Executive Office of Elder Affairs

RESPECT INDEPENDENCE INCLUSION

Community Transition Liaison Program (CTLP) Network Training

June 29, 2023

9:00 a.m. – 11:00 a.m.

For Policy Development - Do Not Distribute

Agenda (120 minutes)

- Welcome (10 min)
- Introduction to CTLP (20 min)
- Documentation Requirements in Aging & Disability (15 min)
- Transition of CSSM to CTLP (15 min)
- Marketing for CTLP (15 min)
- What’s next? (20 min)
- Questions (25 min)
- Appendix

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New EOEA Staff

Julianna Santiago – Community Transition Liaison Program Manager

Email: Julianna.Santiago@mass.gov

Josh Ozer – Rappaport Fellow

Email: Josh.Ozer@mass.gov

Amanda Myers – Behavioral Health Program Coordinator

Email: Amanda.L.Myers@mass.gov

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Introduction to CTLP

Community Transition Liaison Program (CTLP)

Program Description:

The Community Transition Liaison Program (CTLP) supports nursing facility residents in transitioning to the community. CTLP supports any resident (age 22+) of a nursing facility (regardless of insurance) who is interested in receiving support & assistance to transition to the community.

The CTLP Team will engage with residents who are in the nursing facility to understand if they are interested in returning to the community. The CTLP team will provide assistance & coordination with discharge planning, including connecting residents to state programs & local community supports, & will assist the resident in mitigating issues that may impact their ability to successfully transfer to the community.

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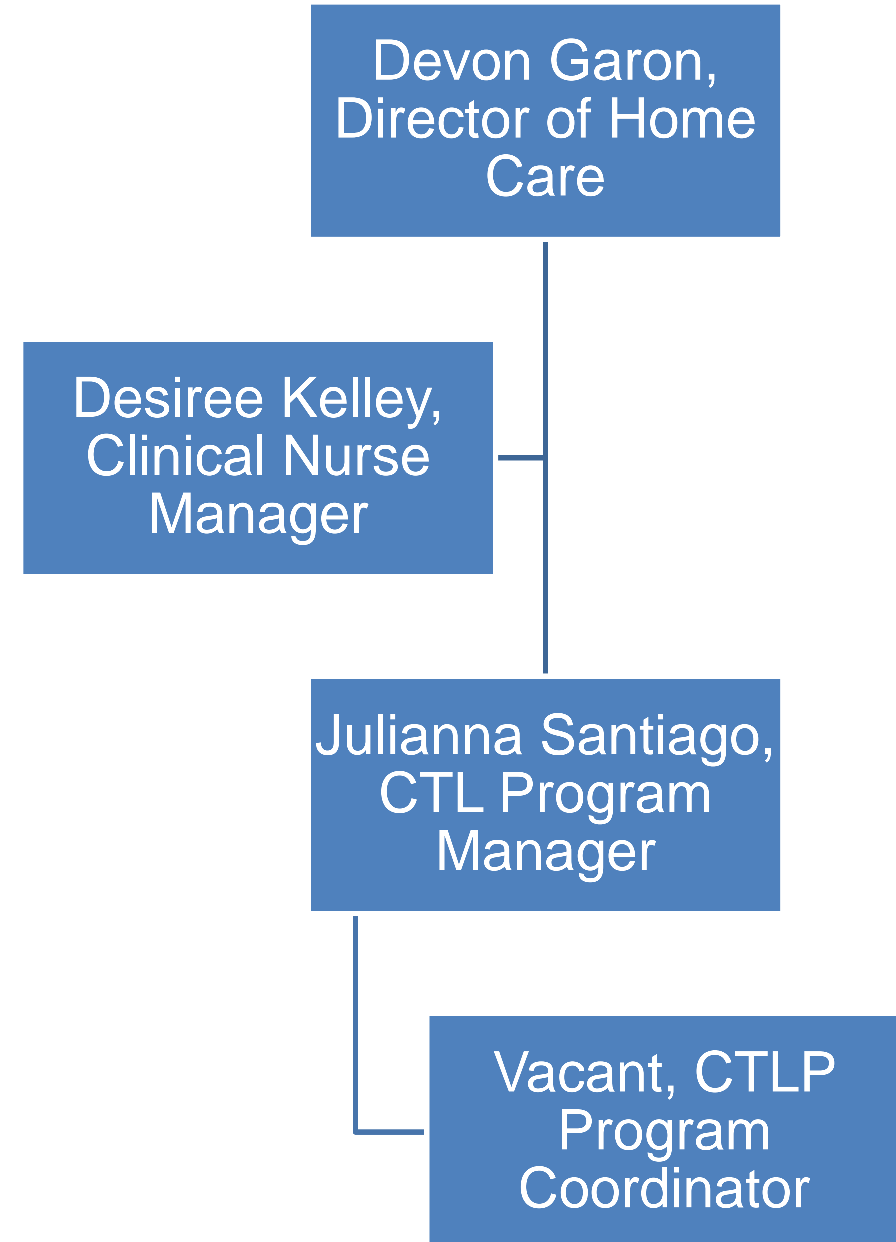
EOEA CTLP Team

Director of Home Care:
- Supervises CTL Program Manager
- Technical assistance

Clinical Nurse Manager:
- Provides clinical oversight & direction to CLTP
- Technical assistance

CTLP Program Manager:
- Oversees CTLP at EOEA
- Liaison between EOEA and other EHS Agencies
- Leads Governance across EHS agencies
- Connection to ASAPs
- Technical assistance

CTLP Program Coordinator:
- Supports CTL Program Manager
- Data collection & aggregation
- Connection to ASAPs
- Technical assistance



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ASAP CTLP Team

- Community Transition Liaison Program Supervisor
- Community Transition Liaison
- CTLP Case Assistant

Note: "CTLP" & "CTL" are abbreviations shared & utilized with nursing facility industry, trade associations, EHS, DDS, DMH, and MRC. ASAPs should refer & utilize the program abbreviations when identifying & introducing staff.

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ASAP CTLP Staff Role Highlights*

Community Transition Liaison Supervisor

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

Community Transition Liaison

- Visits residents to increase awareness & introduce transition to the community as a potential option
- Onsite point of contact for residents, families, NF staff, & all other parties involved with resident's care for NF transitions to the community
- Facilitates person-centered needs assessment & planning
- Completes & follows up on referrals to other programs to ensure timely transition
- Knowledge of long-term care, case management, discharge planning, community resources & benefits to help support an individual's transition from an institutional to a community setting

CTLP Case Assistant

- Supports the Community Transition Liaison
- Gathers documentation to assist with applying for public benefits
- Assists with housing applications

*See previously released *CTLP ASAP Minimum Skill Set & Qualifications April 2023* document

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Identifying Residents for CTLP

How do ASAPs identify potential residents for CTLP?

Current CSSM Consumers
- Transitioning to CTLP*

In-person
- Resident requests
- Resident engagement
- Assistance with discharge planning & transition at any time

Referrals
- Family & informal supports
- Other ASAP Programs
- Nursing Facility Staff

Portal
- Preadmission Screening & Resident Review (PASRR) Portal MassHealth Initiative [under development]
- Proposed launch mid-August
- Portal Training – July 2023
- Additional information to be distributed as it becomes available

* Discussed later in presentation

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What does a CTLP NF Resident look like?

NF Resident Profile Criteria

Length of Stay	Age	Insurance	SMI or ID/DD
• NF stay exceeds 45 days • **Or** NF stay is less than 45 days & resident has requested assistance with transition to community	• Age 22 or older	• Any insurance type	• No PASRR involvement unless Department of Developmental Services (DDS) or Department of Mental Health (DMH) request assistance from CTLP for complex discharges

What is PASRR?

Preadmission Screening & Resident Review (PASRR) is a federal- & state-requirement for all individuals seeking admission to a Medicaid- or Medicare-certified facility designed to identify evidence of:

- serious mental illness (SMI) and/or
- intellectual or developmental disabilities (ID/DD)

Overview of PASRR Process:

1. Level I screener completes Level I Preadmission Screen for an individual seeking admission to a NF to determine if the individual has, or may have, SMI and/or ID/DD.
2. Level I screener suspects that the screened individual has SMI and/or ID/DD & refers that individual to the appropriate PASRR authority for a Level II evaluation.
3. Level II evaluator confirms whether the individual has SMI and/or ID/DD and, if so, whether the individual requires a NF level of care and specialized services.

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Transition Assistance & Implications for CTLP

DDS is the Level II evaluator for individuals who are identified to have or may have ID/DD. If DDS confirms ID/DD diagnosis:

- DDS will support/coordinate discharge planning
  - DDS may request assistance from CTLP for complex discharges

DMH PASRR is the Level II evaluator for individuals who are identified to have or may have SMI. If DMH PASRR confirms SMI diagnosis:

- DMH Case Management Team will support/coordinate discharge planning for individuals with SMI & 90-day Level II Determination
  - May request assistance from CTLP for complex discharges
- Behavioral Health Community Partners (BH CP) will provide options for Long Term Service and Supports (LTSS) needs to individuals with SMI & 12-month Level II Determination
  - If resident identifies goal of transition to the community, resident will be assigned a DMH Transition Case Manager (and follow the above process)

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Soft Launch Expectations

What should ASAPs be working on currently?

- Interview, hire and/or fill open CTLP positions
- Develop business practices & procedures for CTLP in accordance with Business Rules & Scope of Work
- Review your agency website & update to include CTLP language

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What should CTLP teams be working on?

Outreach to Nursing Facilities (NFs)

- Weekly onsite visits to NFs
  - Introduce self as CTLP
  - Develop schedule for CTLP visits to NF
- Build Rapport with NF Staff
  - Provide contact information (email, phone number, etc.)
  - Get to know staff, how best to reach them, their schedule
- Work with NF staff to identify residents interested in discharge to the community
  - Connect with residents – goal is to engage and discuss options

Begin Transition of CSSM consumers to CTLP*

- Warm hand-off of consumers if CTLP Staff differs from CSSM Staff
- Familiarize with case record
- Outreach to consumer, family, other professionals

* Discussed later in presentation

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Documentation Requirements in Aging & Disability

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Business Rule Highlights

- CTLP Care Enrollments
- Journal Note Types
- File Attachment Folder

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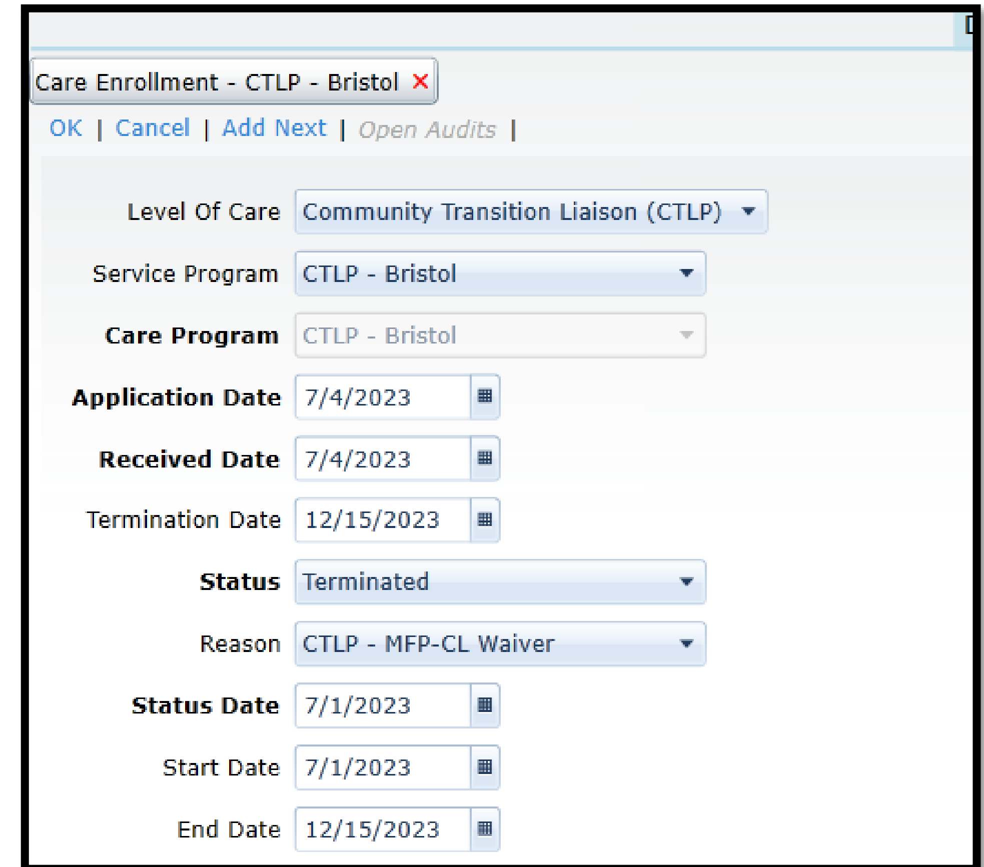
How will EOEA & ASAPS track & report on CTLP consumers?

CTLP Care Enrollments

- Required
- **ASAP Specific**
- **Purpose:**
  - Track individuals with whom the CTLP Team has engaged with
  - Record outcome of CTLP interactions & interventions
  - Demonstrate length of stay



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CTLP Care Enrollments

Creating CTLP Care Enrollment

- Create Care Enrollment for each resident they provide CTLP assistance
- Remains open until resident disposition is completed

Terminating CTLP Care Enrollment

- Terminate when CTLP Team is no longer working with consumer towards transition to the community
- Disposition is completed

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CTLP Care Enrollments

CTLP Care Enrollment Termination Reasons

Enrolled in a Waiver

- ABI-N Waiver
- ABI-RH Waiver
- DDS Adult Supports Waiver
- DDS Community Living Waiver
- DDS Intensive Supports Waiver
- Frail Elder Waiver
- MFP-CL Waiver
- MFP-RS Waiver
- TBI Waiver

CTLP Supported Discharge

- Discharge to Community
- Discharge with DDS Services
- Discharge with DMH Services
- Discharge with MRC Services
- Home Care Program
- MFP Demo
- SCO Enrolled

Change in CTLP Status

- Change in Medical Setting
- Death
- Declines Further CTLP Intervention
- NF Transfer
- Not Interested in Transition

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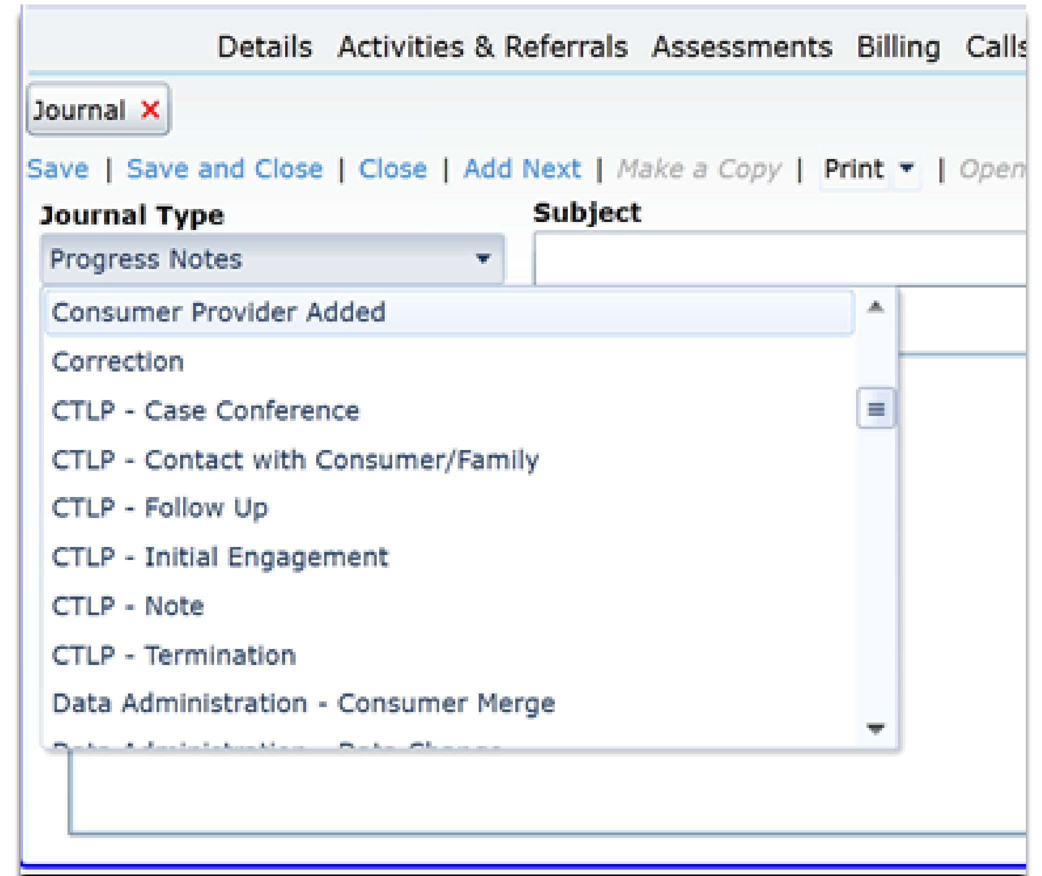
How will the CTLP Consumer journey be represented?

Journal Note Types

- **Purpose:**
  - Document actions, conversations, & engagement with consumer/other relevant parties when providing transition & discharge planning support
- **2 Required Journal Note Types:**
  - **CTLP-Initial Engagement**
  - **CTLP-Termination**



Journal Note Types

Journal Note Type	Description for Use
CTLP-Case Conference	Utilize to document interactions with other entities related to transition and discharge planning on behalf of the consumer. This includes interactions conducted by phone, email, video conferencing etc. with entities including but not limited to NF staff, other State Agencies (DDS, DMH, MRC, etc.), housing authorities, other ASAP Staff or Programs
CTLP-Contact with Consumer/Family	Utilize to document interactions with the consumer, consumer's family, or any other person designated to act on the consumer's behalf.
CTLP-Follow Up	Utilize to document any actions the CTLP Team takes on behalf of the consumer while assisting with transition and discharge planning.
CTLP-Initial Engagement	Utilize after initial engagement with the consumer. Document consumer's interest in engaging with CTLP for assistance with transition and discharge planning. **EOEA REQUIRED**
CTLP-Note	Utilize to document interactions between the CTLP Team and the consumer/family/designee or any actions the CTLP takes on behalf of the consumer.
CTLP-Termination	Utilize to document the termination of the consumer from CTLP. Include the outcome of the CTLP intervention. If the consumer is discharging to the community, include the type of setting the consumer is discharging to as well as any program or service that will support the consumer in the community. **EOEA REQUIRED**

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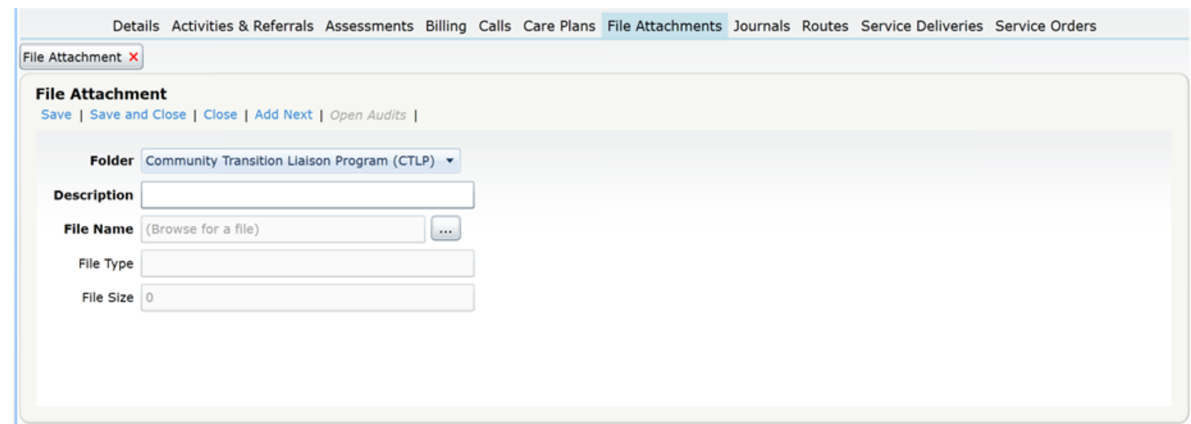
File Attachment Folder

- Optional – Use in accordance with ASAP business practice
- File Attachment Folder Name = Community Transition Liaison Program (CTLP)
- Examples of documents that may be stored:
  - Completed Transition Support Tool (TST)
  - Copies of completed applications
  - Other relevant documents

File Attachments must not include documents containing another consumer's information or sensitive information, including but not limited to PS report, CORI findings, etc.



How will EOEA & ASAPS ensure data quality integrity & continuous process improvement?

CTLP Required Reporting

CTLP Enrollments and Terminations Report

Report forthcoming & tentative release late July

- Requires data entry following July 1 A&D update to validate before release
- Report will be demonstrated at the HAR Writer's Group Meeting on July 7th

Mirrors current CSSM Enrollments and Terminations Report

- ASAPs are required to run on a monthly basis
- Utilize consumer list for validation checks on missing or incorrect termination reasons
  - Detailed in *CTLP Documentation Requirements in A&D Business Rule June 2023*

Identifies all new enrollments for the report run period & all terminations, including breakdown by termination reason

- ASAPS will select their agency & then the start and end date of the reporting period to run

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Transition of CSSM to CTLP

Business Rule Requirements

Overview

- CSSM Program will sunset between July 1, 2023 & September 30, 2023
  - CSSM Care Enrollments
    - No new CSSM Care Enrollments after June 30, 2023
    - Created prior to July 1, 2023 can be modified & terminated
    - With an end date prior to July 1, 2023 should be terminated in accordance with ***Tracking CSSM Enrollment in SAMS Business Rule September 17, 2020***
    - With an end date on or after July 1, 2023 must be terminated in accordance with ***Transition of CSSM Care Enrollments to CTLP Care Enrollments Business Rule June 2023***

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Business Rule Requirements

Required Actions

- Run HAR Report to identify all consumers with an active CSSM Care Enrollment
- Review each active CSSM Care Enrollment to determine if:
  - CSSM Care Enrollment should have been **terminated prior to July 1, 2023**
    - End Care Enrollment in accordance with ***Tracking CSSM Enrollment in SAMS Business Rule September 17, 2020***
  - **Active** transition/discharge planning is currently occurring
    - End Care Enrollment in accordance with ***Transition of CSSM Care Enrollments to CTLP Care Enrollments Business Rule June 2023***
  - **No active** transition/discharge planning is currently occurring
    - End Care Enrollment in accordance with ***Transition of CSSM Care Enrollments to CTLP Care Enrollments Business Rule June 2023***

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Business Rule Requirements

Active Transition/Discharge Planning Currently Occurring

- Terminate CSSM Care Enrollment using **CSSM – Transfer to CTLP** as the termination reason
  - End date = date CSSM Care Enrollment review occurred (Note: must be on or after July 1, 2023)
- Enter a **CTLP Care Enrollment** with the Start Date & Received Date being the same as the end date of the CSSM Care Enrollment

Best Practice – CSSM Team will do a warm transfer to the CTLP Team (if CSSM Team is different than CTLP Team)

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Business Rule Requirements

No Active Transition/Discharge Planning Currently Occurring

- CTL must engage with consumer & determine if they are interested in transition/discharge assistance

If Yes/Interested in transition/discharge -

- Terminate CSSM Care Enrollment using **CSSM – Transfer to CTLP** as the termination reason
  - End Date = date CTL engaged with the consumer (Note: must be on or after July 1, 2023)
- Enter a **CTLP Care Enrollment** with the Start Date & Received Date being the same as the end date of the CSSM Care Enrollment

Provide ongoing engagement & assistance to the consumer for transition & discharge planning through CTLP

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Business Rule Requirements

No Active Transition/Discharge Planning Currently Occurring

- CTL must engage with consumer & determine if they are interested in transition/discharge assistance

If No/ Not Interested in transition/discharge -

- Terminate CSSM Care Enrollment using **CSSM – Refuses Discharge Planning** as the termination reason
  - End Date = date CTL engaged with the consumer (Note: must be on or after July 1, 2023)
- Enter **CTLP Care Enrollment** with the Start Date & Received Date being the same as the end date of the CSSM Care Enrollment
- Terminate the **CTLP Care Enrollment** using **CTLP – Not Interested in Transition**
  - End date = end date of CSSM Care Enrollment

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CSSM Report Clean-up

CSSM Active Enrollment Validation Report

- Currently available in HAR
  - Will be demonstrated at the HAR Writer's Group Meeting on July 7, 2023
- Located in the HAR folder under Community/CSSM (along with User Guide)
- Use report to review all CSSM enrollments for your agency with an "active" status by:
  - Reviewing overall status of active CSSM enrollments
  - Identifying which CSSM enrollments should be terminated prior to July 1, 2023
  - Identifying which CSSM enrollments should be reviewed for transition to CTLP

Report is expected to be run monthly to monitor progress until CSSM sunset on September 30, 2023

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Marketing for CTLP

Marketing Types

- Printed Materials
- CTLP on Mass.gov
- EHS Messaging to NFs

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Printed Materials - Tentative

- EOEA working with EHS Publications to finalize plan for marketing materials

- 3 Potential Printed Materials
  - **CTLP Index Cards**
    - Contains contact information for CTL and ASAP logo
    - CTLP information directed at assisting resident in discharging to the community
  - **Program Flyers**
    - Overview of CTLP
    - To be placed throughout NF on bulletin boards & posted in designated areas
  - **Brochures**
    - More in-depth program overview

- Materials will be translated into multiple languages

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CTLP on Mass.gov

Website: https://www.mass.gov/info-details/community-transition-liaison-program-ctlp

Mass.gov

Search Mass.gov SEARCH

Health & Social Services > ... > Frail Elder Waiver (FEW) > Aging in Community

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Community Transition Liaison Program (CTLP)

This program is available to all nursing facility residents who are 22 years old and older, regardless of insurance type, who are interested in living in the community.

The CTLP Team will work with residents who are in a nursing facility to understand their interest in returning to the community. The CTLP team will provide help with discharge plans, connect residents to state programs and local community supports, and will help the resident advocate and work to resolve concerns related to transitioning to the community.

If you are interested in learning more about how to enroll in the Community Transitions Liaison Program (CTLP), please contact your local Aging Services Access Point (ASAP).

CTLP on Mass.gov

Website:
https://www.mass.gov/service-details/aging-in-community

Mass.gov

Search Mass.gov

Health & Social Services > ... > MassHealth for Seniors and People who need Long-Term-Care Services > Frail Elder Waiver (FEW)

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Aging in Community

Find resources and links about aging in community.

Resources and links

Councils on Aging & Senior Centers
Councils on Aging are the 350 municipal agencies that provide local outreach, social and health services, advocacy, information and referral for older adults, their families and caregivers.

In-Home Services
Home care services are available to help eligible elders continue to live independently and safely at home. The Home Care Program offers a variety of fee for service in home assistance based on income levels.

Housing Options
Elder housing includes affordable supportive housing, shared living in congregate settings, and assisted living residences.

Nutrition Program for Seniors
Services include nourishing meals, screening, education, and counseling, to help older people have healthy nutrition status. Meals are at congregate meal sites and through home-delivered meals to people 60+.

Options Counseling
Options Counseling is a free service. It can help an older person, an adult of any age with a disability, their family members or caregivers make decisions on supportive services if they don't know where to turn. **To speak to an Options Counselor in your area, call MassOption toll free at 1-(800) 243-4636.**

Community Transition Liaison Program
CTLP is available to all nursing facility residents who are 22 years old and older, regardless of insurance type, who are interested in transitioning to living in the community. The CTLP team will provide help with discharge plans, connect residents to state programs and local community supports, and will help the resident advocate and work to resolve concerns related to transitioning to the community.

Report Elder Abuse
Elder abuse includes physical, sexual, and emotional abuse, caretaker neglect, financial

EHS Messaging to NFs

- EHS initial engagement with LeadingAge & MSCA – March 30, 2023
- EHS email blast to NFs – June 15, 2023
- EHS hosted webinar for NF industry – June 22, 2023
  - **Enhanced Care Coordination & Transition Support in Nursing Facilities**
    - Behavioral Health Community Partners (BH CP) for NF Residents
    - DMH Case Management Team
    - Community Transition Liaison Program
- BH CP hosted webinar for NF industry - June 29, 2023
  - **BH CP, DMH, & CTLP Supports in Nursing Facilities**
    - Joint meeting with BH CP management & NF industry administrators
- MassHealth to release NF Bulletins for CTLP & BH CP

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Behavioral Health Community Partners (BH CP) for NF Residents

- BH CP will support:
  - NF residents authorized to receive services from DMH
  - NF residents with a positive Level 2 PASRR determination of Serious Mental Illness (SMI) who have received a determination that NF services are appropriate for up to the next 12 months
- BH CP will provide:
  - Enhanced Care Coordination to all eligible NF residents

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Behavioral Health Community Partners (BH CP) for NF Residents

- Care Coordinators will provide the following services & supports to their enrollees:
  - Outreach & engagement
  - Comprehensive assessment, HRSN screening, & ongoing person-centered treatment planning
  - Care coordination across services including medical, behavioral health, long term services & supports, other state agency services, and as appropriate referrals for DMH Clubhouse & Human Services Transportation (HST)
  - Support for transitions of care
  - Provide options for Long Term Service & Supports (LTSS) needs
  - Medication reconciliation support
  - Health & wellness coaching
  - Connection to social services & community resources

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DMH Case Management Team

- DMH Case Management Team will support:
  - Individuals with positive Level 2 PASRR determination of SMI who are likely to be discharged within 90 days
  - The resident's transition to the community
- DMH CMs will:
  - Work with existing Care Coordination services (BH CP, One Care Plan, etc.)
  - Collaborate with DMH site Office in the community to facilitate referral & enrollment into DMH Services
  - Assist with referrals to other community services & supports
  - Inform NF of plan and coordinate discharge

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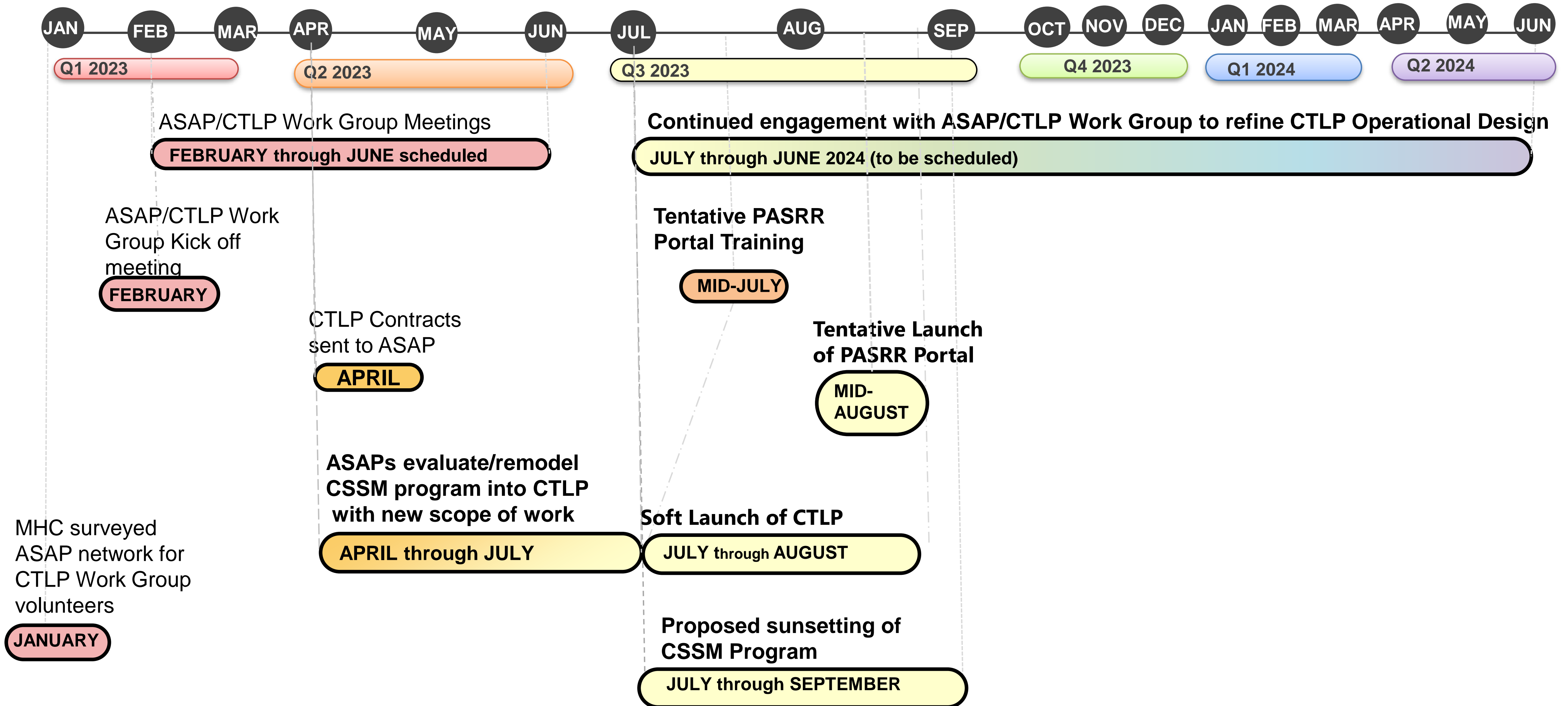
What’s Next?

CTLP Operational Implementation Timeline CY2023 into CY2024



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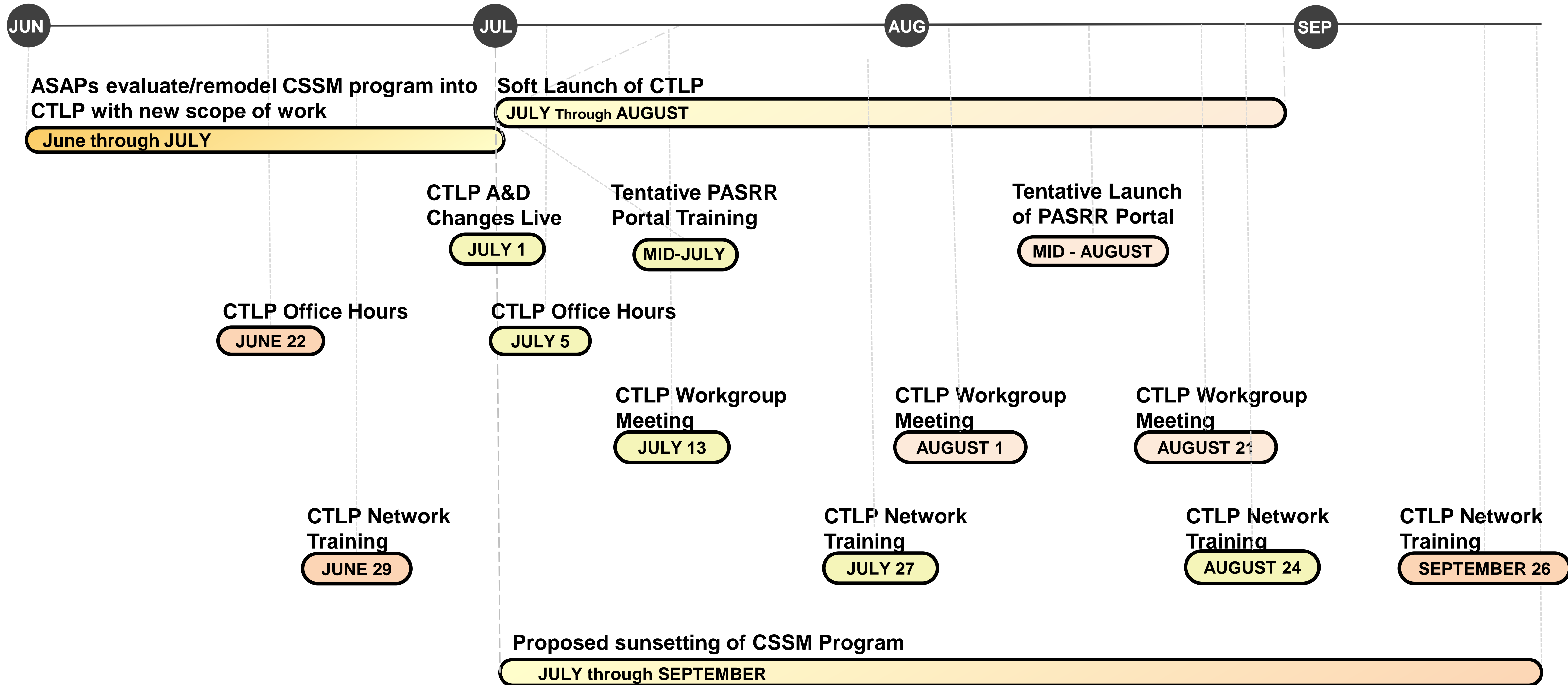
CTLP Operational Implementation Timeline: CTLP Soft Launch Window



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What should CTLP teams be working on?

Outreach to Nursing Facilities (NFs)

- Weekly onsite visits to NFs
  - Introduce self as CTLP
  - Develop schedule for CTLP visits to NF
- Build Rapport with NF Staff
  - Provide contact information (email, phone number, etc.)
  - Get to know staff, how best to reach them, their schedule
- Work with NF staff to identify residents interested in discharge to the community
  - Connect with residents – goal is to engage and discuss options

Begin Transition of CSSM consumers to CTLP*

- Warm hand-off of consumers if CTLP Staff differs from CSSM Staff
- Familiarize with case record
- Outreach to consumer, family, other professionals

* Discussed later in presentation

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Under Development

- Collaboration with OC
- CTLP Implementation Guide/ Best Practices
- EHS Program FAQs
- Role of the RN
- Training Topics & Curriculum
- Transition Support Tool (TST)

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Upcoming Meetings & Trainings

July Office Hours

Wednesday, July 5, 2023

3:00pm – 4:00pm

July CTLP Training (tentative)

Thursday, July 27, 2023

1:30pm – 3:30pm

August CTLP Training (tentative)

Thursday, August 24, 2023

10:00am – 12:00pm

September CTLP Training (tentative)

Tuesday, September 26, 2023

1:00pm – 3:00pm

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Questions?

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Appendix

Resources

800AgeInfo – Document Library

https://documentlibrary.800ageinfo.com/2023/05/cssm-to-ctlp-transition.html

- Available documents
  - CSSM to CTLP ASAP Network Meeting Slide Deck
  - CTLP ASAP Minimum Skill Set Qualifications
- Password Protected Documents
  - Password = EOEA_homecare

Aging & Disability For Professionals
Serving Massachusetts Older Adults and People with Disabilities

Document Library
A Document Repository for Massachusetts Elder Care Professionals

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« Home Care Program Referral & Intake: September 14th, 2022 | Main | Home Care Consumer Profile »

May 05, 2023

CSSM to CTLP Transition

CSSM to CTLP ASAP Network Meeting 5.4.2023

CTLP ASAP Minimum Skill Set Qualifications April 2023

Posted on May 05, 2023 at 12:09 PM in ASAP, Clinical Assessment & Eligibility (CAE), Coordination of Care, Home Care | Permalink

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Resources

800AgeInfo – Document Library

https://documentlibrary.800ageinfo.com/2023/06/ctlp.html

- Available documents
  - CTLP Documentation Requirements in A&D Business Rule – June 2023
  - Transition of CSSM Care Enrollments to CTLP Care Enrollments Business Rule – June 2023

Aging & Disability For Professionals

Serving Massachusetts Older Adults and People with Disabilities

Document Library

A Document Repository for Massachusetts Elder Care Professionals

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« MassHealth Member Eligibility Redetermination Data Sharing for Home Care Program Consumers: PI-23-06 | Main

June 26, 2023

Community Transitions Liaison Program (CTLP)

CTLP Documentation Requirements in A&D Business Rule - June 2023

Transition of CSSM Care Enrollments to CTLP Care Enrollments Business Rule - June 2023

Posted on June 26, 2023 at 08:55 AM in ASAP, Business Rule, Home Care | Permalink

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Resources

800AgeInfo – Document Library

https://documentlibrary.800ageinfo.com/2020/09/cssm-business-rule-september-2020.html

Available documents

- CSSM Enrollments and Terminations Report User Guide
- CSSM Business Rule Sept 2020

Aging & Disability For Professionals
Serving Massachusetts Older Adults and People with Disabilities

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Coordination of Care (3)
Document Library Announcements (2)

« Care Enrollment Termination Reasons | Main | PI-21-01: Cost-Share Program Instruction 2021 »

September 25, 2020

Comprehensive Screening and Services Model (CSSM) Business Rule and Reporting Requirements

CSSM Enrollments and Terminations Report User Guide

CSSM Business Rule Sept 2020

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CTLP Talking Points

Talking points provided to Nursing Facility Industry 6/15/2023 by MassHealth

Community Transition Liaison Program (CTLP), expansion of current Comprehensive Screening and Service Model (CSSM) Program

- What is the Community Transitions Liaison Program? Who is eligible?
    - The CCSM Program is managed by the Aging Services Access Points (ASAPs) and has been in existence since 2005. This program will be rebranded as the Community Transitions Liaison Program (CTLP) with enhanced funding and focus on supporting all nursing facility residents who are 22 and older, regardless of diagnosis or insurance type, who are interested in transitioning to the community.
    - Each nursing facility will have an assigned CTLP team of two people that will operate out of the regional Aging Services Access Point (ASAP) and will coordinate with other state agencies as needed to best support an individual interested in transitioning into the community.
- How will the CTLP teams get involved? Will they be on the premises?
    - Assigned CTLP teams will work with NF staff, NF Ombudsman, NF residents, family and informal supports as well as others.
    - CTLP teams will have a weekly on-site presence at the nursing facility.
    - CTLP teams will provide marketing materials (e.g., flyer, brochures) with program details and team contact information.
    - CTLP teams will be involved with and provide support in discharge planning meetings.
- What can I expect from the CTLP teams assigned to the residents in my facility?
    - CTLP teams will meet with residents to discuss their needs and provide options for a safe plan to return to community living, assist with applications for housing and public benefits including collecting all necessary documentation, and coordinate with state and community agencies to identify resources and make referrals.
    - To accomplish this CTLP teams may need the following from facilities:
        - Continued access to residents;
        - Access to a conference room or a copy machine;
        - Support to help share information about the CTLP program;
        - Referrals to the CTLP program.

EOEA Contact List

Lynn Vidler – Senior Director, Operations and Policy for Home Care Programs

Email: Lynn.Vidler@mass.gov

Devon Garon – Director of Home & Community Programs

Email: Devon.Garon@mass.gov

Desiree Kelley – Clinical Nurse Manager

Email: Desiree.Kelley@mass.gov

Shannon Turner – Home Care Program Coordinator

Email: Shannon.K.Turner@mass.gov

Melissa Enos – Home Care & Program Analytic Nurse

Email: Melissa.A.Enos@mass.gov

Brian Glennon – Home Care Waiver Program Manager

Email: Brian.M.Glennon@mass.gov

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EOEA Contact List

Nicholas Roberts – Home Care Data Analyst

Email: Nicholas.P.Roberts@mass.gov

Dawn Hobill – Quality Manager

Email: Dawn.Hobill@mass.gov

Joel Bartlett – Home Care Provider Coordinator

Email: Joel.D.Bartlett@mass.gov

Dana Beguerie – Frail Elder Waiver/ Senior Care Options Liaison

Email: Dana.Beguerie@mass.gov

Allison Staton – Program Manager

Email: Allison.M.Staton@mass.gov

Amanda Myers – Behavioral Health Program Coordinator

Email: Amanda.L.Myers@mass.gov

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EOEA Contact List

Julianna Santiago – Community Transition Liaison Program Manager

Email: Julianna.Santiago@mass.gov

Josh Ozer – Rappaport Fellow

Email: Josh.Ozer@mass.gov