



Executive Office of Elder Affairs

RESPECT INDEPENDENCE INCLUSION

Hospital to Home Partnership Program Learning Collaborative

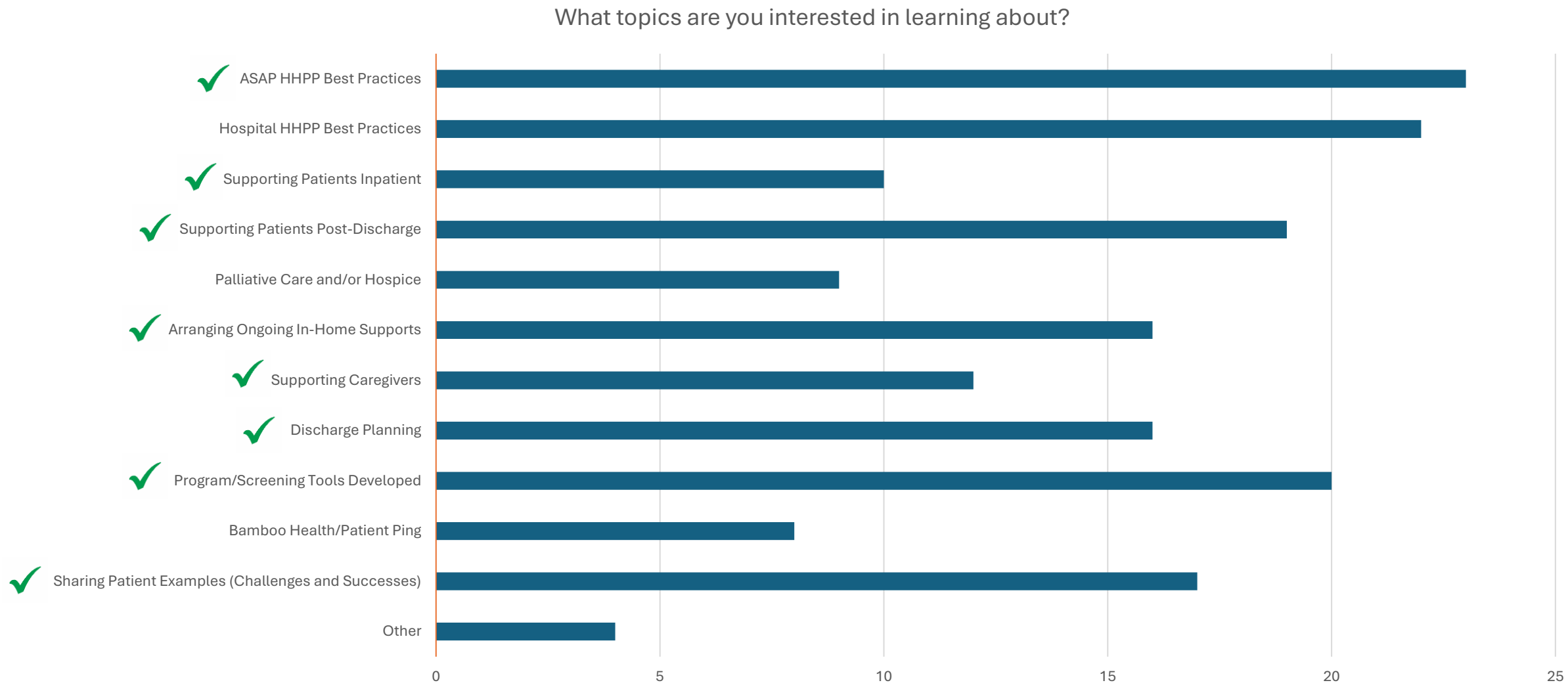
September 18, 2024, 2pm-3pm




Agenda

- Community Transition Liaison Program (CTLP) Overview
  - Julianna Santiago, CTLP Manager, EOEA
  - Carissa Kushmerek, CTLP Coordinator, EOEA
- Group Supervision with Hospital Liaisons and Community Transition Liaisons
  - Ginny Poltorak, Project Development Manager, Elder Services of Worcester Area
- HHPP/CTLP Overview and Patient Experience Story
  - Tremeda Martin, CTLP Supervisor, Old Colony Elder Services
  - Kayla Tierney, HHPP Liaison, Old Colony Elder Services
- Sepsis Awareness Month
- Questions?

HHPP Learning Collaborative Survey Results



Other: Best practices for effective and efficient documentation, Careport Connect (similar to Bamboo Health), iCarol software for H2H

Community Transition Liaison Program Overview

Julianna Santiago
CTLP Manager

Carissa Kushmerek
CTLP Coordinator

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

- engages residents who are in the nursing facility 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 the resident in mitigating issues that may impact their ability to successfully transfer to the community.

CTLP Background

- The Community Transition Liaison Program (CTLP) is an **enhanced** & **expanded** relaunch of the Comprehensive Screening and Services Model (CSSM)
  - The CSSM program was operated by the Aging Services Access Points & had been in existence since 2005
  - ARPA HCBS 9817 enhanced funding initiative which will be state funded moving forward
- Each nursing facility has an assigned team of two dedicated staff members practicing at the top of their skill set that operate out of the regional Aging Services Access Point (ASAP)
- CTLP teams refer & coordinate with other state agencies to assist nursing facility residents in accessing the most appropriate resources available

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 with administrative activities
- Gathers documentation to assist with applying for public benefits
- Assists with housing applications

CTLP Care Coordination

CTLP Care Coordination with Resident

- Addresses:
  - Housing
  - Immigration Issues
  - Legal Issues
  - Community Based Supports

CTLP Staff Tasks

- Care Coordination
- Administrative Tasks
- Housing Search
- Community Assistance Tasks

What does a CTLP NF Resident look like?

NF Resident Profile Criteria

Length of Stay Guidelines

- NF stay exceeds 45 days to ensure completion of PASRR level 2 assessments
- **Or** NF stay is less than 45 days & resident has requested assistance with transition to community

Age

- Age 22 or older

Insurance

- Any insurance type

SMI or ID/DD Guidelines

- No PASRR involvement unless Department of Developmental Services (DDS) or Department of Mental Health (DMH) request assistance from CTLP for complex discharges

How do ASAPs identify potential residents for CTLP?

In-person

- CTLP initiated resident engagement
- Resident initiated requests
- Nursing Facility census
- Assistance with discharge planning & transition

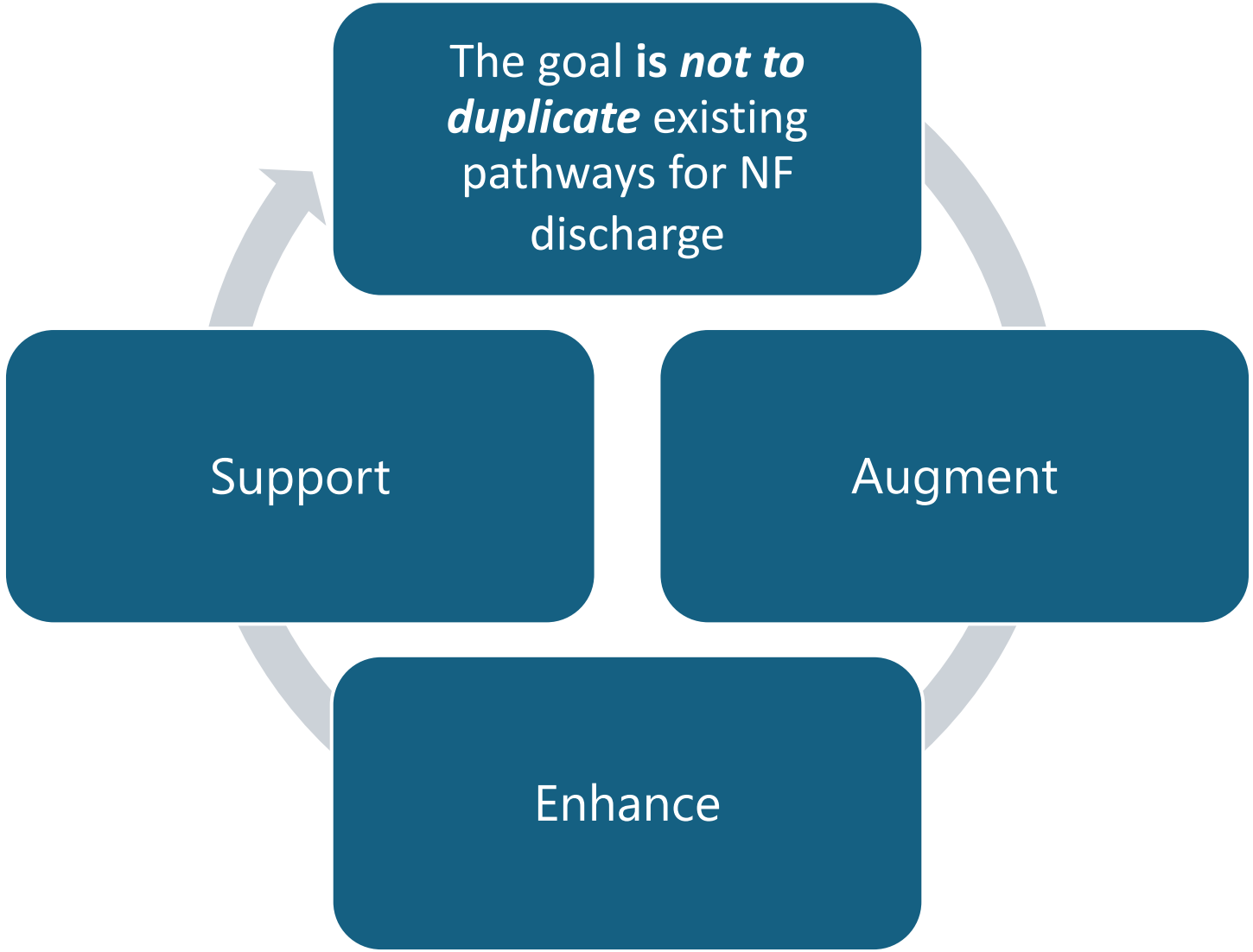
Referrals

- Family & informal supports
- Other ASAP Programs
- MFP Demo Project Office
- Nursing Facility Staff
- Independent Living Center Staff

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

Cross-Agency Collaboration



- **Augment** resources and programs already in place.
- **Enhance** advocacy and the resident's experience.
- CTLP can work alongside other lead agencies if requested and work in a **supportive** capacity.

Ginny Poltorak
Project Development Manager
September 18, 2024

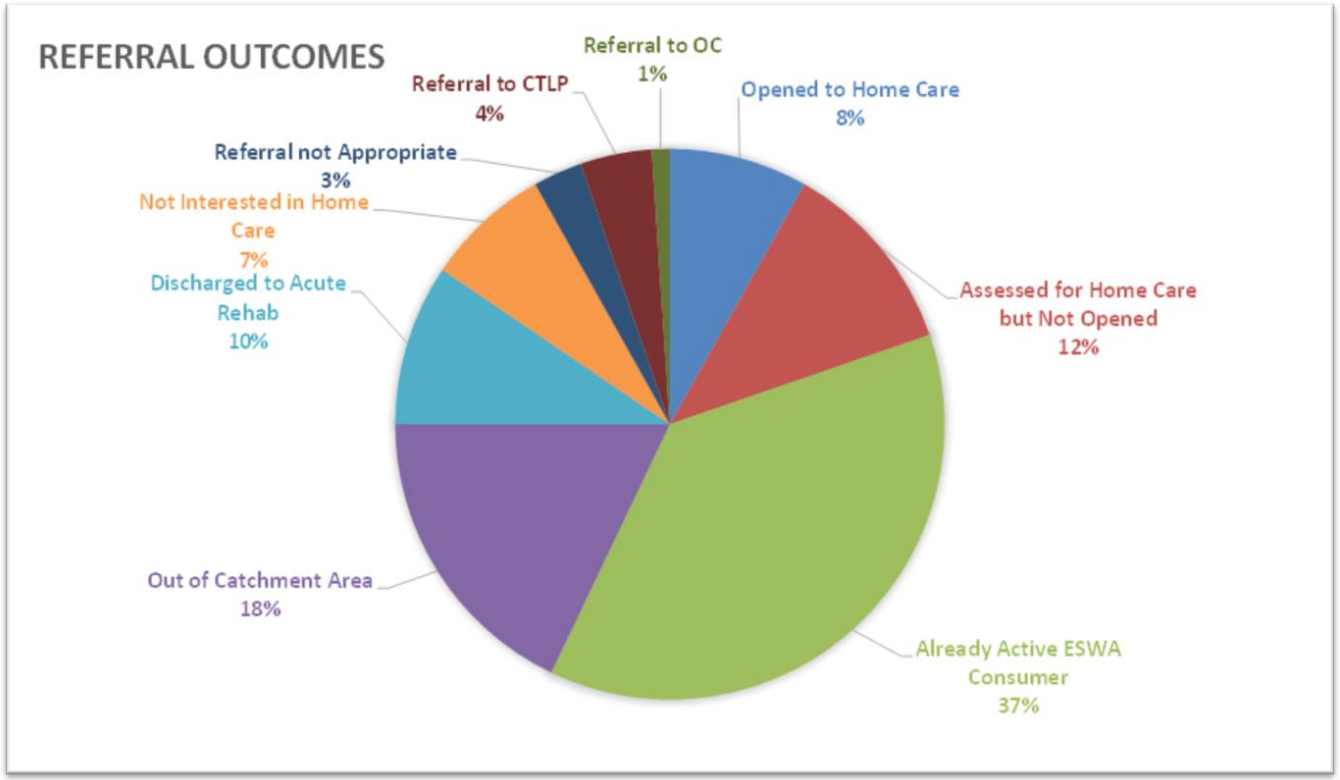
ESWA
Elder Services Of Worcester Area

Group Supervision with Hospital Liaisons and Community Transition Liaisons

Hospital Liaison, Ashley Dean

- UMass Memorial Medical Center
- Memorial Campus
- University Campus

382 referrals from October 2023 to August 2024

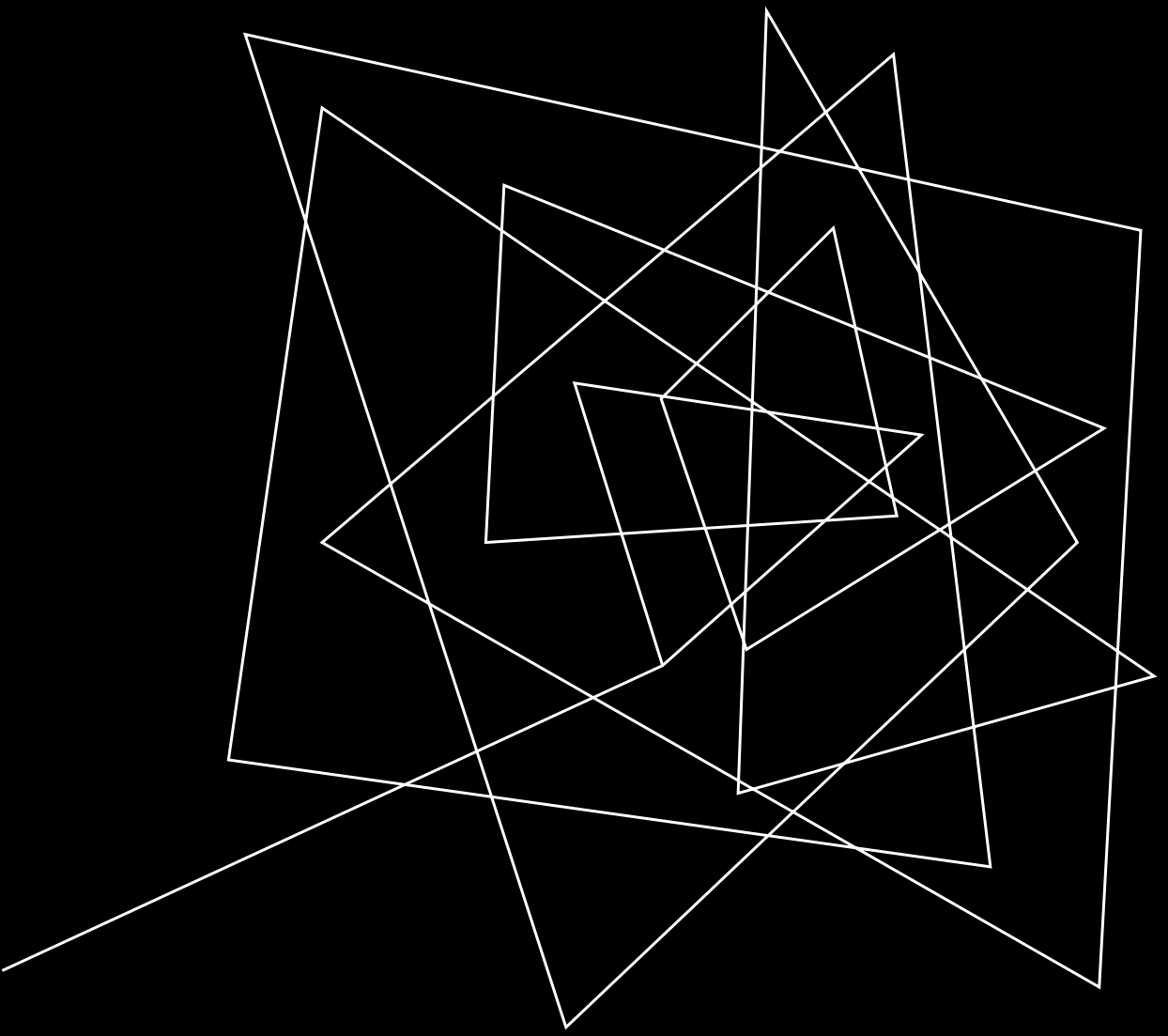


Transitions supervisor

Hospital to Home
Hospital at home
Care Transitions program
Community Transition Liaison Program

CTLP @ ESWA

22 Nursing Facilities
3 CTLP Teams



Success Story

HHPP Overview and Patient Experience Example
Old Colony Elder Services

Tremeda Martin
CTLP Supervisor

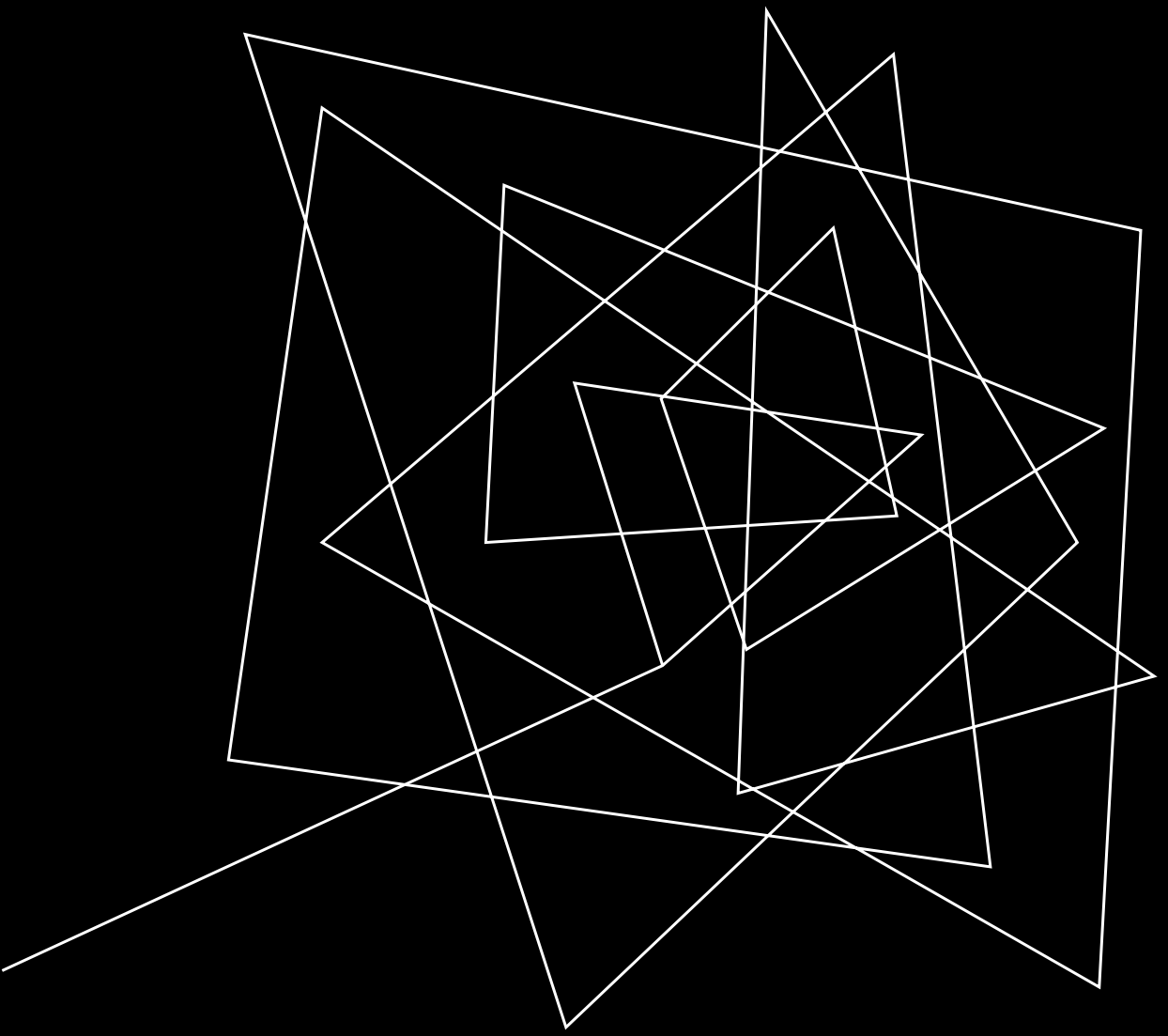
Kayla Tierney
Hospital Liaison

AGENDA

- Referrals
- Provider Relationship
- Meetings
- HHPP to CTLP

REFERRALS

- **Program Structure**
  - Present at BID- Plymouth 3 days a week (Mon, Wed & Fri)
  - RNs, CMs and SWs are the main referral source
    - Receive additional referrals through Patient Ping Admissions
  - Meet the consumer bedside to start initial OSA. Upon a safe and successful discharge from the hospital, provider (BOC) will start rapid in-home services within approximately 48-72 hours.



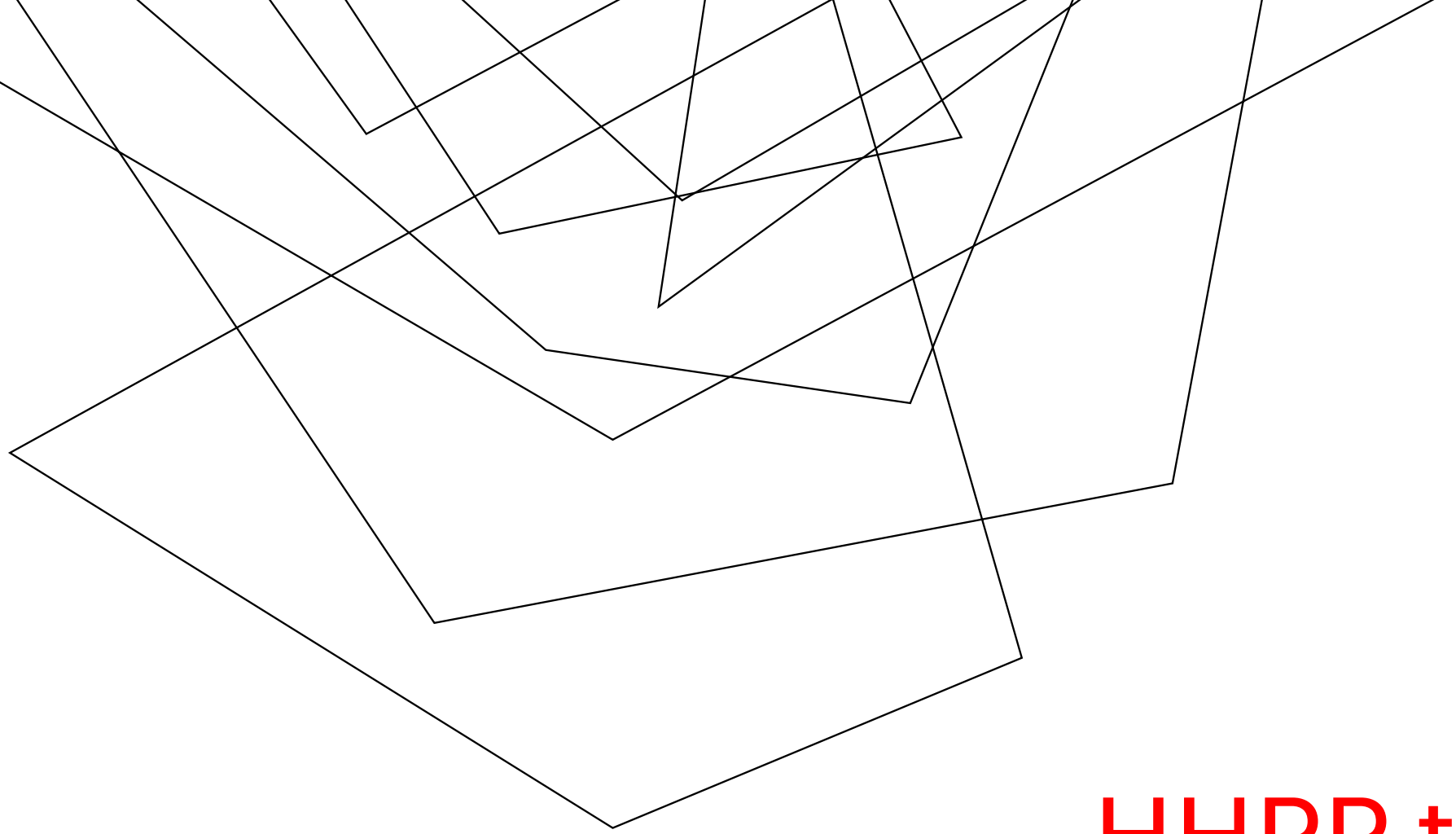
Provider relationship with best of care

Jill, Scheduling Coordinator
- Main Contact

Faye, VP of Operations
- Additional Support for HHPP

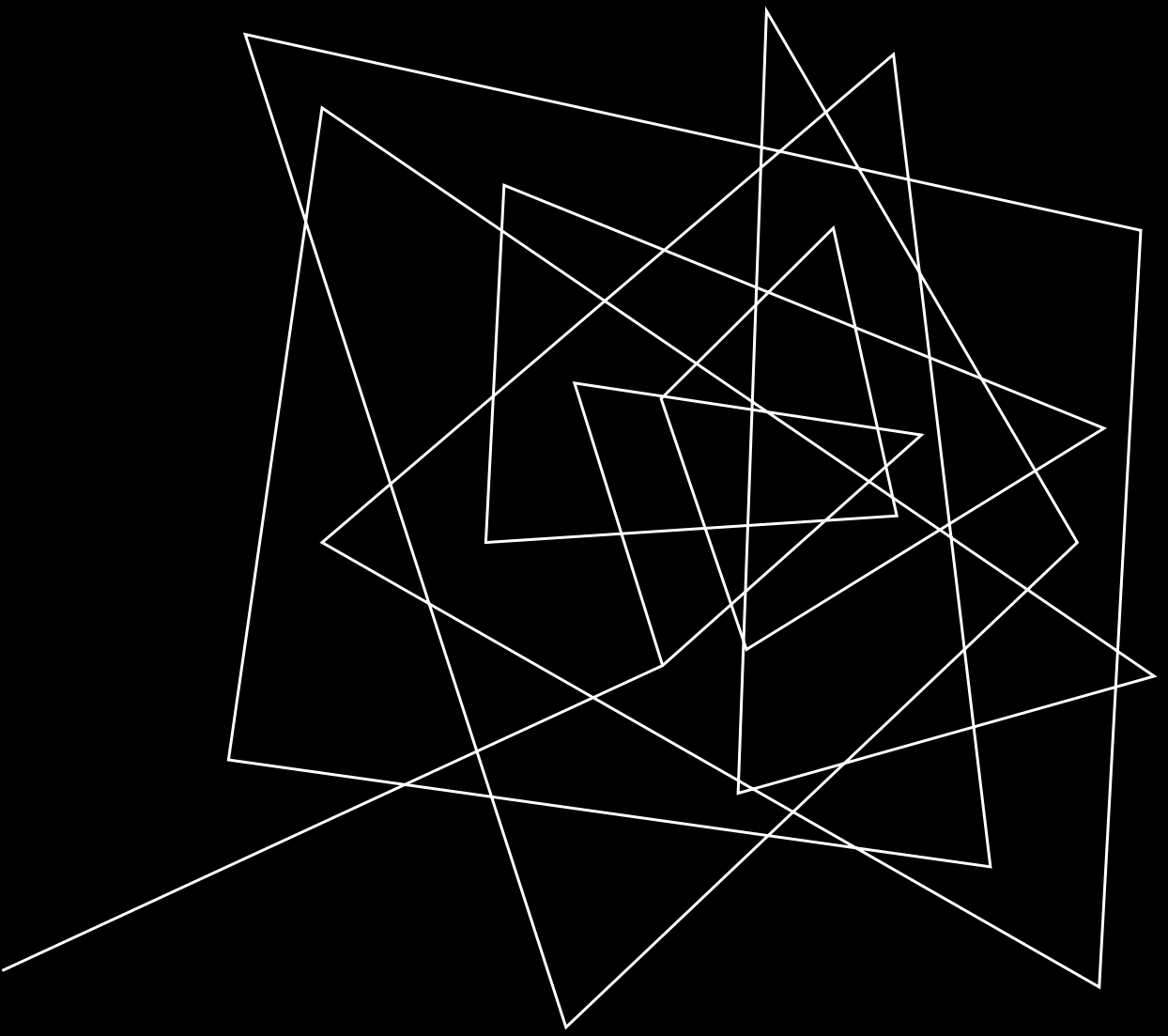
ONGOING SERVICES

- HC CM will complete OSA and submit new ongoing authos to BOC
- If BOC is not able to fill the autho, HHPP services will continue until OCES is able to find a new long-term provider.



HHPP to CTLP

- **CONSUMER A – CTLP referral was made. However, consumer ended up being LTC instead.**
- **CONSUMER B– CTLP referral was made, and Liaison submitted an HC referral. However, consumer decided to enroll in private pay services due to urgency.**
- **CONSUMER C – 59 years old. RN CM reported a concern of the consumer getting lost in the shuffle due to being younger than 60 and needing services before discharging home. Consumer transferred to a rehab and is currently enrolled in the CTLP.**



MEETINGS

- **Bi-weekly mtgs with SUP**
  - Discuss any new cases
  - Ongoing cases
  - Procedures that may need to change
- **Quarterly mtgs with BOC**
  - Progress of program
  - Procedures that may need to change
- **Additional mtgs**
  - OCES Contracts
  - OCES Managers and Supervisors involved

THANK YOU

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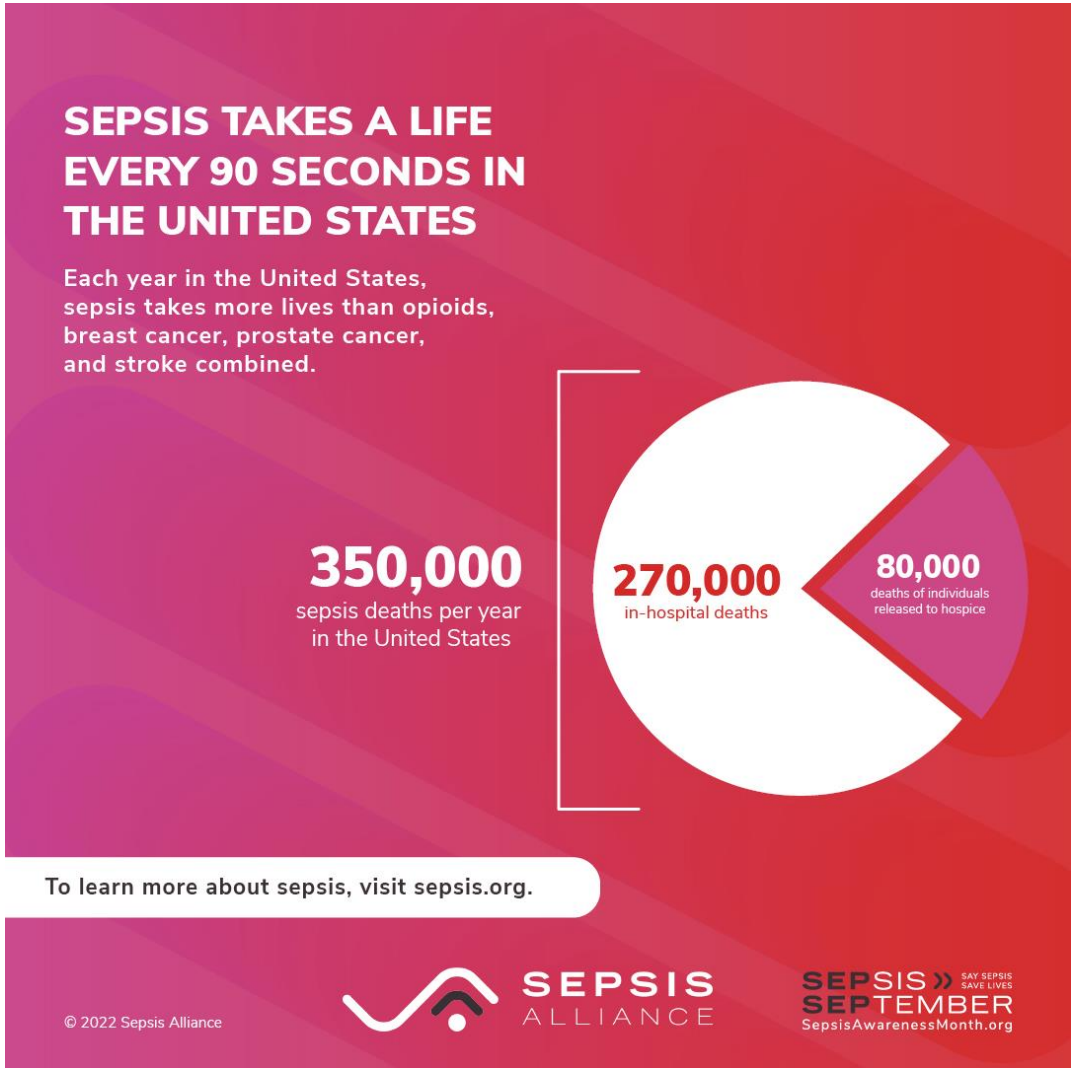
SEPSIS SEPTEMBER
SAY SEPSIS SAVE LIVES
SepsisAwarenessMonth.org

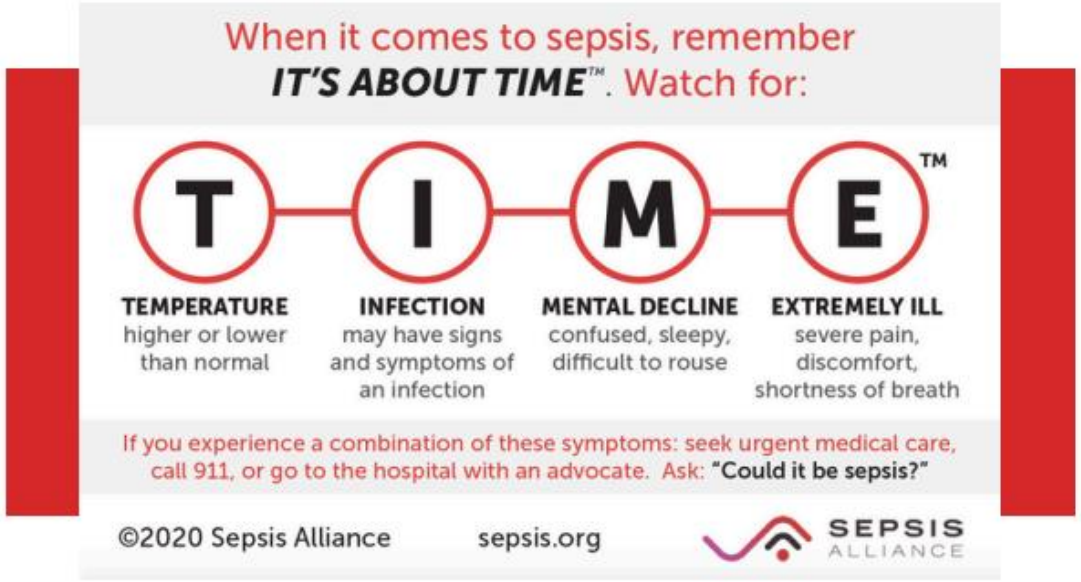
All HHPPs listed sepsis as one of the top three reasons for a hospital admissions for patients.

- Sepsis is a potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs.
  - Leading cause of death in U.S. hospitals
  - Affects an estimated 49 million people worldwide each year



*Materials provided by Sepsis Alliance

- An estimated 37% of U.S. adults have never heard of sepsis
- Sepsis is the number one cause of hospital readmissions, costing more than $3.5 billion each year
- Sepsis is the number one cause of hospitalization in the U.S
  - Costs for acute sepsis hospitalization and skilled nursing are estimated to be $62 billion annually
- Black individuals bear nearly twice the burden of sepsis deaths, relative to the size of the Black population, as compared to white individuals



*Materials provided by Sepsis Alliance

Sepsis Awareness Month Tool Kit

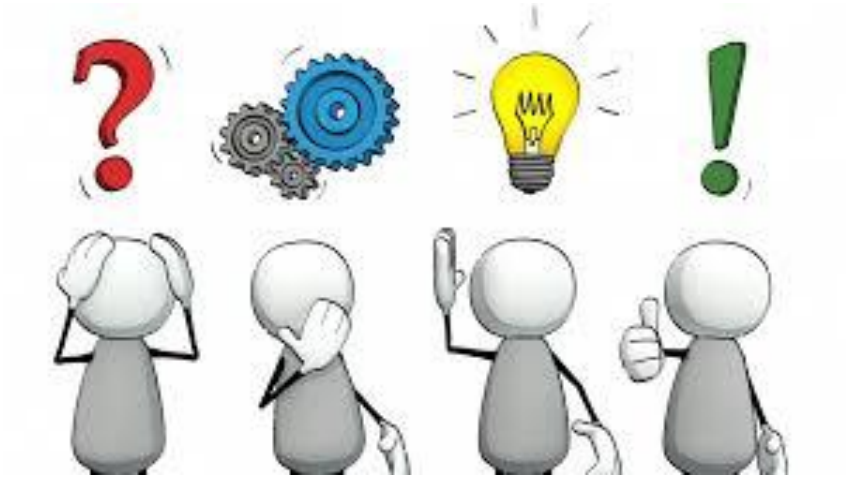
- All information and graphics pulled from tool kit
  - Contains graphics and messaging on Sepsis Awareness for social media
  - Key sepsis facts
  - Printable resources for patients and family members

*Materials provided by Sepsis Alliance

For additional information on sepsis or to download the sepsis tool kit visit
Sepsis Awareness Month | Sepsis Alliance

Questions or Comments

Request for Topics



- Is there a topic we have not yet covered?
- A topic worth revisiting?
- Share additional best practices?
- Discuss and share patient experience stories?

Access all previous HHPP Learning Collaboratives at Hospital to Home Partnership Program (HHPP) - Document Library (800ageinfo.com)

Next Steps

Tentative HHPP Learning Collaborative Schedule

Date	Time
Wednesday, November 13, 2024	1:30pm-3:00pm
Tuesday, January 14, 2025	3:00pm-4:00pm
Wednesday, March 26, 2025	1:30pm-2:30pm

Questions or ideas?

- **Contact Dana.Beguerie@mass.gov**