

# Care Coordinator and Service Coordinator Responsibilities

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## Areas of Overlap for Collaboration Planning

### 1. Assessing and planning of services:

#### a. Assessing:

- i. **Service Coordinator** – Information gathered through intake and assessment for service planning. Includes family assessment and child assessment documenting family concerns and priorities as well as child's strengths and needs in all areas of development. Assessment focuses on functional behavior and is completed by a multidisciplinary team including the service coordinator and two disciplines.
- ii. **Care Coordinator** – Information gathered through Health Risk Assessment. The HRA (Health Risk Assessment) considers all needs of an individual including psychosocial factors, functional, medical, behavioral health (BH), cognitive, LTSS, wellness and preventive needs, as well as the Member's strengths. Member's strengths and goals must be identified, as well as any challenges or barriers to meeting the identified goals.

#### b. Planning of Services:

- i. **Service Coordinator** – Individualized Family Service Plan is developed based upon information gathered through assessment for service planning. IFSP (Individualized Family Service Plan) includes outcomes and goals based upon family priorities and child's needs and the services to be provided to work towards these outcomes and goals. IFSP is completed following Assessment for Service Planning. Parents are given the option to develop the plan five days after completion of ASP (Assessment for Service Planning).
- ii. **Care Coordinator** – Individualized Care Plan (ICP) is developed at the time of HRA (Health Risk Assessment). ICP must:
  1. Reflect the individual's strengths and preferences.
  2. Reflect clinical and support needs that have been identified through a functional needs assessment.
  3. Includes individually identified goals and outcomes.
  4. Reflect the (paid/unpaid) services/supports, and providers of such services/supports that will assist the individual to achieve identified goals.
  5. Identify the individual and/or entity responsible for monitoring the ICP.

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6. With the written, informed consent of the individual, be finalized, agreed to, and signed by all individuals/providers responsible for implementation of the ICP.
7. Prevent service duplication and/or the provision of unnecessary services/supports.

**c. Review of Plans:**

- i. **Service Coordinator** – IFSPs are reviewed every six months; annually; at request of family, provider or service coordinator
- ii. **Care Coordinator** - The ICP must be reviewed and revised upon reassessment of functional need at least once every 12 months, **OR** when the individual’s circumstances/needs change, **OR** at the request of the individual. (Timeline for re-assessment and ICP review varies by waiver and residential setting)

**d. Planning for Collaboration:**

- i. Joint participation in initial ASP and IFSP
- ii. Joint participation in re-assessment and IFSP review
- iii. Considerations:
  1. Initial ASP/IFSP and initial HRA/ICP will not coincide unless child is initially enrolled in MCO at the same time as EI referral

**2. Linking to Services and Supports Identified in the Plan:**

- a. **Service Coordinators** – Work with existing process at the local EI system to identify providers for services listed on the IFSP and schedule initial visits with the family.
- b. **Care Coordinators** - arrange for each Member, the formation and operation of an interdisciplinary care team (ICT). The Care Coordinator will also ensure that each Member’s care (e.g., medical, behavioral health, substance use, LTSS, early intervention and social needs) is integrated and coordinated within the framework of an ICT and that each ICT Member has a defined role appropriate to his/her licensure and relationship with the Member.

**c. Planning for Collaboration:**

- i. Providers on both IFSP and ICT teams
- ii. Identification and Assignment of Providers
- iii. Scheduling with families and monitoring 30 day initiation of services (EI regulation)

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### 3. Making collateral contacts to promote the implementation of the plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered:

- a. **Service Coordinators** – Required to contact the family a minimum of every three months for targeted case management (TCM). TCM can be billed monthly and allowable billable activities include monitoring IFSP implementation through provider contacts and collateral contacts with community agencies to meet family needs.
- b. **Care Coordinators** - If the Member is receiving targeted case management (TCM) services, the Care Coordinator will work collaboratively with, and not duplicate the services provided by the TCM.
- c. **Planning for Collaboration:**
  - i. Ensuring communication
  - ii. Preventing duplication

### 4. Transition:

- a. **Service Coordinators** – Service Coordinators develop a transition plan within 9 months to 90 days to support a family exiting early intervention. Families may transition to community settings or early childhood special education if they meet eligibility criteria. Service Coordinators coordinate a transition conference with the local education agency and/or community programs with parental consent.
- b. **Care Coordinators** - The Care Coordinator and Transition Care Coordinator will work with early intervention providers to transition care for children who “age-out” of the early intervention program and need to continue receiving therapy services. The Care Coordinator will ensure that services are transitioned to non-early intervention providers (PT, OT, speech, etc.). The Care Coordinator will ensure the ICP is updated to incorporate all changes in services and providers.
- c. **Planning for Collaboration:**
  - i. Care Coordinator participation in meeting to develop transition plan
  - ii. Care Coordinator participation in transition conferences
  - iii. Communication regarding EI discharge date