

Position Description  
**COMMUNITY LIVING SPECIALISTS**

**POSITION SUMMARY**

This position is responsible for providing outreach to nursing home providers and residents and ensuring that nursing home residents (in assigned service areas) have information about community living and his/her right to live in the least restrictive setting for their needs. This position will assist residents with removing obstacles to successful relocation and collaborating with local agencies to ensure a smooth transition to the community.

**GOALS AND WORKER ACTIVITIES**

**A. Outreach to Nursing Home Residents and Providers**

1. Develop an outreach plan designed to identify and engage residents who are interested in relocating to the community.
2. Outreach to residents of nursing homes in assigned service area and develop working relationships with key facility staff.
3. Collaborate with nursing home staff to identify potential relocations.
4. Collaborate with discharge planners on addressing barriers to relocation.
5. Advocate on behalf of residents who encounter barriers to relocation. Connect residents with advocacy organizations, such as ombudsman programs, as necessary.
6. Provide formal education and training to nursing facility staff about community living alternatives and options for addressing health and safety in community based settings.
7. Provide informal and formal opportunities for residents to learn about community options and ways to overcome barriers associated with transition.
8. Make presentations to resident councils and other groups as assigned.
9. Develop a process, in collaboration with ADRCs in assigned service area, for receiving MDS Section Q referrals. Respond to referrals within seven days. Provide options counseling and other services that may be necessary.
10. Identify nursing homes that may not be completing or referring people for MDS-Q. Work with the nursing homes to understand the purpose, requirements and the process for making referrals. Contact the State of Wisconsin with any regulatory compliance concerns.

**B. Working with Private Pay Nursing Home Residents**

1. Successfully complete options counseling and other relevant training required to perform duties.
2. As appropriate and in collaboration with the nursing home, work with individuals (and their representatives) who have been admitted to the nursing home for rehabilitation or short-term stays, ideally while the individual has a home, apartment or other community residence.
3. For people who will be discharged as private pay, work with discharge staff in the nursing home to provide information, help overcome barriers and ensure that a safe, sustainable discharge plan is in place. Provide options counseling and service coordination, as appropriate or required beyond typical discharge planning.
4. Follow up with people shortly after discharge to the community to see how they are managing and whether there is additional information or assistance that would be helpful.
5. Collaborate and coordinate with Aging and Disability Resource Centers, according to policies and procedures developed locally, to ensure timely referrals between the ADRC and the Community Living Specialist.

### **C. Working with Medicaid Eligible Residents**

1. In coordination with local Aging and Disability Resource Centers (ADRCs), assist in the dissemination of information to nursing home residents, their families and nursing home staff regarding the availability of public funding for community based services, if required. This includes Family Care, IRIS, and where available, Partnership, PACE, and Virtual PACE.
2. Refer people to the ADRC for a long term care program eligibility determination and enrollment into Family Care, IRIS, PACE, or Partnership, if eligible. Assist with the completion of required paperwork in accordance with policies established between this position and the ADRC.
3. Assist with paperwork required for Money Follows the Person program eligibility.
4. Assist nursing home staff in helping the person apply for Medicaid as necessary.
5. Provide consultation to care managers, MCOs, and IRIS consultants relative to the removal of barriers to the person's success in the community.
6. Collaborate and coordinate with managed care organizations (MCOs) and/or IRIS consultants according to policies and procedures developed in collaboration with local programs.

### **D. Records and Reporting**

1. Submit reports of monthly activities performed, as assigned.
2. Collect and submit DHS required data and complete reports, as assigned.

### **E. Contribute to the Success of Statewide Relocation Initiative**

1. Participate in meetings with statewide/regional counterparts and conference calls.
2. Contribute to the on-going development of processes and procedures, technical assistance, training, and other materials that contribute to successful relocation statewide.
3. Give presentations on the initiative as assigned.
4. Perform other duties as assigned by the Department of Health Services.

## **QUALIFICATIONS, KNOWLEDGE AND SKILLS**

1. Bachelor's degree in human services or related field and a minimum of one year experience with target populations.
2. Extensive knowledge of the long term care needs of elders and people with disabilities.
3. Extensive knowledge of home and community-based services.
4. Experience with relocation, transition, and/or discharge planning is preferred.
5. Understanding of and commitment to the principles of person-centered planning, consumer choice and self-direction.
6. Considerable knowledge of Wisconsin's human service and long term care programs, especially ADRCs, Family Care and IRIS.
7. Excellent organizational skills, communication skills, ability to write and speak concisely to partners and agencies, both public and private, from diverse populations.
8. Demonstrated ability to provide training and technical assistance.
9. Demonstrated ability to develop positive working relationships with a broad range of entities, build consensus, and manage opposing interests and opinions.
10. Considerable ability to collaborate and work as part of a team.
11. Demonstrated ability to work independently, plan, organize and proactively produce quality deliverables in response to multiple assignments, willingness and ability to adapt to change.
12. The position requires a personal vehicle and an ability to drive in order to make regular visits to nursing homes in assigned geographic region and to statewide/regional meetings. Must possess a valid driver's license and maintain adequate auto insurance for job-related travel within Wisconsin.