# My Choice Louisiana

# Annual Mortality Report #4

## Calendar Year (CY) 2024

*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 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.

## SCOPE AND STRUCTURE

In response to Louisiana's Agreement with the U.S. Department of Justice (DOJ), the Louisiana Department of Health (LDH) has established the Mortality Review Committee (The Committee). This Committee is tasked with developing and maintaining protocols for reporting and investigating deaths and significant incidents among individuals in the MCL Target Population (TP), both transitioned and diverted individuals.

The Committee will conduct reviews under specific circumstances, including any unexplained death (a sudden death that is unexpected or is unexplained at the date of death. This includes, but is not limited to suicide, car accident, drowning, and sudden natural causes such as heart attack or stroke), deaths within 60 days of discharge from a Nursing Facility, and any death involving suspected abuse, neglect, or exploitation. The purpose of this process is to:

1. Identify remediation actions for individual cases;
2. Provide system-level quality improvement (QI) recommendations; and
3. Understand circumstances surrounding deaths to reduce future risks.

The Committee is responsible for ensuring the appropriate and timely implementation of identified actions and systemic reforms for the My Choice LA Program.

The Mortality Review Committee (MRC) includes representatives from OAAS and OBH, and includes Quality Management (QM), Policy and Operations staff, Health Standards (HSS), and Adult Protective Services (APS).

Required members of The Committee are:

1. OAAS Quality Manager
2. OAAS Program Operations Manager
3. LDH Registered Nurse
4. HSS Program Manager
5. OAAS Policy Program Manager
6. OBH Quality Program Manager

APS participation is requested as needed, particularly for collaboration in cases of suspected abuse, neglect, or exploitation. This leads to more efficient and timely investigations, interventions, and protections in such cases.

HSS enforces regulatory compliance of health care facilities and provider types within the State of Louisiana. This is accomplished through periodic surveys/inspections of the providers, which are licensed and/or certified to operate in Louisiana. HSS also investigates complaints received regarding allegations of abuse, neglect, exploitation, and extortion, and noncompliance with federal and/or state regulations, which fall under the purview of the state survey agency. Additional expertise (e.g. physicians, representatives of attorney general's office, pharmacists, etc.) may be sought for participation on this body when needed.

The Committee is designated to review all deaths of individuals who are members of the Target Population. The Committee meets and perform strategic reviews, evaluation, and trend analysis on cases meeting criteria, commensurate with a continuous quality improvement approach.

The Committee meets monthly, or as needed, based on case referrals. Committee meetings are rescheduled if not all required members are present, or if a case referral is not presented for review.

Separate from The Committee, the Review Team collects and reviews records and provides documentation and preliminary analysis to The Committee for review. The Review Team consists of OAAS and OBH staff and are separate from The Committee members, aiding LDH in ensuring an impartial collection of records occurs. Responsibilities includes collecting, reviewing and summarizing information gathered during the mortality review process and providing this information to The Committee prior to their convening.

Members of the My Choice Louisiana Mortality Review Committee are:

1. OAAS Quality Program Manager
2. OBH Quality Program Manager

Annually, the Committee will produce a My Choice Louisiana Mortality Report for the calendar year. This report is released publicly to ensure public transparency and promote accountability within the My Choice Louisiana Program.

This is the forth mortality review report from the Committee.

## MORTALITY REFFERALS

**Overview**

For Calendar Year (CY) 2024, twelve (12) mortalities were reported. Of these:

1. Six (6) mortalities were referred to the Mortality Review Committee (The Committee).
2. Six (6) involved individuals who were receiving hospice care at the time of death and therefore were not referred for mortality review.

The six cases reviewed by The Committee met the established referral criteria for mortality review.

**Documentation Collected for Review**

For each referral, the following information was gathered and made available to The Committee:

1. Current plan of care (MCO Case Management, Waiver, MCL ITP, CCM CPOC, as applicable);
2. Current treatment plan from the behavioral health provider;
3. Progress notes for 90 days preceding death for any Home and Community Based (HCBS) provider (behavioral health, support coordination, direct service provider, etc.);
4. Hospital and emergency department records (discharge summaries and ancillary department records from the past year);
5. Medical records from health care providers (past 6 months);
6. Adverse incident reports (past year);
7. Death certificate; and
8. Autopsy records.

After collection, the Mortality Review Team completed the Mortality Review Form, summarizing all events leading up to and immediately preceding the individual's death. The Committee then convened throughout 2024 to conduct a comprehensive review of referrals.

**Case Summary**

Breakdown of the six referred cases

1. Population: 5 transitioned individuals; 1 diverted member who was receiving CCM
2. Referral Types:
    a. 3 unexplained deaths occurring more than 60 days after nursing facility discharge in which mortality review was requested;
    b. 2 unexplained deaths within 60 days of nursing facility discharge; and
    c. 1 diverted individual.
3. 2 cases required individual case remediation or corrective action plans from service

providers.

4. 0 referred to Health Standard Section for review.

*See Appendix A for a visual representation of case types and causes of death.

**Mortality Review Committee Data- CY 2024**

| Category | Count |
|---|---|
| **Total reported deaths** | 12 |
| **Deaths referred to The Committee** | 6 (5 transitioned, 1 diverted) |
| **Reviewed cases** | 6 |
| **Pending cases** | 0 |
| **Cases referred to HSS for review** | 0 |
| **Cases requiring corrective action** | 2 |
| **Corrective action plans approved** | 2 |
| **Corrective action plans pending** | 0 |

## REMEDIATION

Individual remediation activities were requested on two of the six referrals.

1. **Case 2- Corrective Action**

OAAS requested a corrective action plan for Case 2, addressing that they home binder was not obtained after the client's death, durable medical equipment follow-up was not completed prior to death, and health-related tasks were not accurately documented in the plan of care.

2. **Case 5- Corrective Action**

OAAS requested corrective action plan for Case 5 resulting in support coordination remediation. Specifically, critical incident reports should be entered promptly into the critical incident system.

HSS Referrals

3. No HSS referrals were required during CY 2024.

The Committee remains committed to:

1. Identifying remediation activities in individual cases;
2. Addressing identified systemic issues to improve quality of life and home and community based service delivery for members of the Target Population;
3. Developing strategies to reduce risk and prevent adverse events for Louisiana citizens.

## SYSTEMIC IMPROVEMENTS

During 2024, OAAS noted and acted upon the following systemic improvements:

**Self-Neglect Definition Update and Training Implementation**

In 2024, the Committee identified a need to update the definition of self-neglect within the Office of Behavioral Health, prompted by inconsistencies in case identification and management across teams and providers. The revised definition clarified expectations and aligned with best practices and regulatory standards.

Following this update, the Adult Protective Services (APS) team conducted targeted training for Managed Care Organizations (MCOs) and Community Case Management (CCM) providers to enhance their ability to recognize and report self-neglect cases accurately. The recommendation to update the definition and provide training was formally implemented in August 2024, supporting improved early detection and intervention for vulnerable adults.

**Need of Assistive Devices**

Further, the Committee identified a need to ensure certain durable medical equipment, such as a Personal Emergency Response System (PERS), is arranged prior to a participant's transition into the community, rather than after, to support a smoother and safer transition. Efforts are underway to determine what is needed to implement this policy change.

**Documentation Logs**

Implemented an electronic Transition Coordinator Contact Log Tracker to monitor required contacts and due dates, enhancing quality and ensuring timely completion.

## CHALLENGES AND NEXT STEPS

The Committee will continue to meet monthly (unless documentation is pending) to review individual cases, pursue corrective action, review aggregate data to identify statewide, regional or provider-level trends, and recommend system-level quality improvement initiatives as identified.

### Challenges in CY2024

In CY 2024, we continued to see delays in receiving documentation from local coroner's offices, direct service providers and healthcare providers ultimately affecting timely committee review. However, turnaround times improved significantly as compared to previous years:

1. Previous average review time: 172 days.
2. Current average review time: 134 days.

#### Next Steps

The next My Choice Annual Mortality Review Report covering CY 2025 will be made available in the third quarter of 2026.

## APPENDIX A

| Case # | Cause of Death | Unexplained Death | Within 60 days of NF Discharge | Remediation/ Corrective Action | HSS Referral | Accepted by HSS |
|---|---|---|---|---|---|---|
| 1 | Myocardial Infraction; arteriosclerotic heart disease; hypertension | * | | | | |
| 2 | Shock; Sepsis; Renal Failure | * | | | | |
| 3 | Cardiorespiratory Arrest; Cerebrovascular Accident | | * | * | | |
| 4 | Congestive Heart Failure | * | | * | | |
| 5 | Sudden Cardiac Death | * | | | | |
| 6 | Acute on chronic respiratory failure, severe chronic obstructive pulmonary disease | | * | | | |
| | | | | | | |