Statement of Understanding
Between the Virginia Department of Medical Assistance Services, Virginia's Nursing Facilities, Local Contact Agencies and Transition Coordination Providers

Purpose

This Statement of Understanding is between the Virginia Department of Medical Assistance Services (DMAS), Department for Aging and Rehabilitative Services (DARS), Virginia's Nursing Facilities, Virginia's Area Agencies on Aging (AAA) serving as the Local Contact Agencies, Transition Coordination Providers (TCPs), and Centers for Independent Living (CILs) concerning the roles and responsibilities when generating and processing a MDS 3.0 Section Q referral.

Background

The Commonwealth of Virginia strives to ensure that all individuals have the right to receive long-term services and supports in the least restrictive and most integrated settings. This right became law under the American with Disabilities Act (1990) and in 1999 was further interpreted by the U.S. Supreme Court in the Olmstead vs. L.C. decision. The Governor, the Secretary of Health and Human Resources, the Virginia Department of Medical Assistance Services, the Virginia Department for Aging and Rehabilitative Services, Virginia's Area Agencies on Aging, and Virginia's Centers for Independent Living are all committed to informing consumers about opportunities to exercise choice and self-direction. To that end, Virginia successfully applied and received approval for a Centers for Medicare and Medicaid Services' (CMS) Money Follows the Person Demonstration Project.

Virginia's Money Follows the Person (MFP) Demonstration Project has the following goals:

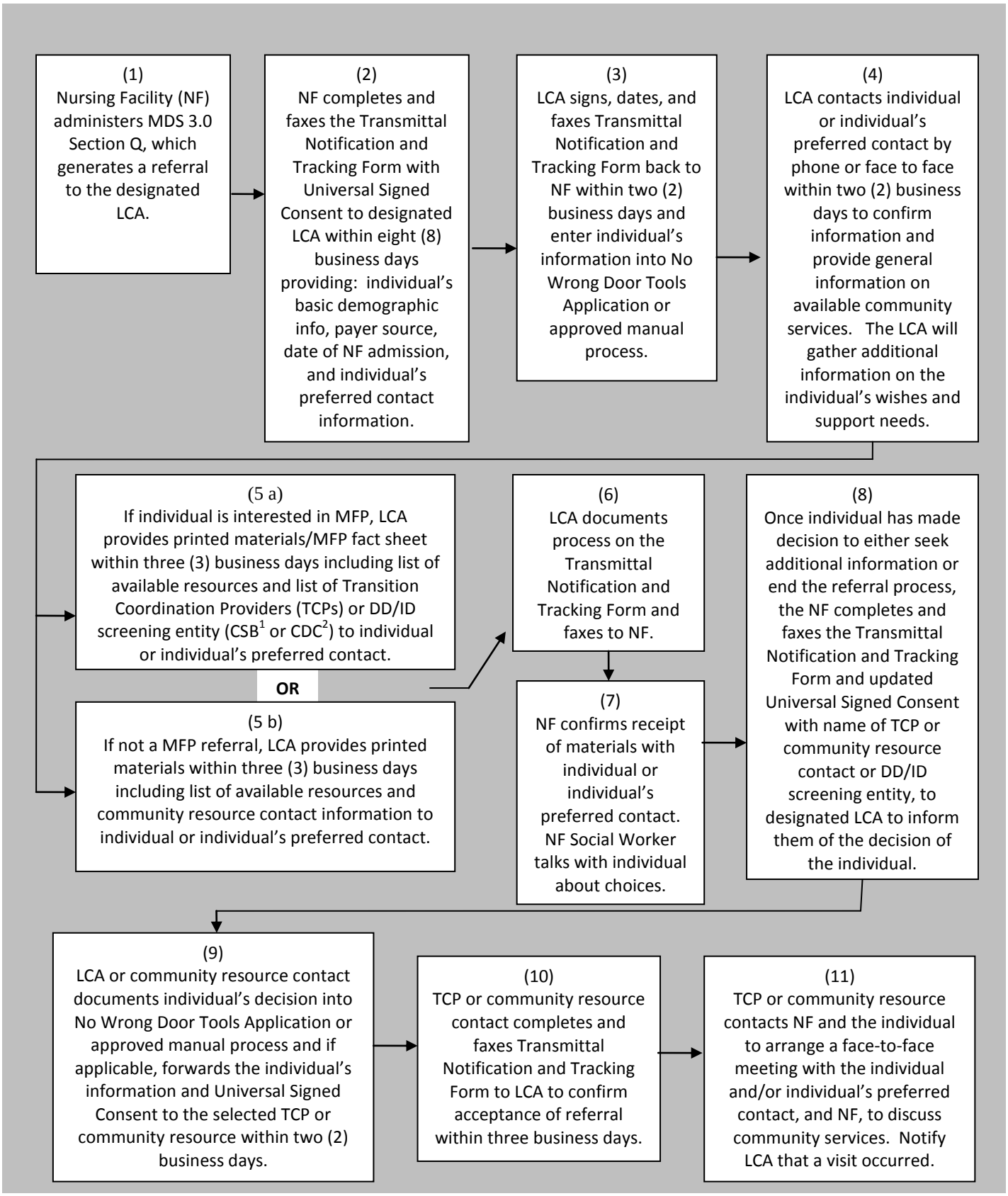
Goal 1 Rebalancing Virginia's long-term support system, giving individuals more informed choices and options about where they live and receive services;

Goal 2 Transitioning individuals from institutions (Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), nursing facilities (NF), and long stay hospitals (LSH) who want to live in the community; and

Goal 3 Promoting quality care through long-term support services that are person-centered, appropriate, and needs-based, ensuring continual improvement is made through a quality management strategy for home and community-based services (HCBS) settings and institutions.

As of October 1, 2010, CMS launched the Minimum Data Set (MDS) 3.0, which includes an enhanced Section Q – Informing Long-Term Care Choice. This enhanced section seeks to broaden the traditional definition of "discharge planning" in nursing facilities (NFs) by recognizing that an expansive range of community-based supports and services are necessary for successful community living. The implementation of Section Q encourages nursing facility interdisciplinary staff to assess both long stay residents who may not have been previously considered as candidates for community living and residents who have previously stated their desire to transition but who have not yet made the transition, to facilitate resident and nursing facility connection and communication with Local Contact Agencies (LCAs). In their role as local lead for Virginia's Aging and Disability Resource Centers Connections (ADRCs), DMAS has designated the Area Agencies on Aging (AAAs) in Virginia to serve as LCAs for Section Q Referrals, providing community resource information for individuals interested in transitioning back to the community. LCAs are encouraged to have strong relationships with NFs, TCPs, CILs, and other community resources so that the Section Q referral process consistently works well. TCPs should do the same with NFs and LCAs. Additionally, each entity is encouraged to participate in options counseling training.

Workflow for the Generation and Processing of a MDS 3.0 Section Q Referral



Note: This referral workflow process does not negate NF discharge planning responsibilities in accordance with the Code of Virginia §32.1-138.

1. CSB – Community Services Board 2. CDC – Child Development Clinic

Roles and Responsibilities

Nursing Facility (NF):

1. Administers MDS 3.0 Section Q at the frequency and manner as directed by CMS. (Step 1 on Workflow)
2. Contacts designated Local Contact Agency (LCA) as directed by responses to MDS 3.0 Section Q within eight (8) business days using the MDS 3.0 Section Q Referral Facsimile Transmittal Notification and Tracking form. (Step 2)
3. Confirms receipt of materials with the individual on community services provided by the LCA. (Step 7)
4. Contacts designated LCA on the decision of the individual and the Transition Coordination Provider (TCP), DD/ID screening entity or community resource chosen by the individual using the MDS 3.0 Section Q Referral Facsimile Transmittal Notification and Tracking form. (Step 8)
5. Coordinates and assists TCP as needed to facilitate a transition to the community.
6. Documents all actions taken by the Nursing Facility and subsequent decisions of individual on their decision to transition to the community.
7. Adheres to Health Insurance Portability and Accountability Act (HIPAA) requirements.

Local Contact Agency (LCA):

1. Responds to fax from Nursing Facility Section Q referral within two (2) business days using the MDS 3.0 Section Q Referral Facsimile Transmittal Notification and Tracking form. (Step 3)
2. Calls or visits with individual, or the individual's preferred contact, within two (2) business days of confirming receipt of referral from nursing facility. (Step 4)
3. Provides information about community living options and available supports and services to the individual/individual's preferred contact. (Step 4)
4. Provides all relevant printed materials on community services including a list of geographically available TCPs or DD/ID screening entity and resources to the individual, or the individual's preferred contact, within three (3) business days of speaking with the individual. (Step 5a or 5b)
5. If applicable, forwards individual's information to the chosen TCP or community resource within two (2) business days of receiving notification of individual's decision from nursing facility. (Step 9)
6. Documents all actions taken by the LCA in No Wrong Door Tools Application or approved manual process. (Step 9)
7. Adheres to the confidentiality and exchange of protected health information guidelines as set forth in Code of Virginia.
8. LCAs which are also TCPs should not promote their TCP services over other similar TCP organizations.

Transition Coordination Provider (TCP) or Community Resource Contact:

1. Responds to fax notification from the LCA for a referral of an individual who is interested in transitioning to the community. (Step 10)
2. Contact the individual interested in transitioning to the community and/or the individual's preferred contact within three (3) business days of receiving fax notification from LCA for a referral.
3. Arranges face-to-face meeting with the individual and/or the individual's preferred contact, and nursing facility staff within ten (10) business days of speaking with the individual. Notifies LCA via fax that a visit occurred with the individual and/or the individual's preferred contact. (Step 11)
4. Coordinates and assists Nursing Facility staff as needed to facilitate a transition to the community.
5. Documents all actions taken by TCP or community resource contact and subsequent decisions by individual to transition to the community.
6. Adheres to Health Insurance Portability and Accountability Act (HIPAA) requirements.