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Enhanced Care Coordination and Transition Support in Nursing Facilities

Dear MassHealth Nursing Facility Providers,

Over the last several years, the needs of the nursing facility population have increased. Nursing facilities have reported an increase in the medical complexity of residents and an increase in need for behavioral health treatment. To support these needs, this summer, the Executive Office of Health and Human Services (EOHHS) will be enhancing the Behavioral Health Community Partners Program, expanding support provided by the DMH Case Management Team, and expanding the Community Transitions Liaison Program. These programs will work in a coordinated manner to provide additional support to specific populations, noted below.

- The Behavioral Health Community Partners Program (BH CP) will support
    - Nursing facility residents authorized to receive services from the Department of Mental Health (DMH)
    - Nursing facility residents with a positive Level 2 PASRR determination of Serious Mental Illness (SMI) who have received a determination that nursing facility services are appropriate for up to the next 12 months ("12-month determination")
- The DMH Case Management Team will support
    - Individuals with a positive Level 2 PASRR determination of SMI who are likely to be discharged within 90 days ("90-day determination")
- The Community Transitions Liaison Program will support

- All other nursing facility residents who are age 22 and older, regardless of diagnosis or insurance type, who are interested in transitioning to the community

Additional information on each initiative can be found below and will be discussed further in a webinar for all nursing facility providers on Thursday June 22, 2023. We strongly encourage that all nursing facilities join the webinar to learn more information.

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Behavioral Health Community Partners (BH CP) Program for nursing facility residents:

- What is the BH CP Program for nursing facility residents?
  - Community-based organizations are contracted with MassHealth to provide enhanced Care Coordination for all eligible nursing facility residents
  - Care Coordinators will provide the following services and support to their assigned Enrollees:
    - Outreach and engagement;
    - Comprehensive assessment, HRSN screening, and ongoing person-centered treatment planning;
    - Care coordination across services including medical, behavioral health, long-term services and supports, and other state agency services, and as appropriate, referrals for DMH Clubhouse and Human Services Transportation (HST)
    - Support for transitions of care;
    - Options Counseling;
    - Medication reconciliation support;
    - Health and wellness coaching; and
    - Connection to social services and community resources
- Which nursing facility residents are eligible for BH CP?
  - Individuals 18 years or older who have received a positive Level 2 PASRR determination of SMI with a 12-month determination
  - Eligibility is not restricted to MassHealth members
- How will the BH CPs get involved? Will they be on the premises?
  - There will be a small number of dedicated BH CPs assigned to each nursing facility to support eligible individuals in those facilities.
  - BH CPs will be notified by DMH of an individual's enrollment into the BH CP Program.
  - Once the individual is enrolled, the BH CP will work to contact the Enrollee either through phone calls, telehealth, or face-to-face visits.
  - BH CP staff are required to be on the premises at times and must have the ability to meet face-to-face with the Enrollee.
  - BH CPs may contact the NF staff (including but not limited to social worker(s) and nurses) through email or phone calls, or ask to schedule time to meet with NF staff.
- What are examples of the type of help the BH CPs assigned to my facility can provide?

- Working with an Enrollee to coordinate Clubhouse and HST services
- Working with LTSS and/or other providers in the community to ensure adequate supports are in place for the Enrollee to transition home or into the community
- Coordinate behavioral health services (including but not limited to psychopharmacology, individual therapy, neuropysch testing)
- BH CPs will conduct a medication review to document current medication/regime

- What can BH CPs expect from me?
  - To accomplish the work described above, BH CPs may request the following from facilities:
    - Assistance or feedback on the best times and ways to communicate with Enrollees (e.g., an Enrollee may prefer afternoon visits or may be hard to communicate with via phone);
    - Support in meeting with Enrollees on the premises;
    - Information on any initial referrals the NF has initiated (e.g., referrals for neuropsych testing, psychotherapy) to assist in follow ups and coordinating care; and
    - BH CPs may obtain Releases of Information and request NF documentation that will assist the BH CPs in completing their Comprehensive Assessment, Care Planning, and Medication Review to document current medication/regime. This documentation can include, but is not limited to, the NF Care Plan, list of medications along with the regimen and dosage amounts, and psychosocial assessment.

DMH Case Management Team:

- What is the DMH Case Management Team? Who is eligible?
  - This is a team of dedicated case managers who work for the Department of Mental Health assigned to nursing facility residents with a positive Level 2 PASRR determination of SMI who are likely to be discharged within 90 days ("90-day determination")
  - They will support the resident's transition to the community.
- What can I expect from the Case Managers assigned to residents in my facility?
  - The dedicated case managers will:
    - Work with existing Care Coordination services (BH CP, One Care plan, etc.);
    - Collaborate with the DMH Site Office in the community to facilitate referral and enrollment into DMH services;
    - Assist with Referrals to other community services and supports (PCA, VNA, home modifications, etc.); and
    - Inform NF of plan and coordinate discharge.
- How will the Case Manager get involved? Will they be on the premises?
  - DMH will assign a case manager to individuals with a PASRR 90-day determination.

- Case managers will utilize in-person and telehealth meetings to engage with the resident and care team;
- Communication will include email, phone and in-person contact.

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.

These programs and initiatives align with the Commonwealth's strong commitment to enhancing the services available for nursing facility residents, providing as many viable paths as possible to the community for those who can safely transition, and increasing the number of services available within the community to support individuals who remain within or transition to the community.

The Executive Office of Health and Human Services (EOHHS), MassHealth, the Executive Office of Elder Affairs (EOEA), and the Department of Mental Health (DMH) are working

closely to ensure coordination of all programs that provide enhanced resources and supports for nursing facility residents and to limit redundancy across programs. Additional information will be provided in a webinar on Thursday, June 22, 2023.

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