



Care Coordinator Responsibilities and Expectations

Care Coordination is a foundation of the MI Health Link program. Every MI Health Link enrollee has a Care Coordinator to assist in accessing services, providing support through care transitions and coordinating care with existing providers. The Care Coordinator also works with coordinating agencies, such as the Pre-paid Inpatient Health Plan (PIHP) for behavioral health or Long Term Supports and Services (LTSS).

MI Health Link Care Coordinator Qualifications

MI Health Link (MHL) Care Coordinators must be one of the following Michigan professionals:

- Licensed registered nurse;
- Licensed nurse practitioner;
- Licensed physician's assistant;
- Licensed Bachelor's prepared social worker;
- Limited license Master's prepared social worker; or
- Licensed Master's prepared social worker.

MI Health Link Care Coordinators must also have experience, training and knowledge related to the following:

- Physical health, aging and loss
- Appropriate support services in the community
- Frequently used medications and their potential negative side effects
- Depression, challenging behaviors, Alzheimer's disease and other disease-related dementias
- Behavioral health and substance use disorders
- Physical and developmental disabilities
- Issues related to accessing and using durable medical equipment, as appropriate
- Available community services and public benefits
- Quality ratings and information about available options, such as nursing facilities
- Applicable legal non-discrimination requirements, such as the ADA, person-centered planning, cultural competency, and elder abuse and neglect.

Care Coordinators will also participate in Person-Centered Planning and Self-Determination educational opportunities offered by the Michigan Department of Health and Human Services (MDHHS) and the MI Health Link Plan for which they work.

MI Health Link Care Coordinator Responsibilities

The MI Health Link Care Coordinator will be responsible for Care Coordination for each enrollee. The Care Coordinator will conduct the Level I Assessment, assure the person-centered planning process is complete, prepare the Individual Integrated Care and Supports Plan (IICSP), coordinate care transitions, and lead the Integrated Care Team (ICT).

The MHL Care Coordinator will be responsible for the following:

- Support an on-going person-centered planning process;
- Assess clinical risk and needs by conducting an assessment process that includes an Initial Screening, a Level I Assessment, and completion of or referral for a Level II Assessment (as appropriate);
- Facilitate timely access to primary care, specialty care, LTSS, Behavioral Health (BH), Substance Use Disorder (SUD), and Intellectual/Developmental Disabilities (I/DD) services, medications, and other health services needed by the enrollee, including referrals to address any physical or cognitive barriers or referrals to the PIHP;
- Create and maintain an Integrated Care Bridge Record (ICBR) for each enrollee to manage communication and information regarding referrals, transitions, and care delivery;
- Facilitate communication among the enrollee's providers through the use of the Care Coordination platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence;
- Notify ICT of the enrollee's hospitalization (psychiatric or acute) and coordinate discharge plan, if applicable;
- Facilitate face-to-face meetings, conference calls, and other activities of the ICT, as needed or requested by the enrollee;
- Facilitate direct communication between the provider and the enrollee or the enrollee's authorized representative and/or family or informal supports, as appropriate;
- Facilitate enrollee and family education;
- Coordinate and communicate, as applicable, with the PIHP Supports Coordinator and/or the LTSS Supports Coordinator to ensure timely, non-duplicative supports and services are provided;
- Following the person-centered planning process, develop with the enrollee and ICT an IICSP specific to individual needs and preferences, and monitor and update the plan at least annually or following a significant change in needs or other factors;
- Coordinate and make referrals to community resources (e.g. housing, home delivered meals, energy assistance programs) to meet IICSP goals;
- Perform ongoing care coordination;
- Monitor the implementation of the IICSP with the enrollee, including facilitating the enrollee's evaluation of the process, progress and outcomes and identifying barriers and facilitate problem resolution and follow-up;
- Advocate with or on behalf of the enrollee, as needed, to ensure successful implementation of the IICSP;

- Support transitions of care when the enrollee moves between care settings including:
 - The MHL Care Coordinator will contact the enrollee once notified of an emergency room visit to review discharge orders, schedule follow-up appointments, review any medication changes, and evaluate the need for revising the IICSP to include additional supports and services to remain in or return to the community.
 - The MHL Care Coordinator will ensure immediate and continuous discharge planning, including electronic and verbal communication with the enrollee and ICT members following an enrollee's admission to a hospital or nursing facility. Discharge planning will ensure that necessary care, supports and services are in place in the community for the enrollee when discharged. This includes scheduling an outpatient appointment, ensuring the enrollee has all necessary medications or prescriptions upon discharge, and conducting follow up with the enrollee and/or caregiver.
 - The Care Coordinator shall make every effort to ensure that home and community based services are in place upon hospital discharge to avoid unnecessary nursing facility placements.
 - The MHL Care Coordinator shall be able to arrange for expedited assessments and other mechanisms to assure prompt initiation of appropriate Home and Community-Based Services (HCBS). If the enrollee is being discharged from a nursing facility or hospital, the Care Coordinator shall coordinate efforts with the nursing facility social worker, discharge planner, or other staff to ensure a smooth transition.
 - Evaluating Section Q of the Minimum Data Set (MDS) for enrollees currently in a nursing facility and discussing options for returning to the community, revising the IICSP and transitioning the enrollee to the most integrated setting.
 - The Care Coordinator will inform the enrollee of his or her right to live in the most integrated setting, inform the enrollee of the availability of services necessary to support his or her choices, and record the home and community based options and settings considered by the enrollee.
 - Engage in other activities or services needed to assist the enrollee in optimizing his or her health status, including assisting with self-management skills or techniques; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status.
 - Assure the Medicaid eligibility redetermination process is completed timely to prevent the loss of benefits.
 - If the enrollee is receiving services that require meeting the Michigan Medicaid Nursing Facility Level of Care Determination (NFLOCD) standards, assure through required Level I and/or Level II Assessments that the enrollee continues to meet the criteria or transitions to services that do not require NFLOCD standards.
 - The Care Coordinator is required to conduct the NFLOCD assessment for enrollees with identified long term care needs, and MDHHS will make final eligibility determinations, unless otherwise directed by the State and CMS.

MHL Care Coordinator Assignments and Change Requests

The MI Health Link plan shall allow the enrollee or his or her authorized representative choice in Care Coordinator and shall ensure every enrollee has a MHL Care Coordinator with the appropriate experience and qualifications based on the Enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).

Coordination with PIHP and LTSS

The MHL Care Coordinator must collaborate with the applicable PIHP Supports Coordinator or identified behavioral health representative as defined in the contract between the MHL plan and the PIHP when the following occurs:

- The enrollee has received services through a PIHP within the last 12 months, or
- A new enrollee requests or is identified as having potential need for BH, I/DD, or SUD services.

The MHL Care Coordinator will lead the ICT. It will be the responsibility of the Care Coordinator to set and lead ICT meetings, as well as facilitate communication among ICT members. LTSS and PIHP Supports Coordinators will be members of ICTs (as applicable) to encourage communication and collaboration between MHLs, PIHPs and other providers. While the MHL Care Coordinator will be the lead of the ICT, the enrollee may request his or her LTSS or PIHP Supports Coordinator to remain his or her main point of contact regarding the ICT.