STATE OF NORTH DAKOTA

COMPREHENSIVE WORKING PLAN TO ENHANCE COMMUNITY SERVICES IN RESPONSE TO *OLMSTEAD*

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Background and Summary of the *Olmstead* Decision

On June 22, 1999, the United States Supreme Court decided *Olmstead v. L.C.*[1] in which the Court determined that it is a form of discrimination under the Americans with Disabilities Act of 1990 (ADA) if a state fails to find community placements for institutionalized individuals with mental disabilities when three factors are present:

1. The state's treatment professionals have determined that community placement is appropriate;

2. The individual does not oppose the transfer to a community setting; and

3. The placement can be reasonably accommodated taking into account the resources available to the state and the needs of others with mental disabilities.

Facts of *Olmstead* Case

The case involved two women, L.C. and E.W., who are mentally retarded and also suffered from mental illness. Both women had a history of treatment in institutional settings. When L.C.'s condition stabilized, the state's treatment team agreed that her needs could be met in a community-based program. Despite this evaluation, L.C. remained institutionalized for nearly three more years. Approximately one year after E.W. was confined to an institution, the state's psychiatrist concluded that she, too, could be treated appropriately in a community-based setting.

In May of 1995, these women filed a lawsuit against the state of Georgia in Federal District Court challenging their continued confinement as an illegal form of discrimination based on disability.

Applicable Law

The portion of Title II of the ADA at issue in the *Olmstead* case provides:

> . . . no qualified individual with a disability shall, by reason of such disability be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. 42 U.S.C. § 12132.

[1] *Olmstead v L.C. ex rel. Zimring*, 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540 (1999)

A “public entity” includes any state or local government and any department, agency or special purpose district. 42 U.S.C. 12131(1)(A),(B).

A federal regulation requires recipients of federal funds to administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons. 28 C.F.R. 41.51(d) (1998). The “integration” regulation further provides that a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. 28 C.F.R. 35.130(d) (1998). The “reasonable modifications” regulation, provides:

> A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity. 28 C.F.R. 35.130(b)(7) (1998).

Supreme Court Analysis

The Supreme Court determined that unjustified isolation is discrimination based on disability and each disabled person is entitled to treatment in the most integrated setting possible for that person. However, the Court also recognized the states’ need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities and the state’s obligation to administer services with an even hand.

The Court found that a state may rely on the reasonable assessments of its own professionals in determining whether an individual meets the essential eligibility requirements for habilitation in a community-based setting. However, there is no federal requirement that community-based treatment be imposed on patients who do not desire it. The Court acknowledged that a state’s responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The law requires “reasonable modifications” to avoid discrimination and allows states to resist modifications that entail a “fundamental alteration” of the state’s services and programs.

The Court indicated that in order to prove that a state has maintained a range of facilities and administered services with an even hand, the state could demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the state’s endeavor to keep its institutions fully populated.

What Does *Olmstead* Require

The Court held that unjustified isolation is properly regarded as discrimination based on disability. To avoid such discrimination, states are required to provide community-based services to individuals with disabilities when the three criteria above are met. However, states are only required to make "reasonable modifications" to avoid discrimination. A state's obligation is not boundless. A "comprehensive working plan" can show that a state has maintained a range of facilities and services. The Court also found that a state can show compliance with the ADA if the state has a waiting list for community-based services that moves along at a "reasonable pace". States may lawfully resist modifications that entail a "fundamental alteration" of the state's services and programs.

SECTION II – THE STATE'S PRE-*OLMSTEAD* HISTORY OF DEINSTITUTIONALIZATION AND CURRENT ACTIVITIES

The State's Efforts to Deinstitutionalize Individuals With Developmental Disabilities

In 1980, the Association for Retarded Citizens (ARC) filed a lawsuit in Federal court against the State of North Dakota alleging constitutional violations on behalf of a class of individuals with developmental disabilities. The suit sought less restrictive, community-based alternatives for care of these individuals than the State institutions in which they then resided.[2]

In reaching a decision, the Federal court noted that there was little consensus among the experts who testified on what constitutes an "institution". The court instead focused on requiring the state to ensure that it cares for individuals with developmental disabilities in the "least restrictive setting" possible. The court acknowledged that institutions could not be entirely done away with as there will always be some number of people who, because of the complexity of their needs and severity of disability, will have to be congregated for care.

For the past twenty years and long before the *Olmstead* decision, the state of North Dakota has been working to ensure that persons with developmental disabilities are being cared for and treated in the least restrictive environment possible. Since the 1960's – when the Developmental Center had over 1,200 residents between its two facilities in Grafton and Dunseith – the resident census has declined to the current level of approximately 137 people. This decrease was a direct result of the availability of the first psychotropic medications and increased community-based supports including the establishment of eight

[2] Association for Retarded Citizens v. Olson, 561 F. Supp. 473 (D.N.D. 1982), aff'd, 713 F.2d 1384 (8th Cir. 1983).

regional human service centers and a growth in the number of private providers. Because of these factors a facility located in Dunseith, North Dakota was closed in December of 1987 leaving the Developmental Center at Grafton as the sole, specialized residential facility in the state. As mentioned, the ARC v. Olson lawsuit prompted improvements in residential options. The resident census dropped to 250 by 1989.

During the 1990's a number of programs were initiated, aimed at further reducing the number of admissions to the Center, while enhancing available services. For instance, the ERIC (Evaluation, Respite, Intake, and Consultation) unit was established to allow more rapid response to regions referring for admissions and to provide informal intervention to prevent admissions. This was later replaced with the new, comprehensive CARES (Clinical Assistance, Resources, and Evaluation Services) program, which was established to ensure high-quality and systematic assistance to private providers and human service centers. Today, the Developmental Center continues to provide needed services and supports to people enabling them to be viable citizens in their communities.

The State's Efforts to Deinstitutionalize Individuals with Mental Illness

For the past 50 years, the North Dakota State Hospital[3] has shown a gradual decrease in the average daily census of hospitalized patients from over 2,500 patients in 1950 to approximately 160 today. A number of factors contributed to this evolution including the availability of the first psychotropic medications, establishment of eight regional human service centers that provide mental health services in the community, and more admission screening.

During the 1990's through to the present day, a dramatic shift occurred away from a more centralized hospital model to one that includes a wider array of community-based services. As a result, the hospital's patient population significantly decreased. This began during 1989 when a change in state law required all voluntary admissions to the State Hospital to be prescreened at one of the regional human service centers.[4] Consequently, more individuals were diverted to community services. The census at the hospital decreased from over 500 patients to approximately 275 patients. Because of this decrease, hospital patient care areas were reduced from 17 to 10 patient care areas. Greater emphasis was placed on case management and other community-based options.

The daily patient census continued to decline during subsequent biennia because of improved screening criteria and an increased focus on shortening the length of stay. The establishment of an 8-bed transitional living facility on the hospital's campus allowed for a less restrictive level of care for individuals who had reached maximum benefit of hospitalization but awaited placement in other

[3] The State's only psychiatric hospital
[4] N.D.C.C. § 25-03.1-04

community facilities. A strong emphasis from the Department of Human Services was placed on integrated case management, serving the whole person with home and community based services where possible.

In order to assist the human service centers with developing new community services, hospital funding was shifted to the human service centers. During the 1997 – 1999 biennium, two additional patient care areas in the hospital closed. A chemical dependency treatment patient care area was able to be closed due to increased community service provision, and a geropsychiatric patient care area closed when patients were transferred to a specialized community program in Valley City. This reduced the total number of hospital patient care areas to eight. In further expanding treatment options, the chemical dependency service unit established a residential level of care to decrease costs for patients who do not require intensive medical services. A 30-bed revocation program using hospital addiction professionals was also established at the Jamestown Law Enforcement Center in collaboration with the Department of Corrections and Rehabilitation.

A further change in state law, requiring that all potential admissions to the State Hospital (both voluntary and involuntary) be prescreened by one of the eight Regional Human Service Centers, became effective in 1999.[5] State Hospital and human service center staff met again with local stakeholders in each region to provide education about the change in screening requirements as part of a continuing focus on providing community-based care. Hospital staff continues to collaborate with human service center staff in further developing needed community-based services. The Division of Mental Health and Substance Abuse meets quarterly with State Hospital and regional human service center staff to discuss admissions and discharge procedures and challenges. Overall, diversification of levels of care and focus on specialized services has occurred simultaneously. The State Hospital continues to provide services for individuals whose needs exceed available community-based services and focuses on minimizing the length of stay in order to facilitate prompt return to the community.

The State's Efforts to Provide Community-Based Services

Developmental Disabilities

North Dakota was one of the first States to receive a Medicaid Home and Community Based Care waiver for individuals with developmental disabilities. In 1984, the first year of the waiver, 68 people received home and community based care services. Since then, there has been steady growth in the Home and Community Based Care waiver program, with 3,077 people choosing this service option in the Waiver year ending March 31, 2005.

[5] *Id*.

In 1982, the majority of individuals with developmental disabilities receiving residential supports received those supports in settings serving sixteen or more individuals, with the fewest number of individuals receiving their supports in settings serving six or fewer. In 1999, the majority of individuals with developmental disabilities receiving residential supports received those supports in settings serving six or fewer individuals, with the fewest number receiving their supports in settings serving sixteen or more.

Not counting the Developmental Center, there are 122 community group homes across North Dakota licensed to provide services to persons with developmental disabilities. Of these, 113 are licensed to provide services to 8 or fewer persons, with 53 licensed to provide services to 6 or fewer persons. Additionally, over 960 persons are supported in their own home or apartment through individual services offered by licensed providers, county social service boards or qualified service providers. In the area of services and supports to families, early intervention services are available for infants with a developmental delay, family subsidy payments are available to assist with the extraordinary cost of caring for a child with a developmental disability, and family-centered services are available to support the primary caregiver in meeting the health, developmental, and safety needs of the eligible individual.

Of the 122 community group homes in the State, none are currently located in Indian Country. In order to assure their children stay in their community, a group of elderly parents of individuals with disabilities on the Turtle Mountain reservation are working to establish an assisted living facility on the reservation that will care for their adult children. Without such a housing option, there is a high probability these individuals will need to leave their tribal community. In terms of keeping people in the most integrated setting, staying on the reservation and being cared for by your own is the next best thing if there is no family able to provide the care. In addition, Lake Region Human Service Center is exploring the feasibility of locating a developmental disabilities case manager in Rolette County.

The Centers for Medicare & Medicaid Services approved North Dakota's request to implement Independence Plus self-directed supports waivers for children and adults with mental retardation and developmental disabilities effective April 1, 2006. Self-directed supports will give people with developmental disabilities and their families greater choice and control in making decisions and obtaining support, and allow them the option of directing a fixed amount of public dollars through an individual budget. The self-directed supports waivers are based upon the belief that in order for eligible individuals with developmental disabilities and their families to fully participate in their community, they must define the life they seek and be supported as they direct a mixture of generic and formal supports that will help them achieve their personally defined outcomes.

The Fifty-ninth North Dakota Legislative Assembly required the Department, with input from developmental disabilities service providers, to develop during the 2005-2006 interim, a plan to transfer appropriate individuals from the Developmental Center to community placements and begin the transfers during the 2005-2007 biennium[6]. The Department must report to the legislative council regarding its plan and the anticipated number of individuals that will be transferred to more community-like settings. The Department convened a workgroup made up of developmental disabilities services providers, advocates, consumer family members, and various divisions within the Department which determined that its goal would be to place 21 residents of the Developmental Center into community settings. The goal is to reduce the population of individuals with developmental disabilities at the Developmental Center and the State Hospital from 137 to 127 by July 1, 2007. The transition goal for July 1, 2009, is a maximum population of 97 individuals and the transition goal for July 1, 2011 is a maximum of 67 individuals residing at the Developmental Center. The workgroup also intends to develop the care infrastructure in the community, and to determine the long-term viability and role of the Developmental Center.

Aging Services

The Aging Services Division provides funding for home and community-based services to individuals age 60 and older through the Older Americans Act of 1965 (OAA) to individuals with disabilities through the telecommunications equipment distribution program; to caregivers through OAA funding; and to older persons and persons with physical disabilities through coordination with the Department's Medical Services Division. This OAA funding is also provided through Aging Services Division (Title III) and through the Administration on Aging (Title VI) to the Tribes. Individuals with disabilities who are under the age of 60 are eligible for OAA funded congregate or home-delivered meals if they reside in a housing facility that has a congregate meal site or if they reside in a non-institutional setting with a person who is 60 years of age or older.

Available services funded by the OAA include: congregate and home-delivered meals, outreach, health maintenance, transportation, information and assistance, vulnerable adult protective services, legal services, senior companion services, home injury prevention, education and advocacy, and the National Family Caregiver Support Program. In federal fiscal year 2005, 28,487 persons in North Dakota received OAA services. In addition, the long-term care ombudsman program served residents of nursing homes, basic care facilities, sub-acute units, and swing-beds; and tenants of assisted living facilities. Guardianship services for vulnerable adults who are not eligible for developmental disabilities guardianship services are also available. The Lake Region Human Service Center also assesses reports of suspected abuse, neglect, self-neglect or exploitation of a vulnerable adult on both the Spirit Lake and the Turtle Mountain

[6] Section 16 of 2005 House Bill no. 1012

Reservations through a memorandum of understanding with the Tribal governments.

Service Payments for the Elderly and Disabled (SPED) and the Medicaid waiver for the aged and disabled were implemented in 1983 to reduce reliance on institutional care by offering quality services in an alternative setting. Through the development of a consumer-focused, affordable social model delivery system, services are provided for the aged and individuals with physical disabilities, who, because of their impairments, have difficulty completing activities that would allow them to remain in their own home. A targeted Medicaid waiver for individuals with traumatic brain injury (TBI) was implemented in 1994; the Expanded SPED program was implemented in 1995, as a companion program to the Basic Care Assistance Program. The number of unduplicated recipients served by the SPED program has grown from 356 in fiscal year 1984 to 1,990 in 2005. For the fiscal year 2005, the Expanded SPED program served 225 clients. Available services include: case management, homemaker, personal care, adult family foster care, respite care, adult day care, non-medical transportation, chore services, emergency response system, environmental modification, specialized equipment and supplies, family home care, residential care services and transitional living services. Because these services allow the individual to choose their own provider, utilization of qualified service providers in Indian Country has been positive. Presently, two tribal programs, the Trenton Indian Service Area and the MHA Elders Organization of the Three Affiliated Tribes have enrolled as qualified service providers.

The most recent service added through funding provided under the OAA is the National Family Caregiver Support Program. This program provides a number of support services to informal caregivers of persons over the age of 60 and to grandparents or other older relatives who are over age 60 and providing care to children age 18 or younger. The service is accessed through the caregiver coordinator located at each of the regional human service centers. Services provided include: information, assistance, individual or family counseling, organization of support groups, individual training and respite care. The Administration on Aging also provides direct funding to each of the Tribes in North Dakota to provide services through the National Family Caregiver Program.

The Department's Aging Services Division is also midway through the implementation of an Alzheimer's disease demonstration grant. The purpose of the three-year demonstration grant from the Administration on Aging is to develop and implement a systems-change approach to save public expenditures by activating disease management efforts and helping families use community-based supports to significantly delay out of home placement of individuals with Alzheimer's disease and related dementias. The grant is focusing on building an alliance between the medical community, the community services network, and

the National Family Caregiver Support Program to increase early dementia identification, treatment options, and caregiver respite.

The Department was successful in making application for a Real Choice Systems Rebalancing Initiative Change Grant, funded by the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. The three-year demonstration grant brings North Dakota stakeholders and consumers into a process to gather information and build consensus on: a system for rebalancing state resources for services for the elderly, people with disabilities, and their families in strengthening self-directed services in communities; development of a new system to provide a single point of entry for services for elderly and people with disabilities who are considering long-term home and community-based services and institutional services in North Dakota; and practical and sustainable public information services for access to all long-term care. The rebalancing initiative will result in a plan and potential legislation for rebalancing resources and developing a single point of entry for long-term care services.

The Department is also working with a guardianship task force to implement state legislation addressing the guardianship needs of vulnerable adults who are not eligible for developmental disabilities guardianship services. Guardianship standards have been developed, training will be conducted in July 2006, and direct services will be provided through contract during the 2005-2007 biennium.

Additionally, the Department's Aging Services and Mental Health and Substance Abuse divisions have partnered with the Mental Health Association to sponsor regional trainings on mental health issues and older persons and continue to work with the Division of Mental Health and Substance Abuse to enhance mental health services for older adults. The Department has contracted with North Dakota State University to provide regional training for natural caregivers to enhance identification of mental health concerns in the elderly and increase access to services. The Department coordinated with the Indian Affairs Commission in relation to their Olmstead Commission Real Change initiative regarding making home and community-based services culturally relevant; and with the Community of Care project in rural Cass County, also funded by the Olmstead Commission. As a result of the Indian Affairs Real Change Initiative, some tribes in North Dakota requested legislative action during the 2005 session that would have clarified that tribes (in addition to counties) could provide case management services. The bill was not successful, but it helped to create a legislative interim committee that is studying tribal and state issues.

Aging Services also organized, facilitated and participated in a broad-based workgroup to address enabling state legislation regarding the "money follows the individual" concept for care. In 2003, the Legislative Assembly passed Senate Bill no. 2330 which states that, to the extent permitted by any applicable waiver, an individual's medical assistance (Medicaid) funds must follow the individual for

whichever service option the individual selects, not to exceed the cost of the service. The workgroup explored the idea that the growth of the cost of institutional care could be curbed through the enhancement of home and community-based services. The workgroup recommended that the Department consider requesting a Medicaid Independence Plus waiver, or modify an existing waiver program, in order to allow additional flexibility in the Medicaid program to pay for more community-based services. As noted below, the Department is in the process of requesting a new waiver and modifying one of its existing waiver programs in order to provide more home and community-based benefits.

Mental Health and Substance Abuse Services

The community-based mental health and substance abuse system in North Dakota provides services to adults who have a serious mental illness (SMI); children diagnosed with serious emotional disorders (SED); those with emotional disorders requiring short term, acute mental health services; and adults and adolescents with substance abuse problems. Services are provided directly by the human service center, through contracts with private providers, or referred to other providers in or out of the region. These include but are not limited to:

- Care coordination
- Crisis stabilization and resolution
- Short-term inpatient services
- Individual, group, and family therapy
- Psychiatric/medical management including medication management and other health services
- Day treatment
- Psychological services
- Human services
- Case aide services
- Evaluation and assessment
- Residential services and supports
- Vocational and educational services and supported employment
- Social and peer support activities

During the 1990's, the number of individuals using community-based mental health and substance abuse services generally increased. In 1990, 13,788 persons accessed community-based services for mental health and substance abuse issues. This number climbed to 25,350 individuals by 1999. A further breakdown reveals that in 1990, 6,103 children and adults accessed services at the regional human service centers for substance abuse problems. That same year, 7,685 children and adults accessed human service center services for mental health issues. In contrast, during 1999 there were 6,613 individuals who accessed substance abuse services while 18,737 individuals accessed mental health services.

In state fiscal year 2004, a total of 20,348 clients were served. This included 768 children through age 17, and 4,655 adults age 18 and over, in substance abuse services and 3,247 children and 11,678 adults in mental health services. In 2005, a total of 19,754 clients were served. This included 796 children and 4,275 adults in substance abuse services and 3,522 children and 11,161 adults in mental health services.

Although American Indians are able to access services via the regional human service centers, the Department has provided additional funding to tribal governments to enhance their substance abuse treatment programs. At present all but one tribally operated treatment program is licensed by the state. The Department funds a 20- bed clinically managed residential treatment program for individuals dependent on methamphetamine. The Department is also working with regional human service centers to implement the MATRIX model of outpatient treatment for individuals with cognitive impairment from drug use often seen in individuals dependent upon methamphetamine or other drugs.

The Department also has a strategic initiative to provide services and housing for adults with chronic mental illness. This includes the goal of developing eight residential service options (one per region) for the chronic mentally ill, dual diagnosis adult population and to identify the need for other residential services, such as crisis beds, in each region. One residential program will be in place the fall of 2006 which will provide 15 beds in the Jamestown area.

The reshaping of the Nation's approach to mental health is well underway building on the work of the President's New Freedom Commission on Mental Health and the subsequent Federal Action Agenda: First Steps. North Dakota's efforts are taking shape as well. Highlighted activities in North Dakota's mental health transformation are:

a) Consumer network providing training and support to consumers to enhance their involvement in policy development, education, and recovery promotion efforts;
b) Workforce development plan to address staff training and hiring challenges;
c) Integrated dual disorder treatment pilot for individuals with serious and persistent mental illness and substance abuse disorders;
d) Enhanced consumer satisfaction survey process at regional human service centers;
e) Science-to-service agenda to form strong relationships with higher education to support research and implementation strategies for effective service delivery;
f) Recovery-focused training efforts statewide with focus on peer support, self-direction, individualized care, empowerment, and hope for recovery

g) Youth advisory board for youth inclusion in policy discussion concerning youth services
h) Trauma-focused evidence-based practice for youth receiving mental health services;
i) Regional pilot using the SAMHSA model of supported employment
j) Suicide prevention efforts;

k) Participation on the Governor's Interagency Council on Homelessness; and
l) Partnering with corrections and the judiciary

Child Welfare and Children's Mental Health Services

During the 1990's, both the Child Welfare and Children's Mental Health System of care have been developing community-based alternatives to out-of-home care. The core of these initiatives includes the development of case management systems that use the wrap-around process. Thus, when children and their families are receiving services from multiple agencies, there would be one plan developed with the family outlining the roles and responsibilities of these agencies in the life of the family. In North Dakota, there is a single system of foster care for children needing out of home placements. So that children from juvenile justice, child welfare and mental health are accessing the same residential treatment centers or therapeutic foster homes.

Tribal governments have jurisdiction of the American Indian children who reside on or are domiciled within the boundaries of the reservations. As a result, the Department has partnered with the Tribal child welfare programs. There are comprehensive agreements in place with each tribe in North Dakota to allow tribes to access foster care funding under Title IV-E and which provide recognition of tribally licensed or approved foster care homes, administrative reimbursement, and education to build professional infrastructure.

United Tribes Technical College received a Circles of Care grant through the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). Circles of Care grants allow the building of infrastructure to increase the capacity and effectiveness of behavioral health systems serving American Indian communities. As a result of these infrastructure improvements, Circles of Care grants will reduce the gap between the need for behavioral health services and the availability of services in American Indian communities.

Called the Sacred Child grant, this grant allowed tribal child welfare programs to develop a wrap around model, utilizing culturally appropriate methods and supports to keep American Indian children with a particular mental health diagnosis in their community. Medicaid recognized these services which enabled the tribal child welfare programs to bill for targeted case management for eligible

children. Medicaid reimbursement for targeted case management for children at risk of placement is also being accessed by tribes.

The Native American Training Institute received a System of Care grant through SAMHSA also. This grant, the Medicine Moon Initiative, is focused on infrastructure development within the tribal child welfare programs. The Medicine Moon Initiative focuses on the actual infrastructure development in the tribal child welfare systems, which are needed in order to improve upon the delivery of services.

During the late 1990's, the out-of-home placements in North Dakota leveled off at approximately 930 youth per month or approximately 1,720 unduplicated youth per year. The length of stay in residential facilities varies from approximately 10.4 months to 4.2 months. Manchester House, with a 4.2-month average length of stay, provides care for youth between the ages of 6 and 12. In order to achieve these short lengths of stay, Manchester works directly with the community and family to develop a community based plan of care. In addition, staff travels to the child's home community to establish a wraparound plan for the child and the family.

Finally, North Dakota placed an average of approximately 35 youth out of state in the past two years. These are children referred to facilities in other states for several reasons, including that the out-of state placement is closer to the child's home than the available in-state placement, or the child needs services that are not provide in-state (e.g., services for children with low intelligence and significant emotional disturbances, adolescent sex offenders with lengthy histories and children with unique medical and behavioral issues).

The Department's Children and Family Services Division has been working with several partner agencies to ensure that children, who are in need of care, are able to access that care in a community placement if at all possible. This work has occurred over the past several years when there has been an increased demand for foster care in North Dakota due to the methamphetamine crisis. Here are some of the salient factors that impact this work:

a) The overall foster care numbers increased from 1,978 in federal fiscal year 2000 to 2,314 in 2005 (a 17% increase).
b) The number of children in family placements (pre-adoptive homes, relative placements and family foster care) increased from 1,266 in 2000 to 1,631 in 2005 or a 28.8% increase in total number of children in family care.
c) The number of children in residential care decreased from 702 in 2000 to 648 children in 2005 or a decrease of 7.7% during this same time period.
d) Approximately one in four children (23.7%) coming into foster care were placed due to methamphetamine use, manufacturing or selling by their parents.

e) In 2005 the Department implemented the TANF Kinship Care Program. This program has enabled kin to provide care for children who would have otherwise gone into foster care. These relatives receive reimbursements similar to that of foster parents to provide that care.
f) In addition, the 2005 Legislative Assembly passed House Bill no. 1110 (codified at N.D.C.C. § 25-03.2-03.1) reaffirming the state's commitment to placements with family when at all possible: This law requires the Department and county social service boards to thoroughly explore the option of kinship care when a child is unable to return home due to safety concerns. Absent kinship options, the Department and county social service boards must provide permanency options that are in the least restrictive care and near the family's home as required by the federal Adoption and Safe Family Act of 1997.
g) The Department issued a request for proposals for Intensive In-Home Services in 2005. The successful bidder was the Village Family Services. Their proposal also provided 3 full time employees to provide family group conferencing. This case management process brings together the extended family network along with informal supports such as friends and clergy to create a care plan for the children and the family.
h) The Village Family Services, in partnership with the Department also applied for a Bush Grant to expand the family group conferencing concept statewide. This application was approved in March 2006 and implementation will begin in the summer of 2006.
i) Finally, the Department has been working with US Search in order to find relatives for the children that come into the foster care system. This search process is able to identify over forty relatives for children in foster care even under the most difficult circumstances. Once the relatives have been identified, the case managers are then able to contact these individuals to explore the possibility of providing a family connection for the child.

The Department has a voluntary treatment program for children who have an emotional disturbance and are in need of out-of-home treatment. This program minimizes the situations in which parents must relinquish custody of their children. The Department is pursuing enhancement of that program to better meet demand.

Medicaid

During the decades of the 1970's and 1980's North Dakota became increasingly dependent on the use of institutional care to deliver long term care services to the citizens of our state. Programs such as Medicaid developed a built-in bias toward institutional care due primarily to the payment mechanism that allowed payment for services received in nursing facilities.

The emphasis began to change somewhat when the federal government authorized States to develop home and community based waivers. The waivers permitted States to provide alternative services that allowed individuals with needs that were normally delivered in nursing facilities to remain in a home or community based setting rather than entering an institution. North Dakota currently operates home and community-based waivers for the elderly and disabled, individuals with traumatic brain injury, and individuals with developmental disabilities.

The Legislative Assembly, Governor Edward Schafer, the Departments of Health and Human Services, concerned citizens and the long-term care industry recognized the need to initiate changes in the way long-term care services were being delivered in North Dakota. Beginning in 1995 a Task Force on long-term care planning met during the next three interim periods between legislative sessions. The Task Force issued reports in June 1996, June 1998, and September 2000, which contained dozens of recommendations to the Legislative Assembly and the executive branch of government designed to promote and create more community-based alternatives for the delivery of long-term care services in North Dakota.

During the past ten years, steps have been taken to improve the ability of individuals to obtain long-term care services in a home or community setting. For example, since 1995, the number of licensed nursing facility beds has been reduced from 7,061 to 6,377, a reduction of 9.7 percent. The number of occupied beds has decreased from 6,840 in 1995 to 5,947 in 2005, a reduction of 893 individuals or a 13 percent reduction. The number of beds occupied by Medicaid recipients reflects a similar decline – going from 3,928 occupied beds in 1995 to 3,351 in 2005, a reduction of 14.6 percent.

North Dakota has encouraged the development of alternatives to nursing facility care by increasing funding for the elderly and disabled Medicaid waiver, the traumatic brain injured Medicaid waiver, Basic Care Assistance Program, Service Payments for the Elderly and Disabled (SPED), and Expanded SPED. Funds became available in 2000 through the Intergovernmental Transfer Program for providers, including nursing facilities, to receive loans and grants to develop alternatives to nursing facility care. Pilot projects have demonstrated the feasibility of providing quality services for persons with Alzheimer's and related dementia. The Legislative Assembly established a moratorium, beginning in 1995, and continuing in the current biennium, on the construction of any new nursing facility beds in the state.[7]

The Department has also worked to expand services offered in the community For example, it added personal care services as a Medicaid optional service. To achieve this, the Department prepared a state plan amendment that was

[7] N.D.C.C. § 23-16-01.1

submitted to CMS in August 2003, with an effective date of September 1, 2003. This change resulted in expanding personal care services to all Medicaid recipients, not just those targeted populations eligible under the waivers. Recipients no longer have to meet skilled nursing facility or ICF/MR level of care in order to receive this service. This translates into a greater number of individuals who can receive assistance, allowing them to maintain independence and stay at home while delaying or preventing the need for institutionalization.

The Department is currently working on an amendment to the aged and disabled waiver to provide attendant care services for individuals who are ventilator dependent. In order to receive this service, an individual must require the use of a ventilator for at least 20 hours per day, must be medically stable as documented by a physician, have an informal caregiver support system for contingencies and must be competent as documented by a physician to actively participate in the development and monitoring of the plan of care. The intent of this additional service is to assist a limited number of individuals to either remain in their homes or transition from an institutional facility to a lesser restrictive environment.

The Department has also established a waiver team that is currently working to renew the aged and disabled waiver. It is hoped that this waiver renewal will include a self-directed care component which would allow recipients to direct their care. This would make possible additional choices, responsibility, and control by the recipient for coordinating and participating in their own care plan and outcomes. This would be done in cooperation with a primary care provider. The recipient would assume responsibility for hiring, training, scheduling, supervising, and terminating the care providers, as the recipient considers appropriate to carry out the plan of care. However, in order to allow truly self-directed care, statutory changes will likely be necessary in order to avoid violation of certain scope of practice laws such as those that govern nursing and other similar health care providers.

The Department also intends to continue to encourage and support the development of alternatives to nursing facility services. Toward this end, the Department has, as described above, begun several initiatives in its Medicaid program to allow more individuals to be cared for in more homelike settings. These initiatives include pursuing a “self-directed care” model that will allow individuals to have more input into their own care and control over the choice of their care provider. In addition, the Department administered a nursing facility alternative funding program (also known as the Intergovernmental Transfer Fund (IGT)) beginning in 1999, which allowed the Department to grant or loan money to nursing facilities to convert all or a portion of the facility to a basic care facility, assisted living facility, or other alternative to nursing facility care. However, no facilities requested IGT funds to convert nursing home beds to other purposes. The Department made loans for five alternative projects and the remainder of loans were for nursing home renovation. The funds were also used for services

that were related to developing, enhancing, or maintaining community-based services and for Service Payments to the Elderly and Disabled (SPED) program which provides payment for services for people who are older or physically disabled and who have difficulty completing tasks that enable them to live independently at home. Since its establishment, the fund has also been used to fund nursing home bed reduction incentive payments that resulted in 286 beds in 29 facilities being bought out of the system.

The long-term care system in North Dakota has been studied in the past. In 1987, North Dakota issued a report entitled Long-Term Care: Issues and Recommendations. The study was based on the conviction that a balance of institutional and non-institutional care and support services is the best way of meeting the needs of North Dakota's older adults. Members of the North Dakota Interagency Task Force on Long Term Care included representatives of the Department, the Department of Health, and the Governor's Office. The study based its evaluation of broad issues concerning long-term care in North Dakota. The Task Force felt that the study ". . . demonstrated a need to examine the structural, functional, financial and social concerns that undermine a comprehensive and fluid long term care delivery system in North Dakota." The Task Force recognized that "the long- term care system is extremely complex and cumbersome". The Task Force made several recommendations aimed at streamlining, simplifying, and consolidating North Dakota's long-term care system, including the development of a single point of entry to the system of long-term care and a system of case management.

The Department and the North Dakota Department of Health convened a long-term care working group in 1993 to provide assistance to the State Health Council in developing a policy under which the Council would review applications for certificate of need for long-term care institutional bed capacity. In January 1994, the working group presented proposed policies to the Council. These proposals were adopted by the Council in March of 1994, and with minor revisions, served as guidelines for consideration of long-term care applications until repeal of the certificate of need statute by the Fifty-Fourth Legislative Assembly.

The nature of the investigation conducted by this working group led directly to identification of several issues and situations unique to North Dakota. This investigation also required a thorough examination of the environment, federal and state policies, and the demographics that drive our system of long-term care. Much of the information developed by the working group was conveyed to the Legislative Assembly.

The bill that repealed the certificate of need program (CON) also provided a two-year moratorium on the licensing of additional long-term care beds. This legislation (Senate Bill no. 2460) directed that a study of long-term care be conducted and a comprehensive report prepared by the Legislative Council in

conjunction with the State Health Council and the Department of Human Services. The State Health Officer and the Executive Director of the Department appointed a Task Force on Long-Term Care Planning to facilitate the study prescribed by Senate Bill no. 2460. The report of the 1993 working group and the guidelines adopted by the Health Council provided the background and starting point for the Task Force, which began its work in September of 1995.

The Fifty-Fifth Legislative Assembly was very receptive to the recommendations of the Task Force. Most of the legislation recommended by the Task Force was enacted. Pilot projects on conversion of existing long-term care bed capacity to serve the Alzheimer's and related dementia population and to test expanded case management were approved and continue as a result of this legislation. Asset protection provided to spouses of institutionalized individuals was extended to spouses of recipients of home and community-based services. Insurance coverage for persons with long-term care insurance providing a home benefit was broadened to include services rendered by qualified service providers. The entire collection of long-term study recommendations was adopted in the form of concurrent study resolutions and all of these resolutions (HCR 3003, HCR 3004, HCR 3005 and HCR 3006) were selected for study during the 1997-1998 interim. All four resolutions were assigned to the Budget Committee on Long-Term Care by the Legislative Council. The examination of basic care rate equalization required by House Bill no. 1012 was similarly assigned.

Governor Edward T. Schafer reappointed the Task Force on Long-Term Care Planning in June of 1997 to assist the Departments of Health and Human Services in providing the Legislative Council with meaningful input in response to the study resolutions. The Task Force again assembled and reviewed available data and studies from across the country in response to the issues identified in the various study resolutions. A presentation was made regarding the national agenda for long-term care and federal entitlement programs by the Deputy Director of the National Association of State Units on Aging. The Task Force again formed several *ad hoc* committees to investigate the issues identified in the study resolutions. The committees, which began its work in October of 1997, received the following study assignments: financing and payment incentives; residential services, definitions and funding reorganization; geropsychiatric services; case management, service availability and qualified service provider training; and Native American long-term care service system. The *ad hoc* committees concluded their studies in late April 1998 and issued reports to the Task Force during April and May. A report issued in June 1998 summarized the committee's findings and the adopted recommendations of the Task Force.

Governor Edward T. Schafer reappointed the Task Force on Long-Term Care Planning in September 1999. The Task Force met for the first time on October 14, 1999. The Task Force formed Ad Hoc committees to review the following areas:

1. Senate Bill 2036 directed the Department of Human Services and the Department of Health to prepare a recommendation for consideration by the Fifty-Seventh Legislative Assembly combining basic care and assisted living services into one system. This committee was also asked to review the senior mill levy match program to determine if it could be used to expand or enhance home and community-based services and was asked to make a recommendation regarding whether the moratorium on basic care bed capacity should be continued.

2. To determine if North Dakota needs to provide care coordination/case management on a comprehensive statewide basis for individuals in need of long-term care services.

3. To study the manner in which long-term care services are provided to Native American elderly and disabled and recommend ways to improve the delivery of long-term care services to this population.

4. To determine if any changes need to be made in the manner that hospitals provide services to individuals in need of long-term care in swing bed usage and in acute care hospitals.

5. To determine if any changes need to be made to the current nursing facility rate equalization policy.

In addition to the areas studied by the *ad hoc* committees, the Task Force requested updates on end-of-life issues and the loan and grant program that was established by Senate Bill no. 2168 to develop alternatives to nursing facility care. The *ad hoc* committees concluded their studies in July of 2000 and issued reports to the Task Force during July and August.

These studies indicate a need for all individuals with disabilities and their families to have access to adequate information about the availability of long-term care services in order to make informed decisions regarding the type of services that best meet their needs. A pre-admission assessment before admission to a skilled nursing facility could be accomplished by a single point of entry system that provides consumers streamlined access to all continuums of care services through one agency or organization. The assessment would determine the type of services that the individual requires to meet long-term care needs and where those services may be obtained, including home and community based services. Persons in need of long-term care and their families could then decide where to obtain the needed services.

SECTION III – NORTH DAKOTA'S *OLMSTEAD* PLANNING PROCESS

Why Develop an *Olmstead* Plan?

The Supreme Court suggested that a state could establish compliance with Title II of the ADA if it has a comprehensive, effectively working plan for placing qualified people in the most integrated setting, and has waiting lists that move along at a reasonable pace.[8] The Centers for Medicare and Medicaid Services (CMS), recommended that states develop a comprehensive, effectively working plan to ensure compliance with Title II of the ADA.[9] In addition to the Supreme Court ruling, on June 19, 2001, President George W. Bush issued an Executive Order directing the United States Attorney General, the Secretaries of Health and Human Services, Education, Labor and Housing and Urban Development to work closely with individual States to implement the decision in *Olmstead v. L.C.,* 527 U.S. 581 (1999), particularly with those States that choose to develop comprehensive, effective plans to provide services to qualified individuals under the criteria set forth in *Olmstead*. Among the most important reasons for developing an *Olmstead* plan is to reaffirm that the State of North Dakota is dedicated to ensuring access to community-based supports and the provision of services to people with disabilities, utilizing the resources available to the State to accomplish that goal, and to recognize that such services and supports advance the best interests of all North Dakotans.

State's Response to *Olmstead*

Creation of *Olmstead* "White Paper"

Following the Supreme Court decision on Olmstead vs. L.C., the North Dakota Department of Human Services established a work group to study the *Olmstead* decision and create a White Paper report. The report (which appears in Appendix A) contains information relative to the then-current system of delivering services in state-operated institutions and community-based settings throughout North Dakota. It also contains the recommendations of the work group for further activity related to the *Olmstead* Decision. The workgroup consisted of representation from the Divisions of Aging Services, Children and Family Services, Disability Services – Developmental Disabilities Unit, and Mental Health and Substance Abuse Services as well as representatives from Medical Services, the Developmental Center, the State Hospital, the regional human service center directors and the Legal Advisory Unit.

It was determined by the workgroup that regional information meetings needed to be held with consumers, families, advocates, and providers in the areas of mental health, aging, developmental disabilities and physical disabilities. Goals established for these meetings included: clarifying the content and nature of the Olmstead decision; updating attendees on the current status of institutional and community based services for various populations in North Dakota; soliciting

[8] *Olmstead v. L.C.*
[9] Centers for Medicare and Medicaid Services, State Medicaid Directors Letter, January 14, 2000.

discussion and input from attendees on areas they see as needing attention. In August of 2000, four meetings were held via the North Dakota Interactive Video Network (IVN). More than 200 persons attended these meetings throughout the state. Discussion occurred at each meeting and the workgroup answered participants' questions. In addition, a brief survey was available for attendees to complete. The surveys were gathered and analyzed by the workgroup.

The efforts of the workgroup culminated in a White Paper for the Executive Office of the North Dakota Department of Human Services outlining background information, workgroup activities, and recommendations for future action.

Establishment of an *Olmstead* Commission

On August 7, 2001, by Executive Order 2001-07, the Honorable John Hoeven, Governor of the State of North Dakota, created the North Dakota Olmstead Commission. The Executive Order recognizes that the State of North Dakota is committed to community-based alternatives for individuals with disabilities, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement and the State can reasonably accommodate the placement, taking into account the resources available to the State and the needs of others with disabilities. The Olmstead Commission was created to develop a plan to implement the *Olmstead* decision by providing appropriate community-based placement for individuals with disabilities, consistent with the needs and available resources of the State. The Commission has been charged with assessing the array of services available to persons with disabilities in North Dakota and with making recommendations to the governor and legislature, if appropriate, to address any gaps in service that have led to or would lead to institutionalization.

The Commission consists of the following: A representative of the Office of the Governor, who shall serve as co-chair; the Attorney General, or his designee; the Executive Director of the Department of Human Services, or her designee, who shall serve as co-chair; the Director of the Office of Management & Budget, or his designee; the Executive Director of the Indian Affairs Commission; a member of the North Dakota Senate; two members of the North Dakota House of Representatives; a representative of the Mental Health Association of North Dakota; a representative of the Arc of North Dakota; a representative of the North Dakota Protection and Advocacy Project; a representative of the AARP of North Dakota; a representative of the North Dakota State Council for Independent Living; and a representative of the public at large.

The initial members of the Commission were appointed in November 2001, and the first meeting was held on December 19, 2001 and, since then, the Commission has continued to meet. In March 2002, the Commission held public meetings across the state to gather input on services for people with disabilities

in North Dakota. Consumers of services, providers and the public were invited to attend.

Federal *Olmstead*-Related Grants

The Olmstead Commission administered two Olmstead-related grants; an initial Real Choice Systems Starter grant to develop plans for improving support systems for community living as well as an Olmstead Financial Support Award from the Center for Mental Health Services. As a follow-up to the initial grants, a three-year Real Choice Systems Change grant was awarded to the Olmstead Commission. With these grants, the Commission funded six local demonstration projects as follows: The Evangelical Lutheran Good Samaritan Society (to develop a simplified access to services model); Independence, Inc., the Knife River Care Center, and Western Sunrise, Inc. (to develop living in place models); Mental Health Association of North Dakota (to develop a services model); and the North Dakota Indian Affairs Commission (to develop a cultural model). The result of each of the demonstration projects was reported to the Olmstead Commission.

The Department applied for a Real Choice Systems Change Rebalancing Initiative grant, which was funded in 2004 for a three-year time period. The goals of the grant are: to develop a mechanism to balance state resources for continuum of care services to strengthen opportunities for choice and self-direction; to develop a system to provide a single point of entry for continuum of care services; and to develop practical and sustainable public information services for all continuum of care services in North Dakota. The grant goals will be achieved through research; focus groups and questionnaires geared to consumers, providers and family members; stakeholder meetings involving more than 100 agencies and organizations, and a broad-based steering committee. Recommendations for legislation will be prepared for the Sixtieth Legislative Assembly.

State Laws Enacted to Promote Home and Community Based Services

After the Olmstead decision, several state laws were enacted to try to more fully promote home and community based services.

In 2001, the Fifty-seventh Legislative Assembly passed a law to require the Department to implement a personal care option in its State Medicaid Plan. To serve individuals who reside in basic care facilities[10]. The personal care program allows Medicaid dollars to be expended to provide certain care services in an individual's home. A related law was passed in 2003, that required the Department to seek a waiver of federal law to permit the disabled and elderly to direct their own care and to permit personal care services to be provided by

[10] N.D.C.C. § 50-24.1-18

nonlicensed personal care service providers to individuals residing in their own homes. [11]

Another law was passed in 2003, that provides that any aged or disabled individual who is eligible for home and community based living must be allowed to choose, from among all service options available, the type of service that best meets that individual's needs.[12] The law further required that the individual's medical assistance funds must follow the individual for whichever service option the individual selects, not to exceed the cost of the service. However, there are barriers to the implementation of this law, including scope of professional practice laws that prohibit unlicensed individuals from providing certain types of care. For example, some care services could be regulated under the North Dakota Nurse Practices Act and would require that the person providing that care be a licensed nurse, or operate under the supervision of a nurse. These barriers are addressed in the action steps below in the hope that resolutions can be found to enable people to have more choices in their care delivery.

A law passed in 2005 which requires the Department to apply for a Medicaid waiver to provide in-home services to children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care.[13]

Task Force to Transition Residents to Community From Developmental Center

In 2005, the Fifty-ninth Legislative Assembly passed House Bill No. 1012 which required the Department, with input from developmental disabilities services providers, to develop a plan to transfer appropriate individuals from the state's Developmental Center (an ICF/MR) to community placements. The Department is required to report to the Legislature on its plan and the anticipated number of individuals that will be transferred beginning in 2005 and ending in 2007. The sum of $50,000 was appropriated to assist with the transition of individuals from the Developmental Center into community placements.

Use of MDS to Transition Residents to Community From Nursing Facilities

The Department is seeking a Data Use Agreement (DUA) with CMS to allow it to access the information contained in the Minimum Data Set which is an instrument used in nursing facilities to assess residents. All certified Medicare or Medicaid nursing facilities must complete, record, encode and transmit to CMS the MDS for all residents in the facility. While the MDS was developed to provide consumers with an additional source of information about the quality of nursing home care and to help providers improve the quality of care for their residents, it is also a tool that could be used to identify and locate nursing facility residents

[11] N.D.C.C. § 50-24.1-18.1
[12] N.D.C.C. § 50-24.1-20
[13] N.D.C.C. 50-24.1-26

who would like to be served in an alternative setting. Because it contains identifying information that is otherwise confidential, the Department must agree to safeguard that information and CMS must approve the arrangement.

If CMS approves the DUA, the Department or its designee will use the MDS information to contact nursing facility residents who wish to be served in a more home-like setting and to assess which residents are most likely to be successful in transitioning from the facility to the community.

SECTION IV – GOALS OF THE *OLMSTEAD* PLAN

As noted above, the *Olmstead* decision indicated that in order to prove that a state has maintained a range of facilities and administered services with an even hand, the state could demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the state's endeavor to keep its institutions fully populated. The *Olmstead* plan aims to identify direct actions to protect and support the ability of people with disabilities to live in the most integrated setting appropriate to their needs. This plan was developed to implement the requirements of the ADA and the *Olmstead* decision in North Dakota, including Indian Country, to allow residents with disabilities to live successfully in the community of their choice with appropriate and desired supports. Guiding principles used in the development of the plan goals included a desire to ensure that individuals will have the fullest range of choice of providers feasible and to encourage the use of evidence-based practices.

The plan is categorized into three major goal statements. Each goal is intended to be achieved through the detailed action steps that follow the goal statement. The *Olmstead* plan identifies the impact of each on laws, policies, procedures, regulations, and funding. This will identify the anticipated level of fiscal or regulatory change required to accomplish goals. These goals describe the reasonable modifications that the state hopes to achieve to its current system of care. The goals take into account the resources available to the state and the needs of all North Dakotans with disabilities in order to try to maintain a balanced range of care and treatment of individuals with diverse disabilities and the state's obligation to administer services with an even hand.

Category A identifies those major activities and specific tasks that can be implemented without fiscal impact or regulatory change.

Category B identifies those major activities and specific tasks that can be implemented with moderate fiscal impact or regulatory change. This would be in cases where funding exists, however, a shift in funds or focus of funds would need to occur to implement the major activities and specific tasks. In addition, a moderate level of regulatory change would apply to modifying policies or procedures within state or local agencies.

Category C identifies those major activities and specific tasks where legislative action would be needed to acquire additional funding or change laws.

Goal 1.0: North Dakota will have the infrastructure necessary to provide to people with disabilities community services and supports that are accessible, effective, responsive, safe, and continuously improving given the resources available to the state and the need to maintain a range of services to accommodate individuals with varying needs and preferences.

Specific Tasks	Category	Responsible Party	Timeline	Progress
b. Reduce barriers to home and community- based services development, including:				
b.1.a. Maintain or sustain adequate and appropriate funding levels for the increased rate of reimbursement for Qualified Service Providers as enacted by the Legislative Assembly in 2007 SB No. 2012.	C	Governor, Department, Advocates, Counties, and the North Dakota Legislative Assembly	Present and through 2009 and future legislative sessions	See completed goal 1.b.1. in Appendix A.
b.2. Collaborate with Tribes to develop additional home and community-based services.	B	The Department, Indian Affairs Commission, and Tribes	Ongoing with progress report and recommendations no later than December 2007.	Panel presentation at the 11/02/07 meeting of the Olmstead Commission. Panel members were: Theresa Snyder, Cheryl Kulas, and Linda Wright. Discussed 1.b.2 and 1.b.3. Who's responsible? What gaps exist in what services? What's available now? How is the responsibility shared?
b.3. Develop and deliver culturally based case management in Indian country.	C	The Department, Indian Affairs Commission, and Tribes		
b.4.a. Educate legislators of the need for guardianship services.	C	North Dakota Guardianship Association, Olmstead Task Force, and the North Dakota Legislative Assembly	Present and through 2009 and future legislative sessions.	See completed goal 1.b.4. in Appendix A.

b.5. Define and pursue self-directed care in the Medicaid program.	B	The Department	Ongoing – Division of Mental Health and Substance Abuse Services will report on workshops after they are completed in 2008.	--Division of Mental Health and Substance Abuse Services is doing workshops on self-directed planning. --Maggie Anderson provided a summary of status of waivers. ND's high use of personal QSPs vs. agency QPSs is an indication of a higher incidence of self-directed care than other jurisdictions
b.6. Increase socialization and personal support opportunities.	B	Advocates; Can Real Choice Rebalancing group provide support for this goal?	Present and ongoing: Need to increase the focus on this	Need to create a model using the conference of churches, state extension system, and faith-based action groups. Ad hoc committee – advocates are in the best position to identify the need
b.7. Identify and address caps on HCBS – they should be equal to caps on cost of institutional care.	C	The Department and Advocates	July 2008 as part of the '09-'11 budget	Personal care services have service caps instead of dollar caps, but SPED and ex-SPED still have dollar caps. HCBS team is working on this as part of the '09-'11 budget. These caps are difficult to apply in a nursing home setting because the Department pays daily rates vs. a fee for service.
b.8. Address bias which exists in federal laws and regulations re: Medicaid payment of institutionalized care but not HCBS.	A	Olmstead Commission	Consider a letter to CMS (copy to Congressional delegation) discussing complexity of waivers, waivers require nursing home level of care vs. home and community-based level of care, problems with access to providers and services in rural ND	

b.9. Identify less restrictive options than the State Hospital for the provision of services to individuals with chronic mental illness.		Olmstead Commission, and the Department	Ongoing	Chronic individuals need a safety net – resources are not available in local facilities. No inpatient facilities means individuals are sent to the State Hospital from some regions; Jamestown and Valley City are seeing development of residential facilities so progress is being made. The State Hospital will continue to exist as an acute inpatient facility for the South Central, Lake Region, and Badlands regions.
b.10..Only individuals eligible for the waiver under Medicaid are entitled to receive "…appropriate treatment, services, and habilitation…in the least restrictive appropriate setting.	A	Olmstead Commission and the Department	No definite timeline	The Department will explore expanding the definition of developmental disability to include those with a disability that is not MR or closely related to MR. Looking at state definitions and looking at possibility of waivers for autism and traumatic brain injury. How might these work in light of the federal definitions which must meet the requirements of institutional care.
d. Increase affordable housing for individuals with disabilities, including Indian Country.	C	Olmstead Commission; Tribal Liaisons; Housing Finance Administration; role for Homebuilders' Association?	December 2006 and ongoing - -	Modification pay might be in one of the waivers – discussed in panel by T. Snyder, C. Kulas, and L.Wright
e. Increase accessible housing including resources to pay for modifications.	C	Olmstead Commission; Housing Task Force: create subgroup to work on accessibility issues	December 2006 and ongoing	"Money follows the person" grant – money is built in to allow one-time modification to homes and vehicles.

f. Research the eligibility criteria for housing assistance and whether there are gaps or overlap with other assistance programs.	A	Olmstead Commission; Housing Task Force (HTF is already working on affordability, accessibility, and visitability issues)	December 2006 and ongoing	Housing task force working with Congressmen re: efforts at the Federal level Booklet re: housing options for disabled is available on the website. Work on increasing public awareness of available programs. Also work on increasing awareness of what the needs are. Identify other avenues that can or should be explored.
g. Develop innovative transportation alternatives including collaboration with the Department of Transportation regarding services provided to older persons and individuals with disabilities.	B	Olmstead Commission and the Department	December 2006 and ongoing	Arranged for DOT to take over transportation which freed up Older Americans money for other programs. Talk to Janis about what AARP is doing in this area.

Goal 2.0: Establish a system to provide comprehensive information and education so people with disabilities can make informed choices about the living options available to them and to prevent or divert people from being institutionalized or segregated.

Specific Tasks	Category	Responsible Party	Timeline	Progress
a. Develop a single point of entry system, including a common assessment process, that will provide information that enables consumers to identify and access long-term care services inclusive of home and community-based services.	C	The Department, RCR Steering Committee, Counties, Advocates, and the North Dakota Legislative Assembly	Present and through the 2007 Legislative Session	The Department prepared a proposal to request ADRC funding. There was no money left at the end of FFY '07. At least January of '08 before the next budget is finalized – it depends on Congress' appropriation of discretionary funds. Asst. Secretary of Aging is aware of ND's application. Grant request is for $800,000 for 3 years. Explore options if ADRC is not federally funded.
b. Expand and coordinate web-based tools that will locate long-term care services including home and community-based services in the state.	B	The Department, Mental Health Association, First Link, and Providers	Presented report to the Olmstead Commission -- Fall 2007. Additional efforts ongoing.	Senior Infoline is being reconfigured. Aging Services Division working with Department's PIO to discuss finalizing a marketing plan.
c. Develop and implement a marketing plan to inform the public about resources available to help make informed choices about long-term care services including home and community-based services.	A	The Department and Advocates	Presented report to the Olmstead Commission -- Fall 2007. Additional efforts ongoing.	Might be part of the ADRC grant. Aging Services Division working with Department's PIO to discuss finalizing a marketing plan.

Goal 3.0: Administer a system for coordinated services to individuals with disabilities in the most integrated setting appropriate to the needs of the individual.

Specific Tasks	Category	Responsible Party	Timeline	Progress
a. Re-evaluate the current case management systems to develop future options for home and community-based services.	B	The Department, Community Healthcare of the Dakotas, Counties, Tribes, Consumers, and Advocates	Ongoing	DHS is reviewing the options for seamless case management. Allow individuals to move from one funding source to another without losing continuity of service.
b. Test how technology could be used to provide case management in rural areas.	B	The Department, and Counties	Preliminary report provided Fall 2007; efforts ongoing	Telehealth: Department to test internally and put rules together following medicare rules. Being done in the Badlands region. Consider "care coordination" where a rural case manager could be an advocate in the community to see that services are provided. This would be a case-by-case solution to addressing gaps.
c. Provide funding for crisis response to allow individuals with disabilities to return to their homes after the crisis has been resolved.	C	The Department, Advocates, the North Dakota Legislative Assembly	2007 or 2009 Legislative Session .	Transition funding to assist in this. May be need for home modification when people come out of crisis. May have "Money Follows the Person" funding available. Transition to the Community Task Force continues to discuss. This is on the task force's November 16, 2007 agenda.
d. Identify and establish benchmark data elements that provide information on access to the most integrated setting.	A	The Department and Advocates	Under development	How do we know the plan is effective? Need to identify what needs to be measured. --Work with the Department's research division to discuss how to measure: in the context of Olmstead specifically, not HCBS generally.

SECTION V – CONCLUSION

The State of North Dakota is dedicated to ensuring access to community-based supports and the provision of appropriate services to people with disabilities, utilizing the resources available to the State to accomplish that goal. These services and supports advance the best interests of all North Dakotans. North Dakota has the basic foundation for a continuum of care that allows a person the choice of receiving services in the community or, when necessary, in an institutional setting. However, the steps above will be necessary to build on that foundation. The final message is that people with long-term care needs are entitled to equal freedom, choice, and respect. Service delivery systems need to identify the strengths and abilities of these people as well as their needs to develop systems that integrate seniors and persons with disabilities into the community when appropriate and desired.