



Executive Office of Elder Affairs

RESPECT INDEPENDENCE INCLUSION

Community Transition Liaison Program (CTLP) Network Training (DDS & Ombudsman)

September 26, 2023

1:00 – 3:00 p.m.

For ASAP Utilization Only - Do Not Distribute




Agenda (120 minutes)

- Welcome (10 minutes)
- Introduction of Guest Speakers (5 min)
  - Department of Developmental Services (DDS)
  - Acquired Brain Injury (ABI) Waiver, Moving Forward Plan (MFP) Waiver
  - Preadmission Screening and Resident Review (PASRR)
  - Long-Term Care Ombudsman
- DDS programs: ABI/MFP Waiver & PASRR (45 min)
  - Questions
- LTC Ombudsman Program (45 min)
  - Questions
- What's Next? (10 minutes)
- Appendix

Introduction
Department of Developmental Services (DDS)

ABI/MFP Waiver Overview

for Community Transition Liaison Program Staff

September 26, 2023

Presentation Overview

- Waiver Eligibility
- Needs and Risk Factors
- DDS and MRC Program Structure
- Outreach
- Waiver Services

Acquired Brain Injury (ABI) Waivers

- For individuals 22+ who are disabled, or age 65+, with an acquired brain injury that was sustained at age 22 or older
  - Examples of ABIs that qualify include brain injuries resulting from stroke, brain trauma, infection of the brain, brain tumor, or anoxia (also includes traumatic brain injury)

- **To qualify for the waiver, a person must apply while they are living in a facility, and their facility stay must be at least 90 days**

- Two ABI waivers – differ by individual's need:
  1. ABI-RH (Residential Habilitation): For participants who need 24-hour supervision and staffing in a provider-operated and staffed setting such as a residential habilitation group home. DDS provides case management.
  2. ABI-N (Non-Residential Habilitation): For participants who do not need 24 hour supports or supervision, and can live in their own home/apt, family home, or Adult Foster Care. MRC provides case management. Includes a limit of 84 hours per week in home support e.g., personal care services, home-making, etc.

Moving Forward Plan (MFP) Waivers

Formerly Money Follows the Person Waivers

- For individuals who are 18 or older and disabled or age 65+
- **To qualify for the waiver, a person must apply while they are living in a facility, and their facility stay must be at least 90 days**
- Two MFP waivers – differ by individual's need:
  1. MFP-RS (Residential Supports): For participants who need 24-hour supervision and staffing in a provider-operated and staffed setting such as a residential habilitation group home. DDS provides case management.
  2. MFP-CL (Community Living): For participants who do not need 24 hour supports or supervision, and can live in their own home/apt, family home, or Adult Foster Care. MRC provides case management. Includes a limit of 84 hours per week in home support e.g., personal care services, home-making, etc.

ABI-MFP Eligible Individuals' Needs and Risk Factors

- ABI & MFP Waiver participants are complex and challenging populations to serve. The majority present with significant mental health and/or substance abuse issues as well as various medical complexities;

- ABI & MFP waiver participants are adults of all ages, various socio-economic backgrounds, some who were living a typical, successful life until an accident happened and a TBI, ABI or other serious disability resulted. Others come from difficult backgrounds all the way back to childhood as victims of neglect and/or abuse and subsequent long term substance abuse and mental health issues.

- Many also present with complex medical needs and assistance with activities of daily living while others are more independent and interested in either supported employment and/or meaningful activities to do during the day.

ABI & MFP Residential Waivers Program Management

- DDS Manages ABI & MFP Residential Waivers through a MassHealth Interagency Service Agreement (ISA)

- DDS has four regional ABI-MFP teams around the state. Their job is to support the ABI-MFP eligible individuals in nursing facilities to transition into the community and to provide ongoing case management to those ABI-MFP waiver participants already living in the community.

- DDS ABI/MFP Service Coordinators also coordinate referrals for other waiver services such as community-based day supports and supported employment.

- DDS regional ABI-MFP teams contract with Residential & Shared Living providers for 24/7 residential supports;

- DDS's Office of Quality Enhancement also oversees licensing and certification for ABI-MFP providers.

ABI & MFP Community Living Waivers Program Management

- MRC Manages ABI & MFP Non-Residential Waivers through a MassHealth Interagency Service Agreement (ISA)
- MRC has four regional ABI-MFP teams around the state. They outreach to and support ABI-MFP eligible individuals in nursing facilities with transitioning into the community.
- Once transitioned they provide ongoing case management.
- MRC Case Managers coordinate all services within the 84 hrs per week of support to the participant.
- MRC oversees Transitional Assistance and Home Modifications for all four waivers.

Outreach to Individuals in Facilities

ABI/ MFP Facility Outreach (MRC/DDS)

- Raise awareness for ABI/MFP amongst residents, families, professional staff
- Provide Support to applicants throughout the application process
- The program aims to assist individuals who are interested in completing the one-page waiver application for the waiver(s) they are interested in.
- Targeted outreach consists of two specific groups:
  - Individuals identified by ASAP Nurses during MassHealth long-term care evaluations as having a brain injury
  - Individuals who have a brain injury diagnosis and express their interest in transitioning back to the community, as indicated in the MDS (Minimum Data Set) Section Q

Outreach to Individuals in Facilities continued

Peer Outreach by Waiver Participants (MRC/DDS)

- The participants involved in the program are ready and willing to share their personal stories with individuals and families who are contemplating transitioning back to the community.
- Additionally, brief videos available, ranging from 3 to 5 minutes in duration, can be utilized to provide information and support in this regard.

Waiver services are available in addition to other MassHealth benefits

- HCBS Waivers provide a layered benefit package that supplements traditional Medicaid benefits available to MassHealth Standard-eligible individuals

- Waiver services cannot duplicate other available services

Transitional Assistance Services

- Assistance with housing search and application processes
- Set-up expenses for individuals moving from a facility to the community, including moving expenses, essential household furnishings, security deposits, etc.
- Supports for obtaining certain equipment or home modifications that may be required to facilitate the participant's transition
- Coordinated by the MRC Case Manager or the DDS Service Coordinator

Residential Support Services

Residential Habilitation – group home settings

- 24/7 care, supervision, and skills training in a provider-operated group setting (typically 4-5 residents)

Shared Living – participant lives with a caregiver

- Caregiver provides skills training, personal care assistance, and household tasks with oversight by a provider agency, with care and supervision available 24/7

Assisted Living Services – certified ALR settings

- Includes assistance with personal care, homemaking, meals, and access to 24-hour on-site staff

Environmental Modifications and Accessibility Supports

Home Accessibility Adaptations

- Adaptations needed to ensure the health, safety, and autonomy of the participant. Can be made to the participant's home, a family home, or to a home available to the participant through shared home supports or shared living.

Vehicle Modifications

- Adaptations or alterations to the participant's primary means of transportation, such as van lifts, tie downs, ramps, specialized seating and safety restraints

Orientation and Mobility Services

- Teach an individual with vision impairment or legal blindness how to move or travel safely and independently in his/her home and community

Specialized Medical Equipment

- Equipment and supplies such as devices, controls, or appliances, specified in the individual service plan, which enable an individual to increase his or her ability to perform activities of daily living

Meaningful Day Activities, Community Engagement & Skills Training

Service	Description
Community Based Day Supports (CBDS)	Small group community-based activities enhance community integration
Day Services	Structured, site-based group programs provide socialization, assistance with functional and prevocational skills, etc.
Prevocational Services	Prepare a participant for paid or unpaid employment, e.g. attention span, task completion, attendance
Supported Employment Services	Training and ongoing support to maintain paid employment
Individual Support and Community Habilitation	One-on-one skills training supports participants to learn or improve skills they need to live as independently as possible
Peer Support	Training, instruction, and mentorship to support participants' self-advocacy and community engagement
Transportation (non-medical)	To enable participants to get to services, activities, and resources in the community when other transportation is not available

In-Home Supports

Category	Services
Activities of Daily Living (ADL) Supports	Waiver Personal Care Home Health Aide Supportive Home Care Aide
Intensive Activities of Daily Living (IADL) Supports	Adult Companion Chore Grocery Shopping and Home Delivery Home Delivery of Pre-packaged Medication Home-delivered Meals Homemaker Laundry

Other Support Services

Category	Services
Family Supports	Alzheimer's / Dementia Coaching Family Training (Training and instruction for unpaid family caregivers about ways to help the participant succeed in the community)
Behavioral Supports	Community Support and Navigation (Flexible, non-clinical services provided to participants with behavioral health needs support their ability to access behavioral health and other medical services and attain the goals in their plan of care)

Helpful Links

ABI and MFP Waivers homepage:

www.mass.gov/acquired-brain-injury-abi-and-moving-forward-plan-mfp-waivers

HCBS Waiver Participant videos:

www.youtube.com/channel/UC_dcg2mD50BOHuF_Wr2ZCzA/videos?disable_polymer=1

PASRR
CTLP Review

Diane Pixley, Director PASRR and Nursing Facility Operations

9/26/23

AGENDA

- PASRR History
- PASRR Purpose
- DDS PASRR Policy
- Definitions: ID/DD
- PASRR Process
  - Level I
  - Level II
- PASRR Team & Roles
- Questions

PASRR HISTORY

- PASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes, and to comply with the Supreme Court decision, Olmstead vs L.C. (1999), under the Americans with Disabilities Act, individuals with disabilities cannot be required to be institutionalized to receive public benefits that could be furnished in community-based settings. PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care.

- In brief, the PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have SMI or ID. This is called a "Level I screen." Those individuals who test positive at Level I are then evaluated in depth, called "Level II" PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.

PASRR PURPOSE

- To identify all applicants to and residents of Medicaid-certified nursing facilities (NFs) regardless of payer, who have or are suspected of having SMI, ID/DD
- To identify such persons who must have the Level II Preadmission Evaluation (PASRR)
- To screen individuals identified as suspected or known to have ID or DD prior to admission(PAS)
- To screen NF residents for continued NF stay or due to a change in condition (RR)
- To make two determinations:
    1. Need for NF services; and
    2. Need for specialized services.

DDS PASRR POLICY 2012-2

- When individuals are identified through PASRR, the Department will, except in special circumstances, identify appropriate services and arrange for community placement for the individual as soon as practicable

- Work with the individual or guardian to arrange community supports

- Once supports and an appropriate residential placement have been determined, continued stay in the nursing facility shall not be authorized through PASRR

Definitions ID/DD

- Intellectual Disability
  - Significantly sub-average intellectual functioning manifests before the age of 18

- Developmental Disabilities
  - Also referred to as related conditions:
  - Individuals who have a severe, chronic disability that meets the following conditions, that have occurred before the age of 22:
  - Cerebral Palsy or Epilepsy, or any other condition, other than mental illness, such as autism, spinal cord injury, head injury, multiple sclerosis, muscular dystrophy, etc.

DDS
Department of Developmental Services

Developmental Disabilities, cont.

- Is manifested before the person reaches the age 22
- Is likely to continue indefinitely
- Results in substantial functional limitations in three or more of the following areas:
    - Self-care
    - Understanding and use of language
    - Learning
    - Mobility
    - Self-direction
    - Capacity for Independent Living

PASRR PROCESS

- Level I Preadmission Screening (PAS):
  - A MassHealth form that is completed to identify, in part, whether an applicant for admission to a NF has indications of SMI, ID/DD. If the individual has or is suspected of having SMI, ID/DD a referral is made to the appropriate PASRR authority. Nursing facilities are responsible for having a Level I Form in the record of all Medicaid NF residents. DDS utilizes the Level I Form as a notification of admission to a nursing facility.

- Level II Preadmission Screening (PASRR):
  - Completed by the appropriate PASRR Authority to determine whether the individual requires the level of services provided by a NF and whether Specialized Services are needed.

- Level II Resident Review (PASRR):
  - Completed by the appropriate PASRR Authority to determine whether the NF resident continues to require the level of services provided by a NF and whether or not the individual continues to require specialized services.

PASRR TEAM

- PASRR Intake/Admission Specialist
- PASRR Specialists
- Active Treatment Clinical Coordinator
  - Active Treatment Specialists

INTAKE/ADMISSIONS SPECIALIST

- Role (Statewide Coordination)
  - Manage the Pre-Admission Screening and Resident Review (PASRR) Intake process
  - Manage the Pre-Admission Screening and Resident Review (PASRR) admission process
  - Report Non-Compliance to PASRR process to DDS, ELD, and EHS
  - DDS Liaison on Medical Review Team (MRT)
  - Education on PASRR process to SNF, Hospitals, ASAPs, CTLPs, DDS Staff, and other stakeholders

- Kim Ramponi, Intake/Admission Specialist
  - Kimberly.Ramponi@mass.gov, 617-691-7007
  - PASRR Intake Line: 617-624-7796
  - PASRR Intake Email: DDS.PASRR@Mass.gov

PASRR SPECIALISTS

- Role (Regional Oversight)
  - Respond to intakes for Level II Pre-Admission Screening and Resident Review (PASRR)
  - Processes Level II PASRR to determine the need for skilled nursing
  - Collaborates with assigned Area Office, and other agencies as required
  - Perform 90-day Level II PASRR, and annual PASRR as necessary until community placement occurs
  - Education on PASRR process to SNF, Hospitals, ASAPs, CTLPs, DDS Staff, and other stakeholders

ACTIVE TREATMENT CLINICAL COORDINATOR

- Role (Statewide Oversight)
  - Coordination of the statewide provision of Active Treatment (AT)
  - Supervises (2) Active Treatment Specialist
  - Coordination and training of provider clinical staff
  - Liaison with the OQE team
  - Education on PASRR process to SNF, Hospitals, ASAPs, CTLPs, DDS Staff, and other stakeholders

- Kate Mills, Active Treatment Supervisor
  - kate.mills@mass.gov, 508-287-4142

ACTIVE TREATMENT SPECIALIST

- Role (Statewide Coordination)
  - Coordinate the statewide delivery of Active Treatment for persons with ID/DD who are expected to remain long-term in a nursing facility

- Karima Taswell, Active Treatment Specialist
  - karima.taswell@mass.gov, 857-321-1041

- Stephanie Goddard, Active Treatment Specialist
  - stephanie.goddard@mass.gov, 781-974-3485

PASRR TEAM, cont.

- Diane Pixley, Director of PASRR and Nursing Facility Operations
  - diane.pixley2@mass.gov, 617-507-9509
- Julie Harmon, PASRR Specialist/Nursing Facility Specialist: South Valley Area (primary contact)
  - julie.harmon@mass.gov, 413-374-4681
- Lisa Hackett, PASRR Specialist/Nursing Facility Specialist: Worcester Area, North Central Area (back up for Julie Harmon)
  - lisa.hackett@mass.gov, 617-448-8608
- Deb O'Neil, (Retired/120 day) PASRR Specialist/Nursing Facility Specialist: South Valley Area
  - deborah.oneil@mass.gov, 617-366-7084
- Theresa Marisseau, PASRR Specialist/Nursing Facility Specialist: Franklin Hampshire Area, Berkshire Area, Springfield Westfield Area, Holyoke Chicopee Area
  - theresa.marisseau@mass.gov, 413-372-2538
- Donald Hardwick, PASRR Specialist/Nursing Facility Specialist: Northeast Region
  - donald.hardwick@mass.gov, 978-766-4189
- Mike Bradley, PASRR Specialist/Nursing Facility Specialist: Southeast Region
  - mike.Bradley@mass.gov, 781-853-0252
- Leslie Hayes, PASRR Specialist/Nursing Facility Specialist: Metro Region
  - leslie.hayes@mass.gov, 857-208-1198

QUESTIONS?

Introduction
Long-Term Care Ombudsman Program

Massachusetts Long Term Care Ombudsman Program

CTLP Meeting

September 26, 2023

What is a Long-Term Care Ombudsman?

Who Represents the LTCOP?*

53 State Long-Term Care Ombudsman Programs

- Each state, Guam, Puerto Rico, and Washington D.C.
- Program structure varies (e.g., centralized, decentralized)

418 local Ombudsman entities

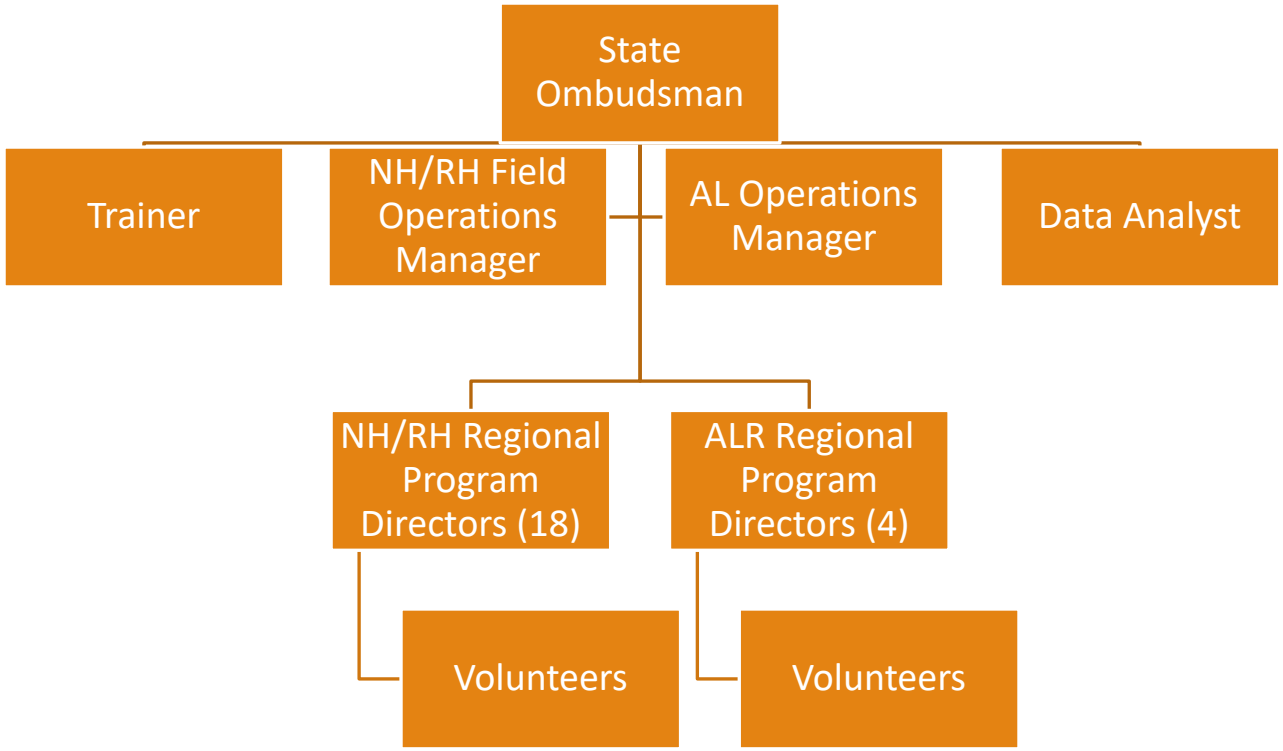
1,381 full-time staff

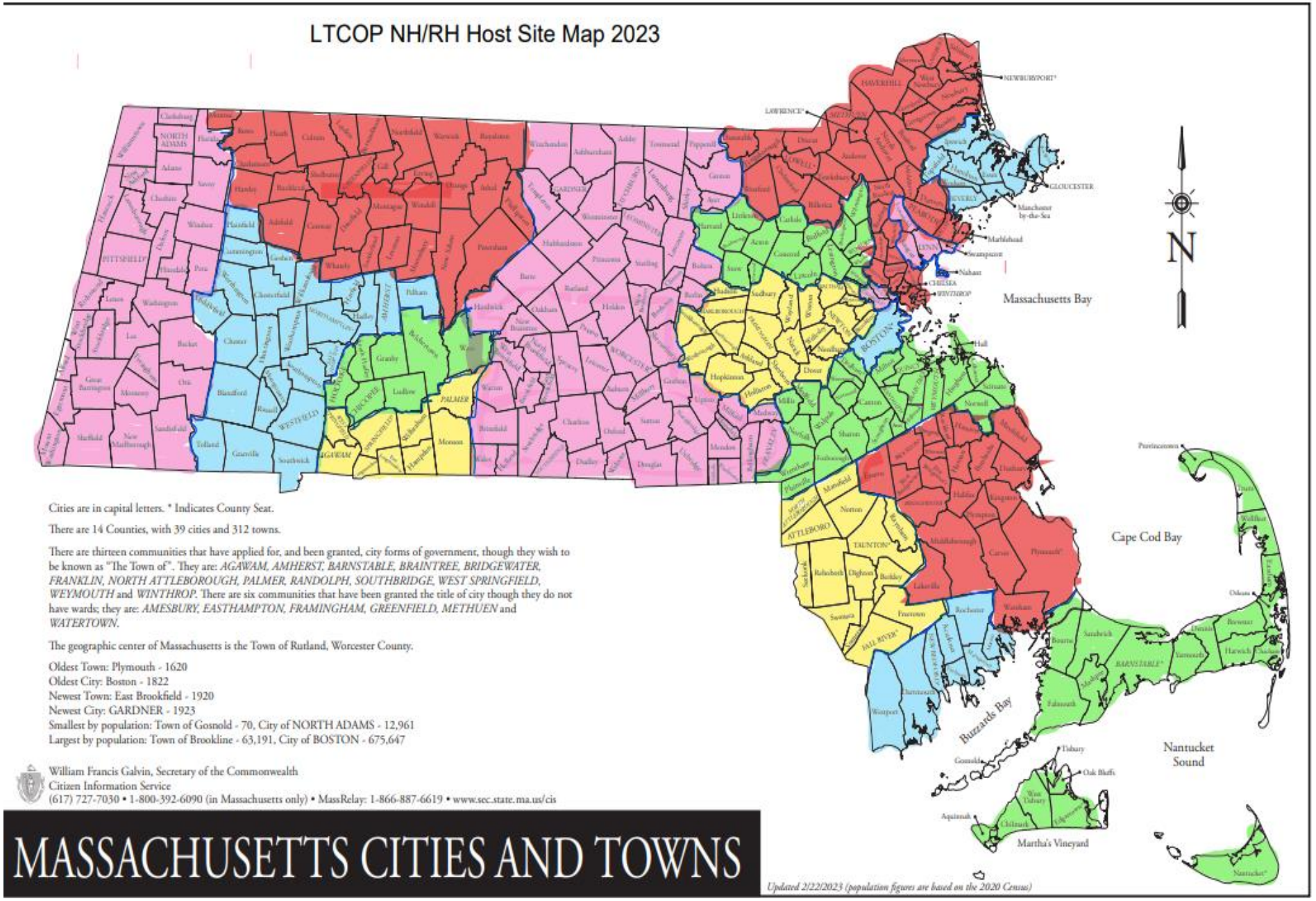
5,152 certified volunteers donated 250,514 hours of service

- All designated representatives of the Office receive training, including volunteers
- Not all programs work with volunteers

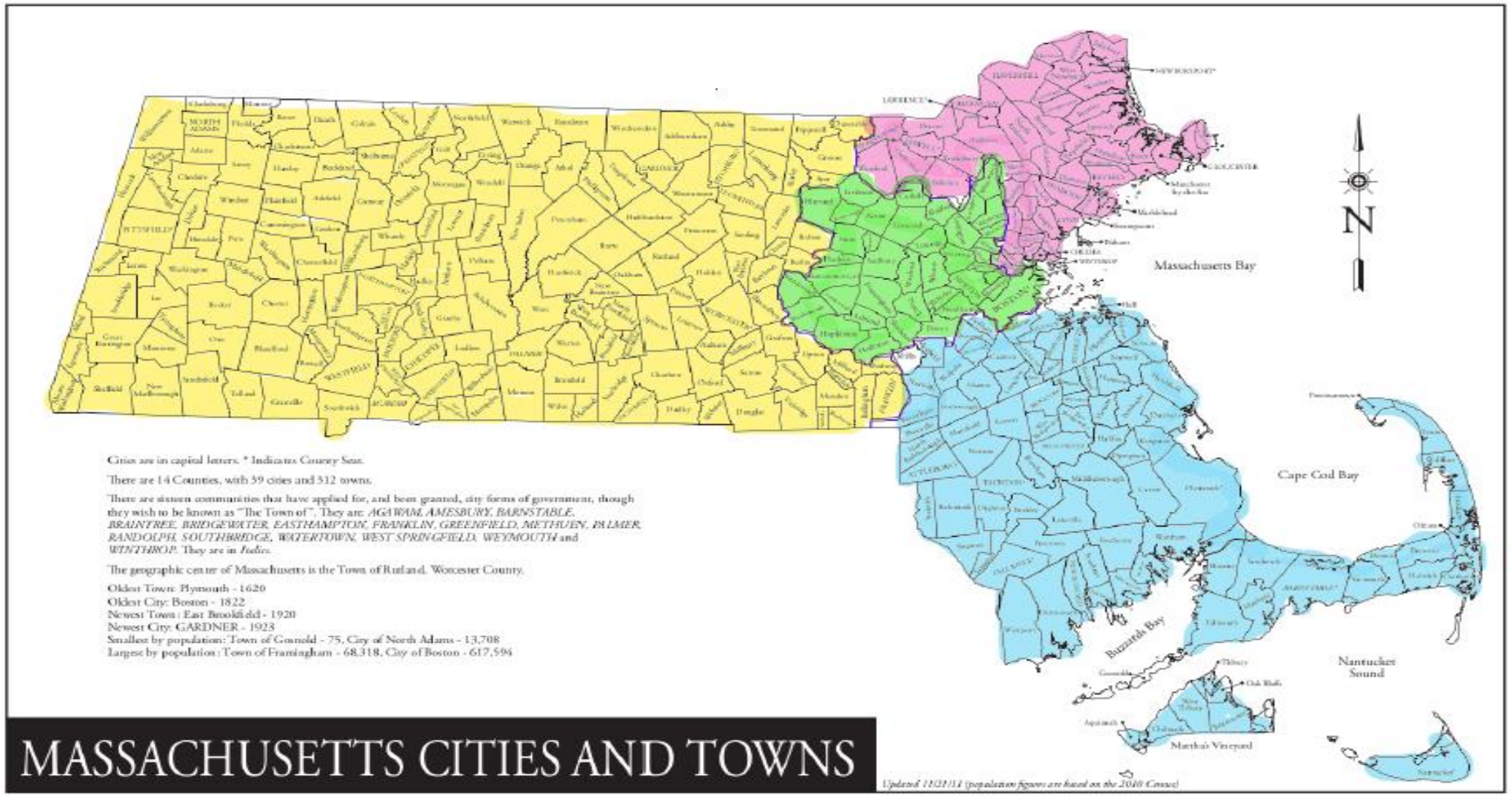
**2020 National Ombudsman Reporting System (NORS) data* https://ltcombudsman.org/omb_support/nors/nors-data

Long-Term Care Ombudsman Program Organization




LTCOP NH/RH Host Site Map 2023
Massachusetts Bay
Cape Cod Bay
Buzzards Bay
Nantucket Sound
Martha's Vineyard
N
Cities are in capital letters. * Indicates County Seat.
There are 14 Counties, with 39 cities and 312 towns.
There are thirteen communities that have applied for, and been granted, city forms of government, though they wish to be known as "The Town of". They are: AGAWAM, AMHERST, BARNSTABLE, BRAINTREE, BRIDGEWATER, FRANKLIN, NORTH ATTLEBOROUGH, PALMER, RANDOLPH, SOUTHBRIDGE, WEST SPRINGFIELD, WEYMOUTH and WINTHROP. There are six communities that have been granted the title of city though they do not have wards; they are: AMESBURY, EASTHAMPTON, FRAMINGHAM, GREENFIELD, METHUEN and WATERTOWN.
The geographic center of Massachusetts is the Town of Rutland, Worcester County.
Oldest Town: Plymouth - 1620
Oldest City: Boston - 1822
Newest Town: East Brookfield - 1920
Newest City: GARDNER - 1923
Smallest by population: Town of Gosnold - 70, City of NORTH ADAMS - 12,961
Largest by population: Town of Brookline - 63,191, City of BOSTON - 675,647
William Francis Galvin, Secretary of the Commonwealth
Citizen Information Service
(617) 727-7030 • 1-800-392-6090 (in Massachusetts only) • MassRelay: 1-866-887-6619 • www.sec.state.ma.us/cis
MASSACHUSETTS CITIES AND TOWNS
Updated 2/22/2023 (population figures are based on the 2020 Census)

Assisted Living Regional Program Areas



The Massachusetts Ombudsman Program by the Numbers

There is 1 State Ombudsman;

32 full-time-equivalent staff;

181 volunteers trained to investigate and resolve complaints.

In 2022 the Program:

provided information and assistance to

5,203

individuals.

conducted

12,770

visits

provided information and assistance to

5,151

LTC facility managers and staff.

attended

14

family council meetings.

attended

191

resident council meetings.

provided

7

training sessions for long-term care facility staff.

The program resolved or partially resolved

60%

of all complaints to the satisfaction of the resident or complainant.

The three most frequent nursing facility complaints handled by Ombudsman program representatives:

- **Response to requests for assistance**
- **Food Services**
- **Discharge or Eviction**

The program worked to resolve

2,743

complaints initiated by residents, their families, and other concerned individuals.

The three most frequent complaints in residential care communities handled by Ombudsman program representatives were:

- **Discharge or eviction**
- **Billing and charges**
- **Care planning**

The statistics in this graphic are based on federal fiscal year (FFY) 2022 NORS Data (October 1, 2021 – September 30, 2022) For more information about the Long-Term Care Ombudsman Program, and volunteer opportunities, visit ltcombudsman.org or email ombudcenter@theconsumervoice.org.

om buds man The National Long-Term Care Ombudsman Resource Center

What Does the LTCOP Do?

- Identify, investigate, and resolve complaints made by or on behalf of residents.
- Provide information to residents about long-term care services.
- Provide technical support for the development of resident and family councils.
- Advocate for changes to improve residents' quality of life and care.
- Represent resident interests before governmental agencies.
- Seek legal, administrative, and other remedies to protect residents.
- Ensure residents have regular and timely access to the LTCOP.

The Role of Certified Ombudsman Staff and Volunteers

Routinely, visit assigned nursing or residential care home on a weekly basis,

- speak with residents,
- make observations about resident rights,
- work to resolve issues of resident rights with staff of the home.

Attend monthly meetings of local program for training and support.

Follow regulations, policies and procedures of the State Long Term Care Ombudsman Program.

Unique Features of the LTCO Program

- The resident guides our action.
- We need resident consent prior to taking any action on a complaint or sharing resident information.
- We seek to resolve complaints to the residents' satisfaction (regardless of their capacity)
- The LTCOP represents residents' interests, both individually and systemically.
- The LTCOP empowers residents and promotes self-advocacy
- We are not mandated reporters of abuse, neglect, or mistreatment.

What we are not…

Adversaries

Friendly Visitors

Surveyors

Regulators

Payer Source Experts

Case Managers

Those who complete applications or appeals

LTCOP Complaint Investigations

Ombudsman representatives:

- Investigate individual complaints and address concerns that impact several or all residents in a facility.
- Can address general concerns they personally observe during a visit (e.g. odors, concerns about the environment, staff not knocking on resident doors before entering).
- Cannot share information without resident consent.
- Investigate to gather the facts, but the main goal is to resolve the issue to the residents' satisfaction.
- Call upon others to fulfill their responsibilities to residents.
- Represent resident needs by working for legislative and regulatory changes (e.g., coordinated systems advocacy lead by the State Ombudsman).

Resident Rights: the Role of Resident Representatives

The Ombudsman provides

Resident-Centered advocacy

and will ALWAYS attempt to determine the wishes of the resident, regardless of the presence of a resident representative.

The Ombudsman does NOT represent the family, the staff of the facility or the host agency.

Get to Know the LTCOP

Contact the LTCOP if you know a resident that may benefit from a visit with a LTCOP representative.

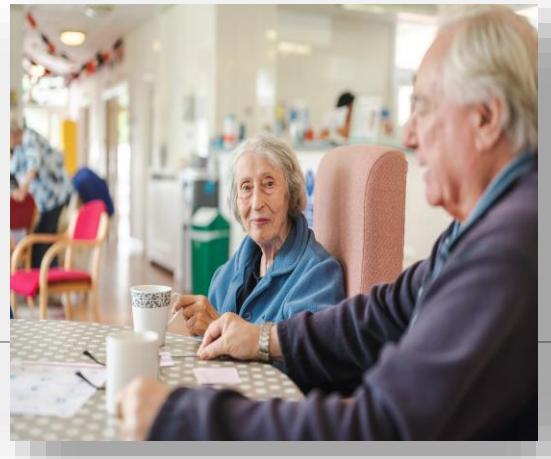
Contact the LTCOP if you, or someone you know, needs information about long-term care services and supports.

Share information about the LTCOP with residents, family members, and your colleagues.

Find your local Ombudsman:

- https://www.mass.gov/doc/nursing-rest-home-ombudsman-local-contact-information/download
- https://www.mass.gov/doc/assisted-living-ombudsman-local-contact-information/download

NURSING HOMES



Generally, these are facilities licensed by the Department of Public Health & CMS

- Medical, rehab/post-hospital and chronic long term care
- Licensed Nursing Home Administrator
- 24-hour care and staff on duty
- Staff include Director of Nurses, Social workers, Dietician, Nurses, CNAs, Therapists
- Paid by Medicare, Medicaid (MassHealth), Insurance, private funds
- Highly regulated

THE RESIDENT COUNCIL

A resident council is an independent group of nursing home residents who meet at a minimum of once a month to discuss concerns and suggestions and to plan activities that are important to them.

Federal law includes the following requirements for resident councils:

- Facilities certified for Medicare and Medicaid must provide a meeting space and respond to the council's concerns.
- Nursing facilities must appoint a council-approved staff advisor or liaison to the resident council.
- The resident council meetings are closed to staff, visitors, and other guests. For staff, visitors, or other guests to attend, the resident council must invite them.

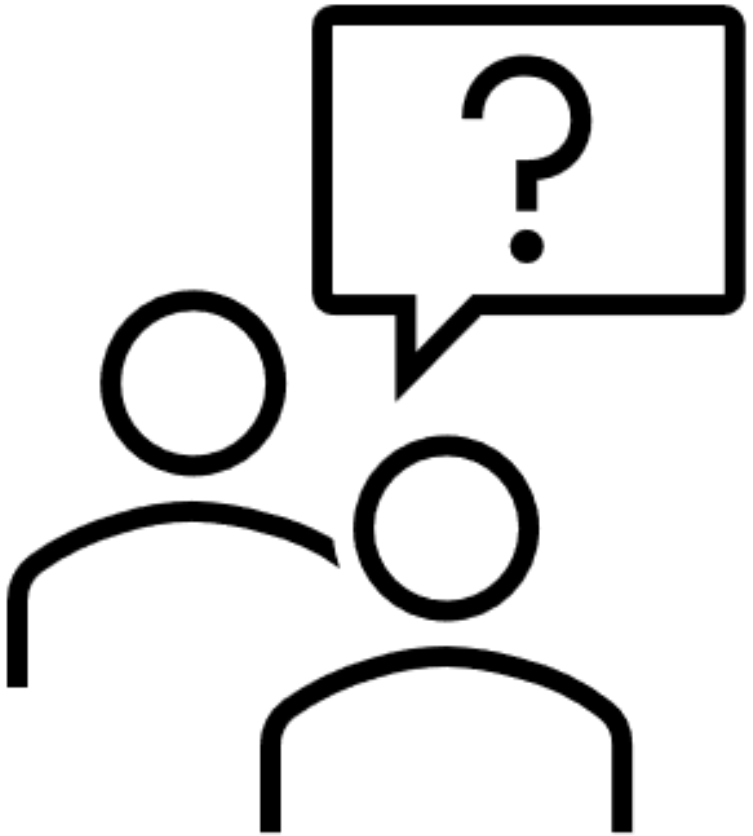
CONTACT US

https://www.mass.gov/doc/nursing-rest-home-ombudsman-local-contact-information/download

https://www.mass.gov/doc/assisted-living-ombudsman-local-contact-information/download

Carolyn Fenn, Director
Tel.: 617-222-7491
Email: Carolyn.M.Fenn@mass.gov

QUESTIONS?



What's Next?

Upcoming Meetings & Trainings

October CTLP Training

Tuesday, October 10, 2023

2:00pm – 4:00 pm

- *Guest Speaker: DMH*

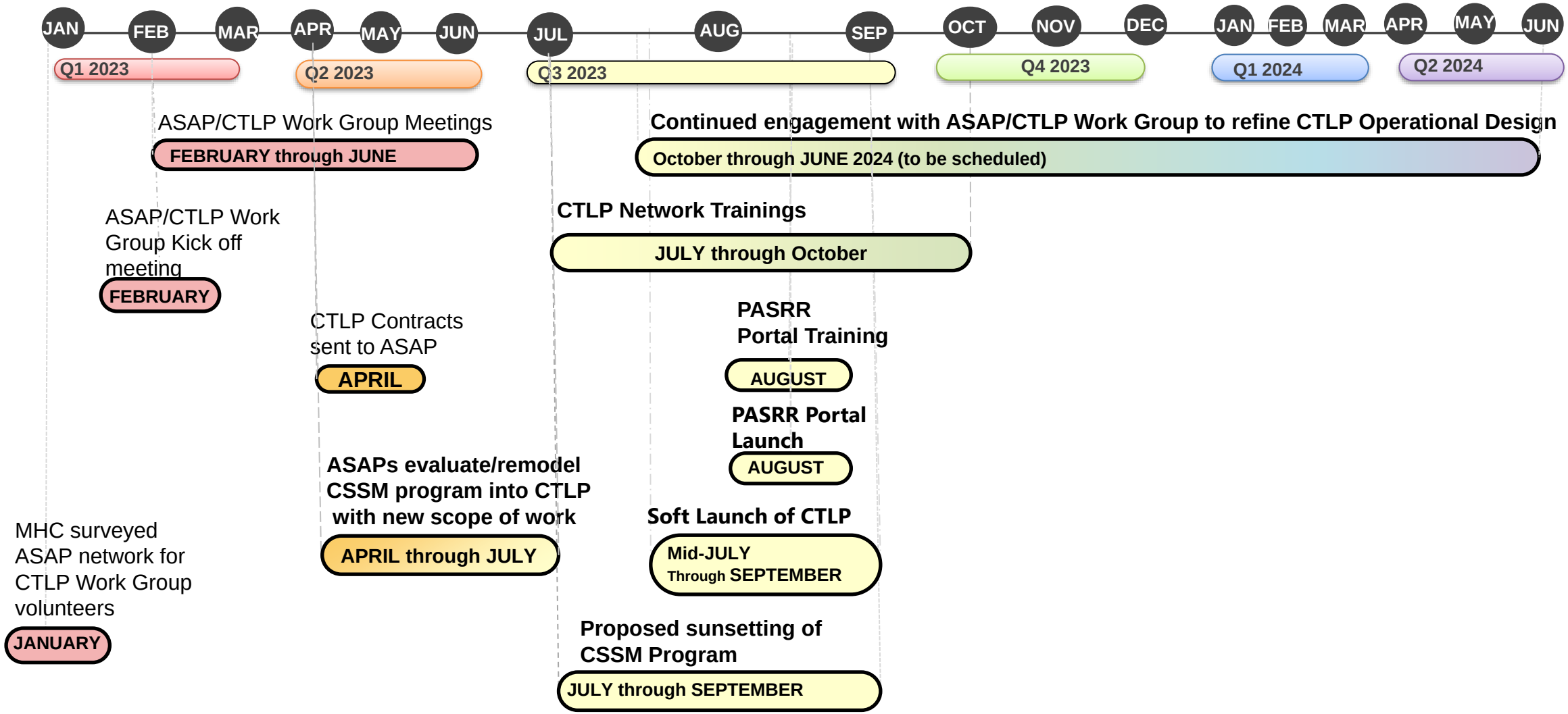
October CTLP Office Hours

Tuesday, October 24, 2023

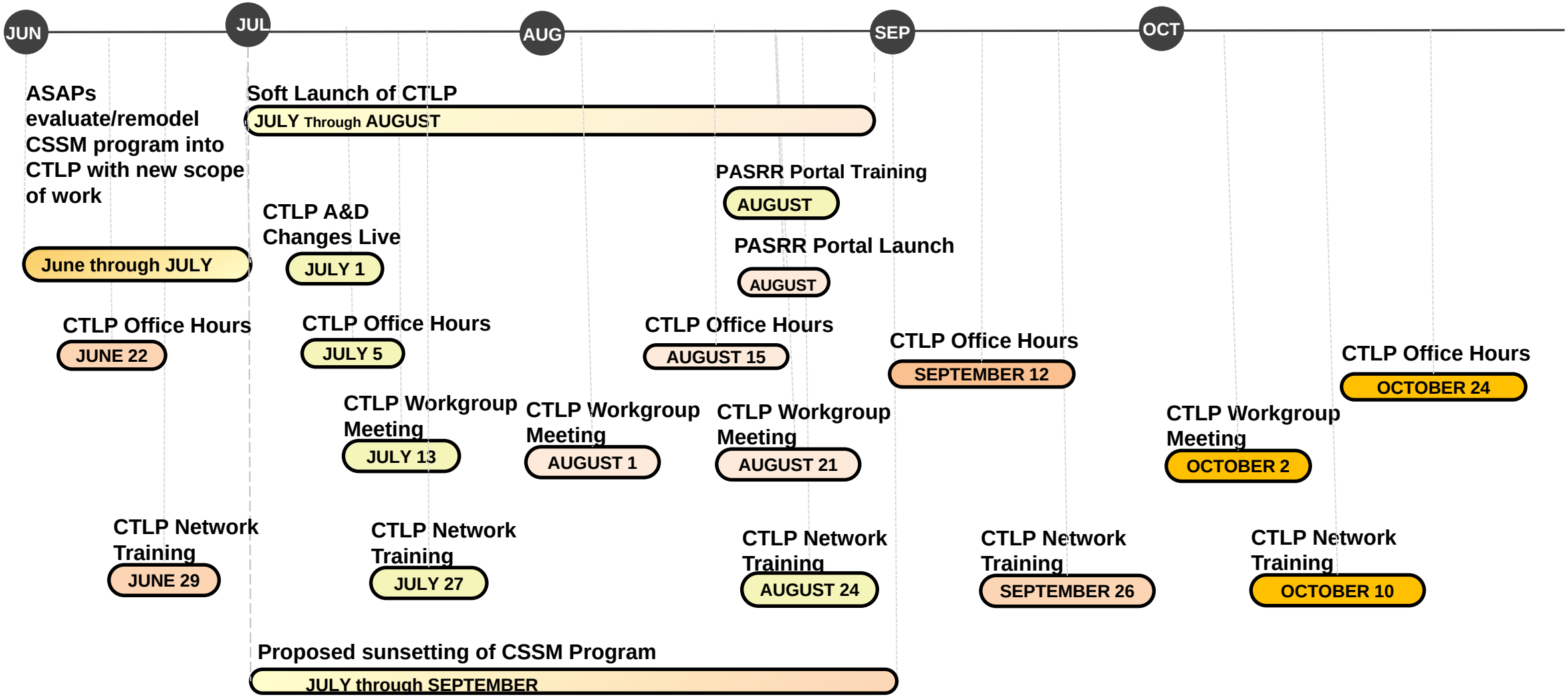
1:30pm-2:30pm

Appendix

CTLP Operational Implementation Timeline CY2023 into CY2024



CTLP Operational Implementation Timeline: CTLP Soft Launch and Trainings (updated)

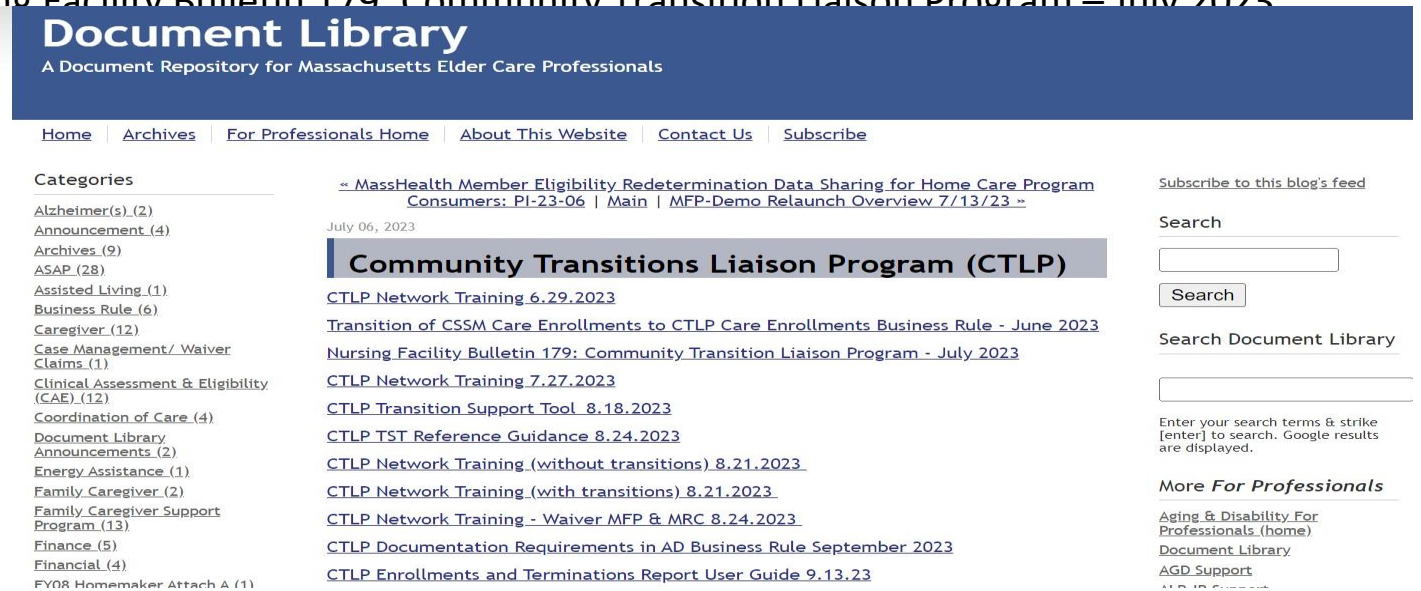


Resources

800AgeInfo – Document Library

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

- Available documents
  - CTLP Network Trainings
  - CTLP Documentation Requirements in A&D Business Rule – September 2023
  - CTLP Enrollments and Terminations Report User Guide – September 2023
  - CTLP Transition Support Tool & Reference Guide
  - 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.

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