North Dakota – Department of Justice Settlement Agreement

Biannual Report
June 14, 2023 – December 13, 2023

ND Department of Human Services
Aging Services Division

Submitted

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Final

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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
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
EVV- Electronic Visit Verification
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-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
TPM – Target Population Member
USDOJ – United States Department of Justice
VAPS – Vulnerable Adult Protective Services

Introduction

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

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

This report describes progress toward the requirements listed in Sections VI–XVI for June 14, 2023 through December 13, 2023. The report builds on the approved SA IP. All the requirements and associated strategies toward compliance that were due or are being worked on in this reporting period are included. New information is provided under the progress report heading highlighted in yellow and target dates were modified when necessary.

A reporting dashboard of the activities conducted in this reporting period are included as Link to Appendix A to this report. They provide statistical data and additional information about the progress that has been made toward the required benchmarks of the SA regarding Long Term Services and Supports (LTSS) Option Counseling, home, and community-based services (HCBS), Aging and Disability Resource Link (ADRL), transition support services, and housing to assist target population members (TPM).

The State created a Year 1 - Year 3 comparison dashboard that highlights the progress and data trends since the SA was signed on December 14, 2020.

Link to Appendix C.

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

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

- **Increase access** to community-based service options through policy, process, resources, tools, and **capacity building** efforts.
- Increase **individual awareness** about community-based service options and create **opportunities** for LTSS Options Counseling.
- Widen the **array of services** available, including more **robust housing-related supports**.

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

- Implement broad access to **training and professional development** that can support improved **quality** of service, highlighting practices that are **culturally informed**, streamlined, and rooted in **person-centered** planning.

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

What We're Proud of

Major accomplishments during the second 6 months of Year 3 – (June 14, 2023 – December 13, 2023) of the USDOJ SA.

- **Transitioned 63 TPMs** from a SNF to integrated community housing where they can receive necessary support while enjoying the freedom and benefits of community living.

- **Diverted 177** new individuals from a SNF by providing necessary services and supports so they can remain at home with their family and friends.

- Provided **information about HCBS** options through **436** unduplicated LTSS Options Counseling referral visits to **406** unduplicated TPMs referred for a long-term stay in a SNF.

- There are **2,336** current Medicaid recipients residing in SNFs. There were **291 unduplicated** initial individual in-reach visits, and **913 unduplicated** annual LTSS OC visits completed during this reporting period. Through this process 54% of all Medicaid recipients residing in SNFs have received an individual in-reach visit.

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

    - Provided **8,193 callers** with information and assistance about HCBS and assisted another **716** through the **web intake** process**.**

    - Referred **820 individuals** from these contacts for **HCBS**, which is an average of **137** per month.

- HCBS Case Managers responded to **826 HCBS referrals** from all sources (ADRL intake, direct referral, MFP, LTC Eligibility Unit, and LTSS Options Counseling visits).

- Provided State or federally funded HCBS to **3,005 unduplicated** adults in this reporting period.

- Provided **permanent supported housing** assistance to **33 (rental assistance) TPMs** who transitioned out of a SNF.

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

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

Lessons Learned – An end of Year 3 perspective.

As we end Year 3 of the Settlement Agreement, the State is finalizing the implementation of projects and has hired all the staff that were funded during the 2023-2025 Legislative session. Seven (7) case management staff were hired to keep up with the steady demand for HCBS. Three (3) of the positions were assigned all the basic care case management cases in the State to reduce the overall weighted caseload of the HCBS case managers. Although this change is still relatively new, we have already seen a decrease in the average weighted caseload for this group. Updated caseload numbers will be included in the next report. An additional nurse administrator was added to the Adult and Aging Services team and will be responsible for establishing quality measures and standards for HCBS. Rate increases for family home care, family personal care, and adult foster care are being implemented to simplify the way rates are established for live-in care and to improve the provider billing experience. The policies to pay for QSP on-call services are being drafted to strengthen the back-up options HCBS recipients will have when their regularly scheduled caregiver is unable to fulfill their shift.

Much of the work in the first three (3) years of the Settlement Agreement focused on strengthening, simplifying, or creating systems change at the State level. As we embark on Year 4, we are in the final stages of completing some very large projects that involve HCBS providers. The State recently launched a new provider enrollment portal that has transformed the application and approval process for agencies and individuals willing to enroll to provide state and federally funded HCBS to eligible individuals. The web-based platform will help QSPs enroll, revalidate, and make provider updates. The system will allow the State enrollment team to efficiently process applications to support the goal of shortening the time between being found eligible for HCBS and receiving necessary care. The State is also finalizing the new QSP registry called Connect to Care ND. The State will use this customized version of ADvancing States DirectCareCareers platform to manage QSP records, connect QSPs with individuals in need of care, and allow enrolled providers to market their services through an online QSP profile. The QSP Hub continues to evolve and is becoming an important part of the QSP support network.

The demand for diversion and transition support services for older adults and adults with physical disability has remained relatively steady throughout Year 3. The State is diverting more TPMs from institutional placement and for the first time we have seen a very small reduction in the total number of transitions completed this year. The State believes that as HCBS become more widely available the diversion numbers will continue to increase and the number of transitions from a SNF will slowly decline. The State is working with the Centers for Independent Living (CILs) to provide additional resources and training to the transition team members with the goal increasing the number of transitions completed within the Settlement Agreement's 120-day requirement. Additional resources have been provided to Minot State University for additional Housing Facilitators who continue to be instrumental in helping people find affordable, accessible housing across the State.

The State continues to work diligently to fully implement all the projects included in the MFP Capacity fund and the ARPA of 2021 Section 9817 10% enhanced FMAP proposal approved by CMS. The additional funds have been critical in the success the State has achieved thus far implementing the requirements of the Settlement Agreement.

As mentioned in the last biannual report the data shows that all the efforts the State has taken, has strengthened, and improved the HCBS delivery system in ND. However, the need for the following changes included in the last report still exist.

- Creating a flexible fee-for-service delivery system that allows providers to react to the ever-changing needs of older adults and adults with physical disability i.e., frequent hospitalizations, request to change providers, etc., while ensuring they are meeting all the federal and state requirements is a real challenge for both the federal and state parties.

- Complex billing and claim correction rules as well as EVV requirements have made providing care and billing for these services much more challenging. Some providers lack the expertise or desire to manage all these complex systems and choose to only work with the private pay market. Work needs to be done at the federal and state level to remove some of the bureaucratic barriers that inhibit creativity and flexibility in the service delivery and payment system, especially for Medicaid funded HCBS.

- Workforce issues continue to place a strain on the service delivery system. Demand for HCBS for all people with a disability is at an all-time high while the ability to recruit and retain qualified staff has never been more challenging. Providers report they struggle to recruit teams to provide services especially in situations that require care to be delivered 24/7.

- Other challenges involve the complex and unique situations of the people who use HCBS. Many individuals have complex medical needs and co-occurring behavioral health/substance use concerns that make case management and service delivery even more complicated including the pace of change that occurs in these instances.

Looking Ahead

A Year 4 IP was recently approved. During Year 4 of the US DOJ SA the State intends to finalize the efforts to improve the provider experience related to provider enrollment and the provider's ability to market their services to TPMs. The State will evaluate the amount of time it takes to submit a complete application to the time it is approved. We will also monitor stakeholder feedback and continue to refine and improve these newly created systems.

The State will work with the US DOJ and the Subject Matter Expert (SME) to refine the data collection process and develop measurable outcomes that can inform future strategies and initiatives as we move into the last years of the SA. Stakeholder engagement continues to be a priority as we attempt to influence change across the health care and service delivery systems.

Year 3 Settlement Agreement Requirements (12/14/22-12/13/23)

The chart below lists the requirements from the Settlement Agreement (SA) that are due during Year 3 of the Settlement Agreement. The State believes that all Year 3 requirements have been met except for transitioning TPMs within 120 days. The State works with TPMs to create safe and efficient transition plans and the goal is to transition people within the 120-day requirement. However, many TPMs have significant barriers to overcome like declining health, need for additional therapy, and specific housing needs that can make meeting this goal very difficult. The State has recently discussed ways State staff can assist the transition teams to take specific actions to resolve reoccurring issues that may be unnecessarily delaying a transition.

SA Section #	Requirement	Due Date
VI.F	Develop an Implementation Plan for Year 4	06/14/2023 extended 10/01/2023 approved 12/14/23
XI. E. 2 (b)	Transition at least 60% of TPMs requesting to receive community-based services from a SNF	12/14/24
XIII.D	Provide technical guidance to SNFs that commit to provide HCBS and rural community providers who commit to expand	Ongoing requirement
XV.D	Submit State Biannual Data Report	06/14/23 extended 7/31/2023 approved 09/20/23

XIV.A 1.	Conduct individual or group in-reach to each nursing facility	Completed annually
VIII.I 2.	Person-centered planning training of Case Managers	Completed annually
X.B.2.	Implement incremental changes to the NF LoC process and community-based services eligibility	06/14/2022 and ongoing
X.B.3.	Require annual NF LoC determination screening for all continued stay in a nursing facility for TPMs.	12/14/2022 and ongoing
XI.B	Transitions occur no later than 120 days after TPM chooses (See Note above)	06/14/2022 and ongoing
XV.D	State Biannual Data Report	12/14/2023 extended 01/31/24

SA Section VI. Implementation Plan

Responsible Division(s)

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

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

Nancy Nikolas Maier has been appointed as the Agreement Coordinator and is responsible for leading the State team tasked with ensuring access to community-based services that allow TPMs to live in the most integrated setting appropriate. Michele Curtis, Settlement Agreement Support Specialist, was hired to assist with administrative and reporting duties required in the SA.

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

Implementation Strategy

The State holds regularly scheduled meetings to review progress toward implementing the strategies included in the IP and to develop new strategies that will assist the State with implementing the requirements of the SA. The information gathered and the experience gained in the past three (3) years of the SA was used to draft updates to the IP. **(Approved December 14, 2023)**

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

Implementation Strategy

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

Progress Report:

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

Increase number of eligible individuals receiving HCBS.

- During this reporting period there were 3,005 unduplicated individuals served under SPED, Ex-SPED, Medicaid waiver, and MSP-PC.
- During the last reporting period (December 14, 2022 – June 13, 2023), there were 2,886 unduplicated individuals served under SPED, Ex-SPED, MW, and MSP-PC.
- That is an increase of 119 (4.1%) unduplicated individuals.

Number of providers enrolled to provide services.

- There are 1,039 individual QSPs and 158 agencies currently enrolled to provide HCBS. There were 152 individual QSPs and 7 agencies that closed during this reporting period.

Average length of time provider remains enrolled to provide services.

- The average length of time is 4.85 years.

ND DHHS 2023 QSP Access Database	
Years of Service	**Number of QSPs**
0-11 months	292

1-5	571
6-10	159
11-15	85
16-20	38
21-25	19
26+	33

Number of consumers served.

- There were 3,005 unduplicated individuals served under all state and federally funded HCBS during this reporting period.

Updated Strategy 2. Implement recommendations from the HCBS rate study conducted with assistance of a contracted vendor with expertise in analyzing rates for HCBS. The State will implement any changes to the rates for HCBS that may be approved during the 2023-2025 legislative session. Full implementation may require regulatory authority that could include approval of a Waiver amendment by the Centers for Medicare and Medicaid Services (CMS). **(Target completion date ~~January 1~~ March 31, 2024)**

Progress Report:

- The State is currently implementing the adult foster care daily rate increase from a max of $99.01 to a uniform daily rate of $150.00 per day and the family home care daily rate increase from a max of $49.56 to a uniform $72.50 per day. All family home care and family personal care services will be paid at the higher rate. The rates better align with the cost of similar residential services like basic care and simplify the rate setting process for providers and the HCBS Case Managers.

- The State is creating the policy that will govern the implementation of other types of financial incentives to encourage providers to provide care to TPMs who have complex needs. The State will create a rate augmentation process using funds from the ARPA 9817 10% appropriation to reimburse providers who may incur additional expenses when providing care to TPMs with complex needs. Examples may include paying for a licensed professional like a nurse to deliver care when tasks are too complex to be delegated to a non-nurse. Other examples may include paying for additional costs for specialized protective equipment or special supplies that are needed to complete personal care tasks. The State will add additional information to upcoming reports as the rate augmentation policy is finalized.

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

Progress Report:

- In the December 14, 2022 – June 13, 2023 reporting period there were 19 community support and residential habilitation providers and 245 agency or individual companionship providers.
- In this reporting period, June 14, 2023 – December 13, 2023, there are 37 community support and residential habilitation providers and 275 agency or individual companionship providers.
    - Thirty-four (34) new residential habilitation and community support recipients began receiving services in this reporting period.

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

Implementation Strategy

Strategy 1. The State will continue to create ongoing stakeholder engagement opportunities including quarterly ND USDOJ SA IP stakeholder meetings through year three of the SA. The State will educate stakeholders on the HCBS array, receive input on ways to improve the service delivery system, and receive feedback about the implementation of the SA.

Progress Report:

Meeting Schedule:

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

Performance Measures

The state will work with NDCAPPS to develop a process to grade quality of stakeholder engagement. **(Updated target completion date ~~December 31, 2023~~ May 1, 2024)**

- The NDCAPPS work group created a stakeholder tool kit that describes best practices for meaningful stakeholder engagement. The tool kit is being finalized and will be published on the Aging Services website.

- Stakeholder feedback summary is completed at the end of the DOJ year. Link to 2023 Listening Session Summary

Updated Strategy 2. The State will continue to work with community partners to hold in-person HCBS Community Conversations in rural and frontier areas of the State including Native American reservation areas in ND. The State will target small communities who lack LTSS options and discuss ways that services can be developed in these harder to serve areas. The meetings will provide information about HCBS and provider enrollment and will include an opportunity to receive valuable feedback from local community stakeholders about the provision of HCBS in rural and Native American communities. State will post meeting minutes, stakeholder requests, and the State's response after each meeting. State will post meeting dates on a calendar of events section on the DOJ portion of the DHHS website. **(Completed December 31, 2023)**

Progress Report:

Performance Measures

Number of stakeholder engagement opportunities provided.

- In-person community conversations were held at the following locations during this reporting period:
    - Fullerton – Family Way Restaurant – 22 attendees
    - Langdon Senior Center – 14 attendees
    - Minto Senior Center – 6 attendees
    - Gwinner Fire/City Hall – 8 attendees
    - Walhalla – Water Family Diner – 11 attendees
    - West Fargo - Senior Safety Academy – 100 attendees
    - Cando – Espresso Yourself Café – 15 attendees
    - Hazen Senior Center – 24 attendees
    - Forman Senior Center – 5 attendees
    - Mandan - State Conference of Veteran's Service Officers – 75 attendees
    - Casselton Senior Day – 50 attendees

- Fargo - Northern Plains Conference on Aging – 50 attendees
- Minot - Trinity Hospital Support Group – 10 attendees
- Fargo - Ethos Home Care Staff Meeting – 12 attendees
- Fargo – One Oak – 15 attendees
- New Salem Community Fair – 7 attendees
- Lakota Community Fair for Older Adults – 30 attendees

- There is a monthly radio show broadcasted to eleven (11) counties that provides information about Aging Services, ADRL, and available HCBS services.

- Aging Services also hosted eighteen (18) virtual presentations conducted by community partners for the Multigenerational Plan on Aging (MPA) during this reporting period. Presentation topics included:
    - SSA Children's Benefits – 42 attendees
    - SSA Medicare – 63 attendees
    - Hearing Loss – 42 attendees
    - Senior Companionship Services – 33 attendees
    - Beware of These Medicare Scams – 25 attendees
    - Homestyle Direct Nutrition Solution – 41 attendees
    - North Dakota Brain Injury Network (NDBIN) – 39 attendees
    - Assistive Technology Can Help Older Adults Remain Safely at Home – Equipment – 52 attendees
    - Assistive Technology Can Help Older Adults Remain Safely at Home – Services – 32 attendees
    - An Introduction to North Dakota's Community Clinical Collaborative (NDC3) – 42 attendees
    - Nurturing Elder Engagement, Memory, and Cognitive Health Through Visual Thinking Strategy – 50 attendees
    - ND Aging in Community Project – 55 attendees
    - Creative Healing: Storytelling Through Traditional Art – 34

attendees

- Exercise Ball Drumming: Training to Promote the Physical, Cognitive, and Social Engagement of Older Adults – 29 attendees
- Art for Life: Folk Arts, Aging, Health, and Wellness – 32 attendees
- AmeriCorps in North Dakota – 24 attendees
- Human Rights in North Dakota – 40 attendees
- The Fair Housing Act and Disability Protections – 43 attendees

Number of attendees.

- See Performance Measures above.

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

- The presentations were attended by hospital case managers, health professionals, and community members.

Location of stakeholder engagement opportunities.

- These events are virtual.

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

Implementation Strategy

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

Progress Report:

- Weekly meetings are conducted between the Agreement Coordinator and the SME.

Meetings are conducted between the Agreement Coordinator and the DOJ bi-weekly or as needed.

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

Implementation Strategy

Strategy 1. The State will meet no less than weekly with SME to discuss topics pertinent to the development of the IP revisions. The revisions to the IP will focus on implementation for the upcoming year, challenges encountered by the State to date,

and strategies to resolve them with plans to address noncompliance if required. **(Ongoing strategy Year 4 IP approved December 14, 2023)**

Strategy 2. Each revision to the IP will include a review of data collected and outcomes achieved, and how that informs revised strategies. **(IP approved December 14, 2023)**

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. **(Ongoing strategy)**

Progress Report:

The DHHS website is updated with the latest information and reports about the SA. The US DOJ SA webpage can be found here https://www.hhs.nd.gov/adults-and-aging/us-department-justice-settlement-agreement.

SA Section VII. Case Management

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

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

Challenges to Implementation

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

Remediation

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

Progress Report:

Seven (7) new case manager positions have been filled including three (3) who are assigned to work Basic Care cases, which do not require a social work degree due to type of case management needed.

Lead worker positions have been added in the Bismarck and Fargo areas due to the number of social worker staff employed in those areas. Weekly meetings are conducted to look at caseloads and capacity across the state to determine which case managers could assist in other territories if needed. There are currently three (3) open case manager positions that will be posted.

Strategy 2. The State will require all newly hired HCBS case managers to complete a comprehensive standardized training curriculum that has been developed within three months of employment. The State will provide ongoing training and professional development opportunities to include cultural sensitivity training to ensure a high-quality trained case management workforce. The State is seeking a new local expert in Native American cultural competency with the native American consultation group 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.

Progress Report:

The NCAPPS federal contract ended in September 2023. The State will continue to contract with HRSI. MFP is paying for project management for the State's PCP work. A toolkit for facilities to understand LTSS options counseling and MFP is being finalized and the HRSI team will be facilitating upcoming PCP training for the State.

Performance Measure(s)

Percent of HCBS Case Managers trained in the standard curriculum.

- One hundred present (100%) of the HCBS managers completed the standard curriculum as required. This includes seven (7) newly hired case managers. New case management staff have three (3) months from the hire date to finish the training.

Percent of HCBS Case Managers trained to cultural sensitivity.

- 68 HCBS case managers attended at least one (1) of the following Cultural Sensitivity Trainings.
    - Cultural and Health Disparities that Exist Within LGBTQ+ Populations.
    - Three (3) trainings offered by North Dakota Office of Refugee

Services.

- Trauma Informed Care, Forced Displacement, and Mental Health
- Trauma Informed Communication and Engagement
- Balancing Work and Well-Being for Service Providers

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

- Prior to training, 40% of staff agree or strongly agree to have knowledge of learning objectives. Sixty (60) percent of staff reported they were neutral, disagree or strongly disagree with having knowledge of learning objectives.
- Post training, 97% of staff agree or strongly agree to have knowledge of learning objectives. Three (3) percent of staff are neutral, disagree, or strongly disagree with having knowledge of learning objectives.

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

Challenges to Implementation

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

Remediation

With the cooperation of Aging Services, the ND Department of Health, Division of Health Promotion submitted a grant application to the Administration for Community Living (ACL) titled, “Alzheimer’s Disease Programs Initiative (ADP–) - States and Community Grants.” If awarded the grant would fund one additional service navigator position. (**Completed October 1, 2022)**

- The State will continue to assess the need and will implement any service navigator full time equivalent (FTE) position that may be approved during the 2023-2025 legislative session.
    - North Dakota was not chosen for the Alzheimer’s Disease Programs Initiative - States and Community Grants.

- The State received appropriation to hire two (2) full-time navigators. The navigators are now supporting all the HCBS case managers in finding a QSP for an eligible individual.

Progress Report:

Performance Measure(s)

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

- The number of referrals received from June 14, 2023 – December 13, 2023 is 540 and all were successfully matched with a provider.

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

- The number of intakes referrals received by case management from the ADRL is 829.

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

- The average number of days to assign a case manager to a referral during this reporting period is one (1) day.

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

- The percent of case management referrals responded to within five (5) days is 100%. Average time to respond is two (2) days.

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

- 100% of the HCBS case managers have been trained on the new case management system.

Strategy 4. Continue the LTSS Options Counseling referral process to identify TPMs who screen at a NF LoC and inform them about HCBS, person-centered planning, and transition services available under Medicaid to help TPMs receive services in the most integrated setting appropriate. All TPMs who are referred for a long-term stay in a SNF are contacted. **(Ongoing strategy)**

Challenges to Implementation

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

Remediation

The State is using ARPA funds and MFP capacity building funds to employ 10 staff to conduct LTSS Options Counseling referral visits. The State will assess

need, hire, and train any additional LTSS Options Counseling FTE that may be approved during the 2023-2025 legislative session. The State continues to use ARPA funds and MFP Capacity dollars to fund these positions. The State is considering adding the cost of these positions to the MFP administrative budget because they are providing outreach to Medicaid recipients eligible for this service. **(Target completion date to secure funding September 1, 2024)**

Progress Report:

Performance Measure(s)

Number of LTSS Options Counseling referrals.

- 513 LTSS Options Counseling referrals were sent to the HCBS case management territories from June 14, 2023 – December 13, 2023.

- 436 TPMs received a visit, 52 individuals referred did not meet the TPM criteria, seven (7) TPMs were unable to be located, 17 were deceased, and one (1) is pending.

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

- Ninety-two (92) TPMs were referred through the LTSS Options Counseling process to MFP. These numbers reflect 56 that came from LTSS OC daily visits, seven (7) came from LTSS OC annual visits, and two (2) facility presentations.

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

- See response above. It was decided by the SME that a breakdown by territory was not necessary.

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

Progress Report:

Looking to secure funding to do eight (8) more runs of the ADRL marketing campaign.

Performance Measure(s)

Number of ADRL contacts per month.

- A total of 27,971 ADRL contacts (calls 8,193, web intake 716, unique

web hits 19,062) were made between June 14, 2023 – December 13, 2023 for an average of 4,661 contacts per month.

Strategy 6. To ensure a sufficient number of HCBS case managers are available to assist TPMs in learning about, applying for, accessing, and maintaining community-based services for the duration of the SA, the State will hire and train any additional FTE that may be approved in the 2023-2025 budget. **(Completed January 1, 2024)**

Progress Report:

North Dakota legislators approved seven (7) additional case managers, one (1) aging generalist, and two (2) service navigators in the 2023-2025. All of the positions have been filled.

Performance Measure(s)

Number of HCBS Case Managers hired by Tribal nations.

- Standing Rock Sioux Tribe has a position which is currently vacant. There is no contract currently, however MFP-Tribal Initiative funds remain available to hire a case manager.

Average tribal case manager retention rate.

- See response above.

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

- There has not been a significant change in the amount of time spent on administrative tasks. It has remained consistent over the past year.

CM Workforce Data	**Reporting period**	**6/23-12/23**
Project	**Sum of Hours**	**% Of Hours**
HCBS Admin	12,341.25	22.53%
HCBS CM	42,439.26	77.47%
Grand Total	**54,780.51**	**100.00%**

CM Workforce Data	**Reporting Period**	**12/22-6/23**
Project	**Sum Of Hours**	**% Of Hours**

HCBS Admin	11,151.60	22.27%
HCBS CM	38,929.17	77.73%
Grand Total	**50,080.77**	**100.00%**

Assignment (Section VII, Subsection B, page 10)

Implementation Strategy

Strategy 1. Ensure that the supervisors are assigning the case manager to TPMs already living in the community and requesting HCBS within two business days. **(Ongoing strategy)**

Progress Report:

- See response in Section VII.A.3.

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

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

TPMs who are already residing in a SNF will be visited by the LTSS Options Counselor that is assigned as the case manager to the facility where they reside. TPMs already residing in the SNF will be seen based on the month that their original NF LoC determination was made and annually thereafter. The case manager will make an in-person visit and will complete person-centered planning and referral to MFP or ADRL transition if appropriate at least annually or upon request. The State worked with the NF LoC vendor to create a report and process for case managers to receive referrals by facility so they can provide services as efficiently as possible. **(Ongoing strategy)**

Progress Report:

Performance Measure(s)

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

- There are 2,236 current Medicaid recipients residing in SNFs. There were 291 **unduplicated** initial individual in-reach visits, and 913 **unduplicated** annual LTSS OC visits completed during this reporting period. Through this process, 54% of all Medicaid recipients residing in SNFs have received an individual in-reach visit.

Number of TPMs assigned to a HCBS Case Manager.

- There are 943 TPMs living in the community and receiving HCBS that were assigned to an HCBS Case Manager during this period.

Number of annual visits made to TPM in SNF.

- There were 913 unduplicated annual PCP visits to TPMs in SNFs during this reporting period.

Capacity (Section VII, Subsection C, page 10)

Implementation Strategy

Strategy 1. Simplify the HCBS case management process to ensure a sufficient number of HCBS case managers are available to serve TPMs. The HCBS case managers are required to keep track of the number of hours they work, and the type of work being performed. Reports can be run to calculate the amount of time spent conducting client-facing case management services versus administrative tasks. This information will be is used to determine staff capacity and number of FTEs needed. **(Ongoing strategy)**

Progress Report:

See response in Section VII.A.6.

Performance Measure(s)

Average weighted caseload per Case Manager.

- The average weighted caseload per Case Manager is 120.

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

- See CM Workforce Data chart in Section VII.A.6.

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

sufficient number of HCBS case managers are available to serve TPMs. **(Ongoing strategy)**

Challenges to Implementation

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

Remediation

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

The State changed the weighted caseload assignment process to ensure the appropriate amount of case management services are being provided to TPMs. The new case management system has streamlined the way HCBS Case Managers complete their work, so all HCBS funding sources carry the same weight. The weight for providing case management to TPMs receiving 24-hour support services and for those who are transitioning from a SNF were increased.

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

Progress Report:

The seven (7) approved case manager positions have been filled and the average caseload is 120 during this reporting period.

Three (3) of the newly hired case managers were assigned a Basic Care caseload and will complete all the annual reviews beginning in December 2023.

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)**

Progress Report:

No SNFs denied access to the facility during this reporting period.

Performance Measure(s)

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

- None

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

- None

Number of investigations initiated due to denial of access.

- None

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

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 annually in year three of the Settlement Agreement.

Progress Report:

Performance Measure(s)

Number of SNF and hospital staffed trained.

- There were staff from 69 SNFs and hospitals who attended training.
- Prior to training, 74% of staff agree or strongly agree to have knowledge of learning objectives. Twenty-six (26) percent of staff are neutral, disagree or strongly disagree with having knowledge of learning objectives.
- Post training, 95% of staff agree or strongly agree to have knowledge

of learning objectives. Five (5) percent of staff are neutral, disagree, or

New 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)**

Progress Report:

Performance Measure(s)

Number of annual visits made to TPMs in SNF.

- 870 individuals attended the annual group presentations in 75 SNFs.
- 913 individual LTSSOC visits were completed.

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

Implementation Strategy

Provide HCBS case managers and relevant State agencies access to all case management tools including the HCBS assessment and PCP. **(Ongoing strategy)**

Progress Report:

Performance Measure(s)

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

- 205 state staff and one (1) contracted staff have access to the case management system. This includes Aging Services case management, ADRL intake, Community Service Coordinators, LTSS OC, VAPS investigators, Housing Facilitators, and Transition Coordinators.

Quality (Section VII, Subsection F, page 11)

Implementation Strategy

To ensure a quality HCBS case management experience for all TPMs the State will conduct annual case management reviews to ensure sampling of all components of the process (assessment/person-centered planning/authorization/safety, contingency plans, and service authorizations) to determine if TPMs are receiving services in the amount, frequency, and duration necessary for them to remain in the most integrated setting

appropriate. **(Ongoing Strategy reviews done annually)**

Progress Report:

Performance Measure(s)

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

- Case management audits, quality assurance, and continuing education for each territory and case manager are completed by December 31st of each year. The report indicates the type of errors, and each case manager is trained individually. Twice per year, State program administrators meet with staff in each case management territory to review all errors.

ADRL (Section VII, Subsection G, page 11)

Implementation Strategy

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

SA Section VIII. Person-Centered Plans

Responsible Division(s)

DHHS Aging Services

Training (Section VIII, Subsection A, page 11)

Implementation Strategy

State staff, public, private, and tribal HCBS case managers will continue to use the fully implemented case management system that includes Charting the LifeCourse person-centered planning framework tools. HCBS case managers will create, with the TPM, the PCP that will be maintained and updated in the system. **(Ongoing strategy)**

Challenges to Implementation

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

Remediation

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

Progress Report:

Person - Centered Planning Competencies have been developed in conjunction with ND Aging Services, NCAPPS, HRSI and Nexus CtLC. Corresponding training and measurement of competencies is in the final stages of development and approval. The updated training will be implemented throughout 2024 and includes "Charting the LifeCourse" person-centered planning framework tools. All case managers are meeting the current training requirements as outlined in the Aging Services Protocol.

Performance Measure(s)

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

- All case managers receive and have completed training on Person Centered Planning and Charting the Lifecourse Vision Tool within three (3) months of hire. The new competency-based training will be implemented throughout 2024 and includes "Charting the LifeCourse" person-centered planning framework tools.

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

    - 913 TPMs, 41%, have an approved Person-Centered Plan (SFN 1265) PCP and Risk Assessment Health and Safety Plan (SFN 1267).

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

- See response under the first performance measure.

Number of HCBS case managers

- There are 72 HCBS case managers, this number includes part-time case managers and supervisors who each carry a small caseload.

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 SA 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)**

Progress Report:

During this time frame, there were 2,623 HCBS person-centered plans of care completed. Since this is to be broken down by month, this count is not unduplicated as any one individual may have more than one care plan during the reporting period.

Performance Measure(s)

Number of PCPs completed per month.

- All PCPs regardless of TPM status:
    - June 14, 2023 – June 30, 2023 – 32
    - July 2023 – 469
    - August 2023 – 460
    - September 2023 – 490
    - October 2023 – 421
    - November 2023 – 447
    - December 1, 2023 – December 13, 2023 – 304

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

- Since March 1, 2022, the State believes that all plans were created in the case management system using the approved PCP format that meets the current State and federal requirements for a PCP and the requirements in the SA Section VIII. C. (1-8). A total of 167 PCPs were reviewed during the 2023 case management audits and 92% were found in compliance. The SME also reviews PCPs for compliance and 98.6% of the most recent set reviewed were found to be in

compliance with Settlement Agreement requirements.

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

Implementation Strategy

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

Progress Report:

Performance Measure(s)

Percent of PCPs completed within required timeframe.

- All plans were completed within the required timeframe.
- There is not a current measurement for data regarding the number of PCPs for TPMs completed within the required timeframe. PCPs are audited for compliance, but the sample of those PCPs comes from all clients, not just TPMs. The HCBS case managers approve their own care plans, as they are state employees.

Number and percent of TPMs who request a second opinion.

- No TPMs have requested a second opinion.

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

Implementation Strategy

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

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

Challenges to Implementation

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

Remediation

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

Progress Report:

Performance Measure(s)

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

- All case managers were trained on ADA and reasonable modifications. Additionally, all new case managers are trained on ADA requirements and reasonable modification within the first three (3) month of hire. A program administrator makes sure that all HCBS Case Managers are trained in reasonable modification.

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

- The reasonable modification training is required for all Aging staff. Based on the answers to the questions in the poll, the staff have a strong understanding of the reasonable modification requirements under the ADA. A pre and post training data comparison is not conducted. The State is working with the legal advisory unit to create a more formal measure of competency as it relates to reasonable modification.

Number of stakeholders provided education about reasonable modification.

- Training to stakeholders was not provided on this topic. Training will be included at the June 2024 DOJ SA Stakeholder meeting. The training will be provided by an attorney from the DHHS Legal Advisory Division.

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

- A total of 27 requests were received, 26 were approved and one (1) was denied.

Reasonable Modifications			
Month/Year Request	**Accommodation Type**	**Approved**	**Denied**
June 1, 2023 – June 30, 2023	Nursing Tasks	1	
July 2023	Medical Transportation/escort	2	
	Nursing Tasks	2	
August 2023	Medical Transportation/escort	1	
	Nursing Tasks	4	
September 2023	Nursing Tasks	5	
October 2023	Nursing Tasks	6	
November 2023	Medical Transportation/escort	3	
	Unique Combination of Services	1	
	Cost of environmental modification over 20% of home value	1	
	Not a TPM		1
December 1, 2023 – December 13, 2023			
Totals		**26**	**1**

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

Implementation Strategy

Strategy 1. The State developed a process to submit all transition plans that identify a setting other than the TPM's home, a family home, or an apartment as the TPM's most integrated setting appropriate to the SME for the first two years of the SA.

Progress Report:

Performance Measure(s)

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

- None of the 47 PCPs completed with individuals referred for MFP this reporting period identify a non-integrated setting.

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

Implementation Strategy

To ensure annual ongoing training, the State will utilize MFP capacity building funds to procure an entity to provide ongoing technical assistance and annual person - centered planning training through September 30, 2025. Training will be required for all HCBS case managers and DHHS Aging Services staff. The entity will also be also required to assist the State in developing person-centered planning policy and procedures, performance measures and core competencies that will assist the TPM in receiving services in the most integrated setting appropriate. **(On-going technical assistance provided through September 2025)**

Performance Measure(s)

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

- See response in Section VIII.A.

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

- See response above.

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

- See response above.

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

Implementation Strategy

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

In years three (3) and four (4) of the SA the State must conduct person-centered planning with an additional 650 TPMs. During the current IP period, the State will set a goal to develop PCPs with at least 325 unduplicated TPMs. At least half of the TPMs who receive person-centered planning each year will be SNF TPMs.

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

Progress Report:

Performance Measure(s)

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

- A total of 1,797 approved PCPs have been completed with 1,797 unduplicated TPMs living in the community from December 14, 2022 – December 13, 2023.

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

Challenges to Implementation

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

Remediation

With the assistance of the NF LoC vendor the State has developed a monthly report that will list 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.

Progress Report:

Performance Measure(s)

Number of PCPs completed with SNF TPMs per month.

- A total of 919 (**duplicated**) PCPs were completed with TPMs in SNF during this reporting period.
    - June 14, 2023 – June 30, 2023 – 60
    - July 2023 – 151
    - August 2023 – 158
    - September 2023 – 155
    - October 2023 – 127
    - November 2023 – 157
    - December 1, 2023 – December 13, 2023 – 111

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

centered planning.

- There were 2,236 Medicaid recipients residing in SNFs and 291 initial person-centered planning visits completed for TPMs residing in SFNs and 913 annual person-centered planning visits during this reporting period for a total of 1,204 which is 54%.

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

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

Progress Report:

The State continues to contract with NCAPPS for PCP technical assistance through September 30, 2025.

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

- Ensure that the Peer Support Resource Center referenced in this document provides opportunity for culturally specific peer supports to the greatest extent possible.

    - The State has determined that the Peer Support Center concept will not be developed as originally intended. The State has held meetings with interested stakeholders to talk about how a Peer Support center could benefit the current HCBS delivery system however it appears there is not a clear path to develop this concept within the amount of time the State has left to use available funding which is by March of 2025.

    - State staff will be holding two stakeholder meetings with current peer support providers in April 2024 to discuss the possibility of scaling their services to better meet the needs of TPMs. Aging Services is partnering with the Behavioral Health Division to potentially contract for peer support staff that could be assigned to each SNF in ND to provide support to TPMs. Peer support staff specially trained in the needs of older adults and adults with disability would be required to provide in-reach at facilities across the State. Peer supports could also be provided to TPMs who have been diverted form a SNF to address barriers they may have to continued community living. Additional

information on how this new initiative will be rolled out will be included in future reports.

- The MFP Transition Coordinators and the LTSS Option Counselors will continue to ask TPMs if they are interested in talking to a peer with a disability who is living successfully in the community. If this service is requested, it is currently provided by local CIL peer support volunteer or staff.

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

    - The State has begun meeting monthly with subject matter experts from Tribal nations knowledgeable about home and community-based services and the needs of their Tribal community. Some of the participants work with the Tribal QSP agency, Title VI Older American Act services. All have valuable experience and knowledge of providing services to older adults and adults with physical disability. The main objective of the meetings is to engage in meaningful dialogue to improve the HCBS system for Tribal elders and individuals with physical disability. **(Ongoing strategy)**

    - A Native American QSP stakeholder engagement meeting was held on January 10, 2024. Staff from the UND Native American Resource Center, Agency QSPs that serve Tribal communities, and representatives from the Tribal nations were in attendance. Aging Services staff were asked to provide information on the difference between Community Health Representative (CHR) targeted case management and regular HCBS waiver case management. Information was provided and the group will discuss the type of case management that would best serve members of tribal nations who need HCBS at the next meeting.

- Including representation from Native Americans and New Americans when gathering public input.

    - See response above.

- Providing cultural sensitivity training created by local subject matter experts to all HCBS case managers.

    - Training continues to be offered. Most recent training, Cultural and Health Disparities that Exist Within LGBTQ+ Populations, was held on October 17, 2023.

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

        - To date, the “Individual Rights and Responsibilities” brochure as well as the SFN 820 SPED Income and Assets, SFN 1047 Application for Services, SFN 1059 Authorization to Disclose Information, SFN 1123 Home and Community-Based Services (HCBS) Authorizing Signatures, and SFN 1647 HCBS Notice of Denial or Termination forms were translated to the following languages: Bosnian, European French, Nepali, Somali, Spanish (Latin American), and Ukrainian.

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

    - Turtle Mountain’s new hire is training with Adult and Aging Services staff on Case Management.

    - MFP funds remain available for any Tribal Nation that is interested in pursuing HCBS services through MFP-Tribal Initiative

    - Standing Rock Sioux Tribe has MFP tribal initiative funds available to hire a Case Manager for HCBS, the position is currently vacant. No contract is in place at this time; however, funding remains available should a contract emerge.

SA Section IX. Access to Community-Based Services

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

Updated Strategy 1. Implement any recommendations from the Service Delivery stakeholder workgroup to add services to the state and federally funded HCBS administered by the State that may be approved during the 2023-2025 legislative session. Full implementation may require regulatory authority that could include approval of a Waiver amendment by CMS. **(Target completion date ~~January~~ June 1, 2024)**

Companionship has been added as an allowable service under SPED and Ex-SPED. In addition, the rates for adult foster care and family home care are being increased and Waiver personal care (daily rate) is being implemented. The EVV system changes that need to be made so that providers can be assured timely payment for this service will not be completed for a January implementation date. The State will continue to work with the vendor to make sure the updates are made as soon as possible and will provide updates in future reports.

Updated Strategy 2. Implement plans create or incentivize on-call services for individuals who rely on daily care to safely live in the community that was approved during the 2023-2025 legislative session. The State will be issuing grants to QSP agencies that provide personal care or extended personal care to TPMs to have a qualified staff member on call during specified hours to respond to the urgent needs of the TPMs they serve. **(Target completion date ~~January~~ July 1, 2024)**

Performance Measure(s)

Number of QSPs offering on-call services.

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

Implementation Strategy

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

Challenges to Implementation

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

Progress Report:

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

QSP Hub staff continue to support individuals and agencies that are interested in becoming a QSP or who are already an enrolled provider. As the QSP Hub becomes more well known they have seen more QSPs joining the agency Building Connections group. The meeting intends to bring QSPs together to learn and support each other as they do this important work.

The QSP Hub is required to complete a quarterly report that includes additional information about the number of callers and type of supports provided to QSPs. The most recent quarterly report is available here. Link to QSP Hub Quarterly Report

QSP Hub staff have been very involved in helping to provide feedback on the newly developed QSP enrollment portal. They agreed to take change requests from QSPs who want to make a change to their provider record while the State fully implements all features of the enrollment portal. They provide valuable feedback on system functionality and will be adding staff to their team soon.

Performance Measure(s)

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

- Eight (8) TPMs either self-directed or expressed interest in self-direction and were supported by the QSP Hub.

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

The QSP Hub offers a variety of outreach and training opportunities monthly. During this reporting period the QSP Hub offered 26 live in-person or live virtual events including:

- Nine (9) building connection meetings,
- Seven (7) in person recruitment events,
- Two (2) advisory group meetings,
- Two (2) co-op meetings, and
- Six (6) new QSP Orientation sessions.

New Strategy 2. To reduce the responsibility of individual QSPs and improve the recruitment and retention of providers statewide, the State will implement any changes to the provider model or include formal self-direction policies in the HCBS waiver and Medicaid State Plan – Personal care that may be approved during the 2023-2025 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, most of the in-home services provided to eligible individuals in ND are funded under the State's Service Payments to the Elderly and Disabled (SPED) program which would require additional state general fund appropriations.

Remediation

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

Progress Report:

Performance Measure(s)

Conduct and complete a feasibility study of a variety of provider models including the co-employer/agency model and a QSP rural cooperative. 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)

Implementation Strategy

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

Progress Report:

TPMs are educated on their right to appeal initially and annually with the Rights and Responsibilities Brochure. Case Managers discuss the Rights & Responsibility Brochure with the TPM and the TPM signs an acknowledgement of receiving and discussing the rights to appeal. Additionally, the TPM signs an Application for HCBS services initially and the PCP initially, annually and every six (6) months which all outline the individual's right to appeal.

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

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

Progress Report:

Performance Measure(s)

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

- All 943 TPMs have been educated on their right to appeal initially and annually with the Rights & Responsibilities Brochure. Case Managers discuss the Rights & Responsibilities Brochure with the TPM and the TPM signs an acknowledgement of receiving and discussing the right to appeal. Additionally, the TPM signs an Application for HCBS services initially and the PCP initially, annually, and every six (6) months which all outline the individual's right to appeal.

Strategy 3. TPMs cannot be categorically or informally denied services. Policy requires HCBS case managers to make formal requests for services or reasonable modification requests when there are unmet service needs necessary to support a TPM in the most integrated setting appropriate. All such requests and appeals must be documented in the PCP. **(Ongoing strategy)**

Progress Report:

Performance Measure(s)

Number of reasonable modification requests received and outcome.

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

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

- There have been no appeals filed after a denial of reasonable modification request.

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

- During the last reporting period, we had one (1) appeal. During this reporting period, we have had five (5) appeals. One (1) of the appeals was withdrawn as the individual passed away. The other four (4) appeals are still in process and have not yet reached a hearing date so we cannot report the outcome.

- There was an increase of four (4) appeals filed from the previous reporting period.

Updated Strategy 4. Determine what can be gleaned from an analysis that was conducted of the number of units being authorized and utilized, by case management territory, to determine if there are significant discrepancies in the number of services available to TPMs across the State. **(Completed April 1, 2022)**

Performance Measure(s)

Number of service units authorized by territory.

- Link to Appendix F

Challenges to Implementation

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

Remediation

The State will work with the case management system vendor to create a report that will compare services authorized versus services utilized. **(Updated Target completion date June 1, 2024).**

Progress Report:

The State is working with the case management system vendor to explore how to create a report that will provide meaningful utilization data and will make recommendations to the State on which report in the case management system will provide the best data. In addition, the State has agreed to work with members of the SME team and the US DOJ SA team to pilot a study of service authorization versus utilization of HCBS. An in-person data summit is being held on February 27, 2024 in North Dakota and more detail will be provided in future reports.

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

Implementation Strategy

Strategy 1. The State will continue to work with the DHHS Legal Advisory Unit and other agencies or boards to determine if a request for reasonable modification, including the delegation of nursing tasks, can be accommodated as required in the SA. HCBS policy includes the process to request a reasonable modification for review and consideration. **(Ongoing strategy)**

Progress Report:

The State created a template for the Case Managers to use to submit reasonable modification requests. The template includes all the information that is necessary to make a timely determination.

Performance Measure(s)

Number of reasonable modification requests received and outcome.

- See reasonable modification chart in Section VIII.F.

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

- There were 26 reasonable modification requests received during the December 14, 2022 – June 13, 2023 reporting period. There were 27 reasonable modification requests received during the June 14, 2023 – December 13, 2023 reporting period.

Strategy 2. Some requests for reasonable modification may conflict with the ND Nurse Practices Act, N.D. Cent. Code § 43-12.1. The State will work to implement any recommendations developed by the Healthcare Accommodations workgroup which includes State staff and members of the Board of Nursing. Recommendations will be shared with stakeholders and their feedback incorporated into any policy or regulatory change required. **(August 31, 2023)**

Progress Report:

A meeting was held with the ND Board of Nursing on November 21, 2023. Accommodations and trends reviewed. Discussion was had regarding engaging the medical community and nurses regarding HCBS and delegating medical tasks to QSPs that are specific to the individuals being supported.

The nursing Program Administrator is holding a webinar about extended personal care and nurse education on April 25, 2024. All current extended personal care providers and any providers interested in these services will be encouraged to attend.

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

Progress Report:

<u>Performance Measure(s)</u>

Number of TPMs receiving extended personal care.

- Currently there are 79 TPMs using Extended Personal Care Services, 24 receiving SPED, and 55 on HCBS Medicaid 1915 (c) waiver.

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

Progress Report:

Performance Measure(s)

Number of requests for reasonable modification and outcome.

- See reasonable modification chart in Section VIII.F.

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

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

Progress Report:

Performance Measure(s)

Number of denials and basis for denial decisions.

- Denials are not tracked by TPM status therefore, the following numbers are based on all denials regardless of TPM status. This count is not unduplicated since the request is a broken down by month. There were 136 program denials during this reporting period.

HCBS Denials		
Month/Year Request	**Denial Reason**	**# of Denials**
June 14, 2023 – June 30, 2023	Functional Eligibility	1
	No Action/services pursued	5
	Unable to Determine Financial Eligibility/Did Not Cooperate	2
July 2023	No Action/services pursued	3
	Not on Medicaid	3
	Functional Eligibility	6
	Health/Welfare/Safety Concerns	1
	Unable to Determine Financial Eligibility/Did Not Cooperate	2
August 2023	100% Fee	3
	Not on Medicaid	3
	Excess Assets	2
	Functional Eligibility	13
	Not in Agreement with Care Plan	1

	Deny Care of Child	1
	No Action/services pursued	1
	Unable to Determine Financial Eligibility/Did Not Cooperate	2
	Unable to Assess/Did not Cooperate	1
September 2023	Functional Eligibility	17
	Not on Medicaid	3
	Excess Income	1
	No Action/Services Pursued	1
	Unable to Determine Financial Eligibility/Did Not Cooperate	3
	Deny Environmental Modification doesn't meet service criteria	1
	Personal Care tasks cannot primarily be used for environmental tasks	1
October 2023	Pet Care	1
	Refuses to apply for Medicaid	1
	100% Fee	1
	Not on Medicaid	2
	Excess Assets	1
	Excess Income	2
	Functional Eligibility	7
	Health/Welfare/Safety Concerns	1
	No Action/Services Pursued	1
	Unable to Determine Financial Eligibility/Did Not Cooperate	2
	Unable to Assess/Did not Cooperate	3
November 2023	Functional Eligibility	18
	100% Fee	1
	Excess Assets	1
	Excess Income	1
	Not on Medicaid	2
	Unable to Determine Financial Eligibility/Did Not Cooperate	1
December 1, 2023 – December 13, 2023	Not on Medicaid	2
	Excess Assets	2
	Excess Income	1
	Functional Eligibility	6

	Unable to Determine Financial Eligibility/Did Not Cooperate	1
	Deny Medical Transportation-Not in Service	1
Totals		**136**

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

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

Updated Implementation Strategy

Strategy 1. Continue to recruit and retain residential habilitation and community-support services funded under the HCBS 1915 (c) Medicaid waiver to provide up to 24-hour support, and community integration opportunities for TPMs who require these types of supports to live in the most integrated setting by assisting up to five eligible agency QSPs with paying for their CQL accreditation.

Progress Report:

Performance Measure(s)

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

- Eleven (11) providers are interested in and being assisted with enrollment under these services.

Number of QSPs successfully enrolled to provide residential habilitation and community support services during this reporting period.

- Enrolled providers - 19
- Enrollments pending - 9

New Strategy 2. Implement recommendations from the HCBS rate study conducted with assistance of a contracted vendor with expertise in analyzing rates for HCBS. The State will implement any changes to the rates for HCBS that may be approved during the 2023-2025 legislative session. Full implementation may require regulatory authority that could include approval of a Waiver amendment by CMS. **(Target completion date ~~January~~ March 1, 2024)**

- See response in Section VI.D.2.

New Strategy 3. Implement any recommendations from the services workgroup to add services to the state and federal funded HCBS administered by the State that may be approved during the 2023-2025 legislative session. **(Regulatory changes complete**

January 1, 2024 implementation will occur through March 31, 2024.)

Progress Report:

The 2023-2025 DHHS budget included funding for the following services and enhancements to the HCBS delivery system:

- $351,000 to increase the quality of HCBS by reimbursing QSP Agency on-call staff.
- $138,150 to pay for two (2) home delivered meals per day under the HCBS Medicaid waiver, SPED and Ex-SPED.
- $280,000 to add companionship services to SPED and Ex-SPED.
- $182,910 to allow bed hold days for community support and residential habilitation paid through the HCBS Medicaid waiver.
- $6,337,174 to 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.
- Authority to 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. This service is budget neutral as an estimated $13 million will be shifted from the Medicaid state plan personal care to the HCBS Medicaid waiver.

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

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

State staff will be responsible for taking any regulatory action necessary to implement the agreed upon recommendations from the workgroup. **(Workgroup established December 2022. Recommendations developed and reported December 31, 2023)**

Progress Report:

Work group was established in December 2022, the internal committee meetings were held monthly beginning July 10, 2023 with representatives from Aging Services administrative team, HCBS Case Managers, HCBS Licensors, and Medical Services.

A public stakeholder meeting was held on December 5, and December 18, 2023. The Adult Foster Care Program Administrator drafted recommendations from workgroup and stakeholder response to submit to Waiver Administrator by December 31, 2023. Link to Appendix E

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

Updated Strategy 1. 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 NFLoC 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)**

Progress Report:

On July 1, 2023, the State began administratively claiming for the cost of operating the LTSS OC services. Receiving federal match for this important service will help to ensure that the State has sufficient funding to continue to provide this service long term. LTSS OC has helped the state create a real awareness of LTSS available to Medicaid members who currently reside in a SNF.

Performance Measure(s)

Number of TPMs who received LTSS Options Counseling visits.

- A LTSS Options Counseling visit was conducted with 1,319 unduplicated TPMs.

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

- Nineteen (17 MFP and 2 ADRL) LTSS Options counseling visits resulted in a transition to the most integrated setting during this reporting period. More people were referred through this process that have not yet transitioned.

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

- See response in Section VIII.I.2.

- Group in-reach visits are not limited to TPM's. Any staff, family, stakeholders, and residents can attend the group informational presentations on LTSS options Counseling. Eight hundred and seventy (870) individuals were reached through the annual presentation on LTSS options counseling at 75 different facilities.

Number and percentage of LTSS options counseling visits where the TPM requested follow up and the follow-up visit occurred.

- There were 11 requests for follow-up visits.

- Eight (8) follow-up visits were completed (73%).

- Three (3) did not occur due to TPM death and/or unable to locate.

Strategy 2. 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)**

Progress Report:

- All TPMs living in SNFs receive a visit from the LTSS Options Counselor staff. The worker will provide required information and their contact information. If the individual chooses not to participate in the person-centered planning discussion the worker documents that on the plan and lets them know they can contact the LTSS Options Counselor any time.

TPMs are also informed they can expect an annual visit around the time of their annual NF LoC redetermination.

- The LTSS OC brochure and flyer have been updated to include the new state branding. An additional flyer insert has been developed and sent for printing with information for the Medicaid benefit of short term stay of six (6) months or less. The flyer insert includes information for qualifying for budgeting that allows individuals to retain housing and pay for expenses.

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

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

Progress Report:

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

Performance Measure(s)

Number of cases staffed per interdisciplinary team meetings and outcome.

- There were 47 (40 unduplicated) cases staffed during this reporting period. Some individuals were staffed multiple times. These staffing are completed in addition to the monthly staffing of the individual cases that are included on the MFP 90+ day report.

  - June 14, 2023 – June 3, 2023 - 4
  - July 2023 – 9
  - August 2023 – 15
  - September 2023 – 5
  - October 2023 – 5
  - November 2023 – 7
  - December 1, 2023 – December 13, 2023 – 2

  The outcomes of staffed cases include:

    - Providing case managers direction on how to effectively mitigate risks and develop a thorough risk assessment,
    - guidance on how to interact with individuals who struggle with behavioral health symptoms,
    - collaboration between the staff within behavioral health, developmental disabilities, and vulnerable adult protective services,
    - MFP/ADRL transitions,
    - other community agencies to provide comprehensive services,
    - providing overall technical assistance and education as to how services may be authorized to fit the needs of consumers.

Number of requests for reasonable modification and outcome.

- See reasonable modification chart in Section VIII.F.

Updated Strategy 2. Continue to conduct an annual NF LoC screening for all Medicaid recipients living in a SNF. The NF LoC determination vendor provides written reminders

to the TPMs or their legal decision maker and the SNF that the annual level of care is due. **(Ongoing strategy)**

Progress Report:

SNFs do annual screenings for TPMs. The NF LoC vendor sends reminders that the annual level of care is due. The TPM or legal decision maker is provided a copy of the annual LoC screening upon determination.

TPMs are made aware that they must continue to meet NF LoC to remain eligible for Medicaid paid SNF care.

Challenges to Implementation

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

Remediation

The State previously convened a NF LoC workgroup to identify a plan to ensure that TPMs who no longer screen at a NF LoC will be allowed sufficient time to safely transition to the community and find necessary supports. The LTCC options counselors, HCBS case managers and the transition coordinators are responsible to implement the recommendations made by the workgroup.

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

Progress Report:

- A process has been developed to allow administrative approval for NF LoC to continue for up to 150 days This process allows for transition coordination and planning for the individual who may no longer meet NFLoC. There have been five (5) individuals who have utilized this service/option.

New Strategy 3. Conduct 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. **(Trainings completed December 31, 2023)**

Progress Report:

Training occurred in September, October, and November (virtual) 2023 with Older Americans Act, Local Contact Agent, Money Follows the Person, LTSS and Maximus. Currently working with HSRI to provide a "toolkit to SNF" outlining NF LoC screenings, LTSS OC and Transitions.

Performance Measure(s)

Number of in person regional meetings.

- There were eight (8) regional meeting held during this reporting period.

Number of regional meeting attendees.

- There were 69 attendees.

Number of webinars.

- One webinar was held during this reporting period.

Number of facilities represented at the webinars.

- There were approximately 24 facilities in attendance.

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

- SNF Administrator – 5
- Director of Nursing – 2
- Social Worker – 37
- Direct Support Staff – 2
- Hospital Staff – 2
- Other – 11

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

Implementation Strategy

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

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

- Develop a formal peer support program through the proposed Peer Support Resource Center that will allow individuals an opportunity to meet other

individuals living, working, and receiving services in an integrated setting before deciding where to receive services.

- The Peer Support Resource Center will create the opportunity for TPMs to connect with a peer who has lived experience navigating and utilizing HCBS**.**

Progress Report:

- See response in Section VIII.I.4.

- Create a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign should include marketing on social media and providing education to the public, professionals, stakeholders and TPMs at serious risk of entering nursing facilities. Campaign will also provide education to those parties that recommend SNF care to TPMs.

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

  - State staff will also have 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 strategies through December 14, 2023)**

Progress Report:

Adult & Aging Services is contracted with an agency to advertise on digital media outlets (e.g., YouTube, Facebook) to promote North Dakota's Aging and Disability Resource Link. Planned dates are:

- October 1 - October 31, 2023, December 1 – December 31, 2023, February 1 – February 31, 2024, April 1 - April 30, 2024.

- July 1 - July 31, 2024, October 1 - October 31, 2024, January 1 - January 31, 2025, April 1 - April 30, 2025.

This effort will identify and outreach to TPMs who are at serious risk of entering nursing facilities and\ provide outreach about HCBS to the public, senior citizen centers, and stakeholders.

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

Progress Report:

- See response in Section VI.E.2

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

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

Progress Report:

- See response in Section X.B.3.

- 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. **(Completed June 14, 2023)**

Progress Report:

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

- The State will investigate options for prompt determination of Medicaid eligibility for HCBS, such as presumptive eligibility for the Medicaid-expansion adult population under the age of 65, to minimize delays involved in the authorization of HCBS **(Updated Target completion date ~~August 31, 2023~~ June 30,2024)**

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

Progress Report:

- A meeting was held on July 21, 2023 with the acting Medicaid Director, the head of the Eligibility unit for Medical Services to discuss presumptive eligibility for TPMs. The State currently allows presumptive eligibility to be determined by qualified hospitals. The Code of Federal Regulations states that an agency must provide Medicaid during a presumptive eligibility period to individuals who are determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible subject to the same requirements as apply to the State options under § 435.1102 and §435.1103

- The Medicaid Services staff advised that presumptive eligibility may not be that effective in helping people access HCBS. The time that Medicaid benefits can be provided until the person is required to submit a full Medicaid application is short. Individuals who are requesting Medicaid LTSS benefits must meet the means testing that requires them to submit additional information which can cause a delay. The State will continue the conversation to ensure we have a full understanding of the process and its impact on TPMs.

- During the 2023 HCBS national conference a CMS official told those in attendance that it is possible to use presumptive eligibility to assist Medicaid applicants in accessing HCBS. The State has a meeting set up with staff from CMS to discuss this topic on January 29, 2024. An update on the meeting outcomes will be reported in subsequent reports.

SA Section XI. Transition Services

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

Updated Strategy 1. The State will continue to use MFP Rebalancing Demonstration grant resources and transition support services under the HCBS Medicaid waiver to assist TPMs who reside in a SNF or hospital to transition to the most integrated setting appropriate, as set forth in the TPM's PCP.

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

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

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

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

- Evaluate the current capacity of the MFP transition coordinators in Bismarck, Grand Forks, Minot, and Fargo to determine if additional FTEs are needed. If the State determines there is a need, the State will request funds in the 2024 MFP budget which requires approval from CMS. **(Ongoing strategy)**

Progress Report:

  - Dakota CIL (Bismarck) has five full-time MFP Transition Coordinators and one full-time assistant coordinator.
  - Independence (Minot) has three full-time and one half-time MFP Transition Coordinator.
  - Freedom CIL (Fargo) has three full-time MFP Transition Coordinators.
  - Options CIL (East Grand Forks) has four full-time Transition Coordinators.
  - All CILs except Minot have an assistant coordinator. Minot uses other CIL staff to help the MFP Transition Coordinators, so the need is being met in all areas of the State.

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

Progress Report:

The State issued a request for proposals to provide QSP incentive grants.

Applicants could receive bonus points for agreeing to provide services in high demand like transition supports. Thirty-nine applications were reviewed. Twenty-three grants were awarded in December 2022.

- The QSP Incentive Grants were awarded on December 7, 2022. Grants ranging from $33,910 to $50,000 were awarded to 23 entities. The awards totaled $1,119,883. ARPA 10% Savings funds were used for this project. Three (3) agencies declined the grant funds (totaling $149,695) stating they were unable to fulfil the grant requirements.
- One contract expired with funds remaining. All other contracts were extended to December 31, 2023 and five (5) contracts received a second extension to June 30, 2024. Link to QSP Grant Award Summary

New Strategy 2. The State will use ARPA of 2021 Section 9817 10% enhanced FMAP for HCBS funds to offer additional incentive grants to support start up and enrollment activity costs for new or existing QSPs to establish or expand their business to provide HCBS. Grants will be awarded in amounts up to $50,000 based on the priority of need of the services the agency will provide. **(Grants awarded by December 31, 2022)**

Progress Report:

Performance Measure(s)

Number and total dollar amount of incentive grants awarded.

- See response above in Strategy 1 of this section.

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

Progress Report:

Additional funds have been approved for the following supplemental services:

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

- Home modifications and vehicle adaptations would be available prior to transition so they 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. CMS asked that these costs be added to the administration budget.

- Pre-tenancy supports such as apartment administrative fees. Pay up to six-months in arrears. **(Completed December 5, 2023)**

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

Progress Report:

While this portion of the Data Learning Collaborative is complete, CMS is forming a peer group of the MFP Data and Quality Analysts, so that individuals can share experiences and trends with other MFP states. This is intended to start in January 2024. Our data and quality analyst has already connected with other states and had initial conversations regarding barriers and potential data driven solutions.

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

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

Progress Report:

MFP staff participated in collaborative meetings held on March 14, 2023. There were several organizations represented including USDA Rural Development, High Plains Fair Housing, Brain Injury Network, NDHFA, Community Options, Recovery Housing Assistance Program, Regional Based Housing Resources, Native Inc., Grand Forks Housing Authority and MFP staff. Everyone in attendance had an opportunity to present information about their respective program to educate other agencies. The goal of the meeting was to find areas where collaboration might be most effective and to ensure we are not duplicating efforts.

The MFP Housing Learning Collaborative reconvened as of April 19, 2023. MFP is assisting in leading the State's efforts in Aging Services' focus and involvement with the Housing Services Collaborative. The collaborative meets quarterly and is continuously working towards their goals and action steps.

New Strategy 6: Hire and train one additional FTE to support the work of the transition coordinators. This position will be responsible for training, providing technical assistance, staffing cases, and completing transition plan reviews. The main purpose of the position is to offer support and guidance to the transition coordination staff to ensure safe, timely and effective transitions. **(Completed September 14, 2022)**

Progress Report:

- The Transition Service Specialist was hired on September 14, 2022. This position completes orientation with contracted transition coordinators, develops a monthly training schedule, provides one-on-one technical assistance, reviews all transition planning documents, and conducts a thorough audit post transition. This position also assists the Housing Facilitation team in the proper documentation and follow-up.

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

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

Progress Report:

The current 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 work with the SME to further address this issue.

Performance Measure(s)

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

- There were 16 transitions that have taken longer than 100 days during this reporting period. All were reported to the SME on the 90+ day report.

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

- Forty-seven (47), or 75% of the 63 individuals who transitioned, were transitioned within 120 days.

- Sixteen (16) or 25% of the 63 individuals who transitioned took 121 days or more to transition.

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

Progress Report:

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

State staff have identified a few systemic issues during these meetings. For example, lack of providers in certain areas of the State, not enough accessible housing units, behavioral health concerns that may jeopardize community living, difficult conviction history, and individuals who lack capacity but do not have a legal decisionmaker. All these issues are being addressed in some way but there are no quick answers or solutions. The State will continue to work with other stakeholders to find solutions to some of these systemic problems.

This continues to happen monthly, and personalized staffing is available as well to help develop action steps toward community living.

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

Progress Report:

<u>Performance Measure(s)</u>

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

- Quarterly reviews of all transitions began in April 2023. Information gathered during each quarterly meeting is used to develop training and future strategies to improve the transition process. Review team includes State staff, HCBS case managers, MFP transition coordinators, and housing facilitators. With the information gathered thus far we have

provided education and resources to aide in successful transition planning. An internal meeting will be held in April 2024 to identify trends, barriers, and gaps that the team will use to develop strategies to address identified systemic issues. Additional information will be included in future version of this report.

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 (1) year post discharge. The HCBS case manager also provides ongoing case management assistance.

Progress Report:

Performance Measure(s)

Number of transition referrals and timelines for case management assignment.

- A total of 152 (139 MFP, 13 ADRL) transition referrals were received, and transition coordinators were assigned within five (5) business days for each referral. Of those 152 referrals, 45 of the referrals were closed for various reasons. This leaves 107 active cases. Of those 107 active cases, there are 75 TPMs who signed the consent form, and the MFP program and transition coordinators are working on those cases.

Number of successful transitions.

- There were 63 (53 MFP, 10 ADRL) transitions successfully completed with TPMs during this reporting period.

Number of PCPs completed with TPMs in SNFs.

- There were 913 PCPs completed by LTSS OC for TPMs residing in a SNF.

Number of groups in-reach activities conducted.

- A total of 75 annual in-reach presentations were completed in SNFs by December 31, 2023

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

Implementation Strategy

Strategy 1. Effective January 1, 2021, the MFP grant was authorized for three additional years with an additional four years of spending through 2028. The State will continue to use the funds and resources from this grant to provide transition supports**. (Ongoing strategy)**

Progress Report:

The federal government extended the Money Follows the Person Rebalancing Demonstration; therefore, we will continue to operate and are not looking at closing out the grant or implementing sustainability measures at this time.

Updated Strategy 2. By December 14, 2024, through increased awareness, including in-reach and outreach efforts, person-centered planning, and ongoing monitoring and assistance, the State will use local, State, and Federally funded HCBS and supports to assist at least 60% of the TPMs who request transition to the most integrated setting appropriate. The State will also divert at least 150 TPMs from SNF to community-based services. **(Ongoing Strategy)**

Challenges to Implementation

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

Remediation

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

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

The State will continue to use the information from the study to develop recruitment and retention strategies that appeal to what QSPs said they like

about providing direct care i.e., ability to help others and job flexibility.

Progress Report:

The QSP Hub has completed a second QSP survey of agency and individual QSPs. The survey received a good response rate. Out of the 926 electronic invitations sent to individual QSPs, there were 207 records received. 202 records (21.8%) were included in the analyses. The QSP Hub plans to complete a provider survey annually.

The first two versions of the survey included information on the number and characteristics of QSPs. For example, what motivated them to enroll as a provider and what are the most rewarding and challenging parts of the job. The third version of the survey will also attempt to answer questions about the capacity of the current provider community to expand operations and will attempt to quantify the number of new providers that may be necessary to meet the future demand for HCBS. The State is working with researchers from UND to develop the third version of the survey. The State is also finalizing a QSP exit survey that will be administered by the QSP Hub to document and better understand the reasons providers stop providing care.

(Target completion date December 14, 2024)

Link to Independent QSP Survey Results

Performance Measure(s)

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

- Out of the 280 (262 MFP, 18 ADRL) referrals received, 183 (174 MFP, 9 ADRL) individuals requested transition by signing the consent form and 118 (105 MFP, 13 ADRL) individuals transitioned (65%) from December 14, 2022 – December 13, 2023.

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

- A total of 319 new TPMs were diverted from a SNF from December 14, 2022 - December 13, 2023.

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

Progress Report:

Number of TPMs transitioned.

- A total of 63 (53 MFP, 10 ADRL) TPMs transitioned from a SNF during this reporting period.

Number of TPMs diverted.

- See response in Strategy 2 above.

SA Section XII. Housing Services

Responsible Division(s)

DHHS

The State's experience implementing the SA has reinforced an understanding of how important it is to help ensure that a person has access to a place to live that they can afford and that is able to meet their needs. As such, one of the primary areas of focus in year 3 of the Implementation Plan was 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 drew 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.

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 the following recommendations from the Housing Access plan.

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

- Conduct additional policy conversations in partnership with public housing authorities and affordable housing providers across ND related to policies, preferences, and practices that would support TPMs.

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

Implementation Strategy

Development of housing needs and preferences tools that will be incorporated into

LTSS Options Counseling and case management processes.

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

Challenges to Implementation

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

Remediation

Continue to work to secure additional resources to support housing / transition efforts and build connecting points into technology platforms that are already being used in service delivery. State funds must be appropriated by the Legislature which meets every two (2) years. 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 Tax Credit program and the Housing Trust Fund, Home Investment Partnership Program, and the ND Housing Incentive fund. **(~~Target completion date May 31, 2024~~. Ongoing strategy)**

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

Implementation Strategy

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

Challenges to Implementation

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

Remediation

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

Progress Report:

Performance Measure(s)

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

- Of the 63 (53 MFP, 10 ADRL) individuals who transitioned from a nursing facility to the community, 21 received rental assistance, 9 were provided home modifications, and 35 received some type of housing assistance from a housing facilitator.
- The most utilized housing services for the TPMs that transitioned during this report period.
    - TPM Rental assistance - 33
    - Housing Search - 18
    - Assistance with Housing Application - 17
    - Housing Assistance - 17
    - Housing Documents assistance - 14
    - Housing Secure Accommodations - 6
    - Housing Modifications - 9
    - Housing Education - 13
    - Housing Accessible Features - 5
    - Address Housing barriers – 7

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

- MFP will continue to support any TPMs that have a need for permanent supportive housing through funding streams, and our launch of housing facilitation services. All MFP recipients are followed for the first 11-12 months of services to continue to establish supports and services to maintain in the community. When it comes to housing costs, we have paid 0%-30% of the rent. Part of our policy is that we would not support moving an individual into a rental unit that is more than 30% of the household income. The 30% is a HUD standard and that is why that amount was adopted into our policy as well.
- A Data Analyst was hired on January 23, 2023 and has begun creating databases to track various types of housing assistance. The Transition Service Specialist is also developing an auditing and quality assurance

process. These activities make it possible to better track housing barriers and housing resources used by the TPMs.

- As of May 1, 2023 we launched a housing facilitator service to assist in housing related matters that isn't tied to funding and therefore may be helpful for some HCBS cases to help individuals stay in their home or have resources as it relates to housing (such as reasonable accommodations, service animals, porting vouchers, and applying for additional assistance or braided funding).

    - Data is tracked in Therap and by the State Housing Facilitators and is reported on the USDOJ SA semi-annual reports.

Housing costs as percent of household income.

- The transition program supports transitions in which the percent of household income is 30% or less of their rental expenses. The household typically uses a housing voucher, or a project based complex to stay within their budgeted expense.

Updated Strategy 2. Develop enhanced housing inventory, integrated with the ADRL system, that identifies availability of housing options that may be suitable to meet the needs of TPMs who have an identified housing barrier. The inventory should include, to the greatest extent possible, information related to accessibility, affordability, availability, and tenant selection criteria as well as information related to a property's status as PSH as per the SA. Develop technology solution to serve as accessibility resource for housing locators who are working to connect TPMs to appropriate housing. **(Target completion date: May 31, 2024)**

Challenges to Implementation

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

Remediation

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

Progress Report:

This is currently being explored. We are looking at what systems other states utilize and are getting feedback on whether this type of system would be worth the expense and the accuracy of the utilization rate.

Strategy 3. Convene State Housing Services workgroup to review and offer feedback on the Low-Income Housing Tax Credit Qualified Application Plan annually, particularly as related to the incorporation of plan elements that would increase TPMs' access to

affordable, appropriate housing options. **(Ongoing strategy)**

Progress Report:

This is ongoing effort and the state participated in the NDHFA public comment sessions on March 2, 2023 and on November 30, 2023 when the session focused on scoring criteria for inclusion of universal design components.

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

Implementation Strategy

Strategy 1. Increase the network of housing facilitators and transition coordinators actively working in the State. **(Ongoing strategy)**

Challenges to Implementation

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

Remediation

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

Progress Report:

Effective May 1, 2023, ND Rent Help only assists the homeless population with rental assistance because of the amount of remaining funds in the program. They discontinued the utility assistance program. After this program ended there was a large increase in requests for housing supports i.e., back rent and on-going rent help but this population is not made up of many TPMs. The only TPMs impacted by the closure of the program are individuals who have already been diverted and live in the community. Through the State housing general fund and MFP rental assistance we prioritize TPMs, and we have been able to serve everyone who has requested assistance.

MFP added both housing facilitator and transition coordinator capacity, as did ND Rent Help. Both efforts grew capacity by contracting with community-based organizations.

	MFP		ND Rent Help (NDRH)	
	Start of Year 3	End of Year 3	Start of Year 3	End of Year 3
Housing Facilitator	3 (via MFP contract with Minot State)	9 (via MFP contract with Minot State) 3 across the state for ADRL in 1/23-3/25	44 (via contracts with 78 agencies, located in all ND. regions)	42 via contracts with 6 agencies, 8 State staff facilitators (Household Engagement Coaches)
Transition Coordinator	6.5 via MFP (Contract with 4 CILS)	15 via MFP (contract with 4 CILs) 5 ADRL across the state	0	0 *Note: While not true "transition coordinators," ND Rent Help added follow-up support to all existing housing facilitator contracts for individuals who needed additional assistance maintaining housing stability.

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

Challenges to Implementation

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

Remediation

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

Progress Report:

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

housing facilitators talk about home and community-based services in the regular course of their work; property owners talk about the need for services and service providers talk about the need for housing.

While this type of “organic” conversation can be hard to track, the impact is unmistakable. The work that occurred throughout Year 1 and Year 2 of the IP has established the connection between housing and services in people’s minds. It has helped TPMs, and the people involved in supporting them, to be more curious about and interested in what’s possible. Our ongoing work is to continue to add clarity to these conversations, but the real success to date is that the essential and foundational connections have been established for many.

Continued partnership between Housing Facilitators, HCBS Case Mangers, and Transition Coordinators has allowed more TPMs to find the permanent supported housing they need to successfully transition to the community.

Performance Measure(s)

Number of referrals made and resulting services accessed.

- 100% of all active referrals received are given to housing facilitators within two (2) business days. These referrals are sent to the housing facilitator supervisors by State staff and each referral is documented. Of the 107 active referrals, 72 have accessed rental assistance, housing search assistance, housing application assistance, assistance with securing documents for housing, education on rights and responsibility of the tenant, assistance to secure accommodations, home modification assistance, accessibility feature assistance, and assistance in addressing barriers.

Strategy 3. Implement practices to guide appropriate identification of professionals who will work together to help overcome barriers that are identified in a TPM ‘s PCP. Professionals from housing facilitation, HCBS case management, transition coordination, rental assistance, and environmental modification will be represented on the Housing Services workgroup to build stronger interconnectivity between disciplines. **(Completed: December 2022)**

Challenges to Implementation

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

Remediation

Communities of Practice to facilitate region-specific knowledge.

Progress Report:

There is a team of State staff and community providers who are brainstorming ways to make environmental modification services more available to TPMs. The State is exploring ways to create a sustainable environmental modification funding stream that will reduce financial risk of providing these services to TPMs.

Performance Measure(s)

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

- 100% of all referrals received are given to housing facilitators within two (2) business days. These referrals are sent to the housing facilitator supervisors by State staff and each referral is documented. This report period there were 152 referrals sent to the housing facilitators.

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

- Of 53 the meetings held, 17 (32%) were held within 14 days of the referral and 25 (47%) were held within 14 days from the date of consent.

- There were 36 (68%) of the team meetings held after 14 days from the referral and 28 (53%) were held after 14 days from the date of consent.

  All team meetings held after 14 days of consent or referral were noted as scheduling conflicts with the HCBS case manager, transition coordinator, housing facilitator, family, social worker, and the consumer themselves.

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

Challenges to Implementation

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

Remediation

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

Progress Report:

There are two (2) reports in the case management system that are utilized to

track housing facilitation data. One (1) report includes the referral information, and another includes the outcome of the assistance. Additionally, an auditing process has been developed for housing facilitation quality assurance.

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

Challenges to Implementation

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

Remediation

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

Progress Report:

During the October 2023 HCBS update, MFP presented on housing services updates.

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

Progress Report:

Performance Measure(s)

Number of LTSS Options Counseling referrals that collect information related to housing barriers.

- 436 (unduplicated) LTSS OC referrals were conducted using the updated form that assesses housing needs.

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

- A total of 152 (139 MFP, 13 ADRL) transition referrals were received, and transition coordinators were assigned within five (5) business days for each referral. Of those 152 referrals, 45 of the referrals were closed for various reasons. This leaves 107 active cases. Of those 107 active cases, there are 75 TPMs who signed the consent form, and the MFP program and transition coordinators are working on those cases.

- Of the 75 active referrals, there are currently 49 person-centered plans completed addressing individual barriers. There are currently 35

person-centered plans completed addressing housing as a barrier.

- There are currently 26 without a person-centered plan as it has not yet been 44 days after the signed consent.

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

Implementation Strategy

Strategy 1. Develop a matrix that identifies the range of existing home and environmental modification resources available in ND as part of the Environmental Modification work group efforts. **(Completed April 1, 2023)**

Challenges to Implementation

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

Remediation

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

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

Progress Report:

The Environmental Modification workgroup continues to meet and has reviewed the home modification resource list. Link to Appendix D

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

Supplement information available from data collected in state case management system with 2-3 focus groups that include HCBS case managers, LTSS 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. This work will be complete by December 2022 to align with the opening of the 2023-2025 legislative session. **(Completed December 2022)**

Challenges to Implementation

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

Progress Report:

Eighteen (18) TPM's were assisted with home modifications through MFP in this reporting period.

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

Challenges to Implementation

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

Progress Report:

Due to federal regulations and state procurement laws, our methods for implementing these adjustments are currently limited.

The definition of environmental modifications in the HCBS waiver was clarified to include allowing for vehicle modification.

Strategy 4. Develop training for housing support providers to know how to access various home modification resources effectively and appropriately, including assembly of funding from multiple sources and expected timelines for authorization of housing modifications. Develop new ongoing training opportunities for housing professionals/teams regarding integration of reasonable modification ideas into the PCP, including resources that help professionals/teams better understand flexibilities that may be possible with reasonable modification and that help TPMs and their families and/or caregivers better understand options available to them. **(Completed January 2023 and ongoing)**

Challenges to Implementation

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

Progress Report:

Training on fair housing and reasonable accommodations was conducted on January 27, 2023 and was attended by 22 individuals. This training is also included in the new hire onboarding process.

Strategy 5. As per SA Section XII(D)(3)(a)-(c), examine policies of housing providers and Medicaid policy (specifically SNF) to create guidance regarding "intent to return home," resulting in a usable resource for eligibility workers and housing support team professionals.

“Intent to Return Home” is identified in individual service plans that involve a person’s “intent” following a change in status. This may preclude a TPM from being able to maintain their housing while temporarily in an institutional setting because of housing provider or Medicaid-related policies and requirements related to time away from a housing unit. Add information about intent to return home to LTSS Options Counseling document as needed, including information that needs to be communicated to a SNF to facilitate continued TPM access to monthly payments which further enable a return home. **Completed September 27, 2023** Link to Short Term Stay insert

Challenges to Implementation

Complexity of underlying systems.

Remediation

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

Progress Report:

During the Enhancing and Building Long Term Services and Supports Training, we input the training in our webinar and the brochures have been distributed to the facilities and the Options Counselors.

Performance Measure(s)

Utilization of intent to return home element of LTSS Options Counseling process.

- A brochure was developed and is provided to TPMs during their initial LTSS Options Counseling visit providing additional information on the intent to return home. **(Completed November 2023)**

Strategy 6. Continue to develop recommended practice guidelines that housing providers can choose to adopt if they want to better align with "intent to return home" goals established in the TPM's service plan or LTSS Options Counseling document. Include clear communication expectations as part of the TPM diversion and transition teams. **(Completed December 2023)**

Challenges to Implementation

Decentralized nature of Federal housing delivery in ND.

Remediation

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

Progress Report:

See response in Strategy 5.

This is an ongoing process, and we continue to follow the transition guidelines and process on a regular basis or situations arise with the administrative team.

Strategy 7. Continue to offer guidance to professionals involved in service teams regarding subsidy rules related to filing change of income forms with housing subsidy providers. Include guidance on how to access resources that can bridge TPM housing costs during out-of-home stays. **(Completed October 31, 2023)**

Challenges to Implementation

Lack of familiarity with housing systems and processes by people who work professionally in HCBS.

Remediation

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

Progress Report:

See response in Strategy 5.

Information was presented at the Building and Enhancing Long-term Systems and Supports meetings held across the State. The meetings are targeted toward hospital and nursing home staff who work with TPMs.

Strategy 8. Develop a benefits management resource as a parallel to the process MFP uses to help ensure people maintain housing even during time in a SNF. This includes training on specific practices that help ensure access to housing even during temporary out-of-home stays (ex. SNF, hospital, rehabilitation center). **(Completed December 2023)**

Challenges to Implementation

Difficulty in incorporating new resource type into referral networks.

Remediation

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

Progress Report:

Performance Measure(s)

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

- There are two (2) individuals during this referral period for which we are maintaining housing during their skilled nursing facility stay. No one lost their housing during this reporting period.

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

Implementation Strategy

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

Challenges to Implementation

Volume of training expected of human service professionals.

Progress Report:

Performance Measure(s)

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

- All MFP Housing Facilitators have been trained on Fair Housing. Additionally, a lunch and learn was conducted on December 14, 2023 about fair housing for the public and any outside or inside entity could participate. Attendees included staff from state agencies, Centers for Independent Living, and hospitals.

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

Implementation Strategy

Strategy 1. Outline State strategy for access to rental assistance, including all resources available (ex. HUD Housing Choice voucher, Mainstream voucher; Veterans

Administration Supportive Housing voucher; Rural Development rental subsidy; State rental assistance (new); emergency rent assistance (State or federal)). Include processes for accessing rental assistance (eligibility, referral, documentation, and determination). Develop State rental assistance brief that outlines State resources and strategy. **(Completed October 2022)**

Challenges to Implementation

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

Progress Report:

Performance Measure(s)

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

- Sixty-three (63) new TPMs who transitioned received some type of rental assistance during this reporting period.

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

Challenges to Implementation

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

Progress Report:

Performance Measures(s)

Number of TPMs who receive rental assistance.

- There are 33 unduplicated TPM's who received State rental assistance during this reporting period. Some of these individuals are also getting federal rent assistance.

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

- None of the 63 TPMs who transitioned are experiencing housing cost burden.

Strategy 3. Continue to enhance the existing ND Housing 101 training course that has been designed to introduce helping professionals to housing concepts, terminology, and market information. Identify additional modules to include in the training curriculum to allow for deeper knowledge on specific topics, and determine which modules need to be

localized to be effective. Include modules for transition and diversion teams regarding applying for rental assistance, and for housing facilitators regarding “Opening Door” as a resource to mitigate housing barriers. **(Completed June 14, 2023 and ongoing strategy)**

Challenges to Implementation

Maintaining appropriate brevity given breadth of topics to include.

Progress Report:

Housing 101 training has been updated and relaunched for all Aging and contract staff to complete. This is tracked in Peoplesoft for completion.

SA Section XIII. Community Provider Capacity and Training

Responsible Division(s)

DHHS Aging Services and Medical Services

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

Implementation Strategy

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

The State is exploring the possibility of funding this service beyond this date. Administrative claiming under Medicaid may be one option for continued funds.

The primary goals of the QSP Hub are to:

- Provide one-on-one individualized support via email, phone, and/or video conferencing to assist with enrollment and reenrollment, electronic visit verification, billing, and business operations to recruit and retain a sufficient number of QSPs. This will include the development of technical assistance tools such as user guides that will be available in multiple languages. **(Target completion date March 31, 2024)**

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

- Facilitate the development of a workgroup of experts to provide guidance on the project. The QSP Hub held their first stakeholder meeting in July 2023 and has provided the attached update to their strategic plan. Link to Appendix G

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

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

- Establish and implement a QSP agency recruitment process. This will include working with small business development organizations to increase the number of QSP agencies available to meet the needs of all eligible individuals. It will also include partnering with local high schools and colleges who offer training to become a direct care provider and informing them about the opportunities to become a QSP. **(Target completion date July 31, 2024)**

Progress Report:

Performance Measure(s)

Number of QSPs assisted by the QSP Hub.

- The QSP Hub completed 1,170 contacts with 532 unduplicated individuals and agency QSPs to assist them during this reporting period.

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

- The State has assisted two (2) QSP Agencies with CQL accreditation during this reporting period. Thirteen (13) agencies have received help with obtaining CQL accreditation since the State began this initiative to increase the quality of QSP services.

Number of new agencies enrolled as providers.

- Fifteen (15) new agency QSPs were enrolled this reporting period.

Number of new independent QSPs enrolled as providers.

- There were 147 new individual QSPs enrolled during this reporting period.

Number of agencies that expand array of services.

- A total of 50 agency QSPs expanded the array of services during this reporting period.

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

- There are three (3) Tribal QSP Agencies
    - Spirit Lake Okiciyapi – 35 clients served
    - Standing Rock Sioux Tribe (N/A)
    - TM Tribal Aging Agency – 16 clients served
    - North Segment Home Services – (N/A)
- MFP-TI is funding a Tribal Nations QSP Agency at Turtle Mountain and we are aware that Spirit Lake Nation has one QSP agency, Home Instead is also working with MHA Nation for QSP supports with this funding.

Strategy 2. Implement inflationary rate increase for all HCBS services that may be approved in the 2023-2025 DHHS budget. **(Implemented first rate increase July 1, 2023)**

Progress Report:

Performance Measure(s)

Rate increases published on July 1, 2023.

- Inflationary rate increases of 3% were granted to QSPs July 1, 2023, and new rates posted on the DHHS website.
- The Legislature approved an addition inflationary increase of 3% for QSPs that will be granted on July 1, 2024.

Updated Strategy 3. Implement recommendations from the HCBS rate study conducted with assistance of a contracted vendor with expertise in analyzing rates for HCBS. The State will implement any changes to the rates for HCBS that may be approved during the 2023-2025 legislative session. Full implementation may require regulatory authority that could include approval of a Waiver amendment by CMS. **(Completed January 1, 2024)**

Progress Report:

Performance Measure(s)

Rate increases published on July 1, 2023

- See response in Strategy 2.

Rate increases effective January 1, 2024

- Family Home Care from $49.56 to $72.50 per day.

- Individual Adult Family Foster Care from a max of $99.07 to $150.00 per day.

- HCBS Case Managers will begin implementing the increases starting March 1, 2024 during the next quarterly contact with the eligible individual.

Number of new providers enrolled to provide these services.

- Family Home Care – 43

- Individual Adult Foster Care – No new homes were enrolled during this reporting period. There are 13 providers enrolled statewide.

Strategy 4. Create a centralized QSP matching portal in cooperation with ADvancing States to replace the current QSP searchable database.

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

The system will have the capacity to create reports, be routinely updated, and available to HCBS case managers and others online. It will allow QSPs to include information about the type of services they provide, hours of work availability, schedule availability, and languages spoken. **(Target implementation date ~~December 1, 2023~~ January 31, 2024)**

Progress Report:

- The *ConnectToCareJobs* portal is almost complete. The official name of the new portal is Connect to Care ND. The State will use the system as the QSP registry, matching portal, and provider enrollment training site. The system will replace the current QSP database. Provider data is being uploaded and an interface between the new QSP enrollment portal and Connect to Care will be built. **Soft launch is scheduled for ~~December 2023~~ January 31, 2024.)**

Performance Measure(s)

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

- See response above

Number of users of portal on monthly basis.

- See response above.

Updated Strategy 5. Pay the CQL accreditation fees for up to five additional agencies who are willing to develop residential habilitation and community-support services for the HCBS Waiver serving adults with a physical disability or adults 65 years of age and older. Deferring costs for accreditation will increase capacity to provide the 24-hour a day services needed to support TPMs with more complex needs in the community. **(Complete as of December 13, 2023)**

Progress Report:

- Currently there are 13 agencies that have received/are receiving assistance with fees. During this period, two (2) new agencies were assisted with the CQL costs.

Updated Strategy 6. The State will create a Communication and Recruitment Plan to engage other agencies as potential community providers for the target population. The plan will include meeting directly with the leadership of specific healthcare agencies like hospitals and 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)**

Progress Report:

Outreach approaches are currently being considered and a plan will be in place and initial contact will be made by the July 1, 2024 target completion date.

Performance Measure(s)

Number of agency conversations completed.

- No agency conversations were completed in this reporting period.

Number of agencies that enrolled as a provider.

- One (1) SNF enrolled as a QSP for Adult Day Care services on March 28, 2023.

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

Progress Report:

Performance Measure(s)

Number of grants awarded by date.

- Twenty-three incentive grants were awarded on December 7, 2022.

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

- Nine (9) QSPs will expand services to tribal and rural/frontier areas.
- Seven (7) QSPs enrolled to become new agency providers.

Number of existing providers expanding to provide HCBS.

- Nine (9) QSP will expand services to tribal and rural/frontier areas.
- Seven (7) QSPs enrolled to become new agency providers.
- Three (3) current QSPs will purchase handicapped accessible vehicles to better serve clients.
- Two (2) QSPs expanded to serve underserved groups.
- Two (2) QSPs expanded to serve in urban areas.

Number of agencies that expand array of services.

- See response in Section XI.A.1.

Strategy 8. To continue to ensure timely enrollment and revalidation of QSPs, the State has amended its contract with the vendor to include provider enrollment services for QSPs. The vendor will follow State requirements and provide sufficient staff to complete all new enrollment applications within 14 calendar days of receipt of a complete application. The vendor will also be required to process provider revalidations prior to the revalidation due date. **(Ongoing strategy)**

Progress Report:

Performance Measure(s)

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

- A total of 135 initial applications were received from July 1, 2023 – December 10, 2023, 113 (82%) were processed within the required timeframe. Processed means that an initial review of the application to determine if it meets all the requirements is complete.
- The responsibility to process QSP applications transitioned from a contracted vendor to five (5) DHHS Medical Services staff on December 11, 2023. The contracted enrollment vendor will continue to process all the applications it had received prior to the transition date. State staff will receive all new QSP enrollment applications and will

process validations received after that date. A new QSP enrollment portal was launched and will be used to improve the accuracy and timeliness of QSP enrollment.

Number of QSP revalidations completed before revalidation due date.

- See response above.

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

Progress Report:

The State decided to hire a contracted vendor to complete the training review project. The State contracted with a vendor to complete an analysis and make recommendations about ND's training requirements that impact HCBS providers across the Lifespan. The vendor has conducted multiple stakeholder events and is currently drafting a summary and recommendations for the State. The state will use the recommendations to improve the training process and requirements for all HCBS providers. **(Recommendations expected April 01, 2023)**

Performance Measure(s)

Number of enrolled QSPs

- 1,038 Individual QSPs
- 160 Agency QSPs

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

The State is working with the QSP Hub to develop a plan to recruit QSPs who have closed in the last 9 -12 months who were in good standing with the State. We will draft a message that will be mailed to QSPs that encourage these

providers to think about working as an independent provider again or working under an agency to help others. 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. The target completion date for this project was changed so that the mailing went out after the QSP Enrollment portal was complete and ready to receive applications. **(Updated target completion date ~~December 1, 2023~~ March 1, 2024)**

Performance Measure(s)

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

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

Implementation Strategy

Strategy 1. The State will provide ongoing critical incident reporting training opportunities for QSPs. Training will be provided through online modules and virtual training events. The State QSP handbook includes current reporting requirements. The State will also work with staff from the QSP Resource Hub to develop 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 about all the content. Training is provided by an Aging Services nurse administrator as necessary. **(Ongoing strategy funded through September 2024)**

Progress Report:

Performance Measure(s)

Number of QSPs trained on reporting procedures.

- June 30, 2023 – 26 attendees
- September 20, 2023 – 7 attendees

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

Progress Report:

- See response in Section XVI.A&B.1.

New Strategy 3. ND will use a portion of the Vulnerable Adult Protective Services Coronavirus Response and Relief Supplemental Appropriations Act of 2021 funds to implement a unified critical incident reporting process. All vulnerable adult protective services staff will have access to the critical incident reporting form in the web-based

data collection system. Reports will be collected and automatically shared electronically to the 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. **(Completed interface with OMB July 31, 2023)**

Progress Report:

ND VAPS created an interface from the VAPS reporting system and the Risk Management Reporting system through OMB to enhance collaboration. ND VAPS was unable to create an interface with the CIR in the case management system. State staff currently manually enter VAPS CIR in the case management system because the volume is relatively low.

CMS recently announced that all state's that have an MFP grant program are required to implement the HCBS Quality Measure Set. One of the required measures includes creating an interface between VAPS and the CIR system that tracks incidents involving Medicaid recipients. The State is working with the State's Information Technology Division to create a process to integrate these two sets of data. Additional information will be included about the progress of this initiative in future reports.

Performance Measure(s)

Number of CIRs reported.

The number of VAPS CIR data cannot be provided at this time. Data will be included once the required HCBS quality measure referenced above is complete.

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

Implementation Strategy

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

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

Recommendations:

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

- Review caseload and referral data to determine where case management shortages exist and developing a plan to request additional resources to address capacity shortages, if necessary, in the next (2023-2025) Executive budget request.

Progress Report:

  - The Department received seven (7) FTE positions in the 2023-2025 Executive Budget Request. Three (3) of the positions have an assigned territory and manage the basic care caseload statewide. The HCBS Case Managers will no longer be providing any basic care case management so it will free up time for them to focus on case management for HCBS. It will also allow them to spend more time on their high needs' cases. In addition, the Department received one (1) Aging Generalist position and two (2) Provider Navigators. All these positions have all been filled as of July 1, 2023.

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

Progress Report:

  - See responses in Sections VII & VIII of this report.

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

Progress Report:

  - The State continues to contract with The Center for Rural Health, located at the University of North Dakota School of Medicine & Health Sciences to operate the QSP Resource Hub. They recently completed the second QSP survey. QSP Resource Hub staff are providing enrollment support for the new QSP Enrollment portal. Link to Independent QSP Survey Results.

- The State will replace the current QSP searchable database with the assistance of ADvancing States and implement the ConnectToCareJobs system to help identify available providers around the State. The system has been customized to meet the States needs and will allow QSPs to better market themselves and share their availability. The system soft launch is set for January 2024.

Progress Report:

  - See response in Section XIII.A.4

Progress Report:

- This work is ongoing. The State included, and was granted, $350,000 in the 2023-2025 DHHS budget to pay QSPs to provide on-call staff that would be available in case of emergency, or if the regularly scheduled provider is unable to complete their shift, etc. The State will work through the procurement process to offer assistance in paying for on call staff to QSPs who provide critical services like personal care and supervision. (**Updated target completion date ~~November 1, 2023~~ March 1, 2024)**

- The State will adopt any new provider models to reduce the administrative burden on individual QSPs that may be approved during the 2023-2025 legislative session.

Progress Report:

- This work is ongoing and additional models are being explored for potential inclusion in the 2025-2027 Executive budget request.

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

Progress Report:

- The requested appropriation to implement rate incentives for providers to help individuals who only need a few service hours each week and rate incentives for those with high needs was not included in the 2023-2025 budget. Therefore, the State will use resources that are available through the ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/ARPA of 2021 to fund this project.

- The State is drafting policy to offer financial incentives to encourage providers to serve individual with high medical needs and individuals with co-occurring behavioral health and substance use. **(Target implementation date April 1, 2024)**

- Continue to provide meaningful statewide training opportunities for all QSPs to ensure understanding of the SA, HCBS, person-centered-planning, and the authorization and claims reimbursement system. The QSP Resource Hub staff will assist the State to ensure quality training is provided.

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

- See response in Section XIII.A.9

- Offer additional incentive grants to encourage large and small agencies to

expand their capacity to serve additional TPMs and expand their service array.

- The State will use resources made available through the ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/ARPA of 2021, to offer additional incentive grants. The State recently requested grant proposals to offer up to four (4) $50,000 QSP incentive grants for individuals and agencies who want to expand or enhance their HCBS agency. Thirty-four proposals were received and are being reviewed by the scoring committee. **(Target grant award release date March 1, 2024)**

Progress Report:

- See response in Section XIII.A.7

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

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

- The State will develop and implement recruitment strategies for any additional HCBS case management FTE that may be approved during the 2023-2025 legislative session.

Progress Report:

- See response in Section VIII.C.

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

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

Progress Report:

- The State recently launched a new QSP enrollment portal which streamlined and greatly improved the enrollment process. All the QSP handbooks are being updated to include information on the new enrollment process. The new handbooks will be posted on the DHHS website and will be linked in the portal.

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

Progress Report:

- N.D. Administrative Code Chapter 75-03-23 was updated to change the length of time between enrollment dates for Agency QSPs from every two (2) years to every five (5) years. The length of time between enrollment dates will also be five (5) years for individual QSPs but they will have to submit and update documentation of competency or proof of other allowable credential every 2.5 years.

- The HCBS Medicaid 1915 (c) waiver was updated on April 1, 2023. The purpose of the amendment is to incorporate administrative language changes that were approved under the North Dakota Administrative Code NDAC effective 10.1.2022, further define waiver language under the services of Environmental Modification, Non-Medical Transportation, Supervision, Residential Habilitation, Community Supports, and Adult Residential Services. The amendment also updated internal processes for person-centered planning, client choices, and handling reasonable modifications requests. Includes that provider enrollment is processed through a contract entity.

Progress Report:

- State staff worked with an IT vendor to create the QSP enrollment portal. The project started in July 2023 and had a 16-week implementation. Daily meetings were held to ensure the process stayed on track. Current portal functionality allows for the submission of new applications. **(QSP enrollment portal launched January 3, 2024)**

- The State is currently working with the vendor on the second phase of the system that will allow the portal to be used for reenrollment and to add or change a provider's service array or service territory. **(Target completion date to add additional functionality to the portal March 1, 2024)**

- The State will compare daily average SNF rates to the overall daily average cost of providing an appropriate package of services for a TPM in a community setting, determine the extent of the disparity, and determine potential rate adjustments or other steps that could reduce the disparity without jeopardizing home and community-based services (HCBS) cost effectiveness or cost neutrality.
    - The State contracted with a vendor to conduct a rate study to determine any potential rate adjustments that would assist the State in recruiting and retaining HCBS providers.
        - See response in Section VI.D.2.

- Successfully develop a reporting and data collection process to implement the required activities of the Settlement Agreement and assess HCBS service quality

and outcomes through NCI and NCI-Aging and Disability (NCI-AD) by hiring one dedicated staff person to address the collection of valid and reliable data in all services, meaningful reporting, and service quality which will be analyzed, trended, and used to improve health outcomes.

Progress Report:

- A data analyst was hired in February 2023 to assist with data and quality reporting for the MFP program. Another team member who is a licensed RN was hired as a quality program administrator to help implement the HCBS quality measures required by the MFP grant and to manage the NCI-AD.

- The State worked with a vendor to implement NCI-AD in ND. Over 400 individuals receiving HCBS participated in the survey. The State intends to complete the NCI-AD survey every two (2) years. The State is waiting for results from the initial survey from Advancing States.

- Hire and train any additional LTSS Options Counseling or HCBS case management FTE that may be approved in the 2023-2025 legislative session. **(Completed December 31, 2023)**

Progress Report:

  - Seven (7) case management positions that were approved in the 2023-2025 Legislative session have been hired and trained.

- Determine the need and request any funds to hire any additional transition coordinator staff in the MFP budget. **(Completed December 13, 2023)**

Progress Report:

DOJ Year 3 Transition Coordinator positions			
CIL	MFP TC count with supervisors	Transition Assistant	ADRL Transition coordinator
Dakota	6	1	2
Freedom	5	1	2
Independence	6	0	1
Options	5	1 Completed	0
Total	22	3	5

- The Bismarck and Faro CIL's will be given additional MFP funding to hire one

new Transition Coordinator in each area in 2024. The Minot CIL currently has one (1) vacancy and is actively recruiting.

- Establish funding for the State assistive technology agency to provide information and training to community providers and caregivers to foster independence so individuals can live more safely and securely in their home. The increased utilization of assistive devices will support increased utilization of home and community-based services. **(Project funded through June 2025)**

    - The ND Department of Health and Human Services, Aging Services has contracted with ND Assistive to provide training and resources to build the knowledge and capacity of providers and caregivers about assistive technology devices and services, so they can recognize the benefits of the technology and take advantage of the available resources to make informed decisions about the people they serve.

    - Through a train-the-trainer model, ND Assistive selected 12 towns to reach in the first year including Watford City, Dickinson, Hettinger, Washburn, Carrington, Mohall, Bottineau, Langdon, Glen Ullin, Lisbon, Devils Lake, and Jamestown. In five (5) of those towns, they have already established relationships with people who are willing to serve as AT ambassadors. They have built a training and communication platform through an app to share training information and connect assistive technology ambassadors.

Progress Report:

- ND Assistive currently have 20 ambassadors and have recruited a new ambassador in Parshall, ND which is part of the Mandan, Hidatsa, and Arikara Nation. The ambassadors are community advocates, retired teachers, case managers, extension agents, home care providers, hospital, and rural telephone cooperative employees. They meet monthly with the ambassadors and brainstorm ways to assist the individuals they have reached. They have seen an increase in referrals in the areas that have an assistive technology ambassador. Morton county saw an increase of 46 referrals last month.

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

Implementation Strategy

Updated Strategy 1. The State will use ARPA of 2021 Section 9817 10% enhanced FMAP for HCBS funds to offer additional incentive grants to support start up and enrollment activity costs for new or existing QSPs to establish or expand their business to provide HCBS. Grants will be awarded in amounts up to $50,000 based on the priority of need of the services the agency will provide. **(Grants awarded December 7, 2022)**

Progress Report:

- See response in Section XIII.A.7.

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

Progress Report:

Performance Measure(s)

Number of SNFs requesting individual technical assistance.

- No SNF requested technical assistance during this reporting period.

Number of SNFs that have enrolled to provide HCBS.

- One (1) new SNF (Missouri Slope Lutheran Home) became an Agency QSP called Missouri Slope at Home. They were approved in September 2023 and enrolled to provide the following services: homemaker, personal care, non-medical transportation, companionship, respite care, supervision, home delivered meals, nurse education, chore, and extended personal care.

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.

Progress Report:

Performance Measure(s)

Number of Tribal entities enrolled to provide HCBS.

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

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

- See response in Section XIII.A.1

Updated Strategy 4. The State submitted a proposal to CMS and has secured the legislative authority to use the temporary 10% increase to the FMAP for certain Medicaid expenditures for HCBS to enhance, expand and strengthen the HCBS system for TPMs.

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

- Developing a pilot program that supports both the recruitment and retention of the direct care workforce in the HCBS industry. Engage workforce partners to identify financial incentives that would be meaningful to members of the workforce and impactful in terms of overall workforce availability. Consider targeted incentives for specified service types (ex. respite), enhanced training/endorsements, duration of service, and complexity of care. **(Ongoing strategy through September 2024)**

- Additional funding beyond that provided under the MFP Capacity Building Grant to develop new community services and supports offered through a series of tiered start-up grants, incentives, and supports to providers who increase their capacity to provide HCBS. Incentives may be used for Skilled Nursing Facilities or health systems who open a HCBS service line, for new providers of high priority services (ex. respite, around-the-clock services, personal care, and nursing), for existing providers who expand into new service geographies, and providers who develop capacity for complex care cases. Awards will incentivize both establishment of new service lines as well as enhancement of established delivery of service. **(Completed December 31, 2022)**

    - Additional grants have been awarded.
    - See response in Section XI.A.

- Contract with a consultant to review the training system that is currently in place to serve both QSPs and direct service providers in all HCBS service lines. Make recommendations and ensure that the training platform is culturally responsive and infuses person-centered practices, is available in multiple languages, and is delivered using modern approaches to effective adult learning. Revise the

training catalog available to the direct care workforce and establish career pathways and progressive endorsements and certifications that allow for implementation of additional initiatives within the ARPA of 2021 Section 9817 10% enhanced FMAP for HCBS funds ARPA ND State Spending Plan, including behavioral health, crisis intervention, and de-escalation competencies. **(Vendor secured recommendations expected April 1, 2024)**

- See response in Section VIII.A.9.

- Increasing transitions and diversions through flexible transition supports from institutions to HCBS settings, and to more appropriate community-based settings, depending on circumstance. An example is establishing a transition fund to supplement available resources for people who are transitioning from institutions to the community. Funds are meant to be flexible and utilized by Transition and Diversion teams to address unexpected needs that arise in the move to a less restrictive setting. Eligible uses include, but are not limited to, environmental modifications, assistive technology, security deposits, furnishings, moving costs, and utility hook-up fees. **(Target completion date December 31, 2024, or until all funds are disbursed or expended)**

Progress Report:

- The ADRL policy and application form was updated on June 23, 2023 making SPED eligible individuals who would screen at a NF LoC and are above the ADRL transition and diversion income eligible limits eligible to participate. This change has increased access to this service to additional individuals. Program staff continue to look for additional transition coordination providers. The ADRL Transition and Diversion program has assisted TPMs who do not otherwise qualify for MFP transition support to transition home from a SNF or stay in the community and receive necessary care. The program eligibility is broad and there has been a lot of referrals to the program since the project started. Additional staff are needed to meet the current demand. The State believes that using the APRA 9817 funds to hire additional staff is a good investment in the HCBS system for TPMs and other Medicaid eligible individuals.

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

Progress Report:

- Cannot assist with ongoing rent for non-target population members.
- Assist with a deposit that includes first month rent.
- Assist with utility deposit.
- Assist TPMs with past due rent with State General Funds.

- TPMs are assigned a Housing Facilitator.
- TPMs are assisted with ongoing rent with State General Funds.

- 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.

Progress Report:

- The State will procure an entity to act as an environmental modification agency that will subcontract with qualified contractors to complete environmental modification projects for eligible individuals. The entity will be able to pay deposit and material costs and will be responsible to work with the HCBS Case Manager and the contractor to follow the project until it is complete. **(Target completion date April 1, 2024)**

- Conduct a QSP Rate Innovations and Gap Analysis. This strategy would aim to identify innovative ways to adjust QSP rates so that services with potential high impact on access to HCBS for older adults and people with disabilities are better incentivized. Examples include a shift differential for QSPs who provide care at night, on weekends, and on holidays; respite care; system of “backup” or emergency care providers-of-last-resort to address high need cases or staff emergency situations; and rates adjusted for intensity**. (Completed December 31, 2022)**

Progress Report:

- Rate study was started July 1, 2022. Recommendations provided November 2022.

- Link to Qualified Service Provider (QSP) Rate Study

- See response in Section VI.D.2.

- 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. **(Updated target completion date ~~November 30, 2023~~ May 1, 2024 and ongoing)**

Progress Report:

- Aging Services has decided to work with the Behavioral Health Division to find a way to procure these services that will allow for quicker implementation. The teams will continue to meet to find the appropriate solution. Additional information will be included in future reports.

- Enhancing the HCBS delivery system requires the support of effective infrastructure. This includes technological and human resources; quality, outcomes, and other measures of success; and a relentless focus on usability of systems. Infrastructure investments should keep the person at the center of design in every system component. Support the development of a *CareToConnectJobs* platform that facilitates connections between QSPs, consumers, and families. **(Updated target completion date ~~December 14, 2023~~ January 31, 2024)**

Progress Report:

- See response in Section XII.A.

- Invest in the ADRL platform to incorporate an affordable housing database and other modifications to support user experiences. Enhance availability of resources to support LTSS Options Counseling and HCBS case management. Equip Developmental Disability and HCBS case managers with resources to facilitate efficient work from HCBS settings.

Progress Report:

- The State is working to create an additional interface between the ADRL and Case Management system to create a process that will improve the efficiencies of referrals to transition services for TPMs residing in a SNF. Work has been completed, waiting for the production date for the interface to update in the case management system **(Target completion date ~~December 31, 2023~~ January 31, 2024).**

- Establish a framework for routine, repeatable, timely access to information identified as core indicators/measures to improve quality, outcomes, and positive impact for TPMs. Define quality in each realm of the system, incorporating National Core Indicators and National Core Measures with State defined priorities. (**NCI-AD survey completed July 2023 and results are expected in 2024. The other parts of the strategy are ongoing)**

Challenges to Implementation

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

Remediation

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

Progress Report:

- The State hired one (1) additional FTE to act as quality manager for Aging Services to help implement the HCBS quality measure framework created by CMS and provide additional support to process CIRs.

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. **(Annual presentations complete date December 14, 2023)**

Challenges to Implementation

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

Remediation

In-reach visits must be conducted in person unless there is a valid documented reason why a face-face visit is not possible. When necessary, for example when COVID-19 visitation restrictions are in place, in-reach visits may be completed virtually. Staff can request to use State owned telecommunication equipment purchased for facilities with COVID-19 relief funds to facilitate virtual

communication. The State will ensure that all State employees will follow required safety procedures including the appropriate use of State provided personal protective equipment (PPE) when entering facilities. The forms used to document the details of the LTSS Options Counseling visits require the case manager to indicate if the visit was held virtually or in-person. State staff review all the completed LTSS Options Counseling forms and will address any issues if TPM meetings are being conducted virtually without a valid reason.

Progress Report:

Performance Measure(s)

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

- A total of 870 individuals attended in-reach presentations at SNFs.

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

- A total of **840 unduplicated** initial individual in-reach visits to people who were recently referred for a long-term stay in the SNF, and **1,797 unduplicated** annual LTSS OC visits were completed with SNF residents during this reporting period.

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

Progress Report:

Performance Measure(s)

Number of LTSS options counseling visits completed every six months.

- A total of 406 (unduplicated) LTSS Options Counseling visits were conducted with TPMs listed on the Daily Referral List during this reporting period. Individuals on this list have all been recently referred for a long-term stay in SNF.

- A total of 913 (unduplicated) LTSS Options Counseling visits were conducted with TPMs listed on the Annual Referral List during this

reporting period. Individuals on this list are individuals who are currently residing in the SNF whose NF LoC annual redetermination is due.

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

Resource Center staff will develop specific expertise that gives TPMs across the lifespan who are interested in transitioning to the most integrated setting appropriate, and those who want to remain in their current home environment but also need available services and supports to do so. It will create the opportunity to connect with a peer who has lived experience navigating and utilizing HCBS**. (Target completion date May 1, 2024) (Updated target completion date ~~December 1, 2022~~ ~~December 31, 2023~~)**

Challenges to Implementation

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

Remediation

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

Challenges to Implementation

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

Remediation

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

Progress Report:

Performance Measure(s)

Number of referrals for peer support and outcome.

- There were no new referrals for Peer Support by the CILs.

Number of individuals receiving information or support from new center.

- See response in Section VIII.I.4

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

Implementation Strategy

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

The ADRL intake process includes questions to assess communication needs. The State will update the LTSS Options Counseling 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)**

Progress Report:

A meeting Is scheduled in January 2024 to begin discussions on updating the DHHS and ADRL website to include information on how to request communication accommodations.

Performance Measure(s)

Number of TPMs who requested and received communication accommodation.

- Thirteen (13) requests were made by TPMs in facilities, all were accommodated.
- No requests were made by TPMs in the community.

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

Implementation Strategy

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

Challenges to Implementation

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

Remediation

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

Progress Report:

Adult & Aging Services is contracted with an agency to advertise on digital media outlets (e.g., YouTube, Facebook) to promote North Dakota's Aging and Disability Resource Link services from approximately:

- October 1 - October 31, 2023, December 1 – December 31, 2023, February 1 – February 31, 2024, April 1 - April 30, 2024.

- July 1 - July 31, 2024, October 1 - October 31, 2024, January 1 - January 31, 2025, April 1 - April 30, 2025.

- The October and December 2023 runs are complete. The campaign continues to produce high rates of individuals watching the video to completion and a high rate of individuals clicking into the website after watching the video.

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

Progress Report:

- See response above under Strategy 1.

Performance Measure(s)

Number of ADRL contacts.

- Calls – 8,193

- Web Intake – 716
- Unique Website Hits – 19,062

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

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

Progress Report:

Medicaid eligibility information is not gathered for this program therefore it is not possible to determine if individuals are TPMs.

Performance Measure(s)

Number of individuals using Lifespan respite.

- Twenty-two (22) applications were received during this reporting period.

Number of TPMs utilizing respite care with the RD rate.

- A total of nine (9) providers caring for individuals over the age of 21 received respite paid at the RD rate during this reporting period.

Number of hours of respite services provided.

- A total of 649.25 respite service hours were provided through the Lifespan Respite Care program to caregivers who provided care for individuals over the age of 21 during this reporting period.

Updated Strategy 2. The State will continue to provide education and respite services to individuals providing natural supports. The State will use additional funding provided by the ARPA to expand evidence-based training programs for TPMs and their natural supports. The State contracts with ND State University Extension and will provide funds to expand the service array to include:

- Fit & Strong an evidence-based group exercise program designed for persons with osteoarthritis (OA). Arthritis is the most common cause of disability among older adults and a major barrier to their participation in physical activity.
- CAPABLE is a client-directed home-based intervention to increase mobility, functionality, and capacity to age in their community for older adults. CAPABLE consists of time-limited services from an occupational therapist, a nurse, and a handy worker working in tandem with the older adult as an inter-professional

team. The goal is to increase the participants' capacity to function at home. **(Ongoing strategy through December 2023)**

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

Progress Report:

Performance Measure(s)

Number of individuals who attended training by service.

- Stepping On – 99
- Powerful Tools for Caregivers – 23
- Tai Ji Quan: Moving for Better Balance – 32
- Fit & Strong - 65

Number of individuals served in the CAPABLE program.

- Eleven (11) individuals enrolled.

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

Implementation Strategy

Updated Strategy. The State will continue to work with the DHHS Civil Rights Officer and the ND Department of Information Technology to review all printed documents and all online information available on the USDOJ Settlement page of the DHHS website to ensure compliance with this SA.

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

Performance Measure(s)

Number of documents converted.

- The DHHS Legal Advisory Unit and the Civil Right Officer are currently in discussions to obtain a third-party vendor to update the website and printed documents to make the online information accessible.

SA Section XV. Data Collection and Reporting

Responsible Division(s)

DHHS Aging Services

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

Updated implementation strategy

Provide the USDOJ and SME biannual reports containing data according to the SA. The State will retain all data collected pursuant to this SA and make it available to the USDOJ and SME upon request. The State will retrieve summary and aggregate data from a variety of sources including the case management system, MMIS data warehouse, and provider enrollment.

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

Progress Report:

Performance Measure(s)

Number of enhancements to the system that were completed.

- There were 21 enhancements completed in Therap from December 14, 2022 – December 13, 2023.

Strategy 2. The State will work with Aging Services business analyst and the case management vendor to design specific reports that will help the State report data required in SA, IP, and related performance measures. State staff requested several custom reports be created to simplify the data collection process and make it easier to complete case management reviews**. (Completed June 30, 2023)**

Progress Report:

- The Aging Services business analyst has worked with the vendor to complete all reports.

Case Management System Reports
Medicaid Waiver Quality Assurance Report

Medicaid Waiver Recipients with Narratives
Medicaid Waiver Goals and Assurance
Monthly Cost by Funding Source
Rural Differential SFN 212 and Rate
Count of Care Plans Completed with TPM
HCBS Cases Worked Summary
HCBS Care Plans by Service Support
HCBS Care Plans by Funding Source
Aging NCIAD Report
I&R Module Report
Housing Facilitator Transition Plan Report
Housing Services Referral Assessment Report
MFP Referrals
MFP Transitions
Financial Assessment
Informed Choice LTSS Options Counseling
Risk Assessment and Safety Plan
Participant Assessment
DOJ Complaints Assessment Report

Performance Measure(s)

Number of reports created.

- Twenty reports were created.

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

Progress Report:

A training was completed on December 7, 2022 and it was determined that their business intelligence tools would not provide more efficient reporting than the custom reports that were built. The State continues to work with the vendor to best utilize the reporting tools in the case management system.

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

Progress Report:

- See response in Section XIII.B.3

Strategy 5. 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.

Progress Report:

Key performance indicators include:

- Referrals to HCBS
- Average weighted HCBS case management caseloads
- Number of TPMs served in a skilled nursing facility (SNF)
- Number of individuals served under all HCBS funding sources
- Number of TPMs diverted from a SNF
- Number of TPMs transitioned from a SNF
- Average annual cost of HCBS and SNF care
- Average length of time from QSP application submission to enrollment
- QSP retention rate
- Number of agency QSPs enrolled
- Number individual QSPs enrolled
- Number of QSPs providing 24/7 services
- Number of QSPs by county
- Percent of CIR remediation plans initiated

Progress Report:

The reports will be posted on the DHHS website every quarter.

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHHS Aging Services and Medical Services

Implementation Strategy

The SME has drafted a Safety Assurance Plan with input and agreement from the State. The plan outlines a range of recommendations that are intended to inform and support the State's actions related to ensuring the safety of and the quality of services

for TPMs, both during the timeframe of this version of the IP, as well as throughout the duration of the SA.

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

- The State has established a consistent incident reporting and response process to be used for all critical incidents. The system captures all data recommended in the plan. The process has been documented in the policy and procedure manual. This includes how and when the critical incident report will be reported to the USDOJ and the SME. The State also developed a single data system accessible to and used by state employees authorized to investigate and/or remediate such incidents. **(Complete)**

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

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

Progress Report:

- ND will use a portion of the Vulnerable Adult Protective Services Coronavirus Response and Relief Supplemental Appropriations Act of 2021 funds to implement a unified critical incident reporting process. All vulnerable adult protective services staff will have access to the critical incident reporting form in the web-based data collection system. Reports will be collected and automatically shared electronically to the 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.

- See response in Section XIII.B.3

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

Implementation Strategy

Strategy 1. The State will provide critical incident reporting training opportunities for QSPs. Training will be provided through online modules and virtual training events. The

training will focus on the State's data system and the State's processes for reporting, investigating, and remediating incidents involving the TPM.

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

Progress Report:

Two (2) QSP Quality Improvement (QI) Program training sessions were conducted during this reporting period.

Performance Measure(s)

Number of QSPs trained on reporting procedures.

- June 30, 2023 - 26
- November 20, 2023 - 7

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

- There were 472 incidents reported during this reporting period and 380 reported during the last reporting period. That is an increase of 92 reports or 24%.

Number of virtual training events conducted.

- Two (2) virtual training events are held each quarter.

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

- Out of the 472 incidents involving TPMs, 325 (69%) were reported timely.
    - June 14, 2023 – June 30, 2023 – 23 out of 31
    - July 2023 – 53 out of 78
    - August 2023 – 62 out of 88
    - September 2023 – 48 out of 68
    - October 2023 – 55 out of 76
    - November 2023 – 51 out of 82
    - December 1, 2023 – December 13, 2023 – 33 out of 49

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)**

Progress Report:

Performance Measure(s)

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

- There are 156 QSPs agencies with 125 requiring a QI program. Nineteen (19) agencies have CQL accreditation. Total number of agencies compliant with the quality standards is 55. Sixteen (16) QSP agencies quality programs have been audited. There are 16 ARC facilities in ND. These facilities are licensed as specialized basic care facilities and therefore meet the quality requirements because of the licensing requirements that must be met.

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

Progress Report:

The NCI-AD survey is complete, results have not been received.

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

Progress Report:

Performance Measure(s)

Percent of critical incident reports submitted, by the State to the SME and USDOJ, within seven days of receiving an incident report.

- There were two (2) incidents that were reported outside of the seven (7) day timeframe.

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

Implementation Strategy

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

Challenges to Implementation

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

Remediation

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

Progress Report:

Performance Measure(s)

Percent of required remediation plans completed.

- 100% of the remediation plan initiated were completed.

Number of training events conducted.

- Two (2) virtual training events were conducted.
  - June 30, 2023 – 26 attendees
  - September 20, 2023 – 7 attendees

Number of critical incident reports submitted on time.

- See response in Section XVI.A&B.1.

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

Implementation Strategy

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

To assure the necessary safeguards are in place to protect the health, safety, 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 business day. **(Ongoing strategy)**

Progress Report:

Performance Measure(s)

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

- Out of the 472 incidents involving TPMs, 460 (97%) were reviewed timely.
    - June 14, 2023 – June 30, 2023 – 31 out of 31
    - July 2023 – 76 out of 78
    - August 2023 – 86 out of 88
    - September 2023 – 66 out of 68
    - October 2023 – 72 out of 76
    - November 2023 – 82 out of 82
    - December 1, 2023 – December 13, 2023 – 47 out of 49

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)**

Progress Report:

Performance Measure(s)

Percent of critical incident reports reviewed by State staff.

- 100% of critical incident reports received were reviewed by State staff.

Number of critical incident reports that have an associated complaint.

- There were 33 complaints involving TPMs during this reporting period.

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. Information gleaned from the review is used to identify and address gaps in the service array and inform future strategies for remediation. (**Ongoing strategy)**

Progress Report:

A list of all deaths is sent out one (1) week prior to quarterly incident reporting meeting to all Critical Incident Report team members and are documented in meeting minutes. Each death is reviewed by HCBS Case Manager and Nurse Administrator. Unexplained deaths are also forwarded to Aging Services Director to review. The Medicaid Fraud Control Unit (MFCU) has joined the CIR team.

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)**

Progress Report:

Performance Measure(s)

Number of amendments reported.

- Adult and Aging Services submitting and received approval for an amendment to the 1915 (c) Home and Community Based Services (HCBS) Waiver with an effective date of January 1, 2024, to implement a new service, and incorporate changes in services and programming approved during the 2023 legislative session.
- This includes:
    - Creating a personal care with supervision service for people who need supervision and help with personal cares. This service will help people who have intermittent care needs throughout the day.
    - Update the rate methodology for Family Personal Care and Adult Foster Care and increase the Adult Foster Care cap to $150.00 per day.
    - Allow up to 30 bed hold days per member/per year for

individuals receiving residential habilitation or community support services.

- Create a component service under extended-personal care to allow for medical escort to assist individuals in accessing needed healthcare in the community.

- Allows for electronic signature and virtual visits if there is an approved reason the visit can't happen in-person. For example, the individual has a contagious condition, infection, etc.

- Allow agency QSPs to renew every five (5) years instead of every two (2). Allow individual QSPs to renew every five (5) years with updated documentation of competency or other allowable credential at 2.5 years.

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)**

Progress Report:

Performance Measure(s)

Number of TPM complaints.

- There were 82 complaints involving TPMs during this reporting period.

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

- All 82 complaints were responded to within the required timeframe.

Link to Appendix B.

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)**

Progress Report:

The Rights and Responsibilities Brochure has been updated and posted to the DHHS Aging Services publications website and distributed to the HCBS Case Managers. Additional training on the updates was held on January 24, 2022, during the HCBS Update meeting. The application for services has also been updated and was manualized on February 1, 2022.

Appendix A

Appendix A is the Dashboard reports.

Appendix B

Complaint Type	# by Type	Pending Outcome	Unsubstantiated	Substantiated	Remediation provided
Absenteeism	16	10	3	3	3 providers have submitted and completed all necessary steps to remediate the issues successfully.
Abuse/Neglect/ Exploitation	4	0	4	0	1 report involving an agency foster care setting was unsubstantiated, however, the agency was required to address three deficiencies that were found.
Care Unacceptable to the Department	46	17	14	15	11 providers have submitted and completed all necessary steps to remediate the issues successfully. 2 providers were given technical assistance. 2 providers were terminated and placed on the State Exclusion List.
Criminal History/Activity	2	1	0	1	Agency terminated employee and involved the police.
Theft	5	0	4	1	1 report of theft was substantiated. The agency immediately terminated the employee and involved the police.
QSP Disrespectful	2	0	2	0	
Inappropriate Billing	4	3	1	0	
Breach of Confidentiality	1	1	0	0	
QSP under the influence of Drugs/Alcohol	1	0	0	1	The agency terminated the employee, involved the police, and filed a report with the CNA licensing board. No systemic issues were found with their screening or training practices.
Other	1	0	0	1	1 complaint was substantiated, the agency failed to communicate important information with the case manager. The agency introduced new policies and procedures to ensure compliance.
Total complaints associated with TPM	82	32	28	22	

Appendix C

Appendix C is the Comparison Dashboard reports.

Appendix D

USC Leonard Davis School of Gerontology

Home Modification and Repairs for Older Adults and Persons with Disabilities

AN INVENTORY OF STATE LEVEL ACTIVITIES

2022

NORTH DAKOTA

A State Profile of Home Modification Activities

NORTH DAKOTA ADULTS AND AGING SERVICES

(State Unit on Aging)
https://www.nd.gov/dhs/services/adultsaging/

State Units on Aging (SUAs) are designated state-level agencies that develop and administer state plans that advocate for and provide assistance, including home modifications or repairs, to older residents, their families, and adults with physical disabilities. SUAs administer funds, including Older Americans Act funds, which may be used to support home modification or repair services through local Area Agencies on Aging and other state and local entities**.**
Program(s) of the North Dakota State Unit on Aging with home modification or repairs include:

1. The North Dakota Adults and Aging Services Division uses **state general funds** to help individuals who are not eligible for Medicaid waiver services pay for home modifications.

2. **Expanded Service Payments for the Elderly and Disabled (Ex-SPED) Program**
   https://www.nd.gov/dhs/services/adultsaging/homecare2.html
   Program Description: This program pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility. The program covers environmental modification services. It is limited to modifying the home to enhance client independence.
   Population Served: North Dakota residents who are Medicaid and Supplemental Security Income (SSI)-eligible, meet certain Activities of Daily Living and Instrumental Activities of Daily Living Requirements, and who would otherwise receive services in a licensed basic care facility.

3. **Service Payments for the Elderly and Disabled (SPED) Program**
   www.nd.gov/dhs/services/adultsaging/homecare1.html
   Program Description: The SPED program provides limited environmental modifications that enhance independence for people who are older or physically disabled and who have difficulty completing tasks that enable them to live independently at home.

Population Served: North Dakota residents with incomes of less than $50,000; inability to pay for services; limitations with four Activity of Daily Living and five Instrumental Activities of Daily Living; capable of managing their own care; and meet other requirements.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES: MEDICAID AGENCY

Medicaid Waiver for Home and Community-Based Services

https://www.nd.gov/dhs/services/adultsaging/homecare3.html
Program Description: This waiver helps eligible individuals who would otherwise require SNF services to remain in their homes or communities. Environmental modification services are available to modify the recipient's home to enhance their ability to function as independently as possible in the home.
Population Served: Medicaid-eligible North Dakota residents at least 65 years of age or residents with a disability by Social Security Disability criteria, living in their own home or apartment, and able to direct their own care.

NORTH DAKOTA STATE ASSISTIVE TECHNOLOGY PROGRAM

North Dakota Assistive

https://ndassistive.org/
The State Assistive Technology Grant Program, funded under the Assistive Technology Act of 2004, supports comprehensive, statewide programs in each state that improve the provision of assistive technology (often home modification-related) to individuals with disabilities of all ages.

NORTH DAKOTA STATE FALL PREVENTION COALITION

North Dakota Falls Prevention Coalition (inactive)

For an up to date list of all state fall prevention coalitions, visit:
https://www.ncoa.org/resources/list-of-state-falls-prevention-coalitions/

This report was compiled by the University of Southern California Leonard Davis School of Gerontology and funded by The Administration for Community Living. All content was accurate at the time of publication. Refer to the agency website to confirm program details.

Appendix E

Adult Foster Care Workgroup Recommendations

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

Introduction:

The Adult Foster Care Workgroup further referred to as "Workgroup" was formed in December 2022 to prepare recommendations for policy changes. The Adult Foster Care Workgroup consists of State staff from multiple areas across the Department of Health & Human Services further referred to as "the Department." Adult Foster Care providers will further be referred to as "providers."

This Workgroup held six meetings across the span of six months to convey current concerns the providers have brought forth. One concern brought forth by a provider was the inability to employ a caregiver to assist with routine activities of daily living or instrumental activities of daily living. A second concern brought forth by a provider was the allotted hours annually the provider is allowed to utilize a respite caregiver.

This Workgroup listened to concerns regarding the enrollment of the providers and obstacles that detour new provider applicants or re-enrollment of current providers.

Workgroup Brainstormed Current Issues

The Workgroup formulated alternatives to increase provider satisfaction and enrollment:

- Revise current State Form Numbers (SFN) that hinder enrollment due to complexities.
- Addressed alternative respite caregiver allowances annually.
- Addressed amending Department regulations to allow for the provider to employ a caregiver(s) to assist during daily living activities while the provider is present in the home.
- Created an anonymous survey regarding questions the Workgroup formulated to increase input responses from stakeholders.

Stakeholder Meeting

The Workgroup held a Stakeholder meeting on December 5, 2023, and invited all stakeholders including Medicaid Waiver Target Population Members, family members, guardians, Department administrative and support staff, tribal representatives, qualified service providers, and other interested stakeholders.

- Emailed invitation to Stakeholder meeting with anonymous survey attached encouraging input from Stakeholders.
- The Workgroup called for feedback regarding current regulations of the Adult Foster Care program.

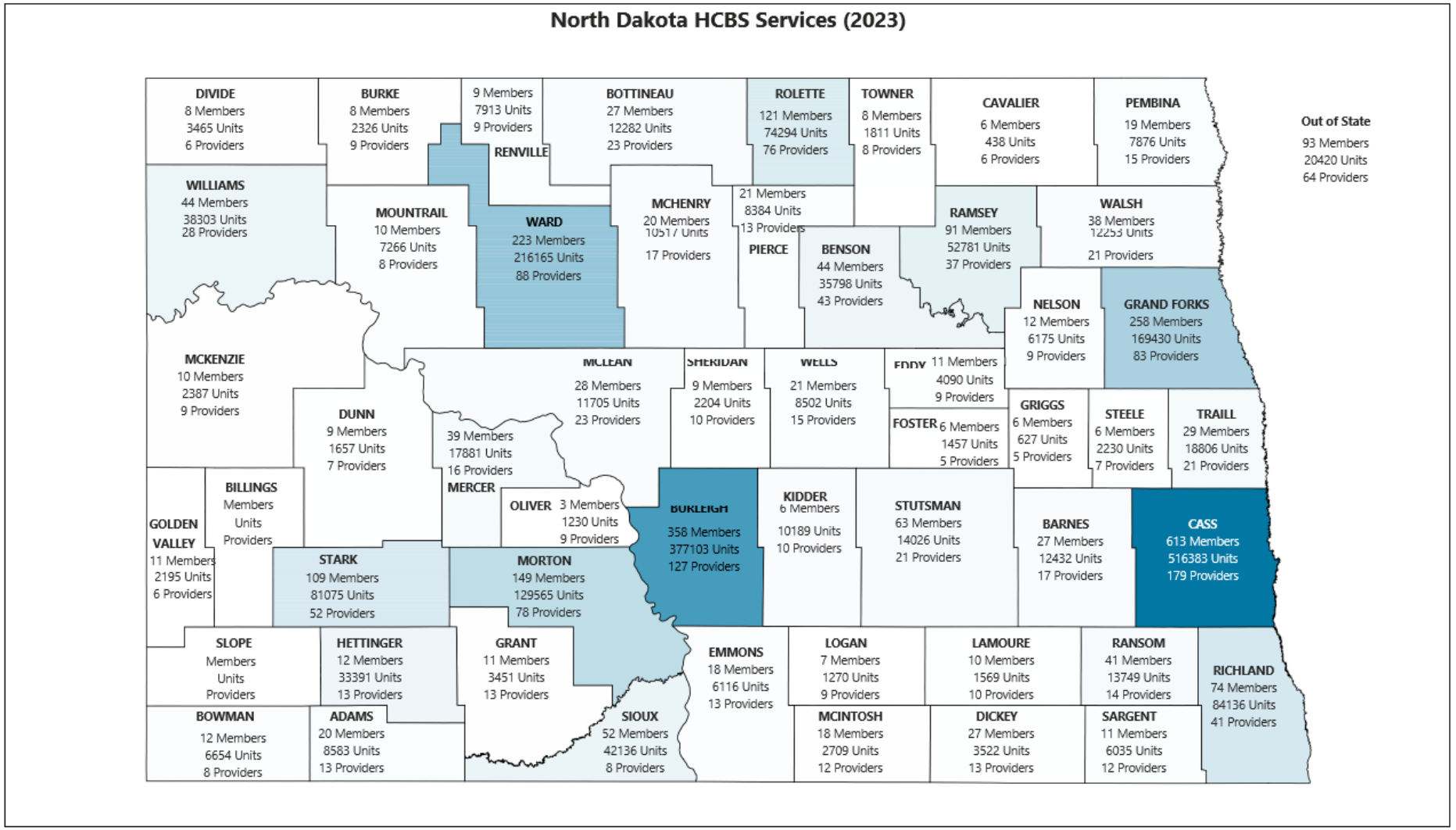
The Stakeholder meeting yielded 27 participants. A review of participants revealed that 40% of those in attendance were not employed by the Department. The survey yielded eight responses with 12.5% currently an active provider, 25.5% interested in applying to become a provider, and 62.5% government agency or other. The Workgroup reviewed the survey results, recommendations and provided opportunities for Stakeholder feedback. Having no feedback from the Stakeholder meeting verbally, written, or additional responses to survey, the Stakeholder meeting was ended.

The Workgroup convened on December 20, 2023, to review the survey results and recommendations from Stakeholder feedback. Discussions regarding the next steps to proceed with making changes to current regulations and rules were reviewed. Barriers to changes were addressed and a plan was formulated to proceed with the Stakeholder and Workgroup recommendations.

Conclusion

Stakeholders provided results regarding the need for an increase in allotted hours for the provider to use respite was determined to need no amendment to current rules or regulations. Stakeholder input revealed the ability of the provider to employ a caregiver to assist with routine daily activities would be beneficial to improve the experience of the Target Population Member and provider. The Workgroup will proceed with a plan to amend current regulations modeling other States with approved use of a provider employing a caregiver(s). The Workgroup will determine method(s) to simplify enrollment as a provider to attract more providers. If the provider pool increases this will improve the Target Population Members' satisfaction with the choice of provider to best fit the needs of the individual.

Appendix F


North Dakota HCBS Services (2023)
DIVIDE
8 Members
3465 Units
6 Providers
BURKE
8 Members
2326 Units
9 Providers
9 Members
7913 Units
9 Providers
RENVILLE
BOTTINEAU
27 Members
12282 Units
23 Providers
ROLETTE
121 Members
74294 Units
76 Providers
TOWNER
8 Members
1811 Units
8 Providers
CAVALIER
6 Members
438 Units
6 Providers
PEMBINA
19 Members
7876 Units
15 Providers
Out of State
93 Members
20420 Units
64 Providers
WILLIAMS
44 Members
38303 Units
28 Providers
MOUNTRAIL
10 Members
7266 Units
8 Providers
WARD
223 Members
216165 Units
88 Providers
MCHENRY
20 Members
17 Providers
21 Members
8384 Units
13 Providers
PIERCE
BENSON
44 Members
35798 Units
43 Providers
RAMSEY
91 Members
52781 Units
37 Providers
WALSH
38 Members
21 Providers
NELSON
12 Members
6175 Units
9 Providers
GRAND FORKS
258 Members
169430 Units
83 Providers
MCKENZIE
10 Members
2387 Units
9 Providers
DUNN
9 Members
1657 Units
7 Providers
MCLEAN
28 Members
11705 Units
23 Providers
SHERIDAN
9 Members
2204 Units
10 Providers
WELLS
21 Members
8502 Units
15 Providers
EDDY
11 Members
4090 Units
9 Providers
FOSTER
6 Members
1457 Units
5 Providers
GRIGGS
6 Members
627 Units
5 Providers
STEELE
6 Members
2230 Units
7 Providers
TRAILL
29 Members
18806 Units
21 Providers
39 Members
17881 Units
16 Providers
MERCER
BILLINGS
Members
Units
Providers
GOLDEN VALLEY
11 Members
2195 Units
6 Providers
OLIVER
3 Members
1230 Units
9 Providers
BURLEIGH
358 Members
377103 Units
127 Providers
KIDDER
6 Members
10189 Units
10 Providers
STUTSMAN
63 Members
14026 Units
21 Providers
BARNES
27 Members
12432 Units
17 Providers
CASS
613 Members
516383 Units
179 Providers
STARK
109 Members
81075 Units
52 Providers
MORTON
149 Members
129565 Units
78 Providers
SLOPE
Members
Units
Providers
HETTINGER
12 Members
33391 Units
13 Providers
GRANT
11 Members
3451 Units
13 Providers
EMMONS
18 Members
6116 Units
13 Providers
LOGAN
7 Members
1270 Units
9 Providers
LAMOURE
10 Members
1569 Units
10 Providers
RANSOM
41 Members
13749 Units
14 Providers
RICHLAND
74 Members
84136 Units
41 Providers
BOWMAN
12 Members
6654 Units
8 Providers
ADAMS
20 Members
8583 Units
13 Providers
SIOUX
52 Members
42136 Units
8 Providers
MCINTOSH
18 Members
2709 Units
12 Providers
DICKEY
27 Members
3522 Units
13 Providers
SARGENT
11 Members
6035 Units
12 Providers

Appendix G QSP Hub

Overall Program Expectation: Establish a Resource Center to assist and support the Qualified Service Providers (QSPs) workforce serving North Dakota's communities.

	Completed/Ongoing
	In Progress

Outcome 1: A Direct Care Resource Center is established to provide technical assistance that will address the needs of individual QSPs, QSP agencies, and family members/informal support providing supportive services.

Objectives	Key tasks	Responsible Parties	Measurable Outcomes	Time Frame
Develop an infrastructure and create implementation plan and processes for the Resource Center.	Hire a full-time Coordinator and other project staff to develop and implement the project activities.	QSP HUB	Coordinator and appropriate staff are hired.	April 2022
	Create a strategic plan outlining how technical assistance, training, and support will be provided to Individual QSP Providers and QSP Agencies who provide home and community-based services to eligible individuals.	QSP HUB	Strategic plan is created and implemented.	March 2022
Provide technical assistance to QSPs and QSP agencies.	Create electronic, HIPAA-compliant system to track technical assistant contacts and indirect contacts with QSPs and QSP agencies.	QSP HUB	Tracking system is created and operational.	July 2022
	Assist with enrollment and reenrollment process: • Obtaining an NPI number • Completion of enrollment/application paperwork • Understanding and securing technology needed to utilize EVV and Therap.	QSP HUB & ND DHHS Aging Services	Number of contacts and subject matter of contact visits	May 2022

	• Authorization process and interaction with HCBS Case Management • Understanding of the full scope of available services and the varying requirements and enrollment processes • Support QSP agencies with the CQL or other accreditation application process • Aid QSPs interacting with Medicaid and Medicaid Vendor for enrollment processes by maintaining an understanding of the documentation requirements and program integrity rules		are documented.	
	Assist with electronic verification and billing processes.: • Understand and complete billing process for services provided. • Utilization of the Electronic Visit Verification System and Therap Systems • Authorization for services requirements • **Information about Medicaid and State HCBS Funding/payment including Client Share (Recipient Liability) billing issues by developing materials for consumers about how these services are important and that they need to pay client share etc.** • Authorization process and interaction with HCBS Case Management	QSP HUB & ND Aging Services	Number of contacts and subject matter of contact visits are documented. Consumer materials are developed.	May 2022
	Assist with enrollment and reenrollment process: - Develop a "pre" enrollment orientation that will be required for every QSP/QSP Agency upon application submission	ND QSP HUB	Develop Content	January 2024
	- Facilitate live and recorded opportunities to complete the required pre-enrollment orientation.	QSP HUB	Live meetings scheduled, recorded (modules?)	January 2024

			information available	
	- Provide data of completed training participants to enrollment to aid in completion of applications.	QSP HUB	Data collection plan and system is in place	January 2024
Utilize data & evaluation to inform and improve the effectiveness of the Resource Center.	Conduct a needs assessment of QSPs and QSP agencies to determine current capacity and unmet needs.	QSP HUB	Survey is conducted and results are analyzed.	April 2022
	Develop and implement ongoing evaluation tools and process to assess technical assistance, training and training tools provided to QSPs and QSP agencies.	QSP HUB	Evaluation plan is created, implemented, and modified as needed.	October 2022
	Develop post survey questions specifically for QSP's no longer working in the field.	QSP Hub & ND Aging Services	Create survey	August 2023
	Survey QSP agencies and individual QSPs that are no longer working as a QSP to identify challenges and barriers resulting in discontinuing employment. Review survey results with NDHHS and create a list of suggested changes that will encourage retention of QSP's.	QSP Hub & ND Aging Services	Survey will be conducted, and results analyzed	Bi- Annually Spring & Fall

Outcome 2: Organizational and collaborative relationships are established to create a foundation for the Resource Center.

Objectives	Key tasks	Responsible Parties	Measurable Outcomes	Time Frame
Develop an advisory workgroup comprised of key stakeholders to provide guidance and advice to the Resource Center.	Identify and recruit advisory workgroup members from QSP agencies, individual QSPs, state and tribal service providers.	QSP HUB	Participation from key stakeholders is secured; advisory committee roles and responsibilities are established	Spring 2023
	Host quarterly meetings: including scheduling, promoting, developing agenda, facilitating, and providing follow up.	QSP HUB	Meeting schedule is established; meetings are recorded. Number of attendees at each meeting is documented and tracked in TruServe.	Spring 2024
	Review information and provide feedback for needs assessments, evaluations, trainings, and TA tools.	QSP HUB & DHHS	Evaluation plan is developed and implemented.	Spring 2024
	Develop recommendations for the DCRC and for ND DHHS Aging Services and Medical Services.	QSP HUB & DHHS	Recommendation report developed and submitted to DHS	Spring 2024
Develop processes to remain informed of current CMS and ND	Participate in regularly schedule meetings with ND DHHS Aging Services and Medical Services.	QSP HUB & ND Aging Services	Meeting schedule is established;	January 22, ongoing

DHHS policies and procedures.			meetings are recorded.	
	Participate in all ongoing QSP training sessions held or sponsored by ND DHHS and integrate updated information into DCRC training materials.	QSP HUB & ND Aging Services	Training session attendance is documented.	January 2022, ongoing
	Establish a communication process between DCRC and Aging Services that will allow updated and accurate information to be shared in a timely manner.	QSP HUB & ND Aging Services	Communication process is established and implemented to ensure accurate information is provided to QSPs.	February 2022 ongoing

Outcome 3: Individual QSPs, QSP agencies, and family members providing support services have access to dynamic education and training opportunities that will meet their needs.

Objectives	Key tasks	Responsible Parties	Measurable Outcomes	Time Frame
Determine training needs of the current direct service workforce and create a topical list and best mode for various topics.	Conduct assessment of QSPs, QSP agencies and family caregivers to determine training tracks and the best mode for training.	QSP HUB	Survey is conducted and results are analyzed.	February 2022 Ongoing
	Review topical suggestions and training tracks with advisory workgroup.	QSP HUB	Survey results are reviewed by advisory	April 2022 ongoing

			committee and recommendations are made to ND Aging Services	
	Coordinate and advertise monthly QSP orientation sessions in cooperation with the ND DHHS Aging Services.	QSP HUB & ND Aging Services	Orientation sessions are scheduled and held on a regular basis. Attendance is documented and tracked. Feedback is collected.	August 2022 Ongoing
Create categorical training series	Establish Hub team with content-expertise from including but not limited to, ND DHHS Aging Services and Medical Services, and experienced QSPs.	QSP HUB	Participation content-experts is secured; Hub team roles and responsibilities are established.	Fall 2022
	Determine possible educational tracks i.e.: General, Clinical, Individual, & Agency Tracks, and the frequency of trainings.	QSP HUB	Training topics and schedules are created and advertised. Participation is documented.	Fall 2022 Ongoing
	Facilitate regular meetings with Hub team to review evaluations and determine future speakers/topics.	QSP HUB	Hub team and DCRC review participant feedback and modify training schedule as needed.	Spring 2023 ongoing

Develop partnerships and training resources for competency certifications	Establish partnership with Train ND through Lake Region State College for QSP training and individual skill building/signoff.	QSP HUB	Processes and procedures are agreed upon; participation is documented.	February 2022
Provide information about access to available Tribal Targeted Case Management Training processes.	QSP Hub will redirect questions regarding tribal targeted case management to either NDHHS regarding case management training or the National Center on Native American Aging for gerontology training.	QSP HUB	Calls regarding Tribal training tracked.	October 2023
Create easily accessible, topic-specific TA tools (toolkit, cheat sheets, guides) for QSPs, QSP agencies and family caregivers.	Create and share FAQs tools based on the feedback from advisory group and QSPs	QSP HUB	TA tools are created and submitted for review.	Spring 2024, ongoing as needed
	Create an onboarding toolkit with guided enrollment forms.	QSP HUB	Onboarding toolkit is created and submitted for review.	Spring 2022
	Partner with EVV contractor, Therap, to develop billing support materials.	QSP HUB	Billing support tools are developed and shared with QSPs.	Fall 2022
	Translate and TA tools into multiple languages as needed by providers.	QSP HUB & ND Aging Services	Multilingual TA tools are created and distributed as needed.	Spring 2023

Outcome 4: A sustainable network of supportive services and expertise exists and is accessible for individual QSPs, QSP Agencies and family caregivers.

Objectives	Key tasks	Responsible Parties	Measurable Outcomes	Time Frame

Develop an informational network for QSPs and family caregivers.	Create a website to provide relevant and accurate information to QSP caregivers.	QSP HUB	Website is created and web traffic is monitored and tracked.	Fall 2022
	Develop process for notifying QSPs, agency QSPs and family caregivers of required changes, updated information, and educational opportunities.	QSP HUB	Process is created and accurate information is shared regularly.	May 2022
Identify resources that will support the QSP services delivery and success.	Collaborate and develop partnerships with support organizations, advocates, and content experts to learn of and share opportunities.	QSP HUB & ND Aging Services	Stakeholders are identified and partnerships are developed through frequent interactions.	Summer 2022
	Provide requested resources and link QSPs with appropriate expertise.	QSP HUB & ND Aging Services	Requested information is researched and shared with QSPs. Contacts are documented.	Summer 2022
Create a mentoring network system for new QSPs & new QSP agencies	Recruit and vet experienced QSPs to serve as mentors that would provide mentoring supports related to managing QSP duties, scheduling, back up help etc.	QSP HUB & ND Aging Services	QSPs are surveyed and a list is created of experienced QSPs willing to provide mentorship. DCRC helps match up mentor and mentee.	Fall 2023
	Create and coordinate mentor training that is approved by the ND DHHS.	QSP HUB & ND Aging Services	Mentor training is developed, approved, and implemented.	Fall 2023

	Evaluate need for compensation and provide any compensation determined appropriate to QSP mentors for the provision of mentoring services.	QSP HUB	Experienced QSPs are surveyed, and feedback is provided to ND Aging Services.	Fall 2023

Outcome 5: Strategic recruitment processes are identified and implemented to increase the total of number of QSP agencies and individual QSPs serving North Dakota communities.

Objectives	Key tasks	Responsible Parties	Measurable Outcomes	Time Frame
Develop recommendations and strategies to make the QSP application process easier.	Survey current QSP agencies and individual QSPs to identify challenges and barriers to the current QSP application process.	QSP HUB	Survey is conducted and results are analyzed.	April 2022
	Review survey results with advisory workgroup and create a list of suggested changes for the QSP application process to present to ND Aging Services.	QSP HUB	Survey results are reviewed by advisory committee and recommendations are made to ND Aging Services	Summer 2022
Develop sustainable recruitment strategies to increase the current amount of individual QSPs and QSP Agencies	Identify and utilize the expertise of area small business development organizations to help QSP agencies start, manage, and grow their businesses.	QSP HUB	Subject matter experts are identified and matched with those requesting assistance.	Spring 2023

	Coordinate outreach activities to promote QSP career opportunities to target populations including high school students; college students or adults who want to work part or full time; retirees who want to help in their communities.	QSP HUB	QSP career information is presented at high school and college career fairs. Community outreach events are scheduled and held to inform and recruit. Number of outreach events and number of attendees at events are documented and tracked in TruServe.	Fall 2023
	Create specific materials for virtual career fairs, community events and targeted to career counselors and work source professionals.	QSP HUB	Recruitment materials are created and distributed to high schools' career offices, higher education career offices, ND Job Service, employment services, etc. Number of recruitment materials distributed is	Fall 2023

			tracked in TruServe.	
	Post card Project: MFP - Create - Mailing out - Create a digital platform for QR Code and data. - Provide Data from QR Code	QSP Hub		August/September 2024
Partner with state agencies to establish QSP agency recruiting and development programs.	Coordinate and provide a monthly "Are you interested in becoming a QSP" webinars with call-in capability.	QSP HUB & ND Aging Services	Monthly webinars are scheduled and held. Attendance is documented.	Summer/Fall 2023

Pop up sessions
Be more Colorful recruitment video.

Outcome 6: Individuals that are self-directing their Home and Community-Based Services will have access to accurate, user-friendly information, tools, and expertise that empower them to make informed choices and better manage their HCBS services.

Objectives	Key tasks	Responsible Parties	Measurable Outcomes	Time Frame
Provide information to individuals self-directing. HCBS services that aids them with managing their services.	Coordinate virtual and community educational sessions in collaboration with ND Aging Services, for target population and service providers that focus on current HCBS processes and relevant topics.	QSP HUB & ND Aging Services	Virtual and community sessions are scheduled and held. The number of participants at	Spring 2024

			each session will be documented and tracked in TruServe. Feedback from post-session Qualtrics surveys is shared with advisory group and ND Aging Services.	
	Create a toolkit for HCBS clients on self-directing services providing detailed information on topics such as how to choose your provider, allowed services, conflict resolution, etc.	QSP HUB & ND Aging Services	HCBS client toolkit is drafted, reviewed approved by ND Aging Services, and shared with HCBS clients. Number of toolkits distributed in hard copy format is documented. Number of electronic toolkit downloads is documented.	Spring 2024
	Collaborate with ND Aging Services to help target population members identify and locate appropriate technical assistance.	QSP HUB & ND Aging Services	HCBS client outreach and feedback will determine technical assistance requested. This information will be	Fall 2022

			shared with ND Aging Services and DCRC will connect client. Client contacts will be documented.	