My Choice Louisiana

Annual Quality Report

Agreement to Resolve the Department of Justice Investigation

Louisiana Department of Health

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LOUISIANA DEPARTMENT OF HEALTH

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Introduction

In 2014, the United States Department of Justice (DOJ) initiated an investigation of the State of Louisiana's mental health service system to assess compliance with Title II of the Americans with Disabilities Act (ADA). Following this investigation, in 2016, the DOJ stated that Louisiana unnecessarily relies on nursing facilities to serve people with serious mental illness instead of serving them in the most integrated setting appropriate to their needs as required by the ADA.

In June of 2018, the State of Louisiana and the Louisiana Department of Health (LDH) signed an agreement with the DOJ to help ensure compliance with the ADA, which requires that the State's services to individuals with mental illness be provided in the most integrated setting appropriate to their needs. The State's efforts to comply with the terms and intent of the agreement are collectively referred to as the My Choice Louisiana initiative.

Pursuant to the Agreement requirements, the State is required to report publically on the data collected specific to the availability and quality of Community-Based Services, gaps in services, and plans for improvement. In an effort to establish a process/mechanism for collecting, analyzing, and reporting on this data, the State worked with the subject matter expert (SME), John O'Brien, the United States Department of Justice attorneys, and My Choice Louisiana stakeholders to identify, define, and outline a methodology for collecting information with the intent to utilize this information to inform continuous quality improvement.

Developing the Quality Matrix

As a starting point the State established an internal work group comprised of subject matter experts from both the Office of Aging and Adult Services (OAAS) and the Office of Behavioral Health (OBH). With assistance from the SME, the work group reviewed the requirements outlined in the Agreement in paragraphs 98-101. Based on the requirements outlined, the following domains were identified as areas of focus to evaluate the quality of services for individuals in the My Choice Louisiana Program:

- Provider Capacity, Access to, and Utilization of Community Based Services
- Referrals to, admission and readmission to, diversion from, and length of stay in nursing facility
- Person Centered Planning, Transition Planning, and Transitions from Nursing Facilities
- Safety and Freedom from Harm
- Physical and mental health wellbeing and incidence of health crisis
- Stability
- Choice and Self-Determination
- Community Inclusion

Utilizing these domains, the work group initiated activities to identify data measures. This activity resulted in over thirty measures being identified. For each measure the team identified:

- Proposed data measure;
- Methodology;
- Data Source; and
- Frequency of reporting the measure.

Once the measures were identified, the team reviewed each measure and mapped it against current quality assurance and improvement efforts for both the Community Choices Waiver and Managed Care Organizations (MCO) to determine if information could be collected specifically for the target population and to create a status of the measure. The measure status identified:

- Whether there was data or a report to support these measures that was currently available (by OAAS or OBH/MCOs);
- Whether the measure and/or methodology would need to be modified; or
- Whether a brand new measure and reporting process would need to be created.

This mapping resulted in a core set of measures that could be reported for the Target Population (TP) utilizing Medicaid claims, Utopia PASRR information, and MCO reporting. In the absence of a community case management benefit, as an interim strategy the transition coordinators (TC) began providing intensive case management supports to members of the TP that had transitioned. With the provision of this support, the TCs complete documentation logs that include a series of questions related to overall wellbeing and the supports they are receiving on a monthly basis. There were several measures that the team identified could be collected through self-reporting processes; however, there needed to be some modifications/revisions to the set of questions on the transition coordination documentation log in order to collect additional information for these measures. In addition to the self-reported measures and as an initial step to have a source or mechanism to verify information collected by the transition coordinators, service reviews conducted by the SME during the year were also included for identified measures in the matrix.

In addition, there were several measures that were based on critical incidents. For the home and community based waiver program, there is a standard set of definitions and a mechanism to collect information specific to critical incidents. In order to collect consistent information for all members of the TP including those not receiving waiver services, the LDH team developed a critical incident form to be completed by the transition coordinators. The definitions and form align with information being collected for those receiving waiver services. With the definitions aligned, the critical incident form was implemented, and the LDH team began collecting and combining the information from both sources in order to report on measures related to this area.

Having reached agreement on the proposed measures, the LDH team in conjunction with the SME initiated work to modify the transition coordination documentation log in order to begin collecting information specific to the self-reported measures. Once a revised set of questions was developed, the LDH team shared the revised documentation log with the Community Services Development Resource Group and the DOJ to get input/feedback regarding the monthly contact log. LDH incorporated recommended changes and provided training to the transition coordinators with full implementation of the new log in March of 2020.

With the revised log and preliminary set of measures identified, LDH determined that next steps should include testing the measures by utilizing the tools developed to begin pulling data at regular intervals to develop reports and evaluate progress.

Internal Process for Reviewing Measures and Outcomes

Each program office established an internal My Choice Quality Review Team (QRT) to review the results of the proposed measures outlined in the quality matrix for transitioned members of the target population. Frequency of these meetings is monthly, during which time they review the current performance reports identifying any issues on both an individual and systemic level and addressing issues and/or making recommendations regarding remediation efforts needed. The OAAS My Choice QRT includes transition coordinator supervisors, quality assurance staff, and other ad hoc members as needed. The OBH My Choice QRT includes transition coordinator supervisor, Peer In-Reach Specialist (PIR) supervisor, network staff, and other ad-hoc members as needed. Following the internal QRT meetings, measure results and findings are shared with the DOJ Quality Workgroup, highlighting any issues requiring elevation and remediation.

While the QRTs are meeting to review the performance measures on a monthly basis, there are other activities that occur in order to address issues, concerns, and gaps in supports/services on a regular day to day basis. Within each program office there is a supervisory structure in place not only to manage the operational aspects of the program, but also to assure that individual post-transition issues are identified and outcomes are achieved for those engaged in the transition process. Supervisors are paired with specific transition coordinators, and in this role they meet frequently to discuss individual cases that have been identified by the individual transition coordinator. During this process the transition supervisor and transition coordinator identify issues/concerns, and provide assistance to address any areas that might result in an individual not meeting outcomes. These activities occur on a real time basis as the issues arise with resolution occurring immediately. The supervisors provide ongoing support, assistance and training to the transition coordinators on a daily basis.

The DOJ Quality Workgroup is comprised of staff from both program offices, the SME, and the project director for the My Choice Louisiana initiative. There are an array of staff including transition coordinator supervisors, project directors, program managers, quality assurance staff, data analytics staff, and network staff. Minimally this workgroup meets quarterly to review results to identify trends/patterns, strengths and problem at the individual, provider, and systemic level; develop and implement strategies to address identified problems and build on successes; track efficacy of those strategies; and revise strategies as needed. . The DOJ quality workgroup utilizes this information to evaluate overall progress and drive continuous quality improvement.

External Process for Reviewing Measures and Outcomes

In an effort to enhance engagement related to the quality assurance processes, a subcommittee of the large advisory committee was created, the My Choice Quality Resource group, to provide feedback and recommendations regarding the matrix, the SME service reviews, and the overall quality assurance process. This resource group began meeting in February 2021 and met monthly through June of 2021. During these meetings, the State provided information regarding the process for collecting the measures, solicited feedback from the group regarding changes to the measures or additional measures to be included in future iterations of the matrix. The resource group provided valuable input and recommendations regarding the measures, processes for collecting information, as well as, frequency for ongoing meetings and process for sharing information with the larger advisory group. Moving forward, this resource group will meet at a minimum on a quarterly basis to review data, identify areas of concern,

and provide recommendations related to strategies to improve quality improvement. The recommendations from this group will be incorporated into ongoing quality assurance efforts.

In addition, the LDH team meets with the SME and DOJ on a quarterly basis to review information collected for the quarter under review. These meetings provide an opportunity to evaluate overall progress, identify areas for improvement as well as discuss the need for modifications to measures and/or processes.

At the recommendation of the SME, the DOJ workgroup initiated processes to share quality assurance strategies with the My Choice large advisory group and other stakeholders in early 2021. As an initial step, the first iteration of the quality matrix was shared with the large advisory group. During one of the standing meetings with this group, each proposed measured was reviewed, soliciting feedback to determine if the appropriate measures were included and/or if there were recommendations regarding the need for additional measures.

Initial Findings

The data for calendar year 2020 is included in Appendix A, B and C. Appendix A is the quality matrix with data for each quarter for calendar year 2020. Appendix B includes the network adequacy reports for behavioral health providers for calendar year 2020. Finally, Appendix C includes graphical depictions for some of the measures included in the quality matrix.

Overall, the data collected have remained consistent or there was some level of improvement during the course of the year. However, there are, several measures that indicate potential systemic issues that the quality assurance workgroup needs to or has begun addressing. The measures outlined below are an average of the quarterly data for CY 2020. These measures include:

- Twenty-five percent (25%) of the transitioned members interviewed reported they did not receive all types of services specified in the transition plan.
- Twenty-one percent (21%) of the transitioned members interviewed reported that they did not receive the services they need.
- Approximately, twenty-three percent (23%) of transitioned members interviewed reported that they did not participate in planning.
- Thirty percent (30%) of transitioned members interviewed reported that they had experienced major incidents.
- Twenty-four percent (24%) of transitioned members interviewed reported that they had a change in medications/treatments, or side effects from, and/or in who gives them.
- Review and analysis of critical incident reports submitted by transition coordinators and using provider and member reported information indicated this measure has gradually trended in a negative direction during calendar year 2020. Approximately 37% of the transitioned members reported a critical incident with most of the critical incidents being identified as a major medical event. All cause admissions to hospital and emergency department presentations represented 75% of these events.
- On average, twenty-five percent (25%) of transitioned members interviewed reported that they were not involved in the community as preferred.

In general, it should be noted that the pandemic did have an impact in terms of the outcomes for several of the measures. For example, PASRR processes were suspended for new admissions to nursing facilities in late March 2020. In order to suspend these processes, the State had to request a waiver from CMS to suspend PASRR assessments and evaluations. LDH was granted permission by CMS to suspend these reviews from late March 2020 throughout the remainder of the calendar year into 2021. In addition to the pandemic, and the multiple times in which PASRR Level II operations were suspended due to the volume of COVID cases in state, Louisiana experienced several weather events throughout the year. In particular, 1135 waivers to PASRR Level II operations were implemented for Hurricanes Laura and Delta.

Due to mitigation strategies and public health emergency orders as a result of the COVID-19 pandemic, there were some limitations to getting out into the community for all citizens in Louisiana including those individuals supported through the My Choice program. Additionally, various supports and services were shifted from in-person visits to telehealth or virtual visit options. While the individuals still received their supports and services, it was often noted in the logs that they did not get them as noted in their transition plans since they were not delivered face to face. Other issues noted specifically for in home personal care type services included sporadic instances of staff not arriving for a specified shift and/or the provider agency not implementing back-up plan as expected. Most of these situations were addressed on an individual basis in terms of remediation; however, this is an area that was identified by the internal quality assurance workgroup as requiring additional action.

As noted, some of the data is being collected through self-reporting processes gathered by the Transition Coordinators through their monthly contact logs. While self-reported information can serve as a good proxy when quantitative data is not available, the team does acknowledge the need to develop processes to offset any reliability concerns regarding this data. The SME service review is one such mechanism to be able to evaluate the reliability of the data collected through the monthly logs. The long term plan in this area includes adopting and implementing the SME's assessment methodology, in order to continue to assess the quality and sufficiency of community-based services.

The SME service review report was another input into the quality process. The SME is responsible for assessing the quality and sufficiency of community-based services for members of the TP. As a part of this quality assessment, the SME reviewed a representative sample of individuals in the TP and developed a report outlining the design of the service reviews, process for conducting reviews, the findings of these reviews, and recommendations that should be considered to make improvements to the My Choice Program. The results of the SME Service reviews conducted throughout calendar year 2020, identified a number of systemic issues identified by the service review team. The issues noted in the SME service review, Attachment A of the SME Report January-June 2021, (SME-Report-January-June-2021.pdf (la.gov)) included:

- Lack of a single plan guiding post-transition services and supports. For some of the individuals, there were multiple plans: Transition Plan, MCO plan of care, CCW plan of care, and a behavioral health provider treatment plan. The plans were often not developed collaboratively nor were they shared or reviewed as a team.
- There is significant variability in the completeness of core assessment and plans, including transition and community plans.
- There is limited information available to the Target Population regarding the My Choice program while in the nursing facility

- Employment aspirations and goals were not discussed or identified in any of the interviews or documentation despite that, when interviewed, some individuals expressed an interest in working.
- While the transition coordinators were personally valued and frequently interacted with the individual, there was a heavy reliance on the transition coordinators to address and problem solve on all issues and barriers. Some transitions coordinators were able to triage and delegate issues to appropriate providers, while others assumed the responsibility to "fix" every issue addressed.
- There was inadequate focus on community inclusion (social, recreation, employment, education, etc.) which is central to maintenance of community tenure.

Proposed Activities to Address Issues

The internal DOJ quality workgroup identified the need to address the issues noted above including a focus on providing additional training and technical assistance to the transition coordinators related to both their role and strategies to assist the transition coordination to complete the monthly log. In discussions with the transition coordinator supervisors and transition coordinators, there were often questions raised regarding the intent of the questions identified on the monthly log. The internal team collectively determined that there was likely a need to revise the instructions for the transition monthly log to further define and clarify the intent of the question as well as, provide a training to all transition coordinators. While the team did initiate some initial discussions and provided clarification regarding the monthly log during standing meetings, a formal training has not been conducted; however, leadership from each of the program offices are working together to make appropriate revisions and develop appropriate training with plans to complete this activity in February, 2022.

In addition to training, the DOJ quality workgroup, the My Choice quality resource group, and the SME have recommended that a more in depth analysis of critical incidents be completed to identify root cause and determine type of remediation strategies that may need to be employed. The SME team will start the initial analysis with LDH in December 2021. An initial focus should be on critical incidents that are often most frequently reported—emergency department visits and inpatient admissions (all cause). OAAS has initiated work at a program office level to work with providers of service, support coordinators and regional offices to address this issue on a systemic level. Specifically for the members of the target population, each program office's Quality Review Teams will conduct a more in depth review of CIRs during their monthly meetings.

Another area of focus both identified by the DOJ quality workgroup and the SME service review relates to community integration. While the pandemic has posed some issues in this area, the team feels like it is important to focus on this this area. Some activities that have occurred to begin addressing this area included the development of an ad-hoc report to evaluate the hobbies, preferences, vocational, social and recreational activities that have been identified as important by the individual in their transition assessment, reviewing this report with the transition coordinators and to ensure the transition coordinators are having some focused conversations post transition to assist the individual with getting connected to these activities. The program offices are working with the OAAS data analytics team to develop a standing report that would make this information readily available to the transition coordinators and supervisors to manage and monitor progress in this area. Other activities the team is considering include planned discussions internally as well as with other states to identify opportunities/strategies to both evaluate and improve in this area. The DOJ quality workgroup will

continue to monitor this area on a quarterly basis and share the information with My Choice quality resource group to identify/determine additional strategies/actions that may need to be deployed.

In an effort to address areas identified through the TC logs where an individual has indicated they did not receive the services they needed, the DOJ quality work group has asked the program office QRTs to conduct a more in depth review of these cases. The QRTs should begin collecting information regarding the service provider and/or support coordinators selected by the individual and currently assigned and providing support in January, 2022. The team wants to utilize this information to better be able to identify any particular trends/patterns in an effort to better develop any necessary strategies to address areas of concern.

In looking at recommendations from the SME service review report regarding the lack of a single plan, the team did have discussions regarding the feasibility of implementing a community plan. It was determined that it does not seem practical to require the transition coordinators to complete a community plan, as the timing of a final community plan and implementation of the new community case management approach is scheduled to occur in a six month timeframe. In preparation for the implementation of community case management benefit, the MCOs have been working collaboratively to develop a single plan of care that will be utilized by the community case managers beginning in CY 2022. Training regarding the transition coordinators role as the interim case manager is planned. As part of this training the intent is to provide messaging regarding expectations around collaboration to include:

- Regular team meetings with all identified parties responsible for supporting the person; and
- Sharing of information/documentation with all members of the team

Through the SME reviews LDH will monitor whether individuals receiving CCM are getting plans of care at discharge and on a regular basis and whether these plan address the needs of the individual.

Finally, LDH has acknowledged since initiating the various processes for collecting data that this was a first iteration of the quality matrix. Based on experience of reviewing and analyzing the data over the course of the last year, many lessons have been learned. Some of the lessons learned include:

- There are several self-report measures that have not produced anticipated outcomes. The following have been identified as measures that are recommended to be removed from the matrix:
    - Number and percent of transitioned members reporting independence with taking care of themselves physically. Initial thoughts related to this area was that a change in ability to care for oneself physically might demonstrate a change in status that should be considered. The results in this area consistently remained in the 90% range. While self-report results for this area remained high, data in other areas demonstrated that persons were still experiencing issues (example: critical incident data). In this instance, the critical incident data source may be a better predictor than the self-report question regarding physical health and well-being. In addition to critical incident data, regular assessments completed by the community case managers and TCs at specified frequencies will provide alternative data sources to evaluate this area.
    - Number and percent of transitioned members self-reporting that they have not experienced any major incidents. There was much variability in terms of data reported for this item. In general, it appears that many people report no major incident even

though there are other data sources (e.g. critical incident reports) to suggest that they have experienced some type of incident (example: critical incident data).

- There are several areas identified as needing revisions and/or expansion in the quality matrix. Some of these are as follows:
    - The focus for the first year has been on collecting data specifically for transitioned members of the target population. The second iteration of the matrix, that LDH will implement in CY 2022, will need to expand to include both transitioned and diverted members of the target population.
    - Throughout the course of the past year, it was identified that the current Utopia PASRR Level II system is older and does not allow the team to pull the full array of data to evaluate effectiveness and progress for identified measures in this area. The OBH PASRR Level II team is actively working on a new system and revisions to the metrics. The changes being proposed will allow for more specificity related to this area and provide a mechanism to evaluate types of specialized services being recommended and received for both new admissions and ongoing stays. It will also provide better information regarding the frequency of annual resident reviews.
    - Based on the collection of data and discussion with the SME, My Choice Quality Resource Group and the DOJ, there are several areas that need to be expanded in a future iteration of the quality matrix. Major areas identified to expand upon include stability, provider capacity/utilization of new services, choice, self-determination, barriers to integration, community inclusion and in general quality of life. In order to address some of the quality of life, stability and community integration components as well as the feedback received regarding reliability of self-reported information, the DOJ quality work group is considering the development of tools and processes to gather information through the TCs once the community case management approach is implemented. Current consideration includes a tool that evaluates these areas prior to or early in the transition process and again post-transition (possibly 9 months post transition). The tools/process needs to be developed and tested and measures developed to be incorporated into the matrix.
    - There is a self-report measure related to medication/treatments that focuses on a change in medication, side effects, and/or who gives meds. Again, there is much variability in terms of the responses to this question. Review of the logs reflected some of these changes were short-term changes such as antibiotics added to the person's treatment regimen to address a specific condition. In general and based on feedback and recommendations received, it seems like a question focused on the type of support someone needs related to medication and/or adherence to medication regiment might be a better measure.
    - There has been recommendations/feedback to separate mental health from physical health and have metrics for each area given the significant co-morbidities of the Target Population.

Summary/Conclusion

Despite the challenges posed through calendar year 2020, the LDH team was able to implement tools/processes to collect data, develop reports to evaluate progress, and test the first version of the

quality matrix. Testing of the tools, reports, and processes as well as feedback and input received from the SME, DOJ, and the My Choice Quality resource group provided valuable information in terms of actions to be taken by the DOJ quality workgroup to revise quality measures and processes in the future with the ultimate goal of informing continuous quality improvement.

With the implementation of the community case management approach, quality assurance processes will expand to include both transitioned and diverted members of the population. Many of the measures that are currently collected utilizing self-reported data through the transition coordinator monthly log will shift to being reported by the community case manager. During the next several months, the DOJ quality workgroup will be working closely with the SME, DOJ and My Choice quality workgroup to complete a variety of activities.

- Crosswalk information to be collected via community case managers to the quality matrix
- Identify new measures based on recommendations received from SME, DOJ and My Choice quality resource group to be incorporated in the next version of the quality matrix
- Develop a tool and processes to collect data for the new measures
- Revise identified existing measures as per recommendations received
- Update the PASRR system to collect information for the Agreement

Appendix A: My Choice Quality Matrix 2020 Data

Domain		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Provider Capacity, Access to, and Utilization of Community Based Services	1.a	Number of community based behavioral health providers available to provide services and accepting new Medicaid participants	# of providers accepting new Medicaid patients by level of care stratified by LDH region	See attached reports			
	1.b	Number of community based behavioral health providers available to serve BH Medicaid beneficiaries stratified geographically by region	Report analysis # of providers accepting new Medicaid patients by level of care stratified by LDH region				
	1.c	Number and percent of specialized behavioral health providers meeting appointment availability standards. 1) Emergent: 1 hour; 2) Urgent: 48 hours (2 calendar days); Routine: 14 calendar days	Statistically significant random sample of providers to obtain next available appointment				
	1.d	Number and percent of transitioned members who report that they received all types of services specified in the transition plan	# of transitioned members who report that they received all types of services specified in plan/total # of transitioned members interviewed.	54/65 83%	31/42 74%	34/49 70%	25/33 76%
	1.e	Number and percent of transitioned members who received services in the amount, frequency and duration specified in the transition plan	SME review of representative sample of individuals transitioned from NFs[1]				

Domain		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	1.f	Number and percent of transitioned members reporting they are receiving the services they need	# of transitioned members reporting they are receiving the services they need/total # of transitioned members interviewed	56/65 86%	33/42 79%	37/49 76%	26/33 79%
Referrals to, admission and readmission to, diversion from, and length of stay in nursing facility	2.a	Referral to nursing homes- Nursing Facility Admission Request	Number of persons that request level 1 admission to Nursing Facility	9432	5809	7807	7804
	2.b	Referral to Level II OBH (as per results of Level I PASRR) requested at admission	Number of individual initial placement requests (# initial placement requests)	687 7%	91 2%	403 5%	257 3%
	2.c	PASRR Outcome Trends	Independent Evaluations vs. desk review	Indep Eval 959	Indep Eval 633	Indep Eval 816	Indep Eval 960
				Total Level II Reviews 2276	Total Level II Reviews 1206	Total Level II Reviews 1514	Total Level II Reviews 1686
	2.d	PASRR Outcome Trends	Total Resident Reviews--# of Resident Reviews conducted (# resident reviews)	1046	688	602	798
	2.e	NF Short Term Authorizations vs. Long Term Authorizations	Number of initial authorizations approved for short term stay(100 days or less) (# short term authorizations)	687	91	788	84
	2.f	PASRR Level II Service Recommendations	Percent of PASRR determinations that recommended referral to Specialized Behavioral Health Services (# referred SS/# approved)	67%	73%	94%	77%

Domain		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	2.g	Services Provided	Number and percent of individuals receiving PASRR Level II Specialized Behavioral Health Services Recommended[2]				
	2.h	PASRR Level II Placement Recommendations	Number and Percent of PASRR determinations indicating that admission to NF is not recommended as it is not the least restrictive setting (#Level II determinations not recommending NF admission/#initial Level II referral requests for placement excluding cases identified as withdrawn)	4%	2%	23 6%	14 7%
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	# of transitioned members who report that they understand their plan of care/treatment plan/total # of transitioned members interviewed.	53/65 82%	37/42 88%	47/49 96%	31/33 94%
	3.b	Number and % of transitioned members who report that they participated in planning	# of transitioned members who report that they participated in planning /total # of transitioned members interviewed.	51/65 78%	30/42 71%	38/49 78%	26/33 79%
	3.c	Number and % of transitioned members who report planning included participation members of their chosen social network	# of transitioned members who report that planning included others of their choosing/total # of	52/65 80%	34/42 81%	46/49 94%	29/33 88%

Domain		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
			transitioned members interviewed.				
	3.d	Number and % of transitioned members who indicated their preferences are being respected	# of transitioned members who report that their preferences are being respected /total # of transitioned members interviewed.	60/65 92%	35/42 83%	42/49 86%	30/33 91%
	3.e	Number and percent of transitioned members whose plan of care addressed their needs	SME review of representative sample of individuals transitioned from NFs[1]				
Safety and Freedom from harm	4.a	Number of critical incidents, stratified by type of incident	Review and analysis of critical incident reports submitted by the TCs and using provider and member reported CI information	# of people that had CIRs = 13 individuals **<u>Categories:</u>** **Falls:** 9 **Maj Medical:** 36 **Maj Injury:** 0 **Maj Behavioral Incident:** 2 **Maj Medication Incident:** 1 **Protective Services:** 1 **Death**: 0 **Other (legal involvement):** 1	# of people that had CIRs = 18 individuals **<u>Categories:</u>** **Falls:** 16 **Maj Medical:** 41 **Maj Injury:** 3 **Maj Behavioral Incident:** 7 **Protective Services:** 4 **Death:** 0 **Other (legal involvement):** 1	# of people that had CIRs = 20 individuals **<u>Categories:</u>** **Falls:** 17 **Maj Medical:** 44 **Maj Injury:** 0 **Maj Behavioral Incident:** 3 **Protective Services:** 4 **Death:** 3 **Other:** 3	# of people that had CIRs = 15 individuals **<u>Categories:</u>** **Falls:** 7 **Maj Medical:** 21 **Maj Injury:** 0 **Maj Behavioral Incident:** 2 **Protective Services:** 2 **Death:** 1 **Other (loss of home):** 2
				ER visits: 18 Hospitalization: 18 Psyc Admission: 9	ER visits: 31 Hospitalization: 17 Psyc Admission: 7	ER visits: 41 Hospitalization: 14 Psyc Admission: 6	ER visits: 14 Hospitalization: 10 Psyc Admission: 3
	4.b	Number and percent of referrals reported to protective service agency for abuse, neglect, and exploitation	Number of abuse, neglect, exploitation referrals made	1	4	4	2

Domain		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	4.c	Number and percent of death investigations that were completed	Number of death investigations that were completed/ Total number of death investigations	0	0	0	0
	4.d	Number and percent of deaths that require a remediation plan	# of transitioned TP members deaths requiring remediation plan/total # of transitioned members interviewed				
	4.e	Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessment (s)	SME review of representative sample of individuals transitioned from NFs[1]				
	4.f	Number and percent of transitioned members reporting that they have not experienced any major incidents	# of transitioned TP reporting no major incidents/total # of transitioned members interviewed	47/65 72%	30/42 71%	30/49 62%	23/33 70%
	4.g	Number and percent of transitioned members reporting that they have been free from abuse, neglect, or exploitation	# of transitioned TP reporting freedom from abuse, neglect, exploitation/total # of transitioned members interviewed	61/65 94%	38/42 91%	46/49 94%	30/33 90%
Physical and mental health wellbeing and incidence of health crisis	5.a	Number and percent of transitioned members reporting good physical and mental health	# of transitioned TP members reporting good physical health and mental health/total # of transitioned members interviewed	56/65 86%	33/42 79%	38/49 78%	27/33 82%
	5.b	Number and percent of transitioned members reporting independence	# of transitioned TP members reporting no change in ability to	61/65 94%	36/42 86%	43/49 88%	30/33 91%

Domain		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		with taking care of themselves physically	complete tasks for themselves/total # of transitioned members interviewed				
	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	# of transitioned TP members reporting a change in medications/treatments, or side effects from and/or who gives them/total # of transitioned members interviewed	10/65 15%	14/42 33%	14/49 29%	8/33 24%
	5.d	Number and percent of participants who utilized crisis services, ED presentations, hospitalizations (as an overlay to see if a person was in crisis)					
Stability	6.a	Number and percent of transitioned members reporting stability in housing	# of transitioned members reporting stability in housing /total # of transitioned members interviewed	60/65 92%	36/42 86%	41/49 84%	30/33 91%
	6.b	Number and % of transitioned members reporting stability in natural supports network	# of transitioned members reporting stability in natural support network/total # of transitioned members interviewed	59/65 91%	35/42 83%	46/49 94%	29/33 88%
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]				
Community Inclusion	8.a	Number and percent of transitioned members	# of transitioned members reporting	48/65 74%	25/42 60%	32/49 65%	26/33 79%

Domain		Proposed Data Measure	Methodology	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		reporting that they are involved in the community to the extent they would like	they are able to be involved in the community to the extent that they would like/total # of transitioned members interviewed				

[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.

Appendix B: 2020 Network Reports

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

Data Measure: (1a) Number of community based behavioral health providers available to provide services and accepting new Medicaid participants
Methodology: # of providers accepting new Medicaid patients by level of care

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

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

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

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

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

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

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

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

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

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

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

Data Measure: (1c) Number and percent of specialized behavioral health providers meeting appointment availability standards.
Methodology: Random sample of behavioral health providers to obtain next available appointment

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

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

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

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

LEVEL OF CARE DEFINITIONS

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

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

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

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

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

American Society of Addiction Medicine (ASAM) Level 2.1: Intensive Outpatient Treatment is professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Intensive outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure. These services include, but are not limited to, individual, group, family counseling and psychoeducation on recovery, as well as monitoring of drug use, medication management, medical and psychiatric examinations, crisis intervention coverage and orientation to

community-based support groups. Intensive outpatient program services shall include evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing and multidimensional family therapy. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but must be a minimum of nine contact hours per week for adults, and a minimum of six hours per week for adolescents at a minimum of three days per week with a maximum of 19 hours per week. This level consists of a scheduled series of face-to-face sessions appropriate to the individual's plan of care.

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

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

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

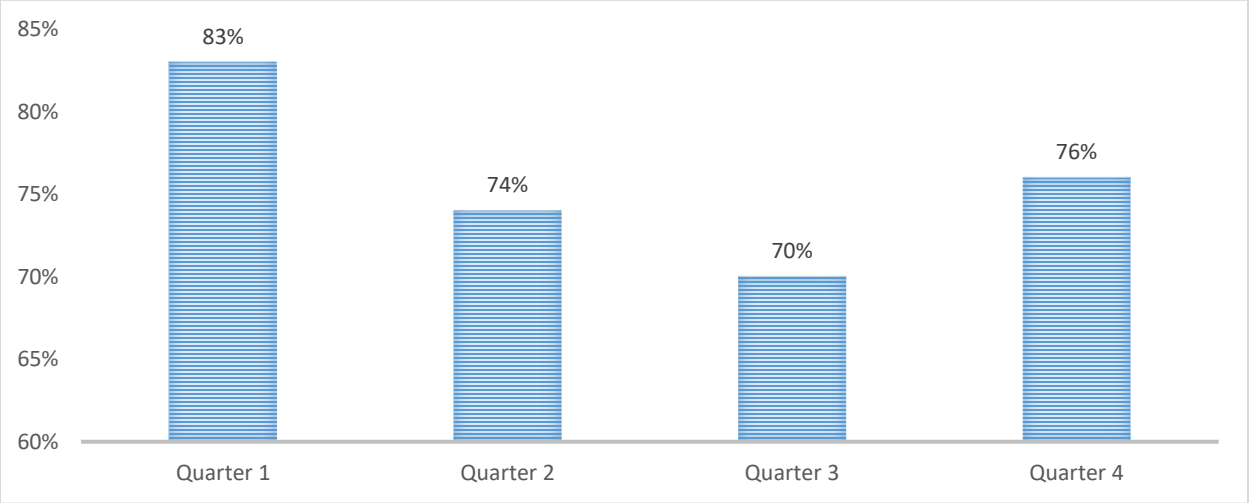
Psychiatric Outpatient (Agency/Facility) – Non-Prescribers - Psychiatric Outpatient services provided by non-prescribing licensed practitioners employed by an agency or facility.

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

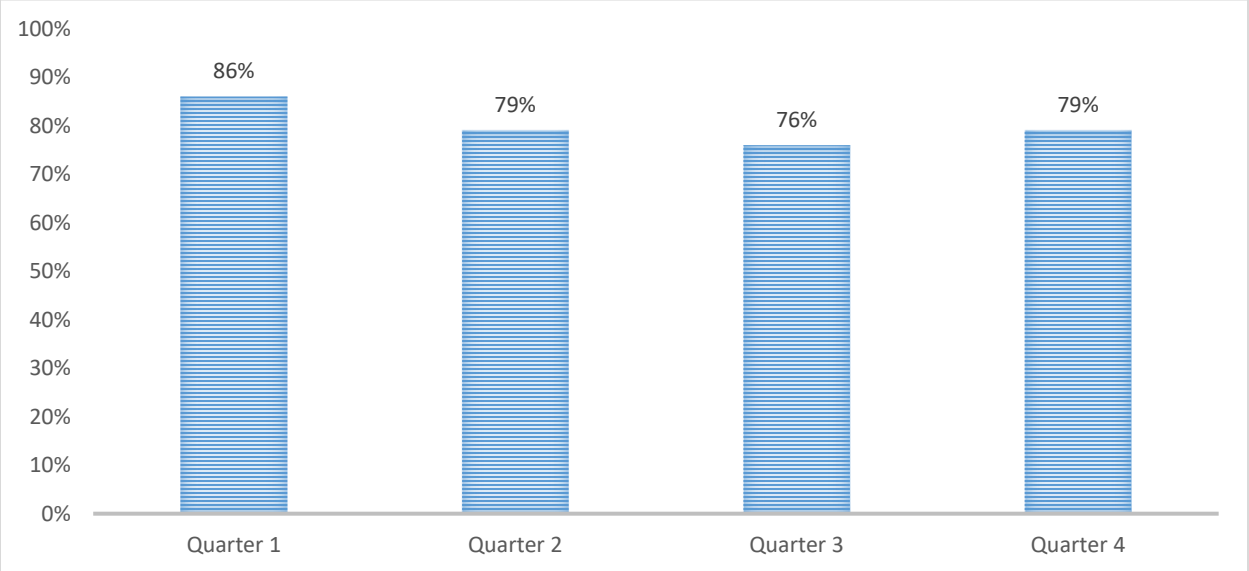
Appendix C: My Choice Louisiana 2020 Quality Data Graphs

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

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

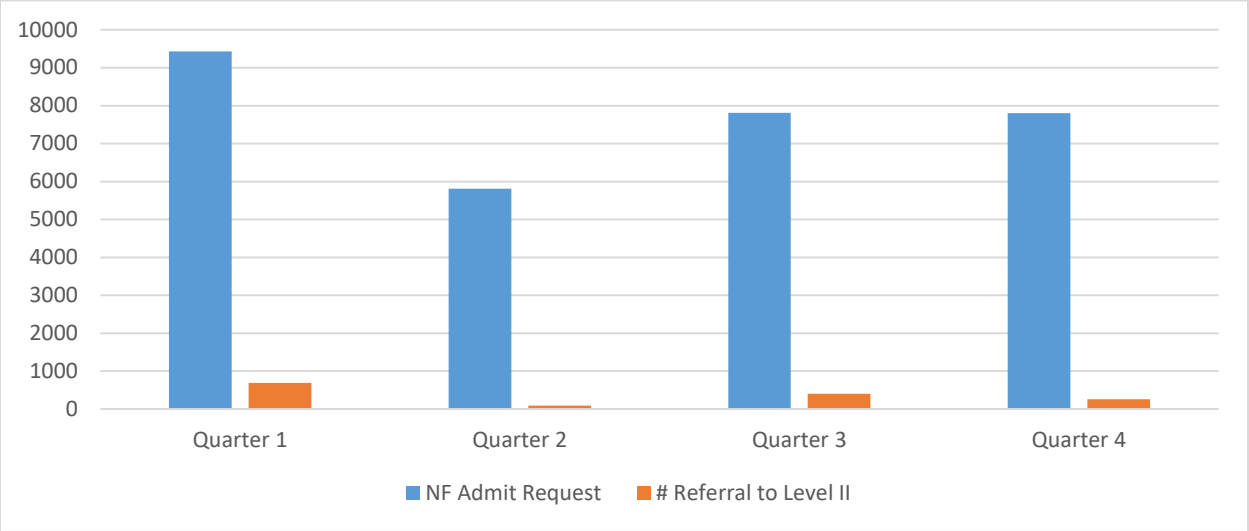


Percent of transitioned members reporting that they are receiving the services they need.



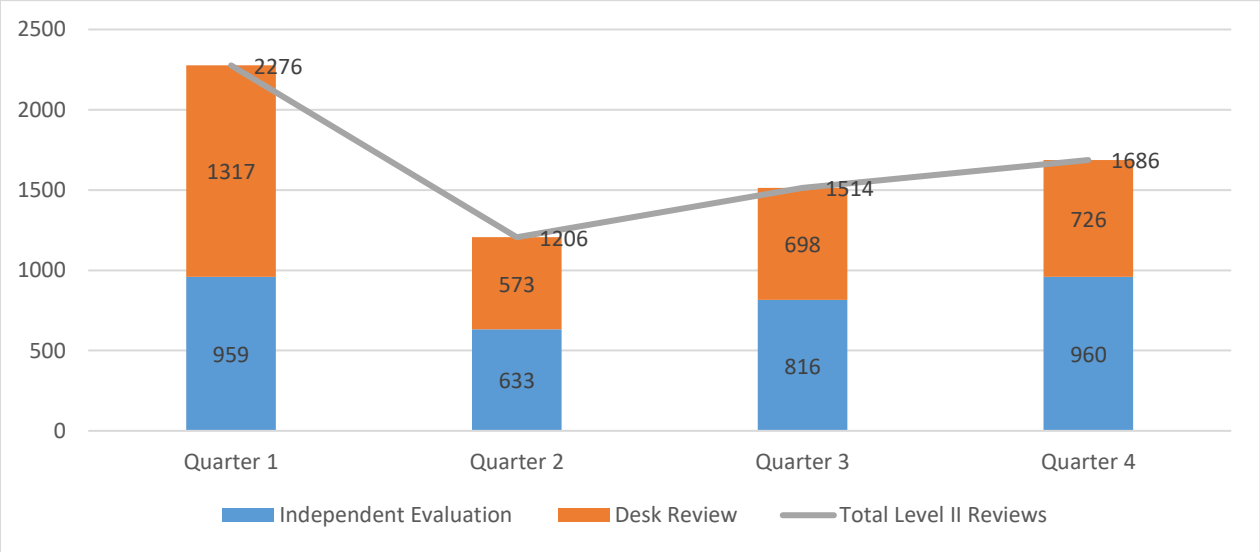
Referrals to, admission and readmission to, diversion from, and length of stay in nursing facility

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



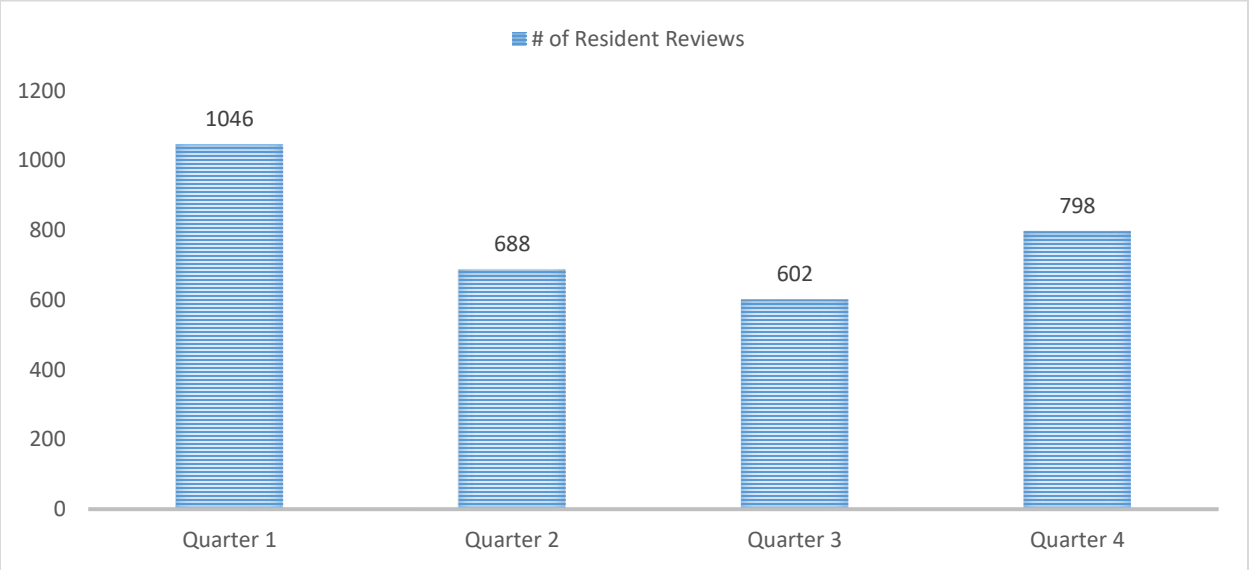
PASARR Outcome Trends – Total PASARR Level II Reviews Conducted by Method

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



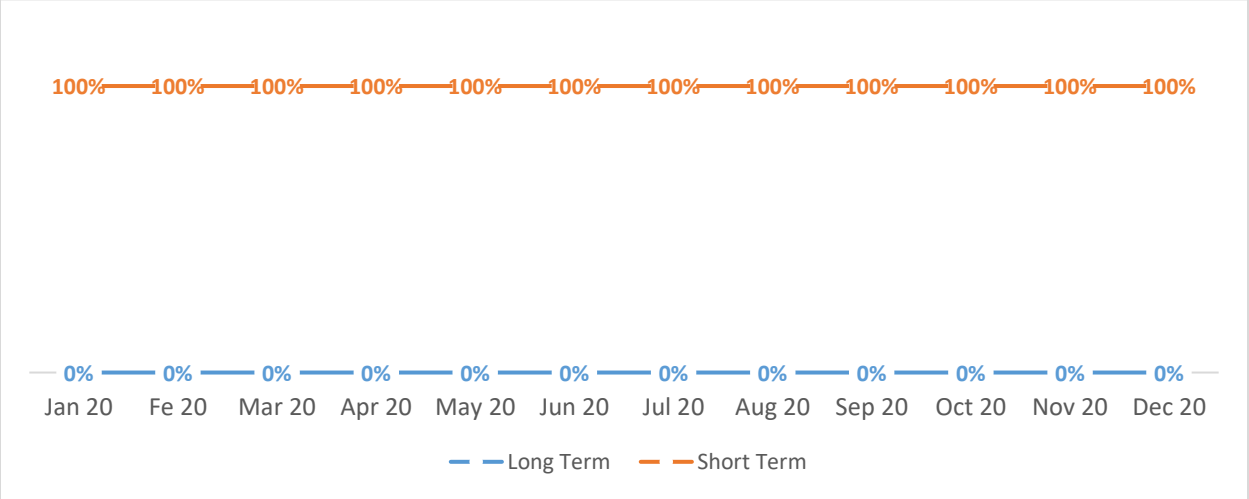
PASARR Outcome Trends – Total Resident Reviews

# of Resident Reviews conducted related to Change in Condition



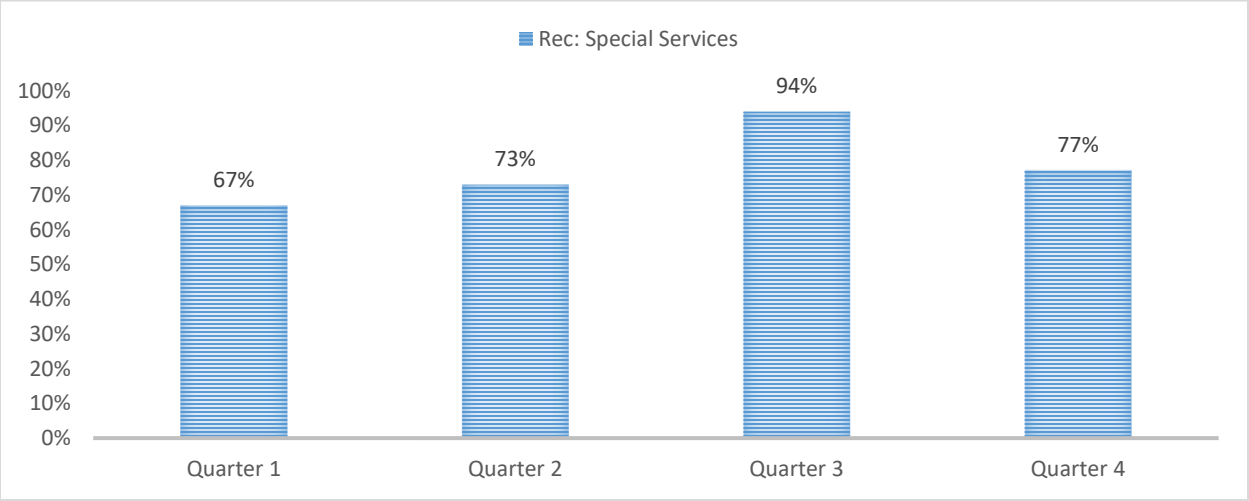
PASARR Outcome Trend – NF Placement Short Term v Long Term

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



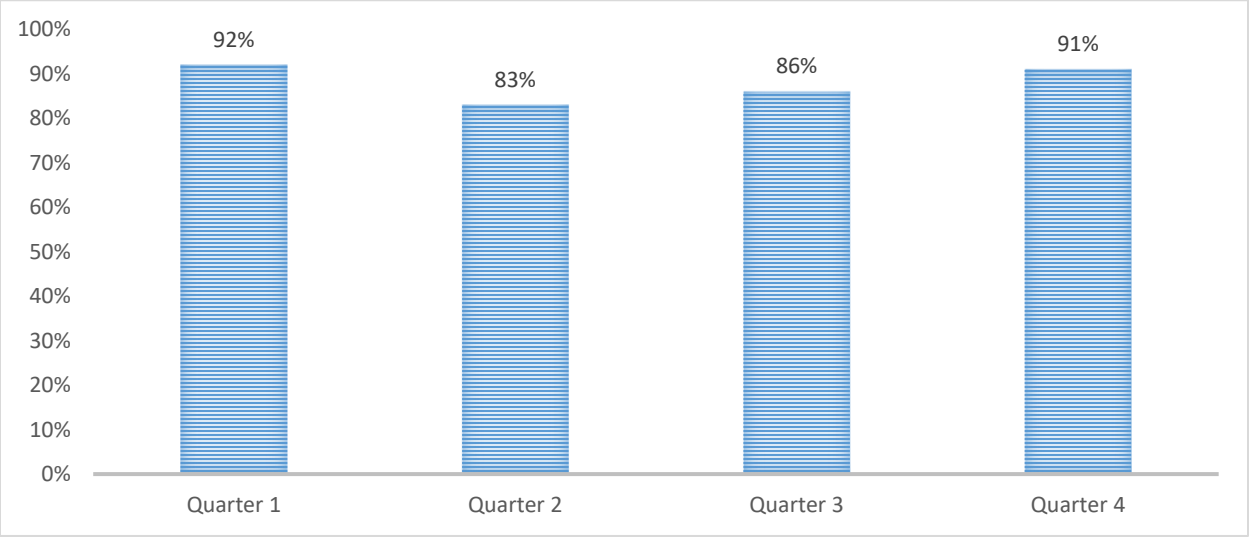
PASARR Outcome Trends – Recommended for Special Services (SMI)

% of PASARR determinations that recommended referral to Special Services



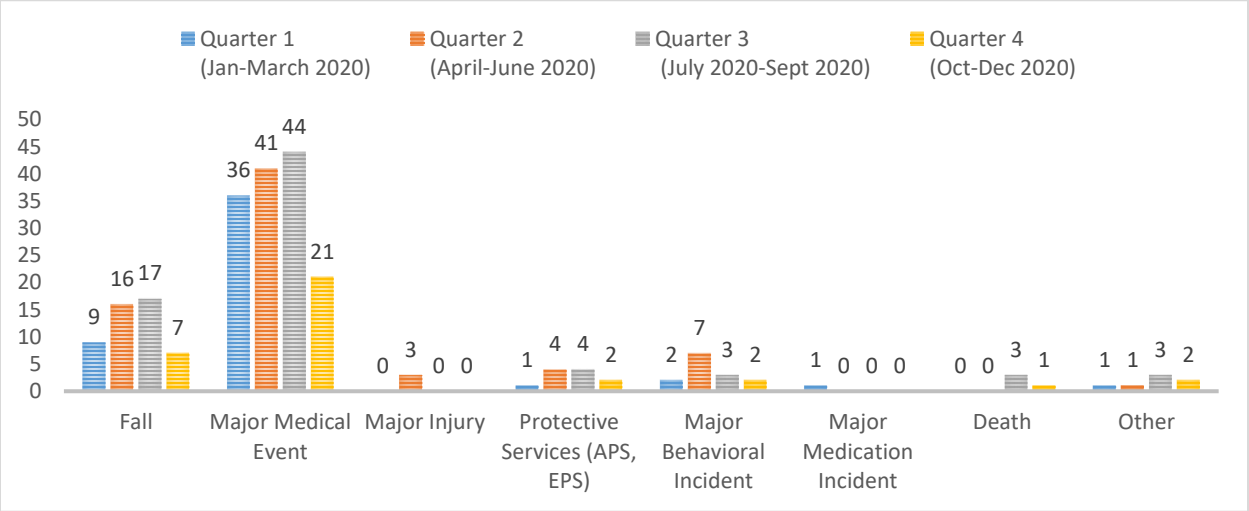
Person Centered Planning, Transition Planning, and Transitions from NF

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

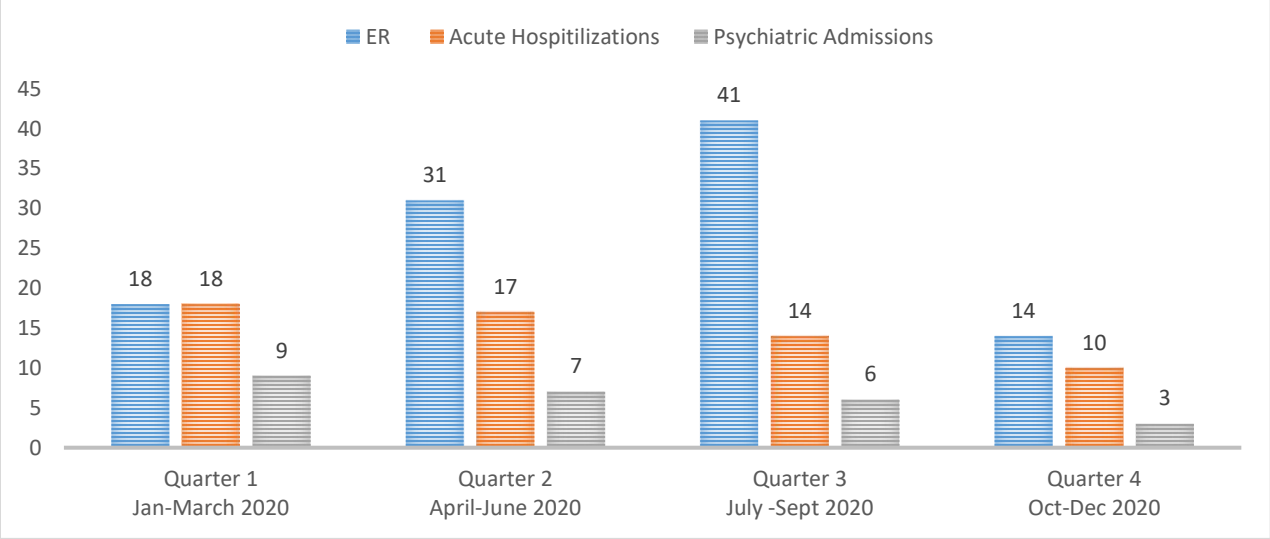


Safety and Freedom from harm

Number of Critical Incidents, stratified by type of incident

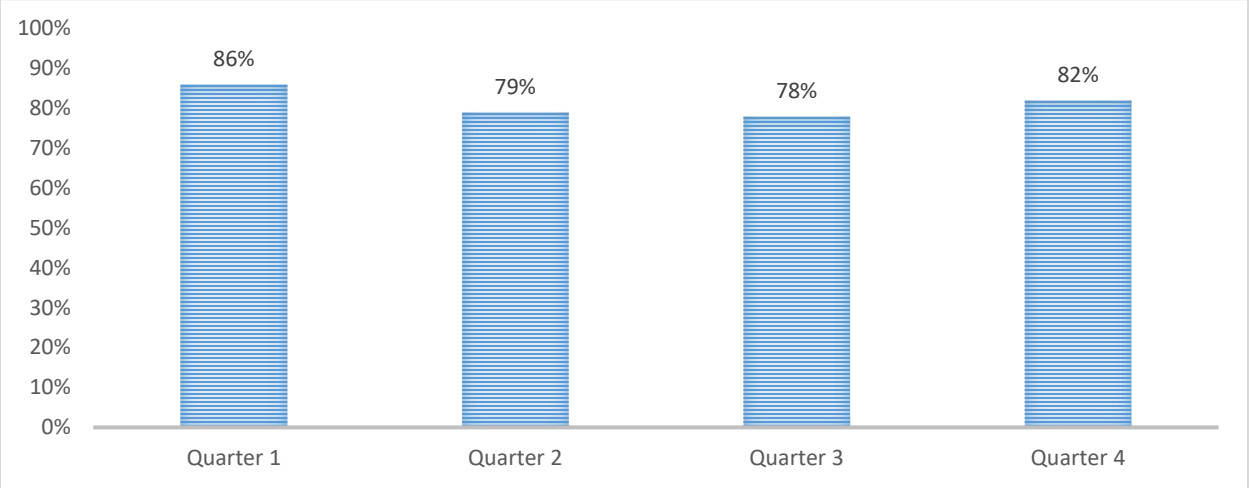


Of total CIRs noted above this graph represents a breakdown of acute hospitalizations, psychiatric admissions, and ER.

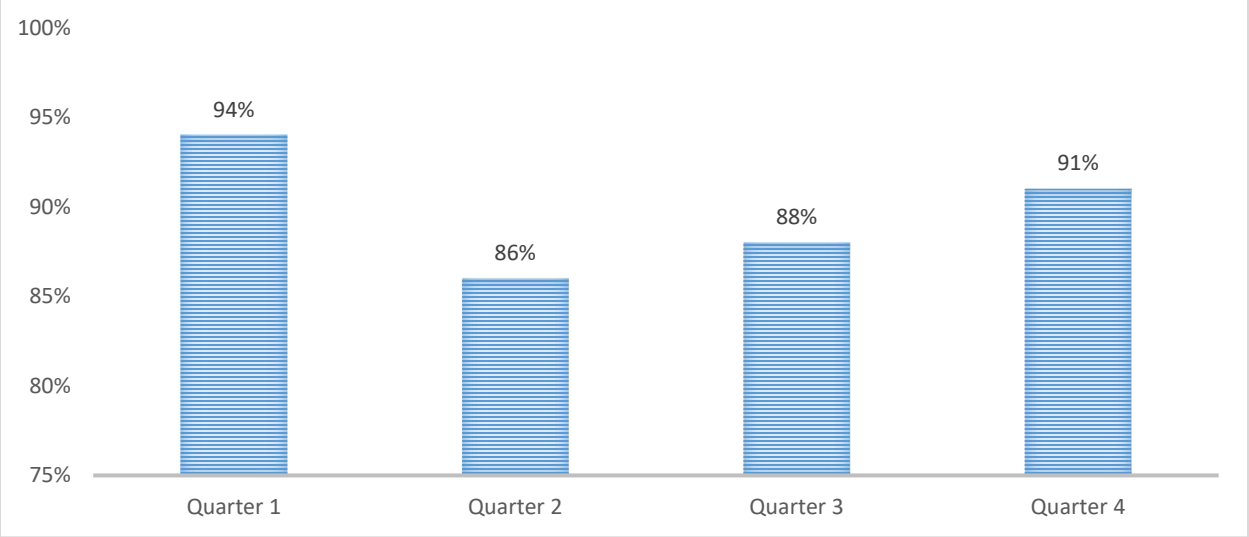


Physical and mental health wellbeing and incidence of health crisis

Percent of transitioned members reporting good physical and mental health.

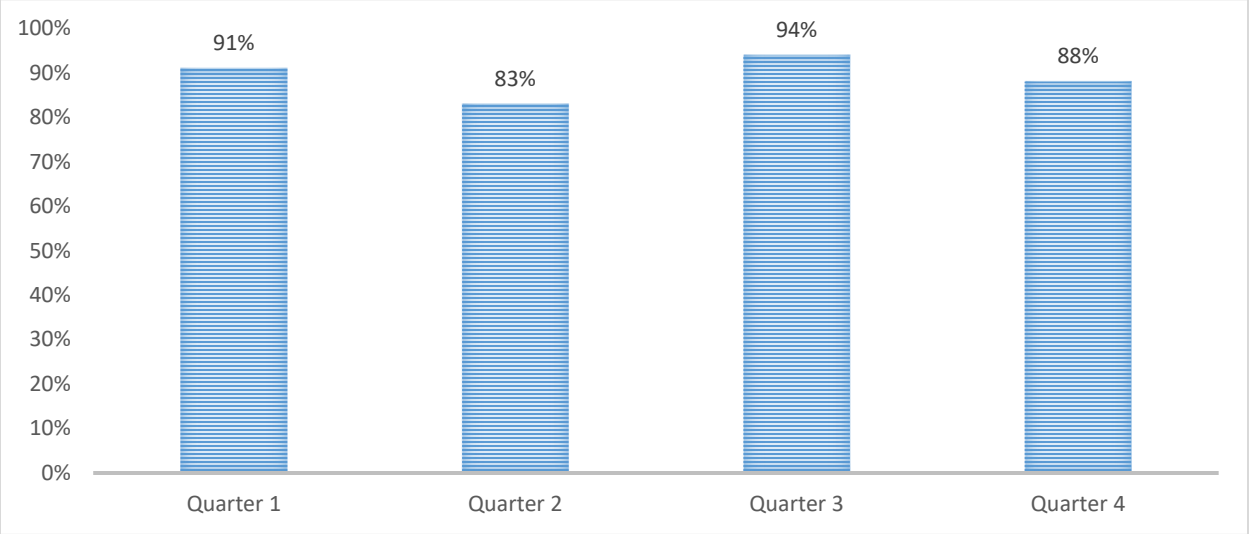


Percent of transitioned members reporting independence with taking care of themselves physically.



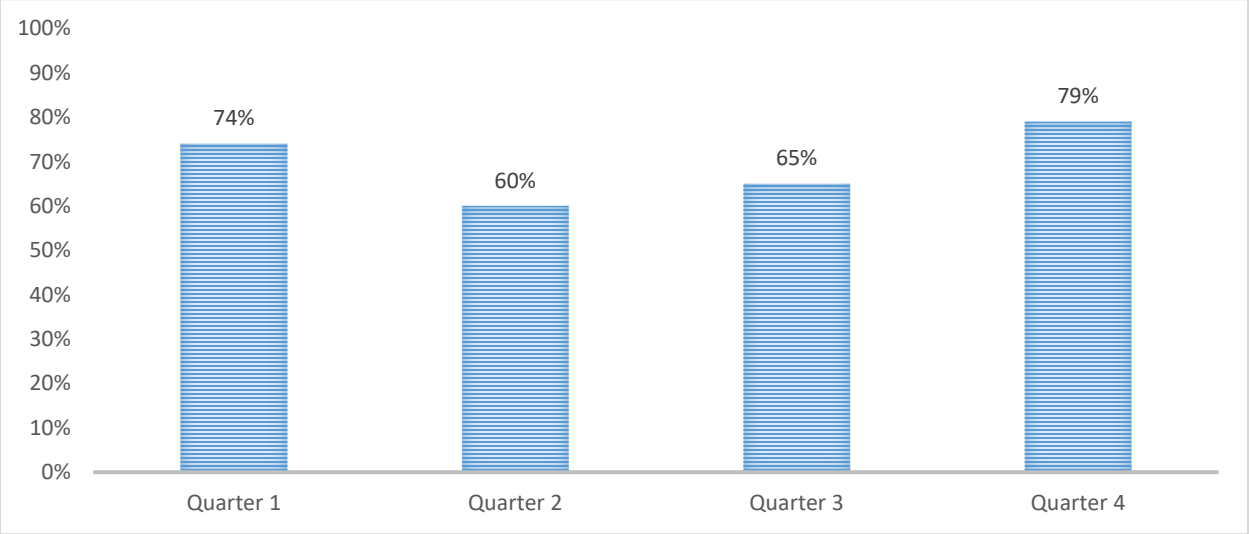
Stability

Percent of transitioned members reporting stability in natural supports.



Community Inclusion

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



LOUISIANA
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