

LTSS Care Partners

Executive Summary:

a. CP Composition

a. A high-level description of the Consortium Entities and Affiliated Partners that comprise the CP

LTSS Care Partners is a newly formed entity that brings together seven community-based organizations to provide LTSS CP services. The seven Member Organizations have experience serving the range of people who will be eligible for LTSS CP services including children, adults and elders. Together, these Member Organizations have annual operating budgets adding up to nearly \$570 million, employ over 8,000 staff, and serve over 70,000 people in Eastern Massachusetts. Each Member Organization is a leader both in its local communities and in its field of service.

- Bay Cove and Vinfen are known for their expertise in providing a wide range of community-based services to people with Intellectual and Developmental Disabilities (I/DD) and Autism Spectrum Disorders many of whom also have co-occurring medical and behavioral health challenges. In addition, both organizations serve people with Serious Mental Illness. Vinfen also serves people with Acquired Brain Injury, and Bay Cove provides a continuum of Substance Use Disorder services.
- The three Aging Service Access Point (ASAP) organizations – Boston Senior Home Care, Mystic Valley Elder Services and Somerville Cambridge Elder Services – have broad and detailed knowledge of the long-term care system, including LTSS management. They provide unbiased information to individuals about their LTSS options through information and referral programs.
- Boston Center for Independent Living, founded in 1974, by and for people with disabilities, was the first Personal Care Management agency in Massachusetts, and provides options counseling and LTSS coordination for a diverse group of people with disabilities.
- Justice Resource Institute, one of the largest human services providers in New England, operates over 100 programs serving diverse populations, including community-based services to children and youth with behavioral challenges and disabilities.

All LTSS Care Partner Member Organizations are committed to the goals of the LTSS CP program: to support Enrollees with complex LTSS needs with living healthfully and independently in the community by strengthening linkages between healthcare providers and community-based organizations. Evidence of this commitment is found in the history of programming at each organization that coordinates care across systems. MassHealth reform will create the necessary structure for the LTSS CP program to be successful by holding ACO providers accountable for Total Cost of Care. This shift will encourage ACOs to expand their programs for people with complex LTSS needs, which has previously occurred but on a much smaller scale.

People with LTSS needs face many challenges when accessing healthcare services. The LTSS system is fragmented and can be difficult for individuals and families to navigate. Each LTSS service has different eligibility criteria and assessment processes. Service specialization in LTSS is critical to meeting the needs of specific populations. At the same time, not all LTSS providers are aware of the range of services and the eligibility criteria and determination process for each. As a result, individuals may be referred to a specific service and provider, but may not be aware of the breadth of their options and may be receiving care that is not fully aligned with their needs. For most individuals, the LTSS system remains disconnected from the systems of medical and behavioral healthcare. Individuals with LTSS needs may have multiple providers of service, but no single person that is coordinating care across systems and settings. Moreover, people with

LTSS needs are among the most medically and behaviorally complex and costly patients in the medical care system. The result of the disconnection between systems represents missed opportunities to use LTSS to reduce use of costly services, such as inpatient, emergency room and institutional placement.

LTSS Care Partners recognizes that to best serve Enrollees, LTSS CP services must be provided in close partnership with ACO/MCOs, the entities at risk for Total Cost of Care in the new delivery system. As a result, LTSS Care Partners will build on existing relationships and methods for collaboration with ACO/MCOs and invest additional staff resources to develop collaborations dedicated to care coordination, reducing duplication of services, and targeting limited resources to the right Enrollees at the right time. All Member Organizations have experience participating on interdisciplinary care teams and coordinating with a range of providers in their roles as LTSS coordinators for One Care, Home Care coordinators, residential and day habilitation-based coordinators, CBFS providers, and Community Service Agencies (CSAs). In addition, the Member Organizations are prepared to share both their specialized LTSS service knowledge and options counseling expertise with medical providers and care managers within ACO/MCOs.

b. Community Partners Population Served

i. List the Service Areas covered by the CP.

Greater Boston: Boston, Revere, Somerville and Quincy, **North:** Malden, **South:** Brockton

ii. Describe the demographics of the populations the CP supports or intends to support in the Service Areas covered.

Seven Member Organizations currently provide services to a range of people with disabilities many of whom will be eligible for the LTSS CP program. Member Organizations provide care coordination and have developed care coordination practices and tools in response to the needs of specific populations. The diversity represented by these individuals has resulted in networking with a multitude of community and healthcare resources. Familiarity with the range of LTSS resources in the various communities and the impetus to research new and individualized resources as needs and preferences are expressed through a self-determined process have led to a wealth of collective and shared knowledge that facilitates the coordination of care. The following are examples of services for specialized populations:

- Bay Cove, JRI and Vinfen coordinate care for people with I/DD, Autism and brain injury, often with co-occurring psychiatric illness and/or physical disabilities. The Member Organizations provide residential and day programs, home-based supports and specialized medical and BH providers.
- JRI operates three specialized, year-round, residential schools for children with high LTSS needs. In that role, it has developed relationships with area providers of home-based and specialized medical services. In addition, as a CSA in four communities JRI coordinates care for children with Serious Emotional Disturbance (SED).
- BCIL provides care coordination and services to individuals confronted with the following challenges: cognitive, mental/emotional, physical, hearing, vision, multiple disabilities, and others including the Personal Care Assistant program.
- Through the Money Follows the Person waiver program, and Comprehensive Screening Service Model, the ASAPs assist nursing facility residents return to the community; this includes individuals with ABI, I/DD, SMI and physical disabilities. Many require significant multidimensional supports to transition successfully, including housing, behavioral, recovery, and other LTSS needs often with increased acuity due to the absence of family and friends.
- BCIL, BSHC, MVES and SCES coordinate care for over 1,000 people with disabilities under the age of 65 who are enrolled in One Care.

c. Overview of 5-Year Business Plan

LTSS Care Partners has created a five-year business plan to build the infrastructure and systems needed to serve over 1,500 people when at full capacity. The capacities and infrastructure that the organization develops will serve to sustain the program throughout the five-year Contract Term and thereafter. The long-term goals are outlined below:

- **Implement a Care Coordination Information Technology system to support LTSS Care Coordinators:** LTSS Care Partners is one of six CPs using the Care Navigator system for documentation and coordination of activities. To support Care Coordinators, LTSS Care Partners will also subscribe to a service to collect Admissions/Discharge/Transfer (ADT) data so that Care Coordinators can support Enrollees in times of transition.
- **Develop system to support communication among Member Organizations:** LTSS Care Partners will set up and maintain a SharePoint site for sharing information across Member Organizations that will contain information on ACO/MCO provider networks, points of contact at primary care practices, LTSS provider network, and local social service providers.
- **Ongoing training and learning:** LTSS Care Partners will develop a robust training program leveraging subject matter experts across Member Organizations and making use of MassHealth trainings as needed. In addition, we will establish Learning Collaboratives for Care Coordinators and supervisors to support ongoing learning, process improvements and share best practices.
- **Care Coordination relationships with ACO provider practices:** LTSS Care Partners recognizes that to be effective, the core LTSS CP services must be provided in close partnerships with ACO/MCOs. Therefore, we will invest considerable staff resources to develop ACO collaborations to coordinate care, reduce duplication of services, and target limited resources.
- **Develop highly effective strategies for engaging Enrollees:** A key focus of LTSS Care Partners will be on Enrollee engagement. We will create an Enrollee Engagement Library of best practices, it will be an important principle of training for Care Coordinators, and it will be infused throughout the Learning Collaborative that will be created. Enrollee Engagement will also be the focus of our Quality Improvement program in the first year of the program.
- **Establish a management team for overseeing administrative processes, IT systems, data, quality management, financial services and analysis:** LTSS Care Partners is building a management company to oversee all administrative processes of the LTSS CP program.

Sustainability

LTSS Care Partners is using DSRIP funds to develop the necessary capacities and infrastructure to operate its LTSS CP program. The capacities and infrastructure that the organization develops will serve to sustain the program throughout the five-year Contract Term and thereafter. Certain investments are tangible: a system to support Care Coordination, marketing materials, including a website. Other investments will help us develop a workforce that is trained in Care Coordination and workflows for coordinating care across systems of care. Sustainability of the LTSS CP program beyond the Contract Term will ultimately depend on our relationships with ACO/MCOs and whether the services that we provide lead to better health at reduced costs. We plan to show value along with a reduction of total medical expense to the ACO/MCOs so that they will invest in this service moving forward.