2023-1

LA-DOJ Ninth Subject Matter Expert (SME) Report

COVERING THE PERIOD OF 1/1/2023 THROUGH 6/30/2023

JOHN O'BRIEN

Contents

I. Introduction

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

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

The Agreement sets forth the requirement for a Subject Matter Expert (SME). The SME is to provide technical assistance to help the State comply with its obligations under the Agreement. The SME has various responsibilities, including analyzing and reporting data on the State's progress in complying with all sections of this Agreement. In addition, the SME is responsible for assessing the quality of community-based services for members of the Target Population (defined in the Agreement). On a regular basis, the SME prepares a Service Review of a representative sample of individuals in the Target Population. These reviews are conducted to look at various domains that are central to the Agreement and focuses on an individual's overall quality of life versus the quality of community based services provided to the member.

The State engaged John O'Brien (formerly of the Technical Assistance Collaborative) in August of 2018 to perform the SME responsibilities. Every six months, the SME drafts and submits 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 ninth SME report, covering the period of 1/1/2023 through 6/30/2023.

While the goal of the agreement is to reduce the inappropriate use of nursing facilities for people with serious mental illness, thus far, the number of people in the Target Population with serious mental illness living in nursing facilities has decreased since the beginning of the Agreement. In June 2018, there were 3,964 individuals in the Target Population in nursing facilities. As of June 30, 2023, there are 3,783 individuals in the Target Population in nursing facilities. While the fact that the number has decreased is a step in the right direction, there is still much work to be done to divert individuals from these facilities and more aggressively transition individuals with serious mental illness from nursing facilities.

The SME uses various sources of information for these semi-annual reports. This includes:

- Information from Managed Care Organizations (MCOs) regarding community case managers (CCMs) and other services (e.g., Assertive Community Treatment (ACT)) who are responsible for ensuring the total needs of the individual are identified and addressed.

- Information from claims and other administrative data (Utopia, OPTS, and MCO provider network reports).
- Information from the SME Service Reviews that provide information on the experience of care for individuals who have been diverted, transitioned, and awaiting transition. During this reporting period, the SME reviewed 56 individuals who were transitioned (29), diverted (8), or were awaiting transition from NFs (19).
- Information from critical incidents including referrals to the mortality review committee.
- Information provided by LDH on a quarterly basis regarding the quality of services and other information included in the Quality Matrix.

The following is the third report that provides a compliance rating regarding the State's progress in each area of the Settlement Agreement. The report is organized using the language of the Agreement as a framework, with paragraphs from critical areas of the Agreement (by number) included in italics. Each of these paragraphs is provided a compliance rating, followed by a discussion and analysis of the State's progress in these areas. The report also includes recommendations by the SME for the State to address in the next reporting period. The SME used the following criteria for determining if LDH was in compliance with each paragraph:

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

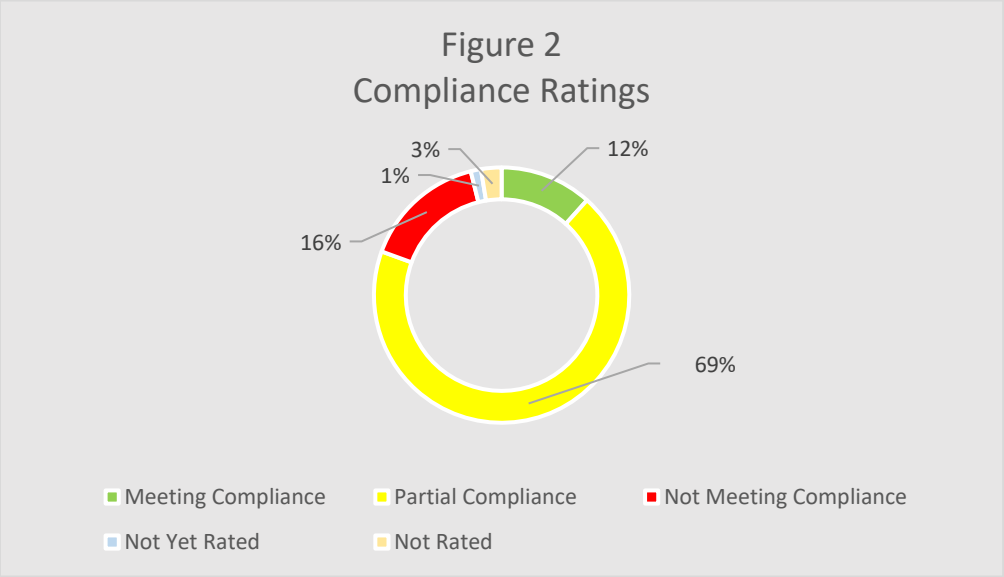
During this reporting period, the SME suggested and both DOJ and LDH agreed that a mid-year compliance review would focus on important paragraphs versus all paragraphs in the Agreement. The focus of this ninth report is on transitions, diversions, quality assurance, and one paragraph where the compliance review indicated in the eighth report as not being met. The SME will review all paragraphs in the Agreement for the next reporting period.

Figure 1 illustrates the Subject Matter Expert's compliance determinations relative to each major section of the Agreement, aggregating to the total number of requirements falling within each compliance category. Within this report, there is a dedicated section for each of the compliance domains listed below, which includes the SME's rationale for each compliance assessment rating. The scores are provided for all paragraphs, including paragraphs that were not reviewed during this reporting period.

Figure 1:
Synopsis of Report & Compliance Assessment for the My Choice Program

Target Population (3)	**Meeting Compliance**	0	**Partial Compliance**	2	**Not Meeting Compliance**	0	**Not Yet Rated**	0	**Not Rated**	1
Diversion and Pre-Admission Screening (11)	**Meeting Compliance**	3	**Partial Compliance**	5	**Not Meeting Compliance**	3	**Not Yet Rated**	0	**Not Rated**	0
Transition and Rapid Reintegration (23)	**Meeting Compliance**	1	**Partial Compliance**	16	**Not Meeting Compliance**	5	**Not Yet Rated**	0	**Not Rated**	1
Community Support Services (23)	**Meeting Compliance**	5	**Partial Compliance**	14	**Not Meeting Compliance**	4	**Not Yet Rated**	0	**Not Rated**	0
Outreach, In reach and Provider Education and Training (7)	**Meeting Compliance**	0	**Partial Compliance**	6	**Not Meeting Compliance**	0	**Not Yet Rated**	1	**Not Rated**	0
Quality Assurance and Continuous Quality Improvement 11)	**Meeting Compliance**	0	**Partial Compliance**	11	**Not Meeting Compliance**	0	**Not Yet Rated**	0	**Not Rated**	0
Total		**9**		**54**		**12**		**1**		**2**

Figure 2 summarizes the Subject Matter Expert's compliance determinations relative to many of the paragraphs in the Agreement. There are 78 distinct paragraphs applicable to this reporting period. LDH is in compliance with 9 paragraphs (12%), in partial compliance with 54 paragraphs (69%), and not meeting compliance with 12 paragraphs (15%). There are 12 paragraphs (4%) that are either not rated or not yet rated.



The 69% of paragraphs in partial compliance continues to reflect valuable, foundational work that LDH has undertaken to accomplish the requirements in this Agreement. This progress is the result of significant effort and commitment on the part of LDH staff, for which they should be commended. However, it is important to emphasize that significant work remains to achieve full compliance on the paragraphs rated in partial compliance.

The parties entered into this Agreement with a shared commitment to achieve compliance with Title II of the ADA. LDH was to accomplish this by transitioning and diverting people with serious mental illness away from unnecessary nursing facility placements, providing them the community-based services and supports sufficient to meet their needs. After more than five years of implementation, a small proportion of those in the Target Population has benefited from the Agreement's ultimate purpose. As of June 2023, LDH has transitioned 525 individuals from nursing facilities since the implementation of this Agreement began in June 2018. As of June 30, 2023, 60 individuals were diverted from NFs based on the State's definition of the diversion population. As indicated above, almost 3,800 individuals in the Target Population continue to remain in NFs. During CY 2020 through early in CY 2022 the pandemic, various storms, as well as workforce shortages for behavioral health and support services created barriers for LDH to achieve some of the projected targets for transition and diversions. As the public health emergency has eased, LDH has made better progress to achieving important targets (e.g., transitions) and milestones (e.g., development of new services) that will comply with this Agreement. However, during this reporting period LDH has underperformed on efforts to transition individuals in the Target Population in NFs who have expressed an interest in moving.

Despite these efforts, LDH projects it will take at least two or more years to transition the more than 556 people who have already expressed a desire to transition, and the hundreds of other individuals on the Active Caseload whom the state has prioritized as potentially interested in transitioning. LDH projects to transition 350 individuals from NF during this calendar year and has fallen short of their projections for

this reporting period. Consequently, hundreds of people who have already indicated they want to move will remain institutionalized unnecessarily.

It is likely that many more individuals will express a desire to transition in the future – as LDH continues to admit new people to NFs, and as improved in-reach should uncover more people who want to move. As discussed in more detail below, there have been improvements to LDH's diversion, in-reach, and transition practices. However, more actions are necessary in order to accommodate people's desire to live in their own homes and communities without undue delay. Greater participation by external stakeholders such as the Transition Support Committee and the My Choice Quality Subcommittee overseeing the quality of community services will also be critical to ensuring positive outcomes for those who are diverted and transitioned from nursing facilities.

There are several areas of focus that the SME recommends for the next six months and beyond. These priority areas have not changed significantly since previous SME reports. These priority areas include transitions, diversions, quality, and continued implementation of community services. Therefore, the SME recommends that LDH concentrate most of its efforts over the next reporting period on the following activities:

- **Increasing the number of individuals transitioned from nursing facilities.** 525 individuals have been transitioned since the beginning of the Agreement. There are 585 individuals on the Active Caseload List (ACL) who are interested in moving. LDH is aiming to transition 350 individuals in CY 2023. This is approximately 60% of the individuals on the Active Caseload List and a much lesser percentage of individuals who are undecided and whom the State has prioritized for transition. As addressed above, this means hundreds of people who have already indicated they want to move will remain institutionalized unnecessarily. In addition, The SME continues to have concerns regarding the revised caseload size and, as indicated in the recommendations is requesting LDH to assertively monitor if this change adversely impacts the Transition Coordinators' (TCs') efforts and ability to effectively carry out their responsibilities.
- **Identifying and addressing major barriers that impede transitions.** While the State has taken steps to implement a more consolidated approach to identify and report barriers for diverting or transitioning individuals from NFs, there is still much work to be done to strengthen and merge these efforts into a streamlined effort as part of a larger quality assurance process. This includes the utilization of the newly created Transition Support Committee (TSC) and ensuring stakeholder input is sought to assist the State to develop strategies to address barriers experienced by the Target Population.
- **Building upon ongoing efforts to contact individuals on the Master List to gauge their interest in moving from NFs and developing follow up in-reach.** This includes the implementation of efforts to address requirements in the Agreement to contact individuals within 3 and 14 days of NF admission. The State has proposed a pilot project in the next reporting period to implement requirements in the Agreement where individuals newly admitted to an NF will receive an initial contact within 3 days of admission and the Nursing Facility Transition Assessment (NFTA) begins within 14 days of admission. There are still delays in contracting for a system and other resources needed to implement these requirements. In addition, there are some additional enhancements to the Peer In-reach Specialist (PIRS) Program to improve the identification of individuals in the Target Population who may be interested in transitioning. These actions are necessary to ensure

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

- **Increasing efforts to divert individuals from NFs who are at highest risk of these admissions.** During this reporting period, LDH has changed the definition of this at-risk group and how MCOs will provide case management to these individuals. The State made changes to the at-risk definition and MCO case management requirements for this population during this reporting period. The SME and DOJ expressed concern about this new definition and LDH proposed changes to the at-risk definition based on this feedback. While the SME agrees with the most recent changes, a whole year will pass where information is not available regarding MCOs' efforts to divert individuals with SMI who are at risk of NF placement.
- **Continuing activities to improve diversion process for people being considered for NF admission and receiving a PASRR Level II evaluation.** LDH has made enhancements during this reporting period to improve efforts to divert individuals with SMI from NFs. This includes standardizing an approach to auditing reviews of PASRR Level II Evaluators', MCOs', and LDH Determination Specialists' decisions regarding admission and diversions from NFs. This audit process also ensured PASRR Level II Evaluators focused on areas that were previously found to be lacking in these reviews. LDH has yet to implement changes to protocols and processes to the PASRR Level II instrument, ensuring evaluators have the tools and the information to be able to have timely and plausible resources for individuals and their caregivers to ensure access to community based services in lieu of NFs.
- **Enhancing and effectively implementing Quality Assurance activities to ensure the quality of community services for Target Population members.** The State continues to collect information to address the quality of services and the experience of care for individuals who have been transitioned from NFs. While LDH does have internal and external quality assurance strategies and quality monitoring in place for Medicaid funded services, the State has not performed an analysis of information, nor included the development of benchmarks for particular areas of DOJ interest under this Agreement. In addition, the State has not coordinated either internal or external quality assurance activities for the My Choice Program for the past two years. The State has not developed its annual plan for CY 2022 or CY 2023. The State should focus internal and external efforts (e.g., engaging the TSC and My Choice Quality Subcommittee) to review and make recommendations regarding the quality of care provided to members of the Target Population. A significant number of resources have been expended on creating the infrastructure to capture and report critical information on the My Choice Program. LDH should focus additional attention on how to best use this information for program improvement purposes. Finally, the State is now an active participant in the SME Service Reviews. They are participating in reviewing documentation and interviewing individuals and their formal and informal supports regarding the quality of care provided to individuals who have been transitioned or diverted from NFs. This has allowed them to better understand individual and systemic issues that have impacted transitions and diversions. The SME and the State will continue these efforts during the next reporting period.
- **Addressing the lack of peer supports.** The SME's service reviews identified many individuals transitioned and diverted from NFs experienced loneliness and described their lack of connection to the community at-large. As discussed in previous reports, quantitative and qualitative evidence indicates that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services and by increasing the use of outpatient services. Peer support improves quality of life, increases and improves engagement with services, and increases whole health and self-management. The State does have peer specialists embedded in ACT teams which is used by a portion (32%) of the Target Population transitioned and 21%

diverted from NFs. However, no appreciable utilization of the Medicaid peer support services approved in February of 2021 has occurred. The State limited the network of providers of these services to Local Governing Entities (LGEs) that did not always have the experience or staff knowledge to implement these services. LDH is in the process of recruiting additional providers to offer peer support services.

- **Better addressing the housing needs of individuals in the Target Population.** This includes ensuring individuals have a real choice in where they want to live. While many individuals participating in the SME Service Review stated they were content with their housing, several individuals cited they were not provided a choice in housing, would prefer to live in some other geographic location, or their housing could be more ADA accessible. In addition, the State has not tracked efforts set forth in their revised housing plan regarding the creation of housing opportunities (new units and vouchers), whether these created units are appropriately offered to individuals who are transitioned or diverted, and whether individuals make use of these opportunities. Ensuring progress in reaching the goal of offering 1,000 units to the Target Population will require this enhanced tracking.
- **Improving the quality of Community Case Management provided to individuals who are diverted or transitioned from NFs.** LDH has taken important steps to ensure the availability of this service statewide. They have also created policies that provide important parameters to ensure individuals receive viable and robust case management services. The CCM program has been successfully engaging a significant percentage of individuals both transitioned and diverted from NFs over the past year. The SME Service Review has identified needed improvements in the CCM process. While almost all individuals had a community assessment, community plan of care (CPOC), and crisis plans, additional work is needed to improve the quality of the CPOCs. This includes a more focused effort to implement existing policies regarding regular team meetings and sharing of critical information across providers regarding goals and services needed to achieve these goals. This will ensure better identification of potential service gaps and potential duplication of efforts. In addition, the State should work with the MCOs to ensure that revised plans of care identify the amount and duration of services needed by the individual.
- **Requesting additional resources for the My Choice Program.** There are several areas in which the SME recommends additional staffing resources to enhance implementation activities consistent with the Agreement. First, LDH should ensure it has sufficient resources for more expeditious transitions of individuals on the Active Caseload List. Existing assumptions regarding the number of TCs or other staff that could perform transitions and caseload size should be revisited for future years to improve the timeliness of transition for all individuals on the Active Caseload List. There are specific staffing resources that LDH should seek, including additional:
    - Peer In-reach specialists who are needed to continue efforts to meet with individuals on the Master List who are undecided or not interested in transitioning.
    - Rapid Integration Transition Coordinators (RITCs) to ensure that every region has sufficient RITC capacity to engage individuals as required by the Agreement within 3 and 14 days from admission.

  LDH should also consider resources to support the Integration Coordinator in their quality assurance efforts. Quality Assurance is critical to the success of the My Choice Program and to assuring substantial compliance with the Agreement. The Integration Coordinator is responsible for coordinating and overseeing the overall Agreement. Having dedicated staff resources, specifically for all quality activities, will support but not supplant the activities of the Integration Coordinator's efforts to achieve compliance with this Agreement.

II. Target Population

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

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

Compliance Rating: Partially Met

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

Compliance Rating: Partially Met

Discussion and Analysis

The SME assessment of paragraphs 24 through 26 is combined. As one of the initial activities, LDH created a list of individuals in NFs who are members of the Target Population. The list includes individuals with an SMI identified through a PASRR Level II evaluation and individuals who do not have a PASRR Level II evaluation, but the MDS indicates they have an SMI. As of July 1, 2023, the State reports that 99% of the individuals on this list had at least one PASRR II evaluation with a confirmed Serious Mental Illness. In the eighth report, LDH reported 96% of individuals on this list had at least one PASRR Level II evaluation. The State regularly analyzes and reviews data from the MDS for current NF residents for an SMI diagnosis to add to this List. The MDS purpose and process is described in previous SME reports.

The State has divided the list of Target Population members in nursing facilities into two groups. This includes an Active Caseload List (ACL) for individuals who have indicated an interest in moving and whom the State has prioritized for transition. LDH has also created a Master List for the remaining individuals who have indicated they are not interested in moving at this time and for individuals who have not been contacted recently about transition.

In the eighth SME report, there were 3,676 individuals in the Target Population in nursing facilities; 2,902 individuals were included on the Master List and 774 individuals on the Active Caseload List. An additional 200 individuals were transitioned and remained on the Active Caseload List for one-year post-transition. For this reporting period:

- There are 3,783 individuals in the Target Population in nursing facilities during the reporting period, 100 more than the previous period.
- There were 3,198 or approximately 10% more individuals on the Master List.
- The number of individuals on the Active Caseload List remained relatively constant (747).

- There were 162 individuals who were transitioned and remained on the Active Caseload List.

The SME notes the number of individuals in the Target Population has fluctuated across the past four reporting periods. Table 1 provides information on changes in the Master List.

Table 1. Number of Individuals on the Master List

Reporting Period	Individuals on the Master List
1/1/2023-6/30/2023	3,198
7/1/2022-12/31/2022	2,902
1/1/2022—6/30/2022	3,256
7/1/2021-12/21/2021	2,795

As noted, there was an increase in the Master List from last reporting period, but the Master List has fluctuated over the last four reporting periods. This reporting period has the second most individuals on the Master List. As noted elsewhere in this report, LDH needs additional focus on diverting individuals from NFs in order to reduce the number of members in the Target Population in NFs.

The ACL remained relatively unchanged this reporting period. Table 2 provides information on changes in ACL.

Table 2. Number of Individuals on the Active Caseload List

Reporting Period	Individuals on the Active Caseload List
1/1/2023-6/30/2023	747
7/1/2022-12/31/2022	774
1/1/2022—6/30/2022	598
7/1/2021-12/21/2021	916

The State continues to review individuals on the Active Caseload List to confirm their continued interest in transitioning. These reviews conducted during this reporting period determined:

- 561 individuals that were previously on the Active Caseload List were not interested in moving and were returned to the Master List.
- 351 additional individuals on the Active Caseload List in June 2023 indicated their interest in moving.

The State continues to report there were several major reasons that individuals on the Active Caseload List were removed from that list. This includes:

- 53% declined transition and were returned to the Master List.
- 15% were discharged from the NF and were in the community for longer than twelve months.
- 10% were successfully closed (individuals had been transitioned or diverted more than a year).
- 5% were discharged within a short period and were not engaged by the TC.

In addition, 17% of individuals were moved from the ACL to the Master List for other reasons, including those individuals who were determined to have dementia or determined not to be in the Target Population.

The State continues to use a process to review each individual being transitioned from the ACL to the Master List. As indicated in the eighth report, the Integration Coordinator and senior staff at OAAS and OBH review each request and determine if the return to the Master List is appropriate. The review occurs every 90 days. Prior to moving the individual from the ACL to the Master List, the Integration Coordinator and leadership from OAAS and OBH:

- Review each individual prior to removing the individual from the ACL
- Identify the rationale of moving the individual to the Master List
- Review the date the individual was placed on the ACL and the number of TC contacts (including the assessment) each individual receives to ensure sufficient contact was made to discuss transition options.

Individuals moved from the ACL to the Master List will receive in-reach on a quarterly basis to gauge their continued interest in transitioning. The outcome of this subsequent in-reach visit would determine the cadence of visits.

The State continues to add individuals to the Target Population list on a daily basis. MDS information is provided to LDH daily for individuals at admission and at other times during their NF stay. Individuals who are identified by the MDS as having SMI are added to the Master List the next day. On a regular basis, the State matches MDS data on individuals who are newly identified as having an SMI to current PASRR Level II data to identify individuals who may have required a Level II screening but did not receive one. The State has developed a process to track the number and timeliness of when these individuals receive a PASRR Level II evaluation as discussed in paragraph 41.

The SME understands that a small number of individuals may be identified as having a potential SMI after they are admitted to the NF. Therefore, the percentage of individuals who have an identified SMI and a PASRR Level II will not be 100%.

LDH is also required to maintain a list of individuals who are diverted from NF, given these individuals are also part of the Target Population. LDH has provided the SME with a list of individuals who were diverted during this review period. Sixty (60) individuals were diverted from January 1, 2023, to June 30, 2023.

Compliance Assessment

Overall, the SME's assessment for these paragraphs indicates:

- LDH has developed and actively maintains a Target Population list of individuals currently residing in nursing facilities.
- The number of individuals in the Target Population and on the Master List in NFs increased this reporting period.
- The number of individuals on the Active Caseload has remained relatively unchanged during this reporting period.
- LDH has a process to identify and refer individuals with a possible diagnosis of SMI, adds these individuals to the Master List, and refers them for a PASRR Level II evaluation, as required by paragraph 25.
- LDH continues to use the ACL to prioritize transitioning a subset of people in the Target Population.
- LDH continues to use the methodology developed during this previous reporting period to measure diversions through the PASRR process.

- LDH maintains a current list of individuals in the Target Population who were diverted from nursing facilities each month and during the reporting period. As of this reporting period, LDH has identified 60 individuals.
- There is still a significant number of individuals who are returned to the Master List from the ACL (561). LDH determined that 53% of individuals previously on the Active Caseload List were not interested in moving at this time. This continued to be high and suggests LDH should review the effectiveness of the in-reach process.

Recommendations

- LDH should implement strategies identified in paragraphs 29 and 30 to reduce the admissions of individuals with SMI to NFs and therefore decrease the number of individuals in the Target Population in NFs.
- LDH should take measures to reduce the percentage of individuals who are moved from the ACL to the Master List who explicitly indicate they are not interested in transition. This diverts much needed TC resources from performing transition activities for individuals who continue to express interest in transitioning.

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

Compliance Rating: Not Rated

Discussion and Analysis

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

For individuals who are Medicaid eligible and who seek behavioral health services, the MCO case manager or behavioral health provider seeks authorization (as necessary) from the MCO to determine if the individual meets medical necessity criteria. If an individual is denied participation in the Waiver or is denied services from their MCO, LDH reports they have the required processes for the individual to appeal that decision. If an individual is not Medicaid eligible and has an SMI, the individual will be encouraged to enroll in the Medicaid program. If the individual is determined to be ineligible for the State's Medicaid program, LDH has the required processes to appeal that decision. If found ineligible, the Office of

Behavioral Health (OBH) will refer the individual to a Local Governing Entity (LGE) for services and supports. The array of services and supports available to those individuals without Medicaid is dependent on the services offered by the LGE and the availability of funding for expanded services beyond that which they are mandated to provide.

III. Diversion and Pre-Admission Screening

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

Compliance Rating: Partially Met

Discussion and Analysis

As discussed in the seventh SME report, the State submitted a revised diversion plan to outline the steps LDH will take to promptly identify individuals in the Target Population seeking admission to NFs and to provide intervention and services to prevent unnecessary institutionalization. The initial and revised State's plan can be found at: https://ldh.la.gov/assets/docs/MyChoice/DiversionPlan.pdf. The plan discusses several strategies that will be critical to implementing an effective diversion system as required by this paragraph. This compliance rating considers the extent to which each of these strategies is being implemented effectively.

Defining the Diversion Population: Similar to the CY 2019 Diversion Plan, the revised plan sets forth definitions for individuals who would be considered diverted from NFs and individuals who are at high-risk for NF placement. Currently, LDH has defined the diversion population as Medicaid enrolled individuals with SMI who seek admission to a nursing facility but are not admitted because the PASRR Level II indicated community placement versus a nursing facility admission. The revised plan used past performance to project that 120 individuals would be diverted from NFs during CY 2022. LDH reports that it diverted 122 individuals in CY 2022 and met the annual projection. LDH projects to divert 137 individuals from NFs through the PASRR Level II process in CY 2023. During this reporting period, LDH diverted 60 individuals through the PASRR Level II process. LDH has yet to develop longer term diversion targets.

As indicated in paragraph 34, the SME recommended, and the State will require PASRR Level II Evaluators to provide uniform information on barriers to diverting individuals from NF placements using a revised PASRR Level II Evaluation. LDH planned on releasing this updated PASRR Level II Evaluation in May. They are delayed and have projected a release date of October 2023.

Developing a Strategy to Address Individuals in the At-Risk Population: LDH developed and implemented a strategy according to the diversion plan for individuals at high risk for NF admission beginning in 2021. In late 2022, LDH changed the definition of the at-risk population. In addition, LDH changed the requirements for MCOs to provide case management to these individuals beginning January 1, 2023. During this reporting period, LDH, in consultation with the SME and the DOJ, have changed the definition of individuals at-risk of NF placement to better align with the initial at-risk definition. These efforts to address this at-risk population are discussed in paragraph 30.

Improving PASRR Processes and Criteria: LDH's Diversion Plan contains several goals related to this, including improving the identification of individuals with SMI through the PASRR Level I, conducting prompt PASRR evaluations, and ensuring PASRR evaluations consider community mental health services.

In the sixth and seventh SME reports, it was recommended that LDH develop a process for identifying individuals prior to admission and during the PASRR process (Level I screening and Level II evaluation) who have few barriers to receiving services in the community even though they meet NF Level of Care. The recommendation took into consideration that there may be individuals with an SMI who seek NF admissions who may have lower physical health needs and home and community-based services and natural supports are readily available to meet their needs. The SME recommended Office of Aging and Adult Services (OAAS) and OBH should develop a strategy for how to best identify and divert this population during this reporting period to further increase diversions from NFs. The State did not choose to pursue this strategy. Rather, LDH decided they would enhance the acumen of PASRR Level II evaluators to better identify individuals who had medical and ADL needs and available natural supports who could provide time-limited assistance. This is discussed in more detail in paragraph 32. The approach is consistent with the SME recommendations in the seventh SME report. The SME recommended LDH develop strategies to ensure that PASRR Level II reviewers were well versed in their knowledge of community-based services to be able to offer options to meet the total needs of individuals seeking NF admission. This includes behavioral and physical health as well as community-based long-term services and supports such as personal care and home health to address activities of daily living and medical conditions (e.g., wound care) that are often needed post-hospitalization. LDH has begun to implement the following two strategies that would provide the PASRR Level II reviewers with information regarding these resources:

- OAAS staff members providing face to face training to PASRR Level II evaluators to better understand the community long term supports, how to access these supports, and timeframes generally for an individual to receive these services. This information is intended to provide PASRR Level II evaluators with information to be used in discussion with individuals who are being referred for NF placement and their caregivers. Having PASRR level II evaluators understand the availability of services and supports that may be provided by caregivers immediately post hospital discharge and prior to receiving services from community-based providers is critical in conveying alternatives to NFs. LDH shared the training with the SME in May. The SME provided comments and suggestions regarding the training. LDH has stated they will implement this training early in the next reporting period.

- OAAS staff members have worked with the OBH PASRR team lead in an audit process to review PASRR Level II evaluators decisions. The audit process identifies whether OAAS agrees with the PASRR Level II Evaluator placement recommendation. Additional information on the OBH PASRR Level II audit process is discussed in paragraph 34.

The SME understands that some services (e.g., transportation to medical appointments, medication oversight, and some activities of daily living) cannot be immediately available during the first few weeks of hospital discharge given referral and service engagement timeframes. Some of these services may be provided by natural supports until formal supports can be secured. The Department reports they have trained PASRR Level II evaluators to identify if the individual has natural supports available to provide these services on a temporary basis. However, LDH reports that many of the individuals recommended for NF placements do not have natural supports that could be used temporarily to support a recommendation for community placement.

In addition, as indicated in the past two SME reports, meeting existing or new diversion targets is dependent on PASRR Level II evaluations. In previous reporting periods, meeting the diversion targets was challenging given LDH had requested 1135 Waivers, due to the Covid-19 pandemic, which waive requirements to complete a PASRR Level II for new NF admissions. For several reporting periods, the State received approval for these Waivers, which impacted the ability for the State to implement its diversion strategy. During this reporting period, LDH did not have an 1135 Waiver in place and is on track for meeting the projected targets for CY 2023.

Developing a Case Management Strategy for Diversions: Since March 2022, LDH has implemented Community Case Management (CCM) for individuals who were transitioned or diverted from NFs. CCMs are responsible for engaging individuals who are diverted from NFs (through the PASRR Level II process), assessing their needs, developing a community and crisis plan, referring individuals to needed services, and tracking individuals for one year post transition. CCMs are to coordinate services including services specified in the Agreement and medical and long-term services and supports to address their healthcare and activities of daily living needs. During the first four months of this reporting period (January through April 2023) a total of 300 individuals were enrolled in the CCM program. Individuals can receive CCM for 12 months post their diversion. More detailed information regarding the CCM program is provided in paragraph 47.

Compliance Assessment

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

- The State revised and updated a diversion plan for the My Choice Program. The State has implemented some parts of the diversion plan, including:
    - Meeting the annual projection in CY 2022 for individuals diverted through the PASRR Level II process. It is too early to determine if they will meet the projected number of individuals diverted for CY 2023. As of June 2023, LDH reports 60 individuals have been diverted through the PASRR Level II process.
    - Developing training and resource materials for community-based options to address ADLs for individuals seeking admission to NFs.
    - Continuing to implement the PASRR Level II audit process, including assistance from OAAS to review individuals who potentially can be diverted from NFs. LDH has reported some initial information on how the PASRR Level II audit process ensures appropriate placement and service recommendations.
    - Continuing to offer CCM for individuals who were diverted from NFs and enrolled in a Healthy Louisiana Plan.
- There are several areas of the LDH revised diversion plan that has yet to be implemented:
    - LDH, at the SME's request, has further refined the at-risk population and methods to track MCO delivered case management for this population.
    - The State has not developed a multi-year diversion projection.
    - While LDH has developed an audit process it has not identified whether these processes have increased diversions.
- The State uses a consistent methodology to track diversions.
- The State did not have an 1135 Waiver in place during this reporting period and therefore LDH did not defer PASRR Level IIs during this period.
- The diversion plan does not specifically address outreach to organizations identified in paragraph 68, including law enforcement, corrections, and courts regarding diversion strategies.

Recommendations

- LDH should continue to implement the elements of the Diversion Plan, including developing multi-year diversion targets aimed at maximizing the number of diversions to community-based services, as appropriate.
- LDH should track and report the number of individuals who have an SMI who are admitted to an NF to determine if the diversion strategies set forth in the report are effective.
- LDH should develop longer term targets for diversions as stated in the diversion plan.
- OAAS and OBH should implement the training and provide the supporting materials to PASRR Level II evaluators to address ADL and other medical needs for individuals in the Target Population seeking admission to an NF.
- LDH should track the effectiveness of the current PASRR Level II audit process.

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

Compliance Rating: Not Met

Discussion and Analysis

This rating has changed from Partially Met to Not Met. A major premise for this paragraph is that care coordination is offered and accepted by individuals at-risk of being in the Target Population. This care coordination, provided by the MCOs, can likely prevent unnecessary admission to NFs. As indicated in paragraph 26, the number of individuals in the Target Population continues to grow. LDH began efforts in CY 2021 to implement a system to identify and divert individuals from avoidable hospitalizations.

A major strategy for diverting individuals from NF admissions is to identify individuals who may be at high risk for hospitalizations that would lead to an NF admission. As indicated in the fifth SME report, the Department finalized a definition for an "at-risk" population in 2021 that included individuals with an SMI, between the ages of 50 and 79, who had one chronic physical health condition and who had recent and multiple Emergency Department (ED) and inpatient admissions (all cause). The assumption is that many of these individuals, with better care coordination, would avoid hospitalization and thereby have reduced referrals to NFs. The State had identified 7,150 individuals in FY 2021 who met the definition of the at-risk[1]. LDH worked with the MCOs to put the at-risk effort into place starting July 2021, which included ongoing identification by the MCOs of individuals in the Target Population, and engaging individuals in care coordination, which included assessing and developing plans of care and coordinating services for these individuals. LDH provided the SME with information regarding MCO case management activity for individuals in the at-risk group. In addition, the State's Medicaid External Quality Review Organization reviewed the MCO case management program for the at-risk population. Findings from both of these efforts identified:

- Variability in the percent of individuals in the at-risk group participating in MCO case management. Approximately 20% of individuals in the at-risk group received MCO case management.

[1] OBH Presentation to MCOs 3/19/2021

- 18% of the at-risk group were unable to be contacted by the MCO and therefore not offered case management.
- 64% of at-risk individuals were still considered open and were not yet engaged by the MCO in case management.
- The EQRO also reviewed a sample of charts (128 individuals) for individuals who were at-risk and enrolled in case management. This chart review indicated:
    - 96% had an assessment—approximately 50% of these individuals received an assessment within 30 days of being identified as at risk.
    - 92% of individuals reviewed had physical health needs, 43% had behavioral health needs, and less than 20% identified needs related to social or vocational interests.
    - 67% of individuals reviewed had a care plan. This was in contrast to the SME review of diverted and transitioned individuals, where 92% of individuals receiving MCO case management had a plan of care.
    - 53.49% of care plans were updated to monitor progress; 52.32% documented timely resolution of issues.
    - 52.34% of members received care coordination that actively assisted the member with locating and arranging for services/supports, scheduling appointments, and arranging for transportation, as needed.
    - 15% of individuals reviewed had a crisis plan to avoid unnecessary hospitalization, incarceration, or out-of-home placement.

As indicated in the eighth SME report, LDH requested and received a plan of correction for each MCO to address the findings of the EQRO report. The State has requested MCOs to address 26 areas in their plans of corrections, including:

- Developing and implementing assertive engagement strategies for the at-risk population
- Improving the number and percent of at-risk members offered case management
- Increasing the number of assessments completed
- Increasing assessments that include member physical health, behavioral health, and social/functional needs and needs reassessed based upon significant changes in member needs in these areas
- Documenting and reflecting the needs of the individual from the assessment in the care plan
- Completing the care plan within 30 days of the assessment
- Ensuring a personalized care plan was developed that included the individual and family
- Ensuring the care plan identified member goals, strengths, needs, and barriers to treatment
- Ensuring care coordination actively assisted the member with locating and arranging for services/supports, scheduling appointments, and arranging for transportation
- Including a crisis plan in the care plan to avoid unnecessary hospitalization, incarceration, or out-of-home placement.

In Fall 2022, the State changed to the definition of the at-risk population following discussions with the SME. Specifically, the State redefined individuals in the at-risk population as having an SMI, but not another chronic condition. They also lowered the age range to adults 18 and over. In addition, LDH proposed to shorten the timeframe for multiple ED and inpatient admissions that would be used to define the at-risk population. Originally, the criteria was six or more ED or inpatient admissions in the last two years (all cause). LDH recommended narrowing the criteria to six or more ED or inpatient admissions in

six months. LDH estimated the size of at-risk population would include 5,000 individuals—a 30% decrease from the size of the at-risk population using the previous definition.

In addition, LDH made changes to the MCO case management approach in January 2023. The new approach included a three tier system and significantly increased the expectation for MCO provided case management for enrollees with SMI. These tiers included:

- Intensive Case Management requiring in-person meetings at least monthly with the individual, and formal in-person reassessments quarterly.
- Medium Case Management requiring meetings at least monthly with the individual and formal in-person reassessments quarterly.
- Low Case Management requiring meetings at last quarterly, with formal in-person reassessments annually.

All members of the at-risk population will be offered MCO case management. MCOs will recommend a tier of case management based on a Health Needs Assessment.

The change in definition of the at-risk population concerned the SME. This change in definition had a decrease in the size of the at-risk population.

Based on conversations with the SME and DOJ, LDH is proposing to redefine the at-risk group to include individuals with SMI, two chronic conditions, between 18 and 75, who had six or more ED visits or inpatient hospitalizations (all cause) in the previous year. In addition, LDH has stated they will be able to track the MCO case management tier for each individual in the at-risk population. LDH has agreed to:

- Collect information related to member identification, assessment and plan of care timelines, and contacts through the MCO case management reporting template (submitted and reviewed quarterly).
- Collect and review service utilization data on the at-risk population on a semi-annual basis to include BH services, primary/preventive care, hospitalizations, and NF admissions.
- Conduct desktop reviews to evaluate MCO case management.
- Produce a report at least annually to include data obtained through the desktop review and claims to evaluate the extent to which the strategy is meeting its intended purposes.

The most recent change in definition of the at-risk population has implications for tracking and reporting efforts for this reporting period. Given these changes, LDH will not be able to provide information regarding the newly revised at-risk population until later next reporting period.

<u>Compliance Assessment</u>

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

- The number of individuals in the Target Population in NFs has increased during this reporting period.
- LDH made significant changes to the definition of the at-risk population that reduced the size of the at-risk population and could impact a major LDH diversionary strategy for individuals with SMI being admitted to NFs. However, LDH is proposing to realign the at-risk definition consistent with the first definition and recommendations from the SME and DOJ.
- LDH has made changes to the MCO case management program that increases expectations for some but not all individuals in the at-risk program.

- There were opportunities for improvement identified during the external quality review which occurred within the first two months of implementation of the at-risk strategy. It is not clear if the changes made in January 2023 will increase performance of the MCO case management approach.
- Information regarding ED or inpatient utilization (all cause) and NF admissions is needed to measure the effectiveness of these efforts to divert at-risk individuals from inpatient hospitals and NFs.

Recommendations

- LDH finalize the definition for the at-risk population as discussed above.
- LDH should undertake the activities agreed to regarding tracking and monitoring the at-risk population and taking the necessary steps to ensure MCOs adequately perform their case management functions. This includes:
    - Collect information quarterly related to the at-risk population including member identification, outreach to offer case management, assessment and plan of care timelines, and MCO case management contacts. This should include:
        - Number and percentage of individuals in the at-risk population by MCO case management tier.
        - Number and percentage of individuals who are enrolled in MCO case management (by tier).
        - Number and percent of individuals who receive an in-person MCO case management visit and the average number of monthly visits by tier.
    - Collect and review service utilization data on the at-risk population semi-annually including ED visits, inpatient hospitalization, and NF admissions. ED and inpatient information should be provided for behavioral health and physical health visits and admission.
    - Conduct desktop reviews to evaluate MCO case management.
    - Produce an annual report to evaluate the extent to which the strategy is meeting its intended purposes.
- LDH should collect information to develop a baseline for the new at-risk population and track information for determining the effectiveness of the at-risk strategy, including ED and IP utilization and NF admissions. This should include:
    - Number of individuals with SMI who seek admission to an NF as captured through the PASRR Level II process.
    - The number of individuals who are admitted to an NF and placed on the Master List.

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

Compliance Rating: Not Met

Discussion and Analysis

LDH reported that it has implemented a number of strategies to improve the PASRR Level I screenings to achieve diversion of individuals with SMI seeking admission to NFs. These steps included modifying the Level I screening instrument, developing and implementing standardized training for personnel (except physicians) who complete any part of the PASRR Level I screening process, and specifying the credentials of individuals deemed qualified to complete the PASRR Level I Screen. Information regarding these specific three steps was provided in previous SME reports.

LDH efforts have focused on trainings for PASRR Level I screeners to improve the identification of individuals with an SMI. However, no large-scale additional PASRR Level I trainings have been conducted since 2018. The State continues to report they will develop and implement training for PASRR Level I screeners when the tracking system is implemented. The new tracking system will identify individuals in the Target Population who were admitted to an NF within three days. LDH has selected a vendor for this tracking system but has not developed the new system. In the seventh and eighth SME report, the State anticipated training would occur during this reporting period as this system was developed and implemented. Given the delays in implementation, no substantial PASRR Level I trainings have occurred in the past five years.

Compliance Assessment

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

- The State identified and implemented strategies early in the Agreement to improve the PASRR Level I screening process in 2018 but has not appreciably revised these strategies since 2018 due to delays in contracting with a vendor to make the necessary system changes.
- LDH has also trained staff completing the MDS to better identify and provide diagnosis information to LDH from the MDS.
- The State has yet to validate effectiveness of these efforts per the SME's recommendation in the seventh reporting period.
- The 2023 Implementation Plan identified PASRR Level I trainings would occur in June of this reporting period. However, this has been delayed due to ongoing contract negotiations.

Recommendations

- LDH should finalize and implement the contract that will provide the necessary changes in the PASRR Level I tracking process. The SME requests the dates for new training (training materials and schedule of trainings) for PASRR Level I during the next reporting period.
- The SME continues to recommend LDH develop goals for these improvements to PASRR Level I training and an evaluation strategy to ensure that these trainings are producing the intended outcome.

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

Compliance Rating: Partially Met

Discussion and Analysis

This rating has changed from Not Met to Partially Met. As discussed in the sixth report, the SME reviewed the most recent list of community options and found these to be insufficient to provide information on community-based options for PASRR Level II Evaluators to use in their evaluation efforts. The seventh SME report recommended the State should develop or require the MCOs to develop a viable list of community options that would be helpful for individuals who seek NF admission. LDH proposed training for the PASRR Level II Evaluators to improve their knowledge of various community-based services and supports that could assist with increased diversions. In the eighth report, the State had not yet developed training or information for PASRR Level II Evaluators to improve their knowledge and acumen for various community services to individuals receiving a PASRR Level II Evaluation. Having community-based options available

and offered to individuals during the PASRR Level II Evaluation process may be helpful to divert some individuals with ADL needs from NF for short term rehabilitation.

During this reporting period, LDH has developed and implemented several strategies for improving information regarding community options when seeking admission to an NF. As indicated in paragraph 29, several of these strategies are in process. This includes training and materials for PASRR Level II Evaluators on services to address an individual's medical or Activities of Daily Living (ADL) needs. As indicated above, the SME has reviewed and provided input to LDH regarding these efforts. LDH states they will implement these trainings early in the next reporting period.

In addition, LDH reports they are in the process of revising the PASRR Level II Evaluation instrument to enhance efforts to provide individuals and caregivers seeking NF admission information regarding physical health services and supports. The changes are in response to SME discussions with the Department regarding federal PASRR Level II requirements and concerns PASRR Level II Evaluators were not identifying resources that could be made immediately available to individuals and caregivers to divert an individual from a potential NF admission. These requirements and concerns were discussed in detail in the eighth SME report. LDH reports to be including a more targeted focus on services that may be needed to address medical needs (e.g., home health services for wound care) and ADLs (e.g., amount and duration of personal care services needed). The SME has provided recommendations to revise the PASRR Level II instrument to better solicit information regarding community options. As indicated in paragraph 29, LDH is proposing to finalize the instrument in October 2023 and train PASRR Level II Evaluators regarding the instrument in the next reporting period.

LDH is proposing PASRR Level II Evaluators begin to collect information regarding barriers individuals seeking NF placement experience that prevent diverting these individuals to the community. This process will address barriers to community living and is similar to current efforts by TCs and PIRS. LDH reports they are planning on implementing this process in October of 2023 and integrating this information into the overall PASRR Level II evaluations to address barriers and improve the quality of care for individuals in the Target Population.

PASRR Level II trainings and audits have been implemented over the past 12 months. Recent training and audit efforts are specifically focusing on improvements to the PASRR Level II Evaluators' review of specific areas, identified by the OBH PASRR Level II Coordinator, to better identify community services that may assist in diversion efforts. A more detailed discussion of these efforts is provided in paragraph 34. In addition, PASRR Level II Evaluators have been trained and are providing consistent information to LDH regarding the availability of an individual's natural support system to provide community options (e.g., transportation to medical appointments, interim personal care) to assist the individual to determine if diversion from an NF is a possibility.

In addition, LDH has facilitated discussions for sharing information about community options with key stakeholders in the PASRR and My Choice processes including Level II Evaluators, MCOs, LDH PASRR Level II Determination Specialists, Transition Coordinators, Peer In-Reach Specialists, and Community Case Managers. In addition, the State solicited input from the My Choice Advisory Committee in May 2023 regarding strategies to promote community options. The SME is requesting information regarding follow-up activities based on the My Choice Advisory Committee input.

Compliance Assessment

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

- OAAS and OBH have developed, but not yet implemented, training and materials that would enhance PASRR Level II evaluators' knowledge and strategies to offer medical and long term services and supports that would address the total needs of the individual prior to NF admission.
- LDH is revising the PASRR Level II instrument to better collect information regarding medical and ADL needs that are primary drivers to nursing home admissions.
- LDH has solicited information from external stakeholders and entities that have regular contact with individuals who have been admitted to or diverted from NFs to identify community resources for individuals seeking NF admission.
- LDH has trained and is requesting the PASRR Level II Evaluators to evaluate the availability of natural supports to provide interim services and supports to prevent an NF admission.
- LDH proposes to collect information on barriers to community placement from PASRR Level II evaluators consistent with current efforts by TCs and PIRS. LDH proposes to use this information to develop strategies for addressing these barriers to improve diversions and transitions.

Recommendations

- OBH and OAAS should implement the process to provide training and materials to PASRR II Evaluators and Determination Specialists regarding the current community options for offering medical and ADL assistance to individuals seeking admission to an NF.
- LDH should review the training and materials with the SME to ensure they provide realistic and useful information regarding these services and supports.
- LDH should finalize the revised PASRR Level II evaluation during the next reporting period. These revisions should identify the services and supports the individual needs and whether these services and supports are readily available in the community.
- The State should audit/monitor how the training has improved PASRR Level II Evaluators' efforts to offer community options and ultimately increase the number of diversions.
- LDH should implement the process for PASRR Level II Evaluators to identify barriers to obtaining community services for individuals seeking NF admission.
- LDH should use this information to address barriers through the My Choice Quality Assurance process that are identified by PASRR Level II Evaluators, TCs, and PIRS.
- LDH should evaluate whether PASRR Level II training and materials are improving the quality and consistency of determinations and recommendations related to services and placement.

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

Compliance Rating: Not Met

As indicated in paragraph 31, LDH has not taken recent steps to change the PASRR Level I screening process to better identify individuals with SMI who are referred to NFs. No large-scale PASRR Level I trainings have been conducted since 2018. The State is proposing new training for PASRR Level I reviewers once changes are finalized for the tracking system. The tracking system was to be operational during CY 2021; however, due to procurement delays the vendor was procured and under contract during the

seventh reporting period. The State indicates the new vendor will play an important role in training staff that complete Level of Care Eligibility Tool (LOCET) and PASRR Level I once changes to the tracking system are complete. In the seventh report, the State reported materials may be available during this reporting period. This material was not available.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration a similar focus as paragraph 31:

- The State identified and implemented strategies early in the Agreement to improve the PASRR Level I screening process in 2018.
- The State has not substantially developed or implemented new training for PASRR Level I screeners since 2018.
- The State has not completed their contracting efforts with the new vendor that will inform the PASRR Level I screening process and the timeframe for implementation of the new PASRR Level I screening is not clear.

Recommendations

- The State should complete the contracting negotiation process and provide the SME information regarding the implementation of this new training (training materials and schedule of trainings) for PASRR Level I during the next reporting period.
- The SME recommends that training of PASRR Level I evaluators begin no later than the next reporting period and be completed by the end of CY 2023.

34. For each individual identified through the Level I screen, LDH will promptly provide a comprehensive PASRR Level II evaluation that complies with federal requirements. It shall be conducted by an evaluator independent of the proposed nursing facility and the State. This evaluation will confirm whether the individual has SMI and will detail with specificity the services and supports necessary to live successfully in the community. It shall address options for where the individual might live in the community. LDH shall provide additional training to ensure that PASRR Level II evaluators are familiar with the complete array of home and community-based services available to provide and maintain community-integration and shall revise Level II forms to include more extensive and detailed information regarding services in the community.

Compliance Rating: Partially Met

Discussion and Analysis

This paragraph has changed from Not Met to Partially Met. LDH has made considerable progress toward complying with this paragraph. As indicated in the seventh SME report, the State has included language in the MCO contracts requiring the use of face-to-face PASRR II for individuals seeking admission to NFs. Prior to these contracts the occurrence of face-to-face meetings were relatively rare.

LDH has implemented policies and incorporated specific requirements within its Medicaid managed care contracts to ensure timeliness of the evaluations. Federal regulations require a preadmission screening determination to be made in writing within an annual average of seven to nine working days of referral of the individual. The most recent data provided to the SME continues to indicate that Medicaid MCOs continue to complete PASRR Level II evaluations within four business days of referral from OBH, consistent

with State requirements. The SME continues to request and LDH provides information on the timing of PASRR Level II evaluations. Specifically, the SME requested information on whether PASRR Level IIs evaluations were performed prior to an individual's admission into an NF. LDH provided recent information regarding the timing of PASRR Level II evaluations and whether these evaluations were performed prior to admission (or diversion) from an NF. Information provided for the reporting period indicated 1,314 PASRR Level II evaluations were completed for new admissions during the first quarter of CY 2023. 97% were completed within 4 business days and prior to admission. Forty two (42), or 3%, were performed after admission to an NF (occurring within 7 days after the admission). This is lower than the eighth reporting period where 4% were performed after admission. LDH reports there are several reasons for these later PASRR Level II evaluations, including individuals admitted through a hospital exemption that do not require a PASRR Level II evaluation and the PASRR Level I process not identifying a need for Level II, but MDS provided immediately after admission flagged the need for a PASRR Level II evaluation.

As indicated in previous reports, the PASRR Level II reviews are performed by the Medicaid MCOs' Level II Evaluators, Licensed Mental Health Professionals who operate independently of the NF and the State. The MCOs have contracted with Merakey, an organization that provides behavioral health services in Louisiana and other states. They do not provide services for the NFs, nor do they provide services directly with the State.

As indicated in paragraph 32, the PASRR Level II evaluation is used to confirm whether an individual referred for nursing facility admission, or identified post admission, has a serious mental illness (SMI). As indicated in the seventh report, the SME has reviewed the PASRR Level II forms and training for evaluators with the tools to determine if individuals have an SMI, including referrals for additional diagnostic evaluations. These trainings and forms require the PASRR Level II to collect information regarding the presence of an SMI diagnosis more reliably.

The ongoing SME Service Reviews examine the PASRR Level II evaluations that provide additional background information regarding the needs of the individual and supporting documentation that supports whether an individual has a mental illness. In reviewing this documentation, PASRR Level II evaluators collect and review information to determine whether the individual has an SMI. The SME Service Review Team deemed this information to be sufficient to determine whether an individual has a diagnosis of SMI.

The paragraph requires LDH to detail with specificity the services and supports necessary to live successfully in the community and requires that the State address options for where the individual might live in the community. To be able to meet this requirement, the PASRR Level II tool must collect information on an individual's needs and services to meet these needs. As discussed in prior SME reports, LDH revised the PASRR Level II evaluation forms in 2017 and again in 2019 to include information on physical/medical, behavioral health, and social history, work history, and functional status (ADLs and IADLs). 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. OBH is undertaking a third revision to the PASRR Level II evaluation to gather more information to include more extensive and detailed information regarding services in the community. This will include more information on medical services and services and supports to address ADLs. During the eighth reporting period, the SME reviewed and provided recommendations to OBH regarding revisions to the PASRR Level II process for collecting and analyzing physical health and long-term services and supports similar to behavioral health needs and

recommendations included in the current PASRR Level II evaluation. LDH was supposed to have this new evaluation in place during this reporting period but has indicated this form will now be completed and implemented in November 2023.

Once information is collected, PASRR Level II Evaluators must make a recommendation as to whether the individual requires the level of services in an NF. To make these determinations, PASRR Level II evaluators must have an understanding and acumen to determine if services and supports to meet the individual's total needs are readily available in the community. As indicated in paragraph 32, LDH has not sufficiently developed information on community resources available to individuals referred for PASRR evaluations that would assist with reviewing the services available to meet the individual's total needs. As indicated in paragraph 32, OAAS and OBH has developed, but has not implemented, training and materials to improve the acumen of PASRR Level II reviewers to identify and recommend physical health and supports to address ADLs and IADLs that would be immediately available to potentially divert individuals from NFs.

In addition, for the past two reports, the SME recommended the acumen of the PASRR Level II reviewers should be enhanced to better identify and address barriers during the evaluation and recommend a decision to divert the individual from an NF admission. As discussed in paragraph 32, the State has developed a list of barriers PASRR Level II reviewers could identify during their evaluation. These are similar to the barriers TCs and PIRS collect now. LDH has stated they will implement this barrier identification process in October 2023.

LDH continues their efforts to oversee PASRR Level II evaluators and the LDH PASRR Level II staff who make a recommendation regarding an NF admission or a continued stay. This oversight process includes an independent review by the OBH PASRR Level II manager of supporting documentation and admission decisions using the PASRR Level II evaluation to support the admission decision. This process also includes a quality review audit tool for pre-admission reviews. The audit tool and process review the quality and appropriateness of PASRR Level II placement and service recommendations of the PASRR Level II Independent Evaluator, Managed Care Organization Review, and OBH PASRR Determination Specialist. The SME has reviewed the audit tool and finds it to be comprehensive.

The SME reviewed the audit tool with the State during this reporting period and has recommended the Department report those areas that have been found (in previous audits and SME service reviews) to be most problematic. In previous reviews several areas would benefit from additional reviews, including:

- Whether the individual has an active substance use disorder (SUD) and could benefit from services to promote their recovery at admission or diversion. The previous PASRR Level II Evaluations lacked information regarding SUD and the SME report found a number of individuals who had an SUD who were transitioned and had no specific SUD services identified in their ITP.
- Whether the individual has service needs specific to their medical condition and ADLs that should be addressed immediately if diverted. As indicated in paragraphs throughout this section, PASRR Level II Evaluators were lacking information regarding these services when making decisions regarding NF placement.
- Whether behavioral health services were recommended consistent with behavioral health needs (other than SUD) identified in the evaluation. LDH's review of the PASRR Level II Evaluators found that many individuals were recommended to have the full complement of behavioral health services, yet their evaluation did not warrant these recommendations.

During this reporting period, the State reports to have audited 52 individuals who were seeking NF placement and received a PASRR Level II during the pre-admission process. The LDHH PASRR Level II coordinator reviewed PASRR Level II Evaluations that were either performed by the PASRR Level II Evaluators or reviewed by the Medicaid MCOs or LDH Determination Specialists. The State identified areas of improvement in the three areas in the paragraph above. Specifically:

- SUD needs were not well identified and therefore few services were recommended by PASRR Level II Evaluators, MCOs, or LDH Determination Specialists.
- Other behavioral health needs were being identified inconsistently by PASRR Level II Evaluators and MCO reviewers.
- Physical health needs were not consistently reviewed and addressed when MCO reviewed the PASRR Level II Evaluations.
- Behavioral health service recommendations in the PASRR Level II Evaluations continue to be inconsistent with decisions by MCOs and LDH Determination Specialists.

To address these findings, the State reports they will undertake the following activities:

- Provide training and materials to PASRR Level II Evaluators regarding home and community based service options.
- Develop training regarding better identification of SUD needs and appropriate services.
- Provide training to assist MCOs and LDH Determination Specialists with recommending specialized services that comports with the individual's needs.

LDH reports they have reviewed the initial impact of the training and reports the following improvements as a result of their initial efforts:

- Ensured physical health needs are always recommended to reflect identified needs.
- Ensured behavioral health recommendations are appropriate to identified needs.

While the SME is encouraged the State is reviewing the impact of their training and coaching efforts, this information does not quantify these results and provide information if these additional steps are increasing diversions.

In addition to these audits, the OBH PASRR Level II Coordinator reviews a sample of PASRR Level II Evaluations for individuals who are admitted to NFs to determine if they agree with the admission decision. During this reporting period, 73 individuals were reviewed. The LDH Coordinator did not initially agree with 16 admission decisions. LDH discussed these differing decisions in monthly meetings with the PASRR Level II Evaluators and MCOs during monthly meetings. During these discussions, the OBH Coordinator discussed the rationale for these differences. The PASRR Level II Evaluators and MCOs provided supporting documentation regarding these decisions. Post these discussions, the OBH Coordinator requested OAAS staff familiar with community-based programs review the 16 individuals to determine if the admission decisions were warranted. These additional reviews indicated:

- Admission decisions for eight individuals (50%) were warranted.
- OAAS disagreed with one admission decision.
- OAAS was unsure whether the admission decision was warranted for seven individuals and additional documentation would be needed to make that determination.

LDH reports they will continue to perform these audits and report these findings on a monthly basis.

In addition to the process to improve the knowledge and acumen regarding community services of PASRR Level II Evaluators, the State is in the process of identifying a process to use current local staff to identify informal and formal supports for additional community options. The State reports they will provide a more detailed strategy during the next reporting period.

Compliance Assessment

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

- The majority of initial PASRR Level II evaluations for individuals seeking admission to an NF are provided promptly. 3% of individuals that were identified through the PASRR Level I as potentially having an SMI did not receive an evaluation prior to admission.
- PASRR Level II evaluations are conducted independent of the proposed NF and the State.
- LDH has taken ongoing efforts to ensure PASRR Level II evaluators receive ongoing training to identify whether individuals referred for these evaluations have a serious mental illness. The SME Service Review Team deemed the information collected to be sufficient to determine whether an individual has an SMI.
- LDH has developed but not yet implemented strategies to ensure the focus of the PASRR Level II evaluations is to identify the total needs of the individual with a specific concentration on medical and ADL supports.
- LDH provided the revised PASRR Level II auditing forms and processes to the SME for review during this reporting period. The SME discussed the forms and processes with LDH and identified areas of focus based on previous audits and SME service review findings.
- The State continues to perform audits of the PASRR Level II process to determine if recommendations for NF admission are warranted and addresses these findings with PASRR Level II Evaluators, MCO, and LDH Determination Specialists. In addition, OBH has included OAAS in their review of admission decisions. The State is generally concurring with NF admission decisions made by PASRR Level II Evaluators after additional discussions and OAAS review.
- LDH has developed training and other strategies to mitigate issues found in previous PASRR Level II audits. The SME recommended in the eighth report that LDH specifically focus on improving identification and service recommendations for SUD and physical health. Additional LDH efforts have focused on better alignment of behavioral health needs and recommendations by PASRR Level II staff.
- The State is revising the PASRR Level II forms to enhance the collection of information to support a PASRR Level II recommendation.
- LDH has developed, but not implemented, a process to collect information on barriers from PASRR Level II evaluators to use during the evaluation process but has yet to implement the strategy for PASRR Level II evaluators to collect information on these barriers for individuals seeking NF admission.

Recommendations

- The State should quantify how their renewed training efforts have improved the PASRR Level II evaluations and ultimately how it will improve diversions from NFs.

- LDH should initiate the process to collect information on barriers through the PASRR Level II process using the list of barriers discussed in paragraph 58 and use this information in developing mitigation strategies to address these barriers.
- If LDH anticipates requesting 1135 Waivers during this upcoming period, LDH will need to develop a better strategy for tracking individuals who need but did not receive a PASRR Level II prior to admission and for completing them quickly.
- LDH should continue its PASRR Level II audit activities, continuing to track and address areas of improvement for the purpose of increasing diversions. LDH should continue efforts to review a sample of NF admissions to determine if decisions were warranted. LDH should provide the SME with information regarding these decisions. If the LDH audits do not increase diversions, the State should consider additional approaches.
- LDH should develop the approach to addressing the total needs of individuals seeking NF placement and develop community options discussed in paragraph 32.

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

Compliance Rating: Met

Discussion and Analysis

This rating has changed from Partially Met to Met. According to LDH, steps were taken in 2018 to strengthen the application and criteria of PASRR Level II evaluations to ensure appropriate identification of dementia as a primary diagnosis. These steps were documented in the fourth SME report (December 2020). The State revised the Utopia system in the eighth reporting period to allow OBH to identify and track individuals who have a suspected or initial diagnosis of dementia. LDH has added "Suspected Dementia" to Utopia to allow for an additional review by the consulting psychiatrist of an individual when there is insufficient documentation to render a determination of primary dementia. The LDH consulting psychiatrist verifies whether all individuals with an initial or suspected dementia diagnosis have dementia or if additional information is needed to make a determination of a dementia diagnosis.

As discussed in the eighth report, LDH requires PASRR Level II Evaluators to collect additional information from NF staff and family members who are suspected of having dementia to garner additional information for the consulting psychiatrist to make a dementia diagnosis. All Level II evaluators, MCO reviewers, and OBH Determination Specialists have been trained on how to use this questionnaire. The consulting psychiatrist reports this information has been helpful to verify a dementia diagnosis.

During this reporting period, LDH reports 190 individuals in the first quarter of this year (7.5 % of all individuals in the Target Population) and 198 in the fourth quarter of CY 2022 (8.7% of all individuals in the Target Population) were identified through the PASRR Level II process as having or suspected of having an initial or suspected primary diagnosis of dementia. The SME met with OBH and the consulting

psychiatrist during this reporting period and confirmed each individual with a suspected or confirmed diagnosis has been reviewed to determine if they have a primary dementia diagnosis. LDH reports that for the fourth quarter CY 2022 and the first quarter of CY 2023 these reviews indicated:

- 286 or 74% of the individuals were determined to have a primary dementia diagnosis.
- 87 or 22% of the individuals were suspected of having a primary dementia diagnosis and were reviewed by the consulting psychiatrist during the next continued stay review period.
- 15 or 4% of the individuals were determined not to have a dementia diagnosis.

The consulting psychiatrist reports ruling out external causes of dementia. However, she reports that very few individuals present with conditions that would be automatically ruled out. The consulting psychiatrist also indicated improvements in documentation provided by the PASRR Level II evaluator. Specifically, she indicated increased and better quality of information from family members has provided important information for making a determination of dementia. This is linked with information in paragraph 34 which indicated LDH has increased efforts to train PASRR Level II evaluators in better engaging family members during the evaluation process.

The consulting psychiatrist continues to identify several conditions that may benefit from a re-review, including a substance use disorder (especially alcohol disorder) and other medical conditions such as individuals with a more recent stroke. These individuals continue to have a suspected diagnosis of dementia and are re-reviewed within a year to determine if the individual has dementia.

In the seventh SME report, the State reported they were doing a historical review of 139 individuals over the past three years to determine if individuals with a suspected or confirmed diagnosis of dementia continued to have this condition. In the eighth report the SME requested information from this review. During this reporting period, LDH provided the SME with the results of this review. A total of 60 individuals reviewed were still in NFs. The remaining individuals were discharged from the NF or were deceased at the time of this review. Of the 60 individuals:

- A significant majority (85%) were found to have dementia.
- 7.5% had a primary diagnosis of SMI versus dementia. LDH reports these individuals were returned to the Master List.
- 7.5% percent had severe physical illness and it was difficult to determine ongoing dementia.

In addition to these activities, LDH is reviewing PASRR Level II documents to ensure additional testing is recommended when a suspected diagnosis of dementia is found. Based on these reviews, the OBH Coordinator has stated that this testing is occurring.

OBH and OAAS have also developed a process for providing community options to individuals (and caregivers) who have a primary diagnosis of dementia. Specific information is provided to these individuals and caregivers regarding the local Alzheimer Association chapters and Louisiana State University (LSU), which has developed a repository of information for individuals with dementia and their caregivers. PASRR Level I and OAAS staff provide this information to individuals who have been determined by OBH to have a primary diagnosis of dementia.

<u>Compliance Assessment</u>

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

- LDH has developed a process for reviewing individuals with a dementia diagnosis since the beginning of the Agreement.
- The percentage of individuals with an initial or suspected diagnosis of dementia remains relatively low during this reporting period. In addition, the percentage of individuals with an initial or suspected dementia diagnosis has remained constant from the previous reporting period.
- LDH has strengthened documentation requirements and training used to establish a primary diagnosis of dementia relative to the PASRR screening process.
- LDH has referred all individuals this reporting period for a PASRR Level II who have a suspected SMI and who are suspected of having a primary diagnosis of dementia.
- LDH has conducted a historical review of individuals with a dementia diagnosis and found 85% of previous individuals with a dementia diagnosis were appropriately diagnosed. Individuals with SMI as a primary diagnosis were returned to the Master List.
- LDH is reviewing and confirming testing is being recommended by the PASRR Level II Evaluators for individuals who may have dementia.
- LDH has developed an additional questionnaire for family members and other individuals involved in an individual's care to gather information regarding decline in mental status and dementia diagnosis (suspected or actual).
- LDH consulting psychiatrist provides an additional professional evaluation for all individuals with a suspected and primary dementia diagnosis to ensure appropriate diagnosis and differentiation. This includes information from the dementia questionnaire discussed above.
- LDH's consulting psychiatrist reviews each individual who has been identified as having or suspected of having dementia to determine if external factors may be causing the dementia.
- LDH has made changes to the Utopia system to track individuals with a dementia diagnosis. This has allowed them to develop a baseline regarding the number of individuals who have been identified through the PASRR Level II process as having dementia and re-evaluate whether an individual continues to have dementia.
- LDH has a process for individuals who receive a dementia diagnosis to receive information regarding community supports and services.

Recommendations

- LDH continues to track the percent of individuals identified as having dementia against the baseline to determine if changes occurred and if these changes are warranted.
- LDH continues to have the consulting psychiatrist review all individuals with suspected or actual dementia diagnosis to determine if they have a dementia diagnosis.

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

Compliance Rating: Met

Discussion and Analysis

As indicated in previous reports, LDH eliminated the behavior eligibility pathway in 2018. The behavior pathway provided an avenue for individuals with SMI to be admitted to NFs without having met other level of care (LOC) criteria for NF placement. NF residents who were admitted per the behavior pathway had no other qualifying condition to meet NF LOC other than SMI. The SME continues to request and

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

Compliance Assessment

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

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

Recommendations

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

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

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in paragraph 34, LDH is in the process of revising the PASRR Level II tool to better collect information regarding the total needs of the individual and enhance decision making regarding whether the needs are such they can be met in the community setting. The intent of the change in the PASRR Level II tool and process is to incorporate other needs into the recommendation for admission to or diversion from an NF.

As indicated in many of the previous SME reports, LDH has developed a system for authorizing temporary stays rather than long-term "permanent" stays. This allows the State to review the ongoing need for NF services in a shorter period of time. OBH now requires a temporary authorization for all individuals where the PASRR Level II confirms that they have an SMI. For pre-admission PASRR Level II requests, authorization requests do not exceed 90 days (or 100 days for persons approved for convalescent care by LDH). This timeframe does not exceed 365 days for those individuals who are already residing in an NF. As indicated in the last several SME reports, this change in process has resulted in 100% of authorizations issued by the OBH PASRR Level II authority being short-term and requiring continued stay requests thereafter. The SME requested information regarding the percent of individuals in the Target Population admitted since January 2023 who received a short-term authorization request. For this reporting period,

the State continues to report that 100% of authorizations issued for this reporting period do not exceed 90 days (or 100 days for persons approved for convalescent care). In the eighth SME report, LDH reported the average length of stay for individuals in the Target Population admitted to an NF was 92 days and that most of the individuals on the Master List stay in the NF for the full 90 days.

During this reporting period, LDH provided more detailed information regarding the length of stays for individuals in the Target Population admitted to NFs. For new admissions, 38% stay less than 90 days and LDH reports most of these individuals transition without needing extensive supports. More specifically:

- 21% of the Target Population stay less than 30 days from admission.
- 11% of the Target Population stay between 31 and 59 days from admission.
- 6% of the Target Population stay between 60 and 90 days from admission.
- 62% of the Target Population requests and receive a continued stay at 90 days post admission.

While the Department has taken steps to develop a process for reviewing requests for these continued stays, there were no clear policies for determining the length of subsequent stays. It was the SME's understanding that each individual who meets level of care during the continued stay review (CSR) process receives a 365-day authorization. However, the State has indicated that approvals for ongoing lengths of stay are variable and are based on various factors. These factors include whether an individual has a transition date, incomplete documentation, or a suspected dementia diagnosis that will need to be confirmed prior to the next CSR. Currently the average length of approval for subsequent continued stay requests is 280 days. This has not changed from the seventh and eighth SME reports.

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

- Aggregate information on reasons for admission into a nursing facility for members in the Target Population.
- Aggregate information on reasons for continued stay approvals for members in the Target Population.
- List of transition barriers for individuals who have requested NF admission and for continued stay.

There continues to be limited information available regarding the reason for an NF admission. Understanding the reasons for admission and ongoing stay will be helpful to determine if additional services and supports should be made available for certain individuals to divert or reduce the length of stay in an NF. In the eighth report, the LDH indicated they are considering developing an inquiry form during the LOCET process to collect this information and/or collect this information in the revised PASRR Level II Evaluation. LDH reports they have not developed this form. During this reporting period, the SME has also suggested to have Rapid Integration Transition Coordinators who will work with the Target Population at admission (as discussed in paragraph 45) to collect this information during their initial visit.

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

In the two previous reports, the SME requested additional information from OBH regarding the number and percent of individuals who received specialized behavioral health services identified in the PASRR

Level II process while in an NF. The Department has made the necessary changes to the Utopia system and is now able to report what specific specialized behavioral health services were recommended through the PASRR Level II process and received by individuals in NFs. They track this information for individuals who were recently admitted to an NF (less than 100 days) and for individuals who remain in an NF (greater than 100 days).

For individuals recently admitted to an NF, LDH reports:

- 37% were recommended for a psychiatric evaluation or psychosocial assessment. 12% of these individuals received this service.
- 26% were recommended for outpatient mental health services (individual, family, or group). 8% of these individuals received this service.
- 10% were recommended for Assertive Community Treatment (ACT). 13% of these individuals received this service.
- 10% were recommended for other Mental Health Rehabilitation (MHR) services. 4% of these individuals received this service.

For individuals who remained in NFs for longer than 100 days, the State reports:

- 29% were recommended for a psychiatric evaluation or psychosocial assessment. 10% of these individuals received this service.
- 30% were recommended for outpatient mental health services (individual, family or group). 4% of these individuals received this service.
- 10% were recommended for Assertive Community Treatment (ACT). 8% of these individuals received this service.
- 18% were recommended for other Mental Health Rehabilitation (MHR) services. 4% of these individuals received this service.

This information indicates that a substantial number of individuals in the Target Population need but do not receive critical behavioral health services after admission or continued stay review.

Compliance Assessment

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

- LDH continues to implement a process to initially approve nursing facility stays for no more than 90 days (or 100 days for persons approved for convalescent care by LDH) for an individual in the Target Population.
- LDH has provided more detailed information regarding the percent of individuals in the Target Population who are discharged prior to the 90 day initial authorization and request a CSR. As indicated above, 38% of individuals are discharged prior to their initial 90 day stay and 62% request a continued stay.
- LDH continues to have an authorization process using standard criteria for ongoing stays for individuals that seek a continued stay. The State reports that the average length of stay for these individuals is approximately 280 days.
- LDH does not currently have sufficient information on the reason for an NF admission and continued stay, the need for specialized behavioral health services, the barriers that prevent an individual from receiving community-based services at the time, or the intended duration for continued stays.

Recommendation

- LDH should continue to track and report authorization for NF admissions to ensure they comport with the 90–100-day requirement.
- LDH should identify and implement a strategy during the next reporting period for collecting and reviewing data regarding reasons for admission.
- LDH should undertake efforts to understand why behavioral health services recommended by the PASRR Level II Evaluator are not provided to individuals during their NF tenure.
- LDH should implement the strategy in paragraph 51 for collecting and reporting information regarding barriers that impact the individual's ability to live in the community and develop a strategy to address these needs for CY 2023.

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

Compliance Rating: Met

Discussion and Analysis

As indicated in previous SME reports, the State has developed a process that requires NFs to submit continued stay requests (CSRs) for continued stays beyond the 90 days of an initial stay, at least 15 days before the authorized temporary admission ends. LDH created policies and criteria for individuals who will be provided a continued stay past the initial 90 or 100 days. The fourth SME report provided a description of the CSR process LDH has developed for individuals in the Target Population and delineates the role of OAAS and OBH. This includes the use of MDS to establish continued NF level of care. The State continues to report that all continued stay requests are reviewed by OAAS regional staff who are independent and not affiliated with the nursing facility.

Compliance Assessment

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

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

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

Compliance Rating: Partially Met

Discussion and Analysis

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

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

- A PASRR Level II is performed by an independent reviewer when a provider requests a subsequent continued stay for an individual (instances where the individual seeks an ongoing stay).
- Annual resident reviews, as required by the Agreement, are being performed on individuals in the Target Population who were admitted to an NF prior to 2018 and for individuals who were admitted after 2018 who did not have a continued stay review during the year. For individuals admitted after the beginning of the Agreement, the PASRR Level II rendered through the CSR process is the annual resident review.
- 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 requested and LDH provided information regarding the number of individuals in the Target Population who received a PASRR Level II based on each of these scenarios over the past year. As discussed in the eighth SME report, the State reported 62% of individuals on the Master List had an annual PASRR Level II review in the last reporting period. LDH also reported that 40% of these individuals received a PASRR Level II for a change in condition. Therefore, some individuals received two PASRR Level II Evaluations—an annual review and a review due to a change in condition.

LDH reports that all individuals, with the exception of individuals identified through the MDS process and needing a PASRR Level II Evaluation, have received either an annual PASRR Level II review through the CSR process and/or a PASRR Level II through a change in medical condition. LDH reported they performed 2,500 PASRR Level II on individuals during the first quarter of CY 2023. Information from LDH on the three scenarios for this reporting period indicated:

- 975 or 38% received an annual PASRR Level II review.
- 669 or 26 % received a PASRR Level II review due to a change in condition.
- 861 or 36% received a PASRR Level II through an initial CSR.

While this is encouraging, LDH should provide additional information to ensure all individuals in the Target Population in NFs are getting a PASRR Level II Evaluation on an annual basis.

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

- The State reports information regarding the number of individuals who received a PASRR Level II for each of the scenarios.
- The State reports all individuals in the Target Population in NFs have received an annual PASRR Level II either prior to admission, during a Continued Stay Review (which occurs within a year), or due to a change in medical condition. Additional information is needed to corroborate this information.

<u>Recommendations:</u>
- Continue to report quarterly to the SME on the number and percent of individuals in each of the three scenarios.
- Provide the SME with information on the number of individuals who did not get a PASRR Level II Evaluation in the previous year (CY 2023).

- Identify and address the reasons individuals in NFs are not getting an annual PASRR Level II review.

IV. Transition and Rapid Reintegration

A. Comprehensive Transition Planning

40. LDH will offer comprehensive transition planning services to all individuals in the Target Population who are admitted to a nursing facility in Louisiana. LDH's approach to transition planning shall address two distinct situations: (1) the need to identify and transition members of the Target Population already in nursing facilities at the effective date of this agreement, and (2) the need to identify and transition members of the Target Population admitted to nursing facilities after the effective date of this agreement.

Compliance Rating: Partially Met

Discussion and Analysis

This rating has changed from Not Met to Partially Met. The State has developed in-reach processes and protocols to offer transition options and transition planning for individuals on the Master List. LDH has had an in-reach process and protocols since CY 2022. These efforts are described in more detail in paragraph 54. As discussed in paragraphs 24-26, individuals who express an interest in moving are placed on the ACL. Although all members of the Master List must be offered comprehensive transition planning services, LDH delivers such services to those individuals on the ACL. As indicated in paragraphs 24-26, individuals on the Master List are currently not interested, undecided, or unable to decide if they are interested in transition.

The transition process is generally the same for individuals who were in NFs prior to the Agreement and for individuals in the Target Population who were admitted after the Agreement.

There are three major issues the Department will need to address to meet the requirements of this paragraph. The first is to ensure that everyone in the Target Population is offered comprehensive transition planning services. The second is to ensure that everyone who is on the Active Caseload List has a Transition Assessment. The third is to ensure that all individuals who have an assessment also have an Individualized Transition Plan (completed or in progress). LDH should ensure the quality of these ITPs to reflect a person-centered planning process that accurately reflects the individuals' desires and needs. The last issue is discussed more thoroughly in paragraph 43.

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

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

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

The SME has reviewed and agreed with these expectations. These efforts reflect LDH's intent to standardize the transition process. Since the eighth report, LDH has been monitoring these requirements. The State also reports on whether TCs in aggregate are meeting these expectations. For this period, LDH reports the following:

- The average number of days from when a person is added to the ACL and is referred to a TC is 17 days.
- The average number of days from when a person is referred to a TC and a completed assessment is 18 days, 4 days more than the standard.
- The average number of days from when a person is referred to a TC and an ITP begins is 29 days, consistent with the standard.
- The average number of days from when an assessment is complete and ITP planning begins is 13 days.

The service review identified two-thirds of the individuals had a projected transition date within 60 days prior to transition.

Some information reported by LDH is consistent with findings from the service reviews, which found that one-third of the Nursing Facility Transition Assessments (NFTAs) were completed within the 14-day timeframe. However, in contrast to LDH information, the service review did find that less than 25% of ITPs were initiated within the timeframe in which the NFTA was completed.

The State continues to track whether individuals on the Active Caseload List are involved in the necessary transition activities. In the eighth report, LDH data indicated:

- Approximately 66% of individuals on the ACL have started an assessment.
- 65% of individuals had a completed assessment.
- Less than 40% of individuals have initiated an ITP and approximately 25% of all individuals have a completed ITP.

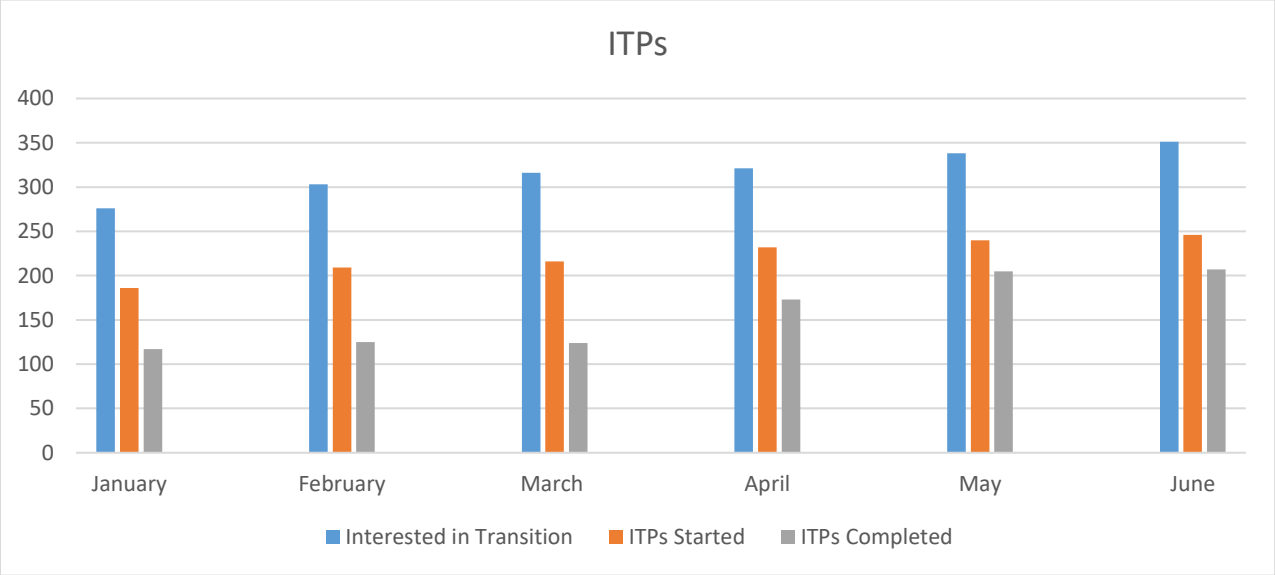
During this period, LDH reported:

- Approximately 80% (474/556) of individuals on the ACL have started an NFTA, an increase of 25% since the last reporting period.
- 78% (463/556) of these individuals have a completed NFTA, representing a 20% increase from the last reporting period.
- 70% (246/351) of all individuals with a completed assessment who are interested in moving have an ITP in process.
- 59% (207/351) of individuals with an ITP in process have a completed ITP.

The number of ITPs in process and completed ITPs has increased in the last reporting period for two reasons. First, actual ITPs developed or finalized have increased substantially since the eighth reporting period (30% and 75% respectively). LDH has redefined the denominator for the percent of ITPs in development or completed. This new definition includes only those individuals who have expressed an interest in transitioning. The SME agrees with this change, given individuals who are not interested or are undecided do not proceed with a transition plan and are returned to the Master List and prioritized for in-reach by a PIRS. If LDH used the previous methodology (number of ITPs completed versus the number of NFTAs) there would still be an increase of 52% from January through May 2023.

This tracker, in the SME's opinion, continued to provide a valuable management tool for LDH executive and management staff to determine the progress of transitions and any "bottlenecks" the State may be experiencing regarding transition activities.

As requested, LDH provides the SME with information on a monthly basis. The activities specifically regarding transition planning are presented in the chart below. For the purposes of this analysis, the focus was on ITPs and the extent to which people who were interested had commenced or completed these plans.



A review of this information indicates:

- The number of individuals who have a completed NFTA and subsequently indicated they are interested in transition increased from 276 individuals in January to 351 individuals in June (27% increase).
- The percentage of individuals interested in transition with an ITP started has generally remained the same throughout this reporting period, at 70%.
- The percentage of individuals interested in transition who have a completed ITP has increased from 42% in January to 59% in June (a 40% increase).

The State reports the increased efforts by LDH TC supervisors have produced this increase. This includes weekly TC-specific reports on transition activities that are provided and discussed with each TC during their weekly (or more frequent) meetings with their supervisors.

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

- LDH has not yet offered transition planning to everyone in the Target Population.
- LDH is actively working on transition planning activities for the 85% of individuals on the ACL who have expressed an interest in moving.
- LDH has developed and is assertively managing the expectations for TCs to complete the Transition Assessment and ITP within timeframes the SME finds acceptable; however, TCs have not complied with these expectations.
- Almost 70% of individuals on the Active Caseload List who have a completed NFTA and have expressed interest in transitioning have an ITP (in process or completed).

Recommendations
- LDH should increase the percentage of individuals on the Active Caseload that have a completed Transition Plan in the next reporting period to 80%. The SME understands that some individuals who are very recently placed on the Active Caseload List over the next six months will likely not have an ITP (in progress or completed).
- LDH should continue to provide the SME information regarding the percentage of TCs that are meeting the timeframe expectations regarding completed Transition Assessments and ITPs and what the plan is to ensure TCs comply with these timeframes.

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

Compliance Rating: Partially Met

Discussion and Analysis
As indicated in previous SME reports throughout the course of this agreement, individuals have been placed on the Master List because MDS data indicates they should have a Serious Mental Illness, but they have yet to receive a PASRR Level II evaluation to confirm this diagnosis. Consistent with the provision of this paragraph, the State must refer these individuals for a PASRR Level II. The Level II evaluation should confirm whether the individual had an SMI as initially identified through MDS data and verify they are a member of the Target Population. LDH provided information for this reporting period regarding the number of individuals who were placed on the Master List when an MDS indicated they may have SMI. LDH has provided MDS information on two cohorts: 1) individuals who are newly admitted and have an MDS indicating they have a possible SMI diagnosis and 2) individuals who have been in NFs longer than 100 days and a subsequent MDS indicated they have a suspected diagnosis of SMI. For this second cohort, these individuals experienced a change in medical condition which prompted a subsequent MDS indicating the individual may have SMI. Information from this reporting period indicated 49 individuals who were recently admitted to an NF and 6 individuals in an NF longer than 100 days had a suspected diagnosis of SMI. For these 55 individuals:

- 31 were discharged within 100 days and did not get a PASRR Level II.
- 4 individuals had their PASRR Level II withdrawn.

- 1 individual was deceased.
- 12 individuals received a PASRR Level II Evaluation. Of these 12 individuals:
    - 10 individuals, or approximately 91%, had an SMI based on the PASRR Level II Evaluation.
    - 2 individuals were found not to have an SMI.
    - The average length of time between identifying if an individual had an SMI (through the subsequent MDS) and the receipt of a PASRR Level II evaluation was 25 days.
- 7 were still awaiting a PASRR Level II. These individuals have been waiting for a PASRR Level II an average of 29 days.

LDH has significantly reduced the length of time for an individual who was identified through the MDS process as needing a PASRR Level II. In the eighth reporting period, it took LDH slightly less than two months for an individual to receive a PASRR Level II evaluation from the date of referral. During this reporting period, the average time from an individual suspected of having an SMI as identified in the MDS and a PASRR Level II review was 25 days.

In the seventh report, the SME recommended that LDH develop and track timeframe expectations for individuals identified through subsequent MDS to receive a PASRR Level II. LDH has set an expectation of 30 days for a PASRR Level II to be completed once an individual identified through the MDS process of having a suspected diagnosis of SMI receives a PASRR Level II evaluation.

Compliance Assessment

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

- LDH continues to make progress to ensure that every individual in the Target Population receives a PASRR Level II.
- LDH continues to track and report the number of individuals who are in an NF and have subsequently been identified through the MDS process as having an SMI and have received a PASRR Level II evaluation.
- LDH has set a standard timeframe expectation for individuals identified as having a potential SMI to receive a PASRR Level II (30 days).
- For the 12 who received a Level II, LDH has reduced the length of time for an individual to receive a PASRR Level II evaluation from the date of referral when they have a potential SMI to 25 days (within the new expectation).
- LDH has not performed a PASRR Level II for seven individuals who were identified post admission during the reporting period as having potential SMI, to confirm their diagnosis. These individuals have been waiting for 29 days to receive a PASRR Level II evaluation.

Recommendations

- LDH should continue to track and report the number of individuals who are in an NF and have subsequently been identified through the MDS process as having an SMI.
- LDH should continue to report the number of individuals who do not have a PASRR Level II evaluation and have recently been identified as having a potential SMI and ensure these individuals receive a PASRR Level II evaluation within the recently established timeframe of 30 days.

Transition Teams

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

Compliance Rating: Partially Met

Discussion and Analysis

The State initially established 18 positions to assist with transitions. The State recruited, hired, and trained all Transition Coordinators (TCs). In FY 2020 the State expanded the number of TCs to 25 individuals; OAAS has 16 TCs and OBH has 9 TCs. During this reporting period, the State added two TC positions (one for each office). In addition to the TCs, OBH and OAAS have seven positions to supervise TCs.

TCs are responsible for working with individuals on the Active Caseload List to assess their community-based needs (including behavioral health needs) and for working with the individual and informal and formal supports to develop a transition plan. They are responsible for facilitating referrals for individuals who are transitioning from nursing facilities to community-based services. TCs are also responsible for regularly scheduled follow up visits for individuals for one year post transition; this includes follow up visits 30, 60, 90, 180, and 270 days post transition or discharge. The State reports that all individuals (with the exception of individuals who have been recently admitted) who have been placed on the Active Caseload List awaiting transition have been assigned a TC.

At the beginning of the Agreement, LDH reviewed information regarding the number of individuals in the Target Population who had a co-occurring intellectual and/or developmental disability (ID/DD) to determine if additional TCs were necessary for the Office for Citizens with Developmental Disabilities (OCDD). In the eighth SME report, there were 22 individuals with co-occurring SMI and ID/DD. During this reporting period there were substantially more individuals with co-occurring SMI and ID/DD in the Target Population. LDH reports 223 individuals with co-occurring SMI and ID/DD were in the Target Population, 39 on the Active Caseload List and 184 on the Master List. The State has continued their decision 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.

The SME continues to recommend LDH reassess its TC capacity. The SME noted various factors that LDH should consider when reassessing this capacity. In addition, the SME recommended LDH use newly developed management tools (and any other information) to determine whether the existing TCs can serve more individuals on the Active Caseload List. During the last reporting period, LDH increased the

caseload size from 25 to 45 individuals for CY 2023. The increase would allow approximately 1200 individuals on the ACL to be assigned a TC (assuming a full complement of TCs). LDH rationale for this increase was discussed in the eighth SME report. LDH has not performed an assessment to determine if this increase had the intended effect on transition planning activities and actual transitions.

The SME also recommended that LDH assess the need to add staffing to transition individuals on the Active List from NFs (which was recommended in the sixth report). This additional capacity could include additional peer specialists, transition coordinators, or even community case managers who are to engage individuals within 60 days of transition. The State has not hired or contracted with additional staff that can support their efforts to transition individuals.

In its 2023 Implementation Plan, LDH committed to transition 350 individuals in CY 2023. This would still mean that approximately 37% of the individuals currently on the Active Caseload would not transition in CY 2023. If LDH meets its goal, up to 206 individuals who are on the Active Caseload List will likely remain in NFs past 2023, underscoring that many individuals who have indicated they are, or may be, interested in moving in the near term will not be offered transition assistance by the TCs over the next six months.

The SME recommended more proactive oversight of transition planning activities to assist LDH in setting and meeting reasonable transition expectations. LDH has specific expectations for the number of transitions each region must accomplish annually and began tracking each region's performance. Specifically, LDH expects each TC transition at least one individual on a monthly basis. LDH tracks the number of transitions projected and completed per month by region and TC. In reviewing this tracking information, there is still unevenness in the number of transitions per region. The SME continues to discuss this issue with the State and suggests further analysis for this variation in the number of transitions per region. LDH has identified the variability may be to several factors, including:

- The report is designed to state where the individuals transitioned to rather than the region the individuals were residing in while in the NF.
- Some regions (e.g., Region 5) have a much lower volume of individuals who are interested in transition.
- TC turnover also impacts the number of individuals transitioned by region and newer TCs may not yet have developed the acumen to meet LDH transition expectations.

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

- LDH has developed transition teams that are composed of transition coordinators from OAAS and OBH, who are responsible for assessing, planning, and facilitating access to necessary community-based services.
- LDH has developed a strategy for addressing transitions for individuals with a co-occurring intellectual or developmental disability and a behavioral health condition.
- LDH has developed and implemented management tools for meeting the transition targets established by the Department.
- The number of individuals with co-occurring SMI and ID/DD has increased substantially during this reporting period.

- LDH has reviewed and adjusted caseload sizes for each transition coordinator so that every individual on the Active Caseload List in an NF will be assigned a TC. This is a substantial increase in caseload size from previous years. The impact of this change has not been assessed.
- Despite the change in caseload size, there are a number of individuals who will not transition in CY 2023. The current projections for CY 2023 are that 350 individuals will transition and therefore over 200 individuals will remain in NFs without additional transition capacity. This number does not account for additions to the Active Caseload based on in-reach.

Recommendations

- LDH should assess the impact of the new caseload size for the TCs. This will include some of the recommendations below (timeliness of transition activities) as well as the quality and frequency of the contacts between the TC and individuals on their caseload.
- LDH should ensure that transition activities (e.g., assessment and ITPs) are performed within the timeframes discussed in paragraph 40.
- LDH should reconsider additional peer supports or other staff to assist TCs with various transition activities. This would support LDH's decision to have TCs have higher caseloads.
- LDH should determine the cause for a marked increase in the number of individuals with ID/DD and revise its current approach for assigning TCs.
- LDH should track information by TC regarding the number of transitions completed throughout the year and take the necessary actions to ensure TCs meet these expectations. The State should report these efforts to the SME and DOJ on a regular basis.

Transition Planning

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

Compliance Rating: Not Met

Discussion and Analysis

This discussion addresses paragraphs 43 and 46 together. Since the beginning of the Agreement, LDH requires ITPs based on a standardized assessment (NFTA) that is completed prior to discharge. The State has made revisions to the assessment and ITP over the past several years to be more person-centered and to gather additional information regarding individuals' interests and desires about integrated day opportunities. The assessment and ITP, as revised, also provide more specificity regarding the housing options that are available in the community post-transition. LDH has developed, but not yet implemented, an addendum to the ITP that will provide information on ongoing services and supports that will be needed post transition until the CCM can work with the individual to develop the CPOC. This addendum will provide recommendations regarding the scope, amount, and duration of services needed at transition. LDH reports this process will be initiated in the next reporting period.

This paragraph requires all members of the Target Population to have an Individualized Transition Plan in order to truly envision their options for community services. LDH has focused its efforts on developing ITPs for members of the ACL. While not everyone on the Active Caseload has an ITP, LDH has increased the ITPs in process or completed (discussed in paragraph 40).

In CY 2022, the SME developed a tool for reviewing the presence and quality of ITPs for individuals participating in the SME service reviews. This tool identified whether the individual had a completed NFTA and ITP. It also reviewed the quality of the NFTA and ITP. As indicated in the previous report, almost 75% of individuals participating in the service review did not have an ITP. During this reporting period, the SME reviewed only those individuals with completed ITPs. Reviews of the absence/presence of ITPs are now LDH responsibility. The SME reviewed the quality of ITPs. This review focuses on whether needs identified in the PASRR Level II and NFTA are addressed in the ITP. The reviews found that major service domains identified as needed in the NFTA such as medical, behavioral supports, community living, and relationship supports, and vocational/educations were not addressed in almost all individuals' ITPs. Support services such as transportation and assistance with ADLs and IADLs were not included in the ITP. Service reviews conducted over the past year (FY 2023) found many of the same issues with ITPs as the previous service review. This included:

- ITPs do not accurately reflect and address all of the individuals' needs and desired outcomes.
- ITPs did not identify all appropriate services and supports.
- Few ITPs reviewed included employment or community integration goals and services to support these goals, which is a shortcoming in the current assessment process.
- There was a lack of clarity as to whether the individual had an active role in choosing where they would live post transition.
- ITPs do not specify the amount, frequency, and duration of services post-transition.

In addition, major tenets of a person-centeredness were absent from these plans. For instance, more than three-fourths of all individuals had plans with no goals. Slightly fewer individuals indicated they had a copy of their ITP. One-half of the ITPs were not signed by the individual, which is one indication of their participation in the planning process.

For individuals transitioned or awaiting transition there were several barriers and issues that impacted and are impacting transition. It should be noted, there were only a few individuals transitioned who did not have the services and supports in place prior to discharge from an NF. Barriers and issues identified in the service review for individuals awaiting transition include:

- The lack of physically accessible housing for individuals with significant mobility impairments.
- An informal policy to suspend the ITP process until housing is secured resulting in TCs not having regular contact with the individual awaiting transition and ITPs not addressing other service needs identified in the NFTA. Waiting for housing to be secured delays referrals to other needed services.
- Income assistance applications not being initiated or finalized before transition. NFs are responsible for completing and submitting the necessary paperwork for Social Security and other income benefits. This results in individuals being transitioned without these benefits and TCs and CCMs needing to make sure that basic needs such as food and funding for utilities are planned for and are regularly available.
- Individuals are rapidly discharged from the NF. These individuals left the facility prior to the discharge planning date. The TC and CCMs indicated there was not enough time to plan for timely post transition services.

Lastly, LDH has required TCs to collect and report information on barriers to transition individuals on the ACL. This information is reported in paragraph 51.

During this period, LDH reports they continue to implement several strategies to improve ITPs. LDH reports they provide training and technical assistance through supervision to TCs to ensure the services identified in the NFTA are addressed in the ITP. This included a focus on better identification of services and supports to address individuals' medical and ADL needs. In addition, LDH reports they will provide additional training to TCs regarding the various LDH programs that offer these services when needed. This training is similar to training LDH plans for PASRR Level II Evaluators, as discussed in paragraph 32.

While this paragraph is specific to ITPs, the service reviews also assessed the quality of NFTAs. This review found various domains not addressed in the NFTA. Two major domains that were not addressed were specific to medical needs and behavioral health supports. There were several significant areas regarding the NFTA process that were absent from these assessments. Most concerning were assessments that did not include the individual's strengths, which is a critical principle of person centeredness. In addition, the assessments did not identify potential transition barriers for individuals during the assessment. Therefore, the service review team relied exclusively on interviews with the individuals and TCs to garner this information.

Compliance Assessment

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

- The quality of ITPs is poor. ITPs still do not address many of the important details required by paragraphs 43 and 46. In addition, ITPs lack person centeredness.
- Individuals awaiting transition report that they did not have their ITPs.
- Informal policies may cause delays in transition. Most ITPs did not have services and supports identified.
- LDH has developed but not implemented an addendum to the ITP to collect information on the amount and duration of services.

Recommendations

- Continue training and supervision strategies that improve the quality of NFTAs and ITPs.
- Report the findings from the compliance reviews of TC transition activity to the SME and DOJ.
- Train TCs and implement the addendum to the ITP to identify amount, scope, and duration of services and supports that are needed and linked to the individual's goals at transition and for the first 30 days post NF discharge.
- Formalize the process of addressing barriers found through services reviews or by TCs. This should include identification of strategies by the My Choice internal quality review team (discussed in paragraph 94) and the Transition Support Committee (discussed in paragraph 58).

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

Compliance Rating: Not Met

Discussion and Analysis

During the fourth reporting period, the State, in collaboration with the SME's team, provided training on person-centered transition planning for TCs, MCO case managers, and other providers. LDH has also contracted with a consultant who provided additional support to TCs over the past year to improve their efforts in developing person-centered transition plans. The SME recommended LDH validate the effectiveness of this training on the quality and the person-centeredness of the ITPs in this reporting period. This validation did not occur and the most recent service review indicated the person-centeredness of the ITPs did not improve this period.

LDH continues to provide the SME with information regarding the process deployed to allow individuals an opportunity to visit potential housing options and the surrounding community, to better envision their lives post transition. These do not include in-person visits to the housing options. LDH has stated that transporting individuals to potential housing options cannot be done by TCs. CCMs are not a viable option since most individuals who apply for housing assistance are not within 60 days of transition. Rather, the TC and/or the LDH Housing Coordinator provide photos and videos of these options. The most recent service review did find that a few individuals who were transitioned indicated in interviews they were not given a choice of housing options. Two other individuals awaiting transition cited the lack of progress discussing or finding housing. One individual was anxious to hear about housing options but had not talked to the TC for several months. Other individuals reported their TC did not contact the member with planning updates or move forward with investigating and/or securing the housing option for three months. One individual stated that he has not been involved in choosing a place to live and is hoping the TC will have some places for him to review when they meet next, but there was no specific date set for that follow up meeting. Five individuals indicated they needed physically accessible housing.

Compliance Assessment

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

- ITPs are not being completed consistent with a person-centered approach despite several years of training and technical assistance to TCs.
- LDH TCs cannot provide transportation for individuals awaiting transition to visit housing opportunities in the community and viable transportation options have not yet been identified.
- Some individuals participating in service reviews indicated a general lack of communication with the TC regarding housing.

Recommendations

- LDH should retrain TC staff and supervisors regarding person-centered planning using the modules developed in CY 2020.
- LDH should develop strategies that are alternatives to TCs to offer in-person opportunities to review housing and other community opportunities prior to transition. This may include contracted agencies that offer peer support and ride-sharing opportunities (Lyft and Uber in urban areas) for the TC and individual to visit housing options.

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

Compliance Rating: Not Met

Discussion and Analysis

The State continues to not have a real-time way to identify when individuals are admitted to a nursing facility. Therefore, the State is not able to meet the 3-day and 14-day requirements in this paragraph. Based on work that the State has set forth in its implementation plan for CY 2021, the State was to have this much-needed functionality in place by October 2021. However, based on contract delays, LDH has stated the tracking system will likely not be operational until later in CY 2023.

During this reporting period, the State has developed a proposed process for meeting this requirement without the ability to identify individuals promptly at admission. LDH is proposing a pilot in regions of the state with the most individuals in the Target Population admitted to an NF—regions 1, 2, 4, 7 and 9. These admissions account for 65% of the new admissions by the Target Population statewide.

LDH proposes an LDH Rapid Integration Transition Coordinator (RITC) who will be responsible for making the initial contact with the individual and providing the face to face visit within the fourteen day period. LDH proposes to use the date of the initial MDS (which is usually completed within three days of admission) to begin the engagement process. During this face to face visit, the RITC will initiate the NFTA and the individual will be placed automatically on the ACL. Similar to other individuals on the ACL, the NFTA will also be used to gauge whether the individual has short-term plans to return to the community (no longer than 60 days) or will likely need a longer stay. The RITC will meet with the individual within 45 and again at 60 days from admission to determine if they will discharge or may be likely to remain in the NF 90 days or longer. If the individual has an imminent planned discharge the RITC will identify supports needed at transition and work with NF staff to track when the transition will occur. The State reports they are developing expectations for RITCs to track discharge activities for these individuals. If the individual is likely to remain in the NF longer than 90 days from admission, the RITC will continue to assess their interest in transitioning. If interested, the RITC will engage a TC to begin the ITP process and commence the transition process. If the individual indicates they are not interested in transitioning, they will be placed on the Master List and will receive an in-reach visit from the PIRS within 90 days.

Compliance Assessment

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

- LDH has not developed the necessary functionality to identify when an individual has been admitted to an NF.
- LDH has developed a plan to implement a pilot project in regions 1,2, 4, 7 and 9 for early engagement efforts required by this paragraph. The State has provided the SME and DOJ with details regarding the specific process for how contact will occur at engagement and other details discussed in the paragraph above.
- LDH has developed position descriptions for RITCs.

Recommendations

- LDH should implement the changes in the contract with the vendor to track the 3-day and 14-day requirement.
- LDH should provide the SME will information on the pilot program that includes:
    - The number of individuals in the Target Population who were admitted to an NF and received early engagement from the RITC within the established timeframes.

  - The reasons why individuals who were newly admitted did not receive timely engagement by the RITC.
  - The number and percent of individuals who were engaged and had a Transition Assessment within the first 30 days post admission.
  - The reasons why individuals did not have a timely and completed Transition Assessment.
  - The number and percent of individuals in the Target Population who were discharged prior to 90 days of admission.
  - The number and percent of individuals who will remain longer than 90 days.
  - The number and percent of these individuals who had an ITP prior to 90 days.
  - The number and percent of these individuals who did not have an ITP prior to 90 days and reasons why an ITP was not performed.
- LDH should develop a strategy for assessing the pilot project by the end of CY 2023.

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

Compliance Rating: Not Met

See the response to paragraph 43.

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

Compliance Rating: Partially Met

Discussion and Analysis

At the beginning of the Agreement, the State did not have a community case management strategy for individuals transitioning from NFs. During the seventh reporting period, LDH implemented a case management approach that relies on a community vendor (i.e., Merakey) under contract to the MCOs to provide community case management. As stated in the seventh SME report, LDH developed Standard Operating Procedures (SOPs) that provide an approach for how community case managers (CCM) will interface with the TCs. Specifically, the SOPs require:

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

- The CCM to attend transition planning meetings with the TC and the individual prior to discharge from the NF.

In addition, LDH requires the TCs to make a referral for CCM and ensure the individual connects with the CCM within 60 days prior to transition. This will allow the CCMs adequate time to engage the individual and participate in discharge planning meetings and final ITP meetings.

During the SME Service Reviews conducted during this reporting period, the SME Service Review team examined documentation from the TC and CCM logs specifically to determine if the CCM was included in the ITP Planning process. The service review also evaluated whether the TC and CCM had ongoing contact post transition to ensure a "warm handoff" occurred. As indicated in paragraph 59, CCMs had individuals on their caseloads who were in the process of transitioning from an NF or who had already transitioned from the NF and were previously receiving intensive case management from the TC. The SME service review found 14 of 29 individuals participating in the service review were assigned a CCM prior to transition. Eleven (11) of these individuals had documentation of CCM's participation in the transition planning meeting.

In paragraph 43, the SME recommended ITPs or other pre-transition planning documents (e.g., CCW or ACT plans) identify the services and supports that should be available to individuals for the first 30 days post discharge from an NF. The plan should specifically identify the services and supports needed and the organization responsible for providing these services and supports.

As discussed in paragraph 43, LDH is in the process of developing an addendum to the ITP that will identify the services, support (including natural supports), and providers needed and requested by the individual during transition planning meetings. LDH states they will incorporate this addendum into the ITP process during the next reporting period.

Compliance Assessment

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

- The sample review showed the CCM was involved in the transition and transition planning process for most individuals 60 days prior to transition.
- At the point of transition, individuals do not have ITPs in place with necessary services needed for the first 30 days. LDH has developed but not implemented an addendum that will identify services and supports that are needed for 30 days post transition. This plan will be helpful to the CCM in their efforts to work with the individual to develop a community plan of care within 30 days post discharge.

Recommendations

- LDH should implement the addendum to the ITP to address services and supports needed and desired 30 days post discharge as indicated in the discussion of paragraph 43.
- MCOs should ensure CCMs participate in transition meetings 60 days prior to the transition date.

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

Compliance Rating: Met

Discussion and Analysis
LDH required MCOs to develop internal protocols to link members transitioning from nursing facilities or diverted from nursing facility care immediately to CCM. The State has SOPs that provide details on the process MCOs use to refer individuals who were transitioned or diverted to CCM on a timely basis. The State implemented this process in March 2022. The State has developed a tracking system that provides information regarding the timeliness of these referrals and engagement status post referral.

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

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

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

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

Compliance Rating: Partially Met

Discussion and Analysis
In the sixth report, the SME recommended LDH should increase the management staff that are overseeing TC activity to address issues identified during and post transition more effectively. As indicated in the eighth report, LDH has added two staff members to oversee the My Choice Program, which allows current staff responsible for managing TCs to focus on those activities.

LDH requires TCs to conduct post-transition follow-up to determine if the individual was receiving services in the community and to generally identify any issues an individual had during the first year of the transition. Specifically, LDH requires TCs to perform post transition assessments at 30, 60-, 90-, 180-, and 365-days post transition. The State developed the necessary protocols and trackers to collect this information. The State reports TCs use a contact log that collects data similar to information collected by the CCMs. This process provides an additional strategy to check-in with individuals who were transitioned and also a strategy to validate information being collected by the CCM.

In the seventh report, the SME recommended LDH develop an oversight process to ensure post-discharge reviews are being conducted by the TC with the cadence established by the Department. LDH reports TC supervisors review a sample of documentation regarding these post discharge reviews. LDH reports this documentation review confirms TCs are conducting post-discharge reviews consistent with the Department's expectations. Service reviews conducted during this past year confirm these post-discharge reviews are occurring.

In addition, the SME recommended LDH develop a process for reviewing the quality of the post-discharge contacts, ensuring that information from these follow-ups provide enough information for LDH to review and act on any concerns being identified by the TC, including a process to report this information to the CCM organizations. The Department has not developed this strategy.

LDH management staff who oversee TCs are also included in the SME service reviews. This requires management staff review NFTAs, ITPs, and contact logs for each individual who is awaiting transition or has recently transitioned. OAAS and OBH management staff are also conducting compliance reviews to ensure TCs are performing their transition functions on a timely basis. In addition, these reviews assess the quality of the NFTAs and ITPs, the frequency of contact with the individual, and whether discharge planning team meetings are occurring.

Compliance Assessment

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

- The State has developed and implemented the necessary policies and tools for conducting post-transition follow-up.
- Consistent with the SME's recommendation, LDH has added My Choice Program management staff that will allow staff that oversee TCs to focus on ensuring follow-up activities are implemented within the LDH timeframes and review the quality of these follow-up activities.
- LDH has developed a strategy to review the quality and cadence of the follow-up activities. While LDH is able to report TCs are meeting the required timeframes for follow-up, they have not provided information to assure that services in the community are initiated and delivered to individuals in a fashion that accomplishes the goals of the ITPs or community plans of care.
- LDH management staff are participating in service reviews and conducting compliance reviews of TCs transition activities.
- There is no post-follow-up strategy similar to that for individuals who are transitioned for individuals who are diverted from NFs.

Recommendations

- LDH should review the quality of the post-discharge contacts, ensuring that information from these follow-ups provides enough information for LDH to assure that services in the community are initiated and delivered to individuals consistent with the community plan of care and act on any concerns being identified by the TC. This information should be reported to the SME during the next reporting period.
- LDH management staff should continue to participate in the service reviews and conduct compliance audits of TCs transition activities.
- LDH should develop a follow-up process for individuals who are diverted from NFs.

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

Compliance Rating: Partially Met

Discussion and Analysis

Historically, some individuals who transitioned from NFs lose Medicaid eligibility when transitioning to the community. Medicaid has more generous income limits for individuals who meet the level of care for a nursing facility than for those who reside in the community. Since the beginning of the pandemic, Congress prevented states from removing Medicaid recipients from the Medicaid program. This requirement lapsed in May 2023.

LDH restarted efforts to track individuals who will lose Medicaid as of May. LDH reports no individuals who transitioned into the community lost Medicaid eligibility post transition even with this change in federal Medicaid policy.

As recommended in previous SME reports, LDH should develop clear pathways for making referrals for these individuals to LGEs for follow-up services, especially as Congress removes the current pandemic policy regarding eligibility. In the previous report, the SME also requested information on whether individuals who have lost Medicaid prior to the pandemic were referred to LGEs and, if available, any information regarding their engagement in services provided or coordinated by the LGE. The State has not provided this information. The SME continues to request this information.

In addition, LDH reports TCs and CCMs have recently received training to assess individuals' eligibility for the Medicaid Purchasing Plan and facilitate the referrals when the pandemic coverage ends. Louisiana's Medicaid Purchase Plan allows those with severe disabilities to go to work but still qualify for Medicaid.

Compliance Assessment

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

- The State has restarted efforts to track individuals who have lost Medicaid eligibility.
- LDH has provided training to TCs and CCMs regarding the Medicaid Purchasing Plan.
- The State has not provided the pathways for referrals to the LGE and other local agencies (e.g., Federally Qualified Health Centers (FQHCs)).

Recommendations

- LDH should track and report the number of individuals transitioned from NFs who lose Medicaid eligibility.
- LDH should develop a referral protocol to other community providers (e.g., LGEs and FQHCs) prior to the end of eligibility coverage under the pandemic.

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

Compliance Rating: Partially Met

Discussion and Analysis

This paragraph went from not met to partially met. In the seventh report, the SME recommended LDH should develop an approach that ensures all individuals on the Master List receive in-reach using the revised approach. During the in-reach process, Peer In-reach Specialists (PIRS) identify barriers to transition individuals who are not interested or are undecided in transitioning to the community. During the NFTA, TCs collect information on barriers for individuals who may not be interested in moving. LDH reports they have initially collected information on 77 unduplicated individuals who were on the ACL. The State reports:

- 13 individuals had suspected dementia and might not be part of the Target Population. These individuals were referred to the consulting psychiatrist for further review.

- 9 individuals were concerned about how their physical conditions would be managed in the community.
- 10 individuals were waiting for housing to become available in the community they selected.

Information regarding these barriers will be provided to the My Choice Internal Quality Assurance Committee to review and to develop strategies to address these barriers. In addition, LDH reports they will refer some barriers and other transition issues to the Transition Support Committee discussed in paragraph 58.

However, everyone on the Master List has not been provided in-reach and therefore information regarding barriers they may be experiencing is not being collected. LDH reports that of the 3,198 individuals on the Master List, about 1,007 have not been contacted using the revised in-reach process discussed in paragraph 54.

Compliance Assessment

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

- LDH has implemented a process to collect and report barriers for individuals who are on the ACL or returned to the Master List from the ACL who are not interested in transitioning.
- LDH has not contacted everyone on the Master List using the revised in-reach process and therefore information regarding their barriers is not available.
- The State has yet to implement a process for developing strategies to address these barriers.

Recommendations

- LDH should ensure they provide in-reach to all individuals on the Master List and obtain information on barriers to transition from these individuals.
- LDH should implement the proposed process for the My Choice Internal Quality Assurance Committee and the Transition Support Committee to review and address barriers identified though in-reach.
- At the individual level, LDH should document efforts to identify and address barriers to community living and to ensure a decision to remain in the nursing facility is meaningful and informed.

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

Compliance Rating: Not Rated

Discussion and Analysis

This paragraph will not be rated given it is the responsibility of the SME to perform the review of individuals who have requested alternative settings for transition. This provision sunsetted in June 2020; however, the State continues to report and review these requests with the SME. The SME developed a protocol and process to meet the requirements of this paragraph. During this evaluation period, LDH reported no members of the Target Population expressed an interest in transitioning from an NF and

requested to be transitioned to a setting other than their family's home or their own housing (single family home or apartment).

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

Compliance Rating: Partially Met

Discussion and Analysis

LDH, through the PIRS process, continues to track the number of individuals on the Master List who are determined not to be able to make a transition decision. LDH has determined that 15% of individuals contacted during the in-reach process for this reporting period are unable to make a decision about transition. LDH collects information on the reasons an individual is unable to make a decision. This includes the following categories:

- Individuals are unable to communicate using words (need interpreter or other communication aides).
- Physical health conditions are too significant and result in the TC being unable to engage the individual.
- Individuals are unwilling to participate in the discussion with the TC or PIRS.

As indicated in paragraph 51, LDH has not provided in-reach to everyone on the Master List and the number of individuals who are unable to make a decision would be greater than what LDH currently reports.

LDH also collects information on individuals who are on the ACL and may not be able to consistently make a decision to transition. For these individuals, LDH reports that TCs, during the early phase of transitions, identify individuals who may present issues relative to safety in the community (e.g., cognitive issues that may be difficult to address in the community). Historically, these individuals are referred to the Service Review Panel that reviews various documentation to determine if safety issues identified are valid. Starting this reporting period, these individuals will be referred to the Transition Support Committee as discussed in paragraph 58.

Compliance Assessment

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

- LDH tracks monthly the number of individuals on the Master List who are determined through the PIRS process as not able to make a decision regarding transition.
- LDH has not provided in-reach to all individuals on the Master List and therefore information regarding potential transition barriers for these individuals is not available.
- LDH has a process for identifying individuals on the ACL who may be unable to consistently make decisions regarding transitions.
- Individuals on the ACL who present safety issues for transitioning will be referred to the TSC.

Recommendations:

- LDH should continue efforts to track and report monthly on the number of individuals on both the Master List and ACL who are determined through the PIRS process as not able to make a decision regarding transition.

- LDH should ensure individuals on the ACL who present safety issues for transitioning are referred to the new TSC. LDH should report the Committee's decision regarding these individuals to the SME during the next reporting period.

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

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

Compliance Rating: Partially Met

Discussion and Analysis

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

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

Since the sixth report, LDH has implemented an in-reach strategy for individuals on the Master List. Within the Office of Behavioral Health (OBH) regional PIRSs were hired to work in tandem with the TCs across program offices. PIRSs are the primary resource accessed to visit individuals on the Master List in the nursing homes, gauging interest in transitioning into the community, providing education and information regarding community living, advocacy, and support to members related to transitioning. PIRSs are utilized to perform in-reach based on their personal recovery experiences. Two PIRSs were previously in the Target Population for the My Choice program. LDH has created expectations regarding the minimum number of contacts per month for each PIRS. Specifically, LDH will require each PIRS to have 40 contacts per month. Each of these visits will be documented through a standardized in-reach log completed by the PIRS after each in-reach visit. As indicated in paragraph 54, PIRSs report barriers experienced by individuals who may be uninterested or undecided regarding transition.

During this reporting period, 3,196 individuals received in-reach from PIRS. LDH reported that 848 or 27% of these individuals indicated their interest in moving and were added to the Active Caseload List. 3,198 individuals remained on the Master List. This included:

- 1,318 or 43% not interested in moving.
- 410 or 15% undecided about moving.
- 460 or 16%, LDH has determined as unable to make a decision about moving, meaning they do not have the ability to make a decision regarding relocation.

In the seventh report, the SME recommended LDH develop a schedule regarding the follow-up in-reach strategy for all individuals on the Master List. LDH has developed the following in-reach schedule for each of these populations.

Outcome of Visit	Type of Contact	Frequency of Contact
Undecided	Face to Face	Minimally quarterly
Not Interested	Face to Face	Minimally every six months
Unable to decide	Face to Face	Minimally once a year

LDH's goal was to engage every member on the Master List during the last reporting period. LDH has not met that goal this reporting period. LDH has prioritized in-reach efforts to individuals who have indicated they are undecided, including individuals who were recently moved back to the Master List from the Active Caseload List. LDH plans to visit everyone who was moved back to the Master List within 90 days, and to complete at least quarterly visits with those who are undecided. While the SME has historically agreed with this approach, LDH needs to enhance its in-reach effort to ensure everyone on the Master List received in-reach.

Currently, 1,007 individuals on the Master List have not yet gone through the newer in-reach process.

In the eighth report, the SME recommended LDH evaluate the quality of in-reach efforts. As discussed in the eighth report and observed during this reporting period, there continues to be significant variation among regions regarding the percent of individuals who have indicated an interest in moving. LDH reports they are working with PIRSs to ensure better consistency for making recommendations for referral from the Master List to the ACL.

Effective, individualized engagement is critical to supporting people's informed decisions about whether to transition. Early in the Agreement, TCs were responsible for performing in-reach efforts as part of the Transition Assessment process. These efforts provided individualized conversations to learn about a person's interests, preferences, and service and support needs. The TCs were also expected to have sufficient knowledge of the service array to respond to questions and concerns about transition, and ultimately identify specific options and locations that address a person's needs and preferences. As discussed in the paragraph, PIRSs are now responsible for performing in-reach for certain groups of individuals on the Master List. However, individuals who are referred to the ACL are provided additional opportunities to discuss interests, goals, and preferences through the NFTAs performed by the TCs.

In the eighth report, the SME recommended regular training of PIRSs and development of resources (such as conversation guides) to support PIRS in-reach efforts to ensure they can provide meaningful information about community options, respond to concerns, and evaluate people's preferences that mirror previous TCs' in-reach efforts. As indicated in paragraph 27, far too many people are returned to the Master List from the ACL due to a lack of interest or ability to make a decision regarding transition. LDH reports they have provided additional training to PIRSs that focuses on better identification of individuals on the Master List who may be interested in transitioning. In addition, the PIRS Supervisor is

provided monthly reports on PIRS activities and referrals from the Master List to the ACL. The PIRS Supervisor also shadows individual PIRSs in their in-reach efforts.

As discussed in paragraph 45, RITCs will be performing NFTAs for all individuals in the Target Population at admission. Similar to initial TC efforts, it is anticipated RITCs will have individual conversations regarding interests, preferences, and services and support needs. Clarity is needed between the various in-reach roles of PIRSs and RITCs.

Compliance Assessment

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

- LDH has conducted face to face in-reach with a substantial portion of the Target Population. However, about 1,007 of the 3,198 individuals on the Master List have not been contacted using the revised in-reach process.
- LDH has developed a longer term in-reach strategy for individuals on the Master List that sets forth expectations regarding frequency of in-reach efforts and monthly contact expectations by the PIRS.
- LDH continues to set and achieved specific targets for each region to provide in-reach to individuals who remain on the Master List.
- LDH continues to track the progress of each regional team's in-reach efforts.
- A significant number of individuals returned to the Master List from the ACL indicated they are not interested in moving or unable to make a decision regarding transition.
- LDH has developed and implemented strategies for ongoing in-reach for individuals who remain on the Master List and have indicated they are undecided, have no interest in transitioning, or are unable to make a decision regarding transition.
- LDH continues to provide training to PIRSs regarding community options for individuals who are on the Master List who have questions and concerns about supports that will be available during and after transition. The State has indicated training on ADLs provided to PASRR II Evaluators and TCs will also be available to PIRSs.
- LDH is providing management tools and supervisory oversight of PIRSs to ensure better referrals to the Master List.
- TCs continue efforts to provide informed choice through the assessment process.
- LDH has proposed an additional in-reach strategy using RITCs for individuals in the Target Population who are newly admitted to NFs.

Recommendations

- LDH should ensure all individuals on the Master List receive an in-reach visit, especially individuals who are relatively newly admitted and have remained in the NF for more than 90 days.
- The State should continue to evaluate the effectiveness of its in-reach strategy to ensure that all members of the Target Population are afforded a meaningful, informed choice about whether to transition, and to ensure that staff are accurately assessing those choices.
- LDH should develop clear roles and responsibilities for in-reach efforts across PIRSs, RITCs, and TCs. This role delineation should ensure there are no gaps or duplication of in-reach efforts.

55. Based upon information gained as a result of outreach, as well as other information available to LDH, LDH may develop a plan to prioritize individuals for transition based upon such factors as location or concentration of members of the Target Population in certain facilities or regions, likelihood of successful transition as measured by MDS-based tools, individual access to housing or availability of housing in the

area in which the person wishes to reside, and other factors. The goal of such prioritization will be to effect multiple successful transitions within two years of the effective date, on a schedule specified in the Implementation Plan, and to incorporate lessons learned into the State's practices.

Compliance Status: Partially Met

Discussion and Analysis

Early in the Agreement, LDH proposed a prioritization process in July 2018 to identify a cohort of individuals who had fewer transition barriers and thus were more likely to experience a successful transition. The State reports that individuals were initially identified using information gathered from the MDS Q+ index and follow-up conversations with the Transition Coordinators. It is unclear how these processes identified individuals with few transition barriers. Per the SME Service Reviews, a number of individuals did have very few transition barriers; however, many individuals had fairly complex physical health and behavioral health conditions and were also able to transition from the NFs.

In the seventh report, the SME encouraged the State to develop a new in-reach process for identifying and prioritizing among individuals in NFs who have expressed an interest in moving rather than relying on MDS data. In addition, LDH has:

- Developed practical targets for transitions for each Transition Coordinator.
- Developed policies for community case managers to be involved in the individual's transition planning 60 days prior to transition.
- Developed timeframes and protocols for TCs to engage with individuals to initiate the assessment and ITP process and will have specific timeframes for RITCs.
- Developed a more assertive in-reach strategy to focus on individuals who are undecided or had been placed on the Master List from the Active Caseload List.
- Created new service opportunities to address the ADL and IADL needs of individuals transitioning who still need some personal care services but who do not qualify for existing Medicaid programs.
- Reviewed individuals' interest and hobbies that may assist TCs in developing community inclusion strategies for individuals interested in transitioning.

In addition, as indicated in paragraphs 54 and 55, the State has implemented a process to have PIRSs and TCs identify barriers and strategies to address barriers faced by individuals in NFs who may be interested in transitioning.

Compliance Assessment

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

- The State did garner lessons learned from early transitions to establish the transition policies and practices discussed above.
- The State prioritizes transitions of individuals based on the current in-reach process that identifies individuals who express an interest in transitioning rather than rely on MDS information.
- The State has begun to collect barrier information from the TCs and PIRSs to provide additional information for LDH to use to improve their transition process.

Recommendations

- LDH should determine whether their efforts to prioritize individuals for in-reach meet the intent of having additional individuals transition.

- LDH should collect and analyze information on barriers as recommended in paragraphs 54 and 55 to make changes to transition policies and community resources to increase transitions and the timeliness of these transitions.
- LDH should recreate efforts to review individuals' community integration interests to assist the TCs and CCMs to better focus on developing resources that may address these needs when transitioned to the community.

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

Compliance Rating: Not Met

Discussion and Analysis

This rating has changed from Partially Met to Not Met. Since the beginning of the Agreement, the State has transitioned 525 individuals. Per the Agreement, the State is required to establish annual targets for successful transitions of Target Population members to the community. As indicated in the four previous SME reports, annual targets should be developed in conjunction with a longer term, aggressive plan for accomplishing "rapid reintegration," consistent with the goals of this Agreement. LDH is required to set forth a timeline for allowing *everyone* who is able to and would like to transition to the community to do so – with sufficient transition, discharge planning, and community-based services to meet their needs – within a set amount of time.

The State developed a methodology to set a transition target for CY 2023. The State revised the methodology used to develop CY 2022 targets. The major change in the methodology was an increase in the average caseloads for transition coordinators. The proposed average caseload for the transition coordinators was 1 to 25 individuals and will be increased to 1:45. LDH indicated this change was due to:

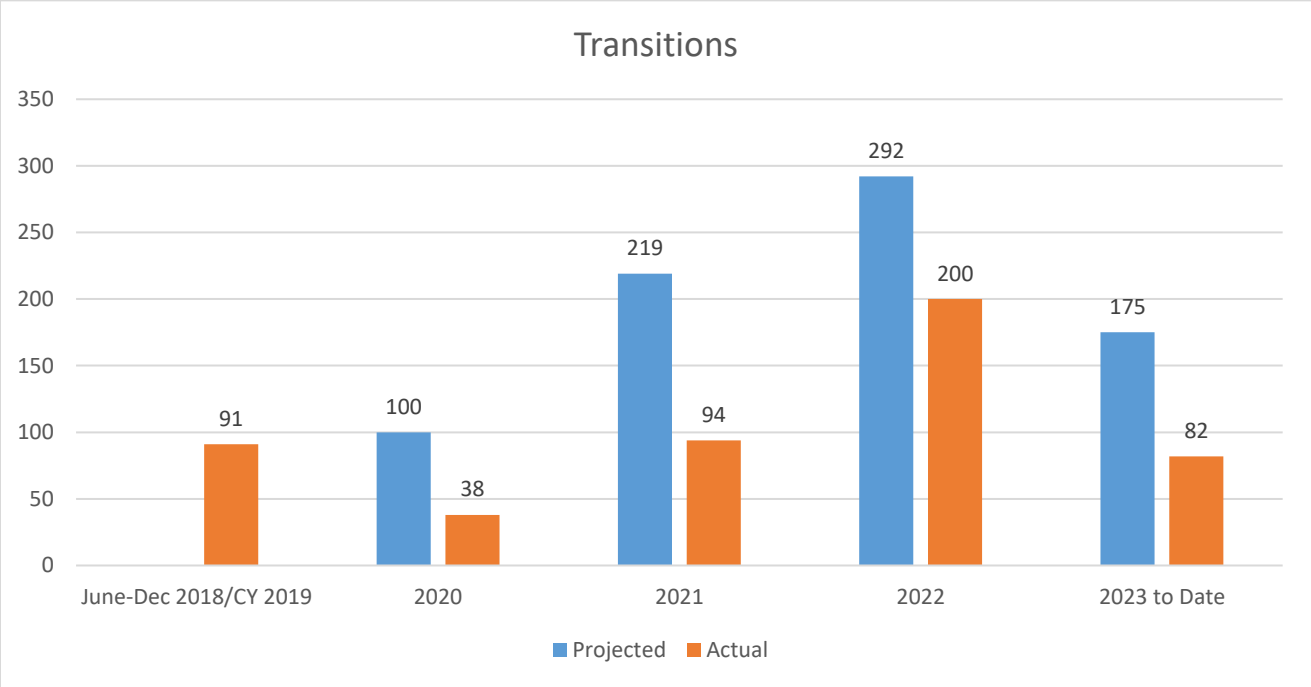
- Newer members being placed on the Active Caseload List who recently expressed an interest in transitioning. In prior years, LDH assigned individuals where documentation indicated they would be likely candidates to transition. Therefore, TCs spent a good deal of time doing in-reach for these individuals to discuss transitioning and in many instances the individual did not express an interest in transitioning.
- TCs no longer performing intensive case management for individuals who were transitioned. In some instances, 20-25% of the TC's time was focused on providing weekly or more frequent contacts with individuals who were transitioned.
- Additional staff resources providing supervision of TCs to better assist them in their job responsibilities.
- Additional staff resources assisting TCs with time-intensive activities including locating housing, assisting the individual to apply for housing, and assistance with landlords during the transition.

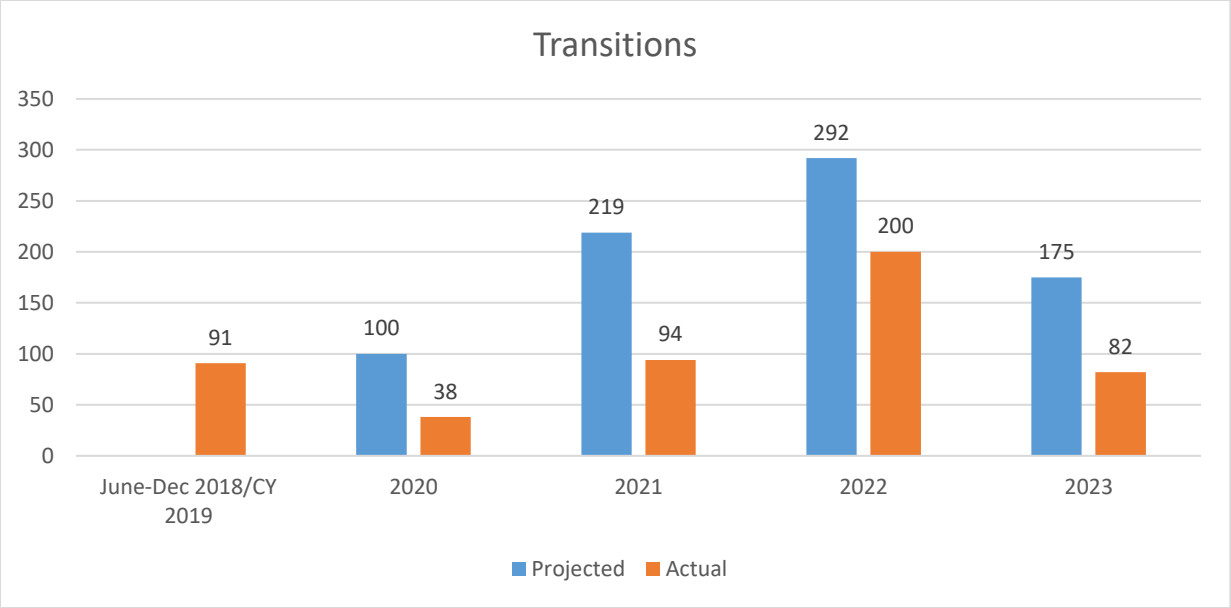
LDH has stated the change in caseload size will allow LDH to assign each individual on the Active Caseload List a TC. The SME has expressed concern regarding these revised caseload sizes and as indicated elsewhere in this report, requests LDH assertively monitor if this change adversely impacts the TCs' efforts and ability to effectively carry out their responsibilities.

LDH has proposed 350 transitions for CY 2023, a 20% increase from CY 2022. While the increase in the number of transitions projected for CY 2023 is encouraging, LDH is not meeting its proposed targets for the reporting period. As of June 30,, LDH reports transitioning 82 (47%) of the 175 individuals they projected to transition during this reporting period.

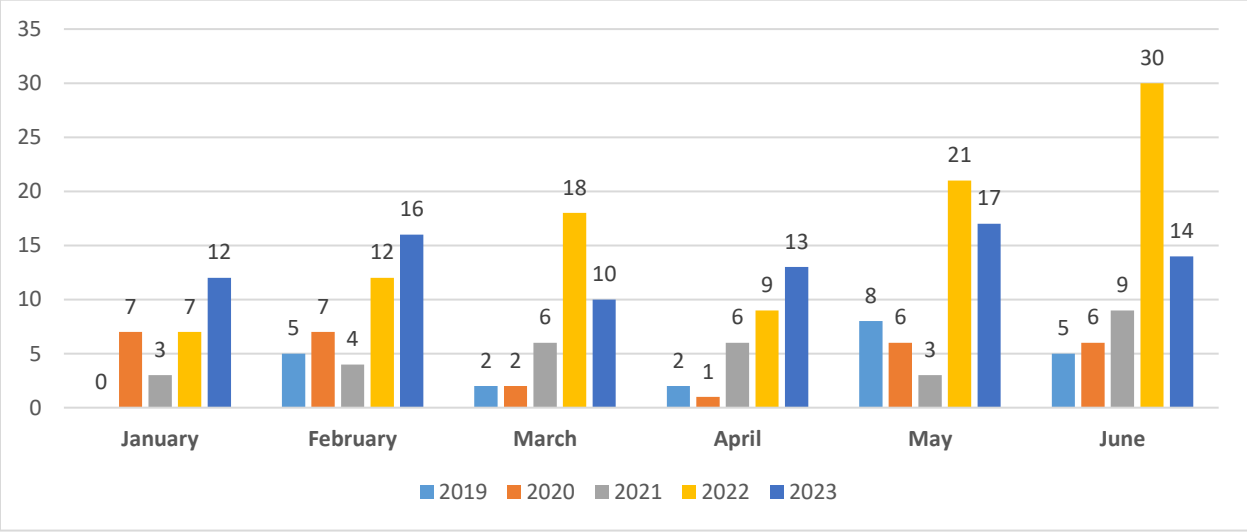
LDH proposed targets for CY 2023 still means the State will need at least two years to successfully transition current members of the Active Caseload. This number does not account for additional individuals who are likely to be placed on the Active Caseload List during these years or account for LDH not meeting transition goals.

The chart below provides a comparison of transition targets versus actual transitions for the five years of the Agreement.





The SME continues to review information on transitions across years on a monthly basis. The chart below provides a comparison by month of individuals transitioned from NFs for the reporting period of January through June 2023. This chart indicates good improvement in half of the months when comparing similar months across years and overall improvement from similar months during the pandemic (2020 and 2021). However, there were significant decreases (20-53%) in three months when compared to CY 2022.



In discussions with LDH, the SME has inquired regarding the root cause of the variability of transition during the reporting period. As indicated in the eighth report, LDH has developed and has implemented the necessary management tools and oversight of the TCs in recent years. LDH reports the variability in transitions is related to the following factors:

- Barriers to ADA accessible housing
- Lack of available PCA providers who are interested and willing to service individuals with SMI
- TC vacancies in regions with a large number of individuals in the Target Population.

As discussed in the seventh and eighth SME reports, the State should re-evaluate staff resources in CY 2023 to transition greater numbers of individuals on the Active Caseload over the next several years. Initially, this Agreement had a five-year horizon for achieving compliance, with transitions from NFs being a foundational premise of complying with this Agreement. While the State has succeeded in implementing numerous activities and initiatives to move toward compliance with the Agreement, it will take LDH much longer to achieve compliance without needed resources. Given that LDH has entered the sixth year of the Agreement, LDH must continue to take action to change course. This should include identifying what additional resources are needed to increase the number of transitions projected long-term rather than projecting transitions based on current staffing capacity.

Finally, in the seventh report, the SME expressed concerns regarding the length of time an individual took to transition (280 days). LDH currently reports this length of time to be similar during this reporting period (274 days). The SME recommended LDH aggressively implement the timeliness standards discussed in paragraph 48 for transitioning individuals on the Active Caseload List. As stated in the previous report, no one should have to wait more than nine months to transition from an NF if they have expressed an interest in moving.

Compliance Assessment

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

- The State is not meeting the transition targets for this reporting period.
- While LDH has developed a sounder methodology for projecting transitions, its performance consistently falls short of those projections.
- The State is not on track to accomplish the necessary transitions within the timeframe originally contemplated under the Agreement.
- The CY 2023 projections are still less than the 585 individuals on the Active Caseload List (or soon to be placed on the Active Caseload List) who are still in NFs and have expressed an interest in moving. It will take the State a minimum of two years to transition individuals on the Active Caseload List or individuals on the Master List who are still undecided about moving. The projected number of individuals on the Active Caseload List does not account for new members of the Target Population who will likely be admitted to NFs over the course of the next several years and who may want to transition in the near future.
- The CY 2023 transitions are higher than transition post pandemic; however, there are variable monthly transitions.

Recommendations

- LDH should review the TCs' activities (timely assessments and ITP development) to ensure the increase in caseload size has not adversely impacted these activities.
- LDH should ensure it has sufficient resources for more expeditious transitions of individuals on the Active Caseload list. Existing assumptions regarding the number of TCs or other staff that could perform transitions and caseload size should be revisited for future years to improve the timeliness of transition for all individuals on the Active Caseload List. There are specific staffing resources that LDH should seek, including additional:

  - Peer In-reach specialists who are needed to continue efforts to meet with individuals on the Master List who are undecided or not interested in transitioning.
  - Rapid Integration Transition Coordinators to ensure that every region has sufficient RITC capacity to engage individuals as required by the Agreement within 3 and 14 days from admission.
- LDH should develop strategies to address the barriers identified through in-reach and NFTAs.
- LDH should aggressively implement the timeliness standards discussed in paragraph 40 for transitioning individuals on the Active Caseload List. No one should have to wait more than six to nine months to transition from an NF if they have expressed an interest in moving.

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

Compliance Rating: Partially Met

Discussion and Analysis

The recent service reviews collected information on whether individuals who were transitioned requested and were returned to their previous living situation. Specifically, interviews were conducted with individuals who were transitioned either back to their previous living arrangement or a new apartment if their previous living arrangement was unavailable. As indicated in the second service review report, there were some individuals who were generally in the communities they were interested in living; however, some individuals who were transitioned wanted to change their current apartment.

As indicated in the service review, the transition date in the ITP changed. The final ITP often identified the transition date. However, the date of transition often changed during the ITP development process. Individuals were transitioned near that revised date set forth in the ITP.

Compliance Assessment

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

- Individuals either transitioned to their previous living situation or a new apartment if their previous living situation was unavailable.
- While the transition date in the ITP was fluid, individuals generally transitioned as of the date in their final transition plan.

Recommendations:

- LDH should continue efforts to ensure individuals transition back to their previous community living situation.
- LDH should track move dates for all individuals who are transitioned consistent with the timeframes in the transition plan.

C. Transition Support Committee

58. LDH will create a Transition Support Committee to assist in addressing and overcoming barriers to transition for individual members of the Target Population when transition team members working with service providers, the individual, and the individual's informal supports cannot successfully overcome those barriers. The Transition Support Committee will include personnel from OAAS and OBH, and ad hoc

representation as needed to address particular barriers in individual cases as well as systemic barriers affecting multiple members of the Target Population. Additional members with experience and expertise in how to successfully resolve barriers to discharge may include OCDD, Assertive Community Treatment team members, Permanent Supportive Housing staff and/or providers, community physical and home health providers, representatives of agencies responsible for benefits determinations, Adult Protective Services staff, LGEs, and certified peer specialists. A list of such ad hoc members shall be approved by the Expert.

Compliance Rating: Partially Met

Discussion and Analysis

This rating has changed from not met to partially met. As indicated in previous reports, the State developed procedures to fulfill the Agreement's requirement to facilitate a Transition Support Committee (TSC) using the My Choice Louisiana Service Review Panel (SRP). The SRP is a cross-agency process that works to identify systemic barriers that impede or prevent transitions and work through individual case-related issues (for all NF transitions). A description of the SRP functions and process was provided in the sixth report.

During this reporting period, LDH has proposed substantial revisions regarding the SRP roles. The State presented these changes in March 2023. The State proposes four changes proposed to the SRP and SRP process, including:

- Renaming the committee—specifically having a Transition Support Committee for the My Choice Program rather than relying on the current SRP to address all referrals from LDH.
- Expanding the roles of the committee, focusing on reviews of individuals with significant barriers to transition, systemic barriers, and longer term re-admissions to NFs.
- Revisiting structure and including representatives from the community and other state agencies to assist in addressing systemic and individual-specific barriers. LDH has discussed the need to vary membership on this committee for discussion of barriers experienced by individuals to respect confidentiality.
- Revisiting committee members—identifying potential additional committee members that have specific experience with systemic issues being identified by LDH. The "core" committee would be comprised of LDH staff and focus on individual members with significant barriers to transition and individuals who have been readmitted.

The State implemented the new Transition Support Committee in May 2023. LDH reports they will begin efforts to review individuals with significant transition barriers and individuals who were readmitted and remained in an NF for more than 90 days. The SME is requesting additional information on TSC activities during the next reporting period.

As indicated in the seventh report, the State has current and proposed strategies for collecting and responding to barriers impacting individuals in the My Choice program. As indicated in paragraphs 54 and 55, LDH implemented the process in which barriers are identified by PIRSs and TCs. The State has indicated they will also use a similar reporting process for PASRR Level II reviewers in the near future. LDH has trained and required PIRSs and TCs to collect information regarding barriers and potential strategies to address identified barriers. LDH has proposed a new process for addressing these barriers. Specifically, the State will use information from the PIRSs and TCs to identify barriers and potential solutions. This information will be provided to the My Choice Internal Quality Committee for their review and discussion.

This Committee will refer certain systemic barriers to the new Transition Support Committee. LDH is in the process of developing criteria for referrals to the Transition Support Committee from the Internal Quality Committee. LDH has stated they will have the criteria by April for implementation in later months (additional time needed to identify systemic barriers). In addition, LDH will also develop criteria for referrals to the Transition Support Committee for individuals with the most barriers to transition. The SME is requesting the status of the criteria and referrals to the TSC during the next reporting period.

While the SME is encouraged by this proposed process, it has not been fully implemented and LDH remains out of compliance with this paragraph.

Compliance Assessment

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

- LDH reviewed the adequacy of the SRP process and determined it was not sufficient for the My Choice Program.
- LDH has developed and recently implemented a new Transition Support Committee to review and address individual and systemic transition barriers for individuals on the Active Caseload List.
- LDH has developed a process (discussed in paragraph 55 and 56) to collect information on barriers and provide the TSC with this information to discuss possible solutions. This new process will address the SME's previous concern and will provide a "home" to organize, identify, and address systemic barriers.
- LDH will include external representatives to the TSC to discuss individual and systemic issues experienced by individuals who are awaiting transition or are concerned about transitions.

Recommendations

- The State provide information on issues discussed and potential resolutions by the TSC to the SME during the next reporting period.
- The State should track if the potential resolutions recommended by the Transition Support Committee have been implemented and track if previous systemic issues have been addressed.

D. Post-Discharge Community Case Management

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

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in the seventh report, LDH implemented the Community Case Management (CCM) Program. The CCM program has been implemented through MCOs who have selected regional providers that will offer case management for individuals who are awaiting transition (projected to be transitioned within 60 days), transitioned, or diverted from NFs. Participation in CCM is voluntary and the individual has to be enrolled with a Medicaid MCO. LDH contractually requires MCOs to offer CCM to individuals who choose to participate, for a period up to twelve months from the date of transition or diversion.

The SME continues to request, and the State provides, information regarding all individuals awaiting transition, transitioned, or diverted from NFs over the past twelve months and who are either engaged or not engaged in CCM. The SME has also requested information regarding the number of individuals who

have declined CCM for the reporting period. Tables 3 and 4 below provide the CCM information for the six month period from November through April 2023 (the most recent data available for the CCM program).

Table 3. Individuals enrolled in CCM

Individuals Receiving CCM	November	December	January	February	March	April
In NF Awaiting Transition	41	59	64	69	74	77
Transitioned	162	175	183	183	197	211
Diverted	48	47	43	48	53	51
Total Individuals Receiving CCM	251	228	290	300	324	339

Table 4. Individuals Declining CCM

Declining CCM	November	December	January	February	March	April
Transitioned	1	1	1	3	0	0
Diverted	3	0	4	0	0	0
Total Declined CCM	4	1	5	3	0	0

The number of individuals receiving CCM has continued to increase since the beginning of the CCM program. During November, 251 individuals were receiving CCM. As of April (the last reporting period available), LDH reports 339 individuals were receiving CCM. The number of individuals who declined CCM has remained consistently low during this reporting period. Six individuals who were transitioned and referred to CCM declined CCM. During this reporting period 13 individuals diverted or transitioned from NFs declined CCM. The State reports no individuals in March and April were referred and not engaged in CCM. In the eighth report, the SME recommended LDH conduct in-reach to individuals who were diverted and chose not to engage in CCM. LDH has provided information regarding reasons individuals choose not to enroll in CCM. These include:

- CCM is unable to reach the individual post transition or diversion.
- The individual declines participation in the CCM program.
- Individual is readmitted to an NF.

LDH also provided information regarding the caseload size for CCMs. This information indicates the CCMs' caseloads are consistent with LDH's policies. In addition, LDH reports monthly on the number of individuals who are readmitted to NFs. During the reporting period of September 2022 through February 2023, five individuals were readmitted to an NF.

In the last two reporting periods, TCs continued to provide Intensive Case Management (ICM) to transitioned individuals who had been residing in the community for longer than 180 days. At the end of this reporting period, 10 individuals were receiving ICM from TCs. LDH expects that TCs will no longer be providing ICM during the next reporting period for those individuals who retained Medicaid post transition.

As indicated above, the Agreement requires an individual to be provided case management, if agreed to by the individual, for one year after transition or diversion.

<u>Compliance Assessment</u>

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

- The State has established the CCM program and has good uptake of referrals for individuals currently residing or recently transitioning from NFs.
- Approximately 13 individuals who diverted from NFs and who were referred to CCM declined CCM during November through April of this reporting period.
- Five individuals were readmitted to NFs during this reporting period, who were transitioned or diverted from NFs.
- LDH requires the CCM to remain engaged with members who are readmitted to an NF unless the member declines CCM services or the stay is expected to be long-term (longer than 30 days).
- LDH does require CCMs to offer ongoing MCO case management after the twelve month period required in the Agreement.

Recommendations

- LDH should continue to track and provide the SME with monthly reports regarding the CCM program as requested in the sixth report.
- LDH should work with the SME to identify the reasons for readmissions of individuals recently discharged from NFs and develop strategies to continue care coordination either through the TCs or RITCs until the individual returns to the community or declines transition.
- LDH should continue to conduct in-reach to individuals who have been diverted on an ongoing basis, to obtain information on why they chose not to enroll in CCM.

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

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in this report, LDH began to implement CCM in February 2022. CCM, as designed, is individualized, person-centered, and reflects the individual's unique strengths, needs, preferences, experiences, and cultural background. It allows individuals to participate in decisions that affect their care and ensures they are provided options regarding their services and supports, including the option to refuse services. The State has developed SOPs that guide the activities of the CCMs and the cadence of CCM contacts prior to and one year after transition. Specifically, the SOP requires CCM involvement and multiple monthly contacts (face to face and virtual) to continue for no less than 365 days, at which time an assessment is conducted to determine ongoing need and desire to continue MCO provided case management. In addition, the SOP sets forth expectations regarding initial assessments, reassessments, and development of a plan of care and a separate crisis plan.

During this reporting period, the service reviews collected and analyzed information regarding consistency and continuity of CCM pre and post transition. Specifically, the service review team requested, and LDH provided, contact logs and other documentation to determine whether CCM activities were being delivered as required by the SOP. The service review indicated:

- All individuals reviewed had a CCM; however, there was unevenness regarding the consistency and continuity within regions reviewed. In one region, there was high turnover of CCMs which resulted in having individuals receiving CCM from multiple individuals in a short span.
- There was variability in whether the CCMs met the contact requirements developed by the State. While the majority of individuals (57%) received the required contracts, many did not. The review indicated there were gaps in the dates of contacts that spanned several weeks and, in one instance, two months.
- All transitioned individuals, except one, had the required documentation: an initial community assessment, individual plan of care, and crisis plan. The one individual did not have a crisis plan.
- All diverted individuals, except one who was diverted, had the initial community assessment, plan of care, and crisis plan. This individual was newly diverted (less than 30 days) and the CCM indicated they were in the process of developing these documents.
- The timeliness regarding the rendering of the assessment and the development of the plan of care was variable. Approximately one-fourth (26%) of the individuals received a timely assessment and plan of care. The other 74% were not timely, although the review indicated the delay in these activities was generally less than 5 business days. For the most recent month, LDH reports a greater number and percentage of plans completed on a timely basis (75%).
- The service review also identified several issues with the quality of the assessments and plans, which are discussed in paragraph 43.

This paragraph also requires that LDH assure that individuals have access to all medically necessary services covered by the State's Medicaid program. One proxy for determining if the State is meeting the intent of this provision is to determine whether the individual is accessing services identified in the plan of care and if they are receiving these services in the amount and duration identified in the plan. The service review of the 37 individuals (29 individuals transitioned and 8 individuals diverted) found that all but one initial plan of care did not specify the amount and duration of services consistently for any individual.

The final sentence in this paragraph requires the State to ensure the capacity of face-to-face engagement with individuals in the Target Population through case management efforts. The State has specified face to face requirements for CCM. Generally, when contacts occurred, approximately 75% of these were face to face contacts, which exceeded the CCM expectation of 50%.

The SME has reviewed the SOPs for CCM this period and provided feedback to LDH regarding changes that would provide flexibility to the CCM program. Specifically, the SME has recommended to have CCMs provide four contacts monthly versus weekly specific contacts. In addition, the SME is recommending fewer CCM contacts for individuals who are participating in ACT given the robust case management requirements for ACT teams. Finally, the SME recommended a cadence of meetings with the individual and major service providers on a regular basis. Currently, CCMs report these team meetings occur when there is a significant issue experienced by the individual. The SME recommended the CCMs coordinate regular team meetings with the individual present and team meetings when there is a change of condition.

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

- All individuals reviewed had a CCM; however, there was unevenness regarding the consistency and continuity of CCM within regions reviewed.
- There was variability in whether the CCMs met the contact requirements developed by the State.
- The required documents were present for all but one individual reviewed. However, only one service plan provided consistent information regarding the scope, amount, and duration of these services.
- The timeliness regarding the rendering of the initial assessment and the development of the initial plan of care varied. There were differences between what the SME found in the service review and what LDH reports.
- LDH has made changes proposed by the SME to the SOP.

Recommendations
- LDH should continue to provide the CCM report to the SME on a monthly basis.
- LDH should work with the MCOs to ensure that reassessments and updates to the plans of care are occurring within LDH policy.
- LDH should review and make changes to the CCM SOP suggested by the SME. LDH should discuss changes with the SME this next reporting period.
- LDH should work with the MCOs to ensure contacts with individuals are consistent with the Standard Operating Procedures.
- LDH should closely monitor the turnover of CCM staff to identify any significant disruptions in the continuity of case management.
- LDH should continue to monitor the timeliness of assessments and initial plan of care development with the MCOs and the CCM organization.
- Plans of care should also address the scope, amount, and frequency of the services included in the plan.

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

Compliance Rating: Partially Met

Discussion and Analysis
As indicated in the seventh report, the State has developed assessment and individual plan of care tools that are intended to capture the desires and needs of the Target Population who have been diverted or transitioned from NFs. The State has also required the MCOs to ensure CCMs receive the Person-Centered Planning training that was developed and implemented in the fifth reporting period. The State reports this training is mandatory for CCMs and must occur before staff commence their case management efforts. In the service review, the CPOCs included information regarding the individuals' vision and goals (which was often stated in their own words) and identified the natural and forma supports needed. The assessment solicited information regarding community inclusion, education, and employment needs. The CPOC is structured to address the needs identified in the community assessment.

The service review focused on the presence and quality of the assessment and individual plan of care. While this paragraph focuses on the plan of care, it is important to assess the quality of the assessment and determine if the individual plan of care adequately addressed needs identified in the assessments including community inclusion, education, and employment. The findings from the service review identified the following:

- As stated in paragraph 60, all individuals who were transitioned had an initial assessment and plan of care.
- The overall quality of the assessments for individuals transitioned was high (85 out of 100 points). A review of the assessments ascertained:
    - Community assessments included information regarding interest and assistance the individual needed to address community inclusion needs.
    - All but one individual were asked to provide information regarding their educational and employment interests.
    - All but one assessment included information regarding the individual's preference. These preferences were generally stated in the individual's own words.
    - Service domains in the community assessment were complete with the exception of transportation, adaptive equipment, and services to address health and wellness. Information was not available for these domains in the assessment for approximately 16% of the individuals reviewed.
    - The natural supports available to the individual were identified for all individuals.
- The quality of the community plan of care was variable as indicated by the score (69 out of 100 points). Of note:
    - The goals in the plans of care were stated in the individuals' words and were clear; however, what was less clear were the specific activities and related services that would meet these goals.
    - All plans of care reflected strengths and preferences.
    - All individuals had signed their plan of care; however, more than half of the individuals indicated in their interview they did not have their community plan of care or crisis plan.
    - There was wide variability regarding the quality of CPOCs. While the assessments included almost all domains discussed above, the CPOCs did not always identify services and strategies to address the needs identified in the assessment. A more detailed review is provided in the service review document.
    - The CPOCs did not specify the amount, frequency, and duration of services post-transition.

The quality of the assessments and plans of care was reviewed for the eight individuals who were diverted and participated in the service review. As indicated in this review, the scores for the assessments and community plans of care were similar to the scores for individuals who were transitioned. There were similar issues regarding assessments and CPOCs for individuals who were diverted.

In the seventh report, the SME also encouraged the State to use the Person Centered checklist developed in CY 2022 in their efforts to educate CCM providers regarding strategies to ensure plans are person-centered. This has yet to occur.

In the seventh report, the SME also recommended CCM providers and advocates/members of the advisory committee review the proposed tools and suggest revisions to these tools, similar to the process for reviewing the NFTA and ITP protocols. This has yet to occur.

Compliance Assessment

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

- The State continues to require all CCMs to be trained using the LDH My Choice Persons Centered Training developed in CY 2021.
- Almost all individuals who were transitioned and diverted had an assessment and an individual plan of care. Individuals without these documents were recently diverted and assessment and plans were being performed.
- The service reviews found that goals identified in the individual plan of care are person centered and that almost all plans identify the individual's strengths and preferences.
- The service reviews also indicated that activities and services identified in the plan were not sufficient to implement these goals.
- All plans of care were signed by the individuals but more than one-half of the individuals interviewed for the service review indicated they did not have their community plan of care or crisis plan.
- A good proportion of individuals (friends and families) participated in plan development at the choice of the individual.
- Community plans of care did not include information regarding scope, amount, and duration of services.
- The State has determined the CCMs have not been specifically trained on the person centered checklist.
- LDH has not sought input from external stakeholders regarding the community assessment or CPOC documents.

Recommendations

- LDH should work closely with the MCOs and CCM staff to improve the community plans of care and ensure the needs identified in the assessment are reflected in this plan.
- LDH should ensure all community plans of care reflect the scope, amount, and duration of services needed by the individual.
- LDH should train CCMs to use the Person-Centered Checklist developed in CY 2022.
- LDH should seek input from external stakeholders regarding the community assessment and CPOC documents.

E. Tracking

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

Compliance Rating: Partially Met

Discussion and Analysis

This paragraph was reviewed. LDH developed and implemented a system to identify and monitor individuals who have transitioned from nursing facilities for the reporting periods three through six. This relied on TCs collecting information regarding everyone enrolled in intensive case management. This information was collected through monthly logs. These indicators were included in the Department's Quarterly Quality Matrix (as discussed in paragraphs 98-99) and reviewed jointly by OAAS and OBH leadership monthly to identify individual and systemic issues. In addition, as discussed in paragraph 98 and 99, LDH has shared and discussed these indicators with a subset of their My Choice Advisory Committee. However, as indicated in paragraph 94, LDH has not met internally or externally regarding various quality assurance activities.

LDH continues to receive standardized monthly reports from MCOs regarding similar information previously collected from TCs as well as more detailed information, reported by individuals, on key case management activities including:

- Initial and ongoing contact with the individual by the CCM
- The date the community assessments and community plans of care were developed
- Whether the individual received all services on his/her plan of care this month
- Whether the individual is making progress toward goals
- If there were services needed but not yet received and, for these individuals, the specific steps the CCM is taking to mitigate service gaps.

Information collected through the tracking system is discussed in more detail in paragraphs 98 and 99.

The SME reviewed each MCO's standardized monthly reports to determine if these reports were complete. These reports focus on individuals transitioned and receiving CCM, which includes all individuals who were transitioned. The most recent monthly report the SME reviewed was February 2023. The SME reviewed this report to determine whether information was complete for individuals who were transitioned or diverted from an NF. The review found that almost all of the 302 individuals had complete information in the tracking system. Individuals who were pre-transition or readmitted to an NF did not have completed information.

As described in the CCM Standard Operating Procedures, LDH requires a scheduled cadence of face-to-face contacts between the CCM and the individual who has been transitioned. CCMs are to report on each contact and whether the contact was face-to-face or virtual. As indicated in paragraph 60, this contact was variable, and the SME recommends LDH work with MCOs to ensure consistency with the SOPs.

During this reporting period, OAAS and OBH leadership, in addition to the Integration Coordinator, accompanied the service review teams to visit individuals who were transitioned, diverted, or in the NF awaiting transition. This included review of individuals' documentation and face to face visits with each individual. LDH and the service review teams met with 54 individuals to discuss their transition experience, current goals and interests (e.g., community inclusion, employment), services received, and gaps in care. LDH reports participating in these service reviews is beneficial to understand the impact the My Choice Program has on individuals as well as drawing on the "lived" experiences of these individuals to make changes to the program.

The combination of the CCM Tracking System and participation of LDH in service reviews provides important information regarding the My Choice program. LDH should use this information in a structured way to make future decisions regarding the My Choice Program. Specifically, it will be important for LDH to incorporate information from the tracking efforts to the overall quality efforts described in paragraph 98 and 99.

Compliance Assessment

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

- LDH has a tracking system to identify and monitor all individuals receiving CCM in the Target Population.
- LDH requires TCs and CCMs to report information on a monthly basis regarding key areas. The TCs and CCMs have been reporting this information on the required basis.
- A review of the initial data reports from MCOs indicates that information collected on almost all individuals transitioned is complete.
- Current community assessments collect information on whether the individual feels safe in their housing and whether there is food security, nutrition, or exercise issues and interests.
- The MCO report monthly on individuals who are not receiving needed medical, behavioral health, or long term services and supports. For each individual, the MCO reports the services needed and the CCM strategy for obtaining access to those services.
- LDH also provides quarterly information on the utilization of Medicaid services by individuals who are transitioned and diverted. This is discussed in more detail in paragraph 100.

Recommendations

- Review data from CCMs to ensure that the cadence required for face-to-face and other visits is being met.
- The State should incorporate the data from the MCO CCM and quarterly service utilization reports in the overall quality improvement process to determine if there are systemic health and safety issues, gaps in services, and efforts that have been successful in addressing these issues.

V. Community Support Services

A. Crisis System

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

In December 2019, LDH, with input from the SME, developed a plan for a statewide crisis response system, which included the crisis services in the Agreement and additional crisis services used in other jurisdictions that have proven efficacy. This framework included the requirements in the Agreement and can be found at https://ldh.la.gov/assets/docs/MyChoice/CrisisFramework.pdf. There are four crisis services that LDH seeks to create for individuals enrolled in Medicaid through a program called the Louisiana Crisis Response System. These include mobile crisis response, community brief crisis support, behavioral health crisis care centers, and crisis stabilization units. Additional information regarding these crisis services can be found at https://ldh.la.gov/assets/docs/MyChoice/CRISIS-PRESENTATION-032921.pdf. As indicated in the seventh report, LDH has taken various steps to implement the plan. This has included developing service definitions, obtaining funding for serviced, obtaining approval from CMS, developing training for crisis providers (in partnership with Louisiana State University) and initial steps to develop the network of crisis providers. The general approach LDH has developed for crisis services requires crisis services be provided in the most integrated setting—with a major focus on ensuring access to mobile crisis services provided to individuals in their home or other community-based settings.

In addition, LDH has developed an interim process for implementing the crisis line for individuals in the adult Medicaid population (including the Target Population) and is in the process of developing a procurement for an ongoing crisis line in CT 2023.

The State has begun efforts to implement all four crisis services (MCR, CBCS, CSUs and BHCC) on a rolling basis. The State has also reviewed their crisis service definitions to align with federal opportunities in the recently passed American Recovery Plan to garner additional federal funding for these new services. LDH has worked closely with the MCOs, LSU, and new providers to stand up four crisis services in select regions of the State. MCR and CBCS services are currently available at varying days and times. LDH has yet to implement an expectation these services will be available 24/7 as required by the Agreement. As of this reporting period, the State has implemented crisis services in select regions.

Region	Services
Region 1	MCR/CBCS (Implemented 4/2022)
Region 2	MCR/CBCS/BHCC/CSUs (Implemented 4/2022)
Region 3	MCR/CBCS/BHCC (Implemented 4/2022)

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

LDH reports they have providers identified who are working on the implementation of services in Region 8 (MCR, CBCS BHCC) which is expected to go live in the next 90 days. LDH continues to work with LSU to identify a provider for Regions 5 and 6. In addition, the State reports that LSU has received numerous applications to provide services in the regions where they are not yet available. However, the majority of submitted applications are incomplete. As this occurs, LSU notifies the applicant of the steps the provider must take if they wish to reapply.

Currently all individuals who receive CCM are required to have a crisis plan. These plans identify the following areas:

- Events or other situations that may trigger a crisis.
- Strategies the individual has used in the past to resolve the crisis.
- Strategies the individual or provider (including the crisis provider) can deploy to de-escalate the crisis and ensure stabilization.
- Plans for caretaking (e.g., children, pets etc.) if the individual is hospitalized.
- Treatments (including medications) the crisis responder should avoid.
- Individuals who should be contacted during a crisis.

The service review identified that all individuals had a completed crisis plan. However, the quality of the plans were variable and none of the plans reviewed identified using the new crisis services as a potential strategy for de-escalation and stabilization.

LDH has also recently revised the initial reimbursement rates for all crisis services. Information provided by agencies offering crisis services allowed LDH to adjust the assumptions used to develop the initial rates. These adjustments were made in December 2022. The rates have been posted in the fee schedule and are also included in the rolling RFA materials. These new rates should serve as incentive for agencies considering delivering these services.

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

- LDH has developed service definitions messaging that mobile crisis services are a community-based service delivered in the member's natural setting with some exceptions for office-based delivery.
- LDH has developed a crisis plan consistent with the intent of this paragraph. This includes mobile response, crisis telephone lines, and three other crisis services (CBCS, BHCC, and CSUs).
- LDH began implementation of CSUs during this reporting period.
- LDH continues to implement crisis services during this reporting period in eight of the ten regions.
- LDH required each individual receiving CCM services to have a brief crisis plan, however the quality of these plans are variable and do not reference existing crisis services as a strategy to de-escalate the crisis.

- LDH has revised reimbursement rates to reflect the implementation experience of crisis providers over the past eight months of implementation.

Recommendations

- Complete the implementation of all four crisis services in all areas of the state during the next reporting period.
- Expand MCR and CBCS services to ensure 24/7 access.
- Develop a strategy to improve the quality of the crisis plans and when appropriate, recommend crisis services available in the individual's area.
- Continue efforts to implement a longer-term 24/7 crisis hotline.
- Continue efforts to work with LSU to provide information to potential crisis applicants regarding the application, training and onboarding process.

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

As discussed in previous SME reports, there is a patchwork of toll-free crisis and help lines currently available to assist individuals, including members of the Target Population, who are experiencing crisis. To address this issue, the crisis plan, as proposed, would ensure that the Target Population and all Louisianans experiencing a behavioral health crisis would have access to a statewide toll-free crisis line. The crisis line will be an important component for the State's crisis system. A key function of the crisis line will be dispatch of the mobile crisis response teams discussed in paragraph 65 and referral to other crisis services. As indicated in paragraph 63, OBH staff has begun drafting a Request for Proposal for a single crisis call center. OBH continues to state they are planning to implement the crisis line later in CY 2023.

Prior to the development of a statewide crisis call center, LDH is requiring the MCOs to receive crisis calls and dispatch mobile teams and make referrals to other crisis services in the interim. The current LDH contract requires MCOs to have this capacity and each of the MCOs have developed a 24/7 crisis line for their enrollees. The MCOs continue to send letters to all adult Medicaid members to inform them of the crisis line and available crisis services.

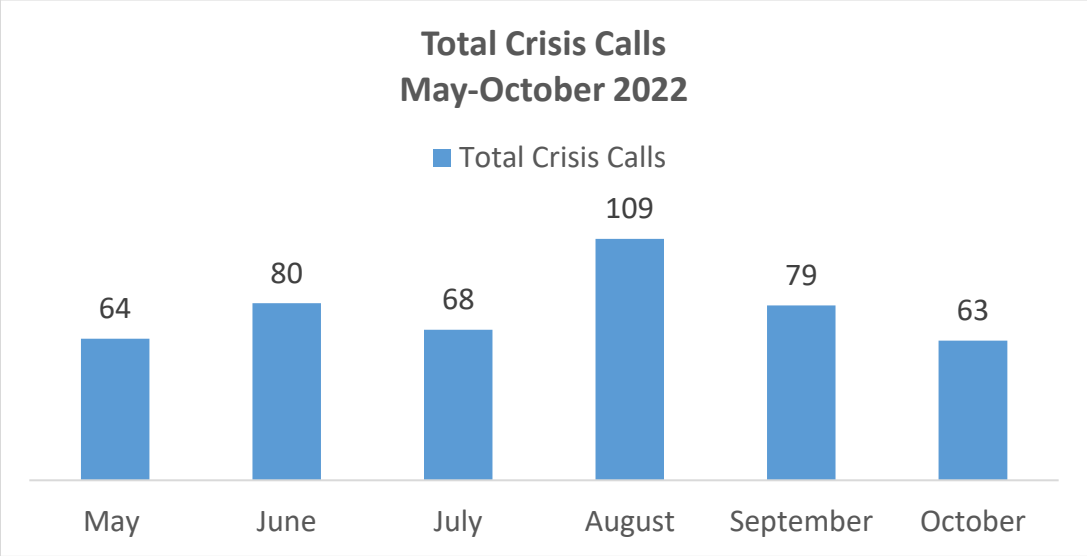
OBH continues to work with the MCOs during this reporting period on the following:

- Continued outreach to members about new crisis services and access to services using a variety of MCO specific strategies.
- LDH and LSU continuing to hold weekly meetings with MCOs/crisis providers.
- MCOs in collaboration with LSU have jointly developed a data template to evaluate usage of emergency departments and inpatient hospitalization.

- MCOs will use this information in the previous bullet in local conversations with healthcare systems and other stakeholders as indicated by the data.
- MCOs and LDH have begun to review options to incentivize the delivery of crisis services in the community when the emergency department is not a medically necessary admission.

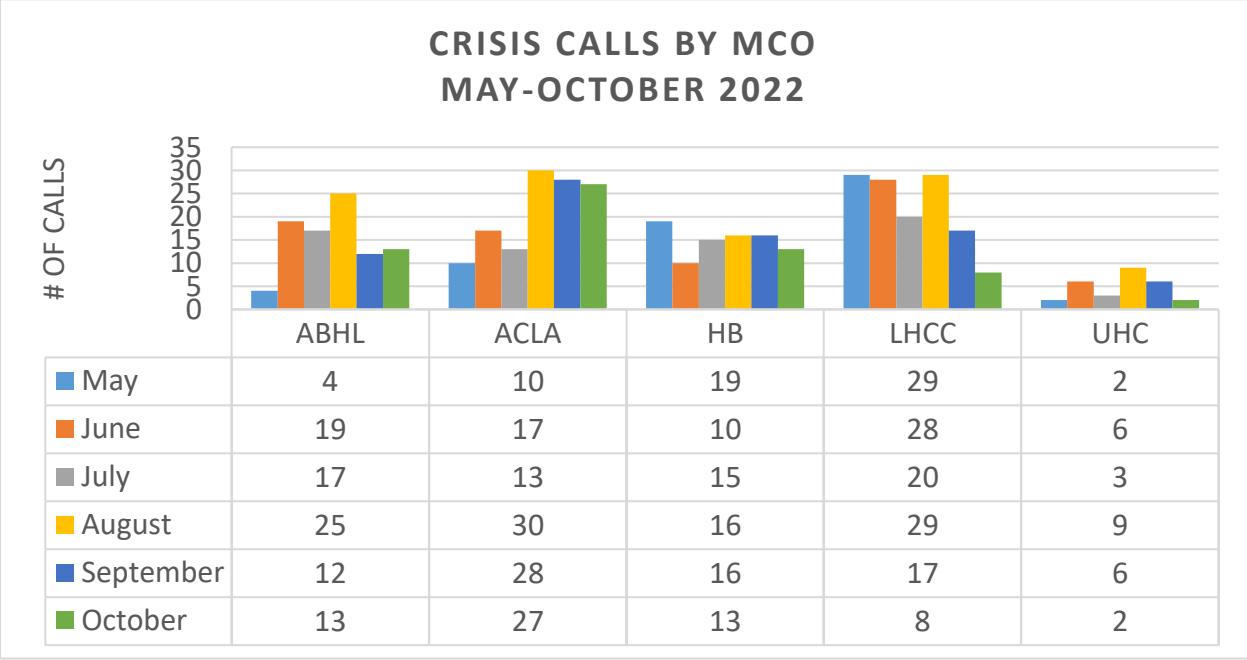
The State reports the total crisis call volume for May through October. The chart below provides this information.

Number of Total Crisis Calls for the 6-month period (May 1 – October 31, 2022)



The chart below provides call volume for each MCO:

Number of Total Crisis Calls by MCO for the 6-month period (May 1 – October 31, 2022)

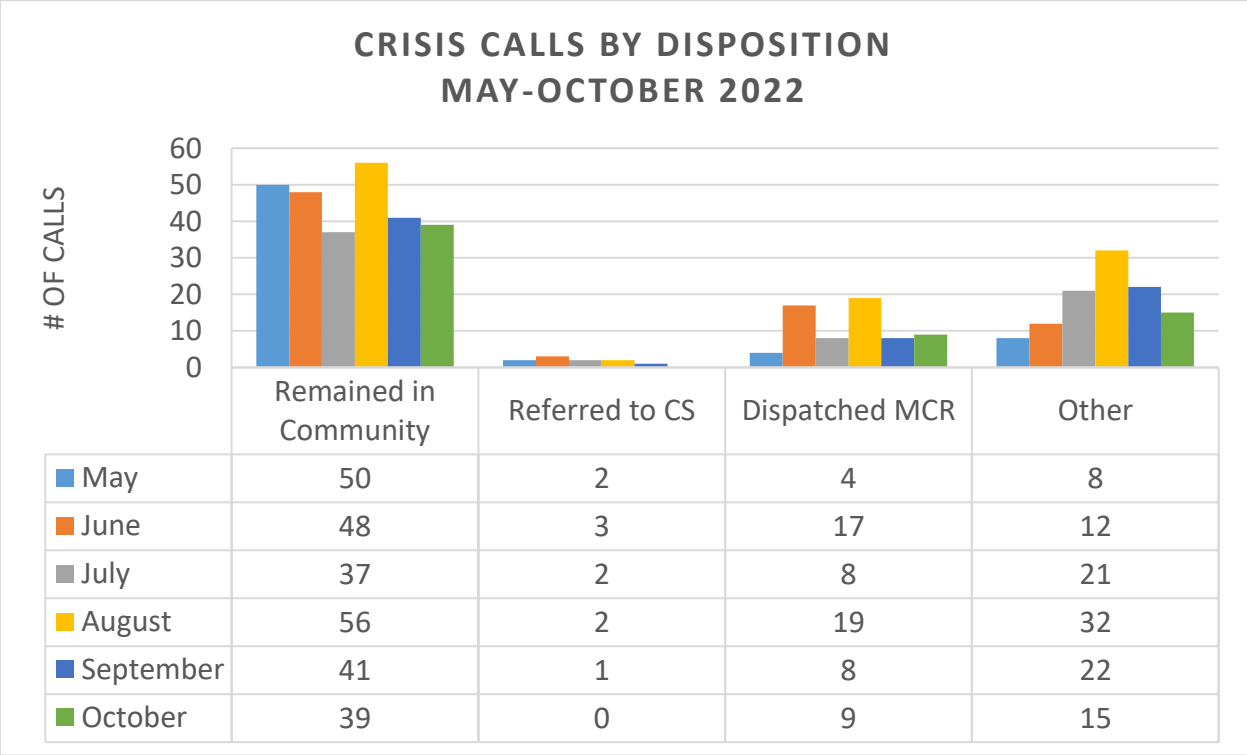


	ABHL	ACLA	HB	LHCC	UHC
May	4	10	19	29	2
June	19	17	10	28	6
July	17	13	15	20	3
August	25	30	16	29	9
September	12	28	16	17	6
October	13	27	13	8	2

As this data indicates, the call volume for the MCO crisis lines remain low. The State reports there were only 463 calls this reporting period. The State and LSU have worked with the MCOs to identify systemic barriers, however the MCOs have not sufficiently addressed these barriers. The regional crisis teams are beginning to identify additional barriers that will need to be addressed during the next reporting period. This includes addressing ambulance policies that require transport to only hospital versus ability transport to BHCC. Another barrier is addressing law enforcement agency concerns about liability if team responds in lieu of law enforcement authorities. Some of these factors are idiosyncratic to the region. For most of the crisis agencies the type of cross-sector/systems development work that is required to shift community practice is unfamiliar. This is not unusual, particularly in a state in which a crisis system of care is relatively new.

While the MCOs have worked to improve the performance of these crisis lines, and all parties have worked to establish care coordination protocols, the crisis call volumes are very low and having 5 crisis lines dispatching teams is inefficient. It was nonetheless—and continues to be--the best interim option until a statewide call center hub is implemented via RFP.

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



	Remained in Community	Referred to CS	Dispatched MCR	Other
May	50	2	4	8
June	48	3	17	12
July	37	2	8	21
August	56	2	19	32
September	41	1	8	22
October	39	0	9	15

This data indicates that most calls were resolved by staff at the MCO crisis line. This is generally an acceptable trend with crisis call centers where the level of crisis may be resolved telephonically versus having mobile crisis dispatched or generating a referral to a crisis service.

LDH and the SME continue to monitor the MCO crisis lines to ensure that the call lines can process crisis calls and dispatch mobile teams. In discussions between crisis agencies and MCOs it became apparent that some MCO call center staff were spending considerable time talking to the caller prior to discussing treatment options. LDH reports that MCO staff have been coached to inform caller of new options early in the call and giving the caller the option of a crisis service or continuing to talk to resolve.

In partnership with MCOs and crisis agencies, LDH has developed a comprehensive, working document called the Crisis Care Coordination Protocols. The purpose of this protocol is to convey expectations for coordinating crisis care across the continuum of crisis care including the MCO crisis line. The protocol content addresses:

- Role of the MCO Related to Crisis Services and responsibilities of operating their Crisis Line
- Guidance on decisions to dispatch MCR from the Crisis Line including:
    - How to identify mobile crisis providers to dispatch
    - Dispatching process
    - Information sharing between the Crisis Line and with MCR providers.

In addition, LDH reports providing technical assistance to all MCOs, and facilitated ad-hoc and topical calls that seek to improve practice, encouraged more creativity and furthered the engagement of MCOs in crisis systems development. The level of investment and creativity of MCO activity is increasing. For instance, the State reports an MCO has hired a Crisis Outreach Specialist and is recruiting another. These specialists will specifically be working on outreaching within regions and building demand for services.

LDH no longer conducts “secret shopper” calls to all the crisis lines. The State reports the early factors that led to concerns (insufficient staffing, undeveloped protocols) have largely been resolved.

In addition to these efforts, the State continues their efforts to implement a state-specific 988 hotline for Louisianans in crisis to connect with crisis services and supports. The State reports they have made significant progress in its 988 initiative and launched on time with two call center providers covering the state. Both call Centers are actively involved with nationally offered TA through Vibrant and have taking advantage of funding opportunities that allowed for expansion of the teams. There is at a minimum, weekly interface between 988 and crisis system leads and in the SME’s opinion are well-versed in the purpose and development of both projects. In November LDH initiated a pilot in region 7 that allows a direct warm telephonic transfer from 988 to the crisis provider for MCR or BHCC services. This was done with agreement by the provider. 988 does not have a mechanism to check Medicaid status.

<u>Compliance Assessment</u>

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

- The State through the MCOs have implemented multiple toll-free crisis lines that operate 24/7.
- LDH has identified and have developed strategies to address MCO crisis line staff to reduce the triage time and refer individuals for MCR through dispatch protocols.
- The State continues to track the callers and dispositions, although additional dispositions or information is needed to meet the terms of the Agreement (e.g., providing phone consultation or connecting with peers).

- MCOs have collaborated on gathering parish-specific data on ED/inpatient hospital utilization to promote constructive conversations with regional hospitals, MCR providers and other stakeholders.
- As indicated in paragraph 63, the State is planning on implementing a Call Center that will establish one statewide call number and will eliminate the multiple crisis line calls numbers, making it easier for Medicaid individuals and stakeholders to access crisis services.

Recommendations

- LDH should continue to provide 1:1 technical assistance to MCOs to enhance outreach efforts to identify individuals who are in need of crisis services.
- LDH, MCOs, and crisis providers should continue to engage system partners to educate about the availability of crisis services and how to access these services.
- LDH should prioritize the release of the statewide call center procurement and have this operational by later CY 2023.
- LDH should continue to work with 988 and 911 to ensure warm handoffs to the newly developed crisis lines or directly with crisis providers.

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

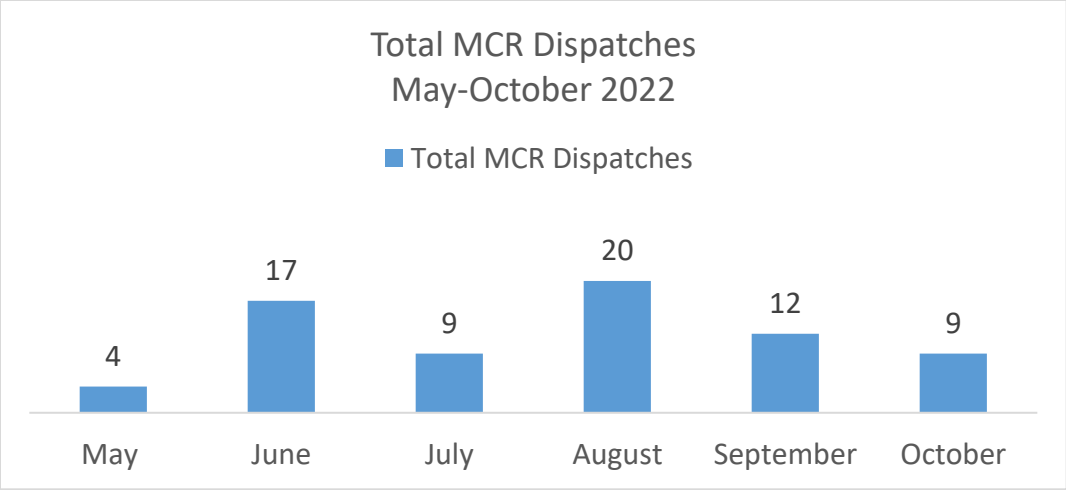
Discussion and Analysis

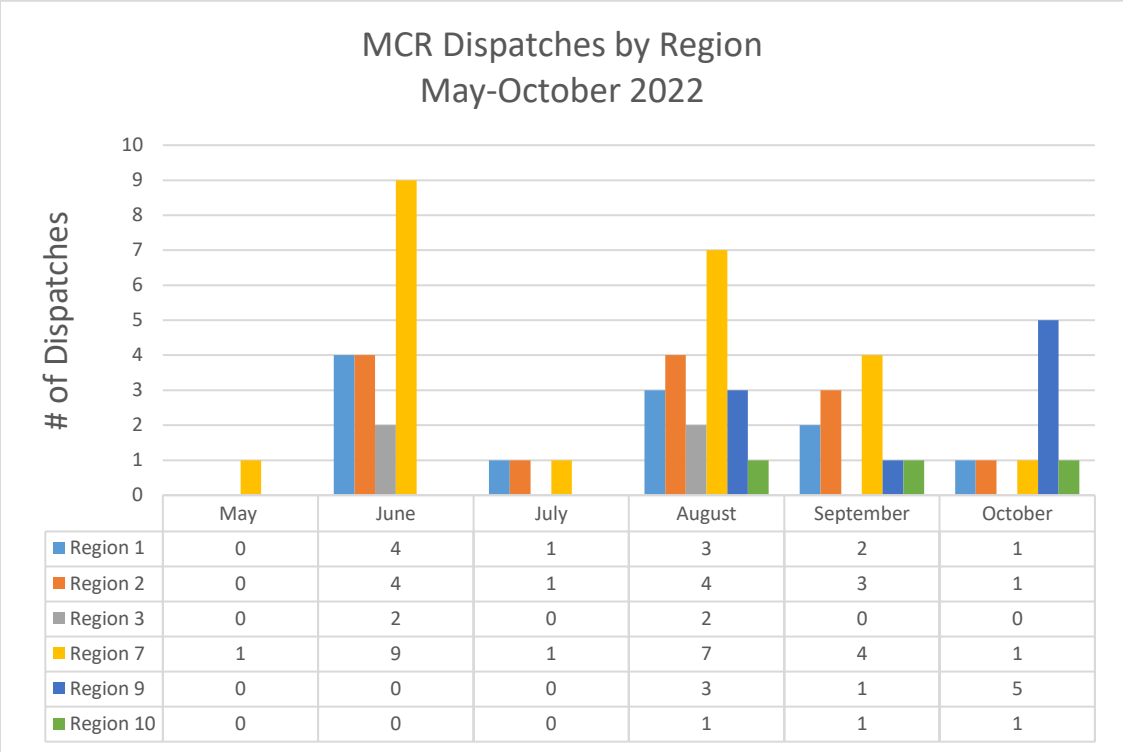
As indicated in paragraph 63, the State partially implemented the mobile crisis response capacity in March. Louisiana State University (LSU) has also been developing network capacity for MCR, CBCS, CSUs and BHCC. During this reporting period, the State reports that LSU has fully trained 106 staff who will be receiving crisis calls or providing crisis services. This includes:

- 48 staff of various crisis services.
- 58 MCO call center staff.
- Region 4 staff from crisis agencies that are preparing to launch in early CY 2023.

As indicated in paragraph 63, MCOs have contracted with service providers offering MCR. MCR teams are available in all regions except region 5 and 6.

The SME requested information regarding initial utilization of MCR services. The charts below provide information regarding MCR dispatches from May through October 2022.

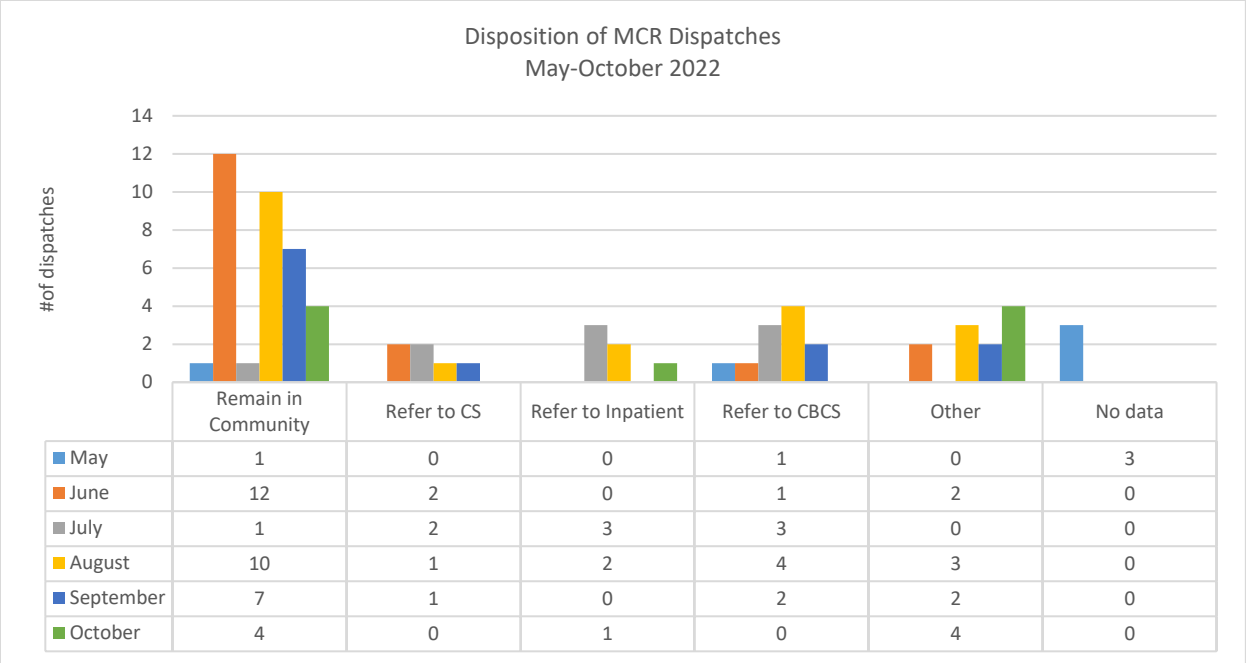




	May	June	July	August	September	October
Region 1	0	4	1	3	2	1
Region 2	0	4	1	4	3	1
Region 3	0	2	0	2	0	0
Region 7	1	9	1	7	4	1
Region 9	0	0	0	3	1	5
Region 10	0	0	0	1	1	1

While utilization of services has increased from the previous report, volumes remain unacceptably low and LDH certainly concurs with this. Only 72 individuals received MCR services during this reporting period. There were no individuals in the Target Population who received MCR services even though 16 individuals (comprising 28 visits) who were diverted or transitioned presented at EDs for behavioral issues. As described earlier in the report, there are recent initiatives to identify any incentives to practice change; including the development of parish-specific data sets to stimulate local conversation.

During this reporting period, LDH provided information on the disposition of MCR services. The chart below provides this information.



	Remain in Community	Refer to CS	Refer to Inpatient	Refer to CBCS	Other	No data
May	1	0	0	1	0	3
June	12	2	0	1	2	0
July	1	2	3	3	0	0
August	10	1	2	4	3	0
September	7	1	0	2	2	0
October	4	0	1	0	4	0

As indicated by this chart, almost all individuals remained in the community. Six or 8% of the individuals were referred to an inpatient behavioral health provider.

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

As indicated in paragraph 63, the State in cooperation with MCOs have developed protocols for dispatching MCR teams through their crisis call centers, for collecting and communicating data between the call center and MCR providers, and for authorizing next level crisis services (CBCS and CSU).

In addition, LSU has started to provide monthly, agency-specific coaching for a period of at least several months to support implementation. Each team receives 6 months of team-specific coaching by members of the LSU training team following completion of the initial training. LSU is now developing two enhancements: an advanced training modules and service-specific (MCR, CBCS, BHCC, CS), cross-agency, learning collaboratives. In the sixth report, the SME recommended LDH develop a strategy to monitor the roll-out of these new crisis services. As discussed in the seventh report, LDH has developed and continues to lead a process for facilitating a standing, brief, semi-weekly huddle of MCOs and crisis teams (via phone conference line) to check in on service demand, access issues, implementation hiccups, and to continue to hone the working protocol. LDH continues these efforts which include:

- 30-minute weekly crisis huddles that focus on:
    - Review of previous 7 days of data from crisis teams and MCOs
    - Review broader performance data set.
    - Identify key accomplishments.
    - Identify key barriers.
    - Streamlining warm handoff between call center and MCR team
    - Adherence to key principles of least restrictive care
- Monthly 60-minute joint meetings that focus on are systemic issues between entities rendering crisis services.

- Monthly 60-minute meeting with crisis agencies to build demand and regional coalitions.

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

Compliance Assessment

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

- LDH has developed MCR capacity in eight regions of the state.
- LSU has undertaken activities, including readiness reviews, to ensure that MCR providers are prepared to offer MCR and continues to offer coaching to these providers.
- MCOs have contracted with MCR providers to serve adults with Medicaid, including individuals in the Target Population.
- According to claims data from July1st through September 30th, no individuals who were transitioned or diverted received MCR services during this reporting period, though a number did have behavioral health crises that led to hospital visits.
- LDH developed a process to meet with MCOs and providers frequently during implementation to identify issues.
- LSU has developed and implemented coaching for each of the MCR teams.
- There continues to be minimal uptake of MCR services. LDH has developed some immediate strategies for MCR providers to increase MCR referrals.

Recommendations

- The State should identify individual(s) dedicated to aid in cross-sector relationship development and to build service demand.
- Increasing the utilization of MCR services by individuals who have been transitioned or diverted from NFs.
- LDH should develop a specific strategy (statewide and local and in conjunction with stage Sheriff and Police associations) for engaging law enforcement partners for the purposes of reducing the use of emergency departments and jails and initiation of involuntary treatment and increasing referrals to voluntary, community-based crisis centers, developing model protocols.
- LDH should develop a specific strategy (statewide and local) for engaging healthcare providers, including Louisiana Hospital Association and MCOs in the process to identify categories of persons who can be well-treated in community based locations and strategies to shift habits of practice.
- LDH should develop a specific strategy to collaborate with EMS/fire providers, including but not limited to EMS providers participating in the Medicare ET3 pilot project to address barriers to transporting to non-ED locations.
- LDH should convene a meeting with parish coroners for purposes of understanding their involuntary commitment practices, how they collect/use data, whether there is a repository for data accessible to LDH/LSU and if not, seek to develop this data repository.
- Review the crisis plans, similar to the CCM review discussed in paragraph 60, for each individual receiving CCM and ensure that each plan, where appropriate, includes information regarding the MCO crisis line and MCR services.
- Identify and contract with providers in regions 5 and 6 to offer MCR.
- LDH should expand coverage of MCR providers to 24/7 access.

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

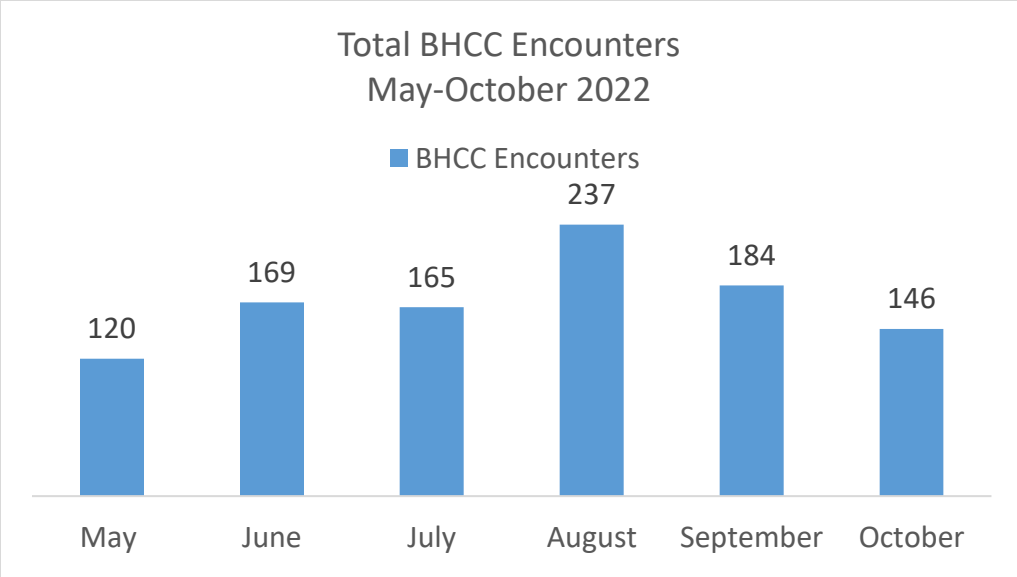
Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

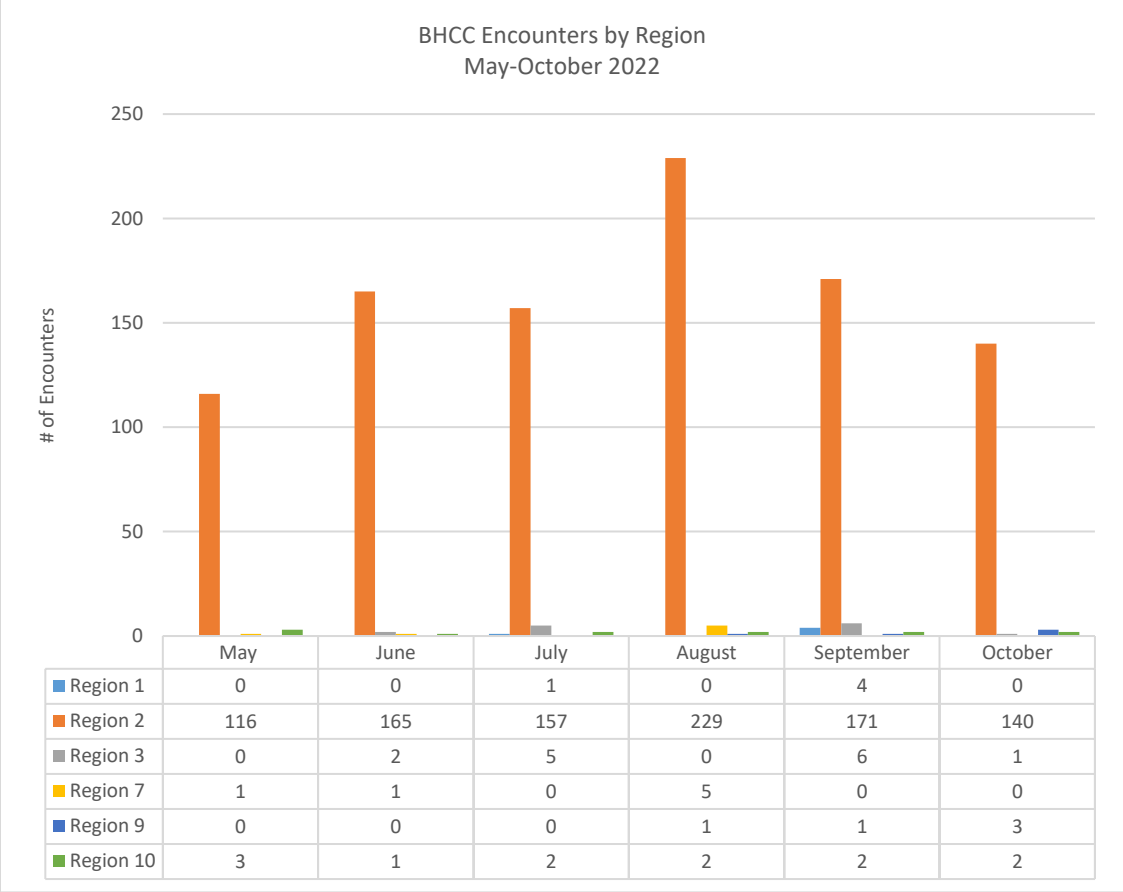
Analysis and Discussion

LDH has developed and has begun to implement Behavioral Health Crisis Care Centers (BHCC) throughout the state. The BHCCs vary in capacity based on the region's Medicaid population and informed by the 2021 Needs Assessment discussed in the sixth SME report. BHCCs serve as walk-in centers to address initial or emergent psychiatric crisis intervention response intended to provide relief, resolution, and intervention through crisis supports and services during the first phase of a crisis for adults. The State received approval from CMS in August 2022 to include CSUs as a service in the Medicaid State Plan. Prior to that time, CSU providers would need to negotiate with MCOs for alternative payment approaches.

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

The SME requested information regarding initial utilization of BHCC services. The State provided information regarding the utilization of BHCC service statewide and by region in the tables below.



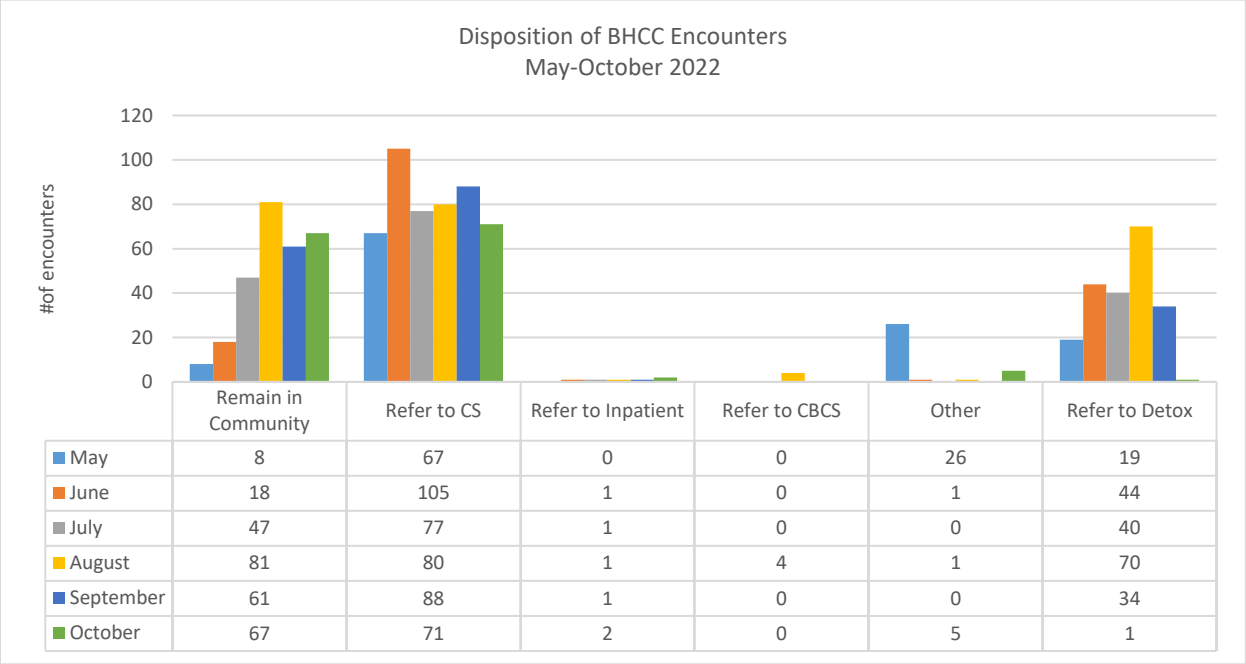


	May	June	July	August	September	October
Region 1	0	0	1	0	4	0
Region 2	116	165	157	229	171	140
Region 3	0	2	5	0	6	1
Region 7	1	1	0	5	0	0
Region 9	0	0	0	1	1	3
Region 10	3	1	2	2	2	2

The State reports 1,021 individuals have utilized BHCC services. Utilization of BHCC continues to be greatest in Region 2, where BHCC efforts have been in development for more than eighteen months. The SME has significant concerns regarding the implementation of BHCC. Similar to MCR, LDH is requiring MCOs and BHCC providers (many of whom also offer MCR) to take immediate steps discussed in

paragraph 64 to ensure the viability and sustainability of MCR and other crisis services. Similar to MCR, no individuals who were transitioned or diverted from NFs received BHCC services, despite the fact that some did go to hospitals because of behavioral health issues during this period.

LDH has also provided information regarding the disposition of individuals seeking BHCC services. The Table below provides disposition information.



	Remain in Community	Refer to CS	Refer to Inpatient	Refer to CBCS	Other	Refer to Detox
May	8	67	0	0	26	19
June	18	105	1	0	1	44
July	47	77	1	0	0	40
August	81	80	1	4	1	70
September	61	88	1	0	0	34
October	67	71	2	0	5	1

As indicated in this chart, almost all individuals remained in the community. Approximately 70% were referred to other behavioral health services. 48% of all individuals receiving BHCC services were referred to other behavioral health community services. An additional 20% were referred for detoxification. Less than 1% were referred to inpatient services.

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

- Collect data by agencies and MCOs to determine where to target future investments. For example, understanding the nature of the crisis that individuals are experiencing may lead to further investments in peer-delivered services, housing supports, or specialized brief crisis services for individuals with co-occurring disorders.
- Work with MCOs to assure that post-crisis services and supports are accessible and effective. This includes timely appointments with prescribers, clinical staff, and peer supports following crisis care, to increase the likelihood of stabilization in the community.
- Develop other “upstream” and less restrictive strategies within outpatient services agencies to develop skills and capacity to provide suicide-specific care in the community and to assure agencies are adequately meeting urgent care needs of their existing clients (timely access for an urgent appointment, meaningful 24/7 crisis support telephonic support, and non-traditional appointment models such as Open Access that allow for same day scheduling).

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

As discussed in paragraph 69, LSU and LDH have prompted agencies to offer Open House tours of their BHCCs and had representation on site at each of the open houses. LSU has developed a Regional Coalition Development Guide as a resource for crisis agencies including BHCCs in conceptualizing and formalizing cross-sector relationships and a working crisis coalition and along with LDH leadership has provided significant telephonic and onsite TA, coaching and modeling of how to engage system partners.

Compliance Assessment

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

- LDH has developed BHCC capacity in most regions of the state.
- LSU has undertaken activities to ensure that MCR providers are prepared to offer BHCC and continues to offer coaching to these providers.
- BHCCs submit reports and LDH monitors the number of individuals receiving BHCC crisis care on a weekly basis.
- MCOs have contracted with BHCC providers in select regions to serve adults with Medicaid, including individuals in the Target Population.
- LDH developed a process to meet with MCOs and BHCC providers frequently during implementation to identify issues.
- There continues to be low uptake of BHCC services and no utilization by individuals who have been diverted or transitioned from NFs. According to claims data from July 1st through September 30th, no individuals who were transitioned or diverted received BHCC services during this reporting period.

Recommendations

- Continue to work with each BHCC to increase referrals, including outreach efforts to law enforcement and additional referral sources.
- LDH should review the crisis plans for each individual receiving CCM and ensure that each plan, where appropriate, includes information regarding the MCO crisis line and BHCC.
- Identify and contract with providers in regions to offer BHCC.
- Continue readiness reviews as BHCCs are opened.
- Develop the necessary oversight structure to ensure these services are offered consistent with the Agreement.
- Develop and implement a strategy to identify additional investments for services and strategies discussed in this paragraph.

67. LDH is working to address the State's opioid crisis and other co-occurring substance use disorders affecting the Target Population. As part of this effort, LDH shall ensure statewide network adequacy of detoxification, rehabilitation, and intensive outpatient substance use disorder (SUD) recovery services. SUD services shall have sufficient capacity to accept walk-ins and referrals for the Target Population from crisis services, emergency services, and law enforcement personnel. With the technical assistance and approval of the Expert, the State shall develop policies, procedures, and core competencies for substance use recovery, rehabilitation, and detoxification service providers.

Compliance Rating: Not Met

Discussion and Analysis

Since 2018, LDH has been implementing significant changes to their SUD service system through a CMS 1115 Demonstration Waiver. The State has developed a continuum of services consistent with the American Society of Addiction Medicine (ASAM) that includes outpatient, intensive outpatient, residential, and withdrawal management services. A review of MCO network adequacy reports for the second half of 2022 (July-December 2022) by the SME indicated that there were no network adequacy issues for the various SUD levels of care during this reporting period. Yet, information suggests that SUD services are underutilized by the Target Population. A finding from the service utilization information in indicates a very small number of individuals received SUD in the first quarter of CY 2023. Less than 1% of individuals who were transitioned and no individuals who were diverted received SUD services during this quarter. This is a decline in the percentage of individuals in the third quarter of CY 2022 and even less than the 2021 Needs Assessment that found 5% of individuals who transitioned or were diverted were receiving an SUD service.

The SME's service review continues to find that over one-half of the individuals participating in the review had an SUD history. Several individuals were actively using (mostly alcohol) and did not want to seek or participate in treatment. While the SME understands that individuals who are actively using substances, including alcohol, can elect not to receive these services, there were few referrals to SUD treatment. While some of these individuals were receiving ACT that does have a SUD counselor on the team, it was not clear what interventions were planned or delivered to address individuals' needs who had SUD. In addition, the service review found instances of individuals who were not able to access SUD services when they were referred for these services. What was also less clear for the service review was the acumen of the CCMs to discuss options and make potential referrals for SUD services when individuals were actively using substances.

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

Compliance Assessment

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

- There is a significantly low utilization rate of individuals in the Target Population (transitioned or diverted) who need but do not receive SUD services despite the availability of SUD services.
- SUD services have not been identified or included in most individuals' ITPs or CPOCs, even though the assessment and service reviews indicates a need for SUD treatment.
- The CCMs may not have the acumen to be able to coach and encourage individuals who are actively using substances to receive SUD services.
- The State has not identified and addressed barriers regarding access to SUD treatment for individuals in the Target Population.

Recommendations

- Ensure the acumen of TCs and CCMs to assess the need for SUD services and provide motivational interviewing strategies to encourage individuals to take the necessary steps to increase goals and SUD intervention for individuals with an identified SUD that have CCM.

- Ensure each individual transitioned or diverted who is actively using substances is provided information regarding SUD treatment services, including alternative treatment settings (e.g., recovery groups).
- Increase the number of plans of care developed by CCMs that have identified goals and interventions for individuals in the Target Population with an SUD.
- Continue to provide information regarding the utilization of SUD services on a quarterly basis for individuals in the Target Population.

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Assessment and Discussion

LDH has continued outreach efforts to law enforcement during this reporting period. During this reporting period, LDH, in partnership with LSU, have focused on building regional collaboratives rather than ad-hoc regional meetings. The purpose of these collaboratives are to continue to have crisis agencies form relationships with law enforcement, judges and police departments. The State reports there has been modest success in some regions that were some of the first regions to go live with crisis services. The State reports they continue to work with other regions that had more recent crisis implementation efforts. In addition to these efforts, LDH reports:

- Law Enforcement leadership were invited to all of the BHCC open houses.
- LDH/LSU have invited law enforcement to attend early, local collaborations where they have been developed and are providing technical assistance to providers in regions where these collaboratives do not exist.
- Crisis agencies are beginning to undertake ride-alongs with law enforcement and accepting direct requests for response.

The regional collaboratives have identified several issues that were raised by law enforcement agencies and coroners. These conversations led to the identification of several barriers. These barriers vary across regions. The major barriers are:

- Liability to police departments if they take an individual to BHCC or contact a MCR rather than taking the individual to an ED.
- Less than 24/7 service hours for crisis services
- Current policy/procedures that direct care law enforcement to bring individuals to emergency departments.

Some of these barriers will be addressed as crisis services are implemented throughout the State and expand to 24/7 coverage. Some of these other barriers may take some time to address given crisis agencies are just developing competencies and relationships with law enforcement and others. Some of these policies have been long standing and will take time to address at the regional level, which is likely the most appropriate focus given local law enforcement policies may be specific to a certain geographic region.

Compliance Assessment

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

- The State has been working with regional crisis providers to develop regional collaboratives which include many of the parties in this paragraph.
- The regional crisis collaboratives exist in some, but not all, regions.
- The State reports they are working with regions with newer crisis providers to establish these collaboratives.
- The engagement of law enforcement varies across regions.
- The State, through these regional collaboratives, have identified policy and service barriers that hinder the use of crisis services by law enforcement and others.

Recommendations

- LDH should continue their efforts to support crisis providers to develop and maintain regional collaboratives that include law enforcement, judges, and coroners to better encourage diversions and referrals to crisis services.
- LDH and LSU should work with local crisis providers to address barriers identified by regional collaboratives that impede engagement of individuals who are in contact with law enforcement. This could include tapping into law enforcement expertise to address some of these regional barriers.
- The State should continue their efforts to provide timely information and meet with State law enforcement agencies regarding the implementation of crisis services and implications for State law enforcement personnel including addressing the liability issues discussed in this paragraph.

69. The State shall develop policies, procedures, and core competencies for crisis services providers, which shall be developed with the technical assistance and approval of the Expert prior to implementation. The State shall also develop quality assurance measures for all Providers of community-based crisis services, including, at a minimum, tracking response times, and dispositions at the time of crisis and at post-crisis intervals of 7 and 30 days. The State shall consult with the Expert in selecting its quality assurance measures for providers of community crisis services.

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

As indicated in paragraph 63, the State, with the assistance of LSU and the SME, has developed policies, procedures, and training for the MCO crisis lines and the four crisis services. The State has finalized the necessary performance metrics for the call center and crisis providers. The SME has reviewed these metrics and believes that are a good starting point for monitoring the crisis lines and crisis services.

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

Behavioral Health Crisis Line	
% Of Incoming Calls Answered	96%

% Of Calls Abandoned	4%
% Of Calls Answered within 30 Seconds	97%

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

LDH is actively working with MCOs and crisis agencies on initiatives that promote access to crisis services and addressing any specific barriers to care as they arise. Communication between MCOs and crisis agencies is good, with well-established lines of communication. One of these strategies include clear processes for service authorization (CBCS, CSU) that providers report is working smoothly.

In addition, as discussed in paragraph 64, the State and MCOs have developed Crisis Care Coordination Protocols to convey expectations for coordinating crisis care across the continuum of crisis care including the MCO crisis line.

LDH reports there have been a number of efforts to engage system partners by crisis agencies, MCOs and LDH. These include:

- Open Houses to better inform the community of newly developed crisis services.
- Development and distribution of marketing materials
- Conference presentations
- Direct information to MCO members
- LSU/LDH technical assistance to crisis agencies on building collaborations with community partners.

The change has largely been driven by LDH, and not a broad, cross-sector consensus on the need for change. Other systems have yet to identify the need for new crisis services. There are concerns about the limited hours and population served. Crisis services is also a new concept for most law enforcement entities. In addition, there is a perception of financial disincentive in shifting care from EDs and ongoing concerns about liability by the hospitals if they allow crisis providers to treat in their facilities. All of these factors paired with still-developing skills in coalition-building may be contribute to very low numbers.

LDH reports to be developing a new data collection tool on a more sophisticated platform. The collection methodology will allow the user to see how a person moves through the crisis system and all of the services they receive.

<u>Compliance Assessment</u>

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

- The State has developed the policies and procedures and developed and implemented training for crisis call line staff and crisis providers.
- The State has developed measures for crisis lines and for all four crisis services, including mobile crisis response, and worked with the SME to develop these measures.
- The State has begun efforts to review MCO crisis lines against the established measures and initially the crisis lines are performing well.
- The State has developed protocols to standardize response by MCOs and providers (including CSUs) to respond to crises.
- The State is working with MCOs and crisis providers on initiatives that promote access.
- LDH is developing a new data collection tool to monitor how a person moves through the crisis system.

Recommendations

- LDH should continue to track and review the performance of the crisis lines against the current measures and provide a report to the SME on a monthly basis.
- LDH should identify and address performance issues for crisis line staff and crisis providers based on these reviews.
- LDH should implement the new data collection tool referenced in this paragraph.
- LDH should continue efforts to provide performance data so that all MCOs and all crisis agencies see the performance numbers for all parties—move to dissemination these reports.
- LDH should develop access to performance information for crisis agencies, MCOs, LSU that allows for sorting/refining data.
- LDH should develop format/method of disseminating public facing reports.
- LDH should consider expanding the role of LSU in collecting/dashboarding key data.

B. Assertive Community Treatment

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

Compliance Rating: Met **(this paragraph was not reviewed during this reporting period)**

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

Compliance Rating: Met **(this paragraph was not reviewed during this reporting period)**

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

Compliance Rating: Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

Paragraphs 70-72 are addressed together. As of December 2022, the State reports there are 45 ACT teams operating within Louisiana that are and will be serving individuals in the Target Population. The SME requested, and LDH provided information on, the number and percent of individuals transitioned from NFs during FY 2022 who received ACT. Currently 94 individuals transitioned from NFs, or approximately 29 %, utilize ACT. The State reports that 2 individuals or 7% of the diverted population are engaged in ACT. During the seventh reporting period the State informed the SME regarding the number and percent of individuals transitioned from NFs and diverted during the first six months of FY 2022 who received ACT. During that period, 60 individuals in the Target Population, or approximately 24%, utilize ACT. The State reports that 12% of the diverted population were engaged in ACT. The 2021 Needs Assessment indicated that approximately 26% of individuals transitioned from NF received ACT and 17% percent of individuals

diverted from nursing facilities received ACT. While there is an increase in the percent of individuals who were transitioned receiving ACT, there was almost 60% fewer individuals who were diverted receiving ACT during the first half of this reporting period . Given the initiation of CCM this reporting period, the SME would hope to see higher ACT engagement rates for individuals diverted from NFs.

In the seventh report, the SME requested information on whether any individuals who requested ACT did not receive this service. LDH has not provided the SME with this information during the last reporting period. In addition, the SME recommended that LDH review policies and other efforts to better identify individuals who will be or have been recently transitioned to determine if these individuals (based on their previous behavioral health ED and IP utilization) should be referred to ACT teams. This would require that TCs or CCMs review data or information (e.g., PASRR Level II) to determine if the individual has frequent crises, ED visits, or long hospitalizations for mental health reasons.

The SME's service review performed during this period did focus on what services individuals indicated they needed and were receiving to successfully remain in the community. This included a review of the individuals service utilization, other record reviews and interviews. During this review, there were a high proportion of individuals whose community plan included and were receiving ACT. Specifically, 10 of the 27 individuals or 37% of the individuals in the sample were receiving ACT. Per the SME's review there was no one in the sample that needed or requested ACT and did not receive ACT.

Given the transition projections for CY 2023, approximately 105 individuals who transition from NFs may need ACT services. (assuming 350 individuals will be transitioned from nursing facilities by December 31, 2023). This is based on the percent of individuals who have been transitioned during 2018 and 2019 (pre-pandemic) and received ACT (26%) and will be expected to increase over time as transitions continue to increase. Given current utilization only a small number of individuals diverted would need ACT—however this is based off of very low utilization.

In the sixth report, the SME reviewed Louisiana's level of care requirements for ACT against similar requirements in other jurisdictions. LDH has not made changes to these requirements and as constructed, the SME continues to believe the admission criteria for ACT are reasonably consistent with other states.

In the fourth SME report, the SME identified that the State does not have defined exit or stepdown criteria. The SME has provided examples of other states' exit/stepdown criteria. The SME reports LDH is working with all 6 Managed Care entities to revise the ACT Service Definition. The state has organized a subgroup of the MCO's to address ACT in particular, and that group will be addressing step-down and use of the Outcomes data system referenced later in this paragraph. LDH reports, they have resumed in person meetings with the ACT teams (which had been suspended due to Covid) and agenda items include discussion of their use of outcomes and other data to ensure that there is a path to stepdown for individuals who no longer need this level of care.

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

Previous fidelity reviews highlighted the lack of employment focus for some of the ACT teams. In the SME's opinion, with respect to the employment area, the ACT teams are singularly positioned to provide intensive supported employment services because the teams already include a dedicated employment

specialist. The State reports that the ACT service definition has been updated to include new emphasis on employment and embedding Individual Placement Supports (IPS) into the existing ACT teams. The State has also adjusted the ACT rate to incentive teams to ensure that ACT employment specialists are well versed to provide IPS.

Work is still ongoing to determine future enhanced fidelity measures to be added to the current Dartmouth Assertive Community Treatment Scale (DACTS). Incorporation of IPS into the current ACT teams has required contract modifications between the MCO's and Case Western Reserve, the entity providing DACT fidelity reviews. Case Western has presented 3 options to the MCOs, and they are in the final stages of discussion in order to select the new payment and operational procedures. All 6 of the MCO's will agree to one uniform method. The State reports the new process will commence in CY 2023.

In the previous report, the SME identified recent summary fidelity reports indicates continued weakness in some areas concerning assessments, individualized treatment plans and individualized treatment. As indicated in the seventh these are major areas for ensuring fidelity and is concerning given previous fidelity reviews where these were not identified as weaknesses. The SME recommended and the state performed on-site reviews of ACT teams in several regions. SME reviewer had the opportunity to "ride along" on several ACT visits in the last reporting period and witnessed several instances of assertive, clinically sound, thoughtful attention to the Members by the team. The SME assessment indicates critical documentation (service plans and ongoing notes) could be improved to reflect the actual provision of services, which in the SME's opinion was consistent with the delivery of ACT. As with all Evidenced Based Practices, continuous quality improvement efforts are important to overcome turnover and the changing environment. The SME believes LDH's resumption of in person meetings with ACT team leadership is helpful in these efforts.

As indicated in the sixth report, the State has developed critical performance measures that are specific to ACT. The purpose of these measures is to determine if high fidelity for an ACT team is associated with better outcomes and if lower fidelity is associated with poorer outcomes (e.g., low intensity services or lack of individualized plans for individuals on an ACT team). OBH collect data to review the performance of each ACT Team. This information is entered into the ACT Outcomes System. Teams continue to have occasional technical glitches with this system, but it is now in use consistently, and the MCO's are reporting data to the LDH. Outcomes measurement will be an agenda item for the upcoming (early spring, 2023) in person ACT leadership meetings.

Compliance Assessment

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

- The State continues to have a sufficient number of ACT team providers statewide.
- The percent of individuals transitioned from NF who receive ACT slightly exceeds the projected penetration from the 2021 Needs Assessment
- There is very low utilization of ACT by diverted individuals during this reporting period.
- Individuals reviewed by the SME who were good candidates for ACT were offered and received ACT.
- Ongoing ACT fidelity reviews are conducted by an independent national organization.
- The State has done reviews of ACT teams to address the issues identified in the fidelity review.
- The State collects important data on outcomes associated with ACT and has analyzed this data to determine what outcomes could be improved.

- MCOs and LDH, during the next reporting period will begin in-person meetings with ACT teams to review outcome information and address issues identified by this data.
- The State has begun to revise the service definition and clarify step-down criteria for ACT.

Recommendations

- Continue to perform fidelity reviews of ACT including a review of their efforts to implement IPS.
- Continue to develop strategies to address the findings from future recent fidelity reviews.
- Consider offering ACT to all individuals who are diverted from NFs (even if it's on a limited basis). These individuals are high risk for continued issues that could assist the CCMs to stabilize these individuals during the first six months of engagement in CCM.
- Continue to analyze information from the ACT Outcome System, including ED and inpatient utilization to identify individuals in the Target Population that could be referred to ACT and develop the step-down criteria to create additional future capacity.

C. Intensive Community Support Services (ICSS)

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

The State continues to measure the availability of and access to Intensive Community Support Services, which include services in the State's current Medicaid behavioral health services, on a quarterly basis utilizing network adequacy reports. For the purposes of this report, the SME has identified the following services to be intensive community supports:

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

The State provides the findings of MCO-generated reports on network adequacy quarterly to the SME. It is also included in the quarterly Quality Assurance matrix developed by LDH. Based on the review of these reports for the CY 2021 and first 2 quarters of CY22 there are no obvious access issues for all but one Intensive Community Support Services. The number of Community Psychiatric Support and Treatment

(CPST) providers generally remained the same in the two quarter of CY 2022 as compared to the previous calendar year. While Intensive Community Support Services could be defined as inclusive of case management services, for the purposes of this report case management is being considered as a stand-alone service for which the State is developing a more tailored strategy. During the seventh reporting period, LDH has proposed changes to the CPST service, to better differentiate the role of this service versus Psycho-Social Rehabilitation (PSR), which had overlapping service definitions.

Similar to ACT, the current needs assessment reviewed the demand for ICSS services by members of the Target Population who are transitioned or diverted from NFs. Recent information from LDH indicates that approximately 14% of individuals who were transitioned received other ICSS services (CPST and PSR). Approximately 3.4% of individuals diverted from NFs received these services. The needs assessment identified that approximately 57% of individuals who were transitioned received other ICSS services (CPST and PSR). Using information from these two data points, approximately 200- additional individuals may need CPST or PSR during CY2023 (assuming, 350 individuals will be transitioned from nursing facilities and 144 individuals will be diverted by December 31, 2023). This continues to be a relatively small number compared to the 14,000 adults who utilized this service in CY 2021 and the current capacity in the network should be sufficient. LDH has performed rate analysis and adjustments for some services (e.g., crisis and ACT), however, the SME is not recommending that the State perform an analysis of rates and billing structures for the MHR services. While rates can be an indicator of barriers to access, the needs assessment and review of the MCO's network adequacy report does not infer there are issues with accessing CPST.

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

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

Compliance Assessment

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

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

Recommendations

- LDH should continue implement the activities in paragraph 79 to develop peer supports.
- LDH should develop a strategy to determine why utilization of CPST and PSR services are significantly lower than what was identified in the Needs Assessment.

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

Compliance Status: Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

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

Compliance Assessment

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

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

Recommendation

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

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

Several existing Medicaid services, such as PSR and CPST, do assist individuals with various IADLs and have been in the State's Medicaid program for almost twenty years. The State received approval to offer peer support services which can also provide assistance to individuals with IADLs such as shopping, transportation, and managing finances. However, as indicated in paragraph 72 these services have yet to be actively implemented.

A major pathway for individuals to receive personal care services is through the CCW program and the Long-Term Personal Care Services Program. These programs support individuals who meet nursing facility level of care with various services including personal care. LDH reports that 144 individuals transitioned received PCS services through either of these programs during the first half of this reporting period .

As discussed in the seventh report, the State began to stand up a third pathway for individuals in the Target Population who needed personal care but did not meet NF level of care. The State obtained the appropriate authority from CMS (e.g., through a 1915(b)(3) Waiver) for this service in the sixth reporting period. The State reports the MCOs have enrolled 37 providers and continue the process of identifying enrolling providers to this newer personal care service. The State reports that only 1 individual transitioned from NFs have received this new personal care service. The SME is concerned about this low utilization but understands this service was implemented during the third quarter of this calendar year. The Department reports claiming for this service may lag (meaning claims may not have been submitted during July 1st through September 30th) and may not reflect more recent utilization.

The SME recommended and LDH provided information collected by CCMs that identify gaps in personal care services. Information collected by the CCMs specifically identifies if there are services the individual needs but has yet to receive. Information reviewed as of July 2022 (the most recent data available) reported 10 of 172 (approximately 6%) individuals who were diverted or transitioned needed but not yet received personal care services.

As discussed in the seventh report, there were several issues with the existing personal care services offered through the Community Choices Waiver and State Plan. Perhaps the major issue with existing personal care services is the lack of timely access for individuals transitioning from NFs. As indicated in the previous SME report and supported by the current service reviews, there have been instances where personal care was not provided on a timely basis for individuals transitioning from NFs. In some instances, personal care services were provided at transition, but gaps in care occurred post transition. OAAS reports these gaps have been and continue to be related to ongoing workforce issues. The State and providers report the pandemic has impacted the ability to recruit and retain qualified individuals to provide these services. The State requested and disbursed additional federal funds through the American Recovery Plan Act (ARPA) to increase salaries for personal care and other direct care service workers as a strategy to address these gaps. The impact of these actions has not been assessed given their recent implementation. During the next reporting period, The SME is requesting information to measure if these efforts positively impacted the availability of these services.

Compliance Assessment

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

- The State has disbursed enhanced reimbursement for personal care services that is aimed at addressing workforce shortages.
- A significant number of individuals are receiving personal care services through the CCW or LTPCS program, however only one Individual received the new personal care benefit for those individuals who are not eligible for current Medicaid PCS.

- MCOs continue to develop the personal care network for individuals in the Target Population who do not meet NF level of care.
- There is a small percentage of individuals (6%) who need but have yet to receive PCS services.

Recommendations

- LDH should continue to track and provide 1915(b)(3) personal care services to all individuals in the Target Population who have been transitioned from an NF who do not meet the level of care for the other personal care benefits.
- LDH should ensure that each individual where the Transition or Community Assessment identify the need for assistance with ADLs have personal care services in their ITP or their Plan of Care.
- LDH should continue to monitor whether individuals who are transitioned or diverted and who needed PCS receive these services in their monthly plan-specific reviews.

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

Compliance Rating: Not Met

Discussion and Analysis

LDH has not performed structured activities that address this paragraph. The SME is unaware of engagement and subsequent discussions with stakeholders regarding a review and possible changes to these provisions. In previous reports, the SME recommended LDH develop an organized process to engage stakeholders to review current provisions, make recommended changes, and develop the necessary policy guidance to address these rights. The State has not undertaken these activities. The SME is recommending the State initiate steps to meet the requirements of this paragraph during the next reporting period.

Compliance Assessment

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

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

Recommendations

- LDH should undertake the following activities during this next reporting period to meet the requirements of this paragraph:
    - Identify members of the existing My Choice Advisory Committee and several additional individuals with lived experience, including individuals in the Target Population, to meet as a subcommittee to address this paragraph.
    - LDH should provide information and solicit recommendations regarding changes to the current protocols and processes used to ensure personal and treatment rights of individuals receiving behavioral health services.
    - LDH should develop a strategy(s) to address the proposed changes and present these changes to the LDH My Choice Advisory Committee for their review.
    - LDH should develop a timeline for implementing these strategies in the next reporting period. All strategies should be implemented by December 31, 2023.

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

The State has a process to credential peer support specialists who could provide the services in this Agreement. As of this report, there continues to be approximately 300 credentialed peer support specialists in Louisiana. Currently, the State, through the MHR program, has policies (through the existing service definitions) that allow peer specialists to provide services, including all four new crisis services: ACT, Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, and Crisis Intervention. As indicated in the seventh report, there is no information readily available to determine the extent to which peer specialists offer these services. LDH states they are currently developing a contract for various activities that will support peer credentialling and tracking of current peer employment information including the delivery of services and supports referenced in this paragraph. The State anticipates this information will be available later in CY 2023 (likely in the tenth SME reporting period).

As discussed later in paragraph 79, a significant reason for the lack of utilization of the new peer support service was an issue with applicants with lived experience passing background checks. There was legislation passed in June to ease criminal background requirements for peer support specialists that may increase the number of peers. There is no information that is currently available to assess the impact on this legislation given its recent passage.

In addition, as indicated in several paragraphs, the service reviews identified that many individuals who were transitioned or diverted experienced isolation and loneliness. Having a robust peer support service available to these individuals would be helpful to address these concerns. Specifically, peer services would provide a meaningful interactions with the individual, assist the individual to identify resources in the community (formal and natural supports) that could be leveraged to address this isolation and loneliness.

Compliance Assessment

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

- The State does have policies to credential peer support specialists.
- The State allows, but does not require, peer support specialists to provide services in A-C of this Agreement.
- The State is not able to track the number of peer support specialists who provide services in Section A-C of this Agreement.
- The State reports they are implementing activities in CY 2023 that will allow them to report on peers delivering services referenced in this paragraph.
- There are barriers to agencies interested in hiring peers (e.g., background checks).

Recommendation

- LDH should implement the strategies discussed to obtain information on the number of peers employed by MHR programs.
- The State should continue to identify barriers to recruiting and employing peers.

- Based on this information, the State should identify strategies to address any significant barriers to recruiting and employing peers.
- LDH should also provide the SME with information on peers delivering new services (e.g., crisis and supported employment) during the next reporting period.

D. Integrated Day Activities

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

Compliance Rating: Not Met

Discussion and Analysis

The State defined a preliminary set of integrated day services for members of the Target Population that includes employment supports, drop-in centers, and adult day opportunities. The State's primary focus continues to be on developing employment opportunities for individuals in the Target Population. These opportunities are to enhance state efforts to offer integrated opportunities for people to work and be provided with high fidelity to evidence-based models, such as Individual Placement Supports (IPS). As indicated in the seventh report, the State finalized a definition for IPS, received approval to include it in the State's Medicaid program, finalized a reimbursement methodology for IPS, trained providers on the importance of employment, and is participating in a National Learning Collaborative on IPS. During this reporting period, they have focused on enhancing the acumen of ACT teams providing IPS. This includes revisions to the ACT service definition and reimbursement methodology to message and incentivize ACT teams to offer IPS. In addition, the State has been accepted into the federal Department of Labor, Office of Disability Employment Policy's ASPIRE program, which provides a learning community for states to enhance access to IPS for individuals with serious mental illness. The first goal for LDH's participation in the ASPIRE program is to ensure the TP will receive IPS Medicaid services and Louisiana Rehabilitation Services (LRS). The second goal is for LDH to implement and expand utilization of IPS programming for the TP through the expansion of Local Governing Entities (LGEs) rendering the service. LDH has also initiated a contract with a consultant to provide specific strategies for individuals with serious mental illness to access services offered by Louisiana Rehabilitation Services (LRS). The consultant will assist the State to create an expedited supported employment referral process between LRS and LGEs. This consultant will assist with policy changes that will promote employment throughout the mental health treatment process at LGEs and assist the State to develop braided or sequential funding for IPS services.

The State has consulted with the national IPS Employment Center, the creators of IPS, to build an infrastructure to provide IPS services. The IPS Employment Center will focus on select areas of the state to provide technical assistance regarding IPS.

Despite these activities, the Department has not created the necessary demand for these services for individuals in the Target Population. In the eighth SME report, LDH identified 136, or approximately 20%, of individuals on the Active Caseload List who have expressed an interest in employment. This represents a substantial number of individuals who would benefit from employment related supports, including IPS. It should be noted, this is a significant improvement on TCs' efforts to discuss and identify interest in employment through the transition assessment process and therefore many individuals who want to work do not have the supports in place to achieve that goal.

As of this report, three individuals in the Target Population transitioned or diverted from NF in the area served by the Capital Area Human Service District LGE are receiving IPS. As indicated in the sixth SME report, a low volume of demand will provide LGEs with fewer incentives to dedicate staff resources to the delivery of IPS, which will impact the availability of this service.

As discussed in paragraphs 70-72, the State has increased its emphasis on employment services through ACT. OBH has developed and released guidance to providers regarding employment services, including the use of existing services (CPST and PSR) to offer employment supports and coaching through the MHR program. This guidance is essential for having MHR providers understand they can offer employment supports to individuals who may not need the intensity of IPS. It is not clear whether this guidance has made an impact on MHR providers to offer supported employment for individuals with SMI in the Medicaid program, including the Target Population.

In previous reports, the SME recommended that additional services or supports be available to the Target Population for ensuring additional integrated day options. The State gathered information to identify drop-in/low-demand social settings that could provide support and engagement to individuals transitioning or being diverted from NFs. Information from the surveys was added to the resource guide for the Transition Coordinators. In the eighth report, the State reports they have done outreach to these drop-in centers to determine if they are still operational during the waning of the pandemic. The State reports all drop-in centers are operational. The State reported they will develop a process in CY 2023 to provide information to these drop-in centers regarding efforts in other states to modernize their approaches and offer activities that will enhance individuals' overall wellness. It is not clear whether LDH has taken steps to meet with these drop-in providers and the SME is requesting information during the next reporting period regarding any efforts to engage drop-in centers for individuals who are transitioned or diverted from NFs.

Finally, as discussed in paragraph 79, there are a number of individuals who were transitioned or diverted who have hobbies and interests identified in the NFTA or community assessments, yet their ITPs or CPOCs do not have specific actions to address these interests.

Compliance Assessment

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

- The State has undertaken important initial steps to identify and develop integrated opportunities for individuals to do during the day, with a focus on IPS.

- The State has contracted with a technical assistance vendor to assist with developing pathways for individuals to access LRS services.
- The State has released guidance for MHR agencies to offer employment supports. It is not clear whether this guidance is having the intended impact of having providers offer supported employment to individuals participating in the MHR program.
- The TCs have enhanced efforts to identify individuals who express an interest in working during the transition assessment process.
- There have been three referrals of individuals in TP to IPS since the launch of this service.
- LGEs have received limited training or technical assistance to launch IPS. The State reports only one LGE, Capital Area Human Service District, has received in-person IPS and job development training. This LGE received ongoing technical assistance from OBH on a monthly basis.
- The State has gathered important information regarding the current status of drop-in centers.
- The State has plans to provide information to drop-in centers regarding approaches to improve the wellness of individuals who participate in their programs.
- The State will participate in the federal ASPIRE initiative to develop access to IPS services for individuals in the TP.

Recommendations

- LDH should leverage the ASPIRE program to address the needs of the TP on the Active Caseload List who have indicated an interest in employment.
- LDH should develop a process to track whether the recently released guidance and changes to the ACT definition has resulted in more individuals participating in the MHR program becoming employed.
- LDH should ensure that TCs and CCMs are initiating referrals to LRS and IPS and track the specific referrals and engagement with IPS.
- LDH should track the number of individuals transitioned or diverted from NFs who are working (paid and volunteer employment).
- LDH should implement efforts to provide information on wellness approaches to drop-in centers.
- LDH should ensure that MCOs implement strategies for assessing the fidelity of IPS for LGEs who are providing IPS.

E. Peer Support Services

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

Compliance Rating: Not Met

Discussion and Analysis

Peer support is an evidence-based practice for individuals with mental health conditions or challenges. Both quantitative and qualitative evidence indicates that peer support lowers the overall cost of mental

health services by reducing re-hospitalization rates and days spent in inpatient services and by increasing the use of outpatient services. Peer support improves quality of life, increases and improves engagement with services, and increases whole health and self-management. The State and the SME believe there is an interest in increasing access to and involvement of peer support specialists.

The State has received CMS approval for a Medicaid reimbursable stand-alone peer support service as of March 2021. Currently, only LGEs can offer this service. The SME requested and received recent information on the number of individuals in the Target Population who received the new peer support services during this reporting period. The State reported there was no utilization of this service by individuals who were transitioned or diverted during this reporting period. The State reports only one LGE is implementing this service. As discussed in the sixth report, the State identified several barriers to this slow implementation. LDH does report that all organizations offering ACT have peer support specialists on their teams.

As indicated in the seventh report, LDH reports they undertook various activities to enhance peer support services. Despite these efforts, there is no real utilization of this service and therefore it is not adequate to meet the needs of the individuals in the Target Population. As discussed in paragraphs 61, the SME service review indicated peer support was the most needed service in discussions with individuals participating in the review. Many individuals expressed feeling lonely and not feeling well integrated into their community. The SME service review team discussed the possibility of peers to address feelings of loneliness and offering strategies for better community inclusion with individuals during the review. Individuals interviewed through the service review expressed interest in this service.

Recently, LDH has been pursuing an alternative strategy for implementation of the Medicaid peer service. Specifically, LDH is working with Medicaid providers of Permanent Supportive Housing to provide this service. They are a distinct provider in the Medicaid Mental Health Rehabilitation Program. These providers report they have peers on staff that have been offering PSH services and are interested in expanding their efforts to offer the Medicaid Peer Support Service. The State reports they are still in discussion with these providers and some additional LGEs to create additional provider capacity for this service.

Compliance Assessment

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

- There has been no significant implementation of a separate peer support service. The lack of utilization of these services over the past two years is discouraging.
- There have been few referrals to LGEs and no utilization of stand-alone peer support services for individuals in the Target Population diverted or transitioned from NFs.
- Individuals participating in the SME service reviews identified significant periods of loneliness and a general lack of identifying and accessing activities that would enhance community inclusion.
- LDH is pursuing a strategy to add more LGEs and have organizations that offer PSH to Medicaid recipients offer peer support to Target Population and other Medicaid beneficiaries.

Recommendation

- LDH should continue efforts to increase LGEs' capacity to offer peer support services.
- LDH should review ACT teams serving the TP diverted or transitioned from NFs to include peer support services in ACT-specific plans and offer peer services with some frequency to address issues with loneliness and community inclusion.

- LDH should continue to pursue having PSH providers offer their services to the Target Population and not rely exclusively on LGEs for the delivery of peer support services.

F. Housing and Tenancy Supports

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

In December 2019, the State developed a Housing Plan, as required under the Agreement. The plan set forth specific actionable strategies with specific annual targets for the creation of additional affordable housing units and rental subsidies to be made available to members of the Target Population.[2] The plan identified development of housing and non-development strategies (e.g., vouchers). The plan also included housing opportunities under the 811 PRA, Low Income Housing Tax Credit (LIHTC) Section 8 programs, and the State Rental Assistance Program.

As indicate in the seventh report, the State has revised its housing plan through 2025. In revising the plan, LDH worked with LHC to better identify the development and non-development strategies for the next three years. The State included similar development and non-development opportunities included in the original plan. In addition, the State collected and analyzed information regarding the Planned Permanent Supportive Housing (PSH) opportunities created, including units/subsidies offered to the Target Population and individuals who took advantage of these opportunities. The analysis of this information is provided in paragraph 81. LDH has met with the SME and DOJ to discuss the implementation of the plan. While it is important to have this plan, it will be important to track progress against this plan frequently (as discussed in paragraph 81).

The State has yet to post the revised plan for stakeholders.

Compliance Assessment

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

- LDH has revised the 2022 housing plan for individuals in the Target Population.
- The housing plan only provides rental assistance for units that are integrated into the community.
- LDH has developed a good working relationship with LHC staff to leverage their resources to access various housing strategies.
- The State has not posted the most recent housing plan.

Recommendations

- LDH should post the current housing plan.

[2] http://ldh.la.gov/assets/docs/MyChoice/MyChoiceHousingPlan.pdf

- LDH should track and update its plan on an annual basis and provide information to the SME and stakeholders regarding the efforts each year to meet the intent of paragraph 81.

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

Over the past four and one-half years, the State has transitioned 441 individuals. Historically, 60% of these individuals have needed assistance with housing. The most recent information on all individuals currently on the Active Caseload with a Transition Assessment has identified approximately 44% will need assistance with housing. .

The State, in its original housing plan, set forth the annual targets for creating additional housing units or rental subsidies that would be available to the Target Population. This includes development opportunities, where the unit or units will need to be created by developers and may include building new structures or rehabilitation of existing units. Sources of funding for these development opportunities include bonds and low income housing tax credits. The plan also included non-development opportunities such the use of vouchers to secure housing. Examples of funding sources for non-development opportunities include Section 8 or non-elderly disabled vouchers.

The State tracks several activities to determine if it is meeting the intent of this paragraph in the Agreement. This includes:

- PSH opportunities created by each strategy within the LDH My Choice Housing Plan
- PSH offered to the Target Population by each strategy within the LDH My Choice Housing Plan
- Target Population housed by each strategy within the LDH My Choice Housing Plan

The State has determined the second measure, the number of PSH offered to the Target Population will determine if the State has met the goal of this paragraph to make 1,000 units available to the Target Population. While the SME understands this is the measure, it will be important to ensure that there are not significant differences between opportunities created, offered and used by the Target Population. As indicated in the seventh report, there were relatively large differences between the number of opportunities created and offered (50% difference) and the number of opportunities created and used by the Target Population (30% difference). The SME believes the variance between offering and using housing opportunities should be small. Very few unused housing opportunities created as part of the Agreement should go unused.

The seventh SME report provided progress towards meeting the intended development of housing opportunities. The seventh report also indicated the State was not on track to meet a planned target of creating 867 opportunities by June of 2023. The State reported they created 357 opportunities. Of these 357 opportunities, 175 were offered to individuals in the Target Population and 120 individuals utilized these housing resources.

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

The initial revised housing plan discussed in the seventh SME report projected over 946 new opportunities (for a total of 1,121 opportunities) to be offered to individuals in the Target Population over the next three years (CY 23 through CY 25). A large number of housing opportunities included turnover estimates from existing PSH opportunities that would be repurposed for the Target Population. Turnover may occur for a variety of reasons, such as the person obtained non-PSH housing, moved out of state, moved to another region, moved in with family member, is no longer interested in PSH program, refused all properties, is ineligible, lost eligibility, is unable to locate, was evicted, abandoned unit, or passed away. The State initially projected 452 opportunities would be created through turnover.

During this reporting period, LDH revisited these projections given some of these new opportunities were duplicative and should not be counted as a new opportunity. The State now projects 336 new opportunities will be offered to the Target Population due to turnover. Therefore, the revised housing plan projects a total of 1,005 housing opportunities created. The chart below provides a breakdown of the production of permanent supportive housing opportunities from 2019 through 2025.

PSH	PSH Production Actual # or Estimate
Documented PSH Offers to the Target Population from 2019-2021	175
Future PSH opportunities to be created from 2022 to 2025	494
PSH turnover estimate from existing PSH	336
Total Estimated PSH offers	**1,005**

It should be noted that OAAS and LHC continues to meet bi-weekly to increase opportunities under the HOME Rental Assistance Program. As indicated in the seventh report, LHC has committed $1 million of HOME funds in CY 2023 to provide 100 tenant-based rental subsidies to the Target Population. LHC Is in the process of working with LDH to implement this strategy during the next reporting period. In addition, OAAS has increased the number of opportunities for the State Rental Assistance program—an increase of nearly 80% for the next two years. This is encouraging since these opportunities provide the most flexibility regarding eligibility criteria (the State and not federal agencies develop this criteria).

As indicated in the previous SME report, the plan projects 172 opportunities being developed for CY 22. While transitions have significantly increased, the State was not able to take advantage of housing opportunities created this year. An additional source of referrals to housing will be from individuals who have been diverted from NFs. As indicated in this report, these individuals are now receiving CCM which is tasked with identifying housing needs and facilitating access to these resources. The State reports that 5 individuals (12% of the diverted population engaged in CCM) have housing needs and were connected with PSH opportunities created under the Agreement.

Given the revised housing plan is complete, LDH has stated they will track the progress of implementing the plan on a quarterly basis. This will be important to identify any significant differences between housing opportunities created, offered and used. As part of this analysis, it will also be important for LDH to provide clarity regarding the methodology used for tracking to ensure these opportunities are tracked correctly.

Compliance Assessment

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

- The State has undertaken various steps to increase integrated housing opportunities for individuals in the Target Population—a significant increase (80%) has been opportunities created through the State's Rental Assistance Program.
- The State has revised the housing plan as recommended to ensure opportunities were not counted multiple times.
- The State did not meet the stated goals for CY 22 for developing housing opportunities for the Target Population.
- There are major differences between the housing opportunities created, offered, and utilized by the individuals in the My Choice Program.
- TCs are creating additional demand that has increased the housing opportunities offered and utilized by the Target Population.
- The State is developing a process to track opportunities created, offered and used by the Target Population, including individuals diverted from NFs.

Recommendations

- Track opportunities on a quarterly basis to determine if opportunities are being created and offered to individuals in the Target Population. The goal should be to have good alignment between opportunities created and used by the individuals in the My Choice Program.
- Continue to work with LHC to develop the 100 opportunities under the HOME Program.
- Provide a clear methodology for how the State tracks the progress toward the implementation of the revised housing plan.

82. Consistent with the State's current Permanent Supportive Housing Program: (a) tenancy supports shall be voluntary; refusal of tenancy supports shall not be grounds for denial of participation in the Permanent Supportive Housing Program or eviction; (b) individuals shall not be rejected categorically for participation in Louisiana Permanent Supportive Housing due to medical needs, physical or mental disabilities, criminal justice involvement, or substance use history; and (c) in order to satisfy the requirements of this Section E, housing shall be community integrated and scattered site. For purposes of this Agreement, to be considered scattered site housing, no more than two units or 25% of the total number of units in a building, whichever is greater, may be occupied by individuals with a disability referred by or provided supports through the State's permanent supportive housing program or individuals who are identified members of the Target Population under this Agreement. For purposes of this Agreement, and consistent with provisions of the State's existing permanent supported housing program, community-integrated housing shall not include licensed or unlicensed personal care, boarding, or "room and board" homes, provider-run group homes, or assisted living facilities. It may include monitored in-home care provided to individuals in the Target Population eligible for Medicaid waiver services.

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

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

As indicated in paragraph 81, the State has revised the My Choice Housing Plan. The plan proposes to include development strategies for CY 2023-2025 that ensure that projects meet the intent that units being developed are integrated and in scattered sites.

Compliance Analysis

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

- The State has current policies and programs that allow an individual to reject housing supports and ensures individuals with certain conditions are not denied participation in the program.
- Current and projected opportunities identified in LDH revised housing plan only offer development and non-development strategies for units that are integrated and scattered site.

Recommendations

- LDH should track and report the creation of housing opportunities developed and offered are consistent with this paragraph.

83. The State shall employ Tenancy Supports Managers (TSMs) sufficient to conduct landlord outreach, provide tenancy supports when Medicaid enrolled providers are unable to do so, provide technical assistance and support to landlords and/or tenancy supports providers during the leasing process, and

address crises that pose a risk to continued tenancy. TSMs shall have demonstrated experience finding and securing integrated housing and providing Tenancy Supports to individuals with mental illness. The State shall take steps to assure the preservation of existing housing for members of the Target Population when a member of the Target Population is admitted to a hospital or nursing facility or is known to be incarcerated in connection with a mental health crisis or behavioral incident.

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

The State employed eight TSMs to provide statewide coverage to assist members of the Target Population transitioning from NFs. This is an increase of 2 TSMs since the previous reporting period. As discussed in the seventh report, TSMs perform the following functions:

- Meeting with the client to perform housing needs assessment.
- Assisting the client in finding appropriate rental housing
- Performing the HUD quality standards inspection of the unit
- Negotiating with the landlord on the client's behalf, including seeking reasonable accommodation under the Americans with Disabilities Act and Fair Housing laws
- Assisting the client in gathering documents necessary for housing applications and lease signing
- Helping the client accomplish move-in, including working with team members and assisting individuals to obtain items needed for move-in
- Working with the client to develop crisis action plans and eviction avoidance plans.
- Serving as point of contact for the property manager/landlord mediation
- Addressing problems that may arise between the client and landlord.
- Assisting households with community referrals as needed
- Implementing eviction avoidance plans, seeking to prevent housing instability and rehousing.
- Providing ongoing tenancy support and community-living skills training during lapses in Medicaid coverage or when the Medicaid provider is unable to successfully engage.
- Maintaining files on all households and providing data as requested on households served.

The SME's opinion is that TSMs should provide a valuable function on behalf of the Target Population and for landlords and local housing authorities. In the sixth report, the SME requested additional information on how the TSMs assisted members of the Target Population to find appropriate housing. The State provided the SME with the following information during this reporting period.

Calendar Year	2018-19	2020	2021	2022
Number of individuals receiving services from TSM	88	27	72	71
Type of Assistance				
Rental Assistance with Rental Assistance Program	74	18	40	64
Rental Assistance with NED Vouchers	14	9	32	7

The State reports they seek to employ TSMs who have relevant experience with federally funded housing programs and landlord recruitment and relationships. Of the 8 TSMs, LDH reports:

- Three previously worked for contracted PSH providers,
- One worked for the local Continuum of Care and also had HA experience,
- One worked for a referral source for PSH,

- Two worked for housing providers in another state and
- One had housing assistance and social services experience.

In addition to supporting individuals in the Target Population TSMs also support landlords and PSH providers. The State reports that TSMs often serve as the initial contact with landlords. Landlords tend to reach out to a TSM when issues arise since they were the first point of contact. They recruit landlords who are willing to accept vouchers that require compliance with Federal housing guidelines and state funded rental assistance. TSMs also negotiate unit rental amounts, collect all paperwork required to become a vendor for both LHA and LDH, provide guidance on bringing units up to standards (when needed) to pass a housing inspection and provide support through the leasing process and request reasonable accommodations when needed. They also provide support to the Individual in the Target Population and provider throughout the housing search and lease up process. TSMs also assist providers with addressing unit issues, including repairs during tenancy. TSMs also assist the individual in completing recertification paperwork. The State also reports, TSMs intervene when there is a crisis related to the housing unit or if the household is at risk of eviction due to lease violations, utility disconnections or unpaid rent. They will work to identify solutions and resources and if a landlord is still wanting to proceed with eviction, they will mediate to keep everyone from going to court and work to rehouse someone as quickly as possible. TSMs are also tasked with maintaining a unit in a client's absence. Per federal guidelines, individuals are initially allowed for up to 90 days for a unit to be unoccupied. During this time, a TSM works with the landlord to let them know the unit hasn't been vacated and ensures payments will continue. Depending on the circumstances, they will either revise paperwork to have the voucher cover the full rent or submit payments to LDH to pay on behalf of the client. In addition, the TSM will make sure the utilities are maintained during their absence. If the end of 90 days is nearing and the client hasn't returned to the unit, they will work to request a reasonable accommodation if there appears to be a solution for the client to return in the near future.

Compliance Analysis

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

- LDH has employed TSMs that perform the duties outlined in this paragraph including support to landlords and PSH providers.
- TSMs have provided assistance to 170 individuals in the Target Population who are seeking housing assistance or approximately 40% of all individuals who have been transitioned.
- LDH reports TSMs have experience with federal housing programs and delivering housing assistance prior to employment.
- TSMs address crisis situations that are directly related to housing and LDH reports TSMs preserve housing (including utilities) when an individual has not returned to the unit.

Recommendations

- LDH should continue to track TSM activities that support the Target Population on a semi-annual basis and report to the SME, including information on the number of individuals in the Target Population who have needed and reasons the TSMs to preserve housing.
- LDH should provide the SME with the strategy deployed to ensure that TSMs are well aware of the newly created crisis providers.

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

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

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

In the seventh report, the SME requested information regarding the number of individuals in 2022 and previous calendar years who needed and received housing-related expenses. Information from the ITPs should identify who needs these supports and TCs should report whether these supports were provided at transition.

Compliance Assessment

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

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

Recommendations

- LDH should develop a strategy to determine if individuals diverted from NFs need and receive similar housing supports.
- LDH should provide information regarding the needs of individuals transitioned and diverted in CY 2022 and that should be used to inform the use of HOME TBRA and additional RAP resources for housing related expenses.

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

Compliance Rating: Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

As indicated in Paragraph 75 of the Agreement, the State has pursued both Medicaid state plan and waiver authorities for several new services. During this reporting period the State received approval of a Medicaid State Plan Amendment for Crisis Stabilization Units. In the seventh report, the State distributing funds to support various My Choice services. This reporting period the State adjusted payments for critical HCBS services (e.g., personal care services) using federal ARPA funds.

As indicated in the sixth report, the State worked with the Medicaid actuaries to develop reimbursement rates for each new service. The SME was engaged in some of these discussions or provided input regarding the assumptions for rate setting based on other strategies that have been used in other states that have mature and well utilized services. The State has recently reviewed these rates and made some changes for various crisis services to reflect the experience of the roll-out of these services. LDH factored the gradual roll out of these services and newer information regarding the costs of delivering these services to adjust these rates.

Compliance Assessment

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

- LDH has pursued the necessary Medicaid changes thus far to meet the intent of this paragraph.
- LDH has implemented and revised reimbursement strategies for new services that should support providers offering these services.
- The Department has provided funding to providers of new crisis services to ensure their sustainability during the initial start-up period.
- The Department has implemented the strategies for increasing reimbursement for much needed HCBS.
- The Department has reviewed the rates for newer services and made adjustments based on the roll out experience.

Recommendations

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

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

A. Outreach

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

Paragraphs 86 and 87 are addressed together. The State developed an initial communication plan for stakeholders to learn about challenges encountered in the implementation of this Agreement, addressing those challenges, and targeted outreach and education needed to implement the plan. A summary of the plan was provided in the seventh SME report. In addition, since the fourth report, the SME has recommended the State revise its outreach plan given its proposed renewed efforts as discussed throughout this report. The outreach plan, at a minimum, should involve NFs, hospitals, LGEs, law enforcement, and other resources the Target Population will need to live independently in the community. The State has not revised the communication plan. One of the issues identified during the service review is the need for ongoing information and education to NF administrators and staff. Interviews with TCs and SME contact with NF administrators indicated NF staff were not aware of the My Choice Program, the process for engagement and transitions. Given the ongoing turnover of NF staff, more targeted educational/informational strategies are needed in any revised outreach plan.

The State began to implement this plan early in the Agreement but has not completed major tasks identified in the Outreach Plan. The State reports they are in the process of revising the Outreach Plan during the next reporting period.

The current outreach efforts continue to focus on disseminating information to the My Choice Advisory Committee, LGEs, and various stakeholders regarding new services such as crisis services.

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

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

As discussed in the sixth SME report, the State previously developed a number of subcommittees, or resource groups, within the Advisory Committee to provide input on key areas, including crisis, community service development, quality management, and community transition. In the SME's opinion, these meetings have been helpful to the State in their efforts to get specific feedback on important areas and activities, as the meetings are interactive and subcommittee members provide helpful comments regarding the subjects of discussion. The SME is continuing to request information regarding the rationale for not holding these meetings, given the barriers identified in Paragraphs 51.

The only exception to the lack of outreach efforts is the ongoing meetings regarding crisis services. The Crisis Resource Group and weekly meetings with the crisis providers continues to provide feedback to the State regarding the implementation of crisis services. The State continues their efforts this reporting period regarding engaging law enforcement, specific to crisis services. These efforts were discussed in more detail in paragraph 68.

The SME recommended in the previous report that the State convene and meet with the Community Transitions Resource Group to discuss the issues that have been identified by the Needs Assessment, TCs, and other individuals regarding barriers to transition, given the low number of individuals transitioned during previous reporting periods. This group would be helpful in the State's efforts to collect information and feedback regarding the array of services needed for individuals in the Target Population. The State has not met with this group.

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

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

As requested by the SME, and as required by this Agreement, the State continues to post their Quality Report and Matrix for the My Choice Program. This report can be found here: https://ldh.la.gov/assets/docs/MyChoice/myCHOICE-Annual-Quality-Report-2021-22.pdf. It should be noted the State posted in January of 2023 SME report for the period January 1, 2022-June 30, 2022.

Compliance Assessment

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

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

Recommendations

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

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

Compliance Rating: Not Yet Rated **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis
During the sixth reporting period, the State conducted meetings with law enforcement as discussed in Paragraphs 68 and 86. Most of these efforts focus on the development of the new crisis services system, which is the likely interface between these systems and diversion. LDH has been appropriately cautious about efforts to meet with these organizations until the appropriate crisis and case management capacity is in place to enhance diversions. The SME will track LDH activities in this area in future reports to assess compliance.

B. In-Reach

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

Compliance Rating: Partially Met

See paragraph 54 for discussion.

C. Provider Training

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

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

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

Compliance Rating: Partially Me **(this paragraph was not reviewed during this reporting period)**

92. The curriculum will emphasize person-centered service delivery, community integration, and cultural competency. The curriculum will incorporate the provisions of this Agreement where applicable. LDH will

seek input from individuals receiving services regarding the training curriculum and will include such individuals in the training where appropriate.

Compliance Rating: Partially Met **(this paragraph was not reviewed during this reporting period)**

Discussion and Analysis

Paragraphs 90-92 are addressed together. The State continues their efforts to train community providers, with a major focus on providers of the new Crisis Stabilization Units (CSUs) which was rolled out during this reporting period. In addition, new crisis providers will receive training as these services are brought online in newer regions. As indicated in the paragraphs in Section V.A, the State has worked with LSU to develop organized and well attended training opportunities for providers offering various crisis services. Those training opportunities are discussed in paragraphs 63 through 66.

The State continues to report they have implemented training for agencies and their staff that will provide CCM. As indicated in the seventh report, the SME has reviewed the training materials developed for CCMs and feels these materials are sufficient for initial training for these providers. The State expects these trainings will occur on a regular basis as CCMs are onboarded to meet the increased number of transitions and diversions.

As discussed in paragraph 78, the State continues efforts to contract with the national IPS Employment Center, the creators of IPS, to build an infrastructure to provide IPS services. The State has also been accepted into the ODEP Policy Academy which will also provide technical assistance to LDH regarding their IPS training efforts. The State has concrete plans to offer training and technical assistance regarding IPS for some LGEs in the next reporting period. Specifically, the State is engaging the IPS Center from Columbia to provide intensive training to LGEs regarding IPS services. In addition, LDH will be training ACT providers regarding the delivery of IPS services.

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

In the sixth report, the SME also recommended in the SME Service Review a training approach to CCW support coordinators and personal care staff that were serving individuals with a serious mental illness. The State has not developed these training efforts but has committed to provide these trainings as part of the CY 2023 Implementation Plan.

Over the past several reports, the SME has requested LDH establish a mandatory training policy, qualifications, and curriculum for Community Providers. In addition, the curriculum is to include initial training and continuing training and coaching for Community Providers. The State has developed training and coaching for crisis providers but has not developed similar approaches for other community services. The SME understands that MCOs continue to train community providers on foundational information regarding various approaches to delivering behavioral health services (e.g., responding to trauma,

administering the LOCUS) in addition to operational trainings (e.g., prior authorization processes, reimbursement). As discussed above, LDH is developing a training approach for various new services and new service providers. Having a site for providers to have access to topics and dates would be helpful for these providers to be aware of these offerings and would also allow LDH to have a more streamlined approach in notifying providers about training opportunities from this site.

Compliance Assessment

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

- The State continues to implement training for agencies offering crisis services and community case management this period.
- The State will be participating in IPS through ODEP that is intended to support select LGEs in the delivery of IPS.
- The State has included a plan for training direct service workers offering PCS services to the Target Population in their CY 2023 Implementation Plan.
- The State has developed a list of training opportunities for new services but has not developed a consolidated list of trainings and training dates for providers.
- The State, in cooperation with the MCOs, implemented training on person-centered planning for behavioral health providers.
- The State has not solicited or incorporated consumer feedback regarding its person-centered planning training or included a strategy for consumers to deliver this training.

Recommendations

- The State should develop a single site for State facilitated training opportunities for providers who serve the Target Population. The State should use this site to communicate opportunities to existing and potential providers of the My Choice program.
- The State should include a process for soliciting and incorporating consumer feedback regarding the person-centered training curriculum and implement a strategy for including consumers in the training.
- LDH should implement the training efforts offered through ODEP for select LGEs.
- The State should provide training regarding mental health and recovery to direct service workers that offer personal care services to individuals in the Target Population as indicated in the CY 2023 Implementation Plan.

VII. Quality Assurance and Continuous Improvement

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

Compliance Rating: Partially Met

Discussion and Analysis

The Agreement requires the Subject Matter Expert (SME) to assess the quality and sufficiency of community-based services for members of the Target Population. As a part of this quality assessment, the SME is responsible for reviewing a representative sample of individuals in the Target Population. The SME has developed two service review reports. The initial report by the SME from 2021 was included in the fifth SME report. Similar to the first report, the second report provides information regarding the design of the service reviews, the process of conducting the reviews, the findings of these reviews, and recommendations that the State should consider to make improvements to the My Choice Program that serves individuals in the Target Population. Appendix C is the second service review report.

As indicated throughout this report, the SME has conducted additional service reviews and has identified similar ongoing issues as well as additional issues for individuals who were recently transitioned or diverted. In addition, these reviews focused on individuals in NF who are awaiting transition and obtaining information regarding their transition experience. A summary of findings from this report indicated:

- Individuals who were transitioned experienced positive changes in their overall well-being post transition. As indicated in the review, individuals who were transitioned were generally found to have good physical health and behavioral health well-being, stability, and good transition outcomes. There were some improvements, but additional work is needed to improve assessments, person centered plans, and community inclusion.
- Individuals who were diverted were found to do poorly across all domains. As indicated in the SME service review report, these individuals are very recently discharged from inpatient hospitals and have complex and acute health and behavioral health conditions. In addition, they need housing and other services (e.g., personal care services) immediately after discharge which are not readily available. This presents significant care coordination challenges for the CCM.
- Individuals who were awaiting transition had generally poor scores for all domains. Issues regarding the timeliness of transition activities, the person-centeredness of plans, and their transition experience was poor or very poor.

There were a number of systemic issues identified through the most recent service review. Table 5 summarizes key issues for each of the population reviewed.

Table 5. Summary of Issues from Service Review Report

Population	Systemic Issues
Individuals Transitioned from NF	• The lack of plans that addressed integrated day was problematic and consistent with the issues that were identified in the first service review. • Continued lack of peer support to address loneliness and better community inclusion is a continued theme for most individuals in the review. • Review found significant CCM staff turnover in one region that impacts the success of the CCM program. • There continues to be a lack of communication among team members to address service gaps or ensure providers are not duplicating case management efforts. • There continued to be issues regarding Medicaid benefits post discharge from an NF. • There were issues with assisting individuals to obtain income benefits such as SSI or SSDI.

	• There is some role confusion between CCM, TC, and other individuals involved in providing care post transition.
Individuals Diverted from NFs	• Community plans of care (CPOCs) were often absent of strategies and specific services that addressed the needs of the individual as identified in the community assessment. • The CPOCs lacked strategies to address integrated day activities. • CCM turnover in one region also impacted the participation of individuals in the CCM program and the overall quality of life for individuals who were diverted. • There is a lack of communication among CCM and formal support providers for individuals who are diverted. • Individuals who are diverted often need services and supports on demand. Systems are not in place to provide needed services and supports immediately after diversion.
Individuals Awaiting Transition	• While there has been marked improvements in the NFTAs since the last review, the quality of the ITPs continues to be poor. • There were several issues related to the availability of housing, CCM, and personal care services. • Despite LDH developing specific expectation timeframes for TCs to engage the individual in the assessment process, and to complete the assessment and ITPs, TCs are not meeting these expectations. • Pain management continues to be an issue and lack of attention to these pain management strategies (medication and other interventions) will complicate transitions. • The turnover of TCs presents several issues as to the availability of staff to continue transition activities for affected individuals. • Some individuals needed income assistance through the SSDI or SSI benefit program and NF did not complete these applications in a timely manner.

The SME meets with LDH on a quarterly basis to discuss the findings of the service review with recommended actions the State should consider to address issues identified during these reviews. As discussed in paragraph 103, the State has been participating in these service reviews over the past year and is seeing first-hand the quality of life for individuals who have been transitioned, diverted, or awaiting transition. As discussed in this report, LDH is also starting efforts to undertake a compliance review of various TC activities.

LDH also requires CCMs to collect information for individuals who are transitioned or diverted from NFs. This information is tracked and reported monthly by OBH and a summary is included in the quarterly quality matrix (Appendix A). TCs perform an additional review of individuals who are transitioned. As indicated in paragraph 42, TCs meet with transitioned individuals on a regular cadence and collect information on domains similar to CCMs. LDH has indicated they collect but have yet to compare information from TCs and CCMs.

In addition to the service reviews, the SME, in previous reports, has recommended LDH develop a process to review the quality of newer services created under the Agreement. LDH reviews the quality of ACT and new crisis services. The State reports they will perform fidelity reviews of IPS provided by ACT teams in CY 2024. Given the status of other IPS activities, it is unlikely the State will perform fidelity reviews of other IPS providers this reporting period. The SME also recommended LDH develop quality measures regarding peer supports. However, there is little utilization of this service as well and LDH efforts would be best spent on continued implementation of this service.

Compliance Assessment

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

- LDH continues to provide relevant information to the SME for conducting service reviews. These reviews provide LDH with information regarding the experience of care and quality of services.
- While the quality of the transition assessments have improved, the quality of the ITPs has decreased.
- The State has developed a process to review the quality of some services (e.g., ACT and crisis). The State has yet to develop a process to review other newer services included as part of this Agreement. However, a priority for LDH should focus on service implementation versus developing quality measures for these services.
- CCMs collect and report information on key measures for individuals who are transitioned and diverted.
- LDH continues efforts to improve the transition activities of TCs. The State has implemented a process for reviewing transition assessments and ITPs.
- The State is collecting information from TC logs to use as a more independent party than CCMs to review the quality of services provided to individuals who have been transitioned. While they have collected this information, they have not made a comparison of similar information from CCMs.

Recommendations

The SME recommends that LDH:

- Address the findings from the second SME Service Review that identified a number of systemic issues and recommendations for improving the quality of services offered to the Target Population.
- LDH should ensure that CCM staff provide the necessary information to review quality of services consistent with the TC strategies over the past two years.
- LDH should compare information collected by CCMs and TCs regarding key quality measures to determine if information regarding these measures are corroborated.

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

Compliance Rating: Partially Met

Discussion and Analysis

The State has implemented a quality assurance system to address this paragraph. The quality assurance system includes the process of collecting and analyzing measures and internal and external activities to review and implement strategies to improve the quality of the My Choice Program. The quality assurance system has been driven by an initial Quality Assurance Plan that sets forth the measures and processes the State will use to improve quality.

Since the third report, the State has developed measures for a substantial portion of the Agreement. As discussed in paragraphs 98 and 99 below, the State tracks information on a quarterly basis that is specific to the quality of various elements of the My Choice Program (e.g., diversions and transitions) as well as other quality indicators. The State has made changes to the measures over the past four years to include feedback from the My Choice Advisory Committee, the SME, and the Department of Justice.

While the State has continued to collect information on many of the topics required by this section of the Agreement, the internal and external process to review this information is lacking. During this reporting period, neither the internal cross-agency quality assurance workgroup nor the quality subcommittee of the My Choice Advisory Committee met. This concerns the SME and, if these efforts are not reinstated, LDH will be out of compliance with this paragraph.

The State completed the first Annual Quality Assurance Report for the My Choice Program during the last two reporting periods. This plan incorporates the work that has been done to collect and analyze data on some of the measures required in paragraph 99. It also sets forth the processes LDH has put in place to use this information to improve the experience of care for individuals transitioned and diverted from NFs as well as to improve the quality of services that are offered to the Target Population. LDH has not developed a subsequent Quality Assurance Annual Plan.

As discussed in paragraph 58, the State is planning to include the TSC as part of their larger quality assurance effort. The TSC role will be to review strategies developed by the internal quality assurance committee for individual and systemic based on issues related to quality.

Compliance Assessment

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

- LDH has developed a quality matrix to monitor many topics required by this Agreement. LDH continues to review and make changes to measures in the quality matrix to continue to address the Agreement and feedback from multiple individuals and organizations.
- The State has not continued their regular meetings of the internal cross-agency Quality Assurance committee or external quality subcommittee of the My Choice Committee to review the quarterly measures discussed in paragraph 99.
- The State did not develop a second annual Quality Assurance Plan.
- LDH has proposed but has not implemented a process to provide information from the internal Quality Assurance committee to the TSC.

Recommendations

- The State should continue to report and track the measures identified in the first quality assurance plan.
- LDH should reinstate cross agency quality assurance efforts to review the data from the Quality Matrix and barriers that have been identified through the recent process created by LDH and to develop strategies for addressing systemic issues identified by the group.

- LDH should provide information from the internal Quality Assurance committee to be reviewed by the TSC and the external subcommittee of the My Choice Advisory Committee.
- LDH should develop and solicit feedback from My Choice Advisory Committee and Quality Assurance subcommittee on the second annual Quality Assurance Plan.

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

Compliance Rating: Partially Met

Discussion and Analysis

Initially, the State had a critical incident reporting (CIR) process that was used by TCs from both agencies (OAAS and OBH) who were providing intensive case management (CY 2020 and 2021). The program offices aligned definitions and processes for individuals transitioned from NFs. TCs completed the CIRs, and captured the elements and measures that align with the definitions and formats used by OAAS. This included information on:

- Falls
- Major Medical Incidents—all cause ED visits and inpatient hospitalizations.
- Major Medication Incidents
- Major Behavioral Health Incidents
- Protective Services: Abuse, Neglect, Exploitation, and Extortion
- Deaths

LDH then combined the critical incidents across program offices and provided aggregate information for the quality matrix.

In the seventh reporting period, CCMs became responsible for CIRs as one of their case management responsibilities. LDH reports the CCMs were trained on CIR processes and requirements. CCMs report critical incidents for individuals transitioned and diverted from NFs. The current definition of critical incidents reported by CCM aligns with and expands on (with the exception of ED and inpatient visits) the previous definition of critical incidents in use by the TCs. These include the critical incidents above and:

- Involvement with law/Victim of a crime
- Use of restraints or seclusion
- Eviction
- Loss or destruction of home

It should be noted that CCMs track and report ED visits and inpatient hospitalizations to LDH separately on a quarterly basis even though LDH no longer considers these critical incidents.

The SME requested, and LDH provided, CIRs for individuals who were receiving CCM. Information from the most recent reports for this reporting period was reviewed. LDH reports there were CIRs for seven individuals in January and February. Five of these reports were specific to exploitation. Most of these

incidents were related to exploitation by the individuals' paid caregivers (e.g., PCA). All of these instances were reported to Adult Protective Services for follow-up. In addition, the CCM provided support and coaching to individuals on their caseload regarding strategies to prevent exploitation. The SME is requesting information regarding any follow-up actions from these reports to APS.

There were two CIRs that identified individuals receiving CCM were neglected. CIRs included individuals living in poor conditions or not having utilities. The CCM reported individuals were removed from these settings and provided housing. The SME is requesting additional information regarding these new settings and whether these incidents were referred to APS.

As indicated above, the CCMs report ED visits and inpatient hospital stays (behavioral health and other causes). The most recent CCM reports identified:

- 28 (7%) individuals receiving CCM had an ED visit (all cause)
- 24 (6%) individuals receiving CCM were admitted to an inpatient hospital (all cause)

This is slightly higher than what LDH reported during the same reporting period in CY 2022. During that reporting period, LDH reported 21 individuals had an ED visit and 18 individuals were admitted to an inpatient hospital for any cause. The increase in the use of these acute medical and behavioral health services may be attributed to increases in the number of individuals transitioned from NFs (almost 200 additional individuals) and diverted from these facilities (120 individuals).

The SME continues to encourage LDH to have renewed focus on critical incidents as part of a larger QA strategy discussed in paragraph 94 during this and subsequent reporting periods.

Compliance Assessment

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

- The State has developed a CIR process for CCMs that includes standardized definitions, reporting processes, and timeframes.
- LDH has aligned their definition of critical incidents to include previous critical incident categories reported by the TC and has added several other categories. The State reported there were seven critical incidents for members of the Target Population for the first two months of this reporting period.
- LDH continues to require CCMs to report major medical events, including reports on the utilization of behavioral health crisis services. As indicated above, 21 individuals visited EDs in the most recent quarter reported and 18 individuals were admitted to an inpatient setting.
- CCMs are referring all CIRs that involve exploitation to APS for follow-up and provide coaching to individuals to prevent future incidents.
- The State tracks and reports information on a monthly basis regarding ED and inpatient utilization, which were previously considered critical incidents.
- LDH incorporates findings from CIRs and major medical events (ED and inpatient hospital utilization) into their overall quality approach.

Recommendations

- The State should continue efforts to identify and respond to CIRs.

- LDH should encourage CCMs to identify alternatives to EDs (e.g., urgent care centers) to address the emergent needs of individuals receiving CCM.
- LDH should provide a summary of findings regarding APS follow-up activities for individuals with critical incidents.
- LDH should incorporate a review of the systemic issues identified through CIRs in the quality assurance process.

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

Compliance Rating: Not Rated

Discussion and Analysis
The SME has not reviewed the processes, protocols, or contractual language that may require community providers to implement critical incident management and quality improvement processes and has been more focused on CIR reporting from TCs and CCMs. This review will be done by the end of this calendar year.

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

Compliance Rating: Partially Met

Discussion and Analysis
As discussed in the sixth and seventh reports, OBH and OAAS have developed a joint mortality review committee protocol for the My Choice Program. The State drafted the first Mortality Review Report in April 2022, but has not posted it. In its 2023 Implementation Plan, the State was to complete the second annual report by July 2023. This has been delayed.

As discussed in the seventh report, the Mortality Review Report provided information regarding the scope and structure for mortality reviews, information on the mortality reviews conducted thus far, and remediation strategies undertaken by the State based on these reviews. Under the current protocol, the mortality review committee is to review any death within one year of discharge from an NF, any unexplained death, and any death in which abuse, neglect, or exploitation is suspected.

Since the beginning of the Agreement, LDH has reported there have been 28 deaths among transitioned members of the Target Population: 1 in 2019, 7 in 2020, 2 in 2021, and 18 in 2022. During this reporting period, LDH has reported 11 deaths. The Integration Coordinator reviews each death and uses criteria to make a referral to the MRC. This criterion takes into account the individual's circumstance and cause of death. Individuals not referred to the mortality review committee were either transitioned from NF to hospice or had end stage medical conditions (e.g., cancer). LDH has referred a total of 24 deaths to the mortality review committee. There were 12 individuals who died who were not referred to the committee.

Of the 24 deaths referred to the mortality review committee, 16 reviews have been completed and eight are still in process. All reviews regarding deaths occurring in CY 2019-2022 referred to the morality review committee have been completed. The findings from these mortality reviews indicate:

- 20% of the reviews completed indicated individuals and agencies provided the appropriate services and followed the standard process for reporting a CIR.
- Critical incident reports are not being filed or not filed on a timely basis by organizations employing direct service workers.
- Direct service workers (DSWs) were not following the plan of care re: frequency of PCA services, ensuring the individual kept appointments with health care professionals or monitoring medication as needed.
- The Support Coordinator did not address concerns identified by direct service workers or follow up with the individual prior to death. Greater involvement by the Support Coordinator was needed with individuals in the CCW program.
- Few team meetings resulted in changes to the individual's plan of care.

LDH reports the following actions were taken to respond to these issues identified by the MRC:

- An additional 20% of all individuals were referred to Health Standards for follow-up; data was not available for actions Health Standards took against agencies serving these individuals.
- DSWs were provided training on monitoring medications and reporting irregularities to their supervisors.
- DSWs were trained on how to monitor smoking, SUD, and diets.
- DSWs were trained on the importance of CIRs and processes and expectations for completing and filing these reports.

The State reports 11 deaths during this reporting period. Nine of these deaths have been reported to the mortality review committee.

As indicated in the eighth report, OBH, OAAS, and other agencies participated on the mortality review team; there was no representation from MCOs, LGEs, and community providers. Also, the OBH Medical Director is not part of the service reviews.

The eighth SME report raised concerns regarding the timeliness of the MRC efforts to review deaths. As indicated in that report, the State indicated this was due to delays in obtaining information on these deaths. As indicated in the seventh SME report, LDH did not have the statutory authority to collect some information needed by MRC. As of June 2022, LDH was granted this statutory authority. The State reports this has allowed enhanced and more expedited collection of information for the MRC. These efforts have provided the MRC with more timely information to complete reviews and render a decision.

Compliance Assessment

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

- The State has developed and implemented reporting and investigation protocols for mortality reviews.
- The mortality reviews are conducted by an interagency team comprised of OAAS and OBH; however, members of the team do not include some individuals in this paragraph nor the OBH medical director.
- LDH has developed and applies various criteria for referrals to the MRC. This has resulted in an average of 60% of all deaths of individuals who have been transitioned or diverted (for up to a year) being referred to the MRC. During this reporting period, LDH has referred over 80% of all deaths to the MRC.
- LDH completed their review of all individuals who were referred to the mortality committee since December 2022. LDH has implemented a process to collect and send information to the MRC on a timelier basis.
- LDH has begun to conduct a review of nine individuals who have died during this reporting period.
- LDH set timeframes for providing information to reduce the time needed to conduct these reviews versus changing the protocol to address lags in information collection.

Recommendations

- LDH should continue their efforts to complete a timely review of individuals who died during this reporting period.
- LDH should add individuals to the Mortality Review Committee as required by this paragraph. This should include regular participation by the OBH Medicaid Director and/or an MCO's Medical Director.
- LDH should post the first Mortality Review Annual Plan and provide a timeframe for completing the second annual report. This should include a review of systemic issues and actions that can be taken by LDH and its partners to address these issues.

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

Compliance Rating: Partially Met

99. The State will collect and analyze consistent, reliable data to improve the availability, accessibility, and quality of services to achieve positive outcomes for individuals in the Target Population. The State will create protocols on collection and analysis of data to drive improvement in services, which shall be developed with the technical assistance and approval of the Expert prior to implementation. Data elements shall measure the following areas: (a) referral to, admission and readmission to, diversion from, and length of stay in, nursing facilities; (b) person-centered planning, transition planning, and transitions from nursing facilities; (c) safety and freedom from harm (e.g., neglect and abuse, exploitation, injuries, critical incidents, and death; timely reporting, investigation, and resolution of incidents); (d) physical and mental health and wellbeing, and incidence of health crises (e.g., frequent use of crisis services, admissions to emergency rooms or hospitals, admissions to nursing facilities, or admissions to residential treatment

facilities); (e) stability (e.g., maintenance of chosen living arrangement, change in providers, work or other day activity stability); (f) choice and self-determination (e.g., service plans are developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services); (g) community inclusion (e.g., community activities, integrated day and employment outcomes, integrated living options, relationships with non-paid individuals); (h) provider capacity (e.g., adherence to provider qualifications and requirements, access to services, sufficiency of provider types); (i) barriers to serving individuals in more integrated settings, including the barriers documented and any involvement of the Transition Support Committee as required by Section V.D.; and (j) access to and utilization of Community-Based Services.

Compliance Rating: Partially Met

Discussion and Analysis

Paragraphs 98 and 99 are addressed together. As discussed in paragraph 94, the State has developed a process for collecting and reporting on measures to address the requirements of these paragraphs. There are a total of 60 measures LDH reports on or will report on in CY 2023. These measures and performance data are reflected in the quality matrix provided in Appendix A, which includes information from all four quarters of CY 2022. Performance measure data was not available for the first two quarters of CY 2023. Measures have been developed and continue to be reported for almost all categories (a)-(h) in paragraph 99 and included in the quality matrix. This includes measures that were previously developed but not reported (e.g., PASRR Level II information). There are several areas that LDH does not have measures for, including:

- 99(d): The number of individuals who have used residential treatment facilities. There is no specific designation for these facilities and previous efforts by the SME (as indicated in paragraph 52) have shown few referrals to group homes (that may be considered a residential treatment facility).
- 99(g): Several community inclusion activities that are specific to this section. LDH does include a self-reported measure collected by CCM regarding whether an individual feels involved in their community to the extent they would like to. LDH does not report information on other parts of (g), such as the participation in integrated day programs or employment/education activities.
- 99(j): LDH does not provide information regarding barriers to service individuals in more integrated settings. As indicated in paragraphs 54-55, the State has implemented and is expanding a process to more systematically identify and address barriers to address (i) of paragraph 99.

In the eighth report, there were measures that were proposed but not yet collected. Of the 60 measures in the Quality Matrix, only two measures have yet to be reported. Both are in the Provider Capacity, Access to, and Utilization of Community Services. This includes the number and percentage of members that have a plan of care that reflects identified needs from the assessment and the number and percentage of individuals who received services in the amount, frequency, and duration specified in the plan of care. As indicated in paragraph 61, LDH is undertaking strategies for addressing these issues with TCs and CCMs which should allow them to report this information in later quarters of CY 2023.

Initially, the reports for community measures focused on individuals who were transitioned from NFs. As indicated in the seventh report, LDH has added various measures that focus on in-reach efforts and active caseload activities. In Quarter 2 of CY 2022, the Department also included individuals who were diverted from NFs for a subset of measures that were focusing on outcomes of individuals who were living in the community. It should also be noted that, as of the second quarter of this calendar year, many measures

are now reported by the CCM rather than TCs who have reduced their efforts to provide intensive case management.

A major issue, as indicated in paragraph 94, is that LDH collects information on almost all measures, but does not have a consistent process for reviewing these measures. In addition, LDH has not developed a baseline and/or a specific expectation or benchmarks for most metrics. While certain metrics such as the number of transition and diversions have these benchmarks, others do not. Therefore, it would be challenging to internal and external quality review efforts to determine if there are specific issues that need to be addressed as a result of their review.

Several of the areas in paragraph 99 were discussed in other sections of the report (e.g., (a) in paragraphs 24-27, and (c) in paragraph 97). Other measures focused on outcomes for individuals who were transitioned or diverted from NFs. These included the following areas: physical and behavioral health wellbeing and incidence of health crisis, stability, and community inclusion. It should be noted that these are areas that were included and scored in the service review discussed in more detail in Appendix C. There are several measures worth noting where the CCM and the service review team collected the same information. A comparison of this information indicates:

- The percentage of individuals who self-reported good physical health for the fourth quarter of CY 2022 was 65%. This is relatively consistent with the SME review, that almost all of the 29 individuals who were transitioned were identified as having good physical health. Several individuals had very good or excellent physical health. However, individuals who were diverted had poorer physical health than individuals who were transitioned, which may account for the 35% of individuals in the LDH quality data who did not report good physical health.
- The percentage of individuals who self-reported good mental health for the fourth quarter of CY 22 was 67%. This was an area where individuals who were transitioned mostly had good scores. However, individuals who were diverted generally had poor behavioral health wellness. This may be directly related to continued issues with acute behavioral health symptoms.
- The percentage of individuals who self-reported stability on various domains was much higher in the LDH quality matrix. Individuals who were transitioned and participated in the service review were generally seen as having good stability across various domains that would impact their lives (e.g., absence of major medical and behavioral health issues, access to medical and behavioral health care, consistent and safe living environment, and some level of structure). However, individuals who were diverted were often found to have poor stability, which reflected their living situations, acute medical and behavioral issues, and other domains.
- The percentage of members reporting that they are involved in the community to the extent that they like to had the greatest discrepancy with the SME service review. LDH reports that 88% of all individuals indicated they are as involved as they like to be. Community integration scores for both individuals who were diverted and transitioned were poor. As indicated in the service review, when interviewed, many of these individuals experienced loneliness, were not aware of community resources that matched their interest or did not have transportation to these community resources.

In previous reports, the SME recommended that the State develop a process to offset any reliability concerns regarding self-reported data in the quality matrix. The State proposed, but has not implemented, a process to have the Transition Coordinators perform interviews with the Target Population member as a second level review to verify that the information being reported by CCMs is accurate. TCs should be able to collect and review information through a more independent review of the quality of services

provided, assessing Target Population members' satisfaction of services, transition, and community tenure more generally. This process was not implemented during this reporting period.

Compliance Assessment

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

- The State continues to collect consistent data to improve the availability, accessibility, and quality of services for areas identified in this paragraph.
- The State has not developed benchmarks or trends for measures in the DOJ Agreement.
- The State did not have a process in place for analyzing these measures during the reporting period but states they have plans to reinstate the quality committees discussed in paragraph 94.
- The State has reported on most measures they added in CY 2022.
- The State will need to develop measures referenced in this paragraph.
- There is a discrepancy in a few measures between what the State reports and what was found in the SME Service Review. The State still has not developed a process to validate the data collected on self-reported measures.
- The State has developed a process for collecting information on barriers for individuals to receive services in the most integrated setting; however, they have not yet reported this information.
- The State reported the new PASRR measures regarding lengths of stay and readmissions.

Recommendations

- State should implement the recommendations in paragraph 94 regarding reinstating internal and external quality assurance committees, including the role of the SRP.
- The State should develop the measures referenced in this paragraph.
- The State should develop benchmarks or trends for the measures in paragraph 99.
- The State should implement the TC secondary review of members in the Target Population's self-reported measures to begin efforts to ensure reliability of the process to collect measures.
- The State should report information on barriers from TCs, PIRS, and, eventually, PASRR Level II evaluators in the quality matrix.

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

Compliance Rating: Partially Met

Discussion and Analysis

In the seventh report, the SME reported on activities undertaken by LDH to address the findings and recommendations from the FY 2021 SME Service Review. There continue to be several areas from the initial SME report the State did not address, specifically revising the ITP to collect information on the frequency and duration of services needed for transition and the need for certain staff (e.g., support coordinators and direct service workers offering personal care services) to receive training regarding mental health conditions to have better insight on providing or coordinating services for individuals with

these conditions. As indicated in paragraphs 59 and 92, the State is undertaking activities to address these areas.

As discussed in paragraph 94, the State has developed an internal quality assurance process to track and analyze information from multiple sources to identify trends and problems at the individual and systemic level. However, this process has not been in place during this reporting period. LDH reports they are beginning efforts to reinstate these quality assurance processes during the next reporting period. As indicated in paragraph 94, if the State does not reinstate this process, they will also be out of compliance with this paragraph.

The SME will be requesting information from LDH regarding steps to reinstate the quality assurance process. The State has asked the SME to participate in both internal and external quality assurance meetings.

Compliance Assessment

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

- During this review period, the State was not using internal processes to analyze data and identify trends, patterns, strengths, and problems at the individual, provider, and systemic levels.
- The State has addressed some, but not all, of the findings from the first SME Service Review Report.
- While the State has developed and implemented certain strategies to address issues in the quality matrix or the SME Service Review, information on the effectiveness of these strategies has yet to be reported.

Recommendations

- Reinstate and build on efforts to review, analyze, and act on data provided by the quality matrix and SME Service Reviews.
- Report on the efforts of the internal and external quality assurance committees.
- Develop a tracking process to determine if the strategies the State has put into place to address issues identified through the quality assurance process using data in paragraphs 98 and 99 had the intended outcomes.

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

Compliance Rating: Partially Met

Discussion and Analysis

As discussed above, the State utilizes a Quality Matrix to collect and report on the data and performance measures required by Paragraph 99 of the Quality Assurance and Continuous Improvement Section of this Agreement.

The State is required to report publicly on all data collected pursuant to this section. Other provisions in the section require LDH to collect data regarding mortalities, critical incidents, and the availability and quality of community-based services. In August 2021, LDH released a needs assessment for individuals in

the Target Population. This needs assessment can be found at: LouisianaNeedsAssessment-Final-Report.pdf (la.gov)

The State currently collects and reports utilization information to the SME on a quarterly basis. LDH has provided the SME with utilization information for the fourth quarter of CY 2022 and first quarter of CY 2023 for individuals who were transitioned or diverted. A summary table is provided in Appendix B The SME reviewed this information and compared this to utilization reported in the third quarter of CY 2022 provided in the eighth SME report. A review of this information indicates:

- There was a decrease in the percentage of individuals who are not receiving Medicaid behavioral health services. LDH reports that 25% of individuals who were transitioned and 40% of individuals diverted did not receive behavioral health services. This information is consistent with the SME service review report for this period.
- There was a slight increase in the percentage of individuals who were transitioned and a significant increase in the percentage of individuals diverted receiving ACT. In the third quarter of CY 2022, 29% of individuals who were transitioned and 7% of individuals diverted received ACT. In the first quarter of CY 2023, 31% of individuals transitioned received ACT and 20% of individuals diverted received ACT.
- There was an increase in the percentage of individuals receiving other MHR services (CPST or PSR) for both transitioned and diverted individuals as compared to the Needs Assessment. In the third quarter of CY 2022, 14% of individuals who were transitioned and 3% of individuals diverted received other MHR services. In the first quarter of CY 2023, 21% of individuals transitioned and 10% of individuals diverted received other MHR services.
- The percentage of individuals receiving outpatient services from a licensed behavioral health practitioner was low and consistent with the information from the third quarter of CY 2022. This is not surprising, given the higher percentage of individuals likely receiving counseling services through ACT or other MHR services.
- There was a slight increase in the percentage of individuals who were transitioned receiving personal care services through the CCW Waiver. In the third quarter of CY 2022, 43% of these individuals received these services. In the first quarter of CY 2023, approximately 46% of individuals who were transitioned received these services.
- There was a marked decrease in the percent of individuals (transitioned and diverted) who received preventative physical health care, especially primary care. In the third quarter of CY 2022, almost 70% of the individuals transitioned from NF received primary care or preventive services. A smaller percentage (4%) of individuals diverted from NFs received this service during that same period. This percentage dropped to 17% for individuals who were transitioned and increased to 20% for individuals who were diverted during the first quarter of CY 2023. This is in contrast to the service reviews, which found almost all individuals had a PCP and to data reported by LDH for February, which indicated almost 90% of all individuals had a PCP.
- There continues to be no utilization of new services (crisis, peer supports, IPS, and 1915b personal care services) by the Target Population.
- The percentage of individuals diverted utilizing inpatient services (general and behavioral health) in the first quarter of this year was consistent with the third quarter of CY 2022. ED utilization decreased for this population from the third quarter of CY 2022 to the first quarter of CY 2021, from 31% to 13% for all cause and from 14% to 8% for behavioral health inpatient admissions.
- The percentage of individuals transitioned utilizing inpatient services (all cause) in the first quarter of 2023 was lower than the third quarter of CY 2022 (9% versus 4%). Percentages of individuals

transitioned who were admitted to a behavioral health inpatient unit remained generally the same (3 %). ED utilization decreased for this population from the third quarter of CY 2022 to the first quarter of CY 2023, from 13% to 7% for all cause admissions. ED behavioral health visits for individuals who transitioned were generally the same between quarters (3%).

Compliance Assessment

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

- LDH tracks service utilization for individuals who are transitioned and diverted more frequently, on a quarterly versus an annual basis.
- There have been increases in utilization of many behavioral health services, including ACT and other MHR services, which may indicate CCMs have been successful at increasing referrals and engaging individuals who were transitioned or diverted in these services.
- There has been a marked increase in the percentage of individuals transitioned who received CCW services this quarter. The percentage of individuals receiving CCW services was very small. This last finding is in contrast to the SME Service Review, which found a significant number of individuals who were diverted (50%) could benefit from services offered through the CCW program.
- LDH publishes data regarding the utilization of health, behavioral health, and long term services and supports on a quarterly basis.
- The utilization of EDs and inpatient hospital services has remained low and relatively consistent from CY 2022 to the beginning of CY 2023.

Recommendations

- LDH should perform additional analysis on why individuals transitioned or diverted from NFs are not getting newly created services.
- LDH should perform additional analysis on why individuals diverted from NFs are not getting personal care services.
- LDH should implement the recommendations in paragraph 95 regarding continued strategies for reducing ED and inpatient utilization.

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

Compliance Rating: Partially Met

Discussion and Analysis

While data has been generally available to other relevant state agencies over the past several years, including the SME Report and Quality Assurance Plan, LDH and the SME have discussed the importance of more tailored information sharing with other state agencies that have a significant role in the My Choice Program. The goals of this tailored approach are to have each agency review relevant data and information, identify and address individual and systemic issues, and develop strategies to enhance implementation. Continued information dissemination regarding the My Choice Program should be continued among LDH and other agencies.

Data sharing efforts continue among agencies, including OCDD, LHC, and LHA. OCDD continues to receive information on individuals transitioned or diverted from NFs who have been identified as having I/DD.

LHA and LHC participate in monthly calls that update My Choice staff regarding current and proposed housing opportunities. OBH reports they have engaged a consultant to work with LRS in efforts to improve referrals and therefore data exchanges are occurring between select LGEs and LRS.

Compliance Assessment

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

- The State collects and disseminates some information regarding the progress of the My Choice Program.
- LDH has certain processes in place to provide OCDD, LRS, and LHC with information on select aspects of the My Choice Program.
- Integration Coordinator, OAAS, and OBH have agreed to develop additional and more targeted efforts regarding better use of information sharing between state agencies regarding the My Choice Program.
- As indicated in paragraph 42, there has been a marked increase in the number of individuals with co-occurring ID/DD and SMI.

Recommendation

- The State should continue to identify the key state agencies that are most likely involved and impacted by the My Choice Program and identify data needed by these agencies to support OAAS and OBH's efforts for the My Choice Program.
- The State should develop and implement data use strategies for these agencies, including clarity regarding goals for information sharing and a regular cadence of meeting with agencies to review data and to make programmatic and policy decisions.
- The State should report the progress of implementing these data use strategies during the next reporting period.
- Given the increased number of individuals with co-occurring ID/DD and SMI, My Choice leadership should meet with OCDD to better understand the causes and implications for this increase.

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

Compliance Rating: Partially Met

Discussion and Analysis

The State is ultimately responsible for ensuring the quality and sufficiency of services provided under this Agreement. Quality can be assessed through various qualitative approaches the State is currently undertaking and expanding (e.g., monitoring outcomes for individuals in the Target Population who are transitioned and diverted; the existing ACT fidelity reviews referenced in paragraph 72). LDH also reports measures on crisis services. In the future, this should be supplemented with reviews of new services such as IPS and peer supports.

The Service Reviews that are conducted by the SME will eventually be conducted by the State. These reviews play a critical role in assessing the quality and sufficiency of services, and understanding the experience of individuals awaiting transition, transitioned, or diverted from NFs. In time, there should be

improvements to the quality of individual assessments and plans of care to assess whether people are receiving needed services and supports in the appropriate amount, frequency, and duration.

As indicated in paragraph 62, LDH staff have partnered with the SME during this reporting period to conduct interviews with individuals, caregivers and friends, CCM, TCs, and other service providers. These efforts have included training and technical assistance from the SME team to LDH regarding the purpose and process of the service reviews. In addition, LDH staff debrief with the SME team member as these reviews occur and are included in debriefing discussions with LDH leadership regarding the outcome of these reviews.

In addition, efforts will need to continue to measure the sufficiency of community-based services provided to individuals transitioned or diverted from NFs. LDH efforts have looked at sufficiency of services through network adequacy reports, which provide information on whether service providers are available (geographically and accepting service referrals) but are not specific to this Target Population.

Compliance Assessment

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

- LDH has and continues to track the sufficiency of services that are managed by the MCOs through network adequacy reports.
- For the past five years, network adequacy of community based behavioral health services has been sufficient.
- CCMs report on services needed but not received by individuals who are receiving CCM. These monthly reports provide information on strategies needed or implemented to address these needs.
- LDH has processes in place to review the fidelity of some evidenced based practices (e.g., ACT). It will need to develop similar processes to review the new services, including IPS and Peer Supports.
- LDH has participated in the SME Service Reviews, including interviews with individuals transitioned or diverted from the community. Such participation will help prepare LDH to adopt and implement the reviews in the future.

Recommendations

- Continue to collect and analyze network adequacy information from MCOs regarding Medicaid services offered to individuals transitioned or diverted from NFs.
- Develop a strategy for reviewing the fidelity and/or practice of new services including IPS, Peer Supports, and all four crisis services.
- Continue to participate in the SME Service Reviews with the eventual goal of having a greater leadership role in these reviews.

Conclusion

This is the third compliance report from the SME regarding the My Choice Program. As indicated earlier, this report focuses on priority sections and not all paragraphs in the report. There continue to be areas where the State has undertaken significant activities to meet the intent of specific paragraphs and are in partial compliance or are in compliance with the Agreement. In other instances, the State has not met the

intent of the requirements set forth in various paragraphs. It should be noted these paragraphs are essential to the Agreement, such as transitions, diversions, and implementation of new services.

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

- Continuing to increase the number of individuals who will be transitioned over the next six months to meet the goal of 350 individuals for CY 2023.
- Implementing the renewed approach for increasing the number of diversions, especially at-risk individuals, and therefore decreasing the number of individuals in the Target Population still in NFs. This will be critical for LDH to successfully comply with this Agreement and not add individuals to the Master List.
- Continuing efforts to provide effective in-reach to individuals on the Master List, especially individuals who were previously interested in transitioning or undecided and have concerns regarding their transition.
- Implementing more assertive efforts to create more opportunities for community inclusion with a particular focus on meaningful work and volunteer opportunities.
- Restarting the quality assurance process to develop dashboard measures, benchmarks, and trends to assess LDH's efforts regarding the My Choice Program. This involves maintaining an internal robust quality assurance process and active engagement with stakeholders, including a subcommittee of the My Choice Advisory Committee.

	Proposed Measure	Methodology	Population	Quarter 1 January-March 2022	Quarter 2 April-June 2022	Quarter 3 July-September 2022	Quarter 4 October-December 2022
Masterlist and In-Reach Efforts							
1.a	Total number of people on Master List (ML)	List of individuals in nursing facilities who have been identified as potential or confirmed members of the target population.	All individuals confirmed or suspected to be a member of the TP.	3452	3278	3152	3302
1.b	Number and percent of new individuals added to the ML	# of new individuals added to the ML/Total # of individuals on ML	All individuals confirmed or suspected to be a member of the TP.	438/3452 13%	437/3278 13%	376/3152 12%	382/3302 12%
1.c	Number and percent of new individuals added to ML based on PASRR Level II	# of individuals added to ML based on PASRR Level II SMI met/Total # of new individuals added to ML	All individuals confirmed or suspected to be a member of the TP.	323/438 74%	297/437 68%	254/376 68%	308/382 81%
1.d	Number and percent of new individuals added to ML based on MDS	# of individuals added to ML based on MDS criteria being met/Total # of new individuals added to ML	All individuals confirmed or suspected to be a member of the TP.	115/438 26%	140/437 32%	122/376 29%	74/382 19%
1.e	Number and percent of individuals on Master List that have been engaged via LDH in-reach process	# of individuals in-reach contact conducted/Total # of individuals on the ML	All individuals identified on the Master List	1856	2331	2607	3158
1.f	Number and percent of individuals identified via in-reach indicating they are interested in transitioning	# of individuals contacted indicating interest in transition/Total # of individuals contacted for in-reach	All individuals identified on the Master List	459/1856 25%	693/2331 30%	694/2607 27%	865/3158 27%
1.g	Number and percent of individuals identified via in-reach work indicating they are undecided regarding transition	# of individuals contacted indicating they are undecided about transition/Total # of individuals contacted for in-reach	All individuals identified on the Master List	189/1856 10%	350/2331 15%	374/2607 14%	453/3158 27%
1.h	Number and percent of individuals identified via in-reach work indicating they are not interested in transitioning at this time	# of individuals contacted indicating they are not interested in transition/Total # of individuals contacted for in-reach	All individuals identified on the Master List	912/1856 49%	1313/2331 56%	1217/2607 47%	1425/3158 45%
Active Caseload							
2.a	Total number of individuals on Active Caseload	Individuals from the Master list that have expressed interest in transitioning that have been assigned a transition coordinator to begin the engagement and transition process.	All individuals assigned to a TC to assess, develop, and coordinate transition	572 (working on engagement/transition activities) 108 (transitioned) Total AC=680	662 (working on engagement/transition activities) 117 (transitioned) Total AC=779	765 (working on engagement/transition activities) 163 (transitioned) Total AC=928	782 (working on engagement/transition activities) 185 (transitioned) Total AC=967
2.b	Total number of individuals added to Active Caseload	# of individuals added to AC	All individuals assigned to a TC to assess, develop, and coordinate transition	223	308	253	196
2.c	Total number of individuals removed from Active Caseload	# of individuals removed from AC	All individuals removed from Active Caseload	270	241	153	119
2.d	Number and percent of individuals removed from Active Caseload Reasons for removal: Successfully closed (transitioned) Declined Transition Discharged prior to TC led transition Court Ordered to Stay in Facility Not Target Population Re-institutionalization	# of people by reason noted/Total number of people removed from AC	All individuals removed from the Active Caseload, delineated by reason for removal.	**Successfully Closed:** 18 - 7% **Declined Transition:** 183 - 68% **D/C prior to TC led transition:** 12- 4% **Court Ordered to stay in facility:** 0 - 0% **Not TP:** 23 - 9% **Re-institutionalized:** 3 - 1%	**Successfully Closed:** 11 - 4% **Declined Transition:** 151 - 62% **D/C prior to TC led transition:** 8- 3% **Court Ordered to stay in facility:** 0 - 0% **Not TP:** 21 - 9% **Re-institutionalized:** 5 - 2%	**Successfully Closed:** 21 - 14% **Declined Transition:** 83 - 54% **D/C prior to TC led transition:** 11- 7% **Court Ordered to stay in facility:** 2 - 1% **Not TP:** 8 - 5% **Re-institutionalized:** 2 - 1%	**Successfully Closed:** 10 - 8% **Declined Transition:** 70 - 59% **D/C prior to TC led transition:** 9 - 8% **Court Ordered to stay in facility:** 1 - 1% **Not TP:** 4 - 3% **Re-institutionalized:** 2 - 2%
2.e	Number of individuals on AC with a completed initial transition assessment	# of individuals with an initial transition assessment that has a start and completion date	All individuals assigned to a TC to assess, develop, and coordinate transition	415	412	468	453
2.f	Average length of time to complete initial transition assessment	Average length of time=calculating the sum of the total number of days to complete the initial transition assessment from the time that the person is added to AC/# of initial transitions completed	All individuals assigned to a TC to assess, develop, and coordinate transition	70 days	61 days	56 days	61 days
2.g	Number of individuals on AC with a completed transition plan	# of individuals with a transition plan that has a start and a completion date Initial plan completion date will be the date that the initial set of	All individuals assigned to a TC to assess, develop, and coordinate transition as well as individuals who stated interest in transition.	255	226	202	157
2.h	Average length of time to complete a transition plan	Average length of time=calculating the sum of the total number of days to complete transition plans from completion of transition assessment/# of transition plans completed 30 days after the completion of the initial assessment	All individuals assigned to a TC to assess, develop, and coordinate transition as well as individuals who stated interest in transition.	109 days	68 days	98 days	91 days
2.i	Average length of time of transitions	Average length of time=calculating the sum of the total number of days from the time the person is placed on the AC to the date of transition	All individuals assigned to a TC to assess, develop and coordinate transition and who transition from the NF.	317 days Looking at information for people transitioned with an add to AC date of 2021/2022 191 days	324 days (all) Looking at information for people transitioned with an add to AC date of 2021/2022 199 days	314 days (all) Looking at information for people transitioned with an add to AC date 2021/2022 138 days	321 days (all) Looking at information for people transitioned with an add to AC date 2021/2022 243 days
2.j	Number and percent of individuals transitioned	# of individuals transitioned/Total # of transitions projected for the annual goal	Individuals identified on Active Caseload that have transitioned with support from TCs.	37/292 13%	97/292 33%	154/292 53%	200/292 68%
2.k	Number and percent of individuals diverted (annual goal)	# of individuals diverted/Total # of diversions projected for annual goal	Individuals defined are referred for NF admission but the PASRR L2 indicates community placement (diversion plan)	29/120 24%	72/120 60%	100/120 80%	127/120 127%
Provider Capacity, Access to, and Utilization of Community Services							
3.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	All individuals accessing BH services	See Network Report	See Network Report	See Network Report	See Network Report

3.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	All individuals accessing BH services	See Network Report	See Network Report	See Network Report	See Network Report
3.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	All individuals accessing BH services	See Network Report	See Network Report	See Network Report	See Network Report
3.d	Number and percent of members reporting they are receiving the all services they need as specified in the plan of care (waiver, non-waiver, behavioral health, etc.)	Self-Report. CCM collects information from the member during the monthly contact. # of members reporting they received all services needed as specified in the plan of care/Total # of TP members interviewed Suggested Question from CCM report template: Are you getting the services listed on your plan of care this month, and are you getting enough of those services?	TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	62/75 82% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	As of June 2022, there are a total of 137 transitioned and diverted members. 72% of members report they received all needed services	As of September 2022, there are a total of 194 transitioned and diverted members. 83% of member report they received all needed services	As of December 2022, there are a total of 222 transitioned and diverted members receiving CCM. 86% of members report they received all needed services
3.e	Number and percent of members that have a plan of care that reflects identified needs from the assessment	SME review of representative sample of members in the TP	Sample of TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.
3.f	Number and percent of transitioned members who received services in the amount, frequency and duration specified in the plan of care	SME review of representative sample of individuals from NFs # of members that received all services as specified in the plan of care/Total # of TP members interviewed	Sample of TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.
Referrals to, admission and readmission to, diversion from, and length of stay in NF							
4.a	Number of persons that request PASRR Level I admission to NF	Total # of persons requesting PASRR Level I admission to NF	Individuals requesting PASRR Level I admission	9179	8810	9100	8987
4.b	Number of Level I PASRRs that indicate presence/history of SMI	Total # of Level I PASRRS that indicate the presence/history of SMI	Individuals requesting PASRR Level I admission	945	924	1052	1052
4.c	Number of referral to Level II SMI authorities from the Level I authority	Total # of referrals to Level II SMI authorities **(excludes deaths and withdrawns)**	Individuals requesting PASRR Level I admission	538 Total Pre Admits 211 Level II Not Required 150 Approvals	710 Total Pre Admits 225 Level II Not Required 267 Approvals	733 Total Pre Admits 367 Level II Not Required 293 Approvals	649 Total Pre Admits 340 Level II Not Required 290 Approvals
4.d	Number of individuals on the master list that have a PASRR Level II	# of individuals on the ML that have a PASRR Level II/Total # of individuals on the ML	Individuals identified on the Master List	3179 92%	2999 91%	2955 94%	3229 98%
4.e	Number and percent of individuals that are admitted into Nursing Facilities that have a completed PASRR Level II upon admission	# admitted with a PASRR Level II/Total # admitted to NF	TP members in NF	New Level I system not available yet	New Level I system not available yet	733 total Pre Admits	649 total Pre Admits
4.f	Number and percent of individuals in the target population that have a PASRR Level II (within the past year) annual review	# of individuals with an annual review (define annual review) within the past year/# of individuals in the TP (define TP –date range)	TP members in NF	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet	965/2270 42.51%	932/2135 43.65%
4.g	Number and percent of individuals in the target population that had a PASRR Level II (within the past year) due to a change in medical status-Define the TP here (is it not just all PASRR cases?)	# of individuals in the target population with a PASRR Level II due to change in medical condition/Total # of individuals in the target population	TP members in NF	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet	572/2270 25.20%	509/2135 23.84%
4.h	Average length of time to complete PASRR Level II due to a change in a medical status (resident review)	# days to complete PASRR Level II reviews which were requested due to a change in medical condition (resident reviews)/Total # of PASRR Level II reviews which were requested due to a change in medical condition (resident reviews)	TP members in NF	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet	Approved RR: 284 Total Number RR: 572	Approved RR: 274 Total number RR: 509
4.i	Number and percent of specialized services recommended by PASRR Level II for new admissions	# of each specialized serviced for Pre-Admits/ total number of Pre-Admits (would need for each SS to get % on each service)	TP members in NF	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet	Report	Report
4.j	Number and percent of specialized services recommended by PASRR Level II for ongoing stays	# of each specialized serviced for Continued Stay Requests / total number of Continued Stay Requests (would need for each SS to get % on each service)	TP members in NF	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet	Report	Report
4.k	Number and percent of individuals that are new admissions that received each specialized service	Involves communication among multiple systems. OPTS data needed to show which Pre-Admits converted into actual NF Admissions; Medicaid claims data would need to be pulled via Procedure Codes for Specialized Services to show that these services were rendered; These two data sets need to be bumped against each other so that recommended specialized services are being received among Actual NF Admissions (over a specified period of time).	TP members in NF	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet	Report	Report
4.l	Number and percent of individuals identified as having an ongoing stay that received each specialized service	Involves communication among multiple systems. OPTS data needed for list of Continued Stay Requests; Medicaid claims data would need to be pulled via Procedure Codes for Specialized Services to show that these services were rendered; These two data sets need to be bumped against each other so that recommended specialized services are being received among Continued Stay Requests (over a specified period of time).	TP members in NF	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet	Report	Report
4.m	Number and percent of PASRR determinations indicating that **admission** to NF is not recommended as it is **not the least restrictive setting**. **This is actual diverted cases.**	# Level II determinations not recommending NF Admission/# initial Level II referral requests for placement excluding cases identified as withdrawn and **not requiring a Level II (deferred to OAAS and OCDD)**	TP members identified as diverted	29/203 14%	43/326 13%	28/366 7.65% number of preadmits with a determination (excludes deceased and withdrawns)	27/354 7.63% number of preadmits with a determination (excludes deceased and withdrawns)

4.n	Average length of stay in nursing facility	Estimated using MDS data	Individuals on the Master List	Pull this data annually-December	Pull this data annually-December	Pull this data annually-December	ML 3.8 years AC 2.8 years
4.o	Number and percent of transitioned members are re-admitted to a NF for greater than 90 days during the first year post transition	Number of transitioned members readmitted for greater than 90 days during the first year of transition/Total number of transitions	TP members identified as transitioned and re-admitted to the facility greater than 90 days during the first year post-transition.	Semi-annual report Report June and December	8/168 5% (To determine denominator - looked at total transition numbers from June 2021-June 2022)	Semi-annual report Report June and December	4/162 5% (To determine denominator - looked at total transition numbers from December 2021-December 2022)
Person Centered Planning, Transition Planning, and Transitions from Nursing Facilities							
5.a	Number and percent of members whose plan of care addresses their needs	SME service review	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now.	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.
5.b	Number and percent of members who participated in the planning meeting	Suggest pulling a sample at specified interval to review. Participation evidenced by presence of the member's signature on the plan of care # number of members signed POC/Total # of TP members included in the sample	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	71/75 95% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	Information from this item planned to be gathered via MCO quality monitoring. Implementation of that monitoring planned for early next year. Working with SME to pull this information as part of the Service Review. Information will not be available until Quarter 4	Information will come from Service Reviews not available now.	100%
5.c	Number and percent of members whose planning meeting included notice of or participation in planning meeting by individuals chosen by the member	Suggest pulling a sample at specified interval to review. Participation evidenced by presence of the member's chosen social network signatures on the plan of care # number of members signed POC/Total # of TP members included in the sample	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	72/75 96% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	Information from this item planned to be gathered via MCO quality monitoring. Implementation of that monitoring planned for early next year. Working with SME to pull this information as part of the Service Review. Information will not be available until Quarter 4	Information will come from Service Reviews not available now.	74%
5.d	Number and percent of members whose plan of care reflect their strengths and preferences	Suggest pulling a sample at specified interval to review the information and comparing information identified in the assessment to the plan to confirm that the plan reflects the member's interests and preferences. # number of members that have a service plan that reflects their interests and preferences/Total # of TP members included in the sample	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	72/75 96% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	Information from this item planned to be gathered via MCO quality monitoring. Implementation of that monitoring planned for early next year. Working with SME to pull this information as part of the Service Review. Information will not be available until Quarter 4	Information will come from Service Reviews not available now.	86%
Safety and Freedom from harm							
6.a	Number of critical incidents, stratified by type of incident	Review and analysis of critical incident reports using provider and member reported CI information	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	During this quarter CCM implemented. For reporting purposes utilized data as previously report (includes only transitioned individuals): Total # of Critical Incidents = 58 Total # of people = 35 Major Medical: 32 Major Medication issue: 1 Falls: 15 Major BH incident: 3 EPS: 2 Death: 4 Loss of Home: 1 Acute Hospitalizations: 17 Emergency Department: 21 Psychiatric Hospitalization: 1 CCM Reporting for March 2022, 4 critical incidents reported. All incidents reported to protective services within 24 hours.	For Q2 2022, there were 8 critical incidents reported. All incidents were reported to protective services within 24 hours of notification.	For Q3, there were 6 critical incidents reported. All incidents were reported within 24 hours to protective services of notification. 3 incidents were for abuse, 2 incidents were for neglect and 1 incident for both- abuse and exploitation.	For Q4, 9 critical incidents reported. 6 incidents reported timely. 3 incidents were not reported to protective services by the CCM within the 24 hours of the incident as the CCM was did not know about the incident or were not aware of the date of the incident. 3 incidents were for neglect, 3 incidents for abuse, and 3 incidents for neglect.
6.b	Number and percent of members that utilized crisis services	CCM reports and review	TP members as defined by the Agreement (transitioned/diverted) that accept CCM		1 CCM member enrolled member received a crisis service	See Service Utilization Report 1 CCM enrolled member received a crisis service	See Service Utilization Report
6.c	Number and percent of critical incidents involving abuse/neglect/exploitation that were referred to the appropriate protective service and or licensing agency	Number of abuse, neglect, exploitation referrals made	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	During this quarter CCM implemented. For reporting purposes utilized data are previously reported (2). CCM reporting for March 2022, 1 incident reported.	8	6	9
6.d	Number of deaths reported	Total number of deaths reported	TP members as defined by the Agreement (transitioned/diverted) that accept CCM and/or are involved with a TC	5	3	5	4
6.e	Number of deaths referred for mortality review	Of the reported deaths, total number of deaths that are referred for mortality review	TP members as defined by the Agreement (transitioned/diverted) that were referred to mortality review.	3	3	4	1
6.f	Number and percent of death investigations that were completed	# of death investigations completed/Total # of deaths referred for mortality review	TP members as defined by the Agreement (transitioned/diverted) with a completed death investigation.	0	1	1	0

6.g	Average length of time to complete a death investigation	Average length of time=calculating the sum of the total number of days from the notification date to the date death investigation completed	TP members as defined by the Agreement (transitioned/diverted) referred to MRC with a completed review.	0	231 days	222 days	None completed during this timeframe
6.h	Number and percent of deaths that require a remediation plan	# of death investigations that result in the need for a remediation plan/Total # of death investigations completed	TP members as defined by the Agreement (transitioned/diverted) referred to MRC with a completed review.	0	1	1	0
6.i	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	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now	78%
6.j	Number and percent of members reporting that they have been free from abuse, neglect, or exploitation	Self-Report. CCM collects information from the member during the monthly contact. # of members reporting they were free from abuse, neglect or exploitation/Total # of TP members interviewed Suggested Question from CCM template: Has anyone been verbally abusive to you, hurt you physically, not taken care or your needs, or taken advantage of you in any way?	TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	74/75 98% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	As of June 2022, there are a total of 137 transitioned and diverted members. 95% of members report free from abuse, neglect, exploitation, or extortion	As of September 2022, there are a total of 194 transitioned and diverted members receiving CCM. 97% of members report they are free from abuse, neglect, exploitation, or extortion.	As of December 2022, there are a total of 222 transitioned and diverted members receiving CCM. 96% of members report they are free from abuse, neglect, exploitation, or extortion.
Physical and behavioral health wellbeing and incidence of health crisis							
7.a	Number and percent of members reporting good physical and BH health Number and percent of members Inpatient/ED Services – BH Utilized Number and percent of Inpatient/ED Services – PH Utilized	Self-Report. CCM collects information from the member during the monthly contact. Suggested Question from CCM template: How are you feeling physically, have you experienced any changes in your physical, or behavioral health, have you had any issues doing things for yourself? Have you gone to the ED/IP for PH? ? Have you gone to the ED/IP for BH?	TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	68/75 90% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals) For March, there are 0 hospitalizations report for those enrolled in CCM for the full month	As of June 2022, there are a total of 137 transitioned and diverted members. 67% of members report good physical health 71% of members report good mental health Approximately 18% of members had an ED visit, with approximately 12% with an inpatient stay.	As of September 2022, there are a total of 194 transitioned and diverted members receiving CCM. 62% of members report good physical health 65% of members report good mental health Approximately 21% of members had an ED visit, with approximately 17% with an inpatient stay.	As of December 2022, there are a total of 222 transitioned and diverted members receiving CCM. 65% of members report good physical health 67% of members report good mental health
7.b	Number and percent of members that report that they need assistance taking medications as prescribed	Self-Report item. CCM collects information from the member during the monthly contact # of members reporting that they need assistance taking medication/Total # of TP members interviewed Question: Do you need help taking your medication as prescribed? Drop down options to be included with this data point: • Yes, need help filling • Yes, need help taking	TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	12/75 15% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals). Question in TC log specific to whether there was a change in medication/treatment, side effects, etc.	As of June 2022, there are a total of 137 transitioned and diverted members. 14% of members report they need assistance taking medication	As of September 2022, there are a total of 194 transitioned and diverted members receiving CCM. 20% of members reported they need assistance taking medication	As of December 2022, there are a total of 222 transitioned and diverted members receiving CCM. 13% of members reported they need assistance taking medication.
Stability							
8.a	Number and percent of members reporting stability in housing	CCM will collect this information during the monthly contact. # of individuals reporting no change in living situation/Total # of TP members interviewed	TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	73/75 97% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	As of June 2022, there are a total of 137 transitioned and diverted members. 69% of members report stability in living situation. It should be noted that the great majority of moves were for members moving from NFs to home and community-based settings.	As of September 2022, there are a total of 194 transitioned and diverted members receiving CCM. 85% of members report stability in living situation.	As of December 2022, there are a total of 222 transitioned and diverted members receiving CCM. 87% of members report stability in living situation.
8.b	Number and percent of members reporting no issues with current living situation	Self-Report. CCM will collect this information during the monthly contact. # of members reporting no issues with current living situation/Total # of TP members interviewed	TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	Information not available yet.	As of June 2022, there are a total of 137 transitioned and diverted members. 85% of members report a good living situation	As of September 2022, there are a total of 194 transitioned and diverted members receiving CCM. 90% of members report a good living situation	As of December 2022, there are a total of 222 transitioned and diverted members receiving CCM. 87% of members report a good living situation
8.c	Number and percent of members reporting stability in natural supports network	Self-Report. CCM will collect this information during the monthly contact. # of members reporting no change in natural support network/Total # of TP members interviewed Suggested question: Have you had any changes in the people like your family or friends who help take care of you/support you?	TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	72/75 96% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	As of June 2022, there are a total of 137 transitioned and diverted members. 96% of members report stability in caregivers	As of September 2022, there are a total of 194 transitioned and diverted members receiving CCM. 96% of members report stability in caregivers	As of December 2022, there are a total of 222 transitioned and diverted members receiving CCM. 97% of members report stability in caregivers.
8.d	Number and percent of members reporting stability in service providers.	Self-Report. CCM will collect this information during the monthly contact. # of members reporting no change in service providers/Total # of TP members interviewed	TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	No information yet	As of June 2022, there are a total of 137 transitioned and diverted members receiving CCM. 94% of members report stability in service providers.	As of September 2022, there are a total of 194 transitioned and diverted members receiving CCM. 97% of members report stability in service providers.	As of December 2022, there are a total of 222 transitioned and diverted members receiving CCM. 94% of members report stability in service providers.
Community Inclusion							

10.a	Number and percent of members reporting that they are involved in the community to the extent they would like	Self-Report. CCM will collect this information during the monthly contact. # of members reporting they participated in activities outside of their home/Total # of TP members interviewed Suggested Question from CCM template: Are you able to do the activities you want outside of your home, such as work, school, hobbies, or visiting with friends and family, etc.	TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	64/75 85% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	As of June 2022, there are a total of 137 transitioned and diverted members. 84% of members report they are involved in the community to the extent they would like	As of September 2022, there are a total of 194 transitioned and diverted members receiving CCM. 84% of members report they are involved in the community to the extent they would like	As of December 2022, there are a total of 222 transitioned and diverted members receiving CCM. 88% of members report they are involved in the community to the extent they would like

Q1 2023

Table 1. DOJ Transitioned Members

# of Target Population members Transitioned with Medicaid
355

Table 2. DOJ Transitioned Members - Home and Community-Based Service Utilization

	Home and Community-Based Service Utilization																						
Member Region of Residence	# of TP Members Transitioned with rendered services	# of TP Members Transitioned Receiving Peer Support Services	% of TP Members Transitioned Receiving Peer Support Services	# of TP Members Transitioned Receiving ACT	% of TP Members Transitioned Receiving ACT	# of TP Members Transitioned Receiving Psychiatrist Services in Outpatient Settings	% of TP Members Transitioned Receiving Psychiatrist Services in Outpatient Settings	# of TP Members Transitioned Receiving LMHP Services in Outpatient Settings	% of TP Members Transitioned Reciving LMHP Services in Outpatient Settings	# of TP Members Transitioned Receiving Personal Care Services	% of TP Members Transitioned Receiving Personal Care Services	# of TP Members Transitioned Receiving Individual and Placement Support Services	% of TP Members Transitioned Receiving Indiviual and Placement Support Services	# of TP Members Transitioned Receiving CPST/PSR	% of TP Members Transitioned Receiving CPST/PSR	# of TP Members Transitioned Receiving SUD Treatment Services	% of TP Members Transitioned Receiving SUD Treatment Services	# of TP Members Transitioned Not Receiving BH Services	% of TP Members Transitioned Not Receiving BH Services	# of TP Members Transitioned Receiving Preventive or Ambulatory Care	% of TP Members Transitioned Receiving Preventive or Ambulatory Care	# of TP Members Transitioned Receiving Waiver Personal Care Services	% of TP Members Transitioned Receiving Waiver Personal Care Services
Region 1	32			11	34.4%	1	3.1%							11	34.4%	1	3.1%	11	34.4%	10	31.3%	24	75.00%
Region 2	38			20	52.6%			7	18.4%	2	5.3%			13	34.2%	1	2.6%	8	21.1%	13	34.2%	18	47.37%
Region 3	13			6	46.2%	1	7.7%	1	7.7%	1	7.7%			3	23.1%			3	23.1%	4	30.8%	10	76.92%
Region 4	29			16	55.2%			2	6.9%					5	17.2%	1	3.4%	7	24.1%	3	10.3%	27	93.10%
Region 5	15			11	73.3%			1	6.7%					1	6.7%			3	20.0%	3	20.0%	14	93.33%
Region 6	27			22	81.5%			1	3.7%	2	7.4%			1	3.7%			4	14.8%	8	29.6%	19	70.37%
Region 7	33			17	51.5%	2	6.1%			1	3.0%			9	27.3%			8	24.2%	10	30.3%	22	66.67%
Region 8	16			4	25.0%	1	6.3%	2	12.5%	1	6.3%							9	56.3%	5	31.3%	13	81.25%
Region 9	17			12	70.6%			1	5.9%	1	5.9%			2	11.8%			2	11.8%	4	23.5%	18	105.88%
Out of State or N/A	1																					1	100.00%
Statewide	212	0	0.0%	113	53.3%	5	2.4%	15	7.1%	8	3.8%	0	0.0%	45	21.2%	3	1.4%	53	25.0%	58	27.4%	166	78.30%
% of Total Transitioned members	60%		0%		32%		1%		4%		2%		0%		13%		1%		15%		16%		47%

* one case no region noted. Included here.

Table 3. DOJ Transitioned Members - Crisis and Hospital Utilization

	Crisis and Hospital Utilization																		
Member Region of Residence	# of TP Members Transitioned with rendered services	# of TP Members Transitioned Utilizing Mobile Crisis	# of TP Members Transitioned Utilizing Behavioral Health Crisis Care (Urgent Center)	# of TP Members Transitioned Utilizing Community Brief Crisis Support	# of TP Members Transitioned Utilizing Crisis Stabilization Services	# of TP Members Transitioned Utilizing Crisis Intervention Services	Unduplicated # of TP Members Transitioned Utilizing Crisis Services	% of TP Members Transitioned Utilizing Crisis Services	# of TP Members Transitioned with ED Visit	% of TP Members Transitioned with ED Visit	# of TP Members Transitioned with BH-ED Visit	% of TP Members Transitioned with BH-ED Visit	Total Number of ED Visits for TP Members Transitioned	Total Number of BH-ED Visits for TP Members Transitioned	# of TP Members Transitioned with IP Visit	% of TP Members Transitioned s with IP Visit	# of TP Members Transitioned with BH-IP Visit	% of TP Members Transitioned with BH-IP Visit	Total Number of IP Visits for TP Members Transitioned	Total Number of BH-IP Visits for TP Members Transitioned
Region 1	32								4	12.5%			6		3	9.4%	1	3.1%	3	1
Region 2	38		1				1	2.6%	6	15.8%	3	7.9%	11	4	4	10.5%	3	7.9%	6	5
Region 3	13								3	23.1%	1	7.7%	3	1	2	15.4%	1	7.7%	2	1
Region 4	29								1	3.4%			1		3	10.3%	3	10.3%	5	5
Region 5	15								4	26.7%			9		3	20.0%	1	6.7%	4	1
Region 6	27								1	3.7%	1	3.7%	16	1						
Region 7	33								4	12.1%	1	3.0%	8	1	3	9.1%	2	6.1%	3	2
Region 8	16								1	6.3%	1	6.3%	3	1	1	6.3%	1	6.3%	1	1
Region 9	17								1	5.9%			2		1	5.9%	1	5.9%	2	2
Out of State or N/A																				
Statewide	212	0	1	0			1	0.5%	25	11.8%	7	3.3%	59	8	19	9.0%	12	5.7%	26	18
% of Total Transitioned members			0%					0%		7%		2%				5%		3%		

Table 1. DOJ Diverted Members

# of Target Population members Diverted with Medicaid
24

Table 2. DOJ Diverted Members Home and Community-Based Service Utilization

	Home and Community-Based Service Utilization																						
Member Region of Residence	# of TP Members Diverted with rendered services	# of TP Members Diverted Receiving Peer Support Services	% of TP Members Diverted Receiving Peer Support Services	# of TP Members Diverted Receiving ACT	% of TP Members Diverted Receiving ACT	# of TP Members Diverted Receiving Psychiatrist Services in Outpatient Settings	% of TP Members Diverted Receiving Psychiatrist Services in Outpatient Settings	# of TP Members Diverted Receiving LMHP Services in Outpatient Settings	% of TP Members Diverted Reciving LMHP Services in Outpatient Settings	# of TP Members Diverted Receiving Personal Care Services	% of TP Members Diverted Receiving Personal Care Services	# of TP Members Diverted Receiving Individual and Placement Support Services	% of TP Members Diverted Receiving Indiviual and Placement Support Services	# of TP Members Diverted Receiving CPST/PSR	% of TP Members Diverted Receiving CPST/PSR	# of TP Members Diverted Receiving SUD Treatment Services	% of TP Members Diverted Receiving SUD Treatment Services	# of TP Members Diverted Not Receiving BH Services	% of TP Members Diverted Not Receiving BH Services	# of TP Members Diverted Receiving Preventive or Ambulatory Care	% of TP Members Diverted Receiving Preventive or Ambulatory Care	# of TP Members Diverted Receiving Waiver Personal Care Services	% of TP Members Diverted Receiving Waiver Personal Care Services
Region 1	2			1	50.0%													1	50.0%	1	50.0%		0.00%
Region 2	2																	2	100.0%	1	50.0%		0.00%
Region 3	1			1	100.0%					1	100.0%											1	100.00%
Region 4	2			2	100.0%															1	50.0%		0.00%
Region 5																							#DIV/0!
Region 6																							#DIV/0!
Region 7	1			1	100.0%																		0.00%
Region 8	1													1	100.0%								0.00%
Region 9	1																	1	100.0%				0.00%
Out of State or N/A																							#DIV/0!
Statewide	10	0	0.0%	5	50.0%	0	0.0%	0	0.0%	1	10.0%	0	0.0%	1	10.0%	0	0.0%	4	40.0%	3	30.0%	1	10.00%
% of Total Diverted members	42%		0%		21%		0%		0%		4%		0%		4%		0%		17%		13%		4%

Table 3. DOJ Diverted Members - Crisis and Hospital Utilization

Crisis and Hospital Utilization																				
Member Region of Residence	# of TP Members Diverted with rendered services	# of TP Members Diverted Utilizing Mobile Crisis	# of TP Members Diverted Utilizing Behavioral Health Crisis Care (Urgent Center)	# of TP Members Diverted Utilizing Community Brief Crisis Support	# of TP Members Diverted Utilizing Crisis Stabilization Services	# of TP Members Diverted Utilizing Crisis Intervention Services	Unduplicated # of TP Members Diverted Utilizing Crisis Services	% of TP Members Diverted Utilizing Crisis Services	# of TP Members Diverted with ED Visit	% of TP Members Diverted with ED Visit	# of TP Members Diverted with BH-ED Visit	% of TP Members Diverted with BH-ED Visit	Total Number of ED Visits for TP Members Diverted	Total Number of BH-ED Visits for TP Members Diverted	# of TP Members Diverted with IP Visit	% of TP Members Diverteds with IP Visit	# of TP Members Diverted with BH-IP Visit	% of TP Members Diverted with BH-IP Visit	Total Number of IP Visits for TP Members Diverted	Total Number of BH-IP Visits for TP Members Diverted
Region 1	2								1	50.0%	1	50.0%	3	2	1	50.0%			1	
Region 2	2								1	50.0%			1		2	100.0%	2	100.0%	2	2
Region 3	1								1	100.0%	1	100.0%	1	1	1	100.0%	1	100.0%	1	1
Region 4	2														1	50.0%	1	50.0%	1	1
Region 5																				
Region 6																				
Region 7	1																			
Region 8	1																			
Region 9	1																			
Out of State or N/A																				
Statewide	10	0	-	0			-	0.0%	3	30.0%	2	20.0%	5	3	5	50.0%	4	40.0%	5	4
% of Total Diverted members								-		13%		8%				21%		17%		

2023

Appendix C

LA-DOJ Subject Matter Expert (SME)

Service Review Report

6/30/2023

JOHN O'BRIEN, SUBJECT MATTER EXPERT

Contents

Introduction

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

The Agreement sets forth the requirement for a Subject Matter Expert (SME). Among other duties, the SME is responsible for assessing the quality of community-based services for members of the Target Population. As a part of this quality assessment, the SME reviews a representative sample of individuals in the Target Population. A quality review is conducted to look at various domains that are central to the Agreement and focuses on an individual's overall quality of life versus the quality of community based services provided to the member.

The Target Population has been identified as either "(a) Medicaid-eligible individuals over age 18 with severe mental illness (SMI) currently residing in nursing facilities" or "(b) individuals over age 18 with serious mental illness (SMI) who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement." The first service review, conducted in 2021, focused on individuals who transitioned from nursing facilities (NFs). For this second review, the SME expanded the focus to include two additional groups of individuals:

- Individuals who were diverted. These are individuals who have an SMI and seek admission to, are referred to, and/or receive screenings and/or evaluations for nursing facility placement and for whom a Pre-Admission Screening and Resident Review Level (PASRR) II review recommends placement in the community.
- Individuals who are in an NF waiting for transition and assigned a Transition Coordinator (TC) to assist with the transition. These individuals also had a completed Nursing Facility Transition Assessment (NFTA) and Individualized Transition Plan (ITP).

A representative sample is identified by region each year for inclusion in the review. Individuals are identified from different regions throughout the state of Louisiana. Individuals are reviewed in four regions each year. The SME selected individuals from regions 1, 9, 2, and 7 who were transitioned, diverted, or awaiting transition. These areas of the state had the most individuals in these three categories.

A total of 60 individuals were identified to participate in the service review. Four individuals declined to participate in the review. Table 1 provides an overview of individuals who participated in the service review and the total number of individuals that were included in the sample.

Table 1. Number of Individuals Participating in FY 2023 Review

Population	Number of Individuals Reviewed	Number of Individuals in the Sample
Individuals Transitioned from NFs	29	123
Individuals Diverted from NFs	8	38
Individuals Awaiting Transition	19	176
Total	**56**	**337**

The sample size produced a minimum of 90% confidence interval across all three populations, meaning that 90% of the individuals included in the review were representative of the total number of individuals in the sample.

The Agreement did not provide specific parameters for assessing the quality of community-based services conducted through the service reviews. Therefore, the SME identified four domains for measuring the quality of the services. These domains are consistent with the areas that LDH used for evaluating the overall quality of the My Choice Program and were based on paragraph 99 of the DOJ Agreement. In addition, the SME added two domains that focused on the assessment and planning process and the overall outcome of the transition or diversion. The six domains are described in Table 2.

Table 2. Domains for Individuals Transitioned or Diverted from NFs

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

Person Centered Assessments and Plans	Individuals in the Target Population and transitioned or diverted from NFs are offered Community Case Management (CCM). Individuals participating in CCM are requested to participate in an assessment and initial community plan of care (CPOC) 30 days post discharge or diversion. The assessment and the POC process are to be guided by principles of person centeredness.
Outcome of Transition or Diversion	Individuals who transition or are diverted will need the appropriate ongoing services and supports (formal and natural) to ensure individuals are successful in their efforts to live in their community.

There were several major positive changes that occurred between the first and second review. First, the easing of the pandemic allowed individuals to have face-to-face and more frequent visits with natural supports including families and friends. In addition, individuals also had face-to-face contacts with their formal supports. Second, LDH implemented the Community Case Management (CCM) program. The CCM program was designed to provide individuals transitioned or diverted with a designated case manager who would work with the individuals to assess their total needs and develop a plan of care. This program is also intended to provide more contact than the intensive case management provided by the TCs prior to the implementation of CCM. Third, LDH has implemented additional services to address the needs of the Target Population in the community. This includes various crisis services that can support individuals who have transitioned or diverted and experience a behavioral health crisis. There are other services LDH has designed, such as supported employment and peer support, which will be an important option for these individuals once implemented. Lastly, LDH has developed various standard operating procedures and policies in addition to management tools for TCs and CCMs. This allows LDH to monitor and evaluate whether individuals in the Target Population are having their needs identified and plans are being developed and implemented in a timely manner.

The following document provides an overview of the methodology and summary from the service review. Given the unique circumstances, the SME developed separate sections for each of the populations participating in the service review. Each section provides an overview of the population, the size of the population reviewed, and demographic information regarding the population. Each section also has detailed findings from the service review followed by systemic issues and recommendations for LDH to consider to improve the quality of services and experience of care for each population.

Methodology

This section provides an overview of the methodology for completing the service reviews. Per the Agreement, the SME is required to select a representative sample for the service review. Once selected, the service review team reviews records including assessments, plans, and contact logs from Transition Coordinators (TCs) and Community Case Managers (CCMs). The team also reviewed service plans from providers (e.g., Assertive Community Treatment, Community Choices Waiver (CCW) Support Coordinators, and other providers). The team also conducted interviews with each individual, their caregivers (when requested by the member), TC, CCM, Community CCW Support Coordinator, behavioral health provider, and other persons recommended by the individual or support network. Based on a review of all of these sources, a summary was produced for each individual providing an overview of the individual's overall strengths, scores in each of the domains described in Table 2, positive aspects and areas of improvement for each domain, and systemic findings.

Reviewers

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

In addition, LDH participated in the second round of service reviews. This is consistent with Paragraph 103 of the Agreement that requires "the State 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." While LDH staff participated in reviewing the records and interviews, they were not providing input regarding overall compliance of TC and CCM activity nor providing information for the summary reviews (discussed later).

Sample Selection

The samples for the reviews were drawn from the three populations described above. The SME requested the assistance of the Human Service Research Institute (HSRI) to create a method for selecting the representative sample. De-identified information on all individuals in each of the three populations was provided to HSRI for identifying the representative sample. The initial sample for the review provided a 95% confidence interval, which is commonly used to choose a representative sample. These reviews focused on individuals in each of the three groups between 1/1/21 and 12/31/21.

The SME service reviews were conducted by region. The regions selected for the second service review were areas of the state with the most significant number of individuals in the Target Population. These regions included:

- Region 2—Baton Rouge
- Region 7—Shreveport
- Region 1—New Orleans
- Region 9—Hammond

Regions 1 and 9 were conducted together given their proximity.

Each individual selected for the reviews was contacted by the TC or CCM to seek their permission and interest in participating in the service review. For individuals in NFs, LDH outreached to the NF administrators regarding the purpose of the review. As indicated above, 56 of 60 individuals agreed to participate in the service review.

Record Review

Once individuals participating in the review were identified, the service review team began to collect records for each individual. The records reviewed were generally the same for all three populations with some nuances. For individuals who were awaiting transition or who had transitioned from an NF, the service review team requested and was provided Minimum Data Set (MDS), Pre-Admission Screening and Resident Review Level II (PASRR Level II) evaluations, History and Physical (if included in PASRR Level II), the NF Transition Assessment (NFTA), Individualized Transition Plan (ITPs), and TC contact logs. Since the last service review, LDH has developed a data platform (OPTS) for NF records for all individuals in NFs, including the My Choice Program. All information requested by the service review team was in OPTS. LDH granted access to data available in OPTS to the service review team.

For individuals who were transitioned and diverted, the service review team worked with the Integration Coordinator and Office of Behavioral Health (OBH) staff to gather critical information post-transition or diversion from the CCMs. These included the community assessment (initial and revised), community plan of care (CPOC) (initial and revised), CCM contact logs, and critical incidents. In addition, the service review team requested and was provided with plans for other services such as the CCW program, various Office of Citizens with Developmental Disabilities (OCDD) Waivers, and service plans from Assertive Community Treatment (ACT) Teams. As indicated below, a significant proportion of individuals were receiving services and supports from these programs.

Compliance Reviews

For this second service review, the team assessed whether TCs and CCMs were performing their functions consistent with LDH policies and/or contractual requirements. Matrices were developed to assist the reviewer in organizing and gathering information for these compliance reviews. In addition, the team reviewed documentation to inform the team's impression of quality of the contents of assessments and plans. This included a determination of whether these plans indicated a person-centered approach to assessment and plan development. The review

also cross walked whether ITPs and CPOCs included needs identified in the NFTA or community assessment. The compliance review also provided LDH with information on the frequency of TC and CCM contact with the individual to measure the level of engagement before, during, and post transition or diversion.

The compliance review focused on the following areas with some differences across populations, noted in parentheses below:

- Timeliness of TC or CCM activities (all individuals)
- Presence of NFTAs and ITPs (individuals awaiting transition)
- Quality of NFTAs and ITPs (individuals awaiting transition)
- Presence of community assessment and community plans of care (CPOCs) and crisis plans (individuals transitioned or diverted)
- Quality of community assessment and POCs and crisis plans (individuals transitioned or diverted)
- TC and CCM logs (all individuals)
- Readmissions (all individuals).

The compliance matrix informed the summaries developed for each individual. Appendix A provides all tools related to reviews of individuals awaiting transition. Appendix B provides all the tools related to the review for individuals who have transitioned from NFs. Appendix C provides the tool related to review for individual who were diverted from an NF.

Interviews

Interviews provided the most valuable source of information regarding the experience of the member, caregiver, and other participants in the transition (including individuals awaiting transition) or diversion process. In addition, the team interviewed individuals regarding needed services and services received. Interviews were requested and conducted with:

- Individual
- Caregiver or significant other (if requested by the individual)
- Transition Coordinators
- Community Case Manager
- Support Coordinator (for individuals participating or referred to the CCW)
- Direct service worker (personal care provider)
- Behavioral health provider (e.g., ACT or Mental Health Rehabilitation provider).

An interview guide was developed for different interviewees. For instance, there was a specific guide for individuals and caregivers, transition coordinators, CCMs, and other service providers. These interview guides are included in the Appendices. These guides sought to solicit information on the key areas of focus: physical health well-being, behavioral health well-being, stability, community integration, and the outcome of the transition. Each individual was contacted and provided potential times (including weekends and evenings) for the interviews. Interviews

commonly lasted about 60 minutes. The review team asked each individual if they would like to have someone present during the review. Some individuals requested their caregiver or direct service worker be present during the interview. All but two interviews with individuals participating in the review were conducted face-to-face.

For individuals who were transitioned or diverted, the interview guides gathered similar information regarding:

- Current living arrangement and satisfaction with these arrangements
- Services they are currently receiving and their perspective regarding the helpfulness of these services
- Their involvement in the development of the CPOC and crisis plan and whether and how they used these plans
- How they spend their time compared to how they would like to spend their time during the day and evening
- Overall satisfaction with their existing situations
- Impression of their transition or diversion experience.

For individuals who were awaiting transition, interviews with the individual focused on the following areas:

- Ongoing contact with the TC
- Involvement in the ITP process and discharge planning meetings (when appropriate)
- How they visualize their community living situation
- Whether they had active input into where they wanted to live
- How they spent their time before they were in the NF and how they would like to spend their time post transition
- Discussion of their perceived service needs
- Impressions from the individual on how well the transition process is working for them.

Review of Claims for Individuals Who Were Transitioned or Diverted

The design of the service review included the collection and analysis of Medicaid claims data for a sample of individuals. The major goal of the review was to examine whether services were delivered consistent with the CPOC. Unfortunately, with the exception of one, the CPOCs provided insufficient detail to compare with claims.

Summary and Scoring

Information collected from the interviews, record reviews, and claims data was reviewed by a team member who developed a summary for each individual participating in the service review. A summary was completed for each individual that provided the following:

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

- Critical incidents
- Summary of records reviewed.

Strengths and areas of improvement were recorded by the service review team for each individual and each domain. The team used a 5-point Likert scale for each of these domains and areas. The evaluation criteria is provided in Table 3. The scoring tool with instructions is provided in the Appendices.

Table 3. Evaluation Criteria Used for Scoring

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

For previous reviews, a two-person team developed the summaries to assess and ensure interrater reliability. Once each reviewer provided a score, these scores were compared to identify and discuss differences. A consensus process addressed major scoring differentials to obtain a final score. For this review, this process was used for a new service reviewer. Specifically, staff conducting previous service reviews were paired with new service reviewers to ensure interrater reliability. Staff that performed previous service reviews were not required to be part of a two-person team.

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

The next section of the report provides information regarding the summary of demographics of individuals participating in the reviews and findings from the reviews. As indicated above, separate summaries and findings have been developed for each of the three populations reviewed.

Individuals Who Transitioned from Nursing Facilities

This section provides the results of the services review for individuals who transitioned from nursing facilities. Twenty-nine individuals who transitioned from NF were included in this review. These individuals were selected from 200 individuals LDH transitioned in CY 2022.

The service reviews for individuals who transitioned were focused on various domains listed in Table 2 and the team reviewed whether CCMs were complying with specific areas LDH established in standard operating procedures (SOPs) for the program.

The population who transitioned was the focus of the first service review in 2021 and allowed comparisons to be made with the second service review.

The following subsections provide an overview of the demographics of individuals who transitioned from NFs, the findings from the service review, systemic issues, and recommendations to LDH for improvements in the process to enhance the experience for these individuals.

Demographics of Individuals Who Transitioned

The average age of individuals who transitioned (as of the interview) was 58 years old. Thirteen individuals (45%) were between 51 and 65 years old. Eight individuals (28%) were between 65 and 75 years old. Seven individuals were under the age of 50 (24%) and one individual was over 75 (79 years old). Table 4 provides information regarding the age of this review cohort.

Table 4. Age of Individuals Who Transitioned from NFs

Ages	Transitioned	%
Average Age	58	N/A
50 and under	7	24%
51-65	13	45%
66-75	8	28%
Over 75	1	3%
Total	29	100%

The majority of individuals who transitioned and participated in the review identified as female (58.6%). Slightly over 41% identified as males. Table 5 provides information on gender.

Table 5. Gender of Individuals Who Transitioned from NFs

Gender	Transitioned	%
Male	12	41.4%
Female	17	58.6%
Total	29	100%

There was some variation regarding the race of individuals in the review. A majority of individuals were African American (58.6%) versus individuals who were Caucasian (41.4%) There were no individuals who identified as Hispanic or another race in the service review for individuals who had transitioned. Table 6 provides information on the race of individuals who were transitioned from NFs.

Table 6. Race/Ethnicity of Individuals Who Transitioned from NFs

Race	Transitioned	%
African American	17	58.6%
Caucasian	12	41.4%
Hispanic	0	0%
Total	29	100%

Nursing Facility Length of Stay Prior to Transition

Individuals participating in the review and who were transitioned in the service reviews had variable lengths of stay. The mean (average) length of stay for individuals who transitioned was approximately 2 years (25.2 months). The median length of stay was 20 months. The range of length of stays was variable. The shortest length of stay was 3 months; the longest length of stay was approximately 8 years (97 months). Information on length of stay is provided in Table 7.

Table 7. Nursing Facility Lengths of Stay for Individuals Transitioned

Mean Length of Stay	Median Length of Stay	Shortest Length of Stay	Longest Length of Stay
25 months	20 months	3 months	97 months

Findings from the Service Review

This subsection provides detailed information regarding individuals who transitioned from NFs and participated in the service reviews. This subsection also provides information from the compliance reviews, interviews, and domain-specific and overall scores for individuals. In addition, scores for individuals participating in the second review were compared to individuals who participated in the first service review[1]. Table 8 provides information from the first and second service review by domain.

[1] SME-Report-January-June-2021.pdf (la.gov)

Table 8 Scores for Individuals Who Were Transitioned

Review	Physical Well-Being	Behavioral Well-Being	Stability	Assessment and Person-Centered Planning	Community Integration	Transition Outcome	Overall Score
First Review	2.63	3.13	3.00	2.38	2.38	3.13	2.77
Second Review	3.03	2.93	3.03	2.69	2.66	3.17	2.92

The overall score for the second review was higher than that for the first review (2.92 versus 2.77 out of 5). There were some differences in domain scores between the two reviews. For instance, individuals' physical well-being is higher in the most recent review. Possible factors that may have improved this domain's score include better access to face-to-face visits with primary and specialty care providers as the pandemic eased. During the pandemic telehealth was used for most medical and behavioral health visits. Some individuals in the first review did not have smart phones or tablets that would enable telehealth. Tracking of medical appointments by the CCM may have increased scores in this domain. Notes often reflected CCMs tracked dates for medical appointments and transportation options to these appointments.

There was also a notable increase in the score for assessment and person-centered planning occurring post discharge. This may reflect the change from TCs providing intensive case management ICM. TCs were not yet trained in person-centered planning prior to the first review. All CCMs were required to participate in this training prior to offering care coordination. Unlike the first service review, assessments and plans were developed for all individuals who were transitioned and participated in the second review. A significant majority of these plans (83%) reflected their strengths and preferences. There was an increase in scores for the community integration domain. This may be reflective of several factors. Individuals in this review identified more natural support from their family and friends. Individuals were also able to attend church or perform daily functions (e.g., grocery shopping) which they were not able to do during the pandemic.

There was little difference in stability and outcomes for individuals who transitioned from NF. Both of these scores were identified as good with some improvements (discussed below). There was a decrease in behavioral health and well-being. There are a number of possible reasons for this change. Individuals in the second cohort have more complicated mental health needs. A number of these individuals were symptomatic and continued to experience delusions and hallucinations. Several individuals in the second review cohort historically used inpatient behavioral health services prior to NF admission and continuously sought care for their mental health symptoms in emergency departments (EDs). A higher percentage of the second review cohort participated in ACT which indicated they may have more significant behavioral health issues. ACT generally serves individuals with recent multiple behavioral health crises, emergency department visits, and inpatient admissions.

Physical Health Well-Being

The service review focused on an individual's physical health well-being by reviewing both chronic and acute medical conditions and the extent to which the individual received services and supports, including durable medical equipment (DME), to address these conditions. In addition, this domain included a review of whether an individual was receiving supports to address their activities of daily living (ADLs) including PCA services, or physical therapies. Team members reviewed PASRR Level II and other documentation (e.g., NF and hospital discharge records) to identify the medical conditions and gathered information from interviews to determine if the individual was receiving services consistent with their medical condition. The service review also collected information to determine if the individual was able to manage their various medical appointments and medications by themselves or whether supports were needed and available to assist with managing these appointments.

All individuals who were transitioned had multiple chronic health conditions, and generally had three or more chronic conditions. The most significant chronic conditions for these individuals are provided in Table 9. These percentages are duplicative.

Table 9. Most Frequent Chronic and Other Medical Conditions for Individuals Transitioned

Condition	Individuals Transitioned
Asthma	11%
Chronic Pain	31%
COPD	37%
Diabetes	31%
High Blood Pressure	37%
Stroke	21%
Urinary Tract Infections-- Chronic	11%

These conditions were similar to those found in the first service review. Some conditions were more prevalent than others. Some conditions were exacerbated by nicotine use. Other conditions required various DME or more complex medication administration. For instance, individuals with COPD and high blood pressure tended to have concurrent nicotine addiction. Some individuals with diabetes often needed insulin to manage this condition. This requires the individual to have the skills to administer the medication or have formal or informal caregivers assist with insulin management. Table 10 provides information on physical health well-being scores.

Table 10. Physical Health Well-being Scores

Very Poor		Poor		Good		Very Good		Excellent	
Individuals	%	Individuals	%	Individuals	%	Individuals	%	Individuals	%
1	3.44%	7	24.1%	14	48.28%	6	20.69%	2	6.68%

As this table indicates, there were eight individuals who had very good or excellent scores regarding this domain. The same number of individuals were identified as having poor or very poor scores in this domain.

The service review team compared the strengths and areas of improvement for individuals who had very good or excellent physical health well-being versus those individuals who had poor or very poor physical health. Individuals who exhibited very good or excellent physical health well-being generally had:

- Strong support from their family or friends to assist them with prompts regarding medications and/or to provide transportation to medical appointments.
- Good medication management strategies which included using pill boxes and receiving education regarding insulin administration (several individuals received this from the NF prior to discharge).
- Having PCA services at transition that assisted them with ADLs and IADLs and had various therapies (speech, physical, and occupational).
- Ability to arrange medical appointments with limited or no assistance.
- Regular exercise regimens they enjoyed, including walks and memberships in health clubs.
- Current enrollment in the Medicaid program reflected their community versus institutional status.

For individuals who were transitioned and had poor or very poor physical health well-being, there were several areas for improvement. These included:

- DME was not in place before or immediately after transition. For some individuals, DME and other medical care supplies were not available to members at the time of moving into new living arrangements. In some instances, individuals and caregivers "made do" until the equipment arrived. While the necessary DME was identified and referrals were made in the ITP and CPOC, staff cited delays from medical equipment providers.
- Individuals interviewed cited the lack of transportation as an issue. While the transition and community assessments indicated the needs for non-emergency transportation, it was less clear as to whether CCMs being familiar with local NEMT providers in rural areas made it difficult to get reliable and timely transportation. The delay or lack of medical transportation led to missed medical appointments that had an impact on individuals' physical health and well-being.
- Occasional gaps in medication refills. This was sometimes due to a missed medication management appointment (3-4 months for one member), change in prescriber, or change in pharmacy.
- Gaps in appropriate Medicaid coverage. Individuals who transition from NFs to the community will need to change Medicaid enrollment status. If this change is not done by the NFs, individuals will not have active and appropriate Medicaid enrollment. Therefore

prescribers, PCPs, and other formal Medicaid supports cannot bill Medicaid for these individuals.

In addition, several individuals in the second review sought physical health care services that could have been addressed through primary care practitioners or through urgent care centers. For instance, several individuals who had urinary tract infections or other urgent medical needs sought care in an ED. When interviewed, CCMs did not always encourage these individuals to seek care in ED alternatives. Other individuals had complex medical conditions and had unplanned hospitalizations that were related to the lack of medical care.

There were some instances of PCA services not being provided consistent with the individual's needs. The SME understands there are instances when an individual declines PCA services when offered. However, none of the individuals reviewed who had an identified need for personal care and were not getting personal care declined this service. Several examples included PCAs not showing up at the planned day or time and churn in direct care staff providing PCA services resulting in multiple staff providing PCA within a short period of time. This required the new PCA staff to quickly familiarize themselves with the individual's needs and personal care activities.

As indicated above, many of these individuals continuously used tobacco products long term, exacerbating their medical conditions. This also caused additional health concerns that required care in an ED or inpatient hospital.

The following were identified as improvements during this second review:

- CCMs tracked PCP and other specialty care appointments across payer sources.
- Individuals in the second review cohort were better informed regarding medication (physical and behavioral health) purposes and adherence and generally took the medication prescribed for their medical conditions.
- There were some modest improvements in medication training pre- and post-discharge from NFs in the second review cohort.
- There were few instances where medications were not provided for the individual prior to discharge from the nursing home.

Behavioral Health Well-Being

The service review focused on behavioral health well-being, which included whether the individual identified the need for behavioral health services post transition and the extent to which the individual received behavioral services and supports. The service review evaluated whether individuals were prescribed and taking medication to address their behavioral health symptoms. The team members reviewed the community assessment, CPOC, PASRR Level II, and other documentations (e.g., behavioral health hospital discharge records) to identify behavioral health conditions. The service reviewers gathered information through interviews and other records (e.g., ACT plans) to determine if the individual was receiving behavioral health services.

All individuals who were transitioned had multiple behavioral health conditions. The most prevalent behavioral health conditions are provided in Table 11.

Table 11. Most Frequent Behavioral Health Conditions for Individuals Transitioned

Condition	Individuals Transitioned
Anxiety	21%
Bi-polar Disorder	21%
Depression	69%
Schizophrenia	59%
Substance Use Disorder	14%

Table 12 provides a breakdown of scores for Behavioral Health Well-being.

Table 12. Behavioral Health Well-being Scores

Very Poor		Poor		Good		Very Good		Excellent	
Individuals	%	Individuals	%	Individuals	%	Individuals	%	Individuals	%
1	3.4%	9	31.0%	12	41.4%	5	17.2%	2	6.7%

Overall, there were seven individuals who scored as having very good or excellent behavioral health. Most of these individuals had very few behavioral health needs and were often needing and receiving medication management and either had the ability or the support network to assist them with managing their medication. Several individuals were actively engaged in services such as behavioral health and interviews with the CCM and ACT providers indicated very good coordination between these two entities and individuals reporting their good satisfaction with the services provided. In addition, the ACT plans for these individuals were detailed and had clear goals and strategies that were recovery focused.

There were over a third of individuals who were transitioned who had poor or very poor scores for behavioral health well-being. As indicated earlier, there were several individuals who were displaying active behavioral health symptoms (e.g., delusions and hallucinations). In addition, there were a number of individuals (21%) who did not receive behavioral health services despite their assessment or interview indicating behavioral health services were important or needed. It was not clear from documentation or interviews whether a referral had been made by the CCM or the referral was made but the service had not been rendered. Similar to medication to address physical health issues, there were also gaps in behavioral health medications for several individuals. While these medications were provided at discharge from the NF, some individuals were unable to immediately locate a psychiatrist to prescribe their medication. While their PCPs could prescribe these medications, these practitioners were not immediately available. In addition, Medicaid enrollment issues prevented individuals from getting psychotropic medications. Surprisingly, these individuals were not hospitalized due to the lack of medications.

There were several issues related to the individuals' behavioral health well-being that were identified in the initial service review that continued to be an issue. For some members, behavioral health services were identified in the ITP, but providers were not engaged at the time of actual transition. For these individuals the CCM made the referrals, but service engagement was not immediate.

There are issues for individuals who were prescribed opioids for pain while in the NF and were not able to obtain a prescription once discharged. One individual went into withdrawal, was hospitalized and discharged to a substance use disorder (SUD) withdrawal management program. However, this program was not accepting referrals and the individual was readmitted to the NF. Overall, there were a number of individuals who identified pain as an issue and no pain management strategy was recommended by the TC or CCM. There are several strategies outlined in the recommendation section that include ensuring a prescriber is available and willing to prescribe pain medications immediately post transition. In addition, there are various pain management alternatives that are available through Medicare and the Louisiana Medicaid program.

There was no obvious substance use or misuse issues identified for most individuals in the record review or interviews. As indicated above, a number of individuals had a history of alcohol or other substance use. Some individuals had not used a substance for many years prior to their nursing facility admission. Several individuals were actively using substances (including alcohol) and were not receiving treatment. During the interview, the CCM did indicate knowledge of this substance use but did not actively encourage treatment.

Individuals received various behavioral health services since discharge from the NF. The unduplicated number and percent of individuals receiving various behavioral health services is provided in Table 13.

Table 13. Behavioral Health Services Received by Individuals Who Transitioned

Service	Number of Individuals	Percent Receiving Service
Assertive Community Treatment (ACT)	11	38%
Mental Health Rehabilitation Services (MHR)	4	14%
Other Behavioral Health Services (e.g., outpatient counseling, Intensive Outpatient Services)	7	24%
Total	**22**	**76%**

As Table 13 indicates, a significant number of individuals were receiving ACT. This number is slightly higher than all individuals who transitioned (31%) as identified in the most recent SME report. A smaller number of individuals received MHR services. These services including housing supports through the MHR Permanent Supportive Housing Program. Almost one-fourth of the individuals who were transitioned received outpatient counseling or participated in intensive outpatient mental health programs (IOP). There were several individuals who declined behavioral

health services. In one instance, the family member was uninterested in having an individual engage in behavioral health services.

Stability

The service review team took a comprehensive approach to assessing stability, focusing on critical social determinants of health (e.g., stable housing, food and income security). In addition, the service review team reviewed critical incidents and other major events such as multiple ED visits and hospitalizations that could lead to stress and instability. Scores on this domain did not change significantly from the second to first review period. Individuals transitioned generally experienced good stability post transition. Similar to the first review, most individuals who transitioned and participated in the second review did not experience income instability. Four individuals reviewed experienced a disruption in income benefits. In general, in the second review:

- Over half (52%) reported they liked where they lived. For all individuals reviewed, housing and housing supports (e.g., security or utility deposit) were identified in the ITP and individuals were generally discharged to a housing option identified in the transition plan. Some individuals were able to return to their home where they resided prior to their nursing facility admission. All but one individual remained in their initial house or apartment post transition.
- Many individuals (48%) who were transitioned indicated their families or friends played an important role in their sense of stability. These individuals reported their families provided assistance that supported their stability including transportation, meals/food, and light housekeeping. Twenty-one percent indicated they developed friendships in the community post transition which also contributed to their stability. Individuals who were transitioned indicated the presence of family and friends contributed to their overall community inclusion (discussed later) which provided additional stability.
- A number of individuals (17%) specifically cited having structure as an important factor in their overall stability. This included having a schedule for the day that included formal supports (participation in services) and informal supports (e.g., attending church activities).

There were several factors identified that led to short or long term instability. While the majority of individuals expressed contentment with housing, 14% expressed concerns regarding their current living situation. Several individuals reported they did not feel safe in their current living arrangement. Others reported they were living with family members and were interested in living independently. One individual was residing in a group home awaiting housing.

CCMs or their family members said two individuals needed 24/7 care. They indicated the lack of this care resulted in seeking medical treatment at EDs or seeking inpatient care specifically for physical health conditions that needed constant management. Three individuals cited the lack of stability was due to formal caregiver issues. Specifically, these individuals provided examples of support staff (e.g., direct service workers) who did not show up at the assigned time or contacting a provider (e.g., ACT) and not getting a timely response.

Seventeen percent of individuals who were transitioned had multiple emergency department visits and inpatient hospitalizations (all cause) which created overall instability of their community tenure and affected their ability to pursue their goals. All ED visits and inpatient hospitalizations were unplanned. For these individuals, there were no specific changes in the community plans of care to address future medical or behavioral health issues.

There also continued to be issues with Medicaid benefits. Some TCs, CCMs, and individuals indicated individuals did not have their Medicaid enrollment status changed by the NF upon discharge. A CCM stated they had tried multiple times to get the NF to make the necessary changes for an individual without much success. Four individuals were discharged from the NF without income benefits (e.g., SSI or SSDI) in place. The CCM and the TC had to identify no or low cost food options (e.g., food pantry) or extend utility payments until these individuals received income supports.

Assessment and Person-Centered Planning

Community Case Managers were responsible for conducting individualized assessment and developing CPOCs for individuals transitioning from an NF. The community assessment and CPOC provided information consistent with the domains in the NFTA and ITP. These domains included:

- Medical
- Behavioral health
- Housing and housing supports
- Social/recreational
- Spirituality
- Educational/Employment
- Durable Medical Equipment
- Transportation
- Health/wellness
- Safety
- Nutrition

The community assessment and CPOC included information regarding the individual's natural supports. The assessment also included information regarding shelter in place and evacuation strategies in the case of a natural disaster.

Each individual was also required to have a crisis plan. The crisis plan collected information from the individual in their own words on how they defined a crisis, signs they were in crisis, and helpful activities to resolve a crisis. The crisis plan identified who should be contacted if the individual was in crisis.

The service review focused on the presence and quality of the community assessment, CPOC, and the crisis plan. While there was an improvement in assessment and person-centered planning for individuals in the second review, this area needed improvement, especially in the quality of the plans of care.

On a positive note, documentation was present for individuals who were transitioned from NFs with the exception of one crisis plan. This was in sharp contrast to the first service review where there was no documentation for individuals transitioned to the community. The first review relied on information from the NFTA and ITP regarding the services and supports that were to be provided post transition. Table 14 provides an overview of the presence of documentation for individuals who were transitioned from NFs.

Table 14. Presence of Community Documentation

Documentation	Yes	No
Community Assessment	29	0
% of records present	100%	0%
Community Plan of Care	29	0
% of records present	100%	0%
Crisis Plan	28	1
% of records present	97%	3%

The service review team assessed the quality of community assessments and CPOC. The review evaluated whether the assessment included information regarding the domains discussed on the previous page. In addition, reviews determined whether the individual's preference was noted and if the CCM reviewed information from other sources (e.g., medical records, other assessments, and evaluations). Generally, the assessments were complete and addressed most service domains. Table 15 provides a summary score for assessment conducted with individuals who were transitioned from NFs.

Table 15. Summary Score of Community Assessments

Number of Individuals	Average Score
29	85.3%

In the first service review, NFTAs often lacked information regarding community interests and social relationships. NFTAs did not include detailed information regarding interests post transition. In the second services review, all but two community assessments included information regarding interest and assistance the individual needed to address community inclusion needs. In the second review all individuals, with the exception of one individual, were asked to provide information regarding their educational and employment interests. This is in sharp contrast to the first service review where few individuals were asked about their education or work interests in their NFTAs.

All but one assessment included information regarding the individual's preference. These preferences were generally stated in the individual's own words. Service domains in the community assessment were complete with the exception of transportation, adaptive equipment, and services to address health and wellness. Information was not available for these

domains in the assessment for approximately 16% of the individuals reviewed. The major area in the assessment that lacked information was whether the CCM included information from other sources.

The service review team assessed the quality of the CPOC. This included a crosswalk of whether needs identified in the community assessment were included in the CPOC. The review also identified whether the individual participated in the CPOC development process and the extent to which family, friends, and formal supports were invited (at the request of the individual) to participate in the planning process. The review also looked at whether the CPOC was provided to the individual. In addition, the reviewers assessed whether the plan reflected the amount, duration, and frequency of services. Table 16 provides the summary score from the review regarding the quality of the plan of care.

Table 16. Summary Score of Community Plans of Care

Number of Individuals	Average Score
29	68.90%

All plans of care reflected the strengths and preferences of the individual. The goals identified in the plan were often stated in the individuals' own words which indicated attention to person-centeredness of the planning process. In addition, other individuals were sometimes included in the planning process. Information on this participation was collected during interviews. The review also identified whether the individual signed the plan.

There was wide variability regarding the quality of CPOCs. While the assessments included almost all domains discussed above, the CPOCs did not always identify services and strategies to address the needs identified in the assessment. Areas that were identified in the assessment and not addressed in the CPOC included:

- While all individuals transitioned from NFs had a primary care physician, 20% of the plans did not have strategies on specific medical services to address various chronic conditions that would require a specialty medical provider (e.g., cardiologist). Plans did not identify home health services (including referrals) for individuals who needed initial or ongoing nursing care. In addition, some plans did not include services (including referrals) for personal care to address ADLs or referrals for speech and physical therapies.
- A review of individuals who specifically had or requested behavioral health services in the assessment found that 20% did not have services or supports identified in their plan.
- Education and employment goals and services were not included in any community plan despite five individuals transitioned from NFs articulating interest in these activities. In discussions with CCMs and TCs there was little knowledge of the individual's interest in school or work and referrals to Louisiana Rehabilitation Services or for employment supports such as Individual Placement Supports created by LDH in 2022.
- Services to support community integration were not included in approximately 27% of plans for individuals whose assessment identified they needed initial or ongoing

assistance connecting with a religious group, contacting family and friends, and building relationships post discharge.

- Approximately 43% of the plans of care did not include information that addressed the needs of individuals who identified assistance with transportation. Transportation, including non-emergency transportation to medical and behavioral health appointments as well as transportation to religious and social events, were identified in the assessment.

Two other areas of note were members stating they did not have their CPOC or crisis plan. Individuals were specifically asked in the interview if they had their plan of care or crisis plan. Approximately 47% of the individuals stated they did not have one or more of these plans. While that is an improvement over the first review where only 25% indicated they had a care plan (usually from the CCW program), the significant percentage of individuals who indicate they do not have a care plan is a continued issue. These plans are important tools for the individual, caregivers, their support network, and organizations involved with providing services to identify potential causes of crisis and strategies that can be deployed to address and prevent the crisis from escalating. Crisis plans are helpful to guide crisis providers in their efforts to respond to a crisis.

Twenty percent of individuals did not have documentation that reflected they were asked about whether other people were invited to participate in the planning process. It is not clear whether the CCM did not document that the request occurred, whether the individual declined having additional people for developing the plan, or whether an individual requested but other people were not invited to participate in the planning process.

In the first review, Transition Coordinators made solid attempts to coordinate the care across multiple organizations and providers. The Transition Coordinators held team meetings with some regularity to discuss potential changes in services and supports. In the second review it was less clear if and how this coordination occurred. In some instances, the CCM and TC were in frequent contact with each other prior to and after an individual transitioned from the NF. In rare instances documentation or CCM interviews identified if a team meeting with providers and the individual occurred. When asked about regularly scheduled team meetings, CCM staff indicated team meetings occurred when there was a crisis or major medical or behavioral event but generally did not occur on a regular basis. In addition, interviews with CCM, TCs, and other formal supports (e.g., support coordinators and ACT staff) identified plans were not always exchanged to assist with ongoing meeting or planning efforts.

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

The service review team was also tasked with reviewing the amount, frequency, and duration of services specified in the CPOC. A major issue in this service review is the lack of this specificity in the plans of care. Only one CPOC had this information. Generally, the only service that consistently had information regarding frequency and duration was CCM. Other services

identified in the plan did not include this information. Therefore, the service review team was unable to make solid assessments of whether the individual was receiving services consistent with the CPOC.

Community Inclusion

Community inclusion was evaluated on a number of factors. Community inclusion was primarily collected through interviews with the individual, family member, CCM, TC, or provider. Questions in the interviews gathered information on how the individual spent their time. For instance:

- Did they go out of the house? Where to? How often?
- Do they see friends and/or family? Where? How often?
- Do they have a job, go to school or volunteer?
- Do they go to any programs like senior center, recreation center, drop in center, library, bingo, mental health groups/self-help groups?

In addition, the review discussed who was important in the individual's life and why. The interviews also sought information about hobbies or other interests. The review team also sought information on what could help the individuals be more involved in the community. The team also identified barriers that present challenges to individuals to become more involved in the community.

Scores for community integration was slightly higher for individuals in the second review versus the first review (2.66 versus 2.38 out of 5). However, this domain was scored lowest among all domains. Table 17 provides information on community inclusion scores.

Table 17. Community Inclusion Scores

Very Poor		Poor		Good		Very Good		Excellent	
Individuals	%	Individuals	%	Individuals	%	Individuals	%	Individuals	%
1	3.4%	12	41.3%	12	41.3%	3	10.3%	1	3.4%

As this table indicates, there are a number of individuals (4) who had very good or excellent scores on community integration. Individuals who had very good or excellent scores for community integration had strong relationships with family (regular visits and outings), attended church activities often, and consistently participated in support groups. One individual reported they were renovating their house, and another reported they were starting a new part-time job that they had found on her own.

Thirteen individuals had poor or very poor community integration scores. Almost all of these individuals expressed they regularly experienced loneliness. Most of these individuals reported they had no natural supports (e.g., families or friends). Some of these individuals were interested in being more active in their community but indicated transportation was lacking to assist them to get to these activities. One individual indicated they had found a volunteer job, but

transportation was very unreliable and therefore they were hesitant to make a work commitment. Very few of these individuals had any structure (including segregated settings such as IOP). In addition, these individuals did not have community integration activities in their plan of care even though their assessments indicated they were interested in supports to make new relationships or rekindle previous relationships with family and friends.

Transition Outcome

The service review assessed the experience of the individual during the transition process as well as the overall transition outcome. There were no major changes in transition outcomes between the first and second service review (3.13 versus 3.17 out of 5). The scoring regarding this domain was based on interviews with the individual who was transitioned (and their family member or friends if present), the CCMs, TC, and the formal provider of services (e.g., ACT or PCA). Interviews with individuals requested information regarding their transition experience including how they experienced the transition and what liked or would do differently regarding the time before and during transition. In addition, the service review team asked the individual if they were satisfied with their current situation and if there was anything the individual would like to do differently.

The service review team asked similar questions during interviews with CCM and TCs to garner their opinion of the overall transition process for the individuals. Specific questions sought to collect information from the TC and CCM (independently) about the collaboration with each other and what other activities could have been put into place to make the transition more successful. The review team also requested information from the CCMs, TCs, and providers regarding anything that could improve the individual's life in the community. Table 18 provides the score on the outcome of transition.

Table 18. Transition Outcome Scores

Very Poor		Poor		Good		Very Good		Excellent	
Individuals	%	Individuals	%	Individuals	%	Individuals	%	Individuals	%
1	3.4%	6	20.1%	11	37.9%	9	31.0%	2	6.9%

As indicated above, the overall outcome of the transition was rated highest among all domains. Almost 80% of individuals who were transitioned had scores between the good and excellent range. There were various themes derived from the interviews regarding these transitions. Some of these themes were consistent with the first service review. For instance:

- The success of the transitions was often reflective of the individual's strengths, interest, and strong commitment to remaining in the community and living independently. In addition, the individual's personal strengths are a major driver to ensure that the transition was and continued to be successful. These strengths facilitated the individual's involvement in the transition process.
- Individuals also identified the TC and/or CCM being helpful prior to and during the transition process. This included helping with medical appointments, medications

(locating closest pharmacy), coordination of housing supports (e.g., furniture) and arranging for DME.

- Transition coordinators and CCM reported they worked well together during the transition.
- Transition coordinator had multiple meetings with the individual and care team prior to transitioning, which seemed to make the transition easier. Most individuals confirmed they had services and supports needed immediately after discharge from the NF. In addition, the TC was helpful in arranging for the NF to provide medication management and medication training (e.g., insulin) prior to discharge.
- Once transitioned, CCMs reported there was coordination among the TC, CCM, direct service worker, and, for some individuals, the OCDD support coordinator. While these meetings occurred, CCMs reported these were often one-off meetings with the formal support provider.
- Housing for several individuals was also reported to have contributed to a successful transition outcome. Several individuals reported they had been provided with a choice of housing prior to transition. Other individuals positively remarked on the newness of the building.

There were issues identified with some transitions. As indicated previously, four individuals had income assistance issues at the time of discharge. NFs were not applying for Social Security Disability Insurance (SDI) or Supplemental Security Income (SSI) while the individual was in the facility, which would follow the individual at transition. In addition, there were delays for two individuals in obtaining Supplemental Nutrition Assistance Program (SNAP) benefits. In these instances, CCMs and TCs often had to piece together supports (e.g., food pantries) until these payments occurred.

There were three individuals who were rapidly discharged from the NF. These individuals left the facility prior to the discharge planning date. The TC and CCMs indicated there was not enough time to plan for timely post transition services. Two individuals returned to their families and another individual was temporarily placed in a group home while the CCM and TC facilitated the housing application process.

Two individuals indicated they were not given a choice of housing arrangements and were seeking to move to another location. One individual had some mobility impairments and was in a non-accessible apartment.

There were three individuals who did not have all the services and supports in place at the time of transition. While some issues cannot be always anticipated, these individuals experienced service access issues immediately post transition.

There were other factors that adversely impacted an individual's transition. As previously indicated, two individuals needed 24/7 supports. Specifically, one individual needed more supports than the LDH PCA programs could provide. For the other individual, the family indicated they needed 24/7 supports but the CCM did not identify if this individual needed this level of

support. Several individuals had a critical incident. One individual experienced a change in housing due to a fire that was inadvertently started by the individual.

Systemic Issues

The services reviews identified a number of systemic issues that were experienced by individuals who participated in the review. The most pressing issue was the lack of some services in CPOCs. Other issues were the lack of some services in the community to address an individual's need as identified in the community assessment and CPOC. CPOCs did not include information regarding the duration and frequency of services or identified specific providers that would render services. While assessments were generally complete and of good quality, the CPOCs were often absent of strategies and specific services that addressed the needs of the individual as identified in the community assessment. Other service access issues included:

- The lack of plans that addressed activities promoting integration was problematic and consistent with the issues that were identified in the first service review. The lack of integrated activities in the community can be a risk for future stability.
- Continued lack of peer support or other alternative supports to address loneliness and better community inclusion is a continued theme for most individuals in the review.
- While the majority of individuals were transitioned from an NF to their own apartments, there were some identified housing issues including:
    - Apartments were not ready when promised, prompting delays in transitions.
    - Several individuals requesting apartments in other locations due to safety or accessibility issues. These individuals were told that it was very difficult to break a lease and they would need to remain in the apartment for the duration of the lease.
    - An individual had significant mobility issues and was transitioned to non-accessible housing which impacted community inclusion, safety and crisis planning, physical and behavioral health.

The review found significant CCM staff turnover in one region that impacts the success of the CCM program. One TC indicated an individual had four CCMs due to turnover**.** This turnover has multiple consequences. First, it impacts the quality of case management and the ability of the individuals to obtain necessary services. Second, it hinders the ability of the TCs to disengage from their intensive case management roles and therefore impacts their ability to focus on individuals awaiting transition. Third, the turnover requires multiple efforts by the TC to outreach the new CCM and discuss individuals they share responsibility for.

There continues to be a lack of communication among team members to address service gaps or ensure providers are not duplicating case management efforts. For instance:

- Service coordinators from the CCW or OCDD Waiver program interact with the direct service worker but have little understanding of other supports the individual is receiving from the CCM or behavioral health providers (e.g., ACT).
- For all but one individual there were no ongoing team meetings with the individual, CCM, or community providers. CCM staff indicated these team meetings would occur for individuals who had critical incidents or major medical events such as ED visits or inpatient admissions and discharge.
- Little collaboration occurred among team members assisting individuals who were transitioning, including sharing plans for various services among providers that have significant contact with the individual and CCM (e.g., ACT and CCW Support Coordinator).

There continued to be issues regarding Medicaid benefits post discharge from an NF. Individuals transitioning from NFs will need a change in Medicaid enrollment status. A change in status is the NF's responsibility. NFs do not perform this function on a timely basis. This delay causes issues with members obtaining needed medications for successful community transition.

There were issues with assisting individuals to obtain income benefits such as SSI or SSDI. There were instances where the TC followed up multiple times with the NF to address changes in Social Security. In some instances, the TC had arranged for SSI/SSDI Outreach, Access, and Recovery (SOAR) to assist with the application process only to find the NF had begun follow-up with the Social Security Administration (SSA).

There is some role confusion between CCM, TC, and other individuals involved in providing care post transition. This is to be expected during new program implementation as functions are transitioning from one organization (e.g., LDH TCs) to the MCO CCM program. For several individuals there was confusion regarding who was responsible for contacting the PCP to order physical therapy or home health services. This confusion caused delays in receiving care.

Recommendations

Based on the service review, the following recommendations are made for individuals who transition from nursing facilities. These include:

- Better identify urgent care options in the community for all individuals who are transitioned from NFs. As indicated above, individuals who transition often seek medical care in EDs that put individuals at risk of inpatient admissions and subsequent referral to an NF. Reasons for this should be explored further; there are community care options available for individuals with urgent needs and CCMs and individuals should be aware of and be referred to these providers as appropriate and available.
- Require CCMs to hold team meetings with the individual, individuals of their choosing including providers of intensive behavioral health services, PCA services, and supportive

housing staff on a regular basis. The purpose of this meeting is to share plans of care to ensure consistency, to revise interventions, identify service gaps and strategies to address these gaps, and assign responsibility for specific follow-up needs. The individual should drive the process in terms of location, time, and content to be discussed.

- Require CCMs to provide CPOCs and crisis plans to individuals on their caseload.
- Have CCM supervisor review all plans and determine if the individual has been offered behavioral health services and supports. As indicated above, approximately one-fourth of individuals were not engaged in formal behavioral health supports. While the SME understands individuals are in various stages of their behavioral health recovery and person-centered approaches should drive an individual's decision to participate in these supports, supervisors should ensure that CCMs are well versed in motivational interviewing and ensuring the behavioral health needs of individuals are offered on an ongoing basis. In addition, CCM supervisors should have processes in place to ensure individuals have their community and crisis plans.
- The CPOCs should include the amount, duration, and frequency of services. If another provider (e.g., ACT or CCW Support Coordinator) has developed a plan, the CPOC should at a minimum reference these plans. LDH should ensure these other plans include amount, duration, and frequency of services.
- Provide CCMs and ACT teams with information regarding formal and informal strategies for addressing community living and social relationship needs. This is an issue across all populations. Individuals who were interviewed expressed loneliness or inability (generally due to transportation options) to participate in community activities. As LDH increases the availability of peer supports that could assist individuals with addressing these issues, CCMs should be made aware of local peer support resources and make the necessary referrals and linkages for these services. In addition, given that over a third of individuals who transitioned participated in ACT, peer support team members on these ACT teams should be deployed to identify opportunities for individuals to have meaningful participation in community activities, address loneliness, and identify formal and informal transportation options.
- Train CCMs and TCs on relevant pain medication and alternative pain management strategies. Given the number of individuals who identified pain issues during the assessment process and the number of individuals who are awaiting transition, this is an important issue. Community prescribers may not feel comfortable providing ongoing pain medication for individuals who are newly referred. Identifying prescribers prior to or immediately after transition will be necessary for many individuals on their caseload. In some instances, individuals will experience significant withdrawal symptoms if not prescribed appropriate pain medications. In addition, prescribers may suggest that pain medications be titrated down, and alternative pain management strategies and services will need to be made available to these individuals post transition.

- Provide information to CCMs and individuals regarding actions they can take to request a change in housing. Individuals who transition have to execute leases on an annual basis with landlords. Breaking a lease is challenging and has implications for the individual, the landlord, and the relationship LDH has with these landlords. However, individuals indicate they do not want to remain in their apartment during the course of the year. As indicated above, individuals with physical accessibility issues find their apartment prevents them from performing ADLs and IADLs. While these situations should have been addressed prior to the transition, CCMs and individuals find themselves in a precarious position with the landlord who insists the individual remain in the apartment for the leasing period. Strategies should be developed for CCMs to engage Tenancy Support Managers and Permanent Supportive Housing staff to assist with negotiations with the landlords in these situations to identify solutions to this issue.
- TCs should work with the NF's administrative staff to discuss strategies for ensuring an individual has the appropriate changes in Medicaid benefits at discharge. Medicaid enrollment categories change when individuals transition from NFs to the community. Individuals need Medicaid benefits at discharge for medications and other formal services. Any delay in this change jeopardizes an individual's stability in the community and could result in an inpatient or subsequent NF admission. LDH should provide guidance regarding the expectations of NFs changing enrollment status at or immediately following discharge.
- The TCs should work with the individuals to have applications for SSA as soon as feasible according to program policies.
- Develop information for TCs and CCMs regarding their respective roles prior to transition, during the transition process, and post transition. The transition of ongoing and intensive case management responsibilities from TCs and CCMs had expected and some unexpected challenges. TCs may be reluctant to detach from individuals they were transitioning, especially when there is significant CCM turnover. CCMs have some, but more limited, involvement early on with individuals who transition and therefore are comfortable "leaning into" the TCs for ongoing support. Individuals who transition more likely have a stronger relationship with TCs and often continue to engage the TC rather than the CCM during the initial phase of transition. The standard operation procedures developed by LDH provide solid guidance and expectations for CCMs to perform their functions prior to and post transition. However, these procedures are devoid of the relationship with the TC (and other providers) during the transition process. In addition, there are no specific SOPs for TCs regarding their expectations post transition. LDH should develop protocols for CCMs and TCs during and post transition. These protocols should be developed with input from TCs and CCMs to better address issues and inform strategies for having clearer lines of delineation for their roles.
- Have MCOs track turnover and, if high turnover continues, work with MCO-contracted CCM organizations to understand high turnover of CCMs and develop strategies to

address and lower turnovers. New programs are often subject to higher turnover. Agencies do not have the experience of offering these services and therefore may not have the information and acumen to recruit supervisors and direct staff for this program. As this organization obtains more experience with the CCM program, in theory, turnover should be lower.

- Train CCMs and TCs regarding the availability of formal supports regarding employment and education. This includes determining when an individual is a good candidate for a referral to Louisiana Rehabilitation Services (LRS), the Medicaid employment benefit available through MCOs or for supported employment assistance that should be provided by all ACT teams.
- Train CCMs and TCs regarding appropriate smoking cessation strategies that can be offered to individuals with nicotine dependence. As indicated in this section, many individuals use nicotine which exacerbates their medical conditions and daily activities.

Individuals Diverted from Nursing Facilities

This section provides the results of the service reviews for individuals who diverted from nursing facilities. Eight individuals were included in the review who were diverted from NFs. As indicated in the introduction, these individuals were diverted during the Preadmission Screening and Resident Review Process (PASRR) that is performed by licensed clinicians when an individual is referred for an admission to an NF. Individuals who were diverted were recommended by the PASSR Level II evaluator and LDH for community tenure versus NF placement. The review focused exclusively on individuals who were diverted and were receiving CCM. As of our third review (February 2023), almost 80% of individuals who were diverted participated in the CCM program.

The service reviews for individuals who were diverted focused on various domains in Table 2 and reviewed whether CCMs were complying with specific areas LDH established in standard operating procedures (SOPs) for the program.

It should be noted, there were fewer individuals who were diverted and participated in the reviews (8) and there was an individual who experienced issues post diversion which decreased these scores in some domains appreciably. This individual was re-hospitalized soon after the initial discharge, transitioned to a group home immediately after the rehospitalization, and experienced acute behavioral health conditions that impacted all domains.

The following sections provide an overview of the demographics of individuals who were diverted from NFs, the findings from the service review, systemic issues, and recommendations to LDH for improvements in the process to enhance the experience for these individuals.

Demographics of Individuals Diverted from Nursing Facilities

The average age of individuals who were diverted was 63 years old. One half of individuals (4) were between 66 and 75 years old. Thirty-eight percent were between 51 and 65 years old. There was one individual under the age of 50 (48 years old). Table 19 provides information regarding the age of this review cohort.

Table 19. Age of Individuals Who Diverted from NFs

Ages	Diverted	%
Average Age	63	N/A
50 and under	1	13%
51-65	3	38%
66-75	4	50%
Over 75	0	0%
Total	8	100%

Individuals who participated in the service review and were diverted were more likely to identify as female (75%) versus male (25%). Table 20 provides information regarding gender.

Table 20. Gender of Participants

Gender	Transitioned	%
Male	2	25%
Female	6	75%
Total	8	100%

There was some variation regarding the race of individuals in the review. Table 21 provides information on the race of individuals who were diverted. A majority of individuals were Caucasian (75%) versus individuals who were African American (25%). There were no individuals who identified as Hispanic or other races.

Table 21. Ethnicity/Race of Individuals Diverted from NFs

Race	Transitioned	%
African American	2	25%
Caucasian	6	75%
Hispanic	0	0
Total	8	100%

Individuals who were diverted were referred for NF admission from several sources, including inpatient general hospitals (2 individuals), inpatient behavioral health hospitals (4 individuals), and families who requested NF care for their family member (2 individuals). Table 22 provides the information on referral source.

Table 22. Referral Source for Individuals Diverted from NFs

Referral Source	Number	Percent
Inpatient General Hospital	2	25%
Inpatient Behavioral Health Hospital	4	50%
Family Member	2	25%
Total	8	100%

As Table 22 indicates, one-half of individuals were referred from inpatient behavioral health facilities and were diverted to the community. While a small number in the sample, it does provide some confirmation that LDH's elimination on the behavioral health pathway may have

impacted these diversions. Two individuals were referred to an NF from families who were concerned about their ability to provide ongoing natural supports for their family member.

Findings from the Service Review

This subsection provides detailed information from the review regarding individuals who were diverted from NFs and participated in the service reviews. This subsection also provides information from the compliance reviews, interviews, and domain-specific and overall scores for these individuals. Table 23 provides information regarding these scores.

The focus on individuals who are diverted is new. Information from the first service review focused on individuals who transitioned from NFs and no comparison data is available for the diversion cohort.

Table 23. Domain Scores for Individuals Who Were Diverted

Physical Health Well-Being	Behavioral Well-Being	Stability	Assessment and Person-Centered Planning	Community Integration	Transition Outcome	Overall Score
2.3	1.9	2.1	2.5	2.0	1.9	2.1

Individuals scored poorly across all domains. These scores are directly related to the urgent and emergent needs of many individuals who were diverted. In general, reviewers found individuals who were diverted had more complicated medical and behavioral health needs than individuals who were transitioned from NFs. Individuals who were diverted had multiple issues that needed immediate resolution versus individuals who were transitioned. Individuals who were transitioned had a more planful process to ensure services and supports were identified and in place prior to being discharged from an NF.

Some individuals experienced housing instability at the time of referral to CCM. Two individuals who were diverted did not have stable housing or were homeless prior to the hospital admission and needed immediate housing upon discharge. The CCM was generally able to assist the individual in identifying housing preferences and applying for the necessary housing and supports. One individual was referred to a group home from the hospital which was not conducive to meeting their needs. Another individual was admitted to a homeless shelter while awaiting housing. Another individual returned to their group home after their inpatient behavioral health stay and indicated interest in independent living to the CCM once diverted. Unfortunately, there is no housing on demand for these individuals. In addition, other individuals were living with families who indicated they would like an independent living arrangement. The CCM was solely responsible for locating housing, making referrals for behavioral health services and personal care services.

Unlike individuals who transition, individuals who were diverted were immediately referred to CCM after their PASRR Level II and did not have a TC to assist them in planning for the diversion. As indicated above, individuals were often referred from general or behavioral health hospitals and had continued acute medical or behavioral health needs. Many of these individuals were experiencing some level of crisis and needed the CCM to identify and access services immediately.

Several individuals denied having mental health issues and refused services. Other individuals had family members who refused both behavioral health services and supports to address their needs. Documentation and interviews indicated the CCM identified and recommended referrals to these services, yet the individual or family refused this assistance.

Other individuals were discharged from inpatient settings without physical and/or behavioral health medications and the CCM needed to immediately find a prescriber and a pharmacy for some of these individuals.

Physical Health Well-Being

The service review focused on physical well-being which included whether medical conditions were present and the extent to which the individual received services and supports, and whether DME was available to address these conditions. In addition, this domain included a review of whether an individual was receiving supports to address their ADLs including PCA services, or physical therapies. The team members reviewed PASRR Level II and other documentation (e.g., hospital discharge records, community assessment, and CPOC) to identify the medical conditions and gathered information from interviews to determine if the individual was receiving services consistent with their medical condition. The service review also collected information to determine if individuals were able to manage their various medical appointments and medications.

All but one individual who was diverted had a chronic health condition. Another individual had one chronic condition. Three individuals had two chronic conditions and three individuals had three or more chronic conditions. In addition to these chronic conditions, individuals who were diverted had other medical conditions. Some of these conditions were re-occurring and others were more episodic. The various medical conditions (chronic and episodic) for these individuals are provided in Tables 24.

Table 24. Frequent Medicaid Conditions for Individuals Who were Diverted

Condition	Individuals Diverted	Percent
Asthma	1	12.50%
COPD	1	12.50%
Diabetes	4	50.00%
High Blood Pressure	2	25.00%
Stroke	1	12.50%
Urinary Tract Infections-- Chronic	1	12.50%
Seizure Disorder	1	12.50%

Unlike their counterparts who were transitioned, some individuals who were diverted had fewer chronic conditions. However, individuals who were diverted had many of the same medical conditions as individuals who transitioned. As these conditions would indicate, most individuals who were diverted needed medical services and supports for these conditions. Some individuals needed medical equipment and changes in their living environment (e.g., accessible unit) to accommodate these conditions.

The distribution of the score for physical health well-being is provided in Table 25. As this table indicates, one-half of all individuals who were diverted had poor or very poor scores in this area. No individuals reported very good or excellent health. This may be expected since most of these individuals are being discharged from a hospital setting and/or have acute medical conditions which may need immediate medical care, ongoing medical care, or ADL supports that take longer to arrange.

Table 25. Scores for Physical Health Well-being for Individuals Diverted

Very Poor		Poor		Good		Very Good		Excellent	
Individuals	%	Individuals	%	Individuals	%	Individuals	%	Individuals	%
2	25%	2	25%	4	50%	0	0%	0	0%

Individuals reporting good health were able to make and follow through with various medical appointments. These individuals were knowledgeable regarding the purpose of the medications and frequency of administering these medications. Several individuals who had diabetes were able to administer their insulin independently. Three individuals, who lived with family members, indicated their support was helpful in managing their medical appointments and prescriptions.

For individuals reporting good health, documentation and interviews indicated the CCM was very involved in assisting the individual or family member with managing their medical issues. For instance, the CCM:

- Arranged a new PCP for an individual who did not have regular primary care
- Worked with the ACT team to facilitate medications and transportation for some physical health appointments
- Arranged transportation to medical appointments through the individual's MCO
- Collaborated with a PCP to obtain DME that required a PCP referral
- Visited an individual during a planned inpatient surgical stay to work closely with the social work discharge staff at the hospital
- Connected the individuals with SNAP and counseled them on the appropriate use of these benefits.

The service review team identified areas of improvement for individuals who had poor or very poor physical health well-being. Individuals who had poor or very poor physical health well-being indicated they were not receiving needed supports from their family or other natural supports to

assist them with prompts regarding their medical appointments, medications, and transportation. For individuals who were diverted and had poor or very poor physical health well-being, there were several other areas for improvement, including:

- Services were not in place immediately at diversion. Some individuals needed physical therapy and home health at discharge from an inpatient hospital. Individuals indicated the need for physical therapy to increase their strength to be mobile and more independent with ADLs. While the CCM made the necessary referrals, these services were not immediately available. One individual reported receiving physical therapy services immediately after discharge that were terminated within a short period of time. The individual and caregiver were unclear why these services stopped.
- Individuals were discharged from the hospital without medication, leaving the individual and CCM to facilitate medical appointments to obtain a prescription even when the individual had a prescriber prior to a referral to an NF.
- The living environment did not support the individual's efforts to get medical care or services in general. There were two individuals who were living in group homes that provided little support to these individuals' efforts to obtain medical care.

One individual who was diverted was confined to bed and had no physical mobility. This individual was reported to have a significant urinary tract infection that required care and reported they could not get to their PCP for an evaluation. The reviewers were concerned given the connection between severe UTIs and effects on mental health well-being in older individuals which would likely precipitate an ED visit or inpatient admission.

An individual had multiple physical health hospitalizations since being diverted. The individual did not agree to be interviewed. The CCM reported the individual had two physical health inpatient admissions due to significant mobility issues. Both of these inpatient admissions resulted in an NF facility referral for rehabilitative care. The individual was in the NF at the time of the review.

Behavior Health Well-Being

All individuals who were diverted had a serious mental illness and all had multiple behavioral health conditions. The most prevalent behavioral health conditions are provided in Table 26.

Table 26. Most Frequent Behavioral Health Conditions for Individuals Diverted

Condition	Individuals Diverted
Bi-polar Disorder	25%
Depression	25%
Schizophrenia	100%
Substance Use Disorder	25%

As previously discussed, the review included an assessment of whether the individual identified needed behavioral health services post transition, the extent to which the individual received

behavioral services and supports, and if the individual was prescribed and taking medication to address their behavioral health symptoms. The team members reviewed available documents including PASRR Level II evaluation (that recommended community versus NF placement), behavioral health hospital discharge records (as appropriate), and the CCM community assessment and CPOC. The service reviewers gathered information through interviews and other records (e.g., ACT plans) to determine if and what behavioral health services the individual was receiving .

All but one individual had poor or very poor behavioral health well-being (Table 27). For this individual, the CCM arranged for the referral to behavioral health services and organized initial telehealth visits with the provider. Six individuals who had poor or very poor behavioral health well-being indicated having no regular behavioral health care prior to or immediately after diversion.

Table 27. Distribution of Behavioral Health Well-being Scores

Very Poor		Poor		Good		Very Good		Excellent	
Individuals	%	Individuals	%	Individuals	%	Individuals	%	Individuals	%
3	37%	4	50%	1	13%	0	0%	0	0%

A majority of individuals (62.5%) were not receiving behavioral health services (other than medication management) despite their assessment or interview indicating behavioral health services were important or needed. One individual was receiving ACT, one individual was participating in IOP, and another individual was receiving behavioral health counseling.

There were multiple other issues reported by the individual, CCM, or behavioral health care provider (e.g., ACT) regarding access to behavioral health services. One individual was referred to ACT but the family member was reluctant to have the team come to the house. In addition, the family member was adjusting the individual's psychotropic medication without consent from the prescriber. The CCM intervened with the family and coordinated a conversation with the psychiatrist and the family member to discuss a medication change. As discussed above, another individual was experiencing significant urinary tract infection issues that, if left untreated, would likely create significant mental health issues.

Two individuals who were receiving behavioral health services were no longer getting these services. Two individuals "graduated" from IOP and were told that there was a waiting period for them to reapply for IOP.

One individual refused behavioral health services, insisting they did not have a mental illness. Another individual refused to take their medication and was actively symptomatic. Another individual was reported to be assaultive and exhibited psychotic behavior but continued to deny they have behavioral health issues. One individual was actively using substances. The CCM and ACT team lead had bi-weekly contact to discuss strategies for addressing the individual's substance use.

Stability

The service review team applied the same stability factors (e.g., critical social determinants of health) for individuals who transitioned to individuals who were diverted. The service review considered critical incidents, ED visits, and hospitalizations that could lead to stress and instability. The overall score was poor (2.1 out of a possible 5) for this domain. Table 28 provides an overview of the distribution of the stability score across individuals who were diverted.

Table 28. Distribution of Stability Scores

Very Poor		Poor		Good		Very Good		Excellent	
Individuals	%	Individuals	%	Individuals	%	Individuals	%	Individuals	%
2	25%	3	37.5%	3	37.5%	0	0%	0	0%

Over one-third of the individuals diverted from an NF reported to have good stability in their lives. These individuals varied in the reasons for achieving and experienced continued stability. One individual was homeless at diversion. The CCM, with the assistance of LDH, completed a housing application and the individual was housed six months after diversion. The individual reported to be satisfied with their housing. Two individuals live with their family who take care of most of their basic needs as well as assist with medication oversight, shopping, and occasional outings.

Approximately two-thirds of all individuals diverted reported poor or very poor stability. There were several factors identified that led to short or long term instability. One individual reported they were living with family members but did not like this living arrangement. The family referred their family member to an NF. However, they did not meet the criteria for this level of care. Another individual lived with her elderly caregivers who were reported to be in poor health. This individual and family refused supports (e.g., personal care, physical therapy, occupational therapy) and any meaningful structure. This individual also had multiple admissions for physical health and behavioral health inpatient care. As previously discussed, one individual had no mobility and was bed bound. They were agitated and have ongoing significant medical care needs that need to be continuously addressed.

As indicated above, several individuals are residing in group homes. One individual has resided in a group home for the past two years and has declined offers for supported housing. Interviews and notes indicate the individual does not have access to food as needed; the group home staff keep the refrigerator locked. Another individual resided in two group homes since diversion (transferred after a behavioral health hospitalization). This individual did not want to be interviewed. The CCM's documentation indicated the individual was being observed during a hospitalization which uncovered an infestation of head and body lice. The documentation further indicated the CCM took appropriate actions to report and resolve the critical incident.

Assessment and Person-Centered Planning

Community Case Managers were responsible for conducting individualized assessment and developing CPOCs for individuals who were diverted from a nursing facility. The community

assessment and CPOC provided information consistent with the domains in the NFTA and ITP. In addition, the assessment and plan of care (and domains) are exactly the same for individuals who are transitioned and diverted from NFs.

Each individual who was diverted was required to have a crisis plan. The crisis plan collected information from the individual in their own words on how they defined a crisis, signs they were in crisis, and helpful activities to resolve a crisis. The crisis plan identified who should be contacted if the individual was in crisis. The service review focused on the presence and quality of the community assessment, community plan of care, and the crisis plan.

The assessment and the plan of care also included information regarding the individual's natural supports. The assessment also included information regarding shelter in place and evacuation strategies in the case of a natural disaster. In addition, the plan of care provided information regarding the individual's formal supports based on the services identified in the plan.

The service review focused on the presence and quality of the community assessment, CPOC, and crisis plan. Documentation was present for individuals who were diverted from NFs. Table 29 provides an overview of the presence of documentation for individuals who were diverted from NFs.

Table 29. Presence of Community Documentation

Documentation	Yes	No
Community Assessment	7	0
% of records present	100%	0
Community Plan of Care	6	1
% of records present	86%	14%
Crisis Plan	7	1
% of records present	86%	14%

It should be noted that one individual was very newly diverted and the CCM was in the process of completing the community assessment and CPOC. This individual was not included in the calculation. This individual was previously homeless and living in a group home, was hospitalized, and then transferred to another region. As Table 29 indicates, all individuals had an assessment. One individual did not have a CPOC or a crisis plan. This individual was also reported to have been recently diverted and the CCM was able to work with the individual to complete the assessment but needed additional time to develop the CPOC and crisis plan.

The service review team assessed the quality of the assessments and CPOCs for individuals who were diverted. The service review team evaluated whether the assessment included information regarding the domains in Table 30. In addition, the review included an evaluation of whether the individual's preference was noted in the assessment and if the CCM reviewed information from other sources (e.g., medical records, other assessments, and evaluations). Generally, the assessments were complete and addressed most domains. Table 30 provides a summary score for community assessments conducted with individuals who were transitioned from NFs.

Table 30. Summary Score of Community Assessments

Number of Individuals	Average Score
7	89.9%

Information in all domains was included in assessments for individuals who were diverted. All but one assessment had information regarding the individual's preference. Preferences were generally stated in the individual's own words. The domains in the assessment were generally complete. For three individuals, the assessments did not indicate whether the CCM uses other sources of information when completing these documents. One assessment did not have information on the individual's health and welfare. For another individual, information was missing regarding whether the individual feels safe in their home. All individuals' employment and educational interests were assessed but none of the individuals identified interest in working or pursuing educational activities.

The service review team assessed the quality of the CPOC. This included a crosswalk of whether needs identified in the assessment were included in the CPOC and included whether the plan had strategies that addressed health and safety needs. The review also identified whether the individual participated in the plan of care development process and the extent to which family, friends, and formal supports were invited (at the request of the individual) to participate in the planning process. The review also looked at whether the individual was provided the CPOC and was aware of their crisis plan. In addition, the reviewers assessed whether the plan reflected the amount, duration, and frequency of services. Table 31 provides the summary score from the review regarding the quality of the plan of care.

Table 31. Summary Score of Community Plans of Care

Number of Individuals	Average Score
7	68.61%

All plans of care reflected the strengths and preferences of the individual. The goals identified in the plan were often stated in the individual's own words which indicated attention to person-centeredness of the planning process. Information regarding the individual's participation in the CPOC development was collected during the interview with the individuals and documentation was reviewed to determine if the individual signed the plan.

There was wide variability regarding the quality of CPOCs. While the assessments included almost all domains discussed above, the CPOC did not always identify services and strategies that were identified in the assessments. Areas that were identified in the assessment and not addressed in the CPOC included:

- Medical services—as indicated above, there were different ancillary medical services that were identified as needed during interviews and identified in the assessment but

not reflected in the CPOC. This included both physical and occupational therapy. In addition, several individuals' assessments indicated the need for assistance with ADLs. CPOCs were either absent of any information regarding PCA services or the plan identified the need for a referral for PCA services but did not include an individual responsible for the referral. In addition, three individuals indicated they had pain issues but CPOCs did not address this issue.

- Behavioral health services—as indicated above, almost two-thirds of the individuals diverted from NF were not receiving behavioral health services. While individuals identified goals that were behavioral health related, the plans did not propose action steps to identify or make referrals for behavioral health services.
- Services to support community integration were not included in any of the plans for individuals whose assessment or goals identified they would like initial or ongoing assistance connecting with a religious group, contacting family and friends, or identifying hobbies or strategies to not feel lonely post diversion.

Six individuals needed transportation (as identified in the assessment), including non-emergency transportation to medical and behavioral health appointments. None of the CPOCs for these individuals included goals or strategies regarding transportation.

Two other areas of note were members having their CPOCs or crisis plan. Individuals were specifically asked in the interview if they had their plan of care or crisis plan. Four individuals stated they did not have one or both plans.

Two individuals had documentation that reflected that they were asked about whether other people were invited to participate in the planning process. Other individuals' documentation, interviews, and POCs did not identify if other individuals were invited to participate in the plan or if the plan's format did not provide that information.

The service review team was also tasked with reviewing CPOCs to determine if the individual received services in the amount, frequency, and duration specified in the CPOC. A major issue in this service review is the lack of this specificity in the CPOC. One individual's CPOC did provide detailed information on the frequency (but not the duration) of the services in the plan. Therefore, the service review team was unable to assess whether the individual was receiving services consistent with the CPOC.

Community Inclusion

Community inclusion for individuals who were diverted were evaluated using the same factors for individuals who transitioned from NFs. Community inclusion was primarily collected through interviews with the individual, family member, CCM, or provider using the interview guide with some modification for individuals who were transitioned. Scores for community integration were poor for individuals who were diverted. Table 32 provides information on community inclusion scores.

Table 32. Community Inclusion Scores

Very Poor		Poor		Good		Very Good		Excellent Column	
Individuals	%	Individuals	%	Individuals	%	Individuals	%	Individuals	%
2	25%	4	50%	2	25%	0	0%	0	0%

As Table 32 indicates, two individuals had a good score on community integration. One individual was living with their family who assisted the individual to attend church and family and community outings. The other individual was very sociable and developed friendships with individuals in their apartment complex. This individual also indicated they had daily structure (e.g., participated in formal support services).

Six individuals (75%) had poor or very poor community integration scores. These individuals indicated in their assessment that they needed initial or ongoing assistance with developing relationships with friends. One-half of these individuals expressed concerns about feeling lonely, either in their CPOCs or interviews. There were no specific actions identified in the CPOC to address this issue. For one individual, the CCM and Support Coordinator were concerned about another individual being withdrawn and not leaving the house. This individual was living with family members and expressed an interest in getting their own place. As indicated above, an individual was bed bound and was not able to participate in any community activities.

Diversion Outcome

The service review assessed the experience of the individuals during the diversion process as well as the overall diversion outcome. The scoring was based on interviews with the individual who was diverted, CCM, and formal provider of services (e.g., ACT or PCA). Interviews with individuals requested information regarding their diversion experience and what they liked or would do differently regarding their time after diversion. In addition, the service review team asked the individual if they were satisfied with their current overall situation and if there was anything the individual would like to do differently. Specific questions sought to collect information from CCM and service providers (independently) about the collaboration with each other and what other activities could have been put into place to make the diversion more successful. The review team also requested information from the CCMs and providers as to whether there was anything that could improve the individual's life in the community. The overall score for the diversion outcome was poor (1.9 out of 5). Table 33 provides the scores on the outcome of diversions.

Table 33. Diversion Outcome Scores

Very Poor		Poor		Good		Very Good		Excellent	
Individuals	%	Individuals	%	Individuals	%	Individuals	%	Individuals	%
3	37.5	3	37.5	2	25%	0	0%	0	0%

As Table 33 indicates, 75% of the individuals had poor or very poor outcomes post diversion. Twenty-five percent had good outcomes. No individuals had very good or excellent outcomes.

There were various reasons for these low scores. For five individuals, there were no services immediately post diversion. These individuals were only receiving medical care from a PCP or from a specialist. As previously indicated, several of these individuals were homeless and had no previous housing to return to. Two of these individuals were living in a group home and neither had referrals for housing despite one individual requesting a different, more independent living arrangement. All but one individual who scored poor or very poor had no involvement in the community although they expressed the need for initial or ongoing supports for community inclusion.

Information regarding the diversion experience was limited. In several instances, the individual did not recall the conversations with the PASRR Level II reviewer. One individual declined to be interviewed and the service review team was not able to gather information regarding their diversion experience. Several family members interviewed did recollect the PASRR Level II process but were displeased regarding the outcome of the evaluation which recommended continued tenure in the community rather than an NF placement. They could not recall if and what community options the PASRR Level II evaluator provided.

There was little documentation of whether regular team meetings between the CCM and care providers occurred. CCM notes indicated a referral for services had been made but little contact occurred. There were two individuals for whom the CCM and service provider (e.g., ACT) had regular contact.

Two individuals had income assistance issues at the time of diversion. These individuals had pending applications for Social Security Disability Insurance (SDI) or Supplemental Security Income (SSI) and were awaiting responses from the SSA regarding these benefits.

Systemic Issues

The services reviews identified a number of systemic issues experienced by individuals who were diverted. While assessments for individuals diverted were generally complete and of good quality, the CPOCs were often absent of strategies and specific services that addressed the needs of the individual as identified in the community assessment. Some of the systemic issues for this cohort are similar to individuals who transitioned and were receiving CCM services. Similar to individuals who transition, a pressing issue was the lack of information in CPOCs developed by the CCM. Documentation regarding the CCM activities and outcome of interventions was lacking. For individuals who were diverted, the CPOC did not include information regarding the duration and frequency of services or identify specific providers that would render services. In addition, there were several service access issues identified in the review including:

- Community inclusion--The CPOCs lacked strategies to address integrated day activities. The lack of integrated activities in the community can be a risk for future stability. Continued lack of peer support to address loneliness and better community inclusion is a continued theme for most individuals in the review.
- Housing--One-half of the individuals who were diverted from NFs were wanting or indicated interest in living in their own apartment. As indicated above, there is no housing on demand. For some individuals, the CCM had assisted the individual to complete the necessary application(s) for housing. For other individuals, the CPOC did not include housing strategies and the CCM had not yet made the referral for housing for these individuals.

The staff turnover in one region also impacted the participation of individuals in the CCM program and the overall quality of life for individuals who were diverted. Individuals who were diverted in this region did not have an ongoing relationship with a consistent case manager. In addition, turnover in this region impacted engaging the member in quality person-centered planning. There was only one CCM in this region for a period of time, impacting the ability to research local resources.

There is a lack of communication among CCM and formal support providers for individuals who are diverted. For instance, one individual participating in the CCW program indicated there was no communication between the CCM and CCW Support Coordinator. Some individuals interviewed complained about the "flurry" of individuals who were checking in on a weekly basis.

CCMs and TCs were interviewed regarding any processes for sharing plans for various services among providers that have significant contact with the individual. In general, plans were not shared between these service providers and CCMs.

As indicated above, individuals who are diverted often need services and supports on demand. While the CCM can make the referral for appropriate Medicaid programs (e.g., CCW and Long Term Personal Care Supports), approval of participating in these programs may take weeks if not months. CCMs did not have information on how to access alternative sources of supports for individuals diverted from NFs while waiting for these approvals. While some of these individuals had natural supports (e.g., family members) who could bridge the gap until formal supports were available, many of these individuals had no formal supports making it difficult to immediately find in-kind or other services.

Interviews indicated there were potential gaps in CCM for individuals who were hospitalized or readmitted to an NF. For some of these individuals the CCM indicated it was policy to disengage when individuals are admitted to an inpatient setting or NF. In these instances, the CCM was not involved in discharge planning from an NF or inpatient hospital which would complicate the identification and delivery of services for these individuals once they were discharged.

Recommendations

The following recommendations have been developed specifically for individuals who have been diverted from NFs. Almost all recommendations in the transition section are applicable to individuals who are diverted. In addition to these recommendations, it is recommended LDH:

- Enhance strategies for immediate engagement of intensive formal supports (e.g., mobile crisis, brief crisis services, or ACT) to support the individual and CCM in their efforts to stabilize immediately post diversion. As indicated above, individuals who are diverted have recently been discharged from general medical or behavioral health hospitals and may be experiencing some crisis, ranging from active behavioral health symptoms to significant anxiety or trauma from their recent hospitalization. CCMs are sometimes solely responsible for managing the crisis (regardless of intensity) and could use additional support to assist with immediate diversionary strategies. LDH reports that all members of the Target Population are eligible to receive ACT if agreed to by the individual. Organizations providing crisis services and ACT have experience with responding to crisis and assisting with efforts to stabilize the individuals in the community. Ensuring this "on call" capacity would provide CCMs and the individual with assistance for either short periods of time until additional supports or initial and ongoing support from ACT teams can be put in place. Given the existing policy for referring Target Population members to ACT, LDH should develop protocols for CCMs to determine the immediacy of these supports and ensure CCMs and the individual receives immediate supports as needed. In addition, these providers should be included in the initial and ongoing team meetings as appropriate.
- Develop an expedited standard housing application process for individuals diverted that have no housing or have unstable housing. The SME understands that on demand housing is not a realistic option; however, LDH should have the capacity to develop strategies that would expedite the housing process for individuals who are diverted and are homeless, experiencing housing instability, and/or are requesting rapid re-housing. There may be limited experience LDH can draw from and create this strategy given some CCM efforts to expedite housing for some of these individuals. LDH may want to consider piloting policies with their housing staff and the Louisiana Housing Corporation (LHC) that would meet the needs of these individuals and provide LDH with an immediate referral when a housing option is readily available.
- Develop a policy that requires inpatient hospitals to provide a 30-day prescription for medications needed for their inpatient stay. LDH and MCOs should determine if they have regulatory or payment leverage to require hospitals to provide either a limited supply of medication or at a minimum a 30-day prescription. Individuals being discharged from hospitals will likely be enrolled in Medicaid but may not have an ongoing prescriber post-discharge.

- Develop strategies to make PCA services available as quickly as possible. While it is unlikely to be able to get same day PCA services when an individual is diverted, LDH should provide options for shortening the length of time it takes to access PCA through either the LTPCS program or PCA services offered to individuals enrolled in managed care through the 1915b3 program.
- Train CCMs to track initial authorization periods for needed services (regardless of Medicaid or Medicare) immediately at diversion. Subsequently, they should assist the individual and caregiver in tracking and requesting authorizations if needed before the end date of the authorization. This assistance will be helpful in ensuring most individuals continue with important services, especially therapies for ADLs, and provide them with ongoing supports for community tenure.
- Monitor, in conjunction with MCOs, the completeness of the CPOC and assure that services identified in the assessment have referrals for providers chosen by the individual. As LDH assumes additional compliance activities for the CCM program, focused attention is needed on whether the CPOC is complete and adequately addresses the needs in the assessment or reassessment.
- The CPOCs should include the amount, duration, and frequency of services. If another provider (e.g., ACT or CCW Support Coordinator) has developed a plan, the CPOC should at a minimum reference these plans. LDH should ensure these other plans include amount, duration, and frequency of services.
- LDH or MCO should provide refresher trainings to CCMs and monitor their efforts to assure individuals have been offered the opportunity to invite other individuals of their choosing to POC meetings.
- Ensure crisis plans identify if the individual was offered the choice of contacting the local crisis provider as needed. LDH has developed a comprehensive crisis system in some areas of the state. Most regions have an identified mobile crisis provider. Individuals who are diverted should be provided information regarding these crisis services and, if appropriate and requested, include MCR as an option to be contacted during a crisis event.

Individuals Awaiting Transition from Nursing Facilities

This section provides the results of the services review for individuals in the Target Population who were waiting to be transitioned from NFs. Nineteen individuals were included in the review of individuals who were on the Active Caseload List (ACL) and waiting to transition. Initially, individuals were selected from all individuals on the ACL. In the first region the team reviewed, most individuals selected to participate in the review did not have completed assessments or plans or had minimal contact with the TCs. Therefore, little information was immediately available to review for these individuals. In subsequent regions, the sample was selected from individuals who had either completed NFTAs and ITPs or for whom the ITP was in process. For these individuals there was more documentation, which also allowed a more informative interview. The service reviews for individuals who were awaiting transition focused on different domains than the other two groups of individuals. The reviews focused on areas that were identified by the SME, LDH, and DOJ. These areas included:

- Timeliness of various activities performed by the TC. The review determined if the NFTA was conducted, ITPs were completed, the transition date was identified, and various discharge activities occurred within timeframes established by LDH.
- The presence and quality of NFTAs and ITPs and whether these processes were person-centered.
- If the individual received in-reach by a peer in-reach specialist and the quality of the in-reach effort.
- The transition experience. This included a review of activities performed by the TC to ensure services were in place prior to transition, level of communication between the TC and the individual awaiting transition, and additional transition activities (e.g., scheduled discharge planning meetings).

The service review assessed whether a CCM was identified (if the transition was within 60 days) and if referrals were made to providers for services identified in the ITP.

During the interviews in the first region, few individuals could recall the in-reach process. They often recalled that there were a number of individuals who discussed the transition process but could not provide much detail regarding in-reach provided by peer in-reach specialists. Therefore, this area was not included in subsequent reviews.

Demographics of Individuals Awaiting Transition

The average age (as of the interview) for individuals who were awaiting transition was 63 years old. Most of these individuals were between 51 and 64 years old. Almost one-third (32%) were between 65 and 75 years old. There was one individual under the age of 50 (43 years old) and one individual who was over 75 (77 years old). Table 34 provides information regarding the age of this review cohort.

Table 34. Age Distribution for Individuals Awaiting Transition

Age	Number of Individuals	%
Average Age	63	N/A
50 and under	1	5%
51-64	11	58%
65-75	6	32%
Over 75	1	5%
Total	19	100%

Individuals who were awaiting transition were generally evenly distributed across two identified genders—10 individuals (53%) identified as male, and 9 individuals (47%) identified female. Table 35 provides an overview of the gender of individuals awaiting transition.

Table 35. Gender of Individuals Awaiting Transition

Gender	Number of Individuals	%
Male	10	53%
Female	9	47%
Total	19	100%

The race of individuals awaiting transition was evenly distributed across individuals who identified as African American and Caucasian. There was one individual in the sample who identified as Hispanic. Table 36 provides information regarding the race of individuals awaiting transition.

Table 36. Race of Individuals Awaiting Transition

Race	Number of Individuals	%
African American	9	47%
Caucasian	9	47%
Hispanic	1	5%
Total	19	100%

Nursing Facility Length of Stay for Individuals Waiting to Transition

Individuals participating in the review and waiting to transition had highly variable lengths of stay. The length of stay was calculated from the admission date to the date interviewed. The mean

(average) length of stay for individuals who transitioned was over 3 years (39.25 months). The median length of stay was 16 months. The shortest length of stay for an individual in an NF waiting to transition was 7 months. The longest length of stay was 16 years. Information on length of stay is provided in Table 37.

Table 37. Nursing Facility Lengths of Stay for Individuals Awaiting Transition

Mean Length of Stay	Median Length of Stay	Shortest Length of Stay	Longest Length of Stay
39.25 months	16 months	7 months	192 months (16 years)

Physical and Behavioral Health Characteristics

Individuals awaiting transition from an NF had varying physical health, including chronic conditions. For two individuals, information from the review indicated each had over 15 healthcare conditions. A majority (57.9%) of individuals awaiting transition had diabetes. Other individuals had a range of chronic conditions including COPD, hypertension, high blood pressure, and heart disease. Table 38 provides an overview of chronic conditions experienced by individuals awaiting transition. As noted above, many individuals had two or more chronic conditions and therefore the number of individuals is duplicated.

Table 38. Chronic Conditions Experienced by Individuals Awaiting Transition

Chronic Conditions	Number of Individuals	Percent
COPD	3	15.8%
Diabetes	11	57.9%
Hypertension	3	15.8%
High Blood Pressure	2	10.5%
Heart Disease	3	15.8%

In addition to these chronic conditions, individuals awaiting NF transition had many other medical conditions. Table 39 provides an overview of the most frequently co-occurring medical conditions for these individuals. As indicated in Table 39 a significant percent (47%) of individuals reported they experienced pain and would likely need medication or pain management strategies upon discharge. In addition, a number of individuals had arthritis or epilepsy and are receiving medications to treat these conditions. Other individuals had experienced a stroke and were reported to have mobility or other issues that were impacting their ADLs. Other individuals were diagnosed with obesity, anemia, and/or Parkinson's' disease, all conditions that would require ongoing medical attention post-discharge. In addition, individuals awaiting transition had various

other medical conditions including Hepatitis C, HIV, cancer, chronic UTIs, traumatic brain injury, and multiple sclerosis.

Table 39. Other Conditions Experienced by Individuals Awaiting Transition

Other Conditions	Number of Individuals	Percent
Anemia	2	10.5%
Arthritis	4	21.1%
Epilepsy	4	21.1%
Obesity	5	26.3%
Pain	9	47.4%
Parkinson's	2	10.5%
Stroke	4	21.1%

Individuals' SMI diagnosis was generally schizophrenia or major depressive disorder. A little more than one-fifth reported having bipolar disorder. Similar to chronic and health conditions, individuals had multiple conditions that were identified as SMI. Table 40 provided information on the mental health diagnosis of individuals who are awaiting transition and participated in the service review.

Table 40. Behavioral Health Conditions Experienced by Individuals Awaiting Transition

SMI Diagnosis	Number of Individuals	Percent
Schizophrenia	11	57.9%
Major Depressive Disorder	11	57.9%
Bi-polar Disorder	4	21.1%

In addition to these behavioral health conditions, individuals awaiting NF transition had other mental health and SUD conditions including anxiety, mood disorders, and cannabis use.

Findings from the Service Reviews

This subsection provides information regarding the individual and composite score for individuals who are awaiting transition from NFs. Each member of the service review team provided a score for each individual for each domain and area. As indicated above, the domains for individuals who were awaiting transition were different than the domains reviewed for individuals who were transitioned or diverted. The findings from this service review is new. Information from the first service review focused exclusively on individuals who transitioned. It was important to perform a service review on these individuals to have a better understanding as to whether individuals were being transitioned in a timely manner and whether the NFTA and ITP were complete and

person-centered. In addition, the review sought to collect information from the individual and others included in the transition process regarding the experience of individuals participating in pre-transition activities. There is no comparison group for the awaiting transition cohort.

The service review scores for individuals awaiting transition is provided in Table 41. As these scores indicate, all three areas of the review and the overall score (1.72 out of 5) were rated poor. A discussion of each of these areas is presented below.

Table 41. Domain Scores for Individuals Awaiting Transition

Area	Timeliness	Assessment and Person-Centered Planning	Transition Experience	Overall Score
Score	1.74	1.74	1.68	1.72

Timeliness

The timeliness of various activities performed by the TC was poor (1.74 out of 5). As Table 41 indicates, the majority of activities were not performed on a timely basis. Over two-thirds of the individuals in the service review had an identified date of transition within 7 days of the assessment being completed. However, one-third (36.8%) of NFTAs were completed within the required 14 days of referral to the TC. Less than one-fourth (21.1%) of ITPs were developed within the timeframe of 30 days from when the individual indicated they were interested in transition. The timeframe for when NFTAs and ITPs were done was variable when not meeting LDH expectations. Some NFTAs and ITPs were completed a week beyond the LDH expectations. Other NFTAs and ITPs were not completed until months after the individual was referred to the TC. While the date of transition was present for most individuals, these dates were fluid and changed during the transition process. No individuals transitioned based on the date identified during the assessment process.

Table 42 provides information on activities performed within LDH's expectations. Most individuals (78.9%) reviewed were not within the 60 days of transition and therefore neither a referral to CCM or a discharge planning meeting occurred. This was indicated in the Not Applicable column.

Table 42. Activities Performed Within Expectations

Activity	Performed within LDH Expectations					
	Yes	Percent	No	Percent	Not Applicable	Percent
NFTA	7	36.8%	12	63.2%	0	0
ITP	4	21.1%	15	78.9%	0	0
Date of Transition	13	68.4%	6	31.6%	0	0
Referral to CCM	2	10.5%	2	10.5%	15	78.9%

Discharge Planning Meeting	2	10.5%	2	10.5%	15	78.9%

Nursing Facility Transition Assessment and Individualized Transition Plan

Transition Coordinators are expected to complete the NFTA and ITP for all individuals who are on the ACL and who have expressed interest in transitioning. The NFTA and the ITP are structured around various domains identified by LDH. Both documents solicit information for planning purposes across various domains, including:

- Housing and housing supports
- Community living and social relationships
- Vocational and educational
- Personal supports
- Behavioral health supports
- Medical and healthcare.

In addition, the assessment collected information on the strengths and barriers for individuals who were waiting transition. The ITP collected information regarding the domains above, information on goals, and whether the individual attended the planning meeting, had signed the ITP, and was provided a copy of the ITP.

The service review evaluated various dimensions of the NFTA and ITP process. The review identified whether NFTAs and ITPs were done for individuals who were awaiting transition. Table 42 provides information on the presence and absence of NFTAs and ITPs. Despite the timeliness issues discussed above, a significant majority of individuals had both documents. Individuals who did not have NFTAs and ITPs were generally in the first region that was based on individuals who were on the ACL regardless of their transition status. Individuals in the second and third region did have both documents.

The review found wide variability in the quality of the NFTA and ITP. The quality of the NFTAs for individuals awaiting transition was 69.57 out of a total possible score of 100. Documentation was reviewed to identify what areas were and were not addressed in the NFTA process. Table 43 identifies areas that were often not addressed in the NFTA.

Table 43. Areas Not Identified in NFTA

Area	Number of Individuals	Percent
Barriers	15	83.3%
Strengths	13	72.2%
Other Services	10	55.6%
Behavioral Health Supports	6	33.3%
Medical Needs	5	27.8%

There were various domains that were not addressed in the NFTA. Two major domains that were not addressed were specific to medical needs and behavioral health supports. For instance, information was not provided on the need for primary care. In addition, for one-third of all individuals in the review, the NFTA did not provide any information regarding behavioral health supports. Therefore, it was difficult to determine what supports were needed (e.g., medication management, ACT, outpatient counseling services) post transition. In addition, three individuals interviewed indicated they did not have any behavioral health conditions and therefore did not need any behavioral health services.

There were several significant areas regarding the NFTA process that were absent from these assessments. Most concerning were assessments that did not include the individual's strengths, which is a critical principle of person-centeredness. In addition, the assessments did not identify potential transition barriers for individuals. Therefore, the service review team relied exclusively on interviews with the individuals and TCs to garner this information.

The quality of the ITPs for individuals awaiting transition was very poor (23.08 out of 100). This score reflected only individuals who had an ITP started or completed. There were many ITPs that did not address the needs in the individual's NFTAs. Areas that were not often addressed in the ITP but were identified as a need in the NFTA are presented in Table 44 below.

Table 44. Areas Not Addressed in ITP

Area	Number of Individuals	Percent
Community Living and Relationship Support	13	92.86%
Transportation	12	85.71%
Goals	11	78.57%
No planning meeting	11	78.57%
Vocational/Educations	10	71.43%
Personal Care Assistance	10	71.43%
ITP Provided to Individual	10	71.43%
Medical Needs	9	64.29%
BH Supports	8	57.14%
Signed ITP	7	50.00%
DME	6	42.86%

The lack of information in these areas is concerning. Major service domains identified as needed in the assessment such as medical, behavioral supports, community living, and relationship supports, and vocational/education were not addressed in almost all individuals ITPs. Support services such as transportation and assistance with ADLs and IADLs were not included in the ITP.

There were a number of individuals who identified the need for medical services and supports in the NFTA that was not included in their ITP. These individuals identified they would like a nurse to "check in on them" for wound care. Another individual requested insulin education to control his diabetes. Another individual requested assistance in locating and coordinating appointments with a primary care provider. Another individual has an assessment that lists the need for physical, occupational, and respiratory therapy.

There were few references to activities related to community living and relationship support despite some individuals who expressed interest in returning to work or seeking volunteer opportunities. Several individuals indicated they would like assistance to return to church and church activities.

Transportation, especially non-emergency medical transportation (NEMT), was often identified as a needed service but not included in the ITP. One individual expressed their concern regarding having available transportation to take them to their dialysis appointments. Without an assurance this transportation was in place, the individual was unwilling to transition. Others identified the need for NEMT for primary care and specialty care appointments.

Durable Medical Equipment was also a frequent need identified in the assessments and interviews. This included shower bench, handheld shower, a grab bar, manual wheelchair, and a personal emergency response system.

In addition, major tenets of a person-centered plan were absent from these plans. For instance, more than three-fourths of all individuals had plans with no goals. Slightly fewer individuals indicated they had a copy of their ITP. One-half of the ITPs were not signed by the individual which is one indication of their participation in the planning process.

Transitions Experience

The service review team collected information regarding the status of the transitions through record reviews and interviews with the individual and the TC. The overall rating for transition activities was poor (1.68 of 5). There were some individuals awaiting transition that did have a positive experience with the transition process. For instance:

- One individual stated they had been involved in the transition process and there was regular communication from the TC regarding the status of transition services and supports. Another individual confirmed the TC was in frequent contact with the individual and individual's family regarding the status of services in the ITP.

- Three individuals indicated their TC was taking the necessary steps regarding locating housing, including providing choice regarding housing options, assisting with the housing referral process (including developing the housing packet), and actively working with the individual to identify housing opportunities in the community selected by the individual.
- Several TCs were very clear regarding the preferences of the individual and what the individual wants in order to be successful.
- Three ITPs were up to date.
- Several individuals indicated their TC was taking the necessary actions to have services and supports (including housing and housing supports) in place prior to transition.

Despite these positive experiences, individuals generally expressed frustrations and concerns regarding their transition experience. For instance, one individual stated no one has talked to them for a while regarding transition and they do not know their transition status. Other individuals interviewed reported the cadence of transition meetings as being sporadic. Another individual did not feel progress with transition was being made. In reviewing the notes, there was a seven month gap in any documentation by the TC for this individual. Another individual indicated they had submitted six applications for housing and had no follow up with the TC until almost three months later, only to find out the applications had been denied and an additional application was needing to be submitted.

Members reported they did not have monthly contact with a TC. For one individual there was no contact with the TC for three months, during which time the individual was having to appeal a denial for the CCW program. Two individuals and their family members were unclear as to their transition status. One expressed irritation at the delay in transitioning but understood housing opportunities in the selected area were in short supply.

In general, there was a lack of documentation that indicated follow through on activities in the ITP by TC. For the majority of individuals, neither the ITP or other documentation identified providers for needed services or referrals to providers if identified.

Housing played a role in the transition process. During interviews, TCs explicitly stated they would not conduct any follow-up referrals for other services until housing was secured, referencing that some individuals were on a two-year wait list. Two individuals awaiting transition cited the lack of progress discussing or finding housing. One individual was anxious to hear about housing options but had not talked to the TC for several months. Another individual reported their TC did not contact the member with planning updates or move forward with investigating and/or securing the housing option for three months. One individual stated that he has not been involved in choosing a place to live and is hoping the TC will have some places for him to review when they meet next, but there was no specific date set for that follow up meeting. Five

individuals indicated they needed physically accessible housing. TCs indicated there were few options for this type of housing, which impeded the transition process.

Several TCs did not initiate activities with NFs to educate individuals regarding their medications prior to transition. Other TCs have not assertively engaged the NF regarding individuals' needed therapies while in the NF that could improve the individual's strength. Individuals identified the need for strength and mobility training prior to discharge to improve their tenure in the community.

In addition to these issues, there were other factors that impacted the experience of individuals who were awaiting transition. For instance:

- Initial transition dates have passed, and no new date was documented.
- No referral information (even if it is a placeholder for future referrals) based on the needs in the assessment.
- Turnover in TCs. In some regions there was only TC, which impacted the quality of transition services.

Overall, the service reviews of individuals awaiting transition is disappointing. The one bright spot was improvements in the NFTA from the initial service review, which had indicated major gaps in the quality of these assessments. However, the quality of the ITPs has not appreciably improved since the first service review. Information regarding services needed was missing in most of these plans. In addition, waiting to amend or complete an ITP until housing is secured is counter intuitive. Individuals interviewed in the assessment process identify needs that should be included in the ITP, even if it is a reminder to the TC to follow up to identify providers, offer choice of providers to the individual, refer the individual to the selected provider, and ultimately include this individual in the discharge planning process prior to transition. The lack of communication between the individuals awaiting transition presents additional issues for the individual who may be anxious about a transition. In addition, this lack of contact erodes the credibility and trust of the TC responsible for assisting the individual to transition.

Perhaps the most disappointing finding is the lack of a person-centered approach to assessments and planning. The number of assessments that did not identify an individual's strengths, the plans that did not have goals or planning meetings, and individuals reporting they did not have their ITP was distressing.

Systemic Issues

While there have been marked improvements in the NFTAs since the last review, the quality of the ITPs continues to be poor, and they are not completed within the timelines required. Therefore, it is difficult to determine if referrals for other services (other than housing) have been

made. When services were identified in the ITP or discussed in interviews, there were several issues related to the availability of specific services. These included:

- Housing —TCs may not be familiar with all housing options and had not taken steps to secure housing for these individuals earlier in the transition process. In addition, there is a lack of affordable, accessible housing in most areas of the state. As indicated above, a number of individuals needed accessible housing and there were no immediate accessible housing resources in the communities they selected.
- CCM—TCs were informed the CCM program was not taking new referrals due to staffing issues. This may have implications for the timing of discharge activities for individuals awaiting transition.
- Personal Care Services and other CCW services—As indicated above, there is a lack of referrals to CCW or other programs (e.g., LTPCS) until housing is secured. Therefore, delays in transitions may occur given delayed referrals to these programs.

Despite LDH developing specific expectation timeframes for TCs to engage the individual in the assessment process, to complete the assessment and ITPs, TCs are not meeting these expectations. One expectation that seems to be met more frequently is the identification of the date of transition on the initial NFTA. However, these dates of transitions are fluid and rarely the actual date the individual will transition. In addition, there is no identified cadence of when TCs meet with the individual awaiting transition. In almost all individuals reviewed there were significant gaps in documentation that identified if the TC met with the individual with any regularity. Interviews with individuals awaiting transition supported this finding. Many did not know the status of their transition since this had not been communicated to the individual with any regularity. Some TCs interviewed indicated they "complete" the transition plan to meet timelines, but it does not adequately address the needs identified within the assessment, especially if the individual needs accessible housing.

Some ITPs are not completed until a few weeks prior to the individual's transition. This delay can create gaps in needed services for the individual until initiated in the home, putting individuals at risk for hospitalization or reinstitutionalization.

As indicated above, there are instances where individuals with a completed assessment (and therefore who have expressed interest in moving) do not have a started or completed ITP. This impacts the transition significantly. If there is not an ITP there is no reasonable pathway for the individual to be transitioned, let alone transition on a timely basis.

The approach TCs use for developing ITP focuses initially on determining if the individual needs housing and housing supports. Initially prioritizing housing is prudent; however, that should not impact identifying the other services during the ITP process. The lack of transition plan development until housing is obtained impacts an individual's transition. Once housing is

secured, the individual may not have sufficient time to receive training on medications or physical therapy to build the strength needed to live in the community. This can create delays or a loss of housing options if the individual is not ready for discharge (e.g., need for PT/OT for strengthening, mobility, self-care, or instructions of medications).

Pain management continues to be an issue. Almost 50% of individuals reviewed identified they had pain and were receiving medication and other treatments to address the pain. Pain management strategies were not included in any ITPs. As discussed in the previous report, lack of attention to these pain management strategies (medication and other interventions) will complicate transitions if community prescribers of pain medication and alternative strategies are not identified. Individuals on pain medication may likely experience withdrawal symptoms if not identified and referred to prescribers and alternative pain management strategies at transition.

The turnover of TCs presents several issues. In these instances, a TC from another region assists the individual to transition. That TC may not be familiar with the resources within this region. In addition, the lack of documentation does not provide the interim TC with the information necessary to actively pursue transition strategies, which delays the transition process.

Some individuals needed income assistance through the SSDI or SSI benefit program. The Social Service Director at the NF did not complete these applications for these individuals and therefore individuals will likely be transitioned with no source of income, which impacts an individual's stability and well-being in all domains.

Recommendations

The following recommendations have been identified based on both individual and systemic issues from the service review. It is recommended that LDH:

- Continue to monitor the timeliness expectations on a monthly basis. LDH has developed various management tools and strategies for tracking the timeliness of critical TC activities. While the SME understands that documentation takes away time from direct service activities, information in ITPs will provide the individual and TCs with a path forward for a well-planned transition.
- Develop and enforce clear policies regarding the frequency of check-ins with individuals who are awaiting transitions. The SME is recommending monthly (if not more frequent) meetings between the individual and the TC. These meetings should specifically provide information on the status of various referrals and changes to the ITP based on the timing of the transition. This should be monthly until 60 days prior to discharge when contact should be more frequent.
- Hold (and document) discharge planning meeting requirements that align with CCM requirements for pre-discharge case management. Interviews with TCs and CCMs

indicated both were holding meetings prior to discharge. However, it was not clear that these meetings were done jointly and that these meetings were supporting and not supplanting each other's efforts to have a planful discharge.

- Clarify the role of TCs and CCMs in the discharge planning process. As discussed in the transition recommendations, LDH and MCOs should have clear policies for transition planning. While the SME understands there may be separate guidance for TCs and CCMs, more explicit language is needed in standard operating procedures that clearly delineate roles during discharge. The SME recommends that TCs continue to have the primary leadership role in conducting and overseeing transition planning activities prior to and on the day of transition.
- Formally document referrals to CCMs to engage 60 days prior to transition. While CCM documentation existed for some individuals who were awaiting transition it was less clear on whether LDH or MCOs are tracking if the referrals for the TCs are done on a timely basis and whether the CCMs are responding to those referrals quickly and within the timeframes established in the SOPs. LDH and MCOs should develop a system to ensure these referrals are made and CCM engagement occurs on a timely basis.
- Continue training, coaching, and enforcement efforts by TC supervisors on NFTAs and ITPs. While the quality of assessments have improved since the last review, the ITPs have not. LDH has developed training for TCs regarding strategies to improve the quality of ITPs. In addition, information in the initial ITP should include placeholders for referrals for services needed as identified in the NFTA. The SME understands that identifying providers of some services in the ITP prior to securing housing or approval of participation in the CCW program may not be possible. However, these placeholders can provide an important reminder to TCs to discuss the ongoing need for the service in follow up meetings and a reminder to identify providers for services in the ITP in a timely manner.
- Create a specific field for the date of transition and have a field that identifies if the date has been updated and when the update occurred. As indicated in the discussion above, transition dates are fluid; the initial date is an estimate of when the TC believes the transition may take place. As these dates change it will be important to note the new date and when the change occurred. These changes will provide TC supervisors with timely information on when the transition will occur and if the transition date has been recently updated to reflect the changes in status on certain referrals.
- Create more opportunities for physically accessible affordable housing. The SME understands the challenges LDH and LHC face in creating physically accessible housing. The SME recognizes LDH and LHC have incentivized developers to create more physically accessible units through various procurement and contracting processes. However, additional steps may need to be taken to ensure these units are developed. LDH and LHC should meet with developers and property managers at least 60 days before a project is completed to provide specific information regarding the number of accessible units needed. That will require that LDH has up to date information on the needs of individuals

awaiting transition who will need physically accessible units. This information will need to be maintained regularly and on a regional and perhaps a subregional basis.

- Develop and implement training regarding pain medications and alternative pain management strategies. Similar to recommendations regarding individuals who transition, LDH should ensure that TCs understand the importance of managing pain and have strategies in the ITP to address medications or alternative pain management strategies immediately after transition.
- Perform monthly monitor efforts and improve the person-centeredness assessment and planning activities. This would include a monthly review of new ITPs to address significant gaps in NFTAs and ITPs regarding:
    - Goals (ITPs)
    - Strengths (NFTAs)
    - Barriers (NFTAs)
    - All services not identified in the ITP that were an indicated need in the NFTA.
- Clarify in a memorandum and include trainings to TC and supervisors that ITP development should continue while housing is being secured. As discussed above, initial ITPs should, at a minimum, include placeholders for other services identified in the assessment. In addition, LDH program management should identify whether this policy and training is being followed or if TCs are continuing to defer planning efforts until housing is secured.
- Provide training and coaching to TCs regarding strategies to engage NFs to provide the necessary services prior to transition that are most needed by individuals awaiting transition (e.g., medication education and administration, therapies and other strategies to improve ADLs).
- Train TCs regarding the availability of formal supports regarding employment and education. This includes determining when an individual is a good candidate for a referral to Louisiana Rehabilitation Services (LRS), the Medicaid employment benefit available through MCOs, or for supported employment assistance that should be provided by all ACT teams.
- Provide training and assistance to TCs regarding assertive strategies for NFs to offer medication training, submit SSA applications, and ensure the NF makes the necessary changes to Medicaid enrollment upon transition.

Conclusion

The second service review provided more detailed findings regarding individuals who transitioned and additional populations of individuals who were diverted or awaiting transition from NFs. The waning of the pandemic, addition of CCM and additional behavioral health services, and attention to person-centered planning for individuals who were transitioned or

diverted had positive impacts on the quality of life for individuals reviewed. However, there are significant service access issues for employment, peer supports that are present, and LDH needs to address immediately. In addition, there are various changes in policies and procedures LDH and MCOs should consider for the CCM program. Perhaps the biggest lifts are LDH's efforts to improve diversions from NFs and the experience of individuals awaiting transition. As indicated in this report, most individuals have acute medical and behavioral health needs and CCMs alone may be ill equipped to address those needs on a timely basis. In addition, information from documents and interviews indicate much work is needed with TCs to improve ITPs and ensure a person-centered approach as well as ensure more frequent and consistent contact with individuals while in an NF and prior to transition.

APPENDIX A Community Case Management Record Review Tool

Member Name/ ID number:					
Date of review:					
CCM Name:					
Date Admitted to NF:					
Date of Diversion:					
Date Transitioned to Community:					
Date of Referral to CCM:					
Date of Initial CCM Assessment:					
Date of PCPC:					
Indicator	**Yes= 1**	**No = 1**	**NA = 1**	**Comments**	**Interpretive Guidelines**
Records Present					
CCM Assessment					Document presence by indicating Yes or absence by indicating No.
% of records present	0	0			0.00%
Community Plan of Care					Document presence by indicating Yes or absence by indicating No
% of records present	0	0			0.00%
Crisis Plan					Document presence by indicating Yes or absence by indicating No
% of records present	0	0	0		0.00%
Timeliness				Place a "1" in the corresponding box for responses. Ensure that if the item is Not Applicable that you place a 1 in that box. If an element is partially met, place a ".5" in the Yes box	Review dates above to determine timeliness
For diverted members, the CCM connects members with service providers for urgent needs within 7 days following referral.					
Initial CCM Assessment is conducted within 30 days of referral from the MCO for transitioned and diverted members					Review first CCM assessment compared to date of referral.

Reassessment is conducted every 90 days or when condition, needs or risk level of the member changes					Changes include but are not limited to changes in physical health or behavioral health conditions, hospitalizations, ED visits, Change in primary caregiver or change in living arrangement. If changes occurred, describe in the Comments section
Person Center Plan of Care was completed within 30 days of D/C from NF for transitioned or 30 days of referrals for diverted members					Review date of PCPC against date of discharge from nursing facility
PCPC is reviewed/updated at least every 90 days or when a significant change in member's needs or circumstances					Significant change would include, but not limited to, avoidable ED visits, hospitalizations, changes in SDOH needs such as housing or food insecurity, social support and family/caregiver needs.
PCPC is revised at least every 6 months					A formal revision of the PCPC is to be conducted at least every 6 months
Timeliness score	0	0	0		0.00%
Assessment Quality					
Assessment addresses all the following domains:					Applies to periodic reassessments too. Review the most recent assessment for this section
Medical needs					Should included physical health needs, comorbidities, medication and treatment adherence.
Behavioral health needs					Include BH needs, SUD, IDD and address medication and treatment adherence, risk for harm
Social/recreational needs					Community inclusion, preferences and engagement, interests, concerns and perceived barriers.
Educational/Vocational Needs					Interests, concerns, perceived barriers
Assessment addresses all the following Services/support needs:					
Housing					Includes documentation of Member's preferences, feelings, choices for living arrangement, neighborhood, and needs
Housing supports					Supports needed to be successful in independently living
Employment					Desires for employment and supports needed

Health/wellness					Educational needs related to support health and wellness living per individuals desires, preferences and perceived barriers
Safety					Safety needs and needed supports.
Transportation					Assess both medical and non medical transportation needs.
Healthcare services and adaptive equipment					List of any durable medical equipment needs, or healthcare services to support independent living (may include home health care, current DME/supplies and needed DME/Supplies, Wound care supplies and services)
Nutrition					Assessment of nutritional needs and supports r/t to diet and intake
Dental services					Review of dental needs and supports to address needs
Individual's preferences					Personals interests, concerns, perceived barriers and preferences
The CCM assessment included information from other sources					Member, Family/Natural supports if desired by member, Medical Provider, Behavioral Provider, MCO CM, CC Waiver, ACT team, Transition Assessment, PCS Agency, MHR provider for CPST or PSR.
Assessment Quality Score	0	0	0		0.00%
Plan of Care					
The Plan identified Interventions/Strategies to address domains identified in the Assessment.					Does the plan reflect needs identified in the assessment and reflect the member's needs, strengths, preferences, choices and goals identified in the assessment. Include strategies to address barriers.
Plan reflected strengths and preferences					5.d These are called out in the current IPOC
Medical needs					
Behavioral health needs					
Housing					
Social/recreational needs					
Educational/Vocational Needs					
Durable Medical Equipment					
Transportation					Are transportation needs addressed for all medical and non medical needs

Other support services identified in Assessment					Services identified specified with Type, amount, Duration and frequency of services including service providers	
In general the plan reflects amount, duration and frequency fo services						
Subtotal	0	0	0		0.00%	
Member signature was on plan					5.b	
Other individuals chosen by individual were included in plan development					5.e Are there CCM notes that indicated individuals were identified and invited to the meeting or had contact with CCM re: plan input	
Plan had strategies that addressed health and safety needs					6.i Plan and Crisis Plan	
Individualized Crisis Plan						
Emergency Preparedness and back up plan						
PCPC was provided to Member and other providers/organizations delivering care					Review documentation log to identify notation of PCPC being provided to Member and other providers/organizations.	
POC Quality Score	0	0	0		0.00%	3.e
Ongoing Case Management						
CCM refers and links members with appropriate providers and services					Includes in plan and out of plan Primary and specialty care services, medications, Substance use/detoxification/treatment, mental health treatment, local housing authorities, supportive employment, education, home health care, and personal care and ensure enrollment in benefit programs.	
Contacts Member per requirements (pre transition)					This is minimal Requirements 60 days pre-transition- 4 face to face contacts with 2 face to face contacts occurring the last 30 days	
Contacts Member per requirements - First 60 days					This is the minimal Requirements First 60 days - 4 Contacts per week (2 to be face to face	

Contacts Member per requirements - 61-180 days					61-180 days - Two contacts per week (1 to be face to face)
Contacts Member per requirements - 181-365 days					181-365 days - Two contacts per month (1 of those to be face to face
Contacts Member per requirements - 365+ days					365+ days - At least 2 times per month (1 to be face to face)
Contacts with Service/Support providers					Minimal Contact with Service/Support Providers within the first two weeks of transition and then 1 once every 60 days for one year. Then contact service/support provider every quarter.
Coordinates services and supports between all agencies that provide services to the member.					Documentation log has evidence of coordination of services and supports
The member is receiving services in the amount, frequency and duration identfied in the plan . If not, the CCM follows up to address.					3. f Comparison of Plan to Claims
If no to row above, CCM followed up to address					
The CCM documents progress or lack of progress as appropriate					Documentation log notes progress or lack of progress with goals.
The CCM documents completely all contacts with members using the indicated template.					Documentation log for contacts is completed in its entirety
CCM immediately addresses issues.					Documentation log and PCPC reflect issues and necessary changes.
Ongoing CM Quality Score	0	0	0		0.00%
Critical Incidents					
Did the member have any critical or adverse incidents?					ED visit, hospitalizations, BH crisis, abuse, neglect, exploitation, or extortion.
Critical incidents are reported to the appropriate agency upon discovery					Abuse, neglect, exploitation, and extortion are reportable events.

Was there a reassessment or plan of care review/change as a result of the Critical Incident					Plan of care review shall be conducted whenever there is a significant change in member's needs or circumstances. A reassessment shall be conducted whenver there is a change in member's condition, risk level or circumstances (such as a hospitalization)
Critical Incidents Score	0	0	0		0.00%
Overall Percentage compliant	0	0	0		0.00%

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

Demographic and Summary Data								
Review ID	DOB	Sex	Region	Transition Date	Date of Last Evaluator Contact	Primary BH Diagnoses	Primary PH Diagnoses	Member Interviewed? (Y/N—Reason)
TAC ID	*DOB*	*M/F/N*	*LDH Region*	*Date DC from NF*	*Date of last TAC reviewer contact with info sources*	*Up to three most prevalent*	*Up to three most prevalent*	*Y/N – Brief reason statement if N*

Member Strengths
Short sentences or bullets listing primary Member strengths that support community tenure.

Community Services (Community Plan/Claims) (Summary of Primary Community-based Services Since NF Discharge or Diversion)			
Service (Plan of Care)	**Ever Received Since Transition or Diversion (X)**	**Receiving at Time of Evaluation (X)**	**Comments (Include reason for stopping, issues with accessing, other)**
List services that are clinically significant for community tenure and/or require continuing or medically necessary follow up care. Plan of Care should address physical and behavioral needs (e.g. medication self-administration, provider follow/up, HHC, day programs)	*X – if Member ever received this service. (Member may not be receiving the service at the time of the evaluator review).*	*X – if Member was receiving the service at the time of the evaluator review.*	*Brief statement describing any significant factors relating to the service. This may include reason for stopping (e.g., member choice, no longer needed, etc.), issues with accessing (e.g., transportation not reliable so member not attending per TP, or member not able to get follow up appointment with PCP for bloodwork due to no appts available), or other factors that impact participation in services on CP or TP.*

Findings: Did individual get services in amount and duration in the plan?	*Yes*	*No*	*Describe differences and any rationale for these differences*

Care Coordination/Case Management (Summary of Care Coordination/Case Management Supports Post Transition and Diversion)				
Care Coordination/Case Management Type	**Ever Received Since Transition or Diversion (X)**	**Date of Discontinuation (if applicable)**	**Interviewed (Y/N/NA)**	**Comments (Include reason for discontinuation, level of involvement, level of team participation)**
Community Case Management	*X – if Member ever was assigned to worker. (Member may not be receiving at the time of the evaluator review).*	*Date worker discontinued support of the member (DC from their caseload).*	*Y/N/NA – if TAC evaluator(s) interviewed the worker as part of this evaluation*	*Brief description of reason for discontinuation (if applicable), level/type of involvement with the member, level of team participation (with care team, other coordinators).*
Provider Case Manager (ACT, PSH)				
CCW Support Coordinator				

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

Critical Incidents/Readmissions/Hospitalizations/ER (Summary of Incidents Since NF Discharge or Diversion)		
Type of Incident	**Date (Month/Yr.)**	**Brief Description/Reason**
Critical Incident	*Date of Critical Incident per LDH form*	*Brief description of the nature of the Critical Incident*
Emergency Department	*Date of ED visit (from claims or notes)*	*Brief description if available. If from claims only, list diagnoses from claims summary*
Hospitalization	*Date of hospitalization (from claims, notes, DC summary)*	*Brief description if available. If from claims only, list diagnoses from claims summary.*
Nursing Facility Readmission	*Date of NF readmission*	*Brief description if available. If from claims only, list diagnoses from claims summary.*
Other		

Evaluation Interviews Completed (Summary of Evaluation Interviews Conducted by Evaluation Team)		
Position Interviewed	**(Y/N/NA)**	**If NA (Not Applicable), explain:**
Member		*Brief description of any NA or N response (e.g., member refused, provider case manager left the company, etc.)*
Transition Coordinator		
Community Case Manager		
CCW Support Coordinator		
Provider (ACT, PSH, PCS)		
Other		

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

Records Reviewed (Summary of Records Reviewed by Evaluation Team)		
Record Type	**Reviewed? (Y/N/NA)**	**Comments (Include strengths, significant omissions, quality concerns, timeliness, etc.)**
Claims Review (1 year unless otherwise noted)		*Brief, preferably bulleted list of comments of issues viewed as significant to the value of the document being reviewed. This is an evaluation of the extent the document reflected the member, NOT a listing of record content.*
PASARR Level I		
PASARR Level II (including Hx & Px unless otherwise noted)		
Transition Assessment (specify initial, 7-day, 30-day, 90 day,180-day, 1 year)		
Transition Plan		
Community Assessment (CCM)		
Plan of Care (CCM)		
CCM Contact Notes/Logs		
Critical Incident Reports		
HCBS Waiver Documents (POC)		
Other		

DIMENSION 1 – PHYSICAL WELL-BEING

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths supporting the physical well-being of the member as evidenced by all sources of information evaluated. Note: these may be strengths of the member and/or things that have been done well by the services and supports.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 3-5)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 11-13)** ○ **Add information from Transitioned CCM IG (Reference Q 3-5, 16-17, and 19-21)** ○ **Add information from Diverted CCM IG (Reference Q 3-5 and 19-20)** ○ **Add information from Provider Interview IG (Reference Q 22-24)** ○ **Add information from the TC IG related to individual's involvement in the transitional planning (Reference Q 4, 14, 16,17)**	• *List of brief statements of issues and areas of improvement that could/should be addressed to better support the physical well-being of the member post transition to the community or diversion from NF.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 3-5)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 11-13)** ○ **Add information from Transitioned CCM IG (Reference Q 3-5, 16-17, and 19-21)** ○ **Add information from Diverted CCM IG (Reference Q 3-5 and 19-20)** ○ **Add information from Provider Interview IG (Reference Q 22-24)Add information from the TC IG related to individual's involvement in the transitional planning (Reference Q 4, 14, 16,17)**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

DIMENSION 2 – BEHAVIORAL HEALTH WELL-BEING

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths supporting the behavioral health well-being of the member as evidenced by all sources of information evaluated. Note: these may be strengths of the member and/or things that have been done well by the services and supports.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 3-5)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 11-13)** ○ **Add information from Transitioned CCM IG (Reference Q 3-5, 16-17, and 19-21)** ○ **Add information from Diverted CCM IG (Reference Q 3-5 and 19-20)** ○ **Add information from Provider Interview IG (Reference Q 22-24)** ○ **Add information from the TC IG related to individual's involvement in the transitional planning (Reference Q 4, 14, 16,17)** ○	• *List of brief statements of issues and areas of improvement that could/should be addressed to better support the behavioral health well-being of the member post transition to the community or diversion from NF.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 3-5)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 11-13)** ○ **Add information from Transitioned CCM IG (Reference Q 3-5, 16-17, and 19-21)** ○ **Add information from Diverted CCM IG (Reference Q 3-5 and 19-20)** ○ **Add information from Provider Interview IG (Reference Q 22-24)Add information from the TC IG related to individual's involvement in the transitional planning (Reference Q 4, 14, 16,17)**

Rating				
1	2	3	4	5

Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

DIMENSION 3 – STABILITY

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths supporting the stability in the community of the member as evidenced by all sources of information evaluated. Note: these may be strengths of the member and/or things that have been done well by the services and supports.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 1,2,6,7,10)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 9-10, 14-15, 18)** ○ **Add information from Transitioned CCM IG (Reference Q 7, 11, 16-18, 22-24)** ○ **Add information from Provider Interview IG Reference Q 16-21)** ○ **Add information from TC IG (Reference Q 6, 7, 13, 16)**	• *List of brief statements of issues and areas of improvement that could/should be addressed to better support the stability in the community of the member post transition or diversion from NF.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 1,2,6,7,10)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 9-10,14-15)** ○ **Add information from Transitioned CCM IG (Reference Q 7, 11, 16-18, 22-24)** ○ **Add information from Provider Interview IG Reference Q 16-21)** ○ **Add information from TC IG (Reference Q 6, 7, 13, 16)**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

DIMENSION 4 – ASSESSMENT AND PERSON-CENTERED PLANNING

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths of the assessment(s) and person-centered planning as evidenced by all sources of information evaluated. Note: these strengths should reflect the context of this specific member's needs and preferences.* ○ **Add information from "CCM Assessment Quality", "Planning"** ○ **Add information from Transitioned Member IG related to individual's involvement in assessment planning (Reference Q 4, 6- 9)** ○ **Add information from Diverted Member IG related to individual's involvement in assessment planning (Reference Q 7, 14-15, 17)** ○ **Add information from TC Transitioned/Diverted IG Q 4** ○ **Add information from CCM Transitioned/Diverted IG Q4-6, 12-15, 22-23**	• *List of brief statements of issues and areas of improvement that could/should be addressed to improve the processes of assessment and the integration of person-centered planning with the member.* ○ **Add information from "CCM Assessment Quality", "Planning"** ○ **Add information from Transitioned Member IG related to individual's involvement in assessment planning (Reference Q 4,6-9)** ○ **Add information from Diverted Member IG related to individual's involvement in assessment planning (Reference Q 7, 14-15,17)** ○ **Add information from TC Transitioned/Diverted IG Q 4** ○ **Add information from CCM Transitioned/Diverted IG Q4-6, 12-15, 22-23**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

DIMENSION 5 – COMMUNITY INCLUSION

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths supporting the community inclusion of the member as evidenced by all sources of information evaluated. Note: these may be strengths of the member and/or things that have been done well by the services and supports.* ○ **Add information from Transition Member IG (Reference Q 8-10)** ○ **Add information from Diverted Member IG Reference Q 16-18)** ○ **Add information from Transitioned/Diverted CCM IG (Reference Q 8-11)** ○ **Add information from Transitioned/Diverted Provider IG (Reference Q 15, 25)**	• *List of brief statements of issues and areas of improvement that could/should be addressed to better support community inclusion of the member post transition or diversion from NF.* ○ **Add information from Transition Member IG (Reference 8- 10)** ○ **Add information from Diverted Member IG (Reference 16-18)** ○ **Add information from Transitioned/Diverted CCM IG (Reference Q 8-11)** ○ **Add information from Transitioned/Diverted Provider IG (Reference Q 15, 25)**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

OVERALL – TRANSITION OR DIVERSION OUTCOME

Strengths	Issues/Areas for Improvement
• *List of brief statements highlighting the best or most successful aspects of the member's transition or diversion and maintenance of tenure in the community. Note: these strengths should reflect the context of this specific member's needs and preferences.* ○ **Add information from Transition Member IG (Reference Q 10)** ○ **Add information from the Diverted Member IG (Reference Q 1-8, 18)** ○ **Add information from Transitioned/Diverted CCM IG Q 23 (D) or 24 (T)**	• *List of brief statements highlighting the least successful or most problematic aspects of the member's transition or diversion and maintenance of tenure in the community. Note: these issues should reflect the context of this specific member's needs and preferences* ○ **Add information from Transition Member IG 11** ○ **Add information from the Diverted Member IG (Reference Q 1-8, 18)** ○ **Add information from Transitioned/Diverted CCM IG Q 23 (D) or 24 (T)**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

Systemic Issues

Brief description of systemic issues needing referral for further Quality Improvement review:

- *Issues not captured elsewhere which reflect potential change in systemic processes. Examples include recommendations for additions to assessment tools, follow up procedures, changes in timing of contacts, etc.*

Community Case Manager Interview—Transitioned Member

General Information

Date_____

Name of Interviewer(s)_____

Name of CCM_____

Name of Member _____

Script

Hello, my (our) name(s) is(are)_____.

I am working with a team that is helping the state of Louisiana to understand the most helpful ways to assist people who have been transitioned from nursing homes to have their needs met in the community. I will be asking you some questions about that process, and in particular about what happened with_____.

Interview Questions--Includes "prompts" to be used at the discretion of the interviewer. Interviewer asks the Global Questions **bolded** below. Prompts for each area follow, which interviewer may use to focus or further the conversation on the interview topic.

1. **Will you please tell me about _____? What are some strengths that they have?**

2. **When did you first start working with _____and how did they come to be connected to you?**

3. **Besides you, who is working with the member now? (Check all that apply)**

__ Primary Care Physician __ Home Health Agency __ Direct Service Worker __ CCW Support Coordinator __ OT/PT __ DME Vendor	__ Assertive Community Treatment __ Outpatient Therapy __ Substance Use Disorder Services __ Community Support __ Partial Hospitalization __ IPS or LRC Staff __ Other

4. **Do you have the plans of care for these services? If so can you share them?**

5. **Please tell me about your experiences connecting _____with these services.**

6. **Do you have regular meetings as a team with the service providers mentioned above? If so, what do these look like?**

7. **Where is _____living now, and did you assist in getting this housing?**

8. **Who else is important in _____'s life? Family, community recreation, church, etc**

9. **What does _____do during the day? Do they have hobbies, a job or desires for employment, volunteering? Etc?**

10. **What do you think helps _____'s community involvement? What are barriers to their involvement? How are these being addressed?**

11. **Overall, how do you think_____is doing in the community?**

12. **Did the Member participate in creating the Plan of Care? How about subsequent updated plans? How often do you discuss the Member's progress on the goals in their plan with them?**

13. **What goals are they working on at this time?**

14. **Does the Member have a copy of this plan?**

15. **Please tell me about _____'s crisis plan. Who has a copy of this plan? Has it been used? Has _____had a crisis since you have worked with them?**

16. **Tell me about the Member's transportation for medical appts; for ADL and recreation.**

17. **Has the Member had any issues with insurance coverage of needed services or DME?**

18. **Can you tell us what you have observed of _____'s abilities to manage things like dealing with utility companies, making doctor's appointments, etc?**

19. **Does the Member self-manage their medications? (both physical health and mental health meds)?**

20. **Do you know if the member received any training in the NF before transitioning concerning medication self-management; ADL's; use of DME; other assistive devices needed in the home?**

21. **Have they had such training since transitioning?**

22. **Please describe any barriers the Member is facing in implementing the plan of care.**

23. **What is the team doing to address the barriers?**

24. **In your opinion, did the transition process work well for _____? In particular, tell me about your collaboration with the TC. In your opinion, could anything have made the transition more successful for the member?**

Interview Guide Transitioned Member

General Information

Date_____

Name of Interviewer(s)_____

Name of Member_____

Location of interview_____

Script

Hello, my (our) name(s) is(are)_____.

I am working with a team that is helping the state of Louisiana to understand the most helpful ways to assist people who were transitioned from nursing facilities.

_____said that you would be a helpful person to speak with about that. May I ask you some questions about your experience? (Make sure the person has been offered water/beverage and is comfortable in the chair, and note if the person needs a break during the interview.)

I am/We are going to take notes of your answers so I/we don't forget what you said, and you are welcome to see what we write.

Interview Questions--Includes "prompts" to be used at the discretion of the interviewer if the Member responses are incomplete**.**

1. **Please tell me about your housing situation now.**

(*Prompts: Do you live alone? With family? With friends? An apartment? A house?*

2. **How long have you lived there? Do you like it there? If no:**
   Do you want to move? Do you need some help finding a new place to live? Have you talked to anyone about that?

3. **What services are you getting now (check list from below)?**

__ CCM __ Home health __ Direct service (housekeeping/shopping) __ OT/PT __ DME?	__ Assertive Community Treatment __ Outpatient Therapy __ Substance Use Disorder Services __ Community Support __ Partial Hospitalization __ Other

a. *Who helped you get these services?*

b. *When did they start?*

4. **Do you take medicine? What do you take? Do you do it yourself? Do you administer these medications yourself?**

5. **How are these services working out for you?**

6. **Do you remember developing your plan of care? Were you wanting other individuals to be involved in that process? If so who and where they involved?**

7. **Do you have a Crisis Plan (explain that it is a written document with what to do when things go badly wrong)?**

8. **Have you had occasion to use the crisis plan? How did it work? Were you able to contact the people you needed when you needed them?**

9. **Can you tell me about how you spend your time?**
   (prompts: Do you go out of the house? Where to? How often? Do you see friends and/or family? Where? How often? Do you have a job, or volunteer? Do you go to any programs like senior center, recreation center, drop in center, library, bingo, mental health groups/self help groups?

10. **Would you like to be doing more things than you do now? What would you like to be doing that you aren't doing now?**

11. **Overall, how satisfied are you with your current situation? Is there anything you would like to add?**

12. **Can you tell me a little about your transition/diversion experience? What was it like? What did you like about it? Anything you would have hoped to do differently?**

Thank you for your time. Would you like to review what you told me? (show document to Member if desired).

Provider Interview—Transitioned/Diverted Member

General Information

Date_____

Name of Interviewer(s)_____

Name of agency_____

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

Name of Staff Person Interviewed _____

Name of Member_____

Script

Hello, and thank you for meeting with us today. We are part of a group working with Louisiana to understand the process of helping people transition or diverted from a Nursing Facility and receiving community care subsequently.

We are interviewing the Member as well as various professionals who have been involved with their care.

Interview Questions--Includes "prompts" to be used at the discretion of the interviewer. Interviewer asks the Global Questions **bolded** below. Prompts for each area follow, which interviewer may use to focus or further the conversation on the interview topic.

1. **What services do you provide to _____?**

2. **How long have you been working with _____and how did they come to your service?**

3. **Please tell me about the Member.**

4. **Please describe the Member's strengths.**

5. **What goals is the Member working on at this time? How is that going?**

6. **Besides you, who are the key participants in the Member's community plan?**

__ Family Members __ Friends __ CCM __ Home health __ Direct service __ OT/PT __ DME	__ Assertive Community Treatment __ Outpatient Therapy __ Substance Use Disorder Services __ Community Support __ Partial Hospitalization __ Other

7. **Have you talked with other providers of _____ care? How does coordination among you work?**

Prompts: Do you share plans? Use the same plan? How often do you meet formally? Informally?

Note: some of the queries after the specific provider type may be redundant to information you have already gathered. If so, skip those questions.

8. **If the Member is on an ACT team:**
    a. **What specialists on the team is seeing _____?**

    b. **How often is the team seeing_____?**

    c. **Is the Member getting meds from the team prescriber? If not, from whom do they get them?**

9. **If the Member is receiving MHR/CPST:**
    a. **How is that going?**

    b. **How often do you see_____?**

    c. **Do you visit_____in their home, or somewhere else? Where?**

10. If the services provider is the Housing Support person:

- **a. Were you involved with finding the housing _____is in now?**
- **b. Was _____involved in that search?**
- **c. Did they state preferences for type and location of housing?**
- **d. Has the current setting been good for _____?**
- **e. Did _____have what they needed in the housing when they moved in? (DME, household goods, etc)**

11. If the services provider is the Direct Service worker OR Home Health worker:

- **a. How long have you been helping_____?**
- **b. What kind of help to you provide?**
- **c. How often do you help_____?**
- **d. Does _____understand your role and cooperate with you in the home?**

Continue interview questions regardless of type of service provided

12. In particular, tell me about your collaboration with the TC and the CCM?.

13. **Did the Member participate in creating the plan you are working on?**

    a. **How about subsequent updated plans?**

    b. **How often do you discuss the Member's progress on the goals in their plan with them?**

14. **Does the Member have a copy of this plan?**

15. **How does the Member spend their time?**
    (Prompts: how often do they go out; do they shop for themselves; do they attend recreational activities; mental health/SUD care; medical appointments; church; work; volunteer; spend time with family/friends?)

16. **Tell me about the Member's transportation for medical appts; for ADL and recreation.**

17. **Has the Member had any issues with insurance coverage of needed services or DME?**

18. **Does the Member have a crisis plan? Has the Member experienced any crises or critical incidents since transitioning? If so, please tell me about them and how they were resolved.**

19. **Please describe any barriers the Member is facing in implementing the community plan you are involved with.**

20. **What is happening to address the barriers?**

21. **Can you tell us what you have observed of _____'s abilities to manage things like dealing with utility companies, making doctor's appointments, etc.?**

22. **Does the Member self-manage their medications? (both physical health and mental health meds)?**

23. **Do you know if the member received any training before their involvement with CCM concerning medication self-management; ADL's; use of DME; other assistive devices needed in the home?**

24. Have they had such training since transitioning?

25. In your opinion, could anything make _____'s community life more successful?

Transition Coordinator Interview—Transitioned Member

General Information

Date_____

Name of Interviewer(s)_____

Name of TC_____

Name of Member _____

Script

Hello, my (our) name(s) is(are)_____.
I am working with a team that is helping the state of Louisiana to understand the most helpful ways to assist people who have been transitioned from nursing homes to have their needs met in the community. I will be asking you some questions about that process, and in particular about what happened with_____.

Interview Questions--Includes "prompts" to be used at the discretion of the interviewer. Interviewer asks the Global Questions **bolded** below. Prompts for each area follow, which interviewer may use to focus or further the conversation on the interview topic.

25. **Will you please tell me about _____? What are some strengths that they have?**

26. **When did _____ transition?**

27. **Where is _____living now, and did you assist in getting this housing?**

28. **Did the individual receive the services that were identified in the ITP? Were there any barriers to facilitating access to the services in the ITP?**

29. **How often have you met or talked to _____ since transition? What are generally the purpose of these conversations?**

30. **Please describe any barriers the Member is facing in implementing the plan of care.**

31. **What is being doing to address the barriers?**

32. **Do you have regular meetings with the CCM for _____? How frequently?**

33. **Is there a team meeting for _____ that includes other providers of care? How often do you meet? Can you give us an example of what is discussed during those meetings? Is the individual present during those meetings?**

34. **Who else is important in _____'s life? Family, community recreation, church, etc**

35. **What does _____do during the day? Do they have hobbies, a job or desires for employment, volunteering? Etc?**

36. **What do you think helps _____'s community involvement? What are barriers to their involvement? How are these being addressed?**

37. **Overall, how do you think_____is doing in the community?**

38. **Tell me about the Member's transportation for medical appts; for ADL and recreation.**

39. **Has the Member had any issues with insurance coverage when they transitioned?**

40. **Does the Member self-manage their medications? (both physical health and mental health meds)?**

41. **Do you know if the member received any training in the NF before transitioning concerning medication self-management; ADL's; use of DME; other assistive devices needed in the home?**

42. **In your opinion, did the transition process work well for _____? In particular, tell me about your collaboration with the CCM. In your opinion, could anything have made the transition more successful for the member?**

Appendix B Community Case Management Record Review Tool

Member Name/ ID number:					
Date of review:					
CCM Name:					
Date Admitted to NF:					
Date of Diversion:					
Date Transitioned to Community:					
Date of Referral to CCM:					
Date of Initial CCM Assessment:					
Date of PCPC:					
Indicator	**Yes= 1**	**No = 1**	**NA = 1**	**Comments**	**Interpretive Guidelines**
Records Present					
CCM Assessment					Document presence by indicating Yes or absence by indicating No.
% of records present	0	0			0.00%
Community Plan of Care					Document presence by indicating Yes or absence by indicating No
% of records present	0	0			0.00%
Crisis Plan					Document presence by indicating Yes or absence by indicating No
% of records present	0	0	0		0.00%
Timeliness				Place a "1" in the corresponding box for responses. Ensure that if the item is Not Applicable that you place a 1 in that box. If an element is partially met, place a ".5" in the Yes box	Review dates above to determine timeliness
For diverted members, the CCM connects members with service providers for urgent needs within 7 days following referral.					

Initial CCM Assessment is conducted within 30 days of referral from the MCO for transitioned and diverted members					Review first CCM assessment compared to date of referral.
Reassessment is conducted every 90 days or when condition, needs or risk level of the member changes					Changes include but are not limited to changes in physical health or behavioral health conditions, hospitalizations, ED visits, Change in primary caregiver or change in living arrangement. If changes occurred, describe in the Comments section
Person Center Plan of Care was completed within 30 days of D/C from NF for transitioned or 30 days of referrals for diverted members					Review date of PCPC against date of discharge from nursing facility
PCPC is reviewed/updated at least every 90 days or when a significant change in member's needs or circumstances					Significant change would include, but not limited to, avoidable ED visits, hospitalizations, changes in SDOH needs such as housing or food insecurity, social support and family/caregiver needs.
PCPC is revised at least every 6 months					A formal revision of the PCPC is to be conducted at least every 6 months
Timeliness score	0	0	0		0.00%
Assessment Quality					
Assessment addresses all the following domains:					Applies to periodic reassessments too. Review the most recent assessment for this section
Medical needs					Should included physical health needs, comorbidities, medication and treatment adherence.
Behavioral health needs					Include BH needs, SUD, IDD and address medication and treatment adherence, risk for harm
Social/recreational needs					Community inclusion, preferences and engagement, interests, concerns and perceived barriers.
Educational/Vocational Needs					Interests, concerns, perceived barriers

Assessment addresses all the following Services/support needs:					
Housing					Includes documentation of Member's preferences, feelings, choices for living arrangement, neighborhood, and needs
Housing supports					Supports needed to be successful in independently living
Employment					Desires for employment and supports needed
Health/wellness					Educational needs related to support health and wellness living per individuals desires, preferences and perceived barriers
Safety					Safety needs and needed supports.
Transportation					Assess both medical and non medical transportation needs.
Healthcare services and adaptive equipment					List of any durable medical equipment needs, or healthcare services to support independent living (may include home health care, current DME/supplies and needed DME/Supplies, Wound care supplies and services)
Nutrition					Assessment of nutritional needs and supports r/t to diet and intake
Dental services					Review of dental needs and supports to address needs
Individual's preferences					Personals interests, concerns, perceived barriers and preferences
The CCM assessment included information from other sources					Member, Family/Natural supports if desired by member, Medical Provider, Behavioral Provider, MCO CM, CC Waiver, ACT team, Transition Assessment, PCS Agency, MHR provider for CPST or PSR.
Assessment Quality Score	0	0	0		0.00%
Plan of Care					
The Plan identified Interventions/Strategies to address domains identified in the Assessment.					Does the plan reflect needs identified in the assessment and reflect the member's needs, strengths, preferences, choices and goals identified in the assessment. Include strategies to address barriers.

Plan reflected strengths and preferences					
Medical needs					
Behavioral health needs					
Housing					
Social/recreational needs					
Educational/Vocational Needs					
Durable Medical Equipment					
Transportation					Are transportation needs addressed for all medical and non medical needs
Other support services identified in Assessment					Services identified specified with Type, amount, Duration and frequency of services including service providers
Subtotal	0	0	0		0.00%
Member signature was on the plan					
Other individuals chosen by the individual were included in the plan development					
Individualized Crisis Plan					
Emergency Preparedness and back up plan					
PCPC was provided to Member and other providers/organizations delivering care					Review documentation log to identify notation of PCPC being provided to Member and other providers/organizations.
POC Quality Score	0	0	0		0.00%
Ongoing Case Management					
CCM refers and links members with appropriate providers and services					Includes in plan and out of plan Primary and specialty care services, medications, Substance use/detoxification/treatment, mental health treatment, local housing authorities, supportive employment, education, home health care, and personal care and ensure enrollment in benefit programs.

Contacts Member per requirements					This are minimal Requirements First 60 days - 4 Contacts per week (2 to be face to face 61-180 days - Two contacts per week (1 to be face to face) 181-365 days - Two contacts per month (1 of those to be face to face 365+ days - At least 2 times per month (1 to be face to face)
Contacts with Service/Support providers					Minimal Contact with Service/Support Providers within the first two weeks of transition and then 1 once every 60 days for one year. Then contact service/support provider every quarter.
Coordinates services and supports between all agencies that provide services to the member.					Documentation log has evidence of coordination of services and supports
The member is receiving services and supports in accordance with the PCPC and assessed needs. If not, the CCM follows up to address.					Documentation log has evidence reviewing services and supports, effectiveness and follow up. Review against initial Claims.
The CCM documents progress or lack of progress as appropriate					Documentation log notes progress or lack of progress with goals.
The CCM documents completely all contacts with members using the indicated template.					Documentation log for contacts is completed in its entirety
CCM immediately addresses issues.					Documentation log and PCPC reflect issues and necessary changes.
Ongoing CM Quality Score	0	0	0		0.00%
Critical Incidents					
Did the member have any critical or adverse incidents?					ED visit, hospitalizations, BH crisis, abuse, neglect, exploitation, or extortion.
Critical incidents are reported to the appropriate agency upon discovery					Abuse, neglect, exploitation, and extortion are reportable events.

Was there a reassessment or plan of care review/change as a result of the Critical Incident					Plan of care review shall be conducted whenever there is a significant change in member's needs or circumstances. A reassessment shall be conducted whenver there is a change in member's condition, risk level or circumstances (such as a hospitalization)
Critical Incidents Score	0	0	0		0.00%
Overall Percentage compliant	0	0	0		0.00%

APPENDIX B

Interview Guide Diverted Member

General Information

Date_____

Name of Interviewer(s)_____

Name of Member_____

Location of interview_____

Script

Hello, my (our) name(s) is(are)_____.
I am working with a team that is helping the state of Louisiana to understand the most helpful ways to assist people who was looking to go into a nursing facility but wasn't admitted to nursing homes because they could have their needs better met in the community.

_____said that you would be a helpful person to speak with about that. May I ask you some questions about your experience? (Make sure the person has been offered water/beverage and is comfortable in the chair, and note if the person needs a break during the interview.)

I am/We are going to take notes of your answers so I/we don't forget what you said, and you are welcome to see what we write.

Interview Questions--Includes "prompts" to be used at the discretion of the interviewer if the Member responses are incomplete**.**

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

1. **We understand that there was a possibility that you would go into a NH on _____in _____, but you did not do so. Do you remember that time?**

2. **Was it your idea to go into a NH? If not, who suggested it?**

3. **Did the person you spoke with explain clearly why the nursing home was not the best option for you?**

4. **Can you tell me what was going on in your life at that time?**

   Prompts: Where were you living then? How was your physical health at that time? Your mental health?

5. **Who talked with you then about getting help outside of the NH?**

6. **Did that person connect you with someone to work with you to get that help?**

7. **Do you recall working on alternatives to going to the nursing home with the staff help? Can you tell me about that?**

8. **Where were you living when you were considering going to a NF?**

9. **Please tell me about your housing situation now.**
   (*Prompts: Do you live alone? With family? With friends? An apartment? A house?*

10. **How long have you lived there? Do you like it there? Do you want to move? Do you need some help finding a new place to live? Have you talked to anyone about that?**

11. **What services are you getting now (check list from below)?**

__ CCM __ Home health __ Direct service (housekeeping/shopping) __ OT/PT __ DME?	__ Assertive Community Treatment __ Outpatient Therapy __ Substance Use Disorder Services __ Community Support __ Partial Hospitalization __ Other

a. *Who helped you get these services?*

b. *When did they start?*

12. **Do you take medicine? What do you take? Do you do it yourself? Do you use insulin? Do you administer these medications yourself?**

13. **How are these services working out for you?**

14. **Do you remember developing your plan of care? Were you wanting other individuals to be involved in that process? If so who and where they involved?**

15. **Do you have a Crisis Plan (explain that it is a written document with what to do when things go badly wrong)?**

16. **Have you had occasion to use the crisis plan? How did it work? Were you able to contact the people you needed when you needed them?**

17. **Can you tell me about how you spend your time?**
(prompts: Do you go out of the house? Where to? How often? Do you see friends and/or family? Where? How often? Do you have a job, or volunteer? Do you go to any programs like senior center, recreation center, drop in center, library, bingo, mental health groups/self help groups?

18. **Would you like to be doing more things than you do now? What would you like to be doing that you aren't doing now?**

19. **Overall, how satisfied are you with your current situation? Is there anything you would like to add?**

Thank you for your time. Would you like to review what you told me? (show document to Member if desired).

Community Case Manager Interview—Diverted Member

General Information

Date_____

Name of Interviewer(s)_____

Name of CCM_____

Name of Member _____

Script

Hello, my (our) name(s) is(are)_____.
I am working with a team that is helping the state of Louisiana to understand the most helpful ways to assist people who have been diverted from nursing homes to have their needs met in the community. I will be asking you some

questions about that process, and in particular about what happened with_____.

Interview Questions--Includes "prompts" to be used at the discretion of the interviewer. Interviewer asks the Global Questions **bolded** below. Prompts for each area follow, which interviewer may use to focus or further the conversation on the interview topic.

1. **Will you please tell me about _____? What are some strengths that they have?**

2. **When did you first start working with _____and how did they come to be connected to you?**

3. **Besides you, who is working with the member now? (Check all that apply)**

__ Primary Care Physician __ Home Health Agency __ Direct Service Worker __ CCW Support Coordinator __ OT/PT __ DME Vendor	__ Assertive Community Treatment __ Outpatient Therapy __ Substance Use Disorder Services __ Community Support __ Partial Hospitalization __ IPS or LRC STaff __ Other

4. **Do you have the plans of care for these services? If so can you share them?**

5. **Please tell me about your experiences connecting _____with these services.**

6. **Do you have regular meetings as a team with the service providers mentioned above? If so, what do these look like?**

7. **Where is _____living now, and did you assist in getting this housing?**

8. **Who else is important in _____'s life? Family, community recreation, church, etc**

9. **What does _____do during the day? Do they have hobbies, a job or desires for employment, volunteering? Etc?**

10. **What do you think helps _____'s community involvement? What are barriers to their involvement? How are these being addressed?**

11. **Overall, how do you think_____is doing in the community?**

12. **Did the Member participate in creating the Plan of Care? How about subsequent updated plans? How often do you discuss the Member's progress on the goals in their plan with them?**

13. **What goals are they working on at this time?**

14. **Does the Member have a copy of this plan?**

15. **Please tell me about _____'s crisis plan. Who has a copy of this plan? Has it been used? Has _____had a crisis since you have worked with them?**

16. **Tell me about the Member's transportation for medical appts; for ADL and recreation.**

17. **Has the Member had any issues with insurance coverage of needed services or DME?**

18. **Can you tell us what you have observed of _____'s abilities to manage things like dealing with utility companies, making doctor's appointments, etc?**

19. **Does the Member self-manage their medications? (both physical health and mental health meds)?**

20. **Have they had any training regarding their medication since being diverted from the NF?**

21. **Please describe any barriers the Member is facing in implementing the plan of care.**

22. **What is the team doing to address the barriers?**

23. In your opinion, did the diversion process work well for _____? In particular, tell me about your collaboration with the TC. Any suggestions for improving it?

Provider Interview—Transitioned/Diverted Member

General Information

Date_____

Name of Interviewer(s)_____

Name of agency_____

Name of Staff Person Interviewed _____

Name of Member_____

Script

Hello, and thank you for meeting with us today. We are part of a group working with Louisiana to understand the process of helping people transition or diverted from a Nursing Facility and receiving community care subsequently.

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

We are interviewing the Member as well as various professionals who have been involved with their care.

Interview Questions--Includes "prompts" to be used at the discretion of the interviewer. Interviewer asks the Global Questions **bolded** below. Prompts for each area follow, which interviewer may use to focus or further the conversation on the interview topic.

1. **What services do you provide to _____?**

2. **How long have you been working with _____and how did they come to your service?**

3. **Please tell me about the Member.**

4. **Please describe the Member's strengths.**

5. **What goals is the Member working on at this time? How is that going?**

6. **Besides you, who are the key participants in the Member's community plan?**

__ Family Members __ Friends __ CCM __ Home health __ Direct service __ OT/PT __ DME	__ Assertive Community Treatment __ Outpatient Therapy __ Substance Use Disorder Services __ Community Support __ Partial Hospitalization __ Other

7. **Have you talked with other providers of _____ care? How does coordination among you work?**
   Prompts: Do you share plans? Use the same plan? How often do you meet formally? Informally?

Note: some of the queries after the specific provider type may be redundant to information you have already gathered. If so, skip those questions.

8. **If the Member is on an ACT team:**

a. What specialists on the team is seeing _____?

b. How often is the team seeing_____?

c. Is the Member getting meds from the team prescriber? If not, from whom do they get them?

9. If the Member is receiving MHR/CPST:
   a. How is that going?

   b. How often do you see_____?

   c. Do you visit_____in their home, or somewhere else? Where?

10. If the services provider is the Housing Support person:
   a. Were you involved with finding the housing _____is in now?

   b. Was _____involved in that search?

   c. Did they state preferences for type and location of housing?

d. **Has the current setting been good for _____?**

e. **Did _____have what they needed in the housing when they moved in? (DME, household goods, etc)**

11. **If the services provider is the Direct Service worker OR Home Health worker:**
    a. **How long have you been helping_____?**

    b. **What kind of help to you provide?**

    c. **How often do you help_____?**

    d. **Does _____understand your role and cooperate with you in the home?**

Continue interview questions regardless of type of service provided

12. **In particular, tell me about your collaboration with the TC and the CCM?.**

13. **Did the Member participate in creating the plan you are working on?**

    a. **How about subsequent updated plans?**

    b. **How often do you discuss the Member's progress on the goals in their plan with them?**

14. **Does the Member have a copy of this plan?**

15. **How does the Member spend their time?**
    (Prompts: how often do they go out; do they shop for themselves; do they attend recreational activities; mental health/SUD care; medical appointments; church; work; volunteer; spend time with family/friends?)

16. **Tell me about the Member's transportation for medical appts; for ADL and recreation.**

17. **Has the Member had any issues with insurance coverage of needed services or DME?**

18. **Does the Member have a crisis plan? Has the Member experienced any crises or critical incidents since transitioning? If so, please tell me about them and how they were resolved.**

19. **Please describe any barriers the Member is facing in implementing the community plan you are involved with.**

20. What is happening to address the barriers?

21. Can you tell us what you have observed of _____'s abilities to manage things like dealing with utility companies, making doctor's appointments, etc.?

22. Does the Member self-manage their medications? (both physical health and mental health meds)?

23. Do you know if the member received any training before their involvement with CCM concerning medication self-management; ADL's; use of DME; other assistive devices needed in the home?

24. Have they had such training since transitioning?

25. In your opinion, could anything make _____'s community life more successful?

Demographic and Summary Data								
Review ID	DOB	Sex	Region	Transition Date	Date of Last Evaluator Contact	Primary BH Diagnoses	Primary PH Diagnoses	Member Interviewed? (Y/N—Reason)

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

TAC ID	*DOB*	*M/F/N*	*LDH Region*	*Date DC from NF*	*Date of last TAC reviewer contact with info sources*	*Up to three most prevalent*	*Up to three most prevalent*	*Y/N – Brief reason statement if N*

Member Strengths
Short sentences or bullets listing primary Member strengths that support community tenure.

Community Services (Community Plan/Claims) (Summary of Primary Community-based Services Since NF Discharge or Diversion)			
Service (Plan of Care)	**Ever Received Since Transition or Diversion (X)**	**Receiving at Time of Evaluation (X)**	**Comments (Include reason for stopping, issues with accessing, other)**
List services that are clinically significant for community tenure and/or require continuing or medically necessary follow up care. Plan of Care should address physical and behavioral needs (e.g. medication self-administration, provider follow/up, HHC, day programs)	*X – if Member ever received this service. (Member may not be receiving the service at the time of the evaluator review).*	*X – if Member was receiving the service at the time of the evaluator review.*	*Brief statement describing any significant factors relating to the service. This may include reason for stopping (e.g., member choice, no longer needed, etc.), issues with accessing (e.g., transportation not reliable so member not attending per TP, or member not able to get follow up appointment with PCP for bloodwork due to no appts available), or other factors that impact participation in services on CP or TP.*

Findings: Did individual get services in amount and duration in the plan?	*Yes*	*No*	*Describe differences and any rationale for these differences*

Care Coordination/Case Management (Summary of Care Coordination/Case Management Supports Post Transition and Diversion)				
Care Coordination/Case Management Type	**Ever Received Since Transition or Diversion (X)**	**Date of Discontinuation (if applicable)**	**Interviewed (Y/N/NA)**	**Comments (Include reason for discontinuation, level of involvement, level of team participation)**
Community Case Management	*X – if Member ever was assigned to worker. (Member may not be receiving at the time of the evaluator review).*	*Date worker discontinued support of the member (DC from their caseload).*	*Y/N/NA – if TAC evaluator(s) interviewed the worker as part of this evaluation*	*Brief description of reason for discontinuation (if applicable), level/type of involvement with the member, level of team participation (with care team, other coordinators).*
Provider Case Manager (ACT, PSH)				
CCW Support Coordinator				

Critical Incidents/Readmissions/Hospitalizations/ER (Summary of Incidents Since NF Discharge or Diversion)		
Type of Incident	**Date (Month/Yr.)**	**Brief Description/Reason**

Critical Incident	*Date of Critical Incident per LDH form*	*Brief description of the nature of the Critical Incident*
Emergency Department	*Date of ED visit (from claims or notes)*	*Brief description if available. If from claims only, list diagnoses from claims summary*
Hospitalization	*Date of hospitalization (from claims, notes, DC summary)*	*Brief description if available. If from claims only, list diagnoses from claims summary.*
Nursing Facility Readmission	*Date of NF readmission*	*Brief description if available. If from claims only, list diagnoses from claims summary.*
Other		

Evaluation Interviews Completed (Summary of Evaluation Interviews Conducted by Evaluation Team)		
Position Interviewed	**(Y/N/NA)**	**If NA (Not Applicable), explain:**
Member		*Brief description of any NA or N response (e.g., member refused, provider case manager left the company, etc.)*
Transition Coordinator		
Community Case Manager		
CCW Support Coordinator		
Provider (ACT, PSH, PCS)		
Other		

Records Reviewed (Summary of Records Reviewed by Evaluation Team)		
Record Type	**Reviewed?**	**Comments**

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

	(Y/N/NA)	(Include strengths, significant omissions, quality concerns, timeliness, etc.)
Claims Review (1 year unless otherwise noted)		*Brief, preferably bulleted list of comments of issues viewed as significant to the value of the document being reviewed. This is an evaluation of the extent the document reflected the member, NOT a listing of record content.*
PASARR Level I		
PASARR Level II (including Hx & Px unless otherwise noted)		
Transition Assessment (specify initial, 7-day, 30-day, 90 day,180-day, 1 year)		
Transition Plan		
Community Assessment (CCM)		
Plan of Care (CCM)		
CCM Contact Notes/Logs		
Critical Incident Reports		
HCBS Waiver Documents (POC)		
Other		

DIMENSION 1 – PHYSICAL WELL-BEING

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths supporting the physical well-being of the member as evidenced by all sources of information evaluated. Note: these may be strengths of the member and/or things that have been done well by the services and supports.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 3-5)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 11-13)** ○ **Add information from Transitioned CCM IG (Reference Q 3-5, 16-17, and 19-21)** ○ **Add information from Diverted CCM IG (Reference Q 3-5 and 19-20)** ○ **Add information from Provider Interview IG (Reference Q 22-24)** ○ **Add information from the TC IG related to individual's involvement in the transitional planning (Reference Q 4, 14, 16,17)**	• *List of brief statements of issues and areas of improvement that could/should be addressed to better support the physical well-being of the member post transition to the community or diversion from NF.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 3-5)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 11-13)** ○ **Add information from Transitioned CCM IG (Reference Q 3-5, 16-17, and 19-21)** ○ **Add information from Diverted CCM IG (Reference Q 3-5 and 19-20)** ○ **Add information from Provider Interview IG (Reference Q 22-24)Add information from the TC IG related to individual's involvement in the transitional planning (Reference Q 4, 14, 16,17)**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

DIMENSION 2 – BEHAVIORAL HEALTH WELL-BEING

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths supporting the behavioral health well-being of the member as evidenced by all sources of information evaluated. Note: these may be strengths of the member and/or things that have been done well by the services and supports.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 3-5)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 11-13)** ○ **Add information from Transitioned CCM IG (Reference Q 3-5, 16-17, and 19-21)** ○ **Add information from Diverted CCM IG (Reference Q 3-5 and 19-20)** ○ **Add information from Provider Interview IG (Reference Q 22-24)** ○ **Add information from the TC IG related to individual's involvement in the transitional planning (Reference Q 4, 14, 16,17)** ○	• *List of brief statements of issues and areas of improvement that could/should be addressed to better support the behavioral health well-being of the member post transition to the community or diversion from NF.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 3-5)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 11-13)** ○ **Add information from Transitioned CCM IG (Reference Q 3-5, 16-17, and 19-21)** ○ **Add information from Diverted CCM IG (Reference Q 3-5 and 19-20)** ○ **Add information from Provider Interview IG (Reference Q 22-24)Add information from the TC IG related to individual's involvement in the transitional planning (Reference Q 4, 14, 16,17)**

Rating				
1	2	3	4	5

Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

DIMENSION 3 – STABILITY

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths supporting the stability in the community of the member as evidenced by all sources of information evaluated. Note: these may be strengths of the member and/or things that have been done well by the services and supports.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 1,2,6,7,10)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 9-10, 14-15, 18)** ○ **Add information from Transitioned CCM IG (Reference Q 7, 11, 16-18, 22-24)** ○ **Add information from Provider Interview IG Reference Q 16-21)** ○ **Add information from TC IG (Reference Q 6, 7, 13, 16)**	• *List of brief statements of issues and areas of improvement that could/should be addressed to better support the stability in the community of the member post transition or diversion from NF.* ○ **Add information from Transition Member IG related to individual's involvement in transitional planning (Reference Q 1,2,6,7,10)** ○ **Add information from Diversion Member IG related to individual's involvement in transitional planning (Reference Q 9-10,14-15)** ○ **Add information from Transitioned CCM IG (Reference Q 7, 11, 16-18, 22-24)** ○ **Add information from Provider Interview IG Reference Q 16-21)** ○ **Add information from TC IG (Reference Q 6, 7, 13, 16)**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

DIMENSION 4 – ASSESSMENT AND PERSON-CENTERED PLANNING

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths of the assessment(s) and person-centered planning as evidenced by all sources of information evaluated. Note: these strengths should reflect the context of this specific member's needs and preferences.* ○ **Add information from "CCM Assessment Quality", "Planning"** ○ **Add information from Transitioned Member IG related to individual's involvement in assessment planning (Reference Q 4, 6- 9)** ○ **Add information from Diverted Member IG related to individual's involvement in assessment planning (Reference Q 7, 14-15, 17)** ○ **Add information from TC Transitioned/Diverted IG Q 4** ○ **Add information from CCM Transitioned/Diverted IG Q4-6, 12-15, 22-23**	• *List of brief statements of issues and areas of improvement that could/should be addressed to improve the processes of assessment and the integration of person-centered planning with the member.* ○ **Add information from "CCM Assessment Quality", "Planning"** ○ **Add information from Transitioned Member IG related to individual's involvement in assessment planning (Reference Q 4,6-9)** ○ **Add information from Diverted Member IG related to individual's involvement in assessment planning (Reference Q 7, 14-15,17)** ○ **Add information from TC Transitioned/Diverted IG Q 4** ○ **Add information from CCM Transitioned/Diverted IG Q4-6, 12-15, 22-23**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

DIMENSION 5 – COMMUNITY INCLUSION

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths supporting the community inclusion of the member as evidenced by all sources of information evaluated. Note: these may be strengths of the member and/or things that have been done well by the services and supports.* ○ **Add information from Transition Member IG (Reference Q 8-10)** ○ **Add information from Diverted Member IG Reference Q 16-18)** ○ **Add information from Transitioned/Diverted CCM IG (Reference Q 8-11)** ○ **Add information from Transitioned/Diverted Provider IG (Reference Q 15, 25)**	• *List of brief statements of issues and areas of improvement that could/should be addressed to better support community inclusion of the member post transition or diversion from NF.* ○ **Add information from Transition Member IG (Reference 8- 10)** ○ **Add information from Diverted Member IG (Reference 16-18)** ○ **Add information from Transitioned/Diverted CCM IG (Reference Q 8-11)** ○ **Add information from Transitioned/Diverted Provider IG (Reference Q 15, 25)**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

OVERALL – TRANSITION OR DIVERSION OUTCOME

Strengths	Issues/Areas for Improvement
• *List of brief statements highlighting the best or most successful aspects of the member's transition or diversion and maintenance of tenure in the community. Note: these strengths should reflect the context of this specific member's needs and preferences.* ○ **Add information from Transition Member IG (Reference Q 10)** ○ **Add information from the Diverted Member IG (Reference Q 1-8, 18)** ○ **Add information from Transitioned/Diverted CCM IG Q 23 (D) or 24 (T)**	• *List of brief statements highlighting the least successful or most problematic aspects of the member's transition or diversion and maintenance of tenure in the community. Note: these issues should reflect the context of this specific member's needs and preferences* ○ **Add information from Transition Member IG 11** ○ **Add information from the Diverted Member IG (Reference Q 1-8, 18)** ○ **Add information from Transitioned/Diverted CCM IG Q 23 (D) or 24 (T)**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

INDIVIDUAL REVIEW SUMMARY INSTRUCTIONS

SYSTEMIC ISSUES

Brief description of systemic issues needing referral for further Quality Improvement review:

- *Issues not captured elsewhere which reflect potential change in systemic processes. Examples include recommendations for additions to assessment tools, follow up procedures, changes in timing of contacts, etc.*

APPENDIX C NF Review Tool						Location in OPTS
Member Name/ ID number:						
Date of review:						
TC Name:						
						InterRAI HC Assessment # 7 "Assessment Reference Date". Date LOC was completed from the InterRAI HC
Date of Initial TC Assessment Started:					Assessment Start Date.	On NF Assessment Tab - D ate assessment began
Date Initial TC Assessment Completed:					TC has 14 calendar days to complete the transition assessment	ON NF Assessment Tab - Transition Assessment Completion Date
Date ITP Started						ITP tab -
Date ITP Completed					TC has 30 calendar days to initiate the transition plan from the date YES was indicated by Member's interest in transition	ITP tab -
Proposed Transition Date					TC has 7 calendar days to identify the projected transition date.	Projected is on the ITP. Actual Transition date is on the Transition Entry form.
Date TC referred to MCO for Community CM					Should be done at least 60 calendar days prior to the projected transition date	SharePoint not in OPTS - My Choice forms, Referrral for CCM, pull up individual Date of referrals
TC/CCM meeting to discuss discharge planning						SharePoint is captured in the initial meeting.
Indicator	**Yes= 1**	**No = 1**	**NA = 1**	**Comments**	**Interpretive Guidelines**	**Place a "1" in the corresponding box for responses. Ensure that if the item is Not Applicable that you place a 1 in that box. If an element is partially met, place a ".5" in the Yes box**
Records Present						
TC Initial Assessment					Document presence by indicating Yes or absence by indicating No	
% of records present	0	0	0		0.00%	
ITP					Document presence by indicating Yes or absence by indicating No	
% of records present	0	0	0	0	0.00%	
Timeliness						
Initial TC Assessment is conducted within 14 calendar days of referral					Review first TC assessment compared to date of referral.	
ITP was completed within 30 calendar days of date noted "Yes" for interest in transition.					Plan start date should be 30 calendar days or less from the assessment completion date.	

ITP start date or projected transition date is entered within 7 calendar days of assessment					Plan start date should be 7 calendar days or less from the assessment completion date.	
TC refers member to CCM within 60 calendar days from projected transition date					Note date on CM Referral form.	
CCM/TC discharge planning meeting is conducted within 10 calendar days of "linkage"					CCM/TC discharge planning meeting is conducted within 10 calendar days of "linkage". Review TC notes to determine date of d/c planning meeting between CCM and TC.	
TC engages CCM within 60 calendar days prior to transition					Referral Form has date of first meeting or look at TC log	
Timeliness score	0	0	0		0.00%	
Assessment Quality					Review PASRR Level II, MDS to see if comports with Transition Assessment and Transition Plan	
Assessment addresses all the following domains:					Applies to periodic reassessments too. Review the most recent assessment for this section	NF Assessment tab will hold all information for Assessment section. Reviewers should use there clinical judgement based on other documentation that assessment adequately addressed the domains
Housing					Includes documentation of Member's preferences, feelings, choices for living arrangement, neighborhood, and needs. Also includes supports needed to be successful in independently living	
Community Living & Social Relationships					Desires for community and social activities and relationships.	
Vocational/Educational					Desires for employment or education and supports needed	
Activities of Daily Living/ Instrumental Activities of Daily Living					Review each ADL and IADL with identified support needs including any equipment/DME/Supplies.	
Transportation					Assess both medical and non medical transportation needs.	
Medication Needs					List of Medications, individuals ability to take medications independently or identification of supports needed.	
Behavioral Health					Identification and assessment of behavioral health conditions, including educational needs, list of provider, Substance use per individuals desires, preferences and perceived barriers.	

Medical and Health Needs					Assessment of chronic conditions, educational needs related to support health per individuals desires, preferences and perceived barriers. Should include identifying providers, necessary appointments scheduled and transportation arrangements. List of any durable medical equipment needs, or healthcare services to support independent living (may include home health care, current DME/supplies and needed DME/Supplies, Wound care supplies and services)	
Individual's preferences					Personals interests, concerns, perceived barriers and preferences	
Does the assessment process reflect multiple dimensions of wellness (spiritual, emotional, intellectual, physical, social, environmental, financial, and occupational)?					Overall review of assessment to determine if each domain has been assessed.	
The TC assessment included information from other sources					Member, Family/Natural supports if desired by member, Medical Provider, Behavioral Provider, MCO CM, CC Waiver, ACT team, Transition Assessment, PCS Agency, MHR provider for CPST or PSR.	Often-assessment may occur prior to some of these supports being in place. TC typically makes these types of referrals as part of the transition process.
Member's strengths and assets identified in the Assessment?					What is the person doing now? Foundation for future changes? Values, interests and priorities, existing motivation, self-efficacy	
Natural Supports were identified in the Assessment					List of Natural supports and ability/willingness to assist	
Service and support needs identified in the Assessment.					Personal Care Services, DME, financial	
Barriers identified in the Assessment					Identification of barriers to meeting goals	
Are necessary services in place for transition						
Assessment Quality Score	0	0	0		0.00%	
ITP						ITP tab
Does the ITP clearly reflect what professionals will be involved in implementing the ITP, and who is responsible for what areas, including Natural Supports?					List of all individuals involved in caring for individuals, roles and responsibilities to include professionals and natural supports.	
The ITP identified Interventions/Strategies to address domains identified in the Assessment.					Does the ITP reflect needs identified in the assessment and reflect the member's needs, strengths, preferences, choices and goals identified in the assessment. Include strategies to address barriers.	

Transportation					Are transportation needs addressed for all medical and non medical needs and arrangements made for initial appointments	
Housing, housing items and Supports					To include any funding to address outstanding debts, independent living supports and housing options.	
Entities Requiring Notification of Transition					Includes financial agencies, fiduciary responsible parties (Bank, Rep Payee, Social Security Administration)	
Barriers are identified with plan of action to address to include those barriers identified in the assessment					Action plan listed to address all barriers identified.	
Community Living and Social Relationships					Identifies Individual desires/preferences as indicated in the assessment.	
Vocational/Educational Needs					Identifies Individual desires/preferences as indicated in the assessment.	
Personal Care Services					Services identified specified with Type, amount, Duration and frequency of services including service providers	
Durable Medical Equipment					Identifies those DME/Supplies/Equipment needs as indicated in assessment and identified provider.	
Behavioral Supports					Identifies Providers/agencies with contact information and date of initial appointment.	
Medical needs					Identifies Providers/agencies with contact information and date of initial appointment.	
Other support services identified in Assessment					Services identified specified with Type, amount, Duration and frequency of services including service providers	
ITP was provided to Member and other providers/organizations delivering care					Review documentation log to identify notation of ITP being provided to Member and other providers/organizations.	
Member sign the ITP					Signature of Member on the ITP	
Were other service and support needs identified on the Transition Assessment incorporated into the ITP?					Cumulatively were all services and supports identified and included into the ITP. Were there other things on the assessment that were not included	
Does the plan include actionable goals and strategies?					Judgement as to whether goals are inclusive, actionable and includes interventions/strategies to address.	
Was there a planning meeting held to discuss ITP?					Documentation that a planning meeting occurred.	
Is there evidence that the Member participated in the development of the ITP?					Signature of Member on ITP plus documentation of the meeting in which individual participated in planning meeting.	

Transition Plan Quality Score	0	0	0		0.00%	If not identified in the assessment are we putting NA in these
Ongoing Transitional Coordination						Contact Documentation Log tab. Most current at top in decending order.
TC refers members with appropriate providers and services					Includes in plan and out of plan Primary and specialty care services, medications, Substance use/detoxification/treatment, mental health treatment, local housing authorities, supportive employment, education, home health care, and personal care and ensure enrollment in benefit programs.	
Monthly contacts with individual					Docmentation from TC log should provide this information	
The TC documents progress or lack of progress as appropriate					Documentation log notes progress or lack of progress with goals. TC contacts the member at appropriate timeframes to keep apprised of transition, check on progress with interventions/strategies.	
The TC documents completely all contacts with members using the indicated template.					IADLs	
TC immediately addresses issues.					Documentation log and ITP reflect issues and necessary changes.	
Ongoing TC Quality Score	0	0	0		0.00%	
ITP Implementation						
The ITP was implemented as scheduled if no barriers were identified					Aggregate review of assessment, ITP and notes to determine that actions were implemented as indicated in the plan	Documentation log in OPTS
Any identified barriers were addressed timely					Review of ITP and TC log to indicate that barriers were identified and immediate actions were taken to resolve barriers.	
ITP Implementation Score	0	0	0		0.00%	
Collaboration between TC and CCM						
CCM participated in ITP					TC notes	
Documentation reveals regular communication between TC and CCM to address transition and barriers					TC and CCM notes. If the CCM is not engaged at the time that the ITP is completed, score as N/A	
The CCM contacted the Member according to the SOP requirements					At least 4 face to face contacts in the 60 calendar day period prior to the member's transition from the NF, with at least 2 of the face to face contacts occurring in the last 30 days prior the member's transition from the NF.	
TC/CCM Collaboration Score	0	0	0		0.00%	
Readmissions						

Why was the Member readmitted?					Will enter according to results from Interviews with CCM, TC and Member.	Client and NF information tab - Case status description as Reinstutionalized.
Could the readmission have been avoided with adjustments to the ITP?					Will enter according to results from Interviews with CCM, TC and Member. Also on initial screen as final disposition.	
Readmission Avoidance Score	0	0	0		0.00%	
Overall Percentage compliant	0	0	0		0.00%	

Nursing Facility Member Interview Guide

General Information

Date_____

Name of Interviewer(s)_____

Name of Member_____

Location of interview_____

Script

Thank you for visiting with me today. My name is _____ and I'm working with a group that is helping Louisiana to improve services for people who have moved out of a nursing facility or would like to do that.
<<introduce other team member if present>>

There are no wrong answers to my questions. I am interested in learning about your experiences with planning your move.
I'm going to ask you some questions about your desired living situation.

May I ask you some questions about that? (Make sure the person has been offered water/beverage and is comfortable in the chair, and note if the person needs a break during the interview.)

I am/We are going to take notes of your answers so I/we don't forget what you said, and you are welcome to see what we write.

Interview Questions--Includes "prompts" to be used at the discretion of the interviewer if the Member responses are incomplete. Interviewer asks the Global Questions **bolded** below. Prompts for each area follow, which interviewer may use to focus or further the conversation on the interview topic.

1. **Can you remember who spoke to you about moving out of the nursing home? Do you remember when that was?**

2. **Was there more than one person? Did they come in person or use the phone or contact you some other way (e.g. Zoom)?**

3. **How frequently is someone talking to you about moving?**

4. **Have you been involved in any planning to get you ready to move? If so, can you tell me what this looks like?**

5. **Can you tell me about what kind of place you would like to have when you move?**
    a. *Location*
    b. *Size*
    c. *Accessibility*
    d. *Outside space*
    e. *Near shopping*
    f. *Near jobs*
    g. *Near recreation*
    h. *Near relatives*
    i. *Near friends*

6. **What kind of input are you having in choosing this place to live? Can you tell me about how that is working for you and who is helping you with this? Have you been out to see any potential places? If not, how did you make that choice?**

7. **Please tell me about how you spent your time before you came to the NF. Did you go out to the store, to church, to recreation centers? Did you spend time with any particular people regularly?**

8. **Did you have a job, go to school, or volunteer anywhere? Are you interested in adding those things to your life when you move to your new place?**

9. **Do you expect to have transportation? Can you tell me how that will work?**

10. **How is your physical health? Do you expect to get help for physical conditions in your home?**

    a. **Medical/Wellness prompts if needed:**
        i. *Do you have any physical medical issues that you have to manage like diabetes (sugar), high blood pressure or other conditions like that?*

        ii. *Will you want help with these things?*

        iii. *Do you need any special equipment for your medical needs (syringes, blood pressure cuff, etc)?*

11. **Do you need help with other things?**
    a. *Cooking*
    b. *Cleaning*
    c. *Paying bills*

12. **Do you see any mental health professionals here in the NF? Will you see MH helpers when you leave here? Before you came here, did you go to any day or rehab programs such as a mental health center or drop- in center?**

13. **Have you participated in making your plans for mental health care? What does that look like?**

14. **Have you had any issues with substance use? If so, are you getting help with that? Do you want help with that?**

15. **What happened to cause you to come to the NF? Do you feel that you are ready to move to the community?**

Global Conclusion:

16. **Overall, how do you feel about how your plans to move are going? Are there some goals that you would like to prioritize? If so, what are these and why are these a priority?**

Would you like to review what you told me? Thank you so much for your help.

Transition Coordinator Interview for Member in Nursing Facility

Date_____

Name of Interviewer(s)_____

Name of Member_____

Location of interview_____

Name of TC_____

Script

Introduce ourselves.

We are interested in learning about your experiences helping the Member plan for transitioning to the community. We are interested in your thoughts about several areas that are important to assess how well the transition process is working?

Interview Questions--Includes "prompts" to be used at the discretion of the interviewer. Interviewer asks the Global Questions **bolded** below. Prompts for each area follow, which interviewer may use to focus or further the conversation on the interview topic.

1. **Please tell us about _____. How long have you been working with them?**

2. **What has been your experience visiting them in the NF?**

3. **What are their strengths?**

4. **Can you describe the individual's involvement in the transition planning process? Have the prioritized any goals? If so, what are they and why did were these priorities?**

5. **Has _____been an active participant in planning to move? Please describe.**

6. **Has the NF been cooperating in your work with _____?**
   Prompts: I.e., made them available for you to visit, provided adequate space to converse privately?

6. **Has _____been provided w opportunities to learn skills they will need after the move, such as medication self management, ADL adaptations, Behavioral Health skills?**

7. **Has _____made use of these opportunities if they have been provided?**

8. **Have you encountered any barriers in helping _____ move to the community? If so, can you describe these? Has that changed the ITP or the move date?**

9. **What else can you share about the process of working toward transition with _____?**

Demographic and Summary Data								
Review ID	DOB	Sex	Region	Transition Date	Date of Last Evaluator Contact	Primary BH Diagnoses	Primary PH Diagnoses	Member Interviewed? (Y/N—Reason)
SME ID	*DOB*	*M/F/N*	*LDH Region*	*Date DC from NF*	*Date of last SME reviewer contact with info sources*	*Up to three most prevalent*	*Up to three most prevalent*	*Y/N – Brief reason statement if N*

Member Strengths
Short sentences or bullets listing primary Member strengths that support community tenure.

Specialized Services Recommended and Received (PASRR Level II)			
Service	**Received while in NF (X)**	**Receiving at Time of Evaluation (X)**	**Comments (Include reason for stopping, issues with accessing, other)**
List specialized BH services that were identified in the PASRR Level II. Include potential services indicated by the assessment or included in the transition plan (e.g.,	*X – if Member ever received this service. (Member may not be receiving the*	*X – if Member was receiving the service at the time*	*Brief statement describing any significant factors relating to the service. This may include reason for stopping (e.g., member choice, no longer needed, etc.), issues with*

medication self-administration, safe transfers, phone usage)	*service at the time of the evaluator review).*	*of the evaluator review.*	*accessing (e.g., member not attending per TP, or member not able to get follow up appointment due to no appts available), or other factors that impact participation in services.*

Care Coordination/Case Management (Summary of Care Coordination/Case Management Supports Post Transition)				
Care Coordination/Case Management Type	**Received while in NF (X)**	**Date of Discontinuation (if applicable)**	**Interviewed (Y/N/NA)**	**Comments (Include reason for discontinuation, level of involvement, level of team participation)**
Transition Coordinator	*X – if Member ever was assigned to worker. (Member may not be receiving at the time of the evaluator review).*	*Date worker discontinued support of the member (DC from their caseload).*	*Y/N/NA – if SME evaluator(s) interviewed the worker as part of this evaluation*	*Brief description of reason for discontinuation (if applicable), level/type of involvement with the member, level of team participation (with care team, other coordinators).*
Managed Care Coordinator				
Community Case Manager				
CCW Support Coordinator				

INDIVIDUAL ACTIVE CASELOAD REVIEW SUMMARY INSTRUCTIONS

Evaluation Interviews Completed (Summary of Evaluation Interviews Conducted by Evaluation Team)		
Position Interviewed	**(Y/N/NA)**	**If NA (Not Applicable), explain:**
Member		*Brief description of any NA or N response (e.g., member refused, provider case manager left the company, etc.)*
Transition Coordinator		
Other		

Records Reviewed (Summary of Records Reviewed by Evaluation Team)		
Record Type	**Reviewed? (Y/N/NA)**	**Comments (Include strengths, significant omissions, quality concerns, timeliness, etc.)**
Claims Review (1 year unless otherwise noted)		*Brief, preferably bulleted list of comments of issues viewed as significant to the value of the document being reviewed. This is an evaluation of the extent the document reflected the member, NOT a listing of record content.*
PASARR Level I		
PASARR Level II (including Hx & Px unless otherwise noted)		
MDS 3.0 Assessment		
Transition Assessment (specify initial, 7-day, 30-day, 90 day,180-day, 1 year)		
Transition Plan		
Transition Coordinator Contact Notes/Logs		
Hx & Px from Hospitalizations post NF		
HCBS Waiver Appeal Documents		
Other		

DIMENSION 1 – TIMELINESS

Strengths	Issues/Areas for Improvement
• *Listing of activities reviewed for which timeliness was met or there was good rationale for a change in timeliness for certain activities*	• *List of activities for which timeliness was not met, or not completed.*

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

DIMENSION 2 – ASSESSMENT AND PERSON-CENTERED PLANNING

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths of the assessment(s) and person-centered planning as evidenced by all sources of information evaluated. Note: these strengths should reflect the context of this specific member's needs and preferences.* ○ **Add information from "Assessment Quality", "ITP" and "Ongoing Transitional Coordination" from Matrix** ○ **Add information from Member IG related to individual's involvement in transitional planning (Reference Q 4)** ○ **Add information from TC IG Q 4**	• *List of brief statements of issues and areas of improvement that could/should be addressed to improve the processes of assessment and the integration of person-centered planning with the member.* ○ **Add information from "Assessment Quality", "ITP" and "Ongoing Transitional Coordination" from Matrix** ○ **Add information from Member IG related to individual's involvement in transitional planning (Reference Q4)** ○ **Add information from TC IG related to barriers to personal centered planning such as lack of cooperation from NF, lack of NF engagement in training individual for community living. (Reference Q 4)** ○ **Any information related to lack of individual being involved in the assessment and person centered planning.**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

INDIVIDUAL ACTIVE CASELOAD REVIEW SUMMARY INSTRUCTIONS

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

DIMENSION 3 – IN-REACH

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths of the In Reach process as evidenced by all sources of information evaluated. Note: these strengths should reflect the contact made with individual once they identified as interested in transitioning to the community.* ○ **Add information from Timeliness section of Matrix** ○ **Add information from Member IG regarding when identified for transitions, frequency/manner of contact (Reference Q 1-3)**	• *List of brief statements of issues and areas of improvement that could/should be addressed to improve the In Reach process.* ○ **Add information from timeliness section of Matrix** **Add information from Member IG regarding when identified for transitions, frequency/manner of contact (Reference Q 1-3)**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

OVERALL – TRANSITION PROCESS

Strengths	Issues/Areas for Improvement
• *List of brief statements of strengths of the Transition Process as evidenced by all sources of information evaluated. Note: these strengths should reflect the implementation of the ITP and Coordination to ensure successful transition.* ○ **Add information from matrix—Review of Ongoing Transitional Process, ITP Implementation and Collaboration between TC and CCM.** ○ **Add information from Member IG regarding how individual feels the planning is progressing (Reference Q 16)** ○ **Add information from TC IG related to individual's progress with transition, barriers, transition process. (Reference Q 6-9)**	• *List of brief statements of issues and areas of improvement that could/should be addressed to improve the Transition Process.* ○ **Add information from matrix— Review of Ongoing Transitional Process, ITP Implementation and Collaboration between TC and CCM.** ○ **Add information from Member IG related to individual's concerns about progress of transition planning, (Reference Q 16)** ○ **Add information from TC IG related to individual's progress with transition, barriers, transition process. (Reference Q 6-9)**

Rating				
1	2	3	4	5
Very Poor	Poor	Good	Very Good	Excellent

Likert Scoring: See scoring criteria (separate document)

Additional Comments:

INDIVIDUAL ACTIVE CASELOAD REVIEW SUMMARY INSTRUCTIONS

Additional comments, significant facts or issues not otherwise captured. May also include specific recommendations for this domain that are not reflected elsewhere but need to be captured for summary.

Systemic Issues

Brief description of systemic issues needing referral for further Quality Improvement review:

- *Issues not captured elsewhere which reflect potential change in systemic processes. Examples include recommendations for additions to assessment tools, follow up procedures, changes in timing of contacts, etc.*