HOME Choice

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

MFP
MONEY FOLLOWS THE PERSON

Community Living Specialist

"HOW-TO" Guide

October, 2010

Helpful Resources

Attachment 1: Section Q of the MDS 3.0
Attachment 2: CLS Provider Agreement and Attachments
Attachment 3: Community Living Plan Addendum and Tracking Sheet
Attachment 4: HOME Choice Transition Program Application
Attachment 5: Description of HOME Choice Qualified Residences
Attachment 6: Sample Cover Letter to the Community Living Plan
Attachment 7: CMS Brochure #11477
Attachment 8: ODJFS Cover Letter Announcing LCA to NF
Attachment 9: HOME Choice Relocation Workbook
Attachment 10: HOME Choice Fact Sheet and Contact Information

Attached Together

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 Demonstration Grant. HOME Choice Transition Program services include the following:

HOME Choice Demonstration Services	***HOME Choice Supplemental Services***
Independent Living Skills Training	Transition Coordination
Community Support Coaching	Community Transition Services (pre-discharge)
HOME Choice Nursing Services	Communication Aids
Social Work/Counseling	Service Animals
Nutritional Consultation	Community Living Specialist
Community Transition Services (post-discharge)	
Respite Services	
Care Management for State Plan only participants	

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

- Roles and Responsibilities
- How to become a CLS provider
- CLS Step by Step Process
- CLS Reporting and Payment
- Interface with the HOME Choice Transition Program
- Helpful Resources

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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	**The Lead Care Planner on the Discharge team** o Discharge Planning responsibility under CFR 483.20(1)(3). o Completes the Care Area Assessment Tool titled "Return to Community Living". o Conducts follow-up assessments and care planning to support individuals in 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. o Develops a comprehensive person-centered care plan for each resident.
HOME Choice Intake and Care Coordination Unit	**State Contact (the policy developer, operations manager, facilitator, and monitor)** o Manage the MDS data for dissemination to Community Living Specialists. o Track the disposition and timeliness of Community Living Specialist services. o Follow-up with CLS providers on referrals accepted to assure timeliness and completion of CLS services. o Assure compliance with the CLS provider agreement. o Process applications for the HOME Choice Transition Program. o Monitor for health and welfare upon return to community living.
PASRR State MH/DD Authorities	**State MH/DD Authorities** o Determine whether placement for persons with MH and/or DD in Ohio Nursing Facilities is appropriate. o Clarify needs and help identify and recommend alternative supports.
Community Living Specialist	**The Initial Information and Referral Source** o Provide information, within timelines established by the ODJFS HCICCU as outlined in the provider agreement, about choices of services and supports in the community that are

	appropriate to meet the individual's needs. ○ Collaborate with the nursing facility to organize the transition to community living if possible.
Transition Coordinator (when applicable)	**Transition Assistance for Medicaid Residents – a Member of the Discharge Team** ○ Assist with the completion of the HOME Choice participant workbook that helps the participant formulate a transition plan, if needed. ○ Participate in team meetings as scheduled by the case manager. ○ Participate in discharge planning from the institutional setting. ○ 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. ○ Provide Housing navigation that assists the participant in securing appropriate housing when moving from an institutional setting to a qualified residence. ○ Assist the resident in connecting to benefits.
Local Administrators/Case Managers	**Case Managers for Community Living – Medicaid Residents – A Member of the Discharge Team** ○ Educate individual and/or guardian about Services and Supports available. ○ Organize and lead team meetings (pre and post discharge). ○ Develop service plan (includes Qualified, Demonstration and Supplemental Services) and coordinate service provision. ○ Assist with linkages to service providers. ○ Incident Reporting and Protection from Harm activities. ○ On-Going Monitoring while in community. ○ Access to 24 hour assistance. ○ Assist with development of back up plan. ○ Assistance with completing housing subsidy paperwork as needed.
Service Providers	**The Community Connection – A Member of the Discharge Team** ○ Provide services and supports. ○ Monitor delivery of services and supports and assure health and welfare of the individual once s/he returns to community living.

How to become a CLS provider

Ohio will accept provider applications to perform CLS services from the following groups:

- PASSPORT Administrative Agencies
- Centers for Independent Living
- Brain Injury Association of Ohio
- County Boards of DD or Councils of Government
- ODMH designated Mental Health agencies and Peer Centers
- ODJFS approved non-profit agencies

The provider agreement is contained within the **"Helpful Resources" section** of this guide. The Medicaid Agency MDS Data Use Agreement is required to perform CLS services. Once ODJFS receives the provider agreement, ODJFS will send the MDS data use agreement to the Centers for Medicare and Medicaid Services for signature and will not release names to the potential CLS until the data use agreement is returned.

CLS Step by Step Process

CLS services will phase in by population group.

Elderly	Phased in beginning November 1, 2010
Physical Disability, TBI, DD	Phased in by January 1, 2011
Mental Health	Phased in by March 1, 2011

STEPS	RESPONSIBLE ENTITY	ACTIVITY
1	Nursing Facility	The nursing facility 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 nursing facility checks "yes" on 0600 and initiates care planning. The nursing facility pre-populates the CMS brochure #11477 as shown in attachment #7 (and located at http://go.usa.gov/xTe). The nursing facility then provides a copy of this brochure to the resident.
2	HCICCU	The ODJFS HOME Choice Intake and Care Coordination Unit (HCICCU) will use MDS data received in the ordinary course of business as the Nursing Facility submission of Section Q information. The HCICCU will pull a weekly MDS report starting the week of November 1, 2010 to include the following fields:

Four reports will be generated internally on a weekly basis using MDS 3.0 data: (1) LCA>60, (2) LCA<60, (3) TBI, and (4) DD. The following fields will be used in the reports: County, Provider Name, Provider No., Provider Address, Provider Telephone No., Resident Last Name, First Name, SSN, DOB, Type of Assessment, Date MDS Complete, Indicators of SMI, Payor Source, ADL, RUG Group, Entry Date, and Type of Entry.

The following filters will be used to populate each of the reports (duplication will be avoided on a quarterly basis):

1. For LCA>60, select and list assessments with:
[Q0300(A) = 1 OR 9] AND
[Q0400(B) = 1] AND
[Q0500(B) = 1 OR 9] AND
[Q0600 = 1 OR 2] AND
[DOB = equal to or >60 years old] AND
[A1800 is not equal to 04 or 06] AND
[A2000 is blank - not discharged] AND
[I5500 = 0] AND
[A1550(Z) = 1]
Note: Some of the fields may be left blank as long as DD and TBI are not present

2. For LCA<60, select and list assessments with:
[Q0300(A) = 1 OR 9] AND
[Q0400(B) = 1] AND
[Q0500(B) = 1 OR 9] AND
[Q0600 = 1 OR 2] AND
[DOB = <60 years old] AND
[A1800 is not equal to 04 or 06] AND
[A2000 is blank - not discharged] AND
[I5500 = 0] AND
[A1550(Z) = 1]
Note: Some of the fields may be left blank as long as DD and TBI are not present

3. For TBI, select and list assessments with:
[Q0300(A) = 1 OR 9] AND
[Q0400(B) = 1] AND
[Q0500(B) = 1 OR 9] AND
[Q0600 = 1 OR 2] AND
[I5500 = 1]

4. For DD, select and list assessments with:
[Q0300(A) = 1 OR 9] AND

		[Q0400(B) = 1] AND [Q0500(B) = 1 OR 9] AND [Q0600 = 1 OR 2] AND [A2000 is blank - not discharged] AND [I5500 = 0] AND [A1550(A) = 1 OR A1550(B) = 1 OR A1550(C) = 1 OR A1550(D) = 1 OR A1550(E) = 1] AND [A1550(Z) = 0] Note: Some of the fields may be left blank as long as TBI is not present. The HCICCU will review the weekly report and will first break out the data into the following three categories: ▪ Residents with less than a 90 day stay will not be referred to the CLS. ▪ Residents with greater than 90 days, Medicaid, will be referred to the CLS for a *face to face* visit. ▪ Residents with greater than 90 days, non-Medicaid, will be referred to the CLS for information and referral via *phone*. The HCICCU will then notify the appropriate Community Living Specialist (CLS).
3	CLS	<u>For residents receiving Medicaid benefits</u>, the CLS will contact the resident (and guardian as applicable) *by phone* within three days of HCICCU notification to: ▪ Begin research using the Connect Me Ohio website and any other sources of information available. The CLS will identify the resident's discharge goals, previous efforts within the community, and identify any informal support systems using the Ohio Community Living Guide. ▪ The CLS shall schedule a face to face meeting 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 face to face meeting should occur within 7 working days of initial phone contact unless the resident requests otherwise. ▪ The CLS will gather necessary resources in preparation for the face to face meeting. <u>For residents who are non-Medicaid</u>, the CLS will contact the resident *by phone* within three days of HCICCU notification and begin research using the Connect Me Ohio website and any other source of available information.

		▪ The CLS will identify the resident's discharge goals, previous efforts within the community, and any informal support systems. ▪ The CLS will identify resources to facilitate the resident's discharge goals and preferences (Medicaid and non-Medicaid). ▪ The CLS will provide, *via mail*, 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. ▪ The CLS provider may choose to meet face to face with non-Medicaid residents. Information by phone is a minimum standard.
4	CLS	For residents receiving Medicaid benefits, the CLS will lead the face to face meeting with the resident. ▪ The CLS will share the results of his/her research through Connect Me Ohio. ▪ The CLS will establish next steps through the completion of a **Community Living Plan (as populated by the Connect Me Ohio website and any other information source)** 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. ▪ The CLS will assist the resident in making initial contacts with potential resources during and/or following the face to face meeting as needed. ▪ If the resident requires transition coordination and meets HOME Choice eligibility requirements, the CLS will assist the resident in completing the application and will ensure that the HOME Choice Intake and Care Coordination Unit receives the application for processing. ▪ At the conclusion of the meeting, the CLS shall have the resident sign that the Community Living Plan Addendum verifying that the face to face meeting occurred.
5	CLS	For residents receiving Medicaid benefits, the CLS will send the resident, *via mail*, within 5 working days of the face to face meeting, a copy of the written Community Living Plan and Addendum. The CLS shall also provide the resident with a copy of the HOME Choice Relocation Workbook.
6	CLS	For residents receiving Medicaid benefits, and within 5 working days of the face to face meeting, the CLS shall also submit the **Community Living Plan Addendum** to the ODJFS HCICCU prior to release of payment by the fiscal intermediary.

		For residents who are non-Medicaid, the CLS will submit the **CLS Tracking Sheet** at least monthly.
7	HCICCU	For residents receiving Medicaid benefits, the HCICCU will data enter the information contained on the **Community Living Plan Addendum** and will provide approval to the fiscal intermediary to provide payment to the CLS.
8	HCICCU	The HCICCU will reconcile all weekly submissions to CLS providers, prevent duplication when possible, and will monitor compliance with provider agreements.

For consistency and continuity of care, each CLS is required to use, at a minimum, the Connect Me Ohio website which contains a detailed description of the programs and services provided by community, social, health, and government organizations. The information is searchable using a variety of criteria and the programs are indexed according to a hierarchical classification system. Use of Connect Me Ohio is a requirement within the provider agreement and is necessary to Ohio moving toward a "no wrong door" system that assures timely access to services and supports across disability groups.

CLS Reporting and Payment

CLS providers are required to obtain a signature from the resident on the **Community Living Plan Addendum** (contained in the "Helpful Resources" Section). Payment will not be released without a signature and completion of all data fields contained in the addendum. The HCICCU will notify the fiscal intermediary to release payment following receipt of an accurate and signed addendum.

CLS providers meeting all requirements outlined within the provider agreement shall receive $150 per Medicaid resident receiving CLS services.

CLS providers will not receive payment for Medicaid residents if the tracking sheet for non-Medicaid residents is not received per the provider agreement.

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, or will have, at least 90 days within the nursing facility (or a continuous stay of 90 days in a combination of hospital/ICFMR facilities/nursing facilities).
- The resident has Medicaid Claims while in the inpatient facility.
- The resident is likely to move to a qualified residence as defined by the HOME Choice Transition Program. See "Helpful Resources" for a description of qualified residences.