ELD Home Care

Revision History

Date	Version	Description	Author
June 26, 2023	1.0	Initial publication	EOEA Home Care Team
September 13, 2023	1.1	Includes updated Care Enrollment Termination reasons, guidance on Activities & Referrals, and post-nursing facility discharge follow-up documentation requirements	EOEA Home Care Team

Documentation Requirements for Community Transition Liaison Program (CTLP) in Aging & Disability (A&D)

The Community Transition Liaison Program (CTLP) enhances and rebrands the Comprehensive Services and Screening Model (CSSM) Program that has been operated by the Aging Service Access Points (ASAPs) since 2005. CTLP launched across the Commonwealth of Massachusetts effective July 1, 2023.

The CTLP supports nursing facility residents in transitioning to the community**.** CTLP supports any resident (age 22+) of a nursing facility (NF) (regardless of insurance) who is interested in receiving support and 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 and coordination with discharge planning, including connecting residents to state programs and local community supports, and will assist the resident in mitigating issues that may impact their ability to successfully transfer to the community.

This document provides sub-regulatory instruction for documentation requirements for CTLP in the EOEA cloud-based data enterprise system, Aging & Disability (A&D) and any associated reporting requirements.

Required documentation for CTLP include:

- ASAP Specific CTLP Care Enrollments
- CTLP Specific Journal Notes
- Activities and Referrals (A&Rs)

For ASAP use:

- CTLP Specific File Attachment Folder

Function & Requirements for CTLP

The CTLP Team is responsible for identifying and outreaching to residents who have been in the NF for more than 45 days and actively engage with the individual or

their designated representative to determine the individual's interest in returning to the community and provide assistance in facilitating the transition.

When a resident requests assistance from the CTLP Team at any time including when their length of stay is less than 45 days, the CTLP Team must engage with the resident and aid in facilitating the transition, this may include referring the resident to other ASAP programs if appropriate. CTLP must engage with residents and provide support and assistance even if found ineligible for other programs. The goal is to continue to provide support and advocacy.

CTLP Resident Criteria

- Resident of NF whose stay exceeds 45 days **or** a resident whose stay is less than 45 days and has requested assistance with transition to community
- Age 22 or older
- Any insurance type
- Has no PASRR involvement unless Department of Developmental Services (DDS) or Department of Mental Health (DMH) request assistance from CTLP for complex discharges

PASRR & Implications for CTLP Involvement

Preadmission Screening and Resident Review (PASRR) is a federal- and state-required process 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)

The PASRR process begins with a Level I Preadmission Screen, which is designed to identify all individuals seeking admission to a nursing facility that have, or may have, SMI and/or ID/DD. If the Level I screener suspects that the screened individual has SMI and/or ID/DD, she or he refers that individual to the appropriate PASRR authority for a Level II evaluation. The Level II evaluator confirms whether the individual has SMI and/or ID/DD and, if so, whether the individual requires a nursing facility level of care and specialized services.

It is the NFs responsibility to ensure PASRR requirements are being met for the individuals being admitted to their facility.

There are 2 different Level II Evaluator types depending on either SMI or ID/DD.

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)

Post-Nursing Facility Discharge Follow-up Requirements

The CTLP Team is responsible for following up post nursing facility discharge with any CTLP consumer whose CTLP **Care Enrollment termination reason is CTLP-Discharge to Community.** Follow-up may be through a variety of two-way communication such as telephone contact, home visit, email, or alternate contact. Best practice is to have direct contact with the discharged consumer. Alternate communication with informal and formal supports is acceptable when consumer communication is limited due to impairments or disability and documentation supports need for outreach to other individuals involved with the consumers care such as informal or formal care providers.

The purpose of the CTLP-Discharge to Community Follow-up is to:

- outreach to consumers through a variety of two-way communication methods,
- ensure consumer services/supports have started,
- determine if the consumer services/supports are meeting the needs of the consumer,
- determine if any additional services or referrals are needed by the consumer or family,
- follow-up on prior referrals, applications and advocacy if needed, and
- assist with additional referrals as appropriate.

Best practice is to follow up initially with a consumer 14-21 days after discharge to the community.

To anticipate consumer needs and variations for outreach and engagement, the timeframe of 14 days to within 30 days after the consumer's discharge should be targeted for a member of the CTLP Team to outreach and engage with the consumer to meet the above objectives.

Outreach timeframe should:

- occur well in advance of the 30th day after consumer discharge,
- not be initiated on day 30 after discharge,
- occur to support the goal of ensuring services/supports have started, services/supports are occurring, determine and act on any additional needs or resources,
- the 14 – 30 day timeframe is to allow for repeated attempts if needed to connect with and engage with the consumer.

If the consumer is not reachable upon the first attempt, an additional two (2) attempts must be made. Each attempt must be documented in the consumer's record.

If the consumer is not reached after three (3) attempts, the ASAP must send an attempt to reach letter to the consumer.

Best practice for outreach attempts includes a variation of modalities including:

- Telephone,
- Telephone and voicemail,
- email,
- drop in or unannounced visit,
- connecting with formal supports, providers and community resources engaged with the consumer to identify a time to call to schedule a time to conduct outreach,
- and connecting with informal supports if attempts with the consumer are unresponsive

Post discharge follow-up is a mechanism to ensure that once the consumer has transitioned to the community, there are no additional unmet needs that that the CTLP may be able to help address that were not identified prior to discharge.

For documentation of this engagement, EOEA requires the use of CTLP specific A&D requirements:

- An A&R for **CTLP Post D/C Follow-up 30days,** and
- A Journal Note Type for **CTLP-Post-D/C Follow-up**

For more detailed information see the appropriate section below.

Requirements ASAP Specific CTLP Care Enrollment

The ASAP specific **CTLP Care Enrollment** in A&D is utilized to:

- track individuals with whom the CTLP Team has engaged with,
- record the outcome of CTLP interactions and interventions, and
- demonstrate the length of stay within the program.

Creating the ASAP Specific CTLP Care Enrollment

The ASAP providing CTLP creates a **CTLP Care Enrollment** for each resident who they provide CTLP assistance. The CTLP Care Enrollment remains open until the resident disposition is completed.

- The CTLP Care Enrollment in A&D includes:
  - **Level of Care=** Community Transition Liaison Program (CTLP)
  - **Service Program=** CTLP – (ASAP Name)
  - **Care Program=** CTLP – (ASAP Name)
  - **Application Date =** On or after July 1, 2023 (CTLP enrollment will not appear as a service program option if the application date is prior to July 1,2023)
  - **Received Date =** Date of initial engagement with consumer
  - **Status =** Active while CTLP Team is actively working with consumer

- **Reason =** Blank while CTLP Team is actively working with the consumer
- **Status Date =** Data entry date
- **Start Date =** Date of initial engagement with consumer
- **End Date =** Leave Blank while CTLP Team is actively working with consumer

Terminating the ASAP Specific CTLP Care Enrollment

The ASAP will terminate the CTLP Care Enrollment when:

- the CTLP Team is no longer working with the consumer towards transition to the community
- the disposition is completed

Examples when to terminate include but are not limited to when the consumer:

- is not interested in discharge to the community after initial engagement with CTLP Team
- is approved for a HCBS Waiver and an entity other than the ASAP provides Case Management and will assume lead in discharge planning
- was discharged to a community living setting
- no longer wishes to work with CTLP Team
- passes away

- Data entry termination of a CTLP Care Enrollment:
  - **Level of Care=** Community Transition Liaison Program (CTLP)
  - **Service Program=** CTLP – (ASAP Name)
  - **Care Program=** CTLP – (ASAP Name)
  - **Application Date =** on or after July 1, 2023
  - **Received Date =** Date of initial engagement with consumer
  - **Status =** Terminated
  - **Reason:** *use the specific reason that applies to the consumer's disposition*

1. **<u>CTLP – ABI-N Waiver</u>**
   a. Use when a consumer has been approved for the ABI-Non-Residential Waiver and a warm transfer has occurred between the case management entity for the waiver and the Community Transition Liaison.

2. **<u>CTLP – ABI-RH Waiver</u>**
   a. Use when a consumer has been approved for the ABI-Residential Habilitation Waiver and a warm transfer has occurred between the case management entity for the waiver and the Community Transition Liaison.

3. **<u>CTLP – Change in Medical Setting</u>**
   a. Use when a consumer discharges from the nursing facility to another medical setting (i.e. acute care hospital) and is not expected to return.

4. **CTLP – DDS Adult Supports Waiver**
    a. Use when a consumer has been approved for the DDS Adult Supports Waiver and a warm transfer has occurred between the case management entity for the waiver and the Community Transition Liaison.

5. **CTLP – DDS Community Living Waiver**
    a. Use when a consumer has been approved for the DDS Community Living Waiver and a warm transfer has occurred between the case management entity for the waiver and the Community Transition Liaison.

6. **CTLP – DDS Intensive Supports Waiver**
    a. Use when a consumer has been approved for the DDS Intensive Supports Waiver and a warm transfer has occurred between the case management entity for the waiver and the Community Transition Liaison.

7. **CTLP – Death**
    a. Use when a consumer expires while working with the CTLP Team.

8. **CTLP – Declines Further CTLP Intervention**
    a. Use when a consumer has been working towards discharge with the CTLP Team then declines further assistance and has not transitioned to the community and has not transitioned to being assisted by another entity.

9. **CTLP – Discharge to Community**
    a. Use when a consumer transitions from the nursing facility to a community living arrangement with assistance from the CTLP Team. Use of this reason would include but is not limited to: discharge to an assisted living residence (ALR)/ assisted living facility (ALF), private home, group home, shelter, half-way house, or rest home setting. Documentation should support any program or agency that will follow the consumer in the community outside of the programs with specific CTLP Termination reasons. *DO NOT USE if consumer is transitioning to a community setting and accessing in-home services through the State Home Care Program – See CTLP – Home Care Program.*

10. **CTLP – Discharge with DDS Services**
    a. Use when the consumer transitions from the nursing facility to a community living arrangement and will receive services from DDS. *DO NOT USE if consumer is accessing a HCBS Waiver managed by DDS.*

11. **CTLP – Discharge with DMH Services**
    a. Use when the consumer transitions from the nursing facility to a community living arrangement and will receive services from DMH.

12. **CTLP – Discharge with MRC Services**
    a. Use when the consumer transitions from the nursing facility to a community living arrangement and will receive services from MRC. *DO NOT USE if consumer is accessing a HCBS Waiver managed by MRC.*

13. **CTLP – Frail Elder Waiver**
    a. Use when the consumer has discharged to the community and will be accessing in-home services through the State Home Care Program and is enrolled in Frail Elder Waiver (FEW).

14. **CTLP – Home Care Program**
    a. Use when the consumer is discharged to the community and will be accessing in-home services through the State Home Care Program and is enrolled in a non-waiver program. *DO NOT USE if consumer is accessing State Home Care Program and FEW – See CTLP – Frail Elder Waiver.*

15. **CTLP – MFP Demo**
    a. Use when a consumer has been approved for the MFP Demo and a warm transfer has occurred between the case management entity for the demo and the Community Transition Liaison.

16. **CTLP – MFP-CL Waiver**
    a. Use when a consumer has been approved for the MFP-Community Living Waiver and a warm transfer has occurred between the case management entity for the waiver and the Community Transition Liaison.

17. **CTLP – MFP-RS Waiver**

a. Use when a consumer has been approved for the MFP-Residential Supports Waiver and a warm transfer has occurred between the case management entity for the waiver and the Community Transition Liaison.

18. **CTLP – NF Transfer**
    a. Use when a consumer transfers to another nursing facility outside of the current catchment area. NOTE: If transferring to a NF within the current catchment area no action is needed.

19. **CTLP – Not Interested in Transition**
    a. Use when consumer is not interested in assistance with transition after initial engagement. *DO NOT USE if consumer has been engaging with CTLP Team for assistance and then changes their mind. See – CTLP – Declines Further CTLP Intervention.*

20. **CTLP – OneCare Enrolled**
    a. Use when a consumer is enrolled in a OneCare Plan and CTLP provided discharge planning assistance.

21. **CTLP – SCO Enrolled**
    a. Use when a consumer is enrolled in a SCO Plan and CTLP provided discharge planning assistance.

22. **CTLP – TBI Waiver**
    a. Use when a consumer has been approved for the TBI Waiver and a warm transfer has occurred between the case management entity for the waiver and the Community Transition Liaison.

- **Status Date =** Data Entry Date
- **Start Date =** Date of initial engagement with consumer
- **End Date =** The date that the consumer has transitioned to the community, or to another entity that will provide discharge planning support and disposition is completed, or the consumer is no longer working towards the goal of discharge with assistance from CTLP

Requirements for CTLP Specific Journal Note Types

In A&D, **CTLP Specific Journal Note Types** are available to assist the program in tracking actions, conversations, and engagement with the consumer and other relevant parties when providing transition and discharge planning support.

For consumers who elect to engage with CTLP for assistance with transition and discharge planning, the CTLP Team must

- consider a person-centered approach, and
- engage with the consumer on a regular basis determined by the consumer's needs and goals.

The CTLP Team must engage with the consumer as appropriate

- to ensure transition goals are being met,
- communication, case management, follow-up, applications, and opportunities are conducted in a timely manner, and
- the consumer feels supported in their transition journey;
- at times engagement may differ and must be at a minimum on a monthly basis.

CTLP Team interactions should be based on interventions and assistance needed by the consumer to effectively and efficiently assist in the transition process and in most instances are more frequent than monthly.

EOEA **requires** the use of three (3) journal note types:

- **CTLP-Initial Engagement** – Must be utilized to document the initial engagement with the consumer. This note must document the consumer's interest in engaging with CTLP for assistance with transition and discharge planning.

- **CTLP-Termination** – Must be utilized to document the termination of the consumer from CTLP. Must 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.

- **CTLP-Post-D/C Follow-up –** Must be utilized to document any actions or interaction of the CTLP when following up with a consumer post-nursing facility discharge. A CTLP Team member must follow up with any consumer whose CTLP Care Enrollment was terminated with the reason **"CTLP – Discharge to Community"** within 14-21 days and no later than 30 days after the nursing facility discharge date.

  Best practice is to follow up initially with a consumer 14-21 days after discharge to the community.
  Outreach should:
  - *occur before the 30th day after consumer discharge,*
  - *not be initiated on day 30 after discharge,*
  - *occur to support the goal of ensuring services/supports have started, services/supports are occurring, determine and act on any additional needs or resources,*

the 14 – 30 day timeframe is to allow for repeated attempts if needed to engage with the consumer.

- Minimum Requirements for journal note type **CTLP-Post-D/C Follow-up:**
  - Method of contact
    - Two-way communication
      - In-person Visit
      - Telephone Call
      - Email
      - Informal & Formal Supports
  - Who participated in the in-person visit or telephone call
  - Identification of where the individual was discharged from and where they are currently living
  - Review of post discharge services and/or follow up appointments such as:
    - ASAP services and/or other home & community-based services
      - Are services provided as anticipated?
      - Are services provided satisfactory?
    - Appropriateness of the discharge plan of care at this time
      - Are there any unmet needs that were not previously anticipated that need to be addressed?
    - Follow up appointments and any barriers preventing the individual from attending their appointment (transportation, conflict with services, etc.)
    - Availability of medications and any barriers preventing the individual from having their medications (transportation, financial, etc.)
  - Documentation of the individual's overall status
  - Documentation of any follow up needed by the CTLP Team (referrals, change in care plan, etc.)

The following **CTLP Specific Journal Note Types** are available for use based on the type of interaction engaged in:

Journal Note Type	Description for Use	Note
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	Use per ASAP business practice

	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.	Use per ASAP business practice
CTLP-Follow Up	Utilize to document any actions the CTLP Team takes on behalf of the consumer while assisting with transition and discharge planning.	Use per ASAP business practice
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.	**REQUIRED** by EOEA for CTLP Program
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.	Use per ASAP business practice
CTLP-Post-D/C Follow-up	Utilize to document any actions or interaction of the CTLP when following up with a consumer post-nursing facility discharge. The CTLP must follow up with any consumer whose CTLP Care Enrollment was terminated with the reason "CTLP – Discharge to Community" within 30 days of nursing facility discharge date.	**REQUIRED** by EOEA for CTLP
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	**REQUIRED** by EOEA for CTLP Program

	type of setting the consumer is discharging to as well as any program or service that will support the consumer in the community.	

CTLP Specific Activities & Referrals
In A&D, CTLP**-Specific Activities & Referrals (A&Rs)** are available to assist the program in tracking future actions.

EOEA **requires** the use of one (1) action type:

- **CTLP Post D/C Follow-up 30days**:

Element	Values	Notes
Action	**CTLP Post D/C Follow-up 30days**	**Required**
Subject		Completed according to agency business practice. Cannot be left blank.
Program	**Optional**	Not recommended by EOEA due to added complexities when using the Status Wizard to close/transfer enrollments
Status	• **Not Started** • **Completed** • **In Progress**	Default is **Not Started**. EOEA requires change of status when A&R is **Completed**. **In Progress** is optional. Enter according to agency business practice **Do not use other Statuses**
Status Reasons	• **Completed (status)** ○ **Completed – On Time** ○ **Completed – Withdrawn** ○ **Completed Late**	Default status is **Not Started**. EOEA requires change of status when A&R is **Completed**. Enter appropriate **status reason** if the post-discharge follow-up results if completed on time **(Completed – On Time),** if the ASAP is

Element	Values	Notes
		unable to reach to the consumer after 3 attempts **(Completed – Withdrawn)** or if the ASAP completes the follow-up late, after 30 days, (**Completed Late**).
Status Date	**Discharge Date from NF**	**Status date is always the date EOEA is basing the report time frame on.**
Due Date	**30 calendar days from Discharge Date (Status Date)**	
Start Date	**Do Not Use**	**Do Not Use**
Date Completed	**Date of contact with consumer**	**Completion date** will default to the date the **Status** is changed to Complete. Change the **Completion Date** from the default date to the date of the contact with consumer The **Completion Date** should never be dated prior to the **Status Date**

Additional CTLP-specific A&R's have been made available for ASAP use in accordance with ASAP business practices related to CTLP. These action types are not required by EOEA.

- **CTLP Referral**
- **CTLP Nursing Facility Visit**

Use of the above action types is to provide ASAPs with a specific Action to:

- Track referrals received for CTLP (CTLP Referral)
- Track next nursing facility visit due (CTLP Nursing Facility Visit)

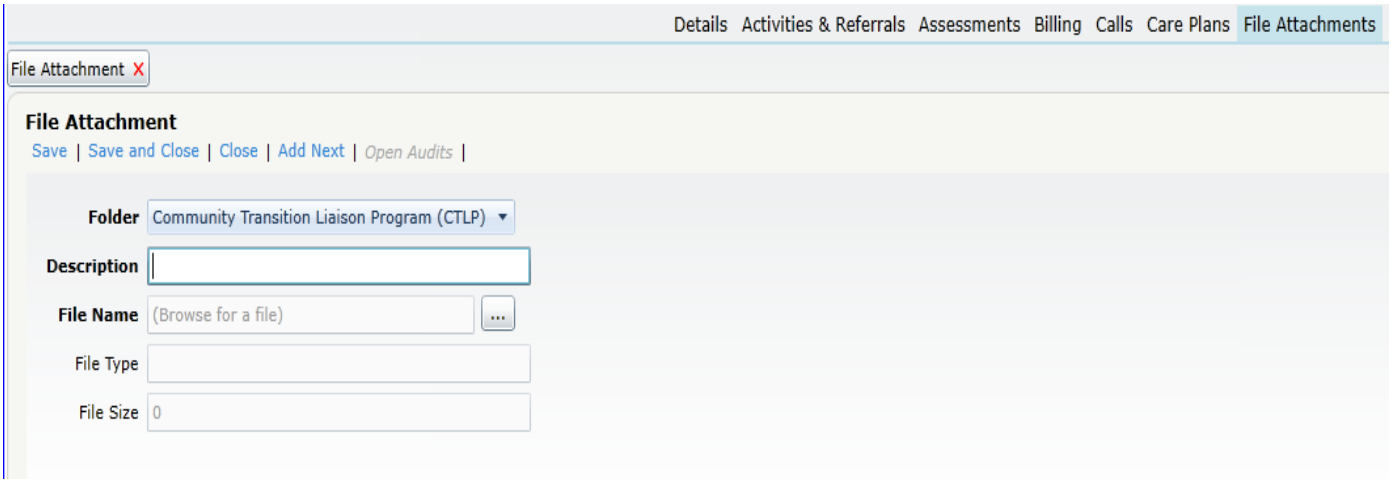
It is not permissible to use these action types for anything other than CTLP related activities defined above.

ELD Home Care

CTLP Specific File Attachment Folder

In A&D, a **CTLP-Specific File Attachment Folder** is available to provide a single location for documents related to CTLP.

File Attachment Folder Name = Community Transition Liaison Program (CTLP)



Documents that may be stored in this file attachment folder include, but are not limited to:

- Completed Transition Support Tool (TST)
- Copies of completed Applications
- Other relevant documents

<u>File Attachments must not include sensitive information (example: Protective Service Report) or documents containing another consumer's information.</u>

Reporting

The ASAP is responsible for:

- generating reports,
- reviewing for quality assurance,
- identifying inaccuracy trends,
- addressing in accuracies, and
- completing necessary follow-up within a timely manner.

All follow up actions completed by the ASAP must be documented in the consumer's A&D record as appropriate.

EOEA requires the HAR report, *CTLP Enrollments and Terminations,* to be run on a monthly basis. See user guide for additional details.

EOEA requires the HAR report, *CTLP Post Discharge Tracking,* to be run on a monthly basis. See user guide for additional details.

If you have questions regarding this business rule, please contact: Julianna Santiago, Community Transition Liaison Program Manager at Julianna.Santiago@mass.gov

ELD Home Care