

## **Virginia Long-Term Care Mutual Aid Plan Memorandum of Understanding**

This **Memorandum of Understanding** (“MOU”) is made and entered into as of the Effective Date by and among long term care (“LTC”) facilities that have agreed to lend support to each other in a Disaster (each a “Participating Facility”).

**WHEREAS**, in order to comply with 42 CFR § 483.73 LTC facilities are required to develop arrangements with other facilities and providers to receive their residents in the event of limitations or the cessation of operations due to an emergency;

**WHEREAS**, in furtherance of Virginia’s Assistant Secretary for Preparedness Hospital Preparedness Program HPP/PHEP Cooperative Agreement, the Virginia Department of Health (“VDH”) and the Virginia Hospital & Healthcare Association (“VHHA”), as VDH’s subcontractor, have created the Virginia Long Term Care Mutual Aid Plan (“LTC-MAP”) to assist LTC facilities with evacuating their residents to another facility during a local or regional disaster;

**WHEREAS**, this MOU is intended to augment, not replace, each facility's Emergency Preparedness Plan;

**WHEREAS**, this MOU provides the framework for LTC facilities to coordinate with government response partners and the Regional Healthcare Coalitions;

**WHEREAS**, this MOU does not replace, but rather supplements, the rules and procedures governing interaction with other response partners during an incident (e.g. public health, emergency management, local emergency medical services, fire departments); and

**WHEREAS**, by signing this MOU each Participating Facility is evidencing its intent to comply with the terms of the MOU by providing support in the event of a local or regional Disaster that exceeds the effective response capabilities of an impacted Participating Facility that has activated its Emergency Preparedness Plan and the LTC-MAP in the manner set forth in this MOU.

**NOW, THEREFORE**, in consideration of their respective undertakings, the Participating Facilities hereby covenant and agree as follows:

### **Article I Definitions**

#### **1.1 Borrowing Facility**

A Disaster Struck Facility in need of resources that obtains those resources from other Participating Facilities.

#### **1.2 Command Center**

A central location where Participating Facility leadership is located during a Disaster in order

to carry out emergency preparedness and response activities and is the primary point of administrative authority and decision making.

### **1.3 Demobilization**

The orderly, safe, and efficient return of an incident resource to its original location and status.

### **1.4 Disaster**

An incident that has the ability to or has compromised a Participating Facility's operating status, exceeds a Participating Facility's effective response capability, or cannot be resolved solely by using the Participating Facility's own resources. It may be an "external" or "internal" incident for the LTC facility and assumes that each affected Participating Facility's Emergency Preparedness Plan has been implemented through the activation of the LTC facility Command Center.

### **1.5 Disaster Struck Facility ("DSF")**

A Participating Facility that is experiencing a Disaster.

### **1.6 Emergency Operations Center ("EOC") – Local or State**

Provides planning, communications, coordination, and oversight of the Disaster response on a local or regional level including coordination with the ESF-8.

### **1.7 Emergency Preparedness Plan**

A plan required by 42 CFR § 483.73 that includes a process to maintain an integrated response during a disaster or emergency situation.

### **1.8 Emergency Support Function 8 ("ESF-8")**

The public health and medical services support function for the local or state government, or federal level, that provides for the organization, mobilization, and coordination of health and medical services in a health emergency or other disasters that require the involvement or activation of ESF-8. ESF-8 operations report up through VDH during a declared disaster.

### **1.9 Evacuating Facility**

A Disaster Struck Facility that needs to transfer its residents to a Stop Over Point or RAF.

### **1.10 Fast Out Evacuation**

The immediate evacuation of residents from a LTC facility due to an immediate threat, such as a fire or flood.

### **1.11 Lending Facility**

A Participating Facility that is providing resources to a Borrowing Facility.

### **1.12 Regional Healthcare Coalition (“RHC”)**

The entity responsible for working with LTC facilities in its geographic area to implement the LTC-MAP and for operating the Regional Healthcare Coordination Center.

### **1.13 Regional Healthcare Coordination Center (“RHCC”)**

A multi-agency coordinating center operated by the Regional Healthcare Coalition designed to act as the hub for communication and coordination for healthcare facilities during a disaster.

### **1.14 Resident Accepting Facility (“RAF”)**

A Participating Facility accepting resident from an Evacuating Facility.

### **1.15 Stop Over Point**

A location to shelter residents during a Fast Out Evacuation until residents can be transported to an appropriate facility.

### **1.16 Virginia Healthcare Alerting and Status System (“VHASS”)**

A secure, web-based emergency management system used to coordinate and streamline individual and regional healthcare response to all hazards. A list of participating facilities will be made available on VHASS by April 1, 2018 or made available by request.

## **Article II Organization Responsibilities**

### **2.1 Virginia Department of Health Office of Emergency Preparedness**

The VDH Office of Emergency Preparedness (“OEP”) with cooperation of the Office of Licensure and Certification (“OLC”) is the primary state agency responsible for coordination of public health and medical emergencies.

### **2.2 Virginia Hospital & Healthcare Association**

VHHA, under contract with VDH, is responsible for administering the Virginia LTC-MAP. In its role as administrator, VHHA will maintain a copy of all signed MOUs and be responsible for program maintenance.

### **2.3 Regional Healthcare Coalitions**

RHCs, under contract with VHHA, are responsible for the regional implementation of the mutual aid activity and are responsible for the day-to-day relationships under this MOU. RHCs will

maintain regional procedures and policies with regards to the implementation of the LTC-MAP program. Additionally, RHCs will maintain contact information and other information specific to a Participating Facility.

## **2.4 Local Health Districts**

VDH Local Health Districts (“LHD”) are the primary local authority responsible for public health and medical emergencies. LHDs will work with their respective Regional Healthcare Coalitions and local Participating Facilities to implement the LTC-MAP and coordinate emergencies with local emergency response partners. The LHDs, under the purview of VDH, have the primary responsibility for coordination of emergencies pertaining to public health. The RHCC assist in this role; however, Participating Facilities may need to coordinate directly with LHD officials regarding local resources.

## **2.5 Participating Facility**

2.5.1 Activities and Exercises. Participating Facilities are responsible for the implementation of the LTC-MAP within their respective facility. Participating Facilities agree to participate in community exercises and drills to test the LTC-MAP’s effectiveness.

2.5.2 Information Update. Participating Facilities are expected to designate emergency contacts to coordinate LTC-MAP initiatives, routinely update their information with the RHCs and VHASS or other electronic system as directed by the RHCs, report any major facility changes that may preclude the Participating Facility from participating or modifying the level of actual participation in the LTC-MAP and maintain a hard copy of the LTC-MAP in a designated location.

2.5.3 Implementation of LTC-MAP MOU. To be considered a Participating Facility the LTC facility must have a signed MOU on file with its respective RHC, and the VHHA.

*It is the objective of this LTC-MAP to exclude activations of the LTC-MAP for situations associated with facility closure and labor action (strikes), unless the event involves immediate threat to resident lives or involves a failure of the infrastructure where the building is untenable.*

2.5.4 Communications. Participating Facilities are responsible for informing emergency agencies and VDH of their situation and defining needs that cannot be accommodated by the Participating Facility itself.

2.5.5 Command Center. A Participating Facility’s Command Center is activated when a facility activates its Emergency Preparedness Plan. A DSF must activate a Command Center in order to request resources through this LTC-MAP.

2.5.6 Public Relations. Participating Facilities are responsible for developing family and media responses and coordinating with other entities for the family and media response for the Disaster.

- 2.5.7 Regional Plan. Participating Facilities should work with their RHC to ensure adherence with any regional procedures, policies, plans or initiatives. Whenever possible, Participating Facilities will update their internal Emergency Preparedness Plan to be compatible with such guidance.
- 2.5.8 Operational Status. Participating Facilities are responsible for notifying and informing VDH, and the RHCC, of their operational status based on regional procedures for communicating this information.
- 2.5.9 Surge Capacity. Participating Facilities must be able to expand bed capacity to 110% of licensed bed capacity for purposes of accepting transfer of residents from Evacuating Facilities.
- 2.5.10 Emergency Preparedness Plan. The terms of this MOU must be incorporated into each Participating Facility's Emergency Preparedness Plan.

### **Article III Activation of LTC-MAP**

#### **3.1 Participating Facility**

During a Disaster, only the authorized administrator (or designee) or Command Center at each Participating Facility has the authority to request or offer assistance through the LTC-MAP. The LTC-MAP is activated by notifying the RHCC and appropriate response agencies via regional activation protocols.

#### **3.2 Regional Healthcare Coordination Center**

Participating Facilities are responsible for notifying and informing the RHCC of its resource needs, staffing needs, or its need to evacuate residents and the degree to which it is unable to meet these needs. Any life-safety emergencies should be reported directly to the local Public Safety Answering Point (PSAP) typically accessed through 911. Any evacuation of residents should be in coordination with the scene incident commander, an individual from the response organization that has overall responsibility for managing the incident, with support from the RHCC, when possible. The RHCC may poll Participating Facilities for availability of resources and prioritize and direct the distribution of resources with the appropriate locality EOC. Once resources have been assigned, the RHCC will inform the DSF which Lending Facility (ies) or RAF(s) to contact to confirm arrangements.

#### **3.3 Sharing of Information**

The RHCC and/or any response partner may use information obtained for the purposes of coordinating a response to a DSF. This may include disclosure to other Participating Facilities and other response partners for, but not limited to, situational awareness, situational reporting, resource requests, and resource coordination.

### **3.4 Pre-Existing Agreements**

Participating Facilities should seek to obtain needed resources through existing agreements and contracts prior to seeking resources through the LTC-MAP.

### **3.5 Supplantation of Existing Relationships**

This MOU and the LTC-MAP are not designed to supplant any existing relationships with local or regional emergency response partners. Participating Facilities should maintain any ongoing relationships with their emergency response partners.

## **Article IV Borrowing Staff**

### **4.1 Communication of Request**

Borrowing Facilities should clearly document their resource needs to the RHCC via the resource request procedures in their respective RHCC emergency operations plan. A Borrowing Facility may make a verbal request to the RHCC to borrow staff from another Participating Facility to expedite the process; however, a written request should be submitted as soon as possible and prior to Demobilization.

The Borrowing Facility's request shall include:

- The type and number of staff requested,
- How quickly staff are needed,
- Logistic information (parking, where to report, and who to report to), and
- How long staff will be needed.

The Lending Facility will provide:

- A list of names and credentials of the borrowed staff.

### **4.2 Right of Refusal**

The Borrowing Facility has the right to reject any and all borrowed staff at any time for any reason.

### **4.3 Identification**

Borrowed staff will be required to present two forms of identification including their facility identification badge.

### **4.4 Documentation**

Borrowing Facilities should clearly document hours worked by borrowed staff by a sign-in and sign-out sheet. Likewise, Lending Facility should maintain independent records for reconciliation.

#### **4.5 Supervision**

Each borrowed staff member shall have an assigned supervisor at the Borrowing Facility. This supervisor is responsible for adequately orienting the borrowed staff member and periodically ensuring his/her performance is adequate.

#### **4.6 Scheduling**

Shifts shall follow the Borrowing Facility's emergency staffing plan. The length of shifts may be negotiated in advance with Lending Facility. Borrowed staff are expected to remain on duty until they are relieved, unable or unsafe to continue or are dismissed. The supervisor is responsible for communicating with them regarding their assignments. Borrowed staff shall document their time.

#### **4.7 Demobilization Procedures**

The Borrowing Facility will provide and coordinate any Demobilization procedures, post-incident stress debriefing, as required, transportation as necessary to return borrowed staff to the Lending Facility, and a copy of the assignment log and time sheets for tracking and payment purposes.

#### **4.8 Costs of Borrowed Staff**

Normal payroll procedures will be followed by each Participating Facility. Borrowed staff will be retained on the Lending Facility's payroll. If a Lending Facility requests reimbursement for borrowed staff time, the Borrowing Facility shall reimburse the Lending Facility the full costs of the borrowed staff including any benefits and taxes. The Borrowing Facility shall submit time sheets to the Lending Facility and the Lending Facility shall generate an invoice. Lending Facility shall supply sufficient documentation to substantiate costs. All financial matters should be worked out directly between Participating Facilities. Failure to pay may result in removal of a Participating Facility from the LTC-MAP program.

#### **4.9 Logistic Needs**

A Borrowing Facility shall be responsible for all logistic needs of borrowed staff including food, transportation and lodging as required. If borrowed staff are transported by the Borrowing Facility, round trip transportation will be required unless explicitly stated otherwise.

### **Article V**

#### **Borrowing Pharmaceuticals, Supplies and/or Equipment**

##### **5.1 Communication of Request**

Borrowing Facilities should clearly document their resource needs to the RHCC via the resource request procedures in their respective RHCC emergency operations plan. A Borrowing Facility may make a verbal request to the RHCC for pharmaceuticals, supplies and/or equipment from another Participating Facility to expedite the process, however, a written request should be submitted as soon as possible and prior to Demobilization.

##### **5.2 Documentation**

The Borrowing Facility and Lending Facility agree to utilize the request forms contained in the region specific mutual aid plans in the absence of facility specific forms. Borrowing Facilities shall accept forms supplied by the Lending Facility assuming they contain sufficient documentation which should include the items involved in the transaction, condition of the material prior to the loan, and the party responsible for the material. The Borrowing Facility is responsible for confirming receipt of any pharmaceuticals, supplies and/or equipment.

### **5.3 Transporting of pharmaceuticals, supplies, and/or equipment**

The Borrowing Facility is responsible for coordinating the transportation of pharmaceuticals, supplies, and/or equipment to and from the Lending Facility. The appropriate EOC will facilitate transportation when requested, and if available. The Borrowing Facility is responsible for all costs associated with transportation including handling and loading of any borrowed equipment.

### **5.4 Maintenance of pharmaceuticals, supplies, and/or equipment**

The Borrowing Facility is responsible for appropriate use, storage, and maintenance of borrowed pharmaceuticals, supplies, and/or equipment upon receipt and during the time the materials are located at the Borrowing Facility. The Borrowing Facility will take specific measures related to the safekeeping of pharmaceuticals as required by law. The Borrowing Facility should take reasonable precautions with regards to storage and use of equipment including being used by properly trained operators.

### **5.5 Return of pharmaceuticals, supplies, and/or equipment**

Reusable pharmaceuticals and supplies which are returned to Lending Facility in clean, damage-free condition shall not be charged to Borrowing Facility and no rental fee may be charged. The Lending Facility shall determine whether returned items are “clean and damage-free.” The Borrowing Facility is responsible for the cleaning, maintenance, and prompt return of borrowed equipment. Borrowed equipment is expected to be returned in good working order, otherwise replacement may be required. Once borrowed equipment is no longer needed by the Borrowing Facility, it shall be returned. Alternatively, a Lending Facility may request orally or in writing that the borrowed equipment be returned. Borrowing Facility should make reasonable efforts to return the borrowed equipment within twenty-four (24) hours of notification.

### **5.6 Payment for pharmaceuticals, supplies, and/or equipment**

A Lending Facility may request reimbursement for materials and expenses. Costs, which shall be determined jointly by the Lending Facility and Borrowing Facility, may include use, breakage, damage, replacement, and return of the borrowed pharmaceuticals, supplies, and/or equipment. Borrowed equipment shall be charged at the current equipment rate or if no rates have been established as mutually agreed upon between the two Participating Facilities. Payment can be made either in-kind or with actual replacement cost. The Lending Facility shall supply sufficient documentation to substantiate costs. Failure to pay may result in removal of a Participating Facility from the LTC-MAP program.

### **5.7 Borrowed Equipment**

Borrowed equipment is provided as is, and Borrowing Facilities should ensure its suitability prior to use. Borrowing Facility is required to supply, at its own expense, any fuel, lubrication, or other consumable costs for borrowed equipment. A Lending Facility may require an operator to be supplied with borrowed equipment. The Borrowing Facility will be responsible for any costs associated with the operator, in addition to the cost of the equipment. In the event an operator is not supplied with borrowed equipment, the Borrowing Facility will be responsible for ensuring that the borrowed equipment is operated by qualified and trained individuals.

## **5.8 Lost, Stolen, Damaged Equipment**

Should borrowed equipment be lost, stolen or damaged, the Borrowing Facility shall be responsible for replacing the borrowed equipment with equipment of “equal condition and capability.” The Borrowing Facility shall not be liable for damage caused by the sole negligence of Lending Facility’s operator(s). If the Lending Facility must lease or rent a piece of equipment while the Lending Facility’s equipment is being repaired or replaced, the Borrowing Facility shall reimburse the Lending Facility for such costs.

## **Article VI Transfer/Evacuation of Residents**

### **6.1 Resident Care Responsibilities**

If a resident is relocated to another Participating Facility, either temporarily or permanently, the resident will be under the care of the RAF until transferred back to the Evacuating Facility. The Evacuating Facility is responsible for transferring extraordinary drugs or other special resident needs, if possible. The Evacuating Facility must accept the resident back once it is operational. There are several scenarios where a resident may not be returned to the Evacuating Facility including resident discharge to home or alternate level of care, resident refusal of transfer, resident unstable for transport, resident death, or permanent closure of the Evacuating Facility.

*From an ethical standpoint, it is expected that no marketing efforts will be made by the RAF to the Evacuating Facility’s residents while these residents are in the RAF’s care.*

### **6.2 Communication of Request**

If conditions at an Evacuating Facility are unsafe, an Evacuating Facility may request a resident transfer to another Participating Facility through the RHCC and on-scene incident commander, if applicable. Written documentation is required prior to the actual transfer of a resident or if a technological failure prevents this, as soon as feasible thereafter.

### **6.3 Right to Refuse**

A Participating Facility has the right to refuse the transfer of any resident to its facility for any reason.

## 6.4 Placement

An Evacuating Facility should coordinate the placement of any residents from its facility with the RHCC. After the request has been made to the RHCC, the RHCC will coordinate identifying RAFs for patient placement. It is then the Evacuating Facility's responsibility to work with the RAF for resident transport. The Evacuating Facility should offer residents who are physically able to be discharged the option to be discharged, prior to transferring the patient to a RAF. A final disposition of each resident should be filed with the RHCC once a patient has been transferred.

## 6.5 Medical Staff

The RAF is responsible for coordinating with its medical staff to assign a provider to each resident received. When possible, the transferring physician will contact the receiving physician to provide information regarding patient care. If a physician is credentialed in both facilities, he/she may continue caring for the patient. If the physician is not credentialed at the RAF location, emergency credentialing and privileging may be applied.

## 6.6 Documentation

An Evacuating Facility will provide the following information to the RHCC and on-scene incident commander:

- The number of residents to be transferred,
- The general nature of each resident's illness or condition, including whether a skilled nursing facility ("SNF") or Nursing Facility ("NF") resident,
- Any specialized services required (e.g. ventilator), and
- Mode(s) of transportation needed.

When transferring a resident to a RAF, an Evacuating Facility will provide the following documentation to the RAF:

- The number of residents to be transferred,
- Each resident's illness or condition,
- Any specialized services required (e.g. ventilator),
- Mode(s) of transportation needed,
- Expected time of arrival,
- Resident / Medical Record / Staff / Equipment Tracking Sheet, attached hereto and incorporated herein as Exhibit A,
- Resident emergency evacuation form for each resident, that includes resident demographic information, contact person, code status, medications, key clinical information, usual mental status, behavior problems/safety risk, isolation precautions, devices and treatments, risk alerts, diet, activities of daily living, and personal belongings sent with resident. A sample resident emergency evacuation form is attached hereto as Exhibit B, and
- If time permits, the entire medical record and other pertinent information such as insurance.

*The Evacuating Facility is responsible for tracking the destination of all residents transferred out and providing this information to the RHCC*

*NOTE: If a Participating Facility utilizes electronic medical records, it should make every effort to batch print medical records, either on-site or off-site. If an Evacuating Facility permits remote access to its medical records system, an Evacuating Facility staff member with access should travel with the residents.*

## **6.7 Transporting of residents**

The Evacuating Facility is responsible for coordinating transportation of the residents to the RAF, as well as any associated costs. The Evacuating Facility should also coordinate the transfer of all medications (including controlled substances) and supplies as time permits.

The RAF will:

- Identify an appropriate location for resident care,
- Designate point of entry,
- Assign appropriate staff, and
- Communicate arrival of residents to the Evacuating Facility or the RHCC.

## **6.8 Supervision/Responsibility**

Once a resident arrives at the RAF he/she becomes the RAF's resident and is under the care of the RAF's admitting physician until transferred to the Evacuating Facility or another facility, discharged, or reassigned.

## **6.9 Notification**

The Evacuating Facility is responsible for notifying the resident's family or legal guardian and the resident's attending or personal physician of the resident transfer. As appropriate, the RAF may assist in this process and shall assume the responsibility for communicating with the resident's family or legal guardian following admission to the RAF.

## **6.10 Exceeding Licensed Bed Capacity**

It is the intent of the LTC-MAP to place displaced residents into open licensed beds whenever possible. In situations where a RAF may exceed its licensed bed capacity to shelter residents, this decision will be made based on published guidance by the VDH OLC and in coordination with the RHCC. Additionally, RAFs should engage the Fire Marshal and Code Enforcement Officials as required.

## **6.11 Fast Out Evacuation**

During a Disaster that requires the fast evacuation of residents, the Evacuating Facility may require residents be evacuated to a Stop Over Point such as an independent living facility, assisted facility, senior center, or other location to provide for the immediate protection of residents. If

long term sheltering is needed, these residents will be moved to a RAF with a more appropriate level of care.

### **6.12 Evacuation with Prompt Return**

In situations where an evacuation (slow or fast) is necessary, but it is clear that the Evacuating Facility will be operational in the near future, the RHCC will attempt where possible to identify RAFs that will allow the Evacuating Facility to achieve the primary goal of keeping Evacuating Facility residents in close proximity to the Evacuating Facility to ensure that staff and families will be able to visit or help provide care for displaced residents.

*An example of this scenario is during a high-heat event where there is an A/C failure but it is anticipated to be operational in a few days.*

### **6.13 Evacuation with Prolonged Return**

In a situation where an immediate evacuation is necessary, but it is clear that the facility may not be reoccupied for a period of time, residents will be moved to RAFs with open beds over a larger geographic area. Residents may initially be moved to a local facility or Stop Over Point for temporary care as open beds are located.

*An example of this scenario would be a significant fire or flooding where the rooms cannot be reoccupied for several weeks.*

Regardless of the scenario, the RAF will work to provide an appropriate level of care, either through open beds, discharging residents ready to go home early, or finding alternative spaces.

### **6.14 Payment for Resident Care**

The Evacuating Facility and RAF will work with each other and the appropriate payer (Medicare or Private Payer) to work through the payment of services for the care of residents. Payment for resident care by Medicaid is addressed in Article VII below.

## **Article VII DMAS Reimbursement Policies<sup>1</sup>**

### **7.1 Reimbursement**

Reimbursement to a DSF for its Medicaid residents who must be temporarily evacuated to a RAF may continue for up to 30 calendar days after the disaster event.

- The DSF does not “discharge” its residents and the RAF does not “admit” the residents transitioning from the DSF.
- The DSF is still considered the provider of record and will continue to bill Medicaid for each day of care.

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<sup>1</sup> See Medicaid Memo: Special “Reimbursement for Individuals Evacuated from a Disaster Struck Nursing Facility Due to Temporary Emergencies” October 4, 2017.

- Reimbursement will be the same as if the individual was residing in the DSF.
- The DSF is then responsible for reimbursing the RAF that accepts its residents during the disaster period.
- No other reimbursement will be made to either the DSF or the RAF.

## **7.2 The DSF and RAF must meet the following conditions:**

### **7.2.1 Contract**

The DSF must have a contract with the RAF, the contract must:

- Include terms of reimbursement and mechanisms to resolve any contract disputes;
- Protocols for sharing care and treatment information between the two facilities; and
- Requirements that both facilities meet all conditions of Medicare or Medicaid participation determined by VDH.

*Note: This MOU is an acceptable contract<sup>2</sup>*

### **7.2.2 Resident Records**

The DSF must notify DMAS of the disaster event, maintain records of evacuated residents with names, dates and their evacuation destination, and regularly update DMAS on the status of the repairs to their facility.

- The DSF must send the required information by email to [evacuation@dmass.virginia.gov](mailto:evacuation@dmass.virginia.gov) or by fax to (804)371-4981.
- Alternatively, the DSF may coordinate with the RHCC to provide DMAS with the required information.

The DSF is responsible for completing the necessary Minimum Data Set (“MDS”) assessments, either directly or by delegating the function to the RAF.

- The RAF need only complete the clinical assessment portion of the MDS for each evacuated resident, and may do this on a paper MDS form if the electronic MDS is not available.
- The RAF may then send the paper MDS assessment back to the DSF.
- The DSF may transmit the updated MDS at a later date, once the emergency is resolved as long as it was completed timely and within the appropriate observation period.

*Note: This process does not require the issuance of the 1135 waiver.*

### **7.2.3 Placement Requirements**

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<sup>2</sup> *Id.*

Nothing shall preclude an individual from asking to be discharged and admitted to another nursing facility or alternative placement during the initial 30-day period. Alternative placements may include:

- Home and Community-Based Services Waiver (e.g., CCC Plus waiver), or
- Program for All-Inclusive Care for the Elderly (PACE)

The DSF must determine within 15 days of the event whether individuals will be able to return to the facility within 30 days of the disaster event. If the DSF determines that it is not able to reopen within 30 days, it must discharge the individuals and work with them to choose admission to the RAF, other nursing facilities, or alternative placements.

- The DSF should proceed with discharge documentation by Day 16 (DMAS does not pay for Day of Discharge) and the RAF should commence with admission procedures by Day 16 for these Medicaid individuals (DMAS does pay for day of admission).

*Note: It is understood that it would be impractical to completely discharge all residents from the DSF and admit them to other facilities or placements in one day; therefore, the process should commence by Day 16 and be completed by Day 30.*

- Admission to the RAF is not a requirement and it may be deemed that the resident could be transferred to a more suitable location at that time if he or she does not meet the RAF's admission criteria or based on resident choice. In this situation, normal discharge procedures apply.
- The RAF or other facility or placement that accepts admission of evacuated residents must follow normal admission criteria.
- Reimbursement to the DSF shall cease when an individual is officially discharged.
- If the resident returns to the DSF after the 30-day timeframe, the RAF or alternate facility will discharge the resident and complete a discharge assessment. The DSF will then consider the resident as a new "admission" (not a "Re-entry") for MDS purposes.

*Note: If the RAF does not accept Medicaid, the RAF will not be able to accept residents enrolled in Medicaid from the DSF for formal admission. In this case, a transfer request would be put into effect.*

Managed Care Organizations (Health Plans) – This MOU will satisfy the requirements referenced in the DMAS Health Plan Contract - Section 12.4.10 – "Nursing Facility Mutual Aid Agreements." This payment plan does not address NF residents covered by private pay, LTC insurance, no pay or SNF residents covered by Medicare, Medicare Managed Care, or private insurance.

*Note: Reimbursement covers facility costs, but not necessarily ambulance/ transportation costs. Each facility should review its facility specific business interruption insurance and agreements with private emergency medical services (EMS) transportation firms or private bus contracts.*

## **Article VIII Term and Termination**

## **8.1 Term**

This MOU is effective as of the Effective Date set forth on the signature page below and shall expire on December 31, 2022. A renewal MOU must be signed prior to the expiration of this MOU to continue participation in the LTC-MAP. Any facilities with an expired MOU may, at any time, request to sign a new MOU to participate in the LTC-MAP.

## **8.2 Termination**

A Participating Facility may at any time terminate its participation in the MOU by written notice to VDH OEP and VHHA. Termination is effective upon VDH OEP's receipt of notice. Any terminating Participating Facility shall remain liable for all obligations incurred during its period of participation, until the obligation is satisfied.

Participating Facilities who are not in compliance with this MOU may be given thirty (30) days to meet compliance. After thirty (30) days, VDH OEP may terminate a Participating Facility's participation in the LTC-MAP due to non-compliance with the terms of this MOU. This decision will be communicated by certified mail to the respective Participating Facility administrator within ten (10) days of the decision.

## **Article IX Miscellaneous**

### **9.1 Hold Harmless**

A Borrowing Facility/Evacuating Facility agrees to hold harmless any Lending Facility/RAF for acts of negligence or omissions on the part of the Lending Facility/RAF good faith response for assistance during a Disaster. The RAF or Lending Facility is responsible for appropriate credentialing of staff and for the safety and integrity of supplies provided to a Borrowing Facility.

### **9.2 Independent Contractor**

Each Participating Facility acts as an independent contractor with respect to the other parties to this MOU. Participating Facilities may not act on behalf of other Participating Facilities and have no rights to any assets except for assets under their own control. Nothing in this MOU alters in any way control of the management, assets, or affairs of any party. Nothing in this MOU shall be construed to give a Participating Facility any right of ownership, possession, use, or control of the facilities or assets of another Participating Facility. No party by virtue of this MOU assumes any liability for any debts or obligations of any kind incurred by another party to this MOU. Nothing in this MOU shall be construed as limiting the rights of any party to contract with any other party on a limited or general basis.

### **9.3 Mediation and Arbitration**

If a dispute arises out of or relating to this MOU, and if said dispute cannot be settled through direct discussions, the parties agree to first endeavor to settle the dispute in an amicable manner by mediation. Thereafter, any unresolved controversy or claim arising out of or relating to this MOU, or breach thereof, may be settled by arbitration, if the parties agree to do so, and judgment

upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The parties to this MOU may seek to resolve disputes pursuant to mediation or arbitration, but are not required to do so.

#### **9.4 Worker's Compensation and Employee Claims**

Employees of a Participating Facility remain employees of that Participating Facility and all costs associated with the employee are the responsibility of the employer. Employers shall provide worker's compensation coverage as required by law.

#### **9.5 Modifications**

The terms of this MOU may not be modified except by VDH and VHHA. Amendments to this MOU must be in writing and signed by Participating Facilities.

#### **9.6 Entire Agreement**

This MOU and any attached exhibits constitute the entire agreement amongst the Participating Facilities. No other terms are agreed to unless in writing and signed by the Participating Facilities.

#### **9.7 Non-Exclusiveness and Prior Agreements**

This MOU shall not supersede any existing mutual aid agreement, transfer agreements, or any other agreements between two or more Participating Facilities. Assistance requested by a party to a mutual aid agreement other than this MOU shall be governed by the terms of that mutual aid agreement, not by this MOU.

#### **9.8 Governmental Authority and Venue**

This MOU shall be interpreted, construed, and enforced in accordance with the laws of the Commonwealth of Virginia. Any legal action that may arise out of this MOU shall be brought in the Commonwealth of Virginia and the City of Richmond.

#### **9.9 No Partnership**

This MOU shall not be interpreted or construed to create an association, joint venture, or partnership among the Participating Facilities or to impose any partnership obligation or liability upon any Participating Facility. Further, no Participating Facility shall have any undertaking for or on behalf of, or to act as or be an agent or representative of, or to otherwise bind any other Participating Facility.

#### **9.10 No Third-Party Beneficiary**

Nothing in this MOU shall be construed to create any rights in or duties to any third party, nor any liability to or standard of care with reference to any third party. This MOU shall not confer any right or remedy upon any person other than the Participating Facilities. This MOU shall not release or discharge any obligation or liability of any third party to any Participating Facilities.

### **9.11 Successors and Assigns**

This MOU is not transferable or assignable, in whole or in part, by any Participating Facility.

### **9.12 Waiver of Rights**

Any waiver at any time by any Participating Facility of its rights with respect to a default under this MOU, or with respect to any other matter arising in connection with this MOU, shall not constitute or be deemed a waiver with respect to any subsequent default or other matter arising in connection with this MOU. Any delay short of the statutory period of limitations, in asserting or enforcing any right, shall not constitute or be deemed a waiver.

### **9.13 Invalid Provision**

The invalidity or unenforceability of any particular provision thereof shall not affect the other provisions hereof, and this MOU shall be construed in all respects as if such invalid or unenforceable provision had been omitted.

### **9.14 Notices**

All notices, requests, approvals, demands and other communications required or permitted to be given under this MOU shall be in writing and shall be deemed to have been duly given and to be effective when delivered personally (including delivery by express or courier service) or, if mailed, four (4) business days after being deposited in the United States mail as a registered or certified matter, postage prepaid, return receipt requested, addressed as follows:

If to VDH OEP:            Director, Office of Emergency Preparedness  
                                  Virginia Department of Health  
                                  109 Governor Street  
                                  13<sup>th</sup> Floor  
                                  Richmond, Virginia 23219

If to VHHA:                Director of Emergency Preparedness  
                                  Virginia Hospital & Healthcare Association  
                                  4200 Innslake Drive, Suite 203  
                                  Glen Allen, Virginia 23060

## Virginia Long-Term Care Mutual Aid Plan Memorandum of Understanding

IN WITNESS WHEREOF, the Participating Facility named below has signed this MOU as of \_\_\_\_\_, 2018 (“Effective Date”).

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Executed MOUs will be retained at the Virginia Hospital & Healthcare Association offices. Please retain one executed copy for your records and mail or e-mail this signed page to:

Kelly Parker  
Director, Emergency Preparedness  
Virginia Hospital & Healthcare Association  
4200 Innslake Drive, Suite 203, Glen Allen, VA 23060  
[kparker@vhha.com](mailto:kparker@vhha.com)

# **EXHIBIT A**

## **Resident / Medical Record / Staff / Equipment Tracking Sheet**

# **EXHIBIT B**

## **Sample Resident Emergency Evacuation Form**