One Care
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How to Work with Long Term Supports Coordinators

What is a Long Term Supports Coordinator (LTS-C)?

LTS-Cs coordinate long term services and supports (LTSS) to support One Care members' independent living and recovery goals through in-home and community-based services.

LTS-Cs know about local vendors. They are from community organizations such as Aging Service Access Points (ASAPs) and Independent Living Centers (ILCs).

LTS-Cs are a part of the member's Care Team and advocate on the member's behalf. LTS-Cs can work with the Care Coordinator to assist the member in meeting their independent living goals. LTS-Cs look at the whole person, beyond medical needs. They learn about the member's interests and goals to assist the member and Care Team in identifying relevant services and community resources.

LTS-Cs identify person-centered care plan goals with the member and their Care Coordinator that meet the member's independent living and recovery needs, community interests, and cultural identity. For example:

- Identify community resources such as local art classes or volunteer opportunities at a community garden.
- Locate culturally appropriate recovery or social meetings.
- Work with the member to brainstorm temporary services to fill their needs while waiting for a long term solution.
    - Example: Grocery store delivery services while waiting for a personal care attendant to do shopping and meal prep.

How can an LTS-C support a member in their recovery?

LTS-Cs can support members with their recovery and mental health goals. Recovery includes mental health and substance use disorder recovery.

Working on these goals with members might include identifying resources in the community such as peer supports or Recovery Learning Communities. The LTS-C might also provide education on recovery needs to the Care Team.

When do I offer an LTS-C to a member?

At a minimum, the Care Coordinator must educate members about LTS-Cs at the following times: (1) during the initial intake and annually during the comprehensive assessment (2) anytime

members report LTSS or behavioral health needs that an LTS-C could assist with, and (3) anytime the Care Coordinator feels an LTS-C would be beneficial to the member. **The member can ask for an LTS-C at any time.**

LTS-Cs can join the Care Team for a short period, to get a new LTSS service in place, or for the full length of a member's participation in One Care. The length of involvement is the member's choice.

LTS-Cs are from ILCs, ASAPs, or other contracted agencies – such as Arcs. When possible, the member should be able to choose between at least two organizations when offered an LTS-C. Members over 60 should be offered an LTS-C from an ASAP. If a member requests a new LTS-C or has a need that would be better met with an LTS-C with specific expertise, those requests should be honored in a timely manner. If there is turnover on the LTS-C side, Care Coordinators should notify the member and work with the old and new LTS-Cs on a proper transition of care.

Differences between Care Coordinators and LTS-Cs

Assignment. Every One Care member has a Care Coordinator assigned to the member from their One Care Plan. The LTS-C is an optional community provider that the member can choose to work with. Care Coordinators should offer One Care members an LTS-C at least annually.

In-person meetings. Not all Care Coordinators can meet with members in person. Most LTS-Cs are available to regularly meet with the member in their home if the member allows. The LTS-C can provide valuable insight from these regular contacts.

Expertise in Community Resources. LTS-Cs have established relationships with LTSS resources and expertise in community resources. Many LTS-Cs have their own LTSS/community resource assessment that they will do with members to identify needs.

Some things LTS-Cs can help with include:

- Matching the member's personal interests and goals with activities in their area.
- Identifying and obtaining LTSS services for members.
- Working with vendors to fill LTSS services for members.
- Problem-solving when the member's needs aren't being met.

Service authorization. The LTS-C will recommend services based on discussions with the member and their Care Team. When the services recommended by the LTS-C are not available, the Care Coordinator will notify the LTS-C and work together to obtain appropriate services to meet member needs.

LTS-Cs are part of the Care Team

LTS-Cs will share their assessments on LTSS, independent living, and community engagement goals with the Care Coordinator. The LTS-C can also contribute to portions of the Comprehensive Assessment. They can also work with the member on the LTSS, behavioral health, and community-based services part of their care plan.

LTS-Cs check on the services they coordinated to ensure the services are meeting their goals. If adjustments need to be made, LTS-Cs will work with the member and their Care Team on the next steps.

Communication Best Practices

Share contact information	• Include your contact information in all communications, including when adding activities to the care management system (if applicable). • Exchange contact information with all LTS-Cs working with your members. Include your direct line and/or work cell phone and email when possible. ▪ Phone conversations build relationships and allow for detailed information exchange. • Ensure that the LTS-Cs you are working with have access to your work and time off schedule.
Agree on communication methods	• Define realistic expectations between you and the LTS-Cs you are working with. Determine how you plan to communicate issues or concerns about the member, and your communication preferences—email, text, and notes in the member record. • Consider creating regular “check-in” times where LTS-Cs can communicate with Care Coordinators (such as monthly office hours). • Know the member’s communication preferences and share them with the LTS-C. • Make sure the member’s communication preferences and accessibility needs are clearly recorded and saved in a place where everyone can see them.
Communicate status updates across teams	• Notify the LTS-C and member when there is a Care Coordinator staffing change and share their name and contact information. ▪ The LTS-C and Care Coordinator should work together on how to best transition care during staffing turnovers. • When known, notify the LTS-C about changes in a member’s health status such as a hospitalization, worsening of a chronic condition, or the loss of life. Changes of address, including short-term stays at a skilled nursing or rehabilitation center, should also be shared.

Workflow Best Practices

- Notify the LTS-C as soon as a service has been authorized to expedite the process of getting the vendor/service started.
- Consider talking to the LTS-C directly with any questions about the LTSS assessment and/or services the LTS-C has recommended to understand the needs the LTS-C is addressing and to increase the chances of getting authorization for services.
- Notify the LTS-C when a recommended service has been denied authorization and work together to identify alternative services to meet the member's needs.
- Include the LTS-C in Care Team conversations when possible and appropriate.
- When possible, consider holding joint home visits with the LTS-C to increase collaboration and streamline the assessment process for the care team and the member.