One Care
MassHealth+Medicare
Bringing your care together

Working as a Long Term Supports Coordinator (LTS-C)

Long Term Supports Coordinators (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.

As an LTS-C, you are an advocate for the One Care member.

- You work with the One Care member to get to know them and ensure that their voice is heard.
- You think creatively about how community services can meet the member's goals and identify existing barriers to obtaining services.
- You educate the Care Team on LTSS and recovery services.
- You monitor services to ensure they continue to meet the member's needs.

What does it mean to be an advocate for a member?

LTS-Cs should advocate on the member's behalf to the Care Team. Advocating can look like:

- Making sure the member's viewpoints and concerns are raised to the Care Team, including their Care Coordinator.
- Working with the member's plan to identify potential community programs to meet the member's needs and goals, such as job training and social events.
- Identifying and advocating for services and programs that may better meet the member's needs than current services they have in place.
- Identifying 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.
- Problem-solving potential barriers that could impact member goals – by identifying practices or services to mitigate those barriers (for example, providing transportation for employment program).

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.

In-person meetings. Not all Plan 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.

Best Practice: *Share the information you learn about the member from visiting them in person with the Care Coordinator. Being the eyes on the ground can be very important for the Care Coordinator if the Care Coordinator does not see the member in person often.*

Independent Living. An LTS-C will work with the member to identify resources in their community that will best support their independent living and recovery goals, while the Care Coordinator will focus more on the member's medical needs.

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

Service authorization. The LTS-C will recommend services based on discussions with the member and their Care Team. The Care Coordinator will work with their health plan to gain authorization for appropriate services based on the recommendations of the LTS-C. 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.

Best Practice: *Notify the Care Coordinator when a vendor has been identified to fill a service. When services are not able to be filled promptly due to staffing shortages, consider if there are alternative services that can be put in place to assist the member while they wait.*

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

Recovery is "a process of changing through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential."[1]

LTS-Cs can support members with their recovery and mental health goals. Recovery includes mental health and substance use disorder recovery, as well as other types of recovery.

Working on these goals with members might include finding 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 should a member be offered an LTS-C?

At a minimum, the Plan Care Coordinator should 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, (3) anytime the Care Coordinator feels an LTS-C would be beneficial to the member.

Members can ask for an LTS-C at any time. If you feel a member you are working with would be better served by an LTS-C with a different background or from a specific agency, you can make that referral to the member and Care Coordinator at any time. In situations where a member does need a different LTS-C, work with the member, their Care Coordinator, and their new LTS-C to ensure a proper transition of care.

[1] "Recovery and Recovery Support." SAMHSA, www.samhsa.gov/find-help/recovery.

Communication Best Practices

Share contact information	• Include your contact information in all communications, including when adding activities in the care management system (if applicable). • Exchange contact information with all Care Coordinators 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 Care Coordinators you are working with have access to your work and time off schedule.
Agree on communication methods	• Define realistic expectations between you and the Care Coordinators you are working with. Determine how you plan to communicate issues or concerns about the member, and your communication preferences – email, text, notes in the member record, etc. • When responding to Care Coordinators in online systems, ask how they would prefer you to note things in their electronic case notes. For example, should you "tag" the Care Coordinator so they see your response? • Care Coordinators may consider creating regular "check-in" times where LTS-Cs can communicate with the Care Coordinators (such as monthly office hours). • Know the member's communication preferences. Make sure their preferences and accessibility needs are clearly recorded and saved in a place where everyone can see them.
Communicate status updates across teams	• Notify the Care Coordinator and member when there is an LTS-C staffing change and share their name and contact information. ▪ The LTS-C and Care Coordinator should consider how to best transition care during staffing turnovers. • When known, notify the Care Coordinator 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.

Best Practice: *Find a contact person at the vendors you work with and ask them about their communication preferences to make obtaining services easier.*

Workflow Best Practices

- Notify the Care Coordinator when a vendor can fulfill a service and share the expected start date of that service.
- Work together with the Care Coordinator when a recommended service is denied to identify alternative services to meet the member's needs.
- Notify the Care Coordinator if there is a long wait for a service due to staffing or vendor shortages.
  - Work with the member and Care Coordinator to identify alternative services to meet member needs in the short term. This may include using flexible benefits that are outside the usual medical benefits offered by One Care.
- Share concerns and observations about members with Care Coordinators and ask to be part of Care Team conversations when possible and appropriate.
- When possible, consider holding joint home visits with the Care Coordinator to increase collaboration and streamline the assessment process for the care team and the member.