Implementation Plan

December 14, 2023 – December 13, 2024

North Dakota Department of Health and Human Services

Aging Services

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Note: The page numbers in parenthesis following the section titles refer to the pages of the Settlement Agreement

List of Acronyms

ADA – Americans with Disabilities Act
ACL – Administration for Community Living
ADRL – Aging and Disability Resource Link
ARPA – American Rescue Plan Act of 2021
CAPABLE - Community Aging in Place, Advancing Better Living for Elders
CMS – Centers for Medicare and Medicaid Services
CIL – Center for Independent Living
CIR- Critical Incident Report
CQL – Council on Quality and Leadership
CtLC – Charting the LifeCourse
CSC – Community Services Coordinator
DD – Developmental Disabilities
DHHS – Department of Health and Human Services
EPCS – Extended Personal Care Services
Ex-SPED – Expanded Service Payments to the Elderly and Disabled
FTE – Full Time Equivalent
FMAP – Federal Medical Assistance Percentage
HCBS – Home and Community Based Services
HCBS waiver – HCBS Medicaid waiver
HSRI – Human Services Research Institute
HTP – Housing Transition Plan
IP – Implementation Plan
LCA – Local Contact Agent
LTSS OC – Long Term Services and Supports Options Counseling
MFCU – Medicaid Fraud Control Unit
MFP – Money Follows the Person
MFP-TI – Money Follows the Person Tribal Initiative
MSP-PC – Medicaid State Plan Personal Care Services
NCAPPS – National Center on Advancing Person-Centered Practices and Systems
NCI – National Core Indicators
NCI-AD – National Core Indicators – Aging and Disability
ND – North Dakota
NDAC – North Dakota Administrative Code
NDHFA – North Dakota Housing Finance Agency
NF LoC – Nursing Facility Level of Care
OAA – Older Americans Act
PCP – Person Centered Plan
PSH – Permanent Supported Housing
QSP – Qualified Service Provider
QSP Resource Hub – Qualified Service Provider Resource Hub
RA – Rental Assistance
SA – Settlement Agreement
SME – Subject Matter Expert

SNF – Skilled Nursing Facilities
SPED – Service Payments to the Elderly and Disabled
TBI - Traumatic Brain Injury
TPM – Target Population Member
USDOJ – United States Department of Justice
VAPS – Vulnerable Adult Protective Services

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.

This updated IP outlines actions to be taken from December 14, 2023, to December 13, 2024, Year 4 of the SA, with annual updates to follow that will outline new and updated 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: Realigning 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.

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 Year 4 IP continue to 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 with the implementation of the new Qualified Service Provider (QSP) enrollment portal and the Connect to Care system which will act as a provider registry and marketing tool.
- Evaluate additional opportunities to provide HCBS through various Medicaid authorities that fund in-home and community-based services, especially models that will allow for fiscal administration support for QSPs.
- Maintain and continue to improve processes related to the following:
    - 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 strive to continuously 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:

- Increase awareness about HCBS and the right to live in an integrated setting through case management, 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 and expectations 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 support service connections.
- Provide incentives to service providers who are willing to expand the HCBS services they offer and implement a QSP on-call service.

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 QSPs are enrolled and available to provide services using the QSP application portal.
- Further develop resource and training centers for direct care workforce, peer specialists, and HCBS providers through a continued partnership with the QSP Hub.
- Implement newly created person-centered planning training and core competencies that can support improved quality of service, highlighting practices that are culturally informed, streamlined, and rooted in person-centered planning.
- Continue to implement 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 for TPMs who are awaiting transition or diversion.

Data and System Tools

The State intends to:

- Continue to refine the functions of the case management platform to better connect all parties involved in serving TPMs, with connections established between related data systems (such as the Critical Incident Reports and Vulnerable Adult Protective Services reports involving TPMs).
- Create resources that support improved practice, including Connect to Care, housing inventory, environmental modification resources, and referral networks.
- Implement HCBS quality measures and analyze the results of the National Core Indicators (NCI) to inform policy and practice and future IP strategies.

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 State used work groups 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 skilled nursing facility (SNF) to community living 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 and XIII 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 analyses that are outlined in the IP will help assure continued attention to benchmarks, key performance indicators and other 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 4 of the SA, as well as new strategies that were designed based on lessons learned and data from the first three (3) years of SA implementation.

It is noteworthy that this revised Implementation Plan pertains to a specific timeframe, namely Year 4 (December 14, 2023, through December 13, 2024) of the Settlement Agreement. Some of the strategies and initiatives in this proposal are contingent on legislative approval and appropriation to fully implement. The State has already started to compile a list of potential new initiatives and services for potential inclusion in the Department of Health and Human Services (DHHS) executive budget request. The Legislature will next convene in January 2025.

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 4 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*	Settlement Agreement Year	Time Period Covered
IP	May 25,	Sept. 22,	Years 1 -2	Dec. 14, 2020 – Dec.

	2021	2021		13, 2022
IPr1**	August 29, 2022	October 14, 2022	Year 3	Dec. 14, 2022 – Dec. 13, 2023
IPr2***	November 1, 2023	December 1, 2023	Year 4	Dec. 14, 2023 – Dec. 13, 2024
IPr3	June 14, 2024	August 15, 2024	Year 5	Dec. 14, 2024 – Dec. 13, 2025
IPr4	June 14, 2025	Aug. 15, 2025	Year 6	Dec. 14, 2025 – Dec. 13, 2026
IPr5	June 14, 2025	Aug. 15, 2026	Year 7	Dec. 14, 2026 – Dec. 13, 2027
IPr6	June 14, 2026	Aug. 15, 2027	Year 8	Dec. 14, 2027 – Dec. 13, 2028

Period of Substantial compliance: Dec. 14, 2028 – Dec. 13, 2029
Termination of SA if Substantial Compliance by Dec. 14, 2029 is achieved.

**The noted approval dates set in the future are estimated based on timelines suggested by the processes that are described in the SA.*

***Implementation Plan Revision (IPr)*

*** The State requested and was granted an extension of the Year 4 IP submission date.

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.hhs.nd.gov/adults-and-aging/us-department-justice-settlement-agreement.

Lessons Learned

During the current period (Year 3) of SA implementation, a few key strategies proved to be very effective in creating awareness and increasing access to HCBS for TPMs.

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. The State has received feedback from the Subject Matter Expert that person-centered plans have shown marked improvement since the start of the Settlement Agreement.

PCP Improvements are apparent in multiple areas including the more consistent identification of risks, plans to mitigate those risks, and the more comprehensive delineation of goals and the action steps necessary to reach those goals.

The data below reflects the first two (2) and one-half years of the Settlement Agreement.

- **267 TPMs transitioned** from a SNF to integrated community housing where they can receive necessary support while enjoying the freedom and benefits of community living.
- **717 TPMs diverted** 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, **3,189** in 2022, and **3,210** to date in 2023.

- 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 answered **32,770 calls** for information and assistance about HCBS and responded to **2,468 web referrals** for HCBS.

- 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 during **3,010 referral** visits to TPMs referred for a long-term stay in SNF.

- 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.
  - **Nineteen (19)** Agency QSPs were **successfully enrolled** as residential habilitation or community-support providers.

- The COVID-19 pandemic and corresponding federal relief funds **increased both the demand** for HCBS and the **resources available to provide them**. Although some of the demand for HCBS increased because of the pandemic health and visitation restrictions in SNFs, the trend has continued post-pandemic. The referrals to HCBS continue to remain high.

Year 4 Priorities

During Year 4 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:

    - Bringing the responsibility for QSP enrollment in-house and finalizing the QSP application portal and Connect to Care systems.

    - 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.

- Reducing the administrative burden 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 system.

- Continue to monitor the capacity of case management, transition coordination and housing facilitation to meet the continued demand for HCBS. 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. This includes monitoring how centralizing Basic Care case management has impacted the HCBS Case Managers workload.

- 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 ensuring TPMs have continued access to rental assistance, environmental modification, and consider how we can incorporate handy man services into the current service array.

- Increase behavioral health supports and training for QSPs. Consider creating a behavioral health endorsement for QSPs who are willing to be trained in this area. Consider value-based rates that allow providers who have earned the endorsement to receive a higher rate for services provided to TPMs.

- Continue to work with Native American stakeholders and other special populations to improve awareness and increase access to culturally informed HCBS. Continue to support the development and growth of Tribal owned QSP agencies.

- Continue to prioritize timely, efficient, and safe transitions for TPMs that are completed within the 120-day benchmark required in the settlement agreement.

IP Performance Measures and Benchmarks

The following is a summary of Year 4 Benchmarks identified in the SA.

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.* This report is submitted within a reasonable timeframe subsequent to the end of the reporting period.

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.* This plan will be submitted within a reasonable timeframe subsequent to the end of the reporting period and submission of the Biannual Report.
- Submit *a **biannual data report** to the USDOJ and SME. SA, Section XV. D.* This report is submitted within a reasonable timeframe subsequent to the end of the reporting period.

By December 13, 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.* This report is submitted within a reasonable timeframe subsequent to the end of the reporting period.
  - Additional **650 TPMs receive person-centered planning and a 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,B, & C pages 8-9)

Nancy Nikolas Maier has been appointed as the Agreement Coordinator. Michele Curtis is the Settlement Agreement Support Specialist. The State holds regularly scheduled internal 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.

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

Implementation Strategy

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)**

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 4 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. The State asks for feedback on a variety of topics, shares data and allows time for attendees to share any issues they feel need to be addressed at each meeting. A Stakeholder feedback summary will be completed at the end of the year.

2024 Meeting Schedule:

- March 21, 2024
- June 20, 2024
- September 19, 2024
- December 12, 2024

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. These meetings are different from the DOJ stakeholder meetings and generally focus on the HCBS needs of one community or area of the State. 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. The State will post meeting dates on a calendar of events section on the DOJ portion of the DHHS website and create a summary of stakeholder feedback at the end of the year. The State will utilize the feedback provided to inform how the State will implement changes to the service array, simplify administration and increase access to HCBS. Invitations to these events are sent to hospitals, SNFs, CILs, QSPs, social service agencies, State staff, advocates, and local community leaders. **(Target completion date December 13, 2024)**

Strategy 3. Include representation from New Americans and other special groups when gathering public input. The State will continue to work with the UND Native American Resource Center staff to hold a monthly stakeholder call with experts from Tribal entities to guide the public input and stakeholder engagement process as it relates to Native American elders and individuals with disability. This group will also be consulted to help identify local subject matter experts who may be willing to provide cultural awareness training with State staff and others who work in Tribal communities in ND.

The State is currently working with advocates from the LGBTQIA+ community and will reach out to the Department's refugee services coordinator to determine the best way to reach the New American, migrant, and refugee population in ND to ensure they are

included in future stakeholder meetings. **(Ongoing Strategy)**

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

Implementation Strategy

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

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.hhs.nd.gov/adults-and-aging/us-department-justice-settlement-agreement. **(Ongoing strategy)**

Section VI. Performance Measure(s)

Number of unduplicated individuals served in HCBS by funding source.

SA Section VII. Case Management

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

Updated Strategy 1. The State will employ HCBS case managers who will provide HCBS case management full time. The State will require all newly hired HCBS case managers to complete a comprehensive standardized training curriculum that has been developed within three (3) months of employment. The State will provide ongoing training and professional development opportunities to include cultural sensitivity training for special populations to ensure a high-quality trained case management workforce. The State will continue to work with Tribal stakeholders to identify local experts 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.

Updated Strategy 2. The State was granted two FTE in the 2023-2025 DHHS biannual budget to serve as provider navigators who will assist all HCBS case managers state-wide in finding QSPs to serve eligible HCBS recipients. The State will consider the feasibility of using the new Connect to Care system formally referred to as ConnecttoCareJobs platform to share referrals for HCBS to QSPs. This will free up time for the case managers and assist them in keeping up with the increased demand for HCBS.

Updated Strategy 3. 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 continue to monitor weighted caseloads of the 68 licensed social workers currently hired as HCBS case managers. The State will also monitor the caseload impact of moving all the Basic Care cases to three (3) specialized basic care case managers. **(Ongoing strategy)**

Assignment (Section VII, Subsection B, page 10)

Implementation Strategy

Ensure that the supervisors are assigning the case manager to TPMs already living in the community and requesting HCBS within two business days. **(Ongoing strategy)**

Capacity (Section VII, Subsection C, page 10)

Implementation Strategy

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, visit requests, and interest in HCBS in general remains high. The State has increased the number of case managers available to serve this population and will continue to monitor the need for additional staff.

Remediation

The State will continue to monitor the need for additional HCBS case managers. The goal is to have a weighted caseload of no more than 100 cases per case manager **(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)**

Updated Strategy 2. Conduct training with hospital and SNF staff to discuss HCBS, LTSS Options Counseling, facilitate 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 and may be provided virtually. **(Ongoing strategy)**

Challenges to Implementation

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

Remediation

Training will be held at least biannually in Year 4 of the Settlement Agreement. **(Target completion date December 13, 2024)**

Strategy 3. Utilize the educational materials created to inform TPMs, family, and 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. **(Ongoing strategy)**

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. Work with the case

management vendor to continue to refine and improve the user experience for staff. Simplification projects include updating the individual home page for HCBS case mangers so they can better navigate through their HCBS assessments, PCPs, and provider authorizations. The State will continue to monitor caseloads and will ask for additional staff if warranted in the next budget request. **(Target completion date June 30, 2024 and Ongoing strategy)**

Quality (Section VII, Subsection F, page 11)

Updated 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. The State can now identify which consumers are TPMs so the audit information will be updated to include data about TPMs. **(Ongoing strategy)**

ADRL (Section VII, Subsection G, page 11)

Implementation Strategy

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

Section VII. Performance Measure(s)

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

Total number of HCBS case managers serving Tribal nations.

Number of SNF and hospital staff trained in NF LoC procedures/LTSS Options Counseling/discharge planning.

SA Section VIII. Person-Centered Plans

Responsible Division(s)

DHHS Aging Services

Training (Section VIII, Subsection A, page 11)

Updated 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.

The State will also continue to work with Human Service Research Institute (HSRI) and LifeCourse Nexus University of Missouri Kansas City Institute for Human Development and stakeholders to finalize the person-centered planning competencies and corresponding training. A sustainable training and staff development program will be part of initial onboarding and ongoing professional development practices to support the core competencies of all Aging Services Division staff and providers. Outline of competencies and training is projected to be finalized by December 2023, with the updated training to meet competencies held throughout 2024. **(Ongoing strategy)**

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 of the Settlement Agreement and these are apparent in PCP documentation. The person-centered planning tool in the case management system will allow all required information to be captured and included in the plan. The PCP will be updated when a TPM goes to the hospital or SNF and remains available and accessible in the 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)**

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)**

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 continue to 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.

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

Implementation Strategy

Updated Strategy 1. The State will inform the SME that a setting other than the TPM's home, a family home, or an apartment was chosen as the TPM's most integrated setting appropriate to meet their needs when the State intends to count the transition to the site to meet the requirements of the SA. Information about the number of TPMs who moved to another type of setting will also be included in the biannual report.

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 continues 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. The entity and State will also be developing a train-the-trainer program for person-centered competencies, learning modules, and hands on learning. Supervisors of State staff will learn how to determine staff competency and will learn ways to remediate any gaps in knowledge identified through the process. **(Updated target completion date December 31, 2025)**

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.

By the end of Year 4 of the SA the State must conduct person-centered planning with an additional 650 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)**

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 visit TPMs in that facility and provide person-centered planning at least annually. **(Ongoing strategy)**

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 NF LoC vendor the State has developed a monthly report that lists TPMs by facility and by their original NF LoC 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.

Updated Strategy 3. To help ensure that HCBS case managers conduct person-centered planning in a culturally responsive way, the State will work with Dr. Jeremy Holloway, Director of Geriatric education at UND to provide training with pre- and post-tests to measure learning on the following subjects:

- Working with New American communities to serve adults with physical disabilities.

- Working with Native American communities to serve adults and elders with physical disabilities. (Potential speakers for this training will be based on recommendations from members of the Native American stakeholder engagement workgroup.)

- Cross-Cultural Communication in the Healthcare Workplace (Three (3) part series).

    - Describe what is Cross-Cultural Communication.
    - Understand why Cross-Cultural Communication is essential in the workplace.
    - Determine how to take the first practical step to improved Cross-Cultural Communication in the workplace. **(All training complete December 13, 2024)**

New Strategy 4. Develop one of the person-centered planning competency modules to address cultural humility and competency. All Aging Services staff will be trained and required to meet these competency standards. **(Target implementation date December 31, 2023 training complete December 31, 2024.)**

New Strategy 5. Ensuring access to interpretive services and translating informational materials into other languages.

The QSP enrollment portal will include tool tips in Spanish, French, Napali, Arabic, and Bosnian. Applicants who need an interpreter to assist them in enrolling as a QSP can call the QSP Hub who will utilize an interpreter service when providing enrollment support.

Section VIII. Performance Measure(s)

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

Number of HCBS case managers who meet core person-centered competencies within the required timeframe.

Number and percent of PCPs reviewed during the State case management review that meet all Settlement Agreement requirements.

Number of denials for TPMs requesting HCBS, associated appeals, and outcomes.

Number of unduplicated PCPs completed for TPMs in the community.

Number of unduplicated annual PCP visits to TPMs in SNF.

Number and percent of PCPs produced by transition coordinators and reviewed by the State that meet all Settlement Agreement Requirements.

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

New Strategy 1. Compile a list of potential services that will enhance the current service array and fill gaps in the service delivery system for potential inclusion in the 2025-2027 DHHS Executive Budget request. Services may be added to one or more of the state or Medicaid HCBS funding sources. For example, adding the Community Aging in Place, Advancing Better Living for Elders (CAPABLE) program to the HCBS waiver. CAPABLE combines the services of a handy man with the expertise of a Registered Nurse (RN) and Occupational Therapist (OT) to help adults with physical disability to continue to live in their home and receive necessary care. **(Target completion June 1, 2024)**

Updated Strategy 2. During the 2023 HCBS national conference CMS informed participants that it is possible to use presumptive eligibility to assist Medicaid applicants in accessing HCBS and that six (6) states have adopted this policy. The State has requested technical assistance from CMS and will be reaching out to the fee for service states who are currently using presumptive eligibility to learn how it was implemented. Once that information is obtained, we will meet with the Medicaid Director and other internal stakeholders to discuss how we might begin the process to implement this in ND. **(Target completion date February 29, 2024)**

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 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.

Updated 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 2025-2027 legislative session.

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, because 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 additional state general fund appropriations would be required to pay for the fiscal intermediary services required under formal self-direction.

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 with choice model and a QSP rural cooperative.

The State has also made considerable investment in systems to improve the QSP enrollment experience and will provide a system where QSPs can market their services to the public. The State also offers free access to EVV and a documentation and billing submission system that will shift some of the administrative burden off of the providers. Conduct and complete a feasibility study of a variety of provider models including the co-employer/agency with choice model and a QSP rural cooperative. If another model is identified Aging Services will request that model/self-direction be part 2025-2027 DHHS Executive Budget request. **(Updated Target completion date July 1, 2024)**

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

Updated Implementation Strategy

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. TPM and HCBS applicants are made aware of the right to appeal any decision to deny/terminate/reduce services by maintaining information in the Application for Services form, and the "HCBS Rights and Responsibilities" brochure. **(Ongoing strategy)**

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

Implementation Strategy

Updated Strategy 1. HCBS policy includes the process to request a reasonable modification for review and consideration. Some requests for reasonable modification may conflict with the ND Nurse Practices Act, N.D. Cent. Code § 43-12.1. The State will continue to meet with the Board of Nursing to review all medically related reasonable accommodations to review trends and make recommendations for policy or legislative changes that will allow more TPMs to live at home and receive necessary healthcare. **(Ongoing strategy)**

Strategy 2. 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)**

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

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 (5) additional eligible agency QSPs with paying for their CQL accreditation. **(Ongoing strategy)**

Updated Strategy 2. Implement recommendations from the HCBS rate study conducted with assistance of a contracted vendor with expertise in analyzing rates for HCBS using funds from the 9817 10% HCBS fund. The State will use existing procurement rules to create an alternate rate augmentation payment that will be used to implement rate enhancements to encourage QSPs to serve additional TPMs. QSPs who agree to accept TPMs who need a lot of care, or QSPs who agree to provide care to individuals who only need access to intermittent care, would be paid a lump sum

amount to augment the rate already paid for these services thus increasing access to HCBS for TPMs. **(Target completion date April 1, 2024)**

Updated Strategy 3. Implement the following services and enhancements to the HCBS delivery system that were included in the 2023-2025 DHHS budget. **(Target completion date January 1, 2024)**

- Increase the quality of HCBS by reimbursing QSP Agency on-call staff.
- Pay for two (2) home delivered meals per day under the HCBS Medicaid waiver, SPED and Ex-SPED.
- Add companionship services to SPED and Ex-SPED.
- Allow bed hold days for community support and residential habilitation paid through the HCBS Medicaid waiver.
- Increase individual adult foster care maximum rate from $96.18 per day to $150.00 per day and to increase the family home care rate from $48.12 per day to $72.50 per day.
- Create a personal care with supervision service in the HCBS Medicaid waiver and switch Medicaid state plan personal care recipients who have supervision needs to the HCBS waiver.

Updated Strategy 4. Finalize the recommendations that will be made by the individual adult foster care workgroup to the current adult foster care rules and policy. The goal of the committee is to review all rules and policy governing this service and to find ways to improve the experience for TPMs and providers.

The workgroup is made up of State staff responsible for writing policy and licensing the individual adult foster care homes. The recommendations made by the internal committee were shared at a meeting on December 5, 2023. 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 December 31, 2023)**

Section IX. Performance Measure(s)

Number of QSPs offering on-call services.

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

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

Number of TPMs receiving extended personal care.

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

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

Number of requests for reasonable modifications received and outcome of those requests per reporting period.

SA Section X. Information Screening and Diversion

Responsible Division(s)

DHHS Aging Services & Medical Services

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

Implementation Strategy

The current LTSS Options Counseling 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 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 will continue to hold 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)**

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

Remediation

If an individual will no longer meet NF LoC criteria, the SNF can request that the State put an administrative hold on the current NF LoC screening for up to 120 days. This will give the SNF and transition team time to create a safe discharge plan for a return to community living. **(Ongoing strategy)**

Strategy 3. Conduct annual in-person regional meetings with SNFs and offer other webinars to train SNF staff on the USDOJ SA, annual NF LoC requirements, HCBS options and effective discharge planning to ensure TPMs can live in the most integrated setting. **(Target completion date December 31, 2024)**

New Strategy 4. Aging Services staff are working with the Behavioral Health Division and the State Hospital to streamline transitions and improve working relationships and expectations of the role that the behavioral health community has in ensuring the health and welfare of transitions involving TPMs with co-occurring behavioral health and substance use disorders. Representatives from each of these areas are participating in

person-centered planning team meetings and will develop a set of goals and expectations of how each entity can support TPMs post transition. **(Target completion date February 1, 2024)**

New Strategy 5. The State will work with behavioral health and traumatic brain injury (TBI) subject matter experts to create a process for QSPs to earn a behavioral health and/or TBI endorsement as part of QSP enrollment. The endorsement would be earned after agency QSP staff or an individual QSPs completes specialized training that will provide them with additional skills to help support TPMs with specialized needs. The State will work to identify the type of training and skills necessary to earn the endorsement. Training could include de-escalation, therapeutic response, and motivational interviewing. The State will also consider the feasibility of paying a higher rate to QSPs that have this endorsement when working with TPMs who need this level of specialized training to ensure successful community living after the next biennium. **(Target completion date July 1, 2024)**

New Strategy 6. Continue to educate QSPs about the existence and availability of crisis services that can assist when a TPM being supported in the community has a mental health crisis. The services include the mobile crisis team and crisis facilities.

The mobile crisis team is coordinated through the State's Human Service Centers (public behavioral health clinics). The mobile crisis team can meet a person where they are, whether this is their home, work, school, or other location. These services are provided by Human Service Center staff or contracted providers in Bismarck, Fargo, Jamestown, Grand Forks, Williston, Minot, and Dickinson. Services will be available in Devils Lake once a provider is found.

What the mobile crisis team offers:

- Stabilizes the crisis quickly.
- Assess for risk of harm to self/others.
- Helps problem-solve by connecting the person to services and resources.
- Provides after-crisis support.

Crisis facilities also offer walk in support at a crisis facility 24 hours 7 days a week for a brief screening in the Bismarck, Fargo, and Jamestown regions. Individuals can walk in and receive short-term, recovery-focused services to help resolve a behavioral health crisis. This could also include one or more overnight stays. Services include withdrawal management, supportive therapy, and referrals to needed services.

Individuals can also walk into any human service center between 8 a.m. and 5 p.m. CST for a behavioral health screening. Mental health professionals work one-on-one with people to assess their situation and help them connect to services either at a human service center or community provider to prevent a future crisis.

If a TPM cannot physically get to a Human Service Center or contracted provider for a behavioral health screening the case manager may request that a reasonable modification to the "walk-in" policy be made. The mental health professionals may make a home visit or other modifications to ensure they have access to necessary care.

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

Implementation Strategy

During the first year of the SA the SME 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 A – Diversion Plan

Link to October 2023 SME Report

The State is currently implementing or has incorporated many of the recommendations included in the Diversion Plan into the initial and subsequent IP strategies. During this implementation plan period the State included strategies that align with the following goals from the Diversion 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.

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

Section X. Performance Measure(s)

Number of individuals reached through group SNF in-reach presentations.

Number and percent of unduplicated LTSS OC visits made to TPMs residing in home, hospital and SNFs.

Number of unduplicated annual PCP visits to TPMs in SNF.

Number of cases staffed per interdisciplinary team meetings and outcomes.

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:

- Continue to 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 future MFP budgets which requires approval from CMS. **(Ongoing strategy)**

- Add a requirement to the next CIL transition coordination contracts that would require the CILs to attempt to hire additional staff to meet the demand for transition coordination in their service territory.

- Continue to address the need for the MFP transition coordinators to provide high quality transition support statewide and consistently adhere to required policy and procedures.

Updated strategy 2. Continue to enhance MFP supplemental services. These services are one-time to short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. The State gathered input from stakeholders and transition coordinators to design and implement additional supplemental services to assist TPMs in transitioning to the community. **(Ongoing Strategy)**

Newly implemented MFP supplemental services include:

- Increasing the amount and access to food pantry stocking for a 30-day period.

- Home modifications and vehicle adaptations available prior to transition so TPMs have what they need to successfully transition day one.

- Targeted training for direct service workforce on the unique needs of the individual prior to transition. These costs are part of the administration budget.

The State is seeking additional funds to further enhance the following supplemental services.

- Assistive technology, companion animals, and other devices to increase opportunities for social interaction.

- Home repairs and deep cleaning.

- Onetime health supplies for example, incontinence supplies, diabetic supplies etc.

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

Updated strategy 1. The State will continue to require that transitions that have been pending for more than 90 days are reported to the MFP program administrator. The MFP State staff will facilitate a team meeting to staff the situation with the transition coordinator, HCBS case manager and housing facilitator and provide more intensive attention to the situation to remediate identified barriers preventing timely transition. Transitions that have been pending for more than 100 days are also 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 signed consent to transition. **(Ongoing strategy)**

Challenges to Implementation:

The SA requires that transitions take no more than 120 days. Although the State agrees that is an appropriate goal for most transitions, some transitions take longer than the 120 days because of the complex needs of the TPM. Rushing transitions can result in unsafe discharge. In some cases, considerable barriers to transition need to be met before a plan is made to move back to the community. For example, TPMs may have an upcoming surgery, or need to learn to use prosthetics before they are ready to transition. If transitions are going to be successful it is necessary to take the time to develop a solid transition plan. The State will continue to work with the SME to further address this issue.

Updated Strategy 2. 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. During the past year the State has identified the following issues to be consistent barriers to TPMs accessing community living. There are strategies in other relevant sections of the IP to mitigate these barriers.

- Lack of providers in certain areas of the State,
- Not enough accessible housing units,
- Timeliness of social security redetermination regarding a change in residence i.e., move from nursing home to home,
- Behavioral health and substance abuse that may jeopardize community living,
- Behaviors towards providers jeopardizing services,
- Criminal conviction history and,
- Individuals who lack capacity but do not have a legal decisionmaker.

Review meetings are conducted quarterly. The State continues to develop the training and strategies to correspond with the needs of State staff, HCBS case managers, MFP transition coordinators and housing facilitators.

New Strategy 3. Social Security and Medicaid can be slow to change the living arrangements of TPMs who have a short-term stay in a SNF because they may not know that an individual is being discharged and they may also be in jeopardy of losing their housing because landlords are not aware that they intend to return home. Sometimes utility and other bills go unpaid while a TPM is in the nursing home. All these things can complicate and delay transition for TPMs who are eager to return to community living. The State will create educational materials for the LTSS OC and SNF discharge planners to help educate themselves, landlords and TPMs in the SNFs about the steps that need to be taken to ensure TPMs can keep their housing, pay their bills, and receive the correct social security benefits post discharge. **(Target completion date April 1, 2024)**

New Strategy 4. Aging Services staff will request to work with the Guardianship Association of ND to assist in determining the best approach for helping TPMs who lack capacity but do not have a legal decision maker to help them make important decisions, including decisions that impact their ability to live in the community and access necessary care. The goal of the collaboration would be to develop strategies and recommendations to help ensure TPMs in this situation are afforded the right to live in the most integrated setting appropriate to meet their needs. **(Target completion date July 1, 2024)**

New Strategy 5. The State will work with Legal Services of ND to develop "futures planning" events and tool kits to educate people about the need to take steps now to ensure their health care and other wishes are known in the event they become incapacitated. The goal of the events will be to provide education and have a completed durable power of attorney for health care or other legal document that is ready to be shared with their family and healthcare providers by the end of each event. **(Target completion date December 13, 2024)**

New strategy 6. Some TPMs, especially those who have been residing in a SNF for a long time, may lack the community living skills necessary to create and follow a household budget that will ensure they are able to manage their expenses post discharge. The State will consider the possibility of requesting to add fiscal management services to eligible TPMs under one or more of the federally funded HCBS. The service would allow the TPM to work with a subject matter expert to complete a monthly budget and develop financial goals that will support long-term success with community-living. **(Target completion date June 1, 2024)**

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

Implementation Strategy

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

Once a TPM is identified through the LTSS Options Counseling referral process or other in-reach strategy, the MFP transition coordinator will meet with the TPM to explain MFP and the transition planning process. Within five (5) business days of the original referral an HCBS case manager is assigned and the team must meet within 14 business days to begin to develop a PCP. The MFP transition 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. **(Ongoing strategy)**

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

Implementation Strategy

Updated Strategy 1. 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. Referrals are the number of TPMs who have signed consent to participate in MFP or ADRL transitions and are actively waiting to transition. 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 and the QSP portal, improve retention and training of providers, and improve the ability of TPMs to find QSPs that match their service needs through the Connect to Care system formally referred to as ConnecttoCareJobs platform. This system connects individuals to a platform for providers to market their skills and be matched with a TPM.

Updated Strategy 2. The QSP Hub recently conducted a second QSP survey with Agency and individuals QSPs. The survey received a good response rate. Thirty-four percent (34%) of agencies and 22% of individual QSPs responded to the survey. The QSP Hub staff are currently analyzing the data and expect to have a draft report by the end of 2023. **(Target completion date December 31, 2023)**

Updated Strategy 3. The QSP Hub plans to complete a provider survey annually. The State will work with the QSP Hub and the lead UND researcher, to develop a QSP capacity survey. The survey will try 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 13, 2024)**

Strategy 4. The State tracks TPMs in the case management system using a unique identifier and will report unduplicated transition and diversion data. **(Ongoing strategy)**

Section XI. Performance Measure(s)

Number and total dollar amount of incentive grants awarded.

Number of TPMs who were re-institutionalized for 30 days or more and the primary reason.

Transition 60% of those requesting transition, who have consented, and are eligible.

SA Section XII. Housing Services

Responsible Division(s)

DHHS

The State's experience implementing the settlement agreement 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 4 of the Implementation Plan will continue to 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 the first three (3) years 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.
Link to Appendix B – Housing Access Plan

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

Goal #1: Ensure that Target Population Members receive housing supports identified in Person Centered Plans that are designed to support a transition to and success living in the community.

Goal #2: Increase access to existing affordable and affordable accessible rental units through policy change and relationship development.

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

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

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

Goal #6: Notify the SME prior to transition of any recommended placements to settings

other than Permanent Supported Housing for review of the transition plan.

Implementation Strategy

Updated Strategy 1. Development of housing needs and preferences tools that will be incorporated into LTSS Options Counseling and case management processes.

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

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. The committee will continue to educate stakeholders about the need for these funds to build affordable and accessible housing in ND. DHHS staff continue to provide input on the annual allocation plan for the federal Low-Income Housing Tax Credit program and the Housing Trust Fund, Home Investment Partnership Program, and the ND Housing Incentive fund. **(Ongoing strategy)**

New strategy 2. Conduct a stakeholder engagement opportunity for people who live in public housing to discuss their thoughts on the current availability and functionality of affordable and accessible housing and whether the current system is meeting their needs. Discuss what is meant by accessibility. This information will be used to inform future policy changes and long term needs for services. **(Target completion date December 31, 2023)**

New Strategy 3. Sometimes people without disabilities end up renting affordable, accessible housing units instead of individuals with disabilities who need them. This can happen because the rental market is very tight and the landlords often make units available on a first come first serve basis. Aging Services will work with the ND Housing Finance Corporation and developers to devise a strategy and recommendations to help ensure that accessible, affordable housing units are available to those individuals who truly need them.

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

Implementation Strategy

Updated Strategy 1. Connect TPMs to integrated community housing with community supports 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 barriers to accessing integrated community housing.

Remediation

Housing case notes were added to the case management system. One case note identifies housing barriers upon referral and the other case note identifies assistance provided to overcome the barriers. The data will be reviewed biannually to look for trends and develop strategies to address the issues.

Updated Strategy 2. Research 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. Identify technology solutions and assess feasibility to serve as accessibility resource for housing locators who are working to connect TPMs to appropriate housing. The State will research options used by other states and develop a recommendation. **(Target completion date May 31, 2024)**

Challenges to Implementation

Complexity of consistent front end data entry that will return high quality data and cost of the system. The current ADRL database https://ndcpd.org/mfp-listings/ includes the housing inventory and will show the characteristics of attributes of the units. For example, are they accessible, affordable, allow pets, etc.

It does not update when units are rented etc. as this process would not be manageable or happen in real time. The housing facilitators help TPMs search and find appropriate housing in the community.

Remediation

Build on housing inventory already developed and maintained by MFP transition team and consider opportunities to further integrate into ADRL-based search capabilities based on the research that will be completed on other State models.

Strategy 3. Convene State Housing Services collaborative 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

New Strategy 1. Complete a housing coordinator crosswalk to identify the entities that offer housing facilitation and make sure these entities are working together to streamline the referral process. The intent is to have housing facilitation provided in a consistent

manner statewide to better serve eligible populations. **(Target completion date June 30, 2024)**

New Strategy 2. The State has developed a Supported Housing Services Collaborative made up of housing and community service providers, DHHS staff, and the State Housing Finance agency. The committee will be updating their goals and action steps to mitigate barriers to effective housing supports that allow eligible populations to access community integrated housing. This process will include defining challenges to implementation. **(Target completion date June 30, 2024)**

Strategy 3. Build on the State's case management system, to ensure that we are continuing to streamline and refine the data collection process. The State will work with the case management vendor to build a report that tracks from the date of request to completion of home modification for TPMs utilizing MFP. **(Target implementation date February 1, 2024)**

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

Implementation Strategy

Strategy 1. 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 environmental 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. **(Ongoing Strategy)**

Updated Strategy 2. Follow Medicaid policy (specifically SNF) to create guidance regarding "intent to return home," resulting in a usable resource for LTSS OC, eligibility workers, landlords, discharge planners 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. Some TPMs are not 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. The State intends to create educational information about "intent to return home" to add to the resources the LTSS Options Counselors and discharge planners etc., can use that includes information that needs to be communicated to SNFs to facilitate continued TPM access to monthly payments which further enable a return home. **(Target completion April 1, 2024)**

Challenges to Implementation

Complexity of underlying systems. Determining who is the party responsible to make sure the checklist is used and that all necessary steps to secure a TPMs

current housing are incorporated into their discharge and transition plans.

Remediation

Involve people with expertise in federal housing and Medicaid in this initiative. Provide education and training that defines responsibilities by role.

Updated Strategy 3. Continue to use funds from MFP to maintain a TPMs housing while in institutional care to ensure they have adequate housing post discharge. **(Ongoing strategy)**

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

Implementation Strategy

Housing Specialists will receive in-person training on federal laws that prohibit housing discrimination against individuals with disabilities, with a particular emphasis on the Fair Housing Act and Title II of the ADA, and the Agreement's requirements.

Training is done annually with Fair Housing of ND and the ND Department of Labor. All Housing Coordinators are required to attend.

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, emergency rent assistance [State or federal]). Include processes for accessing rental assistance (eligibility, referral, documentation, and determination). Information will be added to the environmental modification metric so that all information is contained in one document. **(Targeted completion date July 1, 2024)**

Challenges to Implementation

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

Updated Strategy 2. Expand permanent supported housing capacity by funding and providing rental subsidies for use as permanent supported housing. The 2023-2025 DHHS budget included $300,000 of State funded rental assistance for TPMs. The State will continue to discuss the feasibility of requesting permanent state funding for rental assistance in the 2025-2027 executive budget request. **(Target completion date June 30, 2024)**

Challenges to Implementation

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

Section XII Performance Measure(s)

Number of TPMs who indicated housing as a barrier who were provided PSH.

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

Number of TPMs who transitioned and diverted that received housing facilitation and resulting services accessed.

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

Number of TPMs who receive rental assistance, including those that transition and those who are diverted.

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

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 paid and 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 new technical assistance tools such as user guides that will be available in multiple languages. All technical assistance tools will be updated to reflect the new QSP application portal enrollment process.

- 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.

- Continue to develop the QSP Building Connections stakeholder workgroup and

make updates to the strategic plan.

- 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 QSP agency recruitment initiatives.

New Strategy 2. The QSP Hub with input from the state will develop a Be More Colorful recruitment video featuring a day in the life of a direct support professional/QSP. Be More Colorful is a North Dakota based marketing agency that uses interactive virtual tours to show a realistic job preview of various professions to encourage career exploration of students and adults. The career view video will be used when conducting outreach with high schools, universities, community colleges, at career fairs, and other community events. **(Target completion date April 30, 2024)**

New Strategy 3. Conduct a three-pronged marketing event that includes a direct mailing, social media run of the ADRL marketing videos, and a community enrollment pop-up event in a community that is struggling to find QSPs to support TPMs. **(Target completion date March 31, 2024)**

The State will work with the QSP Hub to target the community of Cavalier, ND. Cavalier, ND is in northeastern ND and there is a shortage of QSPs in that area. A direct mailing postcard will be sent to eligible households that provides information about how to access services and supports from the ADRL and asks people if they are interested in helping their community by becoming a QSP. The postcard mailing includes a QR code that can be scanned and will direct people to the new QSP application portal and the QSP Hub. At the same time, we will boost the ADRL ads to social media and advertise a QSP enrollment pop-up session held in Cavalier to assist anyone who has question or wants to enroll. Data from this effort will be tracked and evaluated to see if targeted outreach like this works and could be replicated in other ND communities.

New Strategy 4. Partner with the QSP Hub to offer access or create training videos or live training events that will expand the business acumen of the QSPs especially agency QSPs. Topics for the videos may include leadership courses, completing cost reports, effective marketing, employee recruitment, engagement, and retention. **(Ongoing strategy funded through September 2024)**

Updated Strategy 5. Developing partnerships with ND high school and college student career counseling services to discuss the possibility of placing individuals working on a CNA certification or those studying to be an RN, OT, PT etc., with QSP agencies to gain experience and coursework credits while providing HCBS. Students could complete a

placement in the community and could be hired as employees or work toward credit hours on their degree.

Updated Strategy 6. Prioritize outreach at community events i.e., street fairs, college fairs and job fairs to reach more people who are not already part of the HCBS delivery network.

Updated Strategy 7. Implement a 3% inflationary rate increase for all HCBS services that was approved in the 2023-2025 DHHS budget. **(Implementation date July 1, 2024)**

Updated Strategy 8. The State will implement changes to the rates for HCBS that were approved during the 2023-2025 legislative session. Family Home Care will change from a daily maximum of $49.56 to $72.50 per day. Individual Adult Foster Care will increase from a maximum daily rate of $99.07 to $150.00 per day. Full implementation required regulatory authority changes that included approval of a Waiver amendment by CMS. **(Target completion date January 1, 2024)**

Updated Strategy 9. Finalize the development and implementation of a provider enrollment portal that will be made available to agency and individual QSPs. The system, which will replace the current paper process, will ask a series of questions, and then intuitively guide the user to the services they are eligible to provide. The portal will allow providers to enter and save their information eliminating the need to provide information multiple times.

The system is rooted in customer service and includes short video tutorials and tool tips to help answer questions quickly which will increase the likelihood of completing the application process in the first attempt. All required enrollment training such as the QSP Fraud Waste and Abuse training and the QSP orientation is contained within the system. The system will also include a screening tool that will allow agency QSPs to check all the required websites to screen employees who will work with individuals who are receiving State or federally funded HCBS. The system will also be used for reenrollment and to add or change a provider's personal information, service array, or service territory.

State staff are currently working with an IT vendor to finalize the QSP enrollment portal. The project started in July 2023 and has a 16-week implementation goal. The system allows for a third party to help an individual who may lack capacity to complete the application process themselves online. The QSP Hub will have access to the system and can provide individual technical assistance upon request. **(Target implementation date January 2024)**

Updated Strategy 10. Create a centralized QSP matching portal in cooperation with ADvancing States to replace the current QSP online searchable database.
The new system will be implemented with State specific modifications to a national website called Connect to Care system formally referred to as 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 updated in real time, 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. The system will interface with the QSP portal and will receive daily updates of new QSPs and changes to current QSP information so information in both systems is always current.

The State will work with the QSP Hub to hold training sessions with QSPs to help them develop their online profile and marketing skills in the system so they can better advertise themselves to potential clients. **(Target soft launch date December 11, 2023)**

Updated Strategy 11. Continue to pay up to $250,000 for the CQL accreditation fees for 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. **(The State has funding available through June 30, 2025 or until funds are expended)**

Updated Strategy 12. 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 SNFs and their provider associations to directly ask for their assistance in providing HCBS to TPMs that live in their service area. **(Updated Target completion date July 1, 2024)**

Updated Strategy 13. Support start-up and enrollment activity costs for new or existing QSPs to establish or expand their business to provide HCBS. Four (4) additional incentive grants will be awarded in Year 4 of the SA in amounts up to $50,000 each based on the priority of need of the services the agency will provide. **(Grants awarded by April 01, 2024)**

New Strategy 14. To continue to ensure timely enrollment and revalidation of QSPs, the State has decided to bring QSP enrollment duties inhouse. The State will be hiring five (5) temporary QSP enrollment staff that will work under the supervision of the Medical Services QSP Enrollment Coordinator. The new staff will use the QSP portal to compete all aspects of QSP enrollment. QSP enrollment staff will also be responsible to manage the Connect to Care formally referred to as ConnecttoCareJobs QSP registry, which will interface with the QSP portal to ensure provider information is accurate and up to date. The goal is to complete all new enrollment applications within 14 calendar days of receipt of a complete application. The QSP enrollment staff will also begin processing new provider revalidations and provider information maintenance requests

once the QSP portal is complete. **(Target implementation date January 31, 2024 and ongoing strategy)**

Updated Strategy 15. Work with a vendor to complete a project to assess the current training requirements and structure for HCBS providers working in Aging Services, Developmental Disabilities Services, Autism Services, and Behavioral Health Services. The vision for the project is to identify and establish innovative workforce training strategies to meet provider needs and improve the quality of life for North Dakotans with disabilities.

The goals of the project are to:

- Identify and address the needs of providers and caregivers,
- Improve the quality of training services by establishing strategic training protocols,
- Establish a standardized set of training policies and procedures across the various services and systems,
- Identify core qualifications for all providers to develop and maintain,
- Improve collaboration and coordination among State agencies and stakeholders.

DHHS has partnered with an independent consulting firm to perform the assessment and develop recommendations to implement pathways for an innovative workforce training strategy. As part of the assessment, they will be asking key stakeholders to complete a web survey and to participate in discovery sessions to provide perspective and inform our understanding of both the current workforce training structure, as well as the needs and desires for the future. Once the information is received the State will design a process to revise the current training for HCBS providers across the lifespan. Future drafts of the IP will contain strategies to implement the training recommendations including the possibility of offering scholarships to providers to encourage participation. **(Target completion date January 31, 2024)**

Updated Strategy 16. 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. Once the new QSP enrollment portal is complete, 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. QSPs who have disenrolled in the past six (6) to nine (9) months and were in good standing with the DHHS will be targeted for this project. Any QSPs who agree to

reenroll and help public pay clients will be offered a recruitment bonus paid with funds from the 9817 10% plan. The State will track the number of individuals we reached and if any of them enrolled to provide care. We will also add language to the QSP handbooks to make sure people are aware of the ongoing opportunity to be a QSP after their family caregiver journey ends. **(Target Completion Date May 1, 2024)**

New Strategy 17. Update ND Admin code 75-03-23 to require a representative of an enrolled QSP agency or an individual QSP to complete a department approved Qualified Service Provider orientation prior to initial enrollment. The State is working with staff from the QSP Hub to create the orientation. The orientation will be recorded as a series of short videos or an eLearning module that will be embedded in the new QSP enrollment portal. QSPs who are revalidating enrollment and QSP applicants will be required to watch the orientation as part of the enrollment process. The new system will track if the videos were watched in their entirety. **(Target implementation date January 1, 2024)**

New Strategy 18. Use funds included in the 2023-2025 DHHS budget to pay a stipend to Agency QSPs who are willing to designate on-call staff that would be available to assist TPMs in the event of an emergency or if the regularly scheduled provider is unable to complete their shift. The State will be working through the procurement process to request proposals from Agency QSPs interested in creating or sustaining an on-call QSP system in their organization. **(Target completion date February 1, 2024)**

New Strategy 19. Use feedback gleaned from the QSP Agency and Native American QSP agency stakeholder meetings to offer financial incentives to encourage providers to serve TPMs with high care needs and TPMs and other individuals whose need for care is intermittent. The State will issue a request for proposals that will allow QSP agencies and agencies willing to become a QSP to create a proposal that demonstrates their plan to serve this growing population.

The scope of service could cover different options like requesting payment for employee travel, training, wait time between serving individuals and retainer wages to keep staff when there is turnover in 24-hour cases. The scope could also include incentives for Agency QSPs to seek additional training for their staff in the provision of services to individuals with dementia, TBI, or behavioral health issues. The funds could also be used to contract with professionals to assist them in developing individual program plans that will mitigate known risk factors to living in the most integrated environment. **(Target completion date March 1, 2024)**

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

Updated Implementation Strategy

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 marketing of ongoing training that will assist QSPs in understanding and complying with safety and incident reporting procedures. The QSP Hub assists in making QSPs aware of training opportunities, but the training content is developed and delivered by an Aging Services nurse administrator. **(Ongoing strategy)**

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

Implementation Strategy

During the first year of the SA the SME 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. Link to Appendix D – Capacity Plan

The State is currently implementing or has incorporated many of the recommendations included in the Capacity Plan into the initial and subsequent IP strategies. During this implementation plan period the State included strategies that align and support the following goals from the Capacity plan.

Goal #1: Identify shortages in case managers and community providers (agencies and individual QSPs), address those shortages, and increase capacity to serve Target Population Members (TPMs) most effectively.

Goal #2: 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.

Goal #3: 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.

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

Implementation Strategy

Updated Strategy 1. The Environmental Modification workgroup will continue to analyze and add information to the matrix that describes which services are working, which services are underutilized and will work on strategies to create awareness and improvements of these programs. The Environmental Modification workgroup

developed a focused approach to evolving North Dakota's approach to home modifications and analyzed barriers experienced by TPMs as identified in PCPs and while delivering transition and diversion services.

Supplemental information is available from data collected in the State case management system with 2-3 focus groups that include HCBS case managers, LTSS Options Counselors, 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. **(Ongoing strategy)**

Challenges to Implementation

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

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 continue to conduct webinars starting 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 upon request. **(Ongoing Strategy)**

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. **(Ongoing Strategy)**

New Strategy 4. Increase the capacity for providers to consult accessibility experts when implementing HCBS such as environmental modification by providing funding to the CILs to allow more of their staff to be trained as accessibility experts.

Challenges to Implementation

Determining what training is most appropriate to ensure staff have the knowledge necessary to provide reliable recommendations about accessibility.

Remediation

The State will work with the CILs and other experts to determine the level and type of training required to ensure well trained staff.

New Strategy 5. 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.

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.
- 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. **(Ongoing strategy through September 2024)**

New Strategy 6. Develop a “Lunch and Learn” webinar with an environmental modification provider who has experience providing environmental modification services to Medicaid waiver participants in ND and other states. The webinar will highlight how the provider has worked within the constraints of the Medicaid authorization and claims submission system to successfully serve TPMs who need this service to live in the most integrated setting. The webinar would be targeted toward the construction and home remodeling industry in ND. The session would be recorded and could be used as a future marketing tool to explain how providing environmental modification services to the Medicaid eligible population could be beneficial to their business. **(Target completion date April 1, 2024)**

New Strategy 7. 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. A request for proposal will be issued and the State will work through the procurement process to secure a vendor **(Target completion date November 30, 2023 and ongoing)**

Section XIII. 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 agencies that stopped providing services.

Number of new independent QSPs enrolled as providers.

Number of independent QSPs that stopped providing services.

Rate increases effective January 1, 2024.

Number of QSPs and individuals trained to Connect to Care system formally referred to as ConnecttoCareJobs by February 29, 2024.

Number of SNFs that have enrolled to provide HCBS.

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 13, 2024 and ongoing)**

Strategy 2. Continue to conduct LTSS Options Counseling 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 NF LoC determination screening tool 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 10 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)**

Challenges to Implementation

TPMs will be seen by the facility case manager/ LTSS Options 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 Options 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.

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 support to do so. It will create the opportunity to connect with a peer who has lived experience navigating and utilizing HCBS**. (Target completion date June 30, 2024)**

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.

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 updated the LTSS Options Counseling 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)**

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

Implementation Strategy

Updated Strategy 1. 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 three (3) times in Year 4 of the SA and will provide 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. State staff will also staff information booths at community events and will make themselves available for media requests and to present information about HCBS at stakeholder meetings and virtual and in-person conferences across the State. **(Ongoing strategy through December 13, 2024)**

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

The State will use an additional $250,000 of supplemental grant funds that were recently awarded to 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 June 2021)**

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

Updated Implementation 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 DHHS Legal Advisory Unit and the Civil Right Officer are discussing bringing in a third party vendor to update the website and printed documents and make the online information accessible. **(Ongoing strategy)**

Section XIV. Performance Measure(s)

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

Number of referrals for peer support and outcome.

Number of TPMs who requested and received a communication accommodation.

Number of TPMs who access respite and the hours provided.

Number of individuals served in the CAPABLE program.

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)

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.

Updated 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 4 of the DOJ SA. Requested enhancements include creating an interface to electronically receive MFP referrals submitted to the ADRL, improve the functionality of the user home page, allow QSPs to use the system to electronically document the care provided, and adding helpful system generated referral alerts and reminders. **(Target completion date December 13, 2024, and ongoing strategy)**

Updated Strategy 2. Design a method to analyze the number of units being authorized and utilized, by case management territory, to determine if there are significant discrepancies in the number of services available to TPMs across the State. A pilot project will be developed that looks at services in a few counties to determine what can be gleaned from this information and if it warrants expanding the data pool to add additional counties and services.

Challenges to Implementation

Ensure that the data analysis and conclusions drawn from the proposed pilot project are designed to account for individual circumstances (hospitalization, provider changes, delayed billing etc.) that may impact how a TPM uses the services authorized in the PCP.

Remediation

The State will work with the case management system vendor and the US DOJ, SME, and other experts to create a report that will produce reliable results that may assist the State in creating additional strategies to successfully implement the requirements of the settlement agreement. **(Target completion date June 1, 2024).**

Updated Strategy 3. Implement 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 provided to the State. The interface would enhance collaboration and reporting of all types of critical incidents involving a TPM that were reported as a CIR, QSP complaint, or to VAPS. It would also help the State implement the HCBS Quality Measure set as required by CMS for states with MFP programs. **(Target completion date December 13, 2024)**

Updated Strategy 4. The State will continue to improve and revise its data collection efforts and will maintain a set of key performance indicators on the Department's website to illustrate the State's progress and challenges implementing the DOJ SA. **(Ongoing strategy)**

Key performance indicators include:

1. Referrals to HCBS
2. Average weighted HCBS case management caseloads.
3. Number of TPMs served in a skilled nursing facility (SNF).
4. Number of TPMs served in the community.
5. Number of TPMs diverted from a SNF.
6. Number of TPMs transitioned from a SNF.
7. Average annual cost of HCBS and SNF care
8. Average length of time from QSP application submission to enrollment.
9. QSP retention rate.
10. Number of agencies enrolled as providers.
11. Number of independent QSPs enrolled as providers.
12. Number of TPMs who are receiving 24/7 care and the number of QSPs authorized to support 24/7 care.
13. Number of QSPs by county; indicate tribal, rural and frontier.

Section XIV. Performance Measure(s)

Number of service units authorized by territory.

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHHS Aging Services and Medical Services

Implementation Strategy

During the first year of the SA SME 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 C – Safety Assurance Plan

The State is currently implementing or has incorporated recommendations included in the Safety Assurance Plan into the initial IP and subsequent IP strategies. During this implementation plan period the State included strategies that align with the following goals from the Safety Assurance Plan.

Goal #1**.** Train community providers on incident reporting and review procedures designed to identify, address, and mitigate harm to Target Population members they serve.

Goal #2: Improve the availability, accessibility, and quality of community-based services provided to TPMs and ensure the continued health and safety of those members.

Updated Strategy 1. 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. The unified system will meet the requirements of the HCBS quality framework that must be adapted by states with an MFP grant. 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 case management 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, 2024)**

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

Implementation Strategy

Updated Strategy 1. The State will continue to provide quarterly critical incident reporting training opportunities for QSPs. The trainings are advertised by sending emails to agency and individual QSPs and posting training dates on the QSP Hub website. The State will also utilize the help of the ND LTC Association to remind their members about reporting requirements and will provide individual training if certain QSPs show a pattern of submitting late reports.

Information about the training is included in the QSP handbooks and will be included in the QSP orientation that will be required as part of QSP enrollment starting January 1, 2024. 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. **(Ongoing strategy)**

Updated 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)**

Challenges to Implementation

Some QSPs struggle to implement a QI program because they lack training and staff to create a robust program.

Remediation

The State has hired a nurse who will be responsible for providing technical assistance to QSP Agencies to help them implement robust QI programs. State staff review all QSP QI programs for compliance. If a QI program does not meet standards, the State will provide technical assistance and may recommend additional training or resources the QSP agency can use to reach compliance. Agency QSPs may also contact the QSP Hub for additional training and support.

Updated Strategy 3. National Core Indicators – Aging and Disabilities (NCI-AD) is a process that measures and tracks the State's performance and outcomes of HCBS provided to TPMs. The NCI-AD survey was completed by over 400 HCBS recipients in 2023. The State will review the results of the study and will collaborate with ADvancing States and the Human Services Research Institute (HSRI) to interpret the results. The State will include strategies to mitigate any identified quality issues, gaps in the service array, etc.in future versions of the IP. Quality performance reports will be made available on the DHHS website and shared at USDOJ stakeholder meetings. The State intends to complete the NCI-AD survey every two (2) years. **(Target implementation date July 1, 2024)**

Strategy 4. The State will continue to submit critical incident reports to the USDOJ and SME within seven (7) days of the incident as required in the SA. **(Ongoing strategy)**

New Strategy 5. Aging Services has hired a nurse administrator who will be responsible to work with State staff to implement the HCBS Quality Measure Set as identified in SMD# 22-003 RE: Home and Community-Based Services Quality Measure

Set (Link to Measuring and Improving Quality in Home and Community Based-Services/Medicaid). The HCBS Quality Measure Set is designed to assess quality and outcomes across a broad range of key areas for HCBS. The HCBS Quality Measure Set is also intended to promote more common and consistent use, within and across states, of nationally standardized quality measures in HCBS programs, and to create opportunities for CMS and states to have comparative quality data on HCBS programs. CMS plans to incorporate use of the measure set into the reporting requirements for specific authorities and programs, including the Money Follows the Person (MFP) program, but has not given a specific date of when that will happen. The State will begin the process of implementing these measures by providing a training for DHHS HCBS staff on the details of the measures and their intended use. **(Target training date April 2024)**

New Strategy 6. Update North Dakota Admin Code 75-03-23 to require Agency QSPs who have accepted an authorization to provide 24-hour supports to an eligible individual to give a 30-day written notice before they can involuntarily discharge the eligible individual from their care unless otherwise approved by the Department. This will increase the quality of 24-hour supports and help the providers to understand the commitment they are making when they agree to assist a TPM with this level of need. If a QSP does not provide a 30-day written notice it will be submitted as a complaint to Aging Services and it may lead to sanctions or termination of a QSPs status. (**Target completion date January 1, 2024)**

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

Updated 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.

Updated 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 and critical incident reporting requirements will be included in the QSP orientation that will be required to enroll or revalidate as a QSP. In addition, the State reminds providers of the reporting timeframes each time a CIR is not submitted on time.
(Orientation required as of January 1, 2024 and ongoing)

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 future incidents.

To assure the necessary safeguards are in place to protect the health, safety, and welfare of all TPMs receiving HCBS, all critical incidents as described in the SA must be reported and reviewed by the State. Any QSP who is with a TPM, involved, witnessed, or responded to an event that is defined as a reportable incident, is required to report the critical incident 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 CIRs. Critical incident reports must be submitted and reviewed within one (1) business day. **(Ongoing strategy)**

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)**

Updated 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 number of services provided to the TPM were implicated in the death. The review is conducted by the quarterly critical incident report committee. The committee review consists of a review of the reason for the death, if there was an obituary/notice of death posted, if law enforcement was involved, and if there was an autopsy completed. Information gleaned from the review is 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)**

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)**

Strategy 2. The State publicizes its oversight of the provision of community-based services for TPMs and provides 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)**

New Strategy 3. The State has seen an increase in the number of complaints that have been filed about the care provided by QSPs. This trend in reporting is indicative of the increased number of individuals receiving HCBS each year, the complexity of the care needed by TPMs, and awareness of the right to file a complaint. The State is monitoring the capacity of the Complaint Administrator to manage the increased reports and has made a request to the Executive leadership team for an additional FTE to be allocated to Aging Services in 2024.

New Strategy 4. Include information in the required QSP enrollment orientation that describes the state and federal documentation and record keeping requirements for HCBS and the penalties for noncompliance. Information from the MFCU about their authority to investigate and prosecute Medicaid provider fraud as well as abuse or neglect of residents in health care facilities, board, and care facilities, and of Medicaid beneficiaries in noninstitutional or other settings will also be included. The purpose of the enrollment orientation is to help ensure that QSPs understand the responsibilities of providing state and federally funded services to TPMs and to deter individuals who may try to take advantage of the HCBS system for personal gain. **(Target implementation date January 1, 2024)**

Section XVI Performance Measure(s)

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

Percent of Agency QSPs required to have a QI program in place that have one.

Number of critical incident reports that have an associated complaint.

Number of amendments reported.

Number of TPM complaints and outcomes

Appendix A: Diversion Plan

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MAS Solutions, LLC
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 B:

Housing Access Plan

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Subject Matter Expert

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.

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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. ~~i~~nvestigator 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 D: Capacity Plan

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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.