1915(i) Care Coordination: Training Workflow

The below guidance is based off the 1915(i) Care Coordination policy, located on the 1915(i) Provider Guidance and Policies webpage. This guide does not countermand any part of any 1915(i) policy.

The resources listed in this training guide are not an exhaustive list of what is available. For this training guide, they are the starting points one could use to find resources for members. Resources will vary depending on where the member lives.

External resources included in this training are provided for reference only. They are independently maintained and are not affiliated with, endorsed by, or approved by the1915(i) program or North Dakota Health and Human Services. Their inclusion does not constitute an endorsement or requirement of the 1915(i) program.

Example Member: James Johnson is a 29 year-old male, couch surfing, untreated bipolar disorder, daily alcohol use, recent jail release (not on probation currently but was in the past), food insecurity, transportation barriers, difficulty understanding paperwork. There is a waitlist for peer support and housing support in member's county of residence.

1. Comprehensive Assessment and Reassessment Activities

Required Activities

- Review the World Health Organization Disability Assessment Schedule (WHODAS) or Daily Living Activities assessment (DLA) during the first meeting, using person-centered interviewing. In the member's individual home page, in Oversight, the WHODAS or DLA score is listed under Assessment List. The guide to look up a member's information in Therap is available on the 1915(i) Provider Guidance and Policies webpage. Also, on this webpage are the other Therap guides you will can reference for Therap processes.

- Gather collateral information (with signed Release of Information (ROI)):
  - Possible entities to contact for collateral information
    - Former Probation Officer
    - Past and current mental health providers
    - Friends and family, the member identifies
    - Any medical entity member has had any contact with, or continues to work with
    - Outreach worker/Social worker member has worked with in the past
    - Any other agency, or service provider member has, or continues to work with

- Document Social Determinants of Health (SDOH) across all five domains:
  - *Economic stability:* No income, no savings, no employment

- *Education:* High school diploma, difficulty understanding paperwork
- *Health and health care:* Untreated bipolar disorder, daily alcohol use, no primary care
- *Neighborhood and built environment:* Couch-surfing, unstable housing, risk of homelessness
- *Social and community context:* Unstable family relationships, limited supports
- Complete an initial risk assessment including (part of the plan of care):
  - Risk
  - Trigger
  - Known Responses
  - Safety Measures in Place
  - Safeguards
- Begin the crisis plan immediately (required within 30 days).
- Verify Home and Community Based Services (HCBS) settings compliance:
  - All services will occur in community based, noninstitutional settings.

Additional Detail for Training

- Coordinators may meet James wherever he feels safe: office, library, coffee shop, etc. (make sure to keep privacy in mind when talking about private health information)
- Coordinators may use multiple short meetings due to his rapid speech, distractibility, or frustration.
- Coordinators should document functional needs in James's own words whenever possible.

Case Note Expectations

- Document every assessment activity, collateral contact, and risk factor.
- Show clear linkage between assessment findings and plan of care (POC) needs.

2. Development of the Individualized Person-centered Plan of Care (POC)

What the Care Coordinator Can Do:

- Facilitate a member directed planning meeting at a location chosen by James.
- Use the required Therap Plan of Care (POC) template, following the Plan of Care Creation guide.

- Ensure goals reflect WHODAS/DLA findings and are SMART Goals ([Click here for the 1915(i) Provider Trainings & Information Sessions webpage](#) for more on-demand trainings).
- Ensure James chooses:
    - Who participates
    - Which providers he prefers
    - How he wants services delivered
- Document all unmet needs:
    - Housing
    - Food
    - Transportation
    - Mental health stability
    - Substance use concerns
    - Legal obligations
    - Safety
    - Employment
    - Upload any relevant documentation into the member's Therap Oversight Document Storage. Review the Saving Documents in Member's Therap Oversight Account guide.

Additional Detail for Training

- Coordinators may break the POC meeting into multiple sessions if James becomes overwhelmed or defensive.
- Coordinators may use visual aids (timelines, goal charts) to help him understand the process.
- Coordinators may read the POC aloud if he struggles with paperwork.

Case Note Expectations

- Show that James directed the meeting.
- Show that the POC reflects his language, preferences, and priorities.

3. Crisis Plan Development, Implementation, and Monitoring

What the Care Coordinator Can Do:

A risk management/crisis plan is in place to ensure the member has access to needed assistance if their regular services and supports are not available. The crisis plan may include electronic devices, other individuals, or other services. Individuals available to provide

temporary assistance to the member include informal natural supports such as a caregiver, family, friends, or another responsible adult.

Care Coordinators: You must provide 24/7 backup contact information to the member within the first week of initial contact: 988 and 911 are good resources to use.

Below are known risks to the member's health and well-being, things that could potentially trigger a crisis, how the member may respond to these triggers in the past, measures in place to minimize the member's risks, and safeguards.

- Risk(s)
- Trigger(s)
- Known Response(s)
- Safety measure(s) in place:
- Safeguard(s)
- Interim supports while waiting for services:
    - Weekly (more if needed) check-ins
    - Linking to food resources and food pantries
    - Helping apply for transportation vouchers
    - Helping access warming centers/shelters
    - Helping access Medicaid transportation
    - Helping obtain a phone through the Lifeline program
    - Helping replace ID and Social Security card
    - Helping complete housing applications
    - Helping maintain contact with housing programs
    - Help connecting member to substance abuse resources
    - The following potential resource lists begin to address the members' needs. These lists are not encompassing of all that is out there, and are meant only as a start, and for educational purposes.
        Housing
        - ND Housing Finance Agency (NDHFA) https://www.ndhousing.nd.gov/?utm_source.com
        - HUD North Dakota www.hud.gov/states/north-dakota
        - Pathways to Success Pathways to Success
        - North Dakota Housing Directory (Shelters & Rental Assistance) www.oacra.com/find-serviceswww.oacra.com/find-services?
        - ND Housing Programs www.hhs.nd.gov/housing-programs

Food

- North Dakota Health & Human Services Food Programs
  www.hhs.nd.gov/food-programs?utm_source=copilot.com

- Apply for Help Portal (SNAP, TANF, WIC, CCAP)
  www.hhs.nd.gov/applyforhelp?utm_source=copilot.com

- Great Plains Food Bank GREAT PLAINS FOOD BANK

Transportation

- North Dakota Transit Services (Bus/Shuttle Directory)
  https://www.ndtourism.com/information/north-dakota-buses-shuttles?utm_source=.com

- NDDOT www.dot.nd.gov/?utm_source=.com

Mental Health

- ND Mental Health Program Directory
  https://www.hhs.nd.gov/behavioral-health/directory?utm_source=.com

- Mental Health America of North Dakota (MHAND)
  www.mhand.org/about.html

- NAMI North Dakota NAMI North Dakota - Support for Mental Health

- Dakota Family Services Dakota Family Services | Fargo, Minot & Online | Mental Health

- Health and Human Services Behavioral Health
  www.hhs.nd.gov/behavioral-health

Substance Use

- ND Health & Human Services – Addiction Services
  https://www.hhs.nd.gov/behavioral-health/addiction?utm_source=.com

- North Dakota Treatment Providers Directory (OACRA)
  www.oacra.com/find-services/nd-treatment-providers?utm_source=.com

- Substance Use Prevention Month Toolkit
  www.hhs.nd.gov/behavioral-health/prevention-month

Legal

- Legal Services of North Dakota (LSND)
  https://lsnd.org/?utm_source=.com

- North Dakota Court System – Legal Self-Help Center & Resources
  www.ndcourts.gov/legal-self-help/other-resources?utm_source=.com

- Dakota Plains Legal Services www.dpls.org/about-us

Safety

- 988 Suicide & Crisis Lifeline (ND)
  www.hhs.nd.gov/crisis?utm_source=.com
- North Dakota Suicide Prevention Coalition (NDSPC) Home | NDSPC
- FirstLink 211 Resources + Services | FirstLink
- ND Response – Stress & Coping Resources Stress & Coping | ND Response
- ND HOPES www.ndhopes.com/about

Employment

- North Dakota Job Service www.jobsnd.com
- Vocational Rehabilitation – ND Health & Human Services www.hhs.nd.gov/vr

SMART Goal Development (Specific, Measurable, Achievable, Relevant, Timely)

Care Coordinator Crisis Goal (first 60 day) (Do not copy and paste either of these goals into a plan of care. You can use them as a starting point, but you need to make any goal you create person-centered for each specific member)

S - Specific: "I will work with my care coordinator to complete my crisis plan, have weekly (or daily if needed) check-ins, and get connected to services for housing, mental health, food resources, employment, and harm reduction. If any services are delayed, I will work with my care coordinator to identify natural supports and community resources I can use in the meantime. My care coordinator will help me stay connected until long-term services begin."

- Why this fits the S in SMART
  - Specifies that the member will complete their crisis plan, participate in weekly or daily check-ins, and get connected to housing, mental health, food, employment, and harm-reduction services.
  - It states that if services are delayed, the member will work with the coordinator to identify natural supports and community resources.
  - Every action is framed as something the member will do with support from the care coordinator.
  - It names the exact tasks, the frequency of contact, and the service areas involved, making the goal concrete and actionable.

M - Measurable: "I will measure my progress by completing my crisis plan, showing up for weekly (or daily if needed) check-ins, and getting connected to the services I need. My progress will also be measured by documenting any referrals made for housing, mental health, food, employment, or harm reduction. If services are delayed, I will track how I use natural supports and community resources."

- Why This fits the M in SMART

- Identifies specific indicators: crisis plan completion, attendance at weekly/daily check-ins, service connections, and documented referrals.
- States that referrals, service connections, and use of natural supports will be documented and reviewed.
- Every element (check-ins, referrals, crisis plan completion, use of supports) can be logged in notes and verified.
- Progress is demonstrated through completed tasks, attendance, and documented steps toward service linkage.

A - Achievable: "This goal is achievable for me because I only need to complete one crisis plan, stay in regular contact with my care coordinator, and start connecting to services within 60 days. My care coordinator will help me work through barriers so I can stay on track. If services take time to start, I will use natural supports and community resources to keep moving forward."

- Why this fits the A in SMART
  - Limits the tasks to completing one crisis plan, maintaining regular contact, and beginning service connections within 60 days, all of which are achievable steps.
  - It states that the care coordinator will help the member work through barriers and stay on track.
  - Explains that the member can use natural supports and community resources when services take time to start.
  - Actions are manageable, time-bound, and supported by the coordinator, making the goal achievable within the crisis-stabilization period.

R - Relevant: "This goal is relevant to my stability and well-being because it focuses on my housing, mental health, food access, employment, and safer substance use practices. Completing my crisis plan and getting connected to services will help me build a stronger support system. These steps will help me make progress in the areas that matter most in my life."

- Why this fits the R in SMART
  - Focuses on core needs like housing, mental health, food access, employment, and safer substance use, all of which directly affect the member's daily stability.
  - Explains that completing the crisis plan and connecting to services will help the member build a stronger support system.
  - Centers on the areas the member identified as most important for improving their life and maintaining stability.
  - Strengthening supports and addressing basic needs are essential steps toward long-term safety, stability, and recovery.

T – Time-Bound: "I will complete this goal within my first 60 days of care. During this time, I will finish my crisis plan, start connecting to services, and participate in weekly check-ins. This timeline helps me stay focused and ensures I get support as quickly as possible."

- Why this fits the T in SMART
    - The member will complete the goal within the first 60 days of care.
    - Identifies that the member will finish their crisis plan, begin connecting to services, and participate in weekly check-ins during those 60 days.
    - 60 days is the care coordination crisis goal window and matches the member's achievable tasks.
    - Provides a defined period that helps the member stay on track and ensures timely support.

Post-60-Day Care Coordination Goal (the time measurements in this goal are only 30 days, because the care coordinator is creating this goal at the 60 day mark when the care coordinator crisis goal ends, and you will be meeting with the member at day 90 for the first quarterly review).

S - Specific: "I will stay connected to my services by completing one action step each week related to my housing, mental health, food resources, employment, or harm reduction. I will meet with my care coordinator every week (more if needed) to review the action step I completed and make sure the services I'm using are still the right fit for me."

M - Measurable: "I will measure my progress by keeping track of the weekly action steps I complete and the weekly meetings I have with my care coordinator. By the end of 30 days, I will have completed at least four action steps and participated in at least four check-ins."

A - Achievable: "This goal is achievable for me because I only need to complete one action step each week, which helps me make steady progress without feeling overwhelmed. My care coordinator will support me each week so I can work through barriers and stay on track."

R - Relevant: "This goal is relevant to my stability and well-being because it focuses on important areas of my life, including housing, mental health, food access, employment, and harm reduction. Staying connected to these services helps me work toward meaningful improvements in my overall health."

T – Time-Bound: "I will complete this goal within a 30-day period. Weekly action steps and weekly meetings give me a clear structure that helps me stay focused and keep moving forward throughout the month."

Additional Detail for Training

- SMART goals should be written in James's voice.
- Goals must be revised quarterly or sooner if circumstances change.
- Coordinators must document barriers (e.g., substance use, legal stress, transportation gaps, etc.).

4. Referrals, Collateral Contacts, and Related Activities

What the Care Coordinator Can Do

- Submit referrals in Therap for:
  - Refer to the Therap Referral guide for what is required on referrals in Therap
  - Document denials or non-responses for peer support and housing support services. As these will be the proof you need if the member wants to use your agency for peer support and housing support as well. Click here to review the 1915(i) Conflict of Interest policy.
- Provide interim supports:
  - Help apply for Supplemental Nutrition Assistance Program (SNAP)
  - Help apply for Medicaid transportation
  - Connect to food pantries, warming centers
  - Help obtain a phone through Lifeline
  - Help replace ID and Social Security card
  - Coordinate with behavioral health providers
  - Coordinate with shelters and outreach teams
  - Coordinate with housing programs
- Connect the member to non-1915(i) services. See the guide to connecting member's to non-1915(i) services.
  - Member is a potential referral to Occupational Therapists (OT), review 9-17-25 Office Hour Recap for more details.
- Maintain weekly collateral contacts with:
  - Former Probation Officer
  - Friends/family he identifies
  - Food pantry coordinators
  - Behavioral health providers
  - Housing programs
  - Any other agency or entity the member is working with.

Additional Detail for Training

- Coordinators may attend appointments with James for navigation support (not clinical or medical meetings). Provided that the meeting's goal is to connect James to another service (1915i or community based) and that connecting James to the new service necessitates an update to the POC. The POC would have a goal added to it that shows the member is connected to the service, and the goal would detail what the member and the service provider are working on.

- Coordinators may help him gather documents.
- Coordinators may help him track deadlines for housing applications.

Case Note Expectations

- Document outcomes of contacts with other services you are working to connect James with. Making sure to document what has occurred so far, and what needs to be done in the future.
- Document all meeting outcomes in case notes, and put meeting information on the POC
- Document all collateral contacts and outcomes.

5. Monitoring and Follow-up Activities

What the Care Coordinator Can Do

- Review provider case notes weekly (once services begin).
- If member is connected to a non-1915i service have a ROI in place that allows you to share information and establish a clear path of communication between you and the non-1915i service.
- Conduct weekly (more if needed) check-ins during the crisis period.
- Minimum face-to-face meetings every 90 days. More is the likely reality, and it will all depend on the members' needs, how many you have.
- Update the POC quarterly using the Quarterly/Interim Reviews & Individual Plan Agenda (IPA) guide.
- Track whether services are being delivered as requested.
- If services end up not meeting members' needs, find an alternative.
- Document interim supports while waiting for peer support and housing support.
- Document changes in risk, safety, or functional needs.

Additional Detail for Training

- Coordinators may meet more frequently if James is unstable.
- Coordinators may help him solve problems with missed appointments.
- Coordinators may help him maintain contact with housing programs (critical for waitlists).

Case Note Expectations

- Document every monitoring activity.
- Show that services are necessary, effective, and aligned with goals.

6. HCBS Setting Compliance Verification

The care coordinator's role includes verification of HCBS Settings Rule compliance. Services must be rendered in a HCBS setting rather than an institutional setting. Care coordinators are responsible for ensuring that services are rendered in non-institutional settings. For service settings other than a member's private residence or a community-based nonresidential setting, care coordinators should refer to the Home and Community-Based Setting policy to determine whether services will be or are being rendered in a compliant setting. SComm 1915(i) admins any time the member enters a non-compliant HCBS setting (Hospital, Jail, State Hospital, etc.)

7. Eligibility Redeterminations

What the Care Coordinator Can Do

- Track eligibility expiration date ND Health Enterprise Medicaid Management Information System (MMIS) webpage
- Begin renewal process no later than 30 days before expiration.
- Coordinate the completion of a new WHODAS/DLA
- Create a new POC.
- Submit the **Care Coordination Request Report (CCRR)**.
- If eligibility lapses:
    - Document any break in eligibility

Additional Detail for Training

- Coordinators should remind James multiple times about renewal deadlines.
- Coordinators may help gather verification documents needed for renewal.
- Coordinators must ensure the POC is fully updated before submission.

Case Note Expectations

- Show proactive tracking.
- Show timely submission.
- Show updated assessments and POC.