented this reporting period. There are crisis services, employment supports, and personal care assistance, in addition to community case management (discussed above) that are being implemented during the coming reporting period. Due to Hurricane Ida, there has been some delay in the implementation of these services. However, LDH has stated they will have these services in place in the first six months of CY 2022. During this period, LDH is expected to continue working on a plan for a single, 24-hour crisis hot line. As recommended in Section V (Community Support Services) in this report, LDH should work with the MCOs to closely monitor the implementation of these services, including regular meetings with the MCOs, technical assistance vendors (e.g., Louisiana State University), providers, and stakeholders to identify and address early implementation issues.
- Developing and implementing strategies to address recommendations set forth in the LDH Needs Assessment and the SME Service Reviews. The SME is recommending the State develop a strategy

for prioritizing the recommendations with particular attention on assessments and care planning that are reflective of a person-centered thinking and a recovery approach.

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.

Compliance Rating: Partially Met

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

Compliance Rating: Partially Met

Discussion and Analysis

The SME assessment of Paragraphs 24 through 26 is combined. As one of the initial activities, LDH created a list of individuals in NFs who are members of the Target Population. The list includes individuals with an SMI identified through a PASRR Level II evaluation and individuals who do not have a PASRR Level II evaluation, but the MDS indicates they have an SMI. As of May 16, 2022, the State reports that 93% of the individuals on this list had at least one PASRR II evaluation with a confirmed Serious Mental Illness. The State regularly analyzes and reviews data from the MDS for current NF residents for an SMI diagnosis to add to this List. The MDS purpose and process is described in previous SME reports.

The State has divided the list of Target Population members in nursing facilities into two groupings. This includes an Active Caseload List for individuals who have indicated an interest in moving and whom the State has prioritized for transition. LDH has also created a Master List for the remaining individuals who have indicated they are not interested in moving at this time or for individuals who have not been contacted recently about transition. As of June 1, 2021, there were 3,845 individuals in the Target Population in nursing facilities, with 598 individuals in nursing facilities on the Active Caseload List and 3,256 individuals on the Master List. It should be noted that an additional 117 have been transitioned and remain on the Active Caseload List for one-year post-transition.

In the previous SME report, there were 3,711 individuals in the Target Population in nursing facilities. 2,795 individuals were included in the Master List and 916 individuals on the Active Caseload List. The increases of individuals in the Target Population are a result of new admissions exceeding discharges, including transitions. The decrease on the Active Caseload List is a result of LDH's follow-up efforts over the past year to provide in-reach to individuals on both the Active Caseload List and the Master List to determine their interest in moving to the community. Between October 2021 and May 2022, the State provided in-reach with each member on the Active Caseload List and determined:

- 772 individuals that were previously on the Active Caseload List were not interested in moving and were returned to the Master List
- 478 individuals on the Master List indicated their interest in moving over the past year and were placed on the Active Caseload List.

The State reports there were several major reasons that individuals on the Active Caseload List were removed from the Active Caseload List:

- 77.5% declined transition and were returned to the Master List.
- 7.5% were discharged from the NF and were in the community for longer than twelve months
- 6.9% died while in the NF and were removed completely from the Master or Active Caseload List.

The balance of the individuals moved to the Master List were for other reasons (court ordered, died post transition).

While the in-reach efforts discussed in paragraph 54 significantly increased the number of individuals on the Master List expressing an interest in transitioning, the SME is concerned about the number of individuals returned to the Master List from the original Active Caseload List. The State reports that many of these individuals were automatically placed on the Active Caseload List based on information (from the MDS data or previous conversations) that indicated their interest in moving. Many of these individuals reportedly declined transition when contacted through the recent in-reach process. This is a significant shift in reported interest, which requires further validation.

As indicated in the sixth SME report, the State has developed and implemented a referral system and prioritization to complete Level II evaluations for individuals on the Master List who were identified by MDS information as having an SMI. The State reports an increase in individuals on the Master List who have received a PASRR Level II. As of the December 2021 report, 88% of the individuals on the Master List had received a PASRR Level II. As of this reporting period, 93% of the individuals on the Master List have received a PASRR Level II evaluation, representing a 5.6% increase. The SME understands that a small number of individuals may be identified as having a potential SMI after they are admitted to the NF. Therefore, the percentage of individuals who have an identified SMI and a PASRR Level II will not be 100%.

The State continues to add individuals to the Target Population list on a daily basis. MDS information is provided to LDH daily for individuals at admission and at other times during their NF stay. Individuals who are identified by the MDS as having SMI are added to the Master List the next day. On a regular basis, the State matches MDS data on individuals who are newly identified as having an SMI to current PASRR Level II data to identify individuals who may have required a Level II screening but did not receive one. The State has not developed a process to track the timeliness of when these individuals receive a PASRR Level II.

LDH must also develop and maintain a list of individuals who are diverted from NF, given these individuals are also part of the Target Population. Beginning in May, per the SME request, LDH began providing this information to the SME on a quarterly basis. However, it is not yet clear that LDH's method for tracking this information is reliable.

<u>Compliance Assessment</u>
Overall, the SME's assessment for these paragraphs indicates:

- LDH has developed and actively maintains a Target Population list of individuals currently residing in nursing facilities but does not maintain a reliable list of all individuals diverted from nursing facilities, as required by Paragraph 26.
- LDH has a process to identify individuals admitted to nursing facilities who should have received a Level II PASSR evaluation and to refer them for the evaluation.
- Members of the Target Population are not timely identified through the Level II process. As indicated in paragraph 41, almost 40% of the individuals on the Master List who have a presumed SMI have yet to receive a PASRR Level II and do not receive one on a timely basis.
- The number of individuals in the Target Population continues to grow.
- LDH has elected to use its Active Caseload to prioritize transitioning a subset of people in the Target Population. In connection with this, there were a significant number of individuals who have been provided in-reach which provided LDH a better opportunity to ensure that individuals on the Active Caseload List were interested in moving.
- There were a significant number (77%) of individuals previously on the Active Caseload List that LDH determined were not interested in moving at this time. This is an extremely high percentage of the individuals who were assigned to Transition Coordinators to begin the transition process and raises questions about the accuracy of LDH's initial and ongoing determinations regarding interest in transition.
- LDH states that 1,753 individuals who were admitted to an NF prior to CY 2022 (through December 2021) have been provided a PASRR Level II. The SME has requested information for this reporting period (similar to the last two reporting periods) regarding the number of individuals on the Master List who have a PASRR Level II evaluation. The State reports 93% of individuals on the Master List have a PASRR Level as of June 1, 2022.

Recommendations

- LDH should ensure individuals identified by the MDS as having an SMI who do not have a recent PASRR Level II (within the past year) receive timely PASRR Level II evaluations (within 30 days of being placed on the Master List).
- LDH should develop a process to track the timeliness for individuals to receive a PASRR Level II when indicated by the MDS.
- LDH should prioritize individuals moved from the Active Caseload List to the Master List for ongoing in-reach activities. At some point in their NF stay they expressed an interested in moving and should be encouraged to revisit that opportunity as soon as possible.
- LDH should maintain a current list if individuals in the Target Population who were diverted from nursing facilities and include the number of diverted individuals in the total count of the Target Population.

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.

Compliance Rating: Not Rated

Discussion and Analysis:
In previous reports, 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 disorder services under the State's 1115 Demonstration Program, and, more recently, the array of crisis services, employment, community case management, and 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 are Medicaid eligible and 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 reports they have 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].

Compliance Rating: Not Met

Discussion and Analysis:
During this reporting period, in response to the SME's request, the State submitted a revised diversion plan to outline the steps LDH will take to promptly identify individuals in the Target Population seeking admission to NFs and to provide intervention and services to prevent unnecessary institutionalization. The SME had requested that the revised diversion plan include:

- Projections regarding diversion (annual and long term) that are specific to individuals whom the PASRR Level II evaluation process identifies should be maintained in the community versus admitted to an NF.
- Strategies to meet CY 2022 and longer-term projections for diversions.

- Evaluation strategies to ensure the PASRR determination process leads to appropriate and meaningful placement and service recommendations and identify and address barriers to diversion.
- Evaluation strategies to determine whether the MCO's efforts to provide enhanced care coordination to the at-risk population are producing the intended outcomes.
- An assurance that referrals from PASRR Level II evaluators to community case management providers are timely and that LDH is tracking these individuals consistent with efforts to track individuals who are transitioned from NFs.
- Outreach to organizations identified in Paragraph 68 including law enforcement, corrections, and courts.
- Regular assessment of whether the diversion strategies are effective, and refinements to the strategy as needed.

Similar to the CY 2019 Diversion Plan, the revised plan sets forth definitions for individuals who would be considered diverted from NFs and individuals who are at high-risk for NF placement. The revised plan also sets a revised target for the number of people who will be diverted from NFs in CY 2022. LDH has not developed longer term diversion targets. The initial and revised State's plan can be found at: https://ldh.la.gov/assets/docs/MyChoice/DiversionPlan.pdf.

In the sixth SME report, it was recommended that LDH develop a process for identifying individuals prior to admission and during the PASRR process (Level I screening and Level II evaluation) who have few barriers to receiving services in the community even though they meet NF Level of Care. As indicated in Paragraph 36, the State has successfully eliminated the behavioral health pathway and therefore individuals should not be admitted solely due to their mental illness. There may be individuals with an SMI who seek NF admissions who may have lower physical health needs and home and community-based services and natural supports are readily available to meet their needs. In the previous report, the SME recommended Office of Aging and Adult Services (OAAS) and OBH should develop a strategy for how to best identify and divert this population during this reporting period to further increase diversions from NFs. The State has not developed these strategies, which will be important to determine if individuals are inappropriately in NFs.

During calendar year 2021, LDH refined its definition of the diversion population. In an effort to better delineate the population, LDH has limited the definition of diversion to the Medicaid population of individuals with SMI who seek admission to a nursing facility but are not admitted because the PASRR Level II indicated community placement versus a nursing facility admission. In the previous plan, LDH had included individuals who had been admitted to a nursing facility and been discharged in 90 days with a completed Transition Assessment and Individualized Transition Plan. LDH did not include these individuals in the revised diversion plan since there were few individuals who met these criteria. In addition, LDH removed the at-risk population from the diversion definition for the Target Population. Most of these individuals had an SMI and various health conditions that placed them at high risk for an NF placement but would not meet the definition of the Target Population. These individuals are part of a larger diversion strategy discussed in paragraph 30.

Finally, meeting existing or new targets for diversions is dependent on PASRR Level II evaluations. As discussed in Paragraph 34, LDH has requested 1135 Waivers due to the Covid-19 pandemic which waive requirements to complete a PASRR Level II for new NF admissions. For several reporting periods (including this period), the State has received approval for these Waivers, which impacts the ability for the State to implement its diversion strategy.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed, but not fully implemented, a plan to divert individuals. Specifically, the State has revised the 2019 Diversion Plan and has added strategies to address many of the SME's recommendations, including:
    - Ensuring Level II evaluators are knowledgeable about the community-based services that are available for nursing facility residents with SMI. This includes training on the Level of Care Utilization System (LOCUS) and the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). This training should provide tools to identify services needed.
    - Revising the directories for community-based resources available to individuals referred for PASRR evaluations, including newer mental health and substance use disorder (SUD) services that were developed in CY 2021 and this reporting period.
    - Revising the PASRR Level II Training to include person-centered assessment strategies that were developed in CY 2021. The training also includes collecting information on medical conditions and support needs to address activities of daily living.
    - Developing revised diversion projections for CY 2022. The revised plan projected that 120 individuals would be diverted from NFs during this calendar year. During the first four months of this reporting period, LDH reports that it has diverted 49 individuals. The State has not developed longer multi-year diversion targets.
    - Developing and implementing strategies for the at-risk population discussed in more detail in paragraph 30 of this report.
    - Developing and implementing an OBH PASRR Determination Specialists Quality Audit Tool and monthly audits as an internal quality improvement process. The tool, initial implementation activities, findings, and remediation strategies are discussed in paragraph 34 of this report.

The State has yet to fully implement the diversion plan. Specifically:

- LDH has begun tracking the number of individuals in the diverted population, although it remains unclear whether this tracking is reliable. LDH has only recently begun engagement efforts to offer community case management and potential referral to community-based services.
- It is too soon to determine the effectiveness of the implementation of the diversion plan.
- The frequency of the implementation of 1135 Waivers has created a challenge for the State to implement their diversion strategy.
- As noted in paragraph 30, the at-risk strategy has yet to be fully implemented and evaluated.
- There are no multi-year diversion projections provided by the Department.
- The diversion plan does not specifically address outreach to organizations identified in paragraph 68 including law enforcement, corrections, and courts regarding diversion strategies.

Recommendations

- LDH should continue to implement the elements of the Diversion Plan, including developing multi-year diversion targets aimed at maximizing the number of diversions to community-based services, as appropriate.
- LDH should track and report the number of individuals who have an SMI who are admitted to NF to determine if the diversion strategies set forth in the report are effective. While the SME is encouraged that LDH is projecting to divert 120 individuals in CY 2022, LDH should determine how these efforts compare to total admissions.
- LDH should leverage its new PASRR audit process to ensure placement and service recommendations are appropriate, and to identify opportunities to increase diversions.
- OAAS and OBH should develop a strategy for how to best identify and divert individuals with an SMI who seek NF admissions who may have lower physical health needs when home and community-based services and natural supports are readily available to meet their needs, during the next reporting period to further increase diversions from NFs.

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.

Compliance Rating: Not Yet Rated

Discussion and Analysis:
LDH has developed and begun efforts to implement a system to identify and divert individuals from avoidable hospitalizations. While working with hospitals is an important strategy (as required in Paragraph 87), it continues to be the SME's opinion that LDH's initial effort would be better spent on working with MCOs versus hospitals directly to prevent 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.

A major strategy for diverting individuals from NF admissions is to identify individuals who may be at high risk for hospitalizations that would lead to an NF admission. As indicated in the fifth SME report, the Department finalized a definition for an "at-risk" population that included individuals with an SMI who had chronic physical health conditions and who had recent and multiple EDs and inpatient admissions (all cause). The assumption is that many of these individuals, with better care coordination, would have preventable hospitalization and reduced referrals to NFs.

During the fifth reporting period, LDH met with the MCOs to discuss these projections and required each MCO to develop a plan for serving the at-risk population. The SME reviewed and commented on these plans in the last reporting period.

The SME requested and LDH provided aggregate (and by plan) information tracked and analyzed by LDH regarding the at-risk population for the first six months of the MCO's efforts to enhance efforts to provide case management to the at-risk population to reduce preventable hospitalizations that could lead to nursing home admissions. The SME has received these reports and is in the process of reviewing the progress MCOs have made to engage individuals in care coordination provided by the MCO and to review whether this engagement is reducing the number and percent of individuals in the at-risk group who present at EDs or seek inpatient hospital admission (all cause). In addition, the SME will be getting some additional data and information regarding the at-risk group in the next reporting period. The SME will use the information to perform an analysis in the next reporting period to determine LDH's compliance for

this paragraph and what additional actions need to be taken with MCOs for individuals who are at-risk of NF placement and enrolled in their plans.

In addition, the State has reported they have asked the External Quality Review Organization (EQRO) to review the MCOs' efforts to provide better care coordination to individuals who meet the at-risk definition. The State reports this information will be available early next reporting period. The SME will review the EQRO report in addition to the MCO reports and provide a compliance rating the next reporting period.

In the past three SME reports, 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.

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

Compliance Rating: Partial Compliance

Discussion and Analysis

LDH reports that it has implemented a number of strategies to improve the PASRR Level I screenings to achieve diversion of individuals with SMI seeking admission to NFs. These steps 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. Information regarding these specific three steps was provided in previous SME reports.

LDH efforts have focused on trainings to PASRR Level I screeners to improve the identification of individuals with an SMI. However, no large-scale additional PASRR Level I trainings have been conducted since 2018.The State reports they will develop and implement training for PASRR Level I screeners when the tracking system is implemented. The new tracking system will identify individuals in the Target Population who were admitted into an NF within three days. LDH has procured and is developing this new system (more information on these efforts is provided in Paragraph 39) and the State reports training is anticipated in the next reporting period.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State identified and implemented strategies early in the Agreement to improve the PASRR Level I screening process in 2018. This included changes to the PASRR Level I referral process and training provided to Level I screeners to improve the identification of individuals with SMI through the PASRR Level I screening.
- LDH has also trained staff completing the MDS to better identify and provide diagnosis information to LDH from the MDS.
- The State has yet to validate effectiveness of these efforts.

Recommendations

- The SME is requesting information regarding the implementation of this new training (training materials and schedule of trainings) for PASRR Level I for the next reporting period.

- The SME is also recommending LDH develop goals for these improvements and an evaluation strategy to ensure that these strategies are producing the intended outcome.

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

Compliance Rating: Not Met

Discussion and Analysis
According to the State, individuals are asked about their interest in and need for community services by PASRR Level II evaluators and are provided information about community options at the time of the evaluation. In the past several reports, the SME 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. LDH states this process will be part of the evaluation and possible changes to the PASRR Level II Program. The State reports that PASRR Level II evaluators as described in paragraph 29 provide information regarding community options for individuals with an SMI seeking NF placement.

The SME requested and LDH provided the most recent list of community options. The SME reviewed the list of community options the State provided and found these to be insufficient to provide information to PASRR Level II evaluators. The State provided regional resource guides that are used by transition coordinators and do not provide important options for PASRR Level II evaluators to consider when making their recommendations regarding NF placement to OBH. In addition, the State reports that the PASRR Level II evaluators should work closely with the MCOs when they are completing their portion of the Level II evaluation (which includes placement and service recommendations) since MCOs are in charge of the provider networks and know where they have providers.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH does not maintain a list of regional and local community options that could be used for PASRR Level II evaluators to provide to individuals and caregivers during the evaluation process that could deter an admission.

Recommendations
- The State should develop or require the MCOs to develop a viable list of community options that would be helpful for individuals who seek NF admission. This should include information regarding medical and support services (such as personal care) as well as housing, housing supports, behavioral health services, and other services and supports most frequently requested or discussed during the PASRR Level II process.
- The State should review the list with the SME to ensure it provides realistic and useful community options.
- The State should train the PASRR II Evaluators and Determination Specialists to incorporate this information into their reviews and decisions.
- The State should audit/monitor this on an ongoing basis to ensure that individuals are, in fact, being provided with this information.

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.

Compliance Rating: Not Yet Rated
As indicated in Paragraph 31, LDH has taken several steps to change the PASRR Level I screening process to better identify individuals with SMI who are referred to NFs.

No large-scale PASRR Level I trainings have been conducted since 2018. The State is proposing new training for PASRR Level I reviewers once changes are finalized for the tracking system. The tracking system was to be operational during CY 2021; however, due to procurement delays the vendor was procured and under contract during this reporting period. The State indicates the new vendor will play an important role in training staff that complete Level of Care Eligibility Tool (LOCET) and PASRR Level I once changes to the tracking system are complete. Once the changes to the PASRR Level I process are implemented, the SME will review the PASRR Level I training for compliance purposes. The State reports these materials may be available in the next reporting period.

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.

Compliance Rating: Not Met

Discussion and Analysis
Although LDH has begun some initial efforts in this area, its progress toward complying with this paragraph is insubstantial. The State has included language in the MCO contracts standardizing the use of face-to-face PASRR II for individuals seeking admission to NFs. Prior to these contracts the occurrence of face-to-face meetings were relatively rare. PASRR Level II reviews are performed by the Medicaid MCOs' Level II Evaluators, Licensed Mental Health Professionals who operate independently of the NF and the State. The MCOs have contracted with Merakey, an organization that provides behavioral health services in Louisiana and other states. They do not provide services for the NFs, nor do they provide services directly with the State.

LDH has implemented policies and incorporated specific requirements within its Medicaid managed care contracts to ensure timeliness of the evaluations. The most recent data provided to the SME continues to indicate that Medicaid MCOs continue to complete PASRR Level II evaluations within four business days

of referral from OBH, consistent with State requirements. In December of 2017, LDH issued guidance to clarify the responsibilities for PASRR Level II evaluators to submit documentation within prescribed timeframes. In the sixth report, the SME requested and LDH provided information on the timing of PASRR Level II evaluations. Specifically, the SME requested information on whether PASRR Level IIs evaluations were performed prior to an individual seeking admission into an NF. LDH provided information regarding the timing of PASRR Level II evaluations and whether these evaluations were performed prior to admission (or diversion) from an NF. Information provided during March and April of 2022 indicated 174 PASRR Level II were completed for new admissions. Of these 174, 14 were performed after admission to an NF.

One of the purposes of the PASRR Level II evaluation is to confirm whether an individual referred for nursing facility admission, or identified post admission, has a serious mental illness. The SME has reviewed the PASRR Level II forms and training for evaluators with the tools to determine if they have an SMI, including referrals for additional diagnostic evaluations. These trainings and forms seek to collect information regarding the presence of an SMI diagnosis more reliably.

As discussed in prior SME reports, LDH revised the PASRR Level II evaluation forms in 2017 and again in 2019 to include information on physical/medical, behavioral health and social history, work history and functional status (ADLs and IADLs). The SME reviewed and made recommendations to the 2019 that were incorporated into the current tool. 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.

As indicated in paragraph 29, LDH has revised and implemented trainings to staff that perform PASRR Level II evaluations. The SME has reviewed the training and found the materials to be markedly improved. The training is more person-centered focused and focuses on reviewing information on medical and physical health conditions that precipitated the NF admissions. The trainings also provide some information regarding specialized services and approaches for working with individuals who are older. Some of the training has also focused on better identification of individuals with dementia. The SME believes these are important trainings to improve the PASRR Level II process

However, the training plan did not address strategies for PASRR II evaluators to develop service recommendations that meaningfully address identified behavioral health, SUD, social, housing, and other lesser physical health needs such as occupational therapies, vision and dental exams, primary care provider (PCP) linkage, home health, and durable medical equipment (DME) that will assist the individual to function with success in the least restrictive setting or when a community placement is more appropriate.

There are several outstanding issues with LDH's implementation of this paragraph. LDH has made some efforts to address these issues. A major issue is the use of 1135 Waivers, which waive requirements to complete a PASRR Level II for new NF admissions. These Waivers were in place during much of 2020 and early 2021 due to the pandemic and for limited amounts of time, including several months during this reporting period, as surges in COVID-19 occurred. These Waivers were also sought for several regions of the State that were impacted by storms in 2020 and 2021. The State's frequent use of these waivers has prevented prompt PASRR Level II evaluations for many individuals with a suspected SMI being admitted to an NF.

As noted in the previous SME report, many individuals who were candidates for a PASRR Level II did not receive the Level II evaluation prior to admission to an NF due to these Waivers. LDH stated they would track individuals who were admitted to an NF who did not receive a PASRR Level II due to a 1135 Waiver through the Continued Stay Review (CSR) process. As indicated in the previous SME report, LDH does not have a solid tracking process regarding the number of individuals who were admitted to NFs who had a deferred PASRR Level II due to these waivers.

As indicated in paragraph 32, LDH has not sufficiently developed directories for community-based resources available to individuals referred for PASRR evaluations.

As discussed in the sixth report, the acumen of the PASRR Level II reviewers should be enhanced to better identify and address barriers during the evaluation and recommend a decision to divert the individual from an NF admission. In previous reports, the SME recommended and LDH developed 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 or a continued stay. The SME recommended and the State developed an initial oversight process to include an independent review of supporting documentation and admission decisions using the PASRR Level II evaluation to support the admission decision.

As reported in the sixth SME report, the State reports they are standardizing processes to improve the quality of these PASRR Level II reviews. The State reports they have implemented a quality review audit tool for Pre-Admission reviews this reporting period. The audit tool and process review the quality and appropriateness of PASRR Level II placement and service recommendations of the PASRR Level II Independent Evaluator, Managed Care Organization Review, and OBH PASRR Determination Specialist. Each month OBH reports they review approximately 18-24 PASRR Level II evaluations per Determination Specialist. The review audits for appropriate and meaningful placement and service recommendations. These audits focus on PASRR evaluations rendered for continued stay requests and ongoing resident reviews. As part of this audit process, LDH's PASRR Program Manager meets with each OBH Determination Specialist monthly to review audits and address any issues/barriers with placement and service recommendations. The initial audit efforts by LDH have initially identified two issues for improvement:

- The need to solicit better engagement of families and informal supports to identify potential for availability of natural supports to support the individual in the community.
- Address conflicting information in various documents (MDS and PASRR Level II) regarding Activities of Daily Living (ADL) information to determine level of functioning and possible community supports that could address ADL in the community versus needing NF care.

LDH is in the process of developing training materials and prompts for PASRR Level II Evaluators to address these two issues. As trends in performance are identified, the State proposes the PASRR Program Manager will explore options for mitigation of additional issues identified through these audits, including process improvements, modifications to evaluation tools, and/or the development of a training plan.

In addition, the SME recommended that LDH begin to develop a list of barriers to community placement identified through the PASRR Level II evaluations and the audits. OBH reports they continue to have individual quarterly meetings with each MCO and Merakey to address individual issues, barriers, and service needs based on PASRR Level II review information. The State reports they continue to meet monthly with the MCOs and the contracted PASRR Level II evaluator agency, Merakey. The State reports the following topics were addressed during these meetings:

- Efforts to improve the quality of PASRR Level II evaluations based on SME report findings. This includes an overview of OBH's new Quality Audit Tool to improve interrater reliability for Level II Evaluators, MCO Reviewers, and OBH Determination Specialists.
- Review of 317 reports (timely, overview of rejection and correction issues, discussion on how MCOs will educate/train new staff that is completing reports to avoid reporting errors)
- Reinforcing the required Person-Centered Planning Training for all Level II Evaluators, MCO reviewers, and OBH DS staff. OBH required these individuals to complete training by the end of October 2022 and each MCO to submit rosters to OBH for PASRR Level II staff who participated in the training.
- Review of Clinical Assessment Template, including expectations by OBH to begin to use these forms.
- Discussion regarding the process PASRR Level II Evaluators and MCOs use to communicate array of community and specialized service options to potential and current NF residents and ensuring that specialized services recommendations are congruent with identified needs of individuals in NFs.

Finally, the SME has requested that OBH PASRR Level II evaluations take into account the medical, support service, and behavioral health needs of individuals seeking NF admission. The focus of the PASRR Level II evaluations seem to be more focused on verifying a diagnosis of SMI and determining specialized behavioral health services once the individual is admitted. In previous discussion with the State, the SME suggested that higher scrutiny be applied for individuals that had lower level of physical health and rehabilitative needs as determined by the LOCET and other documentation. This would require the State to make changes to the admission processes and potentially various tools used by OBH and OAAS to enhance the number of individuals recommended for community placement.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- PASRR Level II evaluations are conducted independent of the proposed NF and the State.
- LDH has taken ongoing efforts to ensure PASRR Level II evaluators receive ongoing training to identify whether individuals referred for these evaluations have a serious mental illness.
- The State has revised the PASRR Level II forms in the previous reporting period to enhance the collection of information to support a PASRR Level II decision.
- Almost all PASRR Level IIs for the period between February and May of this reporting period continue to be performed within timeliness standard required by State standards when there is no 1135 Waiver.
- The State continues to meet with MCOs and the PASRR Level II evaluators on a monthly basis to discuss changes in the PASRR Level II process and is focusing on improving staff's ability to provide information about community services prior to admission and for specialized services for individuals in the Target Population in NFs.
- LDH is challenged to meet the promptness standard as required by this paragraph. These challenges are a result of the use of 1135 Waivers. During this reporting period there was a Waiver granted for a 30-day period due to increases in COVID-19. This impacts the ability of the State to use the PASRR Level II process to divert individuals from NFs and may lead to inappropriate admissions.

- When an 1135 waiver is not in place a small portion of PASRR Level IIs are still completed after the individual is admitted to the NF, precluding the possibility of diversion.
- The current PASRR Level II process has been designed to focus on reviewing the behavioral health needs of the individual seeking NF admission and does not look more broadly at other factors that are contributing to the admission.

Recommendations

- The State should develop an evaluation process to determine how their renewed training efforts have improved the PASRR Level II evaluations and ultimately how it will improve diversions from NFs.
- While LDH has initiated a process to identify barriers through the PASRR Level II process, the State should formalize this process and identify barriers and service gaps and document efforts to resolve these barriers and gaps during these discussions. The SME recommends that LDH use the developed list of barriers discussed in paragraph 58 and use this information in developing mitigation strategies that are discussed at meetings with the MCOs.
- If LDH anticipates requesting future 1135 Waivers, LDH will need to develop a better strategy for tracking individuals who need but did not receive a PASRR Level II prior to admission and completing them quickly.
- LDH should review and report out the reasons for individuals receiving a PASRR Level II post admission especially when there is no approved 1135 Waiver.
- The State should revisit the PASRR Level II process based on the results of the quality audits and a more strategic focus on physical health and ADLs that maybe addressed in the community rather than an NF.

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.

Compliance Rating: Partial Compliance

Discussion and Analysis

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 (December 2020). In this reporting period, LDH has identified 127 individuals where an initial PASRR Level II evaluation determined they had a primary diagnosis of dementia. In the previous SME report, it was recommended that the State continue to analyze information regarding the findings of these reviews to determine the prevalence of individuals with dementia who have been identified by the consulting psychiatrist and determine if these findings may be within what are considered norms in other states. The State reached out to the PASRR Technical Assistance Center (PTAC) and reports there are no suitable proxies for comparing the percent of individuals that have been identified as having dementia and were referred for PASRR Level II evaluation. The SME recommended

for this reporting period, the State track the changes over time regarding the number of individuals identified as having a primary diagnosis of dementia and who were recommended for a PASRR Level II evaluation.

LDH reports they have developed several trainings to improve identification of dementia. During the sixth reporting period, the State reported the consulting psychiatrist working with the OBH PASRR Level II program conducted two updated trainings on dementia assessment and diagnosis. This training was provided for all OBH Determination Specialists, PASRR staff working within the MCOs, and their contracted PASRR Level II Evaluators. The specific focus of training was in how to obtain detailed social, behavioral, and cognitive histories from caregivers to increase the quality of the PASRR Level II evaluation for individuals with dementia.

The most recent PASRR Level II training reviewed by the SME and implemented during this reporting period provided additional guidance for PASRR Level II evaluators to determine changes in mental status and decline in functioning due to mental status. This guidance included questions regarding individuals with an existing dementia diagnosis and identified who made the diagnosis of dementia, the process used to determine the dementia diagnosis, and whether there was recent information that determined this diagnosis was accurate.

During the fifth 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 verified that a dementia diagnosis determines whether the individual would benefit from behavioral health services. The State reports they are piloting a questionnaire for PASRR Level II evaluators to gather additional, more reliable information regarding suspected dementia that will allow the consulting psychiatrist to determine if an individual has dementia. This questionnaire is rendered to NF staff and family members by an OBH Determination Specialists. All Level II evaluators, MCO reviewers, and OBH Determination Specialists have been trained on this document. It has been incorporated into the 2021 Updated OBH Dementia training as well as the 2022 OBH Assessment training.

Individuals with dementia have not been re-reviewed to determine if they continue to have dementia. The Utopia system does not currently track whether an individual has dementia. In discussion with the SME, the LDH consulting 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. In addition, OBH stated they will conduct re-reviews of individuals with a primary diagnosis of dementia and co-morbid conditions that may be “rehabilitated” and with adequate supports, the individual may be successfully transitioned into the community. In the sixth report, the SME requested information on LDH’s efforts to review these individuals who continue to have dementia or for whom there is no longer dementia present.

As discussed, the State reports it does not have a process to track individuals with a primary dementia diagnosis after they are admitted to an NF. The State is proposing to revise the Utopia system in the next reporting period to allow OBH to identify and track individuals who have a suspected or initial diagnosis of dementia. Specific revisions the State proposes includes adding “Suspected Dementia” to Utopia to allow for an additional review by the consulting psychiatrist of an individual when there is insufficient documentation to render a determination of primary dementia. In addition, OBH proposes to identify

when a re-review needs to occur and the consulting psychiatrist suspects the individual's current medical condition may improve, thus not warranting a determination of primary dementia. The State reports re-reviews will occur for individuals with the following diagnoses:

- Metabolic encephalopathy
- Stroke or mini strokes
- Traumatic Brain Injury (recent)
- Anyone recently in Intensive Care Unit (last few months)
- Drug / alcohol abuse
- Post-Surgical Delirium

In addition, the State has developed and provided the SME with policies regarding the frequency of re-reviews (immediately post-admission and during continued stays).

The State reports they are doing a historical review to determine if previous dementia diagnoses were appropriate. OBH is reviewing 140 cases from the 2015-2019 Master List. An OBH Determination Specialist will initiate PASRR Level II evaluations on these individuals by facility. They will request all required Level II documents, dementia documentation, and additional information from the facility and, when appropriate, family members. Once collected, this information will be re-reviewed by the consulting psychiatrist to see if there are any differences in determinations.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has strengthened documentation requirements and training used to establish a primary diagnosis of dementia relative to the PASRR screening process.
- LDH has developed several trainings to PASRR Level II evaluators to better identify individuals with a dementia diagnosis.
- LDH consulting psychiatrist provides an additional professional evaluation for all individuals with a dementia diagnosis (not just individuals with insufficient documentation) to ensure appropriate diagnosis and differentiation.
- LDH has developed a process for reviewing individuals with a dementia diagnosis since the beginning of the Agreement.
- LDH tracks the number of individuals who have been identified through the PASRR Level II process as having dementia; however, the State has not created a baseline for tracking changes regarding the number of individuals identified as having dementia.
- LDH does not have an existing process to track individuals with a dementia diagnosis which would allow them to re-evaluate whether an individual continues to have dementia but has stated they have developed a plan to revise the Utopia system to collect and track this information.
- LDH does not have a process or information for individuals who receive a dementia diagnosis to receive information regarding community supports and services.

Recommendations

- Continue to track the percent of individuals identified as having dementia to determine if changes occurred and if these changes are warranted. This includes developing a baseline for determining changes in the number and percent of individuals determined to have dementia through the PASRR Level II process (initial and at continued stay reviews).
- Ensure the new UTOPIA process is able to track individuals with dementia.

- Implement the process for re-reviewing individuals with dementia who displayed initial characteristics that may indicate dementia may not be long term. These individuals should be identified and referred for in-reach efforts to determine interest in transitioning.
- Report out on whether the changes that were developed in this paragraph were effective. This should include changes in individuals identified as having dementia and whether re-reviews of the conditions discussed in this paragraph are resulting in fewer ongoing dementia diagnoses.
- LDH does not have a process or information for individuals who receive a dementia diagnosis to receive information regarding community supports and services.

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.

Compliance Rating: Met

Discussion and Analysis

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. The SME continues to request information from LDH to determine if individuals with a sole diagnosis related to behavioral health (BH) have been admitted to NFs since 2018. Information from the MDS which is provided prior to admission collects information on diagnosis, including behavioral health diagnosis. Since the fifth reporting period, the SME has requested and received information from MDS data to identify if anyone was admitted to an NF in CY 2021 who had only a BH diagnosis. The State reports that no individual in this reporting period with a sole diagnosis of behavioral health was admitted to an NF.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has eliminated the behavioral health pathway for admission criteria into NFs.
- LDH has developed the necessary reports and reporting process for reviewing MDS information to verify individuals admitted to an NF have a sole diagnosis of behavioral health.
- During the reporting period, LDH reported that no individual was admitted to an NF with solely a behavioral health diagnosis.

Recommendations

- LDH should continue to collect and analyze MDS data at admission to ensure this provision continues to meet the intent of this paragraph.
- LDH should continue to provide the SME with this information for each reporting period.

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.

Compliance Rating: Partially Met

Discussion and Analysis

LDH has developed a system for 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. 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 May 2022 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.

While the Department has taken steps to develop a process for reviewing requests for continued stays, they do not have clear policies for determining the length of subsequent stays. It was the SME's understanding that each individual who meets level of care during the continued stay review process receives a 365-day authorization. However, the State has indicated that approvals for ongoing lengths of stay are variable.

In the previous report, the SME recommended the Department develop protocols for determining the additional length of subsequent NF stays based on an individual's needs versus a re-review at annual intervals. The Department agrees to this change in re-authorization policy but has yet to develop or implement these policies.

In addition, the SME requested information in the sixth SME Report regarding:

- Aggregate information on reasons for admission into a nursing facility for members in the Target Population.
- Aggregate information on reasons for continued stay approvals for members in the Target Population.
- The average length of initial and ongoing approvals (intended duration of the NF admission).
- List of transition barriers for individuals who have requested NF admission and for continued stay.

The SME has been provided information on lengths of stay for initial and ongoing approvals. For CY 2021, the Department reports the average length of stay for initial approvals is 96.6 days and ongoing approvals is 268.8 days. The SME is surprised by the length of stay for initial approvals. The State reports that initial authorizations are capped at 90-100 days. The length of stay may indicate individuals exceed their initial authorization and/or individuals are not transitioned from NFs shortly after admission. Therefore, most of the individuals on the Master List stay in the NF for the full 90 days. The length of stay for ongoing approvals is less than current approaches to authorizations. On average most individuals' length of stay is

less than one year. LDH development and implementation of a more individualized authorization process will hopefully reduce the average length of stay for individuals seeking a continued stay approval.

The SME has met with DOJ and the State to determine what information is currently available on reasons for admissions and continued stay. Understanding the reasons for admission and ongoing stay will be helpful to determine if additional services and supports should be made available for certain individuals to divert or reduce the length of stay in an NF.

The SME and LDH reviewed several tools to discern if information on reasons for admission was readily available. The current PASRR Level II tool collects information on various physical and behavioral health conditions that are present during the evaluation. It also collects information on what services (medical and behavioral health) the individual would benefit from while in the NF. While this is important information, it does not provide specific information regarding the reasons for admission. The Level of Care Eligibility Tool does provide information regarding the various pathways (e.g., skilled rehabilitation, Independent Activities of Daily Living (IADLs), cognitive performance) that may be helpful in discerning the reason for admissions and continued stays for NF placement. However, additional analysis of this data is needed to determine if this information was helpful in meeting the intent of this paragraph.

During this reporting period, OBH has developed and implemented an addendum to the PASRR Level II which is an Evaluation Summary that collects information regarding the service needs (physical, behavioral, and community) that impact the ability for the individual to live in the community. This is a new process and information is not yet available for the SME review during this reporting period.

Through the PASRR process, the State does track the behavioral health services that are needed by individuals in the Target Population that are in an NF. Information from the 2021 Needs Assessment provided information regarding the identified behavioral health needs of individuals based on their PASRR Level II evaluation. The Needs Assessment can be found here:
https://ldh.la.gov/assets/docs/MyChoice/LouisianaNeedsAssessment-Final-Report.pdf

In the previous report, the SME requested additional information from OBH during this reporting period regarding the number and percent of individuals who received specialized behavioral health services identified in the PASRR Level II process while in an NF for CY 2021. The Department is unable to report whether these specialized behavioral health services were provided during the individual's tenure in the NF. This information requires the changes in the Utopia system the State reports will be completed for the next reporting period.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed a process to 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; however, data provided by LDH indicates that initial lengths of stay are almost 97 days.
- LDH has initiated a process for identifying needs and concerns (physical, behavioral health, and support services) that impact an individual's ability to live in the community and could result in shorter lengths of stay.
- The PASRR Level II process does provide information regarding an individual's need for specialized behavioral health services when seeking admission or continued stay in an NF. However, the

Department is unable to report whether these specialized behavioral health services were provided during the individual's tenure in the NF.

- LDH does have an authorization process for ongoing stays for individuals that seek a continued stay. The State reports that the average length of stay for these individuals is approximately 279 days.

Recommendation

- As recommended in paragraph 34, LDH should revise the current PASRR Level II to ensure that the evaluation includes an assessment that an individual's total needs are such they can be met in appropriate community setting.
- LDH should continue to track authorization for NF admissions to ensure they comport with the 90–100-day requirement.
- LDH should develop a process for approving lengths of stay (initial admissions and continued stay) that are based on the individual's need versus a set number of days for every individual being admitted or continuing their stay in an NF. The goal should be to reduce the length of stay for individuals initially entering NFs and substantially reducing the lengths of stay for individuals seeking a continued stay.
- LDH should review data from the LOCET or other strategies to obtain information regarding reasons for admission, the need for specialized services, and any barriers that are identified when an individual is seeking admission. This information will be important to determine additional community supports that would be helpful for diverting individuals or reducing initial or ongoing lengths of stay.
- LDH should review and analyze new information collected through the PASRR Level II process that identifies needs or concerns that impact the individual's ability to live in the community and develop a strategy to address these needs for CY 2023.

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.

Compliance Rating: Met

Discussion and Analysis

As indicated in previous SME reports, the State has developed a process that requires NFs to submit continued stay requests (CSRs) for continued stays beyond the 90 days of an initial stay, 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 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. This includes the use of MDS to establish continued NF level of care. The State reports that all continued stay requests are reviewed by OAAS regional staff who are independent and not affiliated with the nursing facility.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed a process to establish a level of care beyond 90-100 days.
- The process is conducted by a PASRR Level II reviewer that is independent of the NF.

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

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in the response to Paragraph 34, PASRR Level II reviews are performed by the Medicaid MCOs' Level II Evaluators, licensed mental health professionals who operate independent of the NF and the State.

This paragraph provides several scenarios for an individual receiving an additional PASRR Level II during their nursing facility stay tenure:

- A PASRR Level II is 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 continues to request information regarding the number of individuals in the Target Population who received a PASRR Level II based on each of these scenarios over the past year. As discussed in the fifth SME report, information for several of these scenarios continues to be unavailable, in large part due to the lack of existing fields in the UTOPIA system used to collect PASRR Level II data. LDH is finalizing changes to the UTOPIA system during this reporting period to be able to report on the above scenarios. These changes in the UTOPIA system, coupled with information from the existing OPTS system and information from Medicaid claims, will allow LDH to collect information that aligns with the bulleted scenarios and information regarding behavioral health services needed and received. As discussed in the sixth SME report, preliminary data from the State identified that approximately 55% of individuals on the Master List had a subsequent PASRR Level II review in FY 2021. This does not meet the requirement of the Agreement to have everyone in the Target Population in an NF receive an annual resident review.

In the previous report, the SME requested LDH provide report templates in the next reporting period to make available the following information:

- The number and percent of individuals in the Target Population who have received a recent (within the past year) PASRR Level II annual review. For the purposes of identifying whether an individual received an annual resident review, LDH will include PASRR Level II completed during a CSR review OR an annual review for individuals who are no longer subject to CSRs.

- 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 physical or mental 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.

Given the delays in the system changes to UTOPIA, this information was not available.

Performing these subsequent PASRR Level II evaluations will be necessary 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. Subsequent PASRR Level II evaluations will also allow LDH to have an additional "touchpoint" with the individual regarding community alternatives and gauge possible interest in transitioning from the NF.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed and communicated to the vendor the changes necessary to meet the intent of this paragraph.
- LDH has ensured that the changes to the UTOPIA system will be made early in the next reporting period.
- The State cannot provide the data to ensure individuals receive a PASRR Level II for the scenarios set forth in this paragraph, including annual reviews. If not produced in the next reporting period, this paragraph will be found Not Met.

Recommendations:

- Complete the changes to the UTOPIA system within the first 90 days of the next reporting period.
- Provide the SME with the reporting templates for collecting data on the three scenarios set forth in this paragraph.
- By December 31st provide an initial report to the SME on the number and percent of individuals in each of the three scenarios.
- Provide information for individuals with a change in medical condition, as requested in the previous SME report.

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.

Compliance Rating: Not Met

Discussion and Analysis

As indicated in the previous SME reports, the State has developed a process for transition planning services for individuals in the Target Population in NFs. This process was based off the State's Money Follows the Person (MFP) program and consists of a transition assessment and an Individual Transition Plan (ITP). The process is the same for individuals who were in NFs prior to the Agreement and for individuals in the Target Population who were admitted after the Agreement. In 2019, the State, with the assistance of the SME, revised these documents to better address the needs of the individuals in the Target Population based on the initial year of implementation.

There are two major issues the Department will need to address for meeting the requirements of this paragraph. The first is to ensure that everyone who is interested in transition has a Transition Assessment and an Individualized Transition Plan (completed or in progress). In connection with this, there must be regular, meaningful engagement with everyone on the Master List to ensure they have meaningful opportunities for comprehensive transition planning. The second is to ensure the quality of these ITPs to reflect a person-centered planning process that accurately reflects the individuals' desires and needs. The second issue is discussed more thoroughly in Paragraph 43.

With respect to the first issue, as discussed further below, more than 50% of the individuals on the Active Caseload List do not have a completed ITP.

In the fifth SME report, it was recommended that LDH recreate the Status Tracker to provide critical information to identify where individuals are in the transition process. This tracker, in the SME's opinion, will 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 sixth SME report, LDH has developed a monthly status tracker for CY 2022. This status tracker will include the following by region:

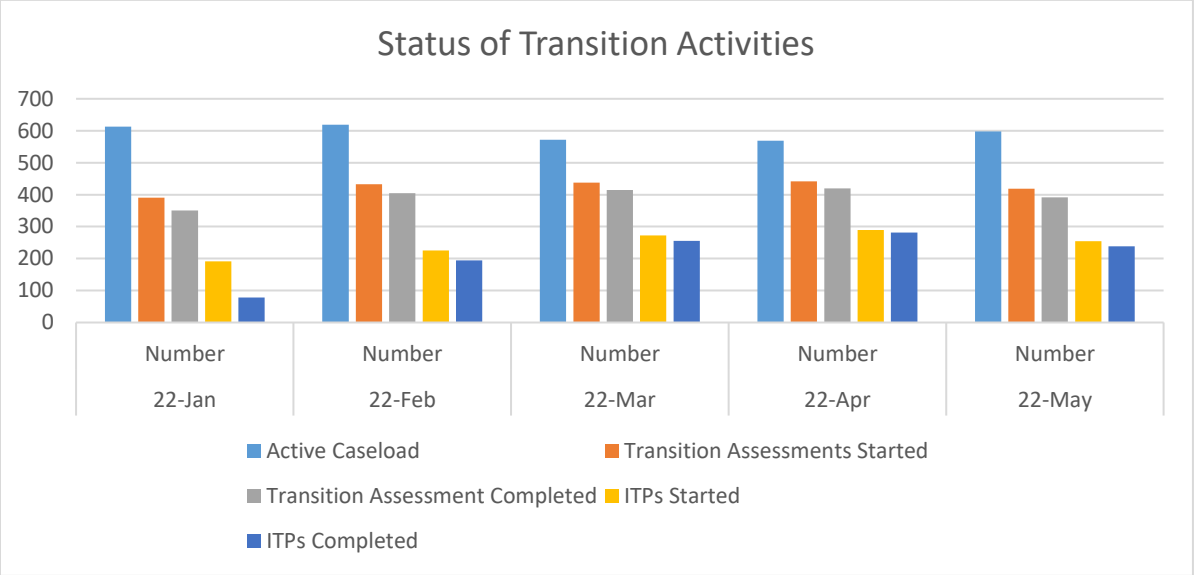
- Activity by the TC over the past 30 and 60 days including finalizing Transition Assessments and developing Transition Plans
- The number of Transition Assessments started and completed
- The number of Transition Plans started and completed.

The transition tracker also provides information on transition and housing needs that are discussed in paragraphs later in this report.

As requested, LDH provides the SME with information on a monthly basis. The activities specifically regarding transition planning are presented in the chart below.

Activity	22-Jan	22-Feb		22-Mar		22-Apr		22-May	
	Number	%	Number	%	Number	%	Number	%	Number	%
Active Caseload	613	100%	619	100%	572	100%	569	100%	598	100%
Transition Assessments Started	391	64%	433	70%	438	76%	442	77%	419	70%

Transition Assessment Completed	351	57%	405	65%	415	73%	420	74%	392	66%
ITPs Started	191	31%	225	36%	272	48%	289	51%	254	42%
ITPs Completed	78	13%	194	31%	255	39%	281	49%	238	40%



As indicated above, LDH increased the number and percent of individuals on the Active Caseload List who have a Transition Assessment and an ITP (in progress or completed) over the first four months. The most significant change has been the ITPs started and the ITPs completed. However, there was a decrease in the number and percent of individuals on the Active Caseload List across all transition activities in May. LDH reports the decrease was due to the number of individuals who were transitioned to and from the Active Caseload List in May. LDH reports that 186 individuals were added to the Active Caseload List in April and May and are just beginning the transition process. They also report that 179 individuals were removed from the Active Caseload List that previously had assessments and ITPs.

More than 50% of the individuals on the Active Caseload List do not have ITP.

During the reporting period, LDH created expectations for the timeframe the TCs have to complete the Assessment, develop the ITP, and transition the individual. Specifically, LDH has set the following expectations:

Activity	Expectation
Date of Referral to TC	TC has 3 calendar days to make initial contact with Member once the individual is placed on the Active Caseload List and an OCET is completed.
Date Initial TC Assessment Completed	TC has 14 days to complete the transition assessment.

Date ITP Completed	TC has 30 calendar days to initiate the transition plan from the date assessment was completed.
Proposed Transition Date	TC has 7 calendar days to identify the projected transition date.
Date TC referred to MCO for Community CM	Should be done at least 60 days prior to the projected transition date.

The SME has reviewed these expectations and believes this is a good starting point for LDH to continue efforts to standardize the transition process.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed the expectations for TCs to complete the Transition Assessment and ITP within timeframes the SME finds acceptable.
- LDH has developed tracking tools to identify the number of individuals who have a Transition Assessment and ITP.
- LDH has increased the number of individuals on the Active Caseload List who have a Transition Assessment and ITP.
- There are still a significant number of individuals on the Active Caseload (51%) who need a completed Transition Plan.

Recommendations

- LDH should ensure that almost all individuals on the Active Caseload have a completed Transition Plan the next reporting period. The SME understands that some individuals who are placed in the Active Caseload List over the next six months will likely not have an ITP (in progress or completed).
- LDH should provide the SME with information on how it monitors the expected timeframes for TCs to complete the Transition Assessment and ITP.
- LDH should provide the SME information regarding the percentage of TCs that are meeting the timeframe expectations regarding completed Transition Assessments and ITPs and what the plan is to ensure TCs comply with these timeframes.

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.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in previous SME reports throughout the course of this agreement, many individuals have been placed on the Master List because MDS data indicates they should have a Serious Mental Illness, but they did not receive a PASRR Level II evaluation to confirm this diagnosis. Consistent with this provision, the State must refer these individuals for a PASRR Level II. The Level II evaluation should confirm whether the individual had an SMI as initially identified through MDS data and verify they are a member of the Target Population. In the fourth 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 had not received a PASRR Level II, and complete Level IIs for these individuals. The State has implemented a

process for identifying individuals who were admitted prior to September 2021 and ensuring these individuals received a PASRR Level II to determine if they are members of the Target Population. The SME requested and received information regarding the number of individuals (282) in CY 2021 who resided in NFs and were identified by a subsequent MDS as having an SMI. Of these 282 individuals:

- 165 or 59% received a PASRR Level II evaluation to determine if they had an SMI.
- 123 or 75% of those individuals who received a PASRR Level II evaluation were determined to have an SMI.
- Average length of time for the 165 individuals who were identified as having a potential SMI per the MDS to receive a PASRR Level II was 152 days from the initial referral for a Level II evaluation.

Based on this information, 40% of individuals who had a potential SMI did not receive a PASRR Level II to confirm their diagnosis. It took five months for an individual to receive a PASRR Level II evaluation from the date of referral. Both of these data points are troubling. All individuals who are on the Master List solely due to a possible SMI should be referred and receive a PASRR Level II to confirm diagnosis. In addition, a five-month delay in receiving a PASRR Level II review is not acceptable.

The SME continues to receive information on the number of individuals who are on the Master List and whether they have received an initial PASRR Level II. The SME requested this information for individuals who were admitted prior to the Agreement and for subsequent years (FY 2019, FY 2020, FY 2021, and FY 2022). The State provided the information in the following table.

All Persons on the Master List that Received a PASRR Level II (by Year of Admission)

Admit Date	Yes	Percent	No	Percent	Total
Prior to FY 2019	931	97%	24	3%	955
FY 2019	198	99%	3	1%	201
FY 2020	263	95%	15	5%	278
FY 2021	569	93%	45	7%	614
FY 2022	1023	85%	185	15%	1208
Total	2984	92%	272	8%	3256

As this table indicates, 92% of the individuals on the Master List have at least one PASRR Level II. The number of individuals who received a PASRR Level II is highest for individuals who were admitted at the start of the Agreement and remain on the Master List. The SME is encouraged by this progress for individuals who were admitted prior to FY 2020. In the sixth SME report, there were at least 10% or more individuals on the Master List who have not received a PASRR Level II in FY 2020. In the sixth report, the SME recommended the State prioritize these individuals for a PASRR Level II to ensure they are part of the Target Population. The State has reported that they prioritized these individuals for a PASRR Level II evaluation. A small percentage of individuals that were admitted to NFs in FY 2020 do not have a PASRR Level II, although as indicated previously in this report, these were likely individuals who were recently identified post admission as having a potential SMI. However, the SME is concerned that 15% of individuals in the last fiscal year are still needing a PASRR Level II.

Ensuring a PASRR Level II is important for all individuals admitted to an NF and is important to meet the terms of the Agreement. Information from the Level II may suggest that an individual should be included in the Active Caseload and prioritized for transition. In the previous report, the SME requested the following information on these individuals:

- The number of individuals in CY 2021 who were in NFs and were identified by a subsequent MDS as having an SMI.
- The number and percent of these individuals who received a PASRR Level II evaluation to determine if they had an SMI.
- The number and percent of these individuals who had an SMI based on the PASRR Level II evaluation.
- The length of time between identifying if an individual had an SMI (through the subsequent MDS) and the receipt of a PASRR Level II evaluation.

LDH reports they are in the process of collecting and providing this information to the SME during the next reporting period.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH continues to make progress to ensure that every individual in the Target Population receives a PASRR Level II.
- LDH has not performed a PASRR Level II for many individuals who were identified post admission as having potential SMI to confirm their diagnosis.
- LDH may take as long as five months for an individual to receive a PASRR Level II evaluation from the date of referral when they have a potential SMI.

Recommendations

- LDH should continue to track and report the number of individuals who are in an NF and have subsequently been identified through the MDS process as having an SMI.
- LDH should continue to track and report the number of individuals who are in an NF and have subsequently been identified through the MDS process as having an SMI and have received a PASRR Level II evaluation.
- LDH should develop and track timeframe expectations for individuals identified through subsequent MDS to receive a PASRR Level II.
- LDH should reduce the percent of individuals who do not have a PASRR Level II evaluation and have recently been identified as having a potential SMI.
- LDH should reduce the length of time between the identification of an individual in an NF who has been identified as having a potential SMI and the individual receiving a PASRR Level II.

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.

Compliance Rating: Partially Met

Discussion and Analysis

The State initially established 18 positions to assist with transitions. The State recruited, hired, and trained all Transition Coordinators (TCs). In FY 2020 the State expanded the number of TCs to 25 individuals; OAAS has 16 TCs and OBH has 9 TCs. This expansion was due to the experience early in the Agreement regarding a more realistic projection regarding the time needed by TCs to perform various transition activities and an increase in the projected number of individuals who would transition from nursing facilities in CY 2020. The role of these Transition Coordinators is similar to those deployed through the MFP 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 were 22 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 sixth report, the SME recommended LDH reassess its TC capacity. The SME noted various factors that LDH should consider when reassessing this capacity. This included:

- Number of individuals LDH has identified who are interested in moving, specifically members on the Active Caseload.
- Transition Coordinator's role and responsibilities with various transition functions. During the reporting period, TCs will reduce their roles in providing intensive case management for individuals who have transitioned and can re-focus efforts to perform transition activities (in-reach, transition assessments, and ITPs).
- Caseload size for Transition Coordinators. Currently the TC's caseload size is 25, which the SME finds reasonable for the roles to be performed by the TCs.
- Transition barriers and other factors will also influence the length of time someone will need to transition and actively remain on a TC's caseload.

The State reports that as of June 1, 2022, there are 715 individuals on the Active Caseload in NFs. 598 of these individuals on the Active caseload List are awaiting transition. This includes 478 individuals who

were added to the Active Caseload List because they expressed an interest in moving during the in-reach process that commenced in April 2021, and 237 individuals who were added to the Active Caseload prior to April 2021 and continue to express an interest in transition. Of the 715 individuals on the Active Caseload, 117 individuals have transitioned from NFs within the past year.

An additional 197 individuals on the Master List were contacted during the period from April 2021 through March 2022 through the in-reach process and were determined to be undecided about transition. Therefore, a total of 805 individuals in the current Target Population may need to be engaged with a TC to facilitate transition in the near term.

In its 2022 Implementation Plan, the State committed to transition 292 individuals in CY 2022. This is approximately 48% of the individuals currently on the Active Caseload who have not yet transitioned and 36% of the overall Target Population in NFs that the State projects may need to be engaged to facilitate transition in the near future. This underscores that many individuals who have indicated they are, or may be, interested in moving in the near term will not be offered transition assistance by the TCs over the next sixth months.

In the previous report, the SME recommended and LDH has undertaken various activities to enhance the number of transitions during the next and subsequent reporting periods:

- LDH has combined the efforts of all TCs to perform transitions of any member of the Active Caseload regardless of whether they were hired by OBH or OAAS.
- LDH has begun efforts to develop a new process for prioritizing TCs' efforts. This includes:
    - Identifying individuals with lower physical health needs that can be transitioned to the community.
    - Reviewing the case mix of each TC caseload to ensure that TCs are engaging and working with individuals that may have mild, moderate, and high service needs.
    - Adding an FTE in both OAAS and OBH that is managing all TC activity.
    - Developing SOPs for CCM to support TCs and not supplant each other's efforts in the transition process.

Despite the SME's recommendations, the State has not hired or contracted with additional Peer Specialists that can support TCs and CCMs in their efforts to transition individuals. Nor has the State reviewed a strategy to employ more staff that can perform transitions. The current caseload expectation (25) means that LDH's TCs should be able to assist approximately 600 individuals to transition per year. This leaves up to 322 individuals who are interested in transitioning without a TC that can even *begin* the transition process.

Further, LDH projected that its current staff would be able to *complete* 292 transitions in CY 2022. If this projection is correct, up to 314 individuals who are already known to be interested in transition will remain in NFs past 2022 because of insufficient TC capacity. Thus far, LDH is not on track to achieve its projection, meaning the number of people who remain in NFs will be even higher. Progress on transitions is assessed and discussed in more detail in paragraph 56.

The SME recommended more proactive oversight of transition planning activities to assist LDH in setting and meeting reasonable transition expectations. In the summer of CY 2021, LDH set specific expectations for the number of transitions each region must accomplish annually and began tracking each region's performance. The tracking information includes data on the number of transitions projected and completed per month. It reflects the progress on transitions and identifies, by region, whether LDH is meeting its transition targets. Tracking this on a regular basis will allow LDH to identify regions that may be experiencing significant challenges in transitioning individuals in the Target Population residing in NFs.

In the previous report, the SME recommended LDH use newly developed management tools (and any other information) to determine whether the existing TCs can serve more individuals on the Active Caseload List or if the department will need to add staffing to transition individuals on the Active List from NFs. This additional capacity could include additional peer specialists, transition coordinators, or even community case managers who are to engage individuals within 60 days of transition. As indicated above, the State has not moved forward with reviewing or developing these strategies.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed transition teams that are composed of transition coordinators from OAAS and OBH, who are responsible for assessing, planning, and facilitating access to necessary community-based services.
- LDH has developed a strategy for addressing transitions for individuals with a co-occurring intellectual or developmental disability and a behavioral health condition.
- LDH has developed caseload sizes for each transition coordinator.
- LDH has developed better management tools for meeting the transition targets established by the Department.
- The current number of TCs (based on current caseload size) is not sufficient to address the number of individuals in NFs who have expressed an interest in transition. As indicated above, there are still 805 individuals who have expressed an interest in moving or are undecided. The current transition projections for CY 2022 will transition 292 of these individuals and therefore over 600 individuals will remain in NFs without additional transition capacity.
- The State has not conducted the required analysis regarding the appropriate number of TCs to hire.

Recommendations

- The Department should ensure that everyone on the Active Caseload List is assigned a Transition Coordinator and that transition activities (e.g., assessment and ITPs) are performed within the timeframes discussed in paragraph 40.
- LDH should consider additional peer supports to assist TCs with various transition activities. This would allow TCs to have higher caseloads and would provide more individuals with a transition coordinator.
- The State should take action to increase transition capacity. This would include additional transition staff (TCs, peers, or possibly community providers such as CCM or ACT) or consider strategies that will allow TCs to have increased caseloads by reviewing their duties and change those activities that may not be value added or delegating activities to others involved in the transition.

- Provide information on the number of individuals with ID/DD over the past several years to determine if the current approach for assigning TCs continues to make sense.

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.

Compliance Rating: Not Met

Discussion and Analysis

This discussion addresses paragraphs 43 and 46 together. Since the beginning of the Agreement, LDH has developed ITPs based on a standardized assessment that is completed prior to discharge. The State has made revisions to the assessment and ITP over the past several years to be more person-centered and to gather additional information regarding individuals' interests and desires about integrated day opportunities. The assessment and ITP, as revised, also provides more specificity regarding the housing options that are available in the community post-transition.

Not everyone on the Active Caseload has an ITP. As indicated in paragraph 40, approximately one-half of these individuals have a completed ITP. In addition, the SME Service Review conducted over the past two years found that the quality of the assessments and ITPs varied. The SME Service Review identified issues with the transition process and the quality of the Transition Assessment and ITPs, including:

- The transition plans did not specify the amount, frequency, and duration of services post-transition.
- The transition plans did not accurately reflect and address all of the individuals' needs and desired outcomes. In particular, individuals' interest in activities that would support community integration were rarely addressed in the transition plan. While the pandemic is certainly a significant barrier to participate in some of these activities, there was no documentation in the plan that addresses interests or activities (e.g., pursuing hobbies) that could have been done in-home.
- The transition plans did not identify all appropriate services and supports. For instance, very few of the assessment and transition plans identified natural supports or other informal supports. The presence of a behavioral health crisis plan was variable.
- None of the transition plans reviewed included employment goals, which is a shortcoming in the current assessment process.
- There was a lack of clarity as to whether the individual had an active role in choosing where they would live post transition.
- Services identified in the Transition Plan were not always provided on a timely basis.

The issues are described in more detail in Attachment A of the Service Review Report:
SME-Report-January-June-2021.pdf (la.gov)

The SME recommended several strategies for LDH to consider for addressing these issues:

- Provide training and technical assistance to TCs regarding important areas established in the Transition Assessment, including identifying services and supports that will enhance community integration (including employment) and medication information and adherence. LDH reports they have provided additional information and training to the TCs to address many of the issues identified in last year's report. This training was provided by the Integration Coordinator early and ongoing in this reporting period. The SME reviewed the training, and the content addresses the issues that were identified in assessment and plans developed with the individual by the TC. LDH is also contracting with an individual who will work with the TCs on-site to improve their efforts to perform assessments and develop person-centered transition plans.

- 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, TCs may want to follow-up with each service (including DME) a few working days before transition occurs. This issue was covered in the trainings discussed in the previous paragraph.

- Enhancing the acumen of TCs to identify and address physical health conditions and resources during the transition process to ensure the individuals who are transitioning have the resources in place to address their physical health needs. This has not been developed.

In the sixth report, the SME requested the State develop and begin to implement a plan for addressing these issues during this reporting period. The State has not developed a plan that sets forth the strategy for addressing several of the findings from the SME review.

The SME will continue efforts during the next reporting period to conduct ongoing service reviews of individuals in the Target Population. These reviews will supplement LDH's efforts to evaluate whether technical assistance and other resources being provided to the TCs are improving assessments and ITPs.

In the sixth report, the SME requested the existing ITP be revised to include detailed information regarding scope, amount, and duration of community services and supports that will be provided to individuals at transition. The plan has not been revised to include this information. While the SME understands the plan is specifically to address transition needs, there should be no gap between the end of the transition plan and the beginning of the Plan of Care developed by Community Case Managers (CCMs).

<u>Compliance Assessment</u>
The SME assessment of the State's compliance with this paragraph took into consideration:

- In the most recent service review, the transition plans did not address many of the important details required by paragraphs 43 and 46. While LDH has made some efforts to address the issues identified in the SME Service Review Report, there isn't an organized approach to improving the quality of the assessments and ITPs.
- The SME requested revisions to the existing ITP to include detailed information regarding the amount and duration of services. These potential revisions have yet to occur.

<u>Recommendations</u>
- Develop and implement a plan to address the issues identified in the SME Service Review Report.
- Revise the ITP to ensure, at a minimum, there is a specific end date for the ITP that is past the beginning of the plan of care developed by the CCM. The SME would suggest that ITPs identify services and supports that are needed at transition and for the first 30 days post NF discharge.

- Ensure that either in the ITP or other pre-transition plans, the appropriate amount and duration of services are initially identified for at least the first 30 days post-discharge.
- LDH should evaluate the effectiveness of the TC training regarding assessment and ITPs.

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.

Compliance Rating: Partially Met

Discussion and Analysis

During the fourth reporting period, the State, in collaboration with the SME's team, revised its training materials related to person-centered transition planning. 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 for developing a meaningful process for working collaboratively with the individual to develop a transition plan. LDH has reviewed the training curriculum with a My Choice subcommittee. The State and the SME team provided five trainings virtually to the TCs in CY 2020 regarding person-centered assessments and planning. The SME recommended LDH validate the effectiveness of this training on the quality and the person-centeredness of the ITPs in this reporting period.

While the SME service review found the quality of the assessments and ITPs were generally poor, the process used for developing plans had some components of a person-centered approach. For instance, the ITP 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, Community Choices Waiver (CCW) support coordinator, and other individuals. Individuals that needed housing post-transition were offered and provided housing and supports generally in the communities they requested. As indicated in paragraph 43, LDH is contracting with an in-state resource to review and provide technical assistance to the TCs to continue efforts to ensure the ITP process is person-centered and the ITPs better reflect the needs and desires of the individual.

The current in-reach process that is discussed in Paragraph 89 includes individuals with lived experience to assist individuals to discuss and provide supports to members of the Target Population who are in NFs. A specific focus of the training and supervision that peer in-reach specialists receive is assisting individuals to visualize what their life could look like once they transition from the facility.

In response to the SME's previous requests, LDH provided the SME with information regarding the process deployed to allow individuals an opportunity to visit potential housing options and the surrounding community, to better envision their lives post transition. Generally, these do not include in-person visits to the housing options. Rather, the TC and/or the LDH Housing Coordinator will provide photos and videos of these options.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The ITP process does incorporate activities that are consistent with a person-centered approach.
- While improvement is needed, LDH is providing additional hands-on technical assistance to TCs to improve the assessment and ITP process, ensuring it is more person-centered.
- While photos and videos may be useful to begin the housing search process, these are not sufficient proxies for in-person visits to prospective housing opportunities.

Recommendations

- LDH implement the strategy to provide technical assistance to TCs to ensure a person-centered planning process
- LDH should review the effectiveness of this technical assistance. This could include an LDH led internal review of a sample of plans and interviews with members of the Target Population to continue to ensure the process is person-centered and results in higher quality ITPs.
- LDH should develop in-person opportunities to review housing and other community opportunities prior to transition.

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.

Compliance Rating: Not Met

Discussion and Analysis

The State does not currently have a real-time way to identify when individuals are admitted to a nursing facility. Therefore, the State is not able to meet the 3-day and 14-day requirements in this paragraph. 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 late CY 2022. The State has chosen a vendor to develop this tracking system; however, the tracking system has not been developed during this reporting period. In addition, the State will need to complete activities set forth in Paragraph 54 regarding the timeframes TCs will need to meet for starting and completing the ITP.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has not developed the necessary functionality to meet the requirements of this Agreement.

Recommendations

- Provide the SME with a presentation regarding the process the Vendor will implement to achieve the requirements of this paragraph.
- Provide the SME with a reporting template the State will use to be able to track the 3-day and 14-day requirement.

- Develop a specific process for how contact will occur at both the 3-day and 14-day timelines. Specifically, the process should address:
    - Who will provide the 3-day and 14-day contacts?
    - How will these staff be notified of new admissions to ensure there is contact within three days?
    - What will be the purpose of the contact and how will the content of these contacts be assessed?
    - How will LDH ensure that contacts are occurring within these timeframes?
    - What is the disposition of these contacts (e.g., immediate discharge, placement on Active Caseload List, etc.)?

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.

Compliance Rating: Not Met

See the response to Paragraph 43.

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.

Compliance Status: Not Yet Rated

Discussion and Analysis

At the beginning of the Agreement, the State did not have a community case management strategy for individuals transitioning from NFs. In late CY 2019, the State implemented an interim intensive case management strategy for these individuals. Specifically, the TCs were required to provide intensive case management while the State developed a longer-term approach for developing and implementing case management. TCs, in their role as intensive case managers, were responsible for 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.

LDH designed and, during this reporting period, implemented a case management approach that relies on community agencies to provide community case management. The Standard Operating Procedures (SOP) developed by LDH provides an approach for how community case managers (CCM) will interface with the TCs. Specifically, the SOPs require:

- The CCM to collaborate with the individual's assigned TC, as well as the MCO, to develop a transition plan and secure providers, resources, and supports in the community that will begin immediately upon the member's transition to the community.
- The CCM to attend transition planning meetings with the TC and the individual.

In the sixth report, the SME recommended an onboarding process for staff providing CCM that includes training on the TC role and the transition process. This training should reflect the standard operating protocols (SOP) developed by the MCO for the CCM program. In reviewing the SOPs, there was some information regarding the different roles and responsibilities of the TCs versus CCM staff. In February 2022, CCMs began providing case management to some eligible members of the Target Population.

Because LDH has only recently begun to implement the necessary community case management strategy, this paragraph does not yet have a compliance rating. However, the review of assessments and ITPs prepared by TCs is informative. The SME recommends that LDH implement the recommendations in paragraph 43 regarding ITPs, ensuring that ITPs or other pre-transition planning documents (e.g., CCW plans) identify the services and supports that should be available to individuals within 30 days of discharge from an NF. In addition, LDH should provide data from the tracking system (discussed in paragraph 48) to ensure that CCMs are engaged in the transition planning process prior to 60 days of discharge. The SME anticipates rating this provision during the next rating period.

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

Compliance Rating: Met

Discussion and Analysis

LDH required MCOs to develop internal protocols to link members transitioning from nursing facilities or diverted from nursing facility care immediately to community case management agencies and for ensuring the PASRR II evaluators make an immediate referral for community case management services. The State has provided information on the proposed SOP that provides detail on the process MCOs will use to refer individuals who were transitioned or diverted to CCM on a timely basis. The State has developed a tracking system that should provide information regarding the timeliness of these referrals and engagement status post referral.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has defined, developed, and implemented a process for providing CCM to support individuals in the Target Population who have transitioned or been diverted from NFs.

Recommendations

- As recommended in paragraph 47, LDH should ensure the process for assigning CCM is consistent with the policies and procedures outlined in the SOP.

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.

Compliance Rating: Partially Met

Discussion and Analysis

At the beginning of the Agreement, LDH required TCs to conduct post-transition follow-up to determine if the individual was receiving services in the community and to generally identify any issues an individual had during the first year of the transition. Specifically, LDH required TCs to perform post transition assessments at 30, 60-, 90-, 180-, and 365-days post transition. The State developed the necessary protocols and trackers to collect this information. In the sixth report, the SME recommended TCs be provided with information regarding their renewed responsibilities to conduct follow up visits using the cadence LDH has developed. The State reports it will use the same contact log as currently used for ICM that will collect data similar to the CCMs from the individual as an additional strategy to check-in with individuals who were transitioned and also a strategy to validate information being collected by the CCM. The State has not developed a similar process for individuals diverted from NFs.

In the sixth report, the SME recommended LDH should increase the management staff that are overseeing TC activity to address issues identified during and post transition more effectively. LDH has added additional staff to oversee the My Choice Program and allows current staff responsible for managing TCs to focus on those activities given these additional staff.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has added My Choice Program staff that will allow staff that oversee TCs to focus on ensuring follow-up activities are implemented within the LDH timeframes and review the quality of these follow-up activities.
- The State has developed the necessary policies and tools for conducting post-transition follow-up.
- Follow-up efforts were placed on hold for the past two years as TCs provided intensive case management and this follow-up was part of the TCs' daily activities.
- The TCs will revert back to their initial oversight roles during the next reporting period, and it is too soon to determine compliance regarding the timing and quality of these post-transition follow-up activities.
- There is no post-follow-up strategy similar to individuals who are transitioned for individuals who are diverted from NFs.

Recommendations

- Develop a process for staff overseeing TCs to include a review that post-discharge reviews are being conducted with the cadence established by the Department.
- LDH should build in a review of the quality of the post-discharge contacts, ensuring that information from these follow-ups provide enough information for LDH to review and act on any concerns being identified by the TC, including a process to report this information to the CCM organizations.
- Develop a follow-up process for individuals who are diverted from NFs. Consider the use of TCs in performing this outreach as part of their ongoing duties.

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.

Compliance Rating: Partially Met

Discussion and Analysis

Some individuals who are transitioned from NFs are at-risk of losing Medicaid eligibility when transitioning to the community. Medicaid has more generous income limits for individuals who meet the level of care for a nursing facility than those who reside in the community. During this reporting period, two individuals who transitioned into the community were at risk of losing Medicaid eligibility post transition. LDH has yet to provide information on the status of these individuals. These individuals will continue to be enrolled in the Medicaid program until the end of the pandemic. CMS has not proposed an exact deadline for states to disenroll individuals post-pandemic.

Over the duration of the Agreement, a total of 21 transitioned individuals have lost Medicaid eligibility. In the fifth and sixth report, the SME provided information on disposition of these individuals, based on information that LDH provided. The SME continues to request this information. The State reports there were no additional individuals who lost Medicaid eligibility due to the current policy in place during the pandemic.

As recommended in previous SME reports, LDH should develop clear pathways for making referrals for these individuals to LGEs for follow-up services. In the previous report, the SME also requested information on whether the 21 individuals who have lost Medicaid were referred to LGEs and, if available, any information regarding their engagement in services provided or coordinated by the LGE. The SME continues to request this information.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State continued to cover most individuals under the Medicaid program during the pandemic.
- The State has not provided the pathways for referrals to the LGE and other local agencies (e.g., Federally Qualified Health Centers).

Recommendations

- LDH should develop a referral protocol to other community providers (e.g., LGEs and FQHCs) prior to the end of eligibility coverage under the pandemic.
- LDH should require TCs and CCMs to assess individuals' eligibility for the Medicaid Purchasing Plan and facilitate the referrals when the pandemic coverage ends.

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.

Compliance Rating: Not Met

Discussion and Analysis

There are several touchpoints for individuals on the Master List to have conversations to gauge their interest in moving. While LDH has implemented better in-reach strategies over the past year, they have not contacted everyone on the Master List using these strategies. Nor have they collected information through this process to identify and address barriers to community living.

The State reports that many individuals on the Master List may have requested a continued stay request at which point it was determined if these individuals remained on the Master List. There is little data to support if and how these decisions were made through the CSR process. Nor were there specific barriers identified through the CSR process.

The State reports they are expanding their in-reach efforts during the next reporting period to ensure in-reach will be provided to all individuals on the Master List over the next 12 months and to begin a more formal process for identifying barriers. Once identified, the State will need a process for how to best address these barriers.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has not contacted everyone on the Master List using the revised in-reach process.
- The State has not implemented the necessary steps to collect information regarding the barriers to transition for individuals on the Master List who may be undecided or not interested due to these barriers.
- The State has yet to develop a streamlined process for addressing these barriers.

Recommendations

- LDH should develop an approach that ensures all individuals on the Master List receive in-reach using the revised approach developed over the past year.
- LDH should require in-reach staff to identify and submit information on barriers to transitions identified through the in-reach process.
- LDH should develop a streamlined process for reviewing and addressing barriers identified though in-reach.

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.

Compliance Rating: Not Rated

Discussion and Analysis

This paragraph will not be rated given it is the responsibility of the SME to perform the review of individuals who have requested alternative settings for transition. The SME developed a protocol and process to meet the requirements of this paragraph. During this evaluation period, LDH reported that two members of the Target Population expressed an interest in transitioning from an NF and requested to be transitioned to a setting other than their family's home or their own housing (single family home or apartment). One individual was requesting to move to a small group home, expressing her desire to have

individuals live with her that could remind her to take her medications and to address some of her Independent Activities of Daily Living (IADL) needs. The other individual had previously lived in group homes prior to their NF stay and requested to return to a group home setting.

The SME reviewed information from the Transition Assessment, ITP, and supporting documentation provided by TCs and TC supervisors to evaluate these requests. One individual seeking a group home placement was hospitalized and died prior to being discharged from the NF. For the other individual, the SME suggested community services (such as personal care) that could likely meet the needs of the individual who needed assistance with medication oversight and IADLs. LDH staff reported the individual would not meet NF LOC and therefore would not be eligible for personal care services from the CCW or LTPCS program. As indicated in paragraph 75, the OBH personal care program has not been implemented during this reporting period. The SME recommended the individual be transitioned to the small group home for a limited period of time, until the OBH PCS program could be put in place and recommended the TC work with the CCM to message that option to the individual and determine if that was an acceptable transition strategy. The State reports the individual is awaiting services and will transition from the NF to their own apartment with personal care and other supports early in the next reporting period.

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

Compliance Rating: Not Yet Rated

Discussion and Analysis

As noted below, LDH has determined 17% of individuals contacted during the in-reach process are unable to make a decision about transition. LDH must develop procedures to ensure these members of the Target Population have the supports needed to make an informed choice about where they want to live and receive services. In addition, LDH continues to report 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). These individuals have been referred to the Service Review Panel that reviews various documentation to determine if safety issues identified are valid. In addition, the State reports the Transition Coordinators 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 fourth 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. As indicated in the sixth report, the SME will work with the State to obtain and review this information in 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.

Compliance Rating: Partially Met

Discussion and Analysis

Paragraphs 54 and 89 are addressed together. As indicated in the sixth report, the SME notes that the terms "outreach" and "in-reach" are both used in this Agreement to describe the activities at issue in this provision. However, LDH policies and documents use the term "in-reach" to describe such activities. These include efforts to engage with individuals who are in the Target Population in NFs to discuss their interest in moving, assign them to either Master or Active Caseloads, and begin the transition assessment and ITP processes. For clarity, the SME uses the term "in-reach" to describe such activities throughout this report. The SME uses the term "outreach" to describe efforts to engage with community stakeholders.

Pursuant to paragraph 89, within six months of the execution of this Agreement, LDH was to develop a plan for ongoing in-reach to every member of the Target Population residing in a nursing facility. Consistent with the requirements in this Agreement, LDH must regularly inform members of the Target Population about the community-based services and supports that can be alternatives to nursing placement, using a variety of strategies, so that they may make meaningful and informed decisions about where to live and receive services.

In the first several years of implementation, the State's in-reach activities focused on members of the Active Caseload. As indicated in the response to Paragraphs 24 through 26, LDH developed a list of individuals in the Target Population who resided in NFs using information provided by the PASRR Level II evaluation or the MDS. As these paragraphs indicated, individuals are either included in the Master List or Active Caseload List. The State's initial processes for adding people to the Active Caseload are discussed in Paragraph 55. Transition Coordinators were responsible for conducting conversations about transition with those on the Active Caseload.

Recognizing the need to enhance in-reach efforts and ensure better engagement with all members of the Target Population, LDH developed an initial in-reach strategy to engage with every member on the Master List at least once between April 2021 and March 2022.

These in-reach activities were to be performed by the following staff:

- Regional teams of OAAS medical certification specialists (who perform initial and ongoing continued stay reviews)
- Transition Coordinators
- Peer Support Specialists (PSS) (termed Peer In-Reach Specialists (PIRS)) who use their personal experience, modeling recovery in action for the in-reach process.

As of March 2021, the Master List included 2,972 individuals. Of this group, LDH reports that approximately 1,000 individuals were admitted after LDH began implementing its Continued Stay Review process (in August 2020). Thus, these individuals should have been contacted through the automatic CSR process and received in-reach from medical certification specialists during that review. An additional 1,939 individuals had not received an in-reach visit through the CSR process. LDH developed a schedule per quarter by region for in-reach to these individuals. As of April 1, 2021, all individuals identified by LDH have received in-reach through the process described in this paragraph. 1,939 individuals were contacted by a TC or PSS.

Of the 1,939 individuals who received in-reach from TC or PSS staff since June 1, 2022, LDH reports that:

- 478 or 25% have indicated their interest in moving and were added to the Active Caseload.
- 197 or 10% are undecided about moving.
- 941 or 49% are not interested in moving.
- For 323 or 17%, LDH has determined these individuals are unable to make a decision about moving, meaning they do not have the ability to make a decision regarding relocation.

Further review is needed to evaluate the quality of this initial in-reach effort. First, in reviewing the most recent in-reach report, there continues to be significant variation among regions regarding the percent of individuals who have indicated an interest in moving. For instance, in Region 8, 33% of individuals provided in-reach indicated an interest in moving, while Region 4 had only 14% of individuals who were interested in moving. In addition, the State reports the balance of individuals on the Master List who did not receive in-reach from a TC or PSS were contacted reading their interest in moving through the CSR process. Currently, LDH does not have information regarding the process used to determine interest in moving for these individuals.

Second, as indicated in paragraphs 25 and 26, LDH reported they have met with everyone on the Active Caseload List to affirm their interest in moving to the community. Many of the individuals were originally placed on the Active Caseload List automatically, based on information from the MDS data that identified the individual was interested in moving. Until recently, no follow up was provided to confirm their interest. As of June 1, 2022, LDH determined that a total of 772 people – 78% of individuals previously on the Active Caseload List – were not expressing interest in transition in the near future. These individuals were transitioned to the Master List and should receive follow-up based on the cadence LDH will need to develop for future in-reach efforts. Such discrepancies in reported interest are concerning. Effective oversight of the in-reach process is needed to ensure that all members of the Target Population are afforded a meaningful, informed choice about whether to transition, and to ensure that staff are accurately assessing those choices.

Effective, individualized engagement is critical to supporting people's informed decisions about whether to transition. LDH's most recent in-reach efforts focused on individuals on the Master List and Active Caseload list for a 12-month period. In the sixth report, the SME requested LDH develop a subsequent in-reach strategy during this reporting period for individuals that remain undecided or indicate they are not interested. The SME suggested LDH consider specific timeframes for performing in-reach for individuals who remain on the Master List, taking into account that some individuals may benefit from in-reach within a shorter time frame, to encourage transitions. These timeframes have yet to be developed by the department and should be included in the subsequent in-reach plan.

<u>Compliance Assessment</u>

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH identified and connected with 1,939 individuals on the Master List using the enhanced in-process developed by the State over the past year.
- LDH reports that approximately 1,000 individuals received in-reach, mostly through the CSR process.

- LDH set and achieved specific targets for each region to provide in-reach to a substantial portion of the Master List by April 2022.
- LDH developed and implemented training for medical certification specialists, TCs, and peer support specialists to improve their in-reach efforts.
- LDH developed the management reports to track progress of each regional team's in-reach efforts.
- LDH has senior leadership at OAAS and OBH meet with the regional teams initially to implement the in-reach efforts and to address concerns regional team members may have regarding in-reach.
- LDH has identified a significant percent of individuals who were previously on the Active Caseload List who were not interested in moving, which raises concerns regarding the initial approach that LDH used to identify individuals who were interested in moving and placed on the Active Caseload List.
- LDH has developed an initial plan for ongoing in-reach for individuals who have indicated little or no interest in transitioning; however, the State has not yet implemented this plan.

Recommendations

- LDH should provide the SME with any information on why individuals who were previously on the Active Caseload List are no longer interested in transitioning.
- LDH should develop a schedule regarding the follow-up in-reach strategy for all individuals in the Master List with prioritization given to individuals who are possibly interested in transition based on the initial in-reach provided.
- The State should evaluate the effectiveness of its in-reach strategy to ensure that all members of the Target Population are afforded a meaningful, informed choice about whether to transition, and to ensure that staff are accurately assessing those choices. As a starting point, LDH should review the approach used in regions that resulted in higher successful in-reach results (i.e., more individuals referred to the Active Caseload List). The State should incorporate valuable lessons learned from regions that could be applied to regions with lower percentages of individuals expressing an interest in moving.
- LDH should implement a process for enhanced oversight of decisions regarding individuals who are proposed to be removed from the Active Caseload List to ensure these decisions are consistently made using specific criteria.

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.

Compliance Status: Not Yet Rated

Discussion and Analysis

LDH began a prioritization process in July 2018 to identify a cohort of individuals who had fewer transition barriers and thus were more likely to experience a successful transition. The State reports that individuals were initially identified using information gathered from the MDS Q+ index and follow-up conversations

with the Transition Coordinators. It is unclear how these processes identified individuals with few transition barriers. Per the SME Service Review, a number of individuals did have very few transition barriers; however, several individuals had fairly complex physical health and behavioral health conditions and were also able to transition from the NFs.

The SME encourages the State to develop a process for identifying and prioritizing among individuals in NFs who have expressed an interest in moving. As recommended in Paragraph 42, there are several strategies the State could undertake to identify individuals with lower transition barriers who may be moved more quickly.

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.

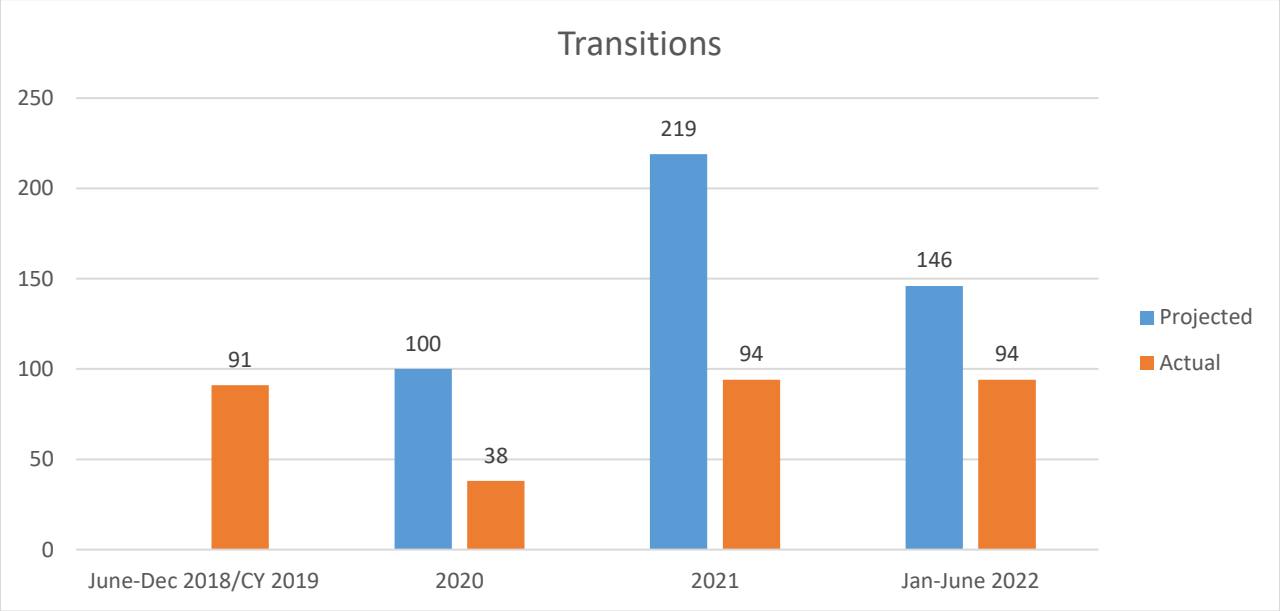
Compliance Rating: Not Met

Discussion and Analysis

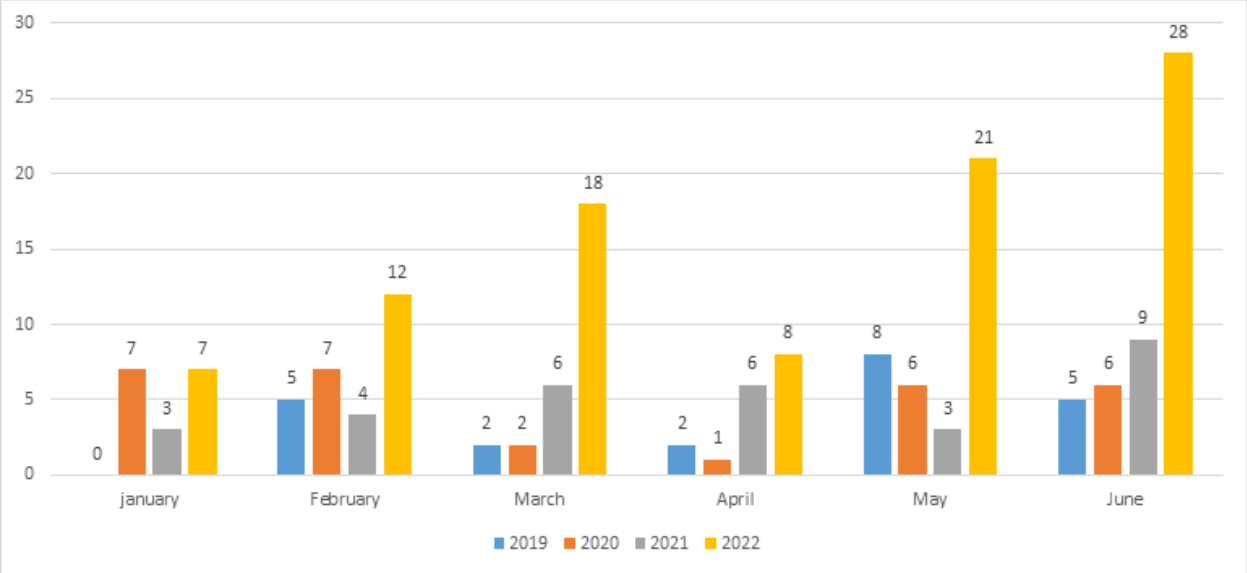
The State is required to establish annual targets for successful transitions of Target Population members to the community. During the first year of the Agreement, there were no transition targets. LDH was in the initial stage of implementation and sought to transition individuals with the fewest barriers to gain valuable lessons learned for subsequent years. For CY 2020, LDH projected to transition approximately the same number of individuals (100) as transitioned in 2019. They transitioned 38 individuals. The lower transitions were directly related to the pandemic and the ability of the TCs to have the necessary engagement to solicit interest in moving and to implement the necessary transition processes. The State developed targets for CY 2021 and CY 2022 with the goal of significantly enhancing the number of transitions from NFs. Specifically, the State developed targets for these two calendar years that were based on critical assumptions rather than historical projections. There were several main drivers LDH used to establish transition targets for CY 2022, including:

- The number of individuals in the TP who currently reside in a nursing facility on the Master List and Active Caseload who have indicated they are interested in transitioning via the in-reach process and have confirmed SMI (as indicated by a PASRR Level II evaluation).
- Staff resources (the current number of transition coordinators statewide).
- The average caseloads for transition coordinators. The proposed average caseload for the transition coordinators is 1 to 25 individuals who are actively working towards transition.
- The percent of individuals who have significant transition barriers impacts the number of individuals that will move in a given year. Currently, LDH reports that 23% of individuals have significant barriers that impact moving. This includes individuals who:
    - Expressed an interest in moving but may have significant legal issues (e.g., felonies or sexual offenses).
    - Have significant health and safety issues (e.g., the level of medical supports may not be readily available in the community where they are choosing to move).
- Length of time from application for the CCW Program to transition for individuals on the OAAS Active Caseload. Currently, this average length of time is approximately four months (down from nine months in 2018) from initial completion of the CCW application to transition. LDH has estimated that one-third of the individuals who apply for the CCW in the last 4 months of CY 2022 may not have the approval and services and supports in place to transition this coming year.

Based on these assumptions, the State committed in its Implementation Plan to transition at least 219 individuals in CY 2021. However, the State fell short of this target, transitioning only 94 individuals in CY 2021. For CY 2022, LDH committed to transition at least 292 individuals in the Target Population from NFs. As of the end of June 2022, the State has transitioned 94 individuals. The chart below provides a comparison of transition targets versus actual transitions for the first four years of the Agreement.



The SME also reviewed information on transitions across years on a monthly basis. The chart below provides a comparison by month of individuals transitioned from NFs. This chart indicates, thus far, good improvement when comparing similar months across years.



However, the current number of transitions for this reporting period is 53% of what LDH projected for this same time period. If LDH maintains this pace, it will achieve just over half of the transitions it committed to complete in CY 2022.

It should be noted that LDH has developed and implemented new management tools over the past twelve months that set specific expectations regarding transitions and track whether these expectations are being met. The increase in transitions, while below the target for the year, are generally increasing on a month-to-month basis, indicating these tools may be the catalyst for this increase.

As indicated in the four previous 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 developed a methodology to set these longer-term transition targets during the sixth reporting period. Originally, these targets were based, in part, on projections regarding the number of individuals in the Target Population in NFs who may be interested in transitioning. The State has relied on its initial in-reach efforts to establish such projections regarding interest. As discussed in paragraph 54, however, much greater oversight is needed regarding the effectiveness of this in-reach and the accuracy with which staff are assessing individuals' choices. Without further validation, LDH's preliminary in-reach data cannot be relied upon to project overall interest in transition.

In the shorter term, LDH has appropriately used its in-reach processes to prioritize transitioning the individuals it knows want to transition in the near future. Currently, LDH is prioritizing transition for 598 individuals on the Active Caseload, whose interest was recently verified. If LDH meets the proposed targets for CY 2022, the State will need at least three years to successfully transition current members of the Active Caseload. This would include the 598 individuals in NFs on the current Active Caseload and the 197 individuals who are on the Master List and are still undecided regarding transition.

This three-year timeframe assumes a significant improvement in the pace of transitions. Moreover, it only reflects the time needed to transition the current Active Caseload, which is less than 20 percent of the total Target Population residing in nursing facilities. It does not account for the many other members of this Target Population, who may well express an interest in transition as LDH's in-reach processes improve. Nor does it account for additional individuals who will be admitted to NFs during the course of this Agreement, who may also request transition.

As discussed in Paragraph 42, the State should re-evaluate staff resources in CY 2022 to transition greater numbers of individuals on the Active Caseload over the next several years. Initially, this Agreement had a five-year horizon for achieving compliance, with transitions from NFs being a foundational premise of complying with this Agreement. At the current pace it will take LDH much longer to achieve compliance. LDH must take action to change course. This should include identifying what additional resources are

needed to increase the number of transitions projected long-term rather than projecting transitions based on current staffing capacity.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has not met and is currently not meeting the targets set forth and agreed upon by LDH and the United States.
- The CY 2022 transition projections are considerably less than the 1,776 individuals on the Active Caseload List (or soon to be placed on the Active Caseload List) who have expressed an interest in moving. Given the number of transition coordinators and caseloads discussed in paragraph 42, it will take the State a minimum of three years to transition individuals on the Active Caseload List or individuals on the Master List who are still undecided about moving.
- While LDH has developed a sounder methodology for projecting transitions, its performance consistently falls short of those projections. Existing assumptions regarding the number of TCs or other staff that could perform transitions and caseload size should be revisited for future years to improve the timeliness of transitioned for all individuals on the Active Caseload List.
- The projected number of individuals on the Active Caseload List does not account for new members of the Target Population who will likely be admitted to NFs over the course of the next several years and who may want to transition in the near future.
- There are still barriers that are impacting timely transitions including the availability of accessible housing, medical equipment, and availability of workforce (e.g., personal care workers).

Recommendations

- LDH will need to meet its targets set forth in current and subsequent transition projections.
- LDH should ensure it has sufficient resources for more expeditious transitions of individuals on the Active Caseload list.
- LDH should aggressively implement the timeliness standards discussed in paragraph 48 for transitioning individuals on the Active Caseload List. No one should have to wait more than 6-9 months to transition from an NF if they have expressed an interest in moving.

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.

Compliance Rating: Not Yet Rated

The previous service reviews did not collect information on whether individuals who were transitioned requested and were returned to their previous living situation. The SME has not requested LDH to track this information but will work with the State to develop and implement a strategy to track this information and to report on the State's compliance.

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.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in previous reports, the State has developed procedures to fulfill the Agreement's requirement to facilitate a Transition Support Committee using the My Choice Louisiana Service Review Panel (SRP). The SRP is a cross-agency process that works to identify systemic barriers that impede or prevent transitions and work through individual case-related issues (for all NF transitions). A description of the SRP functions and process were described in the sixth report. Currently, there are eight members (including chairs and co-chairs) of the Transition Support Committee consisting of OAAS, OBH, and OCDD staff, including health care professionals, TCs, and central office and regional staff. There are no external or ad-hoc members of the SRP that are recommended in this paragraph.

The SME continues to request and LDH provides information regarding the number of individuals in the My Choice Program who have been referred to the SRP during this reporting period and if the SRP was effective in addressing these barriers. LDH reported that six individuals from the My Choice Program were referred to the SRP. The SME has reviewed the documents from the SRP for each of these My Choice participants. Barriers experienced by these individuals include:

- Need for strategies to self-administer insulin (3).
- Lack of ability to participate in the Assessment and ITP process but expressing an interest in moving (1).
- Co-occurring medical and physical health conditions (e.g., Parkinson's, diabetes, and SMI) that require additional supports and planning; however, the individual is non-committal to participating in services post transition (2).
- Individual only wants to live with family member and not on his own, yet the family member does not have the natural support resources to have the individual live at home with them (1).
- Individual did not want to participate in services at transition and withdrew interest in transitioning (1).

The SME reviewed the documentation for each of these individuals. The SRP addressed or is in the process of addressing several of these barriers including identifying services and supports that TCs should pursue, identifying additional opportunities in the community, and providing motivational interviewing for individuals reluctant to receive services post discharge. Two individuals were not recommended for transition at this time.

While the SRP provides a valuable process for the State to review transition barriers, the SME continues to be concerned about the volume of individuals that are referred to the SRP. As indicated in this paragraph, a Transition Support Committee is responsible for 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. Given the barriers listed throughout this report, the SME would anticipate that the number of individuals who will need to have transition barriers addressed would be greater than the six individuals referred to the SRP this reporting period.

The State has current and proposed strategies for collecting and responding to barriers impacting individuals in the My Choice program. However, these strategies would benefit from more organization. For instance, LDH collects (or will collect) information on barriers four ways: TCs, CCMs, PASRR Level II evaluators, and the SRPs. LDH reports they are standardizing the process in which barriers are identified. Using historical information on barriers collected for the past three years of the My Choice Program, the State has developed a list of barriers that TCs, CCMs, and PASRR Level II evaluators will use in their daily activities. The SME has reviewed this barrier list and believes it is a good start to collect consistent information regarding barriers and allows the identification of additional barriers. However, there does not seem to be an identified "home" to be able to organize, identify, and address systemic barriers. In addition, there is little external input from stakeholders regarding barriers and potential solutions to address these barriers.

As recommended in the last three SME reports, the State should consider additional SRP 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 lived experience and expertise related to successfully resolving barriers to discharge. The State has not added these members.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has created a Service Review Panel to address transition barriers for individuals on the Active Caseload List.
- The composition of the SRP has not changed significantly since the creation of this panel and does not include ad-hoc members or individuals external to the State.
- The SRP performs limited reviews for the My Choice Program. Given the information from TCs and others, the SME would expect these reviews to be higher.
- The State has recently developed a list for various individuals (TCs, CCMs, PASRR Level II Evaluators) to report barriers, but there is no single process for addressing these barriers.

Recommendations

- The State should include additional members for the SRP as recommended in previous reports.
- The State should review the adequacy of the SRP process to identify and address barriers for many of the individuals transitioning to the community from NFs.
- Based on this review, the State should either enhance the SRP's role for the My Choice Program or develop an alternative process that will be the "home" for receiving and addressing systemic barriers.

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.

Compliance Rating: Partially Met

Discussion and Analysis

As discussed in previous SME reports, TCs have provided interim intensive case management since CY 2020 to members of the Target Population who transitioned. All individuals who have been transitioned over the past two calendar years received interim case management for twelve months post transition. The diversion population which is part of the Target Population did not receive intensive case management from the TCs.

Originally, LDH had proposed to implement the CCM strategy in November 2021 but delays due to the pandemic and Hurricane Ida pushed implementation out by 60 days. In reviewing the SOPs for the CCM program, there is a requirement that individuals will be provided CCM for twelve months post transition or diversion. Specifically, the SOP requires CCM involvement and multiple monthly contacts (face to face and virtual) to continue for no less than 365 days, at which time an assessment is conducted to determine ongoing need and desire to continue CCM.

In the sixth report, the SME requested a listing of CCM agencies and case management staff. In addition, the SME requested the following information:

- The number of individuals who were transitioned and are receiving CCM.
- The number of individuals who were diverted and are receiving CCM.

LDH has provided the SME with information that lists the CCM agencies and case management staff. The MCOs have contracted with Merakey to provide CCM. The State reports Merakey has CCMs in each LDH region and has also hired licensed staff and nursing staff to supervise and provide technical assistance to the CCMs. Merakey to date has also increased the number of staff providing CCM based on enhanced referrals from TCs and PASRR Level II Evaluators to ensure they comply with the caseload ratio of 1:15 as stablished by LDH. LDH has reported that CCM caseload ratios have been maintained during the first four months of the CCM program. Information provided by the State indicate the current ratio is approximately 1:8.

As indicated in Paragraph 47, CCMs began providing case management in all regions as of March 2022. The target group for the first round of referrals to CCM was: individuals in NFs who are expected to transition within 60 days; transitioned members who had been residing in the community for up to 180 days; and individuals who were diverted March 1, 2022, or later. TCs would continue to provide CCM to transitioned individuals who had been residing in the community for longer than 180 days.

The State reports that 142 individuals have been enrolled in CCM from March through May 25th. The status of these individuals is as follows.

Status	Number of Individuals
Individuals residing in NFs and expected to transition within 60 days	65
Individuals who have been transitioned within the past 12 months	74
Individuals who have been diverted since March 1, 2022	3
Total Enrolled in CCM	**142**

In addition, the State reports 23 individuals continued to receive intensive case management from the Transition Coordinators for this reporting period.

The State reports there were 9 individuals who were disenrolled from CCM as of May 25, 2022. Individuals were disenrolled from the CCM program for various reasons, including declining CCM (3), readmission back into NFs (2), or the individual was not able to be reached.

The State has performed well regarding the roll out of CCM. The State reports CCMs are available in each region and are building capacity as additional referrals occur. The SME did have an initial discussion with leadership from Merakey who oversee the CCM program, and they identified issues and implemented strategies to address initial implementation issues. As indicated by this data and in additional discussions with the State, TCs are making referrals for individuals in NF to CCMs as well as referrals of individuals recently discharged from NFs. The SME is concerned about several issues:

- While the number of individuals refusing CCM is low (2%), approximately 7% are disenrolled from CCM.
- The number of diverted individuals receiving CCM for the first two plus months of CCM being operational seems low and does not match the numbers of individuals LDH report as being diverted. Further explanation is needed on the lower CCM engagement of individuals who are diverted.
- Readmissions, while low, are higher than what has been historically reported by LDH. There were four individuals who were readmitted during this reporting period, which is almost twice the number of readmissions identified in previous reporting periods.

Compliance Assessment

- The State has established the CCM program and has good uptake of referrals for individuals currently residing or recently transitioning from NFs.
- The State has developed a tracking process for CCM staff and participation statewide and by region.
- The State has the SOPs in place to require CCM to be provided 12 months post discharge.
- Seven percent of individuals who transitioned from NFs and referred to CCM were not engaged in CCMs during March through May of this reporting period. Some of these individuals were recently admitted and would seem to benefit from CCM to ensure a timely transition.
- Many individuals who are diverted from NFs are not enrolled in CCM.

Recommendations

- Continue to track and provide the SME with monthly reports regarding the CCM program as requested in the sixth report.
- Work with the SME to identify the reasons for readmissions of individuals recently discharged from NFs and determine strategies for CCMs to continue to be involved with these individuals post their readmission.
- Conduct outreach to individuals who have been diverted since March and attempt to engage them in CCM.

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.

Compliance Rating: Not Yet Rated

Discussion and Analysis

Since the beginning of CY 2020, the TCs were responsible for providing intensive case management services for individuals transitioned from NFs. As indicated in the SME's Service Review, TCs were not required to develop a community plan post transition. 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 the SME Service Review Report, the lack of an overall community plan for the individual that knits together the goals, overall desires, and needs of the individual was a major concern. Effective training and oversight of the new CCM program will be critical in order to ensure that such issues are avoided.

In February, LDH began to implement CCM. CCM, 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 State has invested significant efforts to design and implement the CCM program. In the sixth report, the SME recommended that LDH develop a monitoring process to ensure that:

- Case management is provided consistently and with continuity pre- and post-transition.
- Community Case Managers are identifying and coordinating the services and supports to help the individual maintain community placement.
- Community Case Managers are assuring access to all medically necessary services.
- Community Case Managers and other providers (e.g., ACT) conduct face-to-face engagement of the Target Population.

LDH has developed a reporting and monitoring process that should allow them to monitor the CCM program and to provide information that will be necessary for quality reporting discussed in paragraphs 98-99. This includes reporting by CCMs regarding:

- Ensuring assessment and the plan of care are developed within the timeframes established by LDH.
- Required contacts occur between the CCM and the individual and provider during a month.
- Monthly reporting across various life domains and adherence to the plan of care.

Additional information that addresses the SME recommendations for monitoring are being incorporated into the State's monitoring efforts. LDH has implemented this initial reporting process and provided the SME with the first few months of reporting. This information is discussed in paragraph 62. Information for March 2022 was received by the SME. The SME is awaiting April information (reports are generated 30 days after the final date of the month). This was the first report from the State on the CCM program. The reports indicated:

- Almost all individuals referred for CCM received an assessment and POC within 30 days from referral.
- Almost all individuals received a face-to-face contact within the month of referral to CCM. Those who did not have contact were new referrals (the last several days of March).
- CCMs had contact with other providers involved in providing care to the individual; however, it was not clear if these were team meetings or individual meetings.

In addition, at the recommendation of the SME, LDH staff developed a process to perform initial reviews of the CCM's efforts with individuals who have been transitioned from NFs. The purpose of the review was to identify any issues early in the process and address them with leadership at Merakey. LDH has undertaken this review and reports that they have reviewed their findings with Merakey and have requested additional oversight of various CCM functions.

The SME had recommended that the interim case management strategy offered by the TCs continue during CY 2022 for some individuals who had previously transitioned from NFs between March and September 2021. These individuals had been engaged with the TC for six months and it seemed prudent to have TCs continue offering case management to ensure continuity of care. Individuals who transitioned after September 2021 were shifted to the CCM program in February. LDH reports that as of June 30th, 23 individuals were receiving ICM from the TCs.

Compliance Assessment

The SME will make an assessment of LDH's compliance with this paragraph in the next reporting period given the newness of the CCM program.

Recommendations

- LDH should provide the CCM report to the SME on a monthly basis.
- LDH should continue to conduct its own reviews of assessments and plan of care to ensure they are meeting the needs of the individual and services provided are consistent with the scope, amount, and duration included in the plan.
- LDH should review the CCM report and identify any reporting issues that may arise that would impact the integrity of the quality reporting referenced in paragraph 99 and 100.

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.

Compliance Rating: Not Yet Rated

Discussion and Analysis

The discussion of the plan of care is provided in Paragraphs 43 and 60. As indicated in the fifth SME report, CCMs will need to be well versed in the principles and process to assist the individual to create a plan that

is truly person-centered. LDH has developed some important tools over the past two years to provide information and support to CCMs, TCs, and other service providers for developing person-centered assessments and plans.

In the sixth report, the SME reviewed information regarding the standard operating procedures for CCM. There were several recommendations in this report the State should consider for modifying the SOP. In reviewing the revised SOP, which was finalized in January 2022, the State has addressed these recommendations.

ln the sixth reporting period, the SME reviewed and provided feedback to LDH regarding the proposed assessment tool, plan of care, and crisis planning documents. The SME found these documents to be incomplete and inadequate for identifying and addressing the needs of individuals receiving CCM. LDH worked with the SME team to revise these tools and used the current Transition Assessment and ITP. The SME performed a final review of the tools prior to CCM going live and believes these tools will be helpful for individuals participating in CCM.

The SME also encouraged the State to use the checklist developed earlier this year in their efforts to educate CCM providers regarding strategies to ensure plans are person-centered. The SME also recommended CCM providers and advocates/members of the advisory committee review the proposed tools and suggest revisions to these tools, similar to the process LDH used to review the Transition Assessment and ITP. In the sixth reporting period, LDH provided the SME training materials used for the CCM training. The SME has reviewed the materials, which includes the person-centered planning materials developed for LDH and believes the training is a sufficient starting place for CCM staff.

The SME requested the State develop a tracking strategy in this reporting period, similar to tracking strategies for TCs that provide information regarding:

- Whether CCMs meet the requirements regarding participation in ITP meetings and contacts prior to an individual transitioning from an NF.
- Whether the CCMs perform an assessment and develop a plan of care within the timeframes required by the department.
- Whether the CCM agencies (or MCOs) are providing timely and complete information to LDH as required in the contract to inform the quality matrix and review processes.

As indicated in paragraph 60 and 62, the State has begun efforts to report this information and initial reports indicate this information is currently being tracked by the State.

Compliance Assessment

Due to the recent implementation of the CCM program, the SME will review LDH's compliance with this paragraph in the next reporting period.

Recommendations

Provide the SME with monthly information to ensure that staff are developing the plan of care within the timeframes established by LDH.

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.

Compliance Rating: Partially Met

Discussion and Analysis

LDH has developed and implemented a preliminary system to identify and monitor individuals who have transitioned from nursing facilities. Over the past four reporting periods, the TCs have collected information regarding everyone enrolled in intensive case management. The TCs have used monthly logs to collect information regarding key areas, including services needed but not received as reported by the individual, change in caregivers or living arrangement, change of providers, and critical incidents including ED visits, inpatient admissions, and nursing facility readmissions. Information is also collected to measure whether individuals were involved in the transition plan and community plan process, and information regarding their physical health and well-being. These indicators are reviewed jointly by OAAS and OBH leadership monthly to identify individual and systemic issues. LDH also uses information from these logs for reporting purposes as part of their larger Quality Assurance effort. A review of these indicators is now embedded in LDH's Quarterly Quality Assurance Matrix. 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.

The current process has several limitations. As indicated in these paragraphs, LDH has relied largely on self-reports from each individual, collected by the same TCs and CCMs responsible for the individual's case management, to monitor this information. While having this self-reported information is helpful, it may be biased and may not accurately reflect the experiences of individuals who have been transitioned from NFs. As indicated in previous reports, LDH should have a "look-behind" process for looking to validate the information from the TCs and CCMs.

LDH has also developed a reporting system for MCOs and the CCMs to collect and report information from the assessments, plans of care, and logs that are almost exactly the same as the documentation from TCs. This will require LDH to have these assessments and plans and will provide continuity for reporting information on key outcome measures for the My Choice Program. In addition, the CCMs are required to report if services (medical, behavioral, and long term supports and services) are not being received, the reason the individual is not receiving the service, and specific steps the CCM is taking to mitigate the lack of services. For the first several months of the CCM program, the State reported:

- A significant percentage of individuals who transitioned experienced stability in their living situations, caregiver, and service provider, which is consistent with TCs reporting over the past calendar year.
- Many individuals were engaged in hobbies or reported participating in community activities; however, only one person was working/volunteering.
- Individuals reported they had more issues with their physical health or felt like they were functioning well.

- Individual's access to care varied. While 77% indicated no utilization of hospital or crisis services, there were a number of individuals who were hospitalized, which, as discussed in paragraph 98-99, is a continued concern for the SME.
- In addition, almost one-third of the individuals reported they were not receiving all needed services, which should precipitate LDH to do further review of what services these individuals were not receiving.

While some of the information CCMs are providing is consistent with previous reports from the TCs, there is yet to be enough information to be confident that LDH is using this information to proactively address some of the negative outcomes.

LDH requires a scheduled cadence of face-to-face contacts between the CCM and the individual who has been transitioned. CCMs are to report on each contact and whether the contact was face-to-face or virtual. The SME will review this information in the next reporting period to ensure contacts occur consistently with the SOP.

As recommended in the sixth report, the SME recommended and LDH has initiated a real-time process for monitoring the rollout of CCM while information from the CCM program is being reported based on LDH reporting requirements. Initiating this review during the first few months of the CCM program was to provide LDH with information to ensure that individuals are being referred on a timely basis to CCM and that CCM is engaging these individuals and developing the necessary plans of care. The SME recommended and LDH developed and implemented a process within the first 90 days for this review. LDH requested assistance from the SME to develop and implement this interim review process that collected and reviewed assessments, plans, and CCM logs. The State also did follow-up in-person meetings with some of the individuals reviewed initially by LDH.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed a tracking system to identify and monitor individuals receiving CCM in the Target Population.
- LDH requires TCs and CCMs to report information on a monthly basis regarding key areas. The TCs have been reporting this information on the required basis.
- LDH implemented an initial monitoring process within the 90 days recommended by the SME and LDH met with the CCM vendor to review these findings and recommend strategies to address initial findings.
- The State has yet to develop a look-behind process as recommended in previous reports to validate the information received from TCs and CCMs.

Recommendations

- Review the initial data reports from CCMs to ensure that information collected on all individuals transitioned is complete.
- Review data from CCMs to ensure that the cadence required for face-to-face and other visits is being met.
- The State should use data from the CCM reports to determine if there are systemic health and safety issues, gaps in services, and efforts that have been successful in addressing these issues.
- The State should implement the look behind process described in paragraph 49 to ensure reliability of the CCM reports.

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.

Compliance Rating: Partially Met

Discussion and Analysis

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 Medicaid through a program called the Louisiana Crisis Response System. These include mobile crisis response, community brief crisis support, behavioral health crisis care centers, and crisis stabilization units. Additional information regarding these crisis services can be found at https://ldh.la.gov/assets/docs/MyChoice/CRISIS-PRESENTATION-032921.pdf. Since the release of this framework, the following activities have taken place:

- Developed an internal work plan 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 crisis service definitions, including requirements that crisis services are to be provided in the community, including natural settings, and requirements that crisis plan/strategies are developed for the member to use post current crisis to mitigate the risk of future incidents
- Received funding in their budget for FY 2022 to implement several Mobile Crisis Response (MCR), Community Brief Crisis Support (CBCS), and Behavioral Health Crisis Care Centers (BHCC)
- Requested funding in their FY 2023 budget for Crisis Stabilization Units (CSUs)
- LSU developed and released a Request for Application to select crisis providers to offer the four crisis services
- Selected providers to receive training on crisis services from LSU
- Developed an initial training protocol in cooperation with LSU for crisis providers

- Applied for and was awarded a Transformation and Training Initiative (TTI) grant through the National Association of State Mental Health Program Directors (NASMHPD) to develop short- and long-term plans for implementing triage and dispatch functions associated with the Louisiana Crisis Response System
- Continued to meet with MCOs regarding their responsibilities to provide interim call center responsibilities and crisis provider network functions
- Worked on the development of a draft RFP for a statewide crisis call center
- Developed rates for each crisis service
- Facilitated regular and ongoing presentations regarding the implementation of these services offered through the Louisiana Crisis Response System
- Developed a system to review MCOs' initial call center efforts and current crisis providers to deliver the three services (MCR, CBCS, and BHCC)
- Developed marketing materials for these crisis services to raise awareness of the availability of these services for Medicaid beneficiaries, including the Target Population, experiencing a crisis
- Developed a strategy for ongoing support of crisis providers to ensure their stability and sustainability.

The State has begun efforts to implement the three crisis services (MCR, CBCS, and BHCC) on a rolling basis. Crisis Stabilization Units are slated for implementation in FY 2023. 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. LDH has worked closely with the MCOs, LSU, and new providers to stand up three crisis services in select regions of the state. As of this reporting period, the State has implemented crisis services in select regions.

Region	Services
Region 1	MCR/CBCS (Implemented 4/2022)
Region 2	MCR/CBCS/BHCC (Implemented 4/2022)
Region 3	MCR/CBCS/BHCC (Implemented 4/2022)
Region 7	MCR/CBCS (Implemented 3/2022) and BHCC (Implemented 4/2022)
Region 9	MCR/CBCS/BHCC (Implemented 6/2022)
Region 10	BHCC/CBCS (Implemented 4/2022) and MCR (Implemented 6/2022)

LDH reports they have providers identified who are working on the implementation of services in Region 1 (BHCC), Region 4 (MCR/CBCS/BHCC), and Region 6 (MCR/CBCS). Additionally, they are working with Regions 5 and 8 to implement the full continuum of crisis services and working with Region 6 to implement BHCC.

Data on calls and utilization of services in presented in paragraphs 64 and 65.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed service definitions messaging that mobile crisis services are a community-based service delivered in the member's natural setting with some exceptions for office-based delivery.

- LDH has developed a crisis plan consistent with the intent of this paragraph. This includes mobile response, crisis telephone lines, and three other crisis services (CBCS, BHCC, and CSUs).
- LDH began to implement services in the crisis plan during this reporting period in some, but not all, of the regions.
- LDH required each individual receiving crisis services to have a brief crisis plan.

Recommendations

- Complete the implementation of all three crisis services in all areas of the state during the next reporting period.
- Develop the necessary documents to recruit, select, and train CSU providers.
- Develop an oversight process to ensure that individuals with SMI experiencing a behavioral health crisis have access to timely crisis 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.

Compliance Rating: Partially Met

Discussion and Analysis

As discussed in previous SME reports, there is a patchwork of toll-free crisis and help lines currently available to assist individuals, including members of the Target Population, who are experiencing crisis. 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 statewide toll-free crisis line. The crisis line will be an important component for the State's crisis system. A key function of the crisis line will be dispatch of the mobile crisis response teams discussed in paragraph 65 and referral to other crisis services. As indicated in paragraph 63, OBH staff has begun drafting a Request for Proposal for a single crisis call center. OBH is planning to implement the crisis line later in CY 2023. Prior to the development of a statewide crisis call center, LDH is requiring the MCOs to receive crisis calls and dispatch mobile teams and make referrals to other crisis services in the interim. The current LDH contract requires MCOs to have this capacity. LDH has been working with the MCOs to enhance their crisis call response. LSU has been training MCO call center staff. Over one-half of the 296 individuals trained were staff from these centers. This training is discussed in more detail in paragraph 65. In addition, OBH has been working with the MCOs during this reporting period on the following:

- MCOs sent letters to all adult Medicaid members to educate them about the available crisis services and how to access the services
- LDH is holding weekly implementation calls with the MCOs and crisis providers to identify successes and challenges, and solutions to challenges are identified
- LDH has monthly meetings with MCOs to address challenges such as ensuring accuracy of the crisis services
- LDH and/or MCOs are meeting with community stakeholders to provide education about the availability of crisis services; stakeholders include law enforcement and homeless service providers.

The State reports the crisis call volume for March and April for each MCO was as follows.

MCO Crisis Line—March	#	% of Calls
Aetna Better Health Louisiana	13	15%
AmeriHealth Caritas of Louisiana	10	12%
Healthy Blue	34	40%
Louisiana Healthcare Connections	27	32%
United Healthcare Community Plan	1	1%
Total	72	100%

MCO Crisis Line—April	#	% of Calls
Aetna Better Health Louisiana	7	8%
AmeriHealth Caritas of Louisiana	5	5%
Healthy Blue	29	32%
Louisiana Healthcare Connections	47	51%
United Healthcare Community Plan	4	4%
Total	92	100%

Data regarding MCO call volume for May was not available at the time the report was written. While the SME is not surprised at the low volume in calls for the first two months, it will be critical that the State work with the MCOs to increase awareness and utilization of the MCOs' mobile crisis lines. These are important referral sources for the crisis services developed by the State during this reporting period and, without increased information regarding this resource, individuals in the Target Population and adult Medicaid beneficiaries who are in crisis will be unaware of the call center and crisis services.

Data was also available on the disposition of these calls to the MCO crisis lines. Disposition indicates what the MCOs did in response to these calls.

Call Dispositions—March	#	% of Calls
Call Resolved - Community Stabilized	39	45.90%
Dispatched Mobile Crisis Response	1	1.20%
Referred to Crisis Stabilization Facility	0	0.00%
Other	45	52.90%
Total	85	100.00%

Call Dispositions—April	#	% of Calls
Call Resolved - Community Stabilized	45	48.90%
Dispatched Mobile Crisis Response	5	5.40%
Referred to Crisis Stabilization Facility	1	1.10%
Other	41	44.60%

Total	92	100.00%

This data indicates that almost one-half of the calls were resolved by staff at the MCO crisis line. This is generally an acceptable trend with crisis call centers where the level of crisis may be resolved telephonically versus having mobile crisis dispatched or generating a referral to a crisis service. However, the volume of dispatch and referrals to crisis services is low and will need to be addressed both through greater awareness of the MCO crisis line and availability of crisis services.

LDH and the SME have conducted readiness reviews of the MCO crisis lines to ensure that the call lines were prepared to process crisis calls and were prepared to dispatch mobile teams. The readiness review included a review of:

- Exploration of how staff would understand the new culture and approach to being responsive to crisis needs
- Validation of the crisis line number and ensuring the call line was operational
- How calls would be processed, including dispatching of mobile crisis
- Processes for tracking crisis calls and dispatch to mobile crisis and report development, validation, and submission
- Qualifications of staff answering the call and how calls would be elevated to high level clinicians as needed.

LDH reports they have conducted "secret shopper" calls to all the crisis lines. LDH worked with each MCO to provide feedback on successes of following protocols and opportunities to enhance alignment to the call process protocols.

These reviews identified several implementation issues regarding the MCO crisis lines:

- Most MCOs crisis lines followed protocols
- Identification that a separate line for the crisis calls has not been established
- There was no solid process for collecting and submitting data.

In addition to these efforts, the State continues their efforts 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.

<u>Compliance Assessment</u>

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed an initial strategy for a toll-free crisis line that operates 24/7.
- Individuals who staff the MCO crisis line have received training on various de-escalation strategies and are aware of the criteria for referring individuals to new crisis services.
- The State has begun to track the callers and dispositions, although additional dispositions or information may be needed to meet the terms of the Agreement (e.g., providing phone consultation or connecting with peers).
- As indicated in paragraph 63, the State is developing a Call Center RFP that will establish one statewide call number and will eliminate the multiple crisis line calls numbers, making it easier for Medicaid individuals and stakeholders to access crisis services.

Recommendations

- LDH should provide 1:1 technical assistance to MCOs to enhance outreach efforts to identify individuals who are in need of crisis services.
- LDH, MCOs, and crisis providers should engage system partners to educate about the availability of crisis services and how to access these services.
- LDH should prioritize the release of the statewide call center procurement.
- LDH should explore the use of enhanced Federal Medical Assistance Percentage (FMAP) administrative claiming that can be used to implement and strengthen call centers and crisis mobile services.

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.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in paragraph 63, the State partially implemented the mobile crisis response capacity in March. Louisiana State University (LSU) has also been developing network capacity for MCR, CBCS, and BHCC. LSU identified providers in each region who were at highest readiness for implementation. During this reporting period, the State reports that LSU has:

- Fully trained 296 staff who will be receiving crisis calls or providing crisis services
- Partially trained an additional 180 staff who will be providing crisis services
- 46% of individuals trained were from provider agencies that were delivering various crisis services

As indicated in paragraph 63, MCOs have contracted with service providers offering MCR. MCR teams went live in March 2022 in one region of the State: 7; in April, MCR teams went live in three regions of the state: 1, 2, and 3; in June, MCR teams went live in two regions of the state: 9 and 10. There are two regions (4 and 6) where implementation is underway, and these providers are expected to go live in July and September respectively. The State reports they are working with Regions 5 and 8 to garner interest to provide MCR.

The SME requested information regarding initial utilization of MCR services. The State reports low utilization of MCR services. There was one MCR team dispatched in March, five in April, and four in May. This low take-up of MCR services is concerning to the SME. The SME team has met with LDH staff to recommend an immediate strategy to increase the demand of crisis services. This includes working with the MCOs and MCR teams to increase referrals for MCR. LDH is working with each MCO and MCR provider to do the following:

- Provide data regarding the current utilization of emergency department services for adult Medicaid beneficiaries in their region to use in discussion with MCOs and hospital leadership to improve knowledge of the MCR services in their area.

- Identify providers that would be the most likely referral source for MCR services, including Federally Qualified Health Centers, outpatient clinic providers (including LGEs and hospital-based providers), drop-in centers, and other providers.
- Require MCR providers to provide outreach to these providers during the month of June to increase awareness of and referrals to MCR teams.
- Continue outreach efforts to law enforcement regarding the availability of crisis services in their local communities.
- Meet with the CCMs to increase awareness of MCR and to ensure that the MCO crisis line and MCR are prominently included in crisis plans for individuals transitioned and diverted from NFs.

It will be imperative that LDH require MCOs and MCR providers take these steps immediately to ensure the viability and sustainability of MCR and other crisis services.

Each MCO has developed protocols for dispatching MCR teams through their crisis call centers, for collecting and communicating data between the call center and MCR providers, and for authorizing next level crisis services (CBCS and CSU).

In addition, LSU has started to provide monthly, agency-specific coaching for a period of at least several months to support implementation. Agency-specific coaching has started with each agency. The focus is application of training competencies to practice.

In the sixth report, the SME recommended LDH develop a strategy to monitor the roll-out of these new crisis services. LDH has developed and led a process for facilitating a standing, brief, semi-weekly huddle of MCOs and crisis teams (via phone conference line) to check in on service demand, access issues, implementation hiccups, and to continue to hone the working protocol. During these huddles, LDH, MCOs, and providers:

- Review crisis calls compared to protocols and best practices
    - Identify successes and opportunities
    - Identify new mindset and skills needed for processing crisis calls and recap learnings from training
    - Discuss oversight of calls
- Review crisis reports submitted by the MCO crisis lines and crisis providers
    - identify successes and opportunities of practices
    - identify changes needed to reports
    - Discuss oversight of call center and provider reports
- Discuss low volume of crisis calls and dispatch, identify strategies for identifying individuals in need of crisis services
- Identify marketing efforts and review marketing actions taken.

LDH also reports they are monitoring the number of referrals to MCR teams on a weekly basis and working with the SME team member to request that each MCR team provide the actual number of referrals each week.

<u>Compliance Assessment</u>

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has, or is in the process of, developing MCR capacity in eight regions of the state.

- LSU has undertaken activities, including readiness reviews, to ensure that MCR providers are prepared to offer MCR and continues to offer coaching to these providers.
- MCOs have contracted with MCR providers to serve adults with Medicaid, including individuals in the Target Population.
- LDH developed a process to meet with MCOs and providers frequently during implementation to identify issues.
- There has been minimal uptake of MCR services. LDH has developed immediate strategies for MCR providers to increase MCR referrals.

Recommendations

- Continue to work with each MCR team to increase referrals including outreach efforts to law enforcement and additional referral sources.
- Review the crisis plans, similar to the CCM review discussed in paragraph 60, for each individual receiving CCM and ensure that each plan, where appropriate, includes information regarding the MCO crisis line and MCR services.
- Identify and contract with providers in regions 5 and 8 to offer MCR.
- Continue training and coaching efforts for MCR teams to ensure their practice is consistent with LDH standards.
- Continue to collect and review episode-specific data collected by crisis teams and MCOs; this data, along with Medicaid claims data, will be analyzed to inform actual practice.

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.

Compliance Rating: Partially Met

Analysis and Discussion

LDH has developed and has begun to implement Behavioral Health Crisis Care Centers (BHCC) throughout the state. The BHCCs vary in capacity based on the region's Medicaid population and informed by the 2021 Needs Assessment discussed in the sixth SME report. BH Crisis Care Centers serve as walk-in centers 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.

As indicated in paragraph 63, the State has developed, or is in the process of developing, BHCC capacity in seven areas. There are no BHCC providers in regions 5, 8, and 6. LDH and the SME have conducted readiness reviews of the BHCC centers in regions 1, 2, 3, 4, 7, 9, and 10 to assess the BHCC's readiness to receive and provide crisis care for individuals. The readiness review covered:

- Exploration of how staff would understand the new culture and approach to being responsive to crisis needs
- Virtual tour of how an individual would enter and receive crisis care, including a review of the types of staff an individual would interaction with
- Review of how the BHCC would engage any natural supports
- Processes for tracking crisis care provided and report development, validation, and submission
- Qualifications of staff providing BHCC services.

The SME requested information regarding initial utilization of BHCC services. The State provided the April and May (to date) utilization of BHCC service by provider and region in the table below.

Behavioral Health Crisis Care Provider (April)	#	%
Region 10 Jefferson Parish Human Services Authority	5	4%
Region 2 Recovery Innovations DBA RI International	118	96%
Total	123	100%

Behavioral Health Crisis Care Provider (May	#	%
Region 10 Jefferson Parish Human Services Authority	3	2.5%
Region 2 Recovery Innovations DBA RI International	116	96.7%
Region 7 Merakey	1	.8%
Total	120	100%

Utilization of BHCC is high in Region 2, where BHCC efforts have been in development for more than a year. The SME has significant concerns regarding the implementation of BHCC. Similar to MCR, LDH is requiring MCOs and BHCC providers (many of whom also offer MCR) to take immediate steps discussed in paragraph 64 to ensure the viability and sustainability of MCR and other crisis services.

In the sixth report, the SME recommended LDH pursue the following activities:

- Collect data by agencies and MCOs to determine where to target future investments. For example, understanding the nature of the crisis that individuals are experiencing may lead to further investments in peer-delivered services, housing supports, or specialized brief crisis services for individuals with co-occurring disorders.
- Work with MCOs to assure that post-crisis services and supports are accessible and effective. This includes timely appointments with prescribers, clinical staff, and peer supports following crisis care, to increase the likelihood of stabilization in the community.
- Develop other “upstream” and less restrictive strategies within outpatient services agencies to develop skills and capacity to provide suicide-specific care in the community and to assure agencies are adequately meeting urgent care needs of their existing clients (timely access for an

urgent appointment, meaningful 24/7 crisis support telephonic support, and non-traditional appointment models such as Open Access that allow for same day scheduling).

Given the low utilization of BHCC, LDH does not have sufficient information to develop future investments in crisis services recommended in this paragraph. Nor does LDH have information regarding the availability and utilization of post-crisis supports and other upstream services.

It should be noted that LDH is monitoring the number of referrals to BHCC on a weekly basis with the SME team. LDH is requesting that each agency offering BHCC provide the actual number of referrals each week.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has, or is in the process of, developing BHCC capacity in seven regions of the state.
- LSU has undertaken activities to ensure that MCR providers are prepared to offer BHCC and continues to offer coaching to these providers.
- BHCCs submit reports and LDH monitors the number of individuals receiving BHCC crisis care on a weekly basis.
- MCOs have contracted with BHCC providers in select regions to serve adults with Medicaid, including individuals in the Target Population.
- LDH developed a process to meet with MCOs and BHCC providers frequently during implementation to identify issues.
- There has been minimal uptake of BHCC services. LDH has developed immediate strategies for BHCC providers to increase BHCC referrals.

Recommendations

- Continue to work with each BHCC to increase referrals, including outreach efforts to law enforcement and additional referral sources.
- LDH should review the crisis plans for each individual receiving CCM and ensure that each plan, where appropriate, includes information regarding the MCO crisis line and BHCC. Consider a strategy to have BHCC follow-up with an individual immediately after transition or diversion (when appropriate) to provide information regarding crisis services.
- Identify and contract with providers in regions 5, 6, and 8 to offer BHCC.
- Continue readiness reviews as BHCCs are opened.
- Continue training and coaching efforts for MCR teams to ensure their practice is consistent with LDH standards.
- Develop the necessary oversight structure to ensure these services are offered consistent with the Agreement.
- Develop and implement a strategy to identify additional investments for services and strategies discussed in this paragraph.

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.

Compliance Rating: Not Met

Discussion and Analysis

Since 2018, LDH has been implementing significant changes to their SUD service system through a CMS 1115 Demonstration Waiver. The State has developed a continuum of services consistent with the American Society of Addiction Medicine (ASAM) that includes outpatient, intensive outpatient, residential, and withdrawal management services. A review of MCO network adequacy reports for the first quarter of 2021 (January-March 2022) by the SME indicated that there were no network adequacy issues for the various SUD levels of care during this reporting period. Yet, information suggests that SUD services are underutilized by the Target Population. A finding from the needs assessment is the "extremely low" penetration of SUD service utilization for members of the Target Population. As indicated in the fifth SME report, 48% of individuals with an SMI may have a substance use issue or disorder[1]. As indicated in the needs assessment, less than 5% of individuals who transitioned or were diverted received an SUD service. The SME's service review 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.

The State reports that 3 individuals (1.2%) transitioned from NFs received SUD treatment for the period from July 1, 2021, to March 1, 2022.

In the fifth report, the SME recommended the State identify and address barriers to individuals in the Target Population who have an SUD who may benefit from treatment and recovery services. The SME requested this information for the sixth reporting period and has not received this information.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- There is a significantly low utilization rate of individuals in the Target Population who need but do not receive SUD services despite the availability of SUD services.
- SUD services have not been identified or included in most individuals' ITP, even though the assessment and other information indicates a need for SUD treatment.
- The State has not identified and addressed barriers regarding access to SUD treatment for individuals in the Target Population.

Recommendations

- Ensure the acumen of TCs and CCMs to assess the need for SUD and provide motivational interviewing strategies to encourage individuals to take the necessary steps to increase goals and SUD intervention for individuals with an identified SUD that have CCM.
- Ensure each individual with an existing SUD is provided information regarding SUD treatment services, including alternative treatment settings (e.g., recovery groups).
- Increase the number of plans of care that have identified goals and interventions for individuals in the Target Population with an SUD.
- Continue to provide information regarding the utilization of SUD services on a quarterly basis for individuals in the Target Population.

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

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.

Compliance Rating: Partially Met

Assessment and Discussion

LDH has continued outreach efforts to law enforcement during this reporting period. The State facilitated statewide and regional meetings between crisis providers and state and local law enforcement, including sheriffs, coroners, judges, and police departments. The State reports they have presented at the Louisiana Annual Public Safety Communications Symposium which was attended by state and local law enforcement agencies. In addition, individual regional meetings focused on:

- Protocols for referrals to MCR
- Efforts to enhance pre-trial diversion efforts
- Community coalition meetings to provide an overview of crisis services

The State and several crisis providers participated in a regional Sequential Intercept Model (SIM) workshop with local law enforcement agencies and crisis providers. The SIM details how individuals with mental and substance use disorders come into contact with and move through the criminal justice system (law enforcement, courts, jails, and re-entry into the community). The purpose of the workshop was to identify gaps at each intercept point in the community.

As discussed in paragraphs 65 and 66, the State will target local law enforcement and coroners' offices for additional marketing efforts regarding the MCR and BHCC services.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has been coordinating and attending meetings with local law enforcement, coroners, and crisis providers to discuss new services and protocols for accessing these services.
- The State has begun to participate in the SIM initiative, which is a more modern approach in engaging law enforcement and the criminal justice system to identify resources that may divert individuals from involvement in that system.

Recommendations

- LDH should continue their efforts to meet with law enforcement, judges, and coroners to encourage diversions and referrals to crisis services.
- LDH should also gather information on the successes and issues during the roll-out of crisis services and develop local and systemic strategies to address issues that arise as a result of these conversations.
- LDH should develop a process for collecting and analyzing information to determine if these strategies and other initiatives, such as SIM, are diverting individuals in crisis from law enforcement and coroner's offices.

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.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in paragraph 63, the State, with the assistance of LSU and the SME, has developed policies, procedures, and training for the MCO crisis lines and the three crisis services. Additional policies and trainings will be rolled out this next reporting period for providers of Crisis Stabilization Units. The State has finalized the necessary performance metrics for the call center and crisis providers. The SME has reviewed these metrics and believes that are a good starting point for monitoring the crisis lines and crisis services.

In the sixth report, the SME recommended the State finalize how the MCOs will oversee the provider network against these performance metrics to increase the accountability and performance of all crisis providers. The State has started tracking on these metrics, especially the MCO call lines. The most recent data from April indicates the following:

Behavioral Health Crisis Line	
% Of Incoming Calls Answered	95%
% Of Calls Abandoned	5%
% Of Calls Answered within 30 Seconds	97%

These initial metrics indicate that MCOs are answering calls within an accepted range.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed the policies and procedures and developed and implemented training for crisis call line staff and crisis providers.
- The State has developed measures for crisis lines and for all four crisis services, including mobile crisis response, and worked with the SME to develop these measures.
- The State has begun efforts to review MCO crisis lines against the established measures and initially the crisis lines are performing well.
- The State has yet to implement the policies, etc., for CSUs that will be developed and implemented during the next reporting period.

Recommendations

- Continue to track and review the performance of the crisis lines against the current measures and provide a report to the SME on a monthly basis.
- Identify and address performance issues for crisis line staff and crisis providers based on these reviews.
- Implement the policies and procedures for the CSU 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.

Compliance Rating: Partially Met

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.

Compliance Rating: Partially Met

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

Compliance Rating: Partially Met

Discussion and Analysis

Paragraphs 70-72 are addressed together. As of June 2022, the State reports there are 45 ACT teams operating within Louisiana that are and will be serving individuals in the Target Population. The SME requested, and LDH provided information on, the number and percent of individuals transitioned from NFs during FY 2022 who received ACT. Currently 60 individuals in the Target Population, or approximately 24%, utilize ACT. The State reports that 12% of the diverted population are engaged in ACT. The 2021 Needs Assessment indicated that approximately 26% of individuals transitioned from NF received ACT and 17% percent of individuals diverted from nursing facilities received ACT. While there is some consistency in the percent of individuals who were transitioned receiving ACT, there was almost 30% fewer individuals who were diverted receiving ACT. Given the initiation of CCM this reporting period, the SME would hope to see higher ACT engagement rates for individuals diverted from NFs.

The SME requested information on whether any individuals who requested ACT did not receive this service. LDH has not provided the SME with this information.

Given the transition projections for CY 2022, approximately 77 individuals may need ACT services during CY 2022 (assuming 296 individuals will be transitioned from nursing facilities by December 31, 2022). This is based on the percent of individuals who have been transitioned during 2018 and 2019 (pre-pandemic) and received ACT (26%) and will be expected to increase over time as transitions continue to increase.

In the sixth report, 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.

During the last reporting period, the SME recommended that LDH 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. This

would require that TCs or CCMs review data or information (e.g., PASRR Level II) to determine if the individual has frequent crises, ED visits, or long hospitalizations for mental health reasons.

In the fourth SME 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 exiting/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. The State has not developed these step-down criteria.

As indicated in previous SME reports, the State, through its MCOs, conducts fidelity reviews of ACT providers on an ongoing basis. During the sixth reporting period, fidelity reviews were conducted on 21 ACT Teams. The balance of the reviews (24) were to be conducted in this reporting period. The SME requested and received these fidelity reviews on the 21 teams.

Overall, the overall fidelity of all teams suffered during the pandemic but appear to be rebounding in the first half of 2021. Previous fidelity reviews highlighted the lack of employment focus for some of the ACT teams. 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. In response to these reviews and the Agreement, the State reports the ACT service definition will be updated to include new emphasis on employment and embedding Individual Placement Supports (IPS) into the existing ACT teams. Work has commenced to determine future enhanced fidelity measures to be added to the current Dartmouth Assertive Community Treatment Scale (DACTS). MCOs are working with OBH to determine the best way to accomplish this. The State with the assistance from the SME has provided MCOs with strategies on how best to review IPS provided by ACT teams without having multiple fidelity reviews (ACT and IPS). The SME team has been included in these meetings. The State also indicates a review of the existing ACT rate to determine if additional rate enhancements need to occur to include IPS being delivered through ACT.

The enhanced attention to employment in ACT is welcome. On the other hand, mean summary fidelity reports provided by Case Western (17 organizations from July 2018-December 2021) indicate continued weakness in some areas concerning assessments, individualized treatment plans and individualized treatment. These are major areas for ensuring fidelity and is concerning given previous fidelity reviews where these were not identified as weaknesses. Areas where the mean ratings are higher are related to the structural aspects of the program, such as appropriate staffing, philosophy, and team organization.

As indicated in the sixth report, 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).

OBH collect data to review the performance of each ACT Team. This information is entered into 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 recommended ACT teams be informed on how to use the outcome data they are collecting for quality improvement. The State has not reported if this has occurred.

The SME recommended an analysis of outcomes be completed during this 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. The SME requested the State provide this analysis in the next reporting period. While the State collects outcome information, it has yet to analyze this information.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State continues to have a sufficient number of ACT team providers statewide.
- The percent of individuals transitioned from NF who receive ACT continue to meet the projected penetration from the 2021 Needs Assessment
- Ongoing ACT fidelity reviews are conducted by an independent national organization
- Recent fidelity reviews indicate ACT teams are not meeting fidelity re: assessments, treatment plans and treatment.
- The State has yet to develop a TA plan to address the issues identified in the fidelity review.
- The State collects important data on outcomes associated with ACT, however it has yet to analyze this data to determine what outcomes could be improved
- The State has not developed the step-down criteria for ACT. Analysis of the outcome measures would assist the State in developing this criterion.

Recommendations

- Continue to perform fidelity reviews
- Develop strategies to address the findings from the most recent fidelity reviews—including a focus on assessments, treatment plans and treatment.
- Analyze information from the ACT Outcome System, including ED and inpatient utilization to identify individuals in the Target Population that could be referred to ACT and develop the step-down criteria to create additional future capacity

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.

Compliance Rating: Partially Met

Discussion and Analysis

The State continues to measure the availability of and access to 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 2021 there are no obvious access issues for all but one Intensive Community Support Services. The number of Community Psychiatric Support and Treatment (CPST) providers generally remained the same in the first quarter of CY 2022 as compared to the previous 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 proposed changes to the CPST service, to better differentiate the role of this service versus Psycho-Social Rehabilitation (PSR), which had overlapping service definitions.

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. The needs assessment identified that approximately 57% of individuals who were transitioned received other ICSS services (CPST and PSR). Using information from the needs assessment, approximately 185 additional individuals may need CPST by 2023 (assuming, again, that 296 individuals will be transitioned from nursing facilities by December 31, 2022). This is a relatively small number compared to the 14,000 adults who utilized this service in CY 2021 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. 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.

The SME has not reviewed the quality of some of these services. Unlike ACT and IPS (discussed later in this section) there are no fidelity review tools for these services. LDH does license these providers and reviews whether they are meeting agency and service-specific standards on a regular basis. For the next reporting period, the SME is requesting information on the process used to review providers of ICSS services and determine how licensing agencies and MCOs review the quality of the providers.

As discussed later in paragraph 79, an ICSS that is not being utilized is Peer Support. The lack of any appreciable utilization of this service is very concerning to the SME, given the importance of this service in offering support from people with lived experience in their day-to-day life.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The Department has a process for monitoring the MCOs' efforts regarding the availability of ICSS on a regular basis.
- With the exception of peer supports, ICSS services are generally available to the Target Population.
- Utilization of ICSS services is consistent with the projections established through the Needs Assessment.

Recommendations

- Implement the activities in paragraph 79 to develop peer supports.
- Provide the SME with information regarding the licensing and contracting process for ICSS providers to determine if and how these entities include a focus on quality in these reviews.

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.

Compliance Status: Met

Discussion and Analysis

The State continues to offer and provide these services through the Mental Health Rehabilitation (MHR) program. There are over 400 providers of MHR services throughout the State. The State has made some legislative changes to better delineate the differences between CPST and PSR. The SME has reviewed these changes and feels as if these changes will further delineate the role of agencies that are providing these services. There have not been significant changes in the number of providers that are offering these services. In previous reports, the SME recommended LDH track agency closures that could be directly related to the pandemic. For the third through sixth reporting periods that spanned January 2020 through December 2022, there were very few closures of agencies providing MHR services. The SME has not

requested this information during this reporting period due to the easing of the pandemic and very few changes in the number of MHR providers.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State continues to ensure that MHR services exist in the community.
- The number of MHR providers is robust, and the network of MHR providers remains stable.
- The State reviews and makes changes to the MHR to improve the intent of the program.

Recommendation

- LDH should continue to track the provider network offering MHR services to ensure its ongoing availability.
- LDH should develop a process to ensure the proposed changes to CPST and PSR had the desired impact.

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.

Compliance Rating: Partially Met

Discussion and Analysis

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.[2]"

As indicated in the sixth report, there are several current pathways for individuals to receive in-home personal care through the Medicaid program, including the Community Choice Waiver (CCW), and Long Term Personal Care Services (LTPCS). Both of these pathways require the individual to meet nursing facility level of care. In May 2022, the State began to stand up a third pathway for individuals in the Target Population who needed personal care but did not meet NF level of care. The State obtained the appropriate authority for this service in the sixth reporting period. In addition, LDH requested and received funding for personal care services in their FY 2022 budget. As of this report, this service has yet to go live. The State reports the MCOs are in the process of identifying enrolling providers to this newer personal care service.

Several existing Medicaid services, such as PSR and CPST, do assist individuals with various IADLs and have been in the State's Medicaid program for almost twenty years. In addition, in CY 2021 the State received approval to offer peer support services which can also provide assistance to individuals with IADLs such as shopping, transportation, and managing finances.

[2] LouisianaNeedsAssessment-Final-Report.pdf (la.gov)

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. In addition, there have been instances where personal care services have not been available in a timely manner for individuals transitioning from NFs and there have been instances where personal care was not provided as required in an individual's CCW Plan of Care. The State and providers report the pandemic has impacted the ability to recruit and retain qualified individuals to provide these services. The State has requested additional federal funds through the American Recovery Plan Act (ARPA) to increase salaries for personal care and other direct care service workers as a strategy to address these gaps.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has sought and received the necessary changes to Medicaid to provide services.
- MCOs are currently in the process of developing the personal care network for individuals in the Target Population who do not meet NF level of care.
- There continues to be no personal care services during this reporting period for individuals transitioning or transitioned from NFs who do not meet NF level of care.
- The State has requested and received approval from CMS to enhance reimbursement for personal care services that is aimed at addressing workforce shortages.

Recommendations

- LDH should have the new personal care services available statewide by August 1, 2022, to all individuals in the Target Population who have been transitioned from an NF who do not meet the level of care.
- LDH should ensure that each individual where the Transition or Community Assessment identify the need for assistance with ADLs have personal care services in their ITP or their Plan of Care.
- LDH should review whether information collected by CCMS identifies gaps in personal care services and should provide the SME with information regarding:
    - The number of individuals who have ADL needs and do not have personal care in their ITPs or Plans of Care
    - The number of individuals who state they are not receiving personal care services consistent with their plan of care.
- LDH should implement the ARPA strategies for addressing personal care workforce issues during this next reporting period.

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.

Compliance Rating: Not Met

Discussion and Analysis

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 previous reports, 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.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has not taken steps to address the requirements of this program.

Recommendations

- LDH should undertake the following activities during this next reporting period to meet the requirements of this paragraph:
    - Identify members of the existing My Choice Advisory Committee and several additional individuals with lived experience, including individuals in the Target Population, to meet as a subcommittee to address this paragraph.
    - LDH should provide information and solicit recommendations regarding changes to the current protocols and process used to ensure personal and treatment rights of individuals receiving behavioral health services.
    - LDH should develop a strategy(s) to address the proposed changes and present these changes to the LDH My Choice Advisory Committee for their review.
    - LDH should develop a timeline for implementing these strategies this next reporting period. All strategies should be implemented by June 30, 2023.

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

Compliance Rating: Partially Met

Discussion and Analysis

The State has a process to credential peer support specialists who could provide the services in this Agreement. As of this report, there are over 300 credentialed peer support specialists in Louisiana. Currently, the State, through the MHR program, has policies (through the existing service definitions) that allow peer specialists to provide services, including all four new crisis services: ACT, Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, and Crisis Intervention.

There is no information readily available to determine the extent to which peer specialists offer these services. In the sixth reporting period, the SME requested information regarding peer support specialists providing existing MHR services. The State reports that this information does not readily exist.

As discussed later in paragraph 79, a significant reason for the lack of utilization of the new peer support service is an issue with applicants with lived experience passing background checks. Given this issue, it may be likely that MHR providers are experiencing similar challenges and few peers are offering these services.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State does have policies to credential peer support specialists.

- The State allows, but does not require, peer support specialists to provide services in A-C of this Agreement.
- The State is not able to track the number of peer support specialists who provide services in Section A-C of this Agreement.
- There are barriers to agencies interested in hiring peers (e.g., background checks). There was legislation passed in June to ease criminal background requirements for peer support specialists that may increase the number of peers.

Recommendation

- LDH should request MCOs collect information on the number of peers employed by MHR programs and barriers to recruiting and employing peers.
- Based on this information, the State should identify strategies to address any significant barriers to recruiting and employing peers.
- LDH should develop an ongoing process to review participation of peers in delivering services in A-C of this Agreement.
- LDH should also provide the SME with information on peers delivering new services (e.g., crisis and supported employment) during the next reporting period.

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.

Compliance Rating: Not Met

Discussion and Analysis

In the sixth SME report, the State took activities to identify, develop, or enhance services for individuals during the day. 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's primary focus has been on developing employment opportunities for individuals in the Target Population. These opportunities are to enhance state efforts to offer integrated opportunities for people to work and be provided with high fidelity to evidence-based models, such as Individual Placement Supports (IPS). Over the last two years, the State has finalized a definition for IPS, received approval to include it in the State's Medicaid program, finalized a reimbursement methodology for IPS, trained providers on the importance of employment, and is participating in a National Learning Collaborative on IPS.

Despite these activities, the Department has not created the necessary demand for these services for individuals in the Target Population. There is a historical lack of focus by TCs on identifying employment

interest and facilitating access to employment supports. As indicated in the SME Service Review, few individuals were asked about their employment interests, and none were working at the time of the review. Almost one-half of the individuals in the Service Review stated an interest in employment and doing some meaningful activity. More proactive discussions are needed to identify an individual's interest in employment or meaningful activities during the day in order to create demand for IPS or other services (e.g., ACT) that can effort employment supports. Without this demand there will be few referrals to IPS in the foreseeable future.
As of this report, there are no individuals in the Target Population receiving IPS. As indicated in the sixth SME report, a low volume of demand will provide LGEs with fewer incentives to dedicate staff resources to the delivery of IPS, which will impact the availability of this service.

Creating the demand for IPS will need to be coupled with an approach that trains LGEs on how to deliver IPS. While LGEs have received preliminary training on employment supports, they have not received the necessary training and technical assistance to implement IPS. Developing this infrastructure across all LGEs will take time. The State is initiating a contract with the national IPS Employment Center, the creators of IPS, to build an infrastructure to provide IPS services. The IPS Employment Center will focus on select, but not all, areas of the state to provide technical assistance regarding IPS. This contract has not started.

While IPS and the MHR program can provide valuable employment supports to individuals in the Target Population, Louisiana Rehabilitation Services (LRS) can provide another avenue for employment supports. LDH does not have a strong working relationship with LRS. LDH proposes to contract with a consultant to assist with linkages between OBH and Louisiana Rehabilitation Services to ensure that referrals for IPS are appropriate and LDH does not duplicate efforts or funding for this service. This work has not started and is scheduled to commence the next reporting period.

As indicated in the fifth SME report, OBH has developed, but not released, draft guidance to providers regarding employment services, including the use of existing services (CPST and PSR) to offer employment supports and coaching through the MHR program. This guidance is essential for having MHR providers understand they can offer employment supports to individuals that may not need the intensity of IPS.

In previous reports, the SME recommended that additional services or supports be available to the Target Population for ensuring additional integrated day options. The State gathered information to identify drop-in/low-demand social settings that could provide support and engagement to individuals transitioning or being diverted from NFs. Information from the 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 recommended in the fifth report that the State identify which of these programs are still operational and update the resource guide for the next reporting period. The State has not updated this resource guide as of this report. The State has not undertaken these activities.

<u>Compliance Assessment</u>
The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has undertaken important initial steps to identify and develop integrated opportunities for individuals to do during the day, with a focus on IPS.
- While TCs have been trained on employment supports, there continue to be few individuals who have specific goals and activities in their ITP regarding employment, despite individuals expressing an interest in working.
- There have been no referrals to IPS since the launch of this service.

- The State has not released the guidance for MHR agencies to offer employment supports.
- LGEs have not received the sufficient training or technical assistance to launch IPS.
- The State has not gathered important information regarding the current availability of other day opportunities including drop-in centers.

Recommendations

- LDH should develop a process for reviewing a sample of Transition Assessments, Community Assessment, ITPs, and POCs to determine if TCs and CCMs are identifying employment of other meaningful activities for individuals in the Target Population.
- LDH should ensure that TCs and CCMs are initiating referrals to LRS and IPS and track the specific referrals and engagement with IPS.
- LDH should track the number of individuals transitioned or diverted from NFs who are working (paid and volunteer employment).
- LDH should execute the contracts for enhancing the partnership with LRS and training of LGEs on IPS.
- LDH should undertake the survey recommended in the sixth SME report to identify existing drop-in centers and provide TCs, PASRR Level II evaluators, and CCMs with information regarding these programs for individuals transitioned or diverted from NFs.
- LDH should ensure that MCOs implement strategies for assessing the fidelity of IPS for LGEs who are providing IPS.

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.

Compliance Rating: Not Met

Discussion and Analysis

Peer support is an evidence-based practice for individuals with mental health conditions or challenges. Both quantitative and qualitative evidence indicates that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services and by 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.

The State has developed a stand-alone peer support service. As indicated in the sixth report, LDH has taken the necessary steps for designing and planning for the implementation of this new service. This new service was implemented in March 2021. Over the past year, the SME requested and received information on the number of individuals in the Target Population who received the new peer support services. The State continues to report minimal utilization of this service. There are no members of the Target

Population receiving this service. In the previous report, the State identified several barriers to this slow implementation:

- Some confusion by LGEs on how to seek reimbursement for peer services. Currently some peer services have been underwritten by federal grants and need assistance to convert billing from these grant sources to billing Medicaid.
- LGEs report that the currently approved Medicaid service definition for Peer Services does not allow for reimbursement of group sessions.

In addition, the State and the LGEs have identified a significant barrier for LGEs to employ peer specialists. Specifically, potential peer support staff have been unable to pass background checks required prior to employment.

The State undertook the following activities to address barriers to developing peer supports services:

- Conducted individual meetings with LGEs as needed to provide guidance and technical assistance regarding billing and reimbursement.
- Passed legislation that will not have minor offenses included in background checks.
- Explored additional provider types for expansion of Peer Services, including outpatient providers.
- Partnered with the Louisiana Peer Action Advocacy Coalition (LaPAAC) and The Extra Mile IV to host a virtual peer job fair in December to introduce qualified peers who are seeking employment to the LGEs.

Despite these efforts, there is no real utilization of this service and therefore it is not adequate to meet the needs of the individuals in the Target Population.

In the sixth report, the SME recommended the State develop a strategy to evaluate the effectiveness of peer supports. However, given the lack of implementation of this service, there is no data to evaluate its effectiveness.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- There has been no significant implementation of a separate peer support services. The lack of utilization of these services over the past fifteen months is discouraging.
- There have been no referrals and no utilization of peer support services for individuals in the Target Population.
- While there are promising efforts (e.g., legislation that changes criminal background checks), it is too soon to determine the positive impact of these changes.

Recommendation

- The State should pursue an alternative strategy for implementation of a new peer service, specifically develop a provider type that is specific to peer supports similar to other state's approaches. While the SME understands this will delay the implementation of this service it is highly unlikely, in the SME's opinion, that current providers will have the interest to develop this service.

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.

Compliance Rating: Partially Met

Discussion and Analysis

In December 2019, the State developed a Housing Plan, as required under the Agreement. The plan set 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.[3] The plan identified development of housing and non-development strategies (e.g., vouchers). The plan also included housing opportunities under the 811 PRA, Low Income Housing Tax Credit (LIHTC) Section 8 programs, and the State Rental Assistance Program.

The State has revised its housing plan through 2025. In revising the plan, LDH worked with LHC to better identify the development and non-development strategies for the next three years. The State included similar development and non-development opportunities included in the original plan. In addition, the State collected and analyzed information regarding the Planned Permanent Supportive Housing (PSH) opportunities created, including units/subsidies offered to the Target Population and individuals who took advantage of these opportunities. The analysis of this information is provided in paragraph 81.

The State has included in this revised plan, information for each housing strategy that includes the total PSH opportunities and the PSH opportunities to be created for each of the following three years.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed, revised, and is in the process of implementing the 2022 housing plan for individuals in the Target Population.
- The housing plan only provides rental assistance for units that are integrated into the community.
- LDH has developed a good working relationship with LHC staff to leverage their resources to access various housing strategies.
- LDH is more closely tracking housing opportunities created, offered, and utilized by individuals in the Target Population.

Recommendations

- LDH and LHC should track at a minimum on a quarterly basis housing opportunities created, offered, and utilized by the Target Population.
- LDH should update its plan on an annual basis and provide information to the SME and stakeholders regarding the efforts each year to meet the intent of paragraph 81.

[3] 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.

Compliance Rating: Partially Met

Discussion and Analysis

Over the past three years, the State has transitioned 317 individuals. Approximately 60% of these individuals have needed assistance with housing. Information on all individuals currently on the Active Caseload identifies approximately the same percentage.

The State, in its original housing plan, set forth the annual targets for creating additional housing units or rental subsidies that would be available to the Target Population. The State had planned for 867 units to be created through FY 2023. The State is not on track to meet this target. The State undertook the following activities in an attempt to meet the requirements of this paragraph:

- Implemented a state-funded subsidy rental assistance program within the first 18 months, the My Choice State Rental Assistance Program, to serve a total of 100 individuals in the Target Population.
- LHC created additional Section 811 Project Based Rental Assistance (Section 811 PRA), to be used in conjunction with both existing and new affordable multi-family projects. This award totaled $7 million, to support approximately 140 integrated permanent supportive housing units.

- The State sustained the existing requirements in the Low-Income Housing Tax Credit (LIHTC) program specific to PSH units for the Target Population.

- LDH and LHC applied for new targeted, permanent rental assistance resources from both HUD's Mainstream Program and the Section 811 PRA, with an award received for Mainstream.

- LDH and the LA Office of Community Development (OCD) successfully collaborated to create incentives for PSH developers.

While these strategies increased the housing opportunities, the State fell short of the goal set in the original housing plan. As of this report, the State has created 357 opportunities. Of these 357 opportunities, 175 were offered to individuals in the Target Population and 120 individuals utilized these housing resources. LDH evaluated the progress on the initial housing plan. This includes a review of the planned number of units and subsidy production for each housing strategy set forth in the original plan and whether LDH achieved the projected number of units and subsidy production for the first three years of the Agreement. LDH is also reviewing how many members of the Target Population took advantage of each of these strategies. The table below provides information by each category of development strategy.

Housing Opportunities	PSH Opportunities Planned	PSH Opportunities Created	PSH Opportunities Offered to Individuals in TP	Individuals Served
Development Strategy	141	67	4	4
Non-Development Strategies	726	290	171	116
Total Opportunities:	867	357	175	120

As this table indicates, non-development housing strategies were most often utilized by individuals in the Target Population. This includes:

- My Choice Rental Assistance Program—60%
- Non-Elderly Disabled Vouchers—20%
- Section 811 PRA—10%
- Other sources—10%

LDH reports the primary reason for fewer opportunities being offered to individuals in the Target Population relates to a low demand by individuals both identified and ready to transition. Low demand and readiness were exacerbated by the COVID-19 pandemic, which limited staff ability/options to get into nursing facilities to complete assessments and plan for transition. For many of the opportunities available, the offers had to be utilized or risk losing them completely.

LDH has recently implemented strategies to focus transition efforts and increase demand for PSH. In the previous report, TCs identified that housing was the most significant barrier to transitions. LDH leadership has developed new strategies to increase coordination between the transition coordinators/supervisors and the Housing Coordinator to assure clear lines of communication regarding availability of units and/or subsidies. LDH reports another strategy to create additional opportunities is repurposing existing vouchers through turnover. Turnover may occur for a variety of reasons, such as the person obtained non-PSH housing, moved out of state, moved to another region, moved in with family member, is no longer interested in PSH program, refused all properties, is ineligible, lost eligibility, is unable to locate, was evicted, abandoned unit, or passed away. The State projects an additional 452 opportunities will be created through turnover. However, as discussed with DOJ, some of these repurposing efforts, while important to ensure individuals in the My Choice program are offered housing, will not be able to be counted by the State for the 1,000 unit/subsidy goal. The State is to create and maintain 1,000 units/vouchers. Repurposing opportunities should not be counted multiple times as new individuals in the

My Choice Program use existing units/voucher that were previously used by individuals in the My Choice Program.

The revised housing plan does project over 946 new opportunities (for a total of 1,121 opportunities) to be offered to individuals in the Target Population over the next three years. LDH will need to be revisited given that some of these opportunities have been created and used by the Target Population. As indicated above, some of these new opportunities are duplicative and should not be counted as a new opportunity and would fall short of the 1,000 units the State needs to create and maintain.

Noteworthy is the addition of 42 new Rental Program (RAP) My Choice vouchers and 100 HOME Rental Assistance Program for FY 2023. The RAP My Choice voucher program is the most flexible non-development strategy. The State, rather than HUD, can develop policies that govern the use of these vouchers. The RAP provides short term and longer-term housing opportunities for individuals in the Target Population. Over the past six months, new OAAS leadership worked closely with LHC to increase opportunities under the HOME Rental Assistance Program. LHC has committed $1 million of HOME funds in CY 2023 to provide 100 tenant-based rental subsidies to the Target Population. LHC did not move forward with this strategy, thus far, due to demands associated with disaster and Covid-19 response. In recent discussions, LHC reports they have re-committed to this strategy.

For this calendar year, the plan projects 172 opportunities being developed. If these opportunities are created, the State would have to meet its transition targets for this year to take advantage of these opportunities. As indicated earlier in this paragraph, 60% of all individuals transitioned from NFs will need housing assistance. Given current transitions, it is likely that the State will not be able to take advantage of these opportunities if all 172 are created. Many of these opportunities are time-limited (e.g., needing to be used by the end of CY 2022) and will need to be repurposed for other populations if these opportunities are created but not used by the My Choice Population.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- While the State has undertaken various steps to increase integrated housing opportunities for individuals in the Target Population, it has fallen short of its stated goals for developing housing opportunities for the Target Population.
- There are major differences between the housing opportunities created, offered, and utilized by the individuals in the My Choice Program.
- TCs have not created the demand necessary to take advantage of the housing opportunities created. While the pandemic impacted this demand, it was likely not the sole reason for the lack of referrals to PSH.
- The process for TCs to be informed of housing opportunities was not working well. The State reports they are in the process of developing strategies that will address this issue.
- The State has identified more strategic opportunities in the revised plan. The inclusion of additional RAP vouchers is an important step in meeting the housing needs of individuals in the Target Population.

Recommendations

- Implement the strategies recommended in paragraph 80 that will track opportunities on a quarterly basis to determine if opportunities are being created and offered to individuals in the Target Population. The goal should be to have good alignment between opportunities created and used by the individuals in the My Choice Program.

- Identify the percent of individuals diverted from NF who will need rental assistance opportunities.
- Align housing requests with transition and diversion targets and revisit the housing plan to ensure these opportunities are being offered.
- Work with LHC to make use of the 100 opportunities under the HOME Program.
- Request an additional 100 vouchers for the RAP program for CY 2024 and CY 2025. This is the most flexible housing strategy and most likely to meet the needs of individuals in the My Choice program that may not qualify for other federal housing programs.
- Commit to take advantage of existing turnover of its existing PSH units/subsides for the MY Choice population but note that some turnover opportunities do not count towards the 1,000-unit requirement. LDH should make plans to develop the full 1,000 additional opportunities for the target population.

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.

Compliance Rating: Partially Met

Discussion and Analysis

Existing federal and state policy allows individuals to voluntarily receive tenancy supports. The current Louisiana Permanent Supportive Housing is a cross-disability housing and services program that links affordable rental housing with voluntary, flexible, and individualized community-based services to assist people with severe and complex disabilities to live successfully in the community. Individuals cannot be rejected due to the conditions set forth in this paragraph. As indicated in paragraph 81, the State has created the RAP program to provide housing and housing supports for individuals with conditions and backgrounds that have often created a barrier to housing (e.g., criminal background). The State has developed an approach to developing housing for individuals in the Target Population that is integrated and scattered site.

Compliance Analysis

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has current policies and programs that allow an individual to reject housing supports and ensures individuals with certain conditions are not denied participation in the program.

- Current and projected opportunities identified in LDH revised housing plan only offer development and non-development strategies for units that are integrated and scattered site.

Recommendations

- LDH should review various development strategies for CY 2023-2025 to ensure that projects meet the intent that units being developed are integrated and in scattered sites.

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.

Compliance Rating: Not Yet Rated

Discussion and Analysis

The State continues to employ six TSMs to 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 should provide a valuable function on behalf of the Target Population and for landlords and local housing authorities. In the sixth report, the SME requested additional information on how the TSMs can be helpful to the TCs to assist members of the Target Population to find appropriate housing. The SME requested the following information:

- The number of individuals in the Target Population that have requested and received assistance from the TSMs.
- How LDH ensures TSMs have the required experience to perform their job duties as listed above.

- The TSM activities during the next reporting period regarding the support provided to landlords and providers.
- How TSMs specifically address crisis situations and how the TSMs will work with new crisis providers to ensure that crises are adequately addressed on a timely basis.
- Information from the State that demonstrates existing housing is preserved when people are admitted to a hospital or NF or are incarcerated.

The State reports it is currently collecting this information for the SME to review in the next reporting period.

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.

Compliance Rating: Partially Met

Discussion and Analysis

As discussed in the sixth SME report, the State funds housing-related expenses such as security deposits and other necessities for making a new home through the CCW program for individuals who meet NF level of care, MFP, and the RAP program. In addition, the Tenant-Based Rental Assistance (TBRA) administered by LHA is currently being used for security and utility deposits for persons transitioning to 811 PRA Units.

The SME requested information on the number of individuals in the Target Population who received HOME based rental assistance. As indicated in paragraph 81, the State has deferred this program until CY 2023.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State currently has policies in place and reports they fund various housing related expenses.
- The State has committed to using HOME TBRA for security and utility deposits for CY 2023.

Recommendations

- LDH should provide the SME information regarding the number of individuals in 2022 and subsequent calendar years who needed and received housing-related expenses. Information from the ITPs should identify who needs these supports and TCs should report whether these supports were provided at transition.
- LDH should develop a strategy to determine if individuals diverted from NFs need and receive similar housing supports.
- LDH should provide information regarding the needs of individuals transitioned and diverted in CY 2022 and that should be used to inform the use of HOME TBRA and additional RAP resources for housing related expenses.

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.

Compliance Rating: Partially Met

Discussion and Analysis
As indicated in Paragraph 75 of the Agreement, the State has pursued both Medicaid state plan and waiver authorities for several new services. In addition, the State has pursued and is distributing funds to support various My Choice and other HCBS services using federal ARPA funds. This will allow new services to have funding needed during start-up. In addition, the State reports the ARPA funds will be used to increase funding for various HCBS services, including personal care offered through CCW and state plan LTPCS.

As indicated in the sixth report, the State worked with the Medicaid actuaries to develop reimbursement rates for each new service. The SME was engaged in some of these discussions or provided input regarding the assumptions for rate setting based on other strategies that have been used in other states that have mature and well utilized services. Initial efforts to contract with providers for these new services have not identified that these new rates provide barriers to interest in offering these services.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has pursued the necessary Medicaid changes thus far to meet the intent of this paragraph.
- LDH has implemented reimbursement strategies for new services that should support providers offering these services.
- The Department is in the process of providing funding to providers of new crisis services to ensure their sustainability during the initial start-up period.
- The Department has yet to implement the strategies for increasing reimbursement for much needed HCBS.

Recommendations

- Distribute the ARPA funds to HCBS providers early in the next reporting period.
- Determine if new providers of My Choice services will need ongoing support during start-up in the next reporting period and pursue funding strategies to ensure service sustainability.

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.

Compliance Rating: Partially Met

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.

Compliance Rating: Partially Met

Discussion and Analysis

Paragraphs 86 and 87 are addressed together. The State developed an initial communication plan for stakeholders 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 initial plan contemplated:

1. The creation of a core stakeholder advisory group, as well as stakeholder subcommittees, to advise the department throughout the implementation of the Agreement. The group would be asked to engage their respective organizations throughout implementation and share updates from the advisory group.
2. Regional "town hall" style meetings to listen and present to stakeholders across the State.
3. Regional provider meetings with nursing facility administrators, behavioral health hospitals, and providers.
4. The creation of a My Choice Louisiana website to share the information, including implementation plans, training materials, and presentations.
5. A newsletter-style update to stakeholders, to be shared by email at least quarterly.

The State has not implemented this plan. Early in the implementation of this Agreement, the State had an organized process for outreach to a broad group of stakeholders regarding behavioral health services, including information regarding the My Choice Program. This included creating the My Choice Advisory Committee and conducting regional listening sessions and other opportunities designed by LDH to receive feedback on critical policies and services. The State was planning on similar strategies over the past few years, but the pandemic limited the State's ability to do these in-person meetings.

The current outreach efforts regarding the My Choice Program have been more limited. They revolve around information dissemination to the My Choice Advisory Committee, LGEs, and various stakeholders regarding new services such as crisis services.

The State continues to have bi-monthly meetings of the My Choice Advisory Committee. Initially, the Committee was composed of representatives from LGEs, advocacy organizations, and providers. During this past year, LDH has added several members from peer-run organizations and an individual who has been transitioned from an NF as part of the My Choice initiative.

As discussed in the sixth SME report, the State previously developed a number of subcommittees, or resource groups, within the Advisory Committee to provide input on key areas, including crisis, community service development, quality management, and community transition. 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 SME is requesting information regarding the rationale for not holding these meetings, given the barriers identified in Paragraphs 51. During this reporting period the

State only held meetings with the Crisis Resource Group. The Crisis Resource Group continues to provide feedback to the State regarding the implementation of crisis services.

In addition to the Crisis Resource Group, the State made significant efforts to engage other stakeholders focused on the crisis services roll-out. During this reporting period, the State held three statewide meetings for providers, advocates, law enforcement, and other stakeholders on crisis services to provide an overview of the services and the implementation processes and timeframes. In addition, the State held meetings with all LGEs and subsequent meetings with each region to engage them in the crisis service roll out and to identify implementation issues. The State also met with the Coroners Association, the Louisiana Behavioral Health Advisory Committee, and the Louisiana Hospital Association to provide an overview of the crisis services and roll-out.

The SME recommended in the previous report that the State convene and meet with the Community Transitions Resource Group 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 previous reporting periods. This group would be helpful in the State's efforts to collect information and feedback regarding the array of services needed for individuals in the Target Population. The State has not met with this group.

In the sixth report, the SME recommended LDH meet with these subcommittees, given the barriers identified by the TCs and the recommendations of the Needs Assessment. This information is important for the State to incorporate into a number of areas referenced in this report.

The State reports they have met with several groups this reporting period including the Louisiana Nursing Home Association to provide additional information regarding the My Choice program and reinforce expectations regarding their participation in the transition process.

The State meets with all LGEs on a monthly basis regarding behavioral health issues, including the My Choice Program. In addition, the State meets with the LGEs to have more targeted conversations regarding their responsibilities to provide specific services to individuals in the Target Population. These efforts were discussed in more detail in paragraphs 78 and 79.

The State continues their efforts this reporting period regarding engaging law enforcement, specific to crisis services. These efforts were discussed in more detail in paragraph 68.

The SME participated in a meeting with a provider association regarding the My Choice Program. The association expressed concerns regarding the lack of engagement with their members who have experience with providing services and supports that would facilitate transitions and diversions.

The State has not reported they have met with individuals currently receiving mental health services for the purpose of sharing this information and collecting feedback on the service array available to the Target Population.

In the past three reports, the SME recommended that the State enhance its My Choice website and develop a quarterly newsletter (or a similar communication effort) to keep stakeholders beyond the Advisory Group informed of the progress regarding the Agreement. This did not occur during this reporting period. A revised communication plan, including the newsletter, would be beneficial especially during this time when LDH is standing up services and developing strategies for awareness and referrals

for this service. The State has initiated efforts with the My Choice Advisory Committee to solicit recommendations regarding the quarterly newsletter and changes to the website.

In addition, since the fourth report, the SME has recommended the State revise its outreach plan given its proposed renewed efforts as discussed throughout this report. The outreach plan, at a minimum, should involve NFs, hospitals, LGEs, law enforcement, and other resources the Target Population will need to live independently in the community. The State has not revised the communication plan.

As requested by the SME, and as required by this Agreement, the State has posted their Quality Report and Matrix for the My Choice Program. This report can be found here:
https://ldh.la.gov/assets/docs/MyChoice/myCHOICE-Annual-Quality-Report-2021-22.pdf

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State developed and implemented the initial communication plan developed in CY 2018.
- LDH continues to convene the My Choice Advisory Committee.
- LDH continues to meet with some stakeholders regarding the My Choice Program. These conversations have been limited to creating awareness and capacity of crisis services.
- The State has not revised the communication plan as recommended by the SME.
- LDH has not developed an approach to meet with individuals who have lived experience regarding the services and supports regarding the My Choice Program.
- The State has not met with most of the My Choice Subcommittees during this period.
- The State has not developed the quarterly newsletter.

Recommendations

- The State should revise the communication plan regarding the My Choice Program. To the extent possible, this should include statewide and regional strategies for providing timely information regarding the My Choice Program. These efforts should be a combination of in-person and virtual strategies.
- LDH should re-assess the My Choice subcommittees and begin to meet with these committees on a quarterly basis. These subcommittees have been useful in providing LDH feedback on important issues regarding the My Choice Program.
- The State should make enhancements regarding the My Choice website and develop the quarterly newsletter, based on recommendations made by the My Choice Advisory Committee, to provide information regarding the new service development and information on how individuals, caregivers, and providers can access these services.

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.

Compliance Rating: Not Yet Rated

Discussion and Analysis

During the sixth reporting period, the State conducted meetings with law enforcement as discussed in Paragraphs 68 and 86. Most of these efforts focus on the development of the new crisis services system, which is the likely interface between these systems and diversion. LDH has been appropriately cautious

about efforts to meet with these organizations until the appropriate crisis and case management capacity is in place to enhance diversions. The SME will track LDH activities in this area in future reports to assess compliance.

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.

Compliance Rating: Partially Met

See paragraph 54 for discussion.

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.

Compliance Rating: Partially Met

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.

Compliance Rating: Partially Met

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.

Compliance Rating: Partially Met

Discussion and Analysis

Paragraphs 90-92 are addressed together. The State has reported increased efforts to train community providers, with a major focus on providers of new crisis services. As indicated in the paragraphs in Section V.A, the State has worked with LSU to develop organized and well attended training opportunities for providers offering various crisis services. Those training opportunities are discussed in paragraphs 63 through 66.

As indicated in this report, the State reports they have developed training for agencies and their staff that will provide CCM. The SME has reviewed the training materials developed for CCMs and feels these materials are sufficient for initial training for these providers.

As discussed in paragraph 78, the State is also in the process of contracting with the national IPS Employment Center, the creators of IPS, to build an infrastructure to provide IPS services.

In the sixth report, the State, in cooperation with the MCOs, implemented training on person-centered planning for behavioral health providers. An overview of the development and piloting of this training was discussed in the sixth SME report. MCOs have conducted five initial trainings throughout the state for behavioral health providers. The SME requested information on the number of attendees who participated in this training and any strategy the State or the MCOs have considered to evaluate the effectiveness of this training. The State has provided this information and 72 individuals, and 54 provider organizations participated in the training. It should be noted that the State has yet to seek input regarding the training from individuals receiving services nor has it included training by individuals who were receiving services.

In the sixth report, the SME also recommended in the SME Service Review a training approach to CCW support coordinators and personal care staff that were serving individuals with a serious mental illness. The State has not developed these training efforts.

Over the past several reports, the SME has requested LDH establish a mandatory training policy, qualifications, and curriculum for Community Providers. In addition, the curriculum is to include initial training and continuing training and coaching for Community Providers. The State has developed training and coaching for crisis providers but has not developed similar approaches for other community services.

Compliance Assessment

The SME's assessment of the State's compliance with this paragraph took into consideration:

- The State has developed and implemented training for agencies offering crisis services and case management this period.
- The State has concrete plans to offer training and technical assistance regarding IPS for some LGEs in the next reporting period.
- The State has not developed a plan for training direct service workers offering PCS services to the Target Population.
- The State has not solicited or incorporated consumer feedback regarding its person-centered planning training or included a strategy for consumers to deliver this training.

Recommendations

- The State should develop a single organized training plan for providers who serve the Target Population. Given the roll out of new services, this would be helpful for providers to understand what and when there are opportunities to receive training on new and existing services.
- The State should include a process for soliciting and incorporating consumer feedback regarding the person-centered training curriculum and implement a strategy for including consumers in the training.
- The State should provide training regarding mental health and recovery to direct service workers that offer personal care services to individuals in the Target Population.

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).

Compliance Rating: Partially Met

Discussion and Analysis

In the sixth report, the SME reported there are several strategies the State has deployed to review the quality of services for individuals in the Target Population who will transition or who have transitioned from NFs. While these strategies are a reasonable start to reviewing quality, these activities will need to be expanded over the next reporting periods as additional individuals are transitioned and diverted from nursing facilities and new services are brought on-line. The SME recommends that LDH:

- Begin to incorporate the findings from the SME Service Review that identified a number of issues and recommendations for improving the quality of services offered to the Target Population.
- Develop a process to review the quality of new services. Some of these services (e.g., ACT and IPS) have fidelity instruments that can be used to evaluate quality of services. As indicated in paragraph 69, crisis services have performance measures the State will collect to determine whether providers are initially meeting these standards.
- Ensure that CCM staff provide the necessary information to review quality of services consistent with the TC strategies over the past two years. While this information was self-reported, it does provide LDH with information on how best to target its quality efforts and improve the quality of services for the Target Population.
- Work with the SME to develop a process for reviewing assessments and plans of care developed by the CCMs to ensure that the assessment instrument and processes address several major issues and recommendation from the SME Service Review.

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

Compliance Rating: Partially Met

Discussion and Analysis

The State has finalized its first Annual Quality Assurance Report for the My Choice Program. As recommended by the SME, this plan incorporates the work that has been done to collect and analyze data on some of the measures required in Paragraph 99. It also sets forth the processes LDH has put in place to use this information to improve the experience of care for individuals transitioned from NFs as well as to improve the quality of services that are offered to the Target Population. The State provided the My Choice Advisory Group with the Quality Assurance Report during this reporting period. The My Choice Advisory Committee and the Quality Assurance subcommittee have reviewed the plan but did not have many significant changes.

During this reporting period, the State has continued to collect and analyze information on some of the measures required by this section of the Agreement. During this reporting period, OAAS and OBH 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. In the fourth report, the SME recommended this workgroup identify actionable items to address the systemic issues in subsequent meetings. As indicated in the previous SME report, the quality assurance workgroup was focusing on the root cause of the critical incidents that have been reported for individuals who have transitioned from NFs. The process and findings are discussed in paragraph 95.

The quality matrix originally contained preliminary measures designed to address requirements in paragraph 98 and 99 of the Agreement. The State is continuing to expand and refine this matrix to capture additional information, including:

- Information regarding diverted members of the Target Population
- Additional measures regarding stability, choice, and self-determination
- Provider capacity/utilization of new services
- Barriers to integration.

The State reports they are working on the second annual quality plan and will provide that to the SME and the My Choice Advisory Group in the next reporting period.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed its first Quality Assurance Plan.
- The State has established a cross-agency Quality Assurance committee to review the quarterly measures discussed in paragraph 99.
- The State has engaged stakeholders in their Quality Assurance process for developing the Quality Assurance Plan.
- The State has initiated efforts to do additional analysis on quality measures in paragraph 99 to determine where to focus additional analysis and steps to address systemic issues.

Recommendations

- Identify the next area(s) of focus for the internal quality assurance committee and design and began to implement an approach for analyzing and developing strategies to remediate the area selected.
- Develop a draft of the second annual Quality Assurance Report/Plan and solicit feedback from My Choice Advisory Committee and Quality Assurance subcommittee.

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.

Compliance Rating: Partially Met

Discussion and Analysis

The State has a critical incident report (CIR) process that is used by both agencies (OAAS and OBH). The program offices have aligned definitions and processes for individuals transitioned from NFs. Over the past two years, OBH TCs, as part of their Intensive Case Management responsibilities, complete the CIRs, and have been 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.

During this reporting period, LDH, in cooperation with the SME review team, developed a process to review individuals who had significant CIRs during CY 2021. The reviews focused on CIRs that were related to major medical issues (ED and inpatient utilization) since these were reported most often for individuals receiving ICM. The previous quality matrix had indicated there were 35 individuals with a critical incident reported in the last quarter of 2021. Twenty-nine of these critical incidents were related to ED or IP use. The SME suggested the State review individuals with the most ED and inpatient admissions (all cause). A review of critical incident and Medicaid claims information identified 15 individuals who had significant ED and inpatient utilization for the period July – December 2021. The review determined if all incidents were identified, whether CIRs documentation was complete, and what actions were taken or could be taken to prevent these incidents. Six members of the quality assurance workgroup performed this review, along with the SME review team, using a consistent tool to identify issues and possible strategies for reducing ED visits and hospitalizations.

The review process was recently completed and LDH's Quality Assurance staff presented an overview of process and initial findings to OAAS and OBH leadership during this review. The State is in the process of reviewing the findings and developing strategies for mitigating utilization of EDs and inpatient services.

The SME was encouraged by the work of the quality assurance workgroup. Many of these members not only completed their reviews as planned but also collected additional information in an attempt to better understand why these individuals used ED and inpatient services at such a high rate and determine if there were systemic issues across these reviews that required additional action.

During this period, the CCMs were trained on CIR processes and requirements. CCMs and TCs will be providing CIR reports on individuals who have been transitioned or diverted from NFs since July 2021. Given the newness of the CCM program, the SME does not have data regarding CIR reports from CCM staff.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed a CIR process for TCs and CCMs that includes standardized definitions, reporting processes, and timeframes.
- The State reports data regarding critical incidents for members of the Target Population on a quarterly basis.
- The State has undertaken efforts to better understand the nature of more frequent critical incidents (ED and inpatient service utilization) and to develop strategies to reduce or ameliorate these incidents.

Recommendations

- The State should develop and implement recommendations regarding their review of critical incidents.
- The State should continue to track CIR information regarding ED and inpatient utilization to determine if the proposed strategies are successful.
- The State should track CIRs reported by CCM and use a similar process to identify whether certain reportable events (e.g., claims information on ED and inpatient utilization) are being reported by CCMs.

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.

Compliance Rating: Not Rated

Discussion and Analysis

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 and has been more focused on CIR reporting from TCs and CCMs.

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.

Compliance Rating: Partially Met

Discussion and Analysis

OBH and OAAS have developed a joint mortality review committee protocol for the My Choice Program. 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. A discussion of this protocol is provided in the sixth SME report. Currently, OAAS and OBH has formed an interagency committee that includes some clinicians (e.g., OBH lead psychologist). In addition, there are two organizations that are on the mortality review committee from the Health Standards Section and Adult Protective Services who are not employees or contractors of OAAS or OBH.

The SME requested and the state provided a draft of its first Mortality Review report. This first draft report was reviewed by the SME and provided information regarding the scope and structure for mortality

reviews, information on the mortality reviews conducted thus far, and remediation strategies undertaken by the State based on these reviews. As reported, the State has used the protocol described in previous SME reports to conduct these reviews. Under the current protocol, the mortality review committee is to review any death within 60 days of discharge from an NF, any unexplained death, and any death in which abuse, neglect, or exploitation is suspected. LDH has conducted three mortality reviews to date. All relate to deaths that occurred in CY 2019 and CY 2020. During this timeframe, the State reports that there were seven mortalities reported for the My Choice transitioned population. One occurred in CY 2019 and six occurred in CY 2020. Of those seven, three were not referred to the committee because they did not meet the criteria above. According to LDH, these three individuals were experiencing significant health issues resulting in the need for hospice care. The remaining four cases were referred to the committee based on the specified referral criteria.

The committee initiated three of these four reviews in March 2021. The final review was postponed due to a delay in receiving the death certificate and other necessary documentation. There were several areas the mortality review identified during their reviews:

- Personal Assistant Services were being provided; however, they were not provided at the time that was listed on the plan of care.
- Service logs were not made available to the State for all dates the participant was supposed to receive care.
- Critical Incidents were not documented in the Critical Incident Reporting System as required by the State.

As a result of these findings, the State took the following remediation actions:

- Citing a provider agency for failure to provide services according to the participant's service plan.
- Citing an agency's administration for missing Critical Incidents Reports in the Critical Incident Reporting System.

These citations required the service provider agency to submit a corrective action plan that detailed how they would prevent further reoccurrence of non-compliance within ten days of the citation. LDH staff reviewed and approved the corrective action plan. In addition, the agency had to assure all service plans would be followed as written, and staff would be retrained in providing services according to the participant's service plan.

While there were a number of OBH, OAAS, and other agencies participating on the mortality review team, there was no representation from MCOs, LGEs, and community providers. Also, the OBH Medical Director was not reported to be part of the service reviews. In addition, the mortality review process seems lengthy, and reviews are not being conducted on a timely basis. While the SME understands collecting information from third parties is challenging (especially during a pandemic), these reviews are taking many months to collect and aggregate information and send to the committee. The State reports that it intends to revise the protocol. The Mortality Review Committee will convene to discuss possible methods to reduce timelines or adapt the protocol to account for such delays.

There were an additional four deaths in CY 2021. In addition, there were six deaths in this reporting period (January – June 2022), the highest reported during any period of the Agreement. These deaths have been referred to the mortality review committee and are under review.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed and implemented reporting and investigation protocols for mortality reviews.
- The mortality reviews are conducted by an interagency team comprised of OAAS and OBH; however, members of the team do not include some individuals in this paragraph nor the OBH medical director.
- The mortality review process seems lengthy, and reviews are not being conducted on a timely basis.
- LDH completed their review of the four individuals who were referred to mortality committee who died in CY 2020/2021.
- LDH has begun to conduct a review of seven individuals who have died during this reporting period in CY 2022. Five are in process with the mortality review committee, 2 were recently referred to the committee.

Recommendations

- LDH should complete the review of the seven individuals who have died during this reporting period in CY 2022.
- LDH should add individuals to the Mortality Review Committee as required by this paragraph. This should include regular participation by the OBH Medicaid Director and/or an MCO's Medical Director.
- LDH should determine processes for streamlining information gathering to reduce the time needed to conduct these reviews versus changing the protocol to address lags in information collection.
- LDH should post the first Mortality Review Annual Plan and provide a timeframe for completing the second annual report.

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.

Compliance Rating: Partially Met

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.

Compliance Rating: Partially Met

Discussion and Analysis

Paragraphs 98 and 99 are addressed together. As discussed in Paragraph 94, the State has developed a process for collecting and reporting on initial measures to address the requirements of this paragraph. These measures and performance data are reflected in the quality matrix provided in Attachment A. LDH has amended the initial measures with a particular focus on improving measures specific to PASRR and service utilization. They continue to measure information related to stability, provider capacity, barriers to community integration, choice and self-determination, community inclusion, and quality of life. However, several areas of the matrix require revision and/or expansion in order to satisfy the requirements of this Agreement. This includes measures related to stability, provider capacity/utilization of new services, choice, self-determination, barriers to integration, community inclusion, and general quality of life.

A significant number of quality measures in the matrix are self-reported by the TC. In previous reports, the SME recommended that the State develop a process to offset any reliability concerns regarding self-reported data in the quality matrix. The State proposed, but has not implemented, a process to have the Transition Coordinators perform interviews with the Target Population member as a second level review to verify that the information being reported by CCMs is accurate. This process is being considered for implementation in the next reporting period, when the TCs will no longer be providing intensive case management for individuals who have been transitioned from nursing facilities. TCs should be able to 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 reporting thus far has been limited to transitioned members of the Target Population. LDH will begin reporting during the second period (April – June 2022) to include those who were diverted from nursing facilities.

The data sources identified in the matrix provide the State with reliable information (e.g., Medicaid claims, OPTs, or UTOPIA PASRR information).

Another critical source of information is whether individuals are receiving services consistent with their plan of care. The source for this information is the SME Service Reviews which is to collect and analyze information on:

- Number and percent of transitioned members who received services in the amount, frequency, and duration specified in the CCM 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 SME Service Reviews, there was no comprehensive community plan post-transition. This made reporting certain items on the quality matrix that were specific to the SME review difficult. The SME recommended, and LDH developed an assessment and a care plan for, the provision of CCM that include the components recommended by the SME in the sixth report, including a crisis plan that includes potential causes and strategies for recognizing and addressing crisis (including physical and behavioral health). A review of these plans will be reflected in the SME Service reviews and subsequent quality matrices.

In the fifth report, the SME recommended the State develop (or require the MCOs to jointly develop) protocols and training for CCMs to report the measures in the quality matrix. The MCOs have developed SOPs and trained the CCMs to report the measures in the quality matrix on a basis. The State will include this information in the next reporting period for the period of time between March (when CCM went live) and June 30th.

During this reporting period, the State has developed additional 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." To meet this objective, the State has developed a list of frequent barriers that have been historically reported by TCs and from the SME Service Review Report for TCs to use during their transition efforts. The State reports this information will be collected on a quarterly basis, beginning the next reporting period and provided to the SRP for review and recommendations to develop strategies to mitigate these barriers.

Information from the most recent quality matrix shows that various areas continue to be strong. These areas include:

- Provider capacity and access to community-based services
- Person-centered planning, transition planning, and transitions from NFs
- Physical and mental health wellbeing and incidence of health crisis
- Stability
- Community inclusion.

Areas that continue to be a concern are:

- Safety and freedom from harm. There are still many individuals who transition from NFs who have major medical incidents the first year post transition.
- Referrals to, admission and readmission to, diversion from, and length of stay in NFs. There are inconsistent trends in various areas including:
    - Referrals to Level II OBH (as per results of Level I PASRR) requested at admission.
    - PASRR Level II placement recommendation, which is the major indicator for how well LDH is diverting individuals from NFs.

There are several areas that have no information in the last quarter about individuals using crisis services, given crisis services were not in place during CY 2021.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State is collecting and analyzing consistent data to improve the availability, accessibility, and quality of services for areas identified in this paragraph.
- The State has created and updated protocols on collection and analysis of data to drive improvement in services which the SME has been involved with since the beginning of the Agreement.
- The State still has not developed a process (other than the SME Service Review reports) to validate the data collected on measures self-reported by the TCs and now the CCMs.
- The State has yet to collect the additional information on measures regarding PASRR Level II information.
- There are still major issues with ED and inpatient hospital services utilization. Almost one-half of individuals transitioned from NFs in the fourth quarter of CY 2021 experienced a critical incident and most of these were ED or inpatient visits.
- The State does not have a consistent approach in identifying barriers for individuals to receive services in the most integrated setting, including information from the SRP.

Recommendations

- State should continue its efforts during this next reporting areas to focus on reasons and strategies to address the higher use of ED and inpatient hospital services, including a focused review to determine if various service gaps are driving this utilization.
- The State should implement the TC secondary review of members in the Target Population's self-reported measures to begin efforts to determine the reliability of the process to collect these measures.
- The State should include data on barriers from the SRC in the quality matrix starting in the next reporting period. The State should report the number of individuals experiencing more frequent transition barriers and separately provide information in paragraph 54 on SRP efforts to address these barriers.
- The State should finalize and implement the PASRR measures to better report information regarding lengths of stay and readmissions.

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.

Compliance Rating: Partially Met

Discussion and Analysis

During the last reporting period, the State reviewed data from the first full year of the quality matrix and identified issues with the number of critical incidents experienced by individuals transitioned from NFs. As indicated in paragraph 95, the State undertook a process to further analyze CIR information on

individuals who were transitioned since July 2021. The State's efforts regarding this review were discussed in paragraph 95.

In addition, the SME conducted the first round of service reviews and provided a report to the State during the last reporting period. A summary of findings from the Service Reviews conducted in CY 2021 found:

- 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 were 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.
- 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 their transition plan, but their 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.

The most recent SME Service review report can be found at:
SME-Report-January-June-2021.pdf (la.gov)

The SME will begin the next round of service reviews in FY 2023 and will compare the data reported by CCMs against information collected during the service reviews.

The State has undertaken several steps to address the findings of the SME report during this reporting period. These efforts include:

- Providing training to TCs and CCMs regarding the identification of community engagement needs and ensuring these needs are reflected in transition plans and community plans of care.
- Creating SOPs for CCM to ensure that care coordination post-discharge is available and that team meetings with the individual occur on a monthly basis.
- Requiring individuals who are transitioned or diverted from NF to have a crisis plan.
- Revising the processes for individuals to better ensure that individuals who need housing will be offered housing of their choice on a timelier basis.
- Addressing the personal care workforce shortage through enhancements in reimbursement for services rendered by these individuals.

There are several areas from the SME report the State did not address. The current ITP collects information on services needed at transition but does not address the frequency and duration of services. The SME Service Review report identified the need for certain staff (e.g., support coordinators and direct service workers offering personal care services) to receive training regarding mental health conditions to have better insight on providing or coordinating services for individuals with these conditions.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has begun efforts to collect and analyze data and identify trends, patterns, strengths, and problems at the individual, provider, and systemic levels. These efforts are in their initial stages and have provided important structures to review and enhance quality.
- The State has begun to address some of the findings from the SME Service Review Report.
- There are still important issues the State did not address as a result of the SME Service Review, including building better acumen of the some of the workforce that provides services to the Target Population.
- While the State has developed and implemented certain strategies to address issues in the quality matrix or the SME Service Review, information on the effectiveness of these strategies has yet to be developed.

Recommendations

- Continue efforts to review, analyze, and act on data provided by the quality matrix and SME Service Reviews. As indicated in paragraphs 98-99, CIRs related to EDs, and inpatient hospital utilization continue to be very high and play a major role in an individual's quality of life.
- Develop a training plan for service coordinators and personal care staff that are likely to work with individuals who have an SMI to understand better approaches to addressing these individuals' unique needs.
- Develop a tracking process to determine if the strategies the State has put into place to address issues identified through the quality assurance process using data in paragraphs 98 and 99 had the intended outcomes.

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.

Compliance Rating: Partially Met

Discussion and Analysis

As discussed above, the State utilizes a Quality Matrix to collect and report on the data and performance measures required by Paragraph 99 of the Quality Assurance and Continuous Improvement Section of this Agreement. In January 2022, the State published its first Annual Quality Assurance Report, which includes the My Choice Quality Matrix Data for 2020. Additional enhancements are needed to report an all measures required by Paragraph 99.

The State is required to report publicly on all data collected pursuant to this section. Other provisions in the section require LDH to collect data regarding mortalities, critical incidents, and the availability and quality of community-based services. In August 2021, LDH released a needs assessment for individuals in the Target Population. The needs assessment provided data on the utilization of community-based services, including the number of individuals in the Target Population who received various community-based services. The findings from the initial needs assessment found:

- A greater proportion of the group that had transitioned to the community received support services (ACT, CPST, and PSR) compared to the SMI population as whole.

- The most utilized services for both the transitioned and diverted group were:
    - Assertive Community Treatment (26% and 17%, respectively).
    - PSR (32% and 7%, respectively)
- There were certain services that received a much smaller proportion of behavioral health services: crisis intervention, SUD screening and treatment.

In the sixth report, the State reported its intent to collect information on the utilization of community services by individuals who were transitioned or diverted. In the sixth report, the SME recommended the State develop these same reports in the third quarter (ending March 30th) 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.

The State has provided the SME with this information. The SME reviewed this information against the information provided in the needs assessment from 2021. A review of this information indicates:

- There is a significant portion (55-58%) of individuals who are not receiving Medicaid behavioral health services. While some of these individuals may have Medicare as a payer, this is higher than what would be expected.
- There was a marked decrease in the percent of individuals receiving other MHR services (CPST or PSR) for both transitioned and diverted individuals.
- The percent of individuals transitioned from NFs continue to receive ACT at similar levels, although there was a marked decline in the percent of individuals who were diverted and received ACT.
- The percent of individuals receiving outpatient services from a licensed behavioral health practitioner was consistent with the information from the needs assessment.
- There was a marked increase in the percent of individuals (transitioned and diverted) who received preventative physical health care.
- There were significant decreases in the percent of individuals (diverted and transitioned) utilizing Eds and inpatient services (general and behavioral health), although there were significant differences among regions regarding this utilization. Some regions experienced higher ED utilization (region 7) and inpatient utilization (Region 9) for both medical and behavioral health admissions.

<u>Compliance Assessment</u>

- LDH has begun an annual effort to publish the Quality Matrix (which contains some of the data and performance measures required by Paragraph 99) and other information regarding the utilization of services by individuals in the Target Population.
- The State has processes in place to review the quality of certain services (e.g., ACT and IPS).
- The State has yet to review and analyze the data to identify trends that would lead to individuals not receiving services. The fact that over one-half of the individuals transitioned or diverted from NFs are not receiving necessary services is problematic.

<u>Recommendations</u>

- LDH should perform additional analysis on these individuals' needs and the reasons individuals with behavioral health needs are not getting services.

- LDH should track service utilization for individuals who are diverted more frequently, to determine if CCM is improving identification of behavioral health needs and subsequent utilization of these services.
- LDH should implement the recommendations in paragraph 95 regarding continued strategies for reducing ED and inpatient utilization.
- LDH should timely publish its mortality review reports, and all other reporting required by this Section, on an annual basis.

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.

Compliance Rating: Not Met

Discussion and Analysis

While there are some instances for information sharing across agencies (e.g., LDH and LHC), the State has not developed a formal process for all relevant State agencies to access data collected under this Agreement. Including other State agency input as part of its larger quality assurance framework will be immensely helpful if identifying additional issues and potential solutions that other state agency partners (e.g., OCDD) have implemented in a similar effort for individuals in a large ICF/DD.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has not created a process for sharing information across State agencies.

Recommendation

- The State should identify the key state agencies that are most likely involved and impacted by the My Choice Program. At a minimum, this would include the Office of Medicaid, OCDD, and LHC.
- The State should identify how to best use this data to make programmatic and policy decisions—what are the key decision points OAAS and OBH need to discuss with their partners.
- The State should implement an agency-specific strategy to share and discuss this information.

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.

Compliance Rating: Not Yet Rated

Conclusion

This is the first compliance report from the SME regarding the My Choice Program. As this report indicates, there are many areas where the State has undertaken significant activities to meet the intent of specific paragraphs and are in partial compliance or are in compliance with the Agreement. In other instances, the State has not met the intent of the requirements set forth in various paragraphs. It should be noted these paragraphs are essential to the Agreement, such as transitions, diversions, and implementation of new services.

The recommendations in this report provide potential strategies for LDH to improve the areas that are not met or partially met. The major areas of focus for the next reporting period should include:

- Continuing to increase the number of individuals who will be transitioned over the next six months.
- Developing a renewed approach for increasing the number of diversions and therefore decreasing the Target Population still in NFs. This will be critical for LDH to successfully comply with this Agreement and not add individuals to the Master List.
- Developing rapid referral and transition efforts for individuals identified through this new in-reach process who have expressed a desire to transition.
- Developing better acumen of TCs and CCMs to identify and include services that truly integrate individuals into the community. The State has developed services that could assist in this endeavor, but there are few, if any, individuals in the Target Population referred for these services. The State has to create the demand for these services through better assessments, plans of care, and referrals to these services.
- Continuing efforts to monitor the implementation of new services, including crisis services, community case management, and personal care services.
- Tracking the Housing Plan to ensure units/voucher opportunities are being developed consistent with this plan, and that opportunities are offered to and accepted by the Target Population.

Requirement		Proposed Data Measure	Methodology	Quarter 1 January-March 2021	Quarter 2 April-June 2021	Quarter 3 July-September 2021	Quarter 4 October - December 2021
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.	33/38 87%	38/50 76%	45/57 79%	62/74 84%
	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	35/38 92 %	44/50 88%	49/57 86%	69/74 93%

Requirement		Proposed Data Measure	Methodology	Quarter 1 January-March 2021	Quarter 2 April-June 2021	Quarter 3 July-September 2021	Quarter 4 October - December 2021
2. Referrals to, admission and readmission to, diversion from, and length of stay in nursing facility	2.a	Referral to nursing homes- Nursing Facility Admission Request	Number of persons that request level 1 admission to Nursing Facility	8665	9147	8895	9084
	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)	205 2%	748 8%	229 3%	488 5%
	2.c	PASRR Outcome Trends	Independent Evaluations vs. desk review	Indep Eval 961 Total Level II Reviews 1595	Indep Eval 1019 Total Level II Reviews 2004	Indep Eval 772 Total Level II Reviews 1443	Indep Eval 1120 Total Level II Reviews 1897
	2.d	PASRR Outcome Trends	Total Resident Reviews--# of Resident Reviews conducted (# resident reviews)	529	779	708	757
	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)	66	204	66	151
	2.f	PASRR Level II Service Recommendations	Percent of PASRR determinations that recommended referral to Specialized Behavioral Health Services (# referred SS/# approved)	74%	78%	85%	90%
	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)	3 2%	38 6%	15 10%	26 7%
3. Person Centered Planning, Transition	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:	36/38 95%	47/50 94%	55/57 96%	71/74 96%

Requirement		Proposed Data Measure	Methodology	Quarter 1 January-March 2021	Quarter 2 April-June 2021	Quarter 3 July-September 2021	Quarter 4 October - December 2021
Planning, and Transitions from Nursing Facilities			# of transitioned members who report that they understand their plan of care/treatment plan/total # of transitioned members interviewed.				
	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.	35/38 92%	46/50 92%	55/57 96%	72/74 97%
	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.	35/38 92%	46/50 92%	55/57 96%	68/74 92%
	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.	35/38 92%	42/50 84%	51/57 89%	69/74 93%
	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]				

Requirement		Proposed Data Measure	Methodology	Quarter 1 January-March 2021	Quarter 2 April-June 2021	Quarter 3 July-September 2021	Quarter 4 October - December 2021
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 = 19 individuals **<u>Categories:</u>** **Falls:** 5 **Maj Medical:** 19 **Maj Injury:** 0 **Maj Illness:** 1 **Maj Behavioral Incident:** 0 **Protective Services:** 3 **Death:** 0 **Other (loss of home):** 0 **Other (legal involvement):** 1	# of people that had CIRs = 14 individuals **<u>Categories:</u>** **Falls:** 6 **Maj Medical:** 12 **Maj Injury:** 1 **Maj Illness:** 0 **Maj Behavioral Incident:** 2 **Protective Services:** 1 **Death:** 0 **Other (loss of home/risk of eviction):** 2 **Other (legal involvement):** 2	# of people that had CIRs = 22 individuals **<u>Categories:</u>** **Falls:** 5 **Maj Medical:** 20 **Maj Injury:** 0 **Maj Illness:** 0 **Maj Behavioral Incident:** 0 **Protective Services:** **Death:** **Other (loss of home):** 5 **Other (legal involvement):** 0	# of people that had CIRs = 35 individuals **<u>Categories:</u>** **Falls:** 15 **Maj Medical:** 29 **Maj Medication Issue:** 2 **Maj Injury:** 0 **Maj Illness:** 0 **Maj Behavioral Incident:** 8 **Protective Services:** 1 **Death:** 2 **Other (loss of home):** 0 **Other (legal involvement):** 0
				ER visits: 8 Hospitalization: 11 Psyc Admission: 3	ER visits: 10 Hospitalization: 7 Psyc Admission: 1	ER visits: 5 Hospitalization: 14 Psyc Admission: 1	ER visits: 18 Hospitalization: 17 Psyc Admission: 4
	4.b	Number and percent of referrals reported to protective service agency for abuse, neglect, and exploitation	Number of abuse, neglect, exploitation referrals made	3	1	0	1
	4.c	Number and percent of death investigations that were completed	Number of death investigations that were completed/ Total number of death investigations	3	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	2	0	0	0
	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	Self-report- Interviews with TP members done by TCs:	35/38 92%	39/50 78%	49/57 86%	57/74 77%

Requirement		Proposed Data Measure	Methodology	Quarter 1 January-March 2021	Quarter 2 April-June 2021	Quarter 3 July-September 2021	Quarter 4 October - December 2021
		that they have not experienced any major incidents	# of transitioned TP reporting no major 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	37/38 97%	47/50 94%	56/57 98%	72/74 97%
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	36/38 95%	42/50 84%	51/57 89%	67/74 91%
	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	36/38 95%	45/50 90%	52/57 91%	66/74 89%
	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	3/38 8%	10/50 20%	13/57 23%	10/74 14%
	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)					

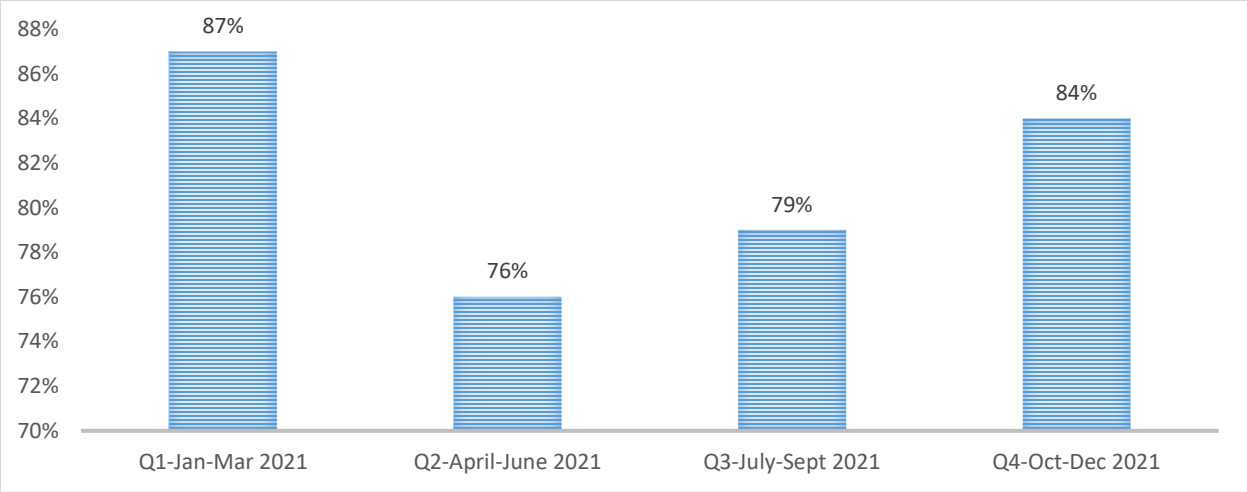
Requirement		Proposed Data Measure	Methodology	Quarter 1 January-March 2021	Quarter 2 April-June 2021	Quarter 3 July-September 2021	Quarter 4 October - December 2021
6. Stability	6.a	Number and percent of transitioned members reporting stability in housing	Self-report- Interviews with TP members done by TCs: # of transitioned members reporting stability in housing /total # of transitioned members interviewed	35/38 92%	45/50 90%	54/57 95%	72/74 96%
	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	36/38 95%	46/50 92%	55/57 96%	69/74 92%
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	28/38 74%	38/50 76%	42/57 74%	62/74 84%

[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.

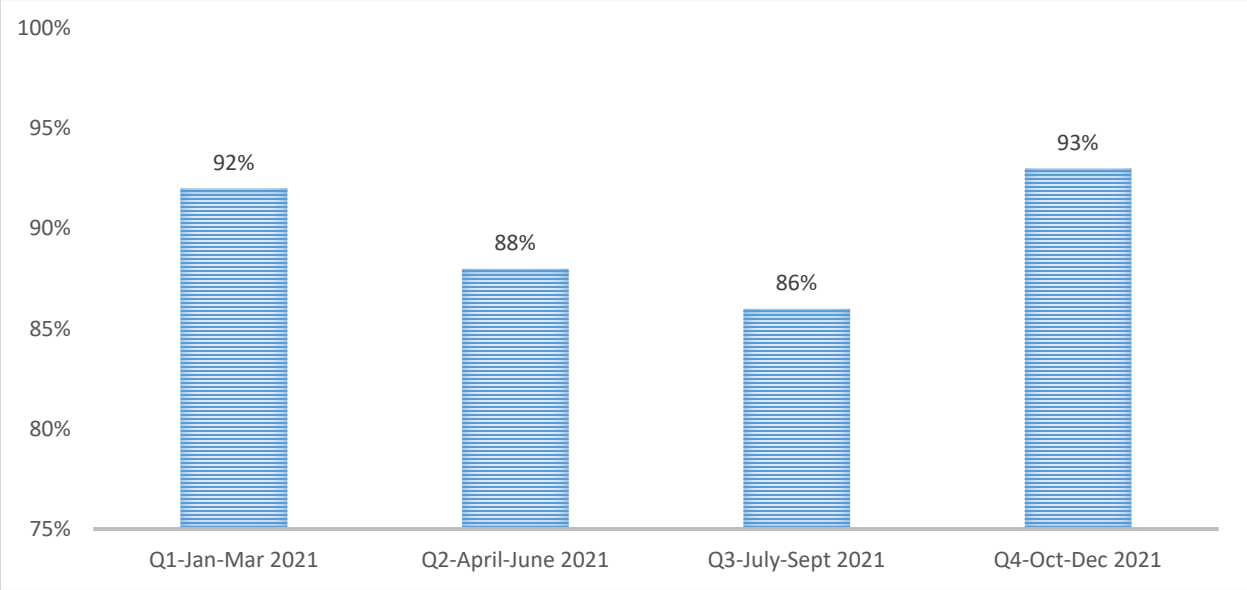
[2] 2.g-OBH has identified changes needed to their system in order to be able to begin reporting this data. In the absence of those system changes the data is not able to be reported for this quarter.

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.

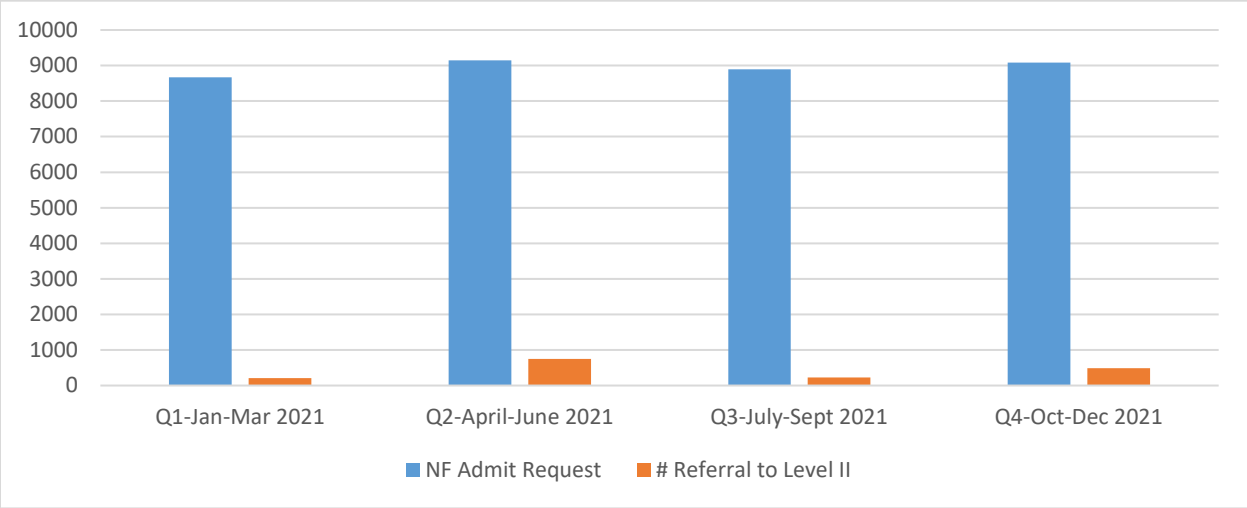


Percent of transitioned members reporting that they are receiving the services they need.



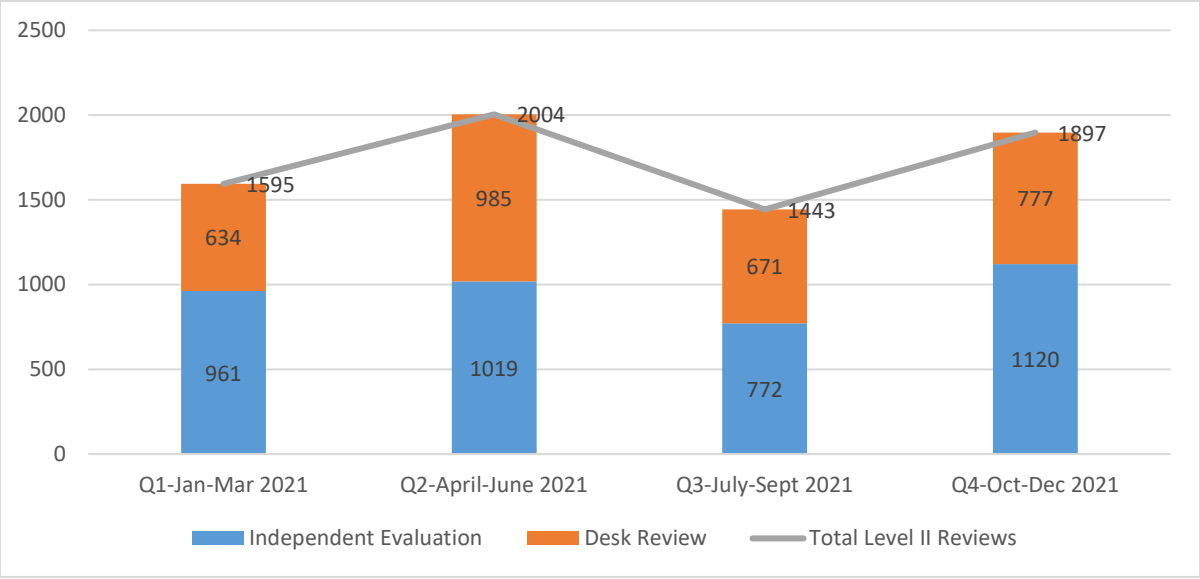
Referrals to, admission and readmission to, diversion from, and length of stay in nursing facility

PASRR Outcome Trend: Number of NF Admissions referred for PASRR Level II (OBH PASRR Level II Data)



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

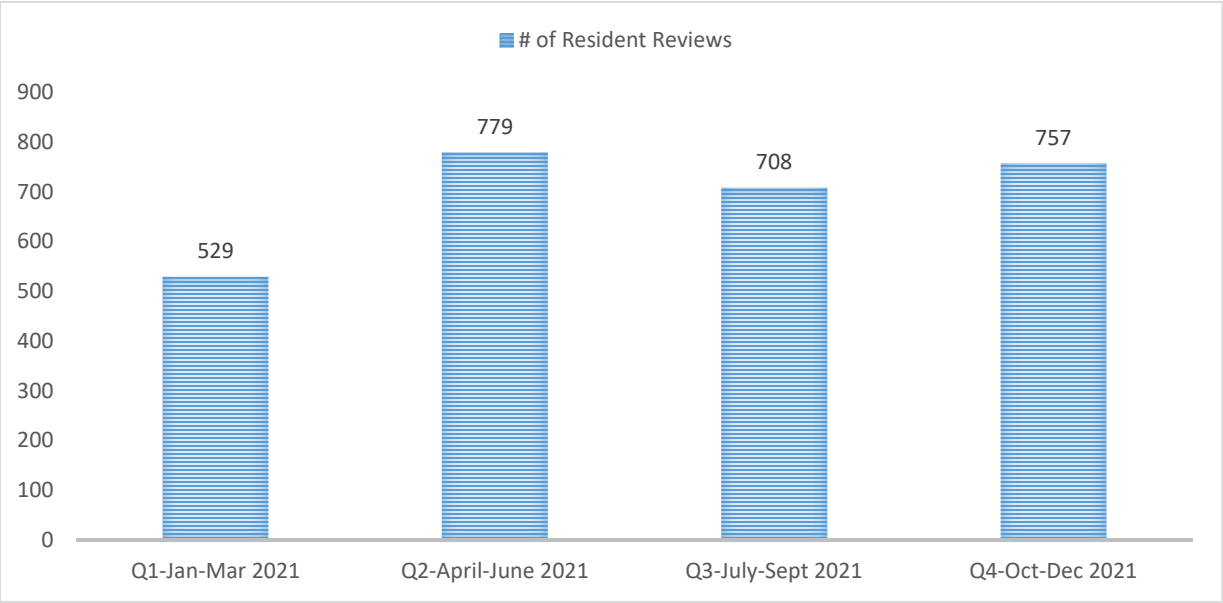
Total # of all types PASARR Level II reviews broken down by those conducted by Independent Evaluation (face to face) verses Desk Review



MY CHOICE LA 2021 DATA

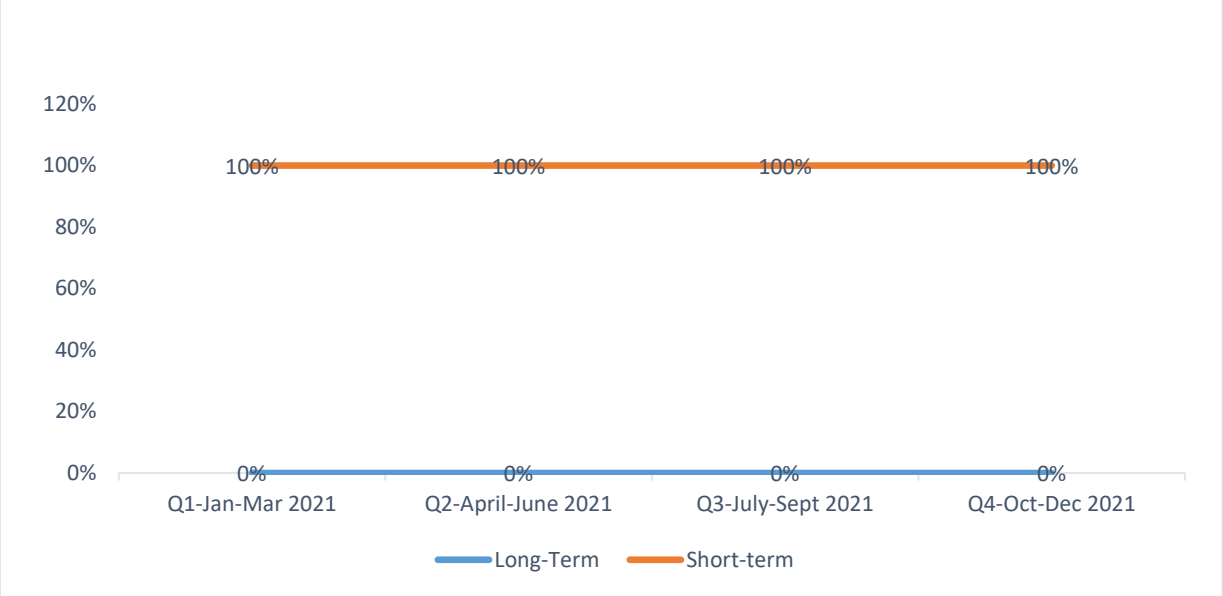
PASARR Outcome Trends – Total Resident Reviews

# of Resident Reviews conducted related to Change in Condition



PASARR Outcome Trend – NF Placement Short Term v Long Term

% of PASARR determinations of NF Placement that resulted in Short Term versus Long Term placement



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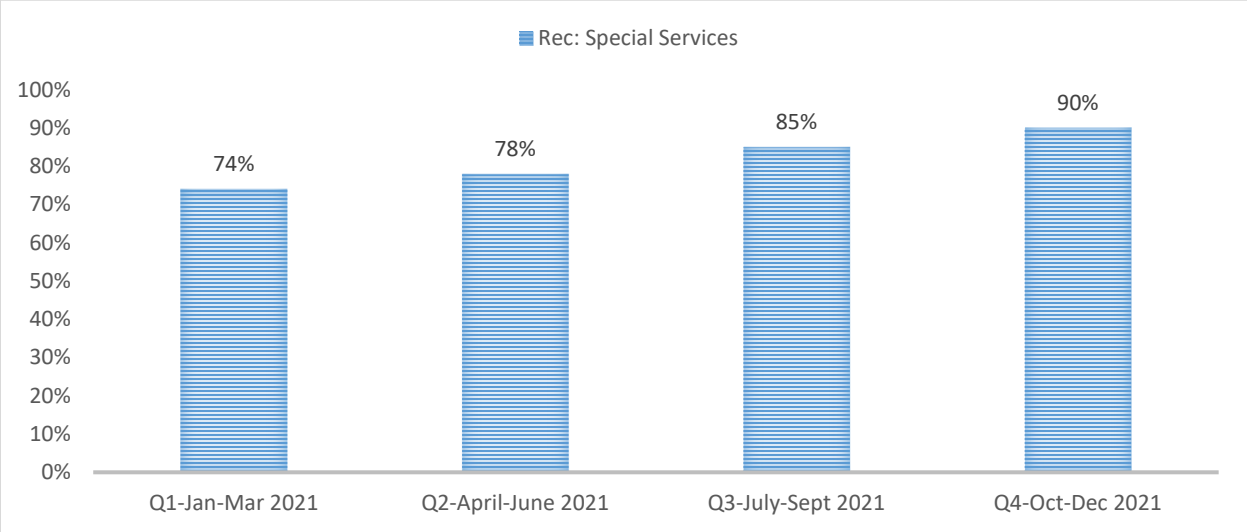
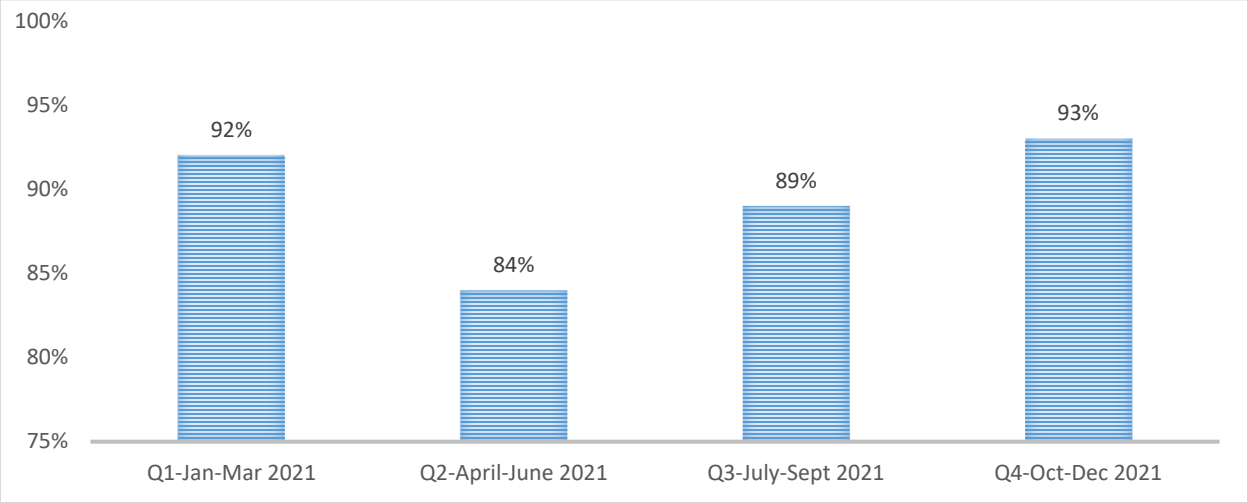
PASARR Outcome Trends – Recommended for Special Services (SMI)

% of PASARR determinations that recommended referral to Special Services



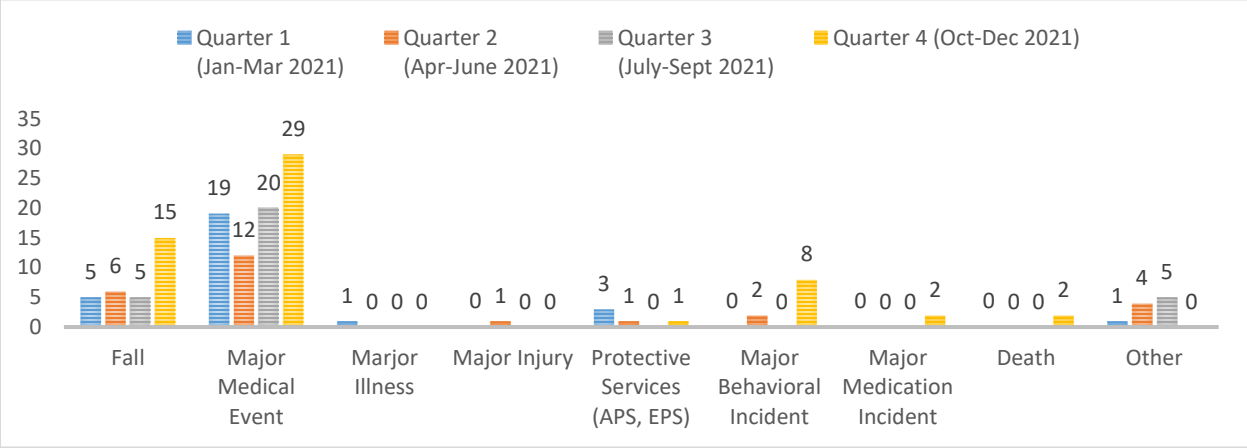
Person Centered Planning, Transition Planning, and Transitions from NF

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

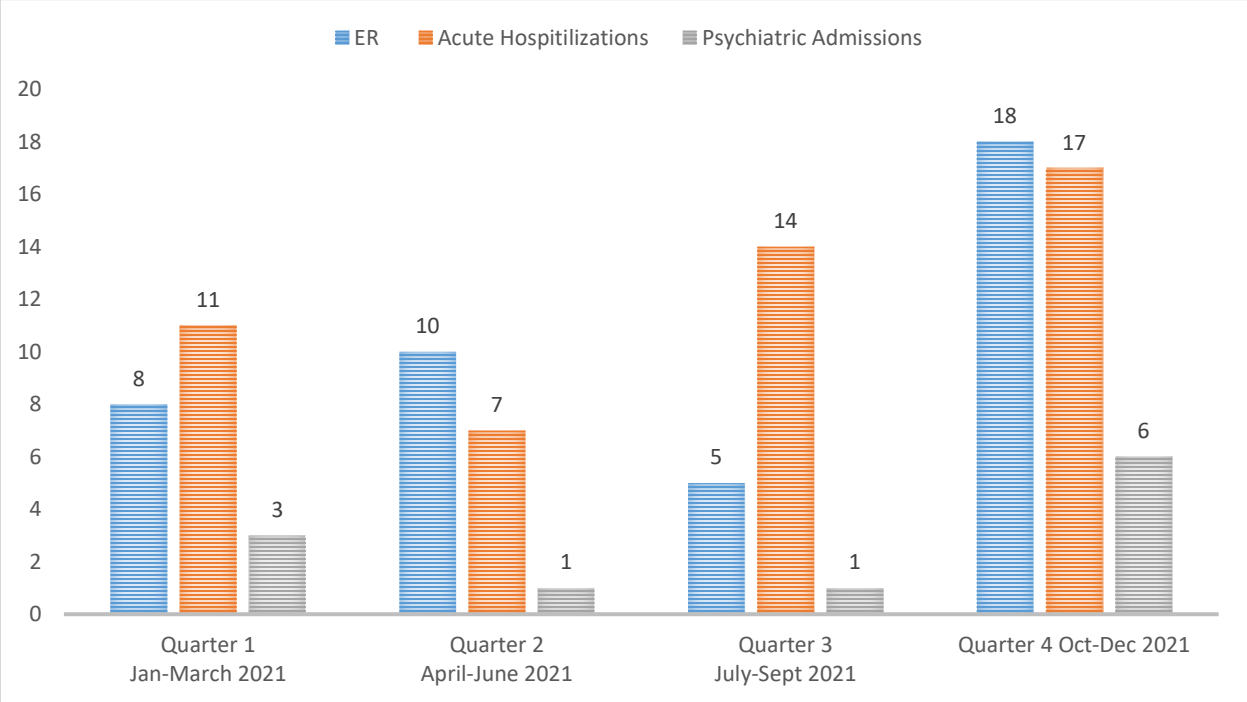


Safety and Freedom from harm

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.



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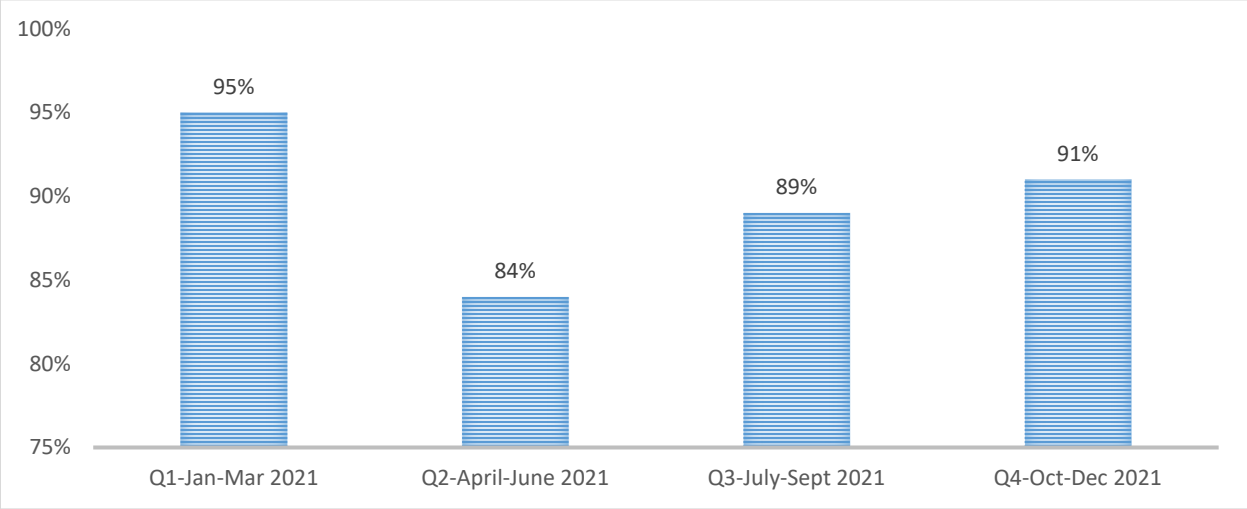
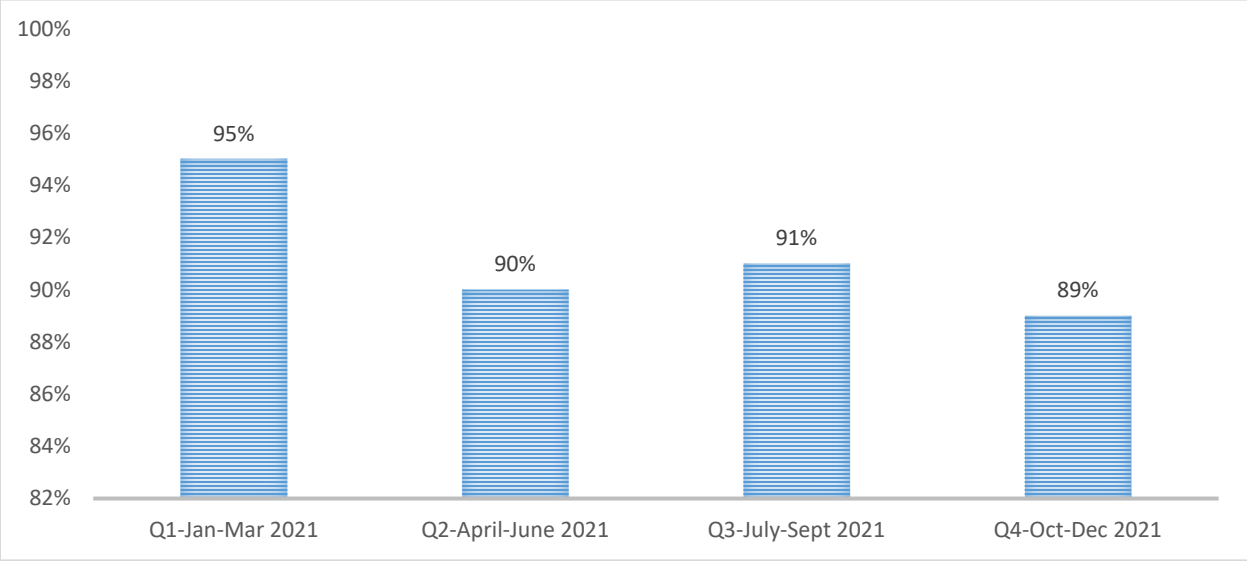
Physical and mental health wellbeing and incidence of health crisis

Percent of transitioned members reporting good physical and mental health.

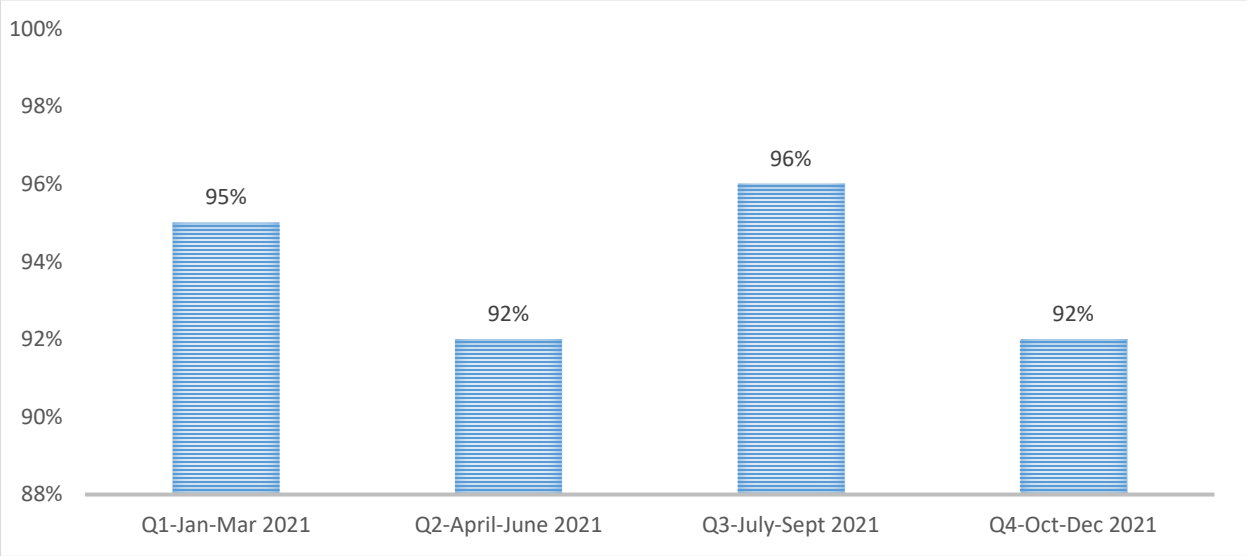


Percent of transitioned members reporting independence with taking care of themselves physically.



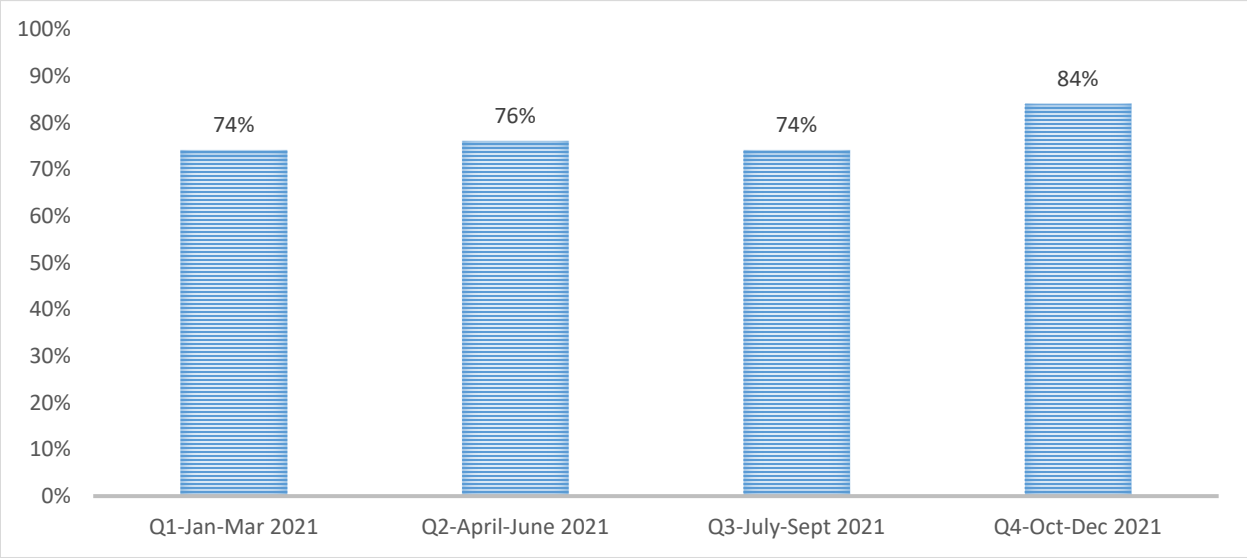
Stability

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



LEVEL OF CARE	2020 Q4 Statewide Total	2021 Q1 Statewide Total	2021 Q2 Statewide Total	2021 Q3 Statewide Total	2021 Q4 Statewide Total
Assertive Community Treatment (ACT)	48	45	45	45	45
Community Psychiatric Support and Treatment (CPST)	410	406	398	394	391
Crisis Intervention (CI)	399	389	380	380	386
Psychosocial Rehabilitation (PSR)	415	410	392	383	383
ASAM Level 1	145	155	160	168	168
ASAM Level 2.1	144	145	155	158	168
ASAM Level 2-WM	37	33	30	29	30
Psychiatric Outpatient (Agency/Facility) – Prescribers (Psychiatrist, Medical Psychologist, Nurse Practitioner (psychiatric specialty) and Clinical Nurse Specialist (psychiatric specialty)	813	818	828	856	858
Psychiatric Outpatient (Agency/Facility) – Non-Prescribers (LAC, LCSW, LMFT, LPC, Psychologist)	2476	2526	2451	2497	2461
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	56	57	57	53	53
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	656	642	621	634	633
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	155	149	144	120	118
Psychiatric Outpatient Licensed Professional Counselor (LPC)	948	938	947	942	947
Psychiatric Outpatient Medical Psychologist	28	31	30	36	38
Psychiatric Outpatient Psychologist	198	188	181	185	185
Psychiatric Outpatient Psychiatrist	392	377	369	383	381

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 2021 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)	12	5	2	6	2	3	9	3	3
Community Psychiatric Support and Treatment (CPST)	87	62	15	33	18	23	71	55	27
Crisis Intervention (CI)	91	58	17	34	16	23	65	57	25
Psychosocial Rehabilitation (PSR)	87	58	17	33	17	23	68	53	27
ASAM Level 1	27	35	6	15	11	13	20	33	8
ASAM Level 2.1	25	31	6	18	10	14	18	37	9
ASAM Level 2-WM	7	11	1	4	1	0	0	1	5
Psychiatric Outpatient (Agency/Facility) – Prescriber (Psychiatrist, Medical Psychologist, Nurse Practitioner, Clinical Nurse Specialist)	388	247	161	152	128	129	157	126	225
Psychiatric Outpatient (Agency/Facility) – Non-Prescriber (LAC, LCSW, LMFT, LPC, Psychologist)	889	680	327	356	251	295	439	365	494
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	12	13	7	5	4	5	3	6	5
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	265	146	21	67	24	36	41	15	104
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	29	11	10	5	11	7	19	24	16
Psychiatric Outpatient Licensed Professional Counselor (LPC)	275	147	68	81	56	34	152	129	98
Psychiatric Outpatient Medical Psychologist	12	11	1	3	0	1	4	3	8
Psychiatric Outpatient Psychologist	113	38	4	11	6	9	12	6	21
Psychiatric Outpatient Psychiatrist	243	83	32	25	21	22	56	13	33

**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: (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 2021 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)	12	5	2	6	2	3	9	3	3
Community Psychiatric Support and Treatment (CPST)	89	63	14	31	18	22	71	58	28
Crisis Intervention (CI)	93	58	15	33	15	23	67	50	26
Psychosocial Rehabilitation (PSR)	86	61	15	31	17	24	67	55	27
ASAM Level 1	27	29	5	18	11	12	18	32	9
ASAM Level 2.1	28	36	3	15	14	15	15	33	8
ASAM Level 2-WM	10	8	1	3	1	0	0	1	5
Psychiatric Outpatient (Agency/Facility) – Prescriber (Psychiatrist, Medical Psychologist, Nurse Practitioner, Clinical Nurse Specialist)	445	241	157	131	139	128	147	123	216
Psychiatric Outpatient (Agency/Facility) – Non-Prescriber (LAC, LCSW, LMFT, LPC, Psychologist)	967	670	313	328	229	294	428	378	475
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	11	14	4	4	2	3	4	9	7
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	253	150	24	59	25	29	40	19	108
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	28	12	7	6	11	7	19	26	16
Psychiatric Outpatient Licensed Professional Counselor (LPC)	265	143	60	77	53	37	146	144	110
Psychiatric Outpatient Medical Psychologist	15	7	1	5	0	4	4	3	6
Psychiatric Outpatient Psychologist	122	35	3	14	4	8	11	6	19
Psychiatric Outpatient Psychiatrist	214	81	30	30	21	26	54	31	34

**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 2021 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)	12	5	2	6	2	3	9	3	3
Community Psychiatric Support and Treatment (CPST)	89	57	17	34	18	28	73	54	28
Crisis Intervention (CI)	86	56	18	32	16	23	68	55	26
Psychosocial Rehabilitation (PSR)	89	59	19	31	16	27	72	53	26
ASAM Level 1	23	29	6	19	11	11	16	32	13
ASAM Level 2.1	19	36	2	17	13	13	9	34	12
ASAM Level 2-WM	5	8	3	4	1	1	2	0	6
Psychiatric Outpatient (Agency/Facility) – Prescriber (Psychiatrist, Medical Psychologist, Nurse Practitioner, Clinical Nurse Specialist)	446	238	162	140	134	123	120	108	211
Psychiatric Outpatient (Agency/Facility) – Non-Prescriber (LAC, LCSW, LMFT, LPC, Psychologist)	908	689	326	359	261	307	426	370	480
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	10	32	3	14	7	6	4	8	18
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	274	142	26	65	18	34	42	18	94
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	32	13	8	9	11	7	28	24	18
Psychiatric Outpatient Licensed Professional Counselor (LPC)	298	154	61	82	50	31	140	133	113
Psychiatric Outpatient Medical Psychologist	12	9	1	5		1	2	2	5
Psychiatric Outpatient Psychologist	104	32	2	12	5	6	13	7	17
Psychiatric Outpatient Psychiatrist	197	79	23	33	22	24	66	24	26

**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 2021 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)	12	5	2	6	2	3	9	3	3
Community Psychiatric Support and Treatment (CPST)	96	61	19	33	19	29	63	60	26
Crisis Intervention (CI)	93	61	18	32	15	25	65	56	24
Psychosocial Rehabilitation (PSR)	94	60	20	36	15	27	69	60	29
ASAM Level 1	27	25	6	22	10	8	16	28	13
ASAM Level 2.1	19	29	4	20	11	7	11	33	11
ASAM Level 2-WM	11	8	3	3	1	0	0	1	6
Psychiatric Outpatient (Agency/Facility) – Prescriber (Psychiatrist, Medical Psychologist, Nurse Practitioner, Clinical Nurse Specialist)	451	225	150	133	120	125	150	101	187
Psychiatric Outpatient (Agency/Facility) – Non-Prescriber (LAC, LCSW, LMFT, LPC, Psychologist)	974	691	324	354	250	297	455	366	474
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	8	17	3	12	5	3	4	7	10
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	264	142	26	69	27	39	41	25	100
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	34	13	7	7	11	7	36	25	17
Psychiatric Outpatient Licensed Professional Counselor (LPC)	288	139	67	92	48	36	136	135	121
Psychiatric Outpatient Medical Psychologist	13	10	1	5	0	2	3	1	4
Psychiatric Outpatient Psychologist	116	31	3	12	4	7	14	7	17
Psychiatric Outpatient Psychiatrist	225	73	35	34	23	27	45	30	48

**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 2021 Q4	Number	Percentage
Providers with appointment available within one hour for emergent care	872	92%
Providers with appointment available within 48 Hours (two calendar days) for urgent care	866	91%
Providers with appointment available within 14 calendar days for routine care	959	92%

Appointment Availability 2021 Q3	Number	Percentage
Providers with appointment available within one hour for emergent care	1066	76%
Providers with appointment available within 48 Hours (two calendar days) for urgent care	1050	81%
Providers with appointment available within 14 calendar days for routine care	1162	87%

Appointment Availability 2021 Q2	Number	Percentage
Providers with appointment available within one hour for emergent care	1033	91%
Providers with appointment available within 48 Hours (two calendar days) for urgent care	1024	88%
Providers with appointment available within 14 calendar days for routine care	1095	86%

Appointment Availability 2021 Q1	Number	Percentage
Providers with appointment available within one hour for emergent care	756	93%
Providers with appointment available within 48 Hours (two calendar days) for urgent care	752	91%
Providers with appointment available within 14 calendar days for routine care	842	88%

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.