

Title: Person-Centered Options Counseling Operational Manual – Draft

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KEY DEFINITIONS AND TERMS

Term	Definition		
Action Plan	A documented plan developed by the consumer with the support of the Person-Centered Options Counseling (PCOC) Counselor as a result of PCOC that contains the consumer's goals, along with the action steps, resources needed, timelines, and responsible parties to achieve the goals.		
Activities of Daily Living (ADL)	Routine activities that people tend do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring, and mobility and ambulation. The need for assistance with medication management and personal hygiene is also considered an ADL.		
Aging and Disability Resource Center (ADRC)	ADRCs serve as a point of entry into the Long-Term Services and Supports (LTSS) system for older adults and individuals with disabilities. Through integration or coordination of existing aging and disability service systems, the ADRC program provides objective information, advice, counseling and assistance, and empowers people to make informed decisions about their LTSS needs.		
American Community Survey (ACS)	A demographics survey program conducted by the U.S. Census Bureau. The ACS gathers information annually in the 50 U.S. states, the District of Columbia, and Puerto Rico.		
Application Assistance	Process of assisting consumers to complete applications to receive state or federally funded services. This process includes completing forms and providing guidance on how to answer questions and submit required documentation.		
At Risk of Long Term Services and Supports (LTSS)	Refers to an individual that may require some LTSS within the next two years. This includes paid and unpaid services and all Medicare-Medicaid dually eligible beneficiaries and supplemental security income (SSI) recipients, among others, that are not in-need of LTSS.		
Caregiver	A person who assists an older adult or person with a disability with ADLs or instrumental activities of daily living (IADL). This person may be a family member or trusted person in the individual's life.		
Care Transition	The process that a consumer experiences as they move through a variety of healthcare settings and healthcare practitioners during an episode related to a change in their acute or chronic illness.		
Case Management	Set of inter-related activities that ensure access to coordinated Medicaid LTSS and the monitoring of service needs and outcomes. Case management is a Medicaid covered service and varies by provider (e.g., managed care organizations, community-agencies, State LTSS specialists, etc.), but generally involves implementing or overseeing the implementation		

Term	Definition		
	of a person's service plan by providing information, referral to appropriate service providers, and the coordination of necessary medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Follow-up with the person/family is an essential component of this process.		
Cognitive Impairment	Deficits in areas of functioning within the brain, including short/long-term memory, orientation to person, place, and/or time, abstract reasoning, or judgement especially related to safety issues. Cognitive impairment can result from various conditions.		
Community Based Services	Services in the continuum of care that are provided in community settings. Often this group of services is known as home and community-based services (HCBS) or in some cases LTSS.		
Decision Support	A core skill of PCOC, it is a process of assisting the consumer in reviewing, educating, and discussing available LTSS options. The PCOC Counselor is there to assist the consumer as they weigh the pros and cons and deliberate the issues which may affect their informed decision.		
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)	The State agency established under the provisions of Rhode Island General Laws (R.I. Gen. Laws) Chapter 40.1-1 whose duty it is to serve as the State's mental health authority and establish and promulgate the overa plans, policies, objectives, and priorities for State programs for adults with intellectual and developmental disabilities as well mental illness and substance abuse education, prevention and treatment.		
Department of Human Services (DHS)	The State agency established under the provisions of R.I. Gen. Laws Chapter 40-1 that is empowered to administer certain human services. Through an interagency service agreement with the Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, DHS was delegated the authority to determine Medicaid eligibility in accordance with applicable State and federal laws, rules, and regulations.		
Eligibility	 A broad term that refers to criteria that an individual must meet to receive a State or federally funded service. There are three stages of eligibility: Pre-Eligibility: The process of providing information, direction, awareness, and choice to consumers before they apply for a State or federally funded program. Eligibility: The process of supporting consumers in applying for and accessing required services. Post Eligibility: Refers to the activities that happen after someone becomes eligible for a program. This includes service delivery, transition support, and measuring health outcomes. 		

Term	Definition	
Executive Office of Health and Human Services (EOHHS)	The entity within the executive branch of Rhode Island State government that is designated as the Medicaid Single State Agency in R.I. Gen. Laws and the Medicaid State Plan. In this capacity, it is responsible for overseeing the administration of all Medicaid-funded LTSS in collaboration with the health and human services agencies under the office's jurisdiction.	
Home and Community-Based Services (HCBS)	Types of person-centered care delivered in the home and community. A variety of health and human services can be provided. HCBS programs address the needs of people with functional limitations who need assistance with ADLs, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care.	
Information and Referral (I&R)	The process of providing information to consumers or family members who are seeking LTSS services. This process may include providing a referral to agencies on the consumer's behalf.	
Intake and Screening	Using information gathered to engage in a conversation about preferences, strengths, needs, and available resources given expressed needs. Use of a standardized screening tool, as appropriate, to learn whether there is a need/potential eligibility for Medicaid (necessary to obtain federal match) and/or any other services.	
Long-Term Services and Supports (LTSS)	LTSS encompass a broad range of paid and unpaid medical and personal care assistance that people may need – for several weeks, months, or years – when they experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability. LTSS includes ADLs (such as eating, bathing, and dressing) and IADLs (such as preparing meals, managing medication, and housekeeping). ¹	
Medicare LTSS Coverage	 Medicare is the federal health insurance program for people who are 65 or older or for younger people with disabilities. Medicare typically covers medically necessary primary care essential benefits for acute care, such as doctor visits, prescription drugs, and hospital stays. Except for the specific circumstances described below, Medicare does not pay for most LTSS or personal care— such as help with bathing or for supervision: <i>Following hospitalization</i>: Medicare will help pay for a short stay in a skilled nursing facility (SNF) following a three-day inpatient stay if a person needs skilled services such as skilled nursing services, physical therapy, or other types of therapy. Limits apply. <i>Medically necessary to treat a condition</i>: If ordered by a physician, Medicare will cover part-time/intermittent skilled nursing and other skilled services at home or in an appropriately certified health facility as 	

¹ Kaiser Family Foundation, *Medicaid and Long-Term Services and Supports: A Primer*, available at <u>https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/#:~:text=%E2%80%9CLong-term%20services%20and%20supports,%2C%20chronic%20illness%2C%20or%20disability</u>

Term	Definition		
	 well as medical social services and durable medical equipment. Fewer limits apply. Prevent further decline: Medicare covers ongoing long-term care services to prevent further decline for people with medical conditions that may not improve. This can include conditions like stroke, Parkinson's disease, ALS, Multiple Sclerosis, or Alzheimer's disease. Hospice: Medicare covers hospice at home, in a nursing facility (NF), or hospice including drugs and palliative care for beneficiaries with terminal illnesses that are not receiving other treatments. Respite for caregivers may also be covered. 		
Medicaid LTSS Coverage	 Medicaid is a state and federal health insurance program that assists low-income families or individuals in paying for LTSS and medical care. Medicaid LTSS coverage includes a broad spectrum of services for persons with clinical and functional impairments and/or chronic illness or diseases that require the level of care typically provided in a healthcare institution (e.g., hospital or nursing facility). In Rhode Island, Medicaid LTSS covers: Skilled or custodial nursing facility/intermediate care facilities for individuals with intellectual disabilities (ICF-IDD) care, community-based supportive alternatives, therapeutic, rehabilitative, and habilitative services, and personal care as well as various home and community-based supports. Primary care essential benefits for acute care services but Medicaid is the payer of last resort if a person has Medicare or commercial coverage of these services. 		
No Wrong Door (NWD)	A framework advanced by the Administration for Community Living (ACL) to create a single, statewide system that supports consumers who need or may at some point need LTSS. Specifically, the NWD concept encompasses a set of operating principles that are designed to reorient the workings of an LTSS system of care to give the needs and preferences of individuals and families a greater voice.		
Office of Healthy Aging (OHA)	The State agency who coordinates all State activities under the purview of the Older Americans Act and administers funding under Titles III and VII - in addition to National Family Caregiver Support programs. OHA is the designated State Unit on Aging and developed and administered the State Plan on Aging, in compliance with all federal statutory and regulatory requirements.		
Paid/Unpaid LTSS	Paid LTSS : HCBS or LTSS health facility services financed out-of-pocket, or by Medicare (short term skilled and subacute care) and/or Medicaid LTSS. Includes paid home care, health facility care (NF, ICF/I-DD, long- term hospital), residential care (group homes, assisted living residence, shared-living, adult foster care) and day services (adult day, therapeutic day, etc.).		

Term	Definition	
	Unpaid LTSS : Home-based LTSS typically provided by family caregivers to people who do not qualify for Medicaid (based on income and/or resources), require services in excess of Medicare coverage and/or do not have severe LTSS needs (less than two ADLs, no serious cognitive impairment).	
PCOC Counselor	Any individual who provides PCOC in accordance with the standards outlined in this manual.	
Person-Centered Options Counseling (PCOC)	An interactive decision-support process whereby consumers, with support from family members, caregivers, and /or significant others, are supported in their deliberations to make informed long-term support choices in the context of the consumer's preferences, strengths, needs, values, and individual circumstances.	
Person-Centered Practices	Practices that focus on the preferences and needs of the individual; empower and support the individual in defining the direction for his or her life; and promote self-determination, community involvement, contribute to society and emotional, physical, and spiritual health.	
Surrogate Decision- Maker	A person legally authorized to make decisions on behalf of an individual who has been declared legally incapacitated.	
The POINT	Rhode Island's "The POINT" offers a statewide, multilingual call, and walk- in center for elders, adults with disability, and their caregivers. The POINT staff help people navigate their short and long-term options for healthcare, housing, respite support, food assistance, and more. The POINT links people to in- and out-of network services and assists clients with benefits enrollment. The Ocean State Center for Independent Living offers specialized services for adults with disabilities and the RI Serves network (operated by the Rhode Island Office of Veterans Affairs) offers specialized services for veterans.	
	hosted and managed by United Way of Rhode Island and co-located with the State's 2-1-1 system. In addition to this main office, there are regional POINT offices throughout the State.	

PURPOSE OF THE PERSON-CENTERED OPTIONS COUNSELING OPERATIONAL MANUAL

The purpose of the Person-Centered Options Counseling (PCOC) operational manual is to provide an overview of PCOC, outline program standards for PCOC, and provide tools that will be used to support PCOC in Rhode Island. The manual serves as a reference tool for PCOC Counselors and helps establish the framework for PCOC for stakeholder review and feedback.

PCOC is part of Rhode Island's "No Wrong Door" (NWD) System Three Phase Strategic Plan. Additional information regarding Rhode Island's No Wrong Door System Three Phase Strategic Plan and NWD concepts is located on EOHHS's website.

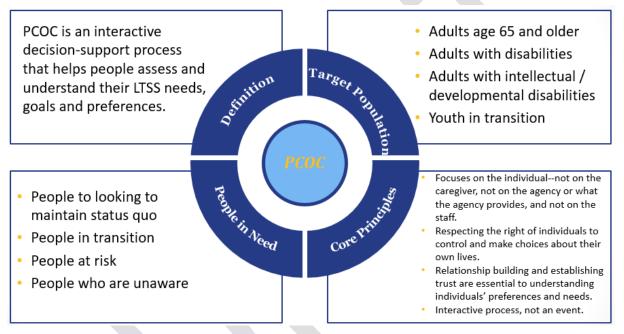
This manual serves as a starting point in designing the process and operational materials to support PCOC delivery in Rhode Island. EOHHS anticipates updating this manual periodically as this program is further developed and as part of general quality improvement efforts.

BACKGROUND

PCOC Overview

Finding and accessing the right long-term services and supports (LTSS) presents a daunting task for many consumers and their families. There are a variety of different service providers, funding streams, and eligibility requirements that can make the search confusing, difficult, or frustrating.² To address this reality, Rhode Island will implement PCOC state-wide to better support consumers in their search for LTSS. **PCOC is an interactive decision-support process that helps people assess and understand their LTSS needs, goals, and preferences**. This approach of supporting consumers is directed by the individual and may include caregivers, natural supports, or those who are legally authorized to represent the individual. PCOC services emphasize the Administration for Community Living (ACL)'s NWD principles and person-centered thinking and practice to support consistent, customer-oriented interactions.

Figure 1. PCOC Overview



PCOC Compared to Other NWD Activities

NWD is a framework or concept advanced by the ACL to create a single, statewide system that supports consumers who need or may at some point need LTSS.³ Specifically, the NWD concept encompasses a set of operating principles that are designed to reorient the workings of an LTSS system of care to give the needs and preferences of individuals and families a greater voice.

No Wrong Door Operating Principles:

• The LTSS system should be person rather than provider or payer-centered and incorporate practices that give priority to each person's unique goals, values, needs, and preferences from the initial point of contact onward.

² Administration for Community Living (ACL), Key Elements of a NWD System of Access to LTSS for All Populations and Payers, available at: https://nwd.acl.gov/pdf/NWD-National-Elements.pdf

³ Administration for Community Living (ACL), Key Elements of a NWD System of Access to LTSS for All Populations and Payers, available at: https://nwd.acl.gov/pdf/NWD-National-Elements.pdf

- LTSS business processes should be standardized, simplified and streamlined to the full extent feasible to ensure ready access to needed services no matter what the point of entry.
- Eligibility, enrollment, and payment practices for public LTSS programs must be modernized and integrated in ways that make the system easier to navigate and understand.
- LTSS IT systems should be retooled to build "connections and crosswalks where they should, but don't yet exist" and to promote "program integrity and service quality while preserving [a person's] dignity and privacy";⁴ and
- Every LTSS initiative related to access should "bolster [or] create opportunities to listen, counsel, and assist where now the practice is to inform and direct".⁵

Within the broader NWD delivery system, PCOC is a pre-eligibility function that typically occurs prior to a consumer receiving publicly or privately funded LTSS. Figure 2 illustrates where PCOC fits within the broader NWD framework.

Figure 2: PCOC within the Broader NWD Framework

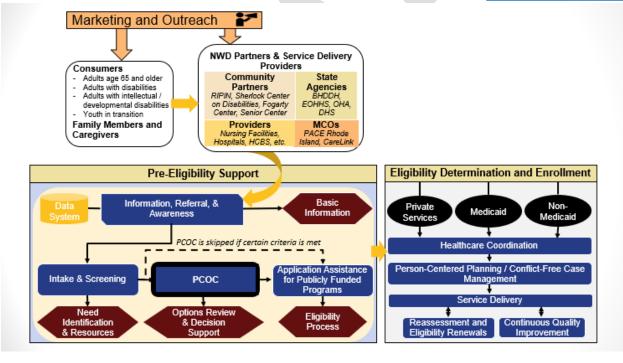
What is NWD?

Concept: NWD

encompasses the universe of pre-eligibility, eligibility, and post-eligibility functions and interactions with Rhode Islanders who are at-risk for or in-need of LTSS and without regard to payer, provider, or personal circumstance.

Strategic Plan of Action:

Phased-in plan that uses the core consumer-centered principles of NWD to strengthen Rhode Island LTSS by modernizing functions and improving access, quality and accountability system-wide.



There are four main activities that support consumers in understanding their LTSS options. Each activity or stage offers varying level of detail based on the consumer's needs and preferences. Figure

⁴ Christina Neill Bowen and Wendy Fox-Grage, "Promising Practices No Wrong Door: Person- and Family-Centered Practices in Long-Term Services and Supports," available at:

http://www.longtermscorecard.org/~/media/Microsite/Files/2017/AARP_PromisingPrac_NoWrongDoor.pdf (p.2)

⁵ Carol V. O'Shaughnessy, "Aging and Disability Resource Centers (ADRCs): Federal and State Efforts to Guide Consumers Through the Long-term Services and Supports Maze," available at:

http://www.nhpf.org/library/background-papers/BP81_ADRCs_11-19-10.pdf (p.4)

3 compares activities that provide guidance and information to consumers on their LTSS options. These activities will be further defined as EOHHS implements a web-based solution to support its NWD system.

Category	Information, Referral & Awareness	Intake & Screening	Person-Centered Options Counseling	Person-Centered Planning (PCP) / Conflict- Free Case Management (CFCM)
Service	Provides basic LTSS	The goal of intake	Interactive counseling and	 Provided to consumers that are deemed
Definition	information to	and screening is to	decision-support process that	eligible for Medicaid LTSS.
	consumers who need	assess if LTSS is	helps consumers seeking or	PCP is an extension of PCOC or an
	immediate/short-term	appropriate and to	planning LTSS understand their	independent activity if a person by passes
	assistance.	assess private v.	strengths, needs, preferences	these steps.
		public options.	and unique circumstances and	 The goal of PCP is to transform a set of
			weigh the pros and cons of	authorized services into a care plan that
			available alternatives.	meets the needs, preferences and health
				goals of a beneficiary.
Service	NWD partners & service	NWD partners +	State agency staff (pilot)	Case managers
Provider	delivery providers	State agency staff	State agency staff + selected	
			existing vendors (full launch)	
Eligibility	Pre-eligibility	Pre-eligibility	Pre-eligibility	Eligibility and Post-eligibility
Phase				
# of	One	One	Multiple over a limited time	Ongoing
Contacts			period.	
Outcome Basic information and Service options and G		Goals and action plan	Person-centered service plan	
	referral	referral		

Figure 3: Key Differences in Select NWD Functions

DEVELOPMENT OF RHODE ISLAND'S PCOC PROGRAM

EOHHS contracted with Guidehouse and ADvancing States to support the PCOC design and implementation process. EOHHS designed its proposed PCOC model and program based on other state research and feedback from stakeholders.

Other State Research

From March to August 2020, Guidehouse and ADvancing States conducted an environmental scan of Rhode Island and other state NWD systems and PCOC programs. This scan leveraged a multimethod research approach and built on state research and peer-to-peer supports provided by ACL to identify best practices in PCOC model structure, tools, information technology (IT) systems, and training. Guidehouse and ADvancing States identified and analyzed best practice states using the following selection criteria:

- The state has a well-regarded NWD system or PCOC model with relevance to Rhode Island.
- The state offers different NWD/PCOC approaches and program features.
- The state has conducted an extensive review of their NWD program and began implementing changes to create a robust NWD system.

Based on the criteria described above, Guidehouse and ADvancing States conducted a comparative research analysis with several states.

Figure 4. Selected States from NWD/PCOC Environmental Scan

Торіс	Selected States
PCOC Model: Structure and approach to PCOC delivery.	Colorado; Massachusetts; Minnesota; Nebraska
NWD/PCOC Tools: Tools/questions used to support PCOC intake and follow-up activities.	Colorado; Massachusetts; Nebraska; South Dakota
NWD IT Systems: <i>IT infrastructure used to support the PCOC process for PCOC counselors and consumers.</i>	Georgia; Minnesota; Virginia
PCOC Training: <i>Training content and materials for PCOC counselors.</i>	New York; Oregon; Nevada; Virginia; Wisconsin

Stakeholder Feedback

During the initial planning stages for the NWD redesign effort, the State conducted a mapping exercise to identify the principal providers of key pre-eligibility, eligibility, and post-eligibility functions. EOHHS found that PCOC is not provided or funded in the scope or method defined in this document and was often confused with other pre-eligibility functions (e.g., information and referral (I&R) or application assistance) that are performed on a routine basis. In August 2020, Guidehouse and ADvancing States used the results of EOHHS's mapping exercise to probe the issue further by conducting interviews with various stakeholders and providers. This process involved engaging with nine State staff members and 13 key informant groups to better understand the State's current approach to PCOC delivery and to identify opportunities for improvement.⁶

Guidehouse and ADvancing States identified significant opportunities to develop and implement a statewide PCOC network. While several State staff and key informant groups indicated that many entities provide PCOC-like services, a formal approach to PCOC delivery is not available in Rhode Island. Rhode Island's current approach to PCOC is informal and often part of other pre-eligibility functions including intake and referral and application assistance. Formal PCOC includes formal training, standardized materials, a reimbursement mechanism for services, connected data systems, and a standardized process to ensure that PCOC is performed consistently or equitably across LTSS users and potential users. Figure 5 summarizes pre-eligibility functions in Rhode Island by provider.

⁶ ADvancing States and Guidehouse conducted phone interviews with the following stakeholders: State Staff including BHDDH, DHS, Medicaid, and PCOC Network, including the POINT/United Way, RIPIN, OHA Case Management Agencies, Service Advisory Agencies, Ocean State Center Independent Living Center (OCSIL), and Sherlock Center for People with Disabilities.



			Pre-Eligibility Functions		s	
#	Entity	Populations Served	I&R	Application Assistance	ос	PCOC
1	Community Action Agencies contracted with Office of Healthy Aging (OHA) (formerly Division of Elderly Affairs (DEA))	Older adults	Yes	Yes	Yes	No
2	The POINT	Older adults and older adults with disabilities (limited)	Yes	Yes (Limited)	Yes	No
3	Department of Human Services (DHS) Social Case Worker (SCWs)	All populations	Yes	Yes	No	No
4	Rhode Island Parent Information Network (RIPIN)	Families of people with developmental disabilities (expanding to other populations)	Yes	Yes	Yes	No
5	Ocean State Center for Independent Living (OSCIL)	People with physical disabilities under the age of 65	Yes	No	Yes	No

I&R = Intake and Referral

OC = Options Counseling

The following themes address PCOC from the perspective of State staff and key informant groups.

Figure 6. Key	Themes from	Stakeholders
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Category	Key Themes	EOHHS Action to Address Findings	
 PCOC (Current State) 1. A formal approach to PCOC is not provided in Rhode Island. Informal options counseling or PCOC-like services are provided across the State but it is limited and spread across multiple programs and parties. 2. Data systems to track consumer information are limited and fragmented. Consumers often have to tell their story two to three times. 3. There is no funding mechanism to support PCOC services. 		<i>Findings 1-6</i> : As a part of the LTSS Three Phase Strategic Plan and as described herein, EOHHS is designing a PCOC program	
PCOC (Future State)	 The POINT/United Way, RIPIN, OSCIL, and OHA CM agencies are organizations that are interested in providing PCOC in the future- state. Some State agencies including DHS and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) also see a role in providing PCOC. This interest and their experience in providing 	to better assist consumers in making informed choices about their LTSS options.	

Category	Key Themes	EOHHS Action to Address Findings
	 pre-eligibility services of various kinds is important for network development. 5. Interviewees offered differing perspectives on the optimal PCOC model, including: 1) a centralized hub model (e.g., the POINT Network or DHS) or 2) have multiple organizations or agencies involved (e.g., RIPIN is a vital part of the PCOC Network). 6. Several interviewees would like to see consumer eligibility determined as part of a screening tool before options are identified and discussed (currently done in the opposite sequence). 	
Issues Impacting Broader NWD Functions	 There is limited information or documentation (e.g., a document that lists all available State and federal benefit options) available for consumers and providers on LTSS options within Rhode Island. A provider directory does not exist for LTSS across programs and populations. As such, the options presented to consumers often depends on the knowledge base of the person they are talking to. State programs and agencies operate in silos. There is limited interagency coordination which can serve as a barrier to access for consumers. Hospital discharge planners often refer consumers to nursing homes because it is the easiest option. Most consumers are unaware of in-home or community-based services. Limited service options and availability drives inappropriate referrals. For example, hospital discharge planners often refer consumers to nursing homes because of limited housing or other available options for consumers. There are significant gaps in the Medicaid application process, including approval timelines and knowledge of eligibility requirements across consumers and providers. 	These findings are being addressed through various initiatives led by the State: • <i>Findings 7 and 8:</i> <i>Marketing and Outreach</i> - As part of Phase I, EOHHS will provide enhanced marketing and outreach efforts to consumers. This includes providing updated information to consumers and providers regarding private and publicly- funded LTSS options. • <i>Finding 9: LTSS</i> <i>Steering Committee -</i> The LTSS Steering Committee was created to serve as the unified authority structure to guide the development and implementation of LTSS redesign initiatives including NWD reforms. In addition, the State is looking at using a single unified IT platform to support several components of NWD which are spread across multiple agencies.

Category	Key Themes	EOHHS Action to Address Findings
		 Findings 10 and 11: Hospital Discharge Initiative - An EOHHS selected vendor is providing options counseling for individuals transitioning out of a hospital that may require LTSS. Finding 12: Application Materials - As part of Phase I, EOHHS is updating its Medicaid LTSS application materials and approach to streamline the Medicaid LTSS application process.

PCOC IMPLEMENTATION

Program Goals and Objectives

The primary goal of the PCOC program is to empower and support people with disabilities, and older adults and their families, by assisting them in identifying their health care goals and preferences and accessing the information they need to make reasoned choices about their care. PCOC Counselors work collaboratively with consumers and families to understand their LTSS needs and support them in evaluating and obtaining required resources. PCOC is a three-step approach of asking for and providing information, offering decision support, and offering assistance in accessing services and programs. The best practices from other states indicate that all three, performed equally well, are the key to any PCOC program's success.

PCOC is guided by a set of core principles:

- ✓ Focuses on the individual—not on the caregiver, not on the agency or what the agency provides, and not on the staff.
- Respecting the right of individuals to control and make choices about their own lives. As such, the individual—not the PCOC Counselor or anyone else—weighs the pros and cons and potential implications of the various options available.
- Relationship building and establishing trust are essential to understanding individuals' preferences and needs. Counselors must take time to listen and use culturally competent, person-centered approaches.
- Interactive process, not an event. Successful PCOC may include multiple contacts over a shortterm period or may be ongoing over a longer period of time.

EOHHS has the following goals and objectives to support the PCOC program:



Goals and Objectives

- Every Rhode Island consumer has access to the high-quality information and PCOC required to understand their LTSS preferences and choices.
- Key starting points for PCOC are clear and easily understood by NWD partners and consumers.
- Each State agency administering LTSS programs is responsible for ensuring populations they serve have access to uniformly trained and certified PCOC Counselors.
- Identify individuals that are at risk of entering an institution with the goal of providing them with information and counseling that will allow them to make informed choices about LTSS.
- Maximize State resources by matching needs and preferences of individuals to the most cost-effective setting.

Implementation Timeline

EOHHS anticipates offering PCOC to a limited number of LTSS consumers via a pilot program by February 2021. During the pilot program, PCOC will use a web-based tool to support PCOC intake and follow-up and will be provided by select staff within DHS, EOHHS, BHDDH, and The POINT. PCOC will be available to all LTSS consumers by July 1, 2021. As the PCOC process is currently under development, EOHHS will release additional information to stakeholders regarding its pilot program prior to its launch.



	Pilot (By February 2021)	Full Launch (By July 1, 2021)			
PCOC Delivery	 ✓ PCOC is provided by select staff within DHS, EOHHS, BHDDH, and The POINT ✓ PCOC is available to a subset of LTSS consumers 	 ✓ PCOC is provided by State agency staff + selected existing vendors ✓ PCOC is available to all LTSS consumers 			
Training	 Provide basic training to PCOC counselors on person-centered thinking concepts 	 ✓ Expand training options to PCOC counselors and other NWD partners ✓ Provide Rhode Island specific PCOC training ✓ Use a web-based platform to deliver trainings 			
PCOC Counselor Requirements	 ✓ Conflict of interest ✓ Skills/abilities ✓ Monitoring ✓ Credentials ✓ Staffing ratios 				
Other	 ✓ Use separate telephone #s specific to the populations served ✓ Implement IT solution to support intake and screening and PCOC 	 ✓ Use a single telephone # with routing options to support all populations ✓ Expand IT solution to support other NWD functions (e.g., consumer satisfaction survey, case management, etc.) ✓ PCOC is required before an applicant can apply for Medicaid LTSS 			

SERVICE DELIVERY AND PROTOCOLS

PCOC Target Population

Rhode Island's PCOC service will be available to the following consumers regardless of insurance type:

- Adults age 65 and older
- Adults with disabilities
- Adults with intellectual / developmental disabilities
- Youth in transition

There are four primary groups of consumers that may need PCOC:

- 1. **People Looking to Maintain the Status Quo**: These are consumers who want to maintain their current situation or level of independence. They want to stay in their homes and communities and avoid nursing homes and hospitalization. These people may need more, or different, services than they already receive. Barriers to accessing services include a loss of consistency, either in their lives or the services they receive, feelings of isolation, difficulty dealing with a complex health system, and trusting that their interests will be foremost.
- 2. **People in Transition**: These are consumers who are moving between housing, providers, or health programs. They want to improve their situation and may need help managing change. Examples include:
 - An individual turning 18 will need to transition to a public program for adults.
 - A patient discharged from a hospital may face relocation to a community-based setting or a nursing home.
 - A nursing home resident may indicate they wish to speak with someone about community-based options.
- 3. **People at Risk**: These are consumers who are at risk of physical injury or are on the verge of returning to a nursing facility or hospital. They often avoid services because they perceive them as a loss of independence. These individuals are able to manage their days but are often at greater risk for crisis. It can be a challenge to reach this population because they often do not know they are eligible for more services or are unaware that a worsening condition requires additional supports.
- 4. **People Who Are Unaware**: These are consumers do not know about LTSS or NWD and are unaware of the services that may be available to them. These people may have had little to no experience with LTSS. In other instances, people haven not sought information about services because of cultural or family aversion to accepting public assistance.

PCOC Modality

During the PCOC pilot program, PCOC will be available via telephone only. EOHHS will consider expanding PCOC modality options (e.g., in-person) as part of the full program launch date.

Information Technology

EOHHS contracted with WellSky to implement an IT solution to support intake and screening, PCOC, and other NWD functions. During the PCOC pilot program, EOHHS envisions that PCOC Counselors will use a web-based IT solution to conduct PCOC activities. EOHHS anticipates that the PCOC process, as described below, may change based on implementation of the IT solution. EOHHS will revise this manual accordingly as the PCOC process is further defined with WellSky.

PCOC Service Delivery

PCOC offers an in-depth conversation that helps consumers seeking or planning LTSS understand their strengths, needs, preferences, and unique circumstances and weigh the pros and cons of available alternatives. Through the PCOC process, consumers and their families receive unbiased

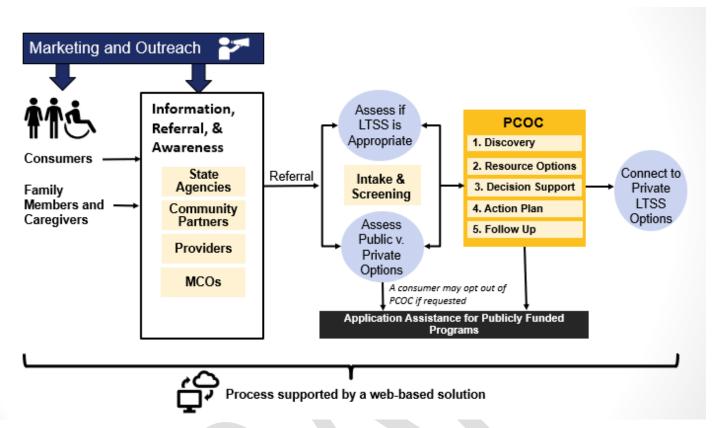
information about relevant programs, support services, financial resources to help pay for services, and support in determining next steps and accessing referral services. EOHHS anticipates that PCOC will reduce the number of consumers discharged from a hospital to a nursing home since in-depth counseling has been proven to help people understand their health goals and preferences, the options that suit their needs best, and how to

PCOC is NOT...

- 1. Information, Referral & Awareness,
- 2. Intake & Screening
- 3. Person-Centered Planning (PCP) / Conflict-Free Case Management (CFCM)
- 4. Assessing (but it can lead to an assessment for eligibility)
- **5.** Developing a service or support plan (but it can involve a referral for service plan development)
- 6. Simply providing information (but it involves this!)
- 7. Simply making a referral (but it certainly can involve this!)

access the services and settings they choose. Hospital discharge planners often direct people to nursing facilities because they do not have the time, resources, and knowledge of LTSS options that PCOC requires. Figure 9 below provides an overview of the full PCOC process from entry to linkage to LTSS services.

Figure 9: PCOC Process



Initiating the PCOC Process

Several situational elements can trigger PCOC including, but not limited to:

- Request or interest in receiving information and advice on LTSS requiring more than one phone contact or when the consumer cannot articulate their need;
- ✓ Recent change in life situation and desire for deeper discussion about LTSS options;
- Existing unmet LTSS needs but consumer is unsure about the process of accessing LTSS and/or what LTSS will best meet their preferences and needs;
- Request for assistance in transitioning from one living situation to another;
- ✓ Interest in participant-directed programs;
- ✓ A hospital admission and planning for discharge;
- ✓ Benefits or program denial and need for decision support about other options;
- A cognitive impairment that could benefit from support including caregiver support and LTSS related to dementia as needed;
- Behavioral health needs requiring options support related to the consumer's specific needs or situation;
- Multiple needs or chronic illness/es requiring support on a broad array of options to meet needs across many services and systems; and/or
- ✓ Memory loss and living alone.

Delivering PCOC Services

Once a consumer receives a PCOC referral, a PCOC Counselor will begin the service delivery process. PCOC Counselors should encourage the eligible consumer to involve natural supports throughout the PCOC process. It is encouraged that all consumers at risk for or in-need of LTSS receive PCOC.

As part of EOHHS's full launch of the PCOC program, EOHHS is proposing to make PCOC a requirement before a consumer can apply for Medicaid LTSS; however, there are several scenarios in which the consumer may possibly skip PCOC including:

- 1) Consumer has already received PCOC.
- 2) Consumer is already receiving LTSS and needs to be assessed for HCBS and/or for a publicly funded program. This may include a consumer who is in an institutional setting but wants back in the community or a consumer that ran out of money and needs to switch to a publicly funded program.
- 3) Consumer is already living in a nursing home and alternative care is not an option given his or her health status.

There are five core components of the PCOC process which are explained in detail below.

1. Discovery

Discovery involves identifying the consumer's goals, needs, and preferences. This includes a personal interview to discover strengths, supports, and values of the consumer. The discovery phase begins by identifying who, if anyone else in addition to the individual, will be participating in the PCOC process. The PCOC Counselor, the individual, and any other person the individual wants to involve (e.g., a family member, caregiver, or close friend) are the participants in PCOC. There are, however, two exceptions to this basic rule:

- 1. If the consumer declines to have other individuals present—at any point in the counseling the PCOC Counselor must respect the consumer's wishes.
- If the consumer has a legally authorized surrogate decision-maker, the PCOC Counselor must require that the surrogate decision-maker be present through all phases of PCOC. This is because only that person is legally authorized to make decisions as a result of PCOC.

From there, the PCOC Counselor will explore why the consumer is seeking LTSS information or was referred to PCOC services. During this phase, PCOC Counselors should make every effort to understand each consumer's preferences, needs, values, and circumstances by:

- Using person-centered practices;
- Developing rapport and trust with the individual;
- Listening to the individual;
- Understanding that no two individuals have exactly the same preferences, needs, values, or circumstances;
- Identifying key supports; and
- Using a series of questions to learn about the consumer's situations and the issues confronting them (e.g., day-to-day routines to determine how they are currently managing;

existing resources and services; preferences about where to live, their visions for the future, and their feelings related to independence and using services).

2. Resource Option Identification

Once a clear picture of the consumer's needs, preferences, and values is established, the PCOC Counselor then identifies resource options that can help meet the consumer's identified needs. During this phase, the PCOC Counselor presents available options through a facilitated discussion that elicits the consumer-identified benefits and drawbacks of each option. In this phase, the following information should be provided, dependent upon the consumer's unique goals, needs, values, and circumstances:

- LTSS options available in the consumer's community tailored to the consumer's current situation;
- Information and support in planning ahead for long-term support;
- Understanding of self-directed and agency-directed supports, and the differences between the two;
- Medicare and Medicaid benefits and options; and
- Other supports and benefits available in the consumer's community including:
 - Informal supports;
 - Social security benefits;
 - Financial and legal planning resources;
 - o Older adult or disability rights resources;
 - Housing and transportation resources;
 - Opportunities for employment or volunteering;
 - Social and recreational resources;
 - o Communication and assistive technology resources; and
 - Caregiver support.

3. Decision Support

After applicable resource options have been identified, the PCOC Counselor then engages in a decision support process that narrows the array of options until a decision can be made that best fits the consumer's identified preferences and needs. It is important to emphasize that this process is person-centered and driven by the consumer or the consumer's surrogate decision-maker. Therefore, it is essential that PCOC Counselors remain unbiased in their approach to option evaluation and ensure that decisions are made in a manner that is congruent with the consumer's needs and wants. The PCOC Counselor should respect the consumer's right to make decisions that entail a certain amount of risk and should take action to prevent a consumer from engaging in risky behavior consistent with legal requirements.

Throughout the decision support process, the following support (as applicable) should be provided while the consumer is considering and making decisions:

- Honoring requests for additional information;
- Providing PCOC in the environment that the consumer chooses;

- Using the method or mode of communication that the consumer uses and prefers;
- Listing options, as requested, and their consistency with the consumer's stated goals;
- Explaining potential risks, consequences, and costs of each available option;
- Exploring alternatives and arranging on-site or virtual tours;
- Coordinating transportation or giving the consumer the information to coordinate transportation;
- Helping the consumer articulate his or her own values, needs, and preferences;
- Providing information and facilitating decision-making at a pace appropriate to the consumer.

4. Action Plan

The fourth component of the PCOC service delivery process includes developing a PCOC Action Plan. The PCOC Action Plan helps the consumer move from identifying the resources that best fit their needs to specifying next steps to access those resources and achieve their long-term support goals. Next steps and actions identified in the Action Plan must be based on the consumer's identified goals, priorities, and desire to proceed. During the Action Plan development process, PCOC Counselors should discuss and document:

- Consumer goals and preferences;
- Action steps to achieve identified goals;
- Available interpersonal and financial supports; and
- Potential risks or challenges to achieving those goals.

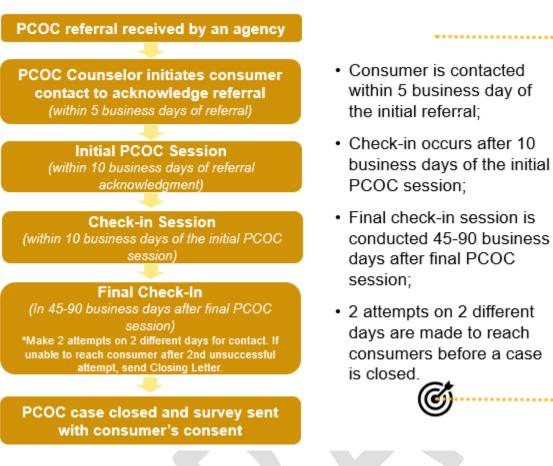
5. Follow-Up

The final step in the PCOC service delivery process is follow-up. Follow-up provides an opportunity for PCOC Counselors to learn about the outcome of previous conversations and ensure the consumer's PCOC Action Plan remains effective and relevant. Follow-up services also help to address the changing needs and preferences of consumers and further refine the decision-making process. During follow-up, PCOC Counselors should verify services by:

- Contacting community resources to verify referrals made;
- Determining whether the referrals were implemented effectively;
- Determining the extent to which the consumer's goals have been met by contacting the consumer according to the agreed upon timeframe;
- Revising action plans as needed to meet consumer needs, preferences, and values;
- Arranging additional services (e.g., family meeting, new referrals) identified through follow-up to assist consumers to receive needed and preferred services; and
- Confirming satisfaction with the PCOC process and the choices the consumer has made.

Figure 10 below provides a timeframe for each step in the PCOC delivery process. This flowchart sets the minimum standard for when each phase in the PCOC process should occur, but also allows for flexibility—supporting a person-centered approach.

Figure 10: PCOC Process and Timeframes



Terminating PCOC Services Once a PCOC case has been initiated, a case may be closed when a consumer:

- Is no longer seeking support;
- ✓ No longer has unmet goals;
- ✓ After two unsuccessful follow up or outreach attempts on two different days;
- ✓ Has exhausted an appeals process and there is a finding that termination is necessary; or
- ✓ Is dissatisfied and the PCOC Counselor has no further alternatives available.

Following case close out, the PCOC Counselor will terminate and send a customer satisfaction survey with the consumer's consent. A consumer may be re-engaged in PCOC at any point he or she indicates a desire to pursue additional support options.

PCOC Intake and Follow-up Form

PCOC Counselors are required to use the PCOC Intake and Follow-up Form to support the PCOC process. Example fields and questions are included in **Appendix A.1** of this manual. This form is meant to guide the PCOC process and to ensure that consumers receive a consistent and similar experience across PCOC Counselors. The PCOC Intake and Follow-up Form should be completed based on the consumer's needs and preferences; therefore, certain sections may be skipped based on consumer preferences. The consumer should have complete control over this process and make

choices about goals and activities that match their interests and desires and address what is important TO them, what is important FOR them, and the best way to SUPPORT them.

Consumer goals and objectives are more likely to be achieved if the consumer selects his or her goals as opposed to the PCOC Counselor developing goals for the consumer. Thus, it is very important that the consumer is prepared to fully participate in the PCOC process.

The PCOC Intake and Follow-up Form includes the following key components:7

- 1. **Consumer Information**: Basic information regarding the consumer receiving PCOC.
- 2. **Consumer Preferences**: Information about the consumer that includes what is important to them, strengths, and their ideal future state.
- 3. Goals and Action Items: Each goal should include a set of action statements that describe how each goal will be achieved. Each action will specifically describe what will be done, where it will happen, when it will happen, who will provide supports, how will the person get there transportation, what accommodations are needed, and any cost. Goals should be simple and clearly stated. In addition, each goal should identify the potential funding source and service options (if applicable).
- 4. **Challenges:** This section is meant to highlight any challenges that the consumer may face in pursuing his or her goals. This includes:
 - a. Community Personal safety, poor boundaries.
 - b. Health Difficulty with daily personal care, challenging health conditions, lack of needed care.
 - c. Financial Overspending, not having enough money, poor management, credit card misuse, theft, giving money to others.
 - d. Community Personal safety, poor boundaries.
 - e. Health Difficulty with daily personal care, challenging health conditions, lack of needed care.
 - f. Relationships Nonconsensual sex, risk for assault, pregnancy, disease, harassment, boundary issues.
 - g. Transportation Being safe on public transportation, getting lost.
 - h. Natural Supports Boundaries, safe relationships, understanding roles and responsibilities.
 - i. Jobs Keeping job, transportation to and from job, personal safety in workplace.
 - j. Housing Home care, kitchen safety, safe food practices, fire safety, neighbor issues.
 - k. Technology How to manage if technology fails.
- 5. **Resources**: Goals must be connected to real world, community activities. Thus, it is very important for the consumer and the PCOC Counselor to take time to understand the opportunities, resources, and supports that are available in all the communities in which the consumer spends time.

⁷ Several categories and descriptions were pulled from Rhode Island's Person-Centered Thinking Guide, February 2018.

- 6. **Counselor Information/Signatures**: PCOC Counselor name and a wet or electronic signature from the consumer and/or legal representative.
- 7. **Follow-up and Closeout**: A plan for reviewing progress and making revisions to the consumer's goals as needed.

PCOC COUNSELOR REQUIREMENTS

Staff who determine the need for PCOC and deliver PCOC service must adhere to the following competency, credentialing, and training standards.

Conflict of Interest

To avoid conflict of interest, PCOC Counselors are not allowed to provide direct care services to consumers or offer any service in which he/she has a financial interest. The PCOC Counselor's only commitment should be toward helping the consumer build a life that makes sense for them. As the PCOC Counselor helps identify supports to help make that happen, he/she needs to be free of any biases and be guided only by the consumer and their identified goals and support needs.

Skills/Abilities

Individuals who deliver PCOC must have training in the statewide PCOC curriculum and be able to:

- Understand consumers' unique preferences, values, needs, and circumstances;
- Understand and educate consumers about public and private sector resources;
- Facilitate knowledge of informal supports and self-direction;
- Encourage future orientation and goal-setting;
- Follow-up after PCOC is complete; and
- Communicate with sufficient skill and clarity, using the consumer's preferred mode of communication, so that consumers will be able to make informed choices.

Credentials

Individuals who deliver PCOC shall have the following minimum qualifications:

- Associate's degree, or equivalent experience as determined by the hiring agency;
- At least one year of experience working directly with older adults and/or individuals with disabilities;
- Knowledge about long term supports and funding systems;
- Knowledge about the issues confronting older adults and individuals with disabilities;
- Good listening, interviewing, and communication skills; and
- Knowledge of principles, methods, and procedures for providing decision support for individuals with physical and/or cognitive disabilities.
- Knowledge of strength-based and person-centered supervision and practice principles.

Training

Agencies providing PCOC shall adhere to the training requirements described in this manual.

Monitoring and Supervision

Agencies providing PCOC shall implement ongoing monitoring to ensure that:

- PCOC is delivered in accordance with these standards;
- The outcomes of PCOC can be tracked and measured for evaluation;

- Agencies providing PCOC implement ongoing supervision for all staff involved in determining the need for and delivering PCOC; and
- PCOC supervisors possess the experience or educational training to oversee staff development, program management, program planning, policy/procedural maintenance, and program evaluation.

Staffing Ratios

Agencies providing PCOC shall assure that staff who determine the need for and who deliver PCOC have sufficient time to devote to their PCOC duties.

TRAINING CURRICULUM

EOHHS is in the process of creating Rhode Island PCOC-specific training materials to support PCOC Counselors. In October 2020, EOHHS assembled a training steering committee comprised of staff from DHS, EOHHS, and BHDDH to develop training materials, determine who needs to complete trainings, and to identify technology solutions to support training virtually.

During the pilot program, EOHHS anticipates providing basic training to PCOC Counselors on person-centered thinking concepts and providing an overview of State-developed PCOC materials. By the full program launch date, EOHHS anticipates providing additional trainings that are more specific to Rhode Island's approach to PCOC service delivery.

EOHHS will update this manual and stakeholders when PCOC trainings are finalized.

QUALITY MANAGEMENT

EOHHS will collect, aggregate, and analyze various performance measures to evaluate the PCOC program. The performance measures will include:

- Process measures that assess how PCOC operations are functioning (e.g., number of people served and timeliness); and
- Outcome measures that evaluate the degree to which the PCOC Counselor is impacting outcomes (e.g., consumer satisfaction).

The figure below provides a summary of the draft measures and the frequency of review.

Figure 11. Proposed Performance Measures

Measure	Frequency of Review	
Number of consumers receiving services by:	Quarterly	
 Type of support (e.g., I&R, PCOC, application assistance, etc.) 		
Type of need		
Consumer profile (e.g., age, sex, race, etc.)		
Referral source		
PCOC Counselor		
Follow-up:	Quarterly	
Number receiving follow-up		
 Percent in which follow-up was complete 		
Number of cases opened, follow-up completed, follow-up pending, and closed	Monthly	
Response time following receipt of referral	Monthly	
Total number of transitions to the community:From the hospitalFrom a nursing facility	Semi- Annually	
Consumer satisfaction survey questions (See Appendix A.2 for a detailed listing of questions)	After a consumer receives PCOC	

In addition to regularly tracking the performance measures identified above, EOHHS anticipates releasing an annual report that summarizes performance and identifies opportunities for improvement. EOHHS anticipates that this report will include performance measure results, feedback

from PCOC Counselors, and other updates impacting the PCOC program. This report is meant to drive quality improvement and to educate stakeholders on outcomes of the program.

MARKETING AND OUTREACH

Within the broader NWD delivery system, marketing and outreach is a critical pre-eligibility function. A combination of broad-based and highly targeted marketing efforts will increase awareness of LTSS and drive inquiries and referrals to the appropriate location.

The goals of marketing and outreach activities are shown in the figure below:

Figure 12. Marketing and Outreach Goals and Objectives



Goals and Objectives

- Increase consumer and caregiver consideration of living at home or in a community-based setting as a realistic option.
- Increase awareness of specific long-term services and supports.
- Direct consumers and caregivers to resources for information, referral and, possibly, options counseling.
- Create a consistent, clear, person-centered voice and common language for all LTSS communications and content.
- Establish a sustainable process for updates to LTSS content.

EOHHS will release a more detailed marketing and outreach plan in early 2021 for stakeholder review and comment. The information included herein is high-level and is subject to change based on the final marketing and outreach plan approved by EOHHS.

Primary audiences:

The marketing and outreach strategy is focused on reaching the broad audience of older adults and adults with disabilities, as well as their decisionmakers, caregivers, and referral sources. EOHHS seeks to increase awareness and inquiry from broad audiences, regardless of financial eligibility. It is the role of the online information resources, referral sources, and the PCOC process to further qualify individuals. EOHHS strives for increased awareness among as many broadly qualified individuals and stakeholders as possible and to generate top-of-mind consideration and word-of-mouth communication.

Accordingly, the primary audiences are:

- Adults age 65 and older and adults with disabilities of any age, income, and insurance type;
- Individuals residing in hospitals and other institutional settings;
- Family members, caregivers, decisionmakers, and supporters; and
- The general public.

As discussed earlier in this report, marketing and outreach tactics and messaging will be tailored to reach four groups of primary consumers that may need PCOC:

- 1. People Looking to Maintain the Status Quo
- 2. People in Transition
- 3. People at Risk
- 4. People who are unaware of LTSS or NWD

Secondary audiences:

Audiences serving as sources of referrals or as service providers include:

- The medical community, including hospitals;
- Administrators and staff of long-term support facilities;
- Long-term support ombudsmen;
- Providers of long-term community supports and other local agencies having regular contact with older adults and/or individuals with disabilities;
- Social workers;
- Health and human services agencies;
- Local government officials and policy makers;
- Advocates and advocacy organizations;
- Hospital/nursing facility social workers and discharge planners;
- Primary Care Physicians, Physician Assistants (PAs), Nurse Practitioners, and staff;
- Community organizations;
- Senior centers;
- Health plans;
- Estate planners and elder care attorneys; and
- Assisted living staff.

Messaging:

Advertising messaging will feature:

- **High quality production values**. EOHHS is competing for consumer attention with for-profit organizations that have large budgets for creative production and media.
- **Person-centered philosophy**. EOHHS's person-centered approach must begin with outreach. Messaging and creative content must set the stage and expectations for a person-centered experience that will be fulfilled by PCOC Counselors.
- **Personal relevance**. EOHHS seeks to be as segmented as possible, so that the audience can see and relate to "people like me."
- Evidence-based messages. For maximum effectiveness, EOHHS concepts have a theoretical foundation, including motivational interviewing, self-object and social learning theory, and stages of change models.

Engagement Strategy:

Marketing and outreach tactics will feature several calls to action to allow consumers to access information and PCOC via their preferred channel. This will include:

- Online landing page with essential LTSS content and inquiry form
- Links to a new, dedicated LTSS website
- Email address
- Phone number
- Text
- List of State Agency and community partners

Marketing Tactics:

Marketing tactics, depending on the final marketing and outreach budget, will consist of:

- An umbrella brand for all interagency LTSSNWD" activity and modes of access.
- Primary aging and disability audiences will be reached via traditional referral sources and media channels (TV, Print, Radio).
- Caregiver audiences will be reached via digital media channels (Search, Social media, Content marketing) in addition to traditional media.
- Referrers and providers will be reached via direct communications (Email, webinars).

APPENDICES – TOOLS TO SUPPORT PCOC

A.1 PCOC Intake and Follow-up Form

PCOC Counselors are required to use the PCOC Intake and Follow-up Form to support the PCOC process. This form is meant to guide the PCOC process and to ensure that consumers receive a consistent and similar experience across PCOC Counselors.

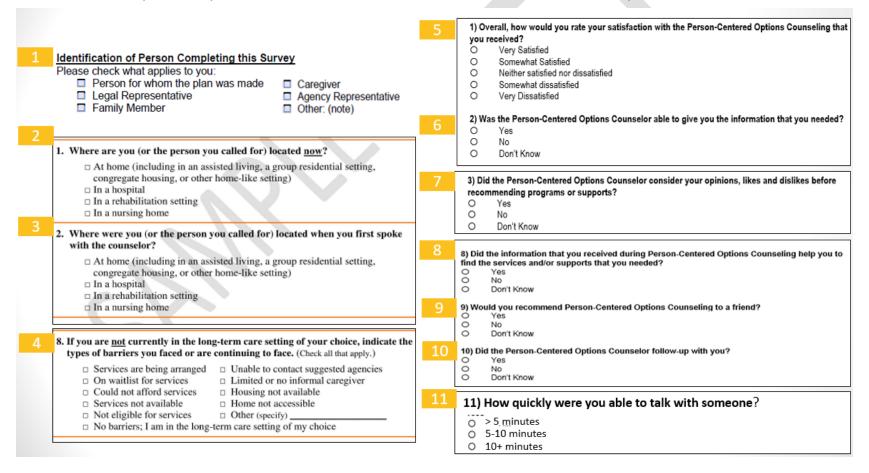
At the time of this manual, EOHHS is working with its IT vendor to incorporate this form into a web-based format. As the PCOC process is formalized and transitioned to a web-based platform, EOHHS anticipates that the PCOC Intake and Follow-up Form fields may change. EOHHS will update this manual once the tool fields are finalized.

Category	Example Questions/Fields			
Consumer Information : Basic information regarding the consumer receiving PCOC.	 Consumer information and demographic information Name(s) of individuals involved in the PCOC process 			
Consumer Preferences : Information about the consumer that includes what is important to them, strengths, and their ideal future state.	 Consumer background/preferences What is your ideal living situation? What do you want now and in the future related to: home, recreation, community involvement, work/volunteer activities What do you do well? 			
Goals and Action Items : Each goal will include a set of action statements that describe how each goal will be achieved. Each action will specifically describe what will be done, where it will happen, when it will happen, who will provide supports, and potential funding sources and service options.	 Goals, action steps Action steps Funding sources Potential service options 			
Challenges: Highlights any challenges that the consumer may face in pursuing his or her goals.	 Risks/challenges Risk mitigation steps 			
Resources: Opportunities and resources and supports that are available in all the communities in which the consumer spends time.	13. Resources available to support goals			
Counselor Information/Signatures : PCOC counselor name and a wet or electronic signature from the consumer and/or legal representative.	14. Signature line			
Follow-up and Closeout: A plan for reviewing progress and revising consumer's goals as needed.	 Date of follow-up and closure Next steps after initial follow-up Summary of outcome(s) 			

A.2 Consumer Satisfaction Survey Questions

EOHHS anticipates releasing a consumer satisfaction survey in 2021 to assess consumer satisfaction, effectiveness of PCOC, and to help maintain and improve overall quality. The survey provides information about the quality of basic components of PCOC and gathers data about the program's effectiveness in helping individuals transition to or remain in the setting of their choice.

PCOC Counselors will be required to offer to every PCOC consumer the opportunity to participate in a consumer survey at the completion of the counseling cycle. The survey distribution method (e.g., mail, telephone, or web-based application) has not been determined. The questions presented below are draft and will be refined as the PCOC process is formalized.



	Neither				
	Strongly		Agree nor		Strongly
In regard to my contact with the PCOC counselors, I feel that:	Disagree	Disagree	Disagree	Agree	Agree
1. I am better informed about options for services and supports.					
2. I was given objective, accurate, and complete information.					
3. I was actively involved in developing my Action Plan.					
4. My Action Plan reflects what is important to me.					
5. Before I contracted The POINT or PCOC Counselor, I considered					
going into a nursing facility or other institution.					
6. My Action Plan will help me stay in my home or community setting.					

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Please share comments regarding your PCOC counselor experience or any other suggestions for improvement.