North Dakota - Department of Justice Settlement Agreement

Biannual Report
December 15, 2021 – June 14, 2022

ND Department of Human Services
Aging Services Division

Submitted July 15, 2022

List of Acronyms

ADA – Americans with Disabilities Act
ACL – Administration for Community Living
ADRL – Aging and Disability Resource Link
CMS – Centers for Medicare and Medicaid Services
CIL – Center for Independent Living
CIR- Critical Incident Report
CQL – Council on Quality and Leadership
DD - Developmental Disabilities
DHS – Department of Human Services
Ex-SPED – Expanded Service Payments to the Elderly and Disabled
FTE – Full Time Equivalent
HCBS – Home and Community Based Services
HCBS waiver - HCBS Medicaid waiver
HRSI - Human Services Research Institute
IC- Informed Choice – References changed to Long Term Services and Supports Option Counseling
IP - Implementation Plan
LTSS Option Counseling – Long Term Services and Supports Option Counseling
MFP – Money Follows the Person
MSP-PC - Medicaid State Plan Personal Care Services
ND – North Dakota
NF LoC – Nursing Facility Level of Care
PCP – Person-centered Planning
PSH – Permanent Supported Housing
QSP – Qualified Service Providers
QSP Resource Hub – Qualified Service Provider Resource Hub
RA – Rental Assistance
SA – Settlement Agreement
SME – Subject Matter Expert
SNF – Skilled Nursing Facilities
SPED – Service Payments Elderly and Disabled
TPM - Target Population Member
USDOJ – United States Department of Justice
VAPS – Vulnerable Adult Protective Services

Introduction

On December 14, 2020, the State of North Dakota (ND) entered into an eight-year Settlement Agreement (SA) with the United States Department of Justice (USDOJ). The SA is designed to ensure that the State will meet the requirements of Title II of the Americans with Disabilities Act (ADA).

The SA requires the State to submit biannual reports to the USDOJ and the Subject Matter Expert (SME) containing data according to the Implementation Plan (IP). The initial IP was approved on September 28, 2021, as required in the SA.

This report describes progress made toward the requirements listed in Sections VI–XVI for the period of December 15, 2021, through June 14, 2022. The report builds on the approved SA IP. All the requirements and associated strategies toward compliance that were due or are being worked on in this reporting period are included. New information is provided under the progress report heading highlighted in yellow and target dates were modified when necessary.

Reporting dashboards are included as Link to Appendix A to this report. They provide statistical data and additional information about the progress that has been made toward the required benchmarks of the SA regarding LTSS Option Counseling (informed choice), home and community-based services (HCBS), Aging and Disability Resource Link (ADRL), transition support services, and housing to assist target population members (TPM).

A complaint report is included in Section XVI of this document as required. It includes a summary of the type of complaints received and remediation steps taken to resolve substantiated complaints involving TPMs that were submitted during this reporting period.

The strategies contained in the IP and the performance measures and statistical data in this report focus on the need to:

- **Increase access** to community-based service options through policy, process, resources, tools, and **capacity building** efforts.
- Increase **individual awareness** about community-based service options and create **opportunities** for LTSS Options Counseling (informed choice).
- Widen the **array of services** available, including more **robust housing-related supports**.
- Strengthen **interdisciplinary connections** between professionals who work in behavioral health, home health, housing, and home and community-based services (HCBS).
- Implement broad access to **training and professional development** that can support improved **quality** of service, highlighting practices that are **culturally-**

informed, streamlined, and rooted in **person-centered** planning.

- Support **improved quality** across the array of services in all areas of the State.

What We're Proud of

Major accomplishments during the first 6 months of (Year Two - (December 15, 2021 – June 14, 2022)) of the USDOJ SA

- **Transitioned 62 TPMs** from a SNF to integrated community housing where they can receive necessary support while enjoying the freedom and benefits of community living.

- **Diverted 140** individuals from a SNF by providing necessary services and supports so they can remain at home with their family and friends.

- Provided **information about HCBS** options through **588** LTSS Options Counseling (informed choice) referral visits to **545** unduplicated TPMs referred for a long-term stay in SNF.

- Provided **centralized intake** using the Aging and Disability Resource Link (ADRL) website and toll-free phone line linking people with disabilities to HCBS support.

    - Provided **6,299 callers** with information and assistance about HCBS and assisted another **540** through the **web intake** process**.**

    - Referred **775 individuals** from these contacts for **HCBS**, which is an average of **129** per month.

- HCBS Case Managers responded to **951 HCBS referrals** from all sources (ADRL intake, direct referral, MFP, LTC Eligibility Unit, and LTSS options counseling visits).

- Provided State or federally funded HCBS to **2,693 unduplicated** adults in this reporting period.

- Provided **permanent supported housing** assistance to **58 TPMs** who transitioned out of a SNF.

- Increased our **administrative capacity to serve** additional TPMs by adding **three additional** community outreach specialists FTE to conduct LTSS options counseling (informed choice) referral visits. There are now 10 staff in this role.

- **Increased awareness** about the possibilities of in-home and community-based services for adults with physical disabilities through numerous presentations, conferences, and training events.

- Engaged with **stakeholders** to inform the strategies used to implement the requirements of the Settlement Agreement in a person-centered and culturally responsive way.

- Increased the **direct service capacity** of HCBS Case Managers by **5%** by implementing a new case management system and reducing administrative burden.

Year Two Settlement Agreement Requirements (12.15.21-12.14.22)

The chart below lists the requirements from the Settlement Agreement (SA) that are due during Year Two of the settlement agreement. The State believes that all year two-year requirements have been met or are on track to be met by December 14, 2022, as required.

SA Section #	Requirement	Due Date
VI.F	Develop an Implementation Plan for Years 3	Submitted 6/14/2022
XIII.D	Provide technical guidance to nursing homes that commit to provide HCBS and rural community providers who commit to expand	Ongoing requirement
XV.D	Submit State Biannual Data Report	07/15/2022
XIV.A 1.	Conduct individual or group in-reach to each nursing facility	Completed annually
VIII.I 2.	Person-centered planning training of Case Managers	Completed annually
VIII.I 3.	Additional 290 TPMs receive person-centered planning	12/14/2022
X.A.1.	Provide information about community-based services to all TPMs who formally request or are referred for placement in a SNF	06/14/2022
X.A.2.	Demonstrate information shared with all TPMs regarding HCBS	09/14/2022
X.B.1.	All screenings and evaluations for nursing facility services included in the PCP	12/14/2022
X.B.2.	Implement incremental changes to the NF LoC process and community-based services eligibility	06/14/2022 and ongoing
X.B.3.	Require annual NF LoC determination screening for all continued stay in a nursing facility for TPMs.	12/14/2022
XI.B	Transitions occur no later than 120	06/14/2022

	days after TPM chooses	
XI.E2. a	Transition 100 TPMs from SNF in the first 2 years of the SA	12/14/2022
Xi.E2. a	Divert 100 at risk-TPMs from SNFs in the first 2 years of the SA	12/14/2022
XII.B1. b	Permanent supported housing to an additional 30 TPMs	12/14/2022
XV.A	Enhance data collection to meet all reporting requirements	06/14/2022
XV.D	State Biannual Data Report	12/14/2022

SA Section VI. Implementation Plan

Responsible Division(s)

ND Governor's Office and ND Department of Human Services (DHS) Aging Services Division

Agreement Coordinator (Section VI, Subsection A, page 8)

Implementation Strategy

Appoint Agreement Coordinator. The Agreement Coordinator is responsible for leading the State team tasked with ensuring access to community-based services that allow TPMs to live in the most integrated setting appropriate.

Progress Report:

- Nancy Nikolas Maier, Director, ND DHS Aging Services Division, was appointed Agreement Coordinator on February 10, 2021.

Draft IP (Section VI, Subsections B and C, page 9)

Implementation Strategy

Conduct a series of project planning sessions to develop and draft strategies to meet requirements.

Progress Report:

- A draft of the revised Implementation Plan was submitted on June 14, 2022.

Service Review (Section VI, Subsection D, page 9)

Implementation Strategy

Strategy 1. Conduct internal listening sessions that include a review of relevant services with staff from the ND DHS Aging Services, Medical Services, and Developmental Disability Divisions. One priority is identification of administrative or regulatory changes that need to be made to reduce identified barriers to receiving services in the most integrated setting appropriate. **(Ongoing strategy)**

Progress Report:

A listening session is conducted during every ND USDOJ SA stakeholder meeting. Feedback is used to modify policy and waiver amendments. The State will continue to hold listening-sessions in the second year of the agreement.

Increase number of SPED recipients.

- During this reporting period there were 378 new individuals enrolled in SPED. Forty of them are TPMs.

Number of providers enrolled to provide services.

- There are 961 individual QSPs and 139 agencies currently enrolled to provide HCBS.

Number of consumers served.

- There were 2,693 unduplicated individuals served under all state and federally funded HCBS during this reporting period.

Strategy 2. Update the SPED client cost share/fee schedule to increase access to services for individuals who needed services but could not afford the SPED client cost share. This will allow additional TPMs who are eligible for SPED to access services in the most integrated setting appropriate. **(Completed July 1, 2019)**

Strategy 3. Increase access to SPED for less impaired individuals who need services to live in the most integrated setting appropriate, thus diverting them from a higher level of care. **(Completed January 1, 2020)**

Strategy 4. Add residential habilitation, community-support services, and companionship to the HCBS 1915 (c) Medicaid waiver. **(Completed January 1, 2020)**

Strategy 5. Implement rate increases for supervision, non-medical transportation, non-medical transportation escort, and family personal care. The services were chosen because the current rates were previously identified as too low to attract enough QSPs. A waiver amendment will be submitted to the Centers for Medicare and Medicaid Services (CMS). **(Completed February 1, 2022)**

Progress Report:

Waiver amendment approved by CMS January 1, 2022. Rate increase became effective February 1, 2022.

Stakeholder Engagement (Section VI, Subsection E, page 9)

Implementation Strategy

The State will create ongoing stakeholder engagement opportunities including quarterly ND USDOJ SA stakeholder meetings the first two years of the SA. The State will educate stakeholders on the HCBS array, receive input on ways to improve the service delivery system, and receive feedback about the implementation of the SA.

Progress Report:

Stakeholder meetings/quarterly listening sessions were held/are scheduled for March 17, 2022, June 9, 2022, September 15, 2022, and December 8, 2022.

Link to 2021 Listening Session and Stakeholder Meetings Summary

The State will work with community partners to hold HCBS Community Conversations in all eight case management territories and Native American reservation areas in ND. The meetings will provide information about HCBS and provider enrollment and will include an opportunity to receive valuable feedback from local community stakeholders about the provision of HCBS in rural and Native American communities. State will post meeting minutes, stakeholder requests, and the State's response after each meeting. State will also create a calendar of events section on the DOJ portion of the DHS website.

Progress Report:

Number of stakeholder engagement opportunities provided.

- Two ND DOJ Stakeholder meetings/listening sessions were conducted during this reporting period.
- One in-person Community Conversation was held during this reporting period

Number of attendees.

- ND DOJ Stakeholder meetings/quarterly listening sessions were held on March 17, 2022, with 57 people in attendance and June 9, 2022, with 55 people in attendance.
- A Community Conversation was held on April 11, 2022, in Mott, ND with 9 attendees.

The State will schedule additional community conversation meetings in the case management territories and the four reservations in 2022. The meetings will be locally advertised as well as listed on the Link to 2022 Calendar of Events/Activities on the Department's website. Feedback is used to make changes in the service delivery system etc. and the changes are shared at ND USDOJ stakeholder SA meetings.

The State is working with the Department of Health, Office of Heath Equity tribal liaisons to schedule community conversations in conjunction with other events being held on the reservation. The State will develop a "one pager" that explains the purpose of the community conversations that will be shared with tribal leaders before events are scheduled. Partnering with the tribal liaisons will help ensure we provide a meaningful opportunity for elders to share their experiences and the needs of their community.

SME Consultation (Section VI, Subsection F, page 9)

Implementation Strategy

Agreement Coordinator will meet weekly with SME and team to consult on IP. Agreement Coordinator will provide required updates to USDOJ, submit draft, and incorporate updates as required.

Progress Report:

- Weekly meetings are conducted between the Agreement Coordinator and the SME.
- Meetings are conducted between the Agreement Coordinator and the DOJ bi-weekly.

SME and IP (Section VI, Subsection G, page 9)

Implementation Strategy

Strategy 1. The State will meet no less than weekly with SME to revise the IP as required by the SA. **(IP revision submitted June 14, 2022)**

Strategy2. Each revision to the IP will include a review of data collected and outcomes achieved, and how that informs revised strategies. **(IP revision submitted June 14, 2022)**

Website (Section VI, Subsection H, page 10)

Implementation Strategy

Establish a webpage for all materials relevant to ND and USDOJ SA on the DHS

website. The plan and other materials will also be made available in writing upon request. A statement indicating how to request written materials is included on the established webpage found here https://www.nd.gov/dhs/info/pubs/doj-settlement.html. **(Completed June 14, 2020)**

SA Section VII. Case Management

Responsible Division(s)

DHS Aging Services Division

Role and Training (Section VII, Subsection A, page 10)

Implementation Strategy

Strategy 1. Specialize role of the HCBS Case Manager. The State will employ HCBS Case Managers who will provide HCBS case management full time. To streamline supervision, training, and the implementation of HCBS consistently across the State, 64 full-time equivalent (FTE) positions were moved from County Social Services to State employment. Specialization will include clarifying roles and responsibilities as it relates to the provision of services to all TPMs, including those living in the community and those residing in a SNF. (**Completed January 1, 2020)**

Strategy 2. The State will create and require a comprehensive standardized training curriculum be completed by all HCBS Case Managers. The State will provide ongoing training and professional development opportunities to include cultural sensitivity training to ensure a high-quality trained case management workforce. The State has contracted with a local expert in Native American cultural competency to develop training for HCBS Case Managers. Post-training evaluation tools to ensure understanding of training objectives will be developed. **(Target completion date December 31, 2021, and ongoing)**

Progress Report:

Performance Measure(s)

Percent of HCBS Case Managers trained in the standard curriculum.

- One hundred (100%) HCBS managers completed the standard curriculum as required. New case management staff have three months from the hire date to finish the training.

Percent of HCBS Case Managers trained to cultural sensitivity.

- There are 66 HCBS Case Managers and 100% received cultural sensitivity training.

- Additional training was conducted on March 31, 2022, for all Aging Services staff including 66 Case Managers.

Percent of HCBS Case Managers found to be competent in key learning objectives after receiving cultural sensitivity training.

Historical Trauma and ACES with Dr. Warne					
Question 1: I can identify at least three ways cultural education can positively impacts how I interact with my clients.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	11%	83%	5%	1%	0%
Post	25%	75%	0%	0%	0%
Question 2: I am knowledgeable of the impact historical trauma has on American Indian health equity.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	10%	51%	33%	5%	0%
Post	18%	67%	14%	2%	0%
Question 3: I know where to find resources to help address my own cultural biases					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	10%	50%	31%	9%	0%
Post	26%	65%	8%	1%	0%
Question 4: I am confident working across cultures.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

Pre	2%	17%	30%	44%	6%
Post	19%	72%	8%	1%	0%
Question 5: I am conscious of my biases and how they impact my professional practice.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	9%	52%	28%	11%	1%
Post	29%	68%	3%	0%	0%
Question 6: I can identify at least three ways cultural education can positively impact how I interact with my clients.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	10%	43%	37%	10%	0%
Post	20%	72%	8%	0%	0%
Question 7: The training was informative and relevant to my practice.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Post	55%	41%	4%	0%	0%

The Culture of Poverty with Dr. Warne					
Question 1: I am knowledgeable about the impact poverty has on American Indian health disparities.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	8.6%	46.7%	35.2%	8.6%	1%
Post	38.5%	59.4%	1%	0%	1%

Question 2: I can describe how the culture of poverty relates to American Indian health disparities.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	5.7%	39%	37.1%	18.1%	0%
Post	33.3%	62.5%	3.1%	0%	1%
Question 3: I can specify at least two unique factors contributing to poverty levels in tribal communities within North Dakota.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	4.8%	29.5%	43.8%	21.9%	0%
Post	36.5%	60.4%	2.1%	0%	1%
Question 4: I know where to find resources to help address my own cultural biases.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	7.6%	49.5%	33.3%	9.5%	0%
Post	28.1%	67.7%	3.1%	1%	0%
Question 5. I can identify at least three ways cultural education can positively impact how I interact with clients.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	4.8%	37.1%	47.6%	10.5%	0%
Post	32.3%	61.5%	5.2%	1%	0%

Strategy 3. The State expanded the ADRL to include a centralized intake process to assist TPMs in learning about and applying for HCBS. **(Implemented January 1, 2021)**

Referrals can be made over the phone or submitted via the internet. The DHS Aging Services Division employs six staff who provide information and assistance in completing the centralized intake process. If a TPM or their legal decision maker wants to apply for HCBS, the intake assessment is sent to an HCBS supervisor who assigns a HCBS Case Manager to complete an assessment and verify eligibility. Person-centered planning is undertaken and completed with each TPM.

Progress Report:

Performance Measure(s)

Number of referrals received by case management territory through the updated ARDL centralized intake process.

- The number of intakes referrals received by case management from the ADRL is 775.

Average number of days to assign an HCBS Case Manager following referral. **(Tracking began May 1, 2021)**

- The average number of days to assign a case manager to a referral is 1 day.

Percent of case management referrals responded to within five business days.

- The percent of case management referrals responded to within five days is 100%.

Number and percent of HCBS case management staff trained on new system.

- There are 66 HCBS Case Managers and 100% have been trained on the new case management system.

Strategy 4. The State implemented an LTSS Options Counseling (informed choice) referral process to identify TPMs who screen at a NF LoC and inform them about HCBS, person-centered planning, and transition services available under Medicaid to help TPMs receive services in the most integrated setting appropriate. The name of the visits has been changed to LTSS Options Counseling as it is a better way to describe the intent of the visits.

LTSS Option Counseling (informed choice) visits are being conducted by 10 LTSS Options Counselors. The ND NF LoC tool has been updated to include questions to identify TPMs. The provision of information about HCBS should be available to everyone. Starting June 14, 2022, the State is conducting LTSS Options Counseling (informed choice) visits with all TPMs to assure that the State meets the provisions of the SA. **(Completed June 14, 2022, and ongoing)**

Progress Report:

Performance Measure(s)

Number of LTSS Options Counseling (informed choice) referrals.

- 703 LTSS Options Counseling (informed choice) referrals were sent to the HCBS case management territories from December 15, 2021 – June 14, 2022. Forty-five referrals did not meet the TPM criteria, four TPMs were unable to be located, twenty-five were deceased, one outcome was pending. Forty individuals had already been seen within the last three months, and 588 LTSS options counseling (informed choice) visits were made.

Number of TPMs referred through LTSS Options Counseling to transition services through MFP.

- Ninety-one TPMs were referred through the LTSS Options Counseling (informed Choice) process to MFP transition services. To date, 14 of the 91 referrals have successfully transitioned to the community. Twenty-six are no longer in the transition process because of personal choice or death. The other 53 are still actively participating in the transition process.

Number of long-term stay NF LoC determinations provided to TPMs by case management territory.

CM Territory #	# NF LoC
Territory 1	69
Territory 2	79
Territory 3	25
Territory 4	96
Territory 5	180
Territory 6	64
Territory 7	127
Territory 8	63
Total	**703**

Strategy 5. Create a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign will include marketing on social media, and providing public education to the public, professionals, stakeholders, and TPMs at serious risk of entering nursing facilities. Campaign will also include providing education to those parties that recommend SNF care to TPMs. **(Target completion date December 14, 2022, and ongoing)**

Progress Report:

The ADRL social media campaign was run again in April of 2022. The digital campaign view through rate was 61.39%, substantially higher than the typical 15% view through rate of similar advertising campaigns. The social media campaign resulted in 2,525 viewers taking action and following the link to learn more. In addition, Aging Services staff presented information and had booths at various community events to raise awareness about HCBS.

Performance Measure(s)

Number of ADRL contacts per month.

- A total of 21,741 ADRL contacts (calls 6,299, 540 web intake, unique web hits 14,902) were made between December 14, 2021 – June 14, 2022, for an average of 3,623 contacts per month.

Strategy 6. To ensure a sufficient number of HCBS Case Managers are available to assist TPMs in learning about, applying for, accessing, and maintaining community-based services for the duration of the SA, the State will assess need and request additional resources, if necessary, in the next biennium executive budget request. **(Updated target completion date January 1, 2023)**

In addition, the State will provide technical assistance, training, and ongoing support to encourage State and tribal providers to enroll to provide HCBS case management to TPMs. This includes using MFP Tribal Initiative funds to help tribal entities hire licensed social workers to provide culturally competent HCBS case management services in Native American communities.

Progress Report:

Performance Measure(s)

Number of HCBS Case Managers hired by Tribal nations.

- Standing Rock Sioux Tribe has MFP tribal initiative funds available to hire a case manager for HCBS, the position is currently vacant.

Strategy 7. Implement a new case management system to simplify the case management processes and reduce time required to complete administrative responsibilities of the position. Reducing administrative burden will free up staff time to conduct person-centered planning and other TPM-facing case management functions. **(Updated target completion date August 1, 2022)**

Progress Report:

Case Managers began using Therap in January of 2021 to create provider service authorizations necessary for claims billing and electronic visit verification (EVV). The Therap case management system is currently used to receive

referrals from the ADRL, store client demographics, complete HCBS participant assessments, caregiver assessment, SPED financial assessment, the vision tool and case notes. The risk assessment and LTSS Options Counseling (informed choice) referral forms for long-term care were recently added. The system is also used for critical incident reporting and for complaints. The full implementation of the case management system will be complete when the person-centered plan is added to the system by August 1, 2022.

Case Managers keep track of their time in the State's workforce system. They track billable case management time and administrative tasks like training etc. Nearly 76% of the Case Managers' time is spent on actual case management tasks. Less than 25% of case management time is spent on administrative tasks. The case management system has not been fully implemented therefore, the information below reflects case management time based on the current case management process.

Performance Measure(s)

Percent reduction in Case Manager time spent on administrative functions after the case management system is fully implemented.

- There has been a 5.34% reduction in the amount of time spent on administrative tasks.

CM Workforce Data	**Reporting period**	**12.21 – 06.22**
Project	**Sum of Hours**	**% Of Hours**
HCBS Admin	12,927.30	24.28%
HCBS CM	40,306.93	75.72%
Grand Total	**53,234.23**	**100.00%**

CM Workforce Data	**Reporting Period**	**12.20-11.21**
Project	**Sum Of Hours**	**% Of Hours**
HCBS Admin	34,228.92	29.62%
HCBS CM	81,317.67	70.38%
Grand Total	**115,546.59**	**100.00%**

Assignment (Section VII, Subsection B, page 10)

Implementation Strategy

Strategy 1. Ensure a HCBS Case Manager is assigned within two business days to all TPMs. **(Target completion date July 1, 2022)**

Remediation

The State will convene a Case Management Assignment workgroup to develop strategies and recommendations to meet the requirements of the SA.

The State will invite TPMs, family, guardians, State staff, tribal representatives, internal and external HCBS case management providers, MFP transition coordinators, hospital and nursing home discharge planners, and other interested stakeholders to participate.

The group's primary purpose is to provide recommendations for the State to consider the development of a tiered case management approach that is respectful of the TPM's wishes and abilities, while also meeting the State's obligation to offer, through a HCBS Case Manager, individualized, community-based services to all TPMs who qualify and accept services.

In addition, the State is exploring ways to better utilize all case management resources in the State to build capacity across the DHS. This includes utilizing new federal funding opportunities to more quickly build the capacity to assign a HCBS Case Manager to all TPMs as required. **(Recommendations complete July 2022**)

Progress Report:

Performance Measure(s)

Number and percent of in-reach visits made to Medicaid consumers residing in SNFs.

- There are 2,367 current Medicaid recipients residing in SNFs and 588 individual in-reach visits were conducted during this reporting period. That is nearly 25% of all Medicaid recipients residing in SNFs that have received an individual in-reach visit.

Number of TPMs assigned to a HCBS Case Manager.

- There are 704 TPMs living in the community and receiving HCBS that were assigned to an HCBS Case Manager during this period.

Average number of contacts by HCBS Case Managers, for those TPMs that initially refuse case management services.

- No TPMs have refused case management services. HCBS recipients must have a Case Manager as part of the PCP process. TPMs who reside in a SNF receive case management from an LTSS Options Counselor who has been assigned to the facility to provide case management.

- Some TPMs in a SNF may initially choose not to participate in a conversation but they are all provided information and contact information for the LTSS Options Counselor. All TPMs will be seen at least annually around the time of their annual NF LoC redetermination.

Strategy 2. If a TPM in a SNF indicates they are interested in HCBS between NF LoC reviews, they are referred to the ADRL and assigned a HCBS Case Manager.

The State will increase SNF in-reach activities by working with the MFP / Centers for Independent Living (CIL) staff to contact current TPMs residing in a SNF and inform them about HCBS. In addition, State staff will conduct follow up visits to build relationships and continued education about HCBS with TPMs who initially refused an LTSS Options Counseling (informed choice) visit. **(As of June 14, 2022, the state will no longer target which TPMs to visit. All TPMs residing in the SNF will be seen by a LTSS Options Counselor)**

Progress Report:

The LTSS Options Counselors will be providing information and case management to TPMs currently residing in the SNF. Staff were assigned to be the Case Manager by facility, rather than by individual, so they can spend enough time in each facility to build trust and relationships with residents, facility staff and families. Positive working relationships between the SNFs and HCBS will result in better discharge planning and transition outcomes for TPMs.

Performance Measure(s)

Average number of days from assignment of a HCBS Case Manager to first contact.

- The average number of days from assignment of a HCBS Case Manager to first contact is two business days for TPMs living in the community.

- A process has been set up to produce a monthly list of SNF TPMs by their annual NF LOC determination month. The LTSS Options Counselors use this list to organize and plan the visit to each facility.

Capacity (Section VII, Subsection C, page 10)

Implementation Strategy

Strategy 1. Simplify the HCBS case management process to ensure a sufficient

number of HCBS Case Managers are available to serve TPMs. The HCBS Case Managers are required to keep track of the number of hours they work, and the type of work being performed. Reports can be run to calculate the amount of time spent conducting client-facing case management services versus administrative tasks. This information will be used to determine staff capacity and number of FTEs needed. **(Six-month reporting began June 14, 2021)**

Progress Report:

There are several strategies throughout the implementation plan that describe the States effort to increase case management capacity. Any request for additional case management staff will be included in the Aging Services proposal for the Department's executive budget request.

HCBS Case Managers can currently provide all necessary case management services listed in a member's Person Centered Plan (PCP). This includes meeting face-to-face with TPMs (if current public health restrictions allow) to discuss community-based service options, as dictated by individual needs, and completing Person Centered Planning when the person is identified as a TPM.

Performance Measure(s)

Average weighted caseload per Case Manager (June 2022).

- There are 55 full time Case Managers with an average caseload of 54 cases.
- Three part-time Case Managers have an average caseload size of 45.
- Eight HCBS supervisors carry an average caseload of 13 cases.

Percent reduction in administrative tasks after case management system is fully implemented.

- See CM workforce data chart in Section VII. Subsection A Strategy 7.

Strategy 2. Continue to ensure a sufficient number of HCBS Case Managers are available to serve TPMs. The State assigns caseloads to individual HCBS Case Managers based on a point system that calculates caseload by considering the complexity of case and travel time necessary to conduct home visits. The State completes a monthly review of statewide caseloads to determine capacity and ensure a sufficient number of HCBS Case Managers are available to serve TPMs. **(Completed May 1, 2021)**

Remediation

The State submitted a request and received approval to use MFP capacity building funds to hire five staff to conduct LTSS Options Counseling (informed choice) referral visits so that the HCBS Case Managers have increased capacity

to provide case management to additional TPMs in the most integrated setting appropriate. Staff will be hired in areas of the State with the highest number of referrals and/or in rural areas where the most travel is required**. (Completed October 1, 2021)**

In addition, the State will review its current weighted caseload assignment process to ensure the appropriate amount of case management services are being provided to TPMs residing in a SNF, and to those who are referred for admission to a SNF.

Progress Report:

MFP funds were used to hire five LTSS Options Counseling (informed choice) staff. Older American Act funding were used to hire five additional LTSS Options Counseling (informed choice) staff.

All 10 staff have been hired. Starting June 14, 2022, they are responsible to visit all TPMs in hospitals and SNF who are referred for a long term stay in the nursing home as required in the agreement.

Access to TPMs (Section VII, Subsection D, page 11)

Implementation Strategy

Strategy 1. Address issues of affording Case Managers full access to TPMs who are residing in or currently admitted to a facility. The DHS promulgated an administrative rule that describes the powers and duties of public and private entities as it relates to the LTSS Options Counseling (informed choice) referral process. ND Admin. Code 75-02-02.4-04 (4) requires these entities to afford HCBS Case Managers full access to TPMs who are residing in or currently admitted to their facility. **(Completed January 2, 2021)**

Facilities that deny full access to the facility will be contacted by the Agreement Coordinator to attempt to resolve the issue and will be informed in writing that they are not in compliance with ND administrative code or the terms of the Medicaid provider enrollment agreement. If access continues to be denied, a referral will be made to the DHS Medical Services Program Integrity unit which may result in the termination of provider enrollment status.

Progress Report:

No SNFs denied access to the facility during this reporting period. Some facilities, families and guardians have asked questions about the State's right to discuss community-based options with their relatives. In response to those questions, a 'Frequently Asked Questions' document has been drafted to assist the LTSS Options Counselors and the MFP Transition Coordinators in explaining an individual's right to visitors, right to participate in care planning and to understand their treatment options. This document was shared with the SNF and Aging Services staff.

Performance Measure(s)

Number and percent of SNFs providing less than full access to TPMs.

- None

Number of referrals for denial of full access made to Program Integrity.

- None

Number of investigations initiated due to denial of access.

- None

Strategy 2. Conduct training with hospital and SNF staff to discuss the LTSS Options Counseling (informed choice) referral process and subsequent changes to the ND NF LoC tool effective January 1, 2021. The training will be adjusted over time to reflect further changes to the NF LoC and LTSS Options Counseling (informed choice) process that will be made during the time this IP in effect.

Remediation

Training will be held at least annually for the first two years of the SA. **(Target completion date December 14, 2022)**

Progress Report:

Performance Measure(s)

Number of SNF and hospital staffed trained on LTSS Options Counseling (informed choice) process.

- Four tentative in-person training dates are scheduled:
  - September 20, 2022
  - Sept 21, 2022
  - Sept 27, 2022
  - Sept 28, 2022
- There are also virtual meetings scheduled for:
  - October 3, 2022
  - October 4, 2022

Strategy 3. Inform facilities in writing that they must afford HCBS Case Managers access to TPMs per State and Federal regulations and the SA. **(Completed March 26, 2021)**

Challenges to Implementation

The health and visitor restrictions put into place because of the COVID-19 pandemic have limited face-to-face access to hospital and facilities.

Remediation

The State will ensure that all State employees follow required safety procedures, including the appropriate use of personal protective equipment, when entering facilities. The State provides PPE for all State employees.

The State purchased telecommunication equipment for 100 SNFs and basic care facilities in ND. Facilities that requested the equipment signed an agreement ensuring that the equipment be made available to all residents to facilitate virtual visitation, including visits with HCBS Case Managers.

Progress Report:

Performance Measure(s)

Number and percent of LTSS Options Counseling (informed choice) visits conducted in-person.

- A total of 545 unduplicated TPMs were contacted to complete a LTSS Options Counseling (informed choice) visit.
- A total of 588 visits were conducted.
    - 561 (95%) were conducted in-person.
    - 27 (5%) were conducted virtually or via telephone due to COVID-19 visitation restrictions.

Case Management System Access (Section VII, Subsection E, page 11)

Implementation Strategy

Provide HCBS Case Managers and relevant State agencies access to all case management tools including the HCBS assessment and PCP. **(Target completion date August 1, 2022)**

Progress Report:

Performance Measure(s)

Number of case management entities that have logins and access to the new

case management system.

- All Aging Services case management staff have access to Therap. On August 1, 2022, the approved PCP will be available in Therap to all Aging field staff and the CIL Transition Coordinators.

Quality (Section VII, Subsection F, page 11)

Implementation Strategy

Strategy 1. Specialize role of the HCBS Case Manager. The State will employ HCBS Case Managers who will provide HCBS case management full time. **(Completed January 1, 2020)**

Progress Report:

The State is continuously looking for ways to simplify and improve the case management process to best serve TPMs. The State is considering several options to increase capacity to serve TPMs which include, finding an alternate way to provide basic care case management, designating specific staff to determine eligibility and manage pending cases. **(Target completion date June 2023)**

Strategy 2. To ensure a quality HCBS case management experience for all TPMs the State will update the current annual case management reviews to ensure sampling of all components of the process (assessment/person-centered planning/safety, contingency plans, and service authorizations) to determine if TPMs are receiving services in the amount, frequency, and duration necessary for them to remain in the most integrated setting appropriate. **(Completed January 1, 2022. Reviews are done annually)**

Progress Report:

Performance Measure(s)

State produces an individual audit summary report and will compile the data into an annual report. The report will measure the error rate by territory and type.

- All audits are completed by December 31st of each year. The current auditing process includes the review of the information listed in Strategy 2. The 2021 audit report was completed by January 31, 2022 but does not measure the error rate by territory and type.

- State staff met to draft protocol for the 2022 audits based on the new case management system and process. The 2022 audit report will measure the error rate by territory and type.

ADRL (Section VII, Subsection G, page 11

Implementation Strategy

The strategies listed in Section VII.A. also apply to this section.

SA Section VIII. Person-Centered Plans

Responsible Division(s)

DHS Aging Services Division

"Charting the LifeCourse" Training (Section VIII, Subsection A, page 11)

Implementation Strategy

Implement new case management system for State staff, public, private, and tribal HCBS Case Managers and QSPs that includes "Charting the LifeCourse" person-centered planning framework tools. HCBS Case Managers will create, with the TPM, the PCP that will be maintained and updated in the new system. **(Updated Target completion date August 1, 2022)**

Remediation

The State will procure a foundational skill building educational series that will be virtually facilitated by the LifeCourse Nexus Team with the HCBS Case Managers and other DHS Aging Services Division staff. This series will be expanded to include a session on conflict resolution. **(Completed January 31, 2022, training on-going)**

Progress Report:

The new case management system will be complete when the person-centered planning tool that meets all settlement agreement requirements is added to Therap on August 1, 2022.

Performance Measure(s)

Number of HCBS Case Managers fully trained in "Charting the LifeCourse" and other person-centered planning tools as of December 31, 2021, January 31, 2022.

- All 121 Aging Services staff participated in the Charting the LifeCourse, PCP training. The initial series was completed on January 20th, 2022. Staff who missed a session will be required to attend make up sessions and new staff will receive the training as part of the initial

onboarding process.

- State staff developed a state form for that met all requirements for a PCP in the DOJ SA. Training was held on February 25, 2022, with all Case Managers. DOJ SA PCP is created as a state form**. (Completed February 25, 2022)**

- Aging Services will provide training on all newly developed PCP tools when the PCP tools are included in the new case management system on August 1, 2022.

- The State is working with NCAPPS and Charting the LifeCourse Nexus to integrate the core person centered competencies into practice. The foundation was laid for the programming through the five part training series which was attended by most staff. The five sessions are now available through Peoplesoft for staff who may have missed a session or joined the Aging Services team after the session was completed.

Number and percent of TPMs that have a completed individualized PCP.

- There are 704 unduplicated TPMs receiving HCBS in the most integrated setting. The approved PCP was implemented effective March 1, 2022. On that date all Case Managers were required to use the new form at their next PCP meeting scheduled with each TPM.

    - 346 (49%) of the 704 TPMs have an approved SFN 1265 PCP and SFN 1267 Risk Assessment Health and Safety Plan.
    - 358 (51%) have a plan but it is not the approved PCP that meets all DOJ SA requirements because the scheduled planning meeting has not happened yet.
    - The State estimates that by the end of September 2022, all TPMs receiving HCBS will have an approved PCP SNF 1265 and SFN 1267 Risk Assessment Health and Safety Plan.

Number of HCBS Case Managers who meet core person-centered competencies.

- The State is currently working with the Administration for Community Living (ACL)/CMS technical assistance opportunity administered by the NCAPPS to develop core competencies for staff. The core competencies of person-centered practice competency domains include strengths-based culturally informed whole person focused; cultivating connections inside the system and out; rights, choice, and control; partnership, teamwork, communication, and facilitations; documentation, implementations, and monitoring. A group will be assembled in September 2022 to develop the training that will enhance and measure person-centered planning skills that meet the core competencies described above.

Policy and Practice (Section VIII, Subsection B & C, page 11)

Implementation Strategy

Strategy 1. Ensure that the HCBS functional assessment and individualized PCP contained in the new case management system meets all requirements of subparts 1-8. The PCP will be updated when a TPM goes to the hospital or SNF and remains available and accessible in the new system when the TPM returns to the community. **(Updated target completion date August 1, 2022)**

Progress Report:

The new case management system is not complete. Therefore, the benchmark to complete 290 PCPs (145 coming from TPMs in SNF) was not met for year one of the SA. The State has agreed to "make up" the required 290 PCPs during the second year of the SA in addition to producing an additional 290 PCPs with TPMs.

Although the State has always conducted person-centered planning with all TPMs and individuals receiving transition assistance, the requirements outlined in the Settlement Agreement can only be found by referring to multiple areas of the individual's file. Therefore, the State created a State form that meets all SA PCP requirements and it has been used since March 1, 2022. This document will be used until the case management system is fully operational. An electronic PCP that meets all the SA PCP requirements has been created in the case management system. State staff will be trained and will begin using the electronic version of the PCP August 1, 2022.

Performance Measure(s)

Number of new PCPs completed by the HCBS Case Manager per month.

- There were 146 total PCPs developed for new TPMs.
    - January – 32
    - February – 4
    - March – 16
    - April – 18
    - May – 16
    - June 1-14 – 8

Number of PCP updated every six months as required.

- Data is currently unavailable.

Strategy 2. Update current policy that states if the TPM enters a SNF and services are not used for at least 30 days, the case should close unless prior approval is received. After discharge, a TPM must submit another application and re-apply for services once

they are ready to resume care in the community. HCBS Case Managers are also required to complete a new functional and financial assessment.

Policy will be updated to clarify that a TPM does not have to reapply for services if they were an eligible recipient before they entered the SNF, and they are there on a short-term NF LoC stay. HCBS Case Managers will update the assessment and PCP to reflect any change in need or preference but will not need to complete a new financial assessment unless there has been a substantial change, or they are due for a required annual reassessment **(Completed July 1, 2021)**

Strategy 3. To facilitate the exchange of information across settings, an interface will be created between the new case management system and the ND Health Information Network (NDHIN) to make a PCP part of the patient health record that is available to qualified clinicians. **(Completed September 23, 2021)**

Strategy 4. The SA states that TPMs will not be required to rely on natural supports if they choose not to do so, or if the proposed person(s) is unable to or unwilling to provide natural supports.

The DHS will add the above statement to the HCBS policy and procedure manual and will also implement the following to meet this requirement:

- Live alone eligibility requirements for residential habilitation and community-supports are too restrictive and will be removed to allow more TPMs to access services. A waiver amendment will be submitted, and administrative code will be updated accordingly. **(Completed January 1, 2022)**

- Currently, TPMs who live with family are not eligible to receive supervision. This requirement will be removed. A waiver amendment will be submitted, and administrative code will be updated accordingly. **(Completed January 1, 2022)**

Progress Report:

The Waiver amendment is approved effective January 1, 2022. The administrative code update is also complete. Policy has been updated to ensure that natural supports are not required to provide services to HCBS individuals. Training on the Waiver Amendment was held on January 24, 2022, and the policy became effective February 1, 2022.

Strategy 5. Every PCP will incorporate all the required components as outlined in Section VIII.C.1-8 and these are apparent in PCP documentation. The person-centered planning tool in the new case management system will allow all required information to be captured and included in the plan. The State will update the annual case management review process to include sample PCPs from each HCBS Case Manager to ensure they are individualized, effective in identifying, arranging, and maintaining necessary supports and services for TPMs, and include strategies for resolving conflict or disagreement that arises in the planning process. **(Updated target completion date July 1, 2022)**

Progress Report:

Performance Measure(s)

Number of PCPs completed per month.

- Fully compliant PCPs per month for all HCBS individuals:
    - March – 104
    - April – 419
    - May – 475
    - June – 371
- Fully compliant PCPs by month for TPMs
    - March – 25
    - April – 115
    - May – 119
    - June – 91

Number and percent of PCPs reviewed by State that meet all requirements.

- 100% of the current PCPs are reviewed and approved by the State. Since March 1, 2022, all plans meet the current State and federal requirements for a PCP and the requirements in the SA Section VIII. C. (1-8)

Strategy 6. The person-centered planning tool has been updated to adequately capture information on housing needs and is specific to each TPM housing barriers. Necessary supported housing services are also identified on the PCP. **(Completed March 1, 2022)**

Policy Manual Update (Section VIII, Subsection D, page 12)

Implementation Strategy

Current policy requires that when a TPM applies for long-term services, the HCBS Case Manager initiates the person-centered planning process.

Progress Report:

Performance Measure(s)

Number of PCPs completed per month.

- See response under Section VIII B &C Strategy 5.

Percent of PCPs completed within required timeframe

- All plans were completed within the required timeframe

Number and percent of PCPs reviewed by the State that meet all requirements.

- See progress report in Strategy 5 above.

Conflict Resolution (Section VIII, Subsection E, page 13)

Implementation Strategy

To resolve conflicts that arise during development of the PCP, the State will request technical assistance from NCAPPS to provide training to assist the HCBS Case Managers in developing the skills necessary to help resolve conflicts that emerge during development of the PCP, including the option for a TPM to obtain a second opinion from a neutral healthcare profession. Conflict resolution will become a core competency used to measure case management understanding of person-centered planning principles. **(Completed April 1, 2022, ongoing**)

Progress Report:

Staff from the Charting the LifeCourse provided training on conflict resolution on January 10th and 20th, 2022. As part of the onboarding process we will require new workers to participate in conflict resolution training. New workers have three (3) months to complete the training. In addition, team staff engage in inter- and intra-agency discussions to help resolve areas of conflict and work with family members, guardians, facility staff, and the TPM to resolve conflicts around identified barriers to living in the most integrated setting.

Performance Measure(s)

Number and percent of TPMs that request a second opinion.

- No TPMs have requested a second opinion.

Reasonable Modification Training (Section VIII, Subsection F, page 13)

Implementation Strategy

Strategy 1. To comply with Title II of the ADA which states that a public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination based on disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

The State will work with the DHS Legal Advisory Unit and other agencies or boards to determine if a request for reasonable modification can be accommodated as required in

the SA. HCBS policy will be updated to determine how requests for reasonable modification may submitted for review and reconsidered. **(Completed February 1, 2022)**

Progress Report:

Performance Measure(s)

Number and percentage of HCBS Case Managers trained on reasonable modification.

- Sixty-four, 98%, of the current Case Managers attended the training provided by the Legal Advisory Unit on March 28, 30, and 31, 2022 or watched the recorded version. One Case Manager is out of the office on leave and will complete the training when they return.

Number of HCBS Case Managers after receiving training who showed increased understanding of reasonable modification requirements under the ADA.

- The presenter completed a brief test with all participants during the training. The speaker asked the test question to the group and the answers were provided and discussed as a group learning tool. An e-learning module is being created and will include a formal learning evaluation tool.

Number of stakeholders provided education about reasonable modification.

- Reasonable modifications were discussed at the ND DOJ Stakeholder meeting held on June 9, 2022, with 55 stakeholders in attendance. **(Completed March 31, 2022**.)

Number of requests received and outcome of those requests per month.

- A total of 20 requests were received, 19 were approved and one was denied.

Reasonable Modifications				
Month/Year Request	**# Received**	**Accommodation Type**	**Approved**	**Denied**
Dec 15, 2021 – Dec 31, 2021	3	Waive live-alone requirement for supervision (1)	1	
		Approve costs over monthly SPED cap long term (2)	2	
Jan 2022	2	Nursing tasks (2)	2	

Feb 2022	3	Combine community transitions services and respite (1)	1	
		Supervision for intermittent needs (1)	1	
		Nursing tasks (1)	1	
Mar 2022	0			
Apr 2022	5	Travel time under Residential Habilitation (1)	1	
		Nursing tasks (3)	3	
		Supervision provided outside of individual's home/grounds (1)		1
May 2022	3	Paid QSP training (1)	1	
		Nursing tasks (1)	1	
		Environmental modification cost over 20% value of home (1)	1	
Jun 1, 2022 – June 14, 2022	4	Nursing tasks (2)	2	
		Med waiver services cost over monthly cap (1)	1	
		Allow spouse payment under MSP (1)	1	
Totals	**20**		**19**	**1**

SME review of transition plans (Section VIII, Subsection G, page 13)

Implementation Strategy

Strategy 1. The State will develop a process to submit all transition plans that identify a setting other than the TPM's home, a family home, or an apartment as the TPM's most integrated setting appropriate to the SME for the first two years of the SA. **(Reporting began June 1, 2021)**

Progress Report:

Performance Measure(s)

Number and percent of transition plans that identify a setting other than a TPM's home, family home, or apartment.

- No transition plans identified a setting other than the TPM's home, family home, apartment, or foster home.

Person-centered planning TA (Section VIII, Subsection H, page 13)

Implementation Strategy

Strategy 1. To ensure annual ongoing training, the State will utilize MFP capacity building funds to procure an entity to provide ongoing technical assistance and annual person-centered planning training through September 30, 2025. Training will be required for all HCBS Case Managers and DHS Aging Services Division staff. The entity will also be also required to assist the State in developing person-centered planning policy and procedures, performance measures and core competencies that will assist the TPM in receiving services in the most integrated setting appropriate. **(Updated target completion date December 31, 2022)**

Progress Report:

Performance Measure(s)

Number and percent of HCBS Case Managers trained on person-centered planning practices.

- All 66 Case Managers or 100% have been involved in a series of trainings to include the five person-centered planning domains of:
    - strengths-based, culturally informed, whole person focused;
    - cultivating connections inside the system and out;
    - rights, choice, and control;
    - partnership, teamwork, communication, and facilitation;
    - documentation, implementation, and monitoring.

The series includes training on and working within the Charting the LifeCourse framework, training on cultural diversity, training on services and programs within DHS along with training on LTSS that are offered through other stakeholders.

All Case Managers have had some if not all the sessions on PCP for the foundation of Charting the Life Course. Forty-six (46) or 69% of the case managers have fully completed the series. Make up sessions and sessions for new workers have been scheduled for August 2022-December 2022. This training will rotate every six months to ensure that the foundation is embedded in Aging Services. Staff who were unable to attend the live training will be required to attend a recorded make-up session.

Core Competencies are in development with a workplan to solidify the action moving forward with a meeting mid-September.

Number of HCBS Case Managers who after receiving training showed increased understanding of person-centered planning principles.

- The State is currently working with the Administration for Community Living (ACL)/CMS technical assistance opportunity administered by the (NCAPPS) to develop core competencies for staff. The team is working on developing a skill building training process and standard performance measures.

Number of HCBS Case Managers who meet core person-centered planning competencies.

- See response above.

Person-Centered Planning process and practice (Section VIII, Subsection I, page 13)

Implementation Strategy

During the IP period, the State must develop PCPs with at least 290 unduplicated TPMs within one year of the effective date and an additional 290 TPMs within two years of the effective date. At least half of the TPMs who receive person-centered planning each year will be SNF TPMs.

Through facility in-reach, community outreach, and increased public awareness of the ADRL and HCBS options, the State seeks to identify TPMs who are interested in receiving services in the most integrated setting appropriate. Based on current case management capacity, TPMs who indicate a preference to receive services in the community are assigned an HCBS Case Manager who will complete a PCP. The State will develop additional strategies so that before the end of the SA, all TPMs will be provided a PCP so they can make an informed choice.

The State has experienced unanticipated delays in the vendor's development and finalization of a Person-Centered Plan form that is fully compliant with the requirements of the Settlement Agreement within the web-based case management system. The State has responded to this challenge with the creation of State forms, to be used in the interim, to meet these requirements. The forms were developed and finalized in February 2022.

The State has provided a sample of new PCPs to the USDOJ and the SME for their review to ensure this benchmark is met for SA year one and year two by December 14, 2022. An electronic version of the approved PCP is being created in the State's case management system and will be finalized on August 1, 2022.

Strategy 1. Ongoing person-centered planning technical assistance is being provided to the State as part of an Administration for Community Living (ACL)/CMS technical assistance opportunity administered by the NCAPPS.

The State will ensure ongoing technical assistance after September 30, 2021, by using MFP capacity building funds to procure person-centered planning technical assistance

from a qualified entity from October 1, 2021 – September 30, 2025. **(Provider procured October 1, 2021)**

Progress Report:

ND was notified on September 16, 2021, that ND DHS has been selected to receive an additional two years of NCAPPS technical assistance. This extends the assistance through September 30, 2023. ND has modified the contract with HSRI in August of 2021 to add the MFP Capacity Building Funds needed to fund the ongoing person-centered planning technical assistance for Aging Services from October 1, 2021 – September 30, 2025.

Strategy 2. Ensure that a PCP is completed with every TPM who requests HCBS, beginning in the initial 24 months, with those expressing interest in HCBS. **(Completed December 14, 2021)**

Progress Report:

Performance Measure(s)

Number of PCPs for TPMs not residing in the SNF that are completed by December 14, 2021, and December 14, 2022.

- A total of 346 approved PCPs have been completed with TPMs living in the community during this reporting period.

Number of PCPs for TPM residing in SNF that are completed by December 14, 2021, and December 14, 2022.

- A total of 58 transition PCPs have been completed with individuals in SNF. On June 14, 2022, the State began seeing all TPMs residing in nursing homes and will complete PCPs with this population.

Number of targeted in-reach visits conducted.

- A second round of group in-reach presentations (the first were held in 2021) began in June 2022 and will be included in the December 2022 report.

Strategy 3. Conduct targeted in-reach to TPMs. To help identify TPMs residing in a SNF, the MFP transition coordinators and DHS Aging Services Division staff who complete LTSS Options Counseling (informed choice) visits will also conduct targeted in-reach to TPMs residing in SNFs to discuss HCBS and the potential benefits of community living. For the first 24 months, if a TPM indicates a preference for community living they will be assigned an HCBS Case Manager and MFP transition coordinator who will complete a PCP. A housing facilitator will also be assigned if the plan identifies housing as a barrier to community living.

Progress Report:

- See information reported under strategy two (2) above.

Performance Measure(s)

Number of targeted in-reach visits conducted.

- The second round of group in-reach presentations (the first were held in 2021) began in June 2022 and will be included in the December 2022 report.

Number of TPMs in SNF referred to MFP.

- A total of 115 TPMs in SNFs were referred to MFP.

Number of HCBS Case Managers assigned to TPMs in SNF.

- Ten LTSS Options Counselors have been assigned as Case Managers to each SNF. They are responsible for providing required information to TPMs.

- An MFP Transition Coordinator and HCBS Case Manager were assigned to 115 TPMs referred to MFP.

Percent of housing facilitators assigned when housing is an identified barrier on the PCP.

- 100% of individuals with a barrier were assigned to Housing Staff, 25 individuals were assisted.

Strategy 4. To help ensure that HCBS Case Managers conduct person-centered planning in a culturally responsive way, the State will implement the following recommendations from the August 2020 "Partnering Equitably with Communities to Promote Person-Centered Thinking, Planning, and Practice" brief. **(Ongoing strategy)**

Progress Report:

- Ensure that the Peer Support Resource Center referenced in the Partnering Equitably with Communities to Promote Person-Centered Thinking, Planning, and Practice document provides opportunity for culturally specific peer supports to the greatest extent possible.

  - The Peer Support Center has not yet been developed. Internal meetings have been held to identify the requirements of a potential request for proposal to secure a provider of this service.

- Holding HCBS Community Conversations in all Native American reservation communities in ND.

    - The State is working with the Department of Health, Office of Heath Equity tribal liaisons to schedule community conversations in conjunction with other events being held on the reservation. The State will develop a one page brief that explains the purpose of the community conversations that will be shared with tribal leaders before events are scheduled. Partnering with the tribal liaisons will help ensure we provide a meaningful opportunity for elders to share their experiences and the needs of their community.

- Including representation from Native American and New American communities on all workgroups described in the IP.

    - Each of the tribal nations are sent an invite to all stakeholder meetings. Additionally, our tribal initiative liaison sends an invite to all tribal stakeholders that have previously attended the meetings. The State will also consult with State Refugee Services Coordinator to discuss ways to engage the new American community.

- Providing cultural sensitivity training created by local subject matter experts to all HCBS Case Managers.

    - Two separate cultural sensitivity trainings were conducted and were attended by 100% of Aging Services staff. See response under Section VII Subsection A Strategy 2.

- Ensuring access to interpretive services and translating informational materials into other languages.

    - Translation services are available whenever needed. CT language link is utilized by DHS staff for translation services. The State is working with the QSP Resource Hub staff to develop QSP enrollment materials in other languages.

- Providing funds through the MFP tribal initiative for Tribal nations to hire HCBS Case Managers to provide culturally competent case management services to tribal members.

    - Standing Rock Sioux Tribe has MFP tribal initiative funds available to hire a Case Manager for HCBS, the position is currently vacant.

    - Each tribal government has used the funds to meet the needs of their community

SA Section IX. Access to Community-Based Services

Responsible Division(s)

DHS Aging Services Division

Policy (Section IX, Subsections A, B & C, page 14)

Implementation Strategy

Strategy 1. HCBS policy will be updated, by service, to clarify that HCBS will be delivered in the most integrated setting appropriate, including at a TPMs home, workplace, and other community settings. **(Completed November 1, 2021)**

Strategy 2. A Service Delivery stakeholder workgroup will be established to identify ways to improve flexibility in the service delivery system. The State will invite TPMs, family members, guardians, State administrative staff, tribal representatives, HCBS Case Managers, QSPs, and other interested stakeholders to participate. The group's primary purpose is to make recommendations for the State to consider regarding ways to improve the authorization and service delivery process and create contingency/emergency back-up plans that do not rely on the TPM to identify informal supports.

The State will use the recommendations to develop contingency/emergency back-up-plan training for HCBS Case Managers, update policy and develop provider recruitment strategies to increase access to other QSPs in the event of an emergency, improve the authorization of services, and updates to the PCP.

State staff will be responsible for taking any regulatory action necessary to implement the agreed upon recommendations from the workgroup. **(Workgroup established updated date September 30, 2022, Recommendations developed and reported December 1, 2022)**

Progress Report:

Performance Measure(s)

Number of contingency plans incorporated into the PCPs that have been audited.

- 100% of the contingency plans incorporated into the current PCPs have been audited by State staff. HCBS Program Administrators review and approve all PCPs.

QSP Resource Hub (Section IX, Subsections D, page 14)

Implementation Strategy

Strategy 1. The State requested and received approval to use MFP capacity building funds to establish a QSP Resource Hub to assist TPMs who choose their own individual QSPs to successfully recruit, manage, supervise, and retain QSPs. The QSP Resource Hub will also help TPMs to understanding the full scope of available services and the varying requirements for enrollment, service authorization, and interaction with HCBS case management. **(Agency procured December 31, 2021)**

Progress Report:

On December 1, 2021, the State contracted with the Center for Rural Health at UND School of Medicine to develop the resource and training center which will be commonly known as the QSP Resource Hub. The State and UND staff meet bi-weekly to discuss progress on the contract requirements and emerging issues. The QSP Resource Hub staff completed an agency and individual QSP survey and are in the process of developing a QSP orientation curriculum that can be used for individuals considering becoming a QSP or for those newly enrolled as a QSP. The QSP Hub is also responsible for developing a strategic plan and recruitment and retention strategies for QSPs.

Performance Measure(s)

Number of TPMs who self-direct or who express interest in self-direction supported by the QSP Resource Hub.

- The QSP Resource Hub is responsible for assisting individuals who choose to self-direct their services. Staff will develop resources and offer training topics that will include information on how to recruit, interview, hire and train direct care staff. **(Target completion date January 31, 2023)**

Right to Appeal (Section IX, Subsection E, page 14)

Implementation Strategy

Strategy 1. Educate HCBS applicants on the right to appeal any decision to deny/terminate/reduce services by adding information to the Application for Services form. HCBS Case Managers will be required to inform TPMs that they can help them file an appeal during the person-centered planning meetings. **(Completed February 1, 2022)**

Strategy 2. Educate TPMs who are already receiving services on their right to appeal any decision to deny/terminate/reduce HCBS by adding information to the "HCBS Rights and Responsibilities" brochure. HCBS Case Managers will be required to inform

TPMs that they can help them file an appeal during the person-centered planning meetings. **(Completed February 1, 2022)**

All TPMs receiving HCBS must be made aware and provided a copy of the required information. HCBS Case Managers are required to explain the information, which is signed by the recipient and/or their legal decision maker, if applicable.

Progress Report:

Performance Measure(s)

Number of TPMs provided written information on the right to appeal.

- 704 individuals have received information on their right to appeal.

Strategy 3. TPMs cannot be categorically or informally denied services. Policy will be updated to require HCBS Case Managers to make formal requests for services or reasonable modification requests when there are unmet service needs necessary to support a TPM in the most integrated setting appropriate. All such requests and appeals must be documented in the PCP. **(Completed February 1, 2022)**

Strategy 4. Conduct an analysis of the number of units being authorized and utilized, by case management territory, to determine if there are significant discrepancies in the amount of services available to TPMs across the State. **(Completed May 31, 2022)**

Progress Report:

Performance Measure(s)

Number of service units authorized and utilized by territory.

- Link to Appendix D

Policy Reasonable Modification (Section IX, Subsection F, page 14)

Implementation Strategy

Strategy 1. The State will work with the DHS Legal Advisory Unit and other agencies or boards to determine if a request for reasonable modification, including the delegation of nursing tasks, can be accommodated as required in the SA. HCBS policy will be updated to determine how requests for reasonable modification may submitted for review and reconsidered. **(Completed February 1, 2022)**

Progress Report:

Performance Measure(s)

- All 66 Case Managers attended the training provided by the Legal Advisory Unit on March 28, 30, and 31, 2022.

Number of stakeholders provided education about reasonable modification.

- Reasonable modifications were discussed at the ND DOJ Stakeholder meeting held on June 9, 2022, with 55 stakeholders in attendance.

Number of reasonable modification requests received and outcome.

- Twenty reasonable modification requests were made, 19 were approved and one was denied.
- See reasonable modification chart in Section VIII -F Strategy 1.

Strategy 2. Some requests for reasonable modification may conflict with the ND Nurse Practices Act, N.D. Cent. Code § 43-12.1. The State will meet with the ND Board of Nursing and will request to convene a Healthcare Accommodations workgroup with members of the Board of Nursing. The purpose of the workgroup is to further explore ways to support TPMs in receiving necessary medical care so they can remain in the most integrated setting appropriate and develop recommendations for the State to consider. If necessary, the State will consider options associated with its oversight responsibilities to resolve any disputes regarding practice differences between nurses and non-nurses to assure that TPM requests for accommodation can be met in the most efficient and effective manner. Recommendations will be shared with stakeholders and their feedback incorporated into any policy or regulatory change resulting from recommendations made by the workgroup. **(Recommendations complete December 2022**)

Progress Report:

A meeting with the ND Board of Nursing was held on May 2, 2022. Discussion included DHS Legal Services, Aging Services, and staff from the ND Board of Nursing. The discussion centered around the reasonable accommodation requests that Aging Services receives from Case Managers related to tasks of a medical nature that must be provided for TPMs to safely live in the most integrated setting. Both agencies agreed to work together to determine if any change in policy or regulatory work could be done to make it easier for TPMs with significant health needs to live safely in the community.

Another meeting was held on July 7, 2022, to further review the most recent accommodations with the North Dakota Board of Nursing. Most of the accommodations include medical tasks such as wound care, deep suctioning of a tracheostomy, and sliding scale insulin. In these situations, a registered nurse is required to provide the oversite and complete the training/competency with the QSP/caregivers to perform these tasks. The concern comes when the individual is unable to self-direct this care. The ND Board of Nursing staff suggested that there is a need for an emergency process/contingency plan to be in place for the QSP to contact an RN when delegating these tasks. The team suggested working with a contract/on call nursing agency to assist as a resource for individual QSPs and QSP agencies in these situations. They provided examples

of work being done in other states that may serve as a model for ND. Quarterly meetings will be held to continue review of medical accommodations that are being made and to formalize any recommendations to ensure TPMs can get the care they need.

Strategy 3. The State will use existing extended personal care services or the nurse assessment program to pay a registered nurse to administer training to the QSP to ensure that the QSP can perform needed nursing-related services for the TPM in the community. **(Completed December 14, 2021)**

Progress Report:

Performance Measure(s)

Number of TPMs receiving extended personal care.

- Currently there are 62 TPMs using Extended Personal Care Services, 20 receiving SPED, and 42 on HCBS Medicaid 1915 (c) waiver.

Strategy 4. Policy will be updated to require the HCBS Case Manager to assist TPMs in making a request for reasonable modification to the State when services are necessary but unavailable are identified during the person-centered planning process. **(Completed February 1, 2022)**

Progress Report:

Performance Measure(s)

Number of requests for reasonable modification and outcome.

- See reasonable modification chart in Section VIII -F Strategy 1.

Strategy 5. The State will track all requests for reasonable modification to identify trends in service gaps, location, utilization, or provider capacity. Reports will be reviewed at a quarterly meeting attended by all DHS Divisions that administer HCBS. Strategies to address identified issues will be established and included in future revisions of the IP. **(Completed February 1, 2022)**

Progress Report:

Reasonable modification requests are being tracked and the State will be setting up a separate meeting to provide adequate time to discuss this topic.

Performance Measure(s)

Number of requests for reasonable modification and outcome.

- See Strategy 1 in this section.

Denial Decisions (Section IX, Subsection G, page 15)

Implementation Strategy

All decisions to deny a TPM requesting HCBS is based on an individualized assessment. TPMs will not be categorically denied services and are provided the legal citation for the denial and their appeal rights as required.

Updated Strategy 1. Continue to educate HCBS applicants on the right to appeal any decision to deny/terminate/reduce services by adding information to the Application for Services form. HCBS Case Managers are required to inform TPMs that they can help them file an appeal during the person-centered planning meetings. **(Ongoing strategy)**

Strategy 2. Continue to educate TPMs who are already receiving services on their right to appeal any decision to deny/terminate/reduce HCBS using the updated "HCBS Rights and Responsibilities" brochure. HCBS Case Managers are required to inform TPMs that they can help them file an appeal during the person-centered planning meetings. **(Ongoing strategy)**

All TPMs receiving HCBS must be made aware and provided a copy of the required information. HCBS Case Managers are required to explain the information, which is signed by the recipient and/or their legal decision maker, if applicable.

Performance Measure(s)

Number of TPMs provided written information on the right to appeal.

- See update under Section IX E.

Service enhancements (Section IX, Subsection H, page 15)

Implementation Strategy

Strategy 1. Add residential habilitation, community-support services, and companionship to the HCBS 1915 (c) Medicaid waiver to provide up to 24-hour support, and community integration opportunities for TPMs who require these types of supports to live in the most integrated setting. **(Completed January 1, 2020)**

Progress Report:

Performance Measure(s)

Number of QSPs who received enrollment assistance.

- Three QSPs received assistance and successfully enrolled to become a community support services or residential habilitation provider in this reporting period. Sixty-two TPMs received this service.

Number of QSPs successfully enrolled to provide services.

- Thirteen QSPs were successfully enrolled to provide residential habilitation and/or community support services since the service was added to the HCBS waiver.

Strategy 2. Update SPED financial and functional eligibility criteria to increase access to SPED. **(Completed July 1, 2019, and January 1, 2020)**

Progress Report:

Performance Measure(s)

Number of TPMs served in the SPED program.

- A total of 125 TPMs are served through SPED during this reporting period.

Percent increase in SPED recipients.

- A total of 102 TPMs were served under SPED in the last reporting period, (June 15, 2021 – December 14, 2021). This is a 22.5% increase in TPMs being served under SPED from December 15, 2021 – June 14, 2022.

Number of individuals who apply for SPED and are denied.

- A total of 64 SPED applications were denied on applicable State law or administrative code. The denial/termination reasons are as follows:
    - 7 - Unable to determine financial eligibility (did not cooperate with financial assessment)
    - 4 - Unable to determine overall eligibility (did not cooperate with assessment)
    - 1 - Disqualifying transfer
    - 6 - Financial eligibility (100% fee)
    - 9 - Financial eligibility (over assets)
    - 26 - Functional eligibility
    - 1 - Health, welfare, safety
    - 2 - Not in agreement with care plan/ does not want services due to SPED fee
    - 8 - No action/services pursued

SA Section X. Information Screening and Diversion

Responsible Division(s)

DHS Aging Services & Medical Services Divisions

Long Term Services & Supports (LTSS) Options (Informed Choice) Referral Process (Section X, Subsection A, page 15)

Implementation Strategy

Strategy 1. Implement an informed choice referral process to identify TPMs and provide information about community-based services, person-centered planning, and transition services to all TPMs and guardians, if applicable, who formally request or are referred for placement in a SNF and who are screened for a continued stay in a SNF.

Because of staff capacity the State only provided this information to TPMs and guardians who express interest in HCBS or who, because of their care needs, are best served in the community. On June 14, 2022, the process changed, and the State began providing the required information to all TPMs as required in the SA.

Progress Report:

MFP funds were used to hire five LTSS Options Counselors (informed choice) staff. Older American Act funding was utilized to hire five additional LTSS Options Counseling staff.

They are responsible for visiting all TPMs in nursing homes and hospitals who are referred for a long term stay in the nursing home as required in by the Settlement Agreement.

Strategy 2. To identify TPMs when they are screened at a NF LoC and ensure that they receive information about community-based services, person-centered planning, and transition services, and therefore have an opportunity to make an informed decision about where to receive services, the ND NF LoC tool has been updated to include questions to identify TPMs who are interested in learning about community-based options or who, because of their level of need, might be best served in the community.

State staff are required to conduct the visits within five business days of the referral. If a TPM chooses HCBS, a HCBS Case Manager is assigned and a referral is made to MFP, if applicable. TPMs are currently asked to indicate in writing whether they received such information.

Progress Report:

Performance Measure(s)

Number of TPMs who received LTSS Options Counseling (informed choice) visits.

- A virtual or in person LTSS Options Counseling (informed choice) visit was conducted with 545 unduplicated TPMs.

Number of LTSS Options Counseling (informed choice) visits that resulted in TPM transitioning to a community setting.

- Twelve LTSS Options Counseling (informed choice) visits resulted in a transition to the most integrated setting during this reporting period.

Number and percent of TPMs in SNFs reached through group or individualized in-reach.

- There were 2,367 Medicaid recipients residing in SNFs and 545 individuals were seen through in-reach visits conducted during this reporting period. Therefore, 23% of all Medicaid recipients residing in SNFs have received an individual in-reach visit. A second round of group in reach meetings began in June 2022 and the results will be included in the December 2022 report.

Number and percentage of LTSS Options Counseling (informed choice) visits where the TPM requested follow up and the follow-up visit occurred.

- There were 18 requests for follow up visits. All 18 follow up visits were completed.

Remediation

The State partnered with staff from National Center on Advancing Person-centered Practices and Systems to hold an LTSS Options Counseling (informed choice) workgroup meeting and invited TPMs, families, guardians, State staff, tribal representatives, HCBS Case Managers, hospital, and nursing home discharge planners, and other interested stakeholders to participate. The group discussed the current state of this process and developed a list of recommendations for the State to consider on how to best provide the required information to ensure the TPMs and guardians have a true understanding of the availability of HCBS that will allow them to live in the most integrated setting appropriate.

The group also addressed how a TPM who, after being provided all required information, may decline community services in favor of SNF placement, if that is their preferred setting. The workgroup reviewed the current process, forms, and educational materials to ensure they are reflective of cultural and geographic

norms, respect the wishes of TPMs who may initially oppose participation in an LTSS Options Counseling (informed choice) visit while considering the State's continued duty to ensure that the TPM understands the specific community-based services that are available to them so they can make an informed decision. **(Workgroup developed October 1, 2021, Recommendations completed April 1, 2022)**

Progress Report:

- A public stakeholder meeting was held on March 23, 2022. Link to Appendix B.

The following recommendations were implemented from the workgroup feedback.

- The State made changes to the SFN 892 questionnaire used during LTSS Options Counseling visits (informed choice) that addressed any concerns related to meeting their financial needs in the community.

- The State changed the amount of time allowed for State staff to visit a TPM in the hospital or nursing home from five days to 10 days. This will allow for the TPM to adjust to their surroundings before having this important conversation.

- Implemented a two week follow up visit after each SNF group in reach presentation. This will allow a TPM and their family members time to consider the information presented and ask any follow up questions they may have.

- Streamlined the internal communication process to funnel all requests for transition supports to the MFP team. And the State designated the MFP Transition Coordinator as the lead, so the TPM has a primary contact through the transition process.

  Performance Measure(s)

  Number of TPMs who received LTSS Options Counseling (informed choice) visits.

  - See Strategy 2 in this section.

  Number of LTSS Options Counseling (informed choice) visits that resulted in TPM transitioning to a community setting.

  - See Strategy 2 in this section.

  Number and percent of TPMs in SNF reached through group or individualized in-reach.

  - See Strategy 2 in this section.

  Number and percentage of LTSS Options Counseling (informed choice) visits where the TPM requested follow up and the follow-up visit occurred.

- See Strategy 2 in this section.

Strategy 3. The current LTSS Options Counseling (informed choice) referral process requires staff to complete the SFN 892 – Informed Choice Referral for Long-Term Care form during each visit. The form requires a signature from the TPM or their legal decision maker to confirm they received and understand the required information. Educational materials to help TPMs understand their options have been developed and are required to be used during each visit.

Remediation

If a TPM refuses an LTSS Options Counseling (informed choice) visit, State staff are required to ask if the TPM would like to schedule a follow up visit or be contacted later. State staff shall leave a copy of the educational materials and ADRL contact information. The LTSS Options Counseling (informed choice) workgroup will develop recommendations to identify strategies to address these issues. **(Workgroup developed October 1, 2021, Recommendations completed April 1, 2022)**

Progress Report:

All TPMs living in SNF will receive a visit from the LTSS Options Counselor (informed choice) staff. The worker will provide required information and their contact information. If the individual chooses not to participate in the person-centered planning discussion the worker documents that on the plan and lets them know they can contact the LTSS Options Counselor (informed choice) any time. TPMs are also informed they can expect an annual visit around the time of their annual NF LoC redetermination.

Based on workgroup recommendations the State developed an updated LTSS Options Counseling (informed choice) brochure that helps TPMs, family, guardians and facility staff understand the new annual NF LoC redetermination requirement that will begin on December 14, 2022.

NF LoC Screening and Eligibility (Section X, Subsection B, page 15)

Implementation Strategy

Strategy 1. Members who meet criteria for a particular SNF service must be offered that same service in the community if the community-based version exists or can be provided through reasonable modification to existing programs and services. As part of the LTSS Options Counseling (informed choice) implementation, all HCBS Case Managers were given access to the TPM's NF LoC screening evaluations to help determine which supports are necessary for them to live in the most integrated setting appropriate. If necessary, services that are identified but are not available in the community, policy was updated to require the HCBS Case Manager to formally request services or submit a reasonable modification request to the State for consideration. This

information is incorporated into the PCP. **(Completed January 1, 2021)**

Remediation

The State has implemented a bi-weekly interdisciplinary team meeting to staff necessary but unavailable service requests with staff from Aging Services, Behavioral Health, and the Human Service Centers to assist individuals who have a serious mental illness and need behavioral health supports to succeed in a community setting. The purpose of the meetings is to discuss how the Divisions can work together to provide the necessary services that will allow the TPM to live in the most integrated setting appropriate.

This concept will be replicated with other DHS divisions to staff reasonable modification requests or to staff situations where it is unclear which HCBS waiver or State plan benefit would best meet the needs and wishes of the TPM. **(Meetings started April 28, 2021)**

Progress Report:

The meetings are now held weekly and allow for cross-divisional interdisciplinary team meetings. Behavioral health, Aging Services, Developmental Disabilities (DD), MFP, and the Human Service centers have been notified of the time slotted for the meetings. If the time slot does not work, arrangements are made to accommodate other interdisciplinary team meetings.

Performance Measure(s)

Number of cases staffed per interdisciplinary team meetings and outcome.

- There were 60 cases staffed from December 15, 2021 – June 14, 2022.

Number of requests for reasonable modification and outcome.

- See reasonable modification chart in Section VIII -F Strategy 1.

Strategy 2. The State established a NF LoC workgroup and invited State staff, hospital, and nursing home discharge planners, HCBS Case Managers, TPMs, family members, guardians, and other interested stakeholders to participate. The primary purpose of the workgroup was to develop recommendations for the State to consider that will help determine what incremental changes need to be made to the initial and continued stay NF LoC eligibility criteria to remove any inherent barrier in the functional eligibility criteria that prevent TPMs from receiving the types of supports necessary to live in the most integrated setting.

The group will also provide recommendations to ensure that TPMs who no longer screen at a NF LoC will be allowed sufficient time to safely transition to the community and find necessary supports. The State will be responsible to complete any regulatory process that will be required to incorporate the agreed upon recommendations.

(Workgroup established December 1, 2021. Recommendations to be completed by September 1, 2022)

Progress Report:

The State determined it would be beneficial to first develop an internal workgroup that consists of staff from Aging Services, Medical Services, and Maximus before engaging with the broader group of stakeholders. Maximus is a contracted vendor responsible for making NF LoC determinations for TPMs being referred to the nursing home or for HCBS that require the participants to screen at a NF LoC. The internal team has implemented several recommendations to ensure that annual NF LoC redeterminations will start by the December 14, 2022, the deadline in the SA for all TPMs. The State is planning to hold stakeholder meetings in November of 2022 for training and to gather input from the broader group.

Internal workgroup recommendations include:

- Developing a brochure that explains the NF LoC redetermination process and the requirement that TPMs must continually meet functional and physical eligibility if Medicaid is the primary payer. The brochure is used by the LTSS Options Counselors (informed choice) staff to educate TPMs, family, guardians, and facility staff.

- Developed a process to create a report for SNF staff that sends a weekly report for facilities to use to identify the residents that are due for their annual redeterminations.

- State worked with the NF LoC contractor to update the training tool used by hospitals, SNFs and HCBS to determine functional eligibility for NF LoC to include information about how to best describe the needs and screen an individual with a traumatic brain injury.

There is no Strategy 3 in this section it was omitted in error.

Strategy 4. Conduct an annual NF LoC screening for all Medicaid recipients living in a SNF. The State will update the contract with the NF LoC determination vendor to allow for annual determinations and require them to assist with educating SNF staff. **(Target completion date December 1, 2022)**

Challenges to Implementation

If a TPM residing in a SNF fails to screen at a NF LoC during the annual redetermination, Federal Medicaid rules require them to be discharged within 30 days. This could negatively impact TPMs who need sufficient time to transition back to the community.

Remediation

The State will convene the NF LoC workgroup described above to identify a plan

to ensure that TPMs who no longer screen at a NF LoC will be allowed sufficient time to safely transition to the community and find necessary supports.

SME Diversion Plan (Section X, Subsection C, page 16)

Implementation Strategy

The SME has drafted a Diversion Plan with input and agreement from the State. The plan outlines a range of recommendations that are intended to inform and support the State's actions related to improving diversions, both during the timeframe of this version of the IP, as well as throughout the duration of the SA.

The State is currently implementing or has incorporated the following recommendations included in the Diversion Plan into the IP. The State will consider implementing other recommendations included in the Plan in future IP revisions.

Progress Report:

- Developing a formal peer support program through the proposed Peer Support Resource Hub that will allow individuals an opportunity to meet other individuals living, working, and receiving services in an integrated setting before deciding where to receive services.
    - State is working with a Project Manager to draft a scope of work and request for proposal to procure a peer support agency through a competitive procurement process. (**Target Completion date December 1, 2022)**
- Creating a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign will include marketing on social media and providing education to the public, professionals, stakeholders and TPMs at serious risk of entering nursing facilities. Campaign will also provide education to those parties that recommend SNF care to TPMs.
    - Efforts are ongoing. Communication plan has been completed and another social media campaign was conducted in March 2022. See response in Section VII. A. 5.
- Assuring that the State contractor for Medicaid NF LoC determinations promptly notifies the Aging Services Division when it receives a NF LoC referral for review and assessment and enters the data into the State system. State contractor currently notifies Aging Services within one business day of the name and contact information of every TPM that was successfully screened the previous business day. This information is tracked in a database and provided to the HCBS Case Managers daily. State staff ensure that the individuals being referred are actual TPMs and all SNFs in ND are enrolled Medicaid providers.

        - The State and the vendor continue to improve and refine the NF LoC information that is sent to the State. The vendor updated their software which will make it easier for State staff to receive more detailed admission information to ensure timely LTSS Options Counseling (informed choice) referrals. A weekly NF LoC annual redetermination report has been created and will be sent to the SNF and the LTSS Options Counseling (informed choice) staff. State staff plan to hold trainings with Hospital SNF staff to educate discharge planners about the new process in November of 2022.

- Promptly assigning an HCBS Case Manager to all TPMs who contact the ADRL by assigning the referral within three business days of the completion of the intake assessment, to an HCBS Case Manager who begins the person-centered planning process.

    - The average number of days from assignment of an HCBS Case Manager to first contact is two business days.

- Working with the national person-centered planning contractors to create a companion guide to the “Charting the LifeCourse” person-centered planning vision tool to reflect the interests and situations of older adults and persons with physical disability and improve the person-centered planning process.

    - Since the development of the approved SFN 1265 PCP and SFN 1267 Risk Assessment Health and Safety Plan there is no longer a need for the companion guide. This strategy will be removed in the June 2022 IP revision.

SA Section XI. Transition Services

Responsible Division(s)

DHS Aging Services Division

MFP and Transitions (Section XI, Subsection A, page 16)

Implementation Strategy

The State will use MFP Rebalancing Demonstration Grant resources and transition support services under the HCBS Medicaid waiver to assist TPMs who reside in a SNF or hospital to transition to the most integrated setting appropriate, as set forth in the TPM’s PCP.

Medicaid transition services include one-time nonrecurring set-up expenses and transition coordination. Transition coordination assists a TPM to procure one-time moving costs or arrange for all non-Medicaid services necessary to move back to the community, or both. The non-Medicaid services may include assisting with finding

housing, coordinating deposits, utility set-up, helping to set up households, coordinating transportation options for the move, and assisting with community orientation to locate and learn how to access community resources. TPMs also have access to nurse assessments and back-up nursing services.

TPMs transitioning from an institutional setting will be assigned a transition team. The transition team includes an MFP transition coordinator, HCBS Case Manager, and a housing facilitator if the PCP indicates housing is a barrier to community living. The transition team will jointly respond to each referral with the MFP transition coordinator being responsible to take the lead role in coordinating the transition planning process. The HCBS Case Manager has responsibility to coordinate the Medicaid services necessary to implement the PCP and facilitate a safe and timely transition to community living.

To ensure these services are available and administered consistently statewide the State will:

Use MFP funds to hire three additional MFP transition coordinators in Bismarck, Grand Forks, and Minot. Two additional FTEs were hired in the Fargo office with Centers for Independent Living (CIL) funds. Staff hired and by trained February 28, 2022.

Progress Report:

- Dakota CIL (Bismarck) has four fulltime MFP Transition Coordinators and one part time assistant coordinator.
- Independence (Minot) has three fulltime and one halftime MFP Transition Coordinators.
- Freedom CIL (Fargo) has two fulltime MFP Transition Coordinators and has funds to hire one more.
- Options CIL (East Grand Forks) has two fulltime Transition Coordinators and funds to hire two more.

Recruit and retain additional community transition providers willing to enroll with ND Medicaid to provide services under the HCBS waiver by reviewing the adequacy of current reimbursement rates, providing incentive grants to encourage providers to enroll and providing technical assistance to the CILs who are interested in expanding their capacity to provide these services. **(Completed February 1, 2022)**

Progress Report:

The State issued a request for proposals to provide QSP incentive grants. Applicants could receive bonus points for agreeing to provide services in high demand like transition supports. Thirty-one applications were reviewed. Fourteen grants were awarded in January 2022. Rates for this service will be reviewed during the upcoming 2023-2024 biannual budget building process.

- Two of the grantees agreed to develop “Community Transition Services”. No new Centers for Independent Living (CIL) have become a Community Transition Service Provider.
- New QSP Incentive Grants will be offered in an amount of up to $50,000 with ARPA 10% Saving Funds during the summer of 2022.
- Link to QSP Grant Award Summary

Conduct a policy review to further define the functions, responsibility, and reporting requirements for MFP and HCBS waiver community transition support services. The policies will be available online. This process will include a review of other high performing state MFP programs to learn about and potentially adopt successful transition strategies to best serve TPMs. **(Target completion upon issuing of CMS guidance)**

- The MFP operational protocol has been updated specific to the DOJ SA but not submitted for review. The MFP operational protocol format is being updated by CMS at this time and they are requesting that no operational protocol amendments be submitted until the new requirements are finalized and communicated to MFP Grantees.

Performance Measure(s)

Number of MFP transition coordinators hired to date.

- A total of 12 full-time and part-time transition coordinators have been hired.

Number and total dollar amount of incentive grants awarded.

Fourteen of the 31 incentive grant applications received were funded. Award amounts varied between $19,294 and $30,000 for a total of $393,607. Grantees **were notified on January 14, 2022**. Additional information will be available about the grants in the next biannual report. Link to QSP Grant Award Summary.

The State is meeting with staff from other state MFP programs to discuss best practices and explore ways to improve our current MFP program. Meetings have been held with New Jersey, West Virginia, and Washington. Upcoming meetings will be held with staff from Connecticut, Ohio, Texas, and South Dakota.

Progress Report:

The takeaway from these meetings is that most of the states had a lot more administrative staff to assist in with the implementation of the MFP grant. This was true even for states that did not have transition numbers as high as ND. The State also found that our policies and procedures were consistent or more comprehensive than what other states are doing.

An idea that was shared that the State would like to pursue is to utilize a neutral third party like a university to collect and report MFP data. This type of expertise

would be very beneficial in telling the story and making the business case of MFP and HCBS that provides the opportunity for people with disabilities to live in the most integrated setting.

MFP Policy and Timeliness (Section XI, Subsection B, page 16)

Implementation Strategy

Strategy 1. The State will include the requirement to report transitions that have been pending for more than 100 days in the MFP policy and procedure manual. The Agreement Coordinator will be responsible for securely forwarding, to the SME and DOJ, a list of the names of TPMs whose transition has been pending more than 100 days. The report will include a description of the circumstances surrounding the length of the transition. The State currently tracks the days from referral to transition. **(Completed June 14, 2022, and on-going)**

Progress Report:

Performance Measure(s)

Number of transitions taking longer than 100 days reported to SME.

- As of June 14, 2022, there are 51 transitions that have taken longer than 100 days.

Number and percent of transitions occurring within the 120-day timeframe.

- Forty individuals moved within 120 days or 65% of transitions during this reproving period.
- Twenty-two individuals transitioned over 121 days or 35% of transitions during this reporting period.

Strategy 2. The State will include the requirement to report transitions that have been pending for more than 90 days to the MFP program administrator in the MFP policy and procedure manual. The MFP program administrator will facilitate a team meeting to staff the situation and provide more intensive attention to the situation to remediate identified barriers preventing timely transition. **(Report submitted by July 31, 2022, and on-going)**

Progress Report:

During the month of May 2022, Aging Services Program Administrators and MFP Staff began meeting monthly to review all pending transitions near, at, or past 90+ days. Information about the transitions and reason for the delay are tracked in a spreadsheet during these meetings, all of which are attended by the MFP Coordinator. This report will be sent to the SME quarterly and discussed at the weekly update meetings.

Strategy 3. The State will conduct a quarterly review of all transitions to identify effective strategies that led to successful and timely transitions, trends that slowed transitions, and gaps in services necessary to successfully support TPMs in the community. This information will be used to develop training and future strategies to improve the transition process. Review team will include State staff, HCBS Case Managers, MFP transition coordinators and housing facilitators.

Progress Report:

Performance Measure(s)

Number of transitions supports team members trained on successful strategies. **(Target completion date August 1, 2022)**

- The formal quarterly reviews to review successful transitions will begin in August 2022. Monthly reviews of all transitions are conducted by regional territory staff and the CIL Transition Coordinators.

- New Transition Coordinators have been provided training two times per month every month from January 2022 to June 2022. Group training on MFP transition services was also provided.

Transition Team (Section XI, Subsection C & D, page 16-17)

Implementation Strategy

To ensure TPMs have the supports necessary to safely return to an integrated setting, the HCBS Case Manager, MFP transition coordinator and housing facilitator (if applicable) will work as a team to develop a PCP that addresses the needs of the TPM.

Once a TPM is identified through the LTSS Options Counseling (informed choice) referral process or other in-reach strategy, the MFP transition coordinator will meet with the TPM to explain MFP and the transition planning process. Within five (5) business days of the original referral an HCBS Case Manager is assigned, and the team must meet within 14 business days to begin to develop a PCP. The MFP coordinator is responsible for continuing to provide transition supports and identify the discharge date. Once the TPM is successfully discharged, the MFP transition coordinator continues to follow the TPM for one year post discharge. The HCBS Case Manager also provides ongoing case management assistance.

Progress Report:

Performance Measure(s)

Track number of transition referrals and timelines for case management assignment.

- 132 transition referrals were completed, and transition coordinators

were assigned within five business days.

Number of successful transitions.

- There were 62 transitions successfully completed with TPMs during this reporting period.

Number of PCPs completed with TPMs in SNF.

- There were 62 transition plans completed during this reporting period.

Number of in-reach activities conducted.

- The second round of group in-reach presentations began in June 2022 and will be included in the December 2022 report.
- 588 individual contacts were made by the LTSS Options Counselors (informed choice) to 545 TPMs/legal decision makers who were screened for a LTC stay in the SNF.

Transition goals (Section XI, Subsection E, page 17)

Implementation Strategy

Strategy 1. Effective January 1, 2021, the MFP grant was authorized for three additional years. The State will continue to use the funds and resources from this grant to provide transition supports. **(Completed January 1, 2021)**

Strategy 2. Through increased awareness, including in-reach and outreach efforts, person-centered planning and ongoing monitoring and assistance, the State will use local, State, and Federally-funded HCBS and supports to assist at least 100 SNF TPMs to transition to the most integrated setting appropriate. The State will divert at least 100 TPMs from SNF to community-based services. **(Required completion date December 14, 2022)**

To meet these requirements, the State needs to develop additional capacity to inform TPMs about HCBS, person-centered planning, and transition supports. The State intends to build capacity by hiring additional staff to conduct LTSS Options Counseling (informed choice) referral visits and conduct facility in-reach to TPMs living in a SNF. **(Ten staff hired by May 2022)**

Progress Report:

The State has hired 10 LTSS Options Counselors (informed choice) to conduct referral visits. They are responsible to visit TPMs in nursing homes and hospitals and will eventually see every TPM who is referred for a long term stay in the nursing home as required in the agreement.

Funds were approved in the 2022 MFP budget to hire additional MFP transition coordinators and transition assistants. One assistant has been hired and coordinates the logistics of the actual move and helps conduct post discharge follow up. **(Updated target completion date February 1, 2022)**

Progress Report:

The MFP budget requesting additional funding to hire staff was submitted on February 1, 2022. All the positions were approved in the budget

- The 2022 MFP budget includes the following funds for the following positions:
    - Dakota CIL (Bismarck): 4 Transition Coordinators, 1 Assistant Transition Coordinator.
    - Freedom CIL (Fargo): 3 Transition Coordinators.
    - Options CIL (East Grand Forks): 3 Transition Coordinators and 1 Assistant Transition Coordinator.
    - Independence (Minot): 3 full-time and 1 part-time Transition Coordinators.

MFP also pays for transition coordination on a fee for service basis for other CIL staff to assist with MFP transition work when necessary. If additional capacity is needed the CIL engage their other independent living specialists to provide MFP or ADRL transition coordination.

Performance Measure(s)

100 unduplicated SNF TPMs successfully transitioned.

- Sixty-two individuals successfully transitioned out of SNFs during this reporting period.

100 unduplicated at risk TPMs successfully diverted.

- 140 individuals were diverted from nursing facility placement during this reporting period. Diversion happens when an individual who screens at a NF LoC and is on Medicaid or at risk of Medicaid receives the necessary HCBS to prevent their institutional placement.

Strategy 3. The State tracks TPMs using a unique identifier and will report unduplicated transition and diversion data. **(Completed December 14, 2021)**

Progress Report:

Remediation

The State will work with the new case management system vendor to integrate the MFP process into the case management system. The system can create

unique TPM records that show the progression of service delivery from initial referral through service provision and case completion. **(Updated target completion date August 1, 2022)**

- All aspects of the case management system including the PCP will be available in Therap by August 1, 2022.

SA Section XII. Housing Services

Responsible Division(s)

DHS

Progress Report:

Many of the strategies outlined in Section XII focus on how the State would identify new ways of working together, to assure connections were made between housing and home and community-based service resources. The strategies identified opportunities to gather data that could provide meaningful insight into housing barriers (XII-C-7, XII-D-1); build awareness amongst professionals who work in either housing or HCBS about the "other side of the HCBS" equation (XII-B-1, XII-C-2, XII-D-4, XII-D-7, XII-E-1, XII-F-3); and build real capacity in our state service and support infrastructure to make transitions and diversions much more possible than they were before (XII-B-2, XII-C-1, XII-C-4, XII-D-2, XII-F-2).

Section XII of the Year 1 IP outlines the beginning stages of several related and ongoing efforts that together will strengthen housing resources available to TPMs in North Dakota. To ensure that housing is not a barrier to transition or diversion, we will continue building our collaboration muscle -- enhancing communication, building on partnerships that have been established, and improving training and resources available to people who are working to support TPMs diversions and transitions.

SME Housing Access Plan (Section XII, Subsection A, page 18)

Implementation Strategy

The SME has drafted a Housing Access Plan with input and agreement from State. The SME Housing Access Plan outlines a range of recommendations that are intended to inform and support the State's actions related to improving housing access, both during the timeframe of this version of the IP, as well as throughout the duration of the SA.

The State is currently implementing or has incorporated the following recommendations included in the Housing Access Plan into the IP. The State will consider implementing other recommendations included in the plan in future IP updates.

- Progress toward establishing an enhanced housing inventory resource.

- Additional policy conversation and partnership with public housing authorities and affordable housing providers across ND related to policies, preferences, and practices that would support TPMs.

- Efforts to establish State-funded rental assistance as well as partnerships that help assure maximum utilization of existing federal rental assistance programs.

Implementation Strategy

Development of housing needs and preferences tools that will be incorporated into informed choice and case management processes.

Strategy 1. Convene State Housing Services workgroup to review current State context and provide housing strategies to be incorporated into the IP. **(Workgroup established April 1, 2021, and ongoing)**

Progress Report:

Workgroup members come together to discuss cross-agency initiatives that arise throughout the year; work is task-focused and involves individuals from both the public and private sector as necessary. Two state agencies with primary responsibility for housing policy in ND -- DHS (MFP, Economic Assistance) and ND Housing Finance Agency (NDHFA) – are the leaders of the work group.

This group of individuals is responsible for moving housing-related policy forward for a broad range of housing needs, including as it relates to optimization of resources to support diversion and transitions of TPMs more effectively.

As an example, workgroup members noticed that people who were receiving transition services were not accessing the State's Opening Doors landlord risk mitigation fund, even when their situation was a good fit for Opening Doors. The ND Housing Finance Agency worked with the DHS MFP team to modify the process and essentially open the door to this tool. After the change, DHS' MFP housing facilitators are tasked with completing the initial enrollment in Opening Doors; the NDHFA required follow-up is handled by transition coordinators, who were already documenting contact with individuals as required by the NDHFA program as part of their transition support work. The new process is being tested with partners in both Bismarck and Minot.

Connect TPMs to PSH (Section XII, Subsection B, page 19)

Implementation Strategy

Strategy 1. Connect TPMs to housing facilitators whose PCP identifies a need for PSH or housing that SME agrees otherwise meets requirements of 28 C.F.R. § 35.130(d) (Milestone dates December 14, 2021 / December 14, 2022 / December 14, 2023 / December 14, 2024)

Progress Report:

Housing facilitators work with the TPM's team to identify suitable housing options when housing has been deemed a barrier by the TPM. The housing facilitators consider a person's decision about where they want to live, and then work on addressing needs related to accessibility of living unit, affordability, and issues of access related to a TPM's criminal background and the background check policies in place by local housing providers.

Performance Measure(s)
Utilization of housing inventory/locator resource by housing support professionals

- New housing inventory locator is not yet in place. Housing facilitators and others working with TPM teams can utilize the existing housing inventory / locator resource maintained by MFP as needed. (**Target completion date May 2024).**

- The state currently uses an MFP housing database which is available to every housing facilitator. The State does not track the number of times the database is used. The link is also assessable through the ADRL, so the public has access.

Number of TPMs who indicated housing as a barrier who were provided PSH. Targets include Year 1 – 20, Year 2 – +30, Year 3 – +60, Year 4+ - number based on need for PSH identified in PCPs.

- Of the sixty-two individuals who transitioned from a nursing home to the community during this reporting period, fifty-eight received rental assistance. Twenty-five received housing facilitation assistance with home modification and thirteen individuals received some type of housing assistance from a housing facilitator.

Housing outcomes including but not limited to the number of days in stable housing post-transition.

- Housing outcomes for each TPM are not yet in place in a way that can be tracked in a systematic way; work group will identify any additional variables that need to be collected to allow for consistent reporting on additional housing outcomes and will update the questionnaire that captures this information in the case management system.

Housing costs as percent of household income

- See information under the previous performance measure.

Strategy 2. Develop housing inventory, integrated with the ADRL system that identifies availability of housing options that may be suitable to meet the needs of TPMs who have an identified housing barrier. The inventory should include, to the greatest extent

possible, information related to accessibility, affordability, availability, and tenant selection criteria as well as information related to a property's status as Permanent Supported Housing (PSH) as per the SA.

Progress Report:

The housing services workgroup discussed housing inventories currently being used in ND and identified an opportunity to strengthen by adding information that describes accessibility features in more detail than is now available.

Strategy 3. Convene State Housing Services workgroup to review and offer feedback on the Low Income Housing Tax Credit Qualified Application Plan annually, particularly as related to the incorporation of plan elements that would increase TPMs' access to affordable, appropriate housing options. **(Completed March 2, 2022)**

Progress Report:

Work group members offered feedback to the annual LIHTC QAP which helped inform NDHFA requirements related to tenant support services.

Connect HCBS and Housing Resources (Section XII, Subsection C, page 19)

Implementation Strategy

Strategy 1. Increase the network of housing facilitators and transition coordinators actively working in the State. **(Complete June 2022)**

Progress Report:

The availability of workforce dedicated to providing housing and transition support grew significantly in Year 1 of the IP. MFP added both housing facilitator and transition coordinator capacity, as did ND Rent Help. Both efforts grew capacity by contracting with community-based organizations.

	MFP		ND Rent Help (NDRH)	
	Start of Year 1	Through 06.14.22	Start of Year 1	Through 6.14.22
Housing Facilitator	3 (via MFP contract with Minot State)	6 (via MFP contract with Minot State)	0	44 (via contracts with 8 agencies, located in all ND regions) *Note: NDRH housing facilitators' work extends beyond work with TPMs.
Transition Coordinator	6.5 via MFP (contract with 4 CILS)	12.5 via MFP (contract with 4 CILS)	0	0 *Note: While not true "transition coordinators", ND Rent Help added follow-up support to all existing housing facilitator contracts for

				individuals who needed additional assistance maintaining housing stability.

Strategy 2. Create network and contact information for housing support professionals to know how they can work together and provide clear guidance on how to effectively divert TPMs from institutional settings. Connect HCBS case management and informed choice referral process to new housing support resources that are available in the State to enable actions outlined in each TPM's PCP. **(Ongoing Strategy)**

Progress Report:

The network of housing support professionals has established strong practices related to diversion, primarily through the leadership of the MFP team (see more detailed description in Strategy 3 below). Because of the enhanced processes that are now in place, there has been an increase in the frequency of conversations that recognize housing and services as connected concepts. HCBS case managers talk about housing in the regular course of their work; housing facilitators talk about home and community-based services in the regular course of their work; landlords talk about the need for services and service providers talk about the need for housing.

While this type of "organic" conversation can be hard to track, the impact is unmistakable. The work that occurred throughout year 1 of the IP has established the connection between housing and services in people's minds. It has helped TPMs, and the people involved in supporting them, to be more curious about and interested in what's possible. Our ongoing work is to continue to add clarity to these conversations, but the real success of Year 1 is that the essential and foundational connections have been established for many.

Strategy 3. Define a process to guide appropriate identification of professionals who will work together to help overcome barriers that are identified in TPM's PCPs. Professionals from housing facilitation, HCBS case management, transition coordination, rental assistance, and environmental modification will be represented on the Housing Services workgroup to build stronger interconnectivity between disciplines.

Progress Report:

These points of connection between professionals involved in TPM diversion and transition-oriented teams, and professional expectations and methods of operating have been established by the collection of work groups involved in the DOJ IP initiatives.

Strategy 4. Staff diversion or transition teams to meet benchmarks required by dates noted in the SA as appropriate, for each TPM who has an identified housing need. **(Strategy completed April 1, 2022, and ongoing)**

Progress Report:

Performance Measure(s)

Establish timeliness metric for connecting diversion or transition team to TPM

- Timeliness Metric: All transitions include participation with a housing facilitator. Once a transition referral is received the case is assigned to a housing facilitator within two business days. The MFP Transition Coordinator will contact housing facilitator and the HCBS Case Manager within five business days of referral to schedule the first Transition Team meeting. The Transition meeting will be held within fourteen business days of the referral. The housing facilitator will then meet with the TPM based on the needs identified during the first meeting.

- State will continue to refine how it tracks and reports on various degrees and types of housing facilitator engagement needed by a particular TPM.

Number and percent of team connections made by timeliness metric.

- 132 referrals had a correctly completed Housing Service Referral Assessment. Some of the data was not entered correctly, complete data including the number of referrals that were timely is not yet available. Training was provided to the housing facilitation staff on how to correctly enter data on June 24, 2022. **(Ongoing Strategy)**

Strategy 5. Assure that there are meaningful connections between housing and case management tracking systems utilized to support the PCP for each TPM. **(Ongoing Strategy)**

Progress Report:

The state was able to add several housing-related fields to the case management system used to support TPM diversion and transition. Housing facilitator staff have full access to the case management system. They use the system to complete their work. Data collection in the system began during IP year 1.

Strategy 6. Incorporate information on system updates in trainings for HCBS workers, including how data collected related to housing will be used in reporting. **(Training complete June 14, 2022, and ongoing)**

Progress Report:

Information on housing data elements was included in staff training on forms that support informed choice and person centered planning.

Strategy 7. Define housing barriers that may face ND renters and ensure those variables are reflected and addressed in informed choice and case management process. **(Completed April 1, 2022)**

Progress Report:

The Housing Services work group identified the most common housing barriers faced by ND renters for inclusion in the informed choice referral process. Informed choice forms were updated in September 2021 (starting point for paper-based collection of information related to housing barriers)

Performance Measure(s)

Number of informed choice referrals that collect information related to housing barriers.

- 545 Informed Choice referrals were conducted using the updated form that assesses housing needs. Staff started using the case management system to support the LTSS options counseling (informed choice) work. Referral data is being collected and additional information will be available during the next DOJ SA reporting period.

Number of PCPs that show evidence that individual-level barriers are referred to and addressed by the Diversion and Transition teams who are working with the TPM.

- Since August 15, 2021, all MFP/ADRL transition TPM has had housing barriers identified and a plan developed to address the identified barriers. The system is paper based, so data was not reportable during the reporting period.

Training and Coordination for Housing Support Resources (Section XII, Subsection D - Housing Services- Page 20)

Implementation Strategy

Strategy 1. Develop a matrix that identifies the full range of home and environmental modification resources available in ND. **(Updated Target completion date December 14, 2022)**

Progress Report:

Gathered information from Medicaid-oriented programs to better understand North Dakota's current model in context of other states. Reviewed non-Medicaid environmental modification program options in parallel with Medicaid funded options. Work informed several of the changes that were made to ND Administrative Code and updates to the HCBS Medicaid waiver that enable greater access to environmental modifications. Changes described in Strategy 2.

Strategies 2. Identify needed program adjustments to broaden access to home and environmental modification resources**. (Completed April 1, 2022)**

In response to public comment the HCBS Medicaid waiver was updated to add Assistive Technology Professionals to the list of professionals that can supply a written recommendation for Environmental Modification and Specialized Equipment services. Installation costs were also added to the coverage of Specialized Equipment as this service is also used to support TPMs to live in an integrated setting.

The qualifications for a QSP for environment modification and specialized equipment were modified to allow a handyman/contractor/tradesman in good standing who is willing to provide a professional reference relevant to their ability to complete the necessary work to meet the qualifications to enroll as a QSP.

The North Dakota Century Code (NDCC 43-07-02) allows for a handyman to complete jobs not exceeding $4,000 without a contractor's license. If the handyman does not have a contractor's license, they must provide a letter of reference showing they meet the qualifications to do minor installs and modifications to the home. The handyman would be allowed to provide installs and modifications to the home not exceeding $4,000 in time and materials. A licensed contractor would qualify as a QSP with their contractor's license and would not be limited to the $4,000 threshold.

Specialized equipment was also updated to include covering the cost of generic technical devices (tablets, computers, etc.) when they are needed for the functionality of other assistive technology such as smart home devices. **(Completed April 1, 2022)**

Strategy 3. Work with Interagency Environmental Modifications workgroup to identify and implement amendments to existing 1915c waivers. **(Completed April 1, 2022)**

Progress Report:

Combined Year 1 Strategies 2 and 3 as both are related to implementation of changes that will be needed to make environmental modifications more readily available in North Dakota.

Workgroup members submitted public comments during administrative rule making process and HCBS waiver update based on early findings from evaluation of environmental modifications programs in North Dakota. The public comments changes resulted in the updates described in Strategy 2 above.

Updated Strategy 4. Develop training for housing support providers to know how to access various home modification resources effectively and appropriately, including assembly of funding from multiple sources and expected timelines for authorization of housing modifications. Develop ongoing training opportunities for housing professionals/teams regarding integration of reasonable modification ideas into the

PCP. **(Updated target completion date December 14, 2022)**

Updated Strategy 5. Identify training resources that help professionals/teams better understand flexibilities that may be possible with reasonable modification of housing services that help TPMs and their families and/or caregivers better understand options available to them.

Progress Report:

Content of Year 1 Strategy 4 was combined with Year 1 Strategy 5.

State staff will conduct training with housing facilitators, HCBS case managers and LTSS Options Counseling staff to help them understand how reasonable modification works, what type of modifications can be requested and how requests are made. **(Updated target completion date December 14, 2022)**

Strategy 6. As per SA Section XII(D)(3)(a)-(c), examine policies of housing providers and Medicaid policy (specifically SNF) to create guidance regarding "intent to return home", resulting in a usable resource for eligibility workers and housing support team professionals.

“Intent to Return Home” is a process that helps to identify in the individual service plan that a person’s “intent” is to return home after SNF placements. The SNF is responsible to complete a SFN 132 Physicians statement for Medicaid temporary stay review for individuals entering a long term care facility form and submit it to the State’s Medicaid eligibility unit. This informs the eligibility staff of the TPMs intent and allows the TPM to keep their income to pay for their housing expenses and Medicaid still covers the SNF stay. The LTSS options counseling staff will be trained about the “intent to return home” process. When a TPM communicates their desire to transition back to the community the worker will be prompted to check with the SNF and ensure that the form has been completed. **(Updated target completion date December 14, 2022)**

Progress Report:

Began building awareness of the issue with professionals involved in Medicaid eligibility, case management and housing supports. The State is ready to start having this discussion and put practices in place that define when and how to contact a TPMs housing provider to help maintain housing during a temporary displacement. State will also seek time on the statewide housing authority conference agenda to discuss the topic and begin exploring policy modifications with individual housing authorities. **(Target completion date December 14, 2022)**

Performance Measure(s)

Number of TPMs who successfully maintain their housing in the community during a SNF stay.

State is exploring options to integrate benefits management / financial planning

into the work of existing diversion and transition teams, recognizing that it may be helpful to supplement with a targeted resource. Vocational Rehab, Economic Assistance Low Income Home Energy Assistance Program and MFP all have viable models that can inform our thinking.

Strategy 7. Develop recommended practice guidelines that housing providers can choose to adopt if they want to better align with "intent to return home" goals established in the TPM's service plan or informed choice document. Include clear communication expectations as part of the TPM diversion and transition teams. **(Updated target completion date December 14, 2022)**

Progress Report:

Please reference progress reported in Strategy 6.

Strategy 8. Offer guidance to professionals involved in service teams regarding subsidy rules related to filing change of income forms with housing subsidy providers. Include guidance on how to access resources that can bridge TPM housing costs during out-of-home stays. **(Updated target completion date December 14, 2022)**

Progress Report:

Please reference progress reported in Strategy 6.

Strategy 9. Develop a benefits management resource as a parallel to the process MFP uses to help ensure people maintain housing even during time in SNF. This includes training on specific practices that help ensure access to housing even during temporary out-of-home stays (ex. SNF, hospital, rehabilitation center). **(Updated target completion date December 14, 2022)**

Progress Report:

Performance Measure(s)

Number of TPMs who successfully maintain their housing in the community during a SNF stay.

Please reference progress reported in Strategy 6.

Fair Housing (Section XII, Subsection E, page 20)

Implementation Strategy

Strategy 1. Broaden access to fair housing training to all housing facilitators and make available to all professionals involved in transitions and diversions. **(Updated target completion date December 14, 2022)**

Progress Report:

Performance Measure(s)

Number and percentage of staff trained (include all disciplines represented by Housing Services workgroup).

- The Department of Labor provided additional training to the MFP Housing Facilitation Staff on fair housing on May 17, 2022.

Rental Assistance (Section XII, Subsection F, page 20)

Implementation Strategy

Strategy 1. Outline State strategy for access to rental assistance, including all resources available (ex. HUD Housing Choice voucher, Mainstream voucher; Veterans Administration Supportive Housing voucher; Rural Development rental subsidy; State rental assistance (new); emergency rent assistance (State or federal)). Include processes for accessing rental assistance (eligibility, referral, documentation, and determination). Develop State rental assistance brief that outlines State resources and strategy. **(Updated target completion date December 14, 2022)**

Progress Report:

Performance Measure(s)

Number of TPMs who transitioned and are receiving various forms of rental assistance.

- Fifty-eight out of the sixty-two TPMs who transitioned received rental assistance during this reporting period.

Housing Services workgroup has been engaged in conversation about how rental assistance resources intersect.

Strategy 2. Expand Permanent Supported Housing (PSH) capacity by funding and providing rental subsidies for use as permanent supported housing. **(Services are available ongoing strategy)**

Progress Report:

Delivered rental assistance to TPMs both with MFP funds and assistance from ND Rent Help. Built a streamlined connection for housing facilitators working with TPMs to be able to quickly access rental assistance for TPMs via the ND Rent Help portal (available for up to 12 months, including assistance with utilities). The temporary assistance provided by ND Rent Help allows time to establish a more permanent source of assistance for a TPM should it be necessary for their situation (ex. connection to housing authority-administered resources).

Performance Measures(s)

Number of TPMs who receive rental assistance.

- Fifty-eight out of the sixty-two TPMs who transitioned received rental assistance during this reporting period.

Number of TPMs who do not experience housing cost burden (i.e., pay more than 30% of their monthly income for housing) by receipt of rental assistance.

- The State is putting processes in place to collect this information.

Strategy 3. Enhance the existing ND Housing 101 training course that has been designed to introduce helping professionals to housing concepts, terminology, and market information. Identify additional modules to include in the training curriculum to allow for deeper knowledge on specific topics, and determine which modules need to be localized to be effective. Include modules for transition and diversion teams regarding applying for rental assistance, and for housing facilitators regarding "Opening Door" as a resource to mitigate housing barriers. **(Updated target completion date June 14, 2023)**

Progress Report:

Updated content of Housing 101 course online module. Simplified information regarding Opening Door program.

SA Section XIII. Community Provider Capacity and Training

Responsible Division(s)

DHS Aging Services and Medical Services Divisions

Resources for QSPs (Section XIII, Subsection A, page 21)

Implementation Strategy

Strategy 1. Use MFP capacity building funds to establish QSP Resource Hub to assist and support Individual and Agency QSPs and family caregivers providing natural supports to the citizens of North Dakota.

Progress Report:

Performance Measure(s)

Number of QSPs assisted by the QSP Resource Hub.

The QSP Resource Hub started taking calls on March 24, 2022.

March 24, 2022 – June 14, 2022

Number of individuals assisted (unduplicated) = 64
Number of individuals assisted (multiple contacts) = 20
Number of agencies = 5

Number of QSP agencies receiving Council on Quality and Leadership (CQL) accreditation reimbursed by the State.

- The State has currently paid for the initial CQL accreditation for seven currently enrolled providers. There are four more agencies working on their next level of CQL accreditation.

Number of new agencies enrolled as providers.

- Four new agency QSPs were enrolled this reporting period. Two providers enrolled to provide care in rural counties.

Number of new independent QSPs enrolled as providers.

- 116 individual QSPs enrolled during this reporting period. Fifty-two individual QSPs signed up to serve in communities with a population of less than 15,000 people. Sixteen individual QSPs signed up to working in communities on a reservation.

- One-hundred forty-one individual QSPs and two agency QSPs were closed during this reporting period.

Number of agencies that expand array of services.

- If a QSP wants to expand their service array they send a letter or email to the enrollment staff who update the change in the QSP access database. Because this is a manual process the data cannot be easily calculated using the current data collection system. The State is working to change the way QSPs enroll and is creating a QSP web portal where providers can securely apply to become a provider, add services, or expand their service territory. Once this system is complete, reports can be run that will provide this information. (**Target completion date for the web portal December 31, 2022)**

Number of such agencies serving tribal and other under-served and rural communities.

- There are three Tribal QSP Agencies
    - Spirit Lake Okiciyapi – 24 clients
    - Standing Rock Sioux Tribe (N/A)

- TM Tribal Aging Agency – 12 clients
- North Segment Home Services – No current clients

- The contract with the Center for Rural Health, located at the University of North Dakota School of Medicine & Health Sciences to develop and implement the QSP Resource Hub was effective December 1, 2021. The State had an initial project kick off meeting with the staff involved to establish priorities and define roles of key staff. Staff will continue to meet bi-weekly, and training sessions are being scheduled on all aspects of the HCBS system. i.e., eligibility, services, provider enrollment, billing etc. QSP Resource Hub staff started providing technical assistance to QSPs on March 24, 2022.

Strategy 2. Implement an inflationary rate increase for all HCBS services that was approved in the 21-23 DHS budget. Providers will receive a 2% increase in year one of the biennium and a 0.25% increase in year two.

Progress Report:

Performance Measure(s)

Rate increases published on July 1, 2022.

- Inflationary rate increases for July 1, 2022, were granted and new rates posted on the DHS website.

Strategy 3. Implement an additional rate increase, as approved in the 21-23 DHS budget, for supervision, non-medical transportation, non-medical transportation escort, and family personal care. A waiver amendment was submitted and approved. **(Completed January 1, 2022)**

Progress Report:

Performance Measure(s)

- The following rate increases were approved on January 01, 2022 and became effective February 01, 2022.
  - Non-Medical Transportation from $3.27 to $8.74 per 15-minute unit.
  - Non-Medical Transportation (Escort) from $3.53 to $6.71 (agency) & $4.89 (individual).
  - Family Personal Care from $76.67 to $150 per day.
  - Supervision from $2.49 to $6.71 (agency) & $4.89 (individual).

Number of new providers enrolled to provide these services during this reporting period.

- Twenty-three individual or agency QSP enrolled to provide Non-Medical Transportation.
- Thirty-eight individual or agency QSPs signed up to provide Non-Medical Transportation- Escort.
- Ten individual QSPs signed up to provide Family Personal Care.
- Twenty individual or agency QSPs enrolled to provide supervision.

Strategy 4. Conduct a QSP survey with the goal of completing a provider inventory, by case management territory, to analyze gaps in services and assess current and available capacity that is not being fully utilized. The survey will seek to determine the number of active agency providers (including which services each provider offers) and the number of active individual QSPs including which services each offers, how many TPMs each QSP currently serves, and how many additional TPMs or service hours they could provide. Results from the survey will also be used to identify barriers to service expansion and strategies to overcome such barriers. **(Survey distributed January 1, 2022, results trended and published March 1, 2022)**

Progress Report:

The QSP Resource Hub completed an agency and individual QSP survey. A link to a presentation summarizing the results is found here. The survey results will be used to inform decisions about training, recruitment strategies and provider rates. QSP Resource Hub staff are developing a formal report for the State that should be completed by August 31, 2022. Staff will also explore how to project the number of QSPs that may be needed to meet the growing demand for HCBS.

Strategy 5. Create a centralized QSP matching portal in cooperation with ADvancing States to replace the current QSP searchable database.

The new system will be implemented with State specific modifications to a national website called *ConnectToCareJobs* to significantly improve the capacity of TPMs in need of community services to evaluate and select individual and agency QSPs with the skills that best match their support needs.

The system will have the capacity to create reports, be routinely updated, and available to HCBS Case Managers and others online. It will allow QSPs to include information about the type of services they provide, hours of work availability, schedule availability, and languages spoken. **(Updated target implementation date June 1, 2023)**

Progress Report:

Performance Measure(s)

Number of QSPs and individuals trained to *ConnectToCareJobs* (**Updated target implementation date June 1, 2023)**

Number of users of portal on monthly basis.

- The Connect to Care Jobs portal has not been implemented. Development discussion has been initiated with the provider of this service and the State is working through the procurement process.

Strategy 6. Pay the CQL accreditation fees for up to 10 agencies who are willing to develop residential habilitation and community-support services for the HCBS Waiver serving adults with a physical disability or adults 65 years of age and older. Deferring costs for accreditation will increase capacity to provide the 24-hour a day services needed to support TPMs with more complex needs in the community. **(Target implementation date October 15, 2021)**

Progress Report:

Number of QSP agencies receiving Council on Quality and Leadership (CQL) accreditation reimbursed by the State.

- The State has paid for the initial CQL accreditation for seven currently enrolled
- One QSP is pending enrollment in July 2022
- Three new agencies working toward CQL systems accreditation

Strategy 7. The State will streamline the agency and individual QSP enrollment process and revise the current enrollment packet. **(Updated target implementation date December 1, 2022)**

Progress Report:

Performance Measure(s)

Number of QSPs trained to the revised processes.

- The initiative to streamline the Agency and Individual enrollment process is not yet complete. An internal DHS workgroup has been developed that includes a system support specialist who will assist in the provider enrollment redesign. The redesign will include the development for a provider portal where QSPs can enter their information electronically. Additional Information will be provided in the next progress report.

Strategy 8. The State will create a Communication and Recruitment Plan to engage other agencies as potential community providers for the target population. The plan will include the development of a series of educational webinars that focus specifically on a particular community-based service and the qualifications that are needed for enrollment. Webinars will be marketed through DHS website, social media page, direct mail, email, and through stakeholder list serves. **(Plan created and strategy ongoing)**

Progress Report:

Performance Measure(s)

Number of webinars offered by topic and number of attendees.

- During the last 6-months, 12 webinars have been conducted addressing HCBS:
    - Funding Sources – December 16, 2021, with 40 individuals in attendance.
    - PACE – January 13, 2022, with 34 individuals in attendance.
    - Case Management (CSC and LTSS Options Counseling (informed choice) – January 27, 2022, with 42 individuals in attendance.
    - Homemaker Services, Non-Medical Transportation, and Personal Care Services – February 3, 2022, with 51 individuals in attendance.
    - Home Delivered Meals, Congregate Meals, and Health Maintenance – February 24, 2022, with 28 individuals in attendance.
    - Respite Care – March 10, 2022, with 26 individuals in attendance.
    - Community Transition Services – March 24, 2022, with 47 individuals in attendance.
    - Extended Personal Care and Nurse Education – April 14, 2022, with 22 individuals in attendance.
    - Chore Service, Specialized Equipment and Supplies, and Environmental Modification – April 28, 2022, with 33 individuals in attendance.
    - Dementia Care Services – May 19, 2022, with 27 individuals in attendance.

- Companionship Services, Emergency Response System, and Supervision – May 26, 2022, with 27 individuals in attendance.
- Family Personal Care and Family Home Care – June 2, 2022, with 19 individuals in attendance

- Each webinar is listed on the Link to 2022 Calendar of Events/Activities and recordings of the webinars are made available on the Link to Aging and Adult Services website.

Strategy 9. Support start-up and enrollment activity costs for new or existing QSPs to establish or expand their business to provide HCBS. Grants will be awarded in amounts up to $30,000 based on the priority of need of the services the agency will provide. **(Grants awarded by February 1, 2022)**

Progress Report:

Performance Measure(s)

Number of grants awarded by date.

- Fourteen incentive grants were awarded on January 14, 2022.

Number of applications received for the QSP incentive grants.

- There were 31 applications received for the QSP incentive grants.

Number of new providers offering services, including number serving tribal and frontier areas.

- See information below.

Number of existing providers expanding to provide HCBS.

- There are some QSPs who expanded or enhanced their ability to serve both rural/frontier and tribal areas.
  - Nine QSPs expanded to serve in rural/frontier areas.
  - Six QSPs expanded to serve in tribal areas.
  - Three QSPs expanded to serve in urban areas.

Number of agencies that expand or enhance capacity to provide HCBS.

- Fourteen of the thirty-one incentive grant applications received were funded. Award amounts varied between $19,294 and $30,000 for a total of $393,607. Grantees will be notified by January 31, 2022. Additional information will be available about the grants in the next

biannual report. Link to QSP Grant Award Summary.

Strategy 10. To reduce the responsibility of individual QSPs and improve the recruitment and retention of providers statewide, the State will consider other provider models including the Agency with Choice/Co-employer model. The State will evaluate the benefit of adding formal self-direction to the HCBS waiver and Medicaid State Plan – Personal care. **(Updated target completion date December 01, 2022)**

Strategy 11. To ensure timely enrollment and revalidation of QSPs, the State has amended its contract with the vendor to include provider enrollment services for QSPs. The vendor will follow State requirements and provide sufficient staff to complete all new enrollment applications within 14 calendar days of receipt of a complete application. The vendor will also be required to process provider revalidations prior to the revalidation due date. **(Updated start date June 1, 2022)**

Progress Report:

Noridian took over the processing of individual and agency QSP enrollment April 5, 2022. There have been some challenges identified in the roll out and the State is working closely with the vendor to resolve the issues.

Performance Measure(s)

Number and percent of new QSP applications processed within 14 calendar days.

Number of QSP revalidations completed before revalidation due date.

- Vendor is building the capacity to provide this data. They hired two additional staff and created a QSP enrollment workflow that will track documents as they move through the enrollment process. Information will be added to the next report.

Critical Incident Reporting (Section XIII, Subsection B, page 21)

Implementation Strategy

Strategy 1. The State will create critical incident reporting training opportunities for QSPs. Training will be provided through online modules and virtual training events. The State will update QSP handbook to include current reporting requirements. The State will also work with staff from the QSP Resource Hub to develop ongoing training that will assist QSPs in understanding and complying with safety and incident reporting procedures. **(First critical incident reporting training completed August 1, 2021, ongoing strategy)**

Progress Report:

Performance Measure(s)

Number of QSPs trained on reporting procedures.

- A total of 103 individuals attended three learning sessions during this period. These training sessions are conducted quarterly.
  - Thirty-five individuals attended on December 17, 2021.
  - Fifteen individuals attended on March 25, 2022.
  - Fifty-three HCBS Case Managers and Program Administrators attended on April 18, 2022.

An e-learning module has been created and is posted to the Aging Services website.

SME Capacity Plan (Section XIII, Subsection C, page 21)

Implementation Strategy

The SME has drafted a Capacity Plan with input and agreement from the State. The plan outlines a range of recommendations that are intended to inform and support the State's actions related to improving capacity, both during the timeframe of this version of the IP, as well as throughout the duration of the SA.

The State is currently implementing or has incorporated the following recommendations included in the Capacity Plan into the IP. The State will consider implementing other recommendations included in the plan in future IP updates.

Progress Report:

Reviewing the weighting system for caseload assignment with a focus on the care coordination needs of TPMs, the provision of the appropriate level of case management services to each TPM residing in a SNF, and those who seek or are referred for admission to a SNF.

- Discussions were held with all the territory HCBS Case Managers about specialization and whether they felt it will help case management time and efficiency. The consensus is that it is not feasible to do it in the rural areas due to distance. The two areas with the highest number of Case Managers are considering it within the next year, however it would be helpful to wait until all the changes are implemented. We have decreased case management requirements for the individuals residing in a basic care facility. The weighted case load has been changed to reflect a higher score for individuals who are transitioning or need 24-hour care versus

those individuals with less service needs. The plan is to request additional case management staff in the DHS Aging Services 23-25 budget request to meet the growing demand for HCBS.

State will consider implementing a tiered case management system to more efficiently build the capacity to assign a HCBS Case Manager to all TPMs as required in the SA.

- See above.

Implementing a new case management system that serves as a centralized data reporting system where information is stored, identifying available capacity for each HCBS Case Manager. This system operates in real-time and is available to the ADRL staff to use in the screening and referral process to optimize the matching of TPMs and available HCBS Case Managers.

- The State and vendor have worked to incorporate all aspects of the case management process into the new system. The system will act as a centralized data reporting system. The system operates in real-time and is available to ADRL staff, MFP staff, and the Housing Coordinators. An additional referral interface is being considered to further streamline HCBS referrals from SNFs. The system has been updated to include a complaint component and all agency QSPs are required to have Therap account to report Critical Incident Reports. The full implementation of the case management system will be complete when the person-centered plan and complaint system are implemented. **(Target completion date July 31, 2022)**

As part of the case management implementation and design, the State conducted a review of required case management documentation and designed the new process with the intent to eliminate unnecessary and duplicative documentation, to reduce the amount of time spent on administrative tasks and enhance HCBS Case Manager capacity.

- In the past six months approximately 76% of the Case Manager's time was spent on billable case management tasks and approximately 24% was spent on administrative duties. The State will continue to monitor these numbers with the goal of further simplifying and streamlining the case management process.

HCBS Case Managers, SMEs from the national person-centered planning technical assistance group, and the MFP Tribal Initiative team were consulted and made recommendations to improve the new process. These efforts are ongoing, and the State is committed to continuously improving the case management system.

- All Aging staff continue to participate in the foundational PCP skill building series. The State is working with the vendor to establish a set

of core competencies for PCPs. Sixteen of the Aging Services leadership staff participated in training to become PCP Ambassadors. The State is holding regular meetings with the ND Office of Health Equity Tribal Health and special population liaisons. The goal of the meetings is to develop effective strategies to reach all people, across all communities and better engage and adjust processes to ensure everyone finds services accessible.

Using caseload and referral data to determine where case management shortages exist and developing a plan to request additional resources to address capacity shortages, if necessary, in the next Executive budget request.

- This work is ongoing. Request for additional staff capacity will be included in the Aging Services proposal for inclusion in the 2023-2025 Executive budget request.

The State specialized the role of the HCBS Case Manager when they became State employees in January 2020. The State is currently updating policy and procedures for HCBS Case Managers, MFP Transition Coordinators, housing facilitators, and others to define roles and responsibilities of each. The State will produce a process map to clearly delineate the responsibilities of each team member. This information will be shared with facility staff, TPMs, and stakeholders.

- Aging Services worked with the State IT Division to create process maps for all major functions of the HCBS. The State is developing visuals for TPM and other professionals to help understand the role of each member of the transition teams and the ADRL referral process. **(Process Maps Completed May 1, 2022)**

The HCBS Case Managers and Aging Services staff are currently being trained in person-centered planning principles with the assistance of nationally recognized subject matter experts.

- See related response above.

The State will work with the QSP Resource Hub to identify and address shortages in agency providers, by case management territory, and identify ways to incentivize current providers to build capacity and recruit additional agency providers and individual QSPs.

- The State contracted with The Center for Rural Health, located at the University of North Dakota School of Medicine & Health Sciences to operate the QSP Resource Hub. One of their first, major initiatives completed is a QSP survey. Link to Independent QSP Survey Results. QSP Resource Hub staff are working on a strategic plan to determine what type of strategies will build provider capacity and retention.

- In addition, the State offered QSP Agencies funds for recruitment and retention bonuses that can be used to help recruit and retain qualified individuals to provide direct support to TPMs. To date 39 agency QSPs have participated, and $575,400 has been allocated. Twenty-one providers have requested reimbursement totaling $370,527.50. **(Completed March 1, 2022)**

The State will conduct a QSP capacity survey with the QSP Resource Hub to assess current and future capacity to serve TPMs. They will also be responsible to create strategies for QSPs to support one another including a QSP list serve.

- See related response above.

The State will be replacing the current QSP searchable database with the assistance of ADvancing States and implement the *ConnectToCareJobs* system to help to identify available providers in all areas of the State. The system will allow QSPs to better market themselves and share their availability with others.

- The State is currently working on a process to meet the State procurement rules so we can move forward with this initiative. **(Updated Target completion date June 1, 2023)**

The State is currently conducting a review of the provider enrollment process to streamline and improve the enrollment experience for providers. Once complete, this information will be shared with all providers.

- This work is ongoing. **(Updated Target completion date December 1, 2022)**

The State is evaluating the capacity to find backup service providers in the event of an emergency and has secured another Lifespan respite grant to provide additional respite opportunities for TPMs and their families.

- This work is ongoing. Information from the QSP Survey and funding from the 10% FMAP fund will be used to help develop capacity for Agencies to provide backup services to TPMs.

Consider adopting a new provider model to reduce the administrative burden on individual QSPs including the Co-Employer/Agency with Choice Model.

- This work is ongoing and additional models are being explored for potential inclusion in the 2023-2025 Executive budget request.

Conduct a rate analysis to determine discrepancies in rates paid to in-home providers and SNF staff.

- Funds from the ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/American Rescue

Plan Act of 2021 used to procure a vendor to complete a rate study. The rate study began on July 1, 2022. Results of the study are scheduled to be available in September 2022. The goal of the study it to determine the best way to attract and retain quality providers to support HCBS across populations. More information will be available in the next report. (**Target completion date October 1, 2022)**

Make changes to the HCBS Medicaid waiver to allow the rural differential (RD) rate to apply to additional services thus increasing access in rural communities.

- Effective January 1, 2022, the RD rate may be used for supervision, companionship, and transition support services.

Conducting an analysis of the number of units being authorized and utilized by case management territory to determine if there are discrepancies in the amount of services available to TPMs across the State.

- See response in Section IX E Strategy 4. **(Target completion date July 1, 2022)**

Using the resources that can be made available through the ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/American Rescue Plan Act of 2021, to provide incentives to providers that will serve TPMs with high level of need or in rural and Native American communities.

- There are several initiatives that seek to remedy this issue. The rate study will help the State consider pricing strategies that will create an incentive to serve TPMs with complex needs, especially in rural areas of the State. The work is ongoing, and progress will be included in future progress reports.

Provide meaningful statewide training opportunities for all QSPs to ensure understanding of the SA, HCBS, person-centered-planning, and the authorization and claims reimbursement system

- This will be a major function of the Resource Hub which started December 1, 2021. The work is ongoing, and progress will be included in future progress reports. The QSP Resource Hub completed an agency and individual QSP study and is currently developing a QSP orientation for interested individuals and newly enrolled QSPs.

Consider revising the QSP training requirements to improve the provider experience and ensure a quality provider workforce.

- This will be a major function of the QSP Resource Hub. The work is ongoing, and progress will be included in future progress reports.

Creating the QSP Resource Hub to improve the support provided to agency and individual QSPs.

- The State entered into a contract with the Center for Rural Health, located at the University of North Dakota School of Medicine & Health Sciences effective December 1, 2021. The QSP Resource Hub started providing technical assistance on March 23, 2022.

Offer incentive grants to encourage large and small agencies to expand and enhance their capacity to serve additional TPMs and expand their service array.

- The State received 31 applications an award 14 entities grants up to $30,000 each. Link to QSP Grant Award Summary. The State will use additional funds to award more grants up to $50,000. (**Target completion date for new grants September 1, 2022)**

Capacity Building (Section XIII, Subsection D, page 21)

Implementation Strategy

Strategy 1. Provide incentive grants to organizations (including SNFs) that enroll and provide HCBS. Grants may also be used for current QSP agencies that are willing to expand their current service array or expand their service territory to assist TPMs in rural areas, including tribal communities.

Progress Report:

- Fourteen of the thirty-one incentive grant applications received were funded. Award amounts varied between $19,294 and $30,000 for a total of $393,607. Grantees were notified on January 14, 2022. Link to QSP Grant Award Summary

- No nursing facilities applied to be a QSP agency during the fall 2021-2022 round of incentive grants.

- Nursing homes and other entities will be provided with information on the 2nd round of QSP agency incentive grants. The new grants will offer awards up to $50,000 **(Target completion date September 2022)**

Strategy 2. The State will provide ongoing group and individualized training and technical assistance to SNFs that express interest in learning about HCBS. The State will develop a HCBS orientation presentation and materials that will be shared with SNFs. State staff will present at the LTC Conference.

Progress Report:

Performance Measure(s)

Number of SNFs requesting individual technical assistance.

- One SNF has requested technical assistance in the last six months.

Number of SNFs that have enrolled to provide HCBS.

- The State continues to remind SNFs of the opportunity to provide HCBS. Two SNFs are enrolled as Agency QSPs and are currently providing services.

Strategy 3. Increase the capacity for providers to serve TPMs on Native American reservation communities by continuing to partner with Tribal nations and to request funds for the Money Follows the Person-Tribal Initiative (MFP-TI).

The MFP-TI enables MFP state grantees and tribal partners to build sustainable community-based long-term services and supports (CB-LTSS) specifically for Indian Country.

The State will continue to support the development and success of Tribal entities who enroll as QSPs to provide HCBS in reservation communities by gathering feedback to improve processes, providing technical assistance, training, and staffing cases to ensure TPMs have the services they need to live in the most integrated settings appropriate. Mandan, Hidatsa, Arikara Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians are currently participating.

Progress Report:

Performance Measure(s)

Number of Tribal entities enrolled to provide HCBS.

- The MFP Tribal Initiative has assisted in the development of a QSP agency on the Turtle Mountain Band of Chippewa Indians Nation and with the Standing Rock Sioux Tribe.
- MFP is working with the South Segment of the Three Affiliated Tribes on a pilot project to offer QSP Services by a member of the tribe that owns and operates the QSP agency.
- The Sprit Lake Nation and the North Segment of the Three Affiliated Tribes are also a QSP Agency that were started without funding from MFP.

Number of individuals receiving HCBS per month by tribal owned QSP agencies.

- TM Tribal Aging Agency (Currently serving 12 HCBS recipients)

- Standing Rock Sioux Tribe (N/A)
- North Segment Home Services (N/A)
- Spirit Lake Okiciyapi (Currently serving 24 HCBS recipients)

Strategy 4. The State submitted a proposal to CMS and will seek legislative authority if approved to use the temporary 10% increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS to enhance, expand and strengthen the HCBS system for TPMs.

Progress Report:

On December 21, 2021, the State received Legislative spending authority to implement the 10% FMAP increase fund. Future progress reports will include additional information on the implementation of the plan.

- Developing a pilot program that supports both the recruitment and retention of direct care workforce in the HCBS industry. Engage workforce partners to identify financial incentives that would be meaningful to members of the workforce and impactful in terms of overall workforce availability. Consider targeted incentives for specified service types (ex. respite), enhanced training/endorsements, duration of service, and complexity of care.

    - In addition, the State offered QSP Agencies funds for recruitment and retention bonuses that can be used to help recruit and retain qualified individuals to provide direct support to TPMs. To date 39 agency QSPs have participated, and $575,400 has been allocated. Twenty-one providers have requested reimbursement totaling $370,527.50. **(Completed March 1, 2022)**

- Additional funding beyond that provided under the MFP Capacity Building Grant to develop new community services and supports was offered through a series of tiered start-up grants, incentives, and supports to providers who increase their capacity to provide HCBS. Incentives may be used for skilled nursing facilities or health systems who open a HCBS service line, for new providers of high priority services (ex. respite, round-the-clock services, personal care, and nursing), for existing providers who expand into new service geographies, and providers who develop capacity for complex care cases. Awards will incentivize both establishment of new service lines as well as enhancement of established delivery of service.

    - A second round of incentive grants will be made available to individuals and other entities interested in providing HCBS to adults with physical disability. The grants will have a maximum award of $50,000. **(Target completion date September 2022.)**

- Contract with a consultant to overhaul the training system that is currently in place to serve both QSP and direct service providers in HCBS service lines. Ensure that the training platform is culturally responsive and infuses person-

centered practices, is available in multiple languages, and is delivered using modern approaches to effective adult learning. Revise the training catalog available to direct care workforce and establish career pathways and progressive endorsements and certifications that allow for implementation of additional initiatives within the ARPA North Dakota State Spending Plan, including behavioral health, crisis intervention, and de-escalation competencies.

- Increasing transitions and diversions through flexible transition supports from institutions to HCBS settings, and to more appropriate community-based settings, depending on circumstance. An example is establishing a transition fund to supplement available resources for people who are transitioning from institutions to the community. Funds are meant to be flexible and utilized by Transition and Diversion teams to address unexpected needs that arise in the move to a less restrictive setting. Eligible uses include, but are not limited to, environmental modifications, assistive technology, security deposit, furnishings, moving costs, and utility hook-up fees.

  Included as eligible beneficiaries, people who are not currently eligible for transition supports from other Medicaid sources, for example people moving from one community setting to another (i.e., parents' home to independent living or non-accessible home to accessible home).

  - The flexible transition program that was started with the ADRL COVID grant has continued using these funds. During this reporting period five TPMs were transitioned to the community using these funds. Thirty-one other individuals have been transitioned out of other congregate settings i.e., basic care, assisted living, domestic violence shelters.

- Consider providing rental assistance to individuals who identify housing costs as a barrier to independent living in the least restrictive setting of their choice. Rental assistance could be first month's rent, deposits for utilities, or supports delivered by housing providers.

  Work to enhance access to the full range of environmental modifications that would help people live successfully in home or community settings. Work with a consultant to identify program adjustments that will broaden access to home modification resources, including examining requirements that define who can provide construction-related services and program definitions that consider assistive technologies, equipment. Consider incentives for builders who are willing to engage as a home modification provider. Develop training for HCBS Case Managers and housing facilitators to appropriately access various environmental modification resources.

- Conduct a QSP Rate Innovations and Gap Analysis. This strategy would aim to identify innovative ways to adjust QSP rates so that services with potential high impact on access to HCBS for older adults and people with disabilities are better incentivized. Examples include a shift differential for QSPs who provide care at

night, on weekends, and on holidays; respite care; system of “backup” or emergency care providers-of-last-resort to address high need cases or staff emergency situations; and rates adjusted for intensity.

    - Rate study started July 1, 2022. Recommendations are due by September 2022.

- Provide behavior intervention consultation and supports to direct service providers. The State is aware that oftentimes it is difficult to find HCBS providers who can, and will, serve clients with behavioral health needs. Strategies to increase these services could include establishing resources for QSPs and other HCBS providers to access, that would create behavior intervention plans, helping staff high need/high complexity cases, and offering consultation to in-home providers as needed.

- Enhancing the HCBS delivery system requires the support of effective infrastructure. This includes technological and human resources; quality, outcomes, and other measures of success; and a relentless focus on usability of systems. Infrastructure investments should keep the person at the center of design in every system component. Support the development of a Care Connect platform that facilitates connections between QSPs, consumers, and families.

- Invest in ADRL platform to incorporate affordable housing database, and other modifications to support user experience. Enhance availability of resources to support LTSS Options Counseling (informed choice) and HCBS case management. Equip Developmental Disability (DD) and HCBS Case Managers with resources to facilitate efficient work from HCBS settings.

- Establish a framework for routine, repeatable, timely access to information identified as core indicators/measures to improve quality, outcomes, and positive impact for TPMs. Define quality in each realm of the system, incorporating National Core Indicators and National Core Measures with State defined priorities.

    - The state has made two attempts to secure a vendor to deliver the surveys. State is currently working with Advancing States to find a vendor to implement NCI-AD in ND.

SA Section XIV. In-Reach, Outreach, Education and Natural Supports

Responsible Division(s)

DHS Aging Services Division

In-reach Practices and Peer Resources (Section XIV, Subsection A, page 22)

Implementation Strategy

Strategy 1. State staff will conduct group in-reach presentations at every SNF in North Dakota. Ensure a consistent message is being used throughout the State. **(Completed September 14, 2021, and repeated annually)**

Progress Report:

Performance Measure(s)

Number of SNF residents who attended group in-reach presentations.

- The second round of Group in-reach presentations began in June 2022 and will be included in the December 2022 report.

Number of individual in-reach/LTSS Options Counseling (informed choice) visits conducted with TPMs residing in SNFs per year.

- A virtual or in person LTSS Option Counseling (informed choice) visit was conducted with 545 unduplicated TPMs residing in SNFs during this reporting period.

Strategy 2. Identify TPMs when they are screened at a NF LoC and ensure that they have an opportunity to make an informed decision about where to receive services. The newly created LTSS Options Counseling (informed choice) referral process provides for virtual or face-to-face person-centered planning and information about the benefits of integrated settings, which may include facilitated visits or other experiences in such settings and offers opportunities to meet with other individuals with disabilities who are living, working, and receiving services in integrated settings, with their families, and with community providers. It requires making reasonable efforts to identify and address any concerns or objections raised by the TPM or another relevant decision maker. **(Implemented January 1, 2021)**

Progress Report:

Performance Measure(s)

Conduct 250 individual in-reach/LTSS Options Counseling (informed choice) visits with TPM residing in SNFs per year.

- A total of 545 unduplicated TPMs residing in an SNF received an LTSS Options Counseling (informed choice) visit during this reporting period.

Number of LTSS Options Counseling (informed choice) visits completed every six months.

- The visits for residents who have been residing a SNF began on June 14, 2022.

Strategy 3. Procure an entity that can serve as a Peer Resource Center in ND. The Peer Resource Center will serve as a centralized place for referral. It will establish a process and requirements for peer support training and reimbursement. It will facilitate appropriate and timely connections between peer support specialists, individuals, and families who would benefit from this type of service.

Resource Center staff will develop specific expertise that gives TPMs across the lifespan who are interested in transitioning to the most integrated setting appropriate, and those who want to remain in their current home environment but also need available services and supports to do so. It will create the opportunity to connect with a peer who has lived experience navigating and utilizing HCBS**. (Updated target completion date December 1, 2022)**

Progress Report:

Performance Measure(s)

Number of referrals for peer support and outcome.

- Six individuals were provided Peer Support by the CILs.

Number of individuals receiving information or support from new center.

- The new Peer Support Center has not yet been developed. Planning team continues to discuss the desired structure and outcomes for the Peer Support Center.

Communication Accommodations (Section XIV, Subsection B, page 22)

Implementation Strategy

The State will make accommodations upon request for TPMs whose disability impairs their communication skills and provide communication in person whenever possible.

The ADRL intake process includes questions to assess communication needs. The State will update the LTSS Options Counseling (informed choice) process to include similar questions. If accommodations are needed the State, hospital, or SNF will provide the necessary accommodation as required. Individual accommodations may include auxiliary aides such as interpreters, large print and Braille materials, sign language for the hearing impaired, and other effective methods to deliver appropriate information to TPMs. The State will update the ADRL and DHS website to include information on how to request accommodations. **(Target completion date October 1, 2021)**

Progress Report:

Performance Measure(s)

Number of TPMs who requested and received communication accommodation.

- Sixteen, (twelve unduplicated) requests were made by TPMs in facilities, all were accommodated. No requests were made by TPMs in the community.

Communications Approaches (Section XIV, Subsections C & D, page 22)

Implementation Strategy

Strategy 1. The DHS communications team will develop a communication plan to ensure frequent outreach and training is available to at risk TPMs and their families about HCBS and the SA requirements. The communication plan will include ways to use the marketing tools developed to promote the ADRL and increase awareness of HCBS. The plan will be revised based on stakeholder input provided during the USDOJ SA stakeholder meetings. **(Completed November 1, 2021)**

Progress Report:

- The Communication Plan was completed on November 1, 2021. The Plan was reviewed at the March 17, 2022, stakeholder meeting and is available on the Aging Services website. Efforts are ongoing. Another social media campaign was conducted in March 2022. See response in Section VII. A. 5.

Strategy 2. Create a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign will include marketing on social media and providing public education to the public, professionals, stakeholders, and TPMs at serious risk of entering nursing facilities. Campaign will also include providing education to those parties that recommend SNF care to TPMs. This includes health care professionals/staff who are most likely to be in regular contact with TPMs and potential TPMs prior to requests or applications for NF admissions, such as geriatricians, primary care physicians serving a significant number of elders, and rehabilitation facility staff. **(Target completion date December 14, 2022)**

Progress Report:

See response above under Strategy 1.

Performance Measure(s)

Number of ADRL contacts.

- Calls – 6,299
- HCBS Intake – 540
- Unique Website Hits – 14,902

Strategy 3. Work with staff from Medical Services and the ND Department of Health to identify common precursor events to subsequent requests for SNF placement (such as hospital admissions for elders for a broken hip, admission to SNF for short-term rehabilitation, etc.).

Use available data to identify individuals utilizing such services and provide those individuals information about long-term community-based services.

Progress Report:

The State developed a report of the most common medical diagnosis of TPMs who are residing in SNF. This information will be used as part of a broader conversation around what contributes to the need for long-term placement in a SNF. This information will be used to inform future strategies that will be included in the next IP.

- Hypertension – 598
- Hyperlipidemia – 483
- Dementia – 431
- Diabetes – 388
- Heart – 378
- Arthritis – 350
- Kidney – 323
- TIA – 301
- Depression – 231
- Pulmonary – 196
- Coronary – 189
- Alzheimer – 167
- Cognitive – 159
- Covid – 156
- Respiratory – 153
- Osteoporosis – 153
- COPD – 131
- Parkinson's – 78
- Cancer – 63
- CVA – 54
- Epilepsy – 51
- Stroke – 35
- TBI – 6

Respite Services (Section XIV, Subsection E, page 22)

Implementation Strategy

Strategy 1. The State will educate providers and stakeholders during the respite services webinar and stakeholder meetings that HCBS policy currently allows the RD rate to apply to the 24-hour cap on overnight respite. **(Policy updated July 1, 2021)**

Progress Report:

Performance Measure(s)

Number of TPMs utilizing respite care with the RD rate.

- A total of 18 TPMs received respite paid at the RD rate during this reporting period.

Number of hours of respite services provided.

- State and federally funded HCBS provided 810.5 hours of respite care to eligible individuals and their family caregivers under the HCBS waiver during this reporting period.

Strategy 2. The State will enhance, expand, improve, and provide supplemental respite services and education to family caregivers in North Dakota with resources provided through a Lifespan Respite Care Program: State Program Enhancement Grant. The State will use the grant to continue to provide and develop new virtual and group training opportunities led by individuals who provide natural support to TPMs. **(Grant received completed June 1, 2022)**

Progress Report:

Performance Measure(s)

Number of trainings on this topic conducted by natural support providers.

- Grant was awarded and Aging Services staff are still developing the training.

Strategy 3. The State will continue to provide education and respite services to individuals providing natural supports. The following in person/virtual training for informal supports is currently available. **(Completed December 14, 2020)**

- Dementia Care Services and Older Americans Act Family Caregiver Support Program training for caregivers of TPMs with dementia.
- Powerful Tools for Caregivers evidence-based training.
- Powerful Tools for Native American Caregiver training.

- Tai Ji Quan: Moving for Better Balance
- Stepping On: Falls prevention program.

The State will use additional funding provided by the American Rescue Plan to expand evidence-based training programs for TPMs and their natural supports. The State contracts with North Dakota State University Extension and will provide funds to expand the service array to include development of the Community Aging in Place – Advancing Better Living for Elders (CAPBLE) program. CAPABLE is a person-centered home-based program that integrates services from an occupational therapist, registered nurse, and a handy man who work together with older adults to set goals to improve function and safety in the home. **(Target completion date January 1, 2023)**

Strategy 4. The State will conduct training for HCBS Case Managers and stakeholders to increase awareness of the North Dakota Community Clinic Collaborative (NDC3) available at NDC3.org. NDC3.org is a one-stop, virtual infrastructure for NDC3 partner organizations, supporting the development, delivery, management, and monitoring of evidence-based programs that promote self-management of chronic health conditions and foster well-being. Professionals can use the system to find evidence-based programs in their community and assist TPMs to enroll. Fact sheets will be created for HCBS Case Managers to provide to TPMs and their natural supports to inform them of the availability and benefits of these programs. **(Target completion date December 1, 2021)**

Progress Report:

Performance Measure(s)

Number of individuals who attended training by service.

- A training was held February 7, 2022, to present on evidence-based practices to all 101 Aging Services staff that were employed at that time.

Accessibility of Documents (Section XIV, Subsection F, page 23)

Implementation Strategy

Strategy 1. The State will work with the DHS Civil Rights Officer and the ND Department of Information Technology to review all printed documents and all online information available on the USDOJ Settlement page of the DHS website to ensure compliance with this SA. **(Updated target completion date May 31, 2022, and ongoing)**

Progress Report:

Performance Measure(s)

Number of documents converted.

- The DOJ Settlement Support Specialist continues training on the process of converting documents to an accessible format. A total of 12 documents have been converted to be accessible. Each document will be tested using an online screen reader application to verify accessibility.

Strategy 2. The DHS will build capacity by training the staff member hired to assist with the implementation and reporting requirements of the SA to review and update documents to ensure compliance with ADA. **(Completed October 26, 2021)**

SA Section XV. Data Collection and Reporting

Responsible Division(s)

DHS Aging Services Division

Methods for Collecting Data (Section XV, Subsections A, B, C & D, pages 23-24)

Implementation Strategy

Provide the USDOJ and SME biannual reports containing data according to the SA. The State will retain all data collected pursuant to this SA and make it available to the USDOJ and SME upon request.

Strategy 1. Contract with a new vendor to implement a case management system. This new system will allow the State to collect and report the aggregate data as required.

Progress Report:

- The State case management system will be used to track individual demographics, assessment data, PCP, case notes, provider authorizations, provider electronic visit verification data, claims submission data, complaints and CIRs. The system also tracks case management referrals. **(Target completion date for full implementation of the case management system August 1, 2022)**

- The State is working with Aging Services business analyst and the case management vendor to design specific reports that will help the State report data required in SA, IP, and related performance measures. **(Targeted completion date December 31, 2022)**

Case Management System Reports - Requested
Aging Funding Source Report
Aging Provider Transition Date
Aging Admitted Individuals that have Case Management Pre-auths
Bulk data for Person Centered Plan and Risk Management
Aging Caregiver Assessment
Aging Financial Assessment
Aging Risk Assessment and Safety Plan
Aging Informed Choice LTSS Option Counseling
Aging NCIAD Quality Survey
Aging Participant Assessment
Aging Complaints Assessment
Aging Initial Service Plan
Program Enrollments 1265-1267
MFP Transition Plan
MFP Housing
Med Waiver Funding Source from Care Plan
Med Waiver Quality Assurance
Med Waiver Recipients with Narratives and Four Quarterly Contacts
Med Waiver Goals and Assurance from Care Plan
Med Waiver Level of Care with NF Level of Care
Med State Plan B & C Level of Care
Authorized Service Report for Care Plans
Cost by Funding Source from Care Plan
Basic Provider Information
Rural Differential closures SFN 212
Count of Care Plans with TPM
Count of HCBS Cases by Funding Source
HCBS Case Management Referral

- The State will request that the case management system vendor provide training to Aging Services staff to learn about the business intelligence tools that are currently available in the case management system. **(Target completion date November 30, 2022)**

- The State will streamline the current dashboard report and will make the following key measures available on the Department's website.

    - Number of unduplicated TPMs served in the state or federally funded HCBS.

    - Number of TPMs being served in a SNF.

- Total number of contacts to the ADRL.
- Total number of individuals referred to HCBS case management.
- Total number of TPMs who transitioned to an integrated setting.
- Total number of TPMs who were diverted from an SNF because they are receiving HCBS in the community.
- Total number of TPMs receiving permanent supported housing.
- Average annual individual cost comparison by HCBS funding source and average annual cost of SNF care.
- Number of new QSPs enrolled.
- Number of PCPs created with TPMs in the community and with TPMs in a SNF.

- The State worked with the Case Management vendor to implement the complaint system, which was completed on June 14, 2022. In the interim the State continued to utilize an Access database to capture and report on complaints. Complaints are received through the ADRL and are assigned to the complaint investigator and complaint reports are run out of Therap.
- All State staff that investigate complaints now have access to the complaint database. In additional all providers are required to have an account in Therap so they can enter the Critical Incident Report (CIR) directly into the system where they are reviewed by an Aging Services Nurse Administrator.
- The State is also considering the feasibility of creating an interface with the VAPS reporting system and the CIR reports in the current case management system. The vendors have been asked to submit a cost proposal and project timeline to the State.

Performance Measure(s)

Number of complaints received through the General Complaint Process.

- Eighty QSP complaints were received, 34 of these QSP complaints involved TPMs.

Strategy 2. Determine staff capacity and number of FTEs needed to provide a sufficient number of HCBS Case Managers to serve TPMs. HCBS Case Managers are required to keep track of the amount of hours they work as well as the type of work being performed. Reports can be run in the State's time and attendance system to calculate

the amount of time spent conducting case management versus administrative tasks.

Progress Report:

Performance Measure(s)

Percent of staff time expended on administrative tasks after the new case management system is fully implemented.

Percent of staff time expended on direct service case management tasks after the new case management system is fully implemented.

See response in Section VII. A. Strategy 7

- Aging Services will request to include ten FTE in the Department's executive budget request to make the Community Outreach Staff classified FTE. The State is determining what amount of additional case management capacity to request.

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHS Aging Services and Medical Services Divisions

Implementation Strategy

The SME has drafted a Safety Assurance Plan with input and agreement from the State. The plan outlines a range of recommendations that are intended to inform and support the State's actions related to ensuring the safety of and the quality of services for TPMs, both during the timeframe of this version of the IP, as well as throughout the duration of the SA.

The State is currently implementing or has incorporated the following recommendations included in the Safety Assurance Plan into the IP. The State will consider implementing other recommendations included in the plan in future IP updates.

- The State has established a consistent incident reporting and response process to be used for all critical incidents. The system captures all data recommended in the plan. The process has been documented in the policy and procedure manual. This includes how and when the critical incident report will be reported to the USDOJ and the SME.

    - This initiative is complete, but the work is ongoing. Quarterly webinar training will be provided to agency and individual QSPs. An e-training module is available online. Link to Critical Incident Reporting (nd.gov). A recorded webinar is also available online.

- The State will implement a workflow process map to identify all steps in the reporting and remediation of critical incidents. The map will be used in future training to ensure understanding of the process and requirements.

  Progress Report:

    - The mapping process is complete. State staff are working on creating a visual aid for providers and staff. **(Updated target completion date October 1, 2022)**

- The State has held and will continue to provide critical incident report training to all providers. Training materials and video recordings are available online.

    - See related response above.

- The State will utilize a workgroup to develop a QI policies and procedures that can be adapted by Agency providers who employ non-family as required in the SA. The State will require the QI plans to include an individual safety plan created as part of the PCP and must be submitted to the State for approval.

  Progress Report:

- The State contracted with CQL to manage the QI workgroups and create standards for the program. Current providers must have a compliant QI program by December 31, 2022. **(QI standards completed February 23, 2022)**

    - The required provider QI standards are now included in the updated Agency QSP handbook. Current agency QSPs have until December 31, 2022, to fully develop their program. Audits will be conducted to ensure compliance starting January 2023.

- The updated HCBS functional assessment includes a safety assessment of the home to ensure adequate equipment or environmental modification services are offered to ensure the home is accessible and functional for the TPM. It also assesses the need for supervision.

    - The updated assessment includes questions about safety, need for environmental modification and supervision. The HCBS waiver allows for a formal assistive technology assessment to be completed as part of specialized equipment and supplies.

- The State holds a quarterly critical incident report meeting where all reports are reviewed. The State will develop a process to include a mortality review of all deaths, except for death by natural causes, to determine whether the quality, scope, or amount of services provided to the TPM were implicated in the death. Information gleaned will be used to identify and improve gaps in the service array.

Progress Report:

- The State has developed this process and the first mortality review was conducted in January 2022. The CIR Team holds quarterly meetings where all deaths are reviewed for trends one week prior to the meeting. The team then discusses these deaths and any trends found at the committee meeting. Information discussed is included in the Team meeting minutes.

- The State has a process for the public to file complaints and has updated the DHS website to include information on how to report. This information is shared at stakeholder meetings and other public events involving TPMs.

Progress Report:

- The State and the Case Management vendor have finalized the implementation of the complaint system. In the interim the State continued to utilize an Access database to capture and report on complaints.

- The complaint process has been updated to include the ADRL intake as the entry point of the QSP complaints. Training has been provided to Case Managers. Information has been added to the website and is reviewed at all ND USDOJ SA stakeholder meetings to ensure ongoing awareness.

Quality Improvement Practices (Section XVI, Subsections A & B, page 24)

Implementation Strategy

Strategy 1. The State will create critical incident reporting training opportunities for QSPs. Training will be provided through online modules and virtual training events. The training will focus on the State's data system and the State's processes for reporting, investigating, and remediating incidents involving the TPM.

The State will update the QSP handbook to include current reporting requirements. The State will also work with staff from the QSP Resource Hub to develop ongoing training that will assist QSPs in understanding and complying with safety and incident reporting procedures. **(First critical incident reporting training completed August 1, 2021)**

Progress Report:

QSP Quality Improvement (QI) Program training sessions were conducted on June 22, 2022, and June 28, 2022, with a total of 60 QSPs in attendance.

Performance Measure(s)

Number of QSPs trained on reporting procedures.

- A total of 60 QSPs attended learning sessions.

Number of virtual training events conducted.

- Both training events were held virtually.

Number of training modules created.

- One training module for online learning has been developed and is posted to the Aging Services website. Link to Critical Incident Reporting (nd.gov)

Number of critical incident reports that were reported on time.

- Out of the 180 incidents involving TPMs, 114 (63%) were reported timely.
    - December 15-31, 2021 – 7 out of 12
    - January 2022 – 18 out of 22
    - February 2022 – 20 out of 34
    - March 2022 – 17 out of 32
    - April 2022 – 17 out of 29
    - May 2022 – 22 out of 29
    - June 1-14, 2022 – 13 out of 22

Strategy 2. Agency QSP enrollment standards will be updated to require licensed agencies or entities employing non-family community providers to have a QI program that identifies, addresses, and mitigates harm to TPMs they serve. This would include the development of an individualized safety plan for each TPM. The QI Plan will be provided to the State upon enrollment and reenrollment as an agency QSP. The safety plan need not be developed by the provider unless it was not included in the PCP developed by the HCBS Case Manager and the TPM. **(QI program required January 1, 2023)**

Progress Report:

Performance Measure(s)

Number of Agency QSPs and entities with QI program in place.

- Thirteen QSPs have the QI program in place by December 31, 2022, because they are accredited by CQ and already meet the requirement. All developmental disability and residential habilitation community supports providers have accreditation by CQL.

Strategy 3. Implement the National Core Indicators – Aging and Disabilities (NCI-AD). The State will collaborate with ADvancing States and the Human Services Research Institute (HSRI) to support implementation. NCI-AD is a process that measures and tracks the State's performance and outcomes of HCBS provided to TPMs. Quality performance reports will be made available on the DHS website and shared at USDOJ stakeholder meetings. **(Updated target completion date July 1, 2023)**

Progress Report:

- The state has made two attempts to secure a vendor to deliver the surveys. State is currently working with ADvancing States to find a vendor to implement NCI-AD in ND.

Strategy 4. The State will convene a QI workgroup. The State will invite State staff, including the Medical Services QI coordinator, QSP agencies, TPMs, family members, guardians, and other interested stakeholders to be part of the group. The group's primary purpose will be to participate in the development of resources and tools to help agencies create a QI program that identifies, addresses, and mitigates harm to TPMs they serve. This will include the development of a process for the State to determine whether providers identify, and report critical incidents as required. Resources will be made available to all QSPs. **(Completed February 23, 2022)**

Progress Report:

- See progress report under strategy 2 above.

Strategy 5. The State developed a process to submit critical incident reports to the USDOJ and SME within seven days of the reporting of the incident as required in the SA. **(Reporting begins June 12, 2021)**

Progress Report:

Performance Measure(s)

Percent of critical incident reports submitted within seven days of incident being reported as required.

- Out of the 180 incidents, 178 were reported timely which is a 99% compliance rate.

Critical Incident Reporting (Section XVI, Subsection C, page 25)

Implementation Strategy

Policy will be updated to require a remediation plan to be developed and implemented for each incident, except for death by natural causes. The State will be responsible to monitor and follow up as necessary to assure the remediation plan was implemented**. (Policy updated July 1, 2021)**

Progress Report:

Performance Measure(s)

Percent of required remediation plans completed.

- There were 12 formal remediation plans required and 100% of the plans were completed.

Number of training events conducted.

- Three virtual training events were conducted.
- 12/17/21 – 35 attendees
- 3/25/22 – 15 attendees
- 4/18/22 – 53 HCBS Case Managers/Program Administrators attended

Number of online modules created.

- One training module for online learning has been developed and was posted to Aging Services website in January 2022.

Case Management Process and Risk Management (Section XVI, Subsection D, page 25)

Implementation Strategy

The State will use the new case management system and the State's internal incident management system to proactively receive and respond to incidents and implement actions that reduce the risk of likelihood of future incidents.

To assure the necessary safeguards are in place to protect the health, safety, and welfare of all TPMs receiving HCBS, all critical incidents as described in the SA must be reported and reviewed by the State. Any QSP who is with a TPM, involved, witnessed, or responded to an event that is defined as a reportable incident, is required to report the critical incident.

Strategy 1. The new case management system will be used to receive and review all critical incidents. Critical incident reports must be submitted and reviewed within one business day. **(Completed July 1, 2021)**

Progress Report:

Performance Measure(s)

Percent of critical incidents reviewed within one business day of receipt.

Out of 180 incidents reviewed, 177 (98%) were reviewed within one business day of receipt.

- December 15-31, 2021 – 12 out of 12
- January 2022 – 21 out of 22
- February 2022 – 33 out of 34
- March 2022 – 32 out of 32
- April 2022 – 29 out of 29
- May 2022 – 28 out of 29
- June 1-14, 2022 – 22 out of 22

Strategy 2. The DHS Aging Services Division will continue to utilize a Critical Incident Reporting Team to review all critical incidents on a quarterly basis. The team reviews data to look for trends, need for increased training and education, additional services, and to ensure proper protocol has been followed. The team consists of the DHS Aging Services Division Director, HCBS program administrator(s), HCBS nurse administrators, Vulnerable Adult Protective Services (VAPS) staff, LTC Ombudsmen, and the DHS risk manager. **(Completed December 14, 2020, and ongoing)**

Progress Report:

Performance Measure(s)

Percent of critical incident reports reviewed by State staff.

- 180 critical incidents reports involving TPMs were received from December 15, 2021 – June 14, 2022, SA. 100% of critical incident reports received were reviewed by State staff.

Strategy 3. Identify workflow processes for the investigation and remediation of reported or otherwise suspected incidents referenced in this section of the SA. The processes will be documented in policy and/or provider contracts and manuals.

Progress Report:

Processes to include:

- Completion of any missing data elements from the initial report to be completed by the lead investigator for the State,
    - The Critical Incident Reporting protocol defines additional investigators who may be involved in the critical incidents including: the Ombudsman, the ND DOH, and VAPs investigators.
- Timelines and guidelines for the investigation of incidents,
    - Program Administrators meet to review these incidents every other week and as needed to ensure there is follow-up if the incident

involves a QSP complaint. As of June 14, 2022, the QSP complaints are now in the case management system, and it can be documented as a task that it also involves Critical Incident report.

- Development of a remediation plan for each confirmed incident, except for death by natural causes, (the remediation plan to include who is responsible for implementing as well as monitoring and a timeline for both), and

    - Remediation plans are documented in the corrective action/plan of future corrective action section within the incident report. The type of remediation plan/timeline is dependent on the type of incident. Each critical incident that is forwarded to the DOJ for review has a remediation plan included for review.

- A method for tracking when an incident has an associated complaint. **(Completed June 14, 2022)**

    - Incidents that have an associated complaint are marked by the QSP complaint Program Administrator in the complaint documentation and noted in the Critical Incident report (GER in Therap).

Strategy 4. The State will develop a process to include a mortality review of all deaths, except for death by natural causes, of TPMs to determine whether the quality, scope, or amount of services provided to the TPM were implicated in the death. The review will be conducted by the quarterly critical incident report committee. Information gleaned from the review will be used to identify and address gaps in the service array and inform future strategies for remediation. **(Completed January 1, 2022)**

Progress Report:

A list of all deaths will be sent out one week prior to quarterly incident reporting meeting to all Critical Incident Report team members and will be documented in meeting minutes. Each death is reviewed by HCBS Case Manager and Nurse Administrator. Unexplained deaths are also forwarded to Aging Services Director to review.

Notice of Amendments to USDOJ and SME (Section XVI, Subsection E, page 25)

Implementation Strategy

The State will submit written notice to the USDOJ and the SME when it intends to submit an amendment to its State-funded services, Medicaid State Plan, or Medicaid waiver programs that are relevant to this SA, and provide assurances that the amendments, if adopted, will not hinder the State's compliance with this SA. **(Reporting began June 1, 2021)**

Progress Report:

Performance Measure(s)

Number of amendments reported.

- Since December 14, 2020, three amendments to the HCBS waiver and a 5-year waiver renewal application were submitted to the USDOJ, and the SME as required.

- The Medical Services 1915 (c) HCBS waiver was approved for a 5-year renewal effective April 1, 2022.

Complaint Process (Section XVI, Subsection F, page 25)

Implementation Strategy

Strategy 1. Implement a process to receive and timely address complaints by TPMs about the provision of community-based services. Complaints that involve an immediate threat to the health and safety of a TPM require an immediate response upon receipt. All other complaints require follow up within 14 calendar days. State staff collaborate with the VAPS unit to investigate complaints. The State will notify the USDOJ and the SME of all TPM complaints received as part of its biannual data reporting as required**. (Reporting began June 14, 2021)**

Progress Report:

Performance Measure(s) Number of TPM complaints

Number of TPM complaints

- There were 35 complaints involving TPMs during this reporting period.

Number of TPM complaints that were responded to within required timeframe.

- All 35 complaints were responded to within the required timeframe. Link to Appendix C.

Strategy 2. The State will publicize its oversight of the provision of community-based services for TPMs and provide mechanisms for TPMs to file complaints by disseminating information through various means including adding information to the DHS website, HCBS application form, “HCBS Rights and Responsibilities” brochure, presentation materials, and public notices. **(Completed February 1, 2022)**

Progress Report:

The Rights and Responsibilities Brochure has been updated and posted to the DHS Aging Services publications website and distributed to the HCBS Case

Mangers. Additional training on the updates was held on January 24, 2022, during the HCBS Update meeting. The application for services has also been updated and was manualized on February 1, 2022.

Strategy 3. The Agreement Coordinator will submit a Complaint Report that includes a summary of all complaints received as part of the biannual data reporting requirements. **(Reporting began June 14, 2021)**

Progress Report:

Performance Measure(s) Number of TPM complaints

Number of TPM complaints that were responded to within required timeframe.

- There were 35 complaints associated with a TPM from December 15, 2021 - June 14, 2022. All complaints were responded to within the required timeframe. Link to Appendix C.

Appendix A

Appendix A is the Dashboard report.

Appendix B

ND Stakeholder Engagement Meeting: Long-Term Care Options Counseling in North Dakota

Meeting Date: March 23, 2022

Agenda

9:00 – 9:15	**Welcome + Introductions + Meeting Goals** *Bevin Croft*
9:15 – 9:30	**Long-Term Care Options Counseling: What it is and why it matters** *Nancy Nikolas-Maier*
9:30 – 9:45	**Review Current Process and Updated Referral Form** *Sandi Erber*
9:45 – 9:50	**Common Themes from Stakeholder Interviews** *Pat Rivard*
9:50 – 9:55	**Break**
9:55 – 10:25	**Conversations about Community Options** *Sandi Erber and Pat Rivard*
10:25 – 10:55	**Follow-Up Strategies** *Sandi Erber and Pat Rivard*
10:55 – 11:00	**Closing + Next Steps** *Bevin Croft*

Meeting Polls

A total of 34 participants joined the meeting and 18 participated in the meeting polls.

In what roles do you self-identify?

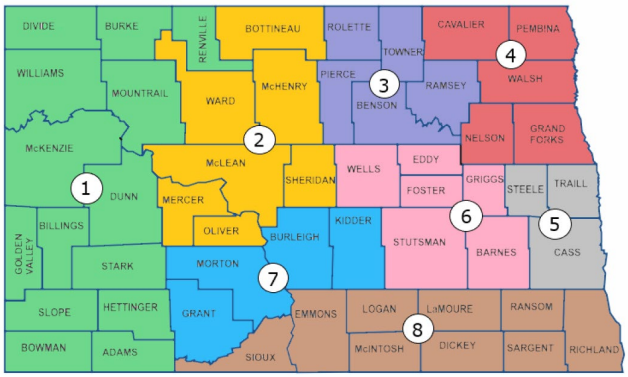
- Person with a disability/person who uses long term services and supports: 4% (1)
- Family member/natural supporter: 4% (1)

In what roles do you self-identify?

- Person with a disability/person who uses long term services and supports: 4% (1)
- Family member/natural supporter: 4% (1)

- Hospital Staff (discharge planner, social worker, administration): 0% (0)
- Nursing Facility Staff (discharge planner, social worker, administration): 8% (2)
- Ombudsman: 0% (0)
- Qualified Service Provider: 0% (0)
- Community Case Manager or Social Worker: 24% (6)
- Tribal Member or Tribal Representative: 4% (1)
- Advocate or Self-Advocate: 12% (3)
- Government Employee (federal, state, tribal, or municipal): 44% (11)

What region do you live or work in?



- 1: 4% (1)
- 2: 14% (3)
- 3: 9% (2)
- 4: 0% (0)
- 5: 23% (5)
- 6: 4% (1)

- 7: 28% (6)
- 8: 14% (3)

Engagement Questions

Should a question be added to the screening form to learn if an individual has concerns about having the financial resources needed to move back into the community?

- *When you were in the community, you said you lived in your home, did you have any concerns about financially meeting your needs?*
    - I think anyone in a facility on Medicaid will have financial concerns.
        - Is this something we need them to talk to us about before they know us though?
    - Financial question should be asked upfront. Most people are willing to discuss finances if they know it will help the ultimate decision they are making.
    - Consider hanging posters around facilities.
        - During COVID, families wouldn't have even been able to see posters – not sure families would see posters because visitation has been restricted.

How can we improve the group meetings?

- The forms for the meetings are helpful and it's obvious there's more effort being put into this because the forms are more complete.

What kind of follow-up should we do with individuals after the group meetings to determine if they are interested in learning more or pursuing community options?

- Offer to come back the following week to meet with residents individually who are interested in pursuing.
- Post-presentation survey.

How should we ensure that families/natural supports are informed of community options and services?

- Advertise in local papers in rural areas or do letters to invite family members.
- Offer to contact families directly if they have an interest.
- Social media outreach.
- Peer visiting training.

What is a good timeframe for follow-up on information on community services? Aging Services currently reaches out 2-5 days after referral. If this should be expanded, how long?

- With hospitalizations specifically, the 5-day window tends to be a little short because the individual has been through so much and are still healing and families might be overwhelmed. One more voice that comes in gets a little overwhelming and lost in translation sometimes. From a team perspective, an extended period would be helpful, either 7 or 10 days so that information is more easily received.
    - Agreement with waiting a few days. The nursing home has so many assessments and therapies to do right away as well as adjusting to the environment and routine of the facility.
- From a Center for Independent Living perspective, sometimes get a referral two weeks after the meeting, so timely communication is critical.

What kind of follow-up should there be for individuals referred via the process but decline to meet with a Case Manager?

- Brochures are nice.
- Having the case worker and nursing home social worker working together more often will be helpful, especially when the resident later chooses to get more information. Then, the conversation can be held at another time.

What recommendations do you have for the follow-up process (frequency of checking in, discussion topics, materials to provide, etc.)?

- Facilities ask for the brochures to include in their admission packet because it's a great way to get the word out.

What kind of follow-up should there be for individuals referred via the process, meet with the Case Manager, and decline to pursue community options?

- When the case worker is in the facility at another time, it would be fine to stop in and visit again in case they have further questions, or just to say hello.
- Provide some testimonies of success.
    - When we hear of dreams and hopes, it can help others think about their options and what's possible for them.
- Casual conversation follow-up.
- Case Manager lets individual know they will be back in the building and ask if it's ok to pop back in – maybe less about LTSS Options Counseling (informed choice) visit and more about relationship building.
- Talking with the nursing facility social worker three to six months after the meeting to see if there's any change with the individual and reconnect with the individual/family.
- Provide the nursing facility with brochures to give to residents/families during annual care conferences and/or upon admission, along with LTSS Options Counseling (informed choice) workers contact information.
    - The process on who to contact is still confusing.
        - Each facility will get a worker assigned to that facility. Do have the ADRL and the information is on all programs – no wrong-door approach to contacting. If anyone calls that number, they will get information on home and community based services and LTSS Options Counseling (informed choice) or community outreach specialists can go out and do a visit.
            - Like the phrase "no wrong door."
        - Having a specific worker in the facility will be great.
- Worker leaves a business card and a brochure after every visit and likes to make special mention to the ADRL line, too.

Are there other suggestions on how to help people in a hospital or nursing facility make informed decisions about where they live and receive services and supports?

- Is there already hospital and nursing home staff training provided or offered to staff so questions can be asked during admission and discharge planning?
- Some social workers are not happy about LTSS Options Counseling (informed choice) coming in to do visits.
    - Example of needing to get the word out to families: Wondered where MFP was in 2018 when mom had a stroke, and nursing home didn't share that with the individual.

        - Having the social worker part of the LTSS Options Counseling (informed choice) visit has been beneficial and reiterating that LTSS Options Counseling (informed choice) is another resource for the individual and the social worker.
        - Social workers often have administration pressuring them to keep long-term care facility beds full.
- Workers in Dickey County have been great but struggle to understand who does what part for discharge planning.
    - The Role Matrix does outline responsibilities.
    - The LTSS Options Counseling (informed choice) workers start the person-centered planning.
    - Consider enhancing the roles and responsibilities process.
- Lack of physician support has been a barrier with nursing facilities as well, so education to the physicians is huge.
- There's more accountability for Centers for Independent Living and less on nursing facility for discharge planning, will there be anything in place imposed for them by the state? Sometimes nursing facilities make the process harder for the CILs but have no accountability.
    - There is administrative code about who governs what, and Aging Services needs to know if a facility blocks someone from coming. People have a right to visitors. This isn't a substitute for discharge planning and there's still an obligation for people to go home.

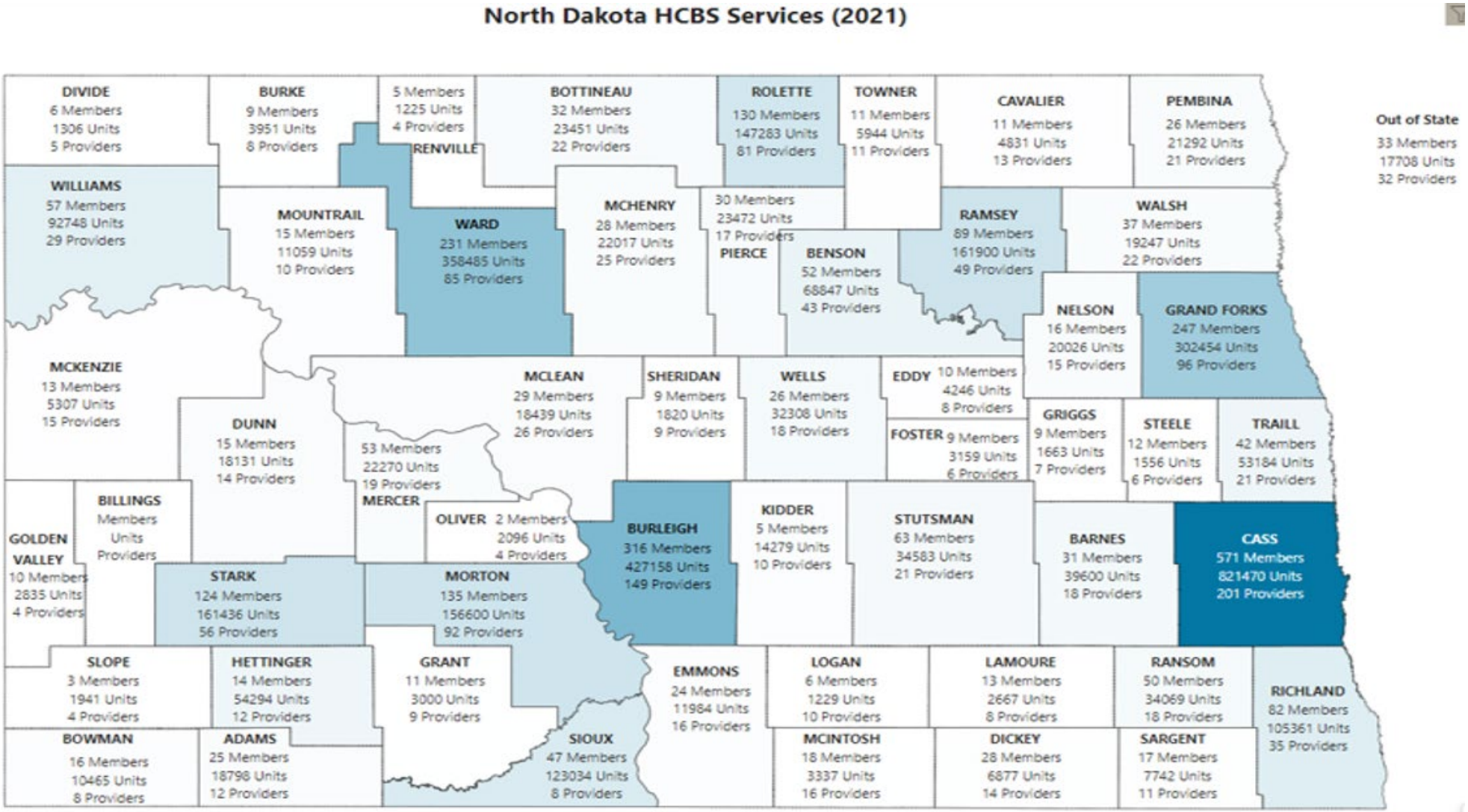
Other Questions and Comments

- Who are the community outreach specialists?
    - They are State staff who work for Aging Services that go out and visit individuals in the community to do LTSS Options Counseling (informed choice) visit.
- Always looking to meet CEU's, will this be submitted as such?
    - Stakeholder engagement don't count, but there are other trainings that CEUs are offered for.
- Appreciation for the meeting, including, "Thank you all for the hard work, it's a process, but it's clear ND is definitely moving in the right direction!"

Appendix C

Complaint Type	# by Type	Pending Outcome	Unsubstantiated	Substantiated	Remediation provided
Absenteeism	5	2	1	2	Provided technical assistance
Abuse/Neglect/Exploitation	8	3	0	5	2 terminated QSP, 1 provided technical assistance-employee was terminated, 2 AFC corrective action issued
Breach of Confidentiality	1	0	0	1	Provided technical assistance
Poor Case Management	0	0	0	0	
Criminal History/Activity	1	0	0	1	Provided technical assistance-staffed with HCBS/SURS team, not a direct bearing offence
Theft	4	3	0	1	Provided technical assistance-employee terminated
QSP Disrespectful	3	2	1		
Inappropriate Billing	3	2	1		
Poor Care	9	4	2	3	2 terminated, 1 provided technical assistance-employee terminated
QSP Damage Recipient Property	0				
QSP under the influence of Drugs/Alcohol	1	0	0	1	Technical assistance-employee was terminated
self-Neglect	0	0	0	0	
Other	0	0	0	0	
Total complaints associated with TPM	35	16	5	14	Complaint Report June 14, 2022

Appendix D


North Dakota HCBS Services (2021)
DIVIDE
6 Members
1306 Units
5 Providers
BURKE
9 Members
3951 Units
8 Providers
5 Members
1225 Units
4 Providers
RENVILLE
BOTTINEAU
32 Members
23451 Units
22 Providers
ROLETTE
130 Members
147283 Units
81 Providers
TOWNER
11 Members
5944 Units
11 Providers
CAVALIER
11 Members
4831 Units
13 Providers
PEMBINA
26 Members
21292 Units
21 Providers
Out of State
33 Members
17708 Units
32 Providers
WILLIAMS
57 Members
92748 Units
29 Providers
MOUNTRAIL
15 Members
11059 Units
10 Providers
WARD
231 Members
358485 Units
85 Providers
MCHENRY
28 Members
22017 Units
25 Providers
30 Members
23472 Units
17 Providers
PIERCE
BENSON
52 Members
68847 Units
43 Providers
RAMSEY
89 Members
161900 Units
49 Providers
WALSH
37 Members
19247 Units
22 Providers
NELSON
16 Members
20026 Units
15 Providers
GRAND FORKS
247 Members
302454 Units
96 Providers
MCKENZIE
13 Members
5307 Units
15 Providers
DUNN
15 Members
18131 Units
14 Providers
MCLEAN
29 Members
18439 Units
26 Providers
SHERIDAN
9 Members
1820 Units
9 Providers
WELLS
26 Members
32308 Units
18 Providers
EDDY
10 Members
4246 Units
8 Providers
FOSTER
9 Members
3159 Units
6 Providers
GRIGGS
9 Members
1663 Units
7 Providers
STEELE
12 Members
1556 Units
6 Providers
TRAILL
42 Members
53184 Units
21 Providers
53 Members
22270 Units
19 Providers
MERCER
OLIVER
2 Members
2096 Units
4 Providers
BILLINGS
Members
Units
Providers
GOLDEN VALLEY
10 Members
2835 Units
4 Providers
STARK
124 Members
161436 Units
56 Providers
MORTON
135 Members
156600 Units
92 Providers
BURLEIGH
316 Members
427158 Units
149 Providers
KIDDER
5 Members
14279 Units
10 Providers
STUTSMAN
63 Members
34583 Units
21 Providers
BARNES
31 Members
39600 Units
18 Providers
CASS
571 Members
821470 Units
201 Providers
SLOPE
3 Members
1941 Units
4 Providers
HETTINGER
14 Members
54294 Units
12 Providers
GRANT
11 Members
3000 Units
9 Providers
EMMONS
24 Members
11984 Units
16 Providers
LOGAN
6 Members
1229 Units
10 Providers
LAMOURE
13 Members
2667 Units
8 Providers
RANSOM
50 Members
34069 Units
18 Providers
RICHLAND
82 Members
105361 Units
35 Providers
BOWMAN
16 Members
10465 Units
8 Providers
ADAMS
25 Members
18798 Units
12 Providers
SIOUX
47 Members
123034 Units
8 Providers
MCINTOSH
18 Members
3337 Units
16 Providers
DICKEY
28 Members
6877 Units
14 Providers
SARGENT
17 Members
7742 Units
11 Providers