DOJ SETTLEMENT AGREEMENT SUMMARY
NURSING HOME AND HOSPITAL DISCHARGE PLANNER PRESENTATION

11.05. 2021

NORTH Dakota

Be Legendary.™

SETTLEMENT AGREEMENT BETWEEN U.S. DOJ & STATE OF ND

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

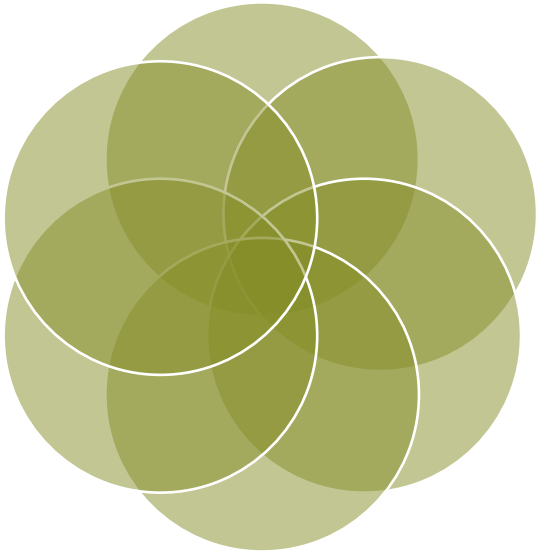
IMPLEMENTATION PLAN

Within 120 days of effective date produce draft plan

Plan Approved 9.21.21

Establish a method to address challenges to implementation

Review relevant services, capacity and barriers



Assign agency and division responsibility for achieving benchmarks

Engage Stakeholders

Identify benchmarks and timelines for meeting Agreement's requirements

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

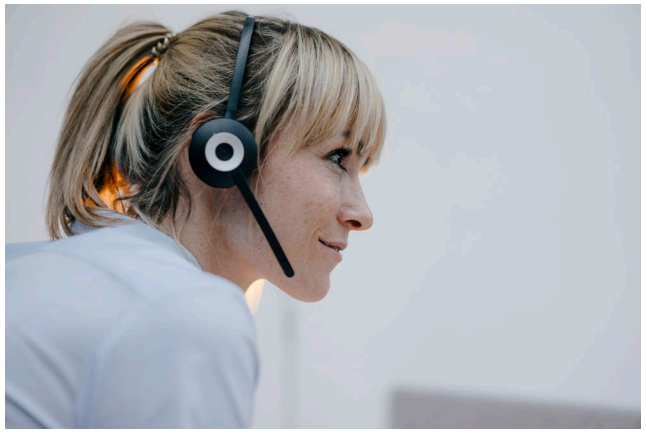
How do you apply or get more information about HCBS?

1-855-462-5465

Website: carechoice@nd.assistguide.net

Email: Carechoice@nd.gov

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

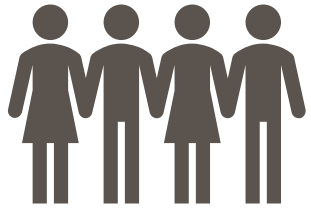


1st 10 months SA

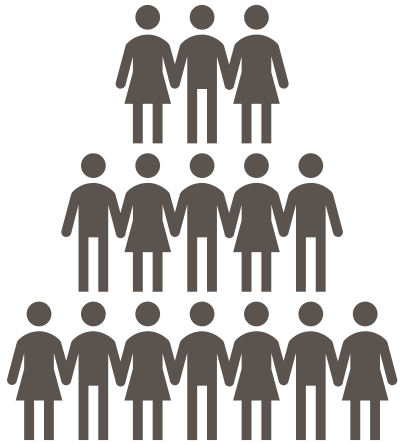
- 9,583 calls
- 44,318 website hits
- 461 web referrals
- 130 avg calls per mo for HCBS

VII. CASE MANAGEMENT

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



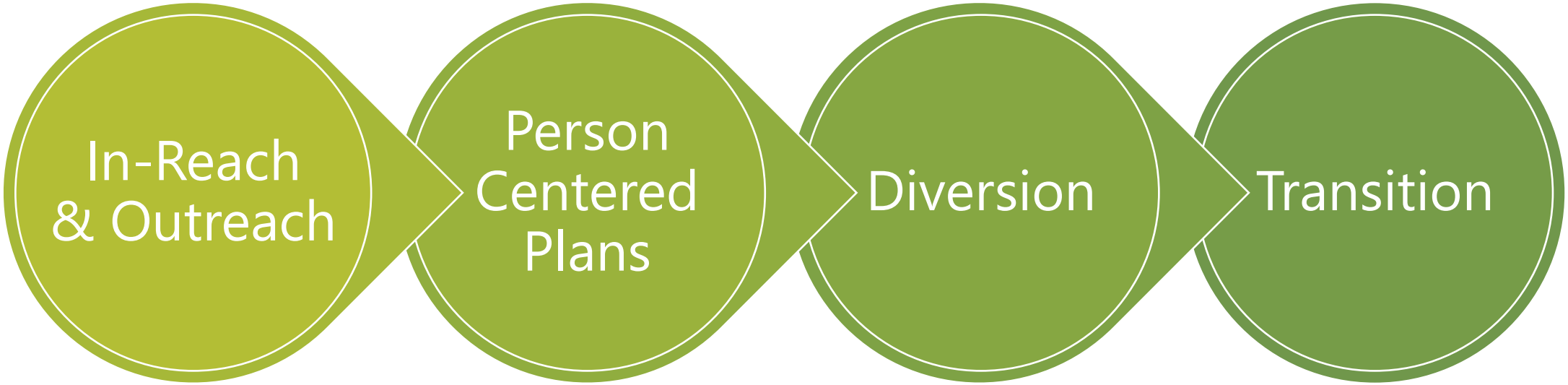
67 HCBS Case Managers



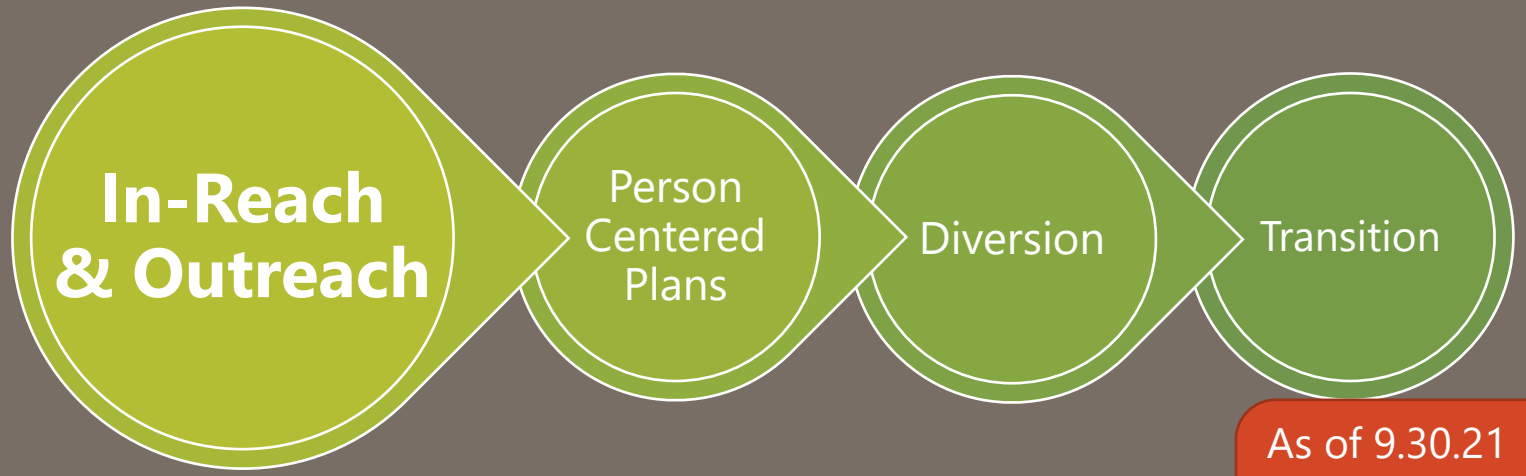
Served 2500 individuals
(July 2021)

- 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

ND / DOJ AGREEMENT STRATEGY



XIV. STRATEGY



As of 9.30.21
All facilities visited
400+ residents attended

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

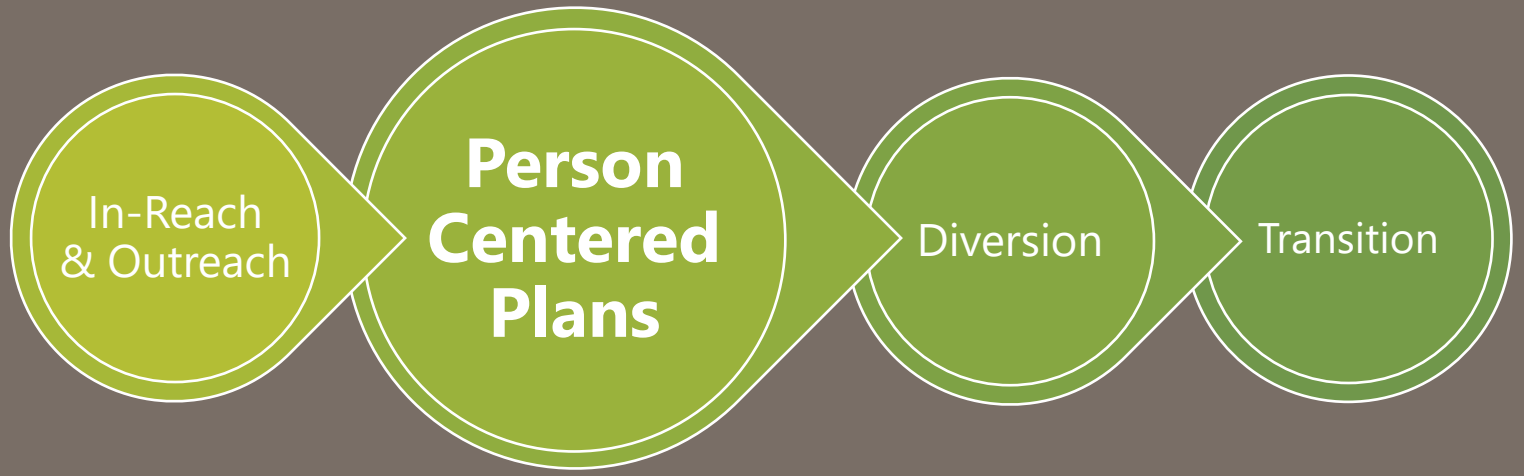
Within 9 months	Year 2	Year 4	Year 5 and after
•Individual or group in-reach to all skilled nursing facilities	•Develop peer support system	•Individual in-reach to at least 1,000 Skilled Nursing Facility target population members	• In-reach to all newly admitted or identified Skilled Nursing Facility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

ND / DOJ AGREEMENT STRATEGY

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

VIII. STRATEGY



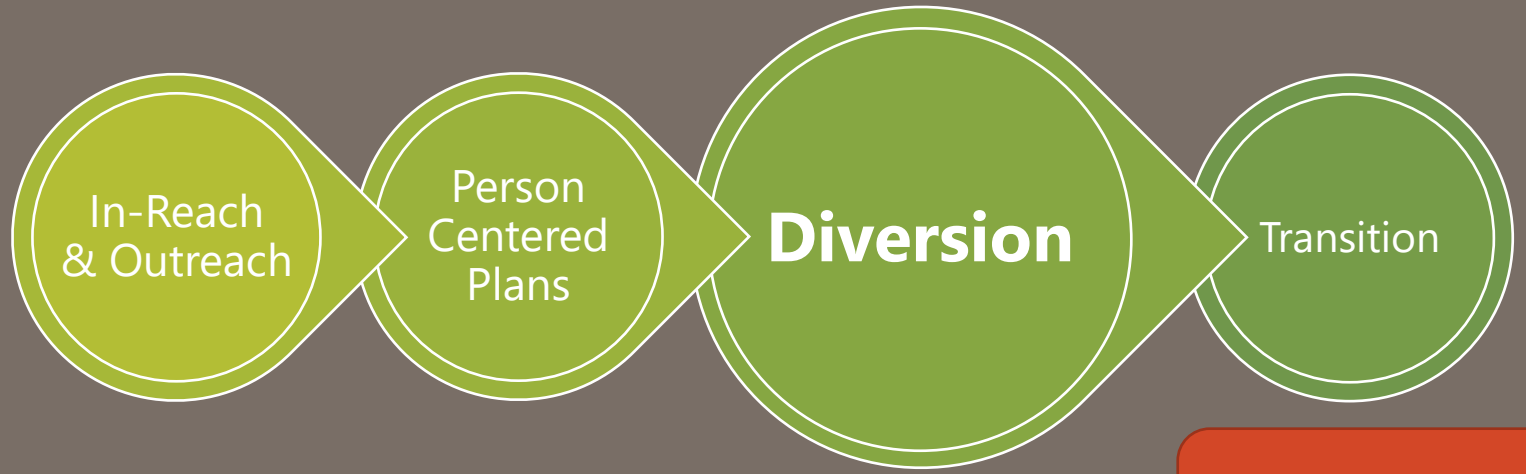
PERSON CENTERED PLANNING

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

GOALS

Year 1	Year 2	Year 4	Year 6	Year 8
•290 Target Population Members (TPM)	•Additional 290 TPM	•Additional 650 TPM	•Additional 670 TPM	•Additional 670 TPM

X. STRATEGY



1st 9 months SA
196 TPM diverted

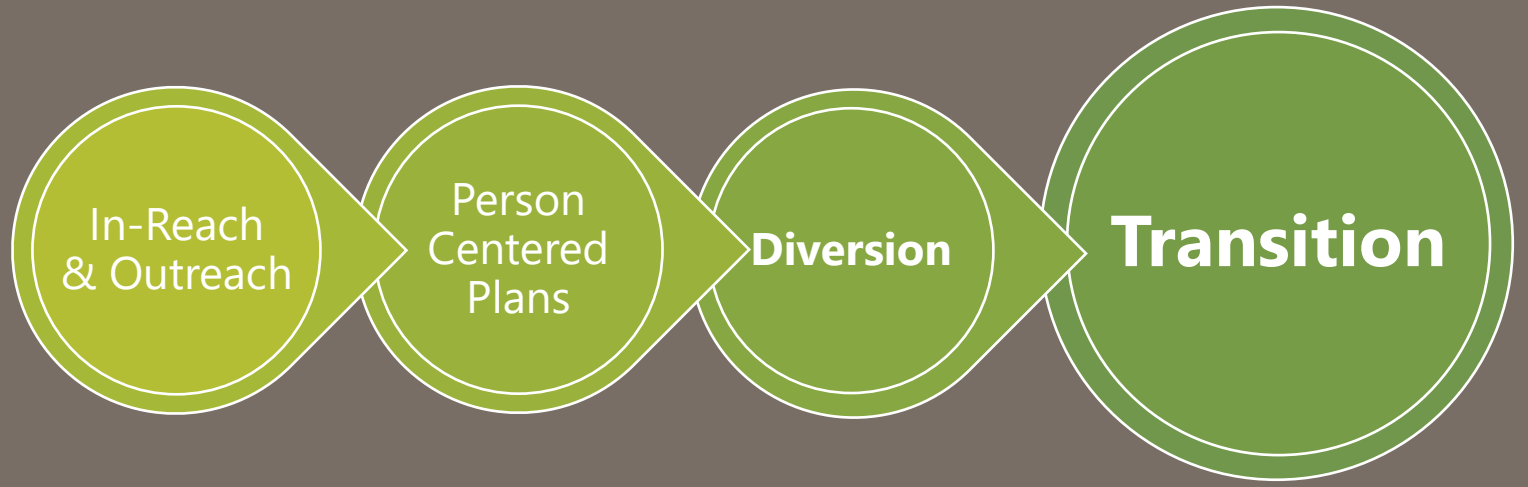
DIVERSION: COMMUNITY LIVING

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

Year 2	Year 4	Year 6	
•100 Target Population Members (TPM)	•150 additional TPM	•150 additional TPM	Total 400 diverted

XI. STRATEGY



1st 9 months SA
53 TPMs MFP transitions

TRANSITION TO COMMUNITY

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

GOALS

Year 2	Year 4	Year 6	Year 8
•Transition 100	•Transition 60% identified through person centered planning (PCP)	•Transition 70% identified through PCP	•Transition all remaining individuals identified PCP

XII. HOUSING SUPPORTS

1st 6 months SA
7 TPMs supported

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			
Year 1	**Year 2**	**Year 3**	**Year 4-8**
•Assist 20 Target Population Members (TPM)	•Assist additional 30 TPM	•Assist additional 60 TPM	•Assist additional number of TPM based on aggregate need

XIII. PROVIDER CAPACITY AND TRAI

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

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

Draft plan to addresses provider capacity, reimbursement rates, incentives to serve individuals with significant medical/supervision needs, those living on Native American reservations and in rural areas

KEY TERMS | DOJ SETTLEMENT
Americans with Disabilities Act

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.

KEY TERMS | DOJ SETTLEMENT
Community Integration Mandate

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.

KEY TERMS | DOJ SETTLEMENT
Informed Choice

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

1st 6 months SA
1,404 IC referral visits
701 interested in HCBS options

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

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)

AMERICANS WITH DISABILITY ACT

Americans with Disability Act

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**.

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

Americans with Disability Act

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.

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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**.

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)

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

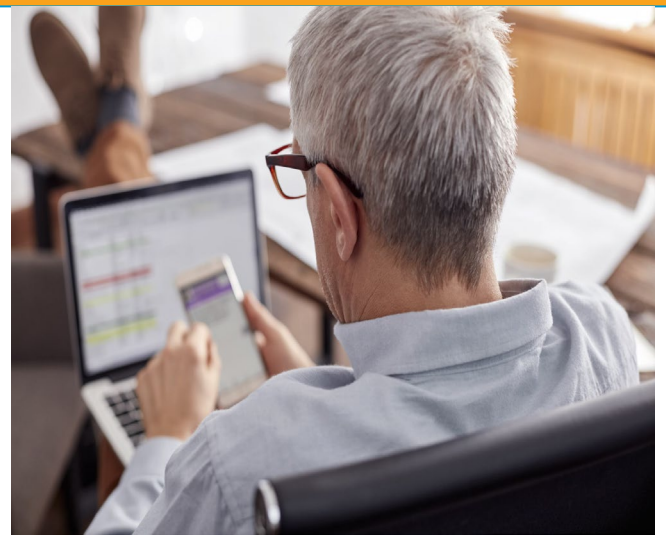
- Referrals should be made as soon as possible to facilitate strong transitions and successful community living
- Informed choice, transition coordination does not replace the normal discharge process
- Provide accurate information about current and ongoing needs of the resident or patient to facilitate 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

LISTENING SESSION

Stakeholder Engagement



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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