



Executive Office of Elder Affairs

RESPECT INDEPENDENCE INCLUSION

Community Transition Liaison Program (CTLP)

Refresher & Program Updates Webinar

September 30, 2024

2:00 p.m. – 3:30 p.m.

For ASAP Utilization Only - Do Not Distribute




CTLP Agenda

- Welcome
- Program Overview
- Tools
- Collaboration
- Documentation Requirements & Reporting
- Data
- Updates
- Questions

CTLP Program Overview

Community Transition Liaison Program (CTLP)

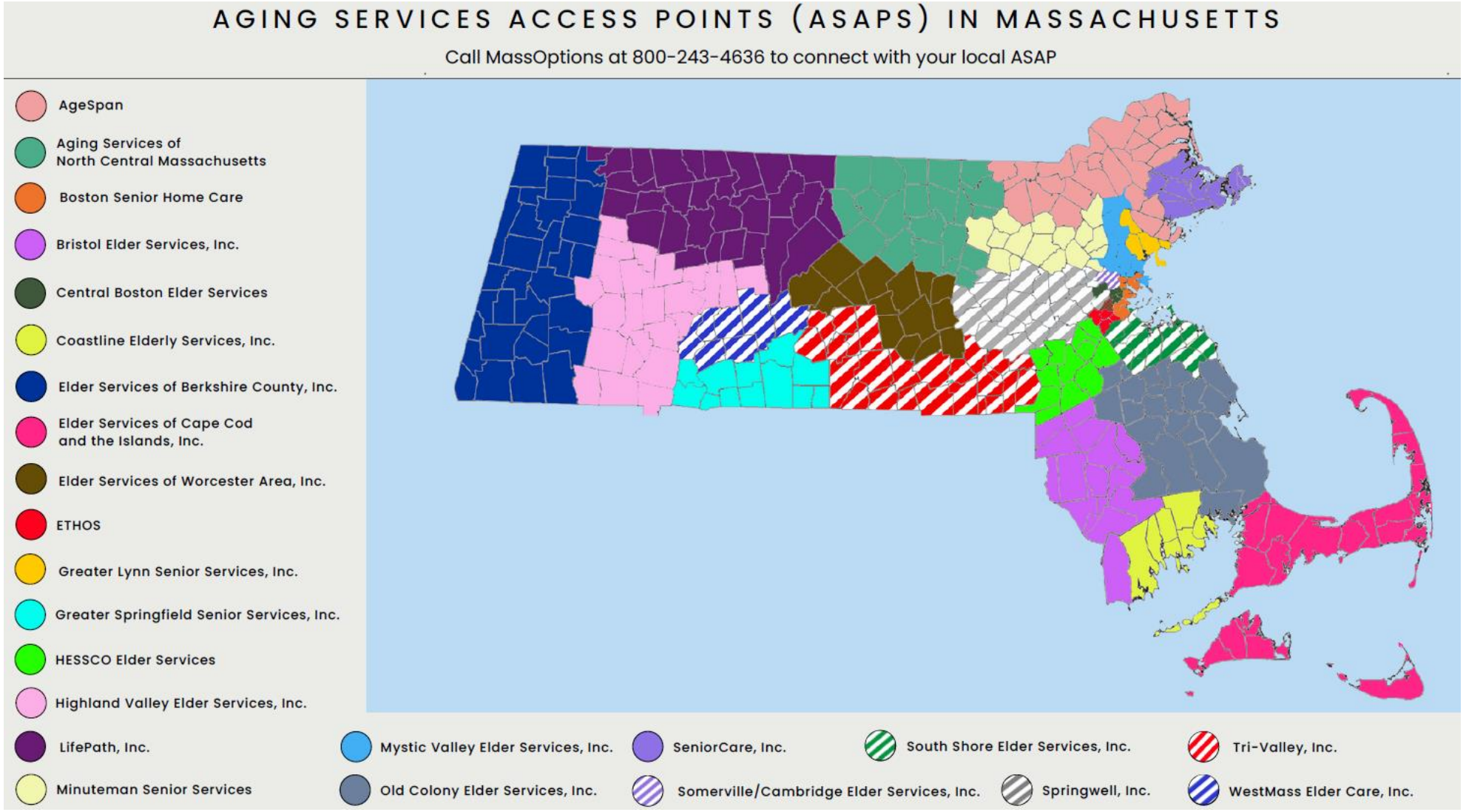
CTLP supports NF residents in transitioning to the community

CTLP Year 2!
Implementation & Launch started July 1, 2023

The CTLP Team

- **Engages** residents who are in the NF to understand if they are interested in returning to the community
- **Provides informed choice** on community transition options
- **Provides assistance & coordination** with discharge planning
- **Connects** residents to state programs & local community supports
- **Assists** with resolving barriers impacting community transition
- **Completes weekly visits to NF**, which are Dept of Public Health licensed NF and accepts MassHealth members, in the ASAP catchment area
    - Not including specialty pediatric facilities
    - Private pay or Veterans NFs visits upon request

45 Statewide CTLP Teams



Teams are **dedicated** positions to the CTLP

Evaluated annually

[ASAPs in Massachusetts | Mass.gov]

CTLP Roles & Care Coordination

CTLP Job Descriptions
are defined by EOEA
in the ASAP Contract

CTLP Supervisor

- Primary contact for CTLP to EOEA Staff
- Provides training, supervision, direction, & oversight to CTLP Team(s)

Community Transition Liaison

- Builds relationship & develops rapport
- Provides community transition options
- Identifies, discusses, & addresses barriers to transition:
  - Housing
  - Immigration Issues
  - Legal Issues
  - Lack of community-based supports
- Collaboration with state programs
- Referrals for programs & community resources

CTLP Case Assistant

- New role with the launch of CTLP
- Administrative Activities
- Applications for housing & public benefits
- Community Assistance Tasks

ASAP CTLP Job Titles must be listed as noted in job description
ASAPs should not be customizing

How do ASAPs identify potential residents for CTLP?

NF Resident must be **age 22+** & can have **any insurance type**

In-person

- CTLP initiated resident engagement
- Resident initiated requests
- Nursing Facility census

Referrals

- Family & informal supports
- ASAP Programs
  - CAE, LTC Ombudsman, HHPP, OC, Home Care, etc.
- MFP Demonstration Project Office
- Nursing Facility Staff
- Independent Living Center Staff

PASRR Portal

- MassHealth's Preadmission Screening & Resident Review (PASRR) Portal
- Identify Residents who are:
  - Dual negatives (ID/DD, SMI)
  - Do not meet the criteria for SMI on Level II evaluation

Thinking About Engagement

PASRR

Short-Term Care & Long-Term Care

- NF stay is less than 45 days & resident requests assistance with community transition
- NF stay exceeds 45 days - ensures completion of PASRR Level 2 assessment

SMI or ID/DD

- No PASRR involvement unless DDS or DMH request assistance from CTLP for complex discharges
- NF Resident may also request CTLP involvement to augment support by DDS/DMH

CTLP Outreach & Engagement

CTLP Teams are required to visit nursing facilities on a weekly basis per ASAP Contract 5.1.3.5.1

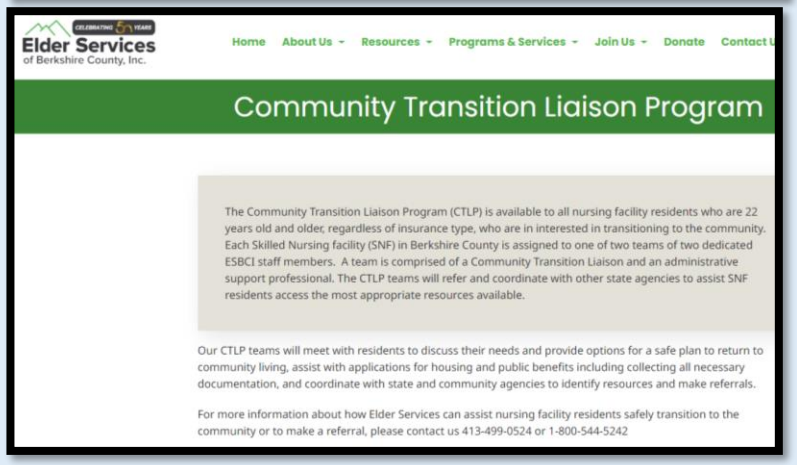
> *"Have an onsite presence at each nursing facility in the ASAP's service area on a regular basis (i.e., at least weekly, unless an alternate schedule is requested and approved by EOEA)"*

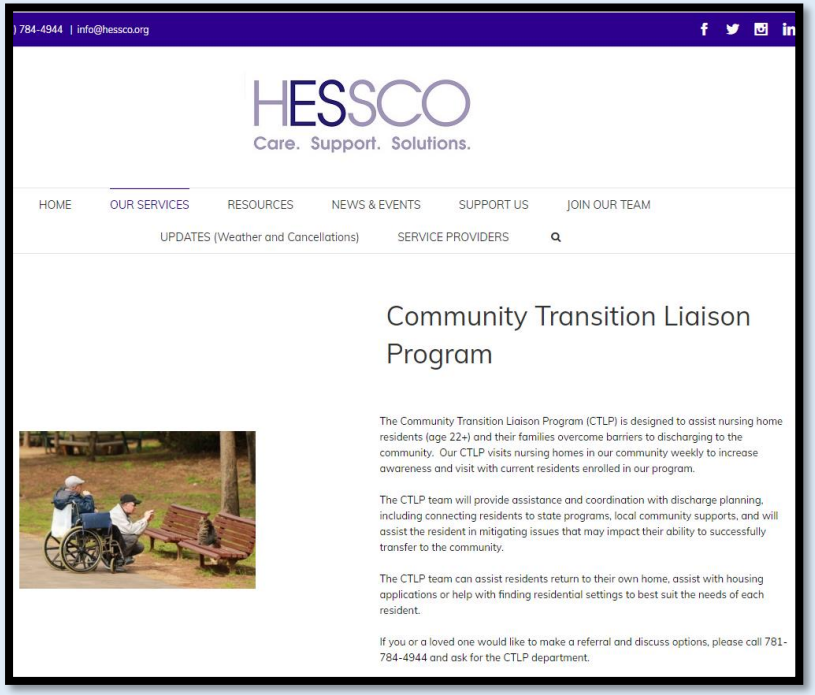
Develop a system to track the number of visits, per NF in their catchment area

Develop relationships with NF staff	Engage with & Advocate for NF residents
• Social Worker • Administrator • Director of Nursing • Activity Director • Business Office Manager	• Resident Council Meetings • President • Activities Schedule • Office Hours • Set Visit Schedule

CTLP on ASAP Websites

- ASAPs must use the CTLP program name
- ASAPs may not rename or rebrand the program or roles for their region
- CTLP is a statewide program, name recognition is vital





CTLP Tools

CTLP Marketing Materials

Marketing Materials	ASAP CTLP Teams	Languages

• **Business Cards**
  • Provide to residents, families, NF staff
• **Brochures**
  • Have displayed in NF common areas
• **Flyers**
  • Post in NFs
• July 2024 Printed materials delivered to ASAPs in 8 languages
	• Distribute materials to
	  • NF Residents
	  • Families
	  • NF Staff
	• Utilize materials to provide information on CTLP & how to contact their regional ASAP CTLP Team
	• July 2024 Access to print & electronic materials based on language needs of residents at NF
		• 8 languages Printed & Electronic
		• English, Spanish, Portuguese, Chinese (Simplified), Chinese (Traditional), Haitian Creole, Italian, Russian
		• 9 additional languages available electronically for printing
		• Khmer, Vietnamese, Greek, Hindi, Polish, German, Cape Verdean Creole, Arabic, Korean

17 languages in total available digitally on: [CTLP 800Ageinfo Document Library]

Transition Support Tool (TST)

General guidance tool

Framing how CTLP Teams identify

- potential programs & resources
- on behalf of a resident
- as they assist in developing a person-centered transition plan.

Excel spreadsheet

Not exhaustive planning document

Systematic collection & prioritizing of key items such as

- Housing Barriers
- MassHealth Eligibility
- Supports Needed
- Safety Concerns
- Informal Supports
- Formal Supports

Utilized to

- Organize work they are engaged in
- Support the resident's transition back to the community
- Prioritize what should be done first and determine next steps

TST Network Feedback

- EOEA solicited feedback regarding use, document usefulness, & suggested enhancements
- EOEA is reviewing feedback provided

Transition Support Tool (TST)

- Provides suggestions for programs which might be available
- Not exhaustive

Money Follows the Person "MFP Demo"
is an option for all NF residents, a "stackable" program. ASAPs do not need to "pre-screen," MFP Project Office will confirm eligibility

Potential Program Worksheet

	Agency:	Other	MRC						DDS		EOEA	
Requirements/Eligibility Criteria	Result of screening	MFP Demo	MFP Community Living Waiver (MFP-CL)	ABI Non-Residential Habilitation Waiver (ABI-N)	Supported Living (SL) Program	SL Expansion Program	Statewide Head Injury Program (SHIP)	Traumatic Brain Injury Waiver (TBI; eligible through SHIP)	Homecare Assistance Program (HCAP)	MFP Residential Support Waiver (MFP-RS)	ABI Residential Habilitation Waiver (ABI-RS)	Frail Elder Waiver (FEW)	Homeca <60
Age	NA												
Age 22-59		X	X	X	X	X	X	X	X	X	X		X
Age 60-64		X	X	X	X	X	X	X		X	X	X	
Age 65+		X	X	X	X	X	X	X		X	X	X	
Anticipated to be living in a facility for at least 60		X											
Anticipated to be living in a facility for at least 90			X	X						X	X		
Alzheimer's dementia or other related disorder													X
Traumatic Brain Injury							X	X					
Acquired Brain Injury diagnosed at or after age 22				X							X		
Physical disability					X				X			X	
Cognitive, sensory or emotional disability					X	X			X				
Has mental health diagnosis						X							
Has SMI													
Needs help with at least one ADL												X	X
Needs help with multiple IADLs					X	X			X			X	X
Is the applicant *potentially* eligible for the following programs?		No	No	No	No	No	No	No	No	No	No	No	No
Financial Criteria													
Meets financial requirements to qualify for HCBS waivers			X	X						X	X	X	
Meets financial requirements to qualify for MassHealth Standard (or MassHealth CommonHealth for MFP Demo)		X	X	X				X	X	X	X	X	

1 Overview Instructions | 2 Transition Support Tool | 3 Potential Program Worksheet | 4 Housing Program Worksheet

CTLP Team Expense Account Funds

Each ASAP CTLP team is allotted $12,000 per team, per fiscal year, to aid in supporting the community transition of skilled nursing facility (NF) residents, known as the CTLP *Team Expense Account (TEA)*.

The TEA is to be utilized for NF resident expenditures that directly support a smooth transition to the community. This includes, but is not limited to:

- **CORI Checks**
- **Housing Application Costs**
- **Birth Certificates**
- **State Issued Identification**
- **Technology** (phone, laptop, tablet)
- **Household Items** (furniture, appliances, cutlery, bedding)
- **Safety Equipment** (grab bars, chair lift, bed rails)
- **Transportation** (Visit housing options, ADH, SDC Clubhouse)
- **Legal Service** (Not Ongoing)
- **Clothing for Resident**
- **Utility Arrears**

Team Expense Account (TEA) Funds & e-Invoicing

- CTLP Supervisors & Fiscal Directors should be in communication regarding the process & usage of TEA

- CTLP Supervisors must email **Supplemental CTLP TEA Spreadsheet** to EOEA with
  - Consumer name
  - Consumer ID
  - Category: Fees, Tangible Items, Services, Other: EOEA Approved
  - Item Description
  - Item Total

- Fiscal Directors submit a separate **CTLP e-Invoicing Template** for all CTLP expenditures through e-Invoicing outlining:
  - CTLP Staff Salaries, Payroll Taxes, Fringe Benefits
  - Program Support (TEA)
  - Other Direct Administrative Expenses

Available online at 800ageinfo.com:
CTLP E-Invoicing & Team Expense Account Business Rule 3.15.24

CTLP Collaboration

Cross-Agency & Program Collaboration

An agency or program that is already assisting a nursing facility resident on transition planning should continue to do so

These programs include, but are not limited to

SCO	One Care	PACE	DMH	DDS	MassAbility	ILC Transition Team	HCBS Waiver

CTLP can become involved, in a supportive capacity, upon request

ASAP Home Care Program Collaboration

- **Home Care Consumer in SNF**
  - HC CM leads the transition work
  - CTLP involvement upon request
- **NF Resident wants to go home**
  - Resident connected to a Home Care program
  - HC Intakes may be completed by CTLP or HC in the NF
- **Warm transfers expected between programs**
  - Not voice mail messages/email messages
  - Case conferences (in -person/via zoom or teams)

ASAP CTLP Collaboration

CTLP collaboration across the ASAP Network

What would be helpful to foster cross agency collaboration of CTLP programs & staff?	How can ASAP nursing staff be leveraged to support CTLP?

CTLP & Options Counseling (OC)

CTLP to refer & work

- with both ASAP OC and ILC OC programs

Encourage coordination, collaboration & warm handoffs between the programs that will benefit residents, OCs & CTLP teams

- Help avoid duplication of efforts
- Resources in the NFs are enhanced providing more support to the residents

During the initial contact

- CTL can identify, explain, & introduce the consumer to OC

CTLP to OC Guidance released to ASAP Network 12/12/2023

Can be accessed on the 800AgeInfo Document Library

ctlp-to-oc-guidance-12.12.23.pdf

CTLP & OC Continued

NF Residents profiled by program

CTLP

- Complex, ongoing needs
- Require long-term assistance
- In-depth support

OC

- Short-term rehab
- and/or who have non-urgent requests or needs, such as
  - under 22 years old
  - needs resources
  - has a family member/caregiver in the community in need of guidance or support
  - requested assistance with resource information only

Warm Transfers

Initiated by the transferring CTLP Team or program with verbal 2-way communication via telephone or virtual engagement

- Provide background information on resident needs, services, & supports
- Outline expectations, hand lead over & discuss any continued involvement
- Leaving a voicemail or sending an email is not adequate or considered a warm transfer

Interdisciplinary Case Conferences

- Helps initiate the warm transfer process
- Includes resident and/or their representative
- Ensures person-centered care planning approach
- Held periodically through the Warm Transfer process

CTLP Success Story

CTLP Outreach to Resident

81-year-old male

Enjoys writing

Residing in NF for 7 months

Single leg amputee, insulin dependent Diabetic

History of falls

No housing in community

CTLP Engagement, Transition Planning & Referrals

Resident voiced to CTL his feelings about living in a Nursing Facility as, “it’s a place to die.”

Community housing options discussed & applications completed

HCBS Waivers, MFP Demonstration & PACE referrals discussed and completed

Transition Coordination

Community Based Housing (CBH) subsidized apartment found within a couple of weeks

- 6 month move-in timeframe

MFP Demonstration Enrollment

- First month’s rent, security deposit, furnishings, durable medical equipment, moving costs

Home Care Service Planning from one ASAP to another

Successful transition to the Community

Warm transfer from CTLP to FEW Case Manager upon discharge

Home Health Aide & Homemaking services through FEW

MFP Demonstration services for 365 days post discharge

Living independently in his own apartment

CTLP ended involvement after working with individual for approx. 7 months

CTLP Documentation Requirements & Reporting

CTLP Care Enrollment

ASAP Specific A&D CTLP Care Enrollment

- Track individuals with whom the CTLP Team has engaged and are actively working
- Record the outcome of CTLP interactions & interventions
- Demonstrate the length of enrollment within the program
- Care Enrollment remains open until the resident disposition is completed

Ending CTLP Care Enrollments

- Completed when the CTLP team is no longer working with resident
- Use only EOEA approved A&D CTLP Termination Reasons
- Must not be left blank
- Use in accordance with the Business Rule
- ASAPs must correct inaccurate or blank terminations reasons

New or updated A&D Termination Reasons effective 6/6/24

CTLP – Discharge to AFC	CTLP – Discharge to ALR with GAFC
CTLP – Discharge to ALR without GAFC	CTLP – Discharge to Rest Home with GAFC
CTLP – Discharge to Rest Home without GAFC	CTLP – EOEA Home Care Program

30 Day Post Discharge Follow Up

CTLP - Discharge to Community

Post discharge follow-up is required

- Outreach through a variety of two-way communication methods
- Ensure services/supports have started
- Determine:
  - if services/supports are meeting the consumer needs
  - if additional services/referrals are needed
- Follow-up on prior referrals, applications, & advocacy if needed

30-Day Post Discharge Follow Up

Outreach Attempt Modalities

- Telephone
- Voicemail
- Email
- Unannounced Visit
- If consumer is not reachable
  - connect with formal supports to help identify time to call or outreach
  - connect with informal supports if attempts with the consumer are unresponsive

Outreach Timeframe

- Occur well in advance of the 30th
- Not to be first initiated on day 30 after discharge
- Allow for repeated attempts if needed to connect with & engage the consumer

Best Practice

- Follow up within 14 – 21 days
- If not initially reachable, an additional two (2) attempts must be made
- If not reachable after three (3) total attempts, an attempt to reach letter must be sent
- Each attempt must be documented in the record

Required Journal Notes & Documentation

CTLP-Initial Engagement

- Initial engagement with the consumer
- Consumer's interest in engaging with CTLP for assistance with transition & discharge planning

CTLP-Termination

- Termination of the consumer from CTLP
- Include outcome of the CTLP intervention
- If consumer is discharging to the community, include type of setting the consumer is discharging to & any program/service that will support the consumer in the community

CTLP-Post-D/C Follow-up

- Any actions or interaction of CTLP when following up with a consumer post-nursing facility discharge

Activity & Referral (A&R)

Required A&R

CTLP Post Discharge Follow Up – 30 days

- Track required Post Discharge Follow up when the CTLP Care Enrollment Termination reason is *CTLP - Discharge to Community*

Optional A&R

CTLP Referral

- Track referrals received for CTLP

CTLP Nursing Facility Visit

- Track next CTLP NF visit due

It is not permissible to use these action types for anything other than CTLP related activities defined above

Reporting & Data Maintenance

The ASAP is responsible for

- Generating reports
- Reviewing for quality assurance
- Identifying inaccuracy trends
- Addressing inaccuracies
- Completing necessary follow-up within a timely manner
- All follow up actions must be documented in the consumer's A&D record

EOEA requires the following HAR reports to be run monthly

- CTLP Enrollments and Terminations
- CTLP Post Discharge Tracking

EOEA requires the CTLP PASRR Portal reports to be run monthly

- ASAP CTLP Teams must develop an internal process to track & demonstrate use of the CTLP PASRR Portal reports upon request

CTLP Data

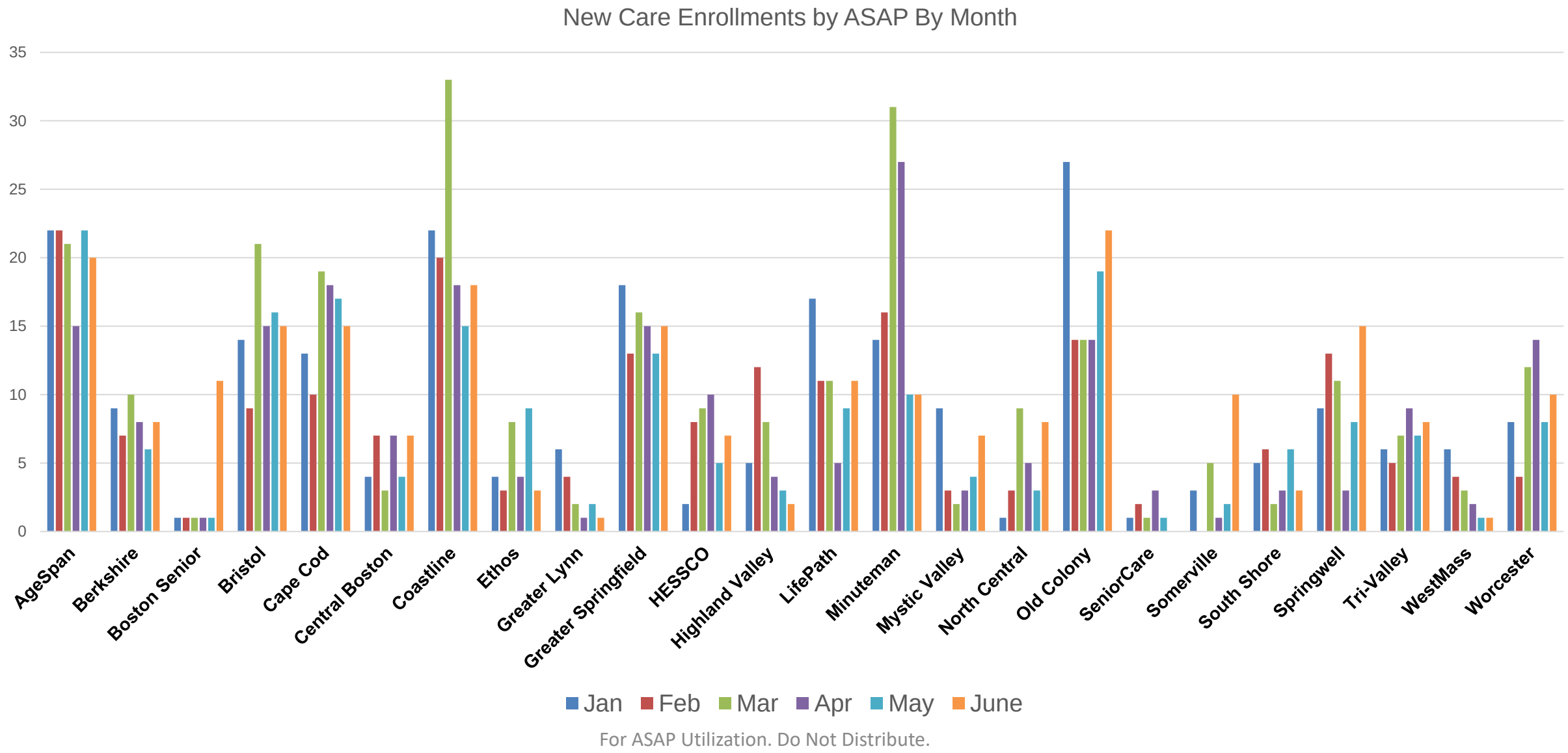
CTLP Resident & Enrollment Information

July 2023 – June 2024 (FY24)

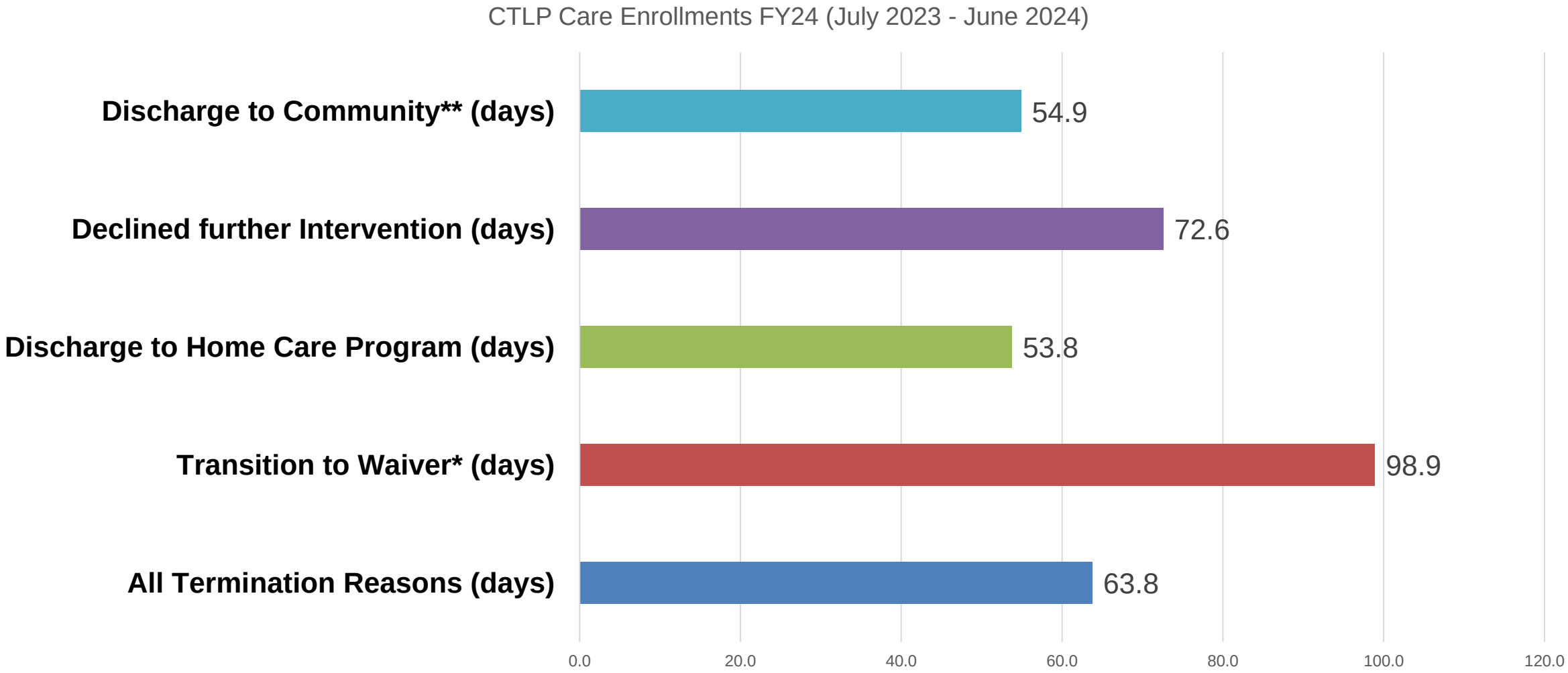
Total Enrollments	Average Length of Enrollment	Average Age
3,362	87 Days*	71

*LOE includes Active & Terminated A&D CTLP Care Enrollments

New Enrollment Trends Jan - June 2024



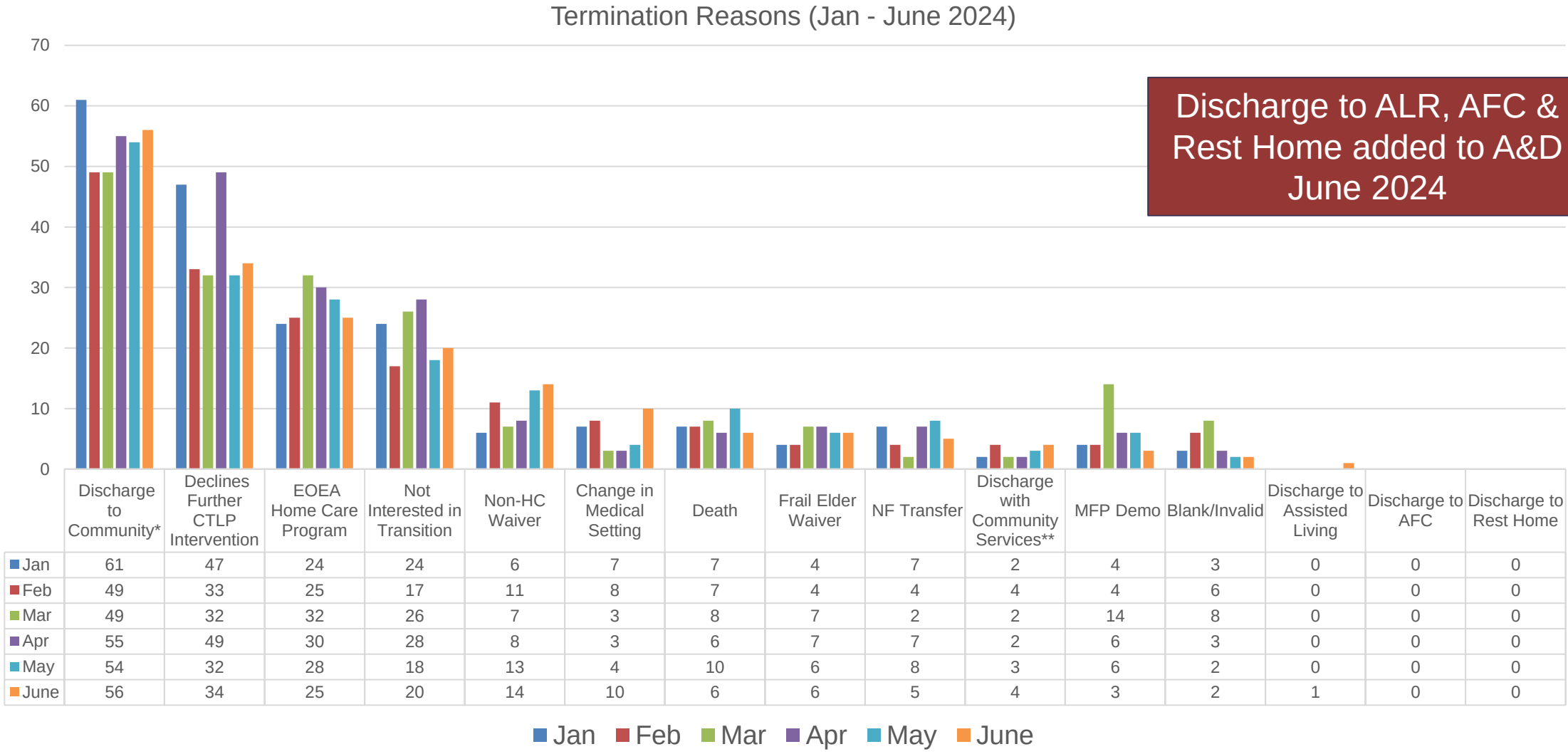
Enrollments: Average Length of Enrollment (LOE)



*Consists of all HCBS Waivers: ABI, DDS, FEW MFP, TBI

****Discharge to Community** details transitions supported by CTLP but no other service program enrolled

Outcomes Jan – June 2024



Discharge to ALR, AFC & Rest Home added to A&D June 2024

	Discharge to Community*	Declines Further CTLP Intervention	EOEA Home Care Program	Not Interested in Transition	Non-HC Waiver	Change in Medical Setting	Death	Frail Elder Waiver	NF Transfer	Discharge with Community Services**	MFP Demo	Blank/Invalid	Discharge to Assisted Living	Discharge to AFC	Discharge to Rest Home
Jan	61	47	24	24	6	7	7	4	7	2	4	3	0	0	0
Feb	49	33	25	17	11	8	7	4	4	4	4	6	0	0	0
Mar	49	32	32	26	7	3	8	7	2	2	14	8	0	0	0
Apr	55	49	30	28	8	3	6	7	7	2	6	3	0	0	0
May	54	32	28	18	13	4	10	6	8	3	6	2	0	0	0
June	56	34	25	20	14	10	6	6	5	4	3	2	1	0	0

*__Discharge to Community__ includes transitions supported by CTLP but no other service program enrolled

**__Discharge with Community Services__ includes DMH, DDS (not Waiver), MRC (not Waiver), SCO, and One Care

CTLP Updates

Marsters v. Healey Lawsuit Settlement

Purpose

To facilitate the transition of qualified nursing facility residents with disabilities to community settings by providing enhanced in-reach, information, & assistance to help them make informed choices about whether to leave their nursing facilities; & by providing expanded residential services, supports & transition assistance to enable them to live in the most integrated setting

Marsters v. Healey Lawsuit Settlement

June 17th, 2024 Settlement Agreement finalized

- Will expand the resources available in MA for individuals such as the plaintiffs & thousands of people like them (called “class members”)
- Allow many NF residents to receive residential services & supports provided in the community instead of in a NF

Over 8 years, requires the Commonwealth

- Provide In Reach, Informed Choice, & Transition Planning
- Provide Special Services for class members who have Serious Mental Illness (SMI)
- Provide Residential Services & Housing Support
- Transition a minimum of 2,400 class members from a NF to the community

Monthly Nursing Facility Visit Reporting

EOEA Key Survey Link: CTLP FY25 - Monthly Nursing Facility Visits Reporting Form

ASAP Requirements

- Complete one monthly *CTLP Nursing Facility Visit Reporting Form* **each month**
- Enter the **previous month's** Nursing Facility Visit data
- Utilize the key survey link below
- Use the same link every month for all monthly submissions throughout the year
- Submit by COB the **10th of the month**

Current Submissions

- 29 total submissions (9/27/24)
  - 15 ASAPs have reported July
  - 14 ASAPs have reported August

Initial Nursing Facility Visit Reporting Request

Due Date

By 10/10/24, ASAPs will submit 3 unique monthly reports for

- July 2024
- August 2024
- September 2024

FY25 Data

EOEA understands that July 2024 & August 2024 NF visit report may not be exact or comprehensive

- Valuable to help establish baseline data

No Need to Wait

ASAPs may enter July 2024 & August 2024 NF visit count at any point before October 10, 2024

More to Come

Informed Choice

- EOHHS to develop Informed Choice Policy for all agencies to utilize, including EOEA
- Recognize individual's right to participate & act on their own behalf
- Participation in decision-making to the fullest extent possible
- Consult with & include chosen supporters

National CLAS Standards

- Intended to advance health equity, improve quality, & help eliminate health care disparities
- Responsive to diverse cultural health beliefs & practices, preferred languages, health literacy & other communication needs
- Incorporate into ASAP practices & the ASAP Contract

Transition Data

- EOEA reviewing additional data points on community transitions
- More specifics on
  - own home, rented, subsidized
  - with/without major home modifications
  - care program
- Measuring time to transition

US Department of Health & Human Services [CLAS Standards - Think Cultural Health (hhs.gov)]

Questions?

Appendix

Resources

- **CTLP Marketing:** CTLP Marketing Materials
- **Transition Support Tool:** CTLP Transition Support Tool & CTLP TST Reference Guidance
- **A&D Requirements:** CTLP Documentation Requirements in A&D Business Rule
- **Team Expense Account:** CTLP E-Invoicing & Team Expense Account Business Rule
- **Options Counseling:** CTLP to OC Guidance
- **Warm Transfers:** ASAP Transfer Business Rule
- **PASRR:** PASRR Portal Network Training
- **NF Reporting Key Survey Link:** CTLP Monthly Nursing Facility Visit Reporting Form

CTLP Document Library on 800AgeInfo:

Community Transition Liaison Program (CTLP) - Document Library

***800ageinfo is migrating to a new platform. An updated link will be provided when available**

Resources

- **MassHealth Bulletins can be accessed:** MassHealth Provider Bulletins
- **MassHealth NF Bulletin 179:** NF Bulletin 179 CTLP
- **Managed Care Entity (MCE) Bulletin 122:** MCE Bulletin122 Enrollment in an integrated care plan while residing in a nursing facility
- **MassHealth NF Bulletin 183:** NF Bulletin 183 NF access and identifying NF residents who may be potential candidates to discharge from a NF and transition to the community

Approved CTLP Care Enrollment Termination Reasons

CTLP – ABI-N Waiver	CTLP – ABI-RH Waiver	CTLP – Change in Medical Setting	CTLP – DDS Adult Supports Waiver	CTLP – DDS Community Living Waiver	CTLP – DDS Intensive Supports Waiver
CTLP – Death	CTLP – Declines Further CTLP Intervention	CTLP – Discharge to AFC*	CTLP – Discharge to ALR with GAFC*	CTLP – Discharge to ALR without GAFC*	CTLP – Discharge to Community
CTLP – Discharge to Rest Home with GAFC*	CTLP – Discharge to Rest Home without GAFC*	CTLP – Discharge with DDS Services	CTLP – Discharge with DMH Services	CTLP – Discharge with MRC Services	CTLP – EOEA Home Care Program*
	CTLP – Frail Elder Waiver	CTLP – MFP Demo	CTLP – MFP-CL Waiver	CTLP – MFP-RS Waiver	

*New or updated Termination Reasons effective 6/6/24
800AgeInfo: CTLP Documentation Requirements in A&D Business Rule (To be updated with new Termination Reasons)