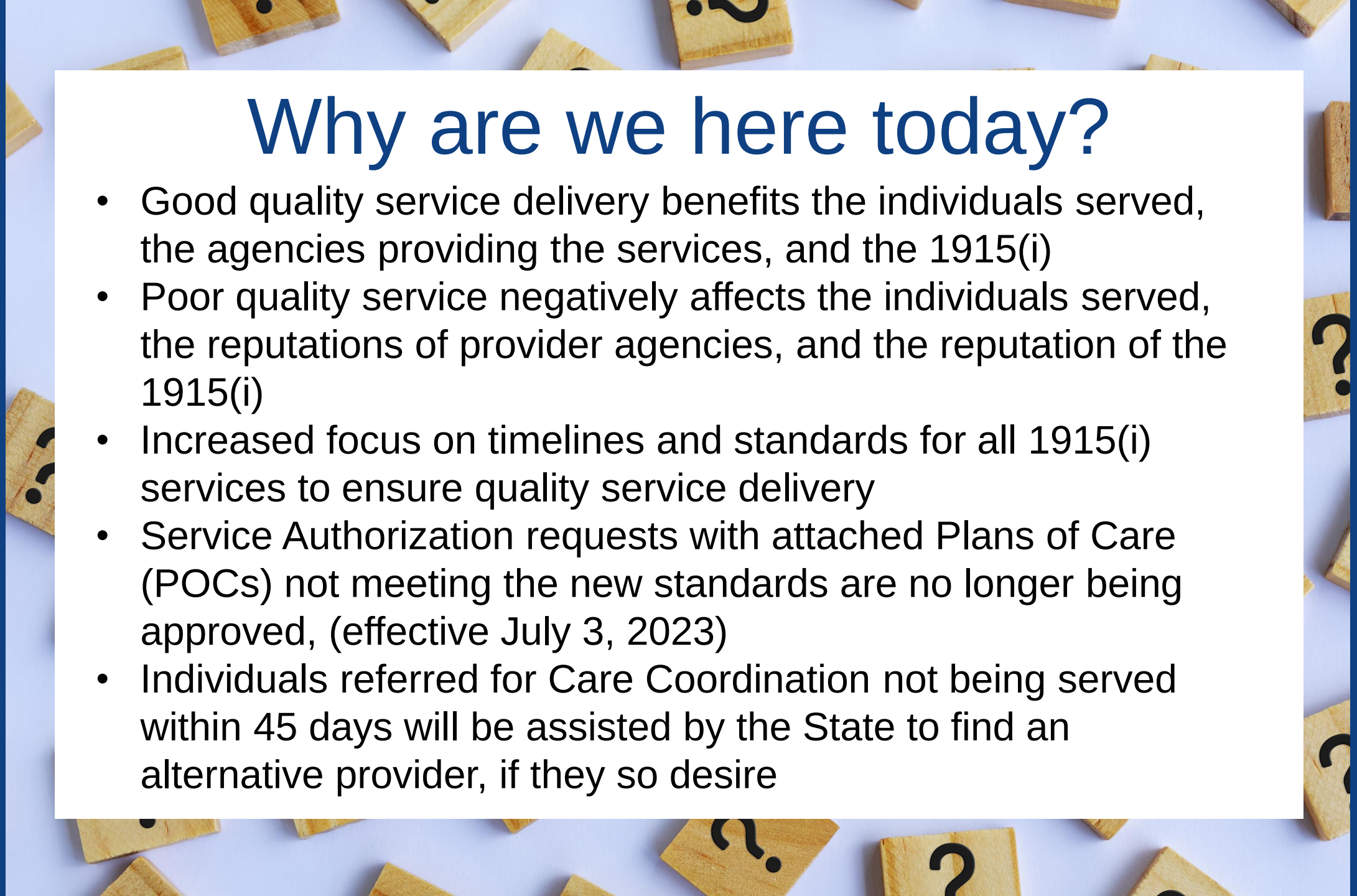
Quality Assurance- Individual Needs, SMART Goals, & 1915(i) Services

NORTH Dakota
Be Legendary.

Health & Human Services

Quality Service Delivery

- Starts with Care Coordination: assessed needs addressed by SMART goals and requests for service on behalf of the individual
- Advanced by close collaboration and shared accountability between Individual Service Providers and Care Coordinator
- Ensured by Plan of Care audits by the 1915(i) team, both upon submission of Service Authorizations and through interim reviews, as well as by monitoring of service provision and increased contact with individuals receiving services



Why are we here today?

- Good quality service delivery benefits the individuals served, the agencies providing the services, and the 1915(i)
- Poor quality service negatively affects the individuals served, the reputations of provider agencies, and the reputation of the 1915(i)
- Increased focus on timelines and standards for all 1915(i) services to ensure quality service delivery
- Service Authorization requests with attached Plans of Care (POCs) not meeting the new standards are no longer being approved, (effective July 3, 2023)
- Individuals referred for Care Coordination not being served within 45 days will be assisted by the State to find an alternative provider, if they so desire

Justification for 1915(i) Services

- Required by Medicaid to establish “medical necessity”… this is why Medicaid agrees to pay for 1915(i) services
- Provided by the Care Coordinator on the Person-Centered Plan of Care
- Ongoing assessments/re-assessments ensure services remain justifiable
- If Medicaid determines claims were paid for services not justified as medically necessary, providers risk repayment

How is a Service “Justified?”

- Needs are assessed (WHODAS; supported by self-assessment, conversation with individual, collateral contacts)
- Goals are established to help the individual address assessed needs
- Services requested on behalf of the individual
- Service providers support individuals to work on objectives, helping them move toward achieving their goals

Overall Score	
Overall WHODAS 2.0 Complex Score 70.75	Date WHODAS 2.0 Assessment Administered Within 90 days of application submission

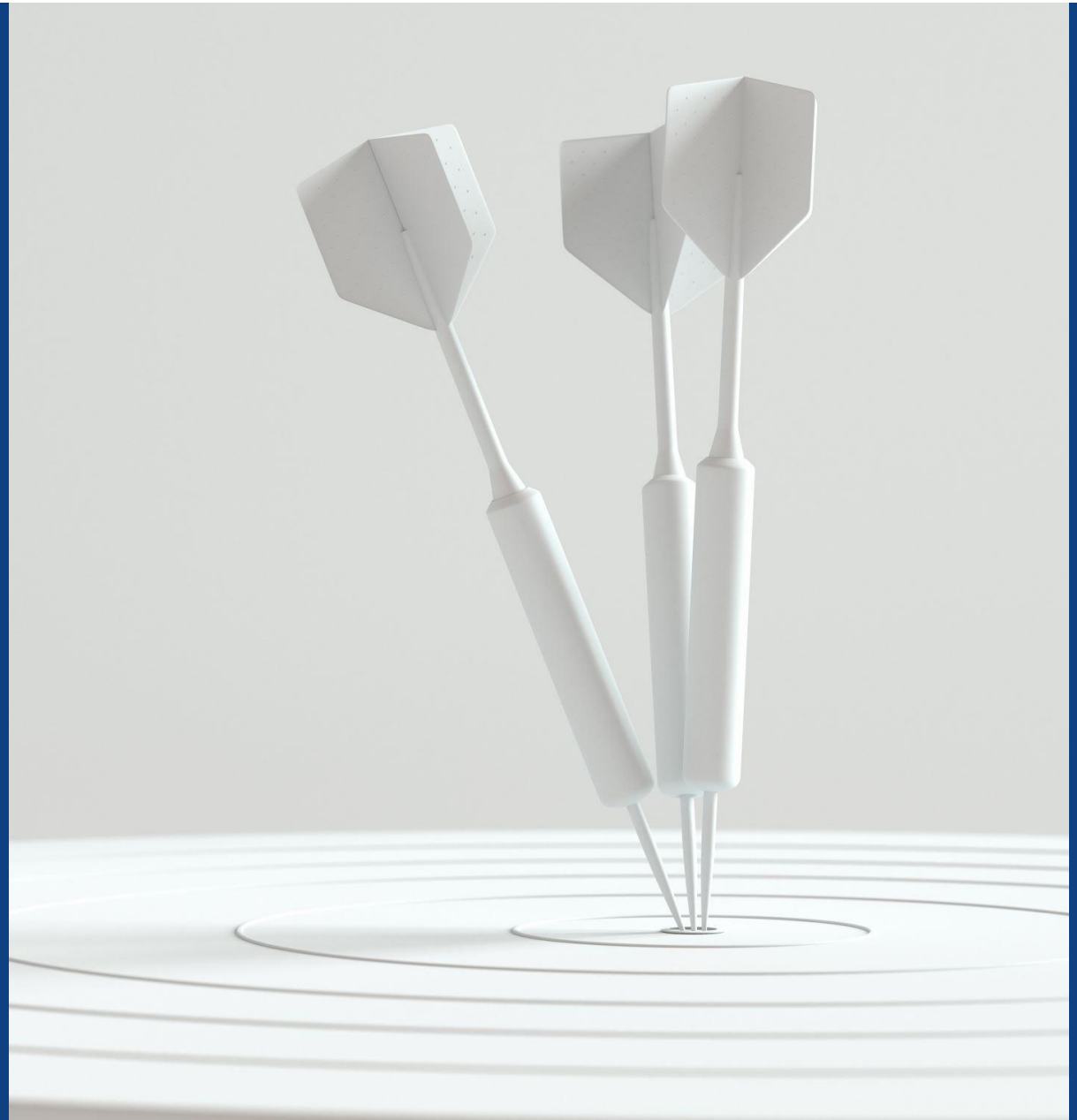
Domain	Score	Domain	Score
Cognition understanding & communicating	55	Getting along interacting with other people	83.33
Participation joining in community activities	95.83	Mobility moving & getting around	75
Life activities domestic responsibilities, leisure, work & school	35.71	Self-care hygiene, dressing, eating & staying alone	50

☑ Attach a copy of the WHODAS 2.0 assessment and scoring sheet.

Qualified Administrator		
☑ I hereby verify that I am an independent agent and meet the criteria above for the definition of an independent, trained and qualified administrator.		
Name of Qualified WHODAS Administrator Elaine Benes	Title LICSW	Agency Therapy For The Rest Of US
Telephone Number (701) 235-8962	Email Address elaine.benes@counselingservices.org	
Signature Elaine Benes	Date 2/18/2022	

Goals vs. Objectives

Goal:
Longer-term outcome desired by the individual; Care Coordinator develops with the individual; Integral part of the Person-Centered Plan of Care; Needs to be SMART and relate to a need identified on the WHODAS



Objective:
Shorter-term action step that helps an individual work toward their goal; Service Providers develop with the individual and help them work toward achievement (Individual Service Plan)

SMART Goals

Specific

Measurable

Achievable/Attainable

Relevant

Timely

Specific

- Addresses what the individual wants in relation to their assessed needs
- Includes action words
- Clear and concise
- Includes the what, how, etc.

Measurable

- Can be evaluated- we can tell when they have achieved it
- Helps to guide development of objectives
- Making progress that can be measured helps people remain motivated

Achievable/Attainable

- Realistically could happen
- Necessary tools are available
- Learning the necessary skills is realistic for the individual

Relevant

- Makes sense for the person
- Achieving it will positively benefit them
- It is important to the person and aligns with other goals they have
- It is the right time in their life to work on this

Timely

- States a timeline
- Timelines are motivating, creating a sense of urgency
- Timeline helps drive the development of objectives

Is it SMART??

I want to be healthy.

No. Why not? How could we make it SMART?

Examples of related objectives??

Is it SMART??

I want to receive Peer Support.

No. Why not? How could we make it SMART?

Examples of related objectives??

Is it SMART??

I want to get a better paying job by January.

Yes!

Examples of related objectives??

Is it SMART??

I want to be happy.

No. Why not? How could we make it SMART?

Examples of related objectives??

Is it SMART??

I want to get a service dog by my next birthday.

Yes!

Examples of related objectives??

Documentation

- All service delivery encounters must be documented
- Documentation must illustrate a connection between the service provided, the related goal on the POC, and the objectives (individual service plan)
- Documentation must reflect delivery of services within the established scope, and support the claim

Documentation (cont.)

- Documentation is not submitted with each claim, but must be retained and provided upon request
- Documentation of services rendered and the individual's progress toward their goals must be provided to the Care Coordinator monthly
- Care Coordinator must meet face-to-face with the individual to review progress, their satisfaction with services, and update the Plan of Care a minimum of quarterly

Service Authorizations

- Care Coordinator includes all services the individual needs on the Plan of Care, establishing a minimum of one SMART goal for each service requested
- Care Coordination agency submits the Service Authorization request for Care Coordination, attaching the POC
- Additional service providers are requested by the Care Coordinator on behalf of the individual via the Request for Service Provider form- date range will always be indicated as “Through DD/MM/YY” (end of the individuals eligibility span)

Service Authorizations (cont.)

- Additional service providers submit their own Service Authorization request, attaching the POC sent to them by the Care Coordinator
- Goals associated with additional services must also be SMART
- Amounts/dates on each Service Authorization request must match amounts/dates on the POC
- Upon approval of the Service Authorization request, service provision may begin

More Information

nd1915i@nd.gov

hhs.nd.gov/1915i