



Executive Office of Elder Affairs

RESPECT INDEPENDENCE INCLUSION

Community Transition Liaison Program (CTLP) Network Training

July 27, 2023

1:30 p.m. – 3:30 p.m.

For Policy Development - Do Not Distribute




Agenda (120 minutes)

- Welcome
- Introduction to PASRR
- Housing Highlights
- What's Next?
- Questions
- Appendix

Introduction to PASRR

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)

Why is PASRR Important?

Prevents individuals from being unnecessarily institutionalized

Identifies individuals with a PASRR related disability

- Serious Mental Illness (SMI) and/or
- Intellectual Disability/ Developmental Delay (ID/DD)

Ensures NF residents with SMI and/or ID/DD receive appropriate care which may include specialized services

Identifies NF residents with SMI and/or ID/DD whose nursing facility stay is no longer appropriate and who should be discharged to a less restrictive setting in a timely manner

Questions?

Overview of PASRR Process

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.

Level I screener suspects (Level I +) that the screened individual has SMI and/or ID/DD & refers that individual to the appropriate PASRR authority for a Level II evaluation.

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

Level I

Purpose:	Required for every individual admitted to a Medicaid- or Medicare-certified facility regardless of payer source	Level I Screener:	Prior to PASRR Portal implementation Level I Form was a paper form that could be completed either electronically (fillable pdf) or handwritten
• Determine if individual has or may have SMI and or ID/DD • Level I "positive" for SMI and/or ID/DD		• RN/LPN, Social Worker, MD, LMHC, MEd, PhD, NP or PA employed by a Nursing Facility, ASAP, or Hospital	

Potential PASRR Level 1 Outcomes

	If positive (+) for ID/DD…	If negative (-) for ID/DD…
If positive (+) for SMI…	*Level I Screener refers to both DMH PASRR & DDS for Level II evaluation*	*Level I Screener refers to DMH PASRR for level II Evaluation*
If negative (-) for SMI…	*Level I Screener refers to DDS for Level II evaluation*	*If negative (-) for both SMI & ID/DD, no further action required*

Questions?

Exempted Hospital Discharge (EHD)

For individuals being admitted from a hospital to a NF, who screen positive (+) on their Level I, they may qualify for an **Exempted Hospital Discharge (EHD)**

What does this mean?

The Level II evaluation will not be completed until 30 days after the individual is admitted to the NF

Why is this important?

Does not delay the individual transferring from the hospital to the NF

Connection to CTLP

This is why PASRR Portal is used to identify individuals who have been in the NF greater than 45 days

Allows time for Level II evaluator to evaluate & determine if the individual meets the criteria for SMI and/or ID/DD

Exempted Hospital Discharges (EHD)*

Must meet all 4 Criteria to qualify for EHD

- **Criteria documented in Level I by Level I screener**

1. Admitted directly from acute hospital after acute medical care
2. Needs NF services to treat same medical condition treated in hospital
3. Is not a current risk to self or others and behavioral symptoms are stable; and
4. Is expected to stay in the NF for less than 30 calendar date as certified by the hospital's attending or discharging practitioner

* Sometimes referred to as a "30-day order"

Questions?

Level II

Level II Evaluator determines:

if individual has SMI &/or ID/DD

if NF is the most appropriate setting

if specialized services are required

- if required, makes recommendations on which specialized services are needed

DMH PASRR Unit (UMass)

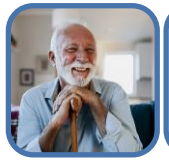
For individuals who have Level I + SMI, DMH PASRR completes a Level II Evaluation

Level II Evaluations happen at multiple points in an individual's NF stay

Admission to NF

At 30 days after admission due to EHD

Prior to expiration of previous Level ll approval dates



Significant change

Annually for individuals with SMI who are determined to need NF level of care

DMH PASRR & CTLP

Level II evaluation by DMH PASRR will confirm if the individual:

Does not have SMI

- No further PASRR involvement
- Must be engaged with by the CTLP Team to determine interest in returning to the community

Has SMI

- Will issue:
  - 90-Day Approval or
  - 12-month Annual Approval

Level II determination letter will contain this information

- **Available in PASRR Portal (once available)**

DMH PASRR & CTLP

90-Day Approval: Individual may be more appropriate for a community Placement

- DMH will assign a DMH Transition Case Manager to individuals with a 90-day approval to coordinate the person's transition from the NF to the community, including:
  - Work with existing Care Coordination services (BH CP, One Care plan, etc)
  - Collaborate with the DMH Site Office to facilitate referral and enrollment into DMH services
  - Assist with Referrals to other community services and supports (PCA, VNA, home modifications, etc.)
  - Coordinate Discharge Date with NF
  - May request assistance from CTLP for complex discharges

DMH PASRR & CTLP

12-Month Approval: Individual needs nursing facility level of care for 12 months

- DMH will refer to Behavioral Health Community Partner (BH CP) for individuals with a 12-month approval for care coordination and coordinate specialized services and other appropriate behavioral health services
  - If resident identifies goal of transition to the community, resident will be assigned a DMH Transition Case Manager (and will follow process for individuals who have been assigned a DMH Transition Case Manager)
  - May request assistance from CTLP

DMH Nursing Facility Transition Team

DMH NF Transition Manager

- Oversight for all assessment, service coordination & transition planning
  - includes PASRR program, coordination of specialized services by BHCP & other Integrated Care Coordination resources
- Manages coordination & oversight of the DMH Transition Team assigned to NFs to facilitate community transitions

DMH NF Transition Specialist

- Provides clinical support & consultation to the PASRR evaluation team, BH CPs, Transition Case Management team
- Consults with DMH continuing care units & community services to assess needs for individuals who may be diverted from NF placement

DMH Transition Case Manager Supervisor

- Direct supervision of the DMH NF Transition Case Managers
- Implement decisions made through the PASRR process
- Assign individuals to transition case managers

DMH NF Transition Case Manager

- Provide statewide case management services
- Lead discharge planning & service coordination activities to support community transitions or diversion of individuals from NF
- Ensure a smooth transition to the community.

Questions?

DDS

For individuals who have a Level I with + ID/DD, DDS completes a Level II Evaluation

Level II Evaluations happen at multiple points in an individual's NF stay

Admission to NF

At 30 days after admission due to EHD

Significant change

Every 90 days for individuals with ID/DD who are determined to need NF level of care

DDS & CTLP

If DDS confirms ID/DD diagnosis a 90-day approval will be issued

- DDS will assign a DDS Transition Coordinator who will:
  - Support & coordinate discharge planning
  - Request assistance from CTLP for complex discharges if needed

DDS & CTLP

DDS Level II Determinations will NOT be available in the PASRR Portal during the initial roll out

How will I know the outcome of a Level II Determination completed by DDS?

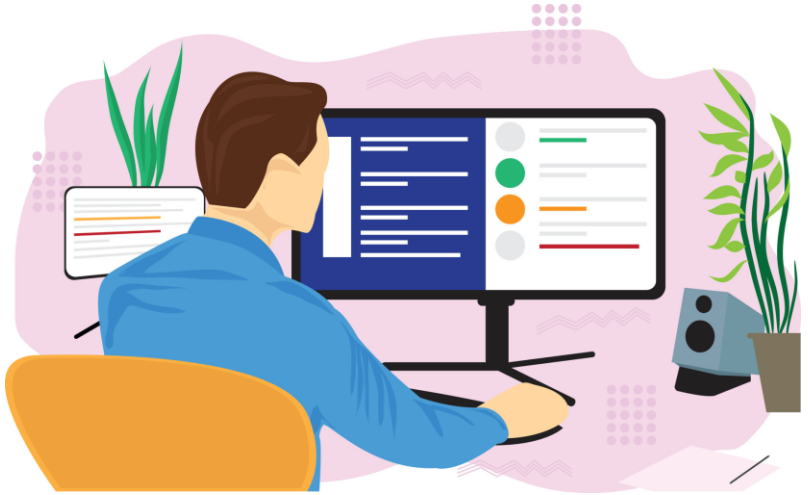
- Ask NF SW if consumer is being followed by DDS while in the NF
  - NF will have a copy of the Level ll Determination letter
- Case conference with the ASAP RN who covers this NF
  - DDS typically shares a copy of the Level II Determination with the ASAP for Level of Care purposes

PASRR Portal

- Training & Launch date pushed back
  - Tentative Portal Training: Mid- August 2023
  - Tentative Launch: Late August 2023

- PASRR Portal is one pathway for identifying potential residents for CTLP

- Within the Portal CTLP Staff will be able to:
  - Determine resident's date of admission
  - Determine residents who were Level I (-)
  - View outcomes related to SMI/DMH PASRR



Questions?

Housing Highlights

Housing Programs

- Multiple housing programs available
- 2 highlighted programs that are intended for individuals who are institutionalized or at risk of institutionalization
  - Community Based Housing (CBH)
  - Lynn Housing & Neighborhood Development Special Purpose Housing Voucher (LHAND)

Community Based Housing (CBH)

Provides affordable housing for individuals with disabilities who are living in institutions and seek an alternative in the community or those who are at risk for institutionalization

Eligibility

- Not a DMH or DDS Consumer
- Institutionalized or at risk for institutionalization
- Disability*
- Income less than 30% AMI (Area Median Income)

Housing Units

- First come, first serve
- New units being funded all the time
- 1 or 2 bedrooms, some studios
- New units must be accessible

*see next slide

Community Based Housing (CBH)

Disability – a physical or mental impairment of a permanent or long and continuous duration that substantially limits one or more major life activities, including but not limited to:

- Mobility impairments
- Cerebral palsy
- Multiple Sclerosis
- Muscular dystrophy
- Epilepsy
- HIV/AIDS
- Brain or spinal cord injuries
- Sensory disabilities
- Emotional disabilities
- Cognitive disabilities

https://www.mass.gov/service-details/community-based-housing-cbh

Community Based Housing (CBH)

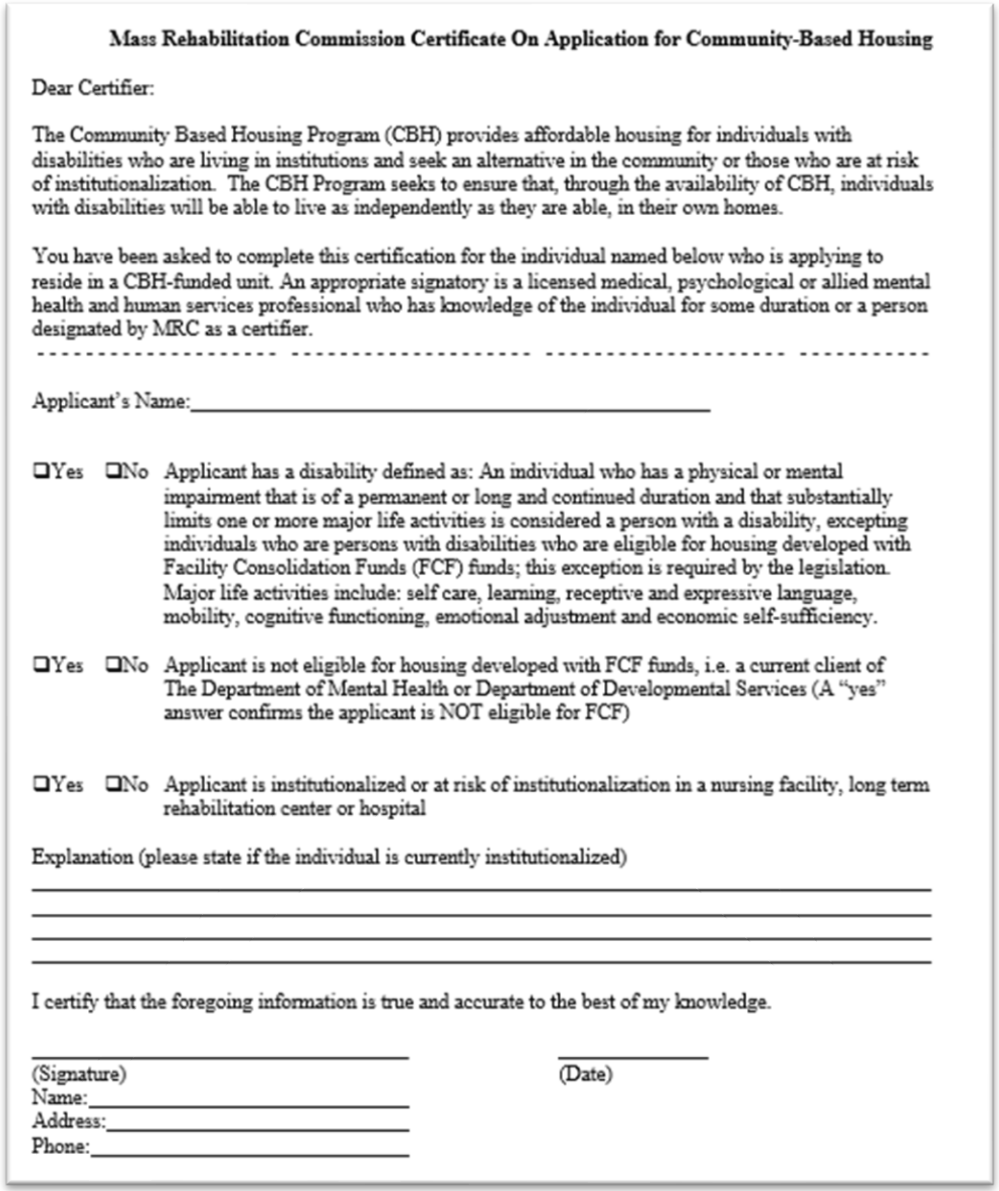
Application Process/ Required Documentation

- Certification Form completed & signed by human/social services worker or medical professional working with the individual in relation to the disability
- Rental application
- Return both items to property manager
- Units are first come, first serve

Learn about available units by getting on the CBH Vacancy Distribution List:

- Julianna Santiago (Julianna.Santiago@mass.gov) will be compiling a list of CTLP staff to be added to this distribution list

Community Based Housing (CBH) Certification Form



Mass Rehabilitation Commission Certificate On Application for Community-Based Housing

Dear Certifier:

The Community Based Housing Program (CBH) provides affordable housing for individuals with disabilities who are living in institutions and seek an alternative in the community or those who are at risk of institutionalization. The CBH Program seeks to ensure that, through the availability of CBH, individuals with disabilities will be able to live as independently as they are able, in their own homes.

You have been asked to complete this certification for the individual named below who is applying to reside in a CBH-funded unit. An appropriate signatory is a licensed medical, psychological or allied mental health and human services professional who has knowledge of the individual for some duration or a person designated by MRC as a certifier.

Applicant's Name:_____

❑Yes ❑No Applicant has a disability defined as: An individual who has a physical or mental impairment that is of a permanent or long and continued duration and that substantially limits one or more major life activities is considered a person with a disability, excepting individuals who are persons with disabilities who are eligible for housing developed with Facility Consolidation Funds (FCF) funds; this exception is required by the legislation. Major life activities include: self care, learning, receptive and expressive language, mobility, cognitive functioning, emotional adjustment and economic self-sufficiency.

❑Yes ❑No Applicant is not eligible for housing developed with FCF funds, i.e. a current client of The Department of Mental Health or Department of Developmental Services (A "yes" answer confirms the applicant is NOT eligible for FCF)

❑Yes ❑No Applicant is institutionalized or at risk of institutionalization in a nursing facility, long term rehabilitation center or hospital

Explanation (please state if the individual is currently institutionalized)

_____
_____
_____
_____

I certify that the foregoing information is true and accurate to the best of my knowledge.

_____ _____
(Signature) (Date)
Name:_____
Address:_____
Phone:_____

Lynn Housing & Neighborhood Development Special Purpose Housing Voucher (LHAND)

LHAND is a special type of Section 8 voucher for a specific population

- Special Purpose Voucher Program
- Issued by LHAND
- May be used anywhere in the state
- Do not need to live in Lynn
- Rolling waitlist

Eligibility

- Non-elderly, between age 18-61
- Has a disability
- Income 50% of AMI
- Currently residing in an institution

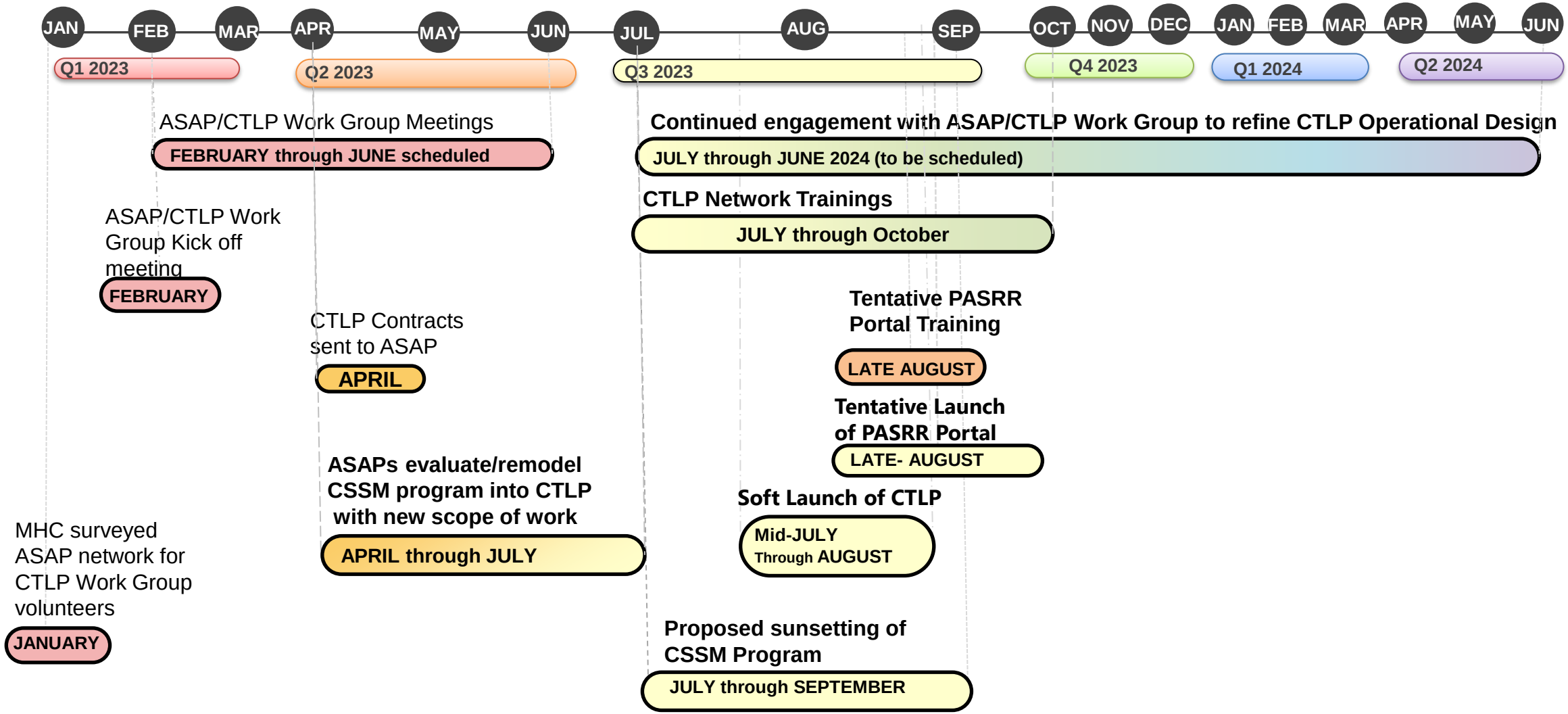
Lynn Housing & Neighborhood Development Special Purpose Housing Voucher (LHAND)

LHAND Referral Process/Application

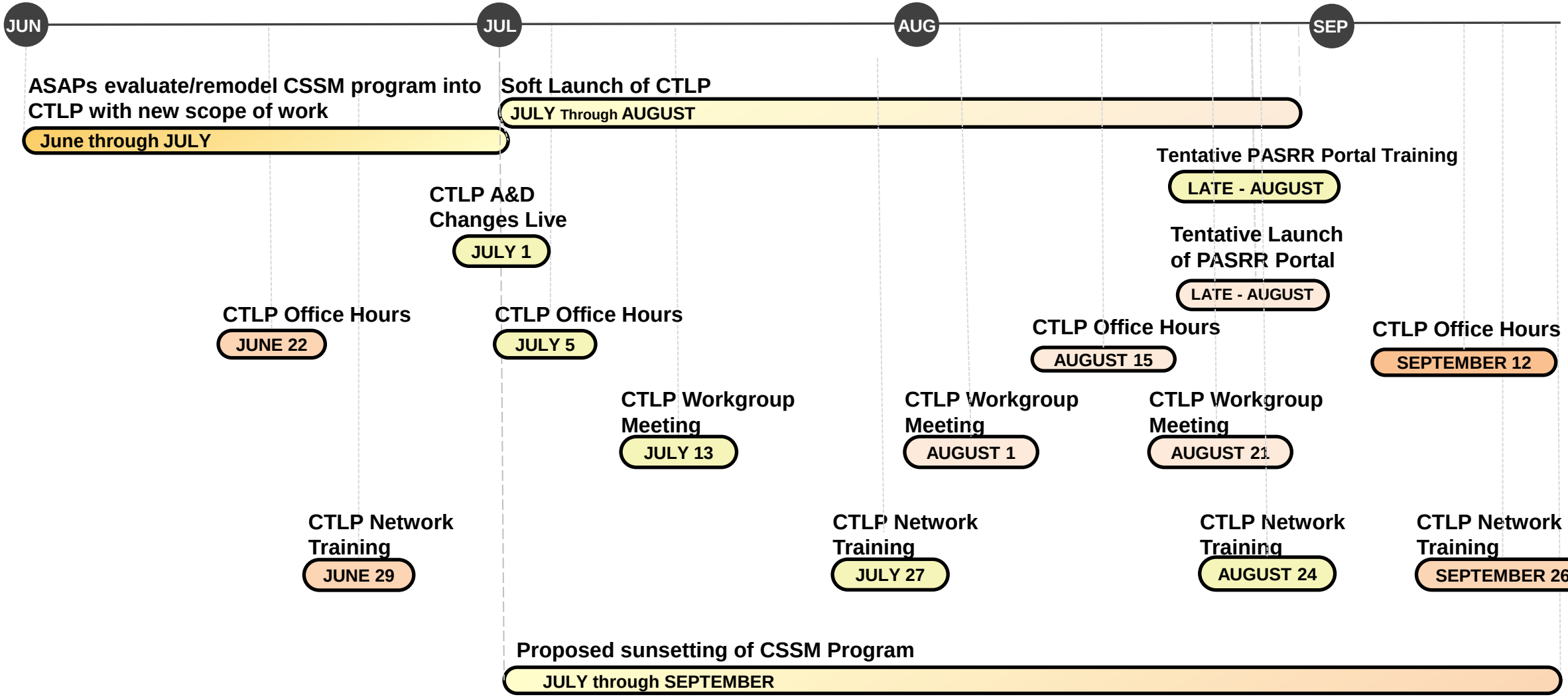
- LHAND Referral Form completed & signed by human/social services worker or medical professional who is working with the individual in relation to the disability
- Referrer contacted by email when applicant's name is nearing the top of the waitlist to confirm the applicant is still residing in institution
- Must complete LHAND Application
- Do not need to reside in Lynn, can use voucher anywhere in the state

What’s Next?

CTLP Operational Implementation Timeline CY2023 into CY2024



CTLP Operational Implementation Timeline: CTLP Soft Launch Window (updated)



Upcoming Meetings & Trainings

August CTLP Office Hours

Tuesday, August 15, 2023

1:30pm – 2:30pm

August CTLP Training (tentative)

Thursday, August 24, 2023

10:00am – 12:00pm

September CTLP Office Hours

Tuesday, September 12, 2023

10:00am – 11:00am

September CTLP Training (tentative)

Tuesday, September 26, 2023

1:00pm – 3:00pm

Questions?

Appendix

Criteria for Serious Mental Illness (SMI)*

- An individual is considered to have SMI for the purpose of PASRR if:

Diagnosis

- Has a major mental illness or disorder
- Includes but not limited to: schizophrenia, paranoia, panic or other severe anxiety disorder, somatoform disorder, personality disorder, other psychotic disorder, or other mental disorder that may lead to a chronic disability

Recent Diagnosis

- Within the past 2 years the individual has experienced:
  - More than one instance of psychiatric treatment more intensive than outpatient care OR
  - An episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment or which resulted in intervention by housing or law enforcement officials

Level of Impairment

- Due to mental illness or disorder the individual has a level of disability that has resulted in functional limitation in major life activities that would be appropriate for the individual's developmental stage within the past 6 months.
- Major life activities: interpersonal functioning; concentration, persistence, and pace; or adaptation to change

No Advanced Dementia

- Does not have co-occurring diagnosis of dementia or ADRD that is both advanced and primary over the mental health diagnosis

* Determined by DMH PASRR Unit (UMass)

Criteria for Intellectual Disability/ Developmental Delay (ID/DD)*

- An individual is considered to have ID/DD for the purpose of PASRR if:

ID

- Started before age 18
- An IQ of 70 or less
- Significant limitations in adaptive functioning
- Expected to persist throughout an individual's life

DD

- Functional limitations in 3 or more areas of life activities before age 22
  - Self-care, understanding/use of language, learning, mobility, self-direction, capacity of independent living
- Expected to persist throughout an individual's life

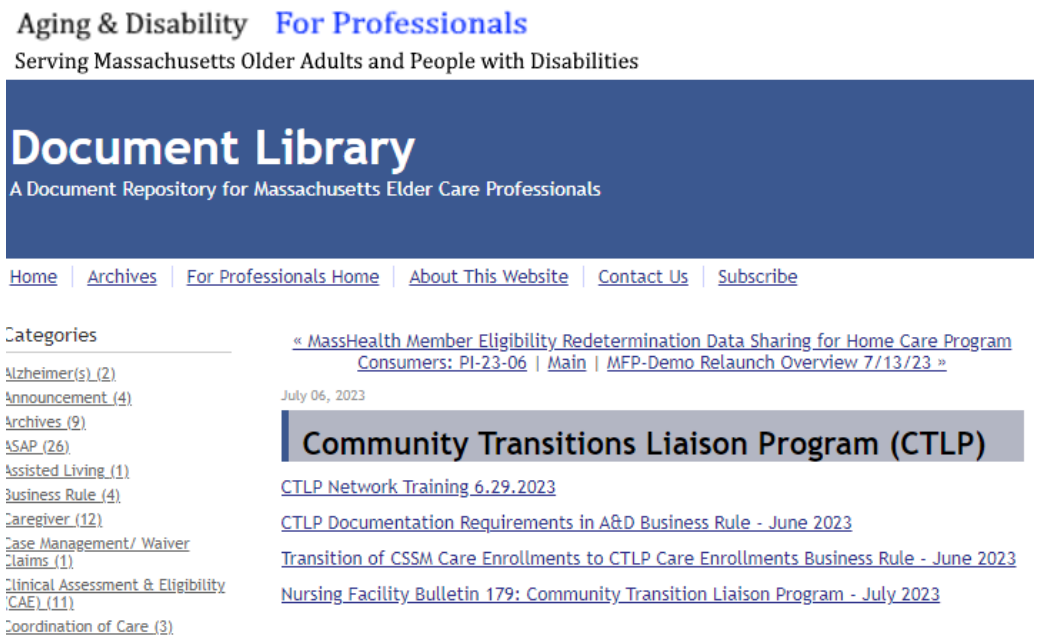
* Determined by DDS

Resources

800AgeInfo – Document Library

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

- Available documents
  - CTLP Network Training 6.29.2023
  - CTLP Documentation Requirements in A&D Business Rule – June 2023
  - Transition of CSSM Care Enrollments to CTLP Care Enrollments Business Rule – June 2023
  - Nursing Facility Bulletin 179: Community Transition Liaison Program – July 2023



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

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

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

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