Title: Person-Centered Options Counseling Operational Manual

Prepared by: Rhode Island's Executive Office of Health and Human Services

April 6, 2023

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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. Rhode Island's ADRC is called The POINT.
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 MyOptions Advisor 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 overall 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: • *Following hospitalization*: 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. • *Medically necessary to treat a condition*: 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 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

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	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.). **Unpaid LTSS**: Home-based LTSS typically provided by family caregivers to people who do not qualify for Medicaid (based on income and/or

Term	Definition
	resources), require services in excess of Medicare coverage and/or do not have severe LTSS needs (less than two ADLs, no serious cognitive impairment).
MyOptions Advisor	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. Since March 2010, the main, statewide office of The POINT has been 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 MyOptions Advisors 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.

EOHHS will update this document on an ongoing basis as this program matures and as part of general quality improvement efforts.

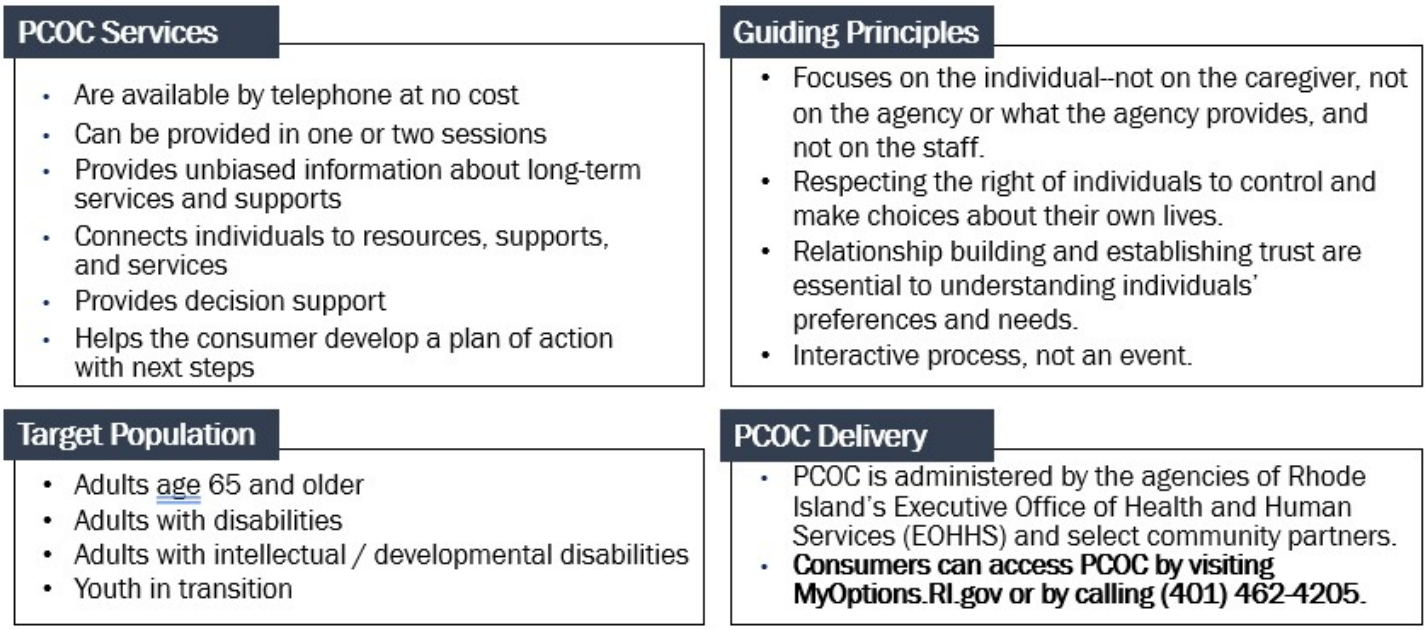
BACKGROUND

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 launched a PCOC pilot program in February 2021 to better support consumers in their search for LTSS. Rhode Island's PCOC program expanded statewide in August 2021.

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:

[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

- 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.
- 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]

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.

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.

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 2 compares activities that provide guidance and information to consumers on their LTSS options.

Figure 2: Key Differences in Select NWD Functions

[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)

Category	Information, Referral, Awareness (IR/A)	Intake and Screening (I&S)	Person-centered Options Counseling (PCOC)	Application Assistance (AP)
Service Definition	Provides basic LTSS information to consumers who need immediate/short-term assistance. Focus is almost always short-term or immediate needs.	Goal is to assess if LTSS is appropriate and to assess private v. public options.	Interactive counseling and decision-support process that helps consumers seeking or planning LTSS understand their strengths, needs, preferences and unique circumstances.	Helping someone complete the application forms for Medicaid and/or other public LTSS programs. May be performed independently or in conjunction with other pre-eligibility.
Example	Consumer is looking for information on how to access meals on wheals. Consumer has no other functional needs.	Consumer is looking for information on assisted living but doesn't now their other LTSS options.	Consumer completes intake and screening and expresses a need for decision-support.	Consumer needs help filling out the DHS application to apply for Medicaid.
# of Contacts	One	One	1-2 sessions (Initial + follow-up)	Varies depending on the consumer
Outcome	Basic information and referral	Referral	A PCOC Action Plan that lists goals and service options	Application submission
Level of Effort	Low	Medium	High	High

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 multi-method 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 analysed 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 3. Selected States from NWD/PCOC Environmental Scan

Topic	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: *IT infrastructure used to support the PCOC process for MyOptions Advisors and consumers.*	Georgia; Minnesota; Virginia
PCOC Training: *Training content and materials for MyOptions Advisors.*	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 4 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.

Figure 4. Current Pre-Eligibility Functions in Rhode Island

#	Entity	Populations Served	Pre-Eligibility Functions			
			I&R	Application Assistance	OC	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 5. Key Themes from Stakeholders

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.	***Findings 1-6***: As a part of the LTSS Three Phase Strategic Plan and as described herein, EOHHS created a PCOC program to better assist consumers in making informed choices about their LTSS options which is provided by The POINT, OSCIL and Child and Family.
PCOC (Future State)	4. The POINT/United Way, RIPIN, OSCIL, and OHA CM agencies are organizations that are interested in providing PCOC in the future-	

Category	Key Themes	EOHHS Action to Address Findings
	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 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	7. 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. 8. 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. 9. State programs and agencies operate in silos. There is limited interagency coordination which can serve as a barrier to access for consumers. 10. 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. 11. 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. 12. 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: • ***Findings 7 and 8: Marketing and Outreach*** - 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. • ***Finding 9: LTSS Steering Committee -*** 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

Category	Key Themes	EOHHS Action to Address Findings
		unified IT platform to support several components of NWD which are spread across multiple agencies. • ***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 has updated its Medicaid LTSS application materials and approach to streamline the Medicaid LTSS application process.

PCOC IMPLEMENTATION

Program Goals and Objectives

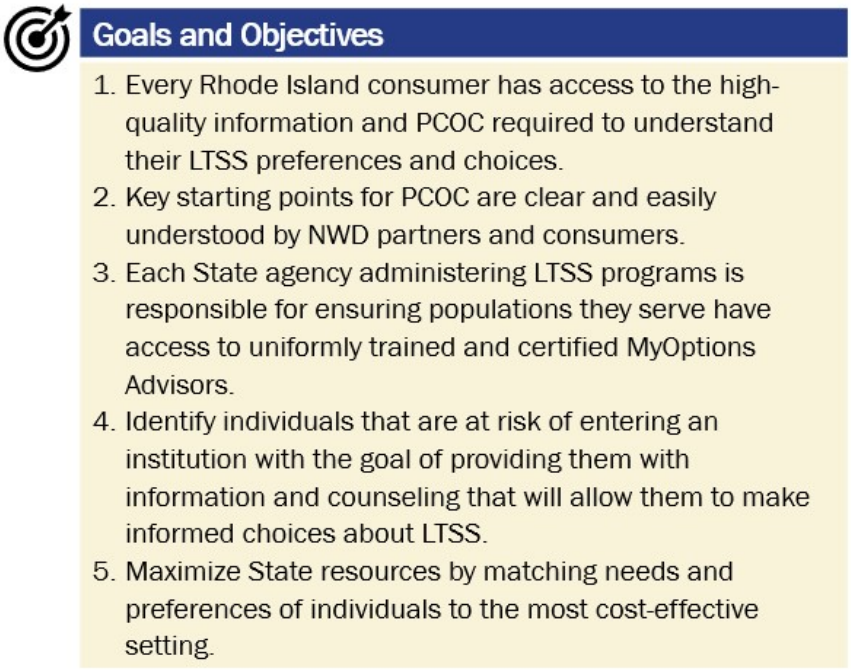
The primary goal of the PCOC program is to empower and support people with disabilities, and older adults and their families, by assisting them in identifying their health care goals and preferences and accessing the information they need to make reasoned choices about their care. MyOptions Advisors 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 MyOptions Advisor 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 short-term period or may be ongoing over a longer period of time.

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

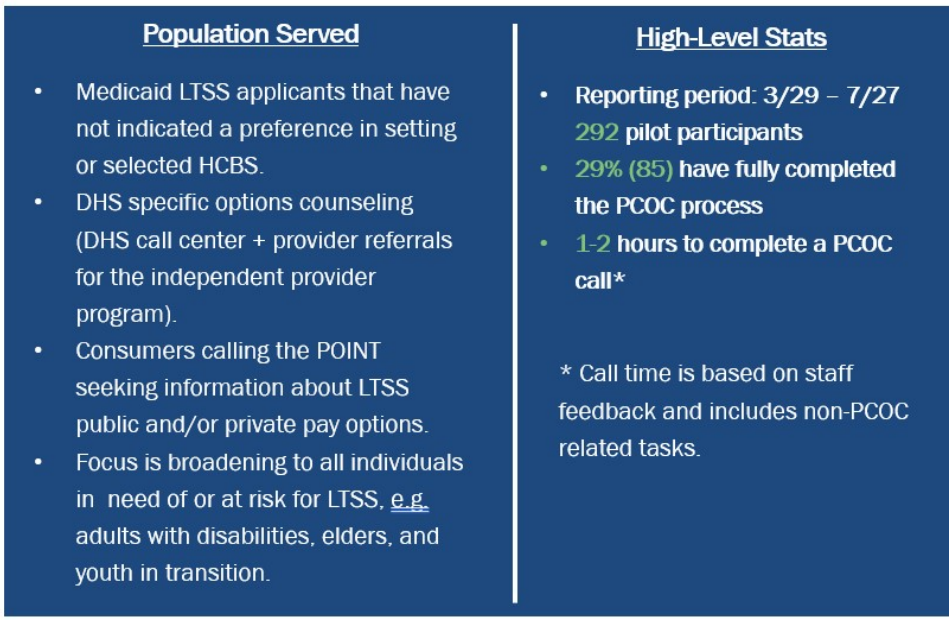
Figure 6. PCOC Goals and Objectives



Implementation Timeline

Rhode Island implemented a PCOC pilot program from March 2021 – July 2021 for a limited number of consumers. The PCOC pilot was supported by eight (8) state staff from DHS and The POINT. Approximately 290 individuals participated in the pilot.

Figure 7. PCOC Pilot Design



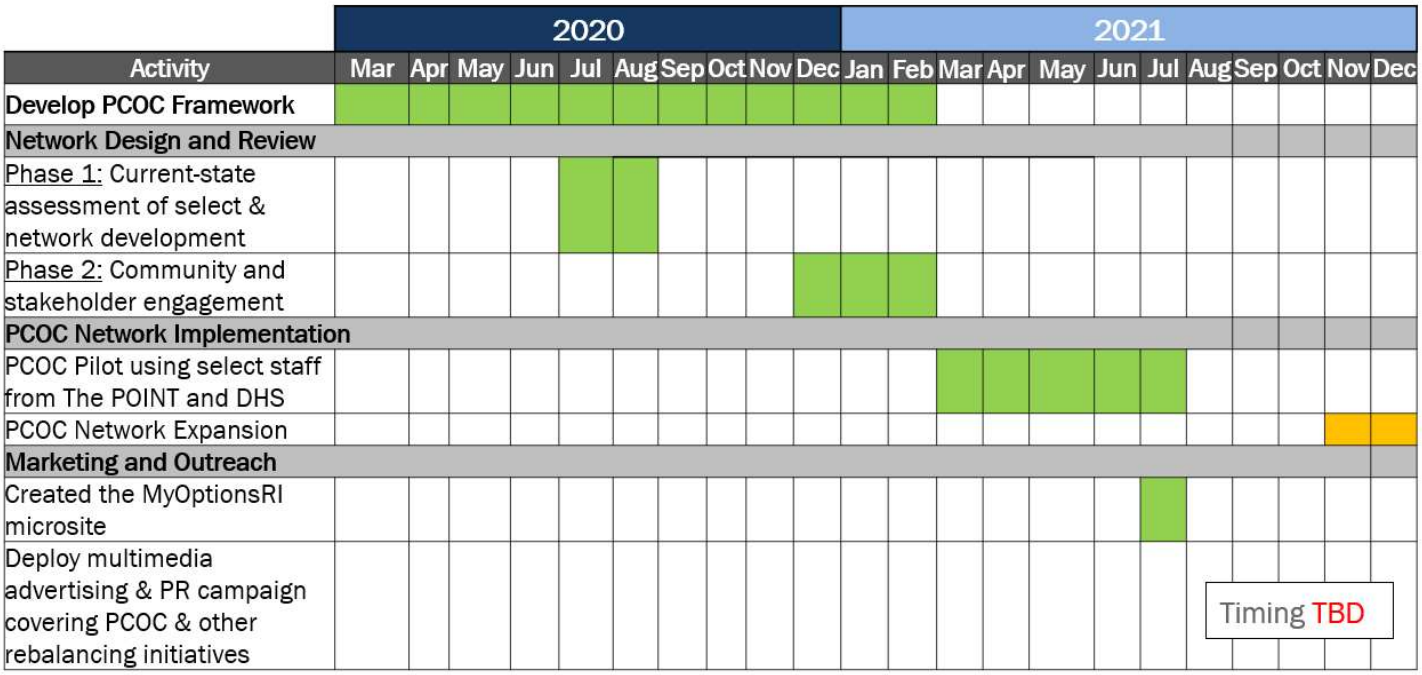
To evaluate the PCOC pilot program, EOHHS hired an external vendor to interview MyOptions Advisors and PCOC participants. The findings from these interviews are shown in the figure below.

Figure 8. PCOC Pilot Design

MyOptions Advisors (7 total)	PCOC Participants (11 total)
1. PCOC is a valuable service to help Rhode Islanders assess and understand their LTSS needs, goals, and preferences. 2. Not all consumers interested in LTSS are willing to participate in PCOC. Many people didn't value the service because they felt like they knew what they needed 3. Consumers do not want to tell their stories multiple times. Data integration is key. 4. An electronic and up-to-date resource directory is needed to support PCOC. 5. It takes 1-2 hours to complete a PCOC call. 6. PCOC training should be ongoing and reflect program realities and include more RI-specific trainings.	**Positive Results** 1. Most participants said the counselors did a great job in the initial interview, and virtually all participants reported feeling that the session was valuable and successful. **Opportunities for improvement** 2. Many participants say they feel stranded and still need assistance navigating the system after they've had the counseling. 3. People do not understand that the precursor to services is a service in its own right. And, if they were aware they were being counseled, they may not value it since they feel that they already know what they want. 4. The PCOC process is not clearly defined. All respondents expressed uncertainty about whether they had "actually" completed the program or even what, exactly, the program entailed.

In August 2021, Rhode Island expanded PCOC by adding additional staff within The POINT and BHDDH. EOHHS will monitor staff capacity and PCOC demand on an ongoing basis. EOHHS's PCOC implementation efforts to date are shown in the figure below.

Figure 9. PCOC Implementation Timeline



SERVICE DELIVERY AND PROTOCOLS

PCOC Target Population

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

- Adults aged 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

At the time of this report, PCOC is available via telephone only. EOHHS will consider expanding PCOC modality options (e.g., in-person) at a later date.

Information Technology

EOHHS contracted with WellSky to provide a web-based platform that supports the entire PCOC process and other NWD functions. All PCOC cases are managed through WellSky.

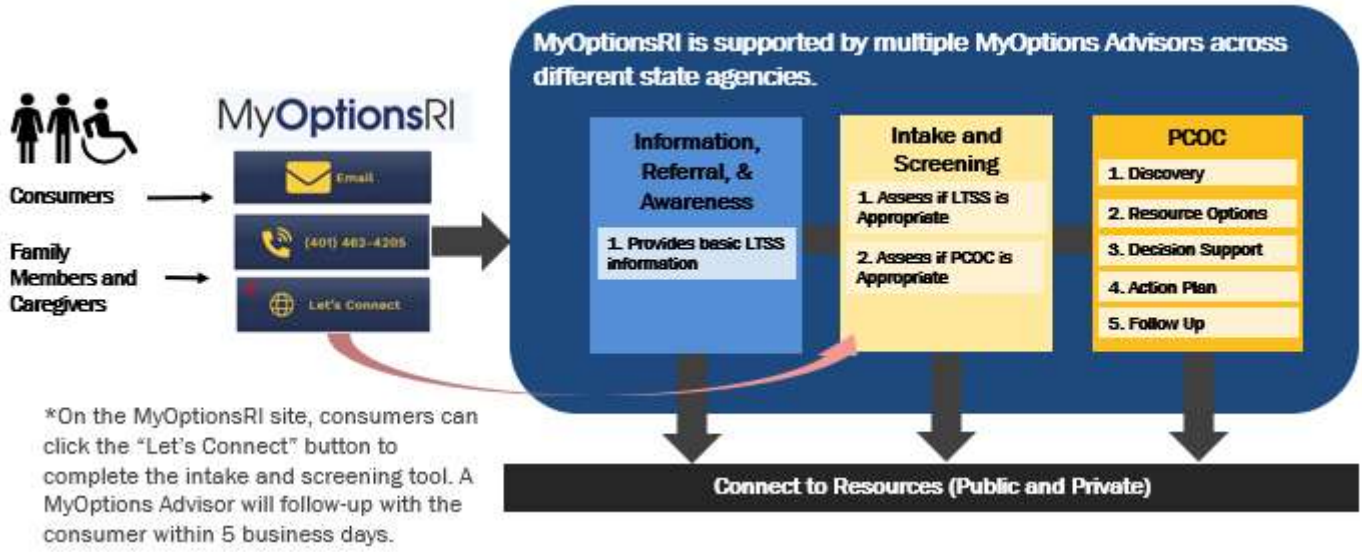
PCOC Service Delivery

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 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 10 below provides an overview of the full PCOC process from entry to linkage to LTSS services.

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!)*

Figure 10: 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.

Intake and Screening

Most consumers will go through the intake and screening process to determine whether someone is in need of LTSS and would benefit from PCOC. Not everyone who asks about LTSS will benefit from PCOC. There are two ways for a consumer to go through the intake and screening process:

1. ***Online LTSS Needs Self-Assessment***: The consumer or an individual on behalf of the consumer, may complete intake and screening online by answering several questions. The online form asks questions to help MyOptions Advisors better understand the consumer and

what matters to them most when making decisions about LTSS. After the form is submitted, a MyOptions Advisor will contact the consumer within five (5) business days for follow-up.

2. ***Calling MyOptionsRI***: If the consumer requires assistance right away, the consumer should call MyOptionsRI at (401) 462-4205 to speak with a MyOptions Advisor. The MyOptions Advisor will walk the consumer through the intake and screening questions.

Delivering PCOC Services

While it is encouraged that all consumers at risk for or in-need of LTSS receive PCOC, PCOC is an optional service. PCOC is not required before a consumer can apply for Medicaid LTSS.

If PCOC is determined appropriate for the consumer, the MyOptions Advisor will begin PCOC. MyOptions Advisors should encourage the eligible consumer to involve natural supports throughout the PCOC process. 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 MyOptions Advisor, 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 MyOptions Advisor must respect the consumer's wishes.
2. If the consumer has a legally authorized surrogate decision-maker, the MyOptions Advisor 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 MyOptions Advisor will explore why the consumer is seeking LTSS information or was referred to PCOC services. During this phase, MyOptions Advisors 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 MyOptions Advisor then identifies resource options that can help meet the consumer's identified needs. During this phase, the MyOptions Advisor 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
    - Older adult or disability rights resources
    - Housing and transportation resources
    - Opportunities for employment or volunteering
    - Social and recreational resources
    - Communication and assistive technology resources; and
    - Caregiver support.

3. Decision Support

After applicable resource options have been identified, the MyOptions Advisor 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 MyOptions Advisors 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 MyOptions Advisor 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 wants to specifying next steps to access those resources and achieve their long-term support goals. The PCOC Action Plan is meant to guide the PCOC process and to ensure that consumers receive a consistent and similar experience across MyOptions Advisors. 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 MyOptions Advisor developing goals for the consumer. Thus, it is very important that the consumer is prepared to fully participate in the development of his or her plan.

During the Action Plan development process, MyOptions Advisors will discuss and document:

- A high-level summary of the person
- Consumer goals and preferences
- Action steps to achieve identified goals

  Potential funding source and resources to support goals.

The PCOC Action Plan will align with the SMART concept:

- ❑ **S is for specific**. Things should be stated clearly and simply. Everyone should be able to look at the description and know who is doing what and by when.
- ❑ **M is for measurable**. This means everyone can tell when something is done (e.g., who, what, by when, etc.).
- ❑ **A is for assigned**. It should be clear who specifically is responsible for getting each action step done. Don't assign steps to "the team" or "the family." List out who specifically is responsible.
- ❑ **R is for relevant**. All aspects of the approach should be relevant to the person and make sense from their perspective. Actions need to be person-centered and person-directed like all parts of the plan.
- ❑ **T is for time bound**. This means a specific date or timeline is listed for each action step. This helps make sure that the person and MyOptions Advisor have a similar understanding of how long something should take. It helps ensure things don't get delayed too long and it provides context for follow-up.

The PCOC Action plan is sent to the consumer via email or mail after the initial PCOC session and after the final PCOC session.

5. Follow-Up

The final step in the PCOC service delivery process is follow-up. Follow-up provides an opportunity for MyOptions Advisors 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, MyOptions Advisors should verify services by:

- 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
- Identifying 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.

Terminating PCOC Services

The MyOptions Advisor or consumer may terminate PCOC at any time. Below is criteria for when a case should be closed:

- ✓ The consumer is no longer seeking support
- ✓ The consumer no longer has unmet goals
- ✓ The consumer is dissatisfied and the MyOptions Advisor has no further alternatives available
- ✓ The MyOptions Advisor completed an initial and follow-up PCOC sessions with the consumer
- ✓ The MyOptions Advisor is unable to contact the consumer to initiate the PCOC session or for follow-up.

Following case close out, the MyOptions Advisor will terminate and send a close-out letter that includes a link to a consumer satisfaction survey. A consumer may be re-engaged in PCOC at any point he or she indicates a desire to pursue additional support options.

Consumer Satisfaction Survey

MyOptions Advisors are required to offer to every PCOC consumer the opportunity to participate in a consumer satisfaction survey at the completion of the counseling session. EOHHS uses the consumer satisfaction survey to assess consumer satisfaction, effectiveness of PCOC, and to help maintain and improve overall quality. This survey is currently available to consumers online at: https://myoptions.ri.gov/follow-up-survey. If the consumer needs assistance to complete the survey, he or she may contact MyOptionsRI at (401) 462-4205 and one of the intake specialists will support the consumer.

Since the consumer satisfaction survey asks questions about the MyOptions Advisor's performance, MyOptions Advisors are not allowed to complete the consumer satisfaction survey on behalf of the consumer they supported.

MYOPTIONS ADVISOR 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, MyOptions Advisors are not allowed to provide direct care services to consumers or offer any service in which he/she has a financial interest. The MyOptions Advisor's only commitment should be toward helping the consumer build a life that makes sense for them. As the MyOptions Advisor 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:

- Associates 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

MyOptions Advisors and supervisors are required to complete the following trainings:

Figure 11. MyOptions Advisor Training Requirements

Training Topic	Description	Frequency	Estimated Hours
Person Centered Thinking (Created by Elsevier)	Training includes 5 key sections: ✓ An Introduction to the No Wrong Door Systems *(Includes 4 lessons)* ✓ Person-Centered Access to Long Term Services and Supports *(Includes 8 lessons)* ✓ Person-Centered Thinking and Practice *(Includes 12 lessons)* ✓ Protection and Advocacy *(Includes 7 lessons)* ✓ Who We Serve *(Includes 6 lessons)*	One-time	25
RI Specific Training Module 1: Overview of RI's PCOC Program *(Created by EOHHS)*	Overview of Rhode Island's PCOC program and concepts.	One-time	1
RI Specific Training Module 2: The PCOC Process *(Created by EOHHS)*	Walk-through of Rhode Island's PCOC process.	One-time	1
WellSky System Training *(Offered by WellSky and/or DHS staff)*	There are two components to this training: 1. A video recording of a high-level walk-through of the PCOC process presented by WellSky. 2. One-on-one training/walk-through offered by DHS staff. Note: If this training is for 3 or more MyOptions Advisors, this type of training will be led by WellSky v. DHS staff.	One-time	3
RI Specific Training Module 3: PCOC Refresher *(Created by EOHHS)*	Refresher training regarding person centered thinking, the PCOC process, and key updates impacting RI's No Wrong Door initiatives and PCOC.	Annual	1

QUALITY MANAGEMENT

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

- Administrative measures that assess how PCOC operations are functioning (e.g., number of people served); and
- Quality and outcome measures that evaluate the degree to which the MyOptions Advisor is impacting outcomes (e.g., consumer satisfaction).

The figure below provides a summary of measures used to evaluate the PCOC program on an ongoing basis.

Figure 12. PCOC Performance Measures

#	Administrative Measures
1	# of PCOC cases opened, pending, and closed
2	# and % of PCOC cases that received a follow-up call
3	Types of referrals provided after PCOC (e.g., OHA community, SNAP, etc.)
4	# of consumers receiving PCOC by consumer profile (e.g., age, sex, race, etc.)
5	Average time to complete the initial PCOC session and follow-up
6	Average # of days: 1) the PCOC session is started after a referral is made and 2) a follow-up session is completed after the initial PCOC session

#	Quality and Performance Measures
1	% increase in utilization/application for self-directed options across PCOC users
2	Medicaid LTSS cost savings that may be directly attributed to PCOC (Annual measure)
3	Medicaid LTSS enrollment shifts to HCBS attributed to PCOC (Annual measure)
4	Consumer satisfaction survey

Consumer Satisfaction Survey

- **Focus**: Assess consumer satisfaction and outcomes of PCOC.
- **# of Questions**: 12
- **Available at**: https://myoptions.ri.gov/follow-up-survey

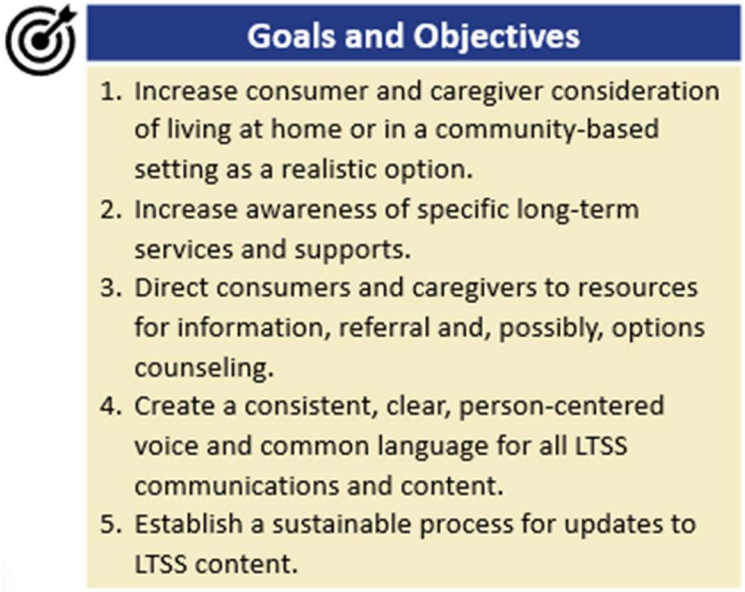
In addition to regularly tracking the performance measures identified above, EOHHS will share PCOC program performance status updates with stakeholders. EOHHS anticipates that future PCOC status updates will include general progress of the PCOC program, consumer satisfaction survey results, and other metrics used to assess program effectiveness. EOHHS will post any PCOC program status updates to the EOHHS website.

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 13. Marketing and Outreach Goals and Objectives



EOHHS will release a more detailed marketing and outreach plan in early 2024 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, adults with physical disabilities, and adults with developmental disabilities, as well as their family members, caregivers, decisionmakers, 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 MyOptions Advisors.
- **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
- List of State Agency and community partners

Marketing Tactics:

There are a wide array of marketing tactics we can leverage to reach our target audiences. A final media recommendation will be provided to EOHHS for approval. Depending on the final marketing and outreach budget, media recommendations may include:

- An umbrella brand for all interagency LTSS/NWD activity and modes of access.
- Primary aging and disability audiences may be reached via traditional referral sources and media channels (e.g. TV, Print, Radio).
- Caregiver audiences may be reached via digital media channels (e.g. Search, Social media, Content marketing) in addition to traditional media.
- Referrers and providers may be reached via direct communications (e.g. Email, Webinars).
- Grassroots efforts may also be used to reach all audiences at appropriate venues (e.g. Senior Centers for aging adults; Conferences for providers; Partnerships with aligned service organizations for caregivers or care recipients).

APPENDICES – TOOLS TO SUPPORT PCOC

A.1 Intake and Screening Questions

Most consumers will go through the intake and screening process to determine whether they are in need of LTSS and would benefit from PCOC. The intake and screening questions (referred to online as the LTSS Needs Self-Assessment) are included online and are listed below.

MyOptionsRI LTSS Needs Self-Assessment

MyOptionsRI offers person-centered options counseling to help Rhode Islanders understand the choices they have for long-term services and supports (LTSS). There are many services available across the state and we connect you to services you want and explain alternatives.
The self-assessment form is for people interested in the LTSS options for:

- Children and adults with disabilities
- Older adults or seniors
- People with behavioral health concerns

The form asks questions to help us to better understand you and what matters to you most when making decisions about LTSS. After you submit the form, someone from our team will contact you to provide support options.
If your situation requires assistance right away, please call MyOptionsRI at (401) 462-4205. If you are Medicaid eligible, living in a nursing home and would like assistance leaving, please contact the Nursing Home Transition Program at (401)462-6393 or by email at OHHS.OCP@ohhs.ri.gov.

Required questions are marked with a red required label.

CONTACT INFORMATION

Please select one of the following options:

◉ *Unanswered* ○ I am completing this form for myself. ○ I am completing this form for another individual.

Are you or the person you are contacting us about:

A Rhode Island resident who lives in the state more than 1/2 a year? required

◉ *Unanswered* ○ Yes ○ No but plan on becoming a resident ○ No

A youth with an intellectual/developmental disability or a serious, chronic and disabling condition who is turning age 19 or 21? required

◉ *Unanswered* ○ Yes ○ No ○ Unknown

Expected to need health care services and supports for a period that is likely to last more than a month?

◉ *Unanswered* ○ No ○ Yes

Have any of the following health conditions, illnesses or disabilities caused this need for services and supports: required All / None

- ☐ A COVID infection and treatment
- ☐ Accident or injury requiring medical treatment (e.g., broken limbs, pneumonia, accident injuries)
- ☐ A chronic medical condition (e.g. heart disease, diabetes, cancer, asthma, stroke, MS)
- ☐ An intellectual/developmental disability (occurring before age 18)
- ☐ Physical condition or disability affecting mobility or functioning (e.g., para or quadraplegeic, neuromuscular disability, etc)
- ☐ Substance use disorder (e.g., alcohol, Rx abuse, illegal drugs)
- ☐ Serious and persistent behavioral health condition (e.g., depression, bi-polar, compulsive disorders, schizophrenia)
- ☐ Memory loss (alzheimer's, dementia)
- ☐ Acquired traumatic brain injury (over age 18)
- ☐ None

Receive any of the following care within the last month: All / None

- ☐ Treatment of a wound or pressure ulcer by a health professional
- ☐ At home health care
- ☐ Daily monitoring by a skilled nurse (LPN or RN)
- ☐ Physical Therapy and/or occupational therapy
- ☐ In patient psychiatric care
- ☐ Treatment with IV medication
- ☐ Hospital stay of 3 days or more
- ☐ Treatment for a substance use disorder

Experience a fall within the last month

◉ *Unanswered* ○ No ○ Yes

Are you or the person you are contacting us about currently living in a nursing home and would like assistance leaving the nursing home?

◉ *Unanswered* ○ Yes ○ No

HEALTH COVERAGE

Health Insurance Information: Do you or the person you are contacting us about have any of the following types of health coverage? Please check all that apply. required All / None

- ☐ VA Health Coverage
- ☐ Medicare
- ☐ Private or Employer Insurance
- ☐ HealthSource RI Plan
- ☐ Rhody Health Partners or Rite Care Plan
- ☐ Medicaid All Other
- ☐ Medicaid LTSS
- ☐ Medicaid Application Pending
- ☐ Uninsured
- ☐ Unknown

FINANCIAL INFORMATION

Do you or the person you are contacting us about receive any of the following? required All / None

- ☐ Social Security Disability Insurance (SSDI)
- ☐ Supplemental Security Income (SSI)
- ☐ Veterans Administration (VA) Benefits
- ☐ Other
- ☐ None
- ☐ Pension or Retirement Plan
- ☐ Retirement, Survivors and Disability Insurance (RSDI)

Which of the following best describes the income you/the person have on a monthly basis? required

- ◉ *Unanswered*
- ○ Less than $2,300 / month
- ○ Between $2,300 - $4,500 / month
- ○ Between $4,500 - $8,500 / month
- ○ Over $8,500 / month
- ○ Unknown

Are you or the person you are contacting us about married? If so, and tell us the combined total resources/assets of both spouses when responding to the question below.

◉ *Unanswered* ○ Yes ○ No

LIVING ARRANGEMENT

Which of the following best describes where you/the person live(s) now? required

If you/the person reside(s) in a home-like setting (house, apartment, condo, etc.), which of the following best describes who else lives there?

- ◉ *Unanswered*
- ○ No one, live alone
- ○ Spouse/partner only
- ○ Spouse/partner and Child
- ○ Sibling(s)
- ○ Adult child/children
- ○ Minor child/children
- ○ Other relatives/friends

ASSISTANCE WITH DAILY ACTIVITIES

Instructional Text

In this section, we would like to know more about the areas of daily life where some type of assistance may be needed by you or the person you are contacting us about.

Do you/the person need help on most days with any of the following: (Check all that apply)

Bathing (e.g., getting in and out of a shower/tub, using faucets, hair/body toweling)

○ Yes ○ No

Dressing (e.g., putting on/taking off clothes. socks, shoes, or stockings)

○ Yes ○ No

Toileting (e.g., getting on or off the toilet, wiping, or changing pads)

○ Yes ○ No

Eating (e.g., eat, drink, using utensils, chewing/swallowing)

○ Yes ○ No

Grooming (e.g., brushing teeth, combing hair, shaving, cutting nails)

○ Yes ○ No

Managing Medications (e.g., filling prescriptions, taking pills/medicines as directed, keeping meds organized)

○ Yes ○ No

Moving About (e.g., going from room to room or outside and back in without a walker or other assistive device)

○ Yes ○ No

Physical transitions (e.g., getting up from or moving between a bed, a chair/wheelchair, or toilet without help)

○ Yes ○ No

Housekeeping (e.g., general cleaning, dusting/vacuuming, washing dishes)

○ Yes ○ No

Preparing Meals (e.g., planning, cooking, serving and clean-up)

○ Yes ○ No

Shopping (e.g., grocery, clothes, prescriptions)

○ Yes ○ No

Laundry (e.g., using washer/dryer, folding, putting laundry away)

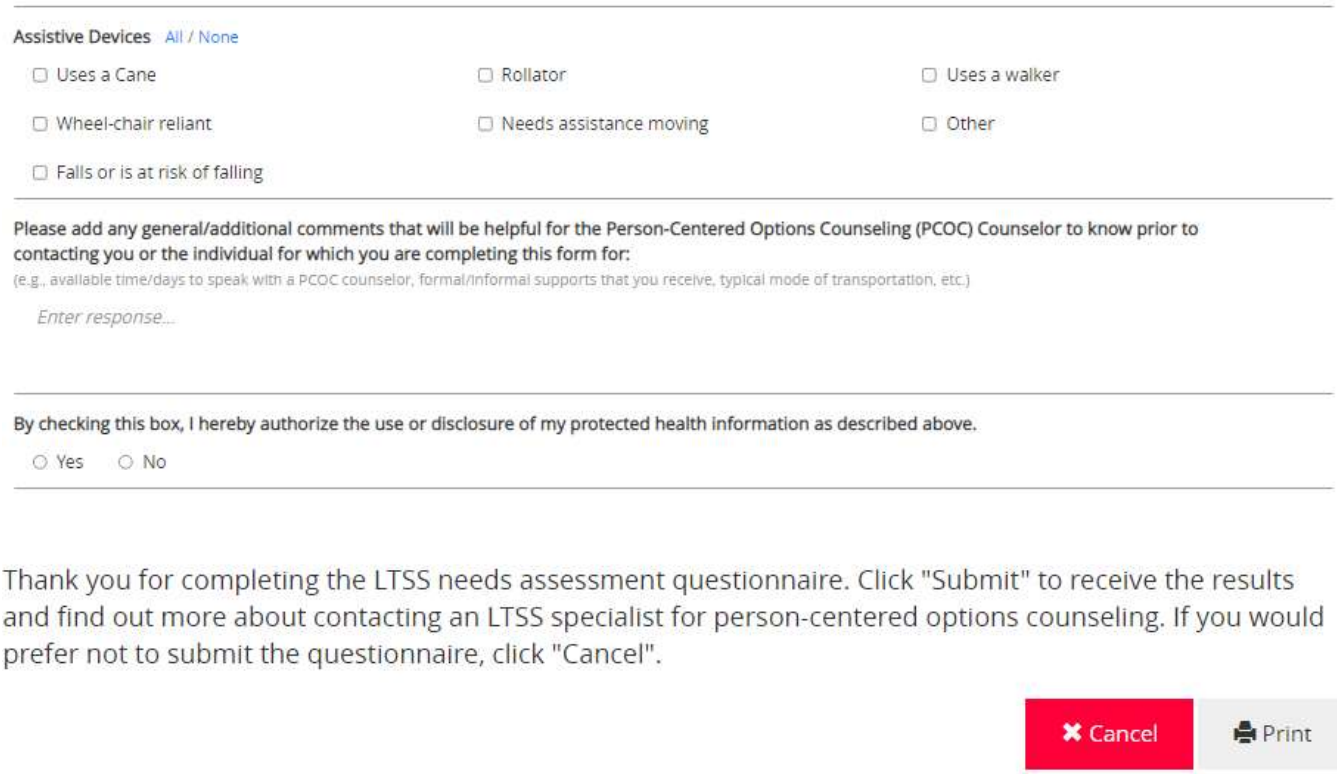
○ Yes ○ No

Handling Mail (e.g., opening, reading, responding)

○ Yes ○ No

Managing Money (e.g., keeping accounts, paying bills, handling cash)

○ Yes ○ No



Thank you for completing the LTSS needs assessment questionnaire. Click "Submit" to receive the results and find out more about contacting an LTSS specialist for person-centered options counseling. If you would prefer not to submit the questionnaire, click "Cancel".

A.2 PCOC Action Plan

The PCOC Action Plan helps the consumer move from identifying the resources that best fit their wants to specifying next steps to access those resources and achieve their long-term support goals. The PCOC Action Plan is meant to guide the PCOC process and to ensure that consumers receive a consistent and similar experience across MyOptions Advisors. The MyOptions Advisor sends the PCOC Action Plan to the consumer after the initial and follow-up PCOC session. The PCOC Action Plan is show in the figure below.

Your PCOC Action Plan:

Person-Centered Profile:

Goal:

Action Steps:

Service Options:

Goal Update:

Goal Status: