Implementation Plan

December 15, 2022 – December 14, 2023

North Dakota Department of Health and Human Services

Aging Services

Submitted June 14, 2022

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List of Acronyms

ADA – Americans with Disabilities Act
ACL – Administration for Community Living
ADRL – North Dakota Aging and Disability Resource Link
APRA – American Rescue Plan Act
CMS – Centers for Medicare and Medicaid Services
CIL – Center for Independent Living
CQL – Council on Quality and Leadership
DHS – Department of Human Services
DHHS – North Dakota Department of Health and Human Services
DOJ – Department of Justice
DSW/FC Resource and Training Center - Direct Service Workforce/Family Caregiver Resource and Training Center
FMAP-Federal Medical Assistance Percentage
FTE – Full-Time Equivalent
HCBS – Home and Community-Based Services
IP - Implementation Plan
MFP – Money Follows the Person
MFP-TI – Money Follows the Person-Tribal Initiative
NAHRO – National Association of Housing and Redevelopment Officials
NCAPPS - National Center on Advancing Person-Centered Practices and Systems
NCI-AD – National Core Indicators – Aging and Disabilities
ND – North Dakota
NDHFA – North Dakota Housing Finance Authority
NF – Nursing Facility
NF LoC – Nursing Facility Level of Care
PCP – Person Centered Plan
PCPs – Person Centered Plans
PSH – Permanent Supported Housing
PPE – Personal Protective Equipment
QI – Quality Improvement
QSP – Qualified Service Providers
RD – Rural Differential
SA - Settlement Agreement
SME – Subject Matter Expert
SNF – Skilled Nursing Facility
SPED – North Dakota Service Payments for the Elderly and Disabled Program
TA – Technical Assistance
TPM - Target Population Member
TPMs – Target Population Members
USDOJ – United States Department of Justice

Introduction

About the Settlement Agreement (SA)

On December 14, 2020, the State of North Dakota (State) 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 addresses a variety of concerns that were brought forward by Target Population Members (TPMs). The concerns included the following:

- Unnecessary segregation of individuals with physical disability in skilled nursing facilities (SNF) who would rather be served in the community,
- Imbalance of funds for services delivered in skilled nursing facilities versus community-based services, and
- Lack of awareness about existing transition services and other available tools people can utilize to access in-community supports.

As defined in Section IV of the SA, for purposes of the SA, a **TPM** is:

- an individual with a physical disability,
- over the age of 21,
- who is eligible or likely to become eligible to receive Medicaid long-term services and supports, and;
- likely to require such services for at least 90 days.

The strategies developed to meet the requirements of the SA will have long-lasting benefits for current and future TPMs who want to live and receive services at home and enjoy the benefits of living in a non-institutional setting. The work to be accomplished as per the SA will:

- Expand awareness of and access to community-based care,
- Allow individuals to make an informed choice about how and where they want to live and receive necessary services, and
- Build upon legislative investments and a shared goal to improve services to North Dakotans.

The North Dakota Implementation Plan

Over the eight years of the SA, the State will define and implement initiatives that will help effectuate system transformation.

The SA requires the development of an Implementation Plan (IP) (defined in Section VI) and subsequent updates at 18 months and annually thereafter.

The updated IP outlines actions to be taken from December 15, 2022, to December 14, 2023, of the SA, with annual updates to follow that will outline both new initiatives and operational challenges and successes.

The IP update identifies benchmarks, timelines, and performance metrics for meeting the SA requirements, assigns agency and division responsibility for achieving those benchmarks, and establishes strategies to address challenges to implementation.

Our Vision: Re-aligning Systems of Care

North Dakota (ND) is actively working to transform the home and community-based services (HCBS) experience for TPMs, making sure it is streamlined, effective, culturally-informed, and a viable alternative to institutional living.

The overarching vision that guides the State's efforts under the SA is to take actions that support the ability of TPMs to make an informed choice about where they want to live and how they want to receive needed services and supports.

Although the State has made strides to increase awareness of HCBS options, too many TPMs' experiences suggest that their main option for receiving supportive services is in an institutional setting, and that few alternative options for services delivered in a home setting exist. Much of this problem stems from a lack of direct care staff willing to provide necessary care.

The IP outlines dozens of strategies that, when taken together, will effectively change systems of care in ND, which will ultimately transform a TPM's ability to choose to live in an integrated community setting.

For this vision to be realized, ND needs to transform people's ability to access HCBS and housing supports and to effectuate necessary reforms in the hospital discharge and long-term care delivery systems in the State.

The strategies contained in the IP 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 informed choice.

- Widen the array of services available, including more robust housing supports.

- Strengthen interdisciplinary connections between professionals who work in behavioral health, home health, housing, and 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.

Policy and Process

The State intends to:

- Streamline and accelerate provider enrollment processes.
- Evaluate additional opportunities to provide HCBS through various Medicaid authorities that fund in-home and community-based services.
- Establish processes that can be operationalized.
    - Annual Nursing Facility Level of Care (NF LoC) screening determinations,
    - Provision of information and assignment of a case manager to all TPMs,
    - Consistent engagement with TPMs through in-reach and outreach, and
    - Effective transition and diversion support teams.
- Review and improve policies around:
    - Case management and transition coordination,
    - Rate structures for difficult-to-access services,
    - Risk management/incident prevention, and
    - Effective integration of reasonable modifications into Person Centered Plans (PCPs).

Case Management and Expanded Services

The State intends to:

- Broaden access to HCBS case management and informed choice referral and person-centered planning processes.
- Expand transition and housing supports, with a focus on building connections between TPMs and professionals involved in both supportive services and housing services.
- Strengthen interdisciplinary connections between professionals who work in behavioral health, developmental disabilities, home health, housing, and HCBS.
- Expand access to permanent supported housing by offering rental assistance and new support service connections.
- Provide incentives to service providers who are willing to expand the HCBS services they offer.

Training and Capacity Building

The State intends to:

- Develop recruitment and retention strategies to help individuals and businesses to develop the capacity needed to expand their offerings of HCBS.
- Increase the efficiency with which Qualified Service Providers (QSPs) are enrolled and available to provide services.
- Further develop resource and training centers for consumers, direct care workforce, peer specialists, and HCBS providers.
- 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.
- Move forward with the HCBS capacity building initiatives outlined in the American Rescue Plan Act (ARPA) of 2021, Section 9817 funding plan, including increased competency related to behavioral health.
- Build capacity across disciplines to foster greater understanding of housing strategies, including rental assistance policies and environmental modifications.

Data and System Tools

The State intends to:

- Continue to enhance the case management platform to better connect all parties involved in serving TPMs, with connections established between related data systems [such as the Aging & Disability Resource Link (ADRL) and rental assistance].
- Create resources that support improved practice, including a QSP match portal, housing inventory, environmental modification resources, and referral networks.
- Implement quality measures, including National Core Indicators (NCI) to inform policy and practice.

A Review of IP Themes

The SA is structured in 18 sections. Sections I – VI and XVII-XVIII outline the overall parameters of the SA. Sections VII – XVI each outline an element of focus, which are intended to support the State's overall responsibility per the SA to serve individuals in the most integrated setting appropriate.

The State's IP is designed to follow the same "section" format as used in the SA. Key themes from each section are summarized below.

1. **Case management** is a core service that helps connect TPMs to the information and resources they need at a moment of a critical life decision. The availability of competent, person-centered case management that is built on a foundation of thorough and timely assessment is a critical component of

any high-functioning HCBS system. *[Section VII of SA]*

2. **Person centered Plans (PCPs)** need to be at the heart of the State's HCBS system. The strategies in the IP are intended to solidify the principles and practices of PCP development as a foundational element of the State's delivery of HCBS, both through training and the establishment of new processes that support in-reach as a critical element of connection. *[Section VIII of SA]*

3. To make non-institutional housing options possible, TPMs must have access to **community-based services** when and where they need them. The IP establishes work groups tasked with identifying opportunities to improve service delivery and reasonable modification processes, develop and deliver targeted training, and access to capacity-building resources and supports for service providers. *[Section IX of SA]*

4. Having access to information at the right time requires both the State and its private health-care partners to modify processes and practices related to screenings and Level of Care assessments. The IP focuses on evaluating and modifying policy as needed, and on establishing a functioning **LTSS options counseling** (Informed Choice) referral process that can effectively identify TPMs and provide them with both information and a PCP to facilitate their informed choice. *[Section X of SA]*

5. Facilitating **transitions** from a SNF to permanent supported housing (PSH) requires coordination of resources and access to both housing and services in the community where a person is going to live. The IP builds capacity across systems to expand the number of successful transitions that occur across North Dakota. *[Section XI of SA]*

6. Permanent supported **housing** (PSH) is the broad term used to describe community-based housing alternatives to an institutional setting. PSH must be integrated, affordable, and accessible as per a TPM's needs. Additionally, the TPM must be able to access the long-term services and supports the TPM needs to maintain independence in the community setting. The State will work with partners to broaden access to supports that create PSH in communities across North Dakota, including rental assistance, transition supports, resources to help modify living environments, and general facilitation of TPMs' needs related to identifying suitable housing. *[Section XII of SA]*

7. In North Dakota, HCBS are delivered primarily by private sector **providers**, both nonprofit and for-profit. Building private sector **capacity** to deliver services will require policy changes, incentives, coaching and support. *[Section XIII of SA]*

8. Making connections at the right time and with the right resources is essential to enabling informed choice. Conducting effective **in-reach** and **outreach**,

building capacity to serve TPMs, empowering peer and **natural supports**, and aligning screening and referral processes to support an individual PCP requires policy modifications, changes in process and practice, and training. *[Section XIV of SA]*

9. The State must be able to measure the impact of the changes it is making across systems by understanding the impact of work that happens within and between systems. The intentional development of cross-system approaches to **data collection** and analysis that are outlined in the IP will help assure continued attention to benchmarks and performance measures. *[Section XV of SA]*

10. Defining and understanding indicators of **quality** in how services are delivered and how systems operate will require the State to examine performance measures that allow for direct assessment. *[Section XVI of SA]*

IP Timeline and Process

The initial IP was developed with input from stakeholders and feedback from both the USDOJ and the Subject Matter Expert (SME) and his team. Expectations for the IP are outlined in Section VI of the SA.

The State's focus in the initial IP (covering the first 24 months of the SA) was to set the foundation for our work by addressing elements from each of the requirements outlined in Sections VI – XVI of the SA. The State's IPs are designed to follow the same "section" format as used in the SA.

This updated IP includes the strategies that will continue to be implemented in Year 3 of the SA, as well as new strategies that were designed based on lessons learned and data from the first year and a half of SA implementation.

It is noteworthy that this revised Implementation Plan pertains to a specific timeframe, namely Year 3 (December 15, 2022, through December 14, 2023) of the Settlement Agreement. The timing for the submission of this revision in the middle of Year 2 of the Agreement (as required by the Settlement Agreement) predates the Executive budget request (submitted around December of 2022) as well as appropriations and authorizations that may be made by the Legislature. The Legislature will next convene in January of 2023 to consider appropriations and legislation for fiscal years 24 and 25. It is anticipated that legislative actions will not be finalized until the Spring of 2023. The highlights of Executive proposals, Legislative actions and any implementation strategies that may be necessary will be reflected in the next revision of the Implementation Plan (for Year 4) that will be submitted in June of 2023.

The document contains hyperlinks to help the reader navigate between the requirements of the SA and the strategies designed to meet those requirements in the IP.

The strategies under each section of the IP provide the details on how the State continues to meet the requirements of the SA during year three of implementation. New or updated strategies are marked as such to aid the reader's review. The IP and strategies within the plan may be revised as necessary to meet the SA requirements.

Sections VI and XVII of the SA outline timelines that apply to the IP and subsequent updates.

Plan	Submitted By	Approved By*	Time Period Covered
IP	May 25, 2021	Sept. 22, 2021	Dec. 14, 2020 – Dec. 14, 2022
IPr1**	June 14, 2022	Aug. 15, 2022	Dec. 15, 2022 – Dec. 14, 2023
IPr2	June 14, 2023	Aug. 15, 2023	Dec. 15, 2023 – Dec. 14, 2024
IPr3	June 14, 2024	Aug. 15, 2024	Dec. 15, 2024 – Dec. 14, 2025
IPr4	June 14, 2025	Aug. 15, 2025	Dec. 15, 2025 – Dec. 14, 2026
IPr5	June 14, 2026	Aug. 15, 2026	Dec. 15, 2026 – Dec. 14, 2027
IPr6	June 14, 2027	Aug. 15, 2027	Dec. 15, 2027 – Dec. 14, 2028

Period of Substantial compliance: Dec. 15, 2028 – Dec. 14, 2029
Termination of SA if Substantial Compliance by Dec. 14, 2029, is achieved

**The noted approval date is an estimate based on timelines suggested by the processes that are described in the SA. **Implementation Plan Revision (IPr)*

The State will report on its progress in achieving the overall objectives of the SA, including updated progress on performance measures and SA benchmarks on a semiannual basis throughout the term of the SA.

The IP and all related reports will be made available to the public via the State's DOJ website: https://www.nd.gov/dhs/info/pubs/doj-settlement.html.

Lessons Learned

During the current SA implementation, a few key strategies proved to be very effective in creating awareness and increasing access to HCBS for TPMs. The data below is reflective of progress made from December 15, 2020 – December 14, 2021.

- Streamlining the training and supervision of the HCBS Case Managers helped to ensure a quality network of professionals able to help TPMs successfully be diverted or transitioned from institutional placement. Using updated person-centered planning tools, case managers conduct effective person-centered

planning to ensure the necessary services and supports are available to help TPMs live in the most integrated setting.

  - **Transitioned 88 TPMs** from a SNF to integrated community housing where they can receive necessary support while enjoying the freedom and benefits of community living.
  - **Diverted 268** individuals from a SNF by providing necessary services and supports so they can remain at home with their family and friends.
  - Provided State or federally funded HCBS to **3,143 unduplicated** adults in 2021.

- Shifting to centralized intake using the Aging and Disability Resource Link (ADRL) website and a toll-free phone line linking people with disabilities to HCBS support, allowed the State to substantially increase the ability to provide information and assistance and help people apply for HCBS.

  - ADRL staff provided **10,854 callers** with information and assistance about HCBS and responded to **1,744 referrals** for HCBS, which is an average of 159 per month.

- Connecting TPMs in hospitals and SNFs who were referred for a long-term stay at a SNF and providing them with information about HCBS, person-centered planning, and transition supports significantly increased the number of referrals to the Money Follows the Person (MFP) program.

  - LTSS options counseling staff provided **information about HCBS** options through informed choice referral visits to **936** TPMs referred for a long-term stay in SNF.

  - In 2021, 83 referrals were made to MFP because of the LTSS Options Counseling (informed choice) visits. In the first 6-months of 2022, MFP received 90 referrals because of the LTSS Options Counseling (informed choice) visits.

- Implementing a transition team that includes the HCBS case manager, MFP transition coordinator, and the housing facilitator has improved the relationships between State and contracted staff and improved the quality of the transition planning for TPMs returning to an integrated setting.

- Adding community support services and residential habilitation to the HCBS 1915 (c) HCBS Medicaid waiver service array and paying for the Council on Quality and Leadership (CQL) accreditation for Agency QSPs helped recruit more Agency QSPs willing to enroll to provide these important 24-hour alternatives to institutional care. This strategy allowed TPMs with some of the highest care needs to safely transition from SNFs to the most integrated setting.

- **Eleven** Agency QSPs were **successfully enrolled** as residential habilitation or community-support providers. The State paid for the initial CQL accreditation for **five** of the Agency QSPs.

- The COVID-19 pandemic and corresponding federal relief funds **increased both the demand** for HCBS and the **resources available to provide them**. Because of the health and visitation restrictions that were required in SNFs, TPMs who may have previously agreed to SNF placement were looking for alternatives even for short-term placement. This accelerated the awareness of HCBS and increased the need for HCBS.

Year Three Priorities

During Year Three of SA implementation, additional key strategies will need to be implemented or finalized to ensure the upcoming Settlement Agreement benchmarks are met and system change efforts are successful. They include:

- Increasing the direct care workforce and improving the QSP experience by streamlining the provider enrollment and revalidation of QSPs. This will include:

    - Ensuring the provider enrollment vendor has sufficient staff to complete all new enrollment applications within 14 calendar days of receipt of a complete application as required and process provider revalidations prior to the revalidation due date.

    - Collaborating with the QSP Hub to design the right type of training, support, and professional development opportunities to retain and attract a sufficient number of QSPs to meet the growing demand for HCBS.

    - Collaborating with stakeholders and industry leaders to find ways to identify and recruit traditional and nontraditional providers willing to expand their business model to include the provision of HCBS.

    - Connecting and recruiting family caregivers who initially enrolled to serve a relative but may be willing to serve as a caregiver for other members of their community if asked.

- Reducing the responsibility of individual QSPs and improving the recruitment and retention of providers statewide. The State will consider other provider models and the feasibility of including formal self-direction policies in the HCBS waiver and Medicaid State Plan – Personal Care that may be approved during the 2023 - 2025 legislative session.

- Implement the recommendations made in HCBS rate study to offer incentives for

QSPs to provide the services and supports most likely to assist TPMs in living in the most integrated setting that may be approved during the 2023 - 2025 legislative session. Offering the right rate for the most effective services will help create real systems change and the most efficient use of resources.

- Increasing awareness and access to HCBS for TPMs requires a case management structure that is able to provide effective person-centered planning and ongoing case monitoring. The State needs to develop internal staff capacity to meet the case management demands of a growing number of TPMs who are living in the most integrated setting appropriate.

    - Additional review and simplification of the HCBS system is necessary to ensure case managers have enough time to provide quality case management.

- Continue to improve and develop the reporting and data collection process to implement the required activities of the Settlement Agreement and effectively use data to assess HCBS service quality and outcomes.

- Use all available Federal and State resources to provide permanent supported housing opportunities to TPMs so they can live in the most integrated setting appropriate.

    - Focus on a structured effort to match some of the hardest-to-resolve barriers to maintaining stable housing with a broadly defined set of solutions that may be able to address and alleviate the barrier.

IP Performance Measures and Benchmarks

The timelines listed under the strategies are estimated internal target completion dates unless otherwise noted. The dates were developed internally by the State and are not governed by the SA and may be modified as necessary and without consequence to the State's compliance with the SA.

The following is a summary of Year Three and Year Four Benchmarks identified in the SA. Much of the work in Year Three will help the State reach the Benchmarks for Year Four.

By June 15, 2023

- Submit an **updated IP** for **Year Four** of the SA to the USDOJ and SME. *SA, Section VI.G*
- Submit *a **biannual data report** to the USDOJ and SME. SA, Section XV. D.*

By December 14, 2023

- Provide permanent **supported housing** to at least 60 TPMs with an identified

need for these services. *SA, Section XII, B(1c)*

- Submit a ***biannual data report*** to the USDOJ and SME. *SA, Section XV. D.*

By June 14, 2024

- Submit an **updated IP** implementation plan for **Year Five** of the SA to the USDOJ and SME. *SA, Section VI.G*
- Submit *a **biannual data report** to the USDOJ and SME. SA, Section XV. D.*

By December 14, 2024

- **Transition 60% of TPMs** who are **requesting transition** from skilled nursing facilities**.** SA, *Section XI, E. (2b)*
  - **Continue to ensure** they occur **no later than 120 days** after the member chooses to pursue transition to the community. *SA, Section XI, E. (2a).*
  - **Divert an** additional **150 at-risk TPMs** from SNFs to HCBS. *SA, Section XI.E. (2b)*
  - Provide permanent **supported housing** to TPMs based on aggregate need. *SA, Section XII, B(1d).*
  - Conduct individual **in-reach to 1,000 TPMs** residing in SNFs. *SA, Section XIV.A.(1).*
  - Submit a **biannual data report** to the USDOJ and SME. *SA, Section XV. D.*
  - Additional **650 TPMs receive PCP**. **Half** need to be **TPMs residing in a SNF**. *SA, Section VIII. I. (3).*
  - Updated IP addresses allocating **resources sufficient to assist with permanent supported housing.** *SA, Section XII. B.*

SA Section VI. Implementation Plan

Responsible Division(s)

ND Governor's Office and ND Department of Health and Human Services (DHHS) Aging Services.

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

Nancy Nikolas Maier has been appointed as the Agreement Coordinator and 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. Michele Curtis, Settlement Agreement Support Specialist was hired to assist with administrative and reporting duties required in the SA.

Draft Updated IP (Section VI, Subsection B & C, page 9)

Implementation Strategy

The State holds regularly schedule meetings to review progress toward implementing the strategies included in the IP and to develop new strategies that will assist the State with implementing the requirements of the SA. The information gathered and the experienced gained in the first year and a half of the SA has been used to draft updates to the IP. **(Submitted June 14, 2022)**

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

Implementation Strategy

Strategy 1. Continue to conduct internal and external listening sessions that include a review of relevant services with stakeholders and staff from the ND DHHS Aging Services, Medical Services, Developmental Disability, and the Behavioral Health Division. 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)**

Performance Measure(s)

Increase number of eligible individuals receiving HCBS.

Number of providers enrolled to provide services.

Average length of time provider remains enrolled to provide services.

Number of consumers served.

Updated Strategy 2. Implement recommendations from the HCBS rate study conducted with assistance of a contracted vendor with expertise in analyzing rates for HCBS. The State will implement any changes to the rates for HCBS that may be approved during the 23-25 legislative session. Full implementation may require regulatory authority that could include approval of a Waiver amendment by the Centers for Medicare and Medicaid Services (CMS). **(Target completion date January 1, 2024)**

Updated Strategy 3. Work with the QSP Hub to increase the number of residential habilitation, community-support services, and companionship providers available to assist TPMs enrolled in the HCBS 1915 (c) Medicaid waiver. **(Target completion date December 14, 2022, and ongoing)**

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

Implementation Strategy

Strategy 1. The State will continue to create ongoing stakeholder engagement opportunities including quarterly ND USDOJ SA IP stakeholder meetings through year three 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.

Meeting Schedule:

- March 16, 2023
- June 15, 2023
- September 14, 2023
- December 14, 2023

Performance Measures

The state will work with NDCAPPS to develop a process to grade quality of stakeholder engagement.

Updated Strategy 2. The State will continue to work with community partners to hold in-person HCBS Community Conversations in rural and frontier areas of the state including Native American reservation areas in ND. The State will target small communities who lack LTSS options and discuss ways that services can be developed in these hard to serve areas. 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 post meeting dates on a calendar of events section on the DOJ portion of the DHHS website. **(Target completion date December 31, 2023)**

Performance Measures

Number of stakeholder engagement opportunities provided.

Number of attendees.

Type of attendees represented at stakeholder engagements. For example, individuals receiving services, advocates, providers etc.

Location of stakeholder engagement opportunities.

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

Implementation Strategy

Strategy 1. The State will meet no less than weekly with SME to discuss topics pertinent to the development of the IP revisions. The revisions to the IP will focus on implementation for the upcoming year, challenges encountered by the State to date, and strategies to resolve them with plans to address noncompliance if required. **(Ongoing strategy plan updated June 14, 2022)**

Strategy 2. Each revision to the IP will include a review of data collected and outcomes achieved, and how that informs revised strategies. **(IP updated June 14, 2022)**

Website (Section VI, Subsection H, page 10)

Implementation Strategy

Maintain a webpage for all materials relevant to ND and USDOJ SA on the DHHS website. The plan and other materials are 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. **(Ongoing strategy)**

The DHS is updating its website because of the merger with the ND Department of Health. The new website will be operational on September 1, 2022, when DHS officially becomes the Department of Health and Human Services (DHHS).

SA Section VII. Case Management

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

Strategy 1. The State will employ HCBS case managers who will provide HCBS case management full time. The State will continue to look for ways to streamline the supervision, training, and the implementation of HCBS consistently across the State. (**Ongoing strategy)**

Challenges to Implementation

Finding qualified case management staff in rural or frontier areas of ND.

Remediation

Hire and closely supervise social workers with less than one year experience and allow staff to telecommute from surrounding areas.

Strategy 2. The State will require all newly hired HCBS case managers to complete a comprehensive standardized training curriculum that has been developed within three months of employment. 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 will continue to contract with a local expert in Native American cultural competency to develop and deliver training for HCBS case managers. Post-training evaluation tools to ensure understanding of training objectives will be developed. **(Ongoing strategy)**

Challenges to Implementation

The State will work with NCAPPS to develop a process to objectively measure increased cultural awareness.

Performance Measure(s)

Percent of new HCBS case managers trained in the standard curriculum within three months of their hire date.

Percent of HCBS case managers trained to cultural sensitivity annually.

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

New Strategy 3. The State used ARPA funds to expand the ADRL capabilities by hiring one staff person to pilot a provider navigator position. The provider navigator will assist the HCBS case managers in Bismarck and Fargo, ND in finding QSPs to serve eligible HCBS recipients. This will free up time for the case managers and assist them in keeping up with the increased demand for HCBS.

Challenges to Implementation

There are other areas in the State that could benefit from the assistance of a service navigator, but the amount of ARPA funds limited the number of staff that can be hired.

Remediation

With the cooperation of Aging Services, the ND Department of Health, Division of

Health Promotion submitted a grant application to the Administration for Community Living (ACL) titled, “Alzheimer's Disease Programs Initiative (ADPI) - States and Community Grants”. If awarded the grant would fund one additional service navigator position. (**Target completion date October 1, 2022)**

- The State will continue to assess the need and will implement any service navigator full time equivalent (FTE) position that may be approved during the 23-25 legislative session.

Performance Measure(s)

Number of individuals eligible for HCBS who were successfully matched with a QSP with the assistance of a service navigator.

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

Average number of days to assign an HCBS case manager following referral.

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

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

Strategy 4. Continue the 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. All TPMs who are referred for a long-term stay in a SNF are contacted. **(Ongoing strategy)**

Challenges to Implementation

Adequate staff capacity to conduct informed choice visits and HCBS case management for all TPMs eligible to receive LTSS options counseling.

Remediation

The State is using ARPA funds and MFP capacity building funds to employ 10 staff to conduct LTSS options counseling/informed choice referral visits. The State will assess need and hire and train any additional LTSS options counseling FTE that may be approved during the 23-25- legislative session. **(Target completion date September 1, 2023)**

Performance Measure(s)

Number of informed choice referrals.

Number of TPMs referred through informed choice to transition services through MFP.

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

Strategy 5. Sustain the public awareness campaign created to increase awareness of HCBS and the ADRL by running the social media ads twice per year. State staff will also man information booths at community events and will make themselves available for media requests and to present information about HCBS at stakeholder meetings and virtual an in-person conferences across the State. **(Target completion date December 14, 2023)**

Performance Measure(s)

Number of ADRL contacts per month.

Number of community events where State staff provided information about HCBS.

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 hire and train any additional FTE that may be approved in the 23-25 budget. **(Target completion date September 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 (MFP-TI) funds to help tribal entities hire licensed social workers to provide culturally competent HCBS case management services in Native American communities.

Performance Measure(s)

Total number of HCBS case managers hired by Tribal nations.

Average tribal case manager retention rate.

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

Assignment (Section VII, Subsection B, page 10)

Implementation Strategy

Strategy 1. Ensure that the supervisors are assigning the case manager to TPMs already living in the community and requesting HCBS within two business days. **(Completed July 1, 2022 and ongoing)**

New Strategy 2. Assign a case manager to every SNF and hospital to provide case management to all TPMs residing in the facility. When TPMs are referred for a long-term stay in the facility it will trigger a referral to the LTSS options counselors who are responsible for providing case management to SNF TPMs. If the TPM expresses interest in HCBS a referral is made to MFP or ADRL transition and a HCBS case manager is assigned, and person-centered planning is completed.

TPMs who indicate during the options counseling visit that they are not currently interested in exploring services in the community will be provided written information on HCBS, asked if they would like to schedule a follow up visit, and provided the name of the case manager assigned to the facility with the instructions to contact them anytime. If they decline a follow-up visit, the case manager will be required to make an annual in-person visit thereafter and will complete a person-centered plan.

TPMs who are already residing in a SNF will be visited by the LTSS Options Counselor that is assigned as the case manager to the facility where they reside. TPMs already residing in the SNF will be seen based on the month that their original NF LoC determination was made. The case manager will make an in-person visit and will complete person-centered planning and referral to MFP or ADRL transition if appropriate at least annually or upon request.

Challenges to Implementation

The State needs to address the logistics of providing case management to all TPMs as required in the agreement.

Remediation

The state will use a tiered case management approach described above 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. The State worked with the NF LoC vendor to create a report and process for case managers to receive referrals by facility so they can provide services as efficiently as possible. **(Ongoing strategy)**

Performance Measure(s)

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

Number of TPMs assigned to a HCBS case manager.

Number of annual visits made to TPM in SNF.

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 is used to determine staff capacity and number of FTEs needed. **(Ongoing strategy)**

Performance Measure(s)

Average weighted caseload per Case Manager.

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

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. **(Ongoing strategy)**

Challenges to Implementation

The volume of ADRL referrals, informed choice visits requests, and interest in HCBS in general remains high. Additional staff are needed to complete case management functions.

Remediation

The State is using ARPA funds to hire two Aging Services generalist case management positions to pilot the concept of having a Case Manager that is trained to provide all services administered by Aging Services. The individual could assist with HCBS case management as well as conduct option counseling visits. Providing support for both OAA services and HCBS allows the State to use OAA funds to help meet the growing need for case management.

The State changed the weighted caseload assignment process to ensure the appropriate amount of case management services are being provided to TPMs. The new case management system has streamlined the way HCBS Case Mangers complete their work, so all HCBS funding sources carry the same weight. The weight for providing case management to TPMs receiving 24-hour

support services and for those who are transitioning from a SNF were increased.

HCBS Case Management requirements for Basic Care were changed to require an annual face to face visit instead of twice per year. Providing annual case management visits is allowed per federal regulation and will significantly decrease the amount of time it takes to provide case management for this population. **(Ongoing strategy)**

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. 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 DHHS Medical Services Program Integrity Unit which may result in the termination of provider enrollment status. **(Ongoing strategy)**

Performance Measure(s)

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

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

Number of investigations initiated due to denial of access.

Strategy 2. Conduct training with hospital and SNF staff to discuss HCBS option counseling, facility case management for TPMs, and the required annual level of care screening, The training will be adjusted over time to reflect further changes to the NF LoC process and to address any emergent issues. **(Target completion date December 14, 2023)**

Challenges to Implementation

Additional training to ensure new hires and existing staff are continuously aware of the informed choice process and the requirement for HCBS case manager access in the SNF.

Remediation

Training will be held at least annually in year three of the settlement agreement. **(Target completion date December 14, 2023)**

Performance Measure(s)

Number of SNF and hospital staffed trained.

Pre and post tests will be used to measure knowledge of training content.

New Strategy 3. Utilize the educational materials created to inform TPMs, family, legal decision makers of the requirements of the SA, LTSS Options Counseling, ongoing case management for SNF TPMs, and that TPMs must complete an annual NF LoC determination. **(Target completion date December 14, 2023)**

Performance Measure(s)

Number of annual visits made to TPMs in SNF.

Updated Strategy 4. Address issues of affording Case Managers full access to TPMs who are residing in or currently admitted to a facility. 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.

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 DHHS Medical Services Program Integrity unit which may result in the termination of provider enrollment status. **(Ongoing strategy)**

Performance Measure(s)

See information under performance measure in Strategy 1.

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. **(Ongoing strategy)**

Performance Measure(s)

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

Quality (Section VII, Subsection F, page 11)

Implementation Strategy

To ensure a quality HCBS case management experience for all TPMs the State will conduct annual case management reviews to ensure sampling of all components of the process (assessment/person-centered planning/authorization/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. **(Target completion date January 1, 2023, and ongoing)**

Performance Measure(s)

The State will compile individual audit data into an annual report and 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)

DHHS Aging Services

Training (Section VIII, Subsection A, page 11)

Implementation Strategy

State staff, public, private, and tribal HCBS case managers will continue to use the fully implemented case management system 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 system. **(Ongoing strategy)**

Challenges to Implementation

New and existing HCBS case managers must be trained on new person-centered planning framework tools and post-training evaluation needs to occur to ensure staff competency. The State will work with NCAPPS to develop a post-training evaluation that measures competency on the framework and develop a related performance measure.

Remediation

The State will continue to work with Human Service Research Institute (HRSI) and LifeCourse Nexus University of Missouri Kansas City Institute for Human Development and stakeholders to adopt performance measures, core competencies, and identify the corresponding skills and abilities necessary to demonstrate proficiency in person-centered planning principles. **(Target completion date December 14, 2023)**

Performance Measure(s)

Number of new HCBS case managers fully trained in “Charting the LifeCourse” and other person-centered planning tools.

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

Number of HCBS case managers who meet core person-centered competencies.

Number of HCBS case managers

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

Implementation Strategy

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 PCP will be updated when an TPM goes to the hospital or SNF and remains available and accessible in the new system when the TPM returns to the community.

During the annual case management review process the State will review 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. **(Ongoing strategy)**

Performance Measure(s)

Number of PCPs completed per month.

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

Person-Centered Planning Policy (Section VIII, Subsection D and E, page 12)

Implementation Strategy

Current policy requires that when a TPM applies for long-term services, the HCBS case manager or the MFP transition coordinator initiates the person-centered planning process. The person-centered planning process policy also includes resolving conflicts that may arise during the process and informing TPMs that they may obtain a second opinion from a neutral healthcare professional about whether they can receive HCBS. **(Ongoing strategy)**

Performance Measure(s)

Percent of PCPs completed within required timeframe.

Number and percent of TPMs who request a second opinion.

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

Implementation Strategy

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 DHHS Legal Advisory Unit and other agencies or boards to determine if a request for reasonable modification can be accommodated as required in the SA. **(Ongoing strategy)**

Challenges to Implementation

TPMs, HCBS case managers, and other stakeholders may not understand reasonable modification as required under Title II of the ADA.

Remediation

The State will conduct annual training with HCBS case managers and stakeholders to increase knowledge and awareness of how to identify and notify the Department that an individual has an anticipated or unmet community service need so that the State can determine whether, with a reasonable modification, the need can be met. The State will continue to track all requests for reasonable modification to identify trends in service gaps, location, utilization, or provider

capacity.

Performance Measure(s)

Number and percentage of HCBS case managers trained annually on reasonable modification.

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

Number of stakeholders provided education about reasonable modification.

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

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

Implementation Strategy

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 DHHS Aging Services 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. **(December 14, 2023, and ongoing)**

Performance Measure(s)

Number and percent of HCBS case managers trained on person-centered planning practices.

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

Number of HCBS case managers who meet core person-centered planning competencies.

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

Implementation Strategy

Through facility in-reach, community outreach, and increased public awareness of the ADRL and HCBS options, the State seeks to reach TPMs and assist them in receiving services in the most integrated setting appropriate.

In years three and four of the SA the State must conduct person-centered planning with an additional 650 TPMs. During the IP period, the State will set a goal to develop PCPs with at least 325 unduplicated TPMs. At least half of the TPMs who receive person-centered planning each year will be SNF TPMs.

Strategy 1. Ensure that a PCP is completed with every TPM who requests HCBS and is still residing in the community. **(Ongoing strategy)**

Performance Measure(s)

Number of PCPs for TPMs not residing in the SNF that are completed by December 14, 2023.

Number of PCPs for TPMs residing in SNFs that are completed by December 14, 2023.

New Strategy 2. The State has assigned a case manager to every SNF and Hospital in the State. The case managers assigned to the facility are required to begin visiting TPMs in that facility and providing person-centered planning at least annually. **(Target Completion Date December 13, 2023)**

Challenges to Implementation

Sufficient staff and system capacity to complete case management assignments and the person-centered planning process.

Remediation

With the assistance of the NFLoC vendor the State has developed a monthly report that will list TPMs by facility and by their original NFLoC determination date. The information on the report will assist the case manager in knowing who needs to be seen each month in each facility. Having the information will create efficiencies by allowing staff to schedule multiple visits at the same facility on the same day. The report will help the State keep track of the TPMs and ensure all TPMs are eventually seen as required.

Performance Measure(s)

Number of PCPs completed with SNF TPMs per month.

Number and percentage of TPMs residing in a facility who have received person-centered planning.

Strategy 3. Ongoing person-centered planning technical assistance is being provided to the State as part of an (ACL)/CMS technical assistance opportunity administered by the National Center on Advancing Person-Centered Practices and Systems (NCAPPS).

The State will ensure ongoing technical assistance by using MFP funds to procure person-centered planning technical assistance from a qualified entity from October 1, 2021 – September 30, 2025.

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

(See Appendix A). Partnering Equitably with Communities (nd.gov) **(Ongoing strategy)**

- Ensure that the Peer Support Resource Center referenced in this document provides opportunity for culturally specific peer supports to the greatest extent possible.
- Holding HCBS Community Conversations in all Native American reservation communities in ND.
- Including representation from Native Americans and New Americans when gathering public input.
- Providing cultural sensitivity training created by local subject matter experts to all HCBS case managers.
- Ensuring access to interpretive services and translating informational materials into other languages.
- Providing funds through the MFP -TI for Tribal nations to hire HCBS case managers to provide culturally competent case management services to tribal members.

SA Section IX. Access to Community-Based Services

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

Updated Strategy 1. Implement any recommendations from the Service Delivery stakeholder workgroup to add services to the state and federal funded HCBS administered by the State that may be approved during the 23-25 legislative session. Full implementation may require regulatory authority that could include approval of a Waiver amendment by CMS. **(Target completion date January 1, 2024)**

New Strategy 2. Implement any recommendations made to create or incentivize on-call services for individuals who rely on daily care to safely live in the community that may be approved during the 23-25 legislative session. Full implementation could require regulatory authority that could include approval of a Waiver amendment by CMS. **(Target completion date January 1, 2024)**

Performance Measure(s)

Number of QSPs offering on-call services.

QSP Hub/Provider Models (Section IX, Subsection D, page 14)

Implementation Strategy

Updated Strategy 1. The State will continue to use MFP capacity building funds to maintain the work of the QSP Hub operated by the Center for Rural Health (formerly referred to as the Direct Service Workforce/Family Caregiver Resource and Training Center) at the University of ND. The QSP Hub assists TPMs who choose their own individual QSPs to successfully recruit, manage, supervise, and retain QSPs. The QSP Hub will also help TPMs to understand the full scope of available services and the varying requirements for enrollment, service authorization, and interaction with HCBS case management. **(Ongoing strategy funded through September 2024)**

Challenges to Implementation

The State will work with the QSP Hub to develop a performance measure to evaluate the success of the support provided by the QSP Hub to TPMs who request assistance with self-direction.

Performance Measure(s)

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

Number of outreach efforts to increase awareness of the role of the QSP Hub.

New Strategy 2. To reduce the responsibility of individual QSPs and improve the recruitment and retention of providers statewide, the State will implement any changes to the provider model or include formal self-direction policies in the HCBS waiver and Medicaid State Plan – Personal care that may be approved during the 23-25 legislative session. **(Provider model/self-direction implemented January 1, 2024)**

Challenges to Implementation

Formal self-directed service options are part of most Medicaid funded HCBS.

States can collect federal medical assistance percentage (FMAP) for self-directed services if approved by CMS. However, most of the in-home services provided to eligible individuals in ND are funded under the State's Service Payments to the Elderly and Disabled (SPED) program which would require additional state general fund appropriations.

Remediation

The State will take all factors into consideration when determining what if any new provider models are needed to ensure TPMs can live in the most integrated setting appropriate to their needs. The State will determine the feasibility of a variety of provider models including the co-employer/agency model and a QSP rural cooperative.

Performance Measure(s)

Conduct and complete a feasibility study of a variety of provider models including the co-employer/agency model and a QSP rural cooperative. **(Target completion date December 14, 2022).**

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

Implementation Strategy

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.

Change in the number of appeals filed and outcome from the previous DOJ SA reporting period.

Strategy 3. TPMs cannot be categorically or informally denied services. Policy requires 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. **(Ongoing strategy)**

Performance Measure(s)

Number of reasonable modification requests received and outcome.

Number of appeals filed after a denial of a reasonable modification request.

Updated Strategy 4. Determine what can be gleaned from an analysis that was conducted 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 April 1, 2022)**

Performance Measure(s)

Number of service units authorized and utilized by territory.

- Link to Appendix J

Challenges to Implementation

The current process does not measure the number of services authorized versus the number of services utilized. Therefore, the ability to measure disparate availability of services by territory is not addressed.

Remediation

The State will work with the case management system vendor to create a report that will compare services authorized versus services unutilized. **(Target completion date December 14, 2022).**

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

Implementation Strategy

Strategy 1. The State will continue to work with the DHHS 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 includes the process to request a reasonable modification for review and consideration. **(Ongoing strategy)**

Performance Measure(s)

Number of reasonable modification requests received and outcome.

Change in number of reasonable modification requests received in the previous DOJ SA reporting period.

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 work to implement any recommendations developed by the Healthcare Accommodations workgroup which includes State staff and members of the Board of Nursing. Recommendations will be shared with stakeholders and their feedback incorporated into any policy or regulatory change required. **(August 31, 2023)**

Strategy 3. The State will continue to 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. **(Ongoing strategy)**

Performance Measure(s)

Number of TPMs receiving extended personal care.

Strategy 4. The State will track all requests for reasonable modification to identify trends in service gaps, location, utilization, or provider capacity. Reports are reviewed at a quarterly meeting attended by all DHHS Divisions that administer HCBS. Strategies to address identified issues will be established and included in future revisions of the IP **(Ongoing strategy)**

Performance Measure(s)

Number of requests for reasonable modification and outcome.

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.

Performance Measure(s)

Number of denials and basis for denial decisions.

Strategy 1. and 2. listed in Section IX.E and the associated measure also apply to this section.

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

Updated Implementation Strategy

Strategy 1. Continue to recruit and retain residential habilitation and community-support services funded under 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 by assisting up to five eligible agency QSPs with paying for their CQL accreditation.

Performance Measure(s)

Number of QSPs who received enrollment assistance to residential habilitation and community support services.

Number of QSPs successfully enrolled to provide residential habilitation and community support services.

New Strategy 2. Implement recommendations from the HCBS rate study conducted with assistance of a contracted vendor with expertise in analyzing rates for HCBS. The State will implement any changes to the rates for HCBS that may be approved during the 23-25 legislative session. Full implementation may require regulatory authority that could include approval of a Waiver amendment by CMS. **(Target completion date January 1, 2024)**

New Strategy 3. Implement any recommendations from the service facility workgroup to add services to the state and federal funded HCBS administered by the State that may be approved during the 23-25 legislative session. **(Target completion date January 1, 2024)**

New Strategy 4. Convene an individual adult foster care workgroup to make recommendations for changes to the current adult foster care rules and policy. The goal of the committee will be to review all rules and policy governing this service and to find ways to improve the experience for TPMs and providers.

The workgroup will be made up of State staff responsible for writing policy and licensing the individual adult foster care homes. The recommendations made by the internal committee will be shared at a public input meeting. The State will invite TPMs, family members, guardians, State administrative staff, tribal representatives, HCBS case managers, QSPs, and other interested stakeholders to participate.

State staff will be responsible for taking any regulatory action necessary to implement the agreed upon recommendations from the workgroup. **(Workgroup established - December 2022. Recommendations developed and reported - June 30, 2023)**

SA Section X. Information Screening and Diversion

Responsible Division(s)

DHHS Aging Services & Medical Services

LTSS Options Counseling (Informed Choice Referral Process) (Section X, Subsection A, page 15)

Implementation Strategy

Updated Strategy 1. Continue to conduct LTSS options counseling (informed choice referral process) with individuals to identify TPMs and provide information about community-based services, person-centered planning, and transition services to all TPMs and guardians, who are screened for a continued stay in a SNF.

TPMs are identified when they are referred for a long-term stay at a SNF. The NFLoC determination screening tool which is required to be submitted for Medicaid serves as the referral. The State receives a daily report of individuals who have recently screened. State staff are required to conduct the visits within ten business days of the referral.

If a TPM chooses HCBS, they are referred to the MFP transition coordinator who assembles the transition services team to begin person-centered planning. The transition team consists of the MFP transition coordinator, HCBS case manager and a housing support specialist.

If the TPM is not initially interested in HCBS they are asked if they want to receive a follow up visit, provided written information about HCBS and the contact number of the case manager. If they decline a follow-up visit, they are provided written information and the contact information of the case manager and are informed that Aging Services staff will make a visit on an annual basis to complete the person centered planning process. TPMs are currently asked to indicate in writing whether they received information on HCBS. **(Ongoing strategy)**

Link to Appendix B - Informed Choice Referrals ND Admin Code 75-02-02.4

Link to Appendix C - Informed Choice Educational Materials

Challenges to Implementation

Staff capacity to conduct informed choice visits and HCBS case management.

Remediation

Recruit and train any additional LTSS options counseling or HCBS case manager FTE that may be approved during the 23-25 legislative session.

Challenges to Implementation

TPMs will be seen by the facility case manager/ LTSS option counselor when initially referred for a long-term stay in a SNF. Current TPMs living in a SNF will be seen annually in the month in which they were currently determined eligible for a SNF. Because it will take time to see all TPMs in a SNF there may be individuals who would benefit from knowing about HCBS options prior to their scheduled visit.

Remediation

LTSS option counselors are required to conduct ongoing group in-reach visits to each SNF at least once per year. Providing group in-reach opportunities will help ensure that TPMs, families, and guardians will have a chance to learn more about HCBS and the benefits of community living. State staff will schedule and advertise a follow up visit at the facility to give TPMs additional time to process the information and ask any follow up questions.

Performance Measure(s)

Number of TPMs who received informed choice visits.

Number of informed choice visits that resulted in TPM transitioning to a community setting.

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

Number and percentage of informed choice visits where the TPM requested follow up and the follow-up visit occurred.

Strategy 2. The current 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. **(Ongoing strategy)**

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 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 are identified but are not available in the community, policy requires the HCBS case manager to formally request services or submit a reasonable modification request to the State for consideration. This information can currently be incorporated into the PCP. **(Ongoing strategy)**

Challenges to Implementation

HCBS case managers may not know if a community-based version of a SNF service exists. Requests for necessary services may involve supports provided through external providers or various Divisions within DHHS including Aging Services, Medical Services, Developmental Disabilities, Behavioral Health, Vocational Rehabilitation, or the Human Service Centers.

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 meeting can also include other DHHS divisions who may be involved in the TPMs care. Division staff discuss reasonable modification requests or staff situations where it is unclear which HCBS waiver or State plan benefit would best meet the needs and wishes of the TPM. **(Ongoing strategy)**

Performance Measure(s)

Number of cases staffed per interdisciplinary team meetings and outcome.

Number of requests for reasonable modification and outcome.

Updated Strategy 2. Continue to conduct an annual NF LoC screening for all Medicaid recipients living in a SNF. The NF LoC determination vendor provides written reminders to the TPMs or their legal decision maker and the SNF that the annual level of care is due. **(Ongoing strategy)**

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 thirty days. This could negatively impact TPMs who need sufficient time to transition back to the community.

Remediation

The State previously convened a NF LoC workgroup 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. The LTCC options counselors, HCBS case managers and the transition coordinators are responsible to implement the recommendations made by the workgroup.

Strategies include training the LTSS Options Counselors to help identify TPMs who may no longer meet a NFLoC and make a referral to MFP or ADRL transition services so robust transition planning, including help from the housing facilitator can begin. The timing of the annual person-centered planning visit may need to happen a few months before the annual NFLoC is due. This would give Aging staff/contractors additional time to plan for a transition should the TPM no longer appear to require skilled services. **(Ongoing strategy)**

New Strategy 3. Conduct in-person regional meetings with SNFs and offer other webinars to train SNF staff on the USDOJ SA, annual NFLoC requirements, HCBS options and effective discharge planning to ensure TPMs can live in the most integrated setting. **(Target completion date June 30, 2023)**

Performance Measure(s)

Number of in person regional meetings.

Number of regional meeting attendees.

Number of webinars.

Number of facilities represented at the webinars.

Number of facility staff represented at the webinars by job type.

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.

(Link to Appendix D - Diversion Plan)

The State is currently implementing or has incorporated recommendations included in the Diversion Plan into the initial IP. During this implementation plan period the State

will implement the following recommendations from the Diversion plan.

- Develop a formal peer support program through the proposed Peer Support Resource Center 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.

    - The Peer Support Resource center will create the opportunity for TPMs to connect with a peer who has lived experience navigating and utilizing HCBS**. (Target completion date May 1, 2023)**

- Create a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign should 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.

    - With the assistance of an advertising vendor the State created a sustainable public awareness campaign, conducted educational webinars about HCBS options that are recorded and posted to the DHHS website. The State will run the social media campaign twice per year and will continue to provide ongoing educational opportunities and use the recorded webinars to ensure TPMs are aware of HCBS options.

    - State staff will also man information booths at community events and will make themselves available for media requests and to present information about HCBS at stakeholder meetings and virtual an in-person conferences across the State. **(Ongoing strategies through December 14, 2023)**

- Identify and outreach to those TPMs who are at serious risk of entering nursing facilities. Provide outreach about HCBS to the public, senior citizen centers, and stakeholders.

    - State will conduct in-person HCBS educational events that are targeted to stakeholders and the public and held at senior citizen centers across the State.

- Provide outreach and information about HCBS that could meet the needs of TPMs requiring long term services and supports as an alternative to nursing facilities and to those who typically make NF LoC assessments and nursing home placements, with a particular focus on:
    i. hospital discharge planners,
    ii. rehabilitation facilities,
    iii. tribal agencies, and
    iv. primary care physicians serving Medicaid patients

    - State will provide in-person and virtual outreach and information events to the groups listed above to provide education on HCBS options and to strengthen relationships with the medical community. **(Target completion date December 14, 2023, and ongoing)**

- Develop a data system that tracks HCBS services and setting offered and whether they were accepted or refused and the reasons why to assist in identifying gaps or limitations in HCBS that could be addressed. **(Target completion date June 14, 2023)**

- The State has implemented the LTSS Options Counseling tools and the PCP into the case management system. The system can produce reports that will assist the State in identifying gaps in services. Reports will be run semi-annually to track trends in data.

- State should investigate options for prompt determination of Medicaid eligibility for HCBS, such as presumptive eligibility for the Medicaid-expansion adult population under the age of 65, to minimize delays involved in the authorization of HCBS **(Target completion date August 31, 2023)**

    - The State will explore the feasibility of implementing presumptive eligibility and other Medicaid authorities for providing HCBS. An internal workgroup will be created that consists of staff from Aging Services and Medical Services. The group will be responsible to research the Medicaid regulations and make recommendations on the benefits and risks of providing HCBS under other authorities.

SA Section XI. Transition Services

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

Updated Strategy 1. The State will continue to 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 may include short-term 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:

- Evaluate the current capacity of the MFP transition coordinators in Bismarck, Grand Forks, Minot, and Fargo to determine if additional FTEs are needed. If the State determines there is a need, the State will request funds in the 2023 MFP budget which requires approval from CMS. **(Target completion date December 31, 2022)**

- Recruit and retain additional community transition providers willing to enroll with ND Medicaid to provide services under the HCBS waiver by reviewing the need to provide additional incentive grants to encourage providers to enroll and proving technical assistance to the Centers for Independent Living (CILs) who are interested in expanding their capacity to provide these services. **(Target completion date December 31, 2022)**

New Strategy 2. The State will use ARPA of 2021 Section 9817 10% enhanced FMAP for HCBS funds to offer additional incentive grants to 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 $50,000 based on the priority of need of the services the agency will provide. **(Grants awarded by December 31, 2022)**

Performance Measure(s)

Number and total dollar amount of incentive grants awarded.

Implementation Strategy

New Strategy 3. Effective January 1, 2022, the definition of supplemental services was modified from one-time to short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. The State will gather input from stakeholders and transition coordinators to design and implement additional supplemental services to assist TPMs in transitioning to the community.

Ideas for additional supplemental services include:

- Food pantry stocking for a 30 day period.
- Home modifications and vehicle adaptations.
- Targeted training for direct service workforce on the unique needs of the individual prior to transition.
- Pre-tenancy supports such as apartment administrative fees. **(Target implementation date December 31, 2022)**

New Strategy 4. The State is participating in the CMS MFP data learning collaborative to meet the enhanced reporting requirements of the MFP grant. The collaborative will help state's enhance MFP data collection and quality, use data to measure MFP program performance and facilitate quality improvement. **(Target completion date August 31, 2023)**

New Strategy 5. The State will participate in the MFP Housing learning collaborative for MFP project teams coordinated by CMS and the new MFP technical assistance provider. The housing learning collaborative will discuss strategies, innovative practices, and tools that MFP programs can leverage to address challenges in locating and securing affordable and accessible housing for Medicaid beneficiaries transitioning from institutions to community-based housing.

The collaborative will inform states of innovative and effective housing strategies via webinars and panel discussions with representatives from federal and state agencies, including peer MFP programs and provide a space for MFP leaders and housing partners to engage with each other through interactive discussions. Staff from MFP, ND Housing Finance Agency and the MFP Housing Initiative Coordinator will participate. **(Target completion date August 31, 2023)**

New Strategy 6: Hire and train one additional FTE to support the work of the transition coordinators. This position will be responsible for training, providing technical assistance, staffing cases, and completing transition plan reviews. The main purpose of the position is to offer support and guidance to the transition coordination staff to ensure safe, timely and effective transitions. **(Target completion date December 31, 2022)**

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

Strategy 1. The MFP policy and procedure manual requires that transitions that have been pending for more than 100 days are reported to the SME. The Agreement Coordinator will be responsible for securely forwarding a list of the names of TPMs whose transition has been pending more than 100 days. The report will include a description of the circumstance surrounding the length of the transition. The State currently tracks the days from referral to transition. **(Ongoing strategy)**

Performance Measure(s)

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

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

Strategy 2. The State will continue to require that transitions that have been pending for more than 90 days are reported to the MFP program administrator in the MFP policy and procedure manual. The MFP State staff will facilitate a team meeting to staff the situation and provide more intensive attention to the situation to remediate identified barriers preventing timely transition. **(Ongoing strategy**)

Strategy 3. The State will continue to 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.

Performance Measure(s)

Number of transitions supports team members trained on successful strategies. **(Ongoing strategy)**

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 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 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.

Performance Measure(s)

Number of transition referrals and timelines for case management assignment.

Number of successful transitions.

Number of PCPs completed with TPMs in SNF.

Number of groups in-reach activities conducted.

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 with an additional four years of spending through 2028. The State will continue to use the funds and resources from this grant to provide transition supports**. (Ongoing strategy)**

Updated Strategy 2. By December 14, 2024, 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 60% of the TPMs who request transition to the most integrated setting appropriate. The State will also divert at least 150 TPMs from SNF to community-based services. **(Ongoing Strategy)**

Challenges to Implementation

The most significant challenge is recruiting and retaining providers who can employ enough direct care staff to provide 24-hour supports when that level of care is necessary to support the TPM in the community.

Remediation

The primary remediation effort is to address the workforce issue through the MFP capacity building funding and the ARPA of 2021 Section 9817 10% enhanced FMAP for HCBS funds. These funds will be used to offer additional incentive grants to recruit new QSPs, fund the QSP Hub, to address enrollment, retention, and training of providers, and improve the ability of TPMs to find QSPs that match their service needs through the *ConnectToCareJobs* system.

This system connects individuals to a platform for providers to market their skills and be matched with a TPM. The State worked with the QSP Hub, (formally referred to as the Direct Service Workforce and Family Caregiver DSW/FC Resource and Training Center) to develop a QSP capacity survey to determine the ability of current providers to staff their currently authorized hours, ability to staff increased hours, and capacity to serve additional clients.

The State will continue to use the information from the study to develop recruitment and retention strategies that appeal to what QSPs said they like about providing direct care i.e. ability to help others and job flexibility. **(Target completion date December 14, 2023)**

Link to Appendix H – (Partially Approved ND plan for ARPA of 2021 Section 9817 enhanced FMAP for HCBS)

Performance Measure(s)

Transition 50% of TPMs requesting transition by December 14, 2023.

125 unduplicated at risk TPMs successfully diverted by December 14, 2023

Strategy 3. The State tracks TPMs in the case management system using a unique identifier and will report unduplicated transition and diversion data. **(Ongoing strategy)**

SA Section XII. Housing Services

Responsible Division(s)

DHHS

The State's experience implementing the SA has reinforced an understanding of how important it is to help ensure that a person has access to a place to live that they can afford and that is able to meet their needs. As such, one of the primary areas of focus in year 3 of the Implementation Plan will be a structured effort to begin to match some of the hardest-to-resolve housing barriers to a broadly defined set of solutions that can help alleviate the barrier(s). We will draw on information gathered during year 1 of the IP to inform next efforts, including as an example, information gathered from housing transition specialists.

State teams will continue to consider specific housing-related items for inclusion in future IPs, with the decision on inclusion based on progress of work that is already underway and issues of high priority as indicated by our experience on the ground.

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

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. (See Appendix F- Housing Access Plan)

The State is currently implementing or has incorporated recommendations included in the Housing Access Plan into the initial IP. During this implementation plan period the State will implement the following recommendations from the Housing Access plan.

- Make progress on the establishment, integration, and operational plan for maintenance of an enhanced housing inventory resource.

- Conduct additional policy conversations in partnership with public housing

authorities and affordable housing providers across ND related to policies, preferences, and practices that would support TPMs.

- 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 LTSS options counseling (informed choice) and case management processes.

Continue to convene State Housing Services workgroup to recommend strategies that will be effective and consider the current State economic realities, housing market, and other policy issues.

Challenges to Implementation

Time and resources to effectively coordinate ongoing housing planning efforts across State systems given pace and volume of system change that is underway.

Remediation

Continue to work to secure additional resources to support housing / transition efforts and build connecting points into technology platforms that are already being used in service delivery. **(Target completion date May 31, 2024.)**

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

Implementation Strategy

Strategy 1. Connect TPMs to PSH whose PCP identifies a need for PSH or housing that SME agrees otherwise meets requirements of 28 C.F.R. § 35.130(d) **(Ongoing strategy)**

Challenges to Implementation

Consistent gathering of data from multiple points of system entry to be able to fully understand the effectiveness of the actions taken to connect TPMs to housing.

Remediation

Variables have been added to most systems and have been refined over the course of Year 1 and 2 of the IP. Continue to provide staff training on the importance of data integrity at point of data entry.

Performance Measure(s)

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.

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

Housing costs as percent of household income

Updated Strategy 2. Develop enhanced 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 PSH as per the SA. Develop technology solution to serve as accessibility resource for housing locators who are working to connect TPMs to appropriate housing. **(Target completion date: May 31, 2024)**

Challenges to Implementation

Complexity of consistent front end data entry that will return high quality data.

Remediation

Build on housing inventory developed and maintained by MFP transition team and consider opportunities to further integrate into ADRL-based search capabilities.

Performance Measures

Utilization rate of housing inventory by diversion and transition teams. (Based on utilization of existing MFP-developed inventory; measure will transition to updated inventory when 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. **(Ongoing strategy)**

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. **(Ongoing strategy)**

Challenges to Implementation

Managing through the high rates of staff turnover experienced by the state's contracted partners for front line housing support roles. Turnover creates challenges in establishing consistent standards of practice, relationships between parties, and ultimately high quality service to TPMs.

Remediation

Partner with provider recruitment efforts currently underway (ex. MFP, ND Rent Help) to establish Communities of Practice that will build and solidify connections between parties engaged in this work.

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 LTSS options counseling (informed choice) referral process to new housing support resources that are available in the State to enable actions outlined in each TPMs PCP. **(Ongoing Strategy)**

Challenges to Implementation

Making sure relationships between professionals who primarily operate separately from each other remain strong. The volume of work each person is dealing with presents a risk.

Remediation

Continued commitment to building and maintaining relationships. The creation of transition team that includes an HCBS case manager, transition services coordinator and housing facilitator has been an effective way to build working relationship across these disciplines.

Performance Measure(s)

Number of referrals made and resulting services accessed.

Strategy 3. Implement practices to guide appropriate identification of professionals who will work together to help overcome barriers that are identified in a TPM 's PCP.

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. **(Target completion date: December 2022)**

Challenges to Implementation

Making the connection between ad hoc community-based teams and specific TPMs with housing needs.

Remediation

Communities of Practice to facilitate region-specific knowledge.

Performance Measure(s)

Number and percent of transition referrals that included a referral to the housing facilitator within two days.

Number and percent of transition team meetings held within 14 days of referral.

Strategy 4. Build on the State's case management system, to ensure that we are continuing to streamline and refine the data collection process. State will work with the case management vendor to build reports that support the tracking of outcomes and impact on TPMs. **(Ongoing strategy)**

Challenges to Implementation

Both State-level data systems (housing and case management) are new; integration practices that need to be refined, reports built, and trained.

Remediation

Identify liaisons working within each system to ensure connections happen at key implementation points, in addition to any automated integrations that may be possible.

Strategy 5. Incorporate information on system updates in trainings for HCBS workers, including how data collected related to housing will be used in reporting. **(Ongoing strategy)**

Challenges to Implementation

The volume of change across systems makes effective training of a busy field staff a continued challenge.

Remediation

Deliver training as an element of an ongoing, coordinated staff training strategy.

Strategy 6. Identify and capture information on housing barriers that may face ND renters, ensuring those variables are reflected and addressed in LTSS options counseling (informed choice) and case management processes. **(Ongoing strategy)**

Performance Measure(s)

Number of LTSS options counseling (informed choice) referrals that collect information related to housing barriers.

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.

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 range of existing home and environmental modification resources available in ND as part of the Environmental Modification work group efforts. **(Target completion date: September 2023)**

Challenges to Implementation

Absence of coherent approach, administration, or definition of environmental modifications in ND systems.

Remediation

Assemble interagency Environmental Modifications workgroup to develop solutions to issues that are identified as barriers to TPM's ability to secure environmental modifications. Workgroup to include representation from DHHS Medical Services, DHHS Economic Assistance, DHHS Executive Office, DHHS Life Skills Transition Center, DHHS Developmental Disabilities, DHHS Aging Services, Department of Commerce Division of Community Services, ND Housing Finance Agency.

State and workgroup members are exploring options to fund environmental modifications in a way that will allow more TPMs to access this service and remove some of the barriers for providers that discourage their participation.

New Strategy 2. Develop and implement a focused approach to evolving North Dakota's approach to home modifications. Analyze barriers experienced by TPMs as identified in PCPs and while delivering transition and diversion services.

Supplement information available from data collected in state case management system

with 2-3 focus groups that include HCBS case managers, LTSS option counselors (informed choice), housing facilitators and transition coordinators.

Inventory options that are available to address most common barriers to housing and explore options that are specific to hardest-to-resolve barriers to housing. Include skilled assessment of modification needs in this analysis as it is a precursor to effective delivery of this intervention.

Recommendations related to highest priority areas will inform decisions about modifications that may be needed in policy, rule, or law. This work will be complete by December 2022 to align with the opening of the 2023-25 legislative session. **(Target completion date: December 2022)**

Challenges to Implementation

Effectively bringing together people who represent disciplines that have not traditionally worked collectively around the topic of home modification.

Strategy 3. Identify needed program adjustments to broaden access to home and environmental modification resources**.** Identify and implement amendments to existing 1915c waivers. **(Target completion date: December 2022 (Identify) / December 2023 (Implement))**

Challenges to Implementation

Aligning timeframes for waiver amendments, modifications to administrative code, and program policy.

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 new ongoing training opportunities for housing professionals/teams regarding integration of reasonable modification ideas into the PCP, including resources that help professionals/teams better understand flexibilities that may be possible with reasonable modification and that help TPMs and their families and/or caregivers better understand options available to them. **(Target completion date: December 2023)**

Challenges to Implementation

Weaving together information from multiple sectors that will have previously considered themselves to be separate from each other (assistive technology, customized adaptive equipment, home rehabilitation/modification).

Strategy 5. 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 identified in individual service plans that involve a person's "intent" following a change in status. This may preclude a TPM from being able to maintain their housing while temporarily in an institutional setting because of housing provider or Medicaid-related policies and requirements related to time away from a housing unit. Add information about intent to return home to LTSS options counseling (informed choice) document as needed, including information that needs to be communicated to SNF to facilitate continued TPM access to monthly payments which further enable a return home. **(Target completion date: July 2023)**

Challenges to Implementation

Complexity of underlying systems.

Remediation

Involve people with expertise in federal housing and Medicaid in this initiative.

Performance Measure(s)

Utilization of intent to return home element of LTSS options counseling (informed choice) process.

Strategy 6. Continue to 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 LTSS options counseling (informed choice) document. Include clear communication expectations as part of the TPM diversion and transition teams. **(Target completion date: December 2023)**

Challenges to Implementation

Decentralized nature of Federal housing delivery in ND.

Remediation

Partnership with ND National Association and Housing Rehabilitation (ND-NAHRO) Organizations and ND Housing Finance Agency (NDHFA).

Strategy 7. Continue to 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. **(Target completion date July 31, 2023)**

Challenges to Implementation

Lack of familiarity with housing systems and processes by people who work

professionally in HCBS.

Remediation

Partnership with ND National Association and Housing Rehabilitation (ND-NAHRO) Organizations and ND Housing Finance Agency (NDHFA).

Strategy 8. 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). **(Target completion date: December 2023)**

Challenges to Implementation

Difficulty in incorporating new resource type into referral networks.

Remediation

Partner with the DHHS Vocational Rehabilitation to explore opportunities to collaborate and expand access to benefits planners.

Performance Measure(s)

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

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

Implementation Strategy

Broaden access to fair housing training to all housing facilitators and make available to all professionals involved in transitions and diversions. **(Ongoing strategy)**

Challenges to Implementation

Volume of training expected of human service professionals.

Performance Measure(s)

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

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. **(Target completion date: October 2022)**

Challenges to Implementation

Capturing information in a synthesized analysis as multiple systems are undergoing changes simultaneously.

Performance Measure(s)

Number of TPMs who are accessing various forms of rental assistance.

Strategy 2. Expand permanent supported housing capacity by funding and providing rental subsidies for use as permanent supported housing. **(Ongoing strategy)**

Challenges to Implementation

Establishing stable funding streams that can support a State rental assistance program.

Performance Measures(s)

Number of TPMs who receive rental assistance.

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

Strategy 3. Continue to 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. **(Ongoing strategy)**

Challenges to Implementation

Maintaining appropriate brevity given breadth of topics to include.

SA Section XIII. Community Provider Capacity and Training

Responsible Division(s)

DHHS Aging Services and Medical Services

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

Implementation Strategy

Updated Strategy 1. Continue to use MFP capacity building funds for the QSP Hub. The QSP Hub assists and supports Individual and Agency QSPs and family caregivers providing natural supports to the citizens of ND. **(Ongoing strategy funded through September 2024)**

The primary goals of the QSP Hub are to:

- Provide one-on-one individualized support via email, phone, and/or video conferencing to assist with enrollment and reenrollment, electronic visit verification, billing, and business operations to recruit and retain a sufficient number of QSPs. This will include the development of technical assistance tools such as user guides that will be available in multiple languages.

- Create and maintain accessible, dynamic education and training opportunities based on the needs of the individual QSPs, QSP agencies, Native American communities, and family caregivers providing natural support services.

- Facilitate the development of a workgroup of experts to provide guidance on the project.

- Develop an informational support network for QSPs including developing a website, listserv, and avenues for QSPs to support one another. This will include the development of a QSP mentorship program that utilizes experienced QSPs to provide support to new QSPs, or QSPs who request individual technical assistance.

- Utilize data and evaluation to inform and improve the effectiveness of the QSP Hub.

- Establish and implement a QSP agency recruitment process. This will include working with small business development organizations to increase the number of QSP agencies available to meet the needs of all eligible individuals. It will also

include partnering with local high schools and colleges who offer training to become a direct care provider and informing them about the opportunities to become a QSP.

Performance Measure(s)

Number of QSPs assisted by the QSP Hub.

Number of QSP agencies receiving Council on Quality and Leadership (CQL) accreditation.

Number of new agencies enrolled as providers.

Number of new independent QSPs enrolled as providers.

Number of agencies that expand array of services.

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

Strategy 2. Implement inflationary rate increase for all HCBS services that may be approved in the 23-25 DHHS budget. **(Implementation date July 1, 2023)**

Performance Measure(s)

Rate increases published on July 1, 2023.

Updated Strategy 3. Implement recommendations from the HCBS rate study conducted with assistance of a contracted vendor with expertise in analyzing rates for HCBS. The State will implement any changes to the rates for HCBS that may be approved during the 23-25 legislative session. Full implementation may require regulatory authority that could include approval of a Waiver amendment by CMS. **(Target completion date January 1, 2024)**

Performance Measure(s)

Rate increases published on January 1, 2023.

Number of new providers enrolled to provide these services.

Strategy 4. 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. **(Target implementation date December 1, 2023)**

Performance Measure(s)

Number of QSPs and individuals trained to *ConnectToCareJobs* by December 1, 2023.

Number of users of portal on monthly basis.

Updated Strategy 5. Pay the CQL accreditation fees for up to five additional 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 December 1, 2023)**

Updated Strategy 6. 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 meeting directly with the leadership of specific healthcare agencies like hospitals and nursing homes and their provider associations to directly ask for their assistance in providing HCBS to TPMs that live in their service area. **(Target completion date December 14, 2023)**

Performance Measure(s)

Number of agency conversations completed.

Number of agencies that enrolled as a provider.

Updated Strategy 7. Support start-up and enrollment activity costs for new or existing QSPs to establish or expand their business to provide HCBS. Additional grants will be awarded in amounts up to $50,000 based on the priority of need of the services the agency will provide. **(Grants awarded by December 31, 2022)**

(Link to Appendix H – Partially Approved ND plan for ARPA of 2021 Section 9817 enhanced FMAP for HCBS)

Performance Measure(s)

Number of grants awarded by date.

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

Number of existing providers expanding to provide HCBS.

Number of agencies that expand array of services.

Strategy 8. To continue 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. **(Ongoing strategy)**

Performance Measure(s)

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

Number of QSP revalidations completed before revalidation due date.

New Strategy 9. To increase the direct care workforce and improve the provider experience, the State with the assistance of the QSP Hub staff will conduct an analysis of the training requirements for direct support professionals in ND. The purpose of this review will be to document the required qualifications to become a direct support professional for any of the state or federally funded HCBS regardless of the population served. The State will then consider developing core competencies that would be recognized and accepted for the purposes of provider enrollment of like services across populations. The State will be responsible for any regulatory work that may be necessary to update provider enrollment standards. **(Target completion date June 30, 2023)**

Performance Measure(s)

Number of enrolled QSPs

New Strategy 10. Each year many individual QSPs enroll to provide care to one person who may be a relative or a friend who needs assistance. When the individual they serve passes away, moves to a SNF etc. they often stop being an individual QSP. Some of these QSPs if asked, may have enjoyed the caregiving role and would be willing to serve other individuals in need of care. Retaining these QSPs would increase the State's capacity to serve TPMs. State staff will work with the staff from the QSP Hub to design an effective outreach campaign to attempt to retain QSPs who originally enrolled to serve a family member or friend. **(Ongoing strategy)**

Performance Measure(s)

Number of individual QSPs retained following change in original client status.

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

Implementation Strategy

Strategy 1. The State will provide ongoing critical incident reporting training opportunities for QSPs. Training will be provided through online modules and virtual training events. The State QSP handbook includes 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. **(Ongoing strategy funded through September 2024)**

Performance Measure(s)

Number of QSPs trained on reporting procedures.

Updated Strategy 2. Continue to implement and improve the strategies in this document that support the following training suggestions included in the Safety Assurance Plan – Link to Appendix I.

- See information in Section XVI – Quality Assurance and Risk Management Strategy 1.

New Strategy 3. ND will use a portion of the Vulnerable Adult Protective Services Coronavirus Response and Relief Supplemental Appropriations Act Of 2021 funds to implement a unified critical incident reporting process. All vulnerable adult protective services staff will have access to the critical incident reporting form in the web-based data collection system. Reports will be collected and automatically shared electronically to the Therap system to be included in the critical incident reports. This will create a unified system for collection and sharing of critical incident reporting throughout Aging Services. This should allow for better coordination of services and data tracking. ND will continue to fund these efforts through the ARPA funding for Adult Protective Services. **(Target implementation date December 31, 2022)**

Performance Measure(s)

Number of CIRs reported

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.

- Use 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 (23-25) Executive budget request.

    - The State will implement any additional case management FTE that may be approved during the 23-25 legislative session.

- The HCBS case managers and Aging Services staff will continue to be trained in person-centered planning principles with the assistance of nationally recognized subject matter experts.

- The State will continue to work with the QSP 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 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 continuing to evaluate the capacity to find backup service providers in the event of an emergency and will implement any additional services or changes in QSP rates that may be approved during the 23-25 legislative session. The State will also continue to use the Lifespan respite grant to provide additional respite opportunities for TPMs and their families.

- The State will adopt any new provider models to reduce the administrative burden on individual QSPs that may be approved during the 23-25 legislative session.

- The State will use resources that are available through the ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/ARPA of 2021, to provide incentives to providers that will serve TPMs with high level of need or in rural and Native American communities.

- Continue to 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. The QSP Resource Hub staff will assist the State to ensure quality training is provided.

- Consider revising the QSP training requirements to improve the provider

experience and ensure a quality provider workforce.

    - The State will use resources made available through the ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/ARPA of 2021, to revise the QSP training with the help of a qualified vendor. State will be responsible for any regulatory work necessary to change the training requirements.

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

    - State will use resources made available through the ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/ARPA of 2021, to offer additional incentive grants.

- Develop a backup plan in the event of a sudden case manager vacancy to ensure that TPMs are adequately served.

    - The State has plans in place to back up case managers who are unavailable or who have scheduled a period of leave. All case managers are trained to implement any HCBS services, therefore, any HCBS case manager across the State could act as back up in any part of the State.

- The State will develop and implement recruitment strategies for any additional HCBS case management FTE that may be approved during the 23-25 legislative session.

- The State should streamline the agency and individual provider enrollment system.

- The State will continue to streamline the enrollment system through a comprehensive review of all documents required to be submitted in the enrollment packs. Duplicative items will be removed and an instruction manual on how to complete enrollment will be updated.

- The State will explore options regarding re-enrollment of providers, determining if that process can be adjusted to lengthen the time between re-enrollment dates.

- The State is developing a provider enrollment portal that will be made available to agency and individual QSPs. The portal will allow providers to enter and save their information eliminating the need to provide information multiple times. The system will be intuitive. Providers will select the type of services they want to offer, and the system will return only the required forms for those services. The system will also be used for reenrollment and to add or change a provider’s service array or service territory.

- The State will compare daily average nursing home rates to the overall daily average cost of providing an appropriate package of services for a TPM in a community setting, determine the extent of the disparity, and determine potential rate adjustments or other steps that could reduce the disparity without jeopardizing home and community-based services (HCBS) cost effectiveness or cost neutrality.

    - The State contracted with a vendor to conduct a rate study to determine any potential rate adjustments that would assist the State in recruiting and retaining HCBS providers.

- Successfully develop a reporting and data collection process to implement the required activities of the Settlement Agreement and assess HCBS service quality and outcomes through NCI and NCI-Aging and Disability (NCI-AD) by hiring one dedicated staff person to address the collection of valid and reliable data in all services, meaningful reporting, and service quality which will be analyzed, trended, and used to improve health outcomes.

    - The State has attempted to procure an entity willing to implement NCI-AD in ND, but the State has not received any bids. The State is requesting technical assistance to draft the next RFP from ADvancing States which administers the NCI-AD program. Once a successful bidder is found the State has the data collection capacity in place to start the survey process. (Target completion date September 1, 2023)

- Hire and train any additional LTSS Options Counseling or HCBS case management FTE that may be approved in the 23-25 legislative session. (Target completion date December 31, 2023)

- Determine the need and request any funds to hire any additional transition coordinator staff in the MFP budget. (Target completion date December 31, 2023)

- Establish funding for the State assistive technology agency to provide information and training to community providers and caregivers to foster independence so individuals can live more safely and securely in their home. The increased utilization of assistive devices will support increased utilization of home and community-based services.

    - The ND Department of Health and Human Services, Aging Services has contracted with ND Assistive to provide training and resources to build the knowledge and capacity of providers and caregivers about assistive technology devices and services, so they can recognize the benefits of the technology and take advantage of the available resources to make informed decisions about the people they serve. This project will be active through 12/31/2023. HCBS Case Managers have been made aware of

this initiative so they can make referrals to assist TPMs.

- Through a train-the-trainer model, ND Assistive has selected 12 towns to reach in the first year including Watford City, Dickinson, Hettinger, Washburn, Carrington, Mohall, Bottineau, Langdon, Glen Ullin, Lisbon, Devils Lake, and Jamestown. In five of those towns, they have already established relationships with people who are willing to serve as AT ambassadors. They have built a training and communication platform through an app to share training information and connect assistive technology ambassadors. ND Assistive will continue to recruit more assistive technology ambassadors in the 12 towns selected with the goal of increasing awareness and use of the technology to optimize the ability of individuals to remain in their own home.

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

Implementation Strategy

Updated Strategy 1. The State will use ARPA of 2021 Section 9817 10% enhanced FMAP for HCBS funds to offer additional incentive grants to 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 $50,000 based on the priority of need of the services the agency will provide. **(Grants awarded by December 31, 2022)**

Strategy 2. The State will continue to provide ongoing group and individualized training and technical assistance to SNFs that express interest in learning about HCBS. The State will also conduct quarterly webinars starting in January 2023 to inform the healthcare community about the potential benefits of providing HCBS. Individual meetings will also be conducted to provide support to any organization interested in expanding their service array. **(Target completion date December 14, 2023)**

Performance Measure(s)

Number of SNFs requesting individual technical assistance.

Number of SNFs that have enrolled to provide HCBS.

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 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.

Performance Measure(s)

Number of Tribal entities enrolled to provide HCBS.

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

Updated Strategy 4. The State submitted a proposal to CMS and has secured the legislative authority to use the temporary 10% increase to the FMAP for certain Medicaid expenditures for HCBS to enhance, expand and strengthen the HCBS system for TPMs. (Link to Appendix H – Partially Approved Spending Plan for Implementation of the ARPA of 2021, Section 9817) Rebalancing Toolkit (nd.gov).

The plan includes the following strategies that directly impact TPMs covered in the SA:

- Developing a pilot program that supports both the recruitment and retention of the 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. **(Ongoing strategy through September 2024)**

- Additional funding beyond that provided under the MFP Capacity Building Grant to develop new community services and supports 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, around-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. **(Target completion date December 31, 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 the direct care workforce and establish career pathways and

progressive endorsements and certifications that allow for implementation of additional initiatives within the ARPA of 2021 Section 9817 10% enhanced FMAP for HCBS funds ARPA ND State Spending Plan, including behavioral health, crisis intervention, and de-escalation competencies. **(Target completion date December 14, 2023)**

- 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 deposits, furnishings, moving costs, and utility hook-up fees. **(Target completion date December 31, 2024, or until all funds are disbursed or expended)**

- Include 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).

- 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, and 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**. (Target completion date December 31, 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. **(Target completion date December 31, 2022, and ongoing)**

- 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. **(Target completion date December 14, 2023)**

- Invest in the ADRL platform to incorporate an affordable housing database and other modifications to support user experiences. Enhance availability of resources to support informed choice and HCBS case management. Equip Developmental Disability and HCBS case managers with resources to facilitate efficient work from HCBS settings. **(Target completion date December 14, 2023)**

- 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. **(Target completion date December 14, 2022)**

  Challenges to Implementation

  Capacity of State staff to implement all the initiatives in a timely and effective manner.

  Remediation

  The State contracted with a vendor with experience helping states implement their plan to act as the project manager and ensure timely implementation.

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

Responsible Division(s)

DHHS Aging Services

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

Updated implementation Strategy

Strategy 1. State staff will conduct annual group in-reach presentations at every SNF in ND and ensure a consistent message is being used throughout the State. State staff will schedule and advertise a follow up visit at the facility to give TPMs additional time to process the information and ask any follow up questions. **(Target complete date December 14, 2023)**

Challenges to Implementation

Depending on the threat level, health and visitor restrictions may be put into place because of the COVID-19 pandemic limiting face to face access to SNFs.

Remediation

In-reach visits must be conducted in person unless there is a valid documented reason why a face-face visit is not possible. When necessary, for example when COVID-19 visitation restrictions are in place, in-reach visits may be completed virtually. Staff can request to use State owned telecommunication equipment purchased for facilities with COVID-19 relief funds to facilitate virtual communication. The State will ensure that all State employees will follow required safety procedures including the appropriate use of State provided personal protective equipment (PPE) when entering facilities. The forms used to document the details of the informed choice visits require the case manager to indicate if the visit was held virtually or in-person. State staff review all the completed informed choice forms and will address any issues if TPM meetings are being conducted virtually without a valid reason.

Performance Measure(s)

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

Number of individual in-reach/informed choice visits conducted with TPMs residing in SNFs per year.

Strategy 2. Continue to 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. 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, and ongoing)**

Performance Measure(s)

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

Number of informed choice visits completed every six months.

Updated 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**. (Target completion date May 1, 2023)**

Challenges to Implementation

MFP capacity building funds will cover costs related to staffing, training, and travel for a two-year period.

Remediation

The State will use ARPA of 2021 Section 9817 10% enhanced FMAP for HCBS funds

Challenges to Implementation

The State needs to accommodate requests for peer support prior to the Peer Support Resource Center being established.

Remediation

The CILs have agreed to take referrals for peer support and match TPMs with individuals living and receiving services in the community who can share their lived experience.

Performance Measure(s)

Number of referrals for peer support and outcome.

Number of individuals receiving information or support from new 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) referral 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 DHHS website to include information on how to request accommodations. **(Ongoing strategy)**

Performance Measure(s)

Number of TPMs who requested and received communication accommodation.

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

Implementation Strategy

Strategy 1. Continue to use the communication plan that was developed by the DHHS communications team to ensure frequent outreach and training is available to at risk TPMs and their families about HCBS and the SA requirements. The communication

plan includes 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, and ongoing)**

Challenges to Implementation

The State will work with the communication team to develop a process to track updates to the communication plan that resulted form stakeholder input.

Remediation

Process will be developed to document changes in the plan and specific strategies developed to reach targeted groups. (**Completed June 14, 2023, and ongoing)**

Updated Strategy 2. Continue to implement a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign will include marketing on social media at least twice per year 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. **(Ongoing strategy)**

Performance Measure(s)

Number of ADRL contacts.

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

Updated Strategy 1. The State will enhance, expand, improve, and provide supplemental respite services and education to family caregivers in ND with resources provided through the Lifespan Respite Care Program: State Program Enhancement Grant and other State and Federal funds. **(Grant received October 2021)**

Performance Measure(s)

Number of individuals using Lifespan respite.

Number of TPMs utilizing respite care with the RD rate.

Number of hours of respite services provided.

Updated Strategy 2. The State will continue to provide education and respite services to individuals providing natural supports. The State will use additional funding provided

by the ARPA to expand evidence-based training programs for TPMs and their natural supports. The State contracts with ND State University Extension and will provide funds to expand the service array to include:

- Fit & Strong an evidence-based group exercise program designed for persons with osteoarthritis (OA). Arthritis is the most common cause of disability among older adults and a major barrier to their participation in physical activity.

- CAPABLE is a client-directed home-based intervention to increase mobility, functionality, and capacity to age in their community for older adults. CAPABLE consists of time-limited services from an occupational therapist, a nurse, and a handy worker working in tandem with the older adult as an inter-professional team. The goal is to increase the participants' capacity to function at home. **(Ongoing strategy through December 2023)**

- The State will continue to conduct training for HCBS case managers and stakeholders to increase awareness of the North Dakota Community Clinic Collaborative (NDC3) available at NDC3.org.

  Performance Measure(s)

  Number of individuals who attended training by service.

  Number of individuals served in the CAPABLE program.

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

Implementation Strategy

Updated Strategy. The State will continue to work with the DHHS 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 DHHS website to ensure compliance with this SA.

The settlement support specialist hired to assist with the implementation of the SA earned her ADA Coordinator certification on June 6, 2022. The support specialist is utilizing virtual training offered through the ADA Coordinator Training Certification Program, LinkedIn as well as Microsoft guidance on making complicated documents accessible and creating accessible documents in Adobe InDesign. The State uses a screen reader to test that a document is accessible. **(Ongoing strategy)**

Performance Measure(s)

Number of documents converted.

SA Section XV. Data Collection and Reporting

Responsible Division(s)

DHHS Aging Services

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

Updated 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. The State will retrieve summary and aggregate data from a variety of sources including the case management system, MMIS data warehouse and provider enrollment.

Strategy 1. Continue to contract with a vendor to maintain and enhance the case management system that was fully implemented August 1, 2022. State staff meet weekly with the vendor and have a list of enhancements that will be implemented during Year 3 of the DOJ SA. Requested enhancements include simplifying how users navigate between different parts of the system, improved printing options and the ability to easily identify who is a TPM through the demographic page and person-centered plan. **(Target completion date December 14, 2023, and ongoing strategy)**

Performance Measure(s)

Number of enhancements to the system that were completed.

Strategy 2. The State will work 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. State staff requested several custom reports be created to simplify the data collection process and make it easier to complete case management reviews**. (Targeted completion date December 31, 2022)**

Performance Measure(s)

Number of reports created.

Strategy 3. The State will continue to request that the case management system vendor provide training to Aging Services staff on the most efficient use of their business intelligence tools that are currently available in the system. **(Target completion date November 30, 2022)**

Strategy 4. Consider implementing an interface with the VAPS reporting system and the CIR reports in the current case management system based on a cost proposal and project timeline to the State. The interface would enhance collaboration and reporting of all types of critical incident involving a TPM that were reported as a CIR, QSP complaint or to VAPS. **(Target completion date March 31, 2024)**

Strategy 5. The State will continue to improve and revise its data collection efforts and will maintain a set of key performance measures on the Department's website to illustrate the State's progress and challenges implanting the DOJ SA.

- 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. (Targeted completion date December 31, 2022)

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHHS Aging Services and Medical Services

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. (Link to Appendix I- Safety Assurance Plan)

The State is currently implementing or has incorporated recommendations included in the Safety Assurance Plan into the initial IP. During this implementation plan period the State will implement the following recommendations from the Safety Assurance Plan.

- 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. The State also developed a single data system accessible to and used by state employees authorized to investigate and/or remediate such incidents. **(Complete)**

- The State established a consistent incident reporting and response process to be used for all reportable incidents as required.

    - The State now requires all QSPs to report critical incidents through the case management system. In addition, All QSP complaints are recorded and tracked in the case management system, State staff involved in reviewing or investigation CIRs have access to the case management system and its reporting functions.

    - ND will use a portion of the Vulnerable Adult Protective Services Coronavirus Response and Relief Supplemental Appropriations Act of 2021 funds to implement a unified critical incident reporting process. All vulnerable adult protective services staff will have access to the critical incident reporting form in the web-based data collection system. Reports will be collected and automatically shared electronically to the Therap system to be included in the critical incident reports. This will create a unified system for collection and sharing of critical incident reporting throughout Aging Services. This should allow for better coordination of services and data tracking. ND will continue to fund these efforts through the ARPA funding for Adult Protective Services. **(Target implementation date December 31, 2022)**

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

Implementation Strategy

Strategy 1. The State will provide 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 as necessary to include current reporting requirements. The State will also work with staff from the QSP Hub to develop ongoing training that will assist QSPs in understanding and complying with safety and incident reporting procedures. **(Ongoing strategy)**

Performance Measure(s)

Number of QSPs trained on reporting procedures.

Percentage change in the number of incidents reported since the last DOJ SA reporting period.

Number of virtual training events conducted.

Number and percent of critical incident reports that were reported, by providers, on time.

Strategy 2. Agency QSP enrollment standards require licensed agencies or entities employing non-family community providers to have a Quality Improvement (QI) program that identifies, addresses, and mitigates harm to TPMs they serve. This would include the development of an individualized safety plan. 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 using the risk assessment in the State's case management system. **(Ongoing strategy)**

Performance Measure(s)

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

Updated 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 DHHS website and shared at USDOJ stakeholder meetings. **(Target completion date December 14, 2023)**

Challenges to Implementation

Contracting with an entity willing to conduct the survey. The State made two attempts to procure an entity willing to implement NCI-AD in ND; no bids were received.

Remediation

The State is working with Advancing states on strategies to update the scope of work in the RFP to attract potential providers. Once a successful bidder is found the State has the data collection capacity in place to start the survey process. **(Target completion date September 1, 2023)**

Strategy 4. The State will continue to submit critical incident reports to the USDOJ and SME within seven days of the incident as required in the SA. **(Reporting required through December 14, 2022)**

Performance Measure(s)

Percent of critical incident reports submitted, by the State, within seven days of incident as required.

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

Implementation Strategy

Policy requires 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**. (Ongoing strategy)**

Challenges to Implementation

QSPs do not always follow critical incident reporting requirements or fail to report critical incidents in a timely manner.

Remediation

The DHHS Aging Services conducts critical incident reporting required trainings for QSPs. Training will be provided through online modules and virtual training events. The QSP handbook includes current reporting requirements. In addition, the State reminds providers of the reporting timeframes each time a CIR is not submitted on time. **(Ongoing strategy)**

Performance Measure(s)

Percent of required remediation plans completed.

Number of training events conducted.

Number of critical incident reports submitted on time.

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

Implementation Strategy

The State will use the 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, 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 in a timely manner.

Strategy 1. The case management system is used to receive and review all critical incidents. Providers and State staff have access to submit CIR. Critical incident reports must be submitted and reviewed within one business day. **(Ongoing strategy)**

Performance Measure(s)

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

Strategy 2. The DHHS Aging Services 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 DHHS Aging Services Director, HCBS program administrator(s), HCBS nurse administrators, Vulnerable Adult Protective Services staff, LTC Ombudsmen, and the DHHS risk manager. **(Ongoing strategy)**

Performance Measure(s)

Percent of critical incident reports reviewed by State staff.

Number of critical incident reports that have an associated complaint.

Strategy 3. The State conducts 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. (**Ongoing strategy)**

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. **(Ongoing strategy)**

Performance Measure(s)

Number of amendments reported.

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

Implementation Strategy

Strategy 1. Continue to receive and timely address complaints by TPMs about the provision of community-based services. Complaints are tracked in the case management system. 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 vulnerable adult protective services 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**. (Ongoing strategy)**

Performance Measure(s)

Number of TPM complaints.

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

Strategy 2. The State publicizes 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 DHHS website, HCBS application form, "HCBS Rights and Responsibilities" brochure, presentation materials, and public notices. **(Ongoing strategy)**

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. **(Ongoing strategy)**

Appendix A: Partnering Equitably with Communities to Promote Person-Centered Thinking, Planning and Practice

Partnering Equitably with Communities to Promote Person-Centered Thinking, Planning and Practice", ND Department of Health and Human Services and NCAPPS, August 2020. Partnering Equitably with Communities (nd.gov)

Appendix B: Informed Choice Referrals in ND Admin Code

Informed Choice Referrals ND Admin Code 75-02-02.4

Appendix C: Informed Choice Educational Materials

Informed Choice Educational Materials

Appendix D: Diversion Plan

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Subject Matter Expert

North Dakota Diversion Plan

On December 14, 2020, the State of North Dakota entered into a Settlement Agreement with the United States Department of Justice. The agreement is designed to serve adults with physical disabilities that are capable of living in integrated community settings with sufficient services and supports, to receive the necessary care in that setting. Those individuals, considered members of the target population for purposes of the settlement agreement, are “individuals with a physical disability over the age of 21 who are eligible or likely to become eligible to receive Medicaid long-term services and supports and are likely to require such services for 90 days.” As a result of the Settlement Agreement, North Dakota has created an implementation plan to address the areas that are currently barriers to allowing Target Population Members (TPMs) to remain in or return to the community.

The Diversion Plan describes the activities needed to facilitate and incentivize the provision of appropriate long term supports and services in home and community-based settings for at risk TPMs as an alternative to admission to a nursing facility. Pursuant to the provisions of Section X and XI of the Settlement Agreement, the Diversion Plan provides for the identification of those seeking or those who have been referred for admission to a nursing facility, State intervention prior to such admission. This includes the provision of person-centered planning with the individuals involved and the offering and provision of appropriate services capable of meeting the individuals’ needs for long term services and supports in the most integrated setting for all TPMs whose Person - Centered Plan (PCP) indicates that diversion is appropriate and unopposed.

The components of the Diversion Plan align with the strategies and activities provided for in multiple sections of the Settlement Agreement and Implementation Plan including, in particular, outreach, Home and Community-Based Services (HCBS) capacity-building, case management, and person-centered planning. Successful implementation of these strategies will reinforce the success of the Diversion Plan.

The SME is aware that North Dakota may have already acted and developed strategies related to some or all of these recommendations, but also thought it important to include in this plan for cross reference. Actions that have already been initiated may be included in the Implementation Plan.

Goal #1: Identify at risk TPMs including those who are considering or seeking admission to nursing facilities, who are hospitalized and at risk of being discharged to nursing facilities and provide education about HCBS to potential TPMs and others who may recommend nursing facility care.

Action: Target outreach to maximize identification of at risk TPMs and optimize opportunities to provide information on HCBS options"

Strategies

1. The SME urges the State to identify and outreach to those TPMs who are at serious risk of entering nursing facilities.
    a. Provide outreach about HCBS to the public, senior citizen centers, and stakeholders.
    b. Review existing data and other information from partners that could identify TPMs and provide them with information on HCBS.
        i. Update and use the Aging and Disability Resource Link (ADRL) database to identify TPMs.
        ii. Use Medicaid claims data to identify TPMs admitted to hospitals, short-term rehabilitation facilities, or using similar services that may reflect a higher likelihood of being a TPM and provide such TPMs with information about HCBS.
2. The SME suggests that the State conduct outreach to offer education to those parties that may recommend nursing facility care to a potential TPM.
    a. Provide outreach and information about HCBS that could meet the needs of TPMs requiring long term services and supports as an alternative to nursing facilities and to those who typically make Nursing Facility Level of Care (NF LoC) assessments and nursing home placements, with a particular focus on:
        i. hospital discharge planners,
        ii. rehabilitation facilities,
        iii. tribal agencies, and
        iv. primary care physicians serving Medicaid patients.
    b. Develop and enter into written agreements or memoranda of understanding that establishes a protocol for hospitals and other facilities to contact the Aging Services Division as part of the facility's discharge planning process or to refer the TPM to the Aging Services Division or both.

Goal #2: Divert TPMs from unnecessary admission to nursing facilities by offering appropriate Home and Community-Based Services, thereby mitigating and preventing unnecessary segregation.

Action: Develop and implement a plan to quickly identify and reach TPMs who have been hospitalized or referred for nursing facility services.

Strategies

1. The SME recommends that the State investigate options for prompt

determination of Medicaid eligibility for HCBS, such as presumptive eligibility for the Medicaid-expansion adult population under the age of 65, in order to minimize delays involved in the authorization of HCBS.

2. The SME urges the State to change current policies and procedures affecting admission to nursing facilities to require State intervention and consideration of HCBS for TPMs prior to admission.
    a. Assure that the State contractor for Medicaid eligibility determinations promptly notifies the Aging Services Division when it receives a NF LoC referral for review and assessment and whenever it determines that NF LoC criteria have been met for a TPM.
        i. Assure that upon receipt of such determination that the State assigns a case manager who promptly engages the TPM in the processes of informed choice. Discussions between the parties and the SME are ongoing relative to the provision of case management services.
        ii. Assure that the assigned case manager's name, the date of the assignment, and the subsequent steps in the person-centered planning process are entered into the State data system.
        iii. Consider using (if this does not already occur) short-term NF LoC certifications for TPMs so that if a nursing facility placement occurs when the person-centered planning process is underway, the offer of HCBS can still be made to the TPM and the PCP can include a transition plan.
    b. The SME recommends that the State revise its informed choice process and documentation as follows:
        i. Consider a revised process for TPMs that do not express an initial interest in HCBS.
        ii. Revise the question about whether or not the TPM would like to "explore" home and community alternatives so that it provides more opportunity to converse.
    c. The SME recommends that the State process and confirm that the TPM is eligible to receive Medicaid-funded nursing facility care and that such facility is authorized to bill Medicaid for that TPM before an assignment is made, if that is the most integrated setting selected by the TPM.
        i. The SME feels that it is important (if it has not already done so) that State policies and procedures applicable to nursing facility admission require the nursing facility to document that a newly admitted TPM was referred to the Aging Services Division for assignment of a case manager prior to admission and that informed choice was discussed and a decision made based on that discussion.
3. The SME recommends that the State consider assigning a case manager to each identified at risk TPM as provided for in the Settlement Agreement. Discussions between the parties and the SME are ongoing relative to the provision of case management services
    a. When it is determined or confirmed through the ADRL intake process that an individual is an at risk TPM with an interest in HCBS, this information should

be immediately transmitted to an HCBS supervisor who should assign a case manager. The case manager should then contact the TPM to conduct an assessment and begin the person-centered planning process.

b. The State should review this process and develop necessary revisions so that as the term of the eight-year Settlement Agreement progresses, case managers are able to be timely assigned (or a viable alternative is approved) to all identified TPMs. This could include a particular focus on those TPMs that do not express an initial interest in HCBS.

4. The SME recommends that the State further develop strategies that ensure progress toward meeting the provisions of Section VIII (Person Centered Planning) of the Settlement Agreement and ensuring that a Person Centered Plan is developed for at risk TPMs. Discussions between the parties and the SME are ongoing relative to the provision of person centered plans.
   a. Complete the functional assessment and person centered planning process prior to or as soon as possible after a decision by the TPM as to where they would like to live.
   b. Provide information about the benefit of integrated settings.
   c. Offer TPMs opportunities to meet with other individuals living, working, and receiving services in integrated settings, preferably in the same geographic area, before making a decision as to where the TPM would like to receive services.
   d. Offer an appropriate and individualized set of HCBS to be provided in the most integrated setting available.
   e. Triage the services and supports necessary to meet the immediate needs of the TPM.
   f. Presume that TPMs who go through the person centered planning process accept the community-based services designed to meet their needs unless they object and opt out of HCBS.
   g. Provide TPMs with the option to self-direct their services.
   h. Take into account the TPMs ethnic, cultural, and spiritual interests and practices.
   i. To the greatest extent possible, TPMs will not be unduly influenced or subjected to bias of any sort during the person centered planning process.
5. The SME recommends that the State develop a data system that tracks HCBS services and setting offered and whether they were accepted or refused and the reasons why to assist in identifying gaps or limitations in HCBS that could be addressed.

6. The SME recommends that the State consider including as part of the person centered planning process discussions about and planning for what the TPM would like to have happen if they are hospitalized, including who will notify the case manager in the event of a hospitalization.

7. The SME suggests that the State work with national person centered planning contractors to design an accelerated process person centered planning process and plan for those TPMs in hospitals that includes informed choice.

8. The SME suggests that the State modify the person centered planning process curriculum to reflect the interests and situations of seniors and persons with physical disabilities.

9. The SME recommends that the State consider waiving training components for a family member who is identified as capable of providing services to the TPM to avoid a nursing home placement for three (3) months. The family member will be expected to complete training within 90 days.

Appendix E: Housing Access Plan

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Housing Access Plan

On December 14, 2020, the state of North Dakota entered into a settlement agreement with the United States Department of Justice (USDOJ). The agreement is designed to serve adults with physical disabilities that are capable of living in integrated community settings with sufficient services and supports and to receive the necessary care in that setting. As part of this agreement, the state committed to providing, at minimum, the following number of Permanent Supported Housing (PSH) options for class members whose Person Centered Plans identify a need for PSH:

- 20 members within one year,
- Additional 30 members within two years,
- Additional 60 members within three years, and
- Additional Permanent Supported Housing based on aggregate need.

Across the country, the lack of affordable and accessible housing options is one factor leading to institutionalization, homelessness, and housing instability. This challenge is often exacerbated in rural areas where there is less housing inventory and, what housing inventory is available, may be older (and therefore less likely to be accessible), of poor quality, and not meet federal, state, and/or local housing standards.

Individuals living with disabilities residing in institutions considering transition come to this difficult housing landscape with their own set of challenges including discrimination in the rental market, incomes often at or below 20 percent of Area Median Income (AMI), those whose sole source of income is Supplemental Security Income (SSI), and difficulties navigating the housing search process while residing in an institutional setting.

Individuals living with disabilities in North Dakota institutions face a myriad of challenges. The recommendations below seek to provide strategies to address these challenges by providing housing supports to Target Population Members (TPMs), enhancing access to existing affordable and accessible rental inventory, creation of new affordable accessible rental inventory, and increasing access to other housing options and opportunities through implementation of a housing locator system.

The SME is aware that North Dakota may have already taken action and developed plans related to some or all of these recommendations but felt they should be included in this plan for cross reference. Actions that have already begun may be included in the Implementation Plan in Section XII.

Goal #1: The Subject Matter Expert (SME) compels the state to ensure that Target Population Members (TPMs) receive housing supports identified in Person Centered Plans (PCPs) that are designed to support a transition to and success living in the community.

Action: It is of critical importance that the State identify the types of housing support services that will be available to the TPM and develop strategies to deliver those services to the TPM.

Strategies

It is recommended that the state:

1. Convene a workgroup to identify the types of housing supports that should be available to TPMs. For reference, it is of strategic importance for the state to review the Informational Bulletin published by CMS in June 2015 on Coverage of Housing-Related Activities and Services for Individuals with Disabilities that describe a range of housing transition and tenancy sustaining services.
2. Conduct a crosswalk of housing transition and tenancy sustaining services that are already covered in existing Medicaid authorities or other state funded programs.
3. Identify mechanisms to pay for housing support services, such as through changes to Medicaid waivers, Money Follows the Person grants, or state funds.
4. Identify the types of positions that will have a responsibility in providing housing supports (e.g.; case managers, housing facilitators, and others identified by the state), and specify the types of housing support services that these positions will offer.
5. Establish a mechanism to assess housing support needs in the person centered planning process.

Goal #2: The SME urges the state to increase access to existing affordable and affordable accessible rental units through policy change and relationship development.

Action 1: It is of critical importance that the State update the current housing inventory to ensure a complete inventory of affordable rental housing opportunities across the state.

Strategies

1. The inventory should identify properties by funding source and location.
2. Where available, the inventory should identify properties by accessibility, target

population, unit size, property management company and contact number for property management company.
3. It is important that this inventory is kept current through a database available through those seeking to locate rental housing.

Action 2: The SME recommends that the state identify opportunities for waiting list preferences and/or dedication of turnover units for TPMs in existing affordable rental housing.

Strategies

It is recommended that the state:

1. Develop a waiting list preference marketing “pitch” for property management companies about the Settlement Agreement, the need for affordable rental housing for TPMs, and how dedicating a small amount of turnover can have a significant impact.
2. Using an updated inventory, identify five (5)-10 property management companies that manage the largest number of affordable rental properties. It is recommended that the state select one of these large property management companies known to be “friendly” to the target or similar population and test the “pitch” with this agency.
3. Work with the United States Department of Housing and Urban Development (HUD), using United States Department of Justice (USDOJ) support as needed, to develop a standardized process for securing waiting list preference for TPMs at these properties.
4. Based on the meeting with the first property management company, refine marketing efforts and continue to meet with the targeted property management companies to secure preference for turnover units.
5. Meet with the North Dakota Apartment Association and share the opportunities to meet preferences/dedicated turnover in affordable and market rate units.

Action 3: The SME recommends that the state identify properties with high turnover and higher than average vacancy rates as potential housing options for TPMs.

Strategies

It is recommended that the state:

1. Conduct a review of occupancy data for properties funded through the Low Income Housing Tax Credit (LIHTC) program.
2. Conduct a review of occupancy data for HUD Assisted Housing properties or request USDOJ assistance securing such data from HUD.
3. Request USDOJ assistance securing current occupancy data from the United States Department of Agriculture (USDA) Rural Housing Service.
4. Meet with property management companies at properties with higher than

average vacancy rates to secure waiting list preferences or come to other referral agreements.

Action 4: It is important for the state to secure set-aside units in existing (4% and 9%) Low Income Housing Tax Credit (LIHTC) units through incentives in upcoming Qualified Allocation Plans (QAPs).

Strategies

It is recommended that the state:

1. Review the language in the Texas Department of Housing and Community Affairs (TDHCA) Qualified Allocation Plan that secures units in existing housing through incentives in the current QAP. (The QAP is a document that states must develop in order to distribute federal (LIHTCs), which can be awarded only to a building that fits the QAP's priorities and criteria.)
2. Consider modifying the QAP, similar to the TDHCA plan, in order to secure units more quickly. The state housing and services agencies should work together to determine how to target QAP incentives, e.g. target incentives to secure one-bedroom fully accessible units.

Action 5: Maximize use of affordable accessible rental units.

Strategies

It is recommended that the state:

1. Conduct a survey – using a relatively simple tool for design such as Survey Monkey – to determine the number of affordable, accessible units that are leased to households that do not require the design features.
2. Work with property managers and service providers through interviews, meetings, or focus groups to understand barriers to leasing accessible units (both affordable and market rate) to persons needing the design features.
3. Develop and implement a series of recommendations based on the focus groups with managers to maximize use of accessible units including use of lease addendum, tenant and/or project-based vouchers for market rate units, and other strategies.

Goal #3: Increase Permanent Supported Housing (PSH) opportunities for TPMs by expanding capacity through rental housing development and rental subsidies.

Action 1: Produce new integrated Permanent Supported Housing units utilizing federal and state capital resources.

Strategies

It is recommended that the state:

1. Review the current incentive structure within the state’s QAP to determine areas

for refinement to further promote development of set-aside units that meet the needs of TPMs.
2. Consider modifying the QAP to ensure incentives are structured in a way that produce units that are integrated, accessible, affordable, and provide access to necessary services. The current state QAP contains a number of incentives, however, these are not structured to result in the combined features needed by the TPM. For example, the QAP includes incentive points for universal design, but not necessarily for those units to target to those whose incomes are at 30% of Area Median Income.
3. Consider reviewing priorities set in other capital funding administered by the state (Housing Incentive Fund, Housing Trust Fund, etc.) to best leverage these resources in combination with LIHTC incentives to create affordable, accessible PSH.
4. Consider whether additional state-funded operating resources are necessary to finance the development of PSH units at rent levels affordable to TPMs.
5. Outline specific criteria for the marketing of accessible units in properties developed with state financing including notification of available accessible units to appropriate referral networks and preferences established for households who need accessible features.

Action 2: The SME urges the state to maximize opportunities for use of federally-funded tenant-based vouchers.

Strategies

It is recommended that the state:

1. Review the Housing Choice Voucher Data Dashboard and identify Public Housing Agencies (PHAs) with low utilization rates. Particular attention should be paid to the utilization rates of Mainstream Vouchers and Non-Elderly Disabled Vouchers (NED).
2. Where vouchers are not being fully utilized, conduct outreach to PHAs to promote a waiting list preference for TPMs.
3. In addition to a waiting list preference, explore whether PHAs have the ability and capacity to project-base some of their voucher portfolio. Increasing the availability of project-based vouchers will provide additional resources for developers to finance PSH units incentivized in the QAP.
4. Work with the local National Association of Housing and Redevelopment Officials (NAHRO) chapter to set-up a committee focused on producing recommendations to increase landlord engagement and participation in the Housing Choice Voucher Program. The committee should consider possible resources to fund landlord incentives and/or mitigation funds as well as strategies for retention (e.g. landlord forums, appreciation events).

Action 3: The SME compels the state to identify state funding to be used for tenant-based vouchers for TPMs to meet Settlement Agreement requirements in

Section XII.B.1 (a-d) when an alternate source of rental assistance is not available to a TPM.

Strategies

The state is urged to:

1. Identify state resources that can be used to support state funded rental assistance for TPMs.
2. Establish a policy that includes the purpose and intended use of vouchers (e.g. for TPMs, bridge to federal source), how the vouchers will be administered, eligibility criteria, TPM cost-sharing requirements (e.g. up to 30% of income), and types of housing that the voucher may be used for (e.g. lease-based permanent supported housing). The state's policy should articulate the timeframe when a TPM will be referred for a state funded voucher, the referral process that will be used, and the housing inspection process.
3. Collect data on the use of state funded vouchers. Data should include, at a minimum, tenant demographic data, tenure in housing, length of time on state voucher, and reasons for termination or eviction.
4. Consult with the Subject Matter Expert on development of the policy for state funded rental assistance vouchers.

Goal #4: Ensure housing specialist have access to updated housing availability options.

Action: Implement an updated housing locator system.

Strategies

It is of critical importance that the state:

1. Continue review of housing locator technology options and select a model to use going forward. It is recommended that the state not develop its own model unless it can demonstrate that it can develop the technology successfully and in a timely manner and that "off the shelf" products cannot meet the state's needs.
2. Select or develop a housing locator that can implemented as rapidly as possible to support the Settlement Agreement's housing benchmarks and that can provide up-to-date housing availability.
3. Secure funding for housing locator technology purchase or development and designate or hire staff to implement and/or work with contracted locator system staff.
4. Provide training in and access to the housing locator technology for all housing and/or transition specialists and case managers working to transition TPMs.

Goal #5: Placements to housing should be consistent with settings as defined as Permanent Supported Housing in the Settlement Agreement.

Action: The SME recommends that the state develop a housing needs and preferences tool that can be used to identify the housing needs and preferences as identified by TPMs and staff during the person centered planning process.

Strategies:

It is recommended that the state:

1. Review housing needs and preferences approaches used by other states to inform their work.
2. Develop a housing needs and preferences tool that can be incorporated into the person centered planning process. This may be added as a section to the Person Centered Plan (PCP) or an additional document added to the PCP.
3. Establish a protocol to notify the Subject Matter Expert when a community placement other than Permanent Supported Housing is recommended or preferred by the TPM.

Goal #6: The Subject Matter Expert shall be notified prior to transition of any recommended placements to settings other than Permanent Supported Housing for review of the transition plan.

Action: A protocol for notifying the Subject Matter Expert (SME) will be developed by the state for when a community placement other than Permanent Supported Housing (PSH) is recommended or preferred by the TPM, providing as much advance notice as possible prior to transition.

Strategies:

It is recommended that the state:

1. Develop a form to share with the SME that addresses the reasons for a referral to a community placement that is not PSH. The form should identify:

    a. All housing options that were considered and recommended;
    b. Target Population Member preferences;
    c. the types of services that would be needed to support the TPM in a PSH setting;
    d. How the housing placement meets the most integrated setting as defined in the Settlement Agreement. Examples of integrated settings can be found in the Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. and the Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule.

2. Establish a process for the SME to review and discuss the pending placement with the state and whether the placement will reflect the state's requirements of an appropriate setting in the Settlement Agreement.

Appendix F: MFP Capacity Building Grant Opportunity Project Narrative

Summary/Abstract

The North Dakota Money Follows the Person (MFP) demonstration project has provided important opportunities to advance the State's institutional transition of individuals from nursing facilities/hospitals to a less restrictive setting, preferably home. Capacity-building and system transformation, continues and is now required through a Settlement Agreement with the United States Department of Justice. There are six components to this proposal that involve multiple divisions within the North Dakota Department of Human Services including Aging Services Division, Medical Services (Medicaid), Developmental Disabilities, Behavioral Health Services, and Children and Family Services. Here is a summary of the components to this proposal:

1. Home and Community-Based Workforce/Provider Retention and Expansion: Access to community-based services and provider capacity development and training, have been identified as the primary barriers that need to be addressed to make community-based services readily available across the State. North Dakota has identified projects to increase provider capacity and quality to include the development of a Direct Service Workforce/Family Caregiver Resource and Training Center. The State agency will also offer provider training and development incentive grants or loans and assist with required accreditation costs. The Resource Center will be implementing Qualified Services Provider (QSP) agency recruitment strategies, QSP recruitment, training and support, and technical assistance to increase the amount of and retain service providers.

2. Institutional Diversion and Transitions: The projects identified to safely transition individuals from SNF/hospitals home include the enhancement of transition support services, an informed choice process, in-reach, and outreach activities to increase knowledge of services and advancing the utilization of assistive technology.

3. Person-Centered Practice: The MFP Grant, the Settlement Agreement, and the technical assistance recommendations from the National Center on Advancing Person-Centered Practices and Systems outline opportunities and requirements for the State to improve training and provision of Person-Centered Practices (PCP). The projects identified include securing ongoing technical assistance on PCP for Aging Services, provision of annual training, development of a train the trainer model, and development of PCP tools for family and individuals receiving services that are culturally sensitive.

4. Children's Service System Capacity Assessment: The State agency will complete a comprehensive needs assessment of child and related family services across the State, to identify short-term, intermediate, and long-term recommendations focused on development of 1915(c) or 1915(i) Medicaid funded services and other system change outcomes that lead to child and family success with minimal barriers to access services. The project would involve a system wide assessment and facilitated implementation of system change recommendations.

5. Quality Monitoring and Data Collection: The State agency will successfully coordinate, communicate, track and report implementation progress of the required activities of the Settlement Agreement and MFP Capacity Building Grant and to assess HCBS service customer satisfaction and quality of services. The projects would include one staff member to coordinate the implementation of the Settlement Agreement and funding for implementation of the National Core Indicators (NCI) and the NCI for the Aging and Disability Populations.

6. Peer and Family Supports: The State agency will develop an in-person and virtual peer and family support referral and support process that will allow individuals from across the lifespan interested in transitioning to an integrated setting the opportunity to connect with a peer who has lived experience navigating and receiving community-based services. Family supports may also include system navigation and benefits counseling to ensure understanding and access to home and community-based services and supports. This service will be coordinated by one entity who could enroll or subcontract with community providers with expertise in services targeted to various groups.

Goals, Objectives, and Outcomes

The goals and actions listed below will ensure that the State agency achieves the objectives of the MFP Capacity Building Grant, the requirements of the Settlement Agreement and technical assistance recommendations from the National Center on Advancing Person-Centered Practices and Systems.

1. Home and Community-Based Workforce/Provider Retention and Expansion

   GOAL: To increase the number and capacity of QSPs and family caregivers that are actively serving clients to support individuals transitioning from SNFs or other institutions by: 1/1/2022.

   a. Direct Service Workforce/Family Caregiver Resource and Training Center: The Resource and Training Center will support the increased number of active QSPs and Family Providers by assisting with enrollment as a provider, providing skill building "ECHO Training", and offering technical assistance with billing, EVV, Therap, business development, marketing,

service authorization, billing, etc. Participation in training and ongoing support will be documented beginning 10/1/2021. Qualified Services Provider (QSP) agency recruitment capacity will also be developed in cooperation with other State entities with the goal of increasing the number of QSP agencies and expanding services offered by existing agencies.

b. **Incentive grants and loans** -Approximately four hundred thousand dollars will be awarded as grants or loans to up to twenty-five agencies. These will be used to incentivize agency providers to expand services or for new agency providers. These grants are also available to tribes who want to certify as an agency. Awards will begin by 10/15/2021 and be completed by 9/30/2025.

c. **Accreditation cost funding** will be provided to new Aging Services providers who are willing to provide services that will meet the more complex needs of individuals who are returning to an integrated setting or who want to remain in the community. Ten agencies will be assisted with CQL or other agency accreditation costs which qualifies them to provide services to individuals with complex medical needs. Awards will begin by 10/15/2021 and be completed by 9/30/2025.

d. **QSP matching portal** will be implemented and modified in cooperation with the ADvancing States organization to significantly improve the capacity of individuals in need of community services to evaluate and select Independent QSPs and QSP agencies with the skills that best match their support needs by June 1, 2022.

e. **Development of case management remote work capacity**: To provide remote Wi-Fi Hotspots and document signature/print capacity for all HCBS case managers/Informed Choice staff to work remotely or closer to the communities in which transitioning individuals live by 12/1/2021.

2. Institutional Diversion and Transitions

The five new transition/informed choice services staff will inform 200 individuals monthly of the community service options available to those who receive Medicaid and who meet level of care screening requirements and provide transition services by 8 /1/2021. Frequency of informed choice will increase to those individualize who stabilize medically.

3. Person-Centered Practice

North Dakota will enhance PCP initial and annual training to all HCBS case managers to include Charting the Life Course Model to HCBS case managers by 10/1/2022. A train the trainer model will be developed by 10/1/2022.and up to five staff will be trained as trainers. PCP tools for families and individuals receiving services will also be developed that may include training videos, handouts, guidebooks, and posters, and

made available or given to approximately 2,100 individuals to encourage their participation in the care planning process.

4. Children's Service System Capacity Assessment

The goal of this project is to complete a comprehensive needs assessment of child and related family services across ND and to identify short-term, intermediate, and long-term recommendations focused on development of 1915(c) or 1915(i) Medicaid funded services that lead to child and family success with minimal barriers to service access. The comprehensive **assessment of the children's service system** will identify and facilitate the implementation of system change recommendations to meet the community support needs of children that are either not served by any waiver or other service system or are underserved by the current State Medicaid waiver system of supports. The intent of this project is to identify service changes to the children HCBS services system necessary to the support and services needs of children that are not being served by any kind of waiver or service at this time. An example of this would be children with a physical disability do not qualify for any HCBS services other than Medicaid State Plan-Person Care program. The project would identify wavier services or system changes needed that more comprehensively meet the HCBS needs of children with any type of disability.

5. Quality and Data Collection:

Successfully develop a reporting and data collection process to implement the required activities of the Settlement Agreement and assess HCBS service quality and outcomes through NCI and NCI-AD by hiring one dedicated staff person to address the collection of valid and reliable data in all services, meaningful reporting, service quality which will be analyzed and trended and used to improve health outcomes.

6. Peer and Family Supports

To develop and implement a **system navigation and benefits counseling system** by peers to ensure understanding of and access to home and community-based services and supports for those who have transitioned from SNFs. This support system will be coordinated by one entity, yet to be identified, who will hire peer supports by 12/1/2021 for up to five peers and will reach out to 25 people. Evaluate program data and based on utilization the goal will remain the same or increase in years two and three based on utilization of the service.

Proposed Projects

The proposed projects identified in the goals and objectives are described in more detail below:

Home and Community-Based Workforce/Provider Retention and Expansion

A. Establishing a Direct Service Workforce/Family Caregiver Resource and Training Center (DSWRC)

The DSWRC will provide continuous technical assistance/training, and guidance to Qualified Services Providers and family care providers. The DSWRC will support both the development of new providers and support their retention long term by providing the following services:

- Provide access to different training methods and topics created or made available from a variety of vendors to increase skills, competencies and confidence of a workforce that often works in isolation.

- Support development of new providers and increase retention and decrease turnover of caregivers who struggle to maintain enrollment due to challenges with provider enrollment, Electronic Visit Verification (EVV), billing, skill building, and other administrative requirements.

- Produce material/information and provide technical assistance on authorizations, enrollment, billing, and EVV to improve the successful delivery of services.

- Make Information and technical assistance training available in a variety of formats (in person, internet, social media, mobile phones, printed materials)

- Provide stress management and coping skills training, caregiver support blog or group support to reduce the stress and burden of being a caregiver.

- Provide module-based training materials on personal care activities, information on a variety of medical diagnosis, strategies for working with people with intellectual disability, brain injury, dementia, behavioral health issues and substance abuse, how to teach skills (habilitation), and effective support strategies for the participants.

- Provide training to individuals on how to select, train and manage QSPs. Communication skills and conflict resolutions training will be offered. This will help increase utilization of QSPs and their retention.

- Establish a Qualified Services Provider (QSP) agency recruitment**:** Establish a QSP agency recruiting and development process in cooperation with other State agencies or a vendor to be selected working with small business development to increase the number of QSP agencies needed to meet the needs of all individuals identified by the Settlement Agreement.

B. Provision of Provider Development Incentive Grants

Offer Provider agency Incentive grants to assist with the startup costs that pose significant barriers to new providers considering offering services to individuals with

complex medical needs. Grants would be targeted for the services that will meet the needs of individuals with the most complex medical needs needed to be successful living in community. These would be competitively awarded to agencies that will provide waiver services, Medicaid State Plan-Personal Care, and 1915(i) services.

C. Accreditation Cost Assistance

Provide payment assistance for the required Council on Qualify Leadership (CQL) accreditation fees to assist with the development of agencies that provide the Medicaid waiver services of residential habilitation and community-support services that will allow up to 24-hour a day services in the community.

D. Services Matching Portal

Provide the modification costs for the QSP Agency matching portal that will be implemented in cooperation with ADvancing States to significantly improve the capacity of individuals in need of community services to evaluate and select QSP agencies.

E. Remote Work Technology Capacity

To provide remote Wi-Fi Hotspots and document signature/print capacity for all HCBS case managers/Informed Choice staff to work remotely.

Institutional Diversion and Transitions:

The proposed projects, identified in the goals and objectives section are described in detail below:

A. Informed Choice and Transition Staff

This project will establish funding for five full-time positions to complete the informed choice process and to provide transition assistance services for individuals discharging from SNFs or hospitals back to a community setting. Staff will determine the frequency in which they meet with individuals in the SNFs to ensure choice of service setting and increase awareness about community services available. The Department will submit a request to the Governor to include these positions in the Executive budget request for the 23-25 biennium.

B. Assistive Technology Utilization

This project will establish funding for the State assistive technology agency to provide information and training to community providers and caregivers to foster independence so individuals can live more safely and securely in their home. The increased utilization of assistive devices will support increased utilization of home and community-based services.

Person-Centered Practice

The State will improve training and provision of Person-Centered Practices to all new and existing HCBS case managers as part of a statewide initiative. The project will secure payment for ongoing technical assistance on PCP for the Aging Services Division staff, provide annual PCP training, implement a PCP train the trainer process, and develop PCP tools for families and individuals receiving services. Training on cultural competency and sensitivity will also be integrated.

Children's Service System Capacity Assessment:

This project will complete a comprehensive needs assessment of child and related family HCBS and other services to identify short-term, intermediate, and long-term recommendations for development of Medicaid Funded Home and Community-Based Services for children with the focus on outcomes that lead to child and family success with minimal barriers to service access. The project will involve a system wide assessment and facilitated implementation of HCBS services and system change recommendations.

Quality and Data Collection:

The project will provide funding to employ a fulltime staff member to help coordinate, communicate, and report implementation progress on the required activities of the Settlement Agreement with the United States Department of Justice. Funding will also support the implementation of the National Core Indicators (NCI) and the NCI for the aging and disability populations. Data that will be gathered includes admissions to nursing homes, number of placement days, outreach activities to nursing homes, informed choice visits, days in transition, services individuals receive and utilization, cost of services in quarter increments, satisfaction with services, critical incidences, readmissions, etc.

Peer and Family Supports:

The project will provide funding for the development of a system of Peer and Family Supports. In-person and a virtual peer and family support referral and service delivery structure will we developed. This will include identifying the State positions or contracted agency responsible that would hire, train, and manage individuals from across the lifespan interested in transitioning to an integrated setting the opportunity to connect with a peer who has lived experience navigating and receiving community-based services. Family supports will include the provision of system navigation and benefits counseling to ensure understanding and access to home and community-based services and supports. This system will be coordinated by one entity who will enroll or subcontract with community providers with expertise in services targeted to various groups.

Project Management

All progress on the programs and initiatives outlined in this proposal will be reported in writing on a semi-annual (twice yearly) basis to the MFP Project Director, with highlights to be included in the CMS semi-annual report and discussed with the CMS Project Officer during ongoing regularly scheduled meetings. Here is a high-level timeline of activity milestones:

- CMS approval post positions/issue RFPs (if necessary) – June 2021
- Hiring of staff/contractors – August 2021
- First CMS Semi-Annual Report update – December 2021
- Conclusion of projects – September 2025

Below we have outlined the reporting structure for each of our project's components:

1. Home and Community-Based Workforce/Provider Retention and Expansion
   The Program Administrators from Aging and Medical Services will coordinate with the Aging Services Director and will coordinate implementation and reporting efforts with the MFP Grant Program Administrator for semi-annual progress.
2. Institutional Diversion and Transitions
   The Program Administrator for the Informed Choice process reports to the Aging Services Director and will coordinate implementation and reporting with the MFP Grant Program Administrator for semi-annual progress reports.
3. Person-Centered Practice
   The Program Administrator for the PCP projects report to the Aging Services Director and will coordinate implementation and reporting with the MFP Grant Program Administrator for semi-annual progress reports.
4. Children's Service System Capacity Assessment
   The Developmental Disabilities, Medical Services, and Children and Family Services Program Administrators will work with the vender contracted for the project with the MFP Grant Program Administrator for semi-annual progress reports.
5. Quality and Data Collection
   The Data Coordinator for the Settlement Agreement reports to the Aging Services Director and will coordinate implementation and reporting with the MFP Grant Program Administrator for semi-annual progress reports.
6. Peer and Family Support
   The Program Administrators responsible report to the Aging Services Director and will coordinate implementation and reporting with the MFP Grant Program Administrator for semi-annual progress reports.

Appendix G: Capacity Plan

MAS Solutions, LLC
Subject Matter Expert

North Dakota Capacity Plan

On December 14, 2020, the state of North Dakota entered into a settlement agreement with the United States Department of Justice (USDOJ). The agreement is designed to serve adults with physical disabilities that are capable of living in integrated community settings with sufficient services and supports and to receive the necessary care in that setting. Those individuals, considered members of the target population for purposes of the Settlement Agreement, are “individuals with a physical disability over the age of 21 who are eligible or likely to become eligible to receive Medicaid long-term services and supports and are likely to require such services for 90 days.” As a result of the Settlement Agreement, North Dakota has created an implementation plan to address the issues that are currently barriers to allowing target population members to remain in or return to the community. Currently, there are more eligible members of the target population on Medicaid residing in nursing facilities than are receiving home and community-based services.

Barriers exist in the capacity of North Dakota’s case management and community providers, both agencies and individual Qualified Service Providers (QSPs) that present challenges in meeting service needs for individuals transitioning from and being diverted from nursing facilities. Included in the agreement is the requirement for the development of a Capacity Plan to provide technical assistance from the Subject Matter Expert (SME) to assist the state with accomplishing the goals of the Settlement Agreement. The Capacity Plan is designed to address these barriers and assist in streamlining and building systems to allow more target population members to remain in or return to the community, with all necessary services and supports to achieve self-determination by living life as they choose to live. Strategies and actions in the Capacity Plan are designed to address short-term needs and build processes and procedures that North Dakota can maintain and sustain into the future.

The SME is aware that North Dakota may have already taken action and developed plans related to some or all of these recommendations but thought it important to include in this plan for cross reference. Actions that have already begun may be included in the Implementation Plan in Sections VII, VII, and XIII.

Goal #1: The SME recommends that the state identify shortages in case managers and community providers (agencies and individual QSPs), address

those shortages, and increase capacity to most effectively serve Target Population members (TPMs).

Action: Identify and address potential shortages in case managers, by case management territory, through implementation of internal efficiencies and building additional case management capacity to serve and support the target population.

Strategies

1. The SME recommends that the state develop a methodology to determine the actual and projected shortage rates for case managers (CM) by case management territory, including rural areas and Native American populations.
    a. Identify gaps in case manager availability to serve Target Population Members (TPMs) in rural areas and in Native American populations by conducting a capacity gap analysis.
    b. Review 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 nursing facility, and those who seek or are referred for admission to a nursing facility (per the provisions of the Settlement Agreement.) Discussions between the parties and the SME are ongoing relative to the provision of case management services. Strategies that move the state forward in providing for case management services could be included in the Implementation Plan.
    c. Consider a graduation in the level of engagement of the CM for TPMs in nursing facilities, those who are not initially seeking to return to the community, and those who are preparing to transition. Frequency of contact and level of engagement should increase as the TPM moves closer to returning to the community. Additional strategies could be considered, throughout the term of the Settlement Agreement, for how to provide an adequate and appropriate level of informed choice and person centered planning for those that are not initially interested in transitioning to the community.
    d. Develop a backup plan in the event of a sudden case manager vacancy to ensure that TPMs are adequately served.
    e. Create a centralized data reporting system where information is stored, identifying available capacity for each case manager. This system must be updated routinely and be available to the Aging and Disability Resource Link (ADRL) staff to use in the screening and referral process to optimize the matching of TPMs and available case managers.
2. The SME recommends that the state develop and implement recruitment strategies for additional case managers if it is determined that shortages exist or are projected to exist. This may include outreach, (particularly in geographic areas lacking capacity), incentive payments, clear procedures, and parties responsible for expediting the recruitment and hiring of additional case managers.

a. Using data that identifies where actual and projected shortages exist, prepare the justification for the next executive budget request to the ND legislature.

3. The SME urges a complete review of required case management documentation and eliminate unnecessary or duplicative documentation, or both, to reduce the amount of time spent on administrative tasks and enhance case manager capacity.
   a. All required documentation for intake, assessment, and ongoing contacts and updates with the TPM is gathered.
   b. Case manager supervisors may make recommendations on what changes can be made efficiently to reduce time spent on administrative duties. Technical assistance is available for independent reviews and recommendations from the SME for this work.
   c. Develop a strategy for determining what forms and processes are codified in administrative code or regulation that require amendments to streamline processes.
4. The SME recommends that the state address case management role clarification and specialization to enhance capacity to meet the needs of TPMs.
   a. Clarify responsibilities of case managers regarding required outreach and frequency of contacts to a TPM.
   b. Adjust existing CM responsibilities to include working with nursing facility discharge planners to assure that TPMs in nursing facilities routinely receive information regarding HCBS and the capacity of a case manager to be assigned.
   c. Consider recruiting, hiring, and training (or engage a contractor) TPM case managers to a medical care coordination model of case management or contracting for this service. This could include hiring individuals with a master of social work degree well versed in addressing individuals with complex medical needs and focused on community transition. Assign these case managers to TPMs discharging from nursing facilities or presenting at hospitals qualifying at a nursing facility level of care and maintain that assignment for the first year. One option for consideration would be that subsequent to year one, other ND-licensed case managers without that specialized experience could assume case management responsibilities for the TPM.
   d. Develop policy and procedures for case managers, housing specialists, natural and family supports, hospitals, and nursing facilities (including discharge planners) to provide support for TPMs, including communication protocols, single points of contact, and documentation requirements.
      i. Implement a process mapping project to clearly delineate which positions are responsible for doing what and when.
   e. Train all case managers in the revised person centered planning process to ensure that the individual or assigned guardian is included in the planning process and cultural needs and preferences are addressed.

Action: 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.

Strategies

1. The SME urges the state to inventory/survey, by case management territory, the number of agency providers (including which services each provider offers) and the number of individual QSPs (including which services each offers, how many clients each QSP currently serves, and how many additional clients or service hours they could provide) to identify gaps in services and capacity for services.
    a. Inventory/Survey current agency providers, analyzing where gaps in services or current and available capacity that is not being fully utilized exist.
    b. Create strategies to eliminate gaps through the expansion of services offered by current agency providers and individual QSPs.
    c. Identify barriers to service expansion and strategies to overcome such barriers.
    d. Implement goals, action steps, and timelines included in the Money Follows the Person (MFP) Capacity Building Grant to increase capacity.
    e. Create a centralized data reporting system where this information is stored, identifies capacity, can be updated routinely, and is available to case managers and others.
2. The SME encourages the state to streamline the agency provider enrollment system.
    a. Identify internal and external barriers to enrollment and how those may be reformed.
    b. Identify staff responsible to complete each activity and outline procedures. Technical assistance is available for independent reviews and recommendations from the SME for this work.
    c. Implement goals, action steps, and timelines included in the MFP Capacity Building Grant to increase capacity.
    d. Inform case managers and others on revisions in the provider enrollment process.
    e. Notify current providers when the revised certification process is complete.
    f. Provide ongoing support during the certification and credentialing process.
    g. Create a communication and recruitment plan to engage other agencies as potential community providers for the target population.
3. Implement the requested MFP Capacity Building Grant goal of increasing access to assistive devices.
4. The SME recommends that the state streamline the individual QSP enrollment process.
    a. Inventory current individual QSPs, identifying where gaps exist or current capacity is not being fully utilized.
    b. Create strategies to eliminate gaps through the expansion of services offered by individual QSPs including simplifying the process by which QSPs add to their service arrays if they are meeting the standards to provide these

additional services.

c. Assure that case managers are aware of the availability of individual QSPs who wish to serve non-family members and are encouraged to develop awareness about individual QSPs and the services they provide to expand the list of providers to TPMs seeking services.
d. Identify and list barriers to service expansion and strategies to overcome barriers.
e. Revise the current enrollment packet, simplify to eighth (8th) grade reading level, revise competency checklist to include only medical tasks, and expand training modalities.
f. Implement the Centers for Medicare and Medicaid Services (CMS) approved (when final) MFP Capacity Building Grant with measurable goals and objectives to support the individual QSP enrollment process.
g. Explore the co-employer model* (described at the end of this goal) to engage existing agencies to assist in enrollment, management, billing, and payroll of individual QSPs.

5. The SME encourages the state to address health and safety needs of TPMs and QSPs by:
   a. Insisting that all TPMs have a back-up caregiver to provide services when the normally scheduled QSP is unavailable (this QSP can also provide regularly scheduled respite);
   b. Marketing respite services to increase use of such services; and
   c. Offering support groups or a “QSP blog” to improve health outcomes, decrease feelings of loneliness, and extend caregiving.
6. The SME recommends that the state evaluate the effectiveness of the individual QSP referral/finder system for TPMs.
   a. Create a centralized database where information about training, geographic area, hours of work availability, schedule of availability, languages spoken, special considerations (i.e., allergies), and consider adding a simple biography of the QSP.
   b. Simplify the “search” ability of the database so the QSP “finder” list is more user friendly for TPM and case managers to locate providers, including a printable version.
   c. Train case managers and individuals on use of the QSP “finder” list.

Co-Employer/Agency with Choice Model

This is an approved CMS self-directed model where a provider agency and the individual (in this instance a TPM) share employer responsibilities. The agency is the employer of record and their Federal Employer Identification Number (FEIN) and National Provider Identifier (NPI) is used. The individual recruits, selects, schedules, manages, assists with training, and can dismiss the individual QSP. The agency sets the employee wage (it can be a pay range) and maintains hiring and firing responsibilities, that the individual QSP is eligible to work, and protects against fraud

and abuse and neglect. The agency manages the authorization for services, bills for services, and pays the employer and employee taxes.

Goal #2: The SME recommends that the state seek to better align authorization processes and reimbursement systems and rates and reduce disparities in nursing facility and HCBS provider staff compensation for the same or similar services regardless of location or setting.

Action 1: Streamline and make consistent the authorization process for community-based services regardless of where the services are provided

Strategy

The SME recommends that the state develops and implements a plan to eliminate discrepancies in authorization processes and reimbursement rates across case management territories to promote equal access to HCBS services regardless of geographic location.

a. The plan to decrease discrepancies in authorization and reimbursement of services could use existing differential reimbursement rates, where those differences are based on incentives for providers to recruit and retain staff and to offer services in underserved areas pursuant to the implementation plan.
b. The plan should include periodic monitoring and review of authorization requests and decisions to assure that discrepancies do not remain or recur.
c. Train individual QSPs and agency providers on the authorization and billing/reimbursement process and the process for doing so should be included.

Action 2: Reduce any significant disparities between the average reimbursement rates for nursing facilities and the average reimbursement rates for a comprehensive package of home and community-based services for comparable TPMs.

Strategies

1. The SME recommends that the state compare daily average nursing home rates to the overall daily average cost of providing an appropriate package of services for a TPM in a community setting, determine the extent of the disparity, and determine potential rate adjustments or other steps that could reduce the disparity without jeopardizing home and community-based services (HCBS) cost effectiveness or cost neutrality.
    a. Address, with the Centers for Medicare and Medicaid Services (CMS), options to eliminate the incremental “time-for-task” approach to reimbursement for HCBS, as this is a significant barrier for HCBS service delivery, and transition to a bundled package of services delivered in a “block” of hours.
    b. Utilize its databases, including Medicaid claims data, to track services authorized, hours or other amount of services actually provided, and the cost

of such services for each TPM. This data should be used to compare the cost of average utilization of HCBS services compared to nursing facility services for a TPM with comparable needs. The data could also be used to track diagnoses, services authorized, utilization, and gaps in services that lead to hospitalization or nursing facility admission.

c. Train individual QSPs and agency providers on the importance of tracking utilization of authorized services, why services are not being utilized, adjust schedules to increase utilization, and monitor the data to ensure services are delivered consistent to the authorization.
d. The SME recommends that the State implement rebalancing strategies and demonstrate progress in rebalancing it long term services and supports.

Action 3: Align reimbursement rates for nursing facilities and QSPs (agencies and individuals) sufficiently to encourage reduction or elimination of disparities in wages paid to staff providing the same or similar services in different settings, taking into account factors such as overtime, commuting times, benefits offered, etc.

Strategy

a. The SME suggests that the state arrange for a compensation study to determine the levels of compensation (wages and benefits) paid to nursing facility staff and agency and individual QSPs who provide the same or similar services. A primary goal of this study would be to determine what, if any, disparities exist between total compensation packages (wages and benefits) in these different settings.
b. It is recommended that the study use a tool (to be developed by the state or a contracted vendor) that allows for a comparison of compensation for nursing facility and agency and individual QSPs based on the service provided and/or job duties, regardless of the particular job titles of the comparable staff.
c. This study would take into account the number of hours' agency and individual QSPs and nursing facility staff work, including overtime hours and commute times to deliver necessary services.
d. The study would take into account any training, certification, or licensure requirements for the services provided to assure comparability.

Goal #3: The SME recommends that the state develop additional incentives for community providers and individual QSPs who serve members with significant medical or supervision needs, or both, (including overnight needs and/or the need for intermittent on-call services), Native American populations, and members in rural areas.

Action: The state is encouraged to develop and implement a plan and procedures that offer higher payment rates and additional incentives to serve the subpopulation members noted above.

Strategy

The SME recommends that the state establish criteria defining “members with significant medical or supervision needs, or both,” and for “rural areas,” for consideration of additional incentives for purposes of this goal and request funding for additional incentives if those are warranted.

a. Include in the Executive Budget a request to the ND Legislature for funding for additional incentives.
b. Adopt and publicize definitions.
c. Provide incentives to agency providers and individual QSPs who complete training for nurse delegated tasks and behavioral support strategies.
d. Codify and communicate information to agency providers and individual QSPs.
e. The implemented plan and action steps should outline the additional incentives available to agency providers and individual QSPs able to serve these subpopulations. The information about how to communicate, apply for, and secure incentives from the state is made readily accessible.
f. The number of agency providers and individual QSPs who accept additional incentives, the number of TPMs served as a result of those incentives, and the additional cost of providing such incentives to be reported to the SME through a data dashboard on a quarterly basis.
g. Continue to implement the rural differential rate that is established and submit to the SME for review and feedback.
h. Implement the MFP Capacity Building Grant, once approved, to pay for certification costs for Tribes to become their own agency providers or for agencies that primarily serve Tribal members.

Goal #4: The SME recommends that the state assure that community providers are trained with sufficient frequency, intensity, and in all areas of North Dakota on:

- **the Settlement Agreement,**
- **Home and Community-Based Services (HCBS),**
- **person centered planning, and**
- **the authorization and reimbursement system.**

Action: Revise statewide training for individual QSPs and agency providers to improve timeliness of service delivery and increase capacity to optimally serve Target Population members.

Strategies

1. It is recommended that the state revise the training process for individual and family QSPs by:
   a. Simplifying readability of forms to an eighth (8th) grade reading level, with a particular focus on provider agreements.
   b. Consider revising the competency training checklist to remove non-medical tasks, such as money management, that currently require medical review.

c. Amending ND Administrative Code 75-03-23, if needed, to incorporate changes in the enrollment and training requirements of agency providers and individual QSPs (forms, training modules, competency tests, renewal, etc.).
d. Giving consideration to using personal care topics training modules with a competency test rather than skill demonstration for non-medical tasks to increase access to training (an example is available from Arizona).
e. Involving the recipient of services in the training process to individualize training to needs and preferences.
f. Working with Native American leaders to revise training to reflect and respect cultural and spiritual beliefs and practices.
g. Giving consideration to using an "update" process when recertifying agency providers and individual QSPs every two years rather than the current process where the entire enrollment packet must be completed again on a yearly basis.
h. Enhancing the Abuse, Neglect, and Exploitation; Blood Borne Pathogen; and HIPAA trainings agency providers and individual QSPs receive.
i. Providing a written module for Medicaid Fraud and Abuse to use for those who do not have computer access to view the current training video.
j. Giving consideration to using provider agencies to assist with training and managing individual QSPs through a co-employer model.
k. Clarifying the incident reporting process to include how changes in health conditions are identified and communicated. Train individual QSPs in the process to include reporting to case managers and to the appropriate department.
l. Revising the individual QSP finder list process to make it easier for a TPM to select an individual QSP.
m. Identifying activities necessary in order to provide ongoing support to individual QSPs that:
    i. Identifies a point of contact and determines an adequate level (frequency) of contact with the individual QSP. The state should consider the resource training center and agency providers for this role.
    ii. Makes training and support tools available in other (than English) common languages – suggest using a 5-10% of population calculation in order to determine the number of translations necessary.
    iii. Reaches out to individual QSPs annually that are identified as having not billed in the previous quarter to attempt to match such persons with an individual or agency to provide service rather than the current process of not recertifying the individual QSP.

2. The SME recommends that the state improve support to agencies by expanding certifications to increase service availability and capacity by:
    a. Designing an outreach plan for agency providers with less than 15 employees to encourage other provision of other services, particularly Residential Habilitation and Support services, essential for the target population. The state may need to dedicate another staff person to assist with this task.
    b. Assisting the agency provider with improving compliance to policy and

procedures for different state services.

c. Designing or using existing materials to help new and smaller agencies establish a business.
d. Revising the agency certification process to include cultural, ethnic, and spiritual considerations when training Tribes to be a provider agency.
e. Reviewing and suggesting changes to ND Administrative Code 75-03-23, if needed, to incorporate changes in the enrollment and training requirements of agency providers (forms, training modules, competency tests, renewal, etc.).
f. Revising the Competency Training Checklist to remove non-medical tasks, such as money management, from medical performance review and allow the agency to approve competency.
g. Giving consideration to allowing agency providers to use state modules or design their own module for approval by the state, to develop a proctored competency test for non-medical tasks that will simplify training processes.
h. Allowing agency provider staff to be trained to assess competencies exempt from nurse delegated tasks, such as transfer and handwashing.
i. Giving consideration to having agency providers train and track family members who provide services to one family member, differently than individual QSPs providing services to other individuals.
j. Encouraging agencies to involve the recipient of services in the training process to individualize training to needs and preferences.
k. Clarifying the incident reporting process to include how changes in health conditions are identified and communicated. Train staff to the process to include reporting to case managers and the appropriate state agency.
l. Simplifying the two-year re-certification process to an “update” rather than complete the entire certification packet.

3. The SME recommends that the state could develop a database to register all agency providers and individual QSPs and categorize if provider is a family QSP or Tribal affiliated.
4. The SME recommends that the state further assess the practicality of developing a training center given the rural and frontier nature of North Dakota.
    a. Determine if the training curriculum can be provided in virtual formats for greater accessibility.
    b. Consider making training available for groups in person or virtually with a live trainer as well as making training options available that are pre-recorded which individuals can access at different times.
    c. Consider a cost-benefit analysis to aid in decision making.
    d. Consider using provider agencies to perform tasks associated with resource training center goals.
5. The SME recommends that the State revise person centered planning training for case managers and train 100 percent of case managers to the revised model.
    a. Schedule and train case managers statewide to revised person centered planning processes.
    b. Train case managers on the revised planning process and tool to use with older persons (+65).

c. Train case managers to the person centered planning process to use with individuals in the hospital or nursing facility (“informed choice interview”) until they begin their transition, when the full planning process and developed plan will be used.
d. Ensure that case managers receive cultural sensitivity training.
e. Train select case managers (or pursue a contractor to do the same) to a medical model or care coordination model of case management to use with TPMs returning to the community from nursing facilities or hospitalization.

Appendix H: Partially Approved Spending Plan for Implementation of ARPA Section 9817

Draft Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817. Rebalancing Toolkit (nd.gov)

Appendix I: Safety Assurance Plan

NORTH Dakota | Human Services
Be Legendary.

MAS Solutions, LLC
Subject Matter Expert

North Dakota Safety Assurance Plan

On December 14, 2020, the state of North Dakota entered into a settlement agreement with the United States Department of Justice (USDOJ). The agreement is designed to serve adults with physical disabilities that are capable of living in integrated community settings with sufficient services and supports, to receive the necessary care in that setting. Those individuals, considered members of the target population for purposes of the Settlement Agreement, are "individuals with a physical disability over the age of 21 who are eligible or likely to become eligible to receive Medicaid long-term services and supports and are likely to require such services for 90 days." As a result of the Settlement Agreement, North Dakota has developed an implementation plan to address the areas that are currently barriers to allowing Target Population Members (TPMs) to remain in or return to the community.

Developing this Safety Assurance Plan is also a requirement of the Settlement Agreement to assure that an incident reporting and review process is established and agency providers employing non-family members to serve TPMs are trained in the system and that such agency providers have a quality improvement program in place that identifies, addresses, and mitigates harm to the TPM. Actions and strategies in the Safety Assurance Plan are designed to address immediate needs and build processes and procedures that North Dakota can maintain moving forward to meet the requirements of the agreement.

Goal #1: The SME recommends that the state train community providers on incident reporting and review procedures designed to identify, address, and mitigate harm to Target Population members they serve.

Action #1: The SME urges the state to establish a consistent incident reporting and response process to be used for all incidents listed under Strategy 1.g (below). The SME also recommends the development and use of a single data system accessible to and used by state employees authorized to investigate and/or remediate such incidents. This process should be in place no later than 18 months from the effective date of the agreement.

Strategies

1. The data elements for reporting incidents should include:

a. report date/time;
b. reporter name;
c. reporter contact info (e.g. email address, phone number,);
d. reporter agency (if any);
e. recipient Last Name, First Name, Medicaid ID, Address, Phone Number, Date of Birth (DOB);
f. general information about the incident; and
g. incident type classifications:
    i. Deaths;
    ii. Life-threatening illnesses or injuries;
    iii. Alleged instances of abuse, neglect, or exploitation;
    iv. Changes in health or behavior that may jeopardize continued services;
    v. Serious medication errors;
    vi. Illnesses or injuries that resulted from unsafe or unsanitary conditions; and
    vii. Any other incident currently required to be reported pursuant to state law or policy or which was required as of the effective date of the Settlement Agreement (December 14, 2020.)

2. The SME recommends that the process for responding to reported incidents include a data system that provides entry fields for:
    a. investigator and/or case manager progress notes,
    b. conclusions with respect to the incident or situation,
    c. the outcome of the review including whether substantiated or unsubstantiated, and
    d. an incident remediation plan, if applicable.
3. The SME recommends that the state identify workflow processes (mapping the steps in the process) for the investigation and remediation of reported or otherwise suspected incidents described above. The processes will be documented in policy and/or provider contracts and manuals. Processes should include:
    a. completion of any missing data elements from the initial report to be completed by the lead investigator for the state,
    b. timelines and guidelines for the investigation of incidents,
    c. development of a remediation plan for each confirmed incident with the exception of death by natural causes, (the remediation plan to include who is responsible for implementing as well as monitoring and a timeline for both), and
    d. A method for tracking when an incident has an associated complaint.
4. The data system and workflow processes will assure the issuance of a report to the Settlement Agreement Coordinator, the United States Department of Justice, and the Subject Matter Expert within seven (7) days for the types of Incidents listed above and a remediation plan for such incidents (with the exception of death by natural causes) as called for in the Settlement Agreement.

Action #2: The SME recommends that the state train community providers on the state's data system and processes for reporting, investigating, and remediating incidents.

Strategies

It is recommended that the state:

a. Develop training materials and curriculum to include a specific focus on the state's data system and the state's processes for reporting, investigating, and remediating incidents to the Target Population Member;
b. Provide this training to agency providers pursuant to a schedule developed by the state;
c. Make the materials and curriculum available to agency providers so that staff can access these online; and
d. Develop materials in the form of videos, virtual and in person group training and self-study modules methods, and alternative communication methods to ensure training is available to all agency providers.

Goal #2: The SME urges the state to ensure that all licensed agencies or entities employing non-family community providers have a quality improvement program that identifies, addresses, and mitigates harm to Target Population Members (TPMs) they serve.

Action: The SME urges the state to require agencies who employ individuals who are not family members of the TPM to have a quality improvement program (process and plan) and provide the plan to the state. The required quality improvement program will identify, address, and mitigate harm to TPMs.

Strategies

1. The SME recommends that the quality improvement process and plan include a review to assure that the TPM has an individualized safety plan that was developed as a component of their person centered plan. The safety plan need not be developed by the provider unless it was not included in the person centered plan developed by the case manager and the TPM. This safety plan will include:
   a. Identifying health issues, behavioral issues, and the individual's access to health care providers;
   b. Safety assessment of the home or other place the individual is living for items such as;
      i. Grab bars in bathrooms,
      ii. Slip and fall hazards such as loose throw rugs,
      iii. Clear pathways between rooms, and
      iv. Documented need for home and environmental modifications and
   c. The determination of level of supervision needed.

2. With the consent of the TPM or his/her legal guardian if applicable, or if otherwise authorized by law; identification of relevant family members, friends, or neighbors who interact with the individual on a regular basis; and the provision of information to those persons on how and to whom to report if significant problems or incidents arise, the SME recommends that the State provide for review of every agency provider's quality improvement program and individual safety plans, if such plans were developed by the provider.
3. It is suggested that the state work with all agency providers to develop performance improvement targets aimed at improving health outcomes for TPMs. The SME recommends that the state develop a clear set of guidelines for incident response, review, investigation, and remediation. The state should outline the specific steps in the process including defining the roles and responsibilities of the state, agency providers, and other relevant parties. The guidelines could make clear, for example, in the case of alleged abuse of a TPM by an agency employee, whether witnesses should be interviewed first by the provider, by state agency staff, law enforcement personnel, or others.

Goal #3: The SME recommends that the state improve the availability, accessibility, and quality of community based services provided to TPMs and ensure the continued health and safety of those members.

Action: The SME recommends that the state take additional actions to ensure the health and safety of TPMs who receive Home and Community Based Services (HCBS) in accordance with the member's person-centered plan. It is recommended that the state develop and publicize its oversight of the provision of HCBS and provide mechanisms for TPMs to file complaints.

Strategies

It is recommended that the state:

1. Provide for a mortality review for every death of a TPM (with the exception of death by natural causes). At least one individual involved in such a review should have relevant health care credentials. The purpose of the review would be to determine whether the quality, scope or amount of services provided to the TPM were implicated in the death. Information from mortality reviews should be used to promote service improvements at the agency provider or across the service system as appropriate.
2. Conduct an audit of the data system periodically (at a minimum of twice annually) to identify if there are agency providers that are over- or under-reporting. This audit would include review of a random sampling of client files and records to determine if there are incidents documented that should have been reported that were not reported or were reported subsequent to the deadline for reporting.
3. Review, on no less than a quarterly basis, incident reporting data to identify common or critical issues being reported, trends in reporting, and what can be done to mitigate harm.

4. Conduct outreach and education to the public and mandated reporters on new processes and data system requirements in order clarify and provide updates on reporting requirements.
5. Develop, per the Settlement Agreement, a mechanism for the public to file complaints relative to the provision of HCBS. The SME recommends that the mechanism include complaints regarding the availability, accessibility, or quality of services as well as the health and safety of TPMs.
6. Consider development and use of an adult abuse registry that would enable the state to identify individuals who have been confirmed to have committed significant abuse or neglect of vulnerable individuals and include procedures governing the employment or supervision of such individuals in the HCBS system.

Appendix J: Service Unit by Territory