

LA-DOJ Subject Matter Expert (SME) Report

COVERING THE PERIOD OF 7/1/2020 THROUGH 12/31/2020

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I. Introduction

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

The Agreement sets forth the requirement for a Subject Matter Expert (SME). The SME is to provide technical assistance to help the State comply with its obligations under the Agreement. The SME has various responsibilities, including analyzing and reporting data on the State's progress in complying with all sections of this Agreement. In addition, the SME is responsible for assessing the quality of community-based services for members of the Target Population (defined in the Agreement). The State engaged the Technical Assistance Collaborative in August of 2018 to perform the SME responsibilities. Every six months, the SME will draft and submit to the Parties a comprehensive public report on Louisiana Department of Health (LDH) compliance, including recommendations, if any, to facilitate or sustain compliance. This is the fourth SME report for the period of 7/1/2020 through 12/31/2020.

The State is required to create an Implementation Plan that describes the actions it will take to fulfill its obligations under the Settlement Agreement and establishes annual goals and targets for achieving the outcomes specified in the Agreement and Plan. In December 2019, the State submitted an Implementation Plan for Calendar Year (CY) 2020.¹ In this plan, the State set forth various tasks that LDH was to accomplish during this period. The plan is divided into six subsections, which contain the associated goals: (1) Transition/Post-transition Activities, (2) Work Flow and Tracking System Development, (3) Diversion Activities, (4) Community Support Services Development, (5) Quality Assurance and Continuous Improvement, and (6) Stakeholder Engagement, Outreach, and In-Reach.

The Target Population for the Agreement is comprised of (a) Medicaid-eligible individuals over age 18 with 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. In June 2018, there were 3,580 individuals in the Target Population.

One of the State's initial activities was to create a Master List of individuals that are in Nursing Facilities who are members of the Target Population. The Master List includes individuals that have been identified as part of the Target Population residing in a nursing facility who have not expressed an interest (either they declined to be transitioned or they had not yet been engaged by LDH to discuss interest in moving). The State's process for developing and maintaining this list is discussed in Section III, Paragraph 26. In the previous SME report there were 2,944 on the Master List.

Additionally LDH had identified a number of individuals in the Target Population who expressed an interest in moving to the community. Utilizing information from the Minimum Data Set (MDS) and

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

interviews with individuals in the Target Population, LDH identified individuals who were interested and likely candidates to transition. The MDS collects individual's preferences for discharge to the community. These individuals were placed on an Active Caseload list that was separate from the Master List. Individuals on the Active Caseload list were and continue to be assigned to a Transition Coordinator who will begin the engagement and transition process. In the last SME report there were 936 individuals on the Active Caseload List.

As of December 2020, 2,814 individuals are on the Master List. An additional 855 individuals are on the active caseload list. Since 2018, LDH has transitioned 143 individuals from nursing facilities. As of this report, 38 had transitioned in CY 2020. In addition, there were 342 individuals that were diverted from nursing facilities in CY 2020. Ninety (90) individuals were seeking admission to a nursing facility, 252 were homeless with a SMI and were at high risk of NF admission. In CY 2021 the State aims to transition approximately 219 individuals (a 119% increase from the 2020 projections). The State also aims to divert an additional 194 individuals from NFs in CY 2021. These transition and diversion aims are laudable for this coming year. However, more diversions and transitions will need to be projected and occur in future years to meet the goals of this Agreement. As described in more detail in the report, the SME is recommending a more robust in-reach strategy that would allow the State to identify and transition individuals in NF. A specific strategy recommended by the SME for this year is for LDH to contact all individuals on the Master List within the next calendar year. As indicated later in this report, more robust in-reach would include the addition of peer specialist to the State's in-reach and transition efforts and during the first few months of CY 2021 expanded use of virtual in-reach during the pandemic.

While there were many tasks for the State to complete during this reporting period, several key tasks are worth noting. The State made progress on the activities discussed below, despite the challenges presented by the ongoing COVID-19 pandemic. Below is a summary of activities the State was to complete during the reporting period, the activities the State undertook, and activities for the next reporting period:

(1) Transition / Post-Transition Activities:

- The State was responsible for enhancing efforts to increase the number of individuals in the Target Population who are successfully transitioned from NFs, based on the targets set forth in the 2020 Implementation Plan. During this period, the State was supposed to:
 - Transition an additional 100 individuals from NFs in FY 2020;
 - Continue efforts to identify and remove transition barriers through a cross-agency process designed to identify and address systemic barriers that impede or prevent transitions;
 - Finalize and deliver person centered thinking and planning training;
 - Identify and implement training for transition coordinators;
 - Implement an interim case management strategy to ensure that individuals remain in the community and receive the services and supports necessary to successfully achieve the goals in their Individualized Transition Plans (ITPs);
 - Finalize an implementation strategy for the provision of case management services (following the interim process), including identifying a Medicaid authority to support the new case management model and developing a plan for implementing this strategy with specific timeframes; and
 - Revise the transition planning and transition monitoring tools and provide the necessary training to the Transition Coordinators (TCs) and others who will be using these tools.
- Since the last report, the State has made progress in these areas:

- Continued the interim case management strategy to ensure that individuals remain in the community and receive the services and supports necessary to successfully achieve the goals in their Individualized Transition Plans (ITPs);
- Revised transition and diversion projections for CY 2020 after evaluating the challenges presented by COVID-19 to LDH and to NF residents. Initially the State had projected that 100 individuals would be transitioned in CY 2020 and 156 individuals would be diverted from NF admissions. The State has revised its transition projections to 38 individuals, not at a rate consistent with the annual targets in the CY 2020 Plan, nor with the risk presented to individuals living in congregate nursing facilities during the pandemic. However, the State did revise its projections for diversions in CY 2020 from 156 to 342. This major increase was due to the number of individuals who were homeless and with an SMI who were diverted into supportive housing opportunities that are discussed later in this report.
- Developed a methodology in order to set targets regarding the number of individuals who will be transitioned and diverted in CY 2021 (219 individuals will be transitioned and 194 will be diverted);
- Developed a strategy for enhanced in-reach efforts to meet those targets;
- Continued efforts to identify and remove transition barriers through the Service Review Panel (SRP) in order to identify and address systemic barriers that impede or prevent transitions; and
- Hired and on-boarded a My Choice Louisiana Peer Support Specialist Program Monitor to work with the transition coordinators on transition and in-reach activities.
- Significant areas of focus for the next 6 months include:
 - On board regionally based peer support specialists, including policies and procedures for these positions, hiring these individuals, and providing the necessary training and supports.
 - Continue to transition individuals from NFs to meet the target for FY 2020 of 219 individuals.
 - Continue efforts to evaluate status of transitions, identify barriers and opportunities to improve the number of transitions into the community.

(2) Work Flow and Tracking System:

- The State was to finalize the necessary documents for the vendors that will create the longer-term tracking system, including specifications for tracking members of the Target Population that are diverted from NFs.
- LDH was to test and go live with the My Choice tracking module that was created in the LDH Office of Aging and Adult Services (OAAS) Participant Tracking System (OPTS) that collects enhanced information on transitions.
- LDH was to refine existing and create new reports in OPTS for quality assurances purposes as well as internal management reports.
- Since the last report, the State has made progress in these areas:
 - Developed proposed reports for tracking Pre-Admission Screening and Resident Review (PASRR) Level II evaluations to comport with the Agreement.
 - Refined and created additional reports required for quality improvement activities as well as internal management reports.

- Developed the draft RFP for the vendor for the longer-term tracking system, including a paperless system.
- Significant areas of focus for the next 6 months include:
 - The State should solicit applications for vendors that will create the longer-term tracking system, including specifications for tracking members of the Target Population that are diverted from NFs.
 - LDH is to test and go live with the My Choice tracking module that was created in the LDH Office of Aging and Adult Services (OAAS) Participant Tracking System (OPTS) that collects enhanced information on transitions. This will include training for TCs and others regarding the new system.
 - Continue ongoing tracking efforts in SharePoint (until the new system is operational) and improve monitoring and consistent report creation across Office of Behavioral Health (OBH) and OAAS.
 - Modifying and implementing changes to the current PASRR Level II tracking system that will allow the State to collect and better report information that was required under the Agreement.

(3) Diversion Activities

- The State was to undertake various tasks to implement diversion activities specific to the Agreement, including:
 - Finalizing and operationalizing the Diversion Plan to track and monitor individuals that had been diverted with clear responsibilities for the State, Managed Care Organizations (MCOs), and providers to assist individuals who have been diverted from an NF.
 - Developing a data-use plan to help the State determine if the changes in the Pre-Admission Screening and Resident Review (PASRR) process over the past two years are effective and continue to make changes to the PASRR process based on data gathered and other relevant information.
 - Modifying PASRR data systems as needed, as well as enabling the ability to capture items identified in the data-use plan.
 - Continuing initial and annual PASRR Level II evaluations and to ensure these are conducted promptly upon referral.
 - Completing the analysis of the at-risk population, including individuals who are homeless, and develop a profile of individuals that would be considered at-risk for meeting the definition of the Target Population based on this analysis.
 - Continuing to make changes to the PASRR process, based on data gathered and other relevant information, as well as modifying PASRR data systems as needed.
 - Enhancing in-reach efforts to include peers working with TCs during the engagement and transition process. One position was funded in the FY 2021 budget set forth by the Governor, with additional positions throughout the State funded by Mental Health Block Grant funds.
- Since the last report, the State has made progress in these areas:
 - Developed an alternative strategy for the Diversion Plan. Originally, the Managed Care Organizations (MCOs) were to provide case management to assist individuals who have been diverted from an NF. While the MCOs provided case management to the diverted population (individuals where a PASRR Level II denied NF placement), the State and the SME had concerns regarding these efforts. The State will implement their longer-term diversion strategy in CY 2021.

- Identified the necessary reports and proposed modifications to the PASRR data systems as needed.
- Continued to perform PASRR Level II evaluations on a timely basis for initial NF admission requests and generated reports on the number of individuals needing an annual PASRR Level II.
- Diverted 277 individuals from being admitted to a nursing facility.
- Completed the data analytics and developed the profile for individuals that would be considered at risk for meeting the definition of the Target Population.
- Revised the original in-reach plan to more aggressively identify individuals on the Master List who are interested in transition as well as include the roles of peer support specialists in the in-reach efforts.
- Hired and on-boarded a My Choice Louisiana Peer Support Specialist Program Monitor to work with the transition coordinators on transition and in-reach activities.
- Significant areas of focus for the next 6 months should include:
 - Develop an approach that will track individuals in the Target Population who have been diverted from NF to determine if they received case management, specific services and supports received, and critical incident reports.
 - Ensuring that the staff that perform PASRR Level II evaluations offer community options in a meaningful way.
 - Finalize at risk criteria with MCOs and develop specific targets and strategies for diverting the at-risk populations.
 - Work with MCOs to identify and track members who meet the definition of the at risk Target Population.
 - Meet with the MCOs regarding these revised expectations regarding critical diversion functions for at-risk population.
 - Develop tracking/reporting for MCOs regarding the at-risk population.

(4) Community Support Services Development:

- The State was to undertake various tasks to develop the array of services that were specified in the Agreement. This included:
 - Finalizing the gaps analysis included in the implementation plan, including data collection regarding the needs of the Target Population and other individuals with SMI;
 - Continuing to implement the quality monitoring efforts provided by Assertive Community Treatment (ACT) providers;
 - Developing the necessary Medicaid authorities for peer services and undertaking the necessary steps to roll out the service;
 - Developing training regarding the new peer support service and possible changes in the process to credential/certify individuals who will provide this service based on information from the RFI responses; and
 - Dedicating more time and resources (including funding) for developing and implementing integrated day activities for the Target Population.
- Since the last report, the State has made progress in these areas:
 - Provided the necessary data to the contractor (Human Services Research Institute) to analyze for the gaps analysis.

- Continued efforts to monitor the quality of ACT providers with a focus on collecting and analyzing data to better identify teams that could step down individuals who may have benefited from this service.
 - Finalized contract language for the provision of case management to be delivered by community agencies in CY 2021 for the transitioned and diverted population.
 - Housed 252 members of the Target Population (diversion population who experienced homeless and SMI) through the Continuum of Care Program.
 - Trained TCs and MCO Case managers regarding person-centered planning approaches specific to individuals with SMI;
- Significant areas of focus for the next 6 months include:
 - Review and discuss the needs assessment report and findings, and develop the initial strategy to address those findings.
 - Engage ongoing dialogue with stakeholders about the crisis system development.
 - Obtain final budget approval for SFY21/22 (pending legislative process).
 - Continue meetings with MCOs, performing ongoing review of ACT providers and outcomes data.
 - Develop options for integrating employment activities within the service array including meeting with MCOs/service providers about how to use the Mental Health Rehabilitation (MHR) program to offer employment supports.
 - Evaluate available data collected from individuals in the Target Population to determine activities that match their interest.
 - Implement Peer Support Services.
 - Obtain HUD approval to prioritize the Target Population for Section 8 vouchers.
 - Review and approve MCO contracts with community case management agencies and develop a selection process for agencies providing community case management.
 - Develop the processes/procedures for linking members to community case management, authorizing services in the service plan, tracking level of care and plan of care timelines.
 - Develop the necessary service definitions and rules regarding personal care services for the Target Population who will need these services.

(5) Quality Assurance and Continuous Improvement

- The State was to undertake various tasks to develop and implement a quality assurance and continuous improvement strategy for the Target Population. This included:
 - Developing a quality assurance/improvement strategy that will include the indicators identified for the Agreement;
 - Continuing to create the reports on measures from the quality matrix and developing and posting public-facing reports on the LDH website; and
 - Implementing changes to the OBH mortality review process, given their new statutory authority to collect pertinent information that will provide better root cause analysis.
- Since the last report, the State has made progress in these areas:
 - Developed the quality assurance strategy, including a process to include stakeholders in the annual review of quality indicators developed for the purpose of the agreement.

- Continued to create the reports on measures from the quality matrix.
- Developed a more robust mortality review process, including protocols and processes for reporting deaths of Target Population members. Office of Behavioral Health (OBH) received the statutory authority necessary to obtain critical and timely information from medical providers regarding the cause of death.
- Significant areas of focus for the next 6 months include:
 - Implement the My Choice Mortality Review Committee process and structure.
 - Develop and post on the LDH website an annual report regarding the My Choice Program that includes annual measures.
 - Review and revise measures to determine what changes and additional measures should be considered.

(6) Stakeholder Engagement, Outreach, and In-Reach:

- There were several activities the State had proposed to undertake during this reporting period, including:
 - Developing a concrete strategy for peer in-reach efforts that includes a timeframe for involving peers in the in-reach process;
 - Developing an alternative strategy for in-reach efforts, especially with ongoing COVID-19 concerns, to individuals on the Master List that includes peers working with TCs during the engagement and transition process;
 - Developing a specific training schedule for providers for critical service set forth in the Agreement, including a master training schedule of topics across LDH and the MCO for providers who are service members of the Target Population; and
 - Creating and implementing a semi-annual communication plan for constituency groups beginning this next period.
- Since the last report, the State has made progress in these areas:
 - Developed an initial strategy to use peers in assisting Transition Coordinators (TCs) to enhance in-reach and education efforts for individuals on the Active Caseload list.
 - Gathered information from other states to enhance their in-reach and transition efforts during the pandemic and implemented telehealth strategies to contact members on the Active Caseload list.
- Significant areas of focus for the next 6 months include:
 - Finalize revisions to the in-reach plan for CY 2020 and beyond.
 - Develop targets for in-reach by the OAAS regional office staff, TCs, and Peer Support Specialists.
 - Continue to 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.
 - Aggressively identify self-advocates or individuals with personal lived experience to participate in committees and recruit them to attend meetings, and/or conduct targeted outreach.
 - Develop a specific training schedule for providers for critical services set forth in the Agreement, including a master training schedule of topics across LDH and the MCO for providers that are service members of the Target Population.

- Develop a schedule of outreach activities intended to provide public updates on implementation activities related to the DOJ Agreement, including semi-annual updates and information regarding the Agreement.

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

- Increasing the number of individuals to be transitioned from nursing facilities. As indicated in this report, LDH is proposing to transition 219 individuals in the Target Population in CY 2021. This represents a significant increase over both CY 2019 and CY 2020. LDH will need to do much work in this next reporting period to continue assessments and transition planning with members on the Active Caseload list that to meet that number. In addition, LDH will have to address how these transitions efforts will occur during the pandemic. While it is hopeful that these individuals will likely be some of the first to receive a vaccine to prevent COVID-19, LDH will need to implement virtual and other arrangements discussed in this report for the first few months of CY 2021. Valuable time will be lost if the State doesn't implement strategies identified in this report to have virtual conversations that can assist with transitions.
- Developing and implementing a strategy to contact individuals on the Master List to gauge their interest in moving from NFs. There are almost 3,000 individuals currently on the Master List. Therefore, this strategy will require that LDH contact approximately 250 individuals on the Master List on average each month. The State has developed a revised in-reach plan that will include additional staff resources, including peer support specialists to perform some of this in-reach. It will also be important for the State to evaluate the number and outcome of these contacts to determine whether additional resources (TCs and peer specialists) will be needed to assist with individuals who have been identified as interested in transition through this renewed effort.
- Developing an implementation strategy for the community case management benefit. While the community case management benefit will not go online until later in CY 2021, there are various activities that will help prepare the State, MCOs, and community providers for this launch, including: developing the assessment tool and plan of care template for community services, determining work flows for individuals in the diversion population, developing training for the community case management agencies, and developing the reimbursement methodology for these agencies.
- Continuing efforts to measure the quality of community services for Target Population members. During this reporting period, LDH will have collected a year's worth of information on the measures developed in early CY 2020. LDH should review the current measures to determine if they need to be modified (either the measure or the methodology) or removed. In addition, LDH should consider new measures for the Agreement. Specifically, LDH should meet with stakeholders to review the existing process and measures, and to solicit input regarding these and possible new measures.
- Contracting for the necessary tracking systems to meet the requirements of the Agreement. Specifically, the State should have the necessary systems to not only support their quality assurance efforts, but, more importantly, identify individuals in the Target Population within 3 days after admission into an NF.

It should be noted, the previous SME report requested data and other information from LDH to better understand the State's progress to meet their responsibilities under the Agreement. Over the past 6 months, the SME prioritized these requests, therefore some of these requests were deferred by the SME until this reporting period. These deferred requests are identified in the report.

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

II. Target Population

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

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

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

Paragraphs 24 through 26 are combined. As one of the initial activities, LDH created a Master List of individuals in NFs who are members of the Target Population. The State analyzed and reviewed data from the MDS and PASRR Level II reviews on individuals who were residing in NFs to create this Master List. The MDS is part of a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process involves a comprehensive, standardized assessment of each resident's functional capabilities and health needs. There were individuals whom the MDS identified had an SMI, but no PASRR Level II screening was performed to determine if they are a member of the Target Population. The State matched MDS data to PASRR Level II data to identify individuals who may have required a Level II screening but did not receive one. Based on these efforts, the State developed a referral system and prioritization to complete Level II screenings. During the last reporting period, the SME reviewed the criteria the State has developed to determine how an individual is identified to be included in the Master List. The criteria that have been developed list various pathways in which an individual is determined to meet the Target Population criteria, including: Medicaid enrollment, confirmed presence of an SMI through the PASRR Level II evaluation and ruling out if the individual has dementia. The criteria and pathways for determining eligibility for the Target Population, in the SME's opinion, provides a reasonable strategy for identifying individuals for the Agreement.

In the previous SME report 2,944 individuals were included in the Master List. As of December 2020, 2,814 individuals are on the Master List. An additional 855 individuals are on the active caseload list. Individuals on the active caseload list have been assigned to a Transition Coordinator who will begin the engagement process.

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

The SME requested information from the State regarding activities that have been completed to meet the requirements of this paragraph for the next reporting period. Per the conversation with the State, this request will be rolled over to the next SME Report.

III. Diversion and Pre-Admission Screening

29. *The State shall develop and implement a plan for a diversion system that has the capability to promptly identify individuals in the Target Population seeking admission to nursing facilities and provide intervention and services to prevent unnecessary institutionalization. The State's plan shall include, but not be limited to, development of services identified in Section VI [of the Settlement Agreement].*

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

- Persons with SMI who seek admission to an NF placement who meet NF Level of Care (LOC) criteria and for whom a PASRR Level II review recommends placement in the community;
- Persons with SMI who are admitted to an NF on a temporary basis and could be transitioned into the community within a short period (90 days);
- Individuals that are experiencing homelessness and have mental illness and/or a substance use disorder (SUD); and
- Persons with serious mental illness (SMI) who are at risk of avoidable hospitalizations, which will then place them at risk for subsequent nursing facility admission. This included individuals that were homeless and with serious mental illness (including individuals with co-occurring substance use disorders (SUD))².

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

Population	Projected Diversions	Actual Diversions
#1 Short Term Nursing Stays	6	N/A
#2 PASRR II Recommendation	120	55
#3 Experiencing Homelessness	30	252
Total	156	277

The total of the diversions for this past six months was greater than the projected diversions. This increase was due to a significant increase in the number of individuals that were identified as experiencing homelessness and having an SMI (Population #3). This increase was due to the pandemic and the State's

² <http://ldh.la.gov/assets/docs/MyChoice/DiversionPlan.pdf>, p. 10

efforts to test, triage, and aggressively house individuals that were homeless, preventing them from returning to congregate shelter settings. The State should be commended for these efforts. However, the SME is requesting information regarding these individuals during the next reporting period to determine if they had characteristics that were comparable to individuals in the PASRR Level II diversion population or the at-risk population discussed in paragraph 29 of the Agreement.

This increase in Population #3 offsets the lower number of individuals in Population #2, projected versus actually diverted. A major factor for lower actual diversions was the pandemic. The State, in its Appendix K emergency waiver from CMS, obtained approval to delay PASRR Level I and II evaluations for individuals seeking admission into nursing facilities from April through mid-June.

Finally, there were few individuals that were actually diverted and were in the first population (short term nursing facility stays). This is largely due to the current lack of a tracking system that allows LDH to identify individuals admitted to a nursing facility on a timely basis. In most instances, LDH TCs initially contact individuals who request a continued stay in a nursing facility. It is anticipated that the State will have a system in place during this next reporting period to identify individuals in the Target Population within 3 days of admission; however, after discussion with the State, the SME is recommending that these individuals be included in the counts and projections of individuals in the Target Population that were transitioned rather than diverted.

Over the past several months, LDH has developed diversion projections for Calendar Year 2021 that were based on similar methodology as that used in 2019. LDH identified the number of individuals who sought NF admission in CY 2020, but the PASRR Level II evaluation did not recommend NF placement. Given that PASRR Level IIs were completed for only 9 months this past year due to the pandemic, LDH had to annualize this number over a 12-month period for CY 2021.

In addition, LDH met internally to determine the number of individuals that had an SMI and were experiencing homelessness. Original projections for 2020 were determined prior to the COVID pandemic, considering both the vouchers available and prior experience at the time with outreach. Clarification received specific to the diversion category and the need for non-congregate shelters during the pandemic resulted in an increase in diversions for CY 2020. While the FY 2020 numbers were significantly higher than projected in CY 2019, a target of 50 individuals was projected for 2021 which is consistent with the number of Non-Elderly Disabled (NED) vouchers that would be available for this population. Therefore, the following projections are proposed for this coming year.

Population	Projected Diversions
#1 PASRR II Recommendation	144
#2 Experiencing Homelessness	50
Total	194

The SME agrees with the methodology the State has set forth for these two groups. However, the SME recommends that the State develop projections for the at-risk group (discussed in paragraph 29 of the Agreement) and track the number of individuals in CY 2021 that were admitted to an NF during the year. This will allow the State to develop a baseline to determine whether the MCO strategies that will be developed in CY 2021 for providing MCO case management for these individuals is effective in reducing the number of at-risk individuals being admitted into NFs.

As discussed in the prior SME report, during this reporting period LDH was to implement an interim case management strategy for individuals who were diverted from NFs based on a PASRR Level II evaluation. The interim strategy was to be implemented by either the Community Choice Waiver (CCW) Support Coordinator (if individuals qualify and agree to participate in the CCW) or by the case managers at one of five Managed Care Organizations (MCOs) if the individual does not qualify or agree to participate in the CCW. This interim strategy was to be in effect until LDH finalizes and implements the proposed community case management approach. To inform this interim strategy, LDH was analyzing data reports from the MCOs regarding their efforts to engage these individuals in case management. As discussed in paragraph 61, this data indicated that MCOs' engagement of these individuals was uneven and would take significant work on the State's part to improve these engagement strategies during the interim period. The State opted instead to continue efforts to design the longer-term community case management benefits for these individuals. These efforts are discussed below.

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

- Finalized an approach to provide case management services for individuals who are diverted, defined as individuals where the PASRR Level II evaluation did not authorize nursing facility placement. The State will develop case management services for these individuals that will be offered by community agencies (versus MCOs) in CY 2021. This approach is similar to the approach for the transitioned population discussed in Paragraph 61.
- Revised the MCO contract to include the Target Population and individuals at risk of being in the Target Population as a group of MCO beneficiaries with Special Health Care Needs (SHCN). This contract change will require MCOs to offer case management to these individuals, especially individuals who are at risk for becoming members of the Target Population.
- Revised existing reporting templates and processes that provide more detail regarding the MCOs' efforts to perform various case management functions (assessment and planning) as well as tracking whether individuals are receiving services identified through the PASRR Level II evaluation. These new reports should enhance LDH's efforts to more closely monitor the MCOs' endeavors to provide case management to individuals that are homeless and have an SMI but who are also in the at-risk population.
- Completed initial and ongoing analysis of data for the members of the Target Population who were diverted from NFs (using the PASRR Level II criteria). The SME assessment of this data is discussed later in this paragraph.
- Developed an initial at-risk definition based on information on the members of the Target Population who were admitted to a nursing facility in CY 2018. The information that was collected and analyzed indicated that individuals with SMI and are high-risk for seeking admission to a nursing facility:
 - Are older individuals (93% were over the age of 50 years old);

- Had one or more co-morbid conditions (66%) with a high likelihood of heart conditions, diabetes, or chronic kidney disease; and
- Had multiple hospitalizations [35% had 3 or more hospitalizations (all cause admissions) in the two years prior to their NF admission].
- Based on this analysis of the at-risk population, LDH met with the MCOs to review the definition of the at-risk population and initiated discussions to obtain their insights into this at-risk group and possible strategies to intervene with these individuals to address their co-morbid conditions and prevent further hospitalizations.

The SME believes the State's approach to provide case management services for individuals who are diverted (defined as individuals where the PASRR Level II evaluation did not authorize nursing facility placement) is consistent with other states' case management strategies, as well as LDH's strategy developed earlier this year. The SME recommends that the State have clearer referral processes for these individuals to ensure timely engagement with community case managers. Specifically, the SME recommends that a referral to case management should occur immediately after the individual is identified through the MCO's PASRR II process. Immediate engagement will improve the likelihood that an individual will receive the services they need to prevent possible future admissions but, more importantly, receive the services and supports they request and require to live successfully in the community.

As indicated in the last SME report, data provided to the SME from LDH for the members of the Target Population who were diverted from NFs (using the PASRR Level II recommendation) indicated high variability across MCOs in the number of individuals who were diverted, were offered case management, and actually received case management. The variability of this approach did not allow the MCOs to report data to the LDH similar to information collected on individuals who had been transitioned from NFs (e.g., services received consistent with the individual's plan, participation in service planning meetings, etc.). This information should be used in discussions with the MCOs to improve their processes for engaging individuals in MCO provided case management.

The SME has received and reviewed information from LDH regarding the MCO's case management effort. This is discussed in more detail in paragraph 61. The SME continues to recommend the State and MCOs continue the data collection and analytics discussed in this section to continue to assess the efficacy of the MCOs' case management strategy that will be necessary for the diversion population who are experiencing homelessness and are at-risk of being in the Target Population. If the data indicates that there are significant numbers of individuals who are not engaged in case management, the State and the MCO will need to identify the root cause of these engagement problems and improve these strategies. For these individuals, LDH should create an alternative outreach strategy requesting MHR and other behavioral health providers to engage these individuals in services in cooperation with the MCO. This may include ACT teams that the MCO could authorize for a time-limited basis to provide outreach in an effort to engage these individuals in treatment. In addition, this may include enhanced outreach by peer support specialists (available in CY 2021) to assist with individuals who may benefit from their engagement, including those individuals who are homeless and have an SMI. Alternatively, the MCO may be able to identify other local behavioral health providers, including Local Governing Entities (LGEs), to assist in the outreach program through crisis intervention or community support services.

The SME also recommends that LDH continue to meet with the MCOs to assertively develop and implement the case management approach for the diversion population. While the initial meeting (which was attended by the SME) was beneficial to start the dialogue with MCOs, additional effort is needed to

develop concrete strategies that the MCO can take to address this population. The SME recommends that LDH direct the MCOs to develop specific strategies by June 2021 to operationalize their case management strategy to address the chronic conditions for these individuals in the at-risk group. Activities that should be considered as key to these strategies are:

- Creating a common way to identify individuals that are at-risk and enrolled in each MCO for their health and behavioral healthcare based on a common definition for at-risk individuals;
- Developing a pilot project that would test out strategies the MCO will deploy to work with these individuals to enhance their specialty and behavioral health care; and
- Developing some common measures across plans for reviewing the effectiveness of these strategies.

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

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

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

To date LDH has not developed nor implemented a system to identify and divert individuals with avoidable hospitalizations. While working with hospitals is an important strategy, it is the SME's opinion that LDH's initial effort would be better spent on working with MCOs to prevent avoidable hospitalizations. These strategies were put on hold based on the SME's recommendation in the last report, in order to shift focus to avoidable hospitalizations.

The SME continues to believe that MCOs have the fiscal incentive to identify these individuals and develop strategies that prevent admission or readmissions for individuals with significant co-morbid conditions and SMI. Hospitals do not have the same incentives. Rather, hospitals have more of an incentive to discharge individuals in a timely manner and therefore have little incentive to initiate a discharge process that may require days, if not weeks, to locate the necessary housing and supports prior to discharge. However, the SME recommends that 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.

As indicated in response to paragraph 29, LDH is working with the MCOs in CY 2021 to finalize and implement a strategy to divert the at-risk population from avoidable hospitalizations, which place them at risk for subsequent NF admission. This will include individuals who were homeless and with SMI (including individuals with co-occurring SUD). LDH has undertaken several steps with these MCOs. LDH has developed and executed additional contract language that specifies the case management expectations for the at-risk individuals. The SME reviewed the MCO contract language and believes it is a

good start for increasing the accountability for the plans to divert at-risk members from emergency department (ED) visits and avoidable hospitalizations. LDH should request that each MCO provide a specific plan for how they will use their case managers to prevent some of these visits and admissions.

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

LDH is in the process of implementing a number of strategies to improve the PASRR Level I screenings and Level II evaluations to achieve diversion of individuals with SMI seeking admission to NFs. The strategies the State identified to improve the PASRR screening process included improving the identification of individuals with SMI through the PASRR Level I screening. The State is reporting that improvements in screening will be included in the process that will be used to develop the tracking system for identifying individuals in the Target Population who were admitted into an NF within 3 days. However, the tracking system will not be operational until CY 2021.

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

According to the State, individuals who receive a PASRR Level II are asked about their interest in, need for community services, and are provided information about community options at the time of the screening. The SME has not yet reviewed the specific strategies and processes that the independent evaluator uses to discuss these options. The last SME report requested information from the State regarding their efforts to ensure that the evaluators offer community options in a meaningful way. The SME believes the State's oversight and evaluation of these strategies are important. The SME has deferred this request until the next reporting period.

In addition, The SME has reviewed the most recent list of community options. It has many resources that would be available to the individual—however it is a daunting list and the SME imagines that individuals will need assistance in understanding and accessing these options. The SME did not review the practices of the MCO PASRR Level II evaluators use when implementing this requirement and will do so in the next reporting period.

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

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

According to LDH, the PASRR Level I screening instrument was modified in June 2018 to incorporate several changes designed to better identify individuals with SMI for diverting them from NF admissions.³ LDH revised the form in response to the PTAC findings that listed Louisiana among the states where too many individuals were identified as having a mental health diagnosis after nursing home admission, suggesting that the pre-admission form may not have been sensitive enough. LDH incorporated best practices from other states in the revision, especially from those states that PTAC found to have better pre-admission identification.

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

The State is proposing to continue their training efforts for PASRR Level I reviewers in CY 2021 once changes are finalized for the tracking vendor. The State indicates the tracking vendor will need to train staff that complete Level of Care Eligibility Tool (LOCET) and PASRR Level I once changes to the tracking system are complete.

The SME was not involved in the 2018 revisions to the PASRR Level I and did not participate in the training opportunity to implement the new screening tool. The SME is very familiar with PTAC and believes LDH took the appropriate steps to initiate a third-party review and revise this tool. The SME continues to recommend that LDH perform the necessary data analytics to determine if there was a change in the number of individuals who were identified as having a mental health diagnosis through this screening and to determine if the changes recommended by PTAC had the desired effect. In the previous SME report, it was recommended that the State track information regarding the number and percent of individuals who are identified as having an SMI during the PASRR Level I evaluation. The State should compare this number and the percent of individuals identified as having an SMI through the PASRR Level I tool prior to June of 2018 to determine if the change in the PASRR Level I screen and training were effective.

In addition, the State reports that additional training, as recommended in the prior SME report, will occur in the next reporting period as LDH makes changes to the information system that will track individuals who are in the Target Population and admitted to an NF.

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.

³ <http://ldh.la.gov/assets/docs/OAAS/PASRR/NFA-Level1-PASRR.pdf>

PASRR Level II reviews are performed by the Medicaid MCOs' Level II Evaluator, a Licensed Mental Health Professional who operates independent of the NF and the State. LDH has implemented policies and incorporated specific requirements within its Medicaid managed care contracts to ensure timeliness of the evaluations. LDH also issued a legal memorandum in December 2017 to providers to clarify their responsibilities to submit required documentation to OBH and Medicaid MCOs within a timely manner for the purposes of PASRR Level II evaluations.⁴ This memo identifies the minimum data to be submitted as part of a PASRR Level II request and the required timeframes for providers sending requested records and information to the Medicaid MCO's PASRR Level II evaluators. The most recent data provided to the SME indicates that Medicaid MCOs are completing PASRR Level II evaluations within four business days of referral from OBH, consistent with State requirements.

In 2019, LDH revised the PASRR Level II evaluation forms to better convey the availability of community-based mental health services that may be appropriate for NF residents with SMI. The MCO PASRR Level II evaluators were trained on the new evaluation form. These revisions are intended to provide consumers and PASRR Level II evaluators more information regarding the continuum of services that are available in the community. As indicated in the previous report, the SME was involved in the review of the revisions to the PASRR Level II evaluations and enlisted the support of PTAC in the review. The SME made recommended changes in the second SME report and the State incorporated the changes into the PASRR Level II screen currently in use.

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

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

The SME requested the most recent PASRR Level II training materials in the previous reporting period. This request has been deferred until next reporting period. In addition, the SME will meet with PASRR Level II evaluators to discuss their approach for confirming individual have a SMI and their approach for identifying housing options and necessary services and supports.

The SME also recommends that LDH develop an oversight process for the MCO PASRR Level II evaluators and the LDH PASRR Level II staff who make the final determination regarding an NF admission. This oversight process should include an independent review of supporting documentation and admission decision using the PASRR Level II evaluation to support the admission decision.

⁴ LDH Legal Memorandum "Provision of Required Documentation for the Purposes of PASRR", 12/4/2017.

As indicated in the last report, the State, due to the COVID-19 pandemic, suspended PASRR processes for new admissions to nursing facilities in late March. LDH was granted permission by CMS in mid-March to suspend these reviews. The Waiver was lifted as of June 15 2020. LDH developed a process for tracking individuals that were admitted to nursing facilities that did not receive a PASRR Level II evaluation. As indicated in the report, individuals admitted to a nursing facility are only provided a 90-100 day initial authorization. If/when an individual requested a continued stay at the end of the initial authorization period, OAAS refers these individuals to OBH for a PASRR Level II evaluation during the CSR process. Therefore, LDH would be able to identify individuals that were in the Target Population through this PASRR Level II evaluation rendered as part of the CSR process. During the Waiver period, 4,754 individuals were admitted to a nursing facility and received a PASRR Level I. Of the individuals, 1,044 requested a continued stay. Of these 1,044 individuals, 383 individuals were referred for a PASRR Level II evaluation. If these 383 individuals:

- 206 were determined not to need a PASRR Level II;
- 177 received a PASRR Level II evaluation and were added to the Target Population; and
- Almost all (176) were approved for a continued stay.

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

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

According to LDH, steps were taken in 2018 to strengthen the application and criteria of PASRR Level II evaluations to ensure appropriate identification of dementia as a primary diagnosis. These steps included:

- Strengthening documentation requirements for dementia to ensure that residents presenting with symptoms that could indicate dementia but might also be caused by overmedication and neglect are not improperly diagnosed with dementia and accordingly excluded from the Target Population;
- Issuing a legal memorandum (May 2018) clarifying the new documentation requirements to verify dementia diagnoses for the purpose of PASRR Level II evaluation;⁵

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

- Contracting with an independent psychiatrist in 2017 to review all PASRR Level II requests that include dementia and Alzheimer's diagnoses; and
- Revising the PASRR Level II evaluation form to include an addendum that clearly delineates the documentation required for requests with a dementia diagnosis.

In addition, the State reported that PASRR Level II Evaluators, MCO staff, OBH determination staff, nursing facilities, and hospitals participated in trainings regarding this new addendum. The SME continues to request information regarding the findings of these reviews to determine the prevalence of individuals who have been identified by the psychiatrist to determine if these findings may be within what may be considered norms in other states.

LDH has developed training on the new dementia diagnosis verification policy. The SME reviewed the training and provided additional content language. The SME indicated that for some individuals the symptoms of dementia may subside if a physical health condition or other stressor is addressed, which might trigger their eligibility for the Target Population. The SME recommended that individuals with dementia and physical health issues should be assessed with some frequency to determine if their dementia symptoms decrease and they are not just ruled out because they have an initial dementia diagnosis. The SME recommendations were included in the dementia diagnosis verification policy. The SME planned to request information this reporting period regarding LDH's efforts to evaluate the effectiveness of the new training and whether the State reassesses individuals with physical health issues and dementia; however, the SME did not make this request and will request this information in the next 6-month subsequent reporting period.

Finally, LDH has been tracking in real time the number of individuals who have transitioned and have been readmitted to nursing facilities. In discussions with the SME and DOJ, the State will be reviewing these readmissions to identify what services and interventions could have been pursued that would have prevented the admission. This will provide valuable information regarding service gaps and the individual's need, to support the array of services available for the Target Population. For this reporting period, the State reports that there were no long-term admissions into NFs.

In the prior SME report, data was requested regarding additional assessments that are done on individuals who have a co-morbid physical health and dementia diagnosis to determine if individuals with these conditions continue to experience dementia. This request is being deferred to the next SME reporting period.

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

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

LDH implemented new regulations to make changes to the behavior pathway effective May 2018.⁶ LDH and DOJ agreed that admission to an NF primarily for a behavioral health condition was not an appropriate admission. The behavior pathway was eliminated as a medical eligibility pathway for NF placement for new admissions. The rule included a “grandfather” clause: NF residents who were admitted prior to the implementation of the new rule were (and are) deemed to meet NF LOC as long as they continue to meet only the behavior pathway eligibility criteria. Residents lose their “grandfathered” status if they no longer meet the behavior pathway, are discharged from the facility, or meet an eligibility pathway other than the behavior pathway.

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

The SME requested information from LDH to determine if individuals with a sole diagnosis related to behavioral health (BH) have been admitted to NFs since 2018. Initially, the SME discussed with the State how information from the PASRR Level I and II evaluations and completed MDS could be used to identify whether an individual with an SMI was admitted to an NF with no underlying physical health condition. This would be a proxy to determine if the elimination of the behavioral health pathway was implemented. Per these discussions, information from the PASRR Level I or II does not provide the information regarding other health conditions and was not a good source of information. The MDS does collect information on diagnosis, including behavioral health diagnosis. For the next reporting period, the SME is requesting information from MDS data to identify if anyone was admitted to an NF in CY 2020 who had only a BH diagnosis.

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

LDH has implemented changes to the evaluation process for NF admissions for all individuals, including members of the Target Population and individuals who would be members of the Target Population if they were admitted to an NF. In general, LDH is now authorizing temporary stays rather than long-term “permanent” stays. This allows the State to review the ongoing need for NF services in a shorter period of time and allows the TCs to work with these individuals earlier in their NF stay toward a possible transition. OBH now requires a temporary authorization for all individuals where the PASRR Level II confirms that they have a SMI. For pre-admission PASRR Level II requests, authorization requests do not exceed 90 days (or 100 days for persons approved for convalescent care by LDH). 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 who received a short-authorization request for individuals in the Target Population admitted since July 2020. The State has reported that 100% of authorizations issued for the

⁶ Louisiana Administrative Code. Title 50, Part II, Subchapter G. Section 10156(l)(1)-(2).

period July through October 2020 do not exceed 90 days (or 100 days for persons approved for convalescent care).

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

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

The State's CSR process reviews activities of daily living (ADL) documentation, nursing notes, physician orders, etc., in conjunction with the most recent MDS 3.0 available at the time of the submission. If there are questions about documentation provided by an NF, OAAS regional staff visit the facility for an onsite review. All individuals requesting a CSR receive a PASRR Level II (regardless of whether they meet level of care). The PASRR Level II evaluation process is similar to the pre-admission screening process. The SME requested additional information regarding the process for TCs to engage individuals where a continued stay request has been performed regardless of whether the individual continued to meet nursing facility level of care. This included information regarding the role that OAAS and OBH have in making continued stay recommendations.

Attachment A provides the CSR process LDH has developed for individuals in the Target Population and delineates the role of the two offices. As indicated in this Attachment, individuals who request a CSR will receive a Level of Care (LOC) review by OAAS. If an individual has a previous PASRR Level II that indicated SMI or if an individual is identified as having SMI during the LOC review (post 90 days), the individual is referred to OBH for a PASRR Level II review. If the PASRR Level II indicates the level of care is not met or recommends the individual could best be served in the community, OBH initiates the discharge and transition planning process. If the PASRR Level II evaluator indicates the NF level of care is met, OBH will authorize a continued stay in the facility up to one additional year.

In the previous report, the SME recommended that LDH continue to collect and analyze data regarding the number and percent of individuals in the Target Population who have requested a continued stay and the percent of individuals who have an approved and a denied continued stay. The table below reflects the dispositions of all Continued Stay Requests for the Target Population during the time period from June 2018 to August 1, 2020.

Target Population Decisions	Count	Percent
Approved	990	98.51%
Denied	14	1.39%
Level II Not Required	1	.1%
Total⁷	1713	100.00%

After reviewing this information, the SME met with LDH and expressed concern regarding the high approval rate and low denial rate. LDH did not share the same concern since LDH believed that many newly admitted individuals in the Target Population were discharged prior to the expiration of their initial 90 day authorization. The SME is requesting information for the next reporting period regarding the

⁷ This is not an unduplicated count; individuals may have received more than one CSR.

number of newly admitted individuals in the Target Population that were discharged prior to the expiration of their initial 90 day authorization.

In addition, the SME continues to recommend that LDH collect and analyze information regarding the reasons for the continued stay approvals and denials and identified any trends in continued stay request by reason and facility.

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

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

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

The SME, in the previous report, has requested information over the past year regarding the number of individuals in the Target Population who received a PASRR Level II based on each of these scenarios. In discussions with the State, information for several of these scenarios is not readily available in large part due to the lack of existing fields in the UTOPIA system used to collect PASRR Level II data. For instance, the State does collect information regarding the number of PASRR Level II that are performed upon an initial request for an NF admission. The State also collects information regarding PASRR Level II evaluations based on initial and subsequent continued stay requests or resident reviews. The data does not differentiate whether these reviews were annual resident reviews or reviews due to a significant change in an individual at a facility. The State is in the process of making changes to the UTOPIA system and, in discussions with the SME, will add the necessary fields to collect data that differentiate between various resident reviews. It is anticipated that the changes will be developed and tested in the next reporting period. Once these changes have been implemented, the SME is requesting an analysis of the different scenarios for how and when an individual receives a PASRR Level II evaluation.

The SME requested and received information on the number of individuals who are in the Target Population who have received an annual resident review for FY 2019 and FY 2020 (to date) and were

admitted to an NF prior to 2018. The State provided several analyses. The first analysis is the number and percent of individuals on the Master List who were admitted prior to the start of the Agreement and have received a PASRR Level II prior to August 2020. The table below provides this information.

Received PASRR Level II	Count	Percent
No	325	21.66%
Yes	1182	78.34%
Total	1507	100.00%

As this table indicates, over 78% of the individuals on the Master list as of August 2020 have received a PASRR Level II. The remaining 22% have not received a PASRR over the 26 month period. In addition, the data does not indicate if they received an annual resident review in 2019 and 2020. The SME is requesting a further analysis of this PASRR information by year for individuals on the Master List who were admitted prior to the beginning of the Agreement and who received a PASRR Level II. This will allow the State to meet the commitment to ensure that everyone in the Target Population received an annual PASRR Level II and, more importantly, to identify the ongoing specialized behavioral health needs for these individuals. The PASRR Level II evaluation will also allow LDH to have an additional “touchpoint” with the individual regarding community alternatives and gauge possible interest in transitioning from the NF.

In addition, the SME recommends that the State identify individuals who are on the Master List, who were admitted prior to the beginning of the Agreement and who did not receive a PASRR Level II. Once these individuals are identified, the State should prioritize these individuals to receive a PASRR Level II over the next reporting period. Based on this information, the State should determine if the individual should be transitioned to the Active Caseload status. At a minimum, the SME recommends that these individuals receive a PASRR Level II to identify any specialized services and support the individual may request while they are currently residing in the NF as well as provide that touchpoint regarding community alternatives and interest in transitioning.

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

Received PASRR Level II by Year of Admission								
Received PASRR Level II	Admit Year							
	2018		2019		2020		Total	%
	N	%	N	%	N	%		
No	60	15.92%	86	14.21%	115	23.28%	261	17.68%
Yes	317	84.08%	519	85.79%	379	76.72%	1215	82.32%
Total	377	100%	605	100%	494	100%	1476	100%

As this table indicates, between 76 and 86 percent of individuals on the Master List admitted after the Agreement received a PASRR Level II. However, 14 to 23 percent of these individuals did not receive a PASRR Level II. Given the 1135 Waiver the state received during March through June of 2020, which did not require individuals seeking an NF admission to receive a PASRR Level II, the 23 percent of individuals who did not receive a PASRR Level II is more of an anomaly. However, for the prior 18 months, there was still a sizeable percent of individuals in the Target Population who did not receive a PASRR Level II. The

SME recommends that the State perform a PASRR Level II in the beginning of CY 2021 for the 200 plus individuals that were admitted to NFs over the last two years to identify and address their behavioral health service needs.

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.

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

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

In addition, the SME's service review is evaluating the transition process. The Agreement required the SME to assess the quality of community-based services for members of the Target Population. As a part of this quality assessment, the SME is reviewing a representative sample of individuals in the Target Population. The SME review is gathering information about individual experiences with transitions from NFs, participation in care planning, safety of placements, physical and mental well-being, crises and acute health episodes, stability of housing, employment or other integrated day choices, choice and self-determination, integration in the community and community inclusion, barriers to community integration, and access to and utilization of services. The SME will develop an initial report on the first round of reviews in the next reporting period.

Transition Teams

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

Prior to finalizing the Agreement, the State embarked on a process to develop the protocols and processes for transitioning individuals in the Target Population from NFs to the community. As indicated in the Agreement, the State had significant experience with this work through a federal demonstration program titled Money Follows the Person (MFP). This positioned the State to modify the existing MFP protocols and processes for the Agreement's Target Population rather than recreating them. This allowed the State to launch its efforts to identify and begin transitions sooner because it did not need to undertake significant development of these protocols and processes during the initial planning phase. The State did modify these protocols and processes for the Target Population for members under the Agreement and will be reviewing and modifying them further on an ongoing basis.

The State initially established 18 positions to assist with transitions. The State recruited, hired, and trained all transition coordinators. Currently, there are a total of 25 transition coordinators. OAAS has 16 TCs and OBH has 9 TCs. The role of these transition coordinators is similar to transition coordinators deployed through the My Place program. These transition coordinators are responsible for in-reach and education to members of the Target Population in nursing facilities. They are also responsible for assessing the community-based needs (including behavioral health needs) of individuals who have expressed interest in transitioning to the community and working with the individual to develop a transition plan. They are responsible for facilitating referrals for individuals who are transitioning from nursing facilities to community-based services.

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

In the opinion of the SME, the State has created the required infrastructure needed to conduct the transition assessments, develop individualized transition plans, and assist individuals with the transition process. The SME has begun to evaluate the experience of members who were transitioned from NFs. This includes reviews of transition plans and the transition planning process, the services received by the individual, and the experience of the transition process (through interviews with individuals who transitioned out of NFs).

During this reporting period, the TCs continued to assume the role of community case managers for individuals who transitioned to the community. As indicated in this report, LDH is required to provide case management to individuals in the Target Population who transition or are diverted from nursing homes for a minimum of 12 months. The State has implemented an interim strategy that relies on the existing TCs to provide case management until a long-term strategy is implemented. The interim case management strategy is discussed in more detail in paragraph 59. Depending on the month, the TCs were providing interim case management for approximately 83-93 individuals in the Target Population who had transitioned from NFs. As interim case managers, the TCs were required to make regular weekly contact with the individual, continue to assess service needs and supports, and develop a community plan for these individuals.

With the onset of the COVID 19 pandemic, the TCs provided most of their case management activities via the telephone. Fortunately, all members of the Target Population who were active on the TCs' caseloads

have telephones and were able to be contacted frequently during the pandemic. Over this past reporting period, in-person case management activities were provided by the TCs. While the use of face-to-face visits were less frequent than before the pandemic, the State reports that the proposed frequency of contacts for TCs while they were providing case management on an interim basis was followed. LDH reported they had secured the needed Personal Protective Equipment (PPE) to protect both TCs and service recipients.

In the SME's assessment, this interim strategy, as designed, provides a consistent case management approach, but should not be used as a long-term solution. The TCs have other important functions that will be compromised if this is the long-term solution. The longer-term case management approach is discussed in paragraphs 59-61. This longer-term case management approach is much needed and will allow the TCs to focus more of their energy on in-reach, education, and transition efforts that will be needed to meet the State projections to increase the number of individuals who will be transitioned in this upcoming year.

In previous SME reports, it was recommended that the State enhance its efforts to increase the number of individuals in the Target Population who are successfully transitioned from NFs. As indicated earlier in this report, there are 3,684 individuals in the Target Population in NFs. The State did a laudable job during the first eighteen months to transition over 100 individuals from NFs and is projected to transition an additional 100 this year. While these early accomplishments are worth recognition, all parties agree that more annual transitions will be needed in order to achieve the goals of this Agreement.

The State has made the assumption that the number of individuals transitioned in FY 2020 would be reflective of similar activity from the previous 18 months. As indicated in the previous report, the pandemic has hindered the State's efforts to meet the 2020 transition targets and the SME is concerned that the pace of transitions will not be sufficient to meet the terms of the Agreement on a timely basis. In the last report, the SME recommended that the State revise the projections for CY 2020 and develop a methodology and plan for CY 2021 targets that will significantly enhance the number of transitions from NFs. The State has addressed both recommendations. The State has revised its projections for transitions for CY 2020. As indicated in the CY 2020 implementation plan, the State projected that 100 individuals would transition this year. They have revised the projections for CY 2020 to 40-50 individuals. COVID-19 limited the ability for the TCs to perform important in-reach and transition functions. For several months, the TCs were unable to have ongoing and face-to-face contact with individuals who were identified for transition. While these restrictions were lifted in July, State public health experts recommended continued limitations on in-person visits with NF residents, given the increase in the number of COVID-19 infections in these facilities.

However, over the past several months, the State has developed alternatives to in-facility visits. This includes TCs carrying out "porch visits," video conferencing (using phones and tablets), and other strategies for connecting with individuals on their caseloads. The State did have conversations with another state involved in a similar settlement agreement to discuss and identify additional strategies that could be used to provide essential in-reach and transition functions. These conversations confirmed the TCs were deploying many of the same tools and strategies the other state used for their in-reach and transition efforts. While concerns about COVID-19 transmission and related restrictions created new barriers to transition efforts, the heightened risk of infection in congregate settings also underscores the importance of the Department's diversion efforts.

As the pandemic continues, the State should seek to expand the use of these alternative strategies to facilitate in-reach and transition.

The State has developed targets for CY 2021 that are based on critical assumptions rather than historical projections. The assumptions for the targets include:

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

Based on these assumptions, the State aims to transition approximately 219 individuals in CY 2021 (136 transitions by OAAS and 83 by OBH), a 119% increase from the projections in 2020. The State is to be commended on establishing these more aggressive transition targets.

These numbers were largely derived by estimating the number of individuals a TC can actively work with over the course of a year; the percentage of those individuals who, based on historical assessments, the State expects will be interested and able to transition; and the time it takes to transition.

As indicated in the last SME report, these annual targets should be developed in conjunction with a longer term, aggressive plan for accomplishing "rapid reintegration," consistent with the goals of this Agreement. LDH should set forth a timeline for allowing *everyone* who is able to and would like to transition to the community to do so – with sufficient transition, discharge planning, and community-based services to meet their needs – within a set amount of time. In addition, this plan should address the barriers identified in this report and enhance in-reach efforts, including better motivational interviewing strategies and use of peers to assist TCs with in-reach efforts. As indicated in this report, the longer term plan should be developed in CY 2021 and take into account:

- The total number of people on the Master List, in order to set related goals that ensure regular in-reach and engagement with all members of the Target Population regarding transition. As indicated in this report, there are over 2,800 individuals currently on the Master List. Therefore, this strategy will require that LDH contact approximately 250 individuals on the Master List on average each month.
- The number of individuals on the Master List who express an interest in moving. The SME understands this number will not be static (some individuals who may initially express no interest may express subsequent interest with additional information or time, thus necessitating continued engagement with all members of the Transition Population). Strategies to provide in-reach to these individuals are discussed in more detail in paragraph 89.
- The actual number of individuals on the current Active Caseload list who continue to express interest in moving to the community.
- The capacity of the TCs to work with individuals that are on the Active Caseload list to transition. Specifically, this includes an assessment of whether the TC workforce is sufficient to engage, assess, plan, broker the community resources, and transition individuals at a reasonable pace. It is very likely that the number of individuals on the Active Caseload list will increase due to these in-reach efforts and LDH will need to have additional TCs in CY 2022 to address these transitions.
- Identifying whether there are community services (health, behavioral health, and long-term services and supports) that are lacking in the community and developing the necessary capacity.

Transition Planning

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

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

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

46. The transition plans will accurately reflect and include: (a) the individual's strengths, preferences, needs, and desired outcomes; (b) a list of the services and supports the individual currently receives; (c) a

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

Paragraphs 43-46 are addressed together. Since the beginning of the Agreement, LDH has developed ITPs based on a standardized assessment that is completed prior to discharge. As indicated in the first SME report, in July 2019 the State revised the assessment to be more person-centered and to gather additional information regarding individuals' interests and desires about integrated day opportunities. This includes information from discussions with the members regarding how they want to spend their days in the community (e.g., employment, volunteer work, or general daytime activities, etc.) and identification of the needed supports to accomplish these goals. The assessment, as revised, provides more specificity regarding the housing options that are available in the community post-transition. The assessment also includes much needed information regarding crisis triggers and crisis planning. In addition, the assessment gathers information on an individual's history of co-occurring mental and substance use disorders as well as behavioral health supports, including the individual's perspective on treatment and those preventive and early intervention strategies that can be used in their transition plan. As of December, 2020 1,089 individuals on the Active Caseload (including those individuals that were transitioned) received a Transition Assessment. Of these 1,089 individuals, approximately 225 Transition Plans have been completed.

The previous SME report recommended that the State consider changes to the assessment and planning document to identify and account for individual's co-morbid conditions. In reviewing the transition assessment, the document does account for co-occurring physical health and SUD co-morbidities. The SME will request a sample of transition assessments and plan this next reporting period to determine whether co-morbid conditions are being identified in the assessment and are included in the Transition Plan.

As indicated in the previous reports, the SME reviewed previous and planned training used to develop the ITP to determine if the approach is person-centered. The SME's review of this material identified issues with the language and approach set forth in these materials. In particular, the materials lacked a person-centered approach that identified the strengths and wishes of individuals during the assessment and planning process. The SME recommended significant revisions to the content of the training. During this reporting period, the State, in collaboration with the SME's team, revised the training materials. These new training materials specifically reframed the approach for TCs, MCO case managers, and other providers for engaging the individual during the assessment process (focusing on strengths and needs versus diagnosis and barriers) and to develop a meaningful process for working collaboratively with the individual to develop a transition plan. Initially, the materials and training were piloted with the TCs. Feedback from this pilot was incorporated into a revised version of the training materials. The State is in the process of implementing a "train the trainers" approach for rolling out this training. The SME recommends this approach be finalized and implemented early on CY 2021.

There are requirements in the paragraphs above that the State has yet to implement. For instance, the State does not currently have a real-time way to identify when individuals are admitted to a nursing

facility. Therefore, they are not able to meet the 3 day and 14 day requirements in paragraph 45 (although the proposed changes to the tracking system will allow them to do this in the future). Based on work that the State has set forth in its draft implementation plan for CY 2021, the state should have this much needed functionality in place over the next six months through procurement of a vendor that can make the changes necessary to identify individuals within three days of admission.

In addition, it will be helpful to understand if and how individuals in NFs are afforded opportunities to visit community settings. The new in-reach process that is discussed in paragraph 89 should include how the State will use existing or new strategies for offering individuals opportunities to “visualize” what their life could look like once they transitioned from the facility.

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

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

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

For paragraphs 47-49, the State has implemented the interim case management strategy for individuals in the Target Population who have been transitioned from NFs. This includes TCs completing weekly and monthly logs that review whether the individual is satisfied with the services they are receiving, whether the individual is receiving the services identified in the ITP, and if the individual has experienced a significant change in services. The SME has received and is reviewing the community plan of care for a select group of individuals and will provide the State feedback in the next reporting period.

In the next reporting period, the SME recommends that the State develop the various tools and protocols that will be used by the new community case managers. This includes training new community case manager on these tools and protocols. The SME recommends that these protocols are developed to be consistent with the case management definition LDH has created. Specifically, these protocols should include:

- How individuals that are transitioned (and diverted) will be offered case management and ensure they have a choice of case managers;
- How the case manager will perform various engagement efforts prior to the transition and within the timeframes established by LDH;
- How the case manager will work in cooperation with the individual, TC, nursing facility staff, and MCO care manager (if appropriate) in developing and implementing the transition plan;
- How and when the case manager will conduct assessments and develop plans of care that are consistent with the person-centered training developed by LDH;
- How frequent community case managers will have contact with the individual;

- Processes for reporting contacts, critical incidents and other pertinent information, and related processes for effective LDH monitoring and oversight, that will allow LDH to ensure the quality of services provided to individuals in the Target Population who have been transitioned or diverted.

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

Over the reporting period, one individual who transitioned into the community will lose Medicaid eligibility post transition. This individual was transitioned in December and their Medicaid will terminate in January. Over the duration of the program, a total of 11 individuals through OBH have lost Medicaid. The State reported the following information regarding these 11 individuals:

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

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

In the period covered by the second SME report, the State provided the SME with information regarding the individuals who are awaiting transition—specifically, any transition barrier that the State has identified for these individuals. These barriers have been identified by transition coordinators, Support Coordinators, and MCO case managers over the course of the past two years. Separate meetings with LDH leadership and these individuals have identified the barriers, and in some instances, possible solutions to address these barriers. Many of these barriers continue to exist for these reporting periods, including:

- Developing relationships with individuals in the Target Population given restricted access to NFs;
- NF shortages have made virtual meetings difficult to arrange;
- Availability of accessible housing, especially in rural areas of the state;
- Transportation assistance, both for transportation within the region to view housing and when transitioning to another region;
- Legal barriers to transition (availability of housing for individuals with criminal backgrounds);
- Lack of natural supports willing and able to assist in meeting the individual's post-transition needs;
- Physical needs that do not rise to the threshold of meeting an NF LOC, which means that some individuals are not eligible for HCBS;
- Service needs for those who, upon transition into the community, will lose Medicaid eligibility;
- Physical, emotional, and cognitive health decline of individuals who may be interested in transitioning, but for whom transitioning poses a health and safety risk;

- Delays in obtaining identification documents or birth certificates, especially when such documents are needed to secure housing;
- Local Social Security Administration offices being closed, adding difficulty to getting award letters;
- Non-cooperation from the NF in supporting transition activities;
- Family concerns regarding the adverse consequences of the transition; and
- Ambivalence of individuals about leaving NFs and changing preferences about arrangements they want in the community.

The State has made a reasonable effort to identify barriers. They have also developed and implemented processes for addressing these barriers across OAAS, OBH, and MCOs. According to the State, MCO case managers and OAAS TCs have developed more frequent and better communication strategies, which has allowed MCO case managers to assist TCs to better identify resources in the community for members who have been transitioned from NFs. This has occurred through regular standing meetings. Additionally, in some instances and as needed, the different organizations meet with service providers to discuss the situation with the member in an effort to overcome barriers. In the meantime, the SME is requesting the State provide documentation as to how these barriers are being addressed either on an individual or systemic basis.

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

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

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

During this evaluation period, LDH reported that two members of the Target Population who were interested in transitioning from an NF requested to be transitioned to a setting other than their family’s home or their own housing (single family home or apartment). The SME has met with LDH leadership and transition coordinators to discuss these requests. During these initial discussions, the SME requested additional information regarding the individuals’ desires and needs, the rationale for requesting these alternative settings, the settings (to the extent they were home-like), and the timing on the transition.

Additional information was provided to the SME. In one instance, the individual and their family members withdrew the request for an immediate transition. In the second instance, the individual had continued to express her interest in moving, but also expressed concerns regarding living alone (e.g., safety, loneliness). The TC had identified several options for the individual that were alternatives to a home, apartment, or other supportive housing arrangement. All of these options were small (3 or fewer people)

and included shared living. Each of the options provided some staff supervision but were not staffed 24/7. The TC is in the process of reviewing these options with the individual (including a site visit). Since these facilities were initially explored with the individual, they were hospitalized and the alternative arrangement is no longer available. The individual has been discharged and continues to express interest in moving. The TC is working with the member to transition after the first of the year.

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

LDH has reported that transition coordinators during the early phase of transitions have identified individuals that may present issues relative to safety in the community (e.g., cognitive issues that may be difficult to address in the community). The transition coordinators engaged the Service Review Panel discussed in the report to review various documentation to determine if safety issues identified were valid. In addition, the transition coordinators will engage the individual's MCO to obtain additional evaluations/assessments to identify or ameliorate concerns that may have been identified as a barrier to transition. In the last report, the SME requested information from the State to better understand how the provisions of this paragraph are operationalized. While this continues to be a request, the State has focused efforts on other areas. The SME will work with the State to obtain and review this information in CY 2021. This request has been deferred until the next reporting period.

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

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

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

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

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

Paragraphs 54 through 57 are addressed together. As indicated in paragraph 25 and 26, LDH developed a Master List of individuals in the Target Population that resided in NFs at the beginning of the Agreement using the methodology established in paragraph 54. TCs began the outreach process in July 2018 to identify a cohort of individuals who were more likely to experience a successful transition. During this reporting period, the SME requested information regarding how LDH identifies individuals who were likely

to have a successful transition and what specific lessons learned the State has obtained from these transitions. The State reports that individuals were initially identified using information gathered from the MDS Q + index and follow-up conversations with the transition coordinators.

In the previous report, the SME requested information from LDH regarding the number of individuals on the Master List who have been contacted by a TC. The State reported that few if any individuals from the Master List were contacted this reporting period. As indicated in paragraph 98, the SME has recommended to include a more robust in-reach strategy for these individuals—recommending that all individuals on the Master List be contacted within the next calendar year.

As indicated in the previous report, the State lacks the information systems and processes to meet the timelines for working with individuals at admission or having a face-to-face contact with the individual within 14 days of admission. The procurement discussed in this report will provide LDH much needed real time information regarding admissions. In discussions with the State, the system changes necessary for accomplishing this goal will be operational on July 1, 2021. In the meantime, the SME recommends that LDH use information from SharePoint to monitor the progress of individuals on the Active Caseload who will be transitioning this year. Specifically, the SME recommends the State track:

- The number of individuals on the Active Caseload List that have a Transition Assessment and date of the Assessment;
- The number of individuals on the Active Caseload List that have a completed Transition Plan and date when the Transition Plan was started and completed;
- The length of time between the completed Transition Plan and proposed transition date; and
- The length of time between the proposed transition date and actual transition data.

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

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

C. Transition Support Committee

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

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

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

As indicated in the previous SME report, it will be important that the State continue to use this process to identify and address barriers to transitions. As recommended in the previous report, the State should consider additional members who can identify systemic barriers affecting multiple members of the Target Population and ad hoc representation to address particular barriers in individual cases. This would include adding members with experience and expertise related to successfully resolving barriers to discharge.

Potential additional members include Office for Citizens with Developmental Disabilities staff, ACT team members, Permanent Supportive Housing staff and/or providers, community physical and home health providers, representatives of agencies responsible for benefits determinations, Adult Protective Services (APS) staff, LGE staff, and certified peer specialists. During the last reporting period, OCDD and APS representatives were included in the SRP. The SME continues to recommend additional members who are working on a daily basis with members who have been transitioned or diverted, especially ACT team members and MCO case managers who have been identified as coordinating additional supports needed by individuals who have transitioned.

D. Post-Discharge Community Case Management

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

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

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

Paragraphs 59 through 61 are addressed together. As indicated above, there is an expectation (per the Agreement) that case management is available to members in the Target Population pre- and post-transition. As stated in previous SME reports, there is not an existing model of case management that will suffice for many of the individuals in the Target Population. For instance, most members of the Target Population who are transitioned from NFs are eligible to participate in the State's Home- and Community-Based Waiver program, administered by OAAS, and are receiving community case management through the waiver's support coordinators. Individuals who do not want to participate in or be eligible for the waiver are served by OBH and provided case management by the TCs.

In the previous report, the SME recommended the State continue its efforts to finalize a strategy for the provision of case management services (following the interim process) during this reporting period. Over the past six months, the State has identified a strategy for implementing the new case management model inclusive of implementation timeframes. This includes finalizing the vision for the case management program, the specific functions of the case manager, the expected frequency of contact with the individual, and drafted contract language between LDH and the MCO to operationalize this effort.

This new case management model will be implemented in CY 2021, and will be available for individuals who transition from NFs, as well as for individuals who will be diverted from these facilities. The case management model is individualized, person-centered, and reflects the individual's unique strengths, needs, preferences, experiences, and cultural background. It allows individuals to participate in all decisions that affect their care and ensures they are provided options regarding their services and supports, including the option to refuse services. The model establishes key functions for the community case manager and sets forth clear expectations of the nature and frequency of contact before, during, and after transitions from the NFs. It also sets forth the requirements for the case manager and the entities that will employ these staff.

The case management model will begin in October 2021. There are several additional activities the State will need to address in the next reporting period:

- Establishing reimbursement methodologies for the service;
- Developing training modules for new case management staff in these community agencies;
- Developing training for support coordination agencies, MCOs, and others who will have contact with newly created case managers.
- Developing LDH monitoring and oversight processes to ensure the agencies' quality and sufficiency of case management services.

The State will continue its interim case management strategy, requiring transition coordinators to provide ongoing case management services. The SME recommends that the interim case management strategy continue past October 2021 to allow onboarding of the community case managers and ensure that individuals who are receiving case management from the TCs do not experience an interruption in their care. In order to support the TCs in their ability to fulfil this function, and enhance transitions, the State reports they have enrolled TCs in the Foundational and Advanced Care Excellence training offered through

California State University. This online training series is designed to help teams who provide case management to populations with special and complex needs.

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

LDH is using the information from the contact logs to be able to gather and analyze information for its Quality Assurance Strategy, creating important indicators on any change in status of these individuals as well as some initial indicators to assess the quality of the services provided. The weekly logs provided LDH leadership with important information regarding the health and well-being of individuals who were transitioned. These logs were used to create the weekly COVID-19 tracking process discussed in the third SME report. In addition, they have provided real time tracking of the status of individuals who have been transitioned and should be continued throughout the duration of the interim case management strategy. As recommended by the SME, the State has indicated that these logs will be incorporated into the longer-term community case management strategy. In July, the State moved to a monthly rather than weekly tracking of key indicators, including critical incidents for individuals that have been transitioned. A review of these indicators are now embedded LDH's My Choice Quality Assurance process. These indicators are reviewed jointly by OAAS and OBH leadership to identify individual and systemic issues.

E. Tracking

62. By the date specified in the Implementation Plan, LDH will develop and implement a system to identify and monitor individuals in the Target Population who remain in Louisiana Medicaid after their transition from a nursing facility in order to: ensure health and safety in the community; assess whether supports identified in the individual's discharge plan are in place and achieving the goals of integration; identify any gaps in care; and address proactively any such gaps to reduce the risk of readmission or other negative outcomes. The monitoring system shall include both face-to-face meetings with individuals in the Target Population and tracking by service utilization and other data.

The State has developed an initial tracking system for individuals who have been identified for transition from NFs. While the long-term plan is to have a more sophisticated approach to tracking, State staff have developed an interim system that captures critical information regarding outreach, the assessment and development of ITPs, and services requested by the individual, including specific information on preferences regarding housing. The interim system also tracks the progress of the individuals who have transitioned to the community.

In November 2019, the interim tracking system was adversely impacted by a cyber-attack on many State information systems. This impeded the ability of the State to access (and enter) data from the interim system. Specifically, information from assessments and ITPs were lost and therefore unavailable on many individuals who were transitioned from NFs over the previous 17 months. This disrupted the reporting process and impacted the ability for the State to garner information that would be helpful for tracking

and analyzing necessary information for reporting and quality assurance purposes. Fortunately, the State has hard copies of the necessary information that have been re-entered into the interim system. The interim tracking system is operational again. The tracking system includes ongoing entry of critical information, including case management logs. This allows the State to create and analyze some of the necessary reports required under this Agreement.

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

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

Phase 2 will include programming of the Transition Assessment, Transition Plan, and post-transition monitoring efforts by the TCs into the system. For this phase, the State has provided the vendor with the necessary business requirement documents. The State has identified the necessary programming changes and provided specifications to the vendor. This should enable the State to reduce the time and resources necessary to track individuals and produce the necessary reports. The State also developed a list of reports that will be needed for tracking and monitoring individuals who are transitioned or diverted from NFs. There are additional reports that the State will need to consider developing once the quality indicators are finalized. These reports have been identified in the quality indicator matrix, which identifies whether the report is an internal management tool and which reports would be available to the public. In addition to these reports, the State should continue to provide more detailed information regarding the status of transitions and diversions as well as information regarding individuals post-transition.

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

In the third SME report, the SME recommended that the State continue their efforts to develop reports regarding individuals who have been transitioned from NFs. The State continues these efforts. The SME also recommended that LDH develop a strategy for collecting similar information for individuals who are diverted from NFs. Given that the interim diversion strategy was not implemented, the State has not developed or implemented this strategy as discussed in Section IV. Since community case management commences in October 2021, the SME recommends the State develop the necessary tracking protocols

for the diversion population at that time. As indicated in paragraph 61, the SME is recommending that the State focus their energy on implementation of the ongoing case management program for individuals in the Target Population that are diverted from NFs rather than taking steps to implement the interim diversion efforts with the MCO's case managers.

As indicated in the previous SME report, the procurement efforts for the longer-term tracking system were delayed due to COVID-19. The SME recommended that the State procure the vendor by September 2020 and perform the due diligence necessary to ensure successful implementation (e.g., readiness review) with full involvement of the parties that are expected to have use of this system. The State was unable to meet that recommended benchmark. The State has proposed that they will release the RFP in early CY 2021 and have a contract with a vendor in Spring, 2021.

V. Community Support Services

A. Crisis System

63. LDH will develop and implement a plan for its crisis services system. LDH will ensure a crisis service system that provides timely and accessible services and supports to individuals with SMI experiencing a behavioral health crisis within their local community. The services shall include a mobile crisis response capacity, crisis intervention services, and crisis telephone lines, consistent with the principles outlined below. Crisis services shall be provided in the most integrated setting appropriate (including at the individual's residence whenever practicable), consistent with community-based crisis plans developed for individuals receiving services, or in a manner that develops such a plan as a result of a crisis situation, to prevent unnecessary hospitalization, incarceration, or institutionalization.

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

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

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

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

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

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

The State has finalized the requirements in the draft service definitions. The State has also requested funding in their budget for FY 2022 to implement several Mobile Crisis Intervention (MCI), Community Brief Crisis Support (CBCS), and Behavioral Health Urgent Care (BHUC) centers. The State has yet to develop the rate setting process for these services during this reporting period, though preliminary conversations have been held with staff regarding initiating this activity. The SME recommends that the State initiate the rate setting process in early CY 2021, allowing ample time for potential changes in the MCO contract and capitation rates.

Over the past few months, the SME worked with the State to review the feasibility of the initial plan given the effect the pandemic will likely have on the LDH budget for several years. Per the discussions, the State is proposing a rolling implementation of various crisis services. The initial focus of these efforts will include standing up MCI and BHUC centers. As indicated above, the State is seeking the necessary funding for these services in FY 2021 with a likely implementation date of January 2022 (dependent on funding from the legislature).

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

There is a patchwork of toll-free crisis and help lines that are currently available to assist individuals, including members of the Target Population, who are experiencing crisis. This includes crisis lines that are operated by MCOs, LGEs, and individual providers. However, there is no coordinated statewide effort. To address this issue, the crisis plan, as proposed, would ensure that the Target Population and all Louisianans experiencing a behavioral health crisis would have access to a toll-free crisis line. The State is developing options for implementing a centralized statewide crisis line that will be able to triage and dispatch mobile crisis teams.

In addition, the State applied for a federal grant to develop the necessary specifications of the statewide call-in center. Through this funding, LDH will also assess and address the infrastructure needs of mobile crisis providers when they become operational. Notification of award should occur in January 2021; if awarded, activities will commence immediately.

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

The State has not implemented the mobile crisis response capacity set forth in the crisis plan. As indicated above, the State has developed service definitions for mobile crisis that set forth the response times and

other expectations for mobile response providers. In addition, the State has developed several options for developing network capacity for MCI, CBCS, and BHUC centers that will include recruiting and training providers who will offer these services. These services will be critical to reducing visits to emergency departments and hospital admissions, not only for behavioral health but for all visits and admissions. As indicated in this report, inpatient hospitals are the referral source for 80% of admissions into nursing facilities. Reducing referrals from hospitals will be directly linked to the ability of the crisis system to reduce these visits and admissions. In order to achieve this goal, the State is exploring options for collaborations with community partners to assist with these activities. The SME recommends that this planning should continue during the next reporting period with the understanding that implementation is dependent on funding.

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

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

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

The findings and recommendations from the needs assessment were not completed during this reporting period. The contractor has received the necessary data to perform the needs assessment and has completed the initial rounds of stakeholder interviews. The needs assessment findings and recommendations will be completed in the first three months of CY 2021.

67. LDH is working to address the State’s opioid crisis and other co-occurring substance use disorders affecting the Target Population. As part of this effort, LDH shall ensure statewide network adequacy of detoxification, rehabilitation, and intensive outpatient substance use disorder (SUD) recovery services. SUD

services shall have sufficient capacity to accept walk-ins and referrals for the Target Population from crisis services, emergency services, and law enforcement personnel. With the technical assistance and approval of the Expert, the State shall develop policies, procedures, and core competencies for substance use recovery, rehabilitation, and detoxification service providers.

Since 2018, LDH was implementing significant changes to their SUD service system through a CMS 1115 Demonstration Waiver. This 1115 Waiver opportunity allowed states to make important changes to their SUD system and required participating states to meet six important milestones. One of these milestones focused on improving access to SUD services. Through participation in the SUD Waiver, the State agreed to continue to offer all levels of residential and outpatient care set forth by the American Society of Addiction Medicine (ASAM). Since 2012, the State has created a continuum of services consistent with ASAM through the Louisiana Behavioral Health Partnership. In addition, one of the State's milestones was to ensure network adequacy for the array of services in the 1115 Waiver. The State currently requests information on a quarterly basis from the MCOs that are responsible for managing these benefits. A review of these reports for the third quarter of 2020 (July-September) by the SME indicated that there were no network adequacy issues for the various SUD levels of care during this reporting period.

In addition to the 1115 Waiver, the State has also received funds through the CARES and SUPPORT Act to address the continuing opioid epidemic. The State had used these funds to expand evidenced-based practices, such as Medication Assisted Treatment (MAT) as well as to increase the availability of recovery coaches in communities throughout Louisiana. In addition, the State has worked with the Pew Foundation to develop and implement policies that seek to improve access to OUD/SUD services, including additional Opioid Treatment Programs (OTPs). In the SME's opinion, Louisiana is taking the necessary steps to improve access to SUD services, including MAT and peer supports, two interventions that are well supported through ongoing evidence.

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

The State has done some initial outreach in early 2020 to emergency medical services (EMS) providers regarding possible approaches to identifying and resolving crisis in the community. The State was interested in EMS efforts to respond to behavioral health crisis to determine if and how they may be included in the crisis network. The State has reported that LGEs in certain areas of the State have engaged law enforcement and developed and trained crisis intervention teams.

Given the ongoing national focus on the role of policing, including calls to reduce the police role in responding to people with MH disabilities, LDH should make outreach to law enforcement a priority for this next reporting period. This was an SME recommendation in the most recent report. An initial focus for this initial outreach effort could be larger law enforcement agencies (e.g., state police, larger municipal police departments) to gain initial information regarding the extent to which these agencies/departments are responding to behavioral health crisis. The SME understands that this will be a challenge given the number of law enforcement agencies in the state, but LDH should be taking those steps now.

69. The State shall develop policies, procedures, and core competencies for crisis services providers, which shall be developed with the technical assistance and approval of the Expert prior to implementation. The

State shall also develop quality assurance measures for all Providers of community-based crisis services, including, at a minimum, tracking response times, and dispositions at the time of crisis and at post-crisis intervals of 7 and 30 days. The State shall consult with the Expert in selecting its quality assurance measures for providers of community crisis services.

As indicated above, the State, in consultation with the SME, has developed the service requirements for each of the services set forth in the crisis plan. The State still needs to finalize the necessary performance metrics for the call center and crisis providers. The SME recommends that these metrics be finalized in the next reporting period. In addition, the State will need to finalize how the MCOs will oversee the provider network against these performance metrics to increase the accountability and performance of all crisis providers.

B. Assertive Community Treatment

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

Currently, there are 45 ACT teams operating within Louisiana that are and will be serving individuals in the Target Population. The SME team has reviewed the adequacy of access to ACT for CY 2019 and 2020 by reviewing information on ACT team capacity and recent MCO network adequacy reports specific to ACT. Upon review, the SME has made an initial determination that the State has sufficient ACT capacity for serving members of the Target Population who are currently in the community. Less known is the demand for ACT services for individuals yet to be transitioned or diverted from nursing facilities. The needs assessment currently underway this period will have information regarding the demand of ACT services for future years. The SME will re-review the adequacy of the ACT network once this information is available.

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

In 2019, as part of the overall implementation plan, the SME reviewed Louisiana’s level of care requirements for ACT against similar requirements in other jurisdictions. As constructed, the admission criteria for ACT are reasonably consistent with other states. In the previous report, the SME identified that the State does not have defined exit or stepdown criteria. The SME has provided examples of other states’ exit/stepdown criteria. In addition, the State continues its efforts to identify which ACT teams may be experiencing more challenges with existing/stepping down individuals from their team. For instance, there are individuals who have been in NFs receiving ACT for several years. It is unclear whether these individuals continue to need ACT or could benefit from other services such as CPST or psycho-social rehabilitation. The intensity of ACT may not always be appropriate for these individuals. OBH, in cooperation with the SME and Medicaid, is collecting and analyzing data regarding the lengths of stay for individuals participating in ACT. This analysis should be completed within the next reporting period to identify ACT teams that may have longer lengths of stays and that could benefit from targeted technical assistance to determine whether those stays are appropriate or whether step-down strategies are needed.

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

As indicated in previous SME reports, the State, through its MCOs, conducts fidelity reviews of ACT providers on an ongoing basis. The SME examined these fidelity reviews for 2019 through 2020 and identified that there were needed improvements for ACT; specifically, the employment area was weak. In the previous SME report, it was recommended that the State and/or the MCOs make the necessary improvements to address these weaknesses. The SME requested the State follow up with the ACT teams to make these improvements and report their findings back to the SME. In the SME's opinion, the ACT teams are singularly positioned to provide intensive supported employment services because the teams already contain a dedicated employment specialist. As indicated above, the 2019 fidelity reviews did indicate some weakness in that area, specifically in training of employment specialists and lack of individualized treatment. The State is addressing these areas for ACT, in particular, in two ways:

- A draft training curriculum has been developed in cooperation with the SME team that will be delivered to the ACT team leaders and employment specialists that will outline expectations for the employment specialist and provide consistent information and technical assistance about providing supported employment in the context of ACT. The newly implemented Outcomes Measurement System records employment status monthly for every ACT member, further raising the profile of employment as a recovery tool. The OBH is consulting with the MCO partners about rollout of this training.
- A Person-Centered Planning training has been developed in cooperation with the SME team and piloted to several groups of transition coordinators, state staff, and MCO staff. The ACT teams are expected to be the first group of providers to receive this training. It is expected that this information will increase the fidelity in providing individualized person-centered treatment plans and service delivery. Examples of employment goals, objectives, and interventions were included in this material. The MCOs will be providing OBH with their plans for sequencing this training.

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

The State has also drafted more stringent requirements for ACT teams regarding fidelity thresholds. Teams must meet particular standards on overall scores and must submit plans of correction on individual scores falling below appropriate standards.

While fidelity reviews are critical for ensuring ACT is being delivered consistent with national standards, it is also equally important for the State to determine if ACT is accomplishing the overall goals for the program. Since August 2020, the State has collaborated with MCOs to implement an outcome reporting form that will be consistent across teams. The report tracks a variety of domains; the outcome areas include hospitalization (physical and psych), ER use, criminal justice involvement, employment, housing status, SUD treatment, education activities, and a measure of client involvement and participation. This outcome tool will be submitted to each MCO monthly, and a composite report across MCOs will be provided to the State. The SME is requesting these reports for the next reporting period to determine whether ACT teams continue to assist individuals in making progress in the domains discussed above.

C. Intensive Community Support Services (ICSS)

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

The State continues to measure the availability and access of Intensive Community Support Services, which include services in the State’s current Medicaid behavioral health services, on a quarterly basis utilizing network adequacy reports. 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 first two quarters of 2020 (most recent network adequacy reports), there are no obvious access issues for Intensive Community Support Services. While Intensive Community Support Services could be defined as inclusive of case management services, for the purposes of this report case management is being considered as a stand-alone service for which the State is developing a more tailored strategy. Similar to ACT, the current needs assessment will review the demand for ICSS services by members of the Target Population who are transitioned or diverted from NFs. The SME will review the adequacy of the MHR network once this information is available. The SME is not recommending that the State perform an analysis of rates and billing structures for the MHR services yet. While rates can be an indicator of barriers to access, the needs assessment may provide other root-cause issues that prevent access and will need to be reviewed.

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

The State continues to offer and provide these services through the Mental Health Rehabilitation program. There are over 400 providers of MHR services throughout the State. There have been changes to this program over the past calendar year, including the biggest change, the expansive use of telehealth by these providers. The State developed policies at the onset of COVID-19 to allow providers the flexibility to use telehealth to deliver MHR services.

The State continues to track the impact of COVID-19 on these providers. Specifically, the OBH is collecting information from MCOs on the number of MHR agencies that have notified their intent to close programs.

In the previous SME report, there were about the same number of program closures (4) pre and post COVID-19 onset. During the reporting period there were 3 additional closures due to the pandemic.

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

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

During the previous reporting period, the State, with the guidance from the SME, reviewed options for enhancing the benefit array for individuals in the Target Population, including services that provide assistance with IADLs. This included conducting an analysis of the individuals who have SMI participating in the CCW program to begin to identify the benefit package needed for these individuals. In addition, the needs assessment that will be completed in early 2021 will also provide information that will shape any additional Medicaid authorities.

The State has targeted FY 2022 for the implementation of these new services, many of which will require additional Medicaid authorities. The State, as recommended by the SME, finalized the initial benefit package and approach for these authorities in this reporting period and will begin the process of requesting the appropriate authority for this service. The initial benefit package will include personal care services and supported employment. LDH has requested funding for their services in their FY 2022 budget. The State will seek a 1915i Home and Community Based Services State Plan Amendment for these services.

Per the CY 2020 Implementation Plan, the State was to develop and submit the necessary authorities for peer services (June 2020) and begin to develop the appropriate Medicaid authority for crisis services in November 2020. The State did not submit the needed Medicaid authority for peer services in June but will submit the State Plan Amendment in January 2021. Upon further review of the existing Medicaid state plan, LDH believes it has the current authority to cover the initial crisis services in the existing State Medicaid Plan.

The State has finalized the approach for case management and personal care services. As indicated in this report, LDH is required by the agreement to develop a case management (paragraphs 59-61). In addition, the state will need to develop services and supports to assist individuals with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). LDH is proposing to add personal care services to the Medicaid program for individuals in the Target Population who would benefit from these supports to assist with ADLs and IADLs. The SME requested that the State finalize its plans for these services by the end of this reporting period, given that these decisions may need budgetary authority for FY 2022. The SME recommended that the State revisit the Medicaid authority timeframes for crisis towards the beginning of the next period if the crisis plan is revisited and changed. As indicated in this report, the State has addressed both recommendations.

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

LDH has not performed structured activities that address this paragraph. The SME is unaware of engagement and subsequent discussions with stakeholders regarding a review and possible changes to these provisions. In the previous report, the SME recommended LDH develop an organized process to engage stakeholders to review current provisions, make recommended changes, and develop the necessary policy guidance to address these rights.

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

Currently, the State, through the MHR program, allows peer specialists to provide services. This includes ACT, Community Psychiatric Supportive Treatment, Psychosocial Rehabilitation, and Crisis Intervention. In addition, the initial Crisis Plan referenced that peer services are simultaneously being developed and will be incorporated into the crisis continuum services as well as other services. As referenced in paragraph 79, the State will implement a freestanding peer support service in CY 2021 that will complement not only the services in VI A-C but also other services such as integrated day services discussed below.

D. Integrated Day Activities

78. The State will develop and implement a plan to ensure that all individuals in the Target Population have access to an array of day activities in integrated settings. Integrated Day activities shall include access to supported employment and rehabilitation services, which may include but are not limited to competitive work, community volunteer activities, community learning, recreational opportunities, and other non-congregate, integrated day activities. These activities shall: (a) offer integrated opportunities for people to work or to develop academic or functional skills; (b) provide individuals with opportunities to make connections in the community; and (c) be provided with high fidelity to evidence-based models. The Implementation Plan will provide for development of supported employment services in the amount, duration, and intensity necessary to give members of the Target Population the opportunity to seek and maintain competitive employment in integrated community settings consistent with their individual, person-centered plans.

The State has undertaken activities to identify, develop, or enhance services for individuals during the day. In June 2019, the State defined a preliminary set of integrated day services for members of the Target Population that include employment supports, drop-in centers, and adult day opportunities. The State continued to implement various activities to improve access to this array, including:

- In September, LDH coordinated a virtual Behavioral Health Symposium titled Changing the Conversation in 2020: Recovering—Rebuilding—Rejoicing. Over 800 individuals attended, including MCOs, behavioral health providers (leadership and clinical staff within agencies), and other stakeholders. As part of this symposium, LDH developed a Pre-Conference specifically addressing the DOJ Agreement. LDH staff provided an update to attendees on LDH activities regarding the Agreement. LDH also provided specific training regarding crisis services and employment approaches and initial training regarding person-centered planning.

- Finalized guidance in December 2020, with the assistance of the SME team, stipulating that illness management and recovery supports in the domain of employment activities be within the scope of current funding methodologies. This document has been reviewed by State leadership and was to be presented to MCO and leadership for discussion and dissemination. The meetings with the MCOs regarding this guidance have not occurred. The SME recommends that this be a priority conversation with the MCOs at the beginning of CY 2021. Without this information, MCOs will be unable to train MHR providers on this guidance.

The State was to continue its efforts to gather information to supplement the LGE surveys to identify drop-in/low-demand social settings that could provide support and engagement to individuals transitioning from NFs or being diverted from them. All LGEs were surveyed in mid-2019 to gather information regarding existing resources available in their areas that would offer drop-in centers. A copy of the survey is provided in Attachment C. The information from the LGE surveys were added to the resource guide for the transition coordinators. These efforts have not continued since many of these programs have limited operations during the pandemic.

As indicated in the previous SME report, the State was granted a second Visionary Opportunities to Increase Competitive Integrated Employment (VOICE) initiative from the Office of Disability Employment Programs, Department of Labor (ODEP DOL) and EconSys. The overall purpose of the VOICE project was to facilitate policy and training in states to enable them to increase employment outcomes for people with disabilities, and in particular this year, people with mental health disabilities. In Louisiana, the project was to address the need for greater inter-agency collaboration between the Louisiana Workforce Commission (LWC), Louisiana Rehabilitation Services (LRS), and OBH.

The VOICE project was to develop communication, joint training (including training on assessment and identification), as well as partnerships among the LGEs, the LRS local/regional offices, and the behavioral health providers in those locations/regions (ACT, MHRs, etc.) LRS did not pursue an extension request for this project. However, OBH has begun internal discussions on how best to develop employment services, including individual placement and support, employment supports, and coaching through the MHR program and continued discussion with LRS. This includes developing a definition of employment service to include as a Medicaid authority, training the MCOs and community providers regarding the messages that various employment supports can be reimbursed through existing Medicaid services (e.g., CPST and PSR).

E. Peer Support Services

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

Peer support is an evidence-based practice for individuals with mental health conditions or challenges. Both quantitative and qualitative evidence indicate that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services and increasing the use of outpatient services. Peer support improves quality of life, increases and improves engagement with

services, and increases whole health and self-management. The State and the SME believe there is an interest to increase access to and involvement of peer support specialists.

During this reporting period, the State continues to allow Peer Support Specialists to deliver various MHR services. There were no specific changes that impacted this policy during this reporting period. The State has finalized a Medicaid framework for peer support services. The vision of these services is to support individuals with SMI in a variety of settings, including in-reach and transition assistance for individuals in the Target Population in NFs (as discussed in paragraph 89). The State has worked with the SME to develop the service parameters and staff qualifications for this new service. The State did identify the need to improve the process for training and recertifying peers, as the current process is not sufficient to support the necessary changes and additions proposed by the State.

The State has taken significant steps to enhance peer support services. In the previous reporting period, the State, in cooperation with the SME team, developed a Request for Information (RFI) to solicit recommendations from stakeholders regarding strategies for improving the training and certification process. The RFI was released in July and LDH received responses in August. Responses provided LDH input in the following areas:

- Training frequency and format.
- Training curriculum for peer support specialists, supervisors and behavioral health providers regarding the role and value of peer specialists.
- Certification and recertification for peer support specialists including state requirements, continuing education requirements, and grandfathering provisions if a peer is currently certified.
- Funding and fees to support the training and certification.

In addition, the State sought and received budget authority for additional peer supports for FY 2021. The State has developed and is currently seeking public comment on Medicaid authority language to implement this service and reports that they will submit the Medicaid State Plan Amendment at the end of this month. State was targeting December 2020 for the implementation of this new service, but has moved this target to late spring 2021, post approval from CMS.

F. Housing and Tenancy Supports

80. The State will develop a plan to provide access to affordable, community-integrated housing for members of the Target Population. This includes but is not limited to expansion of the State's current Permanent Supportive Housing Program, which includes use of housing opportunities under the State's current 811 Project Rental Assistance (PRA) demonstration. Housing services will ensure that members of the Target Population can, like Louisianans without disabilities, live in their own homes, either alone, with family members, or with their choice of roommates.

The State has a Housing Plan, as required under the Agreement. The plan sets forth specific actionable strategies with specific annual targets for the creation of additional affordable housing units and rental subsidies to be made available to members of the Target Population.⁸

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

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

1,000 additional units and rental subsidies before termination of the Agreement. Once targets are achieved, the State shall maintain the availability of units and/or subsidies at the achieved target level for the term of this Agreement. Mechanisms to accomplish these targets shall be specified in the State's Implementation Plan, and include, but are not limited to, the following: (a) the State shall use some portion of the existing capacity in its current Permanent Supportive Housing program to house members of the Target Population through the institutional preference that prioritizes access to PSH units for persons in institutions; (b) the State shall use tenant-based vouchers in conjunction with Tenancy Supports offered through the Louisiana Permanent Supportive Housing Program to create supported housing opportunities for members of the Target Population; a portion of 125 existing vouchers shall be used for members of the Target Population; (c) through its statutory relationship with Public Housing Authorities, the State may seek to make available additional tenant-based vouchers for the Target Population; (d) the State, through the Louisiana Housing Corporation (LHC), shall continue to use existing incentives in the Low Income Housing Tax Credit (LIHTC) Qualified Allocation Plan (QAP) to create new units for the State's Permanent Supportive Housing Program; (e) the State shall additionally establish state-funded short or long term rental subsidies as needed to meet the requirements of this agreement. Within 18 months of the execution of this agreement, the State shall establish a minimum of 100 State-funded short-term rental subsidies to assist with initial transitions.

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

The State has implemented a 100 state-funded subsidy rental assistance program for 2020. This program is referred to as My Choice State Rental Assistance Program and is operated through the same partnership as Louisiana's PSH program with all participants being offered tenancy support services. One million dollars in State general funds were allocated to this purpose starting in State fiscal year 2018-2019. LDH continued to offer short-term rental assistance using these funds throughout 2020, utilizing established program policies and guidelines. In collaboration with LDH, the Louisiana Housing Authority continues to administer the rental assistance subsidies (i.e., rental assistance lasting more than 3 months). LHC and LHA are very close to reaching full utilization of the My Choice rental assistance program at the end of CY 2020. To date, 5 members of the Target Population have received short-term rental assistance, 93 are receiving ongoing rental assistance (i.e. My Choice Voucher) paid through LHA, and 20 additional members are in the process of being housed with My Choice rental assistance.

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

The State has obtained additional tenant-based rental subsidy vouchers to assist members of the Target Population. In 2020, associated with the CARES Act, LDH and LHA applied for and LHA was awarded two awards of 27 (May award) and 75 (November award) NED tenant-based vouchers to be incorporated into its existing Mainstream Voucher program for PSH. Both these new Mainstream Voucher Awards (total of 102 vouchers) will be used by members of the Target Population. LDH and LHA continued to utilize and refine their established program policies and procedures for using these vouchers throughout 2019-2020 and 80 members of the Target Population have been transitioned from NFs using this resource.

LDH is currently working with members of the Target Population to utilize the subsidies awarded by HUD in May. LDH expects to start to utilize mainstream vouchers from the November award in March 2021. In August 2020, HUD awarded LHC additional Section 811 Project Based Rental Assistance (Section 811 PRA), which will be used in conjunction with both existing and new affordable multi-family projects. LHC expects this new Section 811 PRA award, totaling \$7 million, to support approximately 140 integrated permanent supportive housing units. As part of its Section 811 PRA proposal to HUD, LHC proposed to target the integrated PSH units' support, with Section 811 PRA assistance, to members of the Target Population.

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

In addition, in 2020, LDH and the LA Office of Community Development (OCD) successfully partnered to include PSH incentives within the PRIME Multi-Family Rental Housing Development Notice of Funding Availability (NOFA) which offered both CDBG capital funding by OCD and 4% LIHTC financing from LHC. This partnership resulted in 67 PSH set aside units to Target Population members within 14 new multi-family rental housing developments to be created across Louisiana.

These accomplishments are part of LDH's successful efforts to further the specific strategies to create targeted PSH opportunities for Target Population members. In addition to the accomplishments discussed above, LDH, in partnership with LHC, has made significant progress in applying for new targeted, permanent rental assistance resources from both HUD's Mainstream Program and the Section 811 PRA with an award received for Mainstream. In the first quarter of CY 2021, LDH and LHC will conduct a formal progress review of all aspects of the housing plan to assess which strategies were successful in meeting their production targets and which strategies have fallen short in reaching their annual target for CY 2020. LDH and LHC will use this review to refine strategies and implement next steps as well as create new strategies to take advantage of emerging opportunities for the CY 2021 timeframe. This formal review will also be an opportunity to conduct a deeper analysis to develop a PSH delivery plan to synchronize when these PSH opportunities will be available or ready for lease with the planned transitions of Target Population member.

82. Consistent with the State's current Permanent Supportive Housing Program: (a) tenancy supports shall be voluntary; refusal of tenancy supports shall not be grounds for denial of participation in the Permanent Supportive Housing Program or eviction; (b) individuals shall not be rejected categorically for participation in Louisiana Permanent Supportive Housing due to medical needs, physical or mental disabilities, criminal justice involvement, or substance use history; and (c) in order to satisfy the requirements of this Section E, housing shall be community integrated and scattered site. For purposes of this Agreement, to be considered scattered site housing, no more than two units or 25% of the total number of units in a building,

whichever is greater, may be occupied by individuals with a disability referred by or provided supports through the State's permanent supportive housing program or individuals who are identified members of the Target Population under this Agreement. For purposes of this Agreement, and consistent with provisions of the State's existing permanent supported housing program, community-integrated housing shall not include licensed or unlicensed personal care, boarding, or "room and board" homes, provider-run group homes, or assisted living facilities. It may include monitored in-home care provided to individuals in the Target Population eligible for Medicaid waiver services.

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

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

The State, through OAAS, has engaged six TSMs and will provide statewide coverage to assist members of the Target Population transitioning from NFs. These TSMs perform the following functions:

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

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

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

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

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

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

VI. Outreach, In-reach, and Provider Education and Training

A. Outreach

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

For the first 18 months of the Agreement, the State made solid efforts to engage stakeholders. This engagement has consisted of different strategies: education regarding the Agreement; development of a website that has information regarding the Agreement and the Plan; outreach to stakeholders while drafting the initial, 2020, and 2021 Implementation Plans; and the development of an Advisory Committee for the Agreement. The State has reported their efforts to inform the State's Behavioral Health Advisory Committee regarding their activities under this Agreement. Initially, the State reported individual meetings with the Local Governing Entities (LGEs) to introduce them to the TCs, explain the overall approach to the Agreement and the transition process, and offer clarification or information requested by the LGEs. The State has also presented at various statewide conferences, including the Louisiana Nursing Home Association and Ombudsman Conference.

As part of their stakeholder engagement efforts, the State developed the My Choice Advisory Committee, representing consumers, LGEs, advocacy organizations, and providers. Since its inception in the fall of 2018, the State has held 12 statewide Advisory Committee meetings. The committee's meeting agenda generally consists of updates regarding the number of individuals who have been transitioned from the NFs to the community, and an overview of critical areas of work being done under the Agreement. The SME has attended several meetings, which were well-organized and provided important information in terms of the State's progress regarding the Agreement. The State has also created subcommittees for several areas, including:

- The Crisis Resource Group to provide input/feedback and guidance regarding the development of the crisis system.
- The Community Service Development Resource Group assists with the development of community services and capacity building for the My Choice program. This group has provided input/feedback and guidance specific to revisions to the transition assessment/plan and will focus in the next year on case management, other identified support services, and service provider training.
- The Community Transitions Resource Group providing feedback and guidance to address identified barriers to transition.

The SME has attended several of these subcommittee meetings. These meetings have been helpful to the State in their efforts to get specific feedback on important areas and activities, as the meetings are interactive and subcommittee members provide helpful comments regarding the subjects of discussion. The State has developed a subcommittee regarding resource identification, but the State has indicated the subcommittee does not meet regularly and it did not meet during this reporting period. The SME

recommends that the State meet with this committee in early CY 2021, given the barriers discussed in the Transition Section of this report.

The State has also created other opportunities to solicit input into critical services and activities for the Target Population and for individuals with mental health conditions, in general. This included regional listening tours regarding the overall “state of the State behavioral health system” in 2019. During these meetings, the State provided information on some of their efforts, but most of the meeting format is an open forum where participants can respond with critical information to the State regarding gaps, barriers, and other concerns, many of which are directly related to services and other activities under the Agreement. The State was planning on similar tours this calendar year; however, due to the pandemic, these meetings may not occur and may be postponed to later reporting periods.

The State continues to hold regular meetings with the MCOs that include information and updates specific to the Agreement. In addition, the State has a regular schedule of meetings with MCOs regarding PASRR, the My Choice Louisiana Transition Coordination activities, ACT, and, more recently, activities that would support individuals being diverted from NFs. The SME did participate in one of these meetings to discuss strategies to address individuals that were at high risk for possible nursing facility placement. Generally, the MCO participants recognized the need for developing these strategies and LDH has set up additional meetings to develop specific strategies for this group. In addition, LDH provided an overview of proposed crisis services to the MCO and another meeting with the MCO Behavioral Health Medical Directors. While the initial meeting with the MCOs was an information only discussion and there was limited time for the plan representatives to provide feedback, the meeting with the Behavioral Health Medical Directors was a more comprehensive walk through of the crisis services. LDH is planning to continue these discussions with the MCOs and other partners in early CY 2021.

LDH continues to have outreach meetings with MCOs and providers. During this reporting period, OBH continued to convene ACT teams and MCOs to discuss improvement in the delivery of ACT services, as discussed in paragraph 72. While the meetings with the MCOs occur monthly, they are scheduled with the ACT teams on a quarterly basis with the next meeting scheduled to occur in January 2021.

As the SME reported in previous periods, the overall level of engagement from the committee participants continues to be challenging. In meetings attended by the SME, there are few questions or recommendations from committee members. The State continued to make changes in 2020 to better engage the Advisory Committee. LDH continues to solicit information from the Advisory Committee regarding the areas and topics they were interested in discussing several weeks before the meeting. Even with this proactive outreach, the State continued to receive very few suggestions for topics that members are interested in discussing. The State provides important information to the Advisory Committee for their reaction, including the number of individuals who are awaiting transition and information on individuals transitioned. The State provides ample opportunity for the committee to review products developed by the My Choice program (including annual implementation plans). Yet, the State receives little feedback regarding these products. The State has provided a structure (e.g., specific subcommittees) to address more granular issues. These subcommittees do provide valuable feedback. As indicated in the previous report, the State should develop an approach that focuses more time and resources on these subcommittees rather than bi-monthly meetings of the larger Advisory Committee.

In the previous report, the SME recommended that the State enhance its My Choice Website, specifically recommending that the site should include additional information such as information on the Advisory Committee and the agendas and materials presented at the Advisory Committee meetings. It should

include presentations and materials regarding the My Choice program offered to other stakeholder groups. Other states with similar initiatives can be used as a model for the website changes. Specifically, the Rosie D. consent decree in Massachusetts has a well-developed website that the state maintains regularly.

In the previous report the SME recommended that the State also post information in the next period regarding data from the quality measures referenced in paragraph 99 and required in paragraph 101. Posting this information is important to provide transparency regarding the State's progress on all performance measures. The SME is recommending the State delay posting this information during this period and publish in July 2021. The SME is recommending that the State develop a process for incorporating feedback from stakeholders regarding the changes in quality indicators as part of their overall Quality Improvement approach rather than simply posting this information on the website. By April 2021, LDH will have a full year of data for the Advisory Committee and other stakeholders to review. The SME recommends the State provide an orientation session in early CY 2021 for the Advisory Committee and other interested stakeholders regarding the overall quality improvement approach and use this as an opportunity to discuss additional measures for the Agreement. In April 2021 the State would provide the Advisory Committee and other stakeholders the full year data (including changes by quarter) for review and discussion and make suggestions regarding strategies to move indicators in the right direction.

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

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

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

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

As indicated in the previous SME report, the State had not developed an ongoing organized communication plan for these stakeholders. As one element of this plan, The SME recommended that the

State create and implement a semi-annual communication plan for these constituency groups beginning this next period. The State has not undertaken this activity and the SME recommends that LDH develop a quarterly newsletter (or a similar communication effort) to keep stakeholders beyond the Advisory Group informed of the progress regarding the Agreement.

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

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

- Reviewing MCO data regarding the initiation and engagement of individuals diverted from NFs into their case management efforts.
- Reviewing MCOs efforts to conduct a timely assessment and develop a service plan for these individuals as well as ongoing engagement into case management services provided by the MCO.
- Revising processes and protocols for referrals for MCO case management based on this review.

During this reporting period, the State continues to collect data regarding the MCOs' efforts to offer and engage individuals who have been transitioned and diverted from nursing facilities in their case management approach. Based on this data and other factors, the SME does not recommend that LDH continue to pursue a strategy for having MCO provide case management directly for transitioned or diverted individuals. First, data from the MCOs indicate that individuals in the diversion population were unevenly engaged in the MCO case management program. While most of these individuals had an assessment and a plan of care, many have an open versus an engaged status. While this was an improvement from the initial report, much work will need to be done with the MCOs to actively engage individuals. Second, as indicated in paragraph 61 of the report, LDH is in the process of finalizing its approach for case management that will be offered by community providers versus MCO case managers. In the SME's opinion, it is imprudent to exert significant effort to improve the MCO's case management strategy, engage individuals with an MCO case manager, implement the community case management program in CY 2021, and possibly have to transition these individuals from a stable to a new case management arrangement.

In the previous report, the SME requested additional information regarding outreach efforts that are specific to law enforcement, corrections, and courts for the next reporting period. These outreach efforts have yet to occur. As recommended in paragraph 68 of this report, the SME recommends that the State have a targeted outreach effort to law enforcement, especially given the intent regarding the development of crisis services. Given that law enforcement often is on the front line of addressing individuals who experience a behavioral health crisis, it will be critical for the State to discuss their strategy with law enforcement and obtain input and identify strategies to inform law enforcement regarding these strategies.

B. In-Reach

89. Within six months of execution of the Agreement, LDH will develop a plan for ongoing in-reach to every member of the Target Population residing in a nursing facility, regular presentations in the community in addition to onsite at nursing facilities, and inclusion of peers from the Target Population in in-reach efforts. In-reach will explain LDH's commitment to serving people with disabilities in the most integrated setting; provide information about Community-Based Services and supports that can be alternatives to nursing facility placement; provide information about the benefits of transitioning from a nursing facility; respond to questions or concerns from members of the Target Population residing in a nursing facility and their families about transition; and actively support the informed decision-making of individuals in the Target Population.

In December 2018, LDH developed a plan for in-reach to members of the Target Population residing in an NF. The in-reach plan set forth various activities that the State was undertaking in this area, including:

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

As written, the in-reach plan was comprehensive and reflected a solid initial effort to identify individuals who may be transitioned initially. It set forth the foundational workflows for TCs. As indicated in the previous SME report, there were areas of the original in-reach plan that lacked specificity regarding more granular in-reach activities and timeframes. Also indicated in the last SME report was the impact that COVID-19 pandemic had on in-reach activities. For several months, TCs who provided the bulk of the in-reach activities were not allowed to make in-person visits to have initial or follow up discussions with Target Population members who were on the Master List, to discuss and gauge interest in transitioning to the community. While some of these restrictions were lifted during this reporting period, LDH medical directors suggested limited direct in-facility contact by the TCs and others (e.g., OAAS medical certification specialists).

LDH TC leadership in August began to develop alternatives for performing in-reach to members in the Target Population who were in NFs. Specifically, the TCs began to have face to face “porch” visits with members on their Active Caseload as well as to use tablets and phone applications for virtual visits as an alternative to in-person visits.

In addition, the SME and the State had conversations with multiple states that also needed to implement strategies to perform their in-reach efforts for individuals in NFs and long-term care facilities. One state,

North Carolina, was continuing to perform in-reach and had success in continued efforts to transition individuals who were in this Target Population (not at the same pace they had projected at the beginning of the year). The purpose of these conversations was to identify if additional creative strategies were being implemented to enhance in-reach during the pandemic. Based on these conversations, these states were using similar strategies as LDH. During the course of the conversation, North Carolina stated they have approximately 100 peer specialists who are responsible for providing in-reach and transition assistance to approximately 15,000 individuals in their consent decree.

While the SME was encouraged that LDH was implementing similar strategies as these states, it is recommended that LDH enhance its efforts regarding virtual in-reach. Unfortunately, as the pandemic's impact increased during the past two months and the weather does not always lend itself to outside visits, the State should provide TCs and/or require NFs to have tablets or other devices that will enhance the ability to communicate directly with Target Population members. The State may want to target these efforts on NFs that may have the most significant number of members of the Target Population.

The major focus of the State's efforts this past reporting period has been to identify strategies that would improve in-reach efforts. In the last report, the SME requested a status update on the original in-reach plan and recommended that the State make changes to the in-reach plan to enhance efforts for increasing the number of individuals in the Target Population who are successfully transitioned from NFs. The SME recommended several activities to better engage Target Population members who continue to be ambivalent regarding moving into the community (e.g., enhancing motivational interviewing strategies, continued efforts to identify community resources) As indicated in previous SME reports, it was recommended that the State's in-reach efforts begin to include individuals with lived experience (peers) to assist the TCs in having initial discussions with the Target Population about opportunities to transition to the community.

Over the past several months, LDH is making major changes to its in-reach efforts. The SME and DOJ have discussed options for the State to consider to improve these efforts. As indicated previously in this paragraph, LDH did have discussions with other states to identify additional strategies for their in-reach effort. The State has preliminarily identified several strategies for improving in-reach during CY 2021, including:

- Having medical certification specialists who perform initial and ongoing continued stay reviews to perform in-reach strategies. These specialists have contact with many individuals in the Target Population as part of their daily activities and to some degree have an existing relationship with these members. Specifically, the State is considering having these staff members perform outreach to individuals on the Master List to discuss and engage their interest in transitioning.
- Continuing to have TCs perform in-reach strategies for individuals on the Master List, coordinating with the medical certification specialists.
- Including the recently hired Peer Support Specialist (PSS) into both in-reach and transition efforts for individuals in NFs. In addition, the State, over the course of CY 2021, will increase the number of PSSs who will visit individuals in nursing homes, gauging interest in transitioning into the community and providing education, advocacy, and support to members related to transitioning. The State is proposing that this occur through the use of assertive engagement mechanisms the PSSs will use in conjunction with their personal experience, modeling recovery in action.

The SME is hopeful that these renewed in-reach efforts will produce the intended results. The SME recommends the State consider the following in their efforts to enhance in-reach:

- Identify individuals on the existing Master List who have been contacted within the past 12 months and reconnect with them specifically for the in-reach purposes. These individuals may be considered a high priority for additional follow-up since they may be more aware of transition possibilities.
- Identify individuals on the Master List who have not been contacted at all or not contacted within the past year. For these individuals, LDH should set specific targets in their in-reach plan to contact these individuals for transition purposes during CY 2021 and subsequent years.
- Develop and implement training for medical certification specialists, TCs, and PSSs to improve their in-reach efforts. One of the areas that the SME was particularly impressed with was the training North Carolina developed for in-reach staff that sought to develop/enhance the acumen of in-reach workers to discuss and motivate individuals in long term care facilities to consider transition.
- Develop a strategy for increasing the number of PSSs for in-reach efforts for CY 2022 and subsequent years. While the State is commended on its efforts to creatively fund an initial cadre of PSSs who will assist in in-reach and transition efforts, the SME believes these numbers will not be sufficient to assertively continue in-reach efforts for individuals on the Master List. In addition, having a single peer in each region is not recommended long term. Peers in similar situations have often experienced confusion regarding their roles, isolation and higher turnover. The SME would suggest that the State have perhaps twice or three times the number of PSSs to supplement in-reach efforts by CY 2023.
- Develop in-reach strategies that ensure choice for members lacking decision-making capacity.

Developing and implementing these strategies to contact the 2,829 individuals on the Master List to gauge their interest in moving from NFs will require that LDH contact approximately 250 individuals on the Master List on average each month.

C. Provider Training

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

There are various training opportunities for community providers. As indicated in Section V, there has been training on employment supports as well as crisis and person-centered planning during the reporting period. As mentioned earlier, the State designed and held a BH Symposium in September that included a major focus to improve knowledge regarding the overall Agreement and continue efforts to train providers, administrators/non-direct, and staff/supervisors of direct staff on crisis and employment services. The State has indicated the following training continued to be available to providers during the reporting period:

- Introduction to Crisis Intervention and the Role of Communication
- Fundamentals of Cultural and Linguistic Competence in Recovery-Oriented Systems of Care
- MH 101 - Overview of SMI/Emotional Behavioral Distress
- Suicide/Homicide Precautions
- Treatment Planning
- Co-Occurring Disorders: Treatment and Support for Persons with MI and SUD

- Trauma informed Care
- Level of Care Utilization System (LOCUS)
- Substance - Related and Addictive Disorders.

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

As recommended in the previous SME report, the State could benefit from a single organized training plan for providers who serve the Target Population. The SME recommended in the past two reports that the State develop policies and curriculum required under this paragraph during FY 2021. As of this reporting period, the State has not developed this training plan. Therefore, the State should use the balance of FY 2021 (January through June 2021) to develop this training plan, requesting the My Choice Advisory Committee to participate in the development of the plan and to recommend specific curricula.

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

The State, with the assistance of the SME, developed and tested a curriculum that is specific to person-centered service delivery. The purpose of this training is to help practitioners enhance their sensitivity and learn skills that will support them to ensure that the planning and subsequent service delivery for each person they serve is driven by the hopes, dreams, aspirations, and wishes of the person receiving the help. This training manual consists of three modules, each designed to consist of potentially 60- to 90-minute training sessions. Initially, this training was piloted with transition coordinators, who provided feedback regarding the content and delivery of the training. Based on this pilot, the training was amended to incorporate their recommendations.

LDH will begin “train the trainer” efforts to train case managers in Managed Care Organizations, the case managers in the community case management agencies, and all other community providers who will be doing assessment, treatment plans, and/or treatment plan implementation. The SME recommends that roll out of this training be included in the overall training plan discussed in the previous paragraph. As recommended in the previous SME report, MHR agency and LGE staff who perform the bulk of assessments and develop treatment plans should be initially targeted for this training. In addition, the SME recommends the State review this training with members of the My Choice Advisory Committee to obtain and incorporate their feedback.

VII. Quality Assurance and Continuous Improvement

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

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

The State did not meet the timeframes set forth in this paragraph and therefore the SME recommended that LDH create a quality assurance system, including a quality assurance plan, during this reporting period. The SME recommended the plan incorporate the work that has been done to collect and analyze data on the measures identified in paragraph 99 and the processes LDH will use to use this information to improve the experience of care for individuals transitioned from NFs as well as improve the quality of services that are offered to the Target Population.

As indicated in the first SME report, OAAS has a quality assurance approach for individuals that are served in the CCW Waiver. This approach is consistent with the national framework recommended by CMS for quality assurance focusing on participant-centered desired outcomes along seven dimensions, including participant's outcomes and satisfaction. As indicated in the first SME report, OBH did not have a similar framework. The SME recommended that the State should develop a process that is similar to the CCW approach for all Target Population members. Finally, the SME recommended that the State include a stakeholder feedback process as part of their overall quality assurance strategy for the Agreement.

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

While this is good progress, the SME recommends that the workgroup should identify actionable items to address the systemic issues in subsequent meetings.

The State has drafted the design of the quality assurance system, setting forth the process that the State will use to collect, analyze, identify and address individual and systemic issues that result from the process they have created over the past year. In discussions with the State regarding their approach, the SME identified the need to have a process in place that engages the My Choice Advisory Committee and other stakeholders in the quality assurance process. As recommended in paragraph 86, the State should review the overall quality assurance approach with stakeholders and solicit feedback and recommendations. The feedback and recommendations should be included in the overall quality assurance process the State is finalizing this reporting period.

95. For individuals in the Target Population receiving services under this Agreement, the State's quality assurance and critical incident management system will identify and take steps to reduce risks of harm; and ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings, consistent with principles of self-determination. The State will collect and evaluate data; and use the evaluation of data to identify and respond to trends to ensure continuous quality improvement.

The State continues to make progress with regard to developing a critical incident report (CIR) process that will be used by the both agencies (OAAS and OBH). As indicated in the previous SME report, these agencies have separate processes for reporting critical incidents. In October 2019, both program offices identified consistent elements and processes for reviewing and responding to critical incidents. Upon the SME's review of the critical incident definitions and reporting protocols for both agencies, the SME identified several different definitions and processes for reporting critical incidents for the Target Population. The SME recommended in the previous report that these definitions and processes should be made consistent across the two agencies.

In March 2020, LDH developed a weekly tracking system for select critical incidents for the Target Population as a result of the COVID-19 pandemic and included information on COVID-19 testing, members that tested positive for COVID-19, presentations at emergency department for any cause, hospitalization for any cause, and readmission into NFs. This was an important step in ensuring that both agencies used the same definitions for critical incidents reported by the TCs. During this last reporting period, the Integration Coordinator has developed a process for collecting CIRs from each agency and cross walking these CIRs to ensure consistency in reporting. While this is a good short-term solution, additional efforts should be considered for individuals in the My Choice program.

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

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

The SME has not reviewed the processes, protocols, or contractual language that may require community providers to implement critical incident management and quality improvement processes. The SME requested this information for review for this reporting period. The State reports that initial efforts to have community providers report critical incidents will occur with the community case managers in CY 2021. The State has included these requirements in the MCO contracts for this service.

The SME has reviewed the MCO contract regarding critical incident management and quality improvement processes. Currently, MCOs are responsible for developing, submitting, and implementing critical reporting and management procedures for the behavioral health population at large (not specific to the Target Population). These procedures, subject to review and approval by LDH, are to describe how

each MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents. The MCO contracts also define critical incidents consistent with Louisiana statutes and regulations, including abuse, neglect, exploitation, and death.

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

97. The State will establish reporting and investigation protocols for significant incidents, including mortalities. The protocols will require a mortality review of deaths of individuals in the Target Population in specified circumstances, including any unexplained death, any death within 60 days of discharge from a Nursing Facility, and any death in which abuse, neglect, or exploitation is suspected. Mortality reviews will be conducted by multidisciplinary teams, and will have at least one member who neither is an employee of nor contracted with OAAS, OBH, the LGEs, MCOs, and Community Providers. The reporting and investigation protocols for significant incident and mortality reviews shall be developed with the technical assistance and approval of the Expert.

In the previous reporting period, LDH developed an interim protocol for immediately notifying the SME and DOJ on all deaths of members of the Target Population who have been transitioned to the community. This protocol requires TCs to notify via email their immediate supervisor and program office lead within their respective program offices within 24 hours of first knowledge that an individual identified as a transitioned member of the DOJ Target Population has died. The transition coordinator will provide information to their supervisor, including the date of death, cause of death, date of TC's last contact, and whether other individuals were with the member when they died. The program office leads are to contact the LDH Integration Coordinator who will provide information on each death to DOJ in the timeframes specified. The two parties have not finalized this protocol and the SME recommends that this occur immediately.

There have been five deaths of members of the Target Population who had transitioned from an NF during this reporting period. The State followed the protocol described in the previous paragraph. For several individuals, the death was anticipated; the individual had a long term illness with a poor prognosis and was in hospice. However, there was one individual whose death was sudden. There was a significant lack of information regarding the cause of these deaths and any specific details that the State would need to conduct a full mortality review. The SME is requesting that LDH follow up on performing a mortality review with the process discussed below to better understand the circumstances that may have led to that death.

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

improvement over the interim protocol developed during the previous reporting period. The new mortality review protocol includes:

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

In addition, 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.

Upon the SME's initial review, the process and forms for the mortality review committee is very solid. The SME provided some recommendations for improvements (e.g., including timeframes for certain activities). The SME recommends that the State move forward quickly with implementing the process and protocols in the next reporting period.

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

99. The State will collect and analyze consistent, reliable data to improve the availability, accessibility, and quality of services to achieve positive outcomes for individuals in the Target Population. The State will create protocols on collection and analysis of data to drive improvement in services, which shall be developed with the technical assistance and approval of the Expert prior to implementation. Data elements shall measure the following areas: (a) referral to, admission and readmission to, diversion from, and length of stay in, nursing facilities; (b) person-centered planning, transition planning, and transitions from nursing facilities; (c) safety and freedom from harm (e.g., neglect and abuse, exploitation, injuries, critical incidents, and death; timely reporting, investigation, and resolution of incidents); (d) physical and mental health and wellbeing, and incidence of health crises (e.g., frequent use of crisis services, admissions to emergency rooms or hospitals, admissions to nursing facilities, or admissions to residential treatment facilities); (e) stability (e.g., maintenance of chosen living arrangement, change in providers, work or other day activity stability); (f) choice and self-determination (e.g., service plans are developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services); (g) community inclusion (e.g., community activities, integrated day and employment outcomes, integrated living options, relationships with non-paid individuals); (h) provider capacity (e.g., adherence to provider qualifications and requirements, access to services, sufficiency of provider types); (i) barriers to serving individuals in more integrated settings, including the barriers documented and any involvement of the Transition Support Committee as required by Section V.D.; and (j) access to and utilization of Community-Based Services.

Paragraphs 98 and 99 are addressed together. The State, as part of its larger quality assurance framework, has developed a process for collecting and reporting on preliminary measures to address the requirements of this paragraph. These preliminary measures and performance data are reflected in the quality matrix provided in Attachment B.

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

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

The information collected also attempts to gauge the individual's level of involvement in the community.

While self-reported information can serve as a good proxy when quantitative data is not available, the State will need to develop processes to offset any reliability concerns regarding this data. The SME continues to recommend the State review this data carefully and develop processes that would verify information that is being self-reported. This could include having the transition coordinator's supervisor (or a third party) perform interviews with the Target Population member to verify the information being reported is accurate. In addition, the Service Reviews that are being conducted by the SME will also provide verification regarding information collected by TCs.

The State has developed a process to identify barriers to serving individuals in more integrated settings, including information from the Service Review Panel (SRP), as described in paragraph 58. The seven members of the SRP meet weekly to review cases for individuals identified as members of the Target Population in which barriers are hindering the individual's personal goals or the transition itself.

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

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

The State has begun to develop the reports for the measures identified in paragraph 99 for the purposes of meeting the requirements of this paragraph. The reports for the quarter ending in June 2020 is provided in Attachment B. There are several measures that indicate potential systemic issues that the State's quality assurance workgroup should address, including:

- Lower number and percent of transitioned members who report that they received all types of services specified in the transition plan (a decrease from 82 to 67% from May to June).
- Number and percent of transitioned members reporting they are receiving the services they need (a decrease from 83 to 73% from May to June).
- Number and percent of individuals who report that they had a change in medications/ treatments, or side effects from, and/or in who gives them (on average 62% of individuals reported this change).
- Review and analysis of critical incident reports submitted by the TCs and using provider and member reported CI information indicated:
 - On average 14 individuals per month reported a critical incident.
 - These individuals averaged approximately 20 critical incidents in aggregate, with most of these incidents being major medical events (all cause admissions into hospital and emergency department presentations representing 75% of these events).
- Number and percent of transitioned members reporting that they have not experienced any major incidents.
- Number and percent of transitioned members reporting that they are involved in the community to the extent they would like; on average approximately 40% of individuals that have been transitioned reported they have not been involved in the community as much as they would like.

In the previous SME report it was identified that LDH had not developed a clear process for how the reports will be reviewed and factored into a larger quality assurance framework for the Agreement. Over the past six months, the State has developed an initial quality assurance framework, as recommended and discussed in paragraph 94, to meet the requirements of this Agreement.

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

Since January 2019, LDH has provided information to the My Choice Statewide Advisory Committee on the number of individuals who have been assessed, offered to participate in the CCW, and have transitioned from NFs. As stated in Paragraph 94, the SME recommends that the State not only report the data collected under paragraph 99, but also include a review of this data with its stakeholders. While all data should be available and reviewed with stakeholders, the SME continues to recommend a set of dashboards that focus on:

- The transition activities performed by the State for individuals on the Master List. These could include assessments started and completed, offers of participation in CCW, and individuals transitioned.
- The number of individuals who receive a PASRR. This information should include initial PASRRs, annual PASRRs, referrals for a PASRR for individuals who are on the Master List, and PASRRs that are completed due to a change in an individual's status.
- The number of individuals who have been identified as requiring specialized behavioral health service. The State should develop a measure to identify the percent of individuals who received a specialized service consistent with the PASRR recommendation and plan of care.

- The number of individuals who have been diverted from an NF consistent with the definitions set forth in the diversion report.
- The number of admissions and continued stay requests for individuals in the Target Population.
- Information on individuals who have been transitioned from NFs. This should initially include basic demographics, information on housing status, and transition barriers.

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

The State has not developed a formal process for all relevant State agencies to access data collected under this Agreement. The State should consider including other State agency input as part of its larger quality assurance framework. Specifically, the State should have a parallel process for reviewing the measures, including changes in the measures, and specifically discuss implications for their systems and assistance that may be needed to improve the experience of individuals who have been transitioned or diverted that have implications for other systems (e.g., OCDD).

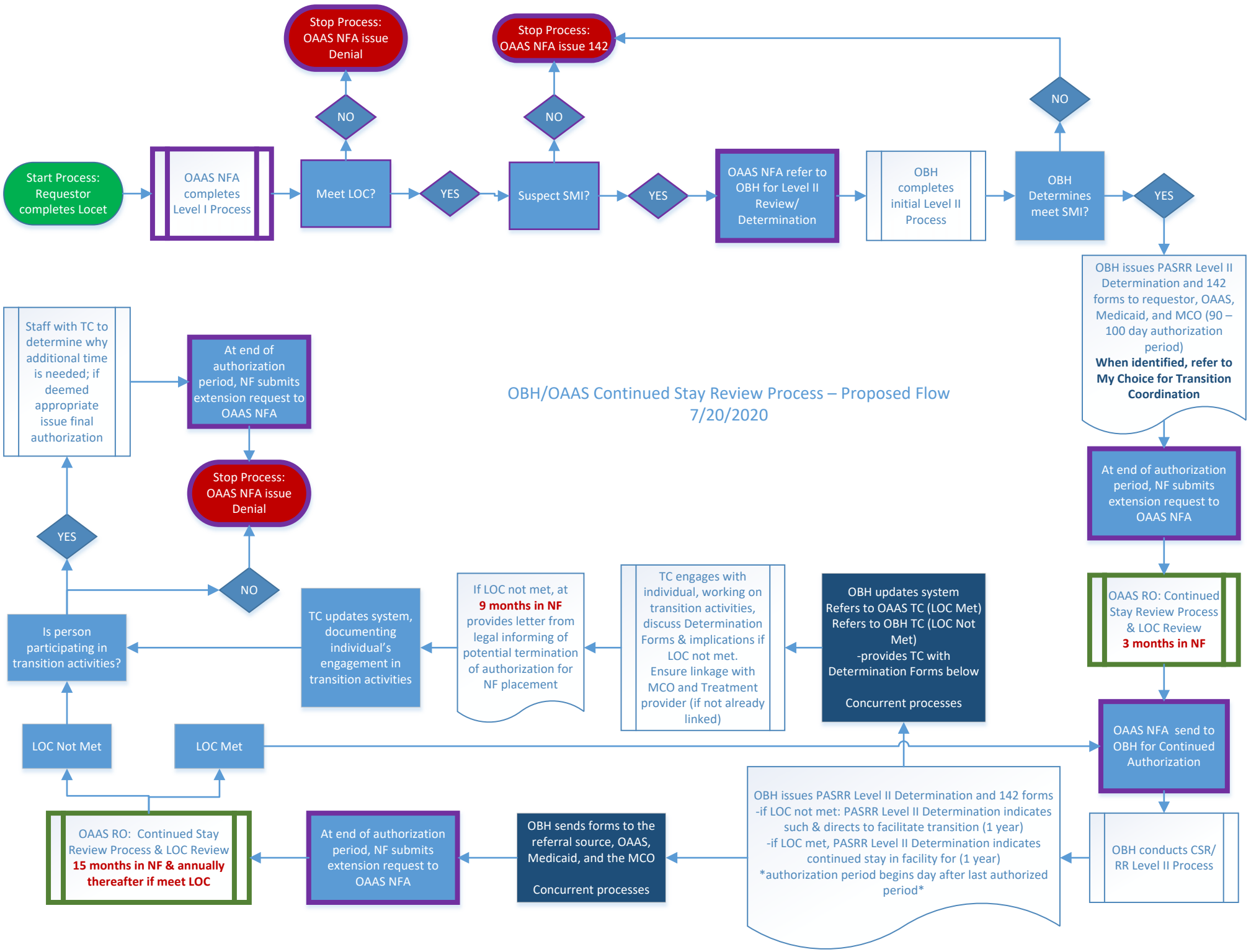
103. Beginning no later than the fourth year following the Effective Date, the State will, with the technical assistance of the Expert, begin to adopt and implement an assessment methodology so that the State will be able to continue to assess the quality and sufficiency of Community-Based Services and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

Conclusion

Since the last SME report, the State has continued efforts in all areas of the Agreement. As indicated in the previous report, the COVID-19 pandemic continued to adversely impact the State's efforts to move forward with activities that are integral to the Agreement. The continued inability to access members in the Target Population in NFs and limited ability to complete timely assessments and provide care coordination has delayed transitions and diversions. The SME anticipates that strategies to address the pandemic will be implemented in CY 2021; however, valuable time will be lost if the State doesn't implement strategies identified in this report to conduct virtual conversations that can assist with transitions.

In the next six months, the State will need to develop aggressive strategies that will allow them to meet the projected number of transitions and diversions set forth for CY 2021. In addition, several areas will need significant attention:

- Meeting the targets set forth regarding the number of individuals that will need to be transitioned in CY 2021; this will include virtual methods to work with individuals during the pandemic.
- Implementing more aggressive in-reach strategies to contact individuals on the Master List to gauge their interest in moving and begin transition activities.
- Considering methods to develop projections and strategies for additional years of the Agreement.
- Developing the necessary infrastructure for the community case management benefit.
- Developing strategies for implementing services that were included in the FY 2022 budget, including crisis, employment, and personal care services.
- Continuing to pursue the strategy set forth in the Housing Plan.

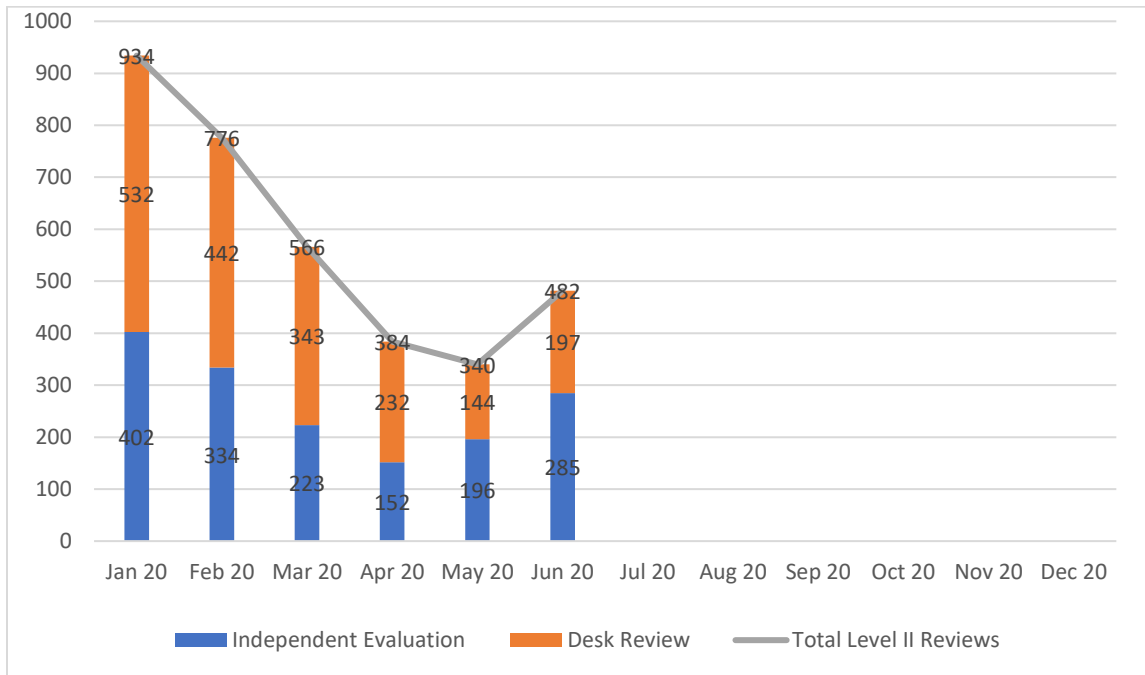


OBH/OAAS Continued Stay Review Process – Proposed Flow
7/20/2020

OBH PASARR LEVEL II DATA (2020 QUARTER 2 DATA BY MONTH)

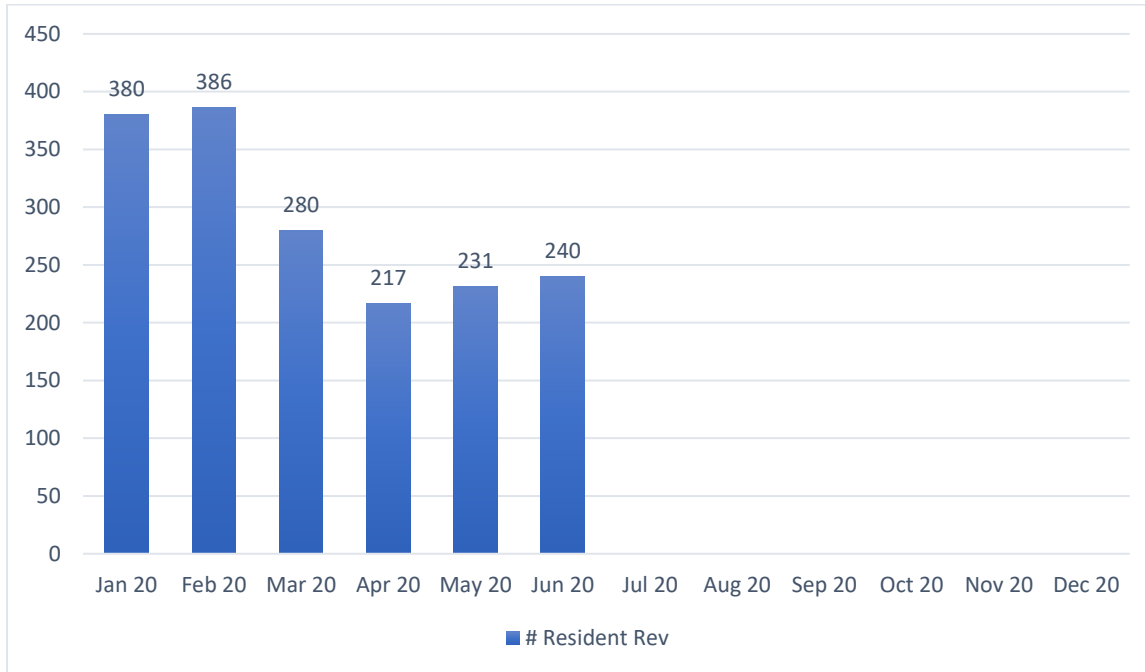
PASARR Outcome Trends – Total PASARR Level II Reviews Conducted by Method

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



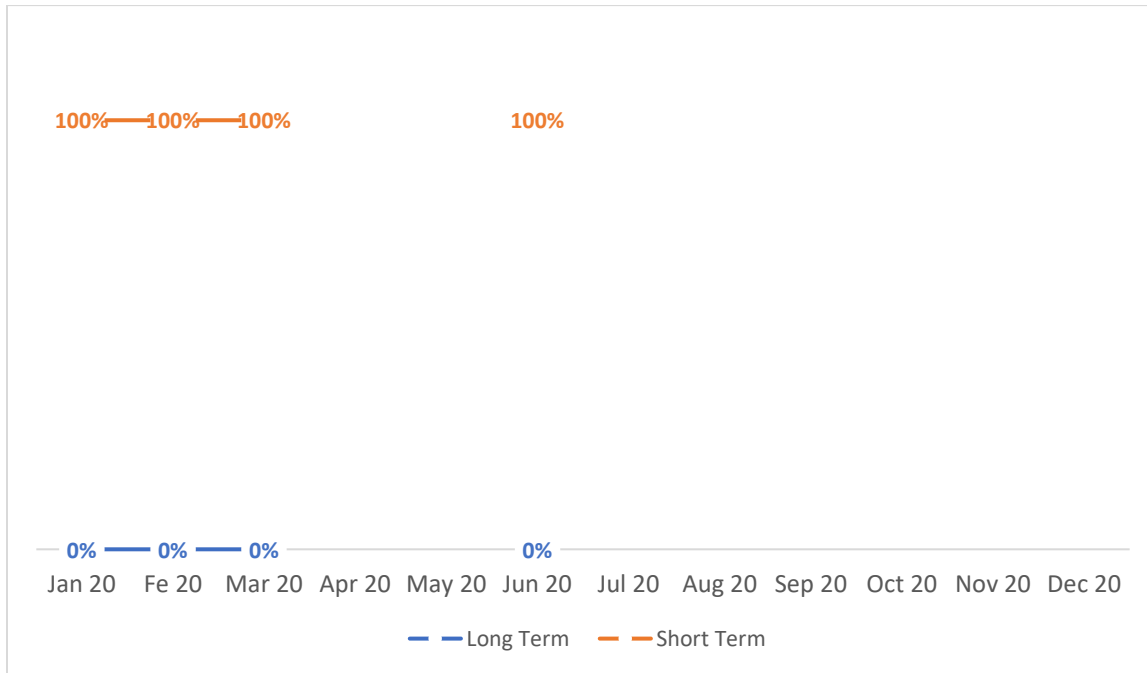
PASARR Outcome Trends – Total Resident Reviews

of Resident Reviews conducted related to Change in Condition

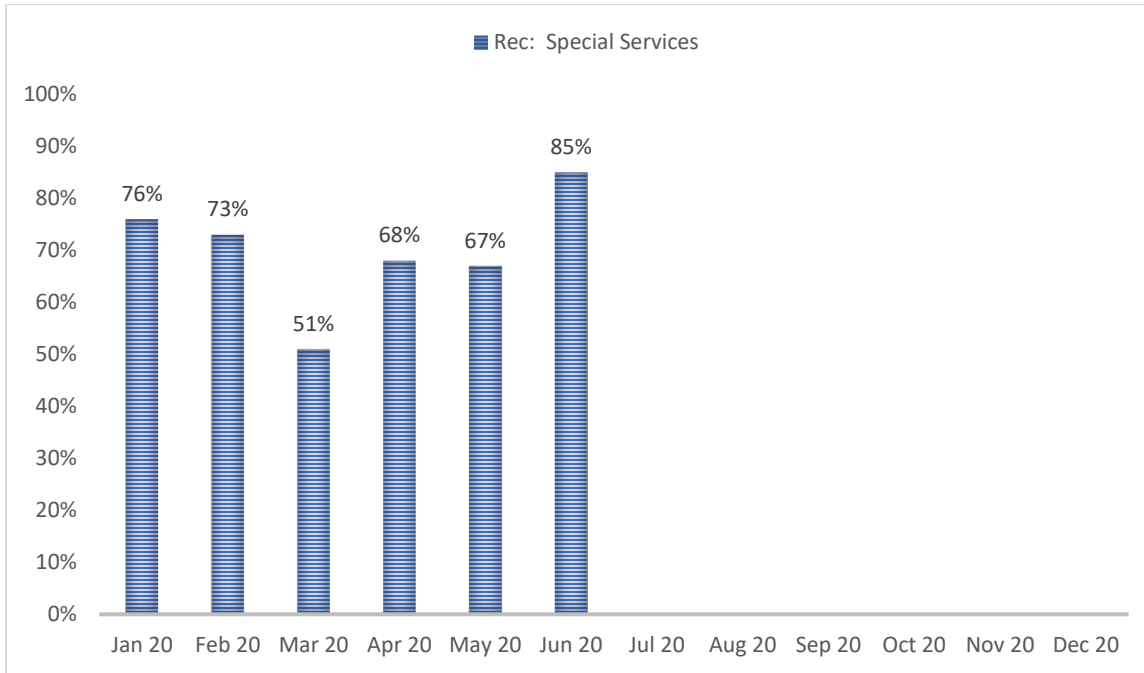


PASARR Outcome Trend – NF Placement Short Term v Long Term

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



PASARR Outcome Trends – Recommended for Special Services (SMI)
% of PASARR determinations that recommended referral to Special Services



ATTACHMENT B MY CHOICE 2020 QUARTER 2 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	April 2020	May 2020	June 2020
98	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 report		
		1.b	Geographic availability of services: Number of community based behavioral health providers available to serve BH Medicaid beneficiaries stratified geographically by region	Report analysis # of providers accepting new Medicaid patients by level of care stratified by LDH region	See attached report		
		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	See attached report		
		1.d	Number and percent of transitioned members who report that they received all types of services specified in the transition plan	Self-report- Interviews with TP members done by TCs: # of transitioned members who report that they received all types of services specified in plan/total # of transitioned members interviewed. Question from Case Management log: #4 Has the participant received services as written in the plan of care and/or treatment plan?	28/38 73.68%	34/41 82.93%	31/46 67.39%
		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:	31/38 81.58%	34/41 82.93%	34/46 73.91%

ATTACHMENT B MY CHOICE 2020 QUARTER 2 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	April 2020	May 2020	June 2020
				# of transitioned members reporting they are receiving the services they need/total # of transitioned members interviewed Question from Case Management contact log: # 12 Has the participant had problems accessing non-waiver behavioral or health care services?			
99	2. Referrals to, admission and readmission to, diversion from, and length of stay in nursing facility	2.a	Referral to nursing homes- Nursing Facility Admission Request	Number of persons that request Level I admission to Nursing Facility	1564	1787	2458
		2.b	Referral to Level II OBH (as per results of Level I PASRR) requested at admission	Number of individual initial placement requests	0	0	91
		2.c	PASRR Outcome Trends	Independent Evaluations vs. desk review	Indep Eval 152	Indep Eval 196	Indep Eval 285
					Total Level II Reviews 384	Total Level II Reviews 340	Total Level II Reviews 482
		2.d	PASRR Outcome Trends	Total Resident Reviews--# of Resident Reviews conducted	217	231	240
		2.e	NF Short Term Authorizations vs. Long Term Authorizations	Number of initial authorizations approved for short term stay(100 days or less)	0	0	91
		2.f	PASRR Level II Service Recommendations	Percent of PASRR determinations that recommended referral to Specialized Behavioral Health Services	128 68%	109 67%	203 85%
		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	Percent of PASRR Level II determinations that recommended that admission to the NF is not recommended	0	0	2%	
	3. Person Centered Planning, Transition Planning and Transitions from Nursing Facilities	3.a	Number and % of transitioned members who report having service plans that addressed their needs	Self-report- Interviews with TP members done by TCs: # of transitioned members who report that they understand their plan of	31/38 81.58%	38/41 92.68%	41/46 89.13%

ATTACHMENT B MY CHOICE 2020 QUARTER 2 DATA

Paragraph #	Requirement	Proposed Data Measure	Methodology	April 2020	May 2020	June 2020
			care/treatment plan/total # of transitioned members interviewed. Question from Case Management contact log: #1 Is the participant aware of and understand their plan of care and/or treatment plan?			
		3.b Number and % of transitioned members who report that they participated in planning	Self-report- Interviews with TP members done by TCs: # of transitioned members who report that they participated in planning /total # of transitioned members interviewed. Question from Case Management log: #2 Were you involved in planning and face to face meetings?	28/38 73.68%	29/41 70.73%	34/46 73.91%
		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. Question from Case Management log: #3 Did you have the people that you wanted to support you at those planning and face to face meetings?	31/38 81.58%	33/41 80.49%	39/46 84.78%
		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.	34/38 89.47%	33/41 80.49%	39/46 84.78%

ATTACHMENT B MY CHOICE 2020 QUARTER 2 DATA

Paragraph #	Requirement	Proposed Data Measure	Methodology	April 2020	May 2020	June 2020	
			Question from Case Management contact log: # 6 Has the participant indicated their preferences are being respected?				
		3.e	Number and percent of transitioned members whose plan of care addressed their needs	SME review of representative sample of individuals transitioned from NFs ¹			
	4. Safety and Freedom from harm	4.a	Number of critical incidents, stratified by type of incident	Review and analysis of critical incident reports submitted by the TCs and using provider and member reported CI information	# of people that had CIRs = 14 individuals Categories: Falls: 5 Maj Medical: 12 Maj Injury: 1 Maj Behavioral Incident: 1 Protective Services: 2	# of people that had CIRs = 12 individuals Categories: Falls: 4 Maj Medical: 13 Maj Injury: 2 Maj Behavioral Incident: 3 Protective Services: 1 Other: 1	# of people that had CIRs = 19 individuals Categories: Falls: 7 Maj Medical: 16 Maj Behavioral Incident: 3 Protective Services: 1
Of the noted CIRS – information here reflects ER visits, hospital admissions, and psych admissions.				ER visits: 10 Hospitalization: 5 Psyc Admission: 3	ER visits: 11 Hospitalization: 4 Psyc Admission: 3	ER visits: 10 Hospitalization: 8 Psyc Admission: 1	
4.b		Number and percent of referrals reported to protective service agency for abuse, neglect, and exploitation	Number of abuse, neglect, exploitation referrals made	2	1	1	
4.c		Number and percent of death investigations that were completed	Number of death investigations that were completed/ Total number of death investigations	0	0	0	
4.d		Number and percent of deaths that require a remediation plan	# of transitioned TP members deaths requiring remediation plan/total # of transitioned members interviewed	0	0	0	

ATTACHMENT B MY CHOICE 2020 QUARTER 2 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	April 2020	May 2020	June 2020
		4.e	Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessment (s)	SME review of representative sample of individuals transitioned from NFs ³			
		4.f	Number and percent of transitioned members reporting that they have not experienced any major incidents	Self-report- Interviews with TP members done by TCs: # of transitioned TP reporting no major incidents/total # of transitioned members interviewed Question from Case Management log: # 17 Has the participant had falls, injuries, or hospitalization?	26/38 68.42%	31/41 75.61%	33/46 71.74%
		4.g	Number and percent of transitioned members reporting that they have been free from abuse, neglect, or exploitation	Self-report- Interviews with TP members done by TCs: # of transitioned TP reporting freedom from abuse, neglect, exploitation/total # of transitioned members interviewed Question from Case Management log: # 18 Has the participant been a victim of verbal or physical abuse (including sexual), neglect or exploitation?	33/38 86.84%	39/41 95.12%	43/46 93.48%
	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 Question from Case Management contact log: # 15 Has the participant had a substantial change in medical condition or mental health condition?	30/38 78.95%	31/41 75.61%	37/46 80.43%

ATTACHMENT B MY CHOICE 2020 QUARTER 2 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	April 2020	May 2020	June 2020
		5.b	Number and percent of transitioned members reporting independence with taking care of themselves physically	Self-report- Interviews with TP members done by TCs: # of transitioned TP members reporting no change in ability to complete tasks for themselves/total # of transitioned members interviewed Questions from Case Management contact log: # 11 Has the participant had a substantial change in the ability to do things for him/herself?	35/38 92.11%	37/41 90.24%	37/46 80.43%
		5.c	Number and percent of individuals that report that they had a change in medications/ treatments, or side effects from, and/or who gives them	Self-report- Interviews with TP members done by TCs: # of transitioned TP members reporting a change in medications/treatments, or side effects from and/or who gives them/total # of transitioned members interviewed Question from Case Management contact log: # 16 Has the participant had a change in medications/treatments, or side effects from, and who gives them?	14/38 36.84%	13/41 31.71%	16/46 34.78%
		5.d	Number and percent of participants who utilized crisis services, ED presentations, hospitalizations (as an overlay to see if a person was in crisis)				
	6. Stability	6.a	Number and percent of transitioned members reporting stability in housing	Self-report- Interviews with TP members done by TCs: # of transitioned members reporting stability in housing /total # of transitioned members interviewed Question from Case Management contact	34/38 89.47%	34/41 82.93%	39/46 84.78%

ATTACHMENT B MY CHOICE 2020 QUARTER 2 DATA

Paragraph #	Requirement		Proposed Data Measure	Methodology	April 2020	May 2020	June 2020
				log: # 9 Has the participant had problems maintaining housing?			
		6.b	Number and % of transitioned members reporting stability in natural supports network	Self-report- Interviews with TP members done by TCs: # of transitioned members reporting stability in natural support network/total # of transitioned members interviewed Question from Case Management contact log: # 7 Has the participant had a change in non-paid caregivers?	34/38 89.47%	34/41 82.93%	37/46 80.43%
	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 Question from Case Management contact log: # 10 Has the participant engaged in social, recreational, educational, or vocational activities as desired?	22/38 57.89%	23/41 56.10%	29/46 63.04%

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.

Requirement: (98-1) The State will assess provider and MCO services, the amount, intensity and availability of such services and quality assurance processes and take corrective action where appropriate

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

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

LEVEL OF CARE	Q1 Statewide Total	Q2 Statewide Total
Assertive Community Treatment (ACT)	45	43
Community Psychiatric Support and Treatment (CPST)	368	419
Crisis Intervention (CI)	318	396
Psychosocial Rehabilitation (PSR)	327	410
ASAM Level 1	146	136
ASAM Level 2.1	150	137
ASAM Level 2-WM	24	26
Psychiatric Outpatient (Agency/Facility) – Prescribers (Psychiatrist, Medical Psychologist, Nurse Practitioner (psychiatric specialty) and Clinical Nurse Specialist (psychiatric specialty)	784	763
Psychiatric Outpatient (Agency/Facility) – Non-Prescribers (LAC, LCSW, LMFT, LPC, Psychologist)	2219	2219
Psychiatric Outpatient Licensed Addiction Counselor (LAC)	32	66
Psychiatric Outpatient Licensed Clinical Social Worker (LCSW)	739	751
Psychiatric Outpatient Licensed Marriage and Family Therapist (LMFT)	160	163
Psychiatric Outpatient Licensed Professional Counselor (LPC)	929	1004
Psychiatric Outpatient Medical Psychologist	34	36
Psychiatric Outpatient Psychologist	203	195
Psychiatric Outpatient Psychiatrist	382	375

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

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

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

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

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

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

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.

ATTACHMENT C
DROP-IN CENTER QUESTIONNAIRE

Name of Facility:

1. How many people do you have enrolled?
2. How many attend on a normal day?
3. How is the center funded? Do people donate? Or, is it strictly supported by the LGE?
4. Do you provide any transportation?
5. How do people find out about you?
6. Could you serve more people with your current staffing arrangement?
7. Do you have a desired ratio of staff/volunteers to persons attending?
8. Do you have volunteers helping out? Persons served volunteering? Are there peer specialists involved?
9. What do people do here? Is there a schedule? Can folks just "hang out" too?
10. Do people go to community events together?
11. Do you provide "counseling" or "treatment" and/or are you in touch with professionals who might be involved with the people who use your DIC?
12. Do you know of any other places like this in this region? In the state?
13. Where else to people go during the day as far as you know?
14. Do you have any activities to encourage or support people getting jobs or volunteer work?
15. Are there any employment activities/programs? If not, is there a protocol if someone requests assistance with employment?
16. What is the age range of the people who come here?
17. Do you know anything about senior centers or rec centers in the area and what they provide?
18. What advice would you have for us as we work to connect people to integrated activities in the community to help them live full and interesting lives outside of nursing facility?