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Money Follows the Person Rebalancing Demonstration:

Process Evaluation Year 3 June 2010-June 2011

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Introduction

The information obtained for this report came from the analysis of key informant interviews reflecting on the third full year of operation of the Connecticut Money Follows the Person (MFP) Demonstration, from June, 2010 to June, 2011. A process evaluation focuses on how a program is implemented and how it operates. It is an effort to describe how the program is functioning, the services it delivers, program achievements and program challenges. Multiple stakeholders are involved in MFP at various levels, including administrative staff, provider agencies, individuals participating in several workgroups and those who work to transition consumers from nursing homes and other institutions into the community. A sample of these multiple stakeholders completed key informant interviews with the University of Connecticut Health Center's Center on Aging MFP evaluation team. Questions for the key informant interviews are found in Appendix A.

Key Informants

Twenty key informants completed telephone interviews reflecting on their experiences in the third year of program implementation. Administrative and workgroup respondents included the MFP Program Director, co-chairs and other members of the Steering Committee; one representative from each of the four active workgroups (evaluation, workforce development, contractor, and transition), and the four Medicaid home and community-based system waiver managers. Providers included the directors of two transition coordinator contractors and one housing agency, all of whom were randomly chosen. In addition, members of two separate transition teams were interviewed, including the transition coordinator, the housing coordinator (if one identified), the case manager who did the assessment, and the social worker from the nursing home. Each interview assessed the respondents' experiences regarding the MFP mission and progress, workgroups, communication, partners, challenges, and achievements. New questions focused on the risk mitigation policy and participant risk agreement and the conference which was held in June of 2011 to promulgate this new policy.

All but two interviews were audio-taped and transcribed; the remaining two used typed interviewer notes. All were analyzed using ATLAS.ti, a qualitative data analysis program. Interviews lasted approximately 30 minutes. Results of the analyses fall into four basic categories, similar to previous process evaluations:

- Achievements and successes
- Strengths and supports
- Barriers and challenges
- Evolution of Connecticut's MFP program

Achievements and Successes

Analysis of the key informant interviews identified four overarching achievements or successes in the third year of program operation:

- Sheer number of individuals who have transitioned
- A shift in thinking, supporting systems change
- Risk mitigation conference

- Person-centered approach

Sheer number of transitions

As of June 2011, 640 consumers had transitioned from qualified institutions into the community. This fact was considered an exceptional accomplishment by the key informants, and was mentioned hand in hand with the increase in program exposure and a greater public awareness, which in turn encourages referrals.

> *MFP is up to about five or six hundred at this point and heading for a goal of 5,000 with every probability of making it and that is amazing. Plus it really has accomplished systems change. Increasingly we have not had to publicize the existence of it because both the staff and the nursing homes and individuals are finding out about the program and are knocking on the door for admission.*

For key informants directly involved with the consumers, the excitement of the consumer now in their own home in the community is really the number one achievement and accomplishment of MFP. While the goal of MFP continues to be systems change and rebalancing of the long term supports and services system, the joy of the consumer residing in the community rewarding for those who participate in the program at all levels.

> *… as far as MFP as a whole, I can only imagine from the satisfaction in my client's eyes when I give them a key or when they come and see an apartment, and they say, 'Really, I can have this?' Seriously – that's the excitement and that is the goal of MFP and to have so many successful transitions – that's great.*

A shift in thinking, supporting systems change

The increased number of transitions continues to reinforce that moving residents from nursing homes back into the community is possible. The more successful transitions that occur, the more this changes the attitudes of people, from non-believers to believers. These transitions not only educate the public, but also influence the legislature and future policy. Connecticut also became the first state to be funded for rightsizing in this time period. This funding is in part targeted to support nursing homes as they shift their focus beyond providing long-term, chronic care.

> *I think that there was a shift in families. Where families would have just accepted that their family member or people themselves were just going to spend the rest of their lives in a nursing home. And understanding and realizing that there is an alternative. … I think that the shift has been positive for that year. People are aware that this is a possibility and it's shifting how they think about what is possible.*
>
> *During that period is where we got that expansion approved and the rightsizing – so during that period is when we became the first state to be funded for rightsizing in the U.S. During that period we exceeded our goal for the number of people who moved out, and during that period we were funded with a larger increase also than any other state in the U.S. So a lot of things happened during that period after we been underway for not even two years.*

Several important or consequential events of the third year made a distinct impression on many of the respondents for this process evaluation. One of those events was the closure of one nursing home in 2010, and the subsequent closure of four others beginning in spring, 2011. This

put extra pressure on the MFP project to help place many of the individuals who were residents in these nursing homes in the community. How MFP dealt with these nursing home closures was considered a major achievement for year three. However, at the same time, the extra pressure of this closure unveiled certain gaps or disparities in the system.

> *… and because we have different people leading the closure it has established a bit of a dynamic in certain places. So... there certainly are on the care planning side, some differences in philosophy and in principles versus transition coordination and MFP principles. And we've seen that disconnect in the principles play out in the closures. But not so much about transition coordination, it's about the principles of person-centered planning and informed choice and informed risk, autonomy and dignity. And we do not in our system interpret all of those the same way.*

Risk mitigation conference

Another important event during this time frame was the first risk mitigation conference and beginning the discussion about the issues related to risk, risk mitigation, and the consumer risk agreement. Held at the end of June, the conference was considered a prominent achievement of MFP for year three. Some of the key informants expressed their satisfaction not only with conference itself, but with the fact that risk mitigation and the participant risk agreement were now in the forefront of many discussions.

> *[The] risk seminar that was held about a month ago, which has started to change attitudes and made people aware of what can be done within the existing system that people just hadn't been aware of in particular. Public health, willingness to have people assume risks by following protocol that they had in existence, and most people didn't know it existed. That's the biggest thing.*

While there was some excitement about the conference, there was also a feeling expressed by a few of the respondents that the conference and the original discussion were just a beginning and that it needed to continue. They felt that the initial conference was just setting the stage for more discourse down the road.

> *I thought that the conference was a wonderful first step. And I thought it was good to have all the voices at the table. I think that the follow-up has probably – there really hasn't been any – so I think sometimes that the ideas and the operation – there is a gap.*

> *I think it's good for us to talk about things like that. I know that it is kind of the beginning of discussing it as a group, big groups like that. I don't know where it is going to end us. I hope it does not get too out of hand – some risks I don't think need to be drawn out like that and mitigated in such a way. But it was good to have nurses there to talk about they have to shift the way that they think about things too. I thought it was good that we were talking about it because that is the only way that people are going to get a chance to do what they want and really make decisions about their lives, and they should be able to do that.*

Person-centered approach

Another broad policy change during this time period was the requirement mandated by law through the Minimum Data Set (MDS) to ask nursing home residents directly, "Do you want to go home?" This meant more people were offered the opportunity to return home or live in the

community. This new law increased individual awareness of choice and opened up new possibilities for every single person living in a nursing home.

> *This was a specific change in the last year. We're looking at a very person-centered interview with a consumer who wants to come home. I think the law on this changed October 1, 2010, but we didn't actually get directives about it until January 2011. … We're not asking their son or daughter, we're asking them, and it's a very different thing and that was a good thing that has happened. And MFP has forced the conversation about person-centered planning and person-centered rights.*

Strengths and Supports

Many of the same strengths and supports established in the early years of the program continued during this third year of MFP.

- A commitment of people involved in the project
- Involvement of multiple partners in every phase
- Opportunities for communication
- Successful and collaborative transition teams
- Program flexibility

Commitment of people involved in the project

The Connecticut MFP project involves many committed people who go above and beyond their role for the success of the program. Extraordinary measures have been taken to assist the project in succeeding and helping consumers who have transitioned in the community. This effort was frequently mentioned by many of the respondents who attributed the various achievements of the program to contributions from these very hard working individuals. There were examples such as a housing coordinator helping out a consumer who was left alone in snow storm, well after his or her official role had ended for that consumer. The extra measure of concern characterizes many of those who are active in MFP, from transition teams to program administrators, to the Director of the demonstration.

> *My impression is that there are people doing exceptional things out there in the field, and doing a wonderful job and often working together as a team in time of crisis, not crisis, but it's quick acting when nursing homes are closing and for people to leap into action and to help folks within a very limited time frame and with not all of the resources that they need.*

> *Dawn Lambert is great. That MFP unit works so hard. That is just phenomenal what a small handful of people have been able to do this past year. It's mind-boggling. They didn't do it all by themselves, but the work that they do. And the transition agencies - everybody that is involved with MFP goes above and beyond. They bend over backwards to make these transitions happen.*

Involvement of multiple partners in every phase

Involving more and more partners has been part of the MFP process throughout its evolution. During this past year, there was increased emphasis on developing housing options and Central Office staff continued to involve various real estate organizations with the idea of finding and

developing accessible and affordable housing. Housing is a prominent barrier in the program, and the housing and transition coordinators continually try to develop associations with various partners, such as landlords, in the community.

> *Continual education in the community about the need for [housing] … We have to demonstrate to people involved in affordable housing that we have adequate support systems for the people going into their properties. So education and lots of incentives for developers to make changes on apartments to make them accessible are necessary. Community education and the time to work with key people in the community are important …*

The increased involvement of new partners and organizations was especially evident in the Workforce Development Workgroup. These new partners include administrators of community colleges, members of the workforce investment system, and others not directly related to the project but whose expertise was sought to help with this monumental task.

> *[T]here is a whole profession out there that is dedicated to this. We felt that it was our role to bring them the information and assist them as much as we can, because they are really the experts. So it took a while to figure out how we fit into all of that and develop the partnerships that we needed to develop. And we spent the last year and a half or two years, really doing that. And I really feel like now, in the last couple of months, the people who are at the table are those that really need to be there. And I think that that is why the work is really starting to ramp up. Now we have community colleges and workforce investment boards and people from the various departments – all engaged in this discussion. … really starting to develop these partnerships which is the foundation for being able to move forward - move this system forward.*

Throughout the evolution of MFP, partnering has been a constant goal, and maintaining these relationships continues into the third year. The Steering Committee is an example of the partnership between people with disabilities and all of the various organizations and state agencies involved with MFP. Respondents commented that in the third year the program had become more cohesive – that different partners were working together more effectively to solve problems. The effectiveness of new partnerships was especially evident with the nursing home closures, as different waiver programs partnered to find the resources needed to support the consumer in the community.

> *It's incredible that the groups work together as well as they do. I think MFP has helped to get various state agencies and non-state groups working together from the DSS [Department of Social Services] with DDS [Department of Developmental Services], and other departments of public health and other agencies, housing, all the groups have been brought together and made aware of one another's needs and have worked together to solve problems.*

> *There are a lot of organizations that are working together to make it happen for these individuals. I've worked for 30 years, and often worked with multi-disciplinary teams and inter-agency types of collaborative and this is something like that. It requires the collaboration between different agencies, state agencies and organizations, like human service providers, the different types of organizations, like the nursing facilities and housing industry and the AAAs [Area*

Agencies on Aging]. So all these different people working together to make this happen.

Others acknowledged that there needs to be more involvement of stakeholders and people with disabilities in the workgroups and Steering Committee.

And I've often wondered if there might be a way that [people with disabilities] could be more involved, more engaged, through maybe not mandating the 51 percent … but have some meaningful engagement with folks, whether it's quarterly – meetings with people with disabilities, I don't know how you would reach out to people. Reach out to people who have transitioned. Maybe you assemble a group of people who have transitioned and listen – maybe you reach out to a group of folks who are on the waiting list – what does that feel like. But it does feel a bit of tokenism to have people around the table but not really engage them.

Opportunities for communication

Multiple venues exist for communication among partners involved in this program, whether it is information from the Program Director, in the Steering Committee or workgroup meetings, or among members of the transition teams. Open communication is an essential part of the success of the program according to some of the respondents. It allows every voice to be heard and encourages good working relationships among all of the partners.

I like the networking before and after and hearing the other examples, such as client successes, best practices, or discussing a form that's not quite right … that kind of thing is useful.

We [Commission on Aging] work with the legislature in trying to communicate what the goals are from MFP as well, we keep them updated, a fact sheet, and whenever we meet with legislators. We're constantly explaining the project to them and answering questions. We put regular updates about MFP on a Facebook page – all kinds of things.

I think that there are a lot of lessons learned and I use that phrase as more of a process … what can we do differently, how can we improve communication. So I think that it is continuous quality improvement. It's happening within teams, between providers, and I mean, or between factions of the process … I think the leadership of MFP definitely keeps us very much in the loop about what is going on.

Within transition teams, team members found that following up with email as opposed to a personal phone conversation was an effective way of keeping all parties involved in the process.

One way to do that that we have started is to keep all of the follow-up via email. That way, everyone can be involved in the process and everyone can be kept informed of what is going on as opposed to having a phone conversation with one of the involved parties.

Successful and collaborative transition teams

Transition teams have increasingly become more cohesive, improving their effectiveness and working relationships. Some respondents referred to their working within the transition team as

"familiar," and each person who is part of the team knows their role and works together collaboratively in getting the job done. Members of one transition team felt that having monthly meetings at the nursing home facilitated this process.

> *They [transition coordinators] have improved so much that it is … so familiar to us. I can only speak about my interactions with them. Anytime I have called, they have returned the calls. And if I say, well we need to do a transition plan meeting to see what is going on. They have called me on several occasions on transitions in which I am not even involved, just to get a second opinion or to get further information, so they will know how to handle whatever other situations they have.*

> *I'm very proud of the people that I am working with. And can't say that things have been easy through the years, but we finally got a flow, finally got a system where it is great – mutual respect and understanding – the ultimate goal.*

> *Everybody [transition team members] has the opportunity to voice their opinions. … And mainly we all agree to a plan – what is in the best interest of the client.*

Flexibility of the program

Throughout the past few years, MFP has had the latitude to be flexible and creative in the way it solves problems or changes protocols. Because the program is a demonstration, new procedures can be developed to meet challenges as they arise or to be responsive to the needs of the consumer. This flexibility was demonstrated in the handling the nursing home closures during the third program year. Being open to trying new things and being creative in any number of ways has added to the success of the program.

> *You know you hear that housing is always a major challenge. And then you hear that Dawn has worked with so and so organization to help them build or renovate more accessible housing. Engaging partners and say, "Hey, we'll help you with this. And this is a need, can you meet that need?' And then, you know, responding in that way, and trying to find creative ways of addressing problems. … And I think that Dawn and MFP have a lot more flexibility than a lot of other state programs, or state agencies, just because it has its own funding stream and it's a demonstration. So it allows for a little bit more flexibility in doing things. It would be great if we could see that throughout more state agencies.*

Barriers and Challenges

The following themes were identified by the key informants as barriers and challenges to the MFP program:

- Programmatic barriers
- Barriers specific to transitioning consumers
- Education and training
- Communication challenges
- Changes in barriers from year 2 to year 3

Programmatic barriers

Lack of necessary funding and staffing was seen as the number one programmatic barrier in the third year. This difficulty was primarily due to the state budget impasse. The threat of layoffs and other state budget issues influenced the staffing of the state agencies responsible for the MFP program. There was a need for additional staff and funding for all levels of the program, particularly MFP Central Office staff, and the need for more transition coordinators.

> *It's the state budget issues. The positions were approved and they were not allowed to fill them. And if you don't have the social workers to process the applications, and you don't have the MFP unit to handle the work, and the eligibility workers to determine that they are eligible and put the information through the system so that the claims could be paid - those are all state employees. And if you don't have those people, then nobody can be moved out.*

> *I think that the staffing – they have definitely been understaffed and everybody has been understaffed, whether it has been in the private agencies with the transition coordinators, AAAs, DDS, DSS, DMHAS [Department of Mental Health and Addiction Services] – I mean they are all understaffed. We have all had a big turnover in staff people leaving, so we're all wearing many different hats, so we may not be able to give the MFP part of our job as much as we could have, maybe a year ago.*

Specific limitations of the program were also perceived as a programmatic barrier. Lack of a universal waiver and the explicit requirements for the existing waivers limited the concept of choice for many consumers desiring to be included in MFP.

> *They [consumers under 65] are not old enough to go out on the home care program and there isn't any other waiver that is available, except PCA [Personal Care Assistance] which is self-directed, for them to transition out. It might not be the right place for them. If they make that 'choice' – because it isn't a choice because there really is no other option other than to stay in the nursing home. That's really not choice.*

Transition coordinators also hoped for more options available for their consumers, and some expressed the desire for a home care plan similar to CT's Home Care Program for Elders (CHCPE) for all ages because of the type of services available in that waiver which are not available in other waivers.

> *I wish that there was more that we could offer our clients either before transition or when they are in the community. Like, the money management that the home care program has - that is a great thing to put into so and so's plan. And that only exists in that waiver. I mean that doesn't exist in the PCA waiver. But people in the PCA waiver may need that - and that's not something that a TC can do, ongoing. I find that the TCs are always trying to do those kinds of things because there is nobody else to do it. …But I wish that there was more out there that we could offer. Case management, somebody to drive somebody somewhere - there is not a lot of transportation. I just wish that there was more that we could give to people that could really set them up to be successful.*

Barriers specific to transitioning consumers

The barriers to transitioning consumers include:

- Length of time to transition
- Housing
- Community supports

Connecticut's MFP program has reached the point where more consumers are interested in MFP than the current program staff can assist, resulting in a list of consumers waiting to be referred to a transition coordinator. This is a direct outcome of the lack of staffing at all levels, primarily the lack of adequate numbers of transition coordinators. Turnover of transition and housing coordinators also contributes to the lack of adequate field staff; respondents attributed this turnover to a low pay scale relative to the amount of work, lack of benefits and lack of mileage reimbursement. Starting new transition coordinators without sufficient training also limits their effectiveness. Recently because of the nursing home closures, a new transition coordinator was given only one day of training before being sent out to that nursing home to help transition some of the residents back into the community.

> *Actually, I think there has been an overwhelming response and no capacity to process the referrals. I believe that they are trying to hire more people. And I believe that the fiscal problems of the state has impacted that directly. … Central Office sends the referral to the transition coordinator that is covering that nursing home, but if they are overloaded, the referral doesn't get sent. … I don't know who they are, because they are sitting on someone's desk.*

> *Oftentimes, by the time we go into the nursing home to do the initial assessment, the client thinks that the transition will happen in about a week, because so much time has passed since they indicated that they wanted to leave the nursing home*

Many of the transition coordinators are not familiar with other contractors and the work that they do, and the ramifications for the consumer may prevent them to move forward in a timely fashion. For example, as a fiscal intermediary, if Allied Community Resources is not informed about a newly hired PCA, that PCA cannot be paid.

> *So that is a problem, I think. That people are coming into the program, and you have to know what the other contractors' roles are. I think that the new people coming on are not given training even if they receive training from the MFP unit about the role of the fiscal intermediary and why it is important to communicate with us and what we need to know and what we do.*

Finding appropriate, accessible, and affordable housing for individuals continues to be a huge barrier in the program. Even though efforts have been made to address the lack of housing, the challenges continue. Some of the housing coordinators revealed that additional time needs to be spent with some consumers who have already transitioned into the community, but who may end up back in a nursing home. Housing laws can require the involvement of members of the transition team even if the person has returned to the nursing home. One respondent suggested that MFP provide incentives to landlords to encourage them take steps such as remodeling in order to rent to consumers on MFP. Another respondent questioned spend down practices, commenting that if people were not so quick to file for Title 19 just to get into the nursing home that they might not be so apt to liquidate their residence. That way, if they do want to go back into the community with MFP, housing would not be an issue because they would still own their residence.

By all means, housing, housing, housing is the main problem. I had a case looking for an apartment with a rent. Oh my goodness, it took six months – the lady was desperate – so we need more handicapped accessible apartments. We need more low income apartments, apartments for people with disabilities, whether they are deaf, blind, or in a wheelchair.

I am spending literally hours trying to help a client who is not completely integrated in the community or clients that don't understand – like trying to negotiate people out of leases for medical reasons so they won't be held liable.

One of the barriers related to community supports and integration has to do with finding homecare agencies that are willing to take on challenging consumers. Even with the new risk agreement, many homecare agencies are reluctant to take on consumers who they do not believe will be safe, because of their own liability concerns. Other respondents indicated that home care agencies should be held accountable for what they do, or fail to do, for the consumer.

But that's what it is – [home care agencies] don't think that people are safe to live on their own so they don't want to take the cases, or they will take the cases, but then there is a huge fuss about it because so and so is getting meds four times a day, and nursing cannot go out four times a day.

Another barrier is for the state – what they will pay for and what they won't pay for. You know, trying to get the insulin in, reading it, for someone there. So where do we go if they are not able to, but they want to leave? And we know that there is a pen that they can use for their insulin, but the state won't pay for it. … Where do we go?

The nursing home staff is not always aware of what the consumer needs to prepare them for living in the community. Many respondents expressed the need for certain guidelines or directives as to what needs to transpire for any transition to happen, including who would be responsible for each one.

The nursing facility staff doesn't really understand what it means to have somebody go into the community … They say that they want to be helpful, but I don't know if they really grasp all of the things that need to be done. I find that to be a little bit difficult. Just working with people who don't necessarily have the mindset that MFP has. I mean setting up people to be as truly independent as they can, with their medications, and with their health.

Education and training

Respondents recognized a need for additional training and education for many of those who are already working in the MFP program, as well as for the general public. State and nursing home social workers and transition coordinators were cited as needing this education or training the most, but many agreed that ongoing training for everyone involved in the program is critical. Changes are frequently incorporated into the program that require additional training for many of the individuals involved at different levels of operation. The need for standardized, ongoing training and education for transition coordinators was mentioned repeatedly.

I think the transition coordinators need more training; I think the different agency staff that are moving people out need more training. I think they get a crash

course in MFP when someone is referred and then they come out at the other end and [it's] like, 'Now I get what it is.' We should be telling them up front. A lot of it, I think, goes back to some of the pressure of moving individuals. And, in saying that, we've had individuals who have taken forever to move and nobody has been pressuring anybody. So I think that each situation… is different.

The TCs are not as familiar with what needs to happen with their process. They are supposed to make all the arrangements for home modifications and AT [assistive technology] but sometimes they are not as knowledgeable about these things.

I would like more meetings with everybody involved, such as Central Office. And more contact with other transition coordinators. Some of my co-workers were saying that there were monthly meetings or every 2 or 3 months, but they said that those are no longer taking place.

Respondents were again asked about the 24/7 emergency backup system. Some had never employed the system so knew nothing about it, and many of the respondents still had the impression that the 24/7 backup was supposed to provide PCAs to consumers in trouble.

I think that it is supposed to provide a system where any consumer who needs assistance and there is nobody there to help them, that they can get emergency assistance 24/7. I think it would be getting another PCA to them.

It's kind of a mystery to me.

Some respondents did understand how the current system works.

… self-directed [consumers] primarily having a private PCA, and they can call this line to have reinforcement about their options for what to do when they have a problem. It's not to solve everything, but coaches them how to get through a difficult situation. It won't find a service for them, but coaches them.

One new additional service of the 24/7 emergency backup number is the transportation service. MFP now has contracts with transportation brokers for the state so that emergency transportation may be made available for people, for example if there is a storm with power outages, or during a hurricane.

<u>Communication challenges</u>

Although some respondents felt that communication was good, others saw a gap in communication across various levels. Many respondents saw a need for more consistent and structured communication processes. Respondents spoke of learning about policy or procedure changes second hand, resulting in confusion, frustration, and wasted time and energy. Respondents also wanted more program updates including trends, such as in the CHCPE report, while others wanted to know more about consumer outcomes after transition, such as hospitalizations. Two mentioned creating a monthly Central Office newsletter, while others mentioned sending the Program Director's monthly report electronically to everyone involved in the program.

We need to have more visible communication across the board at all levels – that is from Central Office – that is kind of a project director role – we need to do that. The past year has just been trying to survive and now we sense that some of the

protocol…is not as aligned as it looked when we first started. Our activities are not as standardized as they need to be, we lack the standardization across transition coordination, across housing coordination, specific to the people that we are moving out.

Are they going to leave [the housing coordinator position] a part time position, or are they going to change it to a full time position? Or are they going to change it where there is no housing coordinator?... I just wish I knew what was going on. Where do we stand with this?

I think that there is always room for improvement when it comes to communication. … Maybe if there was a website or …some sort of structured email that came out … What happens is some people know some information and some people don't – and [the problem is] how do you get the information out to everyone.

Respondents described a communication disconnect between the MFP Central Office and others involved in the project, including members of different committees, workgroups, contractors, and stakeholders. This was most clearly reflected in the decision making process between Central Office, the Program Director, and other stakeholders. People involved in very diverse parts of the project described similar situations, where input was sought and a mutual plan finalized, only to have the plan changed without any input or notice. Instead, people learned of it at a meeting, without any knowledge a change had occurred. This gap in communication was sometimes compounded by lack of any planned follow though for the new decision – how it will be implemented, what the next steps will be. While this communication and decision making style seemed to work for some respondents, it also created anxiety and frustration for others.

But it would be much easier for a lot of people… if [Dawn] made up [her] mind last month…this is how they are going to be, and then [made] more firm decisions. So I think that it creates a lot of anxiety when things are constantly changing.

And some people are really flexible – from the time perspective, from just the way that they are made up, their constitution – other people are not. So it is easy for some to just switch gears...

I would like more consistency or waiting until things are set before [MFP] communicates them – that might be the answer.

Some respondents acknowledged that two positions are needed – a Director and an Assistant Director. As the Director of a large, increasingly complicated, and fast moving project, it is becoming more difficult for Dawn Lambert to fill both shoes. A position such as an Assistant Director could fill in these gaps, and ensure that the right communication, follow through, and other details are taken care of.

I think Dawn is the right person at the right time, I do. To lead us in that way. So, in that end it is really positive. Things are changing so quickly for me that it's hard for me through our communication to stay up to date with what is happening.

More than anything, I think Dawn needs a right-hand person. More than anything, for this project to be viable.

[Dawn is] a really big picture person, and I think that the details get really lost. I think that she should have staff to support her in that way. Not just TCs, not just that type of staff, but really someone that supports her in trying to follow through on all of the details…

Changes in barriers from year two to year three

Changes in barriers from year two to year three tend to reflect the external circumstances that occurred during this particular time period, including:

- State budget impasse
- Facility closures
- Workgroup inactivity

As mentioned earlier, the state budget impasse and subsequent funding delays presented a major barrier in the third year. While the MFP demonstration is a Federal initiative, it is integrated into Connecticut's Medicaid budget. The MFP central office staff are state employees and, therefore, subject to the state restrictions and regulations. Connecticut's state employee hiring freeze and lay offs made it impossible to hire the additional MFP staff necessary to keep pace with the growing numbers of consumers either transitioning or interested in the program.

Five nursing homes either closed or were in the closure process during the third year. This process also impacted CT's MFP program, as transition coordinators struggled to keep up – finding housing, setting up services – in order to transition many of these residents to the community. Some respondents felt that MFP had become a numbers game, merely meeting on paper the goals of transitioning so many consumers, and that some of the original goals of MFP were being overlooked or given lower priority. Others felt the emphasis on the closures pushed these residents to make decisions quickly and further pushed back the referral of consumers already on the waiting list prior to the closure.

Sometimes I'm not sure that some residents and families might have felt a little pressured to make decisions … it did occur to me that maybe we shouldn't be focusing as much on the closings. Certainly I agree that we should try to inform and educate people – but whether – maybe the effort needs to remain with people who have already been identified and who have said, 'I want to transition out.'

The nursing home closures also uncovered or highlighted gaps in the system. Systemic gaps identified included overall lack of community supports, particularly lack of community supports for people with addictions, and lack of supports designed to prevent nursing home admission in the first place. Respondents described the planned rightsizing initiative as one way to address these gaps in the system.

To make significant change, you have to force the system, and when you force the system, gaps become prominent. And now those gaps are becoming ever more prominent. And now I am in the phase where I would really like to see commitment for those gap areas. So I think it's a difficult time for the project actually. In the beginning it's exciting, it's new, everything is possible. And now when it is in motion you see some of its weaknesses.

I would like to see an equal commitment from this administration, this project, for, … the whole issue about people have to go into a NH before being able to qualify for a waiver to transition out. So I would like to see more support on the front end. People with Alzheimer's – you know once you put something in motion, the cracks become apparent – and one of those cracks are people with dementia. How do you help support people in the community who have dementia? And so we keep moving forward and transitioning people out and at the same time, we need to - and I am hopeful what is going to come out of the rightsizing - is addressing the gaps.

This particular time frame saw less workgroup activity overall. A few of the workgroups continued to be active, while others were cancelled more frequently. Respondents felt the lack of an assigned MFP staff member to hold and facilitate meetings, or to provide logistical support such as minutes, contributed to this. Some workgroup members wished for more involvement or support from the Program Director. Oftentimes for a committee to be successful, it needs to involve either an organization who is paid to continue to facilitate and move the committee forward, such as the Evaluation Workgroup, or very strong individuals whose community organizations are committed to the principles of MFP, such as the Workforce Development Workgroup.

Hospital Discharge started but is not doing anything now, the Quality Group – nothing ever happened with that. The housing group – nothing ever came of that. And those are really important. But, you know, who has the time? I don't think that it is fair to depend … on a community partner in that way. Because it does take a lot of time and commitment, and I don't know that everybody has that availability.

The workforce meetings are similar to evaluation in that there is an agenda and they stay on schedule. Information goes out in advance. It's different in that the evaluation is funded versus the workforce development is not. So workforce development is more visionary in terms of the way that it operates – always looking for new partnerships, always looking to move the agenda across multiple moving parts in our state, creating partnerships – so it is action oriented.

I find that unless there is someone to take the initiative and chair for these sub-committees, that the staff at MFP at DSS just does not have the time or resources to do it. And therefore it does not get done. … Without leadership on those committees, nothing is going to get done. But, at the same time, relying on partners around the table that don't have funding to do so, is really a challenge.

Minutes and agendas continued to be problematic for some active committees or workgroups. As in the previous process evaluation, respondents asked that Steering Committee minutes be sent out shortly after the meeting and that all handouts be sent be sent electronically, including the monthly project report. Some also requested that the minutes reflect action items and less of a narrative.

What I would like to see, if anybody had the time,… these were the issues raised, here's more information and at the next meeting, you say okay – this is what the minutes are for. Really they are for action items. Let's just have them be one page of action items instead of a running narrative of the meeting. And then we will use another mechanism... [to] take notes. This is what was discussed, more

information needed. So that there is more continuity. So remember last month, you asked about [this], we've decided to [do this] – so that is how I would like more structure around the meetings. It sounds like accountability, but it is accountability for all of us.

[I would like] Dawn to send out [to the Steering Committee] a report ahead of time about where we are with MFP – so that we have an opportunity to review and then ask questions that are more appropriate at that time.

Meanwhile, respondents from the contractor workgroup expressed a need a need for both minutes and consistent agendas sent in advance, allowing them to prepare for the meeting. They remarked that relying on the contractors alone to provide the agenda and minutes during the past year did not work as well as they hoped, while at the same time they noted that Central Office currently lacked the staff support to provide this. Respondents felt clearer meeting objectives, greater structure, and MFP staff support for minutes and agendas would make the workgroup more effective.

We tried a couple of things and this year was an experiment. The contractors took some responsibility this year because we felt there wasn't enough structure to the group. … Dawn doesn't have the staffing to take over the minutes and agenda, and feels that everyone should be present to hear everything anyway, but I don't feel that's a fair expectation. MFP is not the only thing that we do… Having minutes sent out to us would definitely be useful. It didn't work that well for contractors to do the minutes, etc. during those six months. I know we did it the month we were responsible and I got a number of emails with agenda items from my colleagues in the contractor world for the next meeting. There wasn't an agenda at the last meeting, however, so I'm not sure who will be doing them or the agenda going forward.

It also would be helpful if we could have input into the agenda. Being able to see an agenda before the meeting would be useful as well in terms of being prepared to give input to a subject being discussed. … When there's no agenda sent out prior to the meeting, I can't get information to bring … and I don't feel as prepared as I'd like to be.

For these important committees to continue to do their work or become active, leadership from MFP has to step up and make it a priority to run these groups and give workgroups consistent staff and Program Director support. This has not happened with the current staff funding levels. Hopefully the hiring of more staff people will make it possible to address this issue.

Connecticut's MFP Program – Flexibility versus Fixed Guidelines

Some of the original excitement of the program continues as more and more consumers transition into the community, and as increasingly more professional and lay people buy-in to the idea that individuals can and do live successfully in the community. It is the creative problem solving and ability to adapt to challenges as they arise that is so emblematic of CT's MFP program as a demonstration. Such flexibility allows for changes in the program and can better accommodate the specific considerations of a consumer. Examining the results can unveil the best practices to use for a similar situation in the future.

The flexibility, and you know whatever it takes for a person - and instead of saying that they have to fit into this little box, and if they don't fit into this box then they can't move - how can we shape the box to get the person in there. So I think that the flexibility that we have within the program and the fact that the systems are changing - people are seeing that this was not just one of those little state programs that the governor got on TV about - it's really working, it's really happening, it's really making a difference in our system. The system is shifting and people are looking at how can I get this person into the community that maybe I didn't think could go to the community. I think that people are seeing that it is possible.

While acknowledging that a demonstration necessitates flexibility, several respondents specifically requested having policies and procedures in writing, citing that it is frustrating to know where or how to proceed without having these guidelines in place.

It's unfortunate we don't have any policies or procedures in writing. This is frustrating. We… often have to let our office know what MFP wants and then a month later they change what they want and we have to let our offices know the changes…. any changes need to go out statewide. You can't just say it anecdotally to one place and expect people to [absorb] the information. That's been very frustrating. … Consistent procedures statewide would go a long way in improving the progress of the program and what we do in the meetings … Having a handbook of policies and procedures would be a good first step and having it online so we could all access it would be especially useful.

They need good training for everyone. They should contract out for it if need be and that goes along with having adequate policies and procedures. The processes are such that they need to start with some basics – training, policies, and procedures.

Some suggestions made by the respondents included not only the handbook for procedures, but that all of those participating in MFP should receive standardized training.

But I also think that the other thing we talked about in the beginning that we haven't continued to do is the cross-training between the agencies and the standardized training for anybody involved in MFP. And I think that we have kind of lost sight of that. And I think that it would be good to re-group and how we can move forward with that.

Several respondents suggested taking "a step back" at this juncture in order to re-evaluate the program with input from all stakeholders. Respondents suggested looking at the first years of the program – the challenges and successes, the nursing home closures, current transition process, and consumers served – and use that information to re-evaluate current processes and procedures.

We've been moving so fast – I think it would be nice to stop and re-group. I know that we are meeting our goals on paper, and I know philosophically and I'm totally on-board moving forward, but I think that some of it because of the nursing home closures, those processes, that we need to take a step back because that all happened so fast. And my concern, in general, is that speed doesn't always mean success. And do we really mean to put such tough time frames on the TCs

… You know, and what is really possible is that the person is not put in a situation where maybe all the supports and services are not in place that everybody had envisioned. … I just think that there is a lot of pressure with deadlines and dates and you have to be cautious and conscience of that.

But I think that that – with the nursing home closures, that we've gone through two years in a row… I think that we kind of need to take a step back and look about how we can do this differently. Because we learn something new every time.

To be successful, proposed changes should be reflective of the needs of the transition coordinators and their teams. It was mentioned, who better than the transition coordinators know what works and what does not work as far as transitioning the consumer goes?

If there are going to be changes being made, I would hope that the TCs would be included, because we are the ones that know it the best - or at least know the nitty gritty pieces. So I am assuming that the workgroups are getting together to discuss process, different processes within MFP, and who knows it better. Who knows what doesn't work best. But I should be [involved] because MFP is kind of a work in progress and there are things that do get changed when people voice that they are not working. So it would be good to know what is being discussed, what people are thinking about moving forward with. Because I hate to think that things are going to be changed and people think it's for the better when it really is not, you know. I hate to think that people are doing a lot of work for something that might not be the best. That's one of my main worries in general.

Conclusions and Recommendations

The third year of CT's MFP demonstration included many achievements and successes. The number of individuals who transitioned continued to grow beyond the original goals of the program. This contributed to a growing shift in thinking and culture change. This culture change was also evidenced by the risk mitigation policy initiated in this year which received support from the Department of Public Health, as well as a continued emphasis on a person-centered approach. The commitment and involvement of multiple diverse partners continued to help the project grow. Respondents found many opportunities for communication and team building, seen especially in the increasingly successful and collaborative transition teams. The ability of the program to change and be flexible in meeting challenges as they arose also contributed to the success of the program.

Year three experienced challenges, some totally outside the program's control. Connecticut's deficit, reduced funding for community services, and hiring freeze greatly limited the effectiveness of the program in year three. The nursing homes closures put extra strain on individuals already stretched to their limit. As in years past, there continues to be a growing need for enhanced community supports, such as more inclusive waiver services, as well as the need for more affordable and accessible housing – the lack of which can lengthen the time to transition. More standardized education and training, specifically for field staff, was once again a priority for many respondents. Respondents from different parts of the program continued to ask for increased communication from Central Office, including regular project updates. While acknowledging the need for flexibility in a demonstration program, diverse respondents also saw

a need for more consistent policies and procedures, hand in hand with increased direct and timely communication when changes were made.

Recommendations from this evaluation include:

- Standardize education and training
- Improve communication of program policies and changes
- Assess workgroup structure
- Involvement of more consumers
- Involvement of TCs in discussions of program changes
- Take a step back and re-evaluate
- Improve diversion
- Engage nursing homes pre-transition
- Recognition programs

Standardize education and training

Standardized education and training is clearly needed for everyone working in the MFP program. Most frequently mentioned was the lack of standardized, ongoing training for transition and housing coordinators. This could include not only a core curriculum, but new modules which would cover program changes. Theses new modules could also be an effective way to communicate policy and procedure changes to all involved, such as contractors, access agency care managers, and nursing home social workers. It is also important to continue and enhance the outreach and education of home care providers, nursing home staff, care managers, and others regarding risk mitigation and liability concerns.

Improve communication of program policies and changes

Although some respondents were satisfied with the current communication process, others desired more consistent and structured communication. Respondents requested regular procedural, policy, and program updates, utilizing diverse modalities such as email “shout outs,” newsletters, an MFP website, or electronic monthly reports. In addition to more standardized polices and procedures, enhancing the process to communicate program or plan modifications to all involved could help ensure that everyone is uniformly kept up to date. Revisions or changes to any discussed action or plan especially need to be communicated quickly and effectively. This gap in communication could potentially be mitigated with the creation of an Assistant Director position, which would facilitate comprehensive and consistent communication, follow through, workgroup support, and other details.

Assess workgroup structure

Only a few workgroups met regularly during the third program year, while others were inactive or cancelled frequently. Workgroup members wanted to meet consistently, particularly those who attend the contractor and transition workgroups. Respondents identified inactive workgroups they considered essential to the MFP program, including housing, quality management and discharge planning.

Many workgroup members asked for greater Central Office and Program Director support. This included MFP staff support to create agendas several days in advance of the meeting, to facilitate the meeting, and to take and distribute minutes shortly after the meeting. Advance

agendas would allow workgroup members to prepare for the topics to be discussed. Workgroup members also sought the opportunity to suggest topics for future agendas. Appointing substitute MFP staff could avoid canceling a workgroup due to unavailability of the regular staff person.

Multiple respondents requested that Steering Committee handouts and materials be sent electronically before or soon after the monthly meeting. Respondents suggested restructuring the Steering Committee's minutes to identify action items which would be followed up on each month. Action items would include "homework" for members in order for the group to have a more productive discussion.

Involvement of more consumers

The program would be enhanced by increasing the involvement of more stakeholders and people with disabilities. Mandated by the protocol, a majority of people who sit on the Steering Committee are people with disabilities or family members. One respondent felt that this might not be the most productive way of utilizing the unique feedback these stakeholders could provide to the Steering Committee or to others involved in the decision-making processes of MFP. Working with stakeholders, the Steering Committee could find alternative ways to include stakeholders, such as regular meetings and discussions with people with disabilities including consumers who already transitioned.

Involvement of TCs in discussions of program changes

Transition team members made specific recommendations based on problematic situations they experience regularly, such as medication administration limitations, a consumer's lack of independent living skills, and assignment of transition coordinators to geographically distant consumers. The transition coordinators are on the frontline of the transition process; they have valuable suggestions for enhancing the program and supporting consumers. Implementing a process for soliciting suggestions from transition coordinators could lead to further program improvements.

> *In a dream world, I would like to see a transitional unit in a facility where clients could gain some independence in ADLs [Activities of Daily Living] and IADLs [Instrumental Activities of Daily Living] while in the nursing home before they leave for home. … It would be wonderful if we were all integrated and friendly so that the PCA in the nursing home could be the PCA at home for a while. It would make for a better transition. We've got opportunities to develop new systems, so that's some of my thoughts about that.*

Take a step back and re-evaluate

One common theme in year three was the desire to take a step back and re-evaluate the way that things are done, to discover some of the best practices and communicate these to all individuals involved.

> *How can we improve on what we are doing? How can we streamline things – what did we learn? We're not really sitting and taking the time to [think about] what could we do better – what have we learned – and how can we change things to move forward? I think we need to do that, and I think not for the lack of want to do that or for anybody avoiding it, it's just an issue of time and all the other demands that people have … But say we had these … nursing home closures, can we pull the team together and say, what did we learn? What did we learn from this experience, and what can we do better, and what did we do really well? What can we replicate, because now, guess what, another nursing home is*

announcing that they are going to close. So learning from the experience and pulling a team in and having that kind of communication.

One respondent suggested this re-evaluation process include a follow-up discussion of the recommendations found in the MFP process evaluations. Specifically, Steering Committee members would read the recommendations before the meeting, in order to have a productive discussion of which ones to prioritize.

Improve diversion

Some of the respondents felt that more should be done in the way of preventing people from going into nursing homes in the first place by having more upfront, accessible community supports. As stated by one respondent, people should not have to be in a nursing home in order to be eligible for MFP, but that there should be an eligibility factor outside of being in a nursing home to easily access these supports. Suggestions related to this included greater flexibility between waivers in order to utilize the different community supports provided in each one.

Looking at our own policies and procedures, and making us stop, look, and think about maybe some of our policies and procedures are assisting people into nursing homes, and what can we do to … keep them in the community. So I think that it is the conversation that many of us have wanted to have. It has given us permission to have those conversations – kind of put it out there.

Engage nursing homes pre-transition

As mentioned above, transitioning to community living would be easier for many consumers if more education and life skills training were available prior to transition. Gaining nursing home administrative support for this process is essential. For example, nursing home staff could be more involved in getting the individual more prepared for living in the community and managing some of their own healthcare issues, including administering their own medications. Physical therapists at nursing homes could also be more proactive doing assessments on the consumer's prospective home.

Everybody in the nursing home seems to be on [insulin]. It would be more efficient to teach people while they're still in the nursing home how to read a glucometer and the level of insulin they need. We want people to be more confident when they go home.

Recognition programs

One respondent felt that more positive attention could be directed toward transition teams and others directly involved in the transition process, including consumers, with a statewide recognition ceremony. Another respondent spoke of wanting to "celebrate the successes" of the program as a whole.

There needs to be more celebration of the work the TCs have done as a group. They take on an awesome responsibility and we should celebrate it as a group. I give positive feedback to my staff, but all the contractors should be in on the celebration. … You don't see how much it means to people to be transitioned until you work first hand with them. Some of this could be conveyed during a recognition ceremony and might help generate more enthusiasm among staff for people they work with. I'm not saying it would address [transition coordinator] burnout, but would help make their work more rewarding if they're recognized.

I also think that the larger it gets and the more people we move, that we sometimes forget to celebrate the successes and… I think that it is important to celebrate the successes.

Growth of Connecticut's Money Follows the Person program over the past year:

- Connecticut's Money Follows the Person program continues to grow and meet the needs of individuals who desire to live in the community. That consumers are now asked periodically, "Where would you like to live?" is the first step towards offering the benefits of MFP to every single resident of a nursing home, a truly person-centered decision.

- The MFP program initiated the risk mitigation policy, enlisting the support of the Department of Public health and reaching out to community providers.

- More and more individuals continue to successfully transition from nursing homes into the community – this feature alone is causing system change in Connecticut.

- Culture change is becoming more evident, as public opinion continues to shift, accepting that people who were living in nursing homes are capable of living in the community safely with supports and services.

- Connecticut's leaders and legislature are becoming more aware of the MFP program and its success, and increasingly see the multi-level value of rebalancing the long term supports and services system.

… that we can move [someone] out and surround them with supports and services and see that individual flourish does more to change the long term care system than to talk about the principles and the values and risk. To see it actually happen provides us with real life experiences and stories to tell… So it's not so much the number of people that we move out, it's the successes and the stories, and seeing what happens when people have that opportunity to choose and then flourish.

Appendix A: Workgroup Descriptions

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
Steering Committee	"Goals and objectives. Yes, if you look at the protocol consistent with the by-laws. It's supposed to be policy advisors for the project. That's the role." "The Steering Committee meetings are, I think, what people want to hear. I think that the format is what people want and that is update on MFP, you know, Dawn, is really the meeting. She is giving status reports of the project and its many components."	Once a month. Satisfied with frequency.	Yes	Yes	"A lot of things get talked about at the Steering Committee, but there is really not any power. It doesn't seem that there is a lot of power to influence from the Steering Committee. So they come together and Dawn reports out and there's a lot of great ideas around the table, but I'm just not sure that it gets followed through on always." "[MFP] need[s] to consider other communications methods other than face to face – like an email with the project manager's monthly report instead." "I think that people raise really good questions and some are addressed...and what a gift to have people from all of these different agencies, or within DSS, to answer the question. I hope stakeholders realize what a gift that is and how rare that happens. So that these people from the state agencies are forthcoming is really unprecedented, it doesn't happen in other circles."
By-laws		Did not meet in third year of project.	N/A	N/A	
Contractor	"I think the goals are to make sure all the contractors are all on the same page and it gives Dawn an opportunity to deliver the message to all the contractors, to share the progress of the project	Usually once a month. Satisfied with a monthly frequency.	Sometimes	No	"The productivity of each meeting sometimes could be better, but that is more of a process, a meeting process…. I'm a different kind of person, process orientated, goal oriented, let's get this done. Put it on the agenda, let's come up with a solution to find out how we are going to make it happen. Whereas a lot of times the meetings are a venting

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
	and share future visions of the project."				opportunity." "I think that what would be helpful, as it has occurred on some occasions, that a few days before the meeting is that an agenda is sent out."
Evaluation	"The goals really were to evaluate the client satisfaction, was the primary evaluation. And … they have been working on dashboards to get snapshots of the quality of life and sharing that with folks."	Every 3 months. Satisfied with frequency.	Yes	Yes	" I think that the experience has been positive. It is fairly limited – we only meet quarterly – and it has advanced to the point where we meet via telephone which really serves my needs very well. So I think it has gotten even easier to participate and more focused because it is further along in its process." "So the meetings are run by an agenda and materials are distributed in advance of the meeting. The meetings begin on time … there is active participation, and they are well facilitated meetings. I think that people in general are pretty well prepared. They are movement oriented, so there is a reason for the meeting that we have."
Hospital discharge		Did not meet in third year of project.	N/A	N/A	
Housing		Did not meet in third year of project.	N/A	N/A	
Nominating		As needed. Did not meet in third year of project	N/A	N/A	
Policy		Did not meet in third year of project.	N/A	N/A	
Quality improvement		Has not met	N/A	N/A	

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
Transition	"That particular workgroup was to basically ensure that there were opportunities for discussions about the challenges in transition, and so, looking at the factors that led to that issue and then trying to identify how we could address them."	"They were monthly at first."	"There were agendas at first, not so much now."	Not consistently	"For the transition workgroup, it was an opportunity for us to discuss some of the issues that come up with transition. So a lot of the discussions ended up being about housing barriers, etc., but really sorting out procedurally when we encounter problems with transition, what can we put into place to support that. A lot of it is not client specific, but kind of program specific, about what we can do to remove those barriers."
Waiver manager	"…what we talk about is the development of quality standards and creating greater uniformity across waivers so that when folks do transition, it is seamless."	Monthly	In the form of emails	No	"We…look at our determinations of eligibility and see whether they are compatible with one another, so there is no disparity in regard to who is selected for waiver services, things like that." "Typically there are agendas, but they are more often in the form of emails, and if there are action steps then we deal with them there."
Workforce development	"The vision of the subcommittee is to build and support a robust long term services and supports workforce that is sustainable, respected and skilled. The workforce will support the dignity, choice and autonomy of individuals with disabilities and older adults."	Once a month Satisfied with frequency.	Yes	No	"… Workforce Development is more visionary in terms of the way that it operates – always looking for new partnerships, always looking to move the agenda across multiple moving parts in our state, creating partnerships – so it is action oriented." "It was clear that we are not the workforce system. That we needed to go to the workforce system and the people that are engaged in developing a workforce. [Now] people are at the table are those that really need to be there. Now we have community colleges and workforce investment boards and people from the various departments all engaged in this discussion."

Appendix B: Key Informant Interview

Program goals

1. Please briefly describe the CT Money Follows the Person program. What is it trying to accomplish? What are its goals?

Role

2. How are you involved with the MFP program? What is your role?

3. Are you on any committees, workgroups, or transition teams?

4. What has your experience been like?

   4a. Is there anything you wish had gone differently, or that you would have changed about your involvement in MFP?

Meetings/Workgroups (only ask people representing the Steering Committee or active workgroups)

5. Describe the current [workgroup, committee, or transition team] meetings.

   5a. How often do you meet? Is that enough?
   5b. What are the meetings like in terms of interactions or process?
   5c. Is there a facilitator? Are there agendas or official minutes?
   5d. [If no] Would having this make a difference? Can you tell me more about that?

6. What are the goals or objectives of the [insert name of workgroup, committee, or team from above]?

7. What progress has the group made toward achieving those goals?

8. What has facilitated or limited the progress of the group?

9. What changes would you recommend for your [workgroup, committee, team]?

Structure and process

10. Is there anything you would like to see changed about the structure of the MFP program

11. How are you kept informed about the activities of other workgroups, MFP staff, or other involved individuals?

12. Are there things you would change about the MFP communication process?

13. Do you want more information about the project, beyond your role?

14. I'd like to ask you about the 24/7 Emergency back-up system. First, please describe the system and how it works. (What happens next?)

    14a. Is it operating as expected?
    14b. [If No] - Can you tell me about that?
    14c. Do you have any suggestions for how to improve it?

Partners

15. Describe the interaction between the different organizations or groups which are working together on this program. (Probes: How well do they work together? How do they resolve any differences when working together on the program?)

Progress

16. In your opinion, what have been the major achievements of the MFP program over the past year (since DATE)?
    16a. What has supported or facilitated these achievements?

17. What barriers or challenges has the MFP program encountered in the past year (since DATE)?
    17a. What could be done to prevent or overcome these difficulties in the future?

Risk mitigation

18. What are your thoughts about the new risk mitigation policy and the Participant Risk Agreement? (If they don't know what it is say: the form signed by the consumer and care manager that lists potential risks in their care plans and steps to mitigate the risk, which is backed by the CT Departments of Social Services and Public Health. If they still don't know about it, just record that). Probe if needed: What do you think are the pros or cons of using this form?

19. Did you attend the June 27, 2011 conference on informed risk, entitled "The role of informed risk and choice in decision-making?"
    19a. If Yes: What did you think of the conference?

20. If you have direct contact with consumers, do you talk to them about risk mitigation and informed choice associated with living in the community?

    20a. Is this a new practice or something you've done for a while - elaborate?
    20b. What impact have these conversations had on consumers' choices or plans for living in the community?
    20c. Do you incorporate the Participant Risk Agreement as part of some consumers' care plans?

Program activities related to systems change

21. We are interested in any changes in CT's long term care system.
    What MFP program activities have the biggest impact on rebalancing CT long term care system?

22. Is there anything that you would like to add?