

**Agreement to Resolve the Department of Justice Investigation  
Second Report by Subject Matter Expert  
May 1, 2019 through December 31<sup>st</sup> 2019**

## Section 1--Introduction

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

The Agreement sets forth the requirement for a Subject Matter Expert (SME). The SME is to provide technical assistance to help the State comply with its obligations under the Agreement. The SME has various responsibilities, including analyzing and reporting data on the State's progress in complying with all sections of this Agreement. In addition, the SME is responsible for assessing the quality of community-based services for members of the Target Population (defined in the Agreement). The State engaged the Technical Assistance Collaborative in August of 2018 to perform the SME responsibilities. Every six months, the Expert will draft and submit to the Parties a comprehensive public report on Louisiana Department of Health (LDH) compliance, including recommendations, if any, to facilitate or sustain compliance. This is the second SME report for the period of 3/1/2019 through 12/31/2019.

December 2019 marks the end of the State's initial eighteen-month Implementation Plan. The Agreement set out several foundational tasks that LDH was to accomplish during this period. In particular, the Agreement called for LDH to:

- (a) Develop and deliver training to LDH staff and providers concerning the provisions of this Agreement and LDH's commitment to ending unnecessary institutionalization of people in the Target Population, consistent with *Olmstead* principles;
- (b) Identify nursing facility residents in the Target Population who have the fewest barriers to transition and begin to transition those residents to the community, using transition planning and community-based services in accordance with the provisions of this Agreement;
- (c) Conduct a gap analysis that identifies gaps in services and proposes goals and timeframes to remedy gaps in services;
- (d) Assess Medicaid services, rates, managed care contracts, and billing structures to identify barriers to the provision of community-based services for the Target Population;
- (e) Identify and implement incentives through Medicaid waiver, managed care, and provider contracts to increase use of community-based services and reduce reliance on

institutional long-term care for the Target Population; establish annual targets for diversion and transition of Target Population members to successful placements in the community. For purposes of setting these targets, successful placements are defined as those in which the individual is able to avoid re-institutionalization (not including nursing facility admissions of 30 days or less), incarceration, or homelessness for a period of one year;

- (f) Establish annual targets and strategies for decreasing referrals for individuals with SMI to nursing facilities;
- (g) Assign agency and division responsibility for achieving goals identified in the initial Implementation Plan; and
- (h) Establish collaborative problem-solving among State and local government agencies and entities.

As discussed in more detail throughout this report, the State has made progress on most of these tasks. For instance, the State has:

- Developed and implemented trainings regarding the Agreement for LDH staff, providers, and other stakeholders. LDH has made the Agreement and the initial Implementation Plan a focus of listening sessions conducted throughout 2019;
- Developed a master list of individuals in nursing facilities that have been identified as members of the Target Population under this Agreement. In addition, the State has identified individuals on this master list that have the fewest transition barriers. Over the past 18 months the State has transitioned 91 individuals from nursing facilities, and anticipates transitioning an additional 100 in Calendar Year (CY) 2020;
- Developed a diversion plan that will be implemented in FY 2020 and projected that 126 individuals will be diverted from nursing facilities next year; and
- Assigned responsible agencies and divisions to achieve the goals in the initial 18-month implementation plan. As indicated throughout this report, the State accomplished many tasks set forth in the plan. There are some tasks that were not completed that are included in the CY 2020 Implementation Plan. The major tasks that were rolled over into the CY 2020 plan include:
  - Development of a long-term tracking system for individuals in the Target Population that were transitioned or diverted from nursing facilities;
  - Development of a gaps analysis that identifies the gaps in services and makes recommendations regarding strategies to address these gaps. At the recommendation of the SME, the State will undertake an initial gaps analysis that will include the services identified in the various plans developed in December

2019. These plans outlined new and revised services, which will be included in the gaps analysis in addition to the services and supports currently available to the Target Population; and

- Establishing annual targets and strategies for decreasing referrals for individuals with SMI to nursing facilities.

The State has not made significant changes to the service delivery system. As indicated in this report, the first 18 months focused on significant planning efforts in areas such as housing, crisis, peer support, Assertive Community Treatment, case management, and day services. The implementation of these plans will require additional Medicaid authorities in 2020 and 2021. The State will have to develop provider guidance and reimbursement strategies for these new services. Once the State receives the necessary approval for these services from the Centers for Medicare and Medicaid Services (CMS), the State can make the necessary changes to managed care contracts, when appropriate.

The State has made initial in-roads regarding processes to establish collaborative efforts with other State agencies and local government agencies and entities. For instance, the State has partnered with several local housing authorities to assist in the development of additional housing opportunities to meet the terms of the Agreement. LDH has partnered with State and local agencies responsible for increasing employment opportunities for individuals with disabilities, including individuals with serious mental illness. The State has also created the My Choice Louisiana Service Review Panel (SRP), a cross-agency process that works to identify systemic barriers that impede or prevent transitions, and work through individual case-related issues. Finally, the State did outreach to Local Governing Entities (LGEs) to perform a scan of available crisis services and discuss the process for implementing the proposed crisis services plan developed in December 2019.

Since the last report, the State has made progress in various areas of note. Many of these areas are fundamental to the success of the State's efforts under the Agreement. These include:

- Continuing efforts to transition members of the Target Population from NFs to community-based services;
- Beginning to house members of the Target Population using HUD mainstream vouchers for non-elderly disabled which were applied for and obtained as part of the State's effort to comply with housing requirements in the Agreement;
- Developing a community case management model for individuals who were diverted or transitioned from NFs;
- Continuing to develop an initial draft of Quality Assurance indicators and the data sources needed to support these indicators;
- Developing initial drafts of crisis and housing plans;
- Revising critical processes and protocols, such as the Assessment and Transition Plan;
- Continuing efforts to implement the In-Reach Plan;
- Developing an operational definition for the members of the Target Population who will be diverted from NFs into community-based services;

- Increasing stakeholder engagement through the use of key subcommittees of the Advisory Committee;
- Developing data analytic tools to review the impact that revisions to Level of Care (LOC) requirements and Pre-Admission Screening and Annual Resident Review (PASRR) had on reducing inappropriate nursing home admissions; and
- Finalizing the required plans for housing, crisis, and diversion that were due in December of 2019.

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

- Finalizing the necessary documents for the vendors that will create the longer-term tracking system, including specifications for tracking members of the Target Population that are diverted from NFs;
- Developing a specific training schedule for critical services, including crisis services, employment services, and peer support. In addition to these opportunities, the State should consider other trainings that focus on the principles of recovery, developing person-centered plans, and understanding and operationalizing strategies for social inclusion;
- Enhancing efforts to increase the number of individuals in the Target Population who are successfully transitioned from NFs, based on the targets set forth in the 2020 Implementation Plan. This will require the State to significantly increase the availability of intensive community support services, integrated and meaningful day opportunities, crisis services, and peer supports;
- Continuing efforts to identify and remove transition barriers through a cross-agency process in order to identify and address systemic barriers that impede or prevent transitions;
- Implementing an interim case management strategy, immediately, to ensure that individuals remain in the community and receive the services and supports necessary to successfully achieve the goals in their individualized transition plans;
- Finalizing an implementation strategy for the provision of case management services (following the interim process), including identifying a Medicaid authority to support the new case management model and developing a plan for implementing this strategy with specific timeframes;
- Developing a concrete strategy for peer in-reach efforts that includes a timeframe for involving peers in the in-reach process;
- Finalizing and operationalizing the Diversion Plan with clear responsibilities for the State, Managed Care Organizations (MCOs), and providers to assist individuals that have been diverted from a NF;
- Developing a data-use plan to help the State determine if the changes in the PASRR process over the past two years are effective and continue to make changes to the PASRR process based on data gathered and other relevant information;
- Modifying PASRR data systems as needed, as well as enabling the ability to capture items identified in the data-use plan;

- Implementing the initial activities necessary to complete the gaps analysis included in the implementation plan, including data collection regarding the needs of the Target Population and other individuals with Serious Mental Illness (SMI);
- Improving the quality of services provided by Assertive Community Treatment (ACT) providers by finalizing a set of measures that will be used to profile each ACT team and determine whether these teams are achieving the goals set forth for the service;
- Completing the framework for peer services and undertake the necessary steps to roll out the service, including the development of a training regarding the new peer support service and possible changes in the process to credential/certify individuals that will provide this service;
- Continuing quality assurance and quality improvement efforts, finalizing the quality assurance/improvement strategy, and developing public-facing reports on the measures that are currently available.
- Revising and implementing changes to develop a more robust mortality review process;
- Creating a formal external process improvement strategy to begin gathering qualitative information about the experiences of individuals who have transitioned from NFs, which will provide important lessons to improve the transition experience for individuals in the future;
- Changing the format of the Advisory Group to improve the value of these meetings and broaden the participation of the Advisory Committee;
- Enhancing the in-reach efforts to include peers working with Transition Coordinators during the engagement and transition process; and
- Revising the transition planning and transition monitoring tools and providing the necessary training to the Transition Coordinators and others who will be using these tools.

## **Section 2.1: Workflow and Tracking System Development – Phase 1**

### ***Overview***

By December 2019, the State is to develop and implement a system to identify and monitor individuals in the Target Population who remain in Louisiana Medicaid after their transition from a NF. This will allow the State 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 proactively address any such gaps to reduce the risk of readmission or other negative outcomes. The Agreement also requires the State to implement a monitoring system that includes both face-to-face meetings with individuals in the Target Population and tracking by service utilization and other data. In addition, the Agreement specifically requires the State to assign a Transition Coordinator who will initiate contact with the individual within three working days of admission. This will require the State to develop new functionality to track admissions to NFs on a real-time basis.

The State established an internal, cross-agency workgroup to review existing data systems across various offices. This workgroup is responsible for the development of a permanent,

comprehensive tracking system for the Agreement. The workgroup identified the necessary data sources needed to document activities occurring in order to meet the Agreement requirements. In addition, the State met with other states to learn from their experiences of developing tracking systems in order to guide the development of the system requirements.

To support the immediate work of Transition Coordinators, the State developed an interim tracking and work support system using SharePoint in 2018. This allowed the State to assign individuals to Transition Coordinators and track completion of key transition tasks. While the State is planning to develop and implement a more sophisticated approach to tracking, the interim system currently captures critical information regarding outreach activities, the transition assessment and development of transition plans, as well as services requested by the individual—including specific information on preferences regarding housing. The interim system also tracks the progress of the individuals who have transitioned to the community. Information and data reports from this interim system are easily accessible to state staff and will provide a good foundation for a long-term tracking system in 2020.

### **Assessment**

The Implementation Plan sets forth activities for developing key components of the more formal long-term tracking system that will allow the State to track transitions and diversions from NFs for members of the Target Population. The State proposed the specifications for system requirements of the longer-term tracking system. In reviewing the specifications, the SME found the proposed system requirements to support what the State's prospective needs for tracking individuals that are transitioned or diverted from NFs.

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

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

information regarding the status of transitions and diversions as well as information regarding individuals post-transition.

Since the previous SME report, the State determined it would need a separate system to track initial referrals to NFs, in order to identify individuals in the Target Population early and begin efforts to initiate transitions. The State made the decision that they would need to engage a vendor to assist it in developing this functionality, as developing the necessary infrastructure internally or amending an existing contract were determined to not be viable options. The State reviewed various options for engaging such a vendor over the past six months. This included reviewing options for procurement by either amending existing contracts (which would expedite the system development process) or seeking competitive procurement with the vendor via an RFI/RFP process to develop and implement the new system. Given the scope of the work required for this project, the State determined competitive procurement of a vendor was necessary. This process will postpone the implementation of the new system in calendar year 2020. The SME feels that the State's decision to work with a vendor to develop this tracking system is a judicious choice. Creating this tracking system internally would require staff resources that would be best used in other activities related to this Agreement.

### ***Recommendations***

Over the next several months, the State will need to develop the necessary procurement documents in order to solicit a vendor that will create the long-term tracking system. While the SME understands that the State may have unforeseeable procurement issues, it is recommended that the State procure the vendor by July 2020 and perform the due diligence necessary to ensure successful implementation (e.g. readiness review) with full involvement of the parties which are expected to have use of this system.

It is also recommended that the State review the quality indicators, described in Section 2.6 of this report, and determine if changes are needed to the specifications for the long-term tracking system, also determining what additional reports should be developed. In addition, the State will need to develop specifications for tracking members of the Target Population that are diverted from NFs. This will require that the State define the diverted population (see Section 2.4) and ensure that the State receives information from entities that will be responsible for triaging, coordinating, and providing services to this portion of the Target Population.

## **Section 2.2: Medicaid Managed Care Organization (MCO), LDH Employee, and Provider Training**

### ***Overview***

The Agreement requires the State to develop and deliver training for services to ensure that community providers have the skills and knowledge necessary to deliver quality community-based services consistent with this Agreement. The State is to establish a mandatory training policy, qualifications, and curriculum for community providers, with the technical assistance and approval of the Expert. The curriculum will include initial and continued training and coaching for community providers. The curriculum will emphasize person-centered service delivery,



community integration, and cultural competency. The curriculum must incorporate the provisions of this Agreement, where applicable, and LDH must seek input from individuals receiving services regarding the training curriculum and will include such individuals in the training, where appropriate.

The State also launched an initial training that provided an overview of the Agreement for relevant staff in each MCO, LDH employee staff, and community behavioral health providers.

In late 2018, the State developed and completed an Evidence-Based Practice (EBP) survey of the adult behavioral health system of care in Louisiana. The survey was not specific to the Target Population, but of services for individuals with mental health disorders more broadly. The survey indicated that training was needed in the following areas: trauma and evidence-based practices (such as Assertive Community Treatment), Motivational Interviewing, and Cognitive Behavioral Therapy.

Based on the results of this assessment, the State identified some preliminary training needs. In addition, the state evaluated the existing policy manual, which includes training, qualifications, and curriculum against the requirements of the Agreement, initially, to identify any significant gaps.

### ***Assessment***

The State has taken various steps to meet the provider training requirements of the Agreement. Over the past nine months, the state has identified trainings related to best practices in certain areas for serving individuals in the Target Population exiting institutions. The State has offered training on Motivational Interviewing and provided training on dementia related to the PASRR process. In addition, the State has recommended other areas for training, including: employment, crisis services, and peer support. The State has begun to provide training for enhancing strategies for individuals in the Target Population to become gainfully employed. This initial training focused on LDH Transition Coordinators and community mental health providers. The SME, working in cooperation with the State, developed the training curriculum and materials. The goals of these materials were to understand the connection between employment and health, how employment is a health intervention, challenges and strategies to overcoming employment barriers, and assessing and harnessing the resources of our current systems for the Target Population. Finally, the State has explored options for specific provider types, such as Assertive Community Treatment teams intended to enhance the quality of the service.

One of the requirements under the Agreement is that LDH will establish a mandatory training policy, qualifications, and curriculum for Community Providers with regard to the Agreement and serving the Target Population. As a first step, in July of 2019, the Office of Behavioral Health (OBH), through discussion with the MCOs, reviewed existing trainings offered through the MCOs in an effort to better analyze the existing training systems. The review identified variability among the plans regarding training; however, the MCO's cumulative training curriculum includes a fairly wide range of training opportunities that, in the SME's opinion, is comprehensive. In

addition, most Medicaid providers are in managed care networks and, therefore, have been offered these training opportunities. As the State begins to implement the various plans (crisis, housing and diversion), additional trainings will need to be offered by the MCOs. These trainings are discussed in the recommendation section below. Additionally, OBH reviewed the array of mandatory trainings for unlicensed staff providing community-based services, with the intention of identifying whether or not updates are needed. OBH, based on the review of the existing MCO training, identified additional options for expanding the array of trainings offered. Some initial areas of focus include the following: Person-Centered Planning, Treatment and Discharge Plan Development, Crisis Plan Development, Developing Meaningful Progress Notes, Mental Health 101, and Suicide and Homicide Precautions. Options for training provider groups on the DOJ Agreement were also discussed. As stated above, OBH is also developing a more robust training curriculum that will focus on employment for individuals with mental health conditions. The training curriculum will be offered to a wide range of stakeholders, including: Mental Health Rehabilitation (MHR) providers, Transition Coordinators, Support Coordinators, other behavioral health providers, consumers, and family members. It is anticipated that training regarding employment will go live within the next six months.

As indicated in my previous report, there are current efforts to develop new services. The finalization of these service frameworks and implementation timeframes will drive future provider training or managed care training.

### ***Recommendations***

The State has committed to developing additional training opportunities focused on the three areas set forth above: crisis, employment, and peer support. Over the next six months, the State should develop a specific training schedule for these services. Some of these trainings should be made available statewide (e.g. employment). Training for crisis services should target existing Local Government Entities (LGEs) and other providers that are offering crisis services, in order to assist them in their efforts to deliver services consistent with good practice. Specifically, the training should begin to create the foundation for the crisis services the State will set forth in their Crisis Plan. This will prepare some of the existing crisis providers for enhancements in the system set forth in the Crisis Plan. Similarly, the State will need to develop a curriculum for Peer Support services that will mirror the service framework being finalized by the State. It will be important to develop a strategy for informing existing providers and peer specialists regarding the availability of the training. The content of the training should include information on the requirements of peer specialists, the process for becoming a peer specialist, and probable employment opportunities created by the implementation of the new service. In addition, the State should develop a training for organizations that are likely to be positively impacted by the new peer support service. This includes: drop-in centers, existing crisis providers, emergency departments, NFs, and other venues yet to be determined.

In addition to these opportunities, the State should consider other trainings that are often common staples among the community providers. This includes training regarding the principles of recovery, developing person-centered plans, and understanding and operationalizing strategies for social inclusion.

## **Section 2.3 Transition System Development**

### ***Overview***

One of the overarching goals of this Agreement is to identify and transition all members of the Target Population who have been admitted to NFs, but are able to and would like to receive services in the community. During the first 18 months of implementation, the State is required to identify NF residents in the Target Population who have the fewest barriers to transition, and begin to transition those residents to the community using transition planning and community-based services sufficient to meet their needs. Within the same timeframe, the State is also required to establish annual targets for transition of Target Population members from NFs to successful placements in the community.

One of the initial activities was to create a Master List of individuals that are in NFs who are members of the Target Population. Specifically, the State analyzed and reviewed data from the Minimum Data Set (MDS) and PASRR Level II reviews on individuals that were residing in NFs to create this Master List. The MDS is part of a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process involves a comprehensive, standardized assessment of each resident's functional capabilities and health needs. Initially, 3,122 individuals were included in the Master List. In addition, the State matched MDS data to PASRR Level II data to identify individuals who may have required a Level II screening but did not receive one. Based on these efforts, the State developed a referral system and prioritization to complete Level II screenings. The combination of MDS and PASRR Level II data, in the SME's opinion, provides the best strategy to identify individuals that may need a Level II screen.

The State was also required to develop transition teams composed of Transition Coordinators from the Office of Aging and Adult Services (OAAS), the Office of Behavioral Health (OBH), and the Office for Citizens with Developmental Disabilities (OCDD). The relative number of transition coordinators hired or otherwise provided by each of these LDH offices must 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. Currently, the initial transition teams are specific to OAAS and OBH—all the transitions to date have been specific to the populations that they serve. The number of transition coordinators seems sufficient for this past period. OAAS and OBH have nine transition coordinators each (one per region). As the number of individuals that transition increases and the interim case management process (described later in this report) is implemented, the State will need to review whether the current number of transition coordinators is sufficient.

Since the beginning of the Agreement, the state has recruited, hired, and trained OAAS and OBH Transition Coordinators. The Transition Coordinators are responsible for conducting the assessment and developing an Individualized Transition Plan (ITP) for each member of the Target Population who is residing in a NF. The ITP must address the service needs identified through the PASRR Level II process, as well as additional needs identified by transition team members.

The plans must 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 their 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 they experience 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.

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, that is based on principles of self-determination and recovery. LDH shall ensure that the transition planning process includes opportunities for individuals to visit community settings.

The State is also required to develop a plan for ongoing "in-reach" to every member of the Target Population residing in a NF (discussed in more detail in Section 2.7). This will include providing information about the benefits of transition and about the community-based services and supports that can be alternatives to NFs. The State must also develop procedures for addressing safety and choice for members of the Target population who lack decision-making capacity.

For members of the Target Population who choose to remain in a NF, or move to a setting that is not community-based, the State must document steps taken to identify and address barriers to community living, and efforts to ensure a meaningful and informed decision.

The transition planning process must begin within three working days of admission to a nursing facility. An assigned transition coordinator must initiate contact with the individual within that timeframe. A face-to-face meeting must occur within 14 calendar days of admission for new admissions. In addition, the Implementation Plans must specify timeframes for transition planning for members of the Target Population residing in nursing facilities. The transition teams must also 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.

For those who transition, the Transition Coordinators and LDH managerial staff who oversee their work will conduct post-transition follow-ups to ensure that services in the community are initiated and delivered in a manner that accomplishes the goals of the Transition Plan. Transition Coordinators follow-up with individuals that have been transitioned from a NF during the first week, after the first 30 days, every 90 days after transition, and one year after the transition. The State is required to develop a Transition Support Committee to assist in addressing and

overcoming barriers to transition for individual members of the Target Population. This committee will assist the transition team members working with service providers, the individual, and the individual's informal supports to successfully overcome those barriers.

The State is also required to provide ongoing case-management in the community to members of the Target Population for a minimum of 12 months following discharge from the NF. Specifically, the Agreement required the Implementation Plan 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 re-institutionalization and assist the individual to maintain community placement. The case management approach shall ensure capacity to provide face-to-face engagement, person-centered planning that will assist in achieving outcomes that promote the individual's social, professional, and educational growth, and independence in the most integrated setting.

### ***Assessment***

In the opinion of the SME, the State has created the required infrastructure needed to identify individuals that are members of the Target Population, conduct the transition assessments and individualized transition plan, and assist individuals with the transition process. Additional work is needed, as noted within this section, especially regarding the State's efforts to enhance in-reach activities. However, since the beginning of the Agreement through the end of December, 2019, the State has:

- Completed 638 assessments—an additional 664 assessments are still in process at the time of drafting this report.
  - Of the individuals with completed assessments, 164 have been offered the opportunity to participate in the Community Choices Waiver.
  - 92 individuals have been transitioned to the community from NFs.
  - Of the individuals that have been transitioned, 61 individuals are participating in the Community Choices Waiver and 31 are not. Almost all of these 31 individuals do not meet the level of care necessary to participate in the Waiver.

While these numbers show increases since the last SME report, there were several months that there were few transitions. As requested in the previous report, the State provided the SME with information regarding the individuals that are awaiting transition—specifically, any transition barrier that the State has identified for these individuals. Some of the reported barriers include:

- Availability of accessible housing, especially in rural areas of the state;
- Transportation assistance, both for transportation within region to view housing and when transitioning to another region;
- Legal barriers to transition (availability of housing for individuals with criminal backgrounds);
- Lack of natural supports that are willing and able to assist in meeting the individual's post-transition needs;

- Physical needs that do not rise to the threshold of meeting a nursing facility level of care, which means that some individuals are not eligible for Home and Community Based Services;
- Service needs for those who, upon transition into the community, will lose Medicaid eligibility;
- Physical, emotional, and cognitive health decline of individual's who may be interested in transitioning, but for whom transitioning poses a health and safety risk;
- Delays in obtaining identification documents or birth certificates, especially when such documents are needed to secure housing;
- Non-cooperation from the nursing facility in supporting transition activities;
- Family concerns regarding the adverse consequences of the transition; and
- Ambivalence of individuals about leaving nursing facilities and changing preferences about arrangements they want in the community.

As indicated above, there is an expectation (per the Agreement) that case management is available to members in the Target Population pre- and post-transition. As stated in the last SME report, there is not an existing model of case management that will suffice for many of the individuals in the Target Population. Some, but not all, of these case management functions are provided in existing approaches (e.g., Assertive Community Treatment, Support Coordination, Permanent Supportive Housing staff, and Transition Coordinators). Since the last report, the State has developed, but has not implemented, a case management model that will be available to individuals that transition from NFs, as well as for individuals that will be diverted from these facilities. As drafted, the case management model is individualized, person-centered, and reflects the individual's unique strengths, needs, preferences, experiences, and cultural background. It allows individuals to participate in all decisions that affect their care and ensures they are provided options regarding their services and supports—including the option to refuse services. The model establishes key functions for the community case manager and sets forth clear expectations of the nature and frequency of contact before, during, and after transitions from the NF. It also sets forth the requirements for the case manager and the entities that will employ these staff.

Creating the necessary infrastructure to support the case management model will be important. Specifically, the State will need to develop training materials for providers of case management services, educational materials for the Transition Population regarding the role of the case manager, the reimbursement methodology for the services, and the specific Medicaid authority that will be needed to obtain Federal Financial Participation (e.g. federal match) for this service. The State has begun their efforts to identify the most appropriate Medicaid delivery mechanism for implementing case management.

Over the past year, the State, SME, and DOJ have been concerned regarding the gap in case management services for individuals in the Target Population that have transitioned from NFs. The State has proposed an interim strategy that will rely on the existing Transition Coordinators to provide case management until the long-term strategy is implemented. The SME assessment

believes that this interim strategy, as designed, should provide a consistent case management approach, but does not feel that this should be used as a long-term solution. The Transition Coordinators have other important functions that will be compromised if this was the long-term solution. As indicated above, the current constellation of case management approaches is not sufficient for many of these individuals. It is clear that the State needs to create an interim approach to ensure these individuals have a single point of accountability, and receive case management on a more frequent and consistent basis. Conversations with Transition Coordinators and site visits with individuals that have transitioned have highlighted the need for an interim strategy. Over the past month, the State has drafted an interim approach to case management.

Per the recommendation in the last report, the State has revised the Assessment used by the Transition Coordinators during the initial transition process. The State worked with the SME in April and May to revise the tool. The State also worked with a workgroup of the My Choice Advisory Committee in June to review and provide input regarding the revised Assessment. This workgroup was generally in support of the revised Assessment and provided additional feedback regarding a few specific areas. These areas include: obtaining sensitive information on legal status and charges (which may affect housing options), language regarding how individuals wanted to spend their days, and any concerns they might have regarding loneliness and “down time.”

The new assessment tool is more person-centered, and gathers additional information regarding individuals’ interests and desires about integrated day opportunities. This includes information from discussions with the members regarding how they want to spend their days in the community (e.g., employment, volunteer work, or general daytime activities, etc.) and identification of the needed supports to accomplish these goals. The new Assessment provides more specificity regarding the housing options that are available in the community post-transition. The Assessment also includes much needed information regarding crisis triggers and crisis planning. In addition, the Assessment gathers information on an individual’s history of co-occurring mental health and substance use disorder as well as behavioral health supports, including the individual’s perspective on treatment and those preventive and early intervention strategies that can be used in their transition plan. In July, the Transition Coordinators were trained on the Assessment Tool and began using the tool shortly thereafter.

The State’s efforts to develop procedures for addressing safety and choice for members of the Target population who lack decision-making capacity is variable. Currently, OAAS has policy and procedures for individuals that participate in the Community Choices Waiver for individuals who may lack decision-making capacity. These policies and procedures are consistent with federal guidance and other state approaches to similar policies and procedures for these individuals. OBH does not have similar policies and procedures.

In the previous report it was recommended that the State’s in-reach efforts begin to include individuals with lived experience (peers) to assist the Transition Coordinators in having initial

discussions with the Target Population about opportunities to transition to the community. The state has yet to implement this recommendation.

The Agreement required the State to develop annual projections regarding members of the Target Population that would be transitioned from nursing facilities. In December, the State developed a plan that estimated the number of individuals in the Target Population that would be transitioned from nursing facilities in CY 2020. This plan estimated that 100 individuals would be transitioned from nursing facilities this coming calendar year.

### ***Recommendations***

During 2020, the State will need to enhance its efforts to increase the number of individuals in the Target Population who are successfully transitioned from NFs. These activities should include additional efforts to engage Target Population members who continue to be ambivalent regarding moving into the community. This could include enhancing motivational interviewing strategies, use of peers to assist with in-reach efforts, and continued efforts to identify community resources that are needed by the Target Population specific to their health needs, since many of these individuals have comorbid physical and behavioral health conditions. These efforts should assist the State in meeting the targets for successful transitions for Calendar Year 2020, as required by the Agreement. A number of factors, including the availability of intensive community support services, integrated and meaningful day opportunities, and crisis services, will also drive these targets and peer support services. These transition targets should be taken into account as the State develops the Housing Plan, which has specific targets for providing access to affordable, community-integrated housing for Target Population members, including the creation of 1000 units/subsidies by 2023.

The State must continue its efforts to identify and remove transition barriers, which is critical to the success of achieving the transition targets set forth in implementation plans. While many of these barriers are very person-specific, there are a few systemic barriers that the State can continue to address. These include: developing strategies regarding individual's fear of losing Medicaid, developing service strategies for addressing personal care services for individuals that may not currently qualify for these services, and assisting Mental Health Rehabilitation (MHR) and other providers to have a better understanding of some of the more chronic medical conditions of the Target Population. The State has developed procedures to fulfill the Agreement's requirement to facilitate a Transition Support Committee. Using OAAS's framework for its current Service Review Panel, LDH has developed the My Choice Louisiana Service Review Panel (SRP), a cross-agency process that works to identify systemic barriers that impede or prevent transitions and work through individual case-related issues. The My Choice Louisiana SRP functions as the Transition Committee. As the number of transitions increase, it will be important that the State continue to use this process to identify and address barriers to transitions. The state should consider additional members that can identify systemic barriers affecting multiple members of the Target Population and ad hoc representation to address particular barriers in individual cases. This would include adding members with experience and expertise related to successfully resolving barriers to discharge. Potential additional members include Office for Citizens with Developmental Disabilities staff, 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, LGE staff, and certified peer specialists.

The growing numbers of transitions at this stage of implementation is laudable. It also necessitates that an interim case management strategy be implemented by January, 2020 to ensure that individuals remain in the community and receive the services and supports that are needed to achieve the goals in their individualized transition plans. The State should be commended for responding quickly when concerns were identified about the frequency and sufficiency of contact post-transition. Transition Coordinators are doing more frequent check-ins than originally required, and an interim case management strategy has been developed. As discussed with the State, this will require weekly contacts (face-to-face and phone) with the individuals that have been transitioned.

Over the next six months, the State will need to continue its efforts to finalize a strategy for the provision of case management services (following the interim process). Specifically, it is recommended that the State identify the Medicaid authority necessary to implement the new case management model and have a plan for implementing this strategy with specific timeframes. The plan should address critical activities, including: establishing reimbursement methodologies for the service, developing training modules for potential case management staff, and creating information for individuals in the Target Population regarding the role of the case managers prior to, during, and post transition. In addition, training will need to be developed for Support Coordination agencies, MCOs, and others who will have contact with newly created case managers.

Finally, the SME is continuing to recommend that the State develop a concrete strategy for including peers for in-reach efforts. The State has agreed that this would be a very valuable addition to the in-reach process; it is recommended that the State develop a strategy and timeframe for including peers in the in-reach process. This strategy should address the requirements for peers to perform these activities, the reimbursement strategy for peer in-reach efforts, the development of training for potential peers and Transition Coordinators regarding the importance of peers in these efforts, and a strategy for supervising these peers to support their efforts.

## **Section 2.4 Diversion System Development**

### ***Overview***

Another overarching goal of this Agreement is to divert members of the Target Population away from inappropriate NF placements. The Agreement requires the State to develop and implement a plan for a diversion system that has the capability to promptly identify individuals in the Target Population seeking admission to NFs and provide intervention and services to prevent unnecessary institutionalization. The plan must include the development of community support services required by the Agreement. This includes developing and implementing 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. LDH must incorporate into its plan for diversion any targeted outreach and education needed to successfully implement that plan, including outreach to law enforcement, corrections, and courts.

In the initial eighteen months of the Agreement, the State is required to establish annual targets for diversion of Target Population members to successful placements in the community, and establish annual targets and strategies for decreasing referrals for individuals with SMI to nursing facilities.

The State is also required to implement improvements to its process for screening and evaluating individuals referred to NFs, and to ensure that all individuals applying for nursing facility services are provided with information about community options, in order to prevent unnecessary admissions. In brief, the federal PASRR process requires that all applicants to Medicaid-certified NFs are evaluated for appropriateness for NF placement and service needs. This process begins with all individuals referred for NF placement receiving a PASRR Level I screening. The purpose of this screening is to identify people who are suspected of having a mental illness. Under the Agreement, 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.

For each individual identified through the Level I screen, LDH must 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. The evaluation must include an assessment of whether the individual's total needs are such that they can be met in an appropriate community setting.

All screenings and evaluations must begin with the presumption that individuals can live in community-based residences. LDH must 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.

In Louisiana, the Level I screening is performed by OAAS as the Level I authority. OAAS determines whether or not an individual meets NF LOC. If an individual meets NF LOC and is suspected of having a behavioral health diagnosis, OAAS must send the screening results to OBH as the Level II authority. OBH conducts an initial review to determine if a Level II evaluation is necessary and, when indicated, mandates a Level II evaluation be performed by the Medicaid MCO or its affiliate. This initial review is to determine if there is a true indication of behavioral health needs. Level II evaluations are performed by the Medicaid MCOs' Level II Evaluator, a

Licensed Mental Health Professional who operates independent of the NF and the State. The Level II evaluation is reviewed and verified by the MCO prior to being returned to OBH for final determination regarding placement needs and recommendations for services.<sup>1</sup>

Following approval of a Level II determination, LDH 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 of time 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.

When appropriate, OBH then provides temporary 90-100 day authorizations for NF admissions. When implemented appropriately, this tiered PASRR process should result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care that would comply with the Agreement.

The State has reported that, in 2017, they implemented improvements to its existing processes for screening individuals using the Level I instrument prior to approving NF placement, and has taken steps to ensure that all individuals applying for NF services are provided with information about community options. The State has reported that they developed and offer a standardized training required for all personnel who complete any part of the Level I screenings (with the exception of physicians). For evaluators who are completing the Level II PASRR, the State provided additional training to ensure that they are familiar with the array of home- and community-based services available to support community integration. The State is also required to revise the Level II forms to include more extensive and detailed information regarding services in the community. The SME has not reviewed these trainings to determine if these improvements have resulted in the intended changes.

In addition, the State must ensure that each individual in the Target Population, who has been admitted to a NF, receives a new PASRR Level II screen annually and, upon knowledge of a significant change in the resident's condition, to determine whether their needs can be met in a community-based setting. The evaluation must be conducted by a qualified professional, independent of the NF and the State.

Prior to and during the first six months of the Agreement, the State made various changes to improve the likelihood of individuals being diverted from NFs to community-based services. These changes included:

- Revising the level of care determination process through the PASRR Level II process so that all individuals that are admitted to a NF receive an initial authorization of no more than 90 – 100 days in a NF;

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<sup>1</sup> See "MCO Role in Evaluations & Determinations" for a flow chart conveying the PASRR Level I and Level II process. Included as attachment.

- Standardizing the utilization of temporary authorizations for all positive PASRR Level II reviews it authorizes for NF placement. Authorizations for nursing facility stays will be limited to 90 days (or 100 days for persons approved for convalescent care by LDH). This change will mean that each individual who received an initial Level II and was admitted to a NF will receive annual PASRR II re-reviews, during which the need for continued NF placement and services will be evaluated. In addition, this new requirement should ensure annual reviews for people who were admitted earlier, before this shift to temporary approvals. Additional review of this requirements impact will be reviewed in subsequent SME reports.
- Revising PASRR Level II forms to include more information regarding mental health services in the community;
- Implementing improvements to processes to ensure that individuals applying for NF services receive information about community options;
- Developing and offering standardized training for PASRR Level I reviewers to improve the identification of persons with SMI;
- Completing an initial review of Level II documents to ensure the determination forms include required information, such as intended duration, reason for duration, need for specialized behavioral health (BH) services, and barriers to community-placement at time of temporary admission;
- Developing a Resident Review (RR) form for submission by NF when the need for a RR is identified;
- Developing and offering trainings for Level II reviewers to improve knowledge of community services for individuals that have been referred for Level II screens;
- Eliminating the behavioral pathway as an eligibility pathway for new NF admissions;
- Strengthening documentation requirements used to establish a primary diagnosis of dementia relative to the PASRR screening process; and
- Requiring that all persons screened as potentially having SMI with dementia are referred for a Level II evaluation and, for individuals without sufficient documentation to establish the validity of a primary dementia diagnosis, LDH provides an additional level of evaluation to review the diagnosis that is currently performed by a physician with expertise in dementia.

### ***Assessment***

The State is making progress in its efforts to strengthen the PASRR Level II process to ensure that evaluators have the tools necessary to make recommendations for community placement. The State has done a second revision to the PASRR Level II instrument. The SME has reviewed the instrument and requested that the PASRR Technical Assistance Center (TAC) review the revised form. The PASRR TAC assists state Medicaid program administrators, their staff and contractors, and other state agencies involved with developing PASRR programs. The SME and the PASRR TAC provided the State with recommended changes to the instrument. The State revised the instrument based on these recommendations; this included revising the Level II forms to include more extensive and detailed information regarding services in the community. The State is also taking steps to ensure that processes are in place for each individual who received an initial Level

II screening and was admitted to a NF to receive a new PASRR Level II annually, as required by the Agreement.

The State has also strengthened its documentation requirements and training for individuals and organizations that refer individuals to NFs. For example, the State strengthened documentation requirements used to train providers who are referring individuals for NF placements. The State also revised the document requirements used to establish primary dementia diagnosis and, earlier this summer, provided training to relevant parties regarding the changes to this documentation and the importance of this documentation in PASRR's ability to verify the dementia diagnosis. In addition to this documentation, the State continues to compile comprehensive resource lists for individuals denied NF placement.

In the last SME report, it was recommended that the State review data and other information to determine if these changes (level of care determination, revisions to PASRR instruments, training of PASRR staff) have made a measurable difference in the number of individuals with SMI who are admitted to a NF. It was specifically recommended that the State conduct a multi-year review of admissions and diversions of individuals with SMI that would consist of baseline information for LOC screenings, and PASRR Levels I and II (for both individuals who were seeking admission into NFs and for annual resident reviews for individuals with SMI that were previously admitted to NFs). Over the past several months, the State has begun its data analytic efforts regarding referrals for Level II evaluations, the results of the evaluations, and other key diversion activities. These initial data analytics were completed by mid-December 2019.

In the last SME report, it was recommended that the State continue its efforts to define the diversion population. Over the past several months, the State has developed initial definitions of various populations that may be considered for their diversionary efforts. The State is in the process of analyzing data to validate these definitions, as well as project future diversions, as required by the Agreement. The State has also performed some data analytics regarding individuals that are "at risk" of being referred to a NF. This included a review of key characteristics of individuals that had SMI who were admitted to a NF in 2018. This review indicated that many of these individuals were older, had two or more chronic conditions, and a subset had a significant number of emergency department visits and inpatient stays for both medical and behavioral health conditions. This is critical information that the state will be using as an input for their diversion strategy, but also may reframe some of the community services development needed for an older, more medically vulnerable group of individuals.

The Agreement requires the MCO to establish a process for referring individuals to services if those individuals are denied a NF placement during the PASRR II process. OBH has met with the MCOs to review each of their protocols. LDH's current process requires that every individual that has been denied nursing home placement through the PASRR Level II process is referred for case management provided by the MCOs. The individual has the option to refuse case management. For individuals that accept case management services, the MCO case manager follows up with the individual to identify and provide the necessary behavioral health services and other

supports. If the individual does not accept case management, MCOs provide follow up over several months to engage the individual in case management.

The Implementation Plan required the State to develop a process where MDS responses are verified by a qualified party unaffiliated with the NF. For continued stays in a NF (beyond 100 days) the State has made the necessary procedural changes that require OAAS staff to complete an independent MDS review for all Continued Stay Requests.

The State has developed its Diversion Plan with the assistance of the SME. The Diversion Plan provided definitions and projections for the population diverted from NFs, and set forth the strategy for how these individuals will be engaged, in a meaningful way, with community services and supports. Specifically, LDH has developed a diversion plan and projections for CY 2020 for three populations, which include:

- Persons with SMI who seek admission to, are referred to, and/or receive screenings and/or evaluations for nursing facility placement who do not meet Nursing Facility Level of Care (LOC) criteria or for whom a Pre-Admission Screening and Resident Review Level (PASRR) II review recommends placement in the community (120 individuals);
- Persons with SMI who are admitted to a nursing facility on a temporary basis and could be transitioned into the community within a short period (6 individuals); and
- Persons with serious mental illness (SMI) who experience avoidable hospitalizations that place them at risk for subsequent nursing facility admission. The State is still in the process of developing projections for FY 2020 for this population.

### ***Recommendations***

The State should develop a consumer flow and process for individuals that meet the diversion definition set forth in the Diversion Plan. This should include specific timeframes for accessing case management, and immediate services and supports (including health and behavioral health) that will be necessary to initially triage and stabilize these individuals. While many of these individuals have behavioral health needs, other acute and chronic conditions will need to be addressed to ensure they are not immediately re-hospitalized and re-referred for NF admissions. Once the State develops the processes and protocols for diversions, they will need to train the necessary LDH staff, MCOs, and other providers who will be engaged in the diversion process, the initial triage, and stabilization efforts.

The data analytics on recent admissions to NFs should be discussed with MCOs and community partners (health systems) to develop a strategy for identifying individuals and providing the necessary care management services to prevent admission to inpatient facilities that are the gateway to nursing homes. Specifically, the State should work with their MCOs and community providers regarding strategies to identify the population, have MCOs develop the necessary care management strategies (similar to strategies employed for other high risk/high need populations), and implement the preferred case management strategy. If these strategies are implemented effectively, the State should see a decrease in referrals for individuals with SMI to these facilities. As an additional step, the State should also identify reporting to track the extent

to which these strategies are effective and, if they are not effective, work with the MCOs and community partners to adjust these strategies.

The State is applauded for their initial data analytic efforts on the PASRR Level II process. While this information will be helpful for reporting purposes to the SME and DOJ, it is recommended that the State develop a data use plan that will assist them in determining whether the data is able to identify the effectiveness of the intended changes made over the past two years. The State has access to good data and solid data analytic capacity. It will need to enhance its efforts to use data to support improvement on a continuous basis.

## **Section 2.5 Community Support Services Development**

### ***Overview***

The State is required to develop an array of community support services that meet the needs of the Target Population. There are existing services that provide the foundation for this array, including MHR Services, other behavioral health services offered through the Medicaid program, and long-term services and supports. However, there are gaps in services for individuals with SMI, including employment supports, comprehensive crisis services, case management, peer support services and other supports that are necessary for community integration.

The Agreement sets forth critical activities for the State to undertake in order to enhance existing services or create new services for the Target Population. For instance, the Agreement requires the State to develop and implement a plan for its crisis services system that provides timely and accessible services and supports to individuals with SMI experiencing a behavioral health crisis within their local community. In addition, the Agreement requires the State to expand ACT services to ensure network adequacy and to meet the needs of the Target Population. ACT teams need to operate with high fidelity to nationally recognized standards. In addition, the State is to monitor the MCOs, LGEs, and the 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. The State will also 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. In addition, the State is required to incorporate Peer Specialists into MHR services as well as other services set forth in the Agreement.

The State is also required to develop a plan to provide access to affordable, community-integrated housing for members of the Target Population. This includes, but is not limited to, an expansion of the State's current Permanent Supportive Housing (PSH) program. The State must set annual targets for creation of additional housing units and rental subsidies to be made available to members of the Target Population. The State is also required to establish state-funded short- or long-term rental subsidies, as needed, to meet the requirements of this

Agreement. Prior to January 2020, the State is to establish a minimum of 100 state-funded, short-term rental subsidies to assist with initial transitions. In addition, the State is to employ a sufficient number of Tenancy Support Managers (TSMs) 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 support providers during the leasing process, and address crises that pose a risk to continued tenancy.

Finally, within the first eighteen months of the Agreement, the State was required to conduct an analysis that identifies the gaps in services, and proposes goals and timeframes to remedy gaps in services.

### **Assessment**

The State continues to make progress on planning efforts in all areas identified in the Agreement: crisis services; ACT; Intensive Community Support Services, including case management services; integrated day services; peer support services; and housing.

As indicated in the previous SME report, the State solicited input from a broad range of stakeholders to assist in the development of a modern and comprehensive crisis system of care. The State received 22 responses to the Request for Information (RFI) from consumer groups, LGEs, providers, and other entities. These responses recommended that the State consider the following when developing a statewide crisis system:

- Paying attention to and improving how people experience crisis care;
- Using technology both in the direct delivery of services (e.g., via tele solutions) and at the systems management level (e.g., statewide call center platform and electronic bed board);
- Developing a mechanism for managing the crisis system at either a regional or statewide level (one respondent recommended an “interconnected network of crisis services that are readily available to everyone. These services should collectively work as a unified system under the oversight of an independent Crisis Managing Entity.” Another respondent recommended a single point of accountability for the crisis system.);
- Identifying eligible providers for each service to ensure that it is reasonable for providers to develop the services, given the workforce in the state;
- Identifying a set of core competencies for providers of crisis services (for example: person-centered care, trauma-informed care) and suggestions on rapid development of the related workforce;
- Using peer specialists/peer recovery coaches in service delivery;
- Developing diversion pathways for law enforcement into crisis services, in lieu of arrest;
- Attending to care continuity;
- Using a “Low barrier, no wrong door” approach, not just with service users, but with other system stakeholders;
- Using services that are focused on rapid stabilization (not limited to assessment/referral);
- Developing braided funding methods that maximize all potential funding sources;
- Developing performance standards and transparent/public tracking of those standards;



- Developing payor-agnostic crisis services;
- Establishing a single repository for storing critical medical and behavioral health information (e.g. crisis response plans, advance directives for mental health treatment) for those individuals most likely to experience behavioral health crises;
- Developing real time information exchange platforms; and
- Convening (or using) local behavioral health task forces to develop and support crisis systems of care.

Since the release of the crisis RFI in February 2019 and subsequent comment period, the State has developed a Crisis Plan as required under the Agreement. The Plan incorporates comments received through the RFI process, as well as best practice approaches that have been undertaken in several states. In addition, the State is finalizing draft crisis services that are consistent with more modern approaches to crisis services (Arizona and Washington State) and includes the crisis services set forth in the Agreement. The proposed approach is comprehensive—creating a crisis system for all Louisianans that experience a behavioral health crisis. The State is commended on this proposed approach, accounting for more than the crisis needs of the Target Population and the Medicaid population. The SME recognizes that this will be a heavy but necessary lift for the State, given the comprehensiveness of the proposed population and service array. The State has solicited feedback from a subcommittee of the Advisory group, as well as LGEs (who provide some crisis services), on the approach set forth in the Crisis Plan. The State has finalized the draft service frameworks to be included in the Crisis Plan, including service eligibility criteria and preliminary reimbursement strategies for crisis services.

As indicated in the previous SME report, the State, through its MCOs, has also conducted fidelity reviews of ACT providers. While these reviews were generally positive, there were needed improvements identified for ACT; specifically, the employment area was weak. Through the encouragement of the SME team, the State is also looking at critical performance measures that are specific to ACT. While fidelity reviews are critical for ensuring ACT is being delivered consistent with national standards, it is also equally important for the State to determine if ACT is accomplishing the overall goals for the program. The State has collaborated with MCOs to develop an outcome reporting form that will be consistent across teams. The report will track a variety of domains, including hospitalizations (both psychiatric and general medical), ER use, housing and employment status, and criminal justice involvement. These outcomes can be correlated with Fidelity scores to guide program quality improvement. As part of its overall implementation plan, the State reviewed the level of care requirements for Assertive Community Treatment against similar requirements in other jurisdictions. The SMEs review of Louisiana’s ACT level of care requirements are reasonably consistent with other states; however, they have no defined exit or stepdown criteria.

The State continues to measure the availability and access of Intensive Community Support Services, which include services in the State’s current Medicaid behavioral health services on a quarterly basis. The State has provided the findings of MCO-generated reports on network adequacy to the SME. Based on the review of these reports for the first two quarters of 2019, there are no access issues for intensive community support services. While Intensive Community

Support Services could be defined as inclusive of case management services, for the purposes of this report it is being considered as a stand-alone service for which the State is developing a more tailored strategy.

The State recognizes the need to increase case management capacity and is in the process of pursuing this goal. The State is in the process of finalizing the details of the case management service and identifying the appropriate Medicaid changes necessary to include this service in the array of community support services. More detail on planned activities related to case management is included in Section 2.3 of this report.

The State has also undertaken activities over the past nine months to identify, develop, or enhance services for individuals during the day. The State solicited feedback from the My Choice Advisory Committees to define a continuum of integrated day services and discuss strategies for identifying existing providers of these services. The State has to define a preliminary set of integrated day services for members of the Transition Population that include employment supports, drop-in centers, and adult day opportunities. In addition to identifying this array, the State has:

- Developed a training about employment as a Social Determinant of Health that will be presented to a wide range of stakeholders, including Transition Coordinators, ACT team members, and MHR staff. The training for Transition Coordinators occurred in December 2019, with trainings for additional stakeholders scheduled to occur in early 2020.
- Concluded a collaboration project between OBH and the Department of Vocational Rehabilitation to establish a structure of ongoing meetings to facilitate access to Vocational Rehabilitation services for OBH clients; however, these meetings cannot proceed until the formal memorandum of understanding is revised between the State divisions/offices.
- Conducted surveys with the LGEs to identify drop-in/low-demand social settings that could provide support and engagement to individuals transitioning from NFs or being diverted from them. These surveys indicated capacity deficits that can guide further development of these options. Issues around transportation and staffing are particularly important to address if these settings are to be available for the Target Population. This information will be added to the resource guide prepared for the Transition Coordinators; further, the Transition Coordinators have been queried about their knowledge of such resources in each of their regions.

The State is in the process of finalizing a Medicaid framework for Peer Support services. The vision of these services is to support individuals with SMI in a variety of settings. The State has worked with the SME to develop the service parameters and staff qualifications for this new service. The State is targeting fiscal year 2021 for the implementation of this new service.

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

has undertaken the following steps as part of their planning and implementation efforts regarding housing:

- Finalized, with the assistance of the Louisiana Housing Corporation (LHC), the design of the Rental Assistance Program (RAP) and has begun to implement the program. This includes using the RAP program for rental subsidies and underwriting move-in expenses for individuals in the Target Population that are transitioning from NFs.
- Continued efforts with LDH and Louisiana Housing Authority (LHA) to transition members of the Target Population onto the PSH Project-Based Voucher Program and to tenant-based Mainstream vouchers. LHA and LDH are collaborating to ensure these vouchers are leased up in order to ensure HUD sees a high utilization rate.
- LDH worked with LHA to apply for additional Mainstream Voucher funding from the U.S. Department of Housing and Urban Development (HUD). A larger number of housing vouchers was requested.
- Another Mainstream Voucher Notice of Funding Availability (NOFA) is anticipated in 2020; LHA anticipates applying for these in collaboration with LDH.
- LHC and LDH are currently working to develop an application to the current HUD NOFA through the Section 811 Project Based Rental Assistance (PRA) Program for additional project-based rental assistance funding targeted to supporting members of the Target Population.

As addressed above, within the first eighteen months of the Agreement, the State was required to conduct an analysis that identifies the gaps in services, and proposes goals and timeframes to remedy gaps in services. The SME recommended that the State should undertake a gaps analysis later in the Agreement. This recommendation is based on several factors: the array of community services was not fully defined; many of the services required in the agreement did not exist; and there was no supply to be able to measure need. In addition, the State was performing an inventory on some services that would be helpful as inputs for a more robust gap analysis. Since the last SME report, at the encouragement of the Department of Justice, the State has begun to create a design for the gaps analysis. The design is in the process of being completed.

### ***Recommendation***

While the State is commended on the progress in this area, the next six months will require the state to begin implementation on all areas discussed above. The State should also begin to implement the initial activities set forth in the gaps analysis. The SME, in cooperation with Human Services Research Institute (HSRI), will undertake the gaps analysis. It is anticipated that initial activities for the gaps analysis will include data collection regarding the needs of the Target Population and other individuals with SMI. In addition, data will need to be collected on the availability of services that have been identified by the State to support individuals to live successfully in the community. The State should complete its inventorying efforts on critical services (e.g. drop-in centers, agencies offering employment services for individuals with SMI) that will be necessary inputs to the larger gaps analysis.

The State should continue its efforts to improve the quality of services provided by ACT providers. It is recommended that the State finalize a set of measures that will be used to profile each ACT

team and determine whether these teams are achieving the goals set forth for the service. Once finalized, the state should develop the necessary reports for the profile and review these draft reports with MCOs and ACT teams to finalize an ongoing quality improvement reporting process and technical assistance strategy. In addition, ACT teams should participate in trainings that were referenced in the previous section regarding employment and social determinants of health.

The SME recommends that the State complete the development of the new peer service framework and undertake the necessary steps to implement the service. This will include the development of a training regarding the new framework for peer supports and may include changes in the process to credential/certify individuals that will provide this service. This training may be multi-faceted—focusing on individuals that are interested in providing peer supports, organizations that may offer new peer support services (e.g. drop-in centers), and MCOs that will be involved with the State in efforts to develop the network of Peer Support providers. The State will also need to identify what changes will be needed to Medicaid to cover new Peer Support services.

Many members of the Target Population have been found to have coexisting physical conditions. It is recommended that the State develop strategies to include systematic attention to this domain in all services, for example:

- Wellness Coaches (e.g. peers) can assist persons served to understand their conditions, modify, and enhance healthy behaviors around diet, exercise, and substance use.
- Rehabilitation staff can be educated about the basics of prevalent medical conditions and work collaboratively with health professionals to support healthy lifestyle choices.
- Behavioral Health providers could record and track metabolic information.

## **Section 2.6 Quality Assurance and Continued Quality Improvement**

### ***Overview***

By December 2019, the State is required to develop and implement a quality assurance system consistent with the terms of the Agreement. Specifically, the State is responsible for collecting and evaluating data, and using the results to identify and respond to trends at the individual, provider, and systemic levels. In addition, the quality assurance framework will collect and analyze consistent, reliable data to improve the availability, accessibility, and quality of services in order to achieve positive outcomes for individuals in the Target Population. This quality assurance system must include a critical incident management system that will identify and take steps to reduce risks of harm. The quality assurance system is to be designed to ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings, consistent with principles of self-determination. The State is also responsible for establishing reporting and investigation protocols for significant incidents, including mortalities. At least annually, the State must report publicly on a range of data elements collected pursuant to the Agreement, the availability and quality of community-based services and gaps in services, and plans for improvement.

The State must also require that professional Community Providers and MCOs 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. On a regular basis, and as needed based on adverse outcomes or data, the State is required to assess provider and MCO services, the amount, intensity, and availability of such services, and quality assurance processes. The State is required to take corrective actions where appropriate to ensure sufficient quality, amount, and accessibility of services provided, pursuant to this Agreement.

### **Assessment**

The development of a quality assurance/quality improvement approach has proven to be more challenging than anticipated. Individuals in the Target Population are served through multiple delivery systems that have different measures, methods for reporting these measures, and timeframes for generating reports. For instance, the Community Choices Waiver (CCW) program, managed by OAAS, services the majority of individuals transitioned from NFs. Many of the program's existing quality assurance measures align with the measures set forth in the Agreement, and are required as a condition of the State's Community Choices Waiver. The Community Choices program also has processes in place to generate reports to track these measures. However, it is not always possible to generate reports that are specific to the Target Population, given the data structure and methodology. Reporting is based on a sample of the 4,000+ individuals that participate in this Waiver, many of whom are not part of the Agreement's Target Population. As a result, the reporting may not reflect the experiences of people in the Target Population. Significant changes would be needed to collect and report measures that were only for the Target Population.

Individuals transitioned from NFs to the OBH service system operated through Medicaid are often enrolled in managed care. The State's MCOs currently report some, but not many, of the measures needed for the Agreement. In addition, these reports are either on the Medicaid population in general (in excess of one million enrollees), Medicaid beneficiaries with SMI, or providers that serve individuals with mental illness. There are no current mechanisms for MCOs to report on the Target Population.

The State is able to collect information consistently on various processes that are important to the Agreement. This includes information on the number of individuals that are receiving a PASRR Level II, initial requests for NF admission (long-term versus short-term stays), discharges from NFs, and ongoing requests for continued stays in NFs.

Since the previous SME report, the State continues to finalize an initial set of measures that would be used for the Agreement. This set includes over thirty measures that focus on the accessibility of community services, referrals, admissions and diversions from NFs, person-centered planning, safety and freedom of harm, physical and mental health well-being, stability, choice and self-determination, and community inclusion. For each of these measures, the state has:

- Proposed data measure specifications;
- Identified a methodology for collecting the data;

- Identified the data source;
- Recommended frequency for reviewing the measure; and
- Whether the measure would be included in a public-facing dashboard on its Website.

The State took each measure and mapped it against the current quality assurance and improvement efforts for both the Community Choices Waiver and MCOs to create a status of the measure (or “measure status”). The measure status identified:

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

This mapping indicated there was a core set of measures that could be reported for the Target Population. The State has been developing preliminary reports using these measures and identifying the most appropriate use for these reports. Initial areas of focus included tracking NF admissions and diversions of individuals with SMI, and developing reports that track key indicators for individuals that have been transitioned from NFs. The State is in the process of finalizing these reports for internal and external quality improvement purposes. The State has also created a process for completing the development of the initial set of measures. The initial phase of this work will be developing and reviewing reports using existing measures. The next phase will be developing the changes necessary to modify existing measures to be able to report on the Target Population. This will include reviewing the feasibility of making changes to existing workflows and vendor contracts in order to identify how to report measures for the Target Population. The final phase will include the development of new measures. This will be laborious; given specifications will need to be developed for these measures (e.g. defining the numerator and denominator) and the process for developing the necessary reports for these measures.

The State is making progress with regards to developing a critical incident report process that will be used by the OAAS through its Community Choices program and OBH. Currently, these agencies have separate processes for reporting critical incidents. As of October 2019, both program offices have identified consistent elements and processes for reviewing and responding to critical incidents. There is good cross-office collaboration to develop a reporting process to consistently track critical incidents in the Target Population. The SME has reviewed the elements that will be consistently tracked across both agencies. These elements comport with the requirements of the Agreement.

### ***Recommendation***

The State should continue its quality assurance and quality improvement efforts under the Agreement. The work since the last SME report has identified the major gaps in various systems, which track key measures that will be used for this Agreement. While these gaps are not insurmountable, they have delayed the completion of the work in this area. It is clear that the State will need an additional three months to finalize the quality assurance/improvement

strategy. The strategy should specify the changes that will be needed or developed to operationalize each measure. Some of the proposed strategies may necessitate contract changes that will need to be factored into the overall quality assurance/improvement strategy.

The State should continue its efforts to develop the reports on the measures that are currently available. These efforts should be available to the public regarding the progress the State has made in terms of screening efforts (PASRR Level II) and various transition activities. This includes continued efforts to refine an initial set of dashboards that focus on:

- The transition activities that have been performed by the State for individuals on the Master List. This could include: assessment started, completed, offers of participation in Community Choices Waiver, and individuals transitioned.
- The number of individuals that receive a PASRR. This information should include initial PASRRs, annual PASRRs, referrals for a PASRR for individuals that are on the Master list, and PASRR that are completed due to a change in an individual's status.
- The number of individuals that have been identified as requiring each specialized behavioral health service. The state should develop a measure to identify the percent of individuals that received a specialized service consistent with the PASRR recommendation and plan of care.
- The number of individuals that have been diverted from a NF consistent with the definitions set forth in Section 2.4.
- Information on individuals that have been transitioned from NFs. This should initially include basic demographics, information on housing status, and transition barriers.

The SME recognizes that these are not the full set of reports that would be needed to satisfy the Agreement, but these are important early reports.

The State will need to make changes to develop a more robust mortality review process. OBH and OAAS do have a mortality review process that collects and reviews information on deceased individuals in the Target Population that have transitioned from NFs. While the mortality review process is consistent with similar processes used by other agencies, OBH is limited in their ability to collect information needed from key informants to fully evaluate the circumstance prior to an individual's death. Unlike other state agencies, OBH does not have the statutory authority to collect privileged information from medical providers that may have a significant role in the delivery of health care services to an individual. This causes a significant information gap for the committee and hinders their ability to develop the necessary conclusions and/or take the necessary actions to remedy systemic issues. In addition, the State should develop and negotiate a protocol with the Department of Justice for immediate notification on all deaths of the Target Population that have been transitioned to the community.

The SME continues to recommend that the State focus quality improvement efforts on network development activities. As the State develops new services and creates additional capacity for existing services, it will be important to develop a strategy for measuring the quality of these services. The State should consider indicators related to network development, identify the data

source for these indicators (MCOs or the State), and develop a “dashboard” for stakeholders to review progress of network development activities.

The State should move forward over the next six months to formalize efforts for external process improvement strategies in order to garner information from the experience of individuals initially transitioned from NFs. Specifically, the State should develop a formal, external process to begin to gather qualitative information, which will provide important lessons learned to make the necessary changes to improve the transition experience for the future. It is recommended that this be an ongoing effort, since the members of the Target Population who were initially transitioned may have fewer barriers than individuals who will be subsequently transitioned. External inputs into this process include information from members of the Target Population who have transitioned (and, when appropriate, their families and support network), Transition Coordinators, Tenancy Support Managers, community case managers (including support coordinators), providers, and other key informants who will prove invaluable to ongoing improvements in the transition process.

These external discussions will identify barriers that are impacting transitions (both the number and timing of transitions). While some of these barriers may be directly related to the availability of services, service coverage and other policy issues may be identified that the State will need to address through formal and informal policy changes. The process should include individuals who have direct experience with initial transitions and who will provide information on successful and less successful transition efforts to improve the transition process. Information from both internal and external process improvement efforts should also be conveyed to the Advisory Committee for their discussion and recommendations.

## **Section 2.7 Stakeholder Engagement, Outreach and In-Reach**

### ***Overview***

The Agreement and initial Implementation Plan required the State to conduct broad stakeholder outreach in order to create awareness of the provisions of this Agreement and awareness of actions taken by LDH to accomplish the goals of the Agreement. The State was to develop stakeholder engagement and communications plans, ensuring the inclusion of individuals currently receiving mental health services, family members, and advocates. In addition, the LDH is required to develop and implement a strategy for ongoing communication with stakeholders, community providers, NFs, and hospitals on issues related to implementation of this Agreement, so that LDH learns about challenges encountered in the implementation of this Agreement and can engage the providers in addressing such challenges. As part of their stakeholder engagement effort, the State was also required to develop a public-facing website for the Agreement and related activities.

The State is also required to develop a plan for ongoing in-reach to every member of the Target Population residing in a NF, regular presentations in the community in addition to onsite at NFs, and inclusion of peers from the Target Population in in-reach efforts. This in-reach will explain LDH’s commitment to serving people with disabilities in the most integrated setting appropriate



to the needs those being served; 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. The State transition teams were to begin in-reach efforts with members of the Target Population that resided in NFs.

Since the beginning of this Agreement, the state has developed strategies to provide education regarding the Agreement, development of a website that has information regarding the Agreement and the Implementation Plan, performed outreach to stakeholders while drafting the Plan, and has developed an Advisory Committee for the Agreement. In addition, the State held individual meetings with the LGEs to introduce them to the Transition Coordinators, explain the overall approach to the Agreement and the transition process, and offer clarification or information requested by the LGEs.

The State developed a plan for in-reach to members of the Target Population residing in a NF. The in-reach plan set forth various activities that the State was undertaking in this area, including processes for in-reach in NFs, onboarding staff for in-reach purposes, developing the necessary workflows, and development of information systems to track in-reach activities. The in-reach plan also includes a process to identify peers to work with Transition Coordinators and help to identify and engage with those members of the Target Population who will transition into the community. Finally, the plan includes the development of resource guides for members of the Target Population during the in-reach and transition process.

### ***Assessment***

The State has continued to make efforts to engage stakeholders over the past six months. The State has held six Statewide Advisory Committee meetings since January 2019. The Committee's meeting agenda generally consists of updates regarding the number of individuals that have been transitioned from the NFs to the community, and an overview of critical areas of work being done under the State Crisis Plan, integrated day services approach, and Housing Plan. The meetings are well organized and provide important information in terms of the State's progress regarding the Agreement. However, the overall level of engagement from the Committee participants is not robust. There are few questions or recommendations from Committee members. The lack of engagement may be due to several factors. The structure of these meetings and information do not always evoke committee member participation. In addition, committee members may not always have the experience and information needed on every area that is being presented by the State.

The State has created subcommittees for several areas, including statewide service plans (e.g., crisis and housing), resource identification (in process), identification of service gaps, and related network development activities. In comparison to the Advisory Committee, these subcommittees have been helpful to the State in their efforts to get specific feedback on important areas and activities. The SME attended a subcommittee specifically designed to

provide feedback on revisions to the revised Transition Assessment. The meeting was very interactive and subcommittee members provided helpful comments for revising the Assessment.

The State has also created other opportunities to solicit input into critical services and activities for the Target Population and for individuals with mental health conditions, in general. The State has done two rounds of listening tours regarding the overall “state of the State behavioral health system.” These meetings have been conducted on a regional basis. In each region, the State holds separate meeting for consumers and families, providers, and other stakeholders. In 2019, the first round of listening tours shared general information about the Agreement. The State conducted a second round of listening tours that provided updates and sought feedback specific to crisis. During these meetings, the State provides information on some of their efforts, but most of the meeting is an open forum where participants can respond with critical information to the State regarding gaps, barriers, and other concerns, many of which are directly related to services and other activities under the Agreement.

The State holds regular meetings with the MCOs that include information and updates specific to the Agreement. In addition, the State has a regular schedule of meetings with MCOs regarding PASRR, the My Choice Louisiana Transition Coordination activities, and Assertive Community Treatment programming. The State has monthly presentations to LGEs that provide updates to specific work under the Agreement on a variety of topics, with one meeting being focused on planning for a crisis system. The State has presented to other stakeholder groups (including the Louisiana Supported Living Network) regarding an overview of the Agreement, activities that have occurred since the Agreement was reached, shared information about individuals that have transitioned, and an overview of upcoming activities.

The State has also made progress with the various in-reach strategies that were set forth in the plan. They have created and implemented the necessary processes, procedures, tools, and tracking systems necessary to begin identifying, assessing, and transitioning individual members of the Target Population currently residing in NFs. As indicated in Section 2.3, the State has hired staff and trained them in order to prepare them for their roles. They have also developed workflows and processes that integrate new and existing tasks across multiple LDH offices, which function at both the State and regional levels. They have revised the transition assessment tool, process, developing interim systems, and analytics to support workflows, data collection, monitoring, and process improvement. They have also developed resource guides for members of the Target Population during the in-reach and transition process. The guides include information regarding various resources for food, financial benefits, housing authorities, available crisis services, legal assistance, transportation resources, employment supports, and drop-in centers.

### ***Recommendation***

There are several recommendations for improvement the State should consider. One recommendation is specific to changes in the format of the Advisory Group. One suggestion to improve the value of these meetings would be to have report-outs by the various subcommittees that have done work between Advisory Committee meetings. This would allow the Advisory

Committee to hear what work the committee members have done, and may allow dialogue that is more informal rather than the current format. In addition, the State should also broaden the participation of the Advisory Committee; specifically, the State should continue its efforts to include additional consumers and families. The State continues to struggle with their participation in these meetings, despite good efforts over the past year to do outreach and recruitment for the Committee.

The State should also formalize a schedule of subcommittee meetings. While these meetings have been productive, they have been more ad hoc. Having regularly scheduled subcommittee meetings will be helpful for engagement that is more consistent, especially as the State moves from planning to implementation over the next year.

The State should enhance its in-reach efforts to include peers working with Transition Coordinators during the engagement and the transition process. This is part of the in-reach plan that has yet to come to fruition and it is recommended that the State develop a short-term strategy for onboarding peers in this process.

Finally, there are several tools that the State will need to finalize over the next six months. This includes revision to the Transition Planning and Transition Monitoring tools. Once these tools are completed, the State should provide the necessary training to the Transition Coordinator and others who will be using these tools.

### **Section 3--Conclusion**

Since the last SME report, the State has continued efforts in almost all areas of the initial Implementation Plan. In the next six months, the State will need to move from the planning phase to the implementation phase on many critical tasks and activities. There are three major areas that will need significant attention: the development of the crisis system, operationalization of the Diversion Plan, and implementation of the Housing Plan. The state must also increase the number of individuals that will be transitioning from NFs, and implement the interim case management strategy to ensure individuals have access to a case management benefit as required by the Agreement. In addition, a critical activity that will need to be completed is the development of the transition tracking system referenced earlier in this report (both Phase 1 and 2). A final area of focus is improving engagement of stakeholders over the next 6 months. It is critically important that the State continue its efforts to inform stakeholders regarding activities that are related to the Agreement. This should also include more meaningful stakeholder engagement efforts aimed at identifying barriers to transitions and opportunities, as well as barriers related to the other implementation plans that will be developed later this year.