Care Coordination for Minors on 1915i

This guide outlines possible steps a care coordinator can take when working with a minor (member under age 18) enrolled in the 1915(i) program. Nothing in this guide countermands anything in any 1915(i) policy.

1. Initial Engagement and Onboarding

A care coordinator's first point of contact with a minor member always involves the parent or legal guardian. Within five business days of initial contact, the coordinator completes and submits the Care Coordination Request Report. The coordinator provides both the minor and guardian with the appropriate Member Rights & Responsibilities form (Traditional or Expansion). Both the minor and guardian sign and date this form, which becomes part of the plan of care (POC).

At the first planning meeting, the minor and guardian jointly decide:

- Who will attend, including any teachers, therapists, or other advocates that are identified as being a part of the minor's team.
- Where and when the meeting occurs
- How the minor's preferences and strengths will guide the discussions
- All invited participants receive clear meeting notices.
- All invited participants are listed on the release of information signed by the minor's guardian

2. Comprehensive Assessment and Reassessment

To build an accurate picture of the minor's needs, coordinators use:

- WHODAS 2.0 or DLA eligibility assessments
- A tailored self-assessment co-completed with the minor and guardian
- Collateral information from family members, pediatricians, school staff, social workers and any other team members. Make sure to have a release of information for all of them.

Assessment domains include physical health, emotional well-being, social determinants (e.g., family income, school environment), and safety risks (including self-harm risks). Coordinators document strengths, barriers, and emerging needs in Therap. Annual reassessments mirror the initial process, ensuring that developmental milestones (e.g., transitions to middle school) inform updated goals.

3. Person-Centered Plan of Care (POC) Development

Within 30 calendar days of first contact, the coordinator drafts and submits a POC in Therap using the mandated template. This POC includes:

- A clear statement of the minor's outcomes as expressed by the minor and guardian
- Identification of all services (family peer support, respite, educational aids, etc.)
- Named providers or "TBD" placeholders for anticipated referrals

The minor leads age-appropriate portions of the meeting, with the guardian ensuring legal consent and advocacy. Coordinators translate assessment findings into action items, using plain language that both minor and family understand.

4. Crafting SMART Goals for Minors

Each objective in the POC must be Specific, Measurable, Achievable, Relevant, and Time-bound, for example:
Goal: "By June 30, the member will read for 20 minutes, three times per week, with a tutor at school to improve reading fluency."

- Specific: reading with a tutor
- Measurable: 20 minutes × 3 times weekly
- Achievable: tutor available during after-school program
- Relevant: supports IEP literacy objectives
- Time-bound: evaluation on June 30

Coordinators guide minor and guardian to break larger goals (e.g., "join a club") into smaller steps (identify interests, visit one club meeting), ensuring incremental success.

Connecting to non-1915i Services to create SMART Goals

The ND Medicaid 1915(i) Care Coordination policy outlines expectations for care coordinators to bridge gaps by referring and linking members to services outside the 1915(i) program.

A. Proactive Referral Practices
   - Use the "Referral, Collateral Contacts, and Related Activities" framework to identify and schedule appointments with non-1915(i) supports (e.g., state plan services, vocational rehabilitation, community mental health centers, peer-run organizations, crisis hotlines, faith-based and tribal resources to name a few resources).

B. Collaboration Across Systems
   - Obtain signed releases of information to share pertinent assessment and plan-of-care data with collateral agencies, including 1915(c) waiver case managers, school IEP teams, and other community resources
   - Coordinate with these entities to secure services the member needs and wants to engage in.

C. Interim Supports and Technical Assistance
   - When immediate non-1915(i) services are unavailable, assist members in completing applications (for housing, benefits, educational placements) and leverage natural supports (family, neighbors, volunteers) to maintain continuity of care.
   - Utilize telehealth contacts (up to 75% of monthly interactions) to check in on member well-being and keep crisis or safety plans activated until formal services commence.

D. Rigorous Documentation and Tracking
   - Incorporate follow-up timelines into the Individual Plan Agenda and the plan of care, adjusting goals and next steps based on the member's evolving needs and the availability of external resources.
   - Record every outreach effort, referral acceptance or denial, and interim support action in the member's Therap case notes.

By engaging in these practices, care coordinators ensure that members access the full spectrum of community, educational, and state-plan supports maximizing benefits, and preventing service gaps.

5. Crisis Plan Development and Monitoring

The coordinator collaborates with the minor and guardian to create a crisis plan that includes but is not limited to the following:

- Early warning signs (e.g., withdrawal, mood swings)
- Coping strategies (e.g., breathing exercises, calling a trusted adult)
- 24/7 contacts (e.g., mobile crisis team, guardian, school counselor)

This plan is a part of the POC and is reviewed at every quarterly meeting. If risk escalates, the coordinator checks in on safety and arranges immediate supports.

6. Coordination with Schools and Larger Care Team

- Obtain and review (if the minor has one) the minor's Individualized Education Plan (IEP)
- Attend IEP meetings with guardian consent to align goals and avoid service duplication
- Document in the POC why 1915(i) supports (e.g., supported education) are required beyond IEP services

Regular communication with school psychologists, special educators, and vocational counselors ensures that classroom accommodations complement, and do not replicate, 1915(i) interventions.

7. Monitoring, Follow-Up and Quarterly Reviews

Every 90 days, the coordinator conducts an in-person meeting with the minor and guardian to assess:

- Satisfaction with services
- Progress toward SMART goals
- Continued necessity of each service

During these reviews, the coordinator:

- Updates the Individual Plan Agenda in Therap with discussion points and action steps
- Links agenda items to a revised POC
- Removes achieved goals and adds new objectives as development warrants

Monthly progress reports from providers are reviewed by the care coordinator to confirm service delivery and guide POC adjustments.

8. HCBS Compliance and Eligibility Redetermination

Care coordinators verify that all services occur in home or community settings (not hospitals, juvenile facilities). If a minor enters a non-compliant setting, the coordinator:

- Helps the guardian report the change to 1915i administration
- Plans for post-release suspension and reactivation of services
- Prepares redetermination documents (SFN 741, updated WHODAS/DLA) 30 days before eligibility expiry

By weaving these detailed steps into each stage; engagement, assessment, planning, crisis management, education coordination, referrals, monitoring, and compliance; a care coordinator ensures that minor members receive cohesive, sound, and developmentally appropriate supports.