

During the May 12, 2023 Managed Long-Term Services and Supports (MLTSS) Subcommittee meeting, the Office of Long-Term Living (OLTL) stated that the additional detailed response of Service Coordinator (SC) Responsibilities from PHW would be included in the MLTSS-Meeting-Minutes ListServ, shown below. In addition, the combined Community HealthChoices (CHC) Managed Care Organizations (MCO) Supplemental Nutrition Assistance Program (SNAP) Tracker will also be included as an attachment.

PHW Service Coordinator Responsibilities

The SC is responsible for building a relationship with the Participant, ensuring that the Participant responds or reports when there is a change in condition, ensures and/or assists with the completion of all mandatory Participant contacts and documentation, and ensures that the participant is receiving services according to their goals and Person-Centered Service Plan (PCSP). Their responsibilities include, but are not limited to the below:

- Gaining knowledge of physical, behavioral, developmental, cultural, and social aspects of a Participant's well-being and integrating these elements into the Participant's Care Plan.
- Develop, assess, and adjust as necessary, the Plan of Care and promote desired outcomes.
- Assess the Participant's current health, functional, and safety statuses.
- Assess the Participant's current resource utilization, past and present treatment plan and services, prognosis, short and long-term goals, treatment, and Provider options.
- Address the Participant's personal risk factors to prevent future falls or safety issues within the environment.
- Use the PCSP checklist template to ensure documentation meets all regulatory requirements.
- Develop a schedule for follow-up communications with the Participant and their chosen person-centered planning team.
- Coordinate services between the Primary Care Provider (PCP), specialists, medical providers, and non-medical staff, as necessary, to meet the complete medical and socio-economic needs of clients.
- Develop a Participant Plan of Care based upon a comprehensive assessment with specific objectives, goals, barriers, and interventions designed to meet the Participant's needs.
- Provide Participant and provider education.
- Facilitate Participant access to community-based services.
- Monitor referrals made and the Participant's active participation in community-based organizations, medical care, and other services to support the Participant's overall service coordination plan. In addition, SCs should mitigate barriers to accessing these services, if needed.
- Actively participate in Interdisciplinary Care Team (ICT) service coordination rounds.
- Identify related risk management quality concerns and report these scenarios to the appropriate resources.
- Enter assessments, authorization requests, and necessary clinical information into various medical management systems.
- Direct care to participating network Providers.
- Perform duties independently, demonstrating an advanced understanding of complex service coordination principles.
- Participate in service coordination committees and work on special projects related to service coordination, as needed.
- Assist each participant with redetermination activities as needed.