Purpose is to ensure that the State will meet the ADA requirements by providing services, programs, and activities for individuals with physical disabilities in the most integrated setting appropriate to their needs.

Effective December 14, 2020
Agreement will terminate eight years after effective date if Parties agree that the state has attained substantial compliance with all provisions and maintained that compliance for a period of one year.
VARIETY OF CONCERNS

EXAMPLES PROVIDED BY DOJ

- **Unnecessary segregation** of disabled individuals in skilled nursing facilities

- Adults in skilled nursing facilities who would **rather be in their community**

- **Imbalance of funds** to skilled nursing facilities and community-based services

- **Lack of awareness** about existing transition services and available tools
Who are we trying to reach?

Target population

Basic Eligibility

- Individual with physical disability
- Over age 21
- Eligible or likely to become eligible to receive Medicaid long-term services and supports (LTSS)
- Is likely to require LTSS for at least 90 days.

IF in skilled nursing setting

- Receive Medicaid-funded nursing facility services AND
  - Likely to require long term services and supports
- Receive nursing facility services AND
  - Likely to become eligible for Medicaid within 90 days, have submitted a Medicaid application, and have approval for a long-term nursing facility stay

IF in hospital or home setting

- Referred for a nursing facility level of care determination AND
  - Likely to need services long term
- Need services to continue living in the community AND
  - Currently have a HCBS Case Manager or have contacted the ADRL
WHO IS NOT A MEMBER OF THE "TARGET POPULATION"

Individuals under age 21

Individuals who are not Medicaid eligible

Individuals who are not expected to need services for at least 90 days

Individuals with an intellectual disability or mental illness who do not screen at a nursing facility level of care
Within 120 days of effective date produce draft plan

- Establish a method to address challenges to implementation
- Assign agency and division responsibility for achieving benchmarks
- Review relevant services, capacity and barriers
- Engage Stakeholders
- Identify benchmarks and timelines for meeting Agreement’s requirements

Plan Approved 9.21.21
AGREEMENT VISION

- Long-term care system & supports reform
- Increase access to community-based services
- Increase awareness about service options
- Increase provider capacity & training

Builds upon shared goal of improving services to citizens providing care closer to home
ADRL CENTRALIZED INTAKE

How do you apply or get more information about HCBS?

1-855-462-5465

Website: carechoice@nd.assistguide.net

Email: Carechoice@nd.gov

Relay ND TTY at 1-800-366-6888 or 711

1st 10 months SA
- 9,583 calls
- 44,318 website hits
- 461 web referrals
- 130 avg calls per mo for HCBS
HCBS CASE MANAGERS

- Provide case management for older adults & individuals with physical disabilities receiving:
  - Service Payments for the Elderly and Disabled (SPED)
  - Expanded SPED (Ex-SPED)
  - Medicaid 1915-(c) Waivers
    - Aged and Disabled
    - Tech Dependent
  - Medicaid State Plan Personal Care (MSP-PC) in community
- Conduct informed choice referral visits and Basic Care case management

67 HCBS Case Managers

Served 2500 individuals (July 2021)

1st 9 months SA
657  New cases
Avg 73 new cases month

9
ND / DOJ AGREEMENT STRATEGY

- In-Reach & Outreach
- Person Centered Plans
- Diversion
- Transition
XIV. STRATEGY

IN-REACH

Informing individuals in skilled nursing facilities and hospitals of their care options

OUTREACH

Informing individuals and stakeholders in the community about their care options

GOALS

<table>
<thead>
<tr>
<th>Within 9 months</th>
<th>Year 2</th>
<th>Year 4</th>
<th>Year 5 and after</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Individual or group in-reach to all skilled nursing facilities</td>
<td>• Develop peer support system</td>
<td>• Individual in-reach to at least 1,000 Skilled Nursing Facility target population members</td>
<td>• In-reach to all newly admitted or identified Skilled Nursing Facility target population members</td>
</tr>
</tbody>
</table>

As of 9.30.21
All facilities visited 400+ residents attended
Addressing Staff Capacity

• Process of hiring 10 community outreach specialists to conduct the informed choice visits in hospitals and skilled nursing facilities

• Staff will be assigned to certain facilities to help build relationships with residents and staff

• Free up time for case managers to work with existing clients, new referrals, and transition cases

• Increase capacity to provide transition support services through awareness and increased provider capacity
GOALS

Year 1
• 290 Target Population Members (TPM)

Year 2
• Additional 290 TPM

Year 4
• Additional 650 TPM

Year 6
• Additional 670 TPM

Year 8
• Additional 670 TPM

PERSON CENTERED PLANNING
Medicaid mandated process, developed by individual and case manager to identify supports and services that are necessary to meet the individual’s needs in the most integrated setting.
DIVERSION: COMMUNITY LIVING

Set of activities that allow a target population member to avoid placement in a skilled nursing facility and remain living in their home and community.

GOALS

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 4</th>
<th>Year 6</th>
<th>Total 400 diverted</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 100 Target Population Members (TPM)</td>
<td>• 150 additional TPM</td>
<td>• 150 additional TPM</td>
<td></td>
</tr>
</tbody>
</table>

1st 9 months SA 196 TPM diverted
XI. STRATEGY

TRANSITION TO COMMUNITY

Services to prepare an individual currently residing in a skilled nursing facility to return to an integrated community setting

GOALS

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 4</th>
<th>Year 6</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Transition 100</td>
<td>• Transition 60% identified through person centered planning (PCP)</td>
<td>• Transition 70% identified through PCP</td>
<td>• Transition all remaining individuals identified PCP</td>
</tr>
</tbody>
</table>

Diversion

Person Centered Plans

In-Reach & Outreach

Transition

1st 9 months SA 53 TPMs MFP transitions
XII. HOUSING SUPPORTS

INTEGRATED HOUSING

Federal, state, or local assistance to TPM who need help accessing available integrated housing and support for TPM where lack of housing has been identified as a barrier to community-based services

GOALS

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4-8</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assist 20 Target Population Members (TPM)</td>
<td>• Assist additional 30 TPM</td>
<td>• Assist additional 60 TPM</td>
<td>• Assist additional number of TPM based on aggregate need</td>
</tr>
</tbody>
</table>

1st 6 months SA
7 TPMs supported
XIII. PROVIDER CAPACITY AND TRAINING

State will ensure an adequate supply of qualified trained community providers to enable target population members to transition and live in most integrated settings.

Provide guidance and training to nursing homes and other community providers who make a commitment to provide community-based services.

Draft plan to address provider capacity, reimbursement rates, incentives to serve individuals with significant medical/supervision needs, those living on Native American reservations and in rural areas.
The Americans with Disabilities Act (ADA) requires public agencies to eliminate unnecessary segregation of persons with disabilities and provide services in the most integrated setting appropriate to the needs of the individual.

In 1999 the Federal Supreme Court Olmstead decision affirmed the ADA requirements.
Public entities are required to provide **community-based services** when:

- Community-based services are **appropriate** for the individual; and
- The individual **does not oppose** community-based treatment; and
- Community-based treatment can be **reasonably accommodated**, taking into account:
  - Resources available to the entity and
  - Needs of others receiving disability services.
The process by which the State ensures that Target Population members have an opportunity to make an informed decision about where to receive services.

*December 2020 U.S. Dept of Justice Settlement with State of North Dakota*

**For Example**

- Person-centered planning
- Info about benefits of integrated settings
- Facilitated visits or other experiences in integrated settings
- Opportunity to meet with peers (other individuals with disabilities who are living, working and receiving services in integrated settings)
- Reasonable efforts to identify and address concerns
AMERICANS WITH DISABILITY ACT

Goal is to provide **opportunities** for individual **with disability** to live their lives like individuals without disability

Allow individuals with disabilities **opportunity** to **live, work, and receive** services in integrated settings

**Historically**, society has tended to **isolate** and **segregate** individuals with disability

Tittle II of the ADA requires **public entities** “to administer **services, programs, and activities** in the **most integrated setting** appropriate to the needs of the individual

Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. (ada.gov)
To comply with the ADA’s integration mandate, public entities must reasonably modify their policies, procedures or practices when necessary to avoid discrimination.

The “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”

Individuals who have been institutionalized and segregated have often been repeatedly told that they are not capable of successful community living and have been given very little information, if any, about how they could successfully live in integrated settings.

As a result, individuals’ and their families’ initial response when offered integrated options may be reluctance or hesitancy.
To comply with the ADA’s integration mandate, public entities must reasonably modify their policies, procedures or practices when necessary to avoid discrimination. The obligation to make reasonable modifications may be excused only where the public entity demonstrates that the requested modifications would “fundamentally alter” its service system.

The “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.” Individuals who have been institutionalized and segregated have often been repeatedly told that they are not capable of successful community living and have been given very little information, if any, about how they could successfully live in integrated settings.

Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. (ada.gov)
AMERICANS WITH DISABILITY ACT

How do we know if a person is opposed to the community?

- Individuals must be provided an opportunity to make an **informed decision**
  - Providing information about the **benefits** of community living and an **individualized** written person-centered plan of care
  - Proving an opportunity to tour **integrated affordable housing**

Facilitating **peer supports** and other opportunities to meet with other people with disability living, working **receiving care** in the **community**, their **families** and **community providers**.
ROLE OF HEALTH CARE STAFF

- Allow access to informed choice community outreach specialist and other professionals to ensure individuals have an opportunity to make an informed decision about their care options.

- Ensure that residents with legal decision makers also have access to informed choice community outreach and other professionals.

- Make a timely referral when resident or patients will be discharging to the community or when they express interest in discharging to the community.
ROLE OF HEALTH CARE PROVIDERS

Allow access to informed choice community outreach specialist and other professionals to ensure individuals have an opportunity to make an informed decision about their care options.

Guardians of Incapacitated Persons
N.D. Century Code 30.1-28-12 (5) (b) (c)

When exercising the authority granted by the court, the guardian shall fully safeguard the civil rights and personal autonomy of the ward possible by:
b. Involving the ward as fully as is practicable in making decisions with respect to the ward's living arrangements, health care, and other aspects of the ward's care;
c. Ensuring the ward's maximum personal freedom by using the least restrictive forms of intervention and only as necessary for the safety of the ward or others.
Role of Health Care Providers

Ensure that residents with legal decision makers also have access to informed choice community outreach and other professionals.

42 CFR 483.10 – Resident Rights (Nursing Homes)

• The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

• The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

• In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.
  • The resident’s wishes and preferences must be considered in the exercise of rights by the representative. To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.
ROLE OF HEALTH CARE PROVIDERS

Make a timely referral when resident or patients will be discharging to the community or when they express interest in discharging to the community

- Referrals should be made as soon as possible to facilitate strong transitions and successful community living
- Informed choice, transition coordination does not replace the normal discharge process
- Provide accurate information about current and ongoing needs of the resident or patient to facilitate successful transition
- Help to arrange necessary therapy post discharge
- Consider providing home and community-based services as a part of the continuum of care
OPPORTUNITIES FOR COLLABORATION

Internal and external partners

- State Agencies
- Tribal Nations
- Advocacy Organizations
- Hospitals, Skilled Nursing and Basic Care Facilities
- Home Health, Community-Based Providers and Health Care Professionals
Stakeholder meeting that include a listening session will be held: Dec. 9, 2021, from 1-3:00 p.m. (CT)

The State will educate stakeholders on the home and community-based service array, receive input on ways to improve the service delivery system, and receive feedback about the implementation of the Settlement Agreement.
Contact Information

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DOJ Agreement Coordinator

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