Vermont ADRC-Choices for Care/MFP and Section Q Implementation Strategy FINAL 10.2013

Steps	Process and Process Outcomes
Step 1: MDS 3.0 Section Q Response to Q0500B is "Yes"	NF required to document on MDS Assessment whether resident was asked question Q0500B.
Step 2: NF makes referral to LCA Step 3: LCA	NH sends Section Q Referral Form to LCA <u>via SECURE email</u> , or, if no secure email available, via fax. Under 60 AAAs via email address/fax listed on form VCIL via email address/fax listed on form
documents Section Q referral in REFER	Contact marker in REFER for Section Q/NH Transition referral checked. I&A specialist enters the referral into the Section Q/NH Transition Data Form, including the DATE REFERRAL RECEIVED. LCA contacts
Step 4: LCA Contacts Consumer	LCA contacts consumer within 3 business days of referral to schedule follow-up. LCA contacts consumer of CFC and has a case manager identified, LCA contacts CM to inform them of OC request and follow up. LCA determines lead staff person (OC, case manager) to follow up with individual based on known circumstances. LCA determines lead staff person (OC, case manager) to follow up with individual consumer of CFC and has a contacts CM to inform them of OC request and follow up.
Step 5: Follow Up	 Consumer-specific team (if required) assembled for follow-up visit. Consumer goals identified. Consumer goals identified.
Step 6: Documentation	Options Counseling session data entered in REFER. Referral to CFC/MFP transition coordinator made if potentially CFC/MFP eligible. Referrals must be electronic and emailed to LCA emails Section Q/NH Transition Follow Up Form to NF using SECURE Action steps initiated. If not CFC eligible or CFC and MFP eligible, OC conducts follow up.
Step 7: Transition Planning	If individual continuing with transition and is CFC and MFP eligible, CFC/MFP transition coordinator works with NH social worker and CFC CM to facilitate transition. CFC CM in charge of transition plan. If individual continues work with TC and CFC case manager. It ransition coordinator. Undited to the survey of the surv

Important Notes regarding Choices for Care and the Transition Process

- The Options Counselor (OC) should confirm Choices for Care (CFC) status when they follow up with the individual to schedule and coordinate Options Counseling.
- If the individual is **NOT** enrolled in Choices for Care, the Options Counselor should pre-screen for clinical and financial eligibility. If it looks like the individual may be eligible, then the OC can assist the individual with accessing the 202 LTC Choices for Care Long Term Care Medicaid application.
- If the individual **IS** enrolled in CFC but HAS NOT selected a case management agency and the individual selects a case management agency during the course of the Options Counseling process, that information must be shared with the following individuals:
 - Long Term Care Clinical Coordinator
 - Case management agency selected by individual (HHA or AAA)
 - CFC/MFP Transition Coordinator (if eligible for MFP transition funds)
- If the individual is likely CFC/MFP eligible but has not chosen a case management agency, or the individual does not want to choose a case management agency during the course of the Options Counseling process, a referral should be made to the Transition Coordinator who will follow up with the individual at a later point.
- The Transition Coordinator role is to provide outreach and education and enrollment of eligible nursing home residents to the CFC/MFP project and to support the CFC case manager in facilitating the transition process. The Transition Coordinator is not an Options Counselor or Case Manager.
- Should the individual be CFC/MFP eligible and wish to continue with transition planning, the Options Counselor MUST refer that individual to the Transition Coordinator and the chosen CFC case management agency.
- The CFC case manager drives the transition planning process, and the development of the transition plan. The Options Counselor may continue to work with the individual in the nursing home in collaboration with the transition team if desired, but is not required.