SUMMARY OF KEY ELEMENTS
State of North Dakota / US DOJ Settlement Agreement
Implementation Plan

Dec 14, 2020 – Dec 14, 2022

North Dakota is actively working to transform the home and community-based services experience for Target Population Members, making sure it is streamlined, effective, culturally-informed and a viable alternative to institutional living.

The overarching vision that guides the State's efforts under the Settlement Agreement is to take actions that support the ability of a Target Population Member to make an informed choice about where they want to live and how they want to receive needed services and supports.

For this vision to be realized, we need to transform people's ability to access home and community-based services and housing supports and enable reforms in the hospital discharge and long-term care delivery systems in North Dakota.

To make this vision possible, the strategies contained in the Implementation Plan focus on the need to:

- Increase access to community-based service options through policy, process, resources, tools, and capacity building efforts.
- Increase individual awareness about community-based service options and create opportunities for informed choice.
- Widen the array of services available, including more robust housing-related supports.
- Strengthen interdisciplinary connections between professionals who work in behavioral health, home health, housing, and home and community-based services (HCBS).
- Implement broad access to training and professional development that can support improved quality of service, highlighting practices that are culturally-informed, streamlined, and rooted in person-centered planning.
- Support improved quality across the array of services in all areas of the State.

About the Settlement Agreement

On December 14, 2020, the State of North Dakota (State) entered into an eight (8)-year Settlement Agreement with the United States Department of Justice (USDOJ). The Settlement Agreement is designed to ensure that the State will meet the requirements of Tittle II of the Americans with Disabilities Act (ADA).

The Settlement Agreement addresses a variety of concerns that were brought forward by Target Population Members (TPMs). The concerns included the:

- Unnecessary segregation of individuals with physical disability in skilled nursing facilities (SNF) who would rather be served in the community,
- Imbalance of funds for services delivered in SNF versus community-based services, and
- Lack of awareness about existing transition services and other available tools people can utilize to access in-community supports.

For purposes of the Settlement Agreement, a **Target Population Member** (TPM) is:

- an individual with a physical disability,
- over the age of 21,
- who is eligible or likely to become eligible to receive Medicaid long-term services and supports, and
- is likely to require such services for at least 90 days.

-Section IV Settlement Agreement

The strategies developed to meet the requirements of the Settlement Agreement will have long lasting benefits for current and future TPMs who want to live and receive services at home and enjoy the benefits of living in a non-institutional setting. The work to be accomplished as per the Settlement Agreement will:

- Expand awareness of community-based care,
- Allow individuals to make an informed choice about how and where they want to live and receive necessary services, and
- Build upon Legislative investments and a shared goal to improve home and community-based services to North Dakotans.

The Settlement Agreement requires the development of an Implementation Plan (IP) (defined in Section 6). The IP identifies benchmarks, timelines, and initial performance metrics for meeting the Settlement Agreement requirements, assigns agency and division responsibility for achieving those benchmarks, and establishes strategies to address challenges to implementation.

To operationalize this requirement, the State will develop the IP and a series of IP updates over the life of the Settlement Agreement. The first covers a period of 24 months that began December 14, 2020. Updates will occur annually thereafter.

About the Implementation Plan

The State hosted a series of six listening sessions which were attended by stakeholders who were interested in providing input and feedback that could inform the State's drafting of the IP. In addition, throughout the drafting process, the Subject Matter Expert and his team provided technical assistance to support the State's efforts and drafted four sub-plans that included a series of recommendations to be considered over the life of the SA.

The Settlement Agreement is structured in 18 sections. Sections I-VI and XVII-XVIII outline the overall parameters of the Settlement Agreement. Sections VII-XVI each outline an element of responsibility and focus intended to support the State's overall responsibility as per the Settlement Agreement.

The State's focus in this first 24-month IP is to set the foundation for our work by addressing elements from each of the requirements outlined in Sections VI – XVI of the Settlement Agreement. The State's IP is designed to follow the same "section" format as used in the Settlement Agreement.

- Implementation Plan (section VI)
- Case Management (section VII)
- Person Centered Plans (section VIII)
- Access to Community-based Services (section IX)
- Information, Screening, and Diversion (section X)
- Transition Services (section XI)
- Housing Services (section XII)
- Community Provider Capacity and Training (section XIII)
- In-reach, Outreach, Education, and Natural Supports (section XIV)
- Data Collection and Reporting (section XV)
- Quality Assurance and Risk Management (section XVI)

The document contains hyperlinks to help the reader navigate between the requirements of the Settlement Agreement and the strategies designed to meet those requirements in the IP.

The strategies under each section of the IP provide the details on how the State intends to start meeting the requirements of the Settlement Agreement during the first two years of implementation. The IP and strategies within the plan will be revised as necessary to meet the Settlement Agreement requirements.

The benchmarks and timelines listed under the strategies are estimated internal target completion dates unless otherwise noted. The dates were developed internally by the State and are not governed by the Settlement Agreement and may be modified as necessary and without consequence to the State's compliance with the Settlement Agreement.

Implementation Plan Timelines

Sections VI and XVII of the Settlement Agreement outline timelines that apply to the IP and subsequent updates, each of which is noted with an "r" to indicate "revision".

Plan	Submitted By	Approved By*	Time Period Covered
	Settlement Agreement Effective Date		Dec 14, 2020
IP	May 25 2021	Sept 1 2021	Dec 14, 2020 – Dec 14, 2022
IPr1	June 14 2022	Aug 15 2022	Dec 15, 2022 – Dec 14, 2023
IPr2	June 14 2023	Aug 15 2023	Dec 15, 2023 – Dec 14, 2024
IPr3	June 14 2024	Aug 15 2024	Dec 15, 2024 – Dec 14, 2025
IPr4	June 14 2025	Aug 15 2025	Dec 15, 2025 – Dec 14, 2026
IPr5	June 14 2026	Aug 15 2026	Dec 15, 2026 – Dec 14, 2027
IPr6	June 14 2027	Aug 15 2027	Dec 15, 2027 – Dec 14, 2028
	Period of Substantial Compliance		Dec 15, 2028 – Dec 14, 2029
	Termination of Settlement Agreement if Substantial Compliance is achieved		Dec 14, 2029

**The noted approval date is an estimated review and revision period based on timelines suggested by the processes that are described in the Settlement Agreement.*

The State will report on its progress in achieving the overall objectives of the Settlement Agreement, including updated progress on performance measures and Settlement Agreement benchmarks on a semiannual basis throughout the life of the Settlement Agreement.

The IP and all related reports will be made available to the public via the State's DOJ website: https://www.nd.gov/dhs/info/pubs/doj-settlement.html.

Section VII - Case Management

Case management is a core service that helps connect TPMs to the information and resources they need at a moment of critical life decisions. The availability of competent, person-centered case management that is built on a foundation of thorough and timely assessment is a critical component of any high-functioning HCBS system.

Settlement Requirement
The State will provide HCBS Case Management to assist TPMs in learning about, applying for, accessing, and maintaining community-based services.

SUMMARY OF IP STRATEGIES: Build Case Management Capacity

Section VII Case Management	Goal	Type of Work
Refine and better support the **role of the HCBS case manager** by implementing direct supervision, streamlined consistent administrative processes, and a standardized training curriculum.	Enhance HCBS system capacity	Expand service
Implement a **new case management information system** that allows all case management providers access to assessment and eligibility determination tools, person-centered plan development, creation of service authorizations, and case notes.	Simplify the case management process	Data and System Tools
Expand the Aging and Disability Resource Link (ADRL) to include **centralized intake and application for HCBS.**	Streamline intake and application process	Data and System Tools
Build and implement a sustainable **awareness campaign** that markets the broad array of HCBS to the target audience of TPMs, their families/guardians, and the professionals who often influence and advise TPMs on the most appropriate setting in which to receive services.	Build awareness of HCBS options	Training & Capacity Bldg

Section VIII – Person Centered Plans

Person Centered Plans need to be at the heart of the State's HCBS system. The strategies in the IP are intended to solidify the principles and practices of Person Centered Plan (PCP) development as a foundational element of the State's delivery of HCBS, both through training and the establishment of new processes that supports in-reach as a critical element of connection.

Settlement Requirement
Implement an individualized robust person-centered planning process to assist TPMs in understanding how HCBS can assist them to live in the most integrated setting appropriate for their needs and enjoy the benefits of community living.

REQUIRED BENCHMARK

By 12-14-2021: Complete person-centered planning with **290** TPMs; at least 50% must be completed with TPMs who reside in a SNF.

By 12-14-2022: Complete person-centered planning with a total of **580** TPMs (years 1 and 2); at least 50% must be completed with TPMs who reside in a SNF.

Settlement Agreement, Section VIII, I (3a) and (3b)

SUMMARY OF IP STRATEGIES: Strengthen Foundation with PCP

Section VIII Person-Centered Plans	Goal	Type of Work
Conduct individual and group **in-reach** to TPMs living in a SNF to ensure they know about options to receive care in the community.	Enhance connection through in-reach	Process
Provide all State, private, and tribal HCBS case managers with access to **"Charting the Life Course**" PCP training and tools contained within the new case management system.	Improve quality of case management	Training & Capacity Bldg
Provide **annual training, policy review, and guidance** that will assist the State in making person centered planning practices an integral part of the administration and delivery of HCBS to TPMs across the State.	Enhance quality and modify HCBS practices	Training & Capacity Bldg
Require **cultural competency training** created by local subject matter experts for all HCBS Case Managers and Aging Services staff of the North Dakota Department of Human Services to ensure that person-centered planning is conducted in a culturally responsive way to the greatest extent possible.	Improve cultural responsiveness of PCPs	Training & Capacity Bldg

Section IX - Access to Community-Based Services

To make non-institutional housing options possible, TPMs must have access to community-based services when and where they need them. The IP establishes workgroups tasked with identifying opportunities to improve service delivery and reasonable accommodation processes, develop and deliver targeted training, and access to capacity building resources and supports for service providers.

Settlement Requirement
The State will administer its HCBS, so they are flexible, available statewide and delivered in the most integrated setting appropriate, including a TPMs home, workplace, and other community-based settings. This includes providing reasonable modifications to address barriers to community living.

REQUIRED BENCHMARK

By 12-14-2021: State will enable TPMs who self-direct their care to receive sufficient support to do so including information and assistance to help them identify, select, supervise, and resolve conflicts and challenges with their community providers.

By 9-14-2021: Expand the HCBS Medicaid waiver service array to include residential habilitation, community support services and companionship and amend the SPED functional and financial eligibility criteria to expand access to community-based services.

Settlement Agreement, Section IX, D and H (1) & (2)

SUMMARY OF IP STRATEGIES: Enhance Access to Services

Section IX Access to Community-Based Services	Goal	Type of Work
Establish a **Service Delivery Workgroup** to make recommendations to the State on how to improve the authorization and service delivery system and create emergency and back-up service options for TPMs to access in the event of an emergency or loss of provider.	Evidenced-based recommendations for service delivery improvements	Policy Dev
Establish a **Healthcare Access Workgroup** to discuss reasonable accommodation requests that may conflict with the North Dakota Nurse Practice Act and develop recommendations to increase access to nursing services in the least restrictive setting.	Facilitate utilization of environmental modifications	Policy Dev
Educate case managers, TPMs, guardians/families, and other stakeholders **about reasonable accommodation** and the requirement for HCBS case managers to formally request services and accommodations for TPMs who have unmet service needs that would allow them to live in the most integrated setting appropriate.	Improve access to reasonable accommodations	Training & Capacity Bldg
Recruit and **retain** residential habilitation and community support **providers** to increase access for	Increase provider	Training &

up to 24 hour supports, care coordination, medication administration, and community integration for TPMs who need this level of support.	recruitment and retention efforts	Capacity Bldg
Utilize the **updated** functional and financial eligibility **criteria** for the Service Payments to the Elderly and Disabled (**SPED**) program to increase access to community-based services for TPMs.	Increased access to SPED services	Process

Section X – Information, Screening, and Diversion

Having access to information at the right time requires both the State and its private healthcare partners to modify processes and practices related to screenings and Nursing Facility Level of Care assessments (NF LoC). The IP is focused on evaluating and modifying policy as needed and on establishing a functioning Informed Choice Referral process that can effectively identify TPMs and provide them with both information and a PCP to facilitate their informed choice.

Settlement Requirement
Provide information about community-based services, person-centered planning, and transition services to all TPMs and guardians, if applicable, who formally request or require a screening for a continued stay in a SNF.

REQUIRED BENCHMARK

By 6.14.22: Provide required information to all TPMs and guardians and update the NFLoC approval process to ensure TPMs who are referred for a particular SNF service are offered the same service in the community if a community-based version exists.

By 9.14.2022: Demonstrate that the State provided the required information and ask the TPM to indicate in writing they received such information.

By 12.14.22: Require an annual NFLoC determination screening for all TPMs who reside in a SNF and assure necessary services are incorporated into the PCP and ensure screening and evaluations for SNFs are incorporated into the PCP.

Settlement Agreement, Section X, A & B

SUMMARY OF IP STRATEGIES: Establish Process and Practice

Section X Information Screening and Diversion	Goal	Type of Work
Implement an **informed choice referral process** that seeks to identify TPMs and provide them with all required information and an individualized PCP.	Implement Informed Choice Referral Process	Process
Conduct an **annual NFLoC screening determination** with all TPMs who currently reside in a SNF on an annual basis to ensure TPMs residing in a SNF continue to meet the functional eligibility criteria to require that level of care.	Conduct annual screening determination	Process
Develop an **Informed Choice Workgroup** to develop recommendations on the best way to provide information so TPMs and guardians, if applicable, have a true understanding of community-based options.	Evidenced-based recommendations to improve the Informed Choice process	Policy Dev
Develop a **NFLoC Workgroup** to develop recommendations to ensure the incremental changes made to the NFLoC screening criteria to allow more TPMs to access HCBS.	Recommendations to assure changes made to NF LoC criteria increase HCBS access	Policy Dev

Section XI - Transition Services

Facilitating transitions from a SNF to permanent supportive housing (PSH) requires coordination of resources and access to both housing and services in the community where a person is going to live. The IP builds capacity across systems to expand the number of successful transitions that occur across the State.

Settlement Requirement
Transition TPMs currently residing in a SNF to the community-based setting from their informed choice decision and most integrated setting described in their PCP. Provide transition services sufficient to prepare TPMs to return to the community with the supports necessary to prevent readmission and ensure their health and safety.

REQUIRED BENCHMARK

By 6.14.22: Ensure transitions occur no later than 120 days after the member chooses to pursue transition to the community.

By 12.14.22: Transition at least 100 TPMs from a SNF to the most integrated setting appropriate and divert at least 100 at risk TPMs from SNF.

Settlement Agreement, Section XI, E (2a)

SUMMARY OF IP STRATEGIES: Facilitate Successful Transitions

Section XI Transition Services	Goal	Type
Assign a **transition team** that consists of the HCBS case manager, transition coordinator and housing specialist (if applicable) to ensure an adequate transition plan is in place prior to moving to the community.	Facilitate coordinated, timely and successful transitions	Process
Transition TPMs to the community using resources and services provided by **the Money Follows the Person** (MFP) program and transition support services available under the HCBS Medicaid waiver.	Expand MFP and HCBS transitions	Expand service
Offer **incentive grants** to agencies willing to enroll or expand their service array to include transition supports.	Expand transition supports	Expand service
Conduct a **policy** review and adopt best **practices** from other state's successful MFP programs to **increase** the number of successful **transitions**.	Update transition policy and practice	Policy Dev
Conduct a quarterly review of transitions to identify **effective strategies** that led to successful and timely transitions, trends that slowed transitions, and gaps in services necessary to support successful community living.	Identify effective transition strategies	Policy Dev

Section XII - Housing

Permanent Supported Housing (PSH) is the broad term used to describe a community-based housing alternative to an institutional setting. PSH must be integrated, affordable, and accessible as per a TPMs needs. Additionally, the TPM must be able to access the long-term services and supports they need to maintain independence in the community setting.

The State will work with partners to broaden access to supports that create PSH in communities across the State, including rental assistance, transition supports, resources to help modify living environments, and general facilitation of a TPMs needs related to identifying suitable housing.

REQUIRED BENCHMARK

By 12.14.21: Provide PSH to at least 20 TPMs with an identified need for these services.

By 12.14.22: Provide PSH to at least 30 additional TPMs with an identified need for these services.

Settlement Agreement, Section XII, B(1a) and (1b)

Settlement Requirement
Provide Federal, State, and/or local assistance to TPMs who need help accessing available integrated housing and support for TPMs where lack of housing has been identified as a barrier to community-based services.

SUMMARY OF IP STRATEGIES: Build Connections and PSH Capacity

Section XII Housing Services	Goal	Type of Work
Expand PSH capacity by **funding and providing rental subsidies** for use as PSH.	Expand access to rental assistance	Expand Service
Connect TPMs whose PCP identify a need for PSH **to PSH** or housing that SME agrees otherwise meets requirements of 28 C.F.R. § 35.130(d).	Connect TPMs to PSH	Expand service
Implement staff diversion or **transition teams**, as appropriate, for each TPM who has an identified housing need.	Connect TPMs to housing supports	Expand service
Increase the network of **housing facilitators** and **transition coordinators** working in the State.	Increase housing supports	Expand service
Connect HCBS **case management** to **informed choice** referral process and to new **housing support** resources that are available in the State.	Build connection between teams	Process
Develop a matrix that identifies all home and **environmental modification resources** available in	Inventory of all modification	Data and System

Section XII Housing Services	Goal	Type of Work
the State.	resources	tools
Establish a **Joint Housing Services Committee** to build inter-disciplinary connections (housing facilitation, HCBS case management, transition coordination, rental assistance, and environmental modification).	Build connections between professions	Process
Establish an **Interagency Environmental Modifications workgroup** to identify needed program adjustments to broaden access to home and environmental modification resources, including amendments to 1915c waivers.	Make recommendations to increase access to modifications to living environ.	Policy Dev
Assure connection between housing and case management systems by establishing a practices to connect information for reporting and analysis.	Enhance Information sharing between systems	System tool
Define housing barriers that face North Dakota renters and ensure those variables are reflected in informed choice and case management processes.	Identify housing barriers in PCPs	System tool
Develop **training** for housing support providers to know how to access various **home modification resources** effectively and appropriately and help professionals/teams **integrate reasonable accommodation** ideas **into PCPs.**	Build skills for using environmental modification in PSH	Training & Capacity Bldg
Examine policies regarding "**intent to return home**" and include information about **intent to return** home in the **informed choice process**.	Streamline guidance re intent to return home status	Process
Enhance the existing **North Dakota Housing 101 training** course that has been designed to introduce helping professionals to housing concepts, terminology, and market information, including identification of additional modules to allow for deeper knowledge on specific topics.	Expand awareness of housing and PSH as element of PCP and informed choice	Training & Capacity Bldg

Section XIII - Community Provider Capacity and Training

In North Dakota, HCBS are delivered primarily by private sector providers, both non-profit and for-profit. Building private sector capacity to deliver services will require policy changes, incentives, coaching, and support.

Settlement Requirement
Ensure an adequate supply of qualified trained community providers to enable TPMs to transition and live in the most integrated setting. Provide guidance and training to SNFs and other community providers who make a commitment to provide community-based services.

REQUIRED BENCHMARK

By 6.14.21: State will provide technical assistance to SNFs and community providers who make a commitment to provide HCBS.

Settlement Agreement, Section XIII, D

SUMMARY OF IP STRATEGIES: Build Provider Capacity

Section XIII Community Provider Capacity and Training	Goal	Type of Work
Revise and **streamline** the **QSP** agency and individual **enrollment process** to eliminate barriers to enrollment and improve the provider enrollment experience for QSPs.	Streamline provider enrollment	Process
Contract with a vendor to complete **QSP enrollment and revalidations** which increase staff capacity and decrease the amount of time it takes to enroll as a QSP.	Accelerate provider enrollment	Process
Create a centralized **QSP matching portal** to replace the current QSP database.	Facilitate connections between people and providers	System tool
Provide **incentive grants** that support the start-up and enrollment activities for new or existing QSPs to establish or expand their business to provide HCBS.	Incentivize providers to expand service	Expand service
Request a **rate increase** for supervision, non-medical transportation, non-medical transportation escort and family personal care to ensure to increase provider capacity and access to these critical services for TPMs.	Increase viability of service delivery	Policy Dev
Seek approval from CMS and Legislative authority to **implement** the State's draft Plan for Implementation of the **ARPA** of 2021 **Section 9817**. This plan seeks to	Expand resources to	Training & Capacity Bldg

Section XIII Community Provider Capacity and Training	Goal	Type of Work
accelerate the expansion of HCBS by making investments in various areas of the HCBS system that support an increase in provider capacity, diversions, and transitions from institutional settings.	grow HCBS capacity	
Establish a **Direct Service Workforce/Family Caregiver Resource and Training Center** to help train TPMs and QSPs to understand to the full scope of services and the various requirements for enrollment, billing service authorizations, and interacting with HCBS Case Managers.	Establish Resource and Training Center through MFP Capacity Building grant	Training & Capacity Bldg
Develop a series of **educational webinars** that focus on individual HCBS types to increase understanding of HCBS and to recruit additional providers.	Encourage providers to expand services	Training & Capacity Bldg
Consider **adopting alternative provider models** and formal self-directed services in the HCBS Medicaid waiver to reduce administrative burden and improve the recruitment and retention of QSPs.	Enable new models of service delivery	Policy Dev

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Section XIV - In-reach, Outreach, Education, and Natural Supports

Making connections at the right time and with the right resources is essential to enabling informed choice. Conducting effective In-reach and Outreach, building functional capacity of TPMs, peer and natural supports, and aligning screening and referral processes to support an individual PCP requires policy modifications, changes in process and practice, and training.

REQUIRED BENCHMARK

By 9.14.21: (and annually thereafter)

State will conduct individual or group in-reach to each SNF to inform residents about community-based services and Settlement Agreement requirements

Settlement Agreement, Section XIV, A (1)

Settlement Requirement
The State will provide frequent in-reach, outreach and training to stakeholders and publish information about community-based services for individuals who are likely to become TPMs members while the Settlement Agreement is in effect.

SUMMARY OF IP STRATEGIES: Change of Approach

Section XIV In-reach, Outreach, Education & Natural Supports	Goal	Type of Work
Conduct in-person group **in-reach presentations** in **every SNF** in the State.	Provide information about HCBS to SNF residents	Expand service
Identify TPMs who screen at a NF LoC and **conduct an informed choice referral visit** to ensure they have information to help them make an informed decision about where they want to live and receive necessary services.	Conduct informed choice visits	Expand service
Increase access to **respite services** and training for individuals who act as natural supports for TPMs.	Improve access to and quality of respite	Expand service
Develop an **Informed Choice Workgroup** to develop recommendations on how to improve the current process.	Evidenced-based recommendations to improve the Informed Choice process	Policy Dev
Create a **Peer Support Resource Center** to give TPMs an opportunity to connect with peers who have lived experience navigating and utilizing HCBS.	Create Peer Support Resource Center	Training & Capacity Bldg

Section XIV In-reach, Outreach, Education & Natural Supports	Goal	Type of Work
Create a **public awareness campaign** and communication plan to increase awareness of HCBS and ADRL.	Build awareness of HCBS options	Training & Capacity Bldg
Offer and promote evidence-based **training** to **improve** the **functional ability of TPMs**	Support independence of TPMs	Training & Capacity Bldg

Section XV - Data Collection and Reporting

The State must be able to measure the impact of the changes it is making across systems by understanding the impact of work that happens within and between systems. Intentional development of cross-system approaches to data collection and analyses that occur throughout the IP will help assure continued attention to benchmarks and performance measures.

Settlement Requirement
Create a data collection system that will assist in meeting reporting requirements of the Settlement Agreement including the total number of at risk TPMs and TPMs living in a SNF.

REQUIRED BENCHMARK

By 6.14.22: Enhance the current data collection process to collect data as required in the Settlement Agreement.

Settlement Agreement, Section XV, A

SUMMARY OF IP STRATEGIES: Shared Data Systems

Section XV Data Collection	Goal	Type of Work
Implement a new case management system that will allow the State to collect and report aggregate data as required.	Enhance data collection and reporting by increasing appropriate access to the system	Data and System tools

Section XVI – Quality Assurance and Risk Management

Defining and understanding quality indicators in how services are delivered and how systems operate will require the State to examine quality measures that allow for both direct assessment and comparison to experiences in other states.

Settlement Requirement
Ensure that the HCBS provided meet the identified needs of the TPM and maintain their health and safety.

REQUIRED BENCHMARK

By 6.14.21: The SME is required to produce a safety assurance plan that includes a plan to train community providers about incident reporting, review procedures to mitigate harm and require Agency QSPs employing non-family caregivers to have a quality improvement plan.

State is also required to submit critical incident reports to the US DOJ and the Subject Matter Expert within 7 days of the reported incident.

Settlement Agreement, Section XVI, B

SUMMARY OF IP STRATEGIES: Establish quality and safety strategy

Section XVI Quality Assurance and Risk Management	Goal	Type
Provide an efficient way for providers to submit critical incident reports via the implementation of a **new case management system**.	Efficient reporting of critical incidents	Process
Utilize information gathered from Critical Incident Reporting Team to **develop remediation plans** that will help prevent future incidents.	System improvement informed by data	Process
Convene a **Quality Improvement Workgroup** to draft a quality improvement strategy that can be adopted by Agency QSPs to improve the safety and effectiveness of HCBS.	Recommendations to improve safety and quality	Policy Dev
Implement the **National Core Indicators** – Aging and Disability (NCI-AD) to measure and track the State's performance and outcomes of HCBS delivered to TPMs.	Utilize NCI to Improve quality of services and system	Data and System tools

Taken together, the initiatives outlined in the ND | DOJ Implementation Plan will transform the state's system of home and community-based services, better supporting the ability of a Target Population Member to make an informed choice about where they want to live and how they want to receive needed services and supports.