



Helping Ohioans Move, Expanding Choice  
Ohio's Money Follows the Person (MFP)  
Demonstration Project  
CFDA # 93.791



# Community Living Specialist

## “HOW-TO” Guide

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## Introduction

This guide will help community living specialists (CLS) determine the needs and desires of Ohioans seeking a return to community living. The CLS service is a service under the HOME Choice Transition program, a component of the Money Follows the Person (MFP) Demonstration Grant. HOME Choice Transition Program services include the following:

<b>HOME Choice Demonstration Services</b>	<b>HOME Choice Supplemental Services</b>
Independent Living Skills Training	Housing Navigation
Community Support Coaching	Emergency Rental and Utility Assistance
HOME Choice Nursing Services	<b>Community Living Specialist</b>
Social Work/Counseling	
Nutritional Consultation	
Communication Aids	
Community Transition Services	
Respite Services	
Transition Coordination	
Service Animals	
Case Management for non-waiver participants	

This “how to” guide focuses on the Community Living Specialist Service and includes the following sections:

- Roles and Responsibilities
- Data Use Agreements
- CLS Process
- CLS Reporting and Payment
- Interface with the HOME Choice Transition Program
- Helpful Resources

## Roles and Responsibilities

The nursing facility, local and state partners, case managers, and a transition coordinator (when applicable) may play a key role on the discharge planning team. A team approach is critical to successful community living! Communication and collaboration is very important to successful information sharing and to continuity of care within community settings. Listed below are the roles and responsibilities of entities involved in information, referral, care planning and continuity of care.

Roles and Responsibilities	
Nursing Facility	<p><b>The Lead Care Planner on the Discharge team</b></p> <ul style="list-style-type: none"> <li>○ Discharge Planning responsibility under CFR 483.20(1) (3).</li> <li>○ Completes the Care Area Assessment Tool titled “Return to Community Living”.</li> <li>○ Conducts follow-up assessments and care planning to support individuals achieving the highest level of functioning until the resident is discharged from the facility. This includes collaboration in a thorough assessment of needs and care planning to support the choice to return to community.</li> <li>○ Develops a comprehensive person-centered care plan for each resident.</li> </ul>
HOME Choice Operations Unit	<p><b>State Contact (the MDS Section Q Manager, operations manager, facilitator, and monitor)</b></p> <ul style="list-style-type: none"> <li>○ Manage the Minimum Data Set (MDS) data for dissemination to CLS providers.</li> <li>○ Track the disposition and timeliness of CLS services.</li> <li>○ Assure compliance with the CLS provider agreement.</li> <li>○ Process applications for the HOME Choice Transition Program.</li> <li>○ Monitor participants enrolled in HOME Choice for health and welfare upon return to community living.</li> </ul>
Community Living Specialist (CLS) Providers	<p><b>The Initial Information and Referral Source</b></p> <ul style="list-style-type: none"> <li>○ Provide information, within timelines established by and outlined in the CLS provider agreement, about choices of services and supports in the community that are appropriate to meet the individual’s needs.</li> <li>○ Collaborate with the NF to organize the transition to community living if possible.</li> </ul>
Pre-Transition Case Manager	<p><b>Pre-Transition Case Management for Medicaid Residents – a Member of the Discharge Team</b></p> <ul style="list-style-type: none"> <li>○ Assess whether a HOME Choice applicant is eligible to participate in the HOME Choice program.</li> <li>○ Provide pre-transition services and oversight to ensure a successful transition to the community.</li> <li>○ Reviews the list of Transition Coordination agencies with</li> </ul>

	<p>the applicant and enters the applicant’s preferred choice of a transition coordination agency.</p> <ul style="list-style-type: none"> <li>○ Works in conjunction with the transition coordinator.</li> <li>○ Hands off all information to case manager once transition is complete.</li> </ul>
<p>Transition Coordinator</p>	<p><b>Transition Assistance for Medicaid Residents – a Member of the Discharge Team</b></p> <ul style="list-style-type: none"> <li>○ Assist with the completion of the HOME Choice participant workbook that helps the participant formulate a transition plan, if needed.</li> <li>○ Participate in team meetings as scheduled by the case manager.</li> <li>○ Participate in discharge planning from the institutional setting.</li> <li>○ Arrange, secure or provide transportation for the participant for the purpose of visiting community resources, e.g., to potential housing units or the social security office, or to purchase goods and services, etc.</li> <li>○ Provide housing navigation that assists the participant in securing appropriate housing when moving from an institutional setting to a qualified residence.</li> <li>○ Assist the resident in connecting to benefits.</li> </ul>
<p>Case Manager</p>	<p><b>Case Managers for Community Living – Medicaid or non-Medicaid Residents – A Member of the Discharge Team</b></p> <ul style="list-style-type: none"> <li>○ Educate individual and/or guardian about services and supports available.</li> <li>○ Organize and lead team meetings (pre and post discharge).</li> <li>○ Develop service plan (includes Qualified, Demonstration and Supplemental Services) and coordinate service provision.</li> <li>○ Assist with linkages to service providers.</li> <li>○ Incident reporting and protection from harm activities.</li> <li>○ Ongoing monitoring while in community.</li> <li>○ Access to 24 hour assistance.</li> <li>○ Assist with development of back up plan.</li> <li>○ Assistance with completing housing subsidy paperwork as needed.</li> </ul>
<p>Service Providers</p>	<p><b>The Community Connection – A Member of the Discharge Team</b></p> <ul style="list-style-type: none"> <li>○ Provide services and supports.</li> <li>○ Monitor delivery of services and supports and assure health and welfare of the individual once s/he returns to community living.</li> </ul>

## Data Use Agreements

The Medicaid Agency MDS Data Use Agreement is required to perform CLS services. Once the Ohio Department of Medicaid (ODM) receives the provider agreement, ODM will send the MDS data use agreement to the CMS for signature and will not release names to the potential CLS until the data use agreement is returned.

## CLS Step by Step Process

STEPS	RESPONSIBLE ENTITY	ACTIVITY
1	Nursing Facility	The NF completes MDS 3.0, in accordance with CMS training, at admission, quarterly, annually, and for significant changes in status, and asks the individual if s/he is “interested in speaking with someone about the possibility of returning to the community”. If yes, the NF checks “yes” on 0600 and initiates care planning. The NF pre-populates the CMS brochure #11477. The NF then provides a copy of this brochure to the resident.
2	Statewide MDS Section Q Manager	<p>The Statewide MDS Section Q Manager will use MDS data received in the ordinary course of business as the NF submission of MDS Section Q information. The Statewide MDS Section Q Manager will pull a weekly MDS report to include the following information:</p> <p>Two reports will be generated internally on a weekly basis using MDS 3.0 data: (1) residents under the age of 60, and (2) residents over the age of 60. The following fields will be used in the reports: County, Provider Name, Provider Number, Provider Address, Provider Telephone Number, Resident Last Name, Resident First Name, Social Security Number (SSN), Medicaid ID# if applicable, age including date of birth, days in NF, Type of Assessment, Date of Assessment, ADL’s, and RUG Group, among others.</p> <p>The Statewide MDS Section Q Manager will review the weekly reports and will break out the data into residents with Medicaid, and those residents will be referred to the CLS for an in-person visit, and residents whom are non-Medicaid and those residents will be referred to the CLS for information and referral via <i>phone</i>. The Statewide MDS Section Q Manager will then notify the appropriate Community Living Specialist (CLS) provider.</p>
3	CLS provider	<p><u>For residents receiving Medicaid benefits</u>, the CLS will contact the resident (and guardian as applicable) <i>by phone</i> within three working days of notification to:</p> <ul style="list-style-type: none"> <li>▪ Determine if resident wishes to receive CLS services and to determine whether those services will be delivered by phone or in-person.</li> <li>▪ The CLS shall then schedule an in-person meeting or phone</li> </ul>

		<p>call with the resident, his/her family/guardian (when applicable) and the nursing facility discharge planner (when requested by the person) to identify resources to facilitate the resident’s discharge goals and preferences (Medicaid and non-Medicaid). This in-person meeting should occur within 10 working days of notification unless the resident requests otherwise.</p> <ul style="list-style-type: none"> <li>▪ The CLS will gather necessary resources in preparation for the meeting and will lead the meeting with the resident.</li> <li>▪ The CLS will establish next steps through the completion of a <b>Community Living Plan Addendum (CLPA) (entry into the CLPA web application)</b> which includes, but is not limited to, a list and source for applications to necessary programs, phone numbers needed to assure continuity of care, and any steps needed to locate and secure housing and accommodations.</li> <li>▪ The CLS will assist the resident in making initial contacts with potential resources during and/or following the in-person meeting as needed.</li> <li>▪ If the resident requires transition coordination and meets HOME Choice eligibility requirements, the CLS will assist the resident in completing the HOME Choice application and will ensure that the HOME Choice Operations Unit receives the application for processing.</li> <li>▪ At the conclusion of the meeting, the CLS shall have the resident sign the attestation form verifying that the in-person meeting occurred.</li> <li>▪ The CLS will send the resident, <i>via mail</i>, within 5 working days of the in-person meeting, a copy of the written Community Living Plan Addendum. The CLS shall also provide the resident with a copy of the HOME Choice Relocation Workbook if applicable, unless the resident is also an applicant to the HOME Choice Transition Program. All applicants to the HOME Choice Transition Program receive a relocation workbook from the HOME Choice Operations Unit.</li> </ul>
4	CLS Provider	<p><u>For residents who are non-Medicaid</u>, the CLS will contact the resident, <i>by phone</i> :</p> <ul style="list-style-type: none"> <li>▪ The CLS will identify the resident’s discharge goals, previous efforts within the community, and any informal support systems.</li> <li>▪ The CLS will identify resources to facilitate the resident’s discharge goals and preferences (Medicaid and non-Medicaid).</li> <li>▪ The CLS will provide, <i>via mail</i>, a list and source for applications to necessary programs, phone numbers needed</li> </ul>

		<p>to assure continuity of care, and any steps needed to locate and secure housing and accommodations.</p> <ul style="list-style-type: none"> <li>▪ The CLS provider may choose to meet in-person with non-Medicaid residents. <u>Information by phone is a minimum standard.</u></li> <li>▪ The CLS will submit the <b>Non-Medicaid Tracking Sheet</b> on the 15<sup>th</sup> of each month following the referral month.</li> </ul>
5	Statewide MDS Section Q Manager	<p><u>For residents receiving Medicaid benefits</u>, the Statewide MDS Section Q Manager will run a report in the CLPA web application to summarize all completed <b>Community Living Plan Addendums</b> and will provide approval to the financial management service to provide payment to the CLS.</p> <p>The Statewide MDS Section Q Manager will reconcile all weekly submissions to CLS providers, prevent duplication when possible, and will monitor compliance with provider agreements.</p>

For consistency and continuity of care, each CLS is required to have a resource kit of information which contains a detailed description of the programs and services provided by community, social, health, and government organizations.

### **CLS Reporting and Payment**

CLS providers are required to obtain a signature from the resident on the **attestation form** (attachment). These attestation forms should be filed and available for review at HOME Choice Operation Unit's request. CLS Providers will receive a monthly compliance report from the Statewide MDS Section Q Manager and will be expected to meet compliance.

CLS providers meeting all requirements outlined within the provider agreement for an in-person visit with a Medicaid resident shall receive \$150 per resident. CLS providers meeting all requirements outlined within the provider agreement for a phone call with a Medicaid resident shall receive \$30 per resident.

## **Interface with the HOME Choice Transition Program**

CLS providers shall assist residents in completion and submission of a HOME Choice Application for ALL residents meeting HOME Choice Transition Program Participant Requirements. The requirements are as follows:

- The resident has Medicaid Claims within the last 90 days while in the inpatient facility.
- The resident is likely to move to a qualified residence as defined by the HOME Choice Transition Program.
- The HOME Choice Operations Unit will share the completed CLPA with the HOME Choice pre-transition case manager and/or the transition coordinator.

## **Helpful Resources**

[Section Q of the MDS 3.0](#)

[Link to Attestation Form](#)

[HOME Choice Transition Program Application](#)

[CMS Brochure #11477](#)

[HOME Choice Relocation Workbook](#)

[HOME Choice website](#)

[Community Living Specialist website](#)