Chapter 6: Counseling

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Chapter 6

Counseling[1]

Counseling—providing information and assistance to individuals electing to direct their services—is a key supportive service in self-direction programs. States use a variety of terms to describe the counselor's role, including support broker, service coordinator, flexible case manager, consultant, advisor, and community guide. This Handbook uses the terms counseling and counselors. Regardless of the name used, the goal of counseling is the same: to offer flexible and personalized support to ensure that self-direction works for the participants who choose it.

To be effective, counselors must be able to work with a wide range of participant skill sets, practice person-centered planning, and assist individuals to make informed choices that are consistent with their needs and will help them achieve their goals.

This chapter discusses the key components of counseling and how programs can ensure quality counseling services. It also discusses the differences between counseling and traditional case management and describes various counseling models states use, including those that have combined the case manager and counselor roles.

A. Key Components of Counseling

Counseling comprises two broad activities—providing information about self-direction and providing assistance and training as needed with self-directed tasks. These activities are accomplished within a person-centered framework.

Counselors can provide individuals with detailed information to enable them to make informed decisions about whether self-direction is right for them, and if it is, about how to obtain and manage their services. Because self-direction is a relatively new service delivery option in most states, many individuals will need information about a wide range of topics, including:

- the person-centered planning process
- participants' rights in the program
- resources, choices, and options
- risks and responsibilities associated with self-direction and decision making
- program limitations or restrictions
- reporting changes in condition and needs

- recognizing and reporting critical events, abuse, or neglect
- requesting a review of decisions, reporting grievances, and dispute resolution
- the availability of criminal background checks and processes for conducting them (depending on the program design)

Person-Centered Planning

Person-centered planning (PCP), a critical component of self-direction, assists individuals to exercise autonomy, choice, and control over the services they need. Individuals may assume very different levels of responsibility, from taking complete charge of their planning, service arrangements, and budgets to relying on a representative or family member to assist them with most or all tasks. Given the wide ranges in both abilities and individual preferences, states need to design flexible counseling services to accommodate participants' needs and wishes and to provide the level of support, assistance, and training needed.

The C&C grant states formalized *participant goal setting* as a method to help promote person-centered planning, particularly with elderly persons and working-age adults with disabilities. Counselors assist participants to set goals and develop a services and support plan to achieve them through the use of an individual budget and spending plan. (See Web-Accessible Resources at the end of this chapter for more information.)

In addition to providing information, counselors also encourage participants to seek information on their own. As program staff in one state noted, if counselors are doing more work than participants, something is wrong.[2]

Counselors assist individuals with a wide range of self-directed activities. The extent and type of assistance provided to participants varies depending on their needs and preferences. Specific types of assistance include:

- defining needs, preferences, and goals
- developing the individual budget
- managing the individual budget
- developing a backup plan if a scheduled worker fails to show
- developing a backup plan for emergency situations
- identifying and obtaining services, supports, and resources
- recruiting, hiring, and managing workers

- obtaining training in practical skills related to personnel management or problem solving, including; (1) recruitment strategies; (2) how to interview, select workers, and check references; (3) how to negotiate rates and arrange schedules; (4) how to train workers; and (5) how to manage workers and dismiss/replace them if necessary
- making decisions about the purchase of goods and services
- assessing the quality of services received

Traditional Case Management

Self-direction programs vary in their use of traditional case management. In many programs, both case managers and counselors assist participants, but their roles differ markedly. In others, case managers assume the counseling role in addition to continuing some of their traditional responsibilities. While traditional case managers' responsibilities vary, typical duties include:

- explaining the program, process, and eligibility criteria
- presenting setting (institutional, home, or community-based) and service options (traditional agency or self-direction)
- conducting an assessment to determine eligibility (based on medical, functional, social, and behavioral factors)[3] and to develop a service plan and match needs with resources
- implementing the service plan
- monitoring the provision of services
- assessing the quality of services
- ensuring cost/budget neutrality, if required
- revising the service plan when changes occur
- performing periodic assessments and eligibility determinations

The case managers' role to oversee and monitor service delivery is often required to ensure that Medicaid or other public programs meet state and federal health and welfare requirements. Often, the case management system is a key component of states' quality management systems.

In many self-direction programs, traditional case managers carry out some or all of their responsibilities. If they are not involved at all, then their responsibilities must be carried out by someone else in the program.

Self-direction programs shift some of the case manager's responsibilities to participants and offer a different set of supports through counseling to identify and enhance participants' skills. Counseling links participants not only to traditional services but also to non-traditional goods and services. For example, purchasing a microwave oven can allow participants to prepare their own meals rather than allocating their budget to pay someone to perform this task.

In self-direction programs that provide participants with both a traditional case manager and a counselor, it is important that case managers and counselors understand their respective roles and responsibilities and work collaboratively.

Federal Requirements

The Center for Medicare & Medicaid Services (CMS) has specified that information and assistance must be available to assist participants to manage their self-directed waiver services.[4] Both the §1915(c) and §1915(j) authorities view the roles and responsibilities of the counselor as fundamentally different from those of a case manager.

Prior to approval of a self-direction waiver program, federal reviewers will ask, at a minimum, the following questions:

- Does the waiver program furnish to participants: information about the program's benefits, their responsibilities, and their potential liabilities?
- Who provides the above information and what is the process for providing it?
- Is the above information provided in a timely manner to permit informed decision making?
- If both counselors and traditional case managers are involved in the program, how will they work together, particularly to prevent duplication of services.[5]

While information and support may be furnished by one or more entities, states must ensure that there is no duplication of activities. States must also specify the payment authority (or authorities) under which information and support will be furnished, which will be discussed later in this chapter.

States offering a self-direction option under the new §1915(j) authority will be required to furnish assurance that all individuals are given a support system that provides information, assistance, counseling, and training to ensure that participants are able to manage their services and budgets.[6]

B. Developing a Counseling System

Transferring authority and control over services from professional case managers to participants aided by a counselor requires states to develop a new system, which can be challenging. States have two basic options for providing counseling

services: (1) create a new and separate system or service that provides trained counselors, or (2) modify an existing case management system to include the counseling service. If a state chooses the latter option, case managers will have to undergo counselor-specific training and have a manageable caseload.

Within those two broad options, states have developed a variety of counseling models.

Counseling Service Models

To date, programs have developed several models for providing counseling services. These include:

1. The program develops a new service to fulfill the responsibilities of providing information and assistance. (Model used by Minnesota—see box below). The duties of a traditional case manager may be included in the new counseling service or case management and counselor duties may be provided as distinctly different services to participants.

2. Using a Request for Proposal (RFP) procurement process, the program contracts with a new provider entity to furnish counseling services. (Model used by New Mexico's Mi Via). The new entity may also provide traditional case management services or the program may keep case management functions totally separate.

3. Existing case managers assume additional counseling responsibilities. (Model planned for Pennsylvania's Services My Way). A single provider agency or individual furnishes traditional case management. This same entity or person is trained on person-centered planning and the new self-direction option. Typically, the caseload of the individual is reduced to compensate for the additional duties to support self-direction. The case manger/counselor continues to perform traditional duties as well as new counseling duties.

Most states use some variation of these models in their self-direction programs. Whichever model states choose, time and resources will be required to: (1) create job descriptions; (2) recruit, hire, and train or re-train staff; (3) develop operating protocols, including communication linkages; (4) develop standards and oversight mechanisms; and (5) fund new positions and related administrative and operating costs.

Minnesota's Approach to Providing Information and Assistance

Minnesota's Consumer Directed Community Supports (CDCS) service option uses both traditional case managers and counselors. The counselors—called flexible case managers (FCMs)—provide education about the CDCS enrollment process and forms, assist with developing an individualized budget and spending plan, and assist participants to employ and manage workers and purchase goods. The cost of the FCM service is paid from participants' CDCS budget.

Traditional case managers perform "required case management". Their core functions include: (1) assessing functional eligibility for the program at least annually or when there is a significant change in participants' condition; (2) approving CDCS community support plans (i.e., the service plan) according to established state policy; (3) monitoring participant's spending; (4) providing information and assistance to participants about CDCS; (5) linking participants to a fiscal support entity and flexible case management services; and (6) ensuring health and welfare.

Minnesota does not require participants to use a flexible case manager to prepare their community support plans (i.e., the service plan). They can receive assistance with writing their plan from family or friends and the lead agency case manager who is their required case manager.

Considerations When Selecting a Model

Adding counseling responsibilities to existing case management programs has been one successful approach, particularly in the developmental disabilities service system because the case management system typically is familiar with the principles and practice of person-centered planning and the philosophy of self-determination.[8] However, in the aging service system, case managers may find the philosophy of person-centered planning and/or self-direction new and may be hesitant to assume the counseling role. Because self-direction shifts control and responsibility to participants, counselors cannot operate with the traditional case management mind-set of being responsible for participant decision making or outcomes.[9]

It may be difficult for many traditional case managers to feel comfortable with participants, particularly older participants, taking an active role in managing their own services. Some case managers may doubt that older persons have the interest or capability to do so. When Minnesota first implemented its program, some case managers actively discouraged participants from considering self-direction, and others failed to present it as an option based on their own perceptions of participants' interest and abilities.

The Cash & Counseling Demonstration and Evaluation (CCDE) states have found that delegating counseling tasks to traditional provider agencies was sometimes problematic, particularly if staff lacked sufficient training in program requirements, person-centered planning, and self-direction.[10] Additionally, if caseloads are not adjusted for the increased time needed to learn about and implement a new self-direction option, work overload can interfere with case managers' effectiveness in presenting information about the new option and in assisting those interested in enrolling.

Case managers must have adequate training to fully understand self-direction and to become committed to its philosophy. Otherwise, they may find it very difficult to function as both a traditional case manager and a counselor. However, when traditional provider agencies are fully engaged, success can be achieved. Pennsylvania's Services My Way program plans to use case managers from local Area Agencies on Aging (AAAs) to provide counseling services once they complete training on person-centered planning, the new option, and additional program requirements.

In Kentucky, case managers from local Area Agencies on Aging are also providing counseling. Although these case managers had not previously been associated with the Medicaid waiver programs, they had prior experience working with self-directing individuals in a state-funded program, so were already comfortable with self-direction. See box for a description of Florida's experience.

Florida's Experience Using Traditional Case Managers

In Florida, counseling activities were added to existing case management responsibilities and individuals who enrolled in the C&C Demonstration were assigned to traditional case management agencies. However, many of these agencies and their staff did not initially support the program and as a result, many case managers failed to provide timely assistance to participants.

Florida devoted considerable effort to gain the support of traditional case management agencies. Among other activities, the State published a newsletter to keep these agencies informed about the program's progress, and included "success stories" of participants who had benefited from the program. Support for the program grew gradually among case management agencies and staff, as their skepticism about consumers' ability to direct their own services proved unfounded.[11]

The Arkansas IndependentChoices Program enrolled individuals by using counselors who specialize in the program. Research on the program found that full-time counselors appear to be more efficient, more committed to the

philosophy of self-direction, and more knowledgeable about program rules than part-time counselors.[12]

Counseling and Financial Management Services

When counselors and financial management services (FMS) staff are employed by different organizations, questions are sometimes addressed to the "wrong" organization, and there may be a tendency to "pass the buck" between organizations. Combining counseling and FMS in the same entity can enhance efficiency by facilitating the exchange of critical information, establishing clear accountability, and ensuring that newly enrolled participants receive services in a timely fashion.[13]

Before combining counseling and FMS into a single entity, however, states should consider both the efficacy and practicality of this approach. Combining the two functions may be impractical if a state does not have an entity with the expertise needed to provide all of the services itself or to supervise a fiscal subcontractor. This was the case in Florida, where many case management agencies were reluctant to participate in the CCDE, and few, if any, had the necessary expertise to provide or subcontract for fiscal services.

Combining counseling and FMS may be impractical for other reasons as well. In Florida, over 100 entities provided case management or support coordination; if each also provided FMS, the number of participants served would be too small to support the FMS infrastructure. Arkansas initially combined counseling and FMS in a single organization but has since separated them, largely due to other programmatic changes on the state level.

In contrast, some states—New Jersey and West Virginia—have found it practical to have a single entity provide both counseling and FMS. New Jersey initially began with many counseling agencies and a single FMS entity. After a few years, recognizing the inefficiency of having numerous agencies providing consulting services, the State reduced the number of counseling agencies and later combined counseling and FMS in a single entity that serves the entire state.

Determining the Payment Source for Counseling

Medicaid funds the provision of information and assistance—that is, counseling in self-direction programs—either as a service or as an administrative expense. As discussed above, states may add counseling to an existing service (case management) or create a new service by specifying a new service definition and qualifications for those providing the service. Programs designed in this manner are eligible for federal financial participation (FFP) at the enhanced service rate and must provide participants with free choice of providers.

If states fund counseling as an administrative expense they receive the standard match rate of 50 percent. An advantage of this approach from the state's perspective is that the program can limit the number of providers and may issue RFPs to select one or more vendors to provide counseling services. New Mexico's self-direction program—Mi Via—elected this model and issued an RFP to select a vendor to supply counseling services. While the state has only one vendor, participants may select their own counselor, who is hired by the vendor as a part-time employee. Participant-recruited counselors in New Mexico must complete a prescribed training course and be certified before beginning work with the participant.

If states pay for counseling as a waiver service, they must decide whether or not to deduct the cost of the service from the individual budget. If the cost of counseling is deducted from the individual budget, it is likely that participants will chose to increase workers' wages or purchase additional hours or goods and services rather than purchase additional counseling over and above the initial amount required. This has been demonstrated in Minnesota, where the cost of counseling is paid out of participants' budgets. Consequently, many participants have elected not to purchase this service and have looked to their traditional case manager to furnish the assistance that counselors provide, which has not always been effective because case managers are not trained to provide all counseling services.

Rhode Island requires participants to pay a prescribed fee from their budget for counseling (called advisement services). The State's rationale was that participants who have to pay for counseling services from their budgets will be more likely to fully utilize counselors' services.

Allowing Sufficient Time for Counseling

The CCDE states found that counselors introducing the program to participants and family members took a considerable amount of time. Initial conversations involve discussions about person-centered planning, employer responsibilities, and program features and requirements. Helping participants develop the individual budget was the most time-consuming task. More than one visit was often required to describe, enroll, and prepare an individual to self-direct. However, advance preparation by sending informative materials to the home can minimize the number of home visits needed to develop, implement, and revise the service plan.

Self-direction may be a new concept for many individuals and their families. Counselors should be prepared to provide information and training at a pace that matches participants' ability to understand and retain the information. If participants feel overwhelmed with information, they may become discouraged and elect traditional services even though they want to direct their services. Counselors need sufficient time to work with participants to ensure that they

understand how the program works. Caseload sizes should be adjusted, if necessary, to ensure that counselors have the time they need to fully explain the program, answer participants' and family members' questions, and complete enrollment forms.

Timing of Counseling

Educating and training participants is most effective when done shortly before or after they enroll. Encouraging family members or an informal support person to be present during education and training sessions also appears to improve their effectiveness. Education and training can be facilitated by various tools, including orientation videos and interactive websites.

One example is the Personal Choice Quick Start manual developed for Rhode Island's program. This manual briefly describes the roles and responsibilities of participants, provides tips on communicating with workers and counselors, and discusses successful strategies to manage a budget.[14]

Setting Rates for Counseling Activities

Just as counseling activities vary among states, so do rates and rate setting methodologies. A few states pay counselors a flat rate to assist with spending plan development. Limiting payment in this way can prevent excessive costs for counseling services if the completion of a spending plan is prolonged. New Jersey pays a flat rate for the initial development of the spending plan (with an hourly rate and a cap on the number of hours thereafter). Arkansas effectively lowered its counseling costs by changing its payment methodology from a set monthly fee (per member per month) beginning at enrollment to a flat rate for the development of the spending plan and a monthly capped rate for counseling services thereafter.

However, states may need to consider an exceptions policy for individuals with very large budgets. New Mexico, for example, found that participants in the Developmental Disability and Medically Fragile waivers with annual budgets of $100,000 or higher needed more time than originally allocated to develop individual budgets.[15] Additionally, states should have criteria to determine if a participant's counseling needs are excessive and a representative should be appointed.

Authorizing Counselors to Approve Most Budgets

Establishing policies, processes, and procedures to ensure efficient counseling services can reduce unnecessary paperwork and streamline approvals. States have found two approaches, in particular, to be both effective and efficient: (1) authorizing counselors to approve service plans and individual budgets; and (2) developing a pre-approved list of allowable goods and services and requiring the counselor to seek approval only for items not on the list.

Use of a pre-approved list is an efficient procedure for reviewing spending plans. It can be coupled with audits to ensure that counselors are abiding by the requirement to seek further approval for plans that include goods or services not on the list. The pre-approved list can be modified over time, as permissible uses of the allowance change or if it becomes clear that counselors are not able to make appropriate judgments about some items.

New Jersey and Florida initially had all spending plans reviewed by a state or district level office. When they found that this costly procedure sometimes delayed plan approval due to the time it took to review each document, they changed this requirement. Arkansas, on the other hand, did not require program approval for plans containing only goods and services on a pre-approved list and did not experience a problem with delays in plan approval.

Controlling Costs

States should ensure that individual budgets will not be higher than the costs of serving participants in the traditional system. While self-directing participants should receive the services they need, it is financially, and often politically, problematic for them to receive more state resources for their care than do individuals with comparable needs in the traditional program. Moreover, the program's ability to control costs may be compromised if resources are increased in participants' service plans without regard to costs in traditional programs serving participants with similar needs.

In Florida, counselors, perhaps acting more as advocates and less constrained by the supply of workers than traditional agencies, authorized more hours of care for some participants than would have been authorized in traditional care plans, resulting in higher costs. To prevent a similar problem, New Jersey assigned responsibility for assessment and service planning to Medicaid nurses who were not otherwise involved in the CCDE.

Florida found it impractical to re-assign responsibility for assessment to an external party, but eventually found ways to limit the likelihood that counselors would increase services in care plans beyond what they would have been under the traditional program.

Florida developed standardized care plan protocols for all its waiver programs and compared care plans for participants in the CCDE with those for participants in the traditional program with similar levels of impairment. The State also reviewed plans with high costs relative to participants' level of impairment. In addition, when training counselors, Florida emphasized that participants are responsible only for decisions on how to *spend* resources, not for determining the *amount* of resources available.

States can use these and other procedures to help keep self-direction program expenditures equal to those in traditional programs. Regardless of which system a participant is in—traditional, self-direction, or managed care—the cost of services should be the same. What differs under self-direction is the method(s) through which assessed needs are met.

Providing a Choice of Counselors

Deciding whether to offer participants a choice of counselors is another program design question states must consider. States can allow participants to choose someone from a pool of state-designated counselors, or allow them to hire someone of their own choosing who will then need to complete required training. If States choose the first option only, they must ensure that a sufficient number of counselors are available to permit choice. Whichever option is chosen, states need to guarantee that a sufficient number of counselors are available to meet demand. Doing so helps to ensure a good fit between participants and their counselors.

The availability of a sufficient number of counselors with diverse backgrounds can enable participants to select a counselor with a similar cultural background, one who speaks their language, or one who has experience working with their specific disability (e.g., traumatic brain injury or spinal cord injury). States may address the need for varied backgrounds and skill sets by training a cadre of individuals interested in serving as counselors; participants may then select one who offers a good fit with their needs and interests.

New Jersey initially offered participants the option to locate and hire their own counselor, but discontinued the practice after finding that few participants exercised the option and—for those who did—the process delayed enrollment. The State now offers counseling services through a single entity that provides both counseling and financial management services. Participants may choose among all available counselors and if their initial selection is not a good fit, they may request a replacement.

In Iowa, participants may choose a counselor—called an independent support broker (ISB)—from individuals working for specific agencies, or they may recruit and hire an ISB, who may be a family member. Once selected, the state provides training and certification, but this process can slow the time it takes to receive services.

Setting Caseloads

Counselors need to have a sufficient caseload to be financially viable, to successfully carry out their responsibilities, and to be well versed in the program. One way to achieve this is to limit the number of organizations from which the state draws counselors.

Both New Jersey and Florida initially used a large number of entities for counseling services. As a result, many individual counselors had small caseloads and their many other responsibilities often took priority over their counseling responsibilities. In contrast, Arkansas hired state staff to perform counseling duties and these individuals worked full-time solely with self-directing participants.

After several months' experience with the new program, both New Jersey and Florida decreased the number of counselors. Florida did so by assigning the entire program caseload at a given agency to one or two counselors. New Jersey began to assign newly enrolled participants to the best performing counseling agencies and gradually transferred other participants to these agencies. After several years, New Jersey opted to have a single agency provide counseling services with many fewer counselors.

C. Ensuring the Quality of Counseling Services

Quality management strategies to ensure effective counseling services are discussed below.

Setting Qualifications

Qualifications for counselors will depend on the range of duties they perform. If traditional case managers assume additional counseling functions, states may require additional education and training to understand self-direction, the person-centered planning process, and the range of counseling tasks. The requirements for counselors would be added to existing requirements for case managers (e.g., licensed social workers and nurses, as well as specific educational and experience levels).

The qualifications for counselors, who do not have case management duties, typically focus on the knowledge and skills needed to provide information and assistance with self-direction tasks. Because these activities are more supportive and facilitative and less prescriptive than traditional case management, the skill set might require less attention to education or experience and more to communication skills and knowledge of community resources. Requisite skills for counselors include the ability to:

- communicate with participants, their families, and other support system staff
- understand, accept, and apply the person-centered process and self-direction principles
- understand how an individual's disability might affect communication or behavior
- learn about community resources and how to obtain them

- perform basic math skills to develop an individual budget
- understand and follow program policies

Skills to navigate the human services system may not depend as much on training or certification as on a person's background, history with and knowledge of the community, or relationships with particular individuals, organizations, or groups.

States should identify the responsibilities that require particular expertise or specialized training, those that logically fit together into a reasonable set of tasks and duties, and those that can be performed by individuals with little direct experience. Whatever the duties and related qualifications, developing functional job descriptions that cover all of the counselor's responsibilities is essential.

Once qualifications are articulated, a procedure to verify individuals' qualifications must be developed. Typically, state program staff verify counselors' qualifications; other states assign this responsibility to the FMS entity. Some states require certification for counselors based on mandatory training sessions and the successful completion of skills testing.

Training

Counselors play a critical role in helping participants develop the skills they need to direct and manage their services. To perform this role effectively, they must have adequate training. A counselor training curriculum should include at a minimum: the principles of person-centered planning and self-direction; program policies and procedures; understanding and communicating with particular disability groups, (e.g., working with individuals who have cognitive or speech impairments); and training in specific tasks, such as assessing risks and developing service plans.

Participants may be very interested in self-direction but have concerns about specific responsibilities. For example, if they lack relatives or friends to hire, they may feel that recruiting workers will be too difficult. Counselors can play a critical role in such situations, helping participants develop the skills they need, such as teaching them to find non-traditional workers through creative recruitment strategies.

Developing specific training for counselors on recruiting, hiring, and management techniques is extremely helpful. Having access to worker registries or informal lists of potential workers is also beneficial and can be of great value when workers fail to arrive at their scheduled time. Specific training on how to help participants dismiss workers—particularly family and friends—can also be very helpful as this is an area with which participants have difficulty.

The need for ongoing training to enhance skills and to deal with counselor turnover is critical for an effective counseling system. Several states offer

Internet-based training, which can reduce the cost of the ongoing training needed to deal with staff turnover. For example, Kansas offers training through a six-month, web-based training course that includes person-centered planning, risk management, care plan development, and service coordination.

Computer-based training, DVDs, and videotapes can be very cost-effective methods for providing training for new hires and for continuing education. Manuals also serve as an effective training format and are critical as ongoing reference documents.

Either a website or toll-free telephone number should be available to promptly answer counselors' questions. Pennsylvania uses a web-based system for support coordinators to e-mail questions to a central location and state staff post the answers on the site so that others can benefit from the information. (Support coordinators are AAA care managers who take on the counseling role to provide information and assistance to self-directing participants.)

States should evaluate the adequacy and quality of counselor training, including the content of policy manuals and the effectiveness of specific training programs or presentations. States also need to have a process to identify issues or problems that may indicate that the minimum qualifications they have set are not adequate to provide the assistance needed for self-direction to succeed. This process can consist of a mechanism to obtain feedback about counseling services from participants, workers, state staff, and FMS providers. Participant feedback is probably the single most important source of feedback.

Monitoring and Oversight of Program Design Elements

The creation of policies and procedures to ensure the quality of counseling services is essential. The type and level of oversight applied to the counseling system will depend on the specific program model used. If traditional case managers are providing counseling services, existing oversight procedures must be modified to include the counseling components. If counseling is an additional service, then new oversight procedures will be required. Counselor oversight must be part of the overall strategy to assess the quality of the entire program. See Box below for a description of Minnesota's approach to ensure the quality of counseling services.

Minnesota's Approach to Ensuring the Quality of Counseling Services

Minnesota requires its counselors—called flexible case managers (FCMs)—to pass a certification test. FCMs must be at least 18 years of age, cannot be the parent of a minor child who is the participant or the spouse of the participant, cannot be the paid worker for any participant to whom they are delivering FCM services, and cannot have any direct or indirect financial interest in the delivery of the services in the plan.

Recent measures to strengthen quality assurance for FCMs include:

New FCM Service Standards in 2008. The State developed additional FCM standards to ensure service quality. The standards address: (1) the functions and limitations of FCM services, (2) ethics and values, (3) service and support planning and implementation, (4) support of self-advocacy, (5) fostering self-determination, (6) the right to privacy, and (7) diversity and inclusion.

Due to widespread confusion about the difference between "required" and "flexible" case management services, the State is planning to substitute the term Counselor and/or Support Planner for FCM. The State uses these new terms in self-direction programs funded under Title IIIE of the Older Americans Act, but their use in waiver programs requires CMS approval.

Recertification. FCMs must be recertified every two years, effective 2008.[16]

New FCM Training Curriculum. The new curriculum is based on the new service standards in order to ensure competence and improve service quality. The three-day FCM skills-building course covers: (1) the FCM service standards, (2) expectations and practice of FCM, (3) person-centered planning skills, and (4) partnering with financial management services entities. The course includes exercises to understand the State's three payroll models and exercises for effective service planning and budgeting.

New FCM Networks. A few counties and FCMs themselves have initiated several networking groups around the State. One group is coordinated by a county staff person and state staff occasionally attend the meetings. These groups discuss operational and practice issues and work to improve the quality of FCM services statewide. The State obtains input from these groups on a wide range of FCM service issues. Various FCMs communicate routinely with state staff through the CDCS policy mailbox, various workgroups, trainings, or other correspondence.

Readiness Reviews

Prior to implementation, it is advisable to conduct a review of the counseling process. New Mexico—prior to implementation of its Mi Via program—asked the C&C National Program Office to perform a review of the agency selected to provide counseling. The review included interviews with counseling staff, the FMS entity, and state personnel, as well as a document review to ensure that:

- the entities are operating as specified by the program's policies and procedures
- counselors are able and prepared to perform stated duties
- operating protocols and communication procedures are understood by the counseling agency, the financial management services entity, the participants, and the state office
- quality management measures are in place
- administrative procedures are in place
- participant services are operational
- sufficient numbers of counselors are available to meet anticipated demand

Ideally, the review will be conducted by individuals or entities independent of the program's operational structure, which will help to ensure objectivity.

Resources

Publications

Foster, L., Phillips, B., & Schore, J. (2005). *Consumer and Consultant Experiences in the New Jersey Personal Preference Program.* Washington, DC: U.S. Department of Health and Human Services.

This publication describes the implementation of New Jersey's self-direction program, implemented as part of the CCDE. The study obtained information from in-person discussions with program staff, a mail survey of program consultants, telephone interviews with participants, and program records.

Available at: http://www.cashandcounseling.org/resources/20060607-151609

Foster, L., Phillips, B., & Schore, J. (2005). *Consumer and Consultant Experiences in the Florida Consumer-Directed Care Program*. University of Maryland Center on Aging, College Park, MD.

This publication describes the implementation of Florida's self-direction program implemented as part of the CCDE. The study obtained information from in-person discussions with program staff, a mail survey of program consultants, telephone interviews with participants, and program records. The report discusses lessons learned, including those related to "support coordination services."

Available at: http://www.cashandcounseling.org/resources/20061107-162153

McInnis-Dittrich, K., Simone, K., & Mahoney, K. (2006). *Consultant Training Program*. Boston, MA: Boston College.

This manual addresses two identified training needs for consultants working with participants who direct their services and supports: facilitating the paradigm shift for consultants and understanding the dynamics of choice and decision-making for participants. The manual discusses the philosophical framework necessary for successful implementation of participant-directed services and is designed to be delivered in two half-day sessions.

Available at: http://www.cashandcounseling.org/resources/20060602-113610

Phillips, B. & Schneider, B. (2005). *Moving to IndependentChoices: The Implementation of the Cash and Counseling Demonstration in Arkansas*. College Park, MD: University of Maryland Center on Aging

This report describes the design and implementation of IndependentChoices, Arkansas' model of Cash & Counseling. Lessons learned in Arkansas are discussed, and cover topics including outreach and enrollment, program features, counseling and fiscal services and program structure.

Available at: http://www.cashandcounseling.org/resources/20051202-173537

Web-Accessible Resources

Cash & Counseling National Program Office

Web-address: http://www.cashandcounseling.org

This website contains extensive information about counseling services. Specific resources with links are listed below.

Information concerning participant goal setting and the development and articulation of individual goals is available at: *http://www.cashandcounseling.org/resources/20080303-130304*.

Examples of job descriptions for counselors from New Mexico, Vermont, Washington, and West Virginia are available at: *http://www.cashandcounseling.org/search?TextIndex=job+descriptions*.

Information about Michigan's person-centered planning (PCP) practices, as well as guidance and technical assistance to develop PCP policies and procedures is available at: *http://www.cashandcounseling.org/resources/20080616-162651*.

Clearinghouse for Home and Community Based Services

Web-address: http://www.hcbs.org/

This website is the repository for wide-ranging resources concerning state efforts to expand the delivery of HCBS for people with disabilities and older persons. Self-direction is one of many topics for which resource materials are compiled and made accessible online. For example, a number of resources about counseling can be found at *http://www.hcbs.org/advancedSearch.php*. (Keyword: counseling) Users can also add additional topics, keywords, or type/tools to further narrow results.

Citations, Additional Information, and Web Addresses

1 Suzanne Crisp is the lead author of this chapter. Janet O'Keeffe is the co-author.

2 Suzanne Crisp and Mary Sowers (CMS), (Spring, 2007). Personal communication.

3 In waiver programs, this information is used to make the level-of-care determination.

4 Application for a §1915(c) Home and Community-Based Waiver, Version 3.5, Instructions, Technical Guide, January, 2008. Page 193. Available at: *https://www.hcbswaivers.net/CMS/faces/portal.jsp*

5 Ibid. Page 40–41.

6 1915(j) *Self-Directed Personal Assistance Services State Plan Amendment Pre-Print*. Page 7. Available at: *http://www.hcbs.org/moreInfo.php/nb/doc/2038/*

7 The authors know of one state that has allowed case managers to provide both services to the same participant, but only until the state has sufficient counselors to handle counseling tasks for all participants.

8 Self-determination is a grass roots movement for individuals with disabilities, which promotes independence in the community, authority over public resources, supports that are life-enhancing and meaningful, responsibility to ensure resources are expended wisely, and confirmation of participants' role as self-advocates. The use of the term is much broader than self-direction and refers to an approach to manage all aspects of their lives, not just their services. Additional information is available at *www.self-determination.com*

9 McInnis-Dittrich, K., Simone, K., Mahoney, K. (2006). *Consultant Training Program*. Baltimore, MD: Centers for Medicare & Medicaid Services, Disabled & Elderly Health Programs Group. Available at: *http://www.cashandcounseling.org/resources/20060602-113610*

10 McInnis-Dittrich, K., et al. Op.Cit.

11 Phillips, B., Mahoney, K., & Foster, L. (2006). *Implementation Lessons on Basic Features of Cash & Counseling Programs*. Boston, MA: Cash & Counseling National Program Office. Available at: *http://www.cashandcounseling.org/resources/20070404-152907*

12 Phillips, B., Mahoney, K., Simon-Rusinowitz, L., Schore, J., Barrett, S. Ditto, W. et al. (June 2003). *Lessons from the Implementation of Cash and Counseling in Arkansas, Florida, and New Jersey*. Washington, DC:

Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. Available at: *http://aspe.hhs.gov/daltcp/reports/cclesson.htm*

13 The Consumer Direction Module (CDM)—a web-based software application specifically designed to support self-direction programs—can also help to ensure timely communication. See Appendix II for detailed information about the CDM.

14 Available at: *http://www.cashandcounseling.org/resources/20060519-093748*

15 O'Keeffe, J., Anderson, W., O'Keeffe, C., Coleman, B., Greene, A.M., & Brown, D. (2008). *Real Choice Systems Change Grant Program - FY 2002 Real Choice Grantees and Community-Integrated Personal Assistance Services and Supports Grantees: Final Report*. Baltimore, MD: Centers for Medicare & Medicaid Services. Available at: *http://www.hcbs.org/moreInfo.php/doc/2172*

16 The waiver renewal and amendments necessary to require recertification of flexible case managers have been submitted to CMS for approval.