Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Nursing Facility Bulletin 179
July 2023

TO: Nursing Facilities Participating in MassHealth

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: Community Transitions Liaison Program

Introduction

Over the last several years, the needs of the nursing facility (NF) population have increased. NFs have reported an increase in the medical complexity of residents and an increase in need for behavioral health services. To support these needs, this summer, the Executive Office of Health and Human Services (EOHHS) is introducing the Community Transitions Liaison Program.

Community Transitions Liaison Program Overview

The Comprehensive Screening and Service Model (CSSM) Program is managed by the Aging Services Access Points (ASAPs) and has been in existence since 2005. This program will be expanded and rebranded as the Community Transitions Liaison Program (CTLP), with enhanced funding and focus on supporting all NF residents who are 22 and older, regardless of insurance type, who are interested in transitioning to the community.

Each NF will have an assigned CTLP team of two people who will operate out of the regional ASAP and will coordinate with other state agencies as needed to best support individuals interested in transitioning into the community.

Assigned CTLP teams will work with NF staff, the NF ombudsman, NF residents, family, and informal supports, as well as others. CTLP teams will have a weekly onsite presence at the NF. CTLP teams will provide marketing materials (e.g., flyers, brochures) with program details and team contact information. CTLP teams will be involved with discharge planning and provide support in discharge planning meetings.

CTLP Supports for NF Residents

CTLP teams will support NF residents in the following ways, including, but not limited to:

- meet with residents to discuss their needs and provide options for a safe plan to return to community living;
- assist with identification of needs to be addressed for discharge planning;
- 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.

Responsibilities of NFs for CTLP

NFs are required to support the CTLP teams by providing the following:

- continued access to residents;
- access to a conference room or a copy machine;
- help with sharing information about the CTLP program; and
- referrals to the CTLP program.

NFs are required to comply with the requirements outlined in this bulletin, or will be subject to sanctions. NFs continue to be subject to MassHealth regulations, including 130 CMR 456.000: *Long Term Care Services*; Department of Public Health regulations, including 105 CMR 150: *Standards for long-term care facilities*; and the federal PASRR regulations at 42 CFR 483.100. Pursuant to these regulations, NFs are required to create care plans and perform care coordination and discharge planning for all residents. CTLP teams have specialized training and bring additional expertise in working with and supporting the needs of NF residents with serious mental illness (SMI). CTLP teams will build upon the work of the NF for individuals assigned to them.

If a NF has questions about the Community Transition Liaison Program, they may send an email to Julianna.Santiago@mass.gov, with a copy to InstitutionalPrograms@mass.gov.

MassHealth Website

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Questions

If you have questions about the information in this bulletin, please email your inquiry to InstitutionalPrograms@mass.gov, with a copy to Julianna.Santiago@mass.gov.