Senior LinkAge Line®
Community Living Specialist and Designated Client Services Center Protocols

Version 6.4

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Table of Contents

Appendices

1 Overview of the Return to Community Initiative

1.1 Background and Legislative Authority

The Return to Community initiative (RTCI)—a service of the Senior LinkAge Line® (SLL)—was originally developed through changes to Minnesota Statute 256.975, subdivision 7, paragraph 11, during the 2009 legislative session. In April 2010, RTCI began by targeting nursing home residents who have been in a nursing facility for at least 60 days and meet a set of health and functional criteria.

Statutory changes during the 2013 legislative session expanded in-person assistance to consumers who are considering a move to assisted living/registered housing with services. In addition, "consumers who appeared on the target list after 60 days in the nursing home" was modified to "after 45 days". These changes took effect in March 2014.

RTCI was developed based on research conducted by Dr. Greg Arling, Indiana University Center for Aging Research and Dr. Robert Kane, University of Minnesota School of Public Health. Their research showed that there are more than 60,000 admissions to Minnesota nursing homes each year. While many people discharge back to the community naturally, a small number stay in the nursing home for months or years and spend down to Medicaid. The longer a person stays, the less likely they are to return to the community and the more likely they are to spend down. A 90- to 180-day window after admission is the ideal time period to target residents for community transition. Targeting people earlier in the aging process enables people to make better decisions about their long-term care needs and using their resources more efficiently.

Consumers are identified based on the Minimum Data Set (MDS) assessment that is conducted within 14 days of admission to the nursing facility. The MDS is a comprehensive assessment that is conducted nationally in nursing homes. At a minimum, an MDS is completed for each nursing home resident upon admission, quarterly and annually. Additional assessments can also be completed if residents have significant health decline or improvement, or if they are residing in the nursing home and Medicare Part A is paying for the stay.

1.2 MDS Profile Lists

MDS profile lists are developed in collaboration with the Minnesota Department of Health, University of Minnesota and the Minnesota Department of Human Services. Profile lists are securely shared with Senior LinkAge Line® Community Living Specialists via Web Referral. Consumers appear on the profile list if they:

- Have resided in a nursing facility for at least 45 days
- Have a goal to return to a community setting, based on Section Q of the MDS, and
- Have a 70% or higher probability rate of being successful in the community, based on their health and functional characteristics as recorded upon admission.

1.3 Changes to the MDS and Intersection with Return to Community

In October 2010, significant changes were made to the MDS. These included changes to Section Q. Also known as the Discharge Potential section, it is completed with residents upon admission to the nursing home to determine their discharge goals.

Most residents have a goal to return to the community setting where they resided prior to admission. Residents are also asked questions to find out if they would like to speak to someone about returning to a community setting. If yes, the nursing home makes a referral to the local contact agency. In Minnesota, the local contact agency (LCA) is the Senior LinkAge Line®.

A Section Q referral to the Senior LinkAge Line® does not guarantee that a resident will discharge from the nursing home. It simply provides an opportunity for the resident to learn about his/her options. Minnesota was able to easily implement the Section Q referral protocol due to two strategies that had been implemented prior to the MDS Section Q changes:

- The Return to Community initiative, which requires the Senior LinkAge Line® to provide statewide in-person assistance to private-pay nursing home residents who want to return to a community setting.
- The requirement that all Senior LinkAge Line® specialists have expertise in providing Long Term Care Options Counseling.

Later in the protocol, you will see how MDS Section Q referrals are triaged to Community Living Specialists (CLS) for in-person assistance, if necessary, after receiving Long Term Care Options Counseling from a Senior LinkAge Line® phone based specialist.

1.4 Evaluation of the Return to Community Initiative

Purdue University and the University of Minnesota have been awarded a grant from the Agency for Health Research and Quality (AHRQ) to study the implementation and effectiveness of the Return to Community initiative over the three-year period from September 2012 - September 2015. The Minnesota Department of Human Services (DHS) and Minnesota Board on Aging (MBA) will use findings of the study to inform public policy and improve the RTCI.

The study has three major components:

- Evaluation of the success of the RTCI in facilitating community discharges, delaying Medicaid conversion, and producing Medicaid cost savings, while avoiding undesired outcomes such as increased acute care use or nursing home re-admissions among persons returning to the community.
- Interviews and case studies of the experiences and perceptions of major stakeholders in the RTCI, including Senior LinkAge Line® Community Living Specialists, Client Services Center Specialists, nursing home staff, and residents and their families.

- Refinement of protocols and operational procedures and development of materials that can be disseminated to others interested in developing a similar initiative.

Data collected in the CLS section of Web Referral is continually provided to Dr. Arling and the research team in order to continuously evaluate the service and the health and functional needs of consumers who are being served.

1.5 In-Person Visits

Beginning April 1, 2014 consumers who appear on the MDS profile list and are not open to Medical Assistance will receive in-person visits by Senior LinkAge Line® Community Living Specialists to determine their discharge status. In-person visits will be conducted for the following reasons:

- To ensure consumers receive unbiased information regarding their options for residing in the community
- To make consumers aware that they have the right to live in the least restrictive environment, per United States Supreme Court determination through *Olmstead v. L.C.*
- To validate the MDS Profile List for purposes of the evaluation that is being conducted through the AHRQ grant.
- To comply with the Center for Medicare and Medicaid's (CMS) expectation in the RAI Manual for MDS Section Q Version 3.0 (page Q-16, May 2013) which states, "Some States may determine that the LCAs can make an initial telephone contact to identify the resident's needs and/or set up the face-to-face visit/appointment. However, it is expected that most residents will have a face to face visit."

2 Goals

2.1 Goals for Consumers

- Understand services may be available to help consumers return to or stay in the community setting of their choice
- Be made aware of choices for community supports and get assistance connecting to the supports chosen
- Be able to confidently select where and how to live
- Receive a comprehensive person-centered Community Living Support Plan that will be utilized while residing in a community setting

2.2 Goals for Senior LinkAge Line® Community Living Specialists

- Understand protocols and steps that will be followed to assist a consumer who wants to relocate from a nursing home back to the community or to assist a consumer to remain in the community
- Utilize and be able to explain community supports that may be available and how the consumer may use their own resources to pay for the supports
- Act as an advocate for the consumer, based on desire to return to the community
- Empower the consumer to make choices about supports in the community
- Work with designated caregivers to help them support the consumer and provide resources, if wanted
- Collect comprehensive consumer and caregiver data in a secure, efficient and timely manner in compliance with Senior LinkAge Line® standards and assurances
- Develop a comprehensive, person-centered Community Living Support Plan using templates designated by the Minnesota Board on Aging Consumer Choices Team
- Ensure communications, including standard follow-ups with providers, consumers or caregivers are handled in a timely, respectful and efficient manner
- Understand and convey Senior LinkAge Line® information and concepts to providers that interact either through a mandate or upon voluntary request with the MinnesotaHelp Network™ (hospitals, nursing facilities and health care homes)
- Meet performance standards for inquiries

3 Key Concepts

- The Return to Community initiative is not a program, but an in-person service of the Senior LinkAge Line® available at no cost to non-Medicaid consumers who want to relocate from a nursing home back to the community or who are considering a move to a registered housing with services setting or assisted living and would benefit from support planning.
- The Return to Community initiative is targeted to private-pay (non-Medicaid) consumers in Minnesota.

  - Consumers who are on Medicaid (Medical Assistance or MA in Minnesota), Alternative Care (AC) or a Medicaid managed care plan are referred to their county case workers/managed care coordinators for relocation assistance.
  - Consumers who are moving out of Minnesota or currently reside in another state and want to relocate to Minnesota will not be assisted by a CLS with in-person assistance, but instead be referred to the local Aging & Disability Resource Center (ADRC) for phone-based options counseling.
- Return to Community is a research-based initiative developed by Dr. Greg Arling at Purdue University Center on Aging and Dr. Robert Kane at the University of Minnesota. Comprehensive and accurate data collection in Web Referral is absolutely critical, as this service is being evaluated at various levels.
- Health-care providers who would like more information about the in-person assistance provided by Senior LinkAge Line® Community Living Specialists should be referred to DHS Bulletin #14-25-02.

4 Types of Consumers Served

4.1 MDS Profile Names

- On a weekly basis, each CLS will be assigned "New Return to Community Consumer" Follow-Ups in Web Referral for consumers who meet the targeted profile list based on their admission MDS assessment in the nursing home.
- Consumers will be assigned to the CLS based on the Area Agency on Aging (AAA) region where the nursing home is located and their Medicaid (Medical Assistance or MA in Minnesota) or Alternative Care (AC) status.

4.2 Consumers Previously Assisted by CLS

- Consumers who are not on MA, have previously received discharge assistance from a CLS and are readmitted to a nursing home will be referred to the CLS.
  - If a consumer who was previously assisted by a CLS is back in the nursing home and now open to Medical Assistance, a referral should not be made to the CLS as the county/managed care organization will be notified by a PAS specialist.
- When a Pre-Admission Screening (PAS) is requested for nursing home admission, Senior LinkAge Line® PAS Specialists will review the Community Planning Tool screen in Web Referral to determine if the consumer was directly assisted by a CLS in the past and assign a Contact Consumer Follow-Up in Web Referral to the CLS who directly assisted the consumer during the most recent discharge.
  - If the CLS who directly assisted the consumer in the past is no longer employed by the AAA, follow-up will be assigned to the CLS who serves the nursing homes' county. The SLL PAS specialist will continue to process the

PAS, but will not schedule any follow-up even if the consumer falls into a PAS-targeted follow-up group.

4.3 Consumers Considering a Move to a Registered Housing with Services

- CLS in-person support planning assistance will be offered to those consumers considering a move to a registered housing with services/assisted living setting, not on MA who decide to remain at home or are undecided after a 10 Day Follow-Up.
- When SLL phone specialists provide options counseling to the consumer and follow-up 10 days later, a CLS visit to the home in the community will be offered. If the consumer accepts this referral, the SLL phone specialist will assign a Contact Consumer Follow-Up in Web Referral to the CLS who serves the consumer's county.

4.4 MDS Section Q, Online Referrals or Consumers/Caregivers Who Call the SLL

- Consumers who are referred to the SLL via the online referral or because a consumer/caregiver calls the SLL, are not on Medical Assistance, have been in a nursing facility for more than 30 days and request in-person assistance will be referred to the CLS for in-person assistance.
    - Consumers who are on Medical Assistance or managed care are referred to their county case workers/managed care coordinators for assistance.
- When SLL phone specialists provide options counseling to the consumer based on the online referral submitted, and the consumer requests in-person assistance or the SLL specialist determines that the consumer would benefit from in-person assistance, the SLL specialist will offer a CLS visit to the nursing home. If the consumer accepts the referral, the SLL specialist will assign a Contact Consumer Follow-Up in Web Referral to the CLS who serves the nursing home county.
    - Consumers who have been in a nursing facility for less than 30 days will receive phone-based follow-up from the Pre-Admission Screening Specialists unless otherwise requested by the consumer.

5 Exceptions

5.1 Consumer Located Outside MN or Moving Out of MN

- Consumers who are currently residing in a state other than Minnesota and would like to relocate back to Minnesota will be referred to the local ADRC for options counseling.
    - ADRCs are listed in Web Referral using Problem/Need 007.030 Directory Request and searching by **All Locations** vs. **Client Location**.
- Consumers who are currently residing in Minnesota and would like to discharge to a setting outside of Minnesota will receive phone-based options counseling and be connected to local ADRC/local contact agency based on consumer's discharge destination goal.
    - Includes consumers who are residing in Minnesota and are enrolled in North Dakota Medicaid.

- For consumers who end up moving out of state when the CLS is actively providing discharge assistance (an unknown fact when the assistance began), the CLS will conduct the three-day check in over the phone. The CLS will ensure the consumer has been connected to the ADRC based on the discharge location so further assistance can be provided if needed. CLS will not conduct any further follow-up once the three-day phone call has been completed.
- Consumers who discharge out of state without direct CLS assistance will not be assigned to the CSC for Initial or Quarterly Follow-Up.

5.2 Consumers Applying for MA or Have Pending Application

- Consumers who are under the age of 60 and not on Medical Assistance or have a pending Medical Assistance application will be given in-person assistance by the CLS if requested.
- Consumers who open to Medical Assistance or Alternative Care (AC) when a CLS is actively providing assistance will be warmly transferred to the county case worker/managed care worker once one has been assigned.
  - The CLS should continue to assist the consumer until a case manager/county case worker has been established.
  - The CLS should document this consumer as CLS Assisted
  - If the CLS is currently in the process of completing the 3, 14, 30, 60 or 90 Day Follow-Ups, the CLS will ask the county case worker/managed care coordinator for permission to continue these regularly scheduled Follow-Ups.
    - If permission is granted, the Follow-Ups will continue as scheduled.
    - If permission is not granted, the next scheduled quarterly Follow-Up will be assigned to the Client Services Center staff for completion.

5.3 Consumers Who Leave AMA

- Consumers who leave a nursing facility AMA (against medical advice) will continue to receive follow-up from the CLS if active discharge assistance was being provided at the time the consumer left AMA and consumer agrees to continue working with the CLS.
  - When a nursing home resident leaves a nursing facility AMA, the nursing home has an obligation to file a Vulnerable Adult Report. The CLS can also file a report if warranted, which may be due to the fact that the nursing facility did not file the report.
  - During 3 Day Follow-Up, the CLS should encourage a doctor's appointment as soon as possible to get orders for needed medications and services and assist with making arrangements that are needed to ensure consumers safety.
  - If consumer situation is too dangerous, the CLS can decline further follow-up but needs to file a Vulnerable Adult Report and contact the Consumer Choices Team.
    - Examples of a dangerous situation may include threatening behavior from the consumer/caregiver or dangerous living conditions. Do not hesitate to

contact the Consumer Choices Team to determine if follow-up should be declined or a report filed.

6 Definitions and Acronyms

6.1 Community Planning Tool (CPT)

The Community Planning Tool is a set of fields completed in Web Referral in order to determine the health and functional needs of the consumer and current status of the caregiver. This interview/assessment was developed in collaboration with the CLS, Dr. Arling and the Consumer Choices Team.

- The CPT consists of all fields in the CLS role of Web Referral. It is crucial to document the interaction with the consumer and the level of needs at the time of discharge.
- The CPT will be completed based on the health and functional level of the consumer at the time of discharge for those living in a nursing home.
- For those in the community, the CPT will be completed based on current health and functional needs at the time services and supports are arranged.

6.2 Community Living Support Plan (CLSP)

The Community Living Support Plan is a paper document that is completed for the consumer/caregiver which lays out home- and community-based services based on results of CPT. This document also allows consumers/caregivers to choose between providers based on cost and type of service.

- If consumer is residing in nursing home, this document is completed and signed prior to discharge when service options have been decided upon. Once the consumer is discharged from the nursing home, this marks the starting point of the regularly scheduled Follow-Ups.
- If consumer is residing in community setting, this document is completed and signed once service options have been decided upon. Once this document is signed in the community, this marks the starting point of the regularly scheduled Follow-Ups.

6.3 Release of Information—5-Year (ROI)

The Release of Information-5 Year is a paper document that is signed by the consumer or their designated representative which gives the CLS permission to obtain personal and medical information about the consumer. This document also grants permission to the Senior LinkAge Line® to provide five years of follow-up in the community for evaluation purposes. If this document is not signed, personal information cannot be collected and in-person assistance cannot be continued by the CLS. This document is attached to the appropriate CPT in Web Referral once completed. Examples of the permissions the ROI provides are stated below:

- Review and receive copies of consumer's medical chart at the nursing home
- Communicate with the nursing home staff regarding medical care
- Communicate with family members/friends authorized by consumer

- Consult with the consumer or family members about developing a support plan for returning to living environment of the consumer's choice
- Contact managed care coordinator, if applicable, regarding a discharge plan from the nursing home
- Contact county case worker, if applicable, regarding a discharge plan from the nursing home
- Communicating with medical professionals who are/have been involved in medical needs
- Communicating with home- and community-based service providers to arrange services on the consumer's behalf or assisting family members/friends in arranging services
- Communicating with the nursing home staff to create a supportive service plan for a return home
- Communicating and making a referral, if applicable, to the local Center for Independent Living regarding a discharge plan from the nursing home
- Communicate with nursing home staff after discharge to provide an update on the consumer's living situation in the community

6.4 Release of Information—1 Year (ROI)

The Release of Information-1 Year is a paper document sent to consumers who receive initial and quarterly follow-up from the Client Services Center and have not received direct discharge assistance from a CLS. The document grants similar permissions as the 5-Year ROI but expires after one year as direct discharge assistance was not provided by a CLS and therefore a support plan is not being maintained.

- This document is attached to the appropriate CPT in Web Referral once completed.
- This document must be renewed every year in order to maintain compliance with data collection rules.

6.5 Client Services Center (CSC)

The Client Services Center is staffed with designated SLL specialists who are located in the Slayton office of the Minnesota River Area Agency on Aging. Designated staff provide phone-based follow-up for consumers who are directly assisted by a CLS or naturally discharged with the assistance of the nursing home social worker, county case manager or managed care coordinator. Quarterly follow-up occurs with those directly assisted by CLS. Initial and quarterly follow-up occurs with those who are not directly assisted by CLS.

7 MinnesotaHelp Network™ Tools

7.1 Revation LinkLive™

Secure VOIP system used to conduct inbound and outbound calls to health-care providers, consumers and their designated representatives/caregivers.

- CLS/CSC will use the Community Living Hunt Group for all outbound calls related to RTCI.

- Inbound calls through Revation can be forwarded to a CLS' cell phone. Calls can be forwarded so that CLS can receive calls while they are out of the office but allow the calls to be securely recorded as they are being routed through Revation.
    - A step by step for setting this functionality in Revation is located on the Extranet.

7.2 Resource House Web-based Referral

Secure client tracking system used by all Senior LinkAge Line® specialists to track interactions with consumers, caregivers and health-care providers.

- All in-person/phone based assistance conducted by the CLS will be documented in the CLS role of Web Referral.
- Actual time spent with consumers, caregivers, health-care providers through RTCI is tracked in Web Referral sessions. The clock can be updated to reflect actual time spent providing the service when Web Referral is not actively being utilized. Examples include:
    - Meeting with consumer in nursing home to complete the CPT
    - Time spent researching services and supports in order to develop the CLSP
    - Driving to a nursing facility or consumer's home to complete in-person follow-up

7.3 Extranet

Secure intranet used by Senior LinkAge Line® specialists to document outreach events and to view trainings, protocols, and Information Memorandums.

- All presentations conducted by CLS are documented in the SLL Extranet calendar.

7.4 Medicaid Management Information System (MMIS)

CLS will either have individual access or use chat to contact the Benefits Look Up Hunt Group in Revation to determine if a consumer is on a public program or managed care health plan. Consumers should be reviewed in MMIS regularly to determine Medicaid status as they may have a case worker who should be involved in their support planning. Consumers who are on Medicaid will not be provided in-person assistance by a CLS.

8 High-Level Protocol for CLS Assistance Regardless of Consumer's Setting

All interactions with consumers, health-care providers, caregivers, counties, managed care organizations and any other relevant party related to the consumer will be documented in Web Referral. At a minimum, Problem/Need 050.010 Return to Community Transition Assistance will be used for all Inquiry and Follow-Up sessions.

8.1 CLS Schedules Appointment with Consumer

- If the consumer is their own responsible party, contact will be made with the consumer to gain an initial understanding of the particular situation, goals and preferences for the

consumer. Otherwise contact will be made with the legal representative after documentation is received showing that the caregiver has authority to speak for the consumer.

- If the consumer cannot be contacted due to lack of access to phone or is otherwise unable to be reached, the nursing home discharge planner or designated caregiver will be contacted in order to arrange a time for the CLS to visit.
    - Note: Consumers who appear on the MDS profile list will always be seen in-person to determine the discharge status and to see if they would like assistance returning to a community setting. The initial visit will occur within 3-5 business days of receiving the MDS profile names in Web Referral.
    - An in-person visit will not be completed 1) if the consumer has passed away, 2) is in the hospital at the time of contact, 3) has transferred to another nursing facility or 4) has already discharged prior to the CLS calling the nursing facility.
- See CLS Schedules Appointment with Consumer for more details.

8.2 CLS Initial Visit

- CLS visits consumer and explains the Senior LinkAge Line®, the Return to Community service and the follow-up that is conducted once a CLSP has been developed.
- See CLS Initial Visit for more details

8.3 CLS Obtains Verbal and Signed ROI—5-Year

- The CLS must obtain verbal consent and signed consent via the ROI—5-Year from the consumer/designated representative for each unique instance of assistance provided.
- See CLS Obtains Signed ROI—5-Year for more details

8.4 CLS Meets with Consumer/Caregiver to Complete CPT

- This can be entered directly into Web Referral or via a paper version which can be printed from Web Referral and entered at a later date.
    - If a paper version of the CPT is completed, the results must be kept in a locked backpack or laptop bag until data can be entered into Web Referral and then shredded for security purposes.
- See CLS Meets with Consumer/Caregiver to Complete CPT for more details

8.5 CLS Researches Services and Supports in Web Referral

- Home- and community-based services as well as volunteer services will be located in Web Referral based on the results of the CPT.
- If the CLS notes that services are missing in the database, the CLS shall report any errors or changes needed to the database by either a) using the Report Data Problem link at the top or bottom of the Service Details page, or b) emailing the problem to mnhelpdata@tcaging.com or c) by chatting with the Data Management Hunt Group in Revation.
- See CLS Researches Services and Supports in Web Referral for more details

8.6 CLS Drafts CLSP

- CLS presents support options to consumer and caregivers which displays a variety of providers and costs based on consumer needs and results of the CPT.
- Consumer chooses services based on preference.
- See CLS Drafts CLSP for more details.

8.7 CLS Finalizes CLSP

- Consumer or designated representative signs CLSP based on choices that will be utilized in the community.
- CLS works with consumer and appropriate health care professionals to ensure supports are arranged based on consumer preference.
- See CLS Finalizes CLSP for more details.

8.8 CLS Conducts In-Person Follow-Up

- CLS conducts in-person visit *within* 10 days of nursing home discharge or within 10 days of when final CLSP is signed by consumers who are already residing in community. At a minimum, consumers will receive a phone call within 72 hours of discharge or support plan development until the in-person visit can be conducted.
- See CLS Conducts In-Person Follow-Up for more details.

8.9 CLS Conducts Additional Follow-Up

- 30, 60 and 90 Day Follow-Ups can be conducted in-person or over the phone. The method for completion should be determined by what is best for the consumer and their particular situation.
- See CLS Conducts Additional Follow-Up for more details.

8.10 CSC Conducts Follow-Up

- CLS assigns 180 Day Follow-Up from NH DC or date CLSP was signed for consumers who did not discharge from a nursing facility to designated CSC specialists based on AAA region for continued follow-up.
- Consumers who naturally discharge regardless of how the consumer's name was provided to the CLS will be referred to the CSC for initial phone-based follow-up.
- Follow-up for naturally occurring discharges will begin 14 days from nursing discharge and then continue every 90 days for up to five years with consumer consent.
- See CSC Conducts Follow-Up for more details

9 Creating a New Community Planning Tool Session in Web Referral

- A new Community Planning Tool (CPT) will be created in the CLS role of Web Referral for every consumer served by the CLS no matter how the referral is received.
- Unique data will be captured in the CPT for each referral and nursing home admission.

- A Basic Data screen is present in the CLS role of Web Referral that is not part of the CPT session. The data on this screen will auto-fill the matching fields in the SLL role of Web Referral and the CPT session for the consumer.
- The Basic Data screen will be completed and/or updated for every consumer no matter how the referral is received by the CLS.
- Many fields in the CPT will carry over to a subsequent CPT should the consumer be served at a future date due to another nursing home admission. Detailed field-by-field descriptions regarding the screens in the CPT are found in the Senior LinkAge Line® Web Referral User Guide, located on the Extranet.

9.1 Documenting Discharge Situations

Regardless of how the CLS obtains a request for assistance, the following situations should be documented in the CLS Role of Web Referral in the following ways.

9.1.1 Returned to Hospital

- Consumers who have returned to the hospital and do not have a nursing facility bed hold will be considered discharged for tracking purposes.
    - Reason for Referral: Reason consumer referral was first received
    - Actual Discharge Date: Date consumer released the bed hold
    - Discharge Location: Hospital
    - Type of Discharge: Naturally Occurring
    - Log Note Heading: Consumer Result is Return to Hospital
    - No further follow-up conducted
- Consumers may again be assisted once they return to nursing home but a new CPT must be created in Web Referral to document the new instance of assistance.

9.1.2 False Positive

- Consumers who discharged prior to being in the nursing home for 45 days and appeared on the MDS profile list are considered False Positives.
    - Note: Consumers who appear on the MDS profile list but have already discharged from the facility appear because the nursing facility has not submitted an MDS Discharge Entry to the Minnesota Department of Health by the time the list was developed. The CLS should be confident that the MDS profile list is accurate and the consumer did in fact reside in the nursing facility even if the nursing facility staff states they have no record of the admission.
- The MDS profile lists are developed based on the MDS Admission Assessments submitted by Minnesota nursing facilities to the Minnesota Department of Health.
    - Reason for Referral: MDS Profile List
    - False Positive Discharge Date: Date the consumer discharged from nursing facility
    - Actual Discharge Date: Leave blank
    - Type of Discharge: Leave blank

- Discharge Location: Leave blank
- Log Note Heading: Consumer Result is False Positive
- No further follow-up conducted

9.1.3 Consumer Passed Away

- Consumers who passed away will be documented in Web Referral and no further follow-up will be conducted.
- Note: At any time, if the CLS/CSC is notified that a consumer has passed away, the date of death will be documented on the Discharge Information screen in Web Referral. If the client record in Web Referral has multiple CPT's, the most recent CPT will be accessed to add the Date of Death to the record.
  - Reason for Referral: Reason consumer referral was first received
  - Date of Death: Actual date of death
  - Type of Discharge: Leave blank
  - Discharge Location: Leave blank
  - Log Note Heading: Consumer Result is Passed Away
  - No further follow-up conducted

9.1.4 Consumer Transferred to Another Nursing Home

- Consumers who transfer to another nursing home will be considered discharged for tracking purposes.
  - Reason for Referral: Reason consumer referral was first received
  - Actual Discharge Date: Date consumer transferred to another nursing home.
  - Discharge Location: Another Nursing Home
  - Discharge Type: Naturally Occurring
  - Log Note Heading: Consumer Result is Transfer to Another NH
  - No further follow-up conducted
- Consumers may again be assisted in new nursing home but a new CPT must be created in Web Referral to document the new instance of assistance.

9.1.5 Consumer Staying Long-Term In Nursing Home

- If the designated representative or the consumer states they are staying long-term in the nursing home, information should be obtained regarding why they are not returning to a community setting. This reason should be obtained through a face-to-face visit with the consumer.
  - Reason for Referral: Reason consumer referral was first received
  - Reason Consumer Staying Long-Term: Appropriate reasons consumer is staying long-term in nursing facility
  - Source-Reasons Consumer Staying Long-Term: Who provided reasons for consumer staying long-term in nursing facility
  - Log Note Heading: Return to Community Process Stopped

- No further follow-up conducted

9.1.6 Consumers on MDS Profile List and Still in Nursing Home

- If none of the situations above are applicable and the consumer is still in the nursing home with or without discharge plans through the nursing home, the following steps should be followed:
- Consumers who appear on the MDS profile list are considered priority referrals. These consumers will always receive an in-person visit to determine discharge status from the nursing home and if they are interested in receiving in-person assistance from a CLS as well as follow-up in the community. If the consumer is discharging on the day of the call to the nursing home, an in-person visit is not required. See Consumers Who Discharge Naturally without CLS Assistance for details on how to document these situations in Web Referral.
    - This appointment can be made directly with the consumer or the nursing home discharge planner. Information should be obtained from the discharge planner to determine if the consumer is currently in the nursing home prior to the CLS visit at nursing facility. It is important to confirm the date the consumer was admitted to the nursing facility to ensure the situation is documented appropriately based on the MDS information that was uploaded to Web Referral for follow-up.

10 CLS Schedules Appointment with Consumer

10.1 Sample script to the discharge planner

"Hi, this is [insert name] Community Living Specialist from the Senior LinkAge Line® A One Stop Shop for Minnesota Seniors. I'm calling today because [insert consumer name] has appeared on my list as someone who could benefit from discharging to the community and I need to make an appointment to visit with them. I'll be in the area on [insert date and time] and will stop by to introduce myself and provide information about the Senior LinkAge Line® and our service. I'll make sure to stop by your office as well so we can touch base about my conversation with the consumer and next steps."

10.2 Sample script to the consumer

"Hi, this is [insert name] Community Living Specialist from the Senior LinkAge Line® A One Stop Shop for Minnesota Seniors. I'm calling today as I understand you may be interested in moving out of the nursing home and learning about options for returning home. I'd like to stop by and visit about some options you may have and services that may be available. I'll be in the area on [insert date and time]. Would it be okay if I stop by and see you?"

- If appointment is arranged via the consumer, verbal consent will be documented in Web Referral.
    - Reason for Referral: MDS profile list
    - Verbal Consent: Date consumer provided verbal consent
    - Log Note Heading: Return to Community Verbal Release of Information
    - Heard About SLL: MDS Profile List

10.3 Consumer is Not Interested in CLS Assistance

- If the consumer expresses that they are not interested in a CLS visit, the CLS will document in Web Referral and continue to communicate with the nursing home discharge planner to determine final discharge status for documentation and quarterly follow-up purposes. Initial Follow-Up (14 days from nursing home discharge) will still be scheduled to the CSC if the consumer discharges from the nursing home.
    - Reason for Referral: MDS profile list
    - Log Note Heading: Return to Community Transition Declined
    - Follow-Up Type: Contact Nursing Home should be scheduled for seven days later
    - Continue to follow up with the nursing home until the consumer's final discharge status is determined.
- An in-person visit is not required to determine discharge status for consumers who appear on the MDS profile but are discharging on the day the CLS is calling the nursing home. For tracking purposes, a discharge date, consumer contact information and other required information to complete the CPT should be obtained from the nursing home discharge planner so that initial and quarterly follow-up can be conducted by the CSC.

10.4 Consumers on MDS Profile List with Legal/Designated Representative

- Consumers who have legal or designated representatives to speak on their behalf need to be contacted and offered information about the in-person assistance from a CLS and benefits of follow-up in the community.
    - Documentation and contact information will be obtained from the nursing home or representative to confirm legal authority. If no legal authority exists but the consumer requests that you communicate with their designated representative, this request should be honored through verbal consent by the consumer.

10.4.1 Sample script to the legal representative/designated representative,

- "Hi, this is [insert name] Community Living Specialist from the Senior LinkAge Line® A One Stop Shop for Minnesota Seniors. I'm calling today because when [insert name] was admitted to the nursing home a couple months ago, they expressed a desire to return to a community setting after discharge. The Senior LinkAge Line® securely obtains this information through assessments that are submitted by nursing homes to the Department of Health. Based on how [insert name] responded when they moved in, they said they wanted to go home. I'd like to set up a time to meet with you or discuss some options that may be available in their community. I will be in the area on [insert date and time]. Would that work for you?"
    - If appointment is arranged via the legal/designated representative, verbal consent will be documented in Web Referral.
        - Primary Reason for Referral: MDS profile list
        - Verbal Consent: Date representative provided verbal consent
        - Log Note Heading: Return to Community Verbal Release of Information

- If the legal or designated representative expresses that they are not interested in the CLS visiting the consumer, the CLS will document in Web Referral and continue to communicate with the nursing home discharge planner to determine final discharge status for documentation and quarterly follow-up purposes. Initial Follow-Up (14 days from nursing home discharge) will still be scheduled with designated CSC if the consumer discharges from the nursing home.
  - Log Note Heading: Return to Community Transition Declined
  - Follow-Up Type: Contact Nursing Home should be scheduled for seven days later
  - Continue to follow up with the nursing home until the consumer's final discharge status has been determined

10.5 Consumers Who Discharge Naturally Without CLS Assistance

- Consumers who are residing in a nursing home and declined assistance or did not receive assistance from a CLS due to previous discharge planning will receive initial and quarterly follow-up in the community from the CSC.
  - Therefore, continued contact must be made with the nursing home to obtain discharge status regardless if the CLS provided direct assistance.
- When a community discharge date has been obtained from the nursing home, the following documentation is required in Web Referral along with contact information for the consumer in the community.
  - Primary Reason for Referral: Reason why consumer was first referred
  - Nursing Home Name: Nursing facility where consumer is residing
  - Admit Date: Date admitted to nursing home
  - Actual Discharge Date: Date consumer discharged from nursing home
  - Type of Discharge: Naturally Occurring
  - Discharge Location: Location where consumer discharged
  - Services Offered to Consumer/Caregiver: Options as expressed by nursing home discharge planner
  - Services Accepted by Consumer/Caregiver: Options as expressed by nursing home discharge planner
  - Reasons Why Services Not Arranged: Choose appropriate responses
  - Log Note Heading: Consumer Result is Naturally Occurring Discharge
  - Follow-Up Type: Initial Follow-Up for Naturally Occurring Discharge
    - Follow Up Location: Community Planning Tool for which follow up is occurring
    - Scheduled To: Client Services Center in Web Referral
    - Schedule Date: 14 days from nursing home discharge date

10.6 Consumers Who Are Not on MDS Profile List but Have Requested Assistance

Consumers who are residing in a community setting and interested in support planning or are referred from the nursing home due to an MDS Section Q referral or because the nursing home has identified a

need will be offered assistance from a CLS. All consumers who are referred for assistance will be viewed in MMIS to determine their public program status. Consumers who are not on Medicaid will be offered in-person assistance from a CLS. Regardless of how the consumer is referred, separate from the MDS Profile List, the same protocol applies which is described beginning in Section VI. The main difference is the following:

- **MDS Section Q referrals**
  - Problem/Need: 050.040 MDS Section Q (at a minimum)
  - Primary Reason for Referral: Appropriate response based on online referral
  - Heard About: Section Q Referral
  - Type of Discharge: CLS Assisted-MDS Section Q
- **Referrals from Nursing Home (not Section Q)**
  - Primary Reason for Referral: appropriate response based on online referral
  - Heard About: Nursing Home Discharge Planner
  - Type of Discharge: CLS Assisted-NH Referral
- **Referrals from Ombudsman for Long-Term Care**
  - Primary Reason for Referral: appropriate response based on conversation with Ombudsman
  - Heard About: Ombudsman
  - Type of Discharge: CLS Assisted–Ombudsman Referral
- **Referrals from Senior LinkAge Line® Phone Specialists (caregiver or consumer requests assistance after calling SLL and is residing in nursing home)**
  - Primary Reason for Referral: appropriate response based on conversation with consumer/caregiver and noted by SLL specialists in Web Referral
  - Heard About: Return to Community Brochure or other method noted by SLL Specialists in Web Referral
  - Type of Discharge: CLS Assisted-SLL Referral
- **Referrals from Senior LinkAge Line Pre-Admission Screening Specialists because Consumer was Previously Assisted by CLS**
  - Primary reason for referral: Previous Assistance from CLS
  - Heard About: Senior LinkAge Line
  - Type of Discharge: CLS Assisted-SLL Referral
- **Referrals from SLL Phone Specialists Because Consumer was Considering Move to HWS/AL**
  - Primary Reason for Referral: Registered HWS counseling referral
  - Heard About: Registered HWS Referral
  - Type of Discharge: Will not be completed as consumer will not be residing in a nursing home. Refer to Section 10.7 below.

10.7 Consumers Residing in Community

- Consumers who receive support planning from a CLS in a community setting and never resided in nursing home prior to referral will not complete the following fields in Web Referral:
    - Actual Discharge Date
    - Discharge Type
    - Discharge Location
- Instead the following fields will be completed in order to quantify that a consumer's support plan has been developed in the community and the scheduled Follow-Ups will begin.
    - Support Plan Implementation Date: Enter the date the consumer/caregiver/designated representative signed and approved the final Community Living Support Plan. This is the date you will use to schedule time-sensitive Follow-Ups in Web Referral. Similar to the nursing home discharge date.
    - Services Offered to Consumer/Caregiver: Indicate which services were offered to the consumer/caregiver when developing the Community Living Support Plan. If no services were offered to the consumer/caregiver, choose **None**.
    - Services Accepted by Consumer/Caregiver: Indicate which services the consumer/caregiver accepted as part of their Community Living Support Plan. If no services were offered to consumer/caregiver, choose **Not Applicable**. If no services were accepted by the consumer/caregiver, choose **None**.
    - Reasons Why Services Not Arranged: Indicate why the consumer/caregiver didn't accept the suggested services as part of their Community Living Support Plan. If all services were accepted, choose **Not Applicable-All Services Accepted**. If no services were offered, choose **Not Applicable-No Services Offered**. Otherwise choose appropriate reasons why services were not arranged based on the **Services Offered to Consumer/Caregiver** field but were not accepted.

11 CLS Initial Visit

11.1 Materials for Consumers

Consumers who are seen in the nursing home or in the community will receive information about the Senior LinkAge Line® in-person service and the benefits of follow-up in the community. During the initial visit, the consumer will be provided the Returning Home booklet that was developed for the service. Additional materials should be provided to the consumer and caregiver as appropriate.

- If the AAA runs out of the Returning Home booklets, a MinnesotaHelp Network™ Response form should be submitted via the AAA technical liaison to request additional copies.

11.2 Discussion with Nursing Home Discharge Planner

If the consumer is residing in a nursing home, the discharge planner will be consulted so that introductions can be made and information about in-person service through an SLL CLS can be

provided, especially if the nursing facility is not familiar with these services. This opportunity should be used to build and maintain rapport with the facility staff as they are considered partners in this process. The CLS is not taking over the discharge role but is joining the care plan team at the nursing home on behalf of the consumer.

- If verbal consent from the consumer was obtained prior to the CLS visiting the nursing home, the CLS will consult with discharge planner to obtain a discharge planning update that may or may not be occurring.
    - The CLS will always need to obtain verbal consent to visit if the consumer requested assistance and the consumer is already in the community.

11.3 Nursing Home Materials for Return to Community

The CLS will also ensure that the nursing facility has a supply of SLL brochures, Start Planning Now to Return Home and Remain at Home Successfully. These brochures are provided to each consumer upon admission to the nursing home.

- The CLS or AAA can provide additional brochures to the nursing home if they run out.
    - When brochures are provided to the nursing home, an event should be added to the Extranet calendar to indicate that promotional materials were provided to the facility.
- If the nursing home has questions about the brochure and why they need to distribute them, the CLS should reference DHS Bulletin #14-25-02.
- If the AAA runs out of the SLL brochures mentioned above, a MinnesotaHelp Network™ Response form should be submitted via the AAA technical liaison to request additional copies.

11.4 Sample Script for Explaining RTCI

After the nursing facility has been consulted, the CLS will visit with the consumer and designated representative, if present. Sample script for introducing the Return to Community service to the consumer/designated representative:

> "My name is [insert name], I'm a [social worker or nurse] like [insert NH staff name so consumer can identify], and I work for the Senior LinkAge Line® at the Area Agency on Aging in [insert town]. Even though my office is located in [inset town], our agency works with people in all the counties in [insert northwest, southwest, southeast, central or northeast] MN. Your county is one of the places we cover. We provide many services, including Senior LinkAge Line®, and helping consumers return to their community after a nursing home stay. My job is to travel to all the different nursing homes in our region and talk to people who have told the nursing home staff when they first came here, that they would like to return to the community – whether that's the home they were living in before, a new apartment or even with a family member. Sometimes people end up staying in a nursing home longer than they planned.

"Through this work, we collect information from nursing homes about people who have been admitted and see who may want to receive additional assistance. Each week I follow up with these people to see how I can help them reach their goals of leaving the nursing home.

*If consumer information was obtained from MDS profile list add the following sentence: "*Your name appeared on my list which prompted me to check with [insert NHSW name] to see how you're doing here at the nursing home and how I might be able to help."

"Often this includes working with [insert NHSW name] or family members to put together a plan that might allow the person to return back to the community. We look at different services that are available in the town where you live and their cost, and see if you would be eligible for any of the programs that might help pay for these services to help you stay at home. I can help make the phone calls and do the work to get things set up and help make sure you have everything you might need.

"Most of the time people have no idea about the help and services available in their communities because they've never had to use them before. It's my job to bring that information to you and help you look at all of your options. But the most unique part of Return to Community Initiative and what I do is to keep working with you even after you leave the nursing home so you have someone you can talk to if you need something.

"When you come into the nursing home you have all these people— [insert NHSW name], all the nurses and the aides in and out of your room all the time who can help you with whatever you need. But when it comes time for you to leave the nursing home, they all stay here and you go home. Now you will have me to help. After you've gone home, I'll call you to set up a time to visit you at home to make sure everything is going as well as you would like. We check to find out: "how have the first few days been going; is something harder than you thought; are the services we set up coming like they are supposed to; do you like the agency that you've chosen so far; do you have all your medications; or do we need to make any changes?" We help to make your transition back home as smooth as possible and be sure you have someone to help problem solve if things come up. We certainly don't want for things to not work out the way you want them.

"We do what we can to help you stay living at home and in the community for as long as you want to and are safely able to do so. We will continue to make phone calls to check in on you to make sure you're still doing well at home; we have a short checklist that we run through with you to make sure you're are doing well. And we can keep following up with you for as long as you're interested in having us do so – even up to five years. If you ever get to the point where you no longer want us to call, it's okay to just tell us and we will stop. It's as simple as that.

"The next thing I want to make sure you know is that everything that I can do to help you is FREE. There is no cost involved; you're not going to get any bills; we don't bill Medicare or

your insurances or anything like that. We are completely funded by State dollars that have been set aside to help people in nursing homes look at their options to try and return back to the community versus staying in a nursing home for a long-term stay. So in a nutshell . . . that's what I do. What we do next is kind of up to you.

"Nursing homes are required by law to tell every new resident that comes through their door about the Senior LinkAge Line® and what I do. So when I contact the NHSW, they are required to offer you the opportunity to visit with me in-person – like [insert NHSW name] did for you, which is how I've come to visit with you today. Although the nursing home is required to offer you the visit, whether you want me to help you going forward is up to you. We just want you to know that I am here to help you if you're interested.

"Does any of this sound like something that might be helpful for you? Would you like me to be involved and help however I can?"

11.5 Consumer in Nursing Home Not Interested in CLS Assistance

If the consumer is residing in a nursing home and is not interested in CLS assistance, the CLS will thank them for their time and inform the discharge planner of the decline. The CLS will inform the discharge planner that the CLS will be in continued contact with the nursing home so the ultimate discharge decision can be documented for tracking purposes.

- Log Note Heading: Return to Community Transition Declined
- Follow-Up Type: Contact Nursing Home
- Scheduled Date: Seven days from current date

11.6 Consumer in Community Not Interested in CLS Assistance

If the consumer is residing in the community and is not interested in CLS assistance, the CLS will thank the consumer for their time and ensure that if the consumer has questions in the future, they should call the Senior LinkAge Line® for assistance.

- Log Note Heading: Return to Community Transition Declined
- No further follow-up conducted

11.7 Consumer Interested in CLS Assistance-Nursing Home or Community

If the consumer says they are interested, the ROI—5-Year will be explained to the consumer/designated representative so that the process can continue and private data can be collected about the consumer.

- Date of Verbal Release: Date consumer/designated representative agreed to CLS assistance
- Date of Written Release: Date consumer/designated representative signed ROI-5 Year

11.8 Documenting Initial Visit

- Whether or not the consumer accepts assistance from the CLS, the date of the initial visit with the consumer will be documented in Web Referral.
    - Date of Initial Visit: Date CLS first visited the consumer in nursing facility/their home to discuss their community options.

11.9 Obtaining Consent from Legal Guardian

If the consumer has a legal guardian, consent must be obtained from this legal representative in order to proceed with assisting the consumer. The CLS should attempt to arrange an in-person visit with the guardian to explain services that may be available for the consumer in the community.

- If the guardian does not want to meet in person and instead discusses the consumer's situation over the phone, the Date of Initial Visit should be input into Web Referral based on the date the consult occurred over the phone with the guardian.
- If the guardian does not want assistance from a CLS, the date the guardian refused assistance will be input into Web Referral as the Date of Initial Visit.

12 CLS Obtains Signed ROI—5-Year

Regardless of where the consumer is residing, the consumer or designated representative must sign the Release of Information to collect private data about the consumer and medical information can be obtained from health-care providers including the nursing home. If the ROI is not signed, private data cannot be collected and the RTCI protocol cannot proceed.

- The ROI—5-Year will be used with consumers who are directly assisted by the CLS.

12.1 Obtaining New ROI-5 Year

A new ROI—5-Year will be signed for each unique instance of assistance provided.

- Example: Consumer is assisted in nursing home A and successfully discharges to community setting. Consumer readmits to nursing home B six months later and nursing home B makes referral to SLL for CLS assistance or consumer appears on MDS profile list. Verbal permission and a new ROI—5-Year will be obtained which contains new nursing home name and date consumer gave permission to collect medical information.
- Example: Consumer is assisted in nursing home A and transfers to nursing home B. A new ROI—5-Year will be obtained which contains new nursing home name and date consumer gave permission to collect medical information.

12.2 Sample Script for Explaining the Release of Information-5 Year

Sample script for explaining the ROI to the consumer/designated representative:

"Now, I have this form for us to go through called the Consent for Release of Information. It simply states that you and I have visited today about the Return to Community service and how it works, that you're agreeing to allow [insert nursing home name] to share information with me about how you're doing; to look at your medical information on file; you're agreeing to allow me to talk with the nurses or the therapy department to get information on how things are going or any recommendations they have; to make calls to other providers on your behalf with your consent; that some of the information we talk about will be used for research purposes and statistical data; you're agreeing to the follow-up services that we talked about. Finally just know that at any point in time you can choose to reverse this release of information if you change your mind. Do you feel okay about signing this?

"This next page is the privacy statement. So like everywhere else these days, the doctor's office, your credit card company . . . we have to tell you that you have privacy rights and that your information is kept private and confidential and that we don't share it with others outside of what we've already talked about. The contact information is listed here should you have more questions or want to file a complaint."

12.3 Sharing and Storing ROI-5 Year

- If the consumer, designated representative or nursing home would like a copy of the ROI, this is allowed and encouraged.
- The ROI will be attached to the appropriate CPT in Web Referral once it has been signed by the consumer or guardian/legal representative and the CLS. The Attachments screen within the CPT should be utilized. ROIs can only be attached through an inquiry or a follow up.
    - Attachments Document Type: Privacy Release-Return to Community-5-Year
        - Comments: Release of Information signed on [insert date] by [insert name of who signed and relationship to consumer]
            (1) Example: ROI—5-Year signed on 1-15-2014 by Susan Jones-daughter
            (2) Standard PDF Title: ROI5Year-[ConsumerName]-[DateSigned]
        - Date of Written Release: The Written Release Date automatically updates based on when it was uploaded to the client record in Web Referral. Please ensure date is based on date ROI was actually signed if ROI is not uploaded to Web Referral on same day.

13 CLS Meets with Consumer/Caregiver to Complete CPT

13.1 Completing the CPT

Once the ROI—5-Year has been signed, the CPT will be completed by obtaining information from the nursing home chart, nursing home staff, consumer interview and primary caregiver interview. If the consumer is residing in the community, all information will be obtained from the consumer, primary caregiver, and health care professionals as provided by the consumer.

13.2 Using the Medical Chart to Complete the CPT

If the consumer's medical chart has not yet been viewed because verbal and signed consent was just obtained, the CLS should take this time to update the nursing home discharge planner that consent was received and that the CLS will be actively participating in the discharge planning process.

Most of the information in the CPT can be obtained from the chart including the consumer's social history, demographics, insurance information, fall history, diagnoses, caregiver contact information, advanced directives and medications.

13.3 Accuracy of CPT Data

It is important to note that the fields that are part of the CPT should be accurate at the time of nursing home discharge or when services are arranged for consumers already living in the community.

- All data that is collected in the CPT should be based on what is accurate about the consumer's situation and not what their perception may be.
    - Exception: The BIMS/Emotional Health screen and the Rate Your Health field on the Self Evaluation/CG Supports screen should be completed with exact responses from the consumer.

13.4 Documenting the CPT in Web Referral

All contacts made with staff from various departments of the nursing home and primary care physicians should be tallied and recorded in the **Contacts Out** field on the Inquiry Review Main Page or Follow-Up Status Outcome screen.

See the Senior LinkAge Line® Web Referral User Guide for detailed breakdown of each screen in the CPT including scripts and help prompts which explain how to complete each field whether the person is residing in a nursing home or in the community.

14 CLS Researches Services and Supports in Web Referral

14.1 Tracking Referrals in Web Referral

Based on the results of the CPT and the assessment conducted by the CLS, services and supports will be located in Web Referral. They will be offered to the consumer as part of the support plan when residing in the community. Suggested referrals will be made based on consumer or caregiver preference and supports that meet the needs of the consumer and are available in their community. All referrals will be tracked in Web Referral.

14.2 Recommending a Consumer Apply for Public Programs

The CLS may recommend the consumer apply for public programs. The nursing home discharge planner or business office can typically provide information regarding consumer's application status and if they made a referral to the county. MMIS contains current screening information and should be reviewed for each consumer.

- If consumer applies for public programs and requests assistance filling out forms, CLS can request forms assistance from a local SLL specialist/volunteer.
- If consumer is going to apply for public programs, the CLS, in collaboration with the nursing home, consumer and caregiver, will make a referral to the county of current location for a LTCC/MnCHOICES assessment.
    - Log note heading: Return to Community Public Program Referral
    - In the SLL Role of Web Referral, the LTCC Referral/Follow-Up screen will be completed to document that a referral was made for a face-to-face assessment.
- If the CLS does not recommend the consumer apply for public assistance, the CLS will continue researching home- and community-based services according to the needs of consumer.
- Various providers will be contacted to compare costs for services that are required in order for the consumer to return to the community.

14.3 Consumer Moving to Housing with Services/Assisted Living

- The consumer may be considering a move to a registered housing with services setting/assisted living. If the consumer does not already have a verification code noted in MMIS or in Web Referral, the CLS will generate a verification code and complete the rapid screen based on the information that has already been collected in the CPT.
- To determine if a verification code is already present in MMIS due to a face-to-face screening conducted by lead agency, the screenings section of MMIS will be reviewed to determine if a code is already present. This request should be made through the Benefits Lookup Hunt Group in Revation
    - The verification code functionality and Rapid Screen fields are located on the Rapid Screen session screen on the SLL section of Web Referral.
    - When rapid screen is conducted in Web Referral and a verification code is generated, a **Care Transitions 10 Day Follow Up** in the SLL Role is required before the session can be saved as complete. The **Care Transitions 10 Day Follow Up** should be documented during the 14 Day Check in from NH DC. An additional phone call is unnecessary.
        - Rapid Screen: values based on CPT
        - Verification Code Type: Senior LinkAge Line® if one is not already present in MMIS or Web Referral
        - Problem/Need: 050.008 Registered Housing with Services Counseling in addition to other relevant problem needs.
        - Follow Up Type in SLL Role: Care Transitions 10 Day Follow-Up
    - The Registered Housing with Services section in the Care Transitions 10 Day Follow Up screen in the SLL Role of Web Referral will be completed when the 14 day Check In from NH DC is completed.

15 CLS Creates CLSP

15.1 Purpose of the CLSP

- The CLSP is the primary deliverable from the CLS to the consumer and family. This document summarizes all the coordinated efforts that lead to the most successful discharge possible. This document is to be used by family seeking to know what services have been arranged as well as to learn about additional services that were recommended but not accepted.
- As this document is a culmination of all the CLS's work, it is expected to be completed in its entirety. With a complete and thorough support plan, consumers and families should feel confident about knowing what to expect for their community discharge.

15.2 How to Create a CLSP

- The CLS develops the Community Living Support Plan (CLSP) with the results of the research that was completed regarding service and support providers. CLS will update the consumer record to indicate the time spent in preparing the CLSP and also indicate any information that would be of assistance in the log notes for the meeting.
    - Log note heading: Return to Community Support Plan Development
- A Community Living Support Plan Step-by-Step (Appendix C) on how to complete the CLSP is provided and should be referenced along with a sample Community Living Support Plan (Appendix D).

15.3 Reporting Missing or Agency Discrepancies

- If the CLS determines resource information in Web Referral is incorrect or missing, the CLS shall report any errors or changes needed to the database by either a) using the Report Data Problem link at the top or bottom of the Service Details page, or b) emailing the problem to mnhelpdata@metroaging.org or c) by chatting or d) sending offline Revation message to the Data Management Hunt Group in Revation.
- The CLS will indicate the type of information that is missing, for example:
    - An agency that is in Web Referral but a specific type of service is not listed as part of the agency's record.
    - A known agency is missing from Web Referral.
    - A taxonomy search yields no services.
    - A taxonomy search yields incorrect services.
    - Services related to a Problem/Need search appear incorrect.
- If the CLS experiences difficulties searching for resources, the CLS will contact their SLL Contact Center Coordinator and request assistance to locate information.

15.4 CLS Reviews CLSP with Consumer/Caregiver

- Once the CLSP has been drafted, the CLS schedules a discharge planning meeting with the consumer/caregiver and the nursing home designee. The CLS should document the scheduled

meeting in Web Referral and also assign a Follow-Up to update the consumer's record after the meeting.

- During the discharge planning meeting, the CLS reviews the CLSP and the options the consumer has for returning home. A list of services and their costs will be presented using the Requested/Recommended Service Options in the CLSP. During the meeting the following items should be reviewed:
    - Medication management plan which includes how the consumer will pick up prescriptions in the community.
    - Demonstration of understanding of all medications.
    - Guarantee that medications will be covered by their Medicare Part D plan, if applicable.
    - The emergency backup plan in the event the consumer returns home and an emergency occurs which requires the consumer to respond quickly.
        - The emergency backup plan is to ensure the consumer knows what to do if they are dependent on an agency for example and they do not show up for their scheduled shift.
    - Emergency room triggers/warning signs.
- The results of the meeting will be documented in the consumer log notes of Web Referral.
    - Log note heading: Return to Community Discharge Planning Meeting

15.5 Consumer Approves CLSP

- CLS asks consumer/caregiver to decide on which services should be arranged in the community based on personal budget and preferences. These decisions will be indicated on the CLSP and tracked in Web Referral as an agency that has been "referred." Though a physical "referral" may not have been made, in order to add an agency/provider to the client record in Web Referral, the "referred" button is used when reviewing services.
    - If consumer/caregiver does not approve any of the options presented in the CLSP, CLS modifies the CLSP to meet preferences of the consumer/caregiver.
- CLS arranges follow-up meeting at nursing home with consumer/caregiver to review modified plan and decide on which services should be arranged in the community based on personal budget and preferences. CLS will document summary of meeting in consumer log notes of Web Referral and update time spent in meeting.
    - Log note heading: Return to Community Plan Review
- CLS and consumer/caregiver continue to review and modify the CLSP until the consumer/caregiver approves of the plan.

16 CLS Finalizes CLSP

- The consumer/designated representative/caregiver signs and approves the final CLSP based on personal preferences and budget. CLS will document final decisions on CLSP. A summary of the meeting should be documented in consumer log notes in Web Referral. Any services

that had not been added to the consumer's record in Web Referral should now be added to ensure they match the services the consumer will receive in the community.

- The CLS will attach the final CLSP to the appropriate CPT in Web Referral.
    - Log note heading: Return to Community Final Support Plan
- CLS, consumer/caregiver, and nursing home designee will implement the CLSP. Implementing the plan includes:
    - Discharge order acquired from consumer's attending doctor in nursing home to reflect the services and/or equipment needed for community discharge.
    - Date and time of discharge from the nursing home confirmed.
    - Conversation with caregiver about re-engagement, if applicable.
    - Medication management and how this will occur in the home.
    - Emergency room triggers/warning signs.
    - Home- and community-based services arranged as indicated in the CLSP.
    - Prescriptions from nursing home called into local pharmacy or arranged as part of discharge from nursing home.
    - Appointment scheduled with primary care doctor in community.
- If consumer does not have primary care doctor in the community, the CLS will assist with locating a provider to ensure the consumer is receiving proper care and medications can be refilled as appropriate once discharged from the nursing home.
- CLS will schedule an in-person visit to consumer's location in the community which will occur within 10 days of nursing home discharge or support plan implementation, if consumer already resides in community. Depending on the consumer's needs; if the in-person visit does not occur within 72 hours of nursing home discharge, a phone call will be conducted and the in-person visit will occur within 10 days of nursing home discharge.
    - Follow-Up Type: Within 72 Hour Check in from NH DC
- All contacts made with home and community-based service providers and volunteer agencies when developing the CLSP should be tallied and recorded in the Contacts Out field on the Inquiry Review Main Page or Follow-Up Status Outcome screen.

17 CLS Conducts In-Person Follow-Up

- With consumer consent, the in-person Follow-Up will occur *within* 10 days of the consumer's discharge from the nursing home. At a minimum, a phone call will be conducted *within* 72 hours of nursing home discharge. Information will be collected in all applicable fields of the Within 72 Hour Check In and 10 Day Check In screens in Web Referral.
- Within each of the previously mentioned check in screens, the specialist will indicate if the follow up is being conducted in-person or over the phone. If the check in is conducted in-person, additional fields will appear in a section called "Actions Steps for In-Person Visit." If any of the Action Steps aren't completed, the specialist will indicate the reason within the check-in screen in Web Referral.

- For consumers who were already residing in the community when initial support planning was completed, the in-person follow up is not necessary unless the consumer, caregiver or specialist feels that it's necessary. The exception exists for community-based consumers because the follow-up schedule begins when the consumer signs the support plan which will occur in-person.

17.1 Unable to Reach Consumer-Closing the Follow Up as Complete

- If the consumer cannot be reached after three attempts, the Follow-Up will be closed as complete and a letter sent to encourage the consumer to contact the Senior LinkAge Line® should they have any questions. See **Consumer Letter No Response-CLS Assisted DC** on the Extranet for the letter the CLS will use.
    - Outcome of Check In: Unable to Reach-Letter Sent to Consumer/Caregiver

17.2 Saving the Within 72 Hour Check In from NH DC as Incomplete

- While attempts are made to reach the consumer or caregiver, the Follow-Up in Web Referral will be saved as incomplete until a final outcome has been reached.
- Final outcomes include the initial visit being completed, the consumer cannot be reached after three attempts, the consumer has passed away, or the consumer has been admitted to the nursing home.
    - Contacts Out will be increased each time an attempt to contact the consumer or their primary caregiver/emergency contact is completed.
    - Follow-Up Date on the Follow-Up Status/Outcome screen in Web Referral: Next business day for additional attempt to contact consumer.
    - In-Person Assistance: Applicable value based on final type of assistance that was attempted

17.3 Protocol for Conducting In-Person Visit in Consumer's Home

- During the in-person visit, the CLS should ensure sure that the consumer is safe at home and that services and supports are being provided as applicable. If the consumer requests assistance with setting up additional services or contacting services that are already arranged, the CLS will complete this on their behalf.
- In addition to the questions being completed on the Within 72 Hour Day Check In OR 10 Day Check In screen in Web Referral, the following items will be reviewed with the consumer and documented in Web Referral during the in-person visit which will occur within 10 days of nursing home discharge:
    - Consumer Demonstrates Understanding of Medications
        - The consumer should actively demonstrate by repeating back the med schedule, where they are located and how they are administered.
    - Emergency Plan Reviewed

        - This includes reviewing the consumer plan if they have any sort of emergency at home or if a provider they are dependent on does not show up to provide services.
    - Ensure Prescribed Meds are Filled and Available
        - This requires a visual check to ensure the consumer has all medications as listed on discharge orders or on the most up to date med list from their primary care doctor.
    - Medication Reconciliation
        - This includes reviewing all medications that are considered active for the consumer and ensuring those medications are available for administration. A plan should be made with the consumer/caregiver on how to dispose or put away inactive meds.
    - Ensure PCP Appt. Scheduled
        - This includes making the appointment while you are with the consumer or ensuring the consumer/caregiver will make it. Best practice is that consumers see their primary care doctor within 7 days of a nursing home discharge.
    - If the consumer refuses any of the items listed above during the home visit, the items will be marked as "Not Completed" along with the "Reason Why" in Web Referral.

17.4 Community Outreach Survey

- An SLL Community Outreach Survey with a postage paid envelope addressed to the Minnesota Board on Aging will be provided to each consumer regarding the service provided by the CLS. The survey will only be given once per instance of direct discharge assistance or support planning in the community. This will primarily be given at the 72 hour check in which is conducted in-person but can be given at a later date at the consumer's request or depending on the situation. Whenever the survey is provided to the consumer, it should be provided in-person to avoid mailed surveys that could be missed or thrown away. For those who are assisted by a CLS and are already residing in the community, the Community Outreach survey will be given when the final support plan is signed.
    - Question #1 on the survey, the CLS will pre-select the option of **Helped me leave a nursing home** OR **Arranged for services to come into my home** (if the consumer is already residing in the community).
    - Question, #10, the CLS will pre-select any materials they provided to consumer, i.e. Returning Home Booklet.
    - Bottom of page 2 of the survey, the CLS will add their name to the space labeled, **Community Living Specialist** prior to giving to consumer. This will allow clear tracking when the survey is mailed to the Consumer Choices Team at the Minnesota Board on Aging. If the survey does not contain the CLS name, surveys cannot be tracked to the CLS for their individual dashboards.

17.5 Documenting the In-Person Visit

- Once the in-person visit has been completed, the CLS will notify the consumer that an additional Follow-Up will be provided in a couple of weeks. If questions arise in the meantime, contact should be made with the Senior LinkAge Line® via 1-800-333-2433.
    - Log note heading: Consumer Check In
    - Follow-Up Type: 10 Day or 30 Day Check In from NH DC or other applicable Follow-Ups based on the consumer's needs. For example, contacting an agency or the caregiver.
    - Outcome of Visit/Call: Applicable values based on outcome of visit
    - Follow-Up Status/Outcome Screen
        - Follow-Up Inquiry Date: Date Follow-Up completed with consumer
        - Contacted by: Senior LinkAge Line®
        - Call or Contact Made By: Senior LinkAge Line®
        - Contacts Out: Track how many contacts were attempted and any three-way calls or mailings that were completed to the consumer/caregiver
        - Survey Sent: Outreach Survey
        - Type of Services: Problem Solving/Problem Resolution–In Progress

17.5.1 Consumer Declines Further Contact after In-Person Follow Up

- If the consumer declines further contact whether the check in was completed or not, the record will be closed as complete, and the consumer should be assured if they have questions in the future, to contact the Senior LinkAge Line®.
    - Log Note Heading: Return to Community Decline Further Contact
    - Outcome of Check In: Check In Completed/Consumer Declines Further Contact OR Check In Not Completed/Consumer Declined Contact
    - Follow-Up Status/Outcome Screen
        - Follow-Up Inquiry Date: Date Follow-Up completed with consumer
        - Contacted by: Senior LinkAge Line®
        - Call or Contact Made By: Senior LinkAge Line®
        - Contacts Out: Track how many contacts were attempted and any three-way calls or mailings that were completed to the consumer/caregiver
        - Survey Sent: Outreach Survey
        - Type of Services: Problem Solving/Problem Resolution–Complete
    - No further follow-up scheduled.

18 CLS Conducts Additional Follow-Up

- Additional follow-up is provided with the consumer/caregiver at designated timeframes based on the nursing home discharge date or when the support plan was implemented for consumers already residing in the community. These Follow-Ups can be provided over the

phone or in-person based on the needs of the consumer. However, an in-person visit must be conducted within 10 days of nursing home discharge.

- 10 Day Check in from NH DC
- 30 Day Check in from NH DC
- 60 Day Check in from NH DC
- 90 Day Check In from NH DC

- Once the CLS completes the 90 day Check In from NH DC, additional follow-up will be assigned to the Client Services Center through Web Referral. Follow-Ups conducted by the Client Services Center will not be conducted in-person.

18.1 Timely Completion of Designated Follow-Ups

- Scheduled Follow-Ups should be completed as close to the scheduled date as possible. If a scheduled Follow-Up is completed late, the next Follow-Up should be modified so it's occurring based on the particular timeframe of the Follow-Up type.
  - Example: The 30 day Follow-Up is completed 45 days after nursing home discharge. 60 Day Follow-Up should still be scheduled for 60 days from the consumer discharge date or date the final support plan was signed for consumers already residing in the community.
- A consumer can decline further follow-up at any point which will be documented in Web Referral for tracking purposes.

18.2 Consumer Returns to Hospital While Living in Community

- If a Within 72 Hour, 10, 30 or 60 day follow-up call is conducted, and the consumer has been admitted to the hospital, relevant fields will be completed based on the information that the consumer is in the hospital. The current Follow-Up will be closed as complete and the next designated Follow Up will be scheduled.
  - The CLS will also schedule a Contact Consumer or Contact Caregiver Follow-Up to determine if the consumer has returned home from the hospital or been readmitted to the nursing home.
    - Follow-Up Type: Contact Consumer or Contact Caregiver
    - Follow-Up Date: Based on situation
    - Log Note Heading: Consumer Check In
    - Outcome of Check In: Check In Not Completed/Next Follow Up Scheduled
  - If the consumer returns home, the next Follow-Up will be scheduled in Web Referral following the same timing schedule based on the initial nursing home discharge date or support plan implementation date.
    - Follow-Up Type: Next Scheduled Follow-Up (10, 30, 60, 90)
    - Follow-Up Date: Based on Follow-Up Type and Actual Discharge Date/Support Plan Implementation Date
    - Log Note Heading: Consumer Check In
  - If 30 or 60 Day Check In:

        - Recent Hospital or ER Visit: Yes
        - Reason for Hospitalization or ER Visit: Reason consumer admitted to hospital
        - Outcome of Check In: Check In Not Completed/Next Follow Up Scheduled
    - If the consumer has not returned to their community setting and has been admitted to nursing facility by the time the 90 Day Check In from NH DC is conducted, the Follow-Up will be closed as complete and no further follow-up will be conducted unless the consumer or caregiver requests it.
        - Log Note Heading: Return to Community Process Stopped
        - Outcome of Check In: Check In Not Completed/Consumer Readmitted to Nursing Facility
- If a 90, 180, 270, 360 up to 5040 Day Check In from NH DC follow-up call is conducted, and the consumer has been admitted to the hospital, the Outcome of Check In will be marked as Check In Not Completed/Next Follow Up Scheduled and any other relevant fields will be completed based on the information that the consumer is in the hospital. The Follow-Up will be closed as complete and no further follow-up will be conducted.

18.3 Consumer Readmitted to Nursing Home While Living in Community

- If a Within 72 Hour, 10, 30 or 60 day follow-up call is conducted, and the consumer has been admitted to the nursing home, the Outcome of Check In will be marked as Check In Not Completed/Consumer Readmitted to Nursing Facility and any other relevant fields will be completed based on the information that the consumer is in the nursing home.
    - If contact was made with a caregiver or the consumer, CLS services should be offered to assist the consumer back out of the nursing home and into the community setting of their choice. If consent is provided, refer to CLS Schedules Appointment with Consumer of this protocol.
        - Log Note Heading: Consumer Check In
        - Outcome of Check In: Check In Not Completed/Consumer Readmitted to Nursing Facility
    - If contact was made with caregiver or the consumer and the CLS services are declined for assistance out of the nursing home, the CLS will mark the Follow-Up as complete and no further follow-up will be conducted.
        - Log Note Heading: Consumer Check In
        - Outcome of Check In: Check In Not Completed/Consumer Declined Contact

19 10 Day Check In from NH DC

- The 10 Day Check In can be completed over the phone or in-person depending on consumer's preference. However, an in-person visit must be conducted within 10 days of nursing home discharge. Information should be collected in all applicable fields of the 10 Day Check In screen in Web Referral.

- The CLS will make three attempts to reach the consumer within a seven day period. If the consumer cannot be reached, the primary caregiver and/or emergency contact will be contacted.
- If the consumer does not have a primary caregiver or emergency contact, three attempts will only be made with the consumer. If the consumer cannot be reached after three attempts, a letter will be sent to the consumer with request for return call. See **Consumer Letter No Response-CLS Assisted DC** on the Extranet for the letter the CLS will use.
    - Outcome of Check In: Unable to Reach-Letter Sent to Consumer/Caregiver

19.1 Saving the 10 Day Check In from NH DC Incomplete

- While attempts are made to reach the consumer or caregiver, the Follow-Up in Web Referral will be saved as incomplete until a final outcome has been reached.
    - Final outcomes include the check-in screen being completed, the consumer cannot be reached after three attempts, the consumer has passed away, or the consumer has been admitted to the nursing home.
        - Contacts Out will be increased each time an attempt to contact the consumer or their primary caregiver/emergency contact is completed.
        - Follow-Up Date on the Follow-Up Status/Outcome screen in Web Referral: Next business day for additional attempt to contact consumer.
        - In-Person Assistance: Applicable value based on final type of assistance that was attempted

19.2 Documenting the 10 Day Check In

- Once the 10 day phone call/visit has been completed and the consumer agrees to additional follow-up, the CLS will notify the consumer that additional follow-up will be provided in a couple of weeks. If questions arise in the meantime, contact should be made with the Senior LinkAge Line® via 1-800-333-2433.
    - Log note heading: Consumer Check In
    - Follow-Up Type: 30 Day Check In from NH DC or other applicable Follow-Ups based on additional follow-up that may be needed on the consumer's behalf. For example, contacting an agency or the caregiver.
    - Outcome of Check In: Check In Completed/Next Follow Up Scheduled
    - Follow-Up Status/Outcome Screen
        - Follow-Up Inquiry Date: Date Follow-Up completed with consumer
        - Contacted by: Senior LinkAge Line®
        - Call or Contact Made By: Senior LinkAge Line®
        - Contacts Out: Track how many contacts were attempted as well as any three-way calls or mailings that were completed to the consumer/caregiver
        - Survey Sent: Leave blank
        - Type of Services: Problem Solving/Problem Resolution–In Progress

19.3 Consumer Declines Further Contact at 10 Day Check In

- If the consumer declines further contact whether the check in was completed or not, the record will be closed as complete, and the consumer should be assured if they have questions in the future, to contact the Senior LinkAge Line®.
    - Log Note Heading: Return to Community Decline Further Contact
    - Outcome of Check In: Check In Completed/Consumer Declines Further Contact OR Check In Not Completed/Consumer Declined Contact
    - Follow-Up Status/Outcome Screen
        - Follow-Up Inquiry Date: Date Follow-Up completed with consumer
        - Contacted by: Senior LinkAge Line®
        - Call or Contact Made By: Self
        - Contacts Out: Track how many contacts were attempted and any three-way calls or mailings that were completed to the consumer/caregiver
        - Survey Sent: Leave blank
        - Type of Services: Problem Solving/Problem Resolution–Complete
    - No further follow-up scheduled.

20 30 Day Check In from NH DC

- The 30 Day Check In can be completed over the phone or in-person depending on consumer's preference. Information will be collected in all applicable fields of the 30 Day Check In screen in Web Referral including an updated address and phone number on the Basic Data screen if the consumer has relocated since the last check in.
    - The CLS will make three attempts to reach the consumer within a seven day period. If the consumer cannot be reached, the primary caregiver and/or emergency contact will be contacted. If the consumer does not have a primary caregiver or emergency contact, three attempts will only be made with the consumer. If the consumer cannot be reached after three attempts, a letter will be sent to the consumer with request for return call. See Consumer Letter No Response-CLS Assisted DC on the Extranet for the letter the CLS will use.
        - Outcome of Check In: Unable to Reach-Letter Sent to Consumer/Caregiver

20.1 Saving the 30 Day Check In from NH DC Incomplete

- While attempts are made to reach the consumer or caregiver, the Follow-Up in Web Referral will be saved as incomplete until a final outcome has been reached.
    - Final outcomes include the check-in screen being completed, the consumer cannot be reached after three days, the consumer has passed away, or the consumer has been admitted to the nursing home.
        - Contacts Out will be increased each time an attempt to contact the consumer or their primary caregiver/emergency contact is completed.

- Follow-Up Date on the Follow-Up Status/Outcome screen in Web Referral: Next business day for additional attempt to contact consumer.
- In-Person Assistance: Applicable value based on final type of assistance that was attempted

20.2 Documenting the 30 Day Check In

- Once the 30 day phone call/visit has been completed and the consumer agrees to additional follow-up, the CLS will notify the consumer that additional follow-up will be provided in about a month. If questions arise in the meantime, contact should be made with the Senior LinkAge Line® via 1-800-333-2433.
    - Log Note Heading: Consumer Check In
    - Follow-Up Type: 60 Day Check In from NH DC or other applicable Follow-Ups based on additional follow-up that may be needed on the consumer's behalf. For example, contacting an agency or the caregiver.
    - Outcome of Check In: Check In Completed/Next Follow Up Scheduled
    - Follow-Up Status/Outcome Screen
        - Follow-Up Inquiry Date: Date Follow-Up completed with consumer
        - Contacted by: Senior LinkAge Line®
        - Call or Contact Made By: Senior LinkAge Line®
        - Contacts Out: Track how many contacts were attempted and any three-way calls or mailings that were completed to the consumer/caregiver
        - Heard About SLL: Appropriate value based on how consumer was referred to SLL.
        - Survey Sent: Leave blank
        - In-person Assistance: Telephone or location where consumer lives if completed in community
        - Type of Services: Problem Solving/Problem Resolution–In Progress

20.3 Consumer Declines Further Contact at 30 Day Check In

- If the consumer declines further contact whether the check in was completed or not, the record will be closed as complete, and the consumer should be assured if they have questions in the future, to contact the Senior LinkAge Line®.
    - Log Note Heading: Return to Community Process Stopped
    - Outcome of Check In: Check In Completed/Consumer Declines Further Contact OR Check In Not Completed/Consumer Declined Contact
    - Follow-Up Status/Outcome Screen
        - Follow-Up Inquiry Date: Date Follow-Up completed with consumer
        - Contacted by: Senior LinkAge Line®
        - Call or Contact Made By: Senior LinkAge Line®
        - Contacts Out: Track how many contacts were attempted and any three-way calls or mailings that were completed to the consumer/caregiver

        - Survey Sent: Leave blank
        - Type of Services: Problem Solving/Problem Resolution–Complete
    - No further follow-up scheduled.

21 60 Day Check In from NH DC

- The 60 Day Check In can be completed over the phone or in-person depending on consumer's preference. Information will be collected in all applicable fields of the 60 Day Check In screen in Web Referral including an updated address and phone number on the Basic Data screen if the consumer has relocated since the last check in.
    - The CLS will make three attempts to reach the consumer within a seven day period. If the consumer cannot be reached, the primary caregiver and/or emergency contact will be contacted. If the consumer does not have a primary caregiver or emergency contact, three attempts will only be made with the consumer. If the consumer cannot be reached after three attempts, a letter will be sent to the consumer with request for return call. See **Consumer Letter No Response-CLS Assisted DC** on the Extranet for the letter the CLS will use.
        - Outcome of Check In: Unable to Reach-Letter Sent to Consumer/Caregiver

21.1 Saving the 60 Day Check In from NH DC as Incomplete

- While attempts are made to reach the consumer or caregiver, the Follow-Up in Web Referral will be saved as incomplete until a final outcome has been reached.
    - Final outcomes include the check-in screen being completed, the consumer cannot be reached after three days, the consumer has passed away, or the consumer has been admitted to the nursing home.
        - Contacts Out will be increased each time an attempt to contact the consumer or their primary caregiver/emergency contact is completed.
        - Follow-Up Date on the Follow-Up Status/Outcome screen in Web Referral: Next business day for additional attempt to contact consumer.
        - In-Person Assistance: Applicable value based on final type of assistance that was attempted

21.2 Documenting the 60 Day Check In

- Once the 60 day phone call/visit has been completed and the consumer agrees to additional follow-up, the CLS will notify the consumer that additional follow-up will be provided in about a month. If questions arise in the meantime, contact should be made with the Senior LinkAge Line® via 1-800-333-2433.
    - Log Note Heading: Consumer Check In
    - Follow-Up Type: 90 Day Check In from NH DC or other applicable Follow-Ups based on additional follow-up that may be needed on the consumer's behalf. For example, contacting an agency or the caregiver.

- Outcome of Check In: Check In Completed/Next Follow Up Scheduled
- Follow-Up Status/Outcome Screen
  - Follow-Up Inquiry Date: Date Follow-Up completed with consumer
  - Contacted by: Senior LinkAge Line®
  - Call or Contact Made By: Senior LinkAge Line®
  - Contacts Out: Track how many contacts were attempted and any three-way calls or mailings that were completed to the consumer/caregiver
  - Survey Sent: Leave blank
  - Type of Services: Problem Solving/Problem Resolution–In Progress

21.3 Consumer Declines Further Contact at 60 Day Check In

- If the consumer declines further contact whether the check in was completed or not, the record will be closed as complete, and the consumer should be assured if they have questions in the future, to contact the Senior LinkAge Line®.
  - Log note Heading: Return to Community Process Stopped
  - Outcome of Check In: Check In Completed/Consumer Declines Further Contact OR Check In Not Completed/Consumer Declined Contact
  - Follow-Up Status/Outcome Screen
    - Follow-Up Inquiry Date: Date Follow-Up completed with consumer
    - Contacted by: Senior LinkAge Line®
    - Call or Contact Made By: Senior LinkAge Line®
    - Contacts Out: Track how many contacts were attempted and any three-way calls or mailings that were completed to the consumer/caregiver
    - Survey Sent: Leave blank
    - Type of Services: Problem Solving/Problem Resolution–Complete
  - No further follow-up scheduled.

22 90 Day Check In from NH DC-CLS Assisted

- The 90 Day Check In can be completed over the phone or in-person depending on consumer's preference. Information will be collected in all applicable fields of the 90 Day Check In screen in Web Referral including an updated address and phone number if the consumer has relocated since the last check in.
  - The CLS will make three attempts to reach the consumer within a seven day period. If the consumer cannot be reached, the primary caregiver and/or emergency contact will be contacted. If the consumer does not have a primary caregiver or emergency contact, three attempts will only be made with the consumer. If the consumer cannot be reached after three attempts, a letter will be sent to the consumer with request for return call. See **Consumer Letter No Response-CLS Assisted DC** on the Extranet for the letter the CLS will use.
    - Log Note Heading: Quarterly Check in for CLS Assisted Discharge

- Outcome of Check In: Unable to Reach-Letter Sent to Consumer/Caregiver

22.1 Saving the 90 Day Check In from NH DC as Incomplete

- While attempts are made to reach the consumer or caregiver, the Follow-Up in Web Referral will be saved as incomplete until a final outcome has been reached.
    - Final outcomes include the check-in screen being completed, the consumer cannot be reached after three attempts, the consumer has passed away, or the consumer has been admitted to the nursing home.
        - Contacts Out will be increased each time an attempt to contact the consumer or their primary caregiver/emergency contact is completed.
        - Follow-Up Date on the Follow-Up Status/Outcome screen in Web Referral: Next business day for additional attempt to contact consumer.
        - In-Person Assistance: Applicable value based on final type of assistance that was attempted

22.2 Documenting the 90 Day Check In

- Subsequent quarterly Follow-Ups will be completed by designated Senior LinkAge Line® Specialists in the Client Services Center. While all quarterly Follow-Ups will be assigned to the Client Services Center in Web Referral, the CLS will notify the consumer that another SLL specialist will be calling in about three months.
- Once the 90 day phone call/visit has been completed and the consumer agrees to additional follow-up, the CLS will notify the consumer that another SLL Specialist will be calling in about three months. If questions arise in the meantime, contact should be made with the Senior LinkAge Line® via 1-800-333-2433.
    - Log Note Heading: Quarterly Check In for CLS Assisted Discharge
    - Outcome of Call: Applicable values based on outcome of check in
    - Follow-Up Status/Outcome Screen
        - Follow-Up Type: 180 Day Check In from NH DC or other applicable Follow-Ups based on additional follow-up that may be needed on the consumer's behalf. For example, contacting an agency or the caregiver.
        - Assigned To: Client Services Center
        - Follow-Up Inquiry Date: Date Follow-Up completed with consumer
        - Contacted by: Senior LinkAge Line®
        - Call or Contact Made By: Senior LinkAge Line®
        - Contacts Out: Track how many contacts were attempted and any three-way calls or mailings that were completed to the consumer/caregiver
        - Survey Sent: Leave blank
        - Type of Services: Problem Solving/Problem Resolution–In Progress

22.3 Consumer Declines Further Contact at 90 Day Check In

- If the consumer declines further contact whether the check in was completed or not, the record will be closed as complete, and the consumer should be assured if they have questions in the future, to contact the Senior LinkAge Line®.
    - Log Note Heading: Return to Community Process Stopped
    - Outcome of Check In: Check In Completed/Consumer Declines Further Contact OR Check In Not Completed/Consumer Declined Contact
    - Follow-Up Status/Outcome Screen
        - Follow-Up Inquiry Date: Date Follow-Up completed with consumer
        - Contacted by: Senior LinkAge Line®
        - Call or Contact Made By: Senior LinkAge Line®
        - Contacts Out: Track how many contacts were attempted and any three-way calls or mailings that were completed to the consumer/caregiver
        - Survey Sent: Leave blank
        - Type of Services: Problem Solving/Problem Resolution–Fully Completed
    - No further follow-up scheduled.
- See the Senior LinkAge Line® Web Referral User Guide on the Extranet for detailed instructions on how to complete each screen of the quarterly Follow-Up.

23 CSC Conducts Follow-Up

23.1 Purpose and Role

- Senior LinkAge Line® Client Services Center Specialists conduct initial and quarterly follow-up for the Return to Community initiative. Initial and quarterly follow-up is offered to consumers regardless if the consumer is on Medical Assistance and is offered for five years after discharge from the nursing home or after a support plan is implemented for consumers already residing in the community.
    - Quarterly follow-up through the CSC will always be conducted over the phone.
- The quarterly follow-up calls are provided to ensure consumers are aging in place as successfully as possible. For those consumers who are part of the sampling approach, Long Term Care Options Counseling methods will be used when conducting the quarterly follow-up calls to help ensure consumers are staying in their homes for as long as possible. Long Term Care Options Counseling is defined in the Standards and Assurances and is a standard service provided by all Senior LinkAge Line® specialists. The information collected during these phone calls are used for evaluation purposes and shared with Dr. Greg Arling at Purdue University.

23.2 CLS Assisted Discharges

- The CSC takes over follow-up starting with the 180 Day Check In from NH DC for those who are assisted by CLS. Some CLS may choose to continue providing quarterly follow-up for the consumers they have directly assisted. This is at the discretion of the CLS and should only be maintained if the rest of their workload can be kept up to date.

23.3 Naturally Occurring Discharges

- For consumers who have not been directly assisted by the CLS, the CSC will conduct initial follow-up within 14 days from nursing home discharge to introduce the phone-based follow-up as well as the Senior LinkAge Line®.
- With consumer consent, the CSC will conduct quarterly follow-up phone calls for all consumers living in the community for up to five years.
- The CSC will take a sampling approach when conducting the actual quarterly Follow-Up with consumers who were not reached upon initial phone call which occurs 14 days from nursing home discharge. The sampling approach will be used to manage the number of outbound calls that are currently conducted by the CSC.

23.4 Initial Contact with Consumers Not Assisted by CLS

- When the CSC is conducting the first follow-up call with a consumer who has not received direct assistance by a CLS, the Return to Community initiative and purpose of the follow-up will need to be explained. Contact information for the consumer should be present in Web Referral. If not, consumers on Medicaid can be reviewed in MMIS to obtain current address and phone number.

23.4.1 Consumer Agrees to Additional Follow Up

- If the consumer/caregiver has been contacted and agrees to additional follow-up, an introduction letter about SLL will be sent to the consumer/caregiver including an attached brochure after the initial call. In addition to the introduction letter, the booklet titled, "The Senior LinkAge Line®, A One Stop Shop for Minnesota Seniors. Your link to an expert for aging well at home" will be sent to each consumer/caregiver. The consumer will also be informed that the SLL will call again in a few months to ask questions that will be used for the evaluation. See Initial Follow-Up Letter– Naturally Occurring DC on the Extranet for a copy of the letter that will be used with these consumers.
    - A 90 Day Check In from NH DC Follow-Up will be scheduled in Web Referral for 90 days from the nursing home discharge date.
    - A note should be placed in the instruction area of the Follow-Up to document that the consumer/caregiver agreed to quarterly follow-up so they are not excluded when sampling occurs.

23.4.2 Consumer Cannot Be Reached to Consent to Additional Follow Up

- If consumers cannot be reached after two attempts, the introduction letter and book titled, "The Senior LinkAge Line®, A One Stop Shop for Minnesota Seniors. Your link to an expert for aging well at home" will be sent to these consumers informing them about additional follow-up in a few months. See Initial Follow-Up Letter–Naturally Occurring DC–No Contact on the Extranet for a copy of the letter.
    - A 90 Day Check In from NH DC Follow-Up will be scheduled in Web Referral for 90 days from the nursing home discharge date.

- Notes should be placed in the instruction area of the Follow-Up to document that the consumer/caregiver has not been contacted nor did they agree to quarterly follow-up. This will designate who will be part of the quarterly follow-up calls when sampling occurs.

23.4.3 Consumer Declines Ongoing Follow Up but Requests Information

- If a consumer has been reached and is interested in information from Senior LinkAge Line® but does not want continued follow-up, appropriate SLL materials will be sent to the consumer as well as a letter. See Initial Follow-Up Letter-Naturally Occurring DC-Decline Further Contact on the Extranet for a copy of the letter.
  - A 90 Day Check In from NH DC Follow-Up will not be scheduled in Web Referral.

23.5 Consumer Contact Information Unavailable in CLS Role

- Consumer contact information should always be available on the Basic Data screen in the CLS Role of Web Referral. If the contact fields have not been completed, the consumer address and phone number will be obtained from the Basic Data screen in the SLL Role of Web Referral.

23.6 Obtaining Release of Information-1 Year

- Consumers who are not directly assisted by a CLS with discharge assistance from the nursing home or support plan implementation in the community need to provide permission to the CSC for collecting their personal information via the quarterly Follow-Ups. The CSC will mail the ROI—1-Year to the consumer/designated representative in a self-addressed stamped envelope that will be returned to the MN River AAA.
  - The ROI—1-Year should be sent to consumers who have been reached and accept continued follow-up in the community.
  - Once the ROI—1-Year has been obtained from consumer, it will be attached to the Community Planning Tool in Web Referral that triggered this set of follow-up calls.

24 Conducting a Quarterly Follow-Up-CLS Assisted/Naturally Occurring

- Consumers who have been directly assisted by a CLS receive the highest priority for completion of the quarterly follow-up survey in Web Referral. Consumers who are second priority include those who discharged naturally and *are not* on Medical Assistance. Third priority is those who discharged naturally and *are* on Medical Assistance.

24.1 Verifying if Consumer has Passed Away

- Before a quarterly follow-up call is attempted with a consumer, the CSC will verify if the person has passed away. This information will be obtained via a secure Revation eFolder called Death Records. The CSC will search for the consumer with identifying information provided in the client record of Web Referral. If the consumer has passed away, the Date of

Death will be documented in the most recent Community Planning Tool for which the quarterly follow-up is being conducted.

24.2 Sampling Methodology for Naturally Occurring Discharges

- A sampling approach will be used with consumers to determine who will receive quarterly follow-up calls from the CSC. Consumers included in the sampling approach include those who were discharged naturally from the nursing facility and not reached during the initial phone that occurred 14 days from discharge.
    - Sampling approach: Target every third consumer
    - Every third consumer who has a 90 day Check in from NH DC scheduled in Web Referral, has not been directly assisted by a CLS or reached upon initial call 14 days from discharge will receive two phone call attempts for completing the quarterly follow-up survey.
- The Follow-Ups for the other two consumers will be marked as Complete. These are consumers who have a 90 Day Check In from NH DC and were not reached upon initial phone call 14 days from discharge. The additional documentation will be input into Follow-Ups that are being closed Complete.
    - Log Note Heading: Return to Community Process Stopped
    - Outcome of Call: No Quarterly Call Attempted-SLL Information Sent
    - Follow-Up Status/Outcome Screen
        - Follow-Up Inquiry Date: Date Follow-Up saved as complete
        - Contacted by: Senior LinkAge Line®
        - Call or Contact Made By: Senior LinkAge Line®
        - Contacts Out: 0
        - Survey Sent: Leave blank
        - In-person Assistance: Telephone or Mail depending on most recent type of contact
        - Type of Services: Problem Solving/Problem Resolution–Fully Completed
    - No further follow-up scheduled.

24.2.1 Sample Script for Introducing Quarterly Follow Up

When introducing the quarterly follow-up survey to the consumer/caregiver, the following script can be used:

> "Hello, My name is _____. I am with the Senior LinkAge Line®. The Senior LinkAge Line® is a service of the MN Board on Aging and is provided through six Area Agencies on Aging that cover all counties in Minnesota. The Senior LinkAge Line® can assist you with finding services in your community that can help you stay at home as long as possible. [If first interview - We are contacting you because you were recently discharged from a nursing home.] [If previously contacted for Return to Community - You have spoken previously with a Community Living Specialist regarding how you are doing at home after leaving the nursing home. I am

following up to see how you are doing and to ask you a few questions.] We are gathering information in order to improve services for people who have returned to the community from a nursing home. We want to keep you and others living at home for as long as you can. We are also calling because we would like to give you the opportunity to participate in research for the state of Minnesota. My questions will take about 30 minutes. Would you be willing to participate and answer a few questions?

If consumer answers yes, but has not yet signed a release form: "Thank you, I need to mail you a release form that need to be signed and mailed back to me; I will include a self-addressed stamped envelope for you to return the form. A release form is necessary because we will be collecting private data about you. You are welcome to call the Senior LinkAge Line® if you have questions about the release form once you receive it in the mail.

If consumer answers no: "Thank you for your time. If you change your mind, please call the Senior LinkAge Line®. [End call and document in log notes.]

"Is now a good time for you, or could I schedule a better time to call you back?"

"Before we get started, I just need to go over a few things. First of all, I want to let you know that your participation is voluntary. You do not have to answer any of the questions or you can skip questions at any time. If you would like to stop the interview, we can do that. I can always call you back to complete the interview or you can tell me that you are finished."

24.3 Unable to Reach Consumer

- When conducting the scheduled quarterly Follow-Ups for the consumers identified through sampling and the consumer/caregiver is unable to be reached after two attempts, a letter will be sent to the consumer requesting a call back. The current quarterly Follow-Up will be closed as complete once the letter has been sent. See Quarterly Follow-Up Letter– No Contact on the Extranet for copy of letter to be used. Two letters have been provided for the CSC to use—one for the caregiver and one for the consumer depending on who the primary contact is.
- If the consumer has participated in previous quarterly Follow-Ups but now cannot be reached. A revised letter can be used which specifies the last time contact was made between the SLL and the consumer. See Quarterly Follow Up Letter-No Contact-Existing Consumer
- If the consumer was directly assisted by a CLS and cannot be reached, use letter titled Quarterly Follow-Up Letter-No Contact-CLS Assisted
    - Log Note Heading: Quarterly Check in for Naturally Occurring Discharge OR Quarterly Check In for CLS Assisted Discharge
    - Outcome of Check In: Letter sent to consumer/caregiver
    - Follow-Up Status/Outcome Screen
        - Follow-Up Inquiry Date: Date letter sent to consumer/caregiver
        - Contacted by: Senior LinkAge Line®

- Call or Contact Made By: Senior LinkAge Line®
- Contacts Out: At least four if documenting three voicemails and letter sent
- Survey Sent: Leave blank
- In-person Assistance: Telephone or Mail depending on most recent type of contact
- Type of Services: Problem Solving/Problem Resolution–Fully Completed

  - No further follow-up scheduled.

24.4 Obtaining Verbal and Written Consent

- If the consumer or caregiver is reached and written consent was not obtained during the initial contact, it will be need to be obtained now.
  - If verbal consent was gained during initial contact but the consumer/caregiver did not return the ROI—1-Year, additional verbal consent need to be obtained and another copy of the ROI—1-Year will be mailed with request to return.
  - The reason for follow-up as well as another introduction of SLL should be given to the consumer/caregiver to ensure they understand the service. See Sample Script to Introduce Follow-Up to Consumer/Caregiver.

24.5 Documenting Quarterly Follow Ups

- Quarterly Follow-Ups should be completed with the consumer whenever possible to ensure that the voice of the consumer is being recorded. If the consumer is unable to communicate due to medical needs, the primary caregiver can provide responses based on how the consumer would respond. The BIMS and PHQ-9 will not be recorded if the consumer cannot verbally communicate.
- See Senior LinkAge Line® Web Referral User Guide on the Extranet for detailed instructions on how to complete each screen of the quarterly Follow-Up in Web Referral.

24.5.1 Caregiver Interview

- The Caregiver Interview screen will be completed with the individual who assists the consumer with care or tasks that cannot be completed independently due to a disability or functional limitation. Cares or tasks could include nonmedical care such as help with bathing or dressing; medically necessary care such as assistance with medications or changing dressings; and/or assistance with instrumental activities such as transportation, appointment setting, or home cleaning/maintenance. This individual may be a relative, friend or neighbor.
  - The caregiver interview would NOT be conducted with a paid individual, whether a licensed professional or someone else employed by an agency, family or the consumer.
- Once the Follow-Up screens have been completed with the consumer and caregiver, the consumer/caregiver will be notified that additional follow-up will be conducted in 90 days. If anything is needed in the meantime, they should call the Senior LinkAge Line®. If the

consumer is moving out of state but resources are still being sent from SLL, use the cover letter titled, Mail Resources Follow Up Letter-Out of State

24.5.2 Web Referral Tracking

- Appropriate problem/needs will be attached to each session based on topics that were discussed with the consumer/caregiver.
- Referrals will be made as appropriate through three-way calls. Standard Long Term Care Options Counseling methods should be used when conducting quarterly phone calls with consumers/caregivers.

24.5.3 Mailing Resources and Making Referrals

- Resources may be sent to the consumer/caregiver after a call is completed. See letter titled Mail Resources–Follow Up Letter-Consumer and Mail Resources-Follow Up Letter-Caregiver on the Extranet.
- There may be times when the CSC is mailing resources as well as another copy of the ROI-1-Year. The CSC will use the letters titled, Mail Resources and ROI Follow Up Letter-Caregiver or Mail Resources and ROI Follow Up Letter-Consumer depending on who the mailing is going to.
- If the consumer is on a waiver or a Managed Care Plan, and the consumer is struggling at home, the case manager/care coordinator should be contacted with the consumer's permission to provide an update.
    - Log Note Heading: Quarterly Check in for Naturally Occurring Discharge or Quarterly Check In for CLS Assisted Discharge
    - Outcome of Call: Applicable values based on phone call
    - Follow-Up Type: Next scheduled Follow-Up type based on quarterly follow-up schedule (Example: 180 Check In from NH DC, 270 Day Check in from NH DC)
    - Follow-Up Date: Based on Actual Discharge Date or Support Plan Implementation Date
    - Follow-Up Status/Outcome Screen
        - Follow-Up Inquiry Date: Date Follow-Up completed with consumer/caregiver
        - Contacted by: Senior LinkAge Line®
        - Call or Contact Made By: Senior LinkAge Line®
        - Contacts Out: Number based on attempts to reach consumer/caregiver and any mailings
        - Survey Sent: Leave blank
        - Type of Services: Problem Solving/Problem Resolution–In Progress
- Additional Follow-Ups may be scheduled with the consumer/caregiver as appropriate, based on resources provided in the community or other relevant topics. These phone calls can be completed by a case aide.
- There will be times when the consumer declines further contact after a quarterly call has been completed but would still like resources mailed to them. See letter titled, Mail Resources Decline Further Contact-Existing Consumer

25 Referrals to Other Organizations

25.1 Regional Ombudsman for Long-Term Care

- If CLS does not receive cooperation from consumer's support person(s), they will contact the designated Regional Office of Ombudsman for Long-Term Care staff after gaining the consumer's permission. The Ombudsman will serve as a consumer advocate to reiterate the consumer's right to return to the community.
- See Refer to Referral Protocol between SLL and Ombudsman for Long-term Care dated April 9, 2010.
- If the CLS is not receiving cooperation from the nursing home designee for contacting the consumer, the CLS may call the Ombudsman directly by making an Informational Referral. The Ombudsman may provide insight about the particular nursing home or nursing home designee or the ombudsman may enter the nursing home to contact the consumer on behalf of the CLS. This will vary depending on the exact situation.
    - Log note heading: Return to Community Ombudsman Referral

25.2 Lead Agency for MnCHOICES Assessment

- At any point in the process of helping a consumer, it may become evident that a referral for public programs is needed. MnCHOICES (face to face assessments) are required in order to determine if someone qualifies for Medicaid or a home- and community-based waiver. These assessments are completed by the lead agency (county or tribe).
- Referrals should be made with permission from the consumer or designated representative/caregiver. Referrals will be documented in Web Referral on the LTCC Referral/Follow-Up screen.
    - Log note heading: Return to Community Referral to Public Program
    - SLL Role: LTCC Referral/Follow-Up screen
    - Problem/Need: 031.450 Long-Term Care Consultation (LTCC)

25.3 County Veterans Service Officer

- If consumer is a veteran and gives the CLS permission, a referral will be made to the County Veterans Service Officer (CVSO) for benefits screening. CVSO referrals will be documented in Web Referral. SLL specialists should continue with the protocol even if a referral is made.
    - Log note heading: Return to Community CVSO Referral
    - Problem/Need: 049.090 CVSO Issue
- Consumers can also be referred to the Veterans Linkage Line™ at 1-888-LINK-VET for phone-based counseling. The Veterans Linkage Line™ staff can also be found in Revation.

25.4 Center for Independent Living (CIL) or Lead Agency for Consumers on Medical Assistance

- Consumers who are on Medical Assistance or Alternative Care and residing in a nursing facility have access to Relocation Service Coordination (RSC) for 180 days from the date of the

referral. The nursing home social worker makes the referral to the county of residence. This information can be found in MMIS.

- RSC can be provided by the county, managed care organization or a private vendor if the lead agency chooses to make a referral to that entity. This service can also be provided by Centers for Independent Living.
- Consumers who are on Medical Assistance should not receive in-person assistance from a CLS but instead referred to their designated helping entity for discharge assistance.
- Consumers can also be referred to the Disability Linkage Line™ at 1-866-333-2466 for phone-based counseling. They specialize in assisting consumers age 59 and below.

25.5 Common Entry Point

- According to the Standards and Assurances, Senior LinkAge Line® staff and SOS shall be considered Vulnerable Adults Mandated Reporters and report all suspected maltreatment to the Minnesota Adult Abuse Maltreatment Center (MAARC) regardless of where the vulnerable adult lives or where the maltreatment occurred. Minnesota moved to a statewide reporting system on July 1, 2015. A web-based tool (www.mn.gov/dhs/reportadultabuse/) and toll free number of 1-844-880-1574 are available so reports can be made 24/7.
    - A vulnerable adult can be any person over age 18 who:
        - Has a physical, mental or emotional disability that makes it difficult for the person to care for themselves or to protect themselves from maltreatment
        - Is in a hospital, nursing home, transitional care unit, assisted living, housing with services, board and care, foster care or other licensed care
        - Receives services such as home care, day services, personal care attendant/PCA, employment training, treatment for mental illness, etc.
    - There are three basic kinds of maltreatment:
        - Abuse – physical, emotional or sexual
        - Neglect – The vulnerable person does not have necessary food, shelter, clothing, health care or supervision due to neglect by a caregiver, or because the vulnerable adult cannot meet their own needs.
        - Financial exploitation – The vulnerable adult's money, assets or property are not used for their benefit or are stolen or kept from them.
    - Log note heading: Provider Contact

26 Communications

26.1 Nursing Homes

- On an annual basis, each nursing home in the AAA region will receive an in-service/presentation regarding the assistance that is available through the SLL to ensure that nursing facility staff are aware of the Senior LinkAge Line®, the in-person assistance available for non-MA consumers and how and why referrals for MDS Section Q are made to the Local Contact Agency (LCA). In Minnesota, the LCA is the Senior LinkAge Line®.

- During these presentations and during ad hoc visits, CLS will ensure that nursing facilities have an adequate supply of any SLL materials they may request but especially the Start Planning Now to Return Home and Remain at Home Successfully brochure that is specifically provided to all nursing home residents upon admission.
- All presentations/in-services and offers of SLL or MinnesotaHelp Network™ materials will be documented in the Extranet calendar.

26.2 Regional Ombudsman for Long-Term Care

- The CLS should maintain a positive working relationship with the regional ombudsman for long-term care who serves the residents of the nursing homes located in each AAA region. Ombudsman contact information can be found on the Extranet.

26.3 Nursing Homes Who May be Resistive to Working with CLS

- If CLS does not receive cooperation from designated nursing home staff, the CLS will notify the designated Consumer Choices Team staff, prior to speaking to administrative staff in the nursing home (Director of Nursing or Administrator).
    - Example: Nursing home is refusing to return phone calls from CLS, refusing to cooperate with CLS and carry out wishes of consumer to return to community.
- If CLS does not receive cooperation from the administrator of the nursing home the CLS will notify the designated Consumer Choices Team Return to Community staff, each time this intervention is needed.
    - Log note heading: Return to Community Nursing Home Resistance

26.4 Lead Agencies

- Communication with counties and managed care organizations should happen on an as-needed basis. For consumers who are on a public program or are dual eligible and have a case worker or managed care coordinator and the nursing home would like assistance with the discharge, the CLS should contact the appropriate party to help facilitate the discharge for the consumer from the nursing home.
- If the nursing home expresses frustration with a lead agency due to lack of communication or lack of assistance with discharge planning, and asks the CLS for assistance, the CLS will contact designated staff on the Consumer Choices Team for assistance.
    - Detailed accounts should be provided if follow-up is being requested from the Consumer Choices Team so accurate information can be relayed to policy staff at the MN Department of Human Services. All client information will be sent via Revation and not through regular email.
- Each situation will have unique characteristics with specific needs and should be treated respectfully.

27 Community Living Specialist Metrics

- Individual dashboards for each Community Living Specialist will be created on a quarterly basis and shared with the AAA Directors. Any dashboards produced about the Senior LinkAge Line® are considered public information.
- The dashboards will measure individual aspects of the CLS protocol including data completion and timeliness, monthly discharge goals of at least six per month, CLSP development and completion, in-services to nursing homes on a yearly basis, and consumer satisfaction based on Community Outreach Surveys that are provided to consumers who are directly assisted by a CLS.
- All metrics that are used on the CLS individual dashboard are located in Community Living Specialist Metrics Template (Appendix E).

Appendix A: Medications Tip Sheet-Brand name to Generic Name and Category

A

Brand Name	Generic Name	Category
Abilify	Aripiprazole	Psychotropics: Antipsychotics
Actoplus Met	Metformin-pioglitazone	Hypoglycemics
Actos	Pioglitazone	Hypoglycemics
ALAPRAZolam XR	Alprazolam	Psychotropics: Hypnotic/Sedative
Aler-Dryl (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Aller-Chlor (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Allergy (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Allergy 4 hour (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Allergy Relief (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Allergy Relief (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Allergy Relief Children's (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Allergy-Time (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
ALAPRAZolam Intensol	Alprazolam	Psychotropics: Hypnotic/Sedative
Altaryl (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Amaryl	Glimepiride	Hypoglycemics
Ambien	Zolpidem	Psychotropics: Hypnotic/Sedative
Ambien CR	Zolpidem	Psychotropics: Hypnotic/Sedative
Amitid	Amitriptyline	Psychotropics: Antidepressants
Amitril	Amitriptyline	Psychotropics: Antidepressants
Amrix	Cyclobenzaprine	Skeletal Muscle Relaxants
Amrix;	Cyclobenzaprine	Skeletal Muscle Relaxants
Anafranil	Clomipramine	Psychotropics: Antidepressants
Anafranil	Clomipramine	Psychotropics: Antidepressants
Anaspaz	Hyoscyamine	Anticholinergics: Definite/Strong Only
Anectine	Succinylcholine	Skeletal Muscle Relaxants
Anti-Hist (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Anti-Hist Allergy (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Antivert	Meclizine	Anticholinergics: Definite/Strong Only
Apidra	Insulin glusne	Hypoglycemics
Aplenzin	Bupropion	Psychotropics: Antidepressants
Apo-Butorphanol	Butorphanol	Narcotic Analgesics
Apo-Chlorpropamide	Chlorpropamide	Hypoglycemics
Apo-Flavoxate (Cananda)	Flavoxate	Anticholinergics: Definite/Strong Only
Apo-Flurazepam (Canada)	Flurazepam	Psychotropics: Hypnotic/Sedative
Apo-Methoprazine (Canada)	Methotrimeprazine	Anticholinergics: Definite/Strong Only
Apo-Midazolam (Canada)	Midazolam	Psychotropics: Hypnotic/Sedative
Apo-Oxazepam (Canada)	Oxazepam	Psychotropics: Hypnotic/Sedative
Apo-Tolbutamide (Canada)	Tolbutamide	Hypoglycemics
Arbinoxa	Carbinoxamine	Anticholinergics: Definite/Strong Only
Aripiprex	Aripiprazole	Psychotropics: Antipsychotics
Asendin	Amoxapine	Psychotropics: Antidepressants
Asendin	Amoxapine	Psychotropics: Antidepressants
Astromorph	Morphine	Narcotic Analgesics
Ativan	Lorazepam	Psychotropics: Hypnotic/Sedative

Brand Name	Generic Name	Category
AtroPen	Atropine	Anticholinergics: Definite/Strong Only
Atropine-Care	Atropine	Anticholinergics: Definite/Strong Only
Avandamet	Metformin-rosiglitazone	Hypoglycemics
Avandaryl	Rosiglitazone-Glimepiride	Hypoglycemics
Avandia	Rosiglitazone	Hypoglycemics
AVINza	Morphine	Narcotic Analgesics

B

Brand Name	Generic Name	Category
Banophen (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Benadryl (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Benadryl Allergy (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Benadryl Allergy Childrens (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Benadryl Dye Free Allergy (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Bentyl	Dicyclomine	Anticholinergics: Definite/Strong Only
Bio-Oxazepam (Cananda)	Oxazepam	Psychotropics: Hypnotic/Sedative
Brilinta	Ticagrelor	Antiplatelet Agents
Budeprion XI (DSC)	Bupropion	Psychotropics: Antidepressants
Buprenex	Buprenorphine	Narcotic Analgesics
Buproban	Buproban	Psychotropics: Antidepressants
BuSpar	Buspirone	Psychotropics: Antidepressants
Butisol Sodium	Butabarbital	Psychotropics: Hypnotic/Sedative
Butrans	Buprenorphine	Narcotic Analgesics
Bydureon	Exenatide	None
Byetta	Exenatide	None

C

Brand Name	Generic Name	Category
Carbatrol	Carbamazepine	Anticholinergics: Definite/Strong Only
Carbatrol	Carbamazepine	Anticholinergics: Definite/Strong Only
CeleXA	Citalopram	Psychotropics: Antidepressants
Cerebyx	Fosphenytoin	Psychotropics: Antiepileptics
Chlorphen (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Chlorpromazine Hydrochloride Inj (Canada)	Chlorpromazine	Psychotropics: Antipsychotics
Chlor-Trimeton (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Clozaril	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Clozaril; FazaClo	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Cogentin	Benztropine	Anticholinergics: Definite/Strong Only
Compazine	Prochlorperazine	Psychotropics: Antipsychotics
Complete Allergy Medication (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Complete Allergy Relief (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Compro	Prochlorperazine	Psychotropics: Antipsychotics
Coumadin	Warfarin	Oral Anticoagulant
Cymbalta	Duloxetine	Psychotropics: Antidepressants

D

Brand Name	Generic Name	Category

Dalmadorm	Flurazepam	Psychotropics: Hypnotic/Sedative
Dalmane (Canada)	Flurazepam	Psychotropics: Hypnotic/Sedative
Dantrium	Dantrolene	Skeletal Muscle Relaxants
Dayhist Allergy 12 hr Relief OTC	Clemastine	Anticholinergics: Definite/Strong Only
Demerol	Meperidine	Anticholinergics: Definite/Strong Only
Demerol	Meperidine	Anticholinergics: Definite/Strong Only
Depacon	Valproate Sodium	Psychotropics: Antiepileptics
Depacon	Valproic Acid	Psychotropics: Antiepileptics
Depacon	Divalproex Sodium	Psychotropics: Antiepileptics
Depakene	Valproate Sodium	Psychotropics: Antiepileptics
Depakene	Valproic Acid	Psychotropics: Antiepileptics
Depakene	Divalproex Sodium	Psychotropics: Antiepileptics
Depakote	Valproate Sodium	Psychotropics: Antiepileptics
Depakote	Valproic Acid	Psychotropics: Antiepileptics
Depakote	Divalproex Sodium	Psychotropics: Antiepileptics
Depakote ER	Valproate Sodium	Psychotropics: Antiepileptics
Depakote ER	Valproic Acid	Psychotropics: Antiepileptics
Depakote ER	Divalproex Sodium	Psychotropics: Antiepileptics
Depakote Sprinkle	Valproate Sodium	Psychotropics: Antiepileptics
Depakote Sprinkle	Valproic Acid	Psychotropics: Antiepileptics
Depakote Sprinkle	Divalproex Sodium	Psychotropics: Antiepileptics
Detrol	Tolterodine	Anticholinergics: Definite/Strong Only
Detrol LA	Tolterodine	Anticholinergics: Definite/Strong Only
Detrunorm	Propiverine	None
Diabeta	Glyburide	Hypoglycemics
Diastat AcuDial	Diazepam	Psychotropics: Hypnotic/Sedative
Diastat Pediatric	Diazepam	Psychotropics: Hypnotic/Sedative
Diazepam Intensol	Diazepam	Psychotropics: Hypnotic/Sedative
Dilantin	Phenytoin	Psychotropics: Antiepileptics
Dilantin Infatabs	Phenytoin	Psychotropics: Antiepileptics
Dilaudid	Hydromorphone	Narcotic Analgesics
Dilaudid 5	Hydromorphone	Narcotic Analgesics
Dilaudid - HP	Hydromorphone	Narcotic Analgesics
Diphen (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Diphenhist (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Diprivan	Propofol	Psychotropics: Hypnotic/Sedative
Ditropan XL	Oxybutynin	Anticholinergics: Definite/Strong Only
Dolophine	Methadone	Narcotic Analgesics
Dramamine (OTC)	Dimenhydrinate	Anticholinergics: Definite/Strong Only
Dramamaine Less Drowsy (OTC)	Meclizine	Anticholinergics: Definite/Strong Only
Driminate (OTC)	Dimenhydrinate	Anticholinergics: Definite/Strong Only
Duetact	Gilmepiride-pioglitazone	Hypoglycemics
Duramorph	Morphine	Narcotic Analgesics
Dymelor	Acetohexamide	Hypoglycemics

E

Brand Name	Generic Name	Category
Ecotrin	Asprin	Antiplatelet Agents
Ed Baclofen	Baclofen	Skeletal Muscle Relaxants

Ed ChlorPed	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Ed ChlorPed (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Ed ChlorPed Jr. (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Ed-Chlor-Tan	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Ed-Chlortan (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Edluar	Zolpidem	Psychotropics: Hypnotic/Sedative
Ed-Spaz	Hyoscyamine	Anticholinergics: Definite/Strong Only
Effexor XR	Venlafaxine	Psychotropics: Antidepressants
Effient	Prasugrel	Antiplatelet Agents
Elavil	Amitriptyline	Psychotropics: Antidepressants
Elavil	Amitriptyline	Psychotropics: Antidepressants
Eliquis	Apixaban	None
Enablex	Darifenacin	Anticholinergics: Definite/Strong Only
Endep	Amitriptyline	Psychotropics: Antidepressants
Epitol	Carbamazepine	Anticholinergics: Definite/Strong Only
Epitol	Carbamazepine	Anticholinergics: Definite/Strong Only
Equetro	Carbamazepine	Anticholinergics: Definite/Strong Only
Equetro	Carbamazepine	Anticholinergics: Definite/Strong Only
Euro-Cyproheptadine	Carbamazepine	Anticholinergics: Definite/Strong Only
Exalgo	Hydromorphone	Narcotic Analgesics
EXUBERA	Insulin Inhalation	Hypoglycemics

F

Brand Name	Generic Name	Category
Fanapt	Iloperidone	Psychotropics: Antipsychotics
Fasprin	Aspirin	Antiplatelet Agents
FazaClo	Clozapine	Psychotropics: Antipsychotics
Felbatol	Felbamate	Psychotropics: Antiepileptics
Fexmid	Cyclobenzaprine	Anticholinergics: Definite/Strong Only
Fexmid	Cyclobenzaprine	Anticholinergics: Definite/Strong Only
Flexeril (DSC)	Cyclobenzaprine	Anticholinergics: Definite/Strong Only
Flexeril (DSC)	Cyclobenzaprine	Anticholinergics: Definite/Strong Only
Fortamet	Metformin	None
Fortfivo XL	Bupropion	Psychotropics: Antidepressants
Fresenius Propoven	Propofol	Psychotropics: Hypnotic/Sedative

G

Brand Name	Generic Name	Category
Gabitril	Tiagabine	Psychotropics: Antiepileptics
Gablofen	Baclofen	Skeletal Muscle Relaxants
Gelnique	Oxybutynin	Anticholinergics: Definite/Strong Only
Genahist (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Geodon	Ziprasidone	Psychotropics: Antipsychotics
Geri-Dryl (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
GlipiZIDE XL	Glipizide	Hypoglycemics
Glucophage	Metformin	none
Glucophage XR	Metformin	none
Glucotrol	Glipizide	Hypoglycemics
Glucotrol XL	Glipizide	Hypoglycemics
Glucovance	Glyburide-metformin	Hypoglycemics

Glumetza	Metformin	none
Glynase	GlyBURIDE	Hypoglycemics
Glyset	Miglitol	Hypoglycemics
Gralise	Gabapentin	Psychotropics: Antiepileptics
Gralise Starter	Gabapentin	Psychotropics: Antiepileptics

H

Brand Name	Generic Name	Category
Halcion	Triazolam	Psychotropics:Hypnotic/Sedative
Haldol	Haloperidol	Psychotropics: Antipsychotics
HumaLOG	Insulin lispro	Hypoglycemics
Humalog	Insulin lispro-insulin	Hypoglycemics
HumaLOG KwikPen	Insulin lispro	Hypoglycemics
Humalog Mix 50/50	Lispro protamine	Hypoglycemics
Humalog Mix 75/25	Lispro protamine	Hypoglycemics
Humalin 70/30	Insulin isophane-insulin regular	Hypoglycemics
Hycet	Hydrocodone	Narcotic Analgesics
HyoMax-SL	Hyoscyamine	Anticholinergics: Definite/Strong Only
Hyosyne	Hyoscyamine	Anticholinergics: Definite/Strong Only

I

Brand Name	Generic Name	Category
Infumorph 200	Morphine	Narcotic Analgesics
Interme	Zolpidem	Psychotropics: Hypnotic/Sedative
Invega	Paliperidone	Psychotropics: Antipsychotics
Isopto Atropine	Atropine	Anticholinergics: Definite/Strong Only

J

Brand Name	Generic Name	Category
Jantoven	Warfarin	Oral Anticoagulant
Janumet	Metformin-sitagliptin	Hypoglycemics
Januvia	Sitagliptin	Hypoglycemics
J-Tan PD (OTC)	Brompheniramine	Anticholinergics: Definite/Strong Only

K

Brand Name	Generic Name	Category
Kadian	Morphine	Narcotic Analgesics
Keppra	Levetiracetam	Psychotropics: Antiepileptics
Keppra XR	Levetiracetam	Psychotropics: Antiepileptics
KlonoPIN	Clonazepam	Psychotropics: Hypnotic/Sedatives

L

Brand Name	Generic Name	Category
LaMICtal	Lamotrigine	Psychotropics: Antiepileptics
LaMICtal ODT	Lamotrigine	Psychotropics: Antiepileptics
LaMICtal Starter	Lamotrigine	Psychotropics: Antiepileptics
LaMICtal XR	Lamotrigine	Psychotropics: Antiepileptics
Lantus	Insulin glargine	Hypoglycemics
Lantus SoloStar	Insulin glargine	Hypoglycemics
Latuda	Lurasidone	Psychotropics: Antipsychotics

Levbid	Hyoscyamine	Anticholinergics: Definite/Strong Only
Levemir	Insulin detemir	Hypoglycemics
Levemir FlexPen	Insulin detemir	Hypoglycemics
Levsin	Hyoscyamine	Anticholinergics: Definite/Strong Only
Levsin/SL	Hyoscyamine	Anticholinergics: Definite/Strong Only
Lexapro	Escitalopram	Psychotropics: Antidepressants
Lioresal	Baclofen	Skeletal Muscle Relaxants
LORazepam Intensol	Lorazepam	Psychotropics: Hypnotic/Sedative
Lorcet 10/650	Hydrocodone	Narcotic Analgesics
Lorcet Plus	Hydrocodone	Narcotic Analgesics
Lortab	Hydrocodone	Narcotic Analgesics
Lorzone	Chlorzoxazone	Skeletal Muscle Relaxants
Loxitane	Loxapine	Psychotropics: Antipsychotics
Loxitane	Loxapine	Psychotropics: Antipsychotics
Luminal	Phenobarbital	Psychotropics: Antiepileptics
Lunesta	Eszopiclone	Psychotropics: Hypnotic/Sedative
Luvox CR	Fluvoxamine	Psychotropics: Antidepressants
Lyrica	Pregabalin	Psychotropics: Antiepileptics

M

Brand Name	Generic Name	Category
Margesic H	Hydrocodone	Narcotic Analgesics
Maxidone	Hydrocodone	Narcotic Analgesics
Medi-Meclizine (OTC)	Meclizine	Anticholinergics: Definite/Strong Only
Mellaril	Thioridazine	Anticholinergics: Definite/Strong Only
Mellaril	Thioridazine	Anticholinergics: Definite/Strong Only
Meperitab	Meperidine	Anticholinergics: Definite/Strong Only
Meperitab	Meperidine	Anticholinergics: Definite/Strong Only
Metaglip	Gilpizide-metformin	Hypoglycemics
Methadone HCl Intensol	Methadone	Narcotic Analgesics
Methadose	Methadone	Narcotic Analgesics
Methadose Sugar Free	Methadone	Narcotic Analgesics
Moban	Molindone	Anticholinergics: Definite/Strong Only
Motion Sickness (OTC)	Dimenhydrinate	Anticholinergics: Definite/Strong Only
MS Contin	Morphine	Narcotic Analgesics
Mysoline	Primidone	Psychotropics: Antiepileptics

N

Brand Name	Generic Name	Category
Navane	Thiothixene	Psychotropics: Antipsychotics
Nefogesic	Nefopam	none
Neurontin	Gabapentin	Psychotropics: Antiepileptics
Nighttime Sleep Aid	Diphenhydramine	Anticholinergics: Definite/Strong Only
Nirvam	Alprazolam	Psychotropics: Hypnotic/Sedative
No brand	Fosphenytoin	Psychotropics: Antiepileptics
No brand	Codeine	Narcotic Analgesics
No brand	Fentanyl Alfentanyl	Narcotic Analgesics
No brand	Opium	Narcotic Analgesics
No brand	Butorphanol	Narcotic Analgesics
No brand	Flavoxate	Anticholinergics: Definite/Strong Only

No brand	Perphenazine	Psychotropics: Antipsychotics
Norco	Hydrocodone	Narcotic Analgesics
Norflex	Orphenadrine	Anticholinergics: Definite/Strong Only
Norflex	Orphenadrine	Anticholinergics: Definite/Strong Only
Norpramin	Desipramine	Anticholinergics: Definite/Strong Only
Norpramin	Desipramine	Anticholinergics: Definite/Strong Only
Novolin 70/30	Insulin isophane-insulin regular	Hypoglycemics
NovoLOG	Insulin aspart	Hypoglycemics
NovoLOG FlexPen	Insulin aspart	Hypoglycemics
NovoLOG PenFill	Insulin aspart	Hypoglycemics
NovoLOG/NovoRapid	Insulin aspart	Hypoglycemics
NovoLOG Mix 70/30	Aspart protamine	Hypoglycemics
Novo-Meprazin (Canada)	Methotrimeprazine	Anticholinergics: Definite/Strong Only
Novoxapram (Canada)	Oxazepam	Hypoglycemics
Nozinan (Canada)	Methotrimeprazine	Anticholinergics: Definite/Strong Only
Nubain	Nalbuphine	Narcotic Analgesics
NuLev	Hyoscyamine	Anticholinergics: Definite/Strong Only
Nytol (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Nytol Maximum Strength (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only

O

Brand Name	Generic Name	Category
Oleptro	Trazadone	Psychotropics: Antidepressants
Onglyza	Saxagliptin	Hypoglycemics
Opana	Oxymorphone	Narcotic Analgesics
Opana ER (crush Resistant)	Oxymorphone	Narcotic Analgesics
Orap	Pimozide	Anticholinergics: Definite/Strong Only
Orap	Pimozide	Anticholinergics: Definite/Strong Only
Oscimin	Hyoscyamine	Anticholinergics: Definite/Strong Only
Oscimin SR	Hyoscyamine	Anticholinergics: Definite/Strong Only
Oxecta	Oxycodone	Narcotic Analgesics
Oxpam (Canada)	Oxazepam	Hypoglycemics
Oxpram (Canada)	Oxazepam	Hypoglycemics
Oxtellar XR	Oxcarbazepine	Psychotropics: Antiepileptics
Oxtellar XR	Oxcarbazepine	Psychotropics: Antiepileptics
OxyCONTIN	Oxycodone	Narcotic Analgesics
Oxytrol	Oxybutynin	Anticholinergics: Definite/Strong Only

P

Brand Name	Generic Name	Category
Palgic	Carbinoxamine	Anticholinergics: Definite/Strong Only
Pamelor	Nortriptyline	Anticholinergics: Definite/Strong Only
Pamelor	Nortriptyline	Anticholinergics: Definite/Strong Only
Parafon Forte (DSC)	Chlorzoxazone	Skeletal Muscle Relaxants
Paxil	Paroxetine	Anticholinergics: Definite/Strong Only
Paxil	Paroxetine	Anticholinergics: Definite/Strong Only
Paxil CR	Paroxetine	Anticholinergics: Definite/Strong Only
Paxil CR	Paroxetine	Anticholinergics: Definite/Strong Only

PediaCare Children's Allergy (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Permitil	Fluphenazine	Psychotropics: Antipsychotics
Persantine	Dipyridamole	Antiplatelet Agents
Pexeva	Paroxetine	Anticholinergics: Definite/Strong Only
Pexeva	Paroxetine	Anticholinergics: Definite/Strong Only
Pharbechlor (OTC)	Chlorpheniramine	Anticholinergics: Definite/Strong Only
Pharbedryl	Diphenhydramine	Anticholinergics: Definite/Strong Only
Phenadoz	Promethazine	Anticholinergics: Definite/Strong Only
Phenadoz	Promethazine	Anticholinergics: Definite/Strong Only
Phenergan	Promethazine	Anticholinergics: Definite/Strong Only
Phenergan	Promethazine	Anticholinergics: Definite/Strong Only
Phenytek	Phenytoin	Psychotropics: Antiepileptics
Phenytoin Infatabs	Phenytoin	Psychotropics: Antiepileptics
Piomet	Metformin-pioglitazone	Hypoglycemics
Plavix	Clopidogrel	Antiplatelet Agents
Pletal	Cilostazol	Antiplatelet Agents
PMS-Butorphanol	Butorphanol	Narcotic Analgesics
PMS-Cyproheptadine	Cyproheptadine	Anticholinergics: Definite/Strong Only
PMS- Methotrimeprazine (Canada)	Methotrimeprazine	Anticholinergics: Definite/Strong Only
PMS- Oxazepam (Canada)	Oxazepam	Psychotropics: Hypnotic/Sedative
PMS-Trihexyphenidyl (Canada)	Trihexyphenidyl	Anticholinergics: Definite/Strong Only
Politor	Metformin-pioglitazone	Hypoglycemics
Pradaxa	Dabigatran Etexilate	Oral Anticoagulant
Prandin	Repaglinide	Hypoglycemics
Precose	Acarbose	Hypoglycemics
Prestiq	Desvenlafaxine	Psychotropics: Antidepressants
Pro-Banthine	Propantheline	Anticholinergics: Definite/Strong Only
Procomp	Prochlorperazine	Psychotropics: Antipsychotics
Prolixin	Fluphenazine	Psychotropics: Antipsychotics
Promapar	Chlorpromazine	Psychotropics: Antipsychotics
Promethegan	Promethazine	Psychotropics: Antipsychotics
Promethegan	Promethazine	Anticholinergics: Definite/Strong Only
Prosom	Estazolam	Psychotropics: Hypnotic/Sedative
PROzac	Fluoxetine	Psychotropics: Antidepressants
PROzac Weekly	Fluoxetine	Psychotropics: Antidepressants

Q

Brand Name	Generic Name	Category
Q-Dryl (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Quelicin	Succinylcholine	Skeletal Muscle Relaxants
Quelicin- 1000	Succinylcholine	Skeletal Muscle Relaxants
Quenalin (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only

R

Brand Name	Generic Name	Category
Remeron	Mirtazapine	Psychotropics: Antidepressants
Remeron SolTab	Mirtazapine	Psychotropics: Antidepressants
Respa-BR	Brompheniramine	Anticholinergics: Definite/Strong Only
Restoril	Temazepam	Psychotropics: Hypnotic/Sedative

Revonto	Dantrolene	Skeletal Muscle Relaxants
Riomet	Metformin	Hypoglycemics
Risperdal	Risperidone	Psychotropics: Antipsychotics
Riva-Oxazepam (Canada)	Oxazepam	Psychotropics: Hypnotic/Sedative
Robaxin	Methocarbamol	Anticholinergics: Definite/Strong Only
Robaxin;	Methocarbamol	Anticholinergics: Definite/Strong Only
Robaxin- 750	Methocarbamol	Anticholinergics: Definite/Strong Only
Robaxin - 750	Methocarbamol	Anticholinergics: Definite/Strong Only
Roxicodone	Oxycodone	Narcotic Analgesics

S

Brand Name	Generic Name	Category
Sabril	Vigabatrin	Psychotropics: Antiepileptics
Sanctura	Trospium	None
SAPHRIS	Asenapine	Psychotropics: Antipsychotics
Sarafem	Fluoxetine	Psychotropics: Antidepressants
Scot-Tussin Allergy Relief (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Seroquel	Quetiapine	Anticholinergics: Definite/Strong Only
SEROquel	Quetiapine	Anticholinergics: Definite/Strong Only
Seroquel XR	Quetiapine	Anticholinergics: Definite/Strong Only
SEROquel XR	Quetiapine	Anticholinergics: Definite/Strong Only
Siladryl Allergy (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Silenor	Doxepin	Psychotropics: Antidepressants
Silenor	Doxepin	Psychotropics: Antidepressants
Silphen Cough (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Simply Allergy (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Simply Sleep (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Skelaxin	Metaxolone	Skeletal Muscle Relaxants
Skelaxin	Metaxolone	Skeletal Muscle Relaxants
Sleep Tabs (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Som Pam (Canada)	Flurazepam	Psychotropics: Hypnotic/Sedative
Soma	Carisoprodol	Skeletal Muscle Relaxants
Sominex (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Sominex Max. Strength (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Somnote (DSC)	Chloral hydrate	Psychotropics: Hypnotic/Sedative
Sonata	Zaleplon	Psychotropics: Hypnotic/Sedative
Stagesic	Hydrocodone	Narcotic Analgesics
Starlix	Nateglinide	Hypoglycemics
Stavzor	Divalproex	Psychotropics: Antiepileptics
Stelazine	Trifluoperazine	Anticholinergics: Definite/Strong Only
Stelazine	Trifluoperazine	Anticholinergics: Definite/Strong Only
Surmontil	Trimipramine	Anticholinergics: Definite/Strong Only
Surmontil	Trimipramine	Anticholinergics: Definite/Strong Only
Symax Duotab	Hyoscyamine	Anticholinergics: Definite/Strong Only
Symax FasTabs	Hyoscyamine	Anticholinergics: Definite/Strong Only
Symax - SL	Hyoscyamine	Anticholinergics: Definite/Strong Only
Symax –SR	Hyoscyamine	Anticholinergics: Definite/Strong Only
SymlinPen 120	Pramlintide	Hypoglycemics
SymlinPen 60	Pramlintide	Hypoglycemics
Symmetrel	Amantadine	Anticholinergics: Definite/Strong Only

T

Brand Name	Generic Name	Category
Tavist Allergy (OTC)	Clemastine	Anticholinergics: Definite/Strong Only
TEGretol	Carbamazepine	Anticholinergics: Definite/Strong Only
TEGretol	Carbamazepine	Anticholinergics: Definite/Strong Only
TEGretol XR	Carbamazepine	Anticholinergics: Definite/Strong Only
TEGretol XX	Carbamazepine	Anticholinergics: Definite/Strong Only
Tetra-Formula Nightime Sleep (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Teva-Chlorpromazine (Canada)	Chlorpromazine	Anticholinergics: Definite/Strong Only
Theraflu Multi Symptom (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Thorazine	Chlorpromazine	Anticholinergics: Definite/Strong Only
Ticlid	Ticlopidine	Antiplatelet Agents
Tofranil	Imipramine	Anticholinergics: Definite/Strong Only
Tofranil- PM	Imipramine	Anticholinergics: Definite/Strong Only
Tolinase	Tolazamide	Hypoglycemics
Tolinase	Tolazamide	Hypoglycemics
Topamax	Topiramate	Psychotropics: Antiepileptics
Topamax Sprinkle	Topiramate	Psychotropics: Antiepileptics
Topiragen	Topiramate	Psychotropics: Antiepileptics
Total Allergy (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Total Allergy Medicine (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Toviaz	Fesoterodine	none
Tradjenta	Linagliptin	Hypoglycemics
Transdern-Scop	Scopolamine	Anticholinergics: Definite/Strong Only
Travel Sickness (OTC)	Meclizine	Anticholinergics: Definite/Strong Only
Triaminic Cough/Runny Nose (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only
Trihexyphen (Canada)	Trihexyphenidyl	Anticholinergics: Definite/Strong Only
Trihexyphenidyl (Canada)	Trihexyphenidyl	Anticholinergics: Definite/Strong Only
Trilafon	Perphenazine	Anticholinergics: Definite/Strong Only
Trilafon	Perphenazine	Anticholinergics: Definite/Strong Only
Trileptal	Oxcarbazepine	Psychotropics: Antiepileptics
Trileptal	Oxcarbazepine	Psychotropics: Antiepileptics

U

Brand Name	Generic Name	Category
Ultiva	Remifentanil	Narcotic Analgesics
Unisom	Doxylamine	none
UniVert	Meclizine	Anticholinergics: Definite/Strong Only
Urispas (Canada)	Flavoxate	Anticholinergics: Definite/Strong Only

V

Brand Name	Generic Name	Category
Valium	Diazepam	Psychotropics: Hypnotic/Sedative
Vertin-32	Meclizine	Anticholinergics: Definite/Strong Only
Vesicare	Solifenacin	none
Vicodin ES	Hydrocodone	Narcotic Analgesics

Vicodin HP	Hydrocodone	Narcotic Analgesics
Vicodin	Hydrocodone	Narcotic Analgesics
Victoza	Liraglutide	Hypoglycemics
Viibryd	Vilazodone	Psychotropics: Antidepressants
Vistaril	Hydroxyzine	Anticholinergics: Definite/Strong Only
Vivactil	Protriptyline	Psychotropics: Antidepressants

W

Brand Name	Generic Name	Category
Welbutrin SR	Bupropion	Psychotropics: Antidepressants
Wellbutrin	Bupropion	Psychotropics: Antidepressants
Wellbutrin XL	Bupropion	Psychotropics: Antidepressants

X

Brand Name	Generic Name	Category
Xanax	Alprazolam	Psychotropics: Hypnotic/Sedative
Xanax XR	Alprazolam	Psychotropics: Hypnotic/Sedative
Xarelto	Rivaroxaban	None
Xodol 10/300	Hydrocodone	Narcotic Analgesics
Xodol 5/300	Hydrocodone	Narcotic Analgesics
Xodol 5/300	Hydrocodone	Narcotic Analgesics
Xodol 7.5/300	Hydrocodone	Narcotic Analgesics

Z

Brand Name	Generic Name	Category
Zamicet	Hydrocodone	Narcotic Analgesics
Zamicet	Hydrocodone	Narcotic Analgesics
Zanaflex	Tizanidine	Skeletal Muscle Relaxants
Zarontin	Ethosuximide	Psychotropics: Antiepileptics
Zoloft	Setraline	Psychotropics: Antidepressants
Zolvit	Hydrocodone	Narcotic Analgesics
Zonegran	Zonisamide	Psychotropics: Antiepileptics
Zyban	Buropion	Psychotropics: Antidepressants
Zydone	Hydrocodone	Narcotic Analgesics
Zyprexa	Olanzapine	Anticholinergics: Definite/Strong Only
ZyPREXA	Olanzapine	Anticholinergics: Definite/Strong Only
ZyPREXA Relprevv	Olanzapine	Anticholinergics: Definite/Strong Only
ZyPREXA Zydis	Olanzapine	Anticholinergics: Definite/Strong Only
ZzzQuil (OTC)	Diphenhydramine	Anticholinergics: Definite/Strong Only

Appendix C: Community Living Support Plan Step by Step

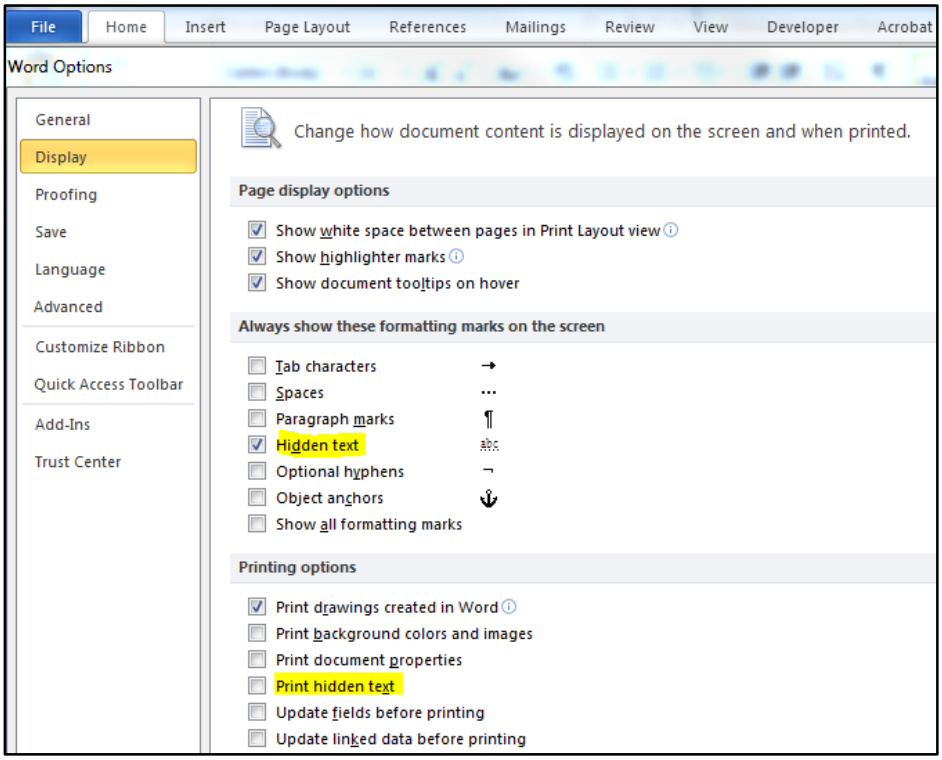
1 Background

This document is a guide for Senior LinkAge Line® Community Living Specialists when completing a Community Living Support Plan in relation to the Return to Community initiative. The purpose of this guide is to ensure a consistent method for completing a Community Living Support Plan (CLSP) is used in order to provide consumers a thorough and comprehensive plan to prepare them for their discharge back to the community.

2 Accessing a Community Living Support Plan

- The CLSP is a protected online form developed in Word located… that allows staff to enter the consumer's information electronically. Each editable field in the CLSP is viewable online.
- To view all editable text fields in the form,
  1. Click the **File** tab.
  2. Click **Options.**
  3. Click **Display.**
  4. Under *Always show these formatting marks on the screen*, select the **Hidden text** check box.
  5. Under *Printing options*, make sure the **Print hidden text** check box is not selected, and then click **OK**. (this will prevent "Enter text" from printing in blank/unused fields) (Figure 1)

Figure 1



3 Completing a Community Living Support Plan

- All applicable fields in the CLSP should be completed by the Community Living Specialist (CLS) and printed in preparation for the consumer's discharge planning meeting.

3.1 Personal Information

- This section includes specific demographic information and discharge details. Every field in this section should be completed.
    - **Support Plan Start Date:** Enter the date the consumer is leaving the nursing home or if consumer is already in the community, enter the date the support plan will be implemented.
    - **Name:** Enter the consumer's name.
    - **Address in Community:** Enter the street address where the consumer will be living upon discharge, or where the consumer plans to reside if the consumer is already living in the community. Include the property name if the consumer is discharging to a facility setting, such as assisted living.
    - **Phone Number in Community:** Enter the phone number(s) where the consumer can be reached.

3.2 Consumer's Strengths and Desired Outcomes

- This section is a narrative that provides details about the consumer's desired outcomes and his/her strengths and needs. The CLS should summarize the consumer's goals identified during development of the support plan and interactions with the consumer. The summary should describe the consumer's goals and what is most important when planning for their future. Some examples include: wanting to live in place where s/he can maintain strong relationship with neighbors and family, having the ability to express his/her opinion clearly, being very motivated to be successful living in home, and having a positive outlook.

3.3 Important Contacts

- This section should include phone numbers and addresses for important contacts. Use the notes column as needed for more specific information that pertains to each contact.
    - **Senior LinkAge Line® Community Living Specialists:** Enter the name, Senior LinkAge Line® phone number and address of the CLS. The notes column could contain date and time of next follow-up appointment, which could be in-person or over the phone.
    - **Prior Nursing Home Name:** Enter the name, phone number and address of the nursing home that consumer is discharging from. The notes column could contain details about discharge time and transportation. For consumers who are already in the community, enter NA.
    - **Emergency Contact:** Enter the name, phone number and address of consumer's emergency contact. The notes column could contain relationship. Examples would include friends or family. This would not include a Community Living Specialist.
    - **Primary Caregiver:** Enter the name, phone number and address of the primary caregiver (the person provides the most help to the consumer). The notes column should include the relationship of the caregiver to the consumer. This could be the same person listed

as the emergency contact. An example of where these could be different is when the consumer's child provides the most help and is the primary caregiver, but the consumer's neighbor is an emergency contact who can provide emergency assistance.

- **Primary Care Physician:** Enter the name, phone number and address of consumer's primary care physician.
  - Enter NA, if the consumer does not have a primary care provider established. Indicate the steps the CLS and consumer have made towards establishing a doctor in the notes column.
  - If there is a physician, indicate the next appointment date and time in the notes column.
- **Pharmacy:** Enter the name, phone number and address of consumer's pharmacy.
  - Enter NA, if consumer doesn't have any medications that require the use of pharmacy.
  - Use the notes column to indicate when medications will be ready for pickup.
- **Other:** Enter the name, phone number and address of other important contacts. This could include their hospice provider, clergy, Senior LinkAge Line® main number, etc.

3.4 Summary of Support Plan

- This is a narrative that provides an overview of the services that are in place for the consumer. This includes a description of the support plan, an emergency backup plan, and any new and prior services.
  - **Summary:** Enter a narrative summary that outlines the most prominent components of the support plan. This could include housing, services, service providers and any preferences.
  - **Emergency Backup Plan:** Enter a description of the consumer's specific backup plan. This could include calling 911, calling doctor for specific symptoms, calling family/friend/neighbor, using PERS, pulling call cord in an apartment, or other appropriate options.

3.5 Your Selected Providers

- This table highlights the consumer's chosen services, the service provider contact information and the monthly service cost.
  - **Provider Info:** Enter the provider name and contact information for each service that consumer has agreed to.
  - **Service:** List the services provided and the details of those services.
  - **Total Monthly Cost:** Indicate the total monthly cost to the consumer. Add up all the monthly costs for the services provided to the consumer to get the total monthly cost.

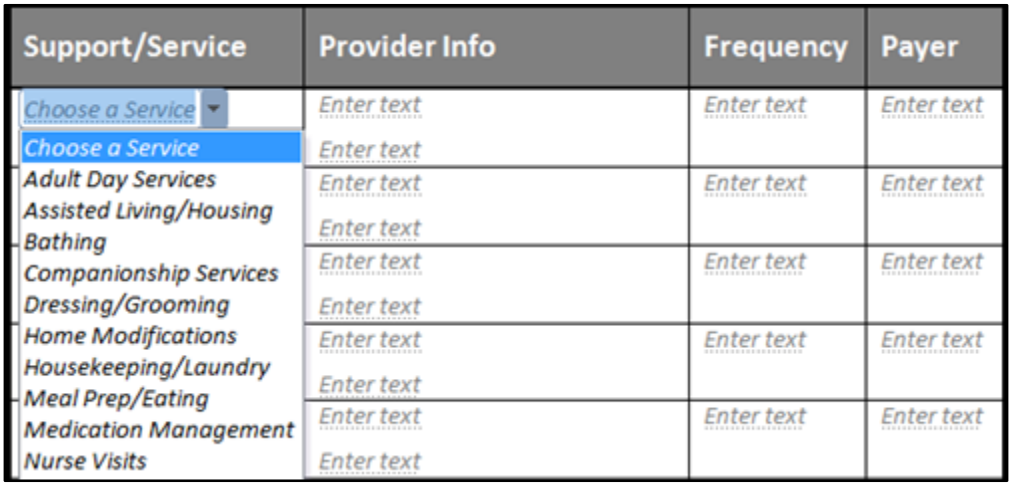
3.6 Signatures

- This section is to obtain the consumer's final approval of the plan.
  - **Consumer (or Designated Representative) Signature:** Have the consumer, guardian, or legal representative sign and date the plan to signify receipt of plan.
  - **Senior LinkAge Line® Community Living Specialist Signature:** Sign and date at time of final approval of plan.

3.7 Requested/Recommended Service Options

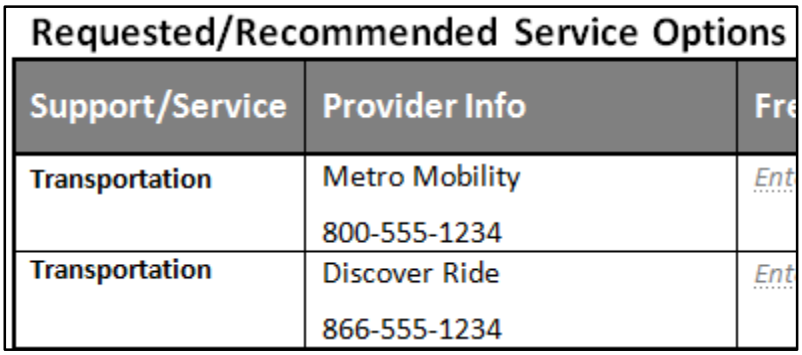
- This section will list all of the requested and recommended services in order for the consumer to review and compare service options and costs. The support services should include all services that the consumer requested, as well as, all services recommended by the CLS. Any services that are provided by the Assisted Living home should be listed separately. This is a comprehensive list of service options; therefore, it should also include services that were arranged prior to CLS involvement. *Note: All services that are provided on the support plan should also be documented in Web Referral.*
    - **Support/Service:** This column includes a dropdown field listing different service types to ensure a range of supports are offered/addressed within the support plan. Select from the dropdown list, the appropriate support service requested by the consumer or recommended by the CLS. (Figure 2)
        - **Other:** You may manually enter a service by typing over the "Choose a Service" text in the *Support/Service* text box if the specific service is not listed in dropdown field.

Figure 2



- If more than one provider is offered for the same service, start a new row using the same service from the *Support/Service* dropdown. (Figure 3)

Figure 3



- **Provider Name and Contact Info:** Enter the provider's name and contact information. Include the name, phone number and address for each provider, if applicable.
- **Frequency:** Enter the schedule and/or frequency of the supports and services being requested. This should be in an easy-to-understand format. *i.e., Daily 8:00am, 11:45am and 5:00pm, Mondays at 9:30am, Tuesday afternoons, 3rd Thursday of the month, etc.*
- **Payer:** Enter how costs for the support or service will be paid. *i.e., private pay, Medicare, private included in rent, etc.*
- **Monthly Cost:** Enter the service costs to help identify the total costs for each option provided. This should be designed to meet the needs of the consumer. *i.e., $10.00 per hour, $25.00 per month, cost included in room and board, etc.*
- **Consumer Choice:** Select the check box to indicate which service(s) the consumer accepted. *Note: These are the services that should be listed in the **Your Selected Providers and Contact Information** section.*

4 Finalizing the Completed Community Living Support Plan

- It is the responsibility of the CLS to review the CLSP prior to presenting it to the consumer to ensure the information documented is accurate, formatted correctly and does not contain grammatical errors.
- The last page of the CLSP does not need to be printed if no services are entered.

4.1 Formatting

- Entering text into the editable text fields may cause tables within the CLSP to shift; causing large gaps between sections and sections to overlap across multiple pages. The CLSP is formatted to allow the user to delete unnecessary spaces so the support plan is more professional and presentable document for the consumer.
    - To delete unnecessary spaces, click on the area you wish to remove and select **Delete** or **Backspace** on your keyboard
    - Select **Enter** on your keyboard to add additional spaces

4.2 Presenting to the Consumer

- The completed CLSP is printed and reviewed with the consumer.
- The final CLSP is approved and signed by the consumer and CLS and provided to the consumer.
- The CLS will scan the signed CLSP and attach it to the respective Community Planning Tool record in Web Referral.

Community Living Support Plan

Personal Information

Support Plan Start Date: 02/02/2015

Name: Jane Doe

Address in Community: Cornerstone Assisted Living of Plymouth
3750 Lawndale Lane N. Plymouth MN 55446
(Include facility name if applicable)

Phone Number in Community: 763-550-0333

Consumer's Strength's and Desired Outcomes:

Jane wishes to get out of the nursing home and receive the minimal services needed. She wants to be located at a place that is convenient for her son and a few friends from church to visit. She is hoping to be in the Plymouth area or a very nearby community. Returning home is not a comfortable place for Jane to return as she is nervous about being secluded which was a factor with her initial injury. Jane is interested in emergency response systems but she doesn't feel that it would be enough support for her to return home comfortably. Jane is looking for a place where she has her own space but also has the opportunity for socialization. She loves to watch movies on Friday nights with a bowl of popcorn and her dog Bridget. Jane also wants to be with seniors at a comparable functional level to herself. Jane has a good relationship with her son who assists with driving. Jane needs to be provided with all options so that she can feel she is making an informed decision. Jane knows what is important and she is very realistic about her needs as well as her feelings. One great strength is that Jane is willing to look at different options in order to find a setting that is satisfactory.

Important Contacts

Contacts	Name	Phone Number	Address	Notes/Other
Community Living Specialist	Jane Smith	**1-800-333-2433** Ext. 12345	123 Elm Street Rochester, MN 55442	Home visit Monday 2/2/2015 at 10:30am
Prior Nursing Home	Happy Hills	763-559-5585	432 Spruce Ave N Amora, MN 55448	Discharging at 10am with your son driving.
Emergency Contact	Patrick Doe	765-555-5656	987 Apple Lane, Mankato MN 55448	
Primary Caregiver	Patrick Doe	765-555-5656	987 Apple Lane, Mankato MN 55448	Son
Primary Care Doctor	Patricia Johnson	432-559-8878	Health Partners, 543 Oak Lane, Carlton MN 55444	Follow Up Appointment: 5/11/2014 at 2:15pm
Pharmacy	Walgreens	756-884-7777	99888 Evergreen Road, New Ulm MN 44888	Medications will be ready 3/1/14 at 9:00am
Other	None			

Community Living Support Plan

Summary of Support Plan:

Based on the review of the support plan, you have chosen to move to Cornerstone Commons 3750 Lawndale Lane N, Plymouth. The phone number is 763-550-0333. This facility allows pets as well as Elderly Waiver in case you ever need to apply for Medical Assistance. You have chosen an apartment that will cost around $3650 a month including rent, laundry services and transportation to medical appointments as needed. Meals and housekeeping are included in the rent. If you need additional care while you are residing at Cornerstone Commons, you can add more services. There will be an additional cost. Your dog Bridget is welcome at the facility. You have chosen to use Fairview Lifeline Services which costs $30/month after a $45 set up fee. You have chosen to use United Way if you ever want a volunteer to come to your apartment and visit you or watch a movie on a Friday night- this was important to you. Your son is part of your emergency backup plan as well as your Personal Emergency Response System.

Your Selected Providers

Provider Info	Service	Monthly Cost
Cornerstone Assisted Living 763-550-03333	Housing, laundry, transportation to medical appointments, housekeeping, and 3 meals per day.	$3600.00
Fairview Lifeline Services 763-544-8848	Emergency response system triggered by pressing button on pendant that you can wear around your neck.	$30.00
United Way-Volunteer 651-224-1141	Volunteer can come for a visit and keep you company. Volunteer will come 3/15 at 7:00pm. You will need to call and set up a schedule for ongoing visitors.	$0.00
	TOTAL MONTHLY COST	$3630.00

Consumer (or Representative) Signature:		**Date: 02/02/2015**
Community Living Specialist Signature:		**Date: 02/02/2015**

Community Living Support Plan

Requested/Recommended Service Options

Support Service	Provider Info	Frequency	Payer	Monthly Cost	Consumer Choice
Housekeeping/ Laundry	Cornerstone Commons 763-550-0333	Thursdays, pickup at 10am	Included in rent	Included in rent	☒
Shopping	Cornerstone Commons 763-550-0333	Monday and Thursday, 1pm	Included in rent	Included in rent	☒
Meal Preparation	Cornerstone Commons 763-550-0333	3 times/day	Included in rent	Included in rent	☒
Eating	Cornerstone Commons 763-550-0333	3 times/day	Included in rent	Included in rent	☒
Dressing/ Grooming	Self				☒
Toileting	Self				☒
Bathing	Self				☒
Medication Management	Self				☒
Supplies/ Equipment	Fairview Lifeline 763-544-8848	NA	Private	$30	☒
Supplies/ Equipment	HealthSense 1-800-576-1779	NA	Private	$25	☐
Supplies/ Equipment	LifeLine 651-771-1193	NA	Private	$35	☐
Transportation	Cornerstone Commons 763-550-0333	As needed	Included in rent or NA for son	Included in rent or NA for son	☒

Community Living Support Plan

Requested/Recommended Service Options

Support Service	Provider Info	Frequency	Payer	Monthly Cost	Consumer Choice
Assisted Living/ Housing	Cornerstone Commons 763-550-0333	24 hour supervision	Private	$3515.00	☒
Assisted Living/ Housing	La Bonne Vie Home 612-735-8480	24 hour supervision	Private	$6750.00	☐
Assisted Living/ Housing	Summerwood of Plymouth 763-383-8888	24 hour supervision	Private	$3200.00	☐
Assisted Living/ Housing	The Waters of Plymouth 763-392-0627	24 hour supervision	Private	$3000.00	☐
Companionship Services	United Way Caring Connection 651-222-5585	As needed	Donation if desired	$0	☒
Companionship Services	I Can Help Twin Cities 952-558-5585	As needed	Donation if desired	$0	☐
					☐
					☐
					☐
					☐
					☐
					☐

Appendix E: Senior LinkAge Line® Return to Community Initiative Metrics and Goals

Action Steps	Goals	Examples	Comments
Comprehensive Data Collection—Complete data collection in the Community Planning Tool (CPT) is pertinent to develop a Community Living Support Plan (CLSP) for the consumer and also for evaluation purposes of the Return to Community service.			
Number of Support Plans Completed, Signed and Uploaded—Completion of the Community Living Support Plan (CLSP) is a key component to display the work the Community Living Specialist (CLS) has done with the consumer. It contains the person-centered elements of identified strengths and goals. It also shows the resources the CLS is recommending and provides a record of the services selected by the consumer. Community Living Support Plans will be attached to the relevant Community Planning Tool in Web Referral for which it was created.			
	90% completion or better		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Community Living Support Plans that Match Web Referral Log Notes			
	Strive for 90% completion		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Percent of Agency Referrals Recorded in CLSP and Tracked in Web Referral			
	Strive for 90% completion		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Percent of Support Plans Reflecting Consumer Needs Indicated in Community Planning Tool			
	Strive for 90% completion		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Evaluation—Due to the research component of the Return to Community Initiative, there has always been an evaluation component. Therefore, thorough data completion is crucial as it is provided to researchers and also used to develop person-centered support plans.			
Missing Critical Components as Defined by Dr. Arling for Evaluation Purposes			
	Strive for 90% completion or better		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Community Planning Tool Data Completion			
	Strive for 90% completion of consumer and caregiver fields.		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Data Completion for Scheduled Follow-Ups in Web Referral—Within 72 Hour, 10, 30, 60 and 90 Day			
	90% completion of critical elements		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Outcome of Call for Scheduled Follow-Ups in Web Referral			
	Documented outcomes show 50% do not decline further contact		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Signed Release of Information Stored in Web Referral—A signed release of information is required for each consumer who is given in-person assistance from a CLS. A Release of Information form will be attached to the relevant Community Planning Tool in Web Referral, based on the instance of assistance.			
	100% signed release forms are uploaded		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral

Profiled Consumers Discharged to Community—Based on qualified consumers who appeared on the profile list, did not pass away or discharge naturally prior to list disbursement, and were not considered a false positive. (False positive is defined as a discharge prior to 45 days starting in March 2014. False positive is defined as a discharge prior to 60 days from April 2010–March 2014.)			
	33% of assigned consumers each calendar quarter are discharged from profile list		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Number of Consumers Who Received Direct Discharge Assistance from Community Living Specialist—MDS Profile List, Section Q Referral, Direct Nursing Home/Provider Referral or SLL Referral			
	Consistently achieve six discharges per month		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Successful Discharges Are Defined through Four Categories: 1. Consumer/Family Rapport—This is critical for completing the Community Planning Tool and establishing a trusting relationship and trust with the consumer and caregivers. 2. Time Management—Due to the large coverage areas of each CLS, it is critical to ensure interaction is documented in Web Referral as soon as possible for accuracy. 3. Consumer Safety—The scheduled in-person visit with consumer should occur within 72 hours of discharge to ensure consumer has the needed services/equipment and understands and has current medications in possession. 4. Provider Rapport—Relationship building with nursing homes and other providers will ensure continued referrals for consumers who could benefit from follow up. Providers will also see value of the Return to Community service and understand why referrals should be made to Senior LinkAge Line®. Ongoing education is crucial to ensure all nursing homes are kept up to date regarding referral protocols.			
Consumer/Family Rapport—Consumers who report satisfaction with in-person assistance received by Senior LinkAge Line® Community Living Specialist			
	90% reported satisfaction		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Extranet Community Outreach Survey Report
Consumer/Family Rapport—BIMS and PHQ9 completed during initial Community Planning Tool			
	Strive for 90% completion		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Reasons BIMS Not Completed, Reasons PHQ-9 Not Completed			
	Strive for less than 50% refusal rate		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Consumer/Family Rapport—Caregiver interview completed when caregiver has been identified on Initial CPT and 90 Day Follow-Up			
	90% Completion for Initial CPT 85% Completion for 90 Day Follow-Up		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Reasons Caregiver Interview Not Completed			
	Strive for less than 50% refusal rate		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral

Time Management—Scheduled Follow-Ups completed in timely manner			
	85% completed within 1 business day 50% on scheduled day of Follow-Up		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Average Length of Time to Conduct Initial In-Person Visit			
	90% completed within 5 days		CLS Protocol - V6.1, Issued May 29, 2014 Data Source: Web Referral
Consumer Safety—Scheduled 3 Day Follow-Ups completed within 72 hours of discharge			
	90% completed within 72 Hours		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Provider Rapport—Discharges by Nursing Home in AAA region			
	50% of nursing homes in AAA region make referral each calendar year		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Web Referral
Maintaining Senior LinkAge Line® Image Is Defined Through Three Categories: Consumer Satisfaction—Consumers must see value in the service provided by the Senior LinkAge Line® in order to request additional assistance from CLS. Building Awareness—Outreach to nursing homes in each AAA region are important as staff turnover is high and services provided by Senior LinkAge Line are not known by all.			
Consumer Satisfaction—Consumers Reported the Quality of Help Received Met Their Expectations			
	90% Yes Response		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Extranet Community Outreach Survey Report
Building awareness among providers			
	85% presentations mentioned Return to Community and SLL Materials are offered		CLS Protocol - V6.0, Issued March 28, 2014 Data Source: Extranet Calendar Report