Revision History

Date	Version	Description	Author
December 12, 2023	1.0	Initial publication	EOEA Home Care Team

Community Transition Liaison Program (CTLP) and Options Counseling (OC) Guidance

Community Transition Liaisons (CTLs) working within the Community Transitions Liaison Program (CTLP) are the lead ASAP contact for the Nursing Facility (NF) residents and staff as they assist with discharge planning and transitioning residents back to the community. CTLs are required to visit the nursing facility at least once per week to meet with residents and is a resource for all residents. Nursing facility staff may make ASAP program referrals through the CTL, including to the Options Counseling (OC) program at the ASAP and the ILC. The goal is to ensure communication between programs, help nursing facility staff identify the ASAP contact, and reduce confusion on which program best serves the resident based on the resident's needs.

Residents with complex needs and/or who are in need of assistance acquiring housing to return to the community are best served by CTLP.

CTLP Resident Criteria

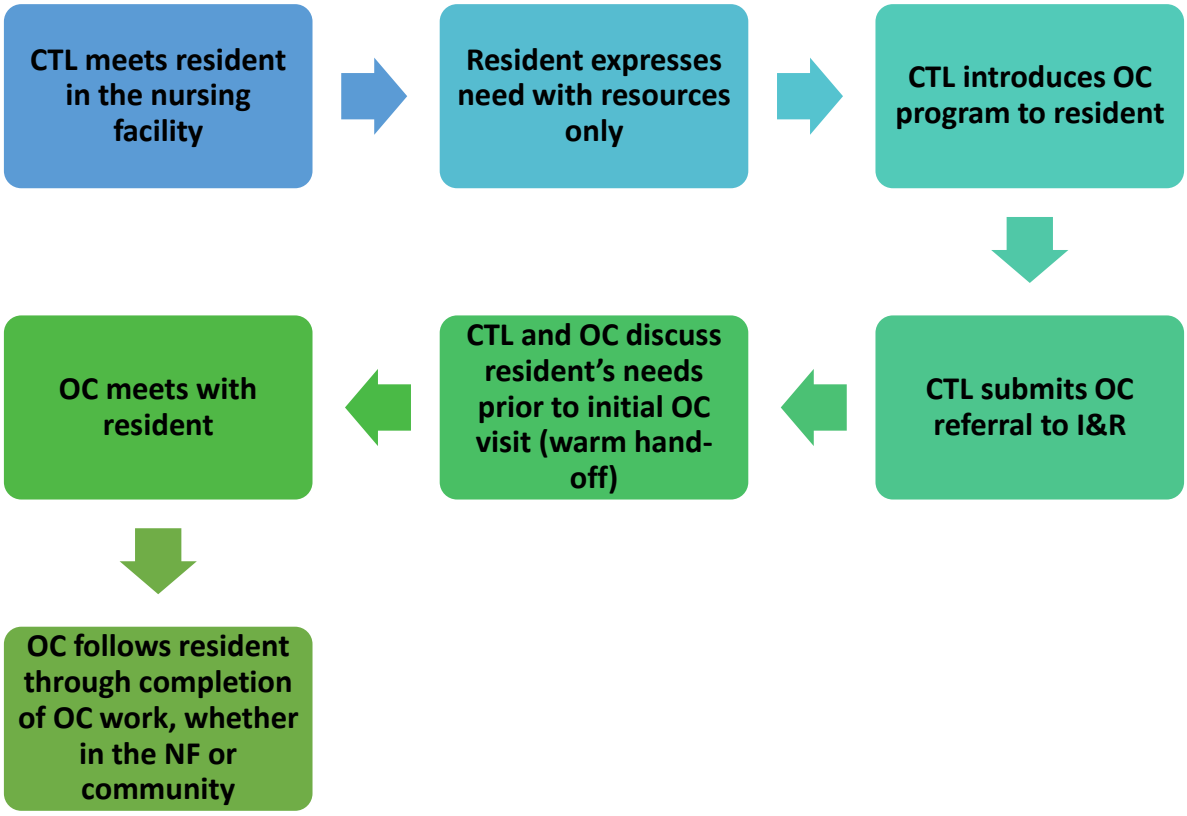
- Age 22 or older;
- Any insurance type; and
- Has no PASRR involvement unless Department of Developmental Services (DDS) or Department of Mental Health (DMH) request assistance from CTLP for complex discharges.
- Resident of nursing facility whose stay exceeds 45 days or a resident whose stay is less than 45 days and has requested assistance transitioning or expresses a need for resources

Residents currently at the nursing facility for short term rehab and/or who have non-urgent requests or needs are still best served by the OC program. During the initial contact the CTL can identify, explain, and introduce the consumer to OC.

Examples include, but are not limited to:

- NF Resident is under 22 years old
- NF Resident needs resources (non-housing)
- NF Resident has a family member or caregiver in the community in need of guidance or support
- NF Resident has requested assistance with resource information only

Work Flow: CTL refers resident to OC program



If requested by the CTLP team, the OC may support the work of the interdisciplinary discharge planning team (IDPT) through:

- collaboration to meet resident's needs
- providing information about community-based options that are relevant to the resident, their family, and/or caregiver(s)

The examples below illustrate when a resident's needs are best met by working directly with an OC for advisement and assistance. A warm hand-off from CTLP to OC is required to ensure a smooth transition without a duplication of services.

Example #1

Resident has stable housing and is requesting non-urgent resources

Individual	88-year-old Haitian Creole speaking female, widowed, and living with daughter, who assists with all ADLs and IADLs. Resident's medical conditions include Congestive Heart Failure (CHF) and COPD (not O2 dependent). Resident was hospitalized for CHF exacerbation and discharged to a nursing facility for PT/OT.
Brief History	During the first week of admission, resident requests to meet with CTL as resident is interested in daughter becoming paid caregiver. Resident does not have MassHealth Standard and appears financially eligible ($980/month income with no assets).
Intervention	CTL provides resident and daughter, who is interpreting for resident, information on Consumer Directed Care (CDC), Adult Foster Care (AFC), and the Personal Care Attendant (PCA) program. Resident and daughter agree AFC would be the best choice. Resident's daughter states resident will be discharged home at the end of the week. CTL makes referral to Options Counseling through I&R to assist resident with applying for MassHealth once the resident returns home and to provide support to resident's daughter through AFC application and assessment process.
Outcome	OC meets resident at the home to assist with the MassHealth application and ensures that all documentation is included. OC contacts resident by phone weekly regarding status of MH application. Resident states that she has no other needs at this time.
Why is this appropriate for OC?	*Short term care advisement, resident's request is not urgent, and resident has stable housing to return to in the community where their needs are being met.*

Example #2

Resident is at the nursing facility for short term rehab and is referring spouse for assistance with resources	
Individual	65-year-old English-speaking male, married and living with spouse in own home. Resident was hospitalized for ankle fracture and surgery. Resident's home is a split level and resident cannot navigate stairs and is sent to a nursing facility. Resident will be discharged home when he can safely ambulate up and down stairs.
Brief History	Resident was independent prior to fracturing ankle while walking his dog. Resident works part time at Stop and Shop to subsidize their social security income and relies on this income to help cover food and some other basic needs. Resident is aware it will be 4-6 weeks before he can return to work.
Intervention	CTL visits with resident during their second week of admission. Resident expresses anxiety over being out of work for a lengthy period and expresses concern over affording food and utilities while without extra income. Resident is concerned for spouse's needs while he is in the nursing facility. Resident states he knows he is over income for SNAP benefits and CTL provides list of local food pantries for resident and e-mails a copy to resident's spouse at resident's request. CTL submits OC referrals for resident and spouse.
Outcome	Resident has been discharged home after two weeks at the nursing facility but has not returned to work. Spouse has been going to the local food bank to address food insecurity. OC contacts resident to discuss SNAP benefits as resident and spouse have high medical costs (Part B supplement and Part D coverage; medication costs (prescription and over the counter), and vision expenses (glasses, contacts, exam fees). ASAP OC provides resident with a SNAP application and reviews the list of documentation needed. ASAP OC calls resident within 10 days of initial conversation to see if the resident has questions, and if additional help is needed. Resident states they were approved for $90/month for ongoing SNAP benefits and still utilize the food pantry. Resident stated they can only afford to pay their rent this month

	and need assistance paying for electric and water bill. ASAP OC assists resident in applying to organizations offering financial assistance to help cover utility costs.
Why is this appropriate for OC?	Short term care advisement, resident's spouse was referred for food insecurity while resident is in the nursing facility, and resident states he may require additional help with finances once home

Example #3

Resident is a caregiver referring care recipient for Home Care services	
Individual	51-year-old English/Cantonese speaking male who lives with and provides care for his 82-year-old Cantonese speaking father. Resident was hospitalized for uncontrolled diabetes (type 2) and wound care. Resident had been inattentive to his personal health and had not seen a medical provider for five years. Resident was unaware he had been living with diabetes prior to admission. He is discharged to a rehab for additional diabetes & wound management.
Brief History	Resident is primary caregiver for father with dementia. There are no services in the home. Resident's sister, who is fluent in English and Cantonese, has come up from Georgia to care for his father while resident is in the nursing facility.
Intervention	CTL meets with resident at the nursing facility to discuss needs. Resident is interested in in-home services for his father and asks CTL to contact sister to discuss services. Resident also requested assistance finding a PCP and learning more about managing his new diagnosis. CTL refers resident and resident's father to the ASAP OC.
Outcome	CTL discusses resident's needs with ASAP OC and introduces ASAP OC to resident at the nursing facility. ASAP OC and resident call local medical provider in area of home, Atrius Health, during visit and resident is assigned a PCP and initial appointment. Resident expressed that he is concerned about managing his

	diabetes after he is discharged home. ASAP OC states they will provide resident with a list of virtual and in-person diabetic support groups and helped resident create a list of questions to address during initial visit with PCP. OC also discussed the Family Caregiver Support Program (FCSP) for resident to receive additional support in caring for his father and managing his diabetes. OC contacts resident's sister to discuss Home Care services and having an assessment conducted while sister is still in town. Sister and father agree to assessment. ASAP OC submits Home Care referral to I&R.
Why is this appropriate for OC?	Short term care advisement for resources, resident is a caregiver and care recipient has needs in the community, resident may be in need of additional supportive services (FCSP) once discharged home

For questions regarding this guidance please contact: Julianna Santiago, Community Transition Liaison Manager, Julianna.Santiago@mass.gov and Carissa Kushmerek, Community Transition Liaison Coordinator Carissa.Kushmerek@mass.gov.