# Money Follows the Person Rebalancing Demonstration

## Process Evaluation
## Year 7
## January-December 2015

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# Table of Contents

## Introduction

Information for this process evaluation came from the analysis of interviews with key informants reflecting on the operation of the Connecticut Money Follows the Person (MFP) Demonstration from January to December, 2015 when the seventh year of program operation ended. The annual process evaluation aims to monitor program activities and determine how well they are delivered and to investigate whether program resources are benefitting consumers. In addition, the process evaluation helps determine what is not working and provides information to improve implementation and strengthen program effectiveness.

MFP involves numerous stakeholders at various levels, including administrative staff, MFP contractors, MFP workgroup members, Medicaid Home and Community-Based Services (HCBS) waiver managers, Access Agencies, and field staff who work to transition consumers from nursing homes and other institutions into the community. Key informant interviews were conducted by the UConn Health, Center on Aging MFP evaluation team with a sample of these stakeholders. Questions for the key informant interviews appear in Appendix C.

## Key Informants

Twenty-five key informants completed telephone interviews sharing their experiences in the seventh year of program implementation. Administrative respondents included the MFP Program Director, a randomly chosen MFP Central Office staff person, a Co-chair of the MFP Steering Committee, two randomly chosen Steering Committee members, and the three Medicaid HCBS waiver managers. The directors or representatives of four contractors who employed specialized care managers, transition coordinators, and/or housing coordinators, and one fiscal intermediary also participated. Six field staff were interviewed: two each of specialized care managers (SCMs), transition coordinators (TCs), and housing coordinators (HCs). In addition, two Transition/Housing Coordinator Supervisors (TCHC Supervisors), and two Specialized Care Manager Supervisors (SCM Supervisors) were interviewed. Two facility social workers who worked with MFP field staff on transitions also completed interviews. Responses from all key informants, including comments and suggestions, were synthesized into this report.

Each interview assessed the respondent's observations and experiences about MFP program goals and progress, meetings or workgroups, communication, education and training, achievements/strengths, and barriers/challenges. All interviews were audio-taped and transcribed. On average, interviews lasted approximately 30 minutes. All were analyzed using ATLAS.ti, a qualitative data analysis program. Overall results of the analyses fell into four basic categories including achievements, strengths, challenges, and program developments. Appendix B comprises information on MFP committees, meetings, and workgroups.

- ➢ Achievements and Successes
- ➢ Strengths and Supports
- ➢ Barriers and Challenges
- ➢ MFP Program Developments and Rebalancing Effects, 2015

## Achievements and Successes

Achievements in 2015 identified by key informants fell under five categories:

- Number and Speed of Transitions
- Successful Transitions
- Continued Culture Change
- Partnerships
- Universal Assessment
- Other Achievements

## Number and Speed of Transitions

When key informants were asked to identify achievements in 2015, as in in previous years, several mentioned the number of transitions. A total of 723 consumers transitioned in 2015 which was more than 20% higher than in 2014 (n=578) (See Figure 1).

Figure 1. Total Number of Consumers who Transitioned in 2014 and 2015
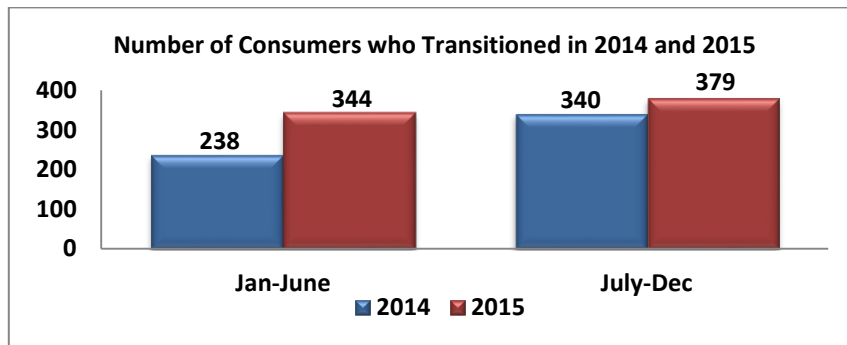


The average length of time from assignment to transition was 249 days for 2015 compared to 272 days for 2014 (See Figure 2). After using the team transition process for more than a year, the average length of time from assignment to transition was less than it was prior to using the team process for transitions.

Figure 2. Average Number of Days from Assignment to Transition
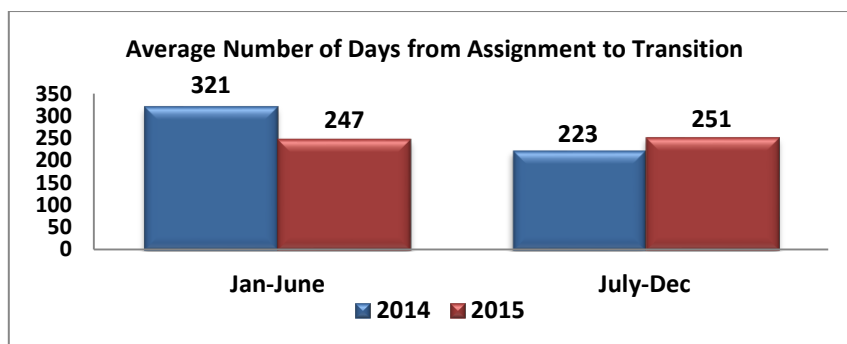


*Personally I think that I was able to exceed my transitions from the year before which is always a goal to help as many people as you can and put them back where they would like to be or help them start, create a future.*

*We just went to a regional meeting and they said Connecticut … is the fourth state to have the top numbers. So, I thought that was a major achievement.*

## Successful Transitions

The number and speed of transitions alone does not define a successful transition. Key informants were asked how they define a successful transition. They identified several components including having all home and community based services and supports in place and ready for the consumer on move-in day. The attainment of personal goals, a person's improved quality of life and the ability to sustain living in the community independently without re-institutionalization are also indicators of success according to key informants.

> *A successful transition to me is one where when the person gets home and the means to meet those needs are there and everything's been addressed. It's when they get home and they don't have meds, or they don't have any way to get to the doctor, or they don't have any food, or the services aren't starting for 3 days because it's a weekend. It's making sure, a successful transition is making sure all those I's are dotted and the T's are crossed so that people don't end up back in because of some failure in the system.*

> *We see a successful transition related to a person being able to realize more their personal goals in community living experience as opposed to just the brick and mortar, methodical, procedural transition into an apartment.*

> *I think a successful transition includes respecting the goals, hopes, and dreams someone has in returning to the community. That they have an experience in the community that causes them to feel fully engaged and participatory in that community and that their quality of life is one that they believe meets what their expectations are.*

> *I think someone who can live out in the community using the proper support services that they need and to remain independent beyond a 12-month period of time, then I think we've done our job.*

> *He had a problem with alcohol again. So we've had to work with him on getting some rehab. I don't feel that that's not a success. The fact that he's still in the community, he's participating, he's a member here, he volunteers once in a while. He's able to keep food on his table. Those kind of things I view that as a success. He's where he wants to be which is in the community … we're dealing with people with complex disabilities and multiple disabilities … to be able to help that person and they stay in the community I view that as a long term success.*

Successful transitions are a reflection on the role of the informant or agency within the Money Follows the Person demonstration. One informant felt it was important to note that gathering the information fully and accurately from the beginning reduces the time it takes to have a successful transition. Another informant felt communication with the consumer is necessary every step of the way prior to the transition. A housing coordinator said having the furniture delivered on time and all the services in place for the first day home contributed to a person's success. Another key informant stated that the transition to the home is not deemed successful if they are only interacting with staff members and that success may only be measured through the Quality of Life evaluations.

> *A successful transition, from my point of view being a discharge planner here, would be that the client, the customer of me and of the vendor, which is Money Follows the Person, that customer is satisfied. That customer is kept in the loop every step of the way.*

*I would define it as someone who's living in an environment of their own choosing with a reasonable expectation of safety and … but most important to me would be the response to the Quality of Life survey. I think it's not a successful transition if someone is still living in an isolated situation where they may only be interacting with their staff members. So really that someone is happy in the environment that they've chosen and that they have a good quality of life.*

Key informants reflected on transitions of people living in skilled nursing facilities for a long time and some spoke about their own personal transition stories. These stories are at the heart of what it means to transition successfully.

*I had one transition that I can think of; she was in the nursing home for an extended period of time. And when she finally got home, she called my co-worker the next day and told her that she woke up feeling like a queen. So just the fact that we can make these people feel free and independent and able to take care of themselves like really, I think is an achievement, one person at a time.*

*Many of us work in MFP in different capacities are drawn to it because of things we've done in our past and we know, we've seen with our own two eyes, people who were near death or never going to accomplish anything or never increase any of their skills and once they moved out of a nursing home they were cured. For lack of a better word. But they were, they have made just incredible achievements, accomplishments and strides in their own personal life and I think that that's hard to measure in data.*

## Continued Culture Change

As the public continues to learn about Money Follows the Person, consumers increasingly request MFP after hearing about the program. Less resistance to the demonstration in skilled nursing facilities is reported because social workers and other staff see the quality of life benefits, especially once people are transitioned and report feeling happier. One respondent commented on the increase in inquiry calls coming from skilled nursing staff. Another respondent reported on the dramatic increase in interest from the community in this past year alone.

*I think that ten years ago, eight years ago, nursing homes were not willing, were not too willing, to make referrals to MFP. Interestingly, we here at this agency get a lot of inquiry, telephone inquiries, from nursing home staff. And they are interested in helping a consumer transition to community living which is exciting. It's a culture change. And several nursing homes in our area have spoken to us about, while individuals are transitioning and their daily census is decreasing, they're thinking about how they can reinvent themselves so that they can still have some long-term care to be responsive to their own individual market or geographic area while being innovative, because they need to be innovative to financially survive, and yet help people in the community.*

*If more like touting of the successes could be made somehow, that's what brings people around. I think a major improvement in 2015 over the previous 2 years is the level of resistance at the nursing home level has reduced because they see that we're getting people out and they're happy. Our interactions with the facility social workers has greatly improved because they trust that we're good at what we do and they know people are happy once they get out.*

*And I spend a great deal of time on Money Follows the Person tasks because I always, I'm a huge advocate, I am a huge advocate. I have had upwards of 25 people on. And I put everybody who can go on, I put them on. And I do so because it's better than staying here, going to a shelter, or going home unassisted.*

*I think a lot of people thought it was going away and was one of those fad things and that the state wasn't really going to put the money behind it and I think that people are starting to understand that they do.*

## Partnerships

Finding housing through partnering with agencies and other housing coordinators was reported as a growing practice in 2015. Quick communication and the sharing of resources saves time as well as provides an opportunity for yet another consumer to find housing in their region and in other parts of the state.

*We share our resources in so far as an apartment falls through for someone, I'll get a message from a Housing Coordinator or I'll send a message to a Housing Coordinator; and say hey, look I've got an apartment here, can you use it and this is the contact information. So that even if my consumer is unable to use that apartment it's out there for somebody else. So it's the sharing of resources I think that we do well.*

*… In our region and further afield because sometimes we do get individuals, and say my area is the northwest region so I'll have somebody who lives a nursing home in Waterbury who wants to live on the shoreline to be closer to family … we share our resources well, contacts, telephone numbers, everything.*

*I also think we made really good strides this year with the housing authorities. The working partnership with them is much better over 2015, that that was all worked on and is going much better.*

Good partnerships go beyond just housing coordinators. Relationships with nursing homes with programs such as right-sizing awards continue to show the industry that MFP is willing to partner with them to take on the change.

*I think the right-sizing awards that were made and the relationships with nursing homes along the way are absolutely outstanding in showing the nursing home industry that we're there to be a partner if they want to come along with the change. So I think that that's been excellent.*

One informant acknowledged the challenges inherent in partnering with multiple agencies, and underscored the importance of having a common goal and individuals willing to lead within departments participating in the partnerships.

*I think it's been challenging to try to collaborate with so many different people and so many different entities because the success of rebalancing isn't naturally dependent upon just like a single person, like the project director. It's not that. It's about making sure that there's a common goal across a lot of different entities and a lot of different departments and then finding leadership within those departments to help lead.*

## Universal Assessment

Enhancements for the Universal Assessment (UA), a standardized tool that calculates consumer's level of need, have been ongoing since it launched in July of 2015 for a pilot group under Community First Choice (CFC) and MFP programs. Respondents emphasized the significant achievement of moving this comprehensive, person-centered assessment forward in

the State in an effort to better meet the social support and service plan needs of eligible individuals.

> *The Universal Assessment, which we already talked about, and the fact that it's here and it's been implemented. I think that that's an outstanding achievement.*

> *Well I guess one of the major achievements was coming up and implementing the UA tool. Because the assessment process with the Readiness Assessment and the tool was, I think the UA was an achievement in that area. I think it's a better tool.*

## Other Achievements

Other achievements mentioned by key informants include a broader systems change that supports the transition process including a range of services and housing options.

> *There has been the integration of screening for a brief intervention around substance misuse, so – but the major achievements are always transitions and broader systems change that has to do with adding on services, different types of services, and being responsive to needs and having housing options and anything related to systems change.*

> *I also think that, quite frankly, Community First Choice is – once we have procedures, once we have some clarity on process and we have written materials and guidelines that we can live with and live by, I think Community First Choice is going to be wonderful.*

> *I appreciate the motivational interviewing training that we all got. I think that's very helpful.*

> *I think as far as the modification process to people's home, I think that was easier to maneuver since we knew exactly who'd be approved. Contractors were – the system for contacting a contractor to start modification seemed like it was streamlined in 2015.*

# Strengths and Supports

The strengths and supports mentioned by key informants for MFP in its seventh year of implementation were similar to those from years past and included the team transition process; positive communication; education and training for TCs, HCs and SCMs; strong staff and stakeholder commitment to MFP and flexibility of the program.

- Team Transition Process
- Positive Communication
- Education and Training
- Commitment of Project Staff and Stakeholders
- Program Flexibility

## Team Transition Process

Begun in March 2014, the team transition process was fully in place and used throughout all of 2015. Each of five regions in the state had between 2 to 10 teams, composed of one or more SCMs, TCs, and HCs. All key informants were asked about the team transition process that was implemented in March 2014 – the benefits, challenges, program effect, and transition process recommendations.

Overall respondents viewed the team transition process as a program strength which contributed to achievements, such as increased number and speed of transitions, better partnering among agencies, enhanced collaboration and problem-solving, and increased support for both consumers and field staff. Challenges with the transition process in 2015 were

identified as well, including team stability, working with team members from different agencies, Team One structure, large caseloads, and Central Office delays with care plan approval.

<u>Advantages of the team approach</u>

As in 2014, key informants once again resoundingly reported that teams improved the transition process – increasing both the number and speed of transitions. Overall, respondents viewed the transition and team process working more smoothly in 2015. Two respondents mentioned that referrals from Central Office were more streamlined and sent to the field more quickly, while another mentioned that by 2015 the referral backlog was eliminated. Two other key informants mentioned that in 2015 more defined roles and responsibilities supported team partnerships and effectiveness.

> *Everybody has specific roles to play. … Everybody knows their role. Everybody knows what to do. So I think having a team, having designated people assigned to – like in the team and everybody knows what to do I think this makes process move faster. I think it's working well … We're moving forward faster, transitioning people faster because we have designated people who do different things.*

> *I believe that the power of numbers has made this successful – this program more successful. And when I say power of numbers I mean the power of number in a team. It's not just one person doing eighty percent of the legwork after that assessment is done. You have the Housing Coordinator really contributing to the transition. You have the SCM really contributing to the transition as far as services and making sure it is facilitated correctly. And all of us… will become involved in transitions to make sure that the continuum of care that's needed, that this client was receiving in the facility, is extended out into the community. I think we all have each other's backs … We support each other because we all believe in what we're doing.*

> *I think one of the big things is just the fact that we're seeing people earlier in the process. I think that allows people to identify those easier transitions. And by doing that it also means less people are just getting fed up and leaving on their own. Or less people are running into situations where their abilities decrease because I know a lot of times in the nursing facilities they'll stop doing physical therapy or occupational therapy and people actually regress. So I think it eliminates some of those cases. But mainly it's just getting out to see people earlier. I think that's one of the biggest strengths.*

Key informants also felt that the regional team transition process increased partnership and coordination among field staff and various contracting and community agencies. In the team approach, housing coordinators in particular are more cooperative with each other, working in partnership to find housing across the state.

> *The service is primarily provided in the community, but what the staff had told me is that having a team of three is a much better and more efficient way to provide service because often the housing specialists will step in for each other … I think the additional staff has allowed us to do our job better.*

> *… being able to identify housing maybe in the northwest corner for someone who wants to move out that way but is actually in a facility in south central. So the coordination efforts, I think, have improved our ability to do what we need to do to move them out.*

Key informants indicated that teaming people with different specialties benefited consumers and supported creative problem solving.

> *I think that, from discussions with the TCs, I think it's good because in our case, it's like a multi-disciplinary discussion or review of cases, and that's always good. So where*

*there's a person from one perspective paired with a person who truly is a community worker and knows what community resources to help individuals with once they get into the community combined with a more traditional social work supervisor, I think that's good.*

Other benefits from using a team structure included increased support for both the field staff and the consumer.

*I feel that I've had more support with my transitions when MFP went to the team model, as far as a team to encompass a consumer transitioning with MFP. I feel that there's more support to everybody involved. … a family member is trying to reach the Housing Coordinator with questions about the RAP, or maybe trying to reach the SCM. So I think with family members and the consumers knowing that they have a team around them, if they reach out to one person they know that the team will respond to some extent.*

In addition, team members identified many benefits of regular team meetings, such as group problem solving, team member support, identifying and overcoming challenges, and keeping the transition moving forward.

*For the team meeting it's usually myself [the HC], the TCs and the SCM. We go through our list of consumers and talk about specific things that might be holding up a transition, or just basically solidify transition dates and stuff for specific individuals. And so we talk about their cases, issues that have come up. Say for example if someone has been on the route for transition and then there's a setback within the nursing home whether it's a health issue or a fall or training for diabetic care and stuff. We're informed of things like that during that meeting.*

## Team approach challenges

Although overall the team transition was perceived as a strength and support, respondents also identified some challenges, such as team stability and cross agency teams, communication and coordination across multiple team members and consumers, larger caseloads with expectations for increased quicker transitions, and issues with care plan approval and Medicaid lookback timing.

As in 2014, maintaining stable teams, consistently working with the same team members, and working with teams whose members come from multiple agencies were mentioned again as challenges in 2015. Field staff remarked that different organizations have different styles or cultures which has the potential to cause some friction. Respondents noted that communication was easier when team members were housed in one place.

*The teams work well when they're in-house. Meaning when I work with my TCs and HCs at [agency], work out of the same office as I do. We work much more productively together. There's better communication. There's a hierarchy to go to if we need to. There's the TC Supervisor, there's the SCM Supervisor and we're all working together here.*

*When people do stay in their roles for like more than year, it really helps. There's a huge learning curve that has to take place. This is complicated work, and in the teams that have been stable, it's been a really good thing.*

A few key informants found that working with multiple MFP staff created some role confusion for consumers or facility staff and underscored the need for clear communication. It was suggested that coordination across multiple team members and agencies was also challenging.

*I think the challenge with the team model is that the more folks you have involved, the harder it is to coordinate services. Despite that, again, I've had conversations with the staff over time, and they feel – because I've asked them how's that working, is it effective to work together with the other providers, people who are doing different aspects of care – and they agree that that is a good way to work. Sometimes they said that the coordination of that has not been what it should be.*

*So consumers or their advocates. So sometimes they don't know what the timeline is, what the specific plan is, [who] the social worker is … with all the different facets of it. And I think it has improved having these Specialized Case Managers and having these teams. I think it has improved some, but I think that there's – but with that, there's kind of a not knowing who's doing what is what we've heard. And people not sure who to ask the questions of and where to go.*

However, this was not universally seen as a concern, as illustrated by this field staff key informant who felt the team approach made it clearer for the consumer:

*I like the team approach and the consumer knows who their team is. They know that the Specialized Care Manager comes out first, does the assessment, and then it's a TC and a Housing Coordinator. So they have their team of people that they know upfront who they're working with.*

One field staff described how keeping the focus on the consumer helps the team transcend challenges such as working with multiple SCMs with different styles or team process issues.

*The focus really shouldn't be on the SCM. It should be on the client. … We need to work as a team, and so if I have to work with an SCM that I don't normally work with – their style might be different and maybe they're not as involved, but the goal is still the same, to transition the person to where they want to live and how they want to live and make sure that they have the services that they need. So whoever the SCM is, you make it work.*

Although the new process created a faster referral, assessment, and TC/HC assignment process, a few key informants commented that the completion of other transition tasks were now more challenging. For example, while SCMs created a care plan very quickly, Central Office approval of the care plan was often delayed. This resulted in TCs and HCs working from an original care plan rather than an approved one. Confirmation of Medicaid eligibility has also become an issue. With the new process, TCs and HCs are assigned and begin working with a consumer very quickly, before Medicaid eligibility is confirmed. If DSS subsequently discovers the need for a five year financial review, this can halt the transition and rental assistance application (RAP) process, as described by one HC:

*What I don't like about it is the fact that housing coordinators are getting assigned too soon when folks aren't ready to actually transition to apartments. There's usually issues that need to be sorted out like [Medicaid eligibility] lookbacks and stuff. … Basically when I go out to see the consumer at the direction of the TC, it's usually under the premise that all the lookbacks have been completed. So I'm being told, after I've done the RAP application and everything, just to hold off until that process is complete. … once a consumer meets with the Housing Coordinator, they think it's going to happen within two or three weeks and don't understand that there's a lot of other little obstacles that need to be resolved before they can actually move out.*

*I think for the consumers, they're being seen a lot quicker in 2015 which made them happier … But being assigned to somebody a week a two after they've been seen by this SCM without knowing whether the state is going to approve their care plan I feel puts the TC and the Housing Coordinator in the possible predicament of disappointing the consumer if something doesn't become approved or they're not eligible for something which has happened.*

Field staff reported that the team transition process increased their caseload while creating pressure to get consumers out quickly, and TC/HC contractors indicated that an increase in operating costs associated with the regional process without any contract increase was problematic.

*I think in 2015 we were able to work with more people. I know it got rid of the waiting list and we've actually – we had our hands full. I know that for sure. I know I had my hands full. We got a lot of referrals.*

*It changed the whole way that we do things. … they went from having us do transitions that were in our geographical location to doing transitions all over the state. So what happened with that is that my mileage expense tripled. It's huge. … And so it's incredibly frustrating to try to operate that program with the same resources that we had when we started.*

*I think it gives, it's so far given the transition coordinators less time to get to know their consumers and … they spend more time than most of the other parts of the team with the consumers. And I also think that because of the way we're identifying people earlier, the less needy consumers are getting more of the attention because the focus is so much on more discharges. I think in our big push to get people out quickly, those people that don't have as many challenges are being pushed ahead for whatever reason. Sometimes it's just they complain more. Sometimes the SCMs are requesting because this person might have housing that we get them out quickly. It's just, and I don't think it's the majority of the cases but it's pretty close, that we concentrate on those that we can get out quicker. So it pushes those people that need a lot of assistance back.*

Field staff and supervisors who oversee Team One field staff also identified the Team One structure as challenging. In 2015, Team Ones consisted of one or two TCs and HCs working with between five to eight SCMs from three different waiver programs – DMHAS, DDS, and ABI. Team Ones functioned not as one team, but as three separate teams which happen to share one or two TCs or HCs. The three different programs have their unique transition process procedures, with differences in TC and HC roles and expectations, web use, meetings, and communication. Some TCs and supervisors felt the Team One structure made it especially difficult for the TC. For example, the SCMs in the differing programs were not aware of the competing demands on the TC's time for that week, such as other scheduled transitions. Lack of SCM-TC communication also meant that some Team One TCs were not aware of transitions until the last minute, making it difficult for them to complete their transition responsibilities.

*Team Ones, which is the team I'm on, have been problematic. The Team Ones are difficult because DDS, DMHAS, and ABI are the 3 outside waivers, so everybody reports to a different supervisor, and no one person is actually in charge. … There aren't usually 2 TCs, just so you know. We only have one TC if that. People tend to come and go. That's an issue, the stability of staffing. … We were all encouraged to update the web with any input. So you come back to the office and you type in the web and then people don't read the web, so you have to call them. And then you call them and you don't have a record of your call, so then you have to write emails. It's just communication is very*

*difficult when people are running in a lot of different directions and everybody reports to
different supervisors.*

## Respondent recommendations

When asked for suggestions to address the new transition process challenges, key informants
focused on both team structure and MFP structure and process.

### New process structure recommendations:

♦ Use one-agency teams as much as possible. To improve relationships and accountability
especially within cross-agency teams, set statewide caseload expectations for SCMs,
TCs, and HCs. Consider implementing a team reporting structure.

*I would definitely say having your teams work together within the same agency would
help. Role definition for TC, HC and SCM. It may work better if there was some sort of
reporting structure. Perhaps if there was more of a reporting structure from the HC/TC to
the SCM.*

♦ Screen cases before assigning to the TC or HC. Have SCMs evaluate the TC's
caseload, including the current caseload size and balance of easier and more
complicated transitions. Have the TC assign the HC after Medicaid and other RAP
eligibility issues have been resolved.

*More effective? Well, I guess that would be a matter of perspective. More effective for
me personally as a transition coordinator supervisor would be giving TCs more
manageable, and I guess consumer-based [caseloads]. And it should take into account a
blend of those quick transitions and the more challenging transitions. For instance,
people that need to hire their own personal care assistants and maybe have some
cognitive difficulties.*

♦ Reconsider the structure of Team Ones. One possibility is to create three Team Ones,
dividing the TCs and HCs by waiver program, so a particular TC or HC works with the
SCMs from just one or two waiver programs, not all three. One key informant's region
has used this model and found it to be successful. When asked if he/she wanted to
change the Team One, this key informant responded:

*No, I don't think so. I mean I think it works. I mean I think we work well as a team. Like I
said, it's communication whether in person is always best and if that's – if we can't, as
long as it's by phone or email I think we make it work.* TCHCSuper-1

### Overall MFP structure and process recommendations:

♦ Hire more CO staff to approve care plans and determine Medicaid eligibility at CO before
assigning the consumer to the field.

♦ Reexamine the state's focus on speed and number of transitions. Determine if this
encourages field staff to give more attention to consumers with fewer challenges.

♦ Increase post-transition follow-up. Most suggestions focused on reducing the TC's
caseload, so he/she could focus spend more time with his/her consumers post-transition,
focusing on integration into the community. One respondent suggested creating a
Community Specialist position.

*I think it could be more effective if we had some community specialists because often the
community involvement and the challenges we're facing in the community once the
person has transitioned take up a majority of our time. And it's more urgent things, so it's
tough to work from your to-do list if you're always handling other people's urgent matters,*

*that aren't always urgent but I think you're getting, that's who you're getting the phone calls from. So it's difficult not to work on those. So I think that would … make it more effective for the people that are actually working on the discharges.*

## The Team Experience recommendations

The team transition process is key to the success of Connecticut's MFP transition program. Approximately one third of key informants were part of a Regional Transition Team for at least part of 2015 – as either SCMs, TCs, or HCs. To gain a better understanding of how the team process is working in the field, these key informants were asked about their teams – team descriptions, meetings, communication, and best practices. Appendix A is a comprehensive description of the team experience from the field staff point of view. Included in the main body of this report are the team best practices identified by these field staff.

♦ Communicate daily with your team members. Good communication is key to working with each other and not duplicating work. This includes communicating updates, issues, and tasks among all team members in a timely manner, and meeting regularly.

> *Best practice would be communication and clear documentation. Clear documentation, communication in identifying strategies to reach a desired end or goal. Working from each other's strength, acknowledging the different perspectives that we all come from… working collaboratively to meet the best end or desired end.*

> *I think daily involvement between the [TC], SCM and the Housing Coordinator are needed for pre-transition people to make transitions happen quicker and more successfully. Honestly, I think daily contact is important … whenever that person is seen in a facility, I think that it has to be communicated. Daily interactions I think should be communicated with team members.*

♦ Meet monthly as a team. Field staff felt that an important part of team communication and cohesion are regular in-person team meetings. To be most effective, one team member recommended each person review their cases and prioritize the next steps ahead of time. One field staff also recommended one on one meetings with the SCM and the TC to focus on that TC's consumers.

> *I think the fact because we take time to meet. Even if it's not at the beginning of the month we'll try and meet later on depending on our Specialized Care Manager's schedule. It's the fact that we actually meet. I think that could be a best practice in itself.*

> *I think everybody on the team coming into the meeting with their ideas written out or listed in the order of what they think how the priority should be or what the major effort should be put on at that time so that you can come to some consensus on what should be done.*

♦ Delegate tasks and track completion for each case. Teams used tools such as timelines, action plans, and task lists. One team recapped the team discussion and next steps for each consumer in the progress notes.

> *I would also say it's best practice to update the [progress] notes in the web during your team meeting so that everyone is on the same page and the notes are getting updated frequently. And then I would also say developing some type of like flow chart or task list for your team so that everyone is on the same page on what they have to do and when it has to get done by.*

> *Again, in those [Team] meetings, they should be setting up action plans. … I think TCs and SCMs just take it for granted that everyone knows what needs to be done or everything is explained in that plan and I don't think that's always the case.*

♦ Assign team members, especially the HCs, when it makes sense for that case. In particular consider if Medicaid eligibility has been verified.

*I think sometimes the process just goes slower than [expected], so I think care plans can be approved faster and just to make sure that we don't put people on the team before they need to be in because sometimes housing coordinators will be involved before they need to be, and then that makes everything more confusing. So I think just staying on a good timeline.*

## Positive Communication

Effective communication is a significant piece of any successful program, including MFP. Many key informants spoke about several aspects of communication in the MFP program that were working well. Several had recommendations to improve communication practices. One respondent referred to communication specifically as a strength of the program, others reported communication challenges which are described further in the "Barriers and Challenges" section of this report.

*I really think it's [the strength] the communication throughout the whole program. You have people that are spread throughout the state and yet we're all working together. And for Housing Coordinators we send out emails when there's available units that we can't necessarily use to other Housing Coordinators in different companies. So just a matter of being able to share our resources with the people that aren't within our company and just spreading it out into the MFP world.*

Respondents were asked how they are kept informed about the current activities or new initiatives of Connecticut's MFP program. Their responses included a combination of ways they receive information: email, various meetings, quarterly retreats and reports, talking with others, and the MFP website.

*Most of the times I get updated about that either through emails or at the retreats that we have four times a year.*

*Conversation with other organizations that are participating as MFP providers. I'm involved with some things at the state level where I'll hear about some of those initiatives. I don't get anything via email, but I also do receive information, again, from our administrator, [Name]. A couple times I've talked with the staff. So various places I guess, and I probably have some decent knowledge of at least several of those new initiatives that you've mentioned, the most of which is probably the Universal Assessment.*

*Sometimes through our supervisor, after supervisor meetings we're given updates and through the retreats.*

*I think the data that's put together by UConn and those reports are really, really helpful.*

*… I think the [MFP] web too is something that, I mean, I stress with my team who I supervise is update the web because that's where we all have access.*

When asked if there were things they would change about the communication process, some key informants had recommendations like making a more formalized process, communicating in writing, using a centralized system that enables everyone to find out the information at the same time, and creating a newsletter.

*The communication process, number one, has to be more formalized with respect to here are the requirements, here's the process, and here's the person to go to if you have a problem that can't be outside of this process. And that's for all of the levels in all of the*

*programs. And then number two, we just – everything is segmented. The TEFT is here. No Wrong Door is over here. There's no understanding if they're ever going to relate. There's no access to a central plan on how the system is going to work. So there needs to be more formal communication. Communication needs to be in writing. There needs to be firm policies and procedures on all of the above. And there needs to be some description of progress of some of these programs and new initiatives.*

*I think, in general, more communication about specific changes in programs, processes, and guidelines would really, it would be really helpful for us to get written, clear communication that is communicated to everyone at the same time. Because what we find is that a lot of times there are changes in the paperwork or the way the paperwork is submitted, and those changes are not communicated in an efficient way. So I think it would be much more efficient, both for us and for the MFP office, if there was sort of a central or a centralized way we could be updated about changes.*

*I think these kinds of initiatives would be nice to hear about maybe like in a quarterly newsletter or*

Other respondents felt communication was working well and no changes are necessary.

*I don't think I would change anything. I think that the reporting is consistent. I think that the state is very on top of notifying us if something is changing or again if there's a new incentive.*

*I mean, we meet during the retreats so I'm sure we will be notified about new initiatives happening in MFP by [Name]. I'm sure that if anything comes up we'll be notified by email. That has been happening until now. So I would not change anything. No.*

## Education and Training

The Transition Coordinators (TCs) and Housing Coordinators (HCs) are required to complete an online education course and the Specialized Care Managers (SCMs) need to take the Motivational Interviewing training. This year respondents were asked what training or education they would recommend for TCs and HCs in addition to the required online course and if there was anything additional they would recommend for SCMs. Along with recommendations for additional training, key informants made positive statements about the current training.

*I thought that the Aging and Disability Specialist certification [online training] through Boston University was excellent. I enjoyed doing that very much.*

*I think the online training is great. I think that's a great practice. From the standpoint of somebody who was responsible for the training of your staff you were doing it all the time. So having the online training everybody gets the same information. They all get the same thing. I think that's a best practice. I think it's great.*

*I think the motivational interviewing that I took with Dr. Broffman was excellent. I think that that has absolutely helped me in my own job.*

*Now in the past two, two and a half years, and it may be concurrent with or in response to the person-centeredness training [included in the Motivational Interviewing training], I noticed that the goal sheets are very personal and that's terrific.*

Along with the positive comments about the current training for TCs, HCs and SCMs, there were recommendations made by key informants for additional types of training including: a general cross training so everyone has same knowledge base on specifically stated topics (e.g., mental health, team building, dementia, brain injury, substance abuse, common diagnoses). Training

about CFC and the UA were also mentioned a few times, as was a way to reinforce the training including opportunities to practice skills learned.

Additional training and education specifically recommended for TCs and/or HCs:

> *… more information around working with people with dementia. And also working with people more effectively with mental health conditions.*

> *… we had motivational interviewing training last year. That would be great for TCs and HCs, and I know some of them were included. So I think that should be standard practice for them, standard training for them.*

> *I think maybe if they had a training from Allied to understand our role would be good. I just think that a lot of agencies don't really understand what we're contracted for, what our exact role in the programs are. So I think a general training would be good to communicate to the TCs and everybody.*

> *I think for HCs I would recommend having a realtor come in in order to develop like bargaining skills.*

> *For HCs probably more about the inspection process and why it takes 15 days for an inspector to come out. I think more information on the availability of affordable housing in terms of new developments … changes in Fair Housing laws, anything concerning tenancy, and ADA ...*

> *I think a lot more training on like Medicaid, Medicare, and more insurance things would be helpful.*

> *I think a lot of stuff on housing. I don't know if Central Office – they used to do this I think way back when, but like quarterly housing meetings because I mean that's always changing and there's always something you're learning. And I think to pull the TCs in on that as well.*

> *For example, the Community First Choice, I think most of the TCs are somewhat in the dark about how that's working, or what our roles are going to be, or how that can even help our consumers. And I know we've touched on it in some of the retreats but it may need more focused, a more focused meeting where that's the only thing discussed.*

> *… I think probably just things on general health education, things maybe on chronic health and mental health conditions because we need to have a better understanding of the medical, the complexities that our consumers face … it's just something to know and be able to dialogue with our consumers about and helping them to establish basic healthcare baselines for themselves when they're transitioning back into the community, and how do they know that they don't feel well or what are some of the symptoms that they may experience and know when they may need to go to an emergency room or not.*

Additional training and education recommended for SCMs:

> *I think the motivational interviewing training definitely helps a lot, but I've noticed that the SCMs – granted I don't really know a lot about what the SCMs deal with – but I think given that we work with a lot of substance abuse populations, it might be best for them to have some sort of training related to that. Just because, when you're using motivational interviewing training and if you have someone that's just not willing to accept the fact that they have a substance use disorder, they might have to use a different tactic in order to communicate with them and educate them better.*

> *Follow-up training, yes, with the UA. And also more CFC training. So related to the paperwork and integrating CFC into the waivers. So having kind of ongoing or follow-up*

*training rather than being just in a position to sort of figure it out one by one as we go forward.*

Also, there were a few recommendations of additional training and education for all:

*I think for everyone in the process to better understand the roles a family caregiver plays … they should be trained on how to empower and get a sense of the caregiver's needs in it as well, in this transition. Because at the end of the day, it's the caregiver that oftentimes will be the consistent factor that's going to be helpful in empowering that consumer to live independently. So we talk about person centeredness, that's critical, and I think we do a good job with that sort of training – understanding the role of the person – but then I think also taking it a step further and where there is an informal caregiver involved, are we listening and really attuned to the needs of that informal caregiver support and how can we better empower them? I'm pleased that we're going to be moving forward with a pilot project, it looks like, to do some caregiver training. I think that's absolutely critical.*

*I think there should be a little cross-training. … if a TC is getting something I think it should be offered to the SCM and the Housing Coordinator. I think that there should really – we should all be on the same – have the same knowledge and resources at fingertips. We all have different jobs in different roles in the transition, but I think that we all should have a uniform knowledge-base.*

*I'll say this – it's same thing for them [TCs and HCs] and the Specialized Case Managers – there's currently no brain injury specific training … it's very difficult to create a care plan and look at transitioning someone without really having a good understanding of strategies for working with people with brain injuries and some of the challenges and specific areas that they really need to focus on … There's a real difference between the challenges and memory of someone with a brain injury as somebody with, for instance, dementia or Alzheimer's or something.*

*I'm not sure how you capture this or how people learn it, but sort of systems issues, like navigating complicated systems issues because you have DSS, you have DMHAS, you have nursing facility, and it's like all of these major system issues converge all around a transition, so it's kind of negotiating the waters and how to collaborate in that work. And I think some of the folks are just so young and coming out of school that that's a challenge, and that's probably a bigger reason why people are just turning over because it's very complicated. You're dealing with all kinds of systems issues, all kinds of personnel staff.*

## Commitment of Project Staff and Stakeholders

Again this year, the extraordinary commitment of MFP project and field staff was highlighted in the MFP process evaluation interviews. Key informants mentioned the strong commitment they see from the Dawn Lambert, MFP Program Director. Respondents referred to the level of transparency, commitment and ownership among stakeholders which was considered a hallmark of CT's MFP program. Several people also spoke about the teamwork and collaboration of Steering Committee members. Also discussed was the way staff support one another and work on transitions collaboratively as partners. The availability of staff at Central Office when questions arise was mentioned along with the importance of having MFP specific eligibility workers. The evaluation and data from UConn and the commitment of all staff to attend quarterly retreats were listed as strengths.

16

*I mean I think what is really important is that because we have our own team up in Central Office. We have our own eligibility team. So if we have questions on anything or SNAP benefits, like everything like instead of having to go through like regional offices for Medicaid questions and information because we have our own team there.*

*I'm a person who used to live in a nursing home a long time ago and I don't believe that should be, I think people should have options. I don't think that should be something that you're mandated that you have to go to a nursing home because the community support's not there. So I'm incredibly passionate about this kind of a program.*

*I think one of the strengths is UConn's research component behind it. I think it certainly gives some objective, gets some objective information about how the program's working from the person's perspective which is what's most important.*

*And so I think that it's got great leadership with Dawn and the ability to really kind of make a difference. And I feel that that's really singular to this Steering Committee. I think that we really do make a difference in terms of the direction and the challenges of MFP. I feel that everyone is really invested who comes to those meetings [Steering Committee] and it's always a very good dialogue with a lot of different perspectives … it may take a while as all government bureaucracy does – but things happen and things change as a result of it.*

*I think one of the significant strengths of MFP is in Dawn Lambert, because having worked, again with various state agency folks and people throughout my career, she is able to really look at the large picture and get things done. And I think she's the reason that we're kind of at the forefront of the country in terms of MFP. And so I think her willingness to both listen and her kind of passion for the program really is evident in terms of where we are.*

*… Eventually people do go out. Eventually people do get to their own place. And that is why I will always continue to refer because a nursing home is not right for several of the, many of the people who come to nursing homes. If I could be of any help to making this better, I really do believe in it, and I would be absolutely willing to sit on some sort of planning board or really be able to lend my vision – if it's important – to what would really work and really imbuing the resident and empowering the resident to drive the bus and get some of us who want to drive it kind of on the seat behind them.*

*And I think the meetings that they have, the quarterly meetings, for the large gatherings for the staff are really, really important because I really think that shows that, when you're doing transitions with people, it can become very isolating and you can kind of feel like I'm the only one doing this and nobody understands how hard it is and I think giving folks those opportunities to have those large stays when they get together and network and just kind of talk with the similar issues regardless of what waiver they're working in or what part of the state. I think that's really important.*

## Program Flexibility

It was evident from the interviews that many respondents valued the fact that as issues came up in MFP, and different needs were identified, new guidelines were proposed to meet those needs and many project staff had a chance to give their input. Partnership and good communication with partners was mentioned as contributing to flexibility in serving people.

*I've been working as a Housing Coordinator for MFP since 2013. And I think the tweaks that have been made along the way have made it a more efficient program. And I think as long we keep recognizing what's not working – or I should say what could be done*

*better – as long as we keep recognizing that along the way and make those amendments that I think we have a pretty good program that's efficient, that helps people realize where they want to be in so far as their level of independence.*

*Well I think that the fact that the MFP program at times can be flexible in terms of its support and ability to, let's see, to address barriers. So for example, if we find out that a consumer at the last moment is having problems with their Medicaid coverage; the MFP office can help to rectify the situation so that the person can move towards transition without difficulty.*

*Well I think in Connecticut the biggest strength is the amount of, is the housing voucher, having that rental assistance is huge. I think the fact that we have a lot of data and the project is continually making changes based on that data. I think that's excellent.*

## Barriers and Challenges

Similar to 2014, three central themes related to barriers and challenges were identified in 2015. This year, the most barriers and challenges were associated with successful transitions, followed by programmatic barriers and communication challenges:

- Barriers to Successful Transitions
- Programmatic Barriers
- Communication Challenges

## Barriers to Successful Transitions

Respondents described housing-related difficulties most often, followed by the length of time it took to transition and challenges with the look-back. Notably, workload barriers were not reported by respondents nearly as frequently as in the previous year. Other challenges related to successfully remaining in the community.

### Housing

Length of time waiting to get an apartment inspected for the Rental Assistance Program (RAP) continues to be problematic. Limited resources for affordable, accessible, safe housing for independent living also continue to be a challenge throughout the state. In addition, working with landlords and identifying housing for consumers with criminal backgrounds or those without an income is challenging.

*In terms of housing, I already said the housing coordinators are waiting a long time for an apartment to be inspected for RAP. There used to be a quicker turnaround time. I remember two, two and a half, three years ago there was a very, fairly quick turnaround time for inspections, but maybe there's just an overload in the system and there is so little housing. But that's a problem.*

*… It's always a challenge, certainly here in Bridgeport and New Haven where we work. There's slim pickings in terms of the housing … finding safe, affordable, accessible apartments or independent living locations where people can feel safe and so those with disabilities can navigate within that space and pretty much on their own.*

*But accessibility is a huge barrier. I've had landlords tell me sure you can go ahead and do modifications but you can turn the apartment back to what it was before the person moved in? We've had things like that. But that's basically it. There aren't enough accessible apartments available.*

*In regards to the housing process, I would say that a lot of the barriers have to do with the histories that our clients have. We've had clients that have evictions, they have*

*unpaid utility bills, they have criminal backgrounds. And it's really hard to find landlords that are willing to accept these people. So it's just a matter educating the landlords, telling what the program's about, and just asking them to give them a chance.*

*I can talk about folks who have no income that makes it difficult. It would be nice if they had income or at least started an application for social security disability benefits prior to a referral. Because for me when landlords see that an individual doesn't have income it's like okay, so how are they going to pay for the utilities? How are they going to purchase food? How are they going this, that? And what happens if their utilities are shut off – who's going to pay that? Will your agency pay that?*

## Length of time to transition

Specialized care managers, transition coordinators, transition and housing coordinator supervisors, nursing home social workers, and several Steering Committee members voiced concern about the often lengthy transition process. Reasons cited as most problematic in slowing the process down included waiting for a neuropsychological evaluation to be completed for people with brain injuries, waiting for PT evaluations or necessary equipment (e.g., working with the facilities to get the necessary equipment certain consumers need), waiting for a care plan to be approved by the state, or working with consumers with short Ascend dates.

*Yes, from what we hear from participants, and again what I've heard at the Steering Committee, I think still we have – it's still a very – it takes way too long to get people out, and the whole process. And I think for people with brain injuries some of that has to do with getting the neuropsychological evaluation, but I think that we still have – in my mind it still takes far too long to get people out under the program, and the communication is part of that.*

*But also PT evals – we have – that's a challenge. Some of the facilities don't want to do them for us and that's always a struggle.*

*And challenges too, in some cases, some of the ABI, some of the more difficult cases to get DME [Durable Medical Equipment] that has to be justified that could be a little challenging. For example, say if someone doesn't meet the criteria for a bariatric hospital bed, however if they're under the weight limit, but they might be - the bed like a standard hospital bed might be a little too small for them you have to justify why one is needed.*

*I think that the care plan is probably the biggest thing that slows our transitions down. I know there's only one person currently working on approving them, but sometimes when we have Ascend issues, it slows down the process for us.*

*I think the challenge was the amount of referrals, and being able to prioritize because everybody believes they're a priority. And but for me it was basically okay, trying to look at the Ascend dates and seeing when this person had to leave. One of the biggest challenges in 2015 was that we got a lot of people that had short Ascend dates. So I would be assigned, say for example, in October to someone who was going to leave in the middle of November which really isn't enough time to find housing for somebody with no income and poor credit history. That was one of the biggest challenges for me.*

To complicate matters, it was mentioned that delays in care plans can be associated with consumer disengagement which has the potential to further delay the transition process. In some circumstances, a consumer's lack of trust and confusion during the process further contributed to transitions not occurring in a timely manner. Insufficient communication between team members, especially when working out of different agencies, was mentioned as another contributory factor in slowing the length of time to transition.

*Well, I think the SCMs are right on target with their care plans. But I think what's happening is because there's a lengthy time period to approval at times that the consumers are becoming disengaged in the whole process.*

*Really early on, yeah. Because sometimes it takes a lot of – it takes folks some time to decide whether that's what they want. Do I want to work with someone who's going to know most of my business and credit history and what I can and can't do? They feel very vulnerable and putting their trust in someone who's going to find them adequate housing and set up all these things for them – It's a lot to think about when you say, yeah sure I'll allow you to steer me this way until I get out, and share information with you – that sometimes you get folks that just clam up and no longer want to share information because it's too much for them ...*

## Look-back

Respondents mentioned that the team, particularly special care managers and transition coordinators, often find out late that a consumer requires a look-back for a Medicaid application. To complicate matters, it is often not clear who should be gathering all the information needed in the process of looking back and this confusion hinders the transition process significantly. The process is reportedly more challenging for consumers who originate from other countries.

*… It seems that the team, the SCMs and the TCs, are finding out very late when consumers require a look-back or other eligibility requirement issues, and that's a problem. It's a real problem … and then there's the issue of who is supposed to be doing that to begin with. If you're a DSS worker and you're working on Medicaid, who's doing the look-back, period? Who's getting all the information? … a lot of our clients are from another country which makes the look-back even more difficult … obtaining the IDs and the birth certificates is a large roadblock in our area. A majority of our consumers, according to the TCs, have no forms of ID, including Social Security cards, and consumers can't apply for Medicaid, RAP, housing without the IDs. And so we're just running around helter skelter to get that information.*

*I'm finding that that was happening with probably one in every three consumers. … I can tell you the major hurdle has been the financial lookbacks coming into play two, three months after I've developed a relationship with a consumer. We're moving forward with housing, and we're being notified that now they have to pull a full five-year lookback. And these people, they feel like the wind has just come right out of their sail.*

## Workload

Contractors were especially vocal in sharing concerns about caseload size and the challenge of gathering a lot of information for a number of consumers in order to move the transition process forward.

*So it comes down from a management perspective of being able to manage all of this information flow for all of these consumers because of the lookbacks, because of the need to get the IDs. And when you're working with 30, 35, 40 consumers at a time, and you're trying to transition some of those, it just becomes a juggling act and paper trail.*

*Well I mentioned the caseload size before. And again, that was a question I asked of our administrator here earlier, and he tells me that our caseload per case manager is probably around 25, I believe, or a couple more. It depends. So I think always the size of the caseload is important so staff people have more ability to spend more time with fewer clients. So I think that's one issue.*

Other challenges included problems encountered with the discharge process itself and difficulty in coordinating meetings with nursing facility staff, particularly social workers. Some respondents expressed concern that lack of independent living skills and a paucity of community supports combined with perceived pressure from Central Office to move people out more quickly even if they're not prepared, creates a transition barrier.

> *But discharge is fragmented. I always hold my breath when a Money Follows the Person person leaves. I always give them my business card. I always tell them we're 24/7. The anxiety that these folks feel is tremendous. Some of them have been in an institution for a year, 2, 3. Some of them are quadriplegic folks who got long-term approval, but because they're 44 years old, they want to go out into their own place. If I had my rehab director on right now, she would be beside herself. We just discharged a quad person who is a quad who has steps to get in and there's no ramp.*

> *The most challenges I encounter are probably with the social workers at the nursing home. Some of the administrators are not too familiar with our program or know exactly how it works. So sometimes they don't want to have meetings or don't want to help out with certain things that need to be done for the consumer in order to leave the nursing home. But eventually we just educate them and it gets going to where it needs to be going.*

> *The feeling that they need more skills training and unfortunately with the pressure on how many and how fast the consumers don't always get the skills training and the peer support that they need. And they don't always get the deinstitutionalization help that they need before they transition out. And so they have an institutional mind when they're out in the community. And they have an expectation that things are going to be done for them like they were in an institution and that's not what happens when you're living in a community. So we have them call like how come you're not doing this for us? Well you're in the community now. And I find that in comparing to earlier when there wasn't so much pressure on the time and the number we were able to give a little more time to each consumer and that consumer had a better chance in my opinion of success when they moved out because they had more of the skills that they needed in order to cope with being out in the community.*

An additional challenge mentioned by respondents addressed concerns that consumers with more complex needs often have greater difficulty remaining in the community safely.

> *I think what I see, in brain injury one of the barriers is that on MFP you can only get someone out at the level of care at the facility that they are in. And with the ABI Waiver Program you – which is what they would be transitioning too – the funding is up to 150 percent. And so I think for people, whether or not it's a brain injury or anyone who has very complex needs, it's much more challenging to get out, to be able to safely live in the community at that basic nursing home level of care.*

Respondent recommendations

When asked for suggestions associated with transition barriers, respondents offered the following recommendations:

♦  Implement better processes to address housing challenges.

> *I think that it is still very, very difficult for staff to find housing, and there are other barriers that we need to spend some time on this year maybe using the Lean process to streamline everything from security deposit to rental assistance to working with the*

*housing authorities and identification of housing.*

*I would like to see MFP at some point in the future be a leader in taking the state to the next level on creating housing that is better housing not just another high-rise, low-income or low-to-moderate-income housing complex like we have in most of our urban areas. I think that needs some work.*

*Regarding home modifications I think that we should have – right now we have choices. There's like 15 or 18 different contractors throughout the state. Some of them don't work in our area, but I think each region should have their own maybe like three or four different contractors to choose from.*

♦ Resume quarterly MFP housing meetings and include TCs/HCs.
♦ Improve initial screening process.

*I think for a TC or a Housing Coordinator, I think what would make it helpful is that when you're being assigned to a new client that … if there is a financial look-back needed, that this is something that the DSS when they're screening the application will see that this is a necessity, and they start the process immediately before a TC even becomes involved.*

*Well, to get somebody to the financial eligibility income level sometimes people need to have these pooled trusts established. And I do see when I am getting a client assigned to me that might not have the care plan approved, fifty percent of the time they already know that a look-back will be necessary and that screening will be needed. … So it seems like half the time this stuff has been looked at and processed before being assigned. So I just think a more thorough – across the board that should be done for everybody.*

♦ Improve implementation of protocols associated with discharge and transition.

*The resident needs to be actively involved in their discharge. Every other discharge that I do out of this building, the resident is the active participant and leads it. I don't lead it. They do. And that's what I would like to see with Money Follows the Person. Because then I could more fully bond to the process myself.*

*I honestly think it would be very beneficial if we could get some sort of like credit background check on our clients. I don't know if that affects HIPAA or anything like that, but if we were able to – because a lot of the times we have these clients, and when they apply to an apartment and then it comes back that they have a criminal background or an unpaid bill, or they've had evictions that they weren't comfortable telling us about. And if we had known about it before-hand we may have been able to go to the landlord and just explain to them what had happened and work with them instead of just kind of being blind-sided by it.*

*And too, the care plan to be approved before a TC or Housing Coordinator is assigned because nothing ever moves until that care plan is – I mean, the Allied training, everything – does not happen for these consumers until we have an approved care plan.*

♦ Offer more education, training and support for nursing facilities.

*… I think that there should be more education to the nursing homes and the social workers or staff of the nursing homes just about MFP, what are our expectations, what do we expect of them, and what do they expect of us. Just to kind of be clear because sometimes too we need to get documents and IDs for people and sometimes the nursing facility won't assist in that. It's easier for them to request a social security card than it is for a TC.*

*… We've really worked hard at this site because we have, like I said, upwards of 2000 people on Money Follows the Person at the same time. And so we talked about when you've got these buildings like us that have these preponderance of folks that are involved in the program, why not give us somebody who comes once a week. Position somebody to be at the building who is cross trained, at least can answer questions, and can take care of some of the things that need to be taken care of.*

♦ Increase staff for the modification process.

*The modification process has been improved quite a bit, but it is still cumbersome to get through for transition coordinators. It can take a lot of your time, and I don't think transition coordinators are necessarily knowledgeable about modifications that are needed. We're trusting physical therapists to make these judgements, and we're getting people out there and finding that it's not sufficient, that they may need more. So I think that's, that's another place where we may need – and it doesn't have to be a lot – but I think we may need more staff to oversee that modification process. Getting the quote, planning the modifications that should be put in place – somebody who has a little more knowledge about that.*

♦ Increase information sharing.

*I think just sharing information, the more the better. If, I feel like even if there's like a sheet that says your case manager is, your housing coordinator is, your, and the phone numbers just so they can refer back to and kind of, so I think just to help. I think as families understand what the roles are, it just facilitates.*

## Programmatic Barriers

Most programmatic barriers were associated with funding and staffing, community supports and policies and were mentioned about as often in 2015 as in 2014. Barriers associated with Central Office were mentioned far less this year than last. Programmatic barriers included:

- Funding and staffing
- Community supports and program limitations
- Policies
- Central Office
- Other programmatic barriers
- Respondent recommendations

### Funding and staffing

Lack of funding was again a major programmatic barrier in 2015 and included challenges associated with state funds, funds being frozen, or being underfunded for the program.

*I was feeling, in June of '15, like we were finally cooking with gas. We were moving along, and we had process down and we were doing great and I was all happy and proud, and then the state budget got in the way. At that point, it was no longer clear that money flowed with the person. There was no money following the person. And that hurt morale greatly.*

*I think the fiscal instability of the state, not make families nervous about is this really, am I going to really get this money next year. It makes providers nervous about do I want to put time and effort in and is this money going to disappear. So I think when the state is in that type of fiscal crunch people they're a little more timid about putting together complex plans.*

*So when [Name] retired they froze our funds and also at that particular time North Central AAA also had a person that they put in another position so they were short a TC. They froze the funds. So that affected the funding that we had for the supervisor position because you get $5000 per TC. So we had $10,000 less than what we had when we hired [Name]. So [Name] was willing to take that on as a part-time, supervisor part-time TC which means that I owe her. But she is supervising the TCs for both agencies plus she has her own load. She has to fill her own benchmarks as if she were a fulltime TC.*

*I understand you have to have the documentation for whatever but every consumer is different … Every consumer needs something different. And so there are things that are on the not pay for list that somebody really, really needs sometimes. So where do we get that?*

Lack of funds for additional staff was another challenge and mentioned in relationship to high caseloads per manager.

## Community supports and program limitations

As in the previous year, respondents continued to comment on limitations in community-based resources, particularly the need for better housing options. There continue to be concerns related to supporting people with more complex needs in the community, especially those who have a lot of physical and mental or cognitive challenges, and those on the state plan.

*I think the client-centered program as it is, is sometimes difficult if the person really has a lot of physical, mental cognitive challenges and are still trying to sort of fit a round hole in a square peg. It's still like the MFP's vision to move them back out to the community which is great but sometimes maybe not as feasible as it's made out to seem.*

*I think the other thing that's frustrating is people not really understanding what it really does take to support a person with pretty complex needs in the community … it's not cheap and MFP was never meant to be a cheap program, but yet aggregately you will see definitely, we see the savings but it's really, a lot of the folks we work with have very complex needs. So it looks like our supports and services cost more versus like someone in the elder waiver, or the PCA waiver.*

*I think one of the big challenges that I'm seeing more of because we're getting people earlier, I get a lot of people that don't have any income and that makes it really difficult, and because most of them are State Plan, so they're going out with no services and no money …*

## Policies

Respondents mentioned frustration with insufficient written guidelines, inconsistent policies related to benchmark payments to reward staff as well as significant increases in mileage that occurred as a result of changes made to teams, particularly the creation of regional teams. Like last year, respondents expressed concern related to lack of increased compensation for work completed.

*… there's a lack of written guidelines and processes. So on the one hand, I just said it's really nice that the MFP office can be very flexible and supportive in terms of care planning or in terms of getting around barriers. But on the other hand, it would be very helpful for us to have written guidelines and processes and written updates to those processes as they come up that are disbursed to everyone at the same time.*

*One, Allied has to … publish some final policies and procedures. For example, we just got kicked back most of the rental application fees, and the question is why. We have check stubs from the landlord. Allied is saying they now need X, Y, Z. Well, if you don't*

*put it in writing, if it's not part of a dictated, if you will, or publicized process or procedure, then we don't know. And so now agencies like us are left to scramble to find some other documentation when we already have the check stub from the landlord.*

*I see how hard my staff work and we were promised a cost of living increase about I don't know 3, 4, well 4-5 years ago. I can't remember. We never received any kind of contract increase. The other thing that's been frustrating is it impacts the morale. I think it's not just with our agency. I think it's across the board with this but it was incentive program. You meet the benchmarks; you get a lump sum of cash kind of thing. That was given the first year. It was supposed to be ongoing. That was given the first year and then nobody knows what happened to that. We meet the benchmarks but we've not received any kind of incentive. And so the staff is kind of like, why are we doing this? And it looks bad for the directors really.[1]*

*And then they went from having us do transitions that were in our geographical location to doing transitions all over the state. So what happened with that is that my mileage expense tripled. It's huge. I have anywhere from $1000 to $1200 a month in mileage. And so it's incredibly frustrating to try to operate that program with the same resources that we had when we started. … Some of the bigger nonprofits absorb that but the smaller nonprofits. It's difficult for us to absorb something like that. So it's not that we don't believe in the program. We believe in transitioning people. We believe in supporting them so they can live in community-based settings but I had to lay off a part-time person to support MFP. That shouldn't happen. I shouldn't have to lay off a core person to support MFP because the cost got higher. I should have been able to go back and say, hey I had this increase. Can you help us with that? But that's not something that I know that would get any kind of positive response.*

## Central Office

While there were fewer challenges associated with Central Office this year than last, Contractors voiced concern about the inflexibility and lack of responsiveness of CO regarding contracts and the contractors' fiscal obligations to their own organization. Another challenge pertained to frustration in not hearing about program changes from CO in a timely manner.

*Other program challenges are, I would say at times there are program changes, and we're informed about it, but it's usually kind of at the last minute. So we don't have time to prepare for changes so that we're having to kind of backtrack and redo some paperwork or we have to figure out how we're going to adjust to new work that's already starting. So we don't have time to prepare for receiving that new work.*

## Other programmatic barriers

Other programmatic barriers included adhering to contracts involved with multiple areas (e.g., housing, staffing, eligibility), problems with Allied's rules that are associated with proof of payment and what CO approves as transition expenses, and the need to be more efficient in how work is done, including better communication. A gap in independent living skills, training, and peer counseling prior to transition was mentioned as was the stressful issue of dealing with people who demonstrate challenging behaviors and for whom there is a lack of community support.

*The housing issue, the DSS staffing issue with respect to eligibility issues, the Allied issue is a real block, and the obtaining IDs and birth certificates, and the more personal issue of we need to help these care managers and SCMs with respect to their own*

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[1] Contractors that stated they met the benchmarks and didn't receive the bonus actually did not meet the benchmarks and that information has since been clarified for all contractors.

*functioning and reward them. We need to look at those contracts and make sure that those contracts are being adhered to.*

*… a challenge for Allied is the eligibility issues that we're having. Because once we pay the people, we have to bill it to Medicaid, and we're getting a lot of denials on stuff … in general, there's a lot of, it's a lot of work to deal with eligibility issues in general over the years.*

*But there really does seem to be a need for us and for everyone to be more efficient in the way we work and the way we communicate.*

*Well, you're dealing with adults that are physically, emotionally, mentally challenged. You're dealing with a younger drug and alcohol abuse population. And very stressful when people are very resistant to the services that are being offered to them, and you feel a lot of responsibility in helping somebody start their life over on the best – putting their best foot forward, best face forward. And there aren't, with these state plan people, there's not a lot of support for them to go forward back into the community. … Unfortunately, things come up as you're getting to know your consumer and starting the process with them. And they're looking for a way to start their life over, and unfortunately what they want may not align with their abilities moving forward. So there's a lot of stressful situations.*

Cultural bias and ageism were also mentioned as programmatic barriers.

*… we still have a cultural bias that is, that's preventing more people from moving into the community and that some of that bias is coming from institutional providers, from medical providers who don't necessarily believe that people can or should. I think there's still some ageism as far as thinking about the 91-year-old and whether or not that individual should return to the community. I think that still exists. So I think some of the cultural paradigm change hasn't totally taken place yet, and that's a problem that we need to work on with education and telling stories.*

Another programmatic barrier that is increasing involves consumers that do not meet the nursing home level of care. These consumers are not approved for long-term nursing home care by Ascend, but MFP still has to find housing for these people.

*… I think MFP is designed for people with – elderly people … people with physical, mental disabilities … I am not happy about all these folks being referred to MFP. … [who] get to the nursing home because they're homeless or they're drug addicts and their Ascend is expiring. … I don't think MFP should be for people who really don't qualify to be in a nursing home.*

## Respondent recommendations

Respondents provided numerous suggestions regarding some of the programmatic barriers mentioned including:

♦ Continue to identify and address program difficulties.

*… the nature of this demonstration project is about preventing and overcoming program difficulties. And because it's a demonstration program, this program is all about finding difficulties and hitting them first and then addressing them.*

♦ Address challenges through more frequent communication.

*I think just making sure that the transaction, the transition coordinators are putting the correct information into the Medicaid system. Usually like there's issues with start dates or something and if they put in the wrong date or something or small errors or sometimes*

*it's small issues. Other times it's bigger issues because it's a new service or something, and that's worked through with the state and Medicaid … I think maybe if we could have more consistent conference calls, we could deal with issues better.*

♦ Increase awareness to strengthen community partnerships.

*I think that getting the word out universally through a global advertising campaign, I think that that's really important, and we hope to do that later this year connecting directly at a community level. Because I would say, over the next couple of years, we're shifting focus a little bit from a systems perspective in the protocol to a community focus and strategically partnering at a community level to make sure that the primary goals of Money Follows the Person … can be achieved. Because that's achieved at the community level, and we need to partner with communities to be part of this. So state government can't make that happen. Communities are really where the goals are achieved or not achieved.*

*I think that advertisement would be good … Maybe like a commercial or just more like billboards, something in that nature.*

♦ Increase community-based resources by partnering with more providers.

*I think maybe we need to connect more with pockets of providers who have been doing things differently for a long time that we haven't reached out to, like specialized groups and associations that work with people with mental health disabilities and the homeless networks that have their own networks for finding housing in place that seem to be pretty effective … those are the kinds of things that I think of that we want to work on next.*

♦ Focus on quality of life and financial fiscal responsibilities.

*I don't know if there's anything that can be done. I think the more, I think the positive stories and the impact on the quality of life and people focusing on the quality of life, the financial fiscal responsibility is very important but I also think looking on the quality of people's lives.*

♦ Tighten program policies and procedures.

*I think that policies and procedures need to be tightened, particularly around Allied issues.*

♦ Provide more frequent training to communicate policy and program changes and further follow-up training to ensure ongoing support.

*… there's just so many like different programs that are changing and when things are – when a program changes you should have like a training or an in-service so you know currently what is being used and how it's being used.*

♦ Provide Motivational Interviewing training to other advocacy staff.

*I've sent staff to Motivational Interviewing, core staff. I think that's a good thing. It would be great to have some of this training like that open to other staff that work with the program. Not just the TCs. But it would seem to me that if you're going to have a workshop that if I wanted to send an advocate that works with the people that are transitioned out it would be really, really helpful especially since we have zero dollars for staff development to be able to send our core staff to that.*

♦ Increase program staff.

*I think, it sounds like the program needs more staff, that it's under resourced to some*

*extent, and that the goal that we have, which I think is very ambitious and critical to being able to deliver services in a cost-effective manner as we age as a society and as the needs grow for long-term services and supports, I think we've got to reach these benchmarks and goals. I just worry that the state budget, financial outlook, is going to be one that may hamper our ability to fully rebalance our long-term care system.*

♦ Develop a better trained workforce.

*I think one of those things would be a community specialist. And I think also there needs to be better trained aides. Someone who might delve into what the person might want to do and try and guide them to do those things. I think people get out there at times and don't know that there are options for them because their support is really not designed for that, for community involvement. Their support in those agencies are focusing on just taking care of their medical needs. So better trained workforce.*

## Communication Challenges

Communication challenges continued to occur in 2015 and included concerns about lack of direct communication, poor communication between CO and Transition Coordinator/ Housing Coordinator (TC/HC) Contractors, and gaps in program awareness, including not passing on information in a timely manner.

- Lack of direct communication
- Poor communication between CO and TC/HC Contractors
- Gaps in program awareness
- Other communication barriers
- Respondent recommendations

### Lack of direct communication

Respondents indicated that communication is often indirect and incomplete leading to confusion and contributing to unnecessary frustrations associated with the program. Some respondents related concerns specifically about communication challenges in working with other state departments while other respondents mentioned challenges related to the Steering Committee. In addition, social workers experienced communication challenges that impacted the transition process.

*… The state will send a targeted email that is not informative about a process. For example, the TEFT grant, they will say the TEFT grant is moving along and we need the following. There's no background. There's no update on where we are. So response number one is, there is no central point that we know of that describes progress on all of the above … We asked about the nursing home grant and did not get an answer about where there is a resource that describes the original award, progress to date, and future plans. MyPlaceCT – we access MyPlaceCT all the time. I'm not sure I understand why or what that is going to evolve into. And it seems like the state once again is coming up with here's another website or here's another access 800 telephone number. Disregard everything else, use this one. … With respect to the newer initiative of No Wrong Door, we're not sure where that is at all. … we don't know about the progress of most of those initiatives, nor is there one central location that we know of where we can go or we can direct anyone else to go to find progress and status.*

*I think the most challenging part would be communication. And as good as it is to have that team, I think just maintaining the communication, making sure that the case notes are up to date and reflected in the web for those times where there are regular communication or there isn't communication for a week and able to look on the web and make sure that everyone is on the same page and that the case notes are clear.*

*I think one of the challenges of MFP is communication. I believe that for instance the Steering Committee is supposed to be on a website. I don't think there's any information on the Steering Committee, who's on it, what it's doing, any of that type of thing … I think the biggest frustration that we have is no consistent administrative support, and so that really creates challenges. … we used to have volunteers take the minutes, and in recent meetings Dawn has been taking the minutes which is really not effective at all.*

Social workers also experienced challenges in working with MFP staff and staff from other state departments, primarily not understanding the roles of everyone involved or their responsibilities.

*I first want to say that I completely respect and I actually really like the people who are coming into the building and working with the residents; however, I do not understand the disjointed and convoluted roles that they play. The clients themselves don't understand either. We are not given a breakdown of who does what. … And I will say to you, I am a consummate professional. I have never, ever been negative or critical in front of a resident of Money Follows the Person. … Well if you are backtracking and checking up on the work that we're doing to make sure we're doing it okay, why aren't you just doing it yourself?*

*… I would say three-quarters of my MFP clients had mental illness or a developmental disability. The hold-up and frustration often came when I had – when we included both state case managers … I had, for instance, a client with spina bifida. So we had to involve DDS and they just – my experience with them is they just could not get their act together. They were slow. They didn't communicate well within each other. They – that was my biggest frustration in working with some of the other state departments.*

## Poor Communication between CO and TC/HC Contractors

During 2015, lack of Contractor meetings continued to make it challenging for contractors to be informed and to effectively do their job.

*… The Central Office doesn't communicate with us. … And I'm not cc'd on the emails. If I hear something, it comes from my supervisor and I believe that as a director there are some communications that should come from director to director. Not from DSS, Medicaid director or program director to my staff to me. I'm not a power person but this puts me in a very difficult position sometimes because there are decisions that I need to make for the good of my office that I'm not allowed to make because there's not any communication.*

*We meet the benchmarks but we've not received any kind of incentive. And so the staff is kind of like, why are we doing this? And it looks bad for the directors really because we come back from a, we used to have a contractors meeting. We stopped having those…. They were very helpful because we could bring problems that we saw to the table. But we haven't had those this year. So we would find out at the contract meetings there would a benchmark cash award but nobody got it.[2]*

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[2] Contractors that stated they met the benchmarks and didn't receive the bonus actually did not meet the benchmarks and that information has since been clarified for all contractors.

## Gaps in program awareness

Gaps in program awareness occur when communication is problematic and for some that involved not being able to reach a care manager to learn how the program works. In other cases, it was associated with the Steering Committee and a need for improved administrative support to reduce informational gaps. Sometimes gaps in program awareness referred to lack of communication to TCs about new initiatives or a lack of information related to a particular program or to how a consumer is doing after they have transitioned into the community.

> *And then they call us because they can't reach their care manager, so I don't know if the caseloads were too high. It was very challenging to reach, it's sometimes still is a problem reaching care managers.*

> *Other program challenges are, I would say at times there are program changes, and we're informed about it, but it's usually kind of at the last minute. So we don't have time to prepare for changes so that we're having to kind of backtrack and redo some paperwork*

> *… there are so many initiatives, and it is impossible to keep up. So I think that figuring out how to communicate this information to folks is something for DSS to think about. For example, they should be doing training for all new hires. I've never been trained. I had to reach out and ask for a tour of MFP's web and so forth.*

## Other communication barriers

Other communication barriers included a breakdown in communication between the family and the program.

> *I think it's a great program. I think you're open to feedback. I think ongoing communication between the family and the program continues to be what I see as the, that's the main reason people are calling us, if there's a breakdown in communication. So as that improves, then perhaps, I think that would only help the process.*

## Respondent recommendations

Respondents offered some of the following recommendations for improving communication.

- ♦ Provide more formal and direct communication.

> *The communication process, number one, has to be more formalized with respect to here are the requirements, here's the process, and here's the person to go to if you have a problem that can't be outside of this process.*

> *… I would like to have more direct information from I guess either DSS or from the Area Agency especially around the initiatives because it's important to know to make sure that our staff are aware of, if we look at these initiatives as additional support or tools for them to do their job and thus be able to serve the client better, then I can do a better job of quality assurance – I guess I could say – if I had more knowledge about them.*

> *I recommend or would appreciate more standardized updates in terms of processes, programs, guidelines, and a kind of centralized communication with those updates so that everyone is hearing them at the same time instead of our receiving various emails with kind of informal communication about updates.*

> *Maybe minutes from the monthly meetings would be nice. We do always have an agenda, and everybody sort of sits there taking their own minutes. It would be nice if there were official minutes so, in case you didn't attend, you would get them.*

*I think these kinds of initiatives would be nice to hear about maybe like in a quarterly newsletter or something for MFP just to know what's happening in these areas.*

♦ Encourage MFP consumers to participate in public meetings

*… making sure that from a communication in the room perspective that there are enough microphones and there's an easy way to use microphones. … encourage more consumers of Money Follows the Person to attend and be participating; I think we need to try to find a way to maybe move around or have a public meeting in the field that's a little bit easier for people to get to or bring our meetings or field work to various communities and do some interviewing and reaching into the communities where our clients live and make sure that we're hearing directly from them. So getting good feedback from actual clients and empowering that to happen would be a good next step.*

♦ Provide better dissemination of Steering Committee meeting information.

*So I think that would be the biggest thing is having the support to be able to kind of have a central place that all the information comes out of so that we can get agendas out more than the night before and get minutes out and that type of thing.*

♦ Implement more efficient communication between MFP and nursing home staff.

*So I would really suggest that we streamline communication and really focus on customer service, being a resident, being able to have their arms around their own transition and what that's going to look like. Right now they are victims of it.*

## MFP Program Developments and Rebalancing Effects, 2015

### Program Developments

Rebalancing initiatives related to MFP continued to develop or be active in 2015, including TEFT (Testing Experience and Functional Tools grant), Community First Choice, the Universal Assessment, and the housing initiative. Other program developments mentioned by respondents included the restructuring of the MFP unit, caregiver education and training demonstration services, and simplifying the housing modifications contractor process, and the integration of screening for a brief intervention around substance use.

*The establishing, the rotating list of contractors to be used instead of having to get 3 bids from 3 different contractors on the list. That's huge. Now the TCs know they just go to the list and they know who the contractor is and he does one set of bids.*

*I'm pleased that we're going to be moving forward with a pilot project, it looks like, to do some caregiver training. I think that's absolutely critical.*

*We're seeing now there's going to be some efforts around trying to get pre-designated, kind of site-specific RAP grants and housing subsidies so that there'll be a consistent flow in availability of accessible housing. And I think doing that proactive work to have a few places that are going to have regular MFP clients housed in those apartment units will be helpful as kind of a steady stream that we can only dip into if we have an emergency or if things are moving quicker than we anticipated or we hit a roadblock with the traditional housing coordinating process. That would be very helpful to have some of these new developments or current developments where one or two apartments in a unit are designated for MFP housing subsidy and to make sure those are on hand and available at the drop of a hat. It is a really exciting and innovating way to go about it, and we'll see how it works.*

## Community First Choice

The Community First Choice (CFC) State Plan amendment was mentioned both an achievement and a program development in 2015. Positive comments about CFC included the importance of self-direction and person-centeredness and the increased availability of community personal care supports to a wider range of people. Challenges mentioned included lack of procedures and guidance for agencies.

> *[There is] the Community First Choice Council, which is part of and associated with the Money Follows the Person Steering Committee. That's a group of ten people that work a little bit more in depth around a new state plan amendment to offer personal care assistance and other supportive services to those who qualify for Medicaid and to receive those services in a home and community-based setting.*

> *I think that [one program effect was] the development and implementation of Community First Choice, which was led by the Demonstration. I think that the flagship that will be kind of like a stamp has changed forevermore in the State of Connecticut, leading and underscoring the importance of self-direction and person-centeredness.*

> *I also think that, quite frankly, Community First Choice is – once we have procedures, once we have some clarity on process and we have written materials and guidelines that we can live with and live by, I think Community First Choice is going to be wonderful.*

## MFP unit restructuring

A few respondents mentioned the integration of the MFP CO with the HCBS Alternate Care unit. Some MFP CO staff will stay with MFP under the Strategy side of the new Community Options unit, while other MFP staff, such as the MFP social workers and eligibility staff will become part of the Operations side. In 2015 only a few respondents were aware of this upcoming change. Some voiced concern as they were not quite sure how it would be implemented and its effect on the MFP unit, while others saw the move as a way to provide more resources and support to the MFP CO staff and beneficial to consumers as well.

> *I kind of have heard what's changing now which is a bit concerning that it's going to be kind of wrapped into home and community-based services and that type of thing, so I don't – I can't speak to it. I guess I don't know enough about it yet.*

> *The structure that will be changing is that the social work and eligibility staff will come under supervision in the HCBS unit. … building in some structure around the people that are doing the work to support them I think is going to be a real positive.*

> *I think that we need training in both directions. They need training about more of the clinical aspect and diagnostics and so forth. As well, we need to have a better understanding of whether it's MFP, CFC, just the whole DSS, Medicaid. You know, it's very complicated, and it takes forever to learn. And I think, as well, they don't necessarily have the most up-to-date information on people. And I think sometimes we're at an impasse because people aren't budging. We were concerned about the clinical care, and they want to get people out, so sometimes it's that tango. So, I think training and education in both directions is important.*

## Integrating MFP and other rebalancing initiatives

As the rebalancing initiatives continued to grow, the MFP structure and its relationship to the rebalancing initiatives continues to evolve. When asked about the MFP structure and process, some respondents said the current structure was working well, while others remarked on the lack of an overall, cohesive plan for MFP and other rebalancing initiatives. These key informants

experienced rebalancing initiatives such as MFP, TEFT, CFC, Balancing Incentive Program, and No Wrong Door as discrete grants, with no overarching structure or organization in place.

> *Everything is segmented. The TEFT is here. No Wrong Door is over here. There's no understanding if they're ever going to relate. There's no access to a central plan on how the system is going to work. What's the state aiming for, for the system? ... But what's the end goal for the end-user, meaning the consumer? We're not seeing that, and we don't understand it other than we have been told verbally that anyone should be able to access information from any point which makes no sense at all, absolutely no sense.*

> *I'd definitely like to see a more defined process of implementation that can be worked through. Currently, it is a bit more broad and philosophical to work it through as we go, and that does consume a lot of resources.*

One key informant expressed how while change is hard, people would ultimately benefit from these new initiatives.

> *I think that that's part of why some of these changes are, they're difficult right now, it's difficult to go through a lot of change right now, but I think we're all looking forward to a time when things will be, I think, more streamlined with the use of the universal tool and potentially with Community First Choice and the continuation of the waivers that can provide people with the services they need. So I think it's all, they're all, those are all good things that are happening in Connecticut.*

## MFP and Related Initiatives Effects on Rebalancing

The most frequently mentioned effects of the MFP program were to give people choices about where they receive their long term services and supports. Respondents reported that MFP was a driving force in the movement towards community based services and related initiatives, and that it continued to raise people's awareness.

> *I think the biggest, the biggest impact it's had is it allows consumers, individuals, and advocates to dream. Before Money Follows the Person, it seemed like it was a little bit of the luck of the draw where you got, where and if you got to decide how and where you received services was dependent on finding a program and navigating to something and jumping through hoops and a lot of things needed to go right. And it seems like Money Follows the Person was that second chance for people who may have encountered a barrier and defaulted into a nursing home and now felt they could dream and have that chance that they didn't have on the front end, or lost on the front end, to return to the community and live independently.*

> *Well I think it's helping to lead change. I think it's certainly not the only thing that's leading change, but I think that Money Follows the Person does help push the system a little bit through identifying the gaps and challenges and addressing them one by one. I also think the power…of the demonstration is really telling the story through the eyes of the people that we serve, especially those that a lot of people thought could never live in the community, and telling the story about how they do.*

> *I think the more people – people talk to each other in communities. People talk to each other. In DDS, they talk to each other. The regional DDS case managers whose cases we help get out of nursing homes see that they're happy and doing well, so they're willing to refer more people to us. And the more people we get out, the more successes we have. It's like a ball that just rolls. So to me, that's a huge positive impact overall. People are beginning to trust that MFP does work for people and it improves people's lives. And people seem to recognize even when you say I work with MFP, they'll say "Oh I know what that is," where they didn't before.*

*Well, having a big network of hospital, nursing home, home care people that I speak with on a regular basis, all have told me about the trend of patient's hospitalization being decreased, their admissions to nursing homes being decreased because of the services that are now available for people to live at home and stay at home. So I think it has had a positive – a very, definitive positive effective … it seems like the state and this program has made it possible for people to do that.*

One respondent talked about the benefit to the community and the role of MFP in the movement to build more accessible housing, while another key informant focused on the effect on partnering of all the providers, organizations, and state agencies involved in providing or facilitating community supports. Respondents also mentioned cost savings to the state and the effect of MFP on rebalancing combined with other state initiatives.

*I think that people are happier out in their community in their own home. In their own apartment with their own stuff once they figure out that hey the meal comes from me. I ring a bell and nobody's going to bring it. I also think that there are more people available for community participation. To be involved. They bring something of value to the community. So long term effect would be that the community becomes more aware of the value of people with disabilities and people who are elderly.*

*I think that the other thing that has been happening, I think slowly but surely, is that I do think that the silos for all the different programs that have been so separate and apart in the past are, I think with the introduction of the Universal tool and probably with Community First Choice, that some of those barriers between all of those different programs and waivers and that that silo type of a system is starting to break down a little bit ...*

*I think it definitely is helping with the rebalancing efforts, but I also think there are other things that have happened at the same time that have contributed to rebalancing that haven't been acknowledged. And that would be the changes in the PASS-R system and the way we approve level of care for people in nursing homes. I think we're certainly guarding the front door better of nursing homes, and we have added steps to when we do approve nursing home stay, we approve them either long term or short term depending on the patient's presenting situation. And we've been doing that now since 2010.*

On the other hand one key informant was concerned about the cost of live-in PCAs and how that might affect cost savings. Two key informants and also voiced concerns about the availability of community supports or providing enough supports to consumers with multiple disabilities, while another mentioned specifically how MFP has given people who are medically complex the ability to live at home.

*I love the vision of MFP. I love for those people who really want to leave the facility and are able to. It's great for their families. It's great for them. I think the client-centered… program as it is, is sometimes difficult if the person really has a lot of physical, mental cognitive challenges. … sometimes I'm curious about the MFP program and their vision financially because with the new live-in rates we're moving people back out into the community where it's costing more than keeping them in the facilities which I know is sort of the State goal for it to be more inexpensive to send them out to the community. So I wonder how long that will or when that will actually make an impact on the program? I worry about that.*

*I think the overall effect is positive. I think that people that are compromised medically are now able to live their life in a home environment and that's a powerful thing. And I think that people are extremely happy and grateful for this program.*

The two other effects on rebalancing mentioned by respondents were nursing home closures and the reduction in nursing home occupancy. Three more skilled nursing facilities closed or were in the closure process in 2015, and approximately thirty nursing homes have now closed or are currently in the closure process since 2010. One respondent remarked that he/she knew of nursing homes which are considering changing their business model as a result of this.

*Several nursing homes in our area have spoken to us about, while individuals are transitioning and their daily census is decreasing, they're thinking about how they can reinvent themselves. … I know there's been closure of some facilities and that's good, although I would've preferred to see a closure of a long-term care facility and conversion to some kind of innovative housing, but I don't think that's happening.*

*What effect? Well, I mean, we're moving out a lot of people and I don't know if it's really MFP, I mean, but a lot of nursing facilities have been closing. I think a lot of people obviously want home and community-based services. They want to be home. They thrive. They do better at home. But I just think it's all client-driven. They have to want MFP. They have to want to move home and accept the services. So it's definitely the big impact is home and community-based services, people living at home and being happier.*

## Conclusions

As one of forty-six states and the District of Columbia, Connecticut has continued to make progress in transitioning people from institutions to the community and helping shape the future of long-term services and supports and other health system reforms.

In its seventh year, the MFP Demonstration realized numerous achievements and successes. Transitions were 20% higher in 2015 than the previous year and after using the team transition process for over a year, the average length of time from assignment to transition decreased. In addition to a growth in successful transitions, the program has been an active catalyst for promoting culture change for the nursing home population and for encouraging consumer autonomy and choice. Partnerships between many different entities have flourished and supported expanded outreach, referrals, and transition support. Enhancements for the UA have continued to move the comprehensive, person-centered assessment forward and have been beneficial in providing better social support and service plan needs for eligible individuals.

Strengths and supports were similar to previous years and included the recently implemented team transition process, positive communication, education and training, the strong commitment of project staff and stakeholders, and program flexibility.

Despite the numerous achievements and strengths of the program, Connecticut continued to face barriers to successful transitions, programmatic barriers, and ongoing communication challenges. Like many other states, transition challenges were often related to issues associated with length of time to transition and the discharge process, lack of affordable, accessible, and safe housing, and a shortage of community supports. The look-back and workload-related issues also presented challenges.

## Recommendations

Many of the recommendations from this evaluation are the same or similar to those made in 2014 and fit into the following categories:

- ➢ Continue to evaluate staffing levels and address need for stable, consistent teams
- ➢ Continue to update and distribute written policies and protocols to SCMs, TCs, and HCs
- ➢ Monitor the implementation and usefulness of written policies and protocols
- ➢ Distribute written policies and procedures to facility staff involved in transitions
- ➢ Improve team operation
- ➢ Expand the effectiveness of HCBS
- ➢ Provide greater post-transition support
- ➢ Evaluate the long term successfulness of transition
- ➢ Improve communication
- ➢ Provide an overview of all the rebalancing initiatives to stakeholders

### Continue to evaluate staffing levels and address need for stable, consistent teams

- ❖ Continue to work with the contractors to support stable and consistent teams.

- ❖ Minimize the impact of different organizational styles or cultures by restructuring them so as much as possible they are in-house and not from multiple agencies.

- ❖ Ensure adequate Central Office staffing to approve care plans as they are submitted.

### Continue to update and distribute written policies and protocols to SCMs, TCs, and HCs

- ❖ Continue to update written policies and protocols for all field staff and supervisors, and distribute to all staff, including new staff as part of their initial training, to describe program structure and ensure continued quality improvement and effectiveness of service.

### Monitor the implementation and usefulness of written policies and protocols

- ❖ Monitor the implementation and usefulness of written policies and protocols over time through periodic field staff feedback to determine how they may need to be revised.

### Distribute written policies and protocols to facility staff involved in transitions

- ❖ Ensure that facility personnel, such as social workers, receive policies and protocols regarding the roles of MFP field staff they work with so there is clarity relevant to responsibilities during transition.

### Improve team operation

- ❖ Create an updated Action Plan with clearly outlined tasks and upload it to the web after each meeting.

- ❖ Develop a fillable Action Plan form on the web. Field staff can use it as a living document and update it at team meetings or check off when individual tasks get done. Solicit field staff suggestions from SCMs, TCs, and HCs when designing the form.

- ❖ Schedule regular monthly meetings in advance so they are in people's calendars.

- ❖ Update the Anticipated Transition Date for pre-transition consumers during each monthly meeting. This will especially help Central Office and the team work more efficiently, as CO uses the anticipated transition date to prioritize tasks, such as approving care plans, transition budget exceptions, or Medicaid eligibility.

❖ Considering the team's full caseload, during the monthly team meeting create one Priority Action List listing only the most pressing issues which require attention within the next few days. This will help the team prioritize the most urgent issues for all their consumers, as creating one list of the next steps for all consumers would not be feasible nor helpful for prioritizing immediate goals.

❖ To facilitate communication and coordination among the diverse Team One programs, create a transition progress tracking list of all the Team One consumers. Include important dates such as when referred to field, TC or HC assigned, care plan approved, anticipated transition date, discharge planning meeting scheduled, and date transitioned. Update the list at least weekly.

## Expand the effectiveness of HCBS

❖ Define policies and procedures for Community First Choice (CFC). Communicate these effectively to all parties involved in home and community-based services, including MFP stakeholders and those involved in the wider HCBS.

❖ Renew the focus on issues related to community housing. Restart the quarterly housing workgroup and include stakeholders, such as HCs, TCs, and advocates. Reach out to nursing home administrators and landlords to participate as well.

❖ Continue to work with the Alternate Care Unit for an effective and seamless integration of Community Options: Strategy and Operations. Continue efforts to reach out to all stakeholders in MFP and home and community-based services.

❖ Continue efforts to engage nursing homes to use resources, such as the rebalancing grants, to transform their business model to include focus on home and community-based services.

## Provide greater consumer post-transition support

❖ Provide greater post-transition support to consumers, focusing in particular on community integration and consistent paid supports. Consider reducing the TC's caseload so that he/she can spend more time with the consumer post-transition and work with him/her.

## Evaluate the long term successfulness of transition

❖ Continue to evaluate the long term successfulness of transition with a focus on stability, critical incidents, and community integration.

## Improve communication

❖ Designate one CO staff member to develop and maintain one comprehensive email list to impart all MFP information to stakeholders such as SCMs, TCs, and HCs and their supervisors, contractor agency directors/designees, CO staff, and Steering Committee members. Use this to send out information such as Steering Committee and Supervisor meeting agendas, minutes, and handouts, CO MFP monthly report, UConn reports, and any CO outside presentations.

❖ Provide a written copy of the CO monthly report to the Steering Committee. Distribute in advance of the meeting so people can review prior to the Steering Committee meeting.

## Provide an overview of all the rebalancing initiatives to stakeholders

❖ Describe the diverse rebalancing initiatives in one document and provide an overview which effectively shows the relationships between them. Communicate this directly to all

stakeholders, including the Steering Committee, Contractors, DMHAS, DDS, DSS, and advocates.

# Appendices

Appendix A: The Team Experience

Appendix B: Committee, Meeting, and Workgroup Descriptions

Appendix C: Key Informant Interview

# Appendix A: The Team Experience

The team transition process is key to the success of Connecticut's MFP transition program. Approximately one third of key informants were part of a Regional Transition Team for at least part of 2015 – as either SCMs, TCs, or HCs. These team, or field staff, key informants were purposely chosen to represent all five regions and all home and community-based services (HCBS) programs. To gain a better understanding of how the team process is working in the field, these key informants were asked about their teams – team descriptions, meetings, communication, and best practices.

## Team descriptions

In 2015, there were fourteen different organizations or state agencies which employed SCMs, TCs, and/or HCs. Most teams had two TCs and one to two HCs, and one or more SCMs. Team Ones were structured differently, with usually one or two TCs and HCs working with between five to ten SCMs from three different waiver programs – DMHAS, DDS, and ABI.

Most team member key informants came from mixed agency teams, with members from two or even three different organizations. Even with this number of people and organizations involved, many team members felt they worked primarily with the same people or had a stable team structure, especially if all team members came from the same agency. Some field staff described team changes and turnover which had happened during the year or how the team is currently working to make their team members more consistent.

> *Probably 80 percent of my clients are with the same SCM, and then 20 percent are with another. So I work with two SCMs right now, but that can change and become three or four rather quickly depending on circumstances with the SCM. So I work primarily with two SCMs and one Housing Coordinator.*

> *Okay, in our team we have one Specialized Care Manager, two TCs, and one HC. The TCs and the HC are in the same office while the Specialized Care Manager is housed in the [Access Agency]. … I generally work with all the same people. … I think I work with a great bunch of people. They're very open, very honest. We can really talk about any short comings anyone has or anything like that just openly and honestly.*

## Team meetings

Most field staff described meeting monthly or more often with their primary team members, even teams with members from different SCM/TC/HC agencies. Sometimes TC Supervisors attended as well. The exception to meeting monthly were Team One respondents. The SCMs from the three programs met separately with the Team One TCs and HCs, and although they described meeting pretty regularly, most did not have a standing monthly meeting.

Overall, the team meetings focused primarily on consumers currently in the transition process, reviewing the progress over the past four weeks and identifying the next steps in the process. One team member described reviewing all post-transition cases if within 90 days after transition as well. All the field staff felt the meetings were worthwhile – whether it was a team meeting, a TC or HC specific meeting, or an internal agency-specific field staff meeting.

> *Yes, we meet once a month and we go through our caseload together, but we talk about it daily again. We're in constant communication. [We review] every open case and everybody within that 90-day post-transition period, sometimes even further. Sometimes we're reviewing people that've been in the community five or six months if there's something, some issue that's come up with them or some need.*

> *Well we'll each go through our list of consumers and answer any questions. See how we can move forward. Bring questions to the supervisor that we need answered and note in*

*the Web so everybody stays in the loop. … We will review most open cases unless it's something that we're all aware of and doesn't need discussion.*

*My DDS Specialized Care Manager and I are constantly meeting and talking all the time. We do meet in in person. Like my DHMAS team, it's usually email and on the phone to discuss. I don't have that many DHMAS cases right now so it's – but we're definitely communicating a lot.*

*… we used have meetings every two weeks, but I'm trying – this is too much. We all have – all the caseloads are growing dramatically and the work – it's just very difficult to manage at this time. So we try to meet once a month.*

Team members found the team meetings helpful in keeping track of their consumers, prioritizing, determining next steps, and assigning tasks. Team members also found that regular meetings supported collaboration and made sure that everyone was on the same page.

*I think they're productive because when you have the team of three focusing on the client of one and everybody's available. Everybody can tell you exactly what they're working on. It's like the pieces of the puzzle coming together. … I think it's very efficient and it really has made things move along quicker.*

*Well I think that's how, mostly that's helpful in prioritizing what needs to be done. Because you have a chance, I know the SCM has their ideas of what needs to be done right away, and transition coordinators have their ideas, and housing coordinators have their ideas of what needs to be done. But when you get together as a group it's a lot easier, and then everyone has a better expectation of what we can get done during the next month or two weeks.*

*I really thought the meetings were productive … I really liked it because it gave me like a task list of things that I had to get done before the next team meeting. So it kept me on my toes.*

When asked how they made sure the goals set in the meeting were met, team members talked about delegating tasks, individual and team responsibility, and following up with each other. Key informants described using task lists, flow charts, and timelines.

*How do we as a group make sure the goals are met? Basically by delegating, I guess. The TCs usually suggest that I meet with them within the next week or so, if the issues have been resolved, and we'll set a deadline for me to meet with them or they'll set deadlines for themselves in so far as making sure that the look-backs have been done.*

*We would set goals via tasks that we had to get done. And… the next team meeting we would go over those tasks that had to get done and talk about them and whether or not we were able to complete them.*

*Sometimes we'll do a timeline. I've even done a written timeline and we'll have deadlines, things like that and then we'll follow-up or email with each other.*

## Team communication

Team members all mentioned staying in communication with each other outside of meetings by emails, texts, telephone, progress notes in the web, or stopping by if in the same office.

*Thus far I'm working with a really good team. We email, we call, we see each other kind of like on a fly by night basis sometimes, but we seem to communicate very well. The Specialized Care Manager is always in the loop; the TC is always in the loop. I do a lot of going back and forth with the TCs just to make sure I'm doing things in a timely manner in terms of following their timelines and everything for the person's transition.*

*Well, definitely keeping the web updated with progress notes and everything. That's really important. We email. We talk on the phone a lot. We're definitely communicating a lot. But I think the web too is something that, I mean, I stress with my team who I supervise is update the web because that's where we all have access. So for DHMAS and DDS and housing they can just go on the web and read my notes and know where we're at. So I think that's really important.*

## Additional meetings

Field staff informants also described a variety of additional field staff meetings which supported transition activities. Again, all respondents felt the meetings were helpful for them and their team members.

o Several respondents described having regular, internal meetings at their respective agencies. For example, one TC Supervisor described monthly meetings just for the TCs he/she supervised, while another organization held meetings just for their SCMs.

o One agency held regular clinical forums with a medical doctor, for both their home care agency staff and their MFP team members, including team members from other partnering agencies.

*Our MFP team consists of a supervisor who is obviously part-time, the housing person and two TCs, and the SCM from [agency]. They are all invited to participate with the access agency staff in clinical case forums. And that has worked out really well because we have an MD [name] who presents and then spends an hour in Q&A discussion on particular issues such as this person has this chronic disease, and I am not sure how the manifestation of the disease is going to impact on the person's activities of daily living in the community. Because in the nursing home there is somebody to watch over and guide; where at home the person is pretty much on their own. So there's that motivational issue that he addresses, and those clinical case forums are working really well, and they're part of the MFP process in this agency.*

o In addition to the monthly SCM-TC-HC Team meetings, one respondent described weekly, regional TC-HC meetings, which brought together all the TCs and HCs in that region. Another respondent described having team meetings focused on housing, with all the team members attending, and then additional SCM/TC meetings.

*We have weekly meetings with just our TCs and our housing coordinators. … I think it would be important anywhere. The TCs and HCs are working even after the SCM's portion, the majority of their role has taken place. … In my agency we do have that situation where the HC and the TC are different agencies and they do meet more regularly than with the SCMs.*

*So for housing meetings, everyone usually goes around in a circle and we'll go down by the list of names, and we'll say where we are with the person, and if there's any challenges, what needs to be done. And then as a team collectively, we'll decide who's going to do what part to make the challenge resolved.*

## Working as a team – benefits

Similar to other key informants, benefits to working as a team identified by field staff included seeing consumers earlier in the process, team collaboration and problem solving, and increased consumer and team member support.

*I think, obviously the big one is that it identifies the action plan. Makes for a quicker turnaround on the plan of care's approval. What else? It's allowed us to move people out*

*quicker when there are less challenges, because the people are being seen quicker initially. I think those are the main things.*

*I mean I'm all for the team approach. I like having a team to work together and to brainstorm and to talk about the case and make sure that everything is in place. I like that.*

*It's helpful for me in that as the Housing Coordinator I'll say this person's been on my – I've been assigned to this person and have not been given the okay to move ahead with the RAP certificate. And so we'll talk about those issues at that meeting, and then they'll let me know within a week or two once they've resolved an issue, they'll let me know when I can actually meet with that person. Or if [the TC], say for example, is meeting with a person before me, [the TC] will ask for a RAP application and will get the RAP certificate signed for me.*

## Working as a team – challenges

Challenges identified by field staff were similar to those identified by overall respondents as well, such as working with multiple agencies, cross agency teams, communication, team stability, and increased caseload. Some supervisors identified the Team One structure as problematic. Instead of one unified team, Team Ones function as three separate teams which happen to share a TC and HC. This was especially challenging for the TCs as the different SCMs were not aware of the competing demands on the TC's time, such as other transitions.

*I think in some situations when there hasn't been direct accountability for work and for workload that – again, I don't have any numbers, but I can see sometimes that it appears that the length of time to transition is extended when you don't have a team that's made up of SCM, TC, and HC all within the same organization.*

*My only frustrations actually stemmed from working with outside agencies because it was more difficult to communicate with them effectively. And that was just I think because … even though they have like a Transition Coordinator role in both companies, companies do their role differently even though we have like a set guideline of what we're supposed to do. So that was just a little difficult working with outside agencies because they just did their job a little differently.*

## Team meetings best practices:

When asked for team best practices or recommendations, field staff had several recommendations.

♦ Communicate daily with your team members. Good communication is key to working with each other and not duplicating work. This includes communicating updates, issues, and tasks among all team members in a timely manner, and meeting regularly.

*Best practice would be communication and clear documentation. Clear documentation, communication in identifying strategies to reach a desired end or goal. Working from each other's strength, acknowledging the different perspectives that we all come from … working collaboratively to meet the best end or desired end.*

*Well I think … the more communication between and among the team members, the better the service quality seems to be. … So I would say when communication is at its best, then the team model and the operation of the team is probably at its best quality.*

*I think daily involvement between the [TC], SCM and the Housing Coordinator are needed for pre-transition people to make transitions happen quicker and more successfully. Honestly, I think daily contact is important … whenever that person is seen*

*in a facility, I think that it has to be communicated. Daily interactions I think should be communicated with team members.*

♦ Meet monthly as a team. Field staff felt that an important part of team communication and cohesion are regular in-person team meetings. To be most effective, one team member recommended each person review their cases and prioritize the next steps ahead of time. One field staff also recommended one on one meetings with the SCM and the TC to focus on that TC's consumers.

*I think the fact because we take time to meet. Even if it's not at the beginning of the month we'll try and meet later on depending on our Specialized Care Manager's schedule. It's the fact that we actually meet. I think that could be a best practice in itself.*

*I think everybody on the team coming into the meeting with their ideas written out or listed in the order of what they think how the priority should be or what the major effort should be put on at that time so that you can come to some consensus on what should be done.*

♦ Delegate tasks and track completion for each case. Teams used tools such as timelines, action plans, and task lists. One team recapped the team discussion and next steps for each consumer in the progress notes.

*I would also say it's best practice to update the [progress] notes in the web during your team meeting so that everyone is on the same page and the notes are getting updated frequently. And then I would also say developing some type of like flow chart or task list for your team so that everyone is on the same page on what they have to do and when it has to get done by.*

*Again, in those [Team] meetings, they should be setting up action plans. … I think TCs and SCMs just take it for granted that everyone knows what needs to be done or everything is explained in that plan and I don't think that's always the case.*

♦ Assign team members, especially the HCs, when it makes sense for that case. In particular consider if Medicaid eligibility has been verified.

*I think sometimes the process just goes slower than [expected], so I think care plans can be approved faster and just to make sure that we don't put people on the team before they need to be in because sometimes housing coordinators will be involved before they need to be, and then that makes everything more confusing. So I think just staying on a good timeline.*

# Appendix B: Committee, Meeting, and Workgroup Descriptions 2015

| Meeting | Meeting description | Productive | Challenging | Respondent suggestions or comments |
|---|---|---|---|---|
| Steering Committee | "… There's the MFP Steering Committee that is a statewide committee that meets on a monthly basis, and those members are nominated and voted on in order to be participants there."<br><br>"And then for the Steering Committee, it's really getting overall input on the strategies, on the bigger picture of things that are happening external to MFP. Making sure we're on track with the goals and to understand what systemic barriers may be in place at a community, state, or federal level and having those kinds of dialogues to inform the project."<br><br>"So it's a very good cross section of people who are from state agency folks, people who represent various constituencies, individuals who are served under MFP. And it's always been a very good attendance."<br><br>"I think it's very good that rather than creating new spinoff committees or councils, we've made a concerted effort to have the Steering Committee be the broad umbrella and then let all the other items, like a housing workgroup or a Community First Choice or other kind of innovations, like workforce development, come under that umbrella and feed up through one single channel so that we're | "They're productive. They're helpful in that it is really about the overarching mission and principles and values and programming and broad rebalancing linkages. … It's really about connecting the dots across all of the systems, and that's what provides, that's what's useful to me."<br><br>"I think it's also been very important for developing consumer relationships between various consumer groups. So I know that by participating and getting to know some of the folks who are at the table, my relationships with those community stakeholders have deepened, and it's helped my work in advocating for other policy solutions that may come up and, while not directly involving Money Follows the Person, are still helpful to our shared constituency. So I also find it very important from a professional networking and kind of community stakeholder-building perspective."<br><br>"Well at a Steering Committee meeting … they meet and give about updates on the issues that are going on in the different programs, and they discuss them and ask questions to the audience sometimes. And I think they're very informative."<br><br>"… my experience with MFP is one that it is a very valuable meeting, that the items that are discussed, we can expect action | And so the fact that we don't have any kind of consistent administrative support from the MFP office is very difficult…. we used to have volunteers take the minutes, and in recent meetings Dawn has been taking the minutes which is really not effective at all. So I think that would be the biggest thing is having the support to be able to kind of have a central place that all the information comes out of so that we can get agendas out more than the night before and get minutes out and that type of thing."<br><br>"I think that there are some people on the Steering Committee who find it a little challenging for transportation, but I think the transportation's always going to be a concern."<br><br>"Well I think one of the things that always is frustrating about Steering Committees or groups is there's many people that sit in those committees that are wonderful advocates … and they think they know how things work but they really don't understand how things work and sometimes they're not necessarily advocating for the correct stuff. … The other frustrating part has been [trying] to keep some of the self-advocates themselves engaged whether it's because of transportation or their own physical health or whatever….It's really good to get people who are receiving the services to be part of it."<br><br>"… Information is shared but I still think … the meetings are one-sided." | "The Steering Committee is led and has always been led by great co-chairs who I just think do a great job, and the entire committee does a great job. I mean for me it's just a great opportunity to be able to touch base with a really trusted, reliable, incredibly expert group of people who just want to see the same goals achieved."<br><br>"I feel that everyone is really invested who comes to those meetings and it's always a very good dialogue with a lot of different perspectives. And so I think it's very valuable and I think it's really important for the program.<br><br>"The only thing I would have is having public comment at the end as well as at the beginning so that the public has the opportunity to respond to what goes on in the meeting."<br><br>"… we don't hear about the specific challenges, problems that are occurring really. And I think if there was either some time set aside or some opportunity to really hear about what some of the ongoing challenges from the people being served by MFP. I think that would helpful….But to be able to have the Steering Committee perhaps be able to problem-solve on some things that are kind of more systemic in nature that perhaps we could have input into I think might help."<br><br>"And so I think that it's got great leadership with Dawn and the ability |

| Meeting | Meeting description | Productive | Challenging | Respondent suggestions or comments |
|---------|---------------------|------------|-------------|-----------------------------------|
| | thinking across different agencies and breaking down silos.…I think that puts us in a good position for success moving forward." | on them…"<br><br>"… my experience with the MFP Steering Committee that I like is that it was, there's a lot of dialogue. So there was a lot of problem solving and trying to figure out what works the best. So even if there were bumps in the system … the focus was on how to overcome these challenges effectively. And it felt like a productive committee." | "I honestly think that they're meeting monthly for the sake of meeting and not because there's content, and I … don't have half a morning or half a day every month to devote to that to hear the same information. … it's not a good use of peoples' time, given the frequency and the length and the rambling of the meeting. | to really kind of make a difference. And I feel that that's really singular to this Steering Committee. I think that we really do make a difference in terms of the direction and the challenges of MFP." |
| SCM/TC/HC Supervisor's Meeting | "Well the typical meeting is facilitated by the MFP Team Leads. … there is a good representation of the access agencies and any of the agencies providing the transition and housing coordination. And there are also representatives from UConn, and very often Allied representatives attend. Generally, the agenda is sent out by [Name] a little bit before the meeting, and we're given opportunity to send in suggestions for agenda items before the meeting."<br><br>"The transition coordinator supervisors from the Access Agencies and CCCI, and the 2 leads from DSS lead the meeting. [Name] and [Name]. [Name] is usually there. So MFP leadership is there and all the statewide TC supervisors. The outside DSS agencies – DMHAS, DDS, and that's it. Just the 2 of those of the outside agencies."<br><br>"… the second Tuesday of every month. We go up to DSS in Hartford, and we [meet] just | "I think that they're helpful in terms of when discussions come up about processes or questions or requests for suggestions about changing processes or paperwork. I think that's very helpful."<br><br>"Very helpful. That's where we get the updates on any new initiatives and updates on ongoing things and have a chance to ask questions and get training on process, MFP process."<br><br>"… And generally it's a good discussion. I think – it feels as if people feel comfortable asking questions and seeking input."<br><br>"The Supervisors meetings are pretty productive in that all of the supervisors, obviously, are there, and we can hear from each supervisor how things are working with their respective agencies and any challenges that they're having as well as successes and things that are working well, questions that they have regarding transition budgets or overall processes and being able to really describe and explain the processes from our perspective but also getting a | "I think where sometimes [we] get stuck is that at the end of the meeting. There are usually a few items that we're told will be followed up on with updated processes or paperwork in the future, and I don't think that that always happens. I think sometimes we're all too busy and there's a lot of change underway at the same time, and sometimes we – it seems like we have good discussions about what's needed, but then it falls through on the other end where the things don't get resolved."<br><br>"I would definitely like to see an action plan that the group approves. Things that we need to do when we come out of the meeting. I think a lot of times we identify things and it seems like it goes nowhere. It's kind of just a gripe session instead of actually being more productive."<br><br>"I think, there's lots of system changes that we talk about that are needed and then we don't get reports back on those suggestions or the recommendations we make so it looks like nothing is being done." | "Well I think it might be helpful – I don't think we've ever had any follow-up minutes or a follow-up list of action stuff, but I think that might be helpful. And then to identify who would be following up on something and then to send out – by email or somehow – an update prior to the next meeting. Or it could be something that could be reviewed at the next meeting to see where we are in terms of the action steps."<br><br>"Well, the supervisors meeting we are definitely kept informed. That's something we – that's one of our topics that we talk about every month is MFP updates. And they do let us know about the new programs that are coming out, if they're going to have trainings on them so like we're definitely kept in the loop."<br><br>"I think they definitely identify a lot of challenges. We get updated on the new things that are happening and we are educated on the new processes or on the old processes that aren't quite understood." |

| Meeting | Meeting description | Productive | Challenging | Respondent suggestions or comments |
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| | as a team … we have an agenda … we let them know otherwise they create the agenda for us." | better understanding of what they're seeing, especially when they're requesting like a process change or making a suggestion or having some type of a difficulty or something. It's a great opportunity to discuss those issues and work through those."<br><br>"… it's definitely worthwhile. We get a lot of information from these meetings, and they're very important." | | |
| CO Meeting | "… we have a weekly meeting every Thursday and that's all of us here at staff, our eligibility workers, social workers, our health program assistants and associates, Dawn and Karen as well." | "… With those meetings, they're productive to a degree. We definitely increased the effectiveness of the meeting in terms of kind of discussing various projects that we're working on and getting an update on things like CFC or processes changes or things that are coming up or questions that we may have. So those meetings have gotten better." | | "The Central Office meetings are just really important to be able to communicate what's going on and to hear from the staff what their priorities are and to make sure there's open communication within the Central Office here because there are a lot of people that I currently supervise, and it's hard to day to day touch base with all of them. So I think though its primary objective there is to make sure that everybody knows what's going on and for people to be able to identify problem areas."<br><br>"The staff meetings, we use a different report that UConn does, which is our staff satisfaction. They've often provided comments to help make that meeting more effective. It's gone from a 2-hour meeting to a 1-hour meeting for example." |
| Contractor Meeting | "… We used to have a contractors meeting.  We stopped having those. She doesn't have a contractors meeting with us anymore. And about once a quarter the directors of all the agencies would get together and have a contractors meeting. They were very helpful because we could bring problems that we saw to | | | |

47

| Meeting | Meeting description | Productive | Challenging | Respondent suggestions or comments |
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| | the table. But we haven't had those this year." | | | |
| Discharge Meeting | "And the discharge planning meetings, those typically involve the SCM or myself for the ones that I attend, the housing coordinator sometimes, the facility social worker, consumer, nursing staff, PPO team and possibly their family or friends or anyone that they would like to have at those meetings. And it's really just to discuss their current status and progress and care needs post transition, any need for other unique equipment or PC equipment. It's just really a good opportunity just to see where the consumer stands prior to returning home just so that we make sure that everyone is on the same page and that services are put in place appropriately so that their return home is successful and safe to the best of our ability." <br><br> "… always the Transitional Coordinator, the Housing Coordinator, myself, either the Assistant Director of Nursing or the Director of Nursing. If the patient was involved with therapy, the therapy staff, the patient and the family." <br><br> "… The things we talk about are the things that are needed to be set up in the community for this person. Trying to take as many of the challenges even some of the risks and plan for those types of things. A lot of times we talk about things that may have been overlooked." | "I found them to be productive. I found that it was very good in that they let us know or the team know what the status of the discharge was, if there are hold-ups and an explanation for that. It was primarily a great communication tool. What's going on? Where are we at? What are the hold-ups? And what MFP process was in that? What the MFP process was and whether if there was a hold-up. If so, was it because of a glitch somewhere or a set-back with the MFP process or was it a problem where the patient maybe had a set-back? So they were in the way of communication so that everybody could be on the same page and have an understanding of the status of the discharge." <br><br> "… it's very helpful because as team we want to make sure that we have – the client is all set to go home. Education is completed. DME [Durable Medical Equipment] is ordered. The doctor's appointment is set up so we kind of sit there and make sure there's been no changes medically to the person. Do they need to get reassessed? So like kind of all of that would come up at the meeting. So we make sure the person is all ready to go. So it's definitely helpful." | "Sometimes the nurses aren't always there. So we always ask that somebody or a representative if it's not the director of nursing if it's the nurse on the floor….So, I mean, obviously I would rather have – we want the nurse to be there because their input is obviously very important and essential to safety - to discharge." <br><br> "… It's difficult getting everyone there even though we request it. I know I request it every time, many times the SCM hasn't been there. I think normally that's in the cases where it's a State disability plan. I'm not sure why. I mean we still have challenges that I think could use the input of the SCMs." | "Well I think they, most of the time they [discharge meetings] put the consumer more at ease. They take away some of the anxiety for them. It definitely makes my job easier if everyone involved understands what their roles are. I think we do identify everyone's roles and it just lays out kind of a checklist for what we plan to do on that day of discharge." <br><br> "The meetings are good….we set up the transition date, and we go from there. So that's the meeting where we determine when client's going home, what is needed next, specific doctor's appointment has to be made. We need to make sure that visiting nurses are involved always. We need to make sure that client has DMEs that are needed. So that's the meeting that actually is the most important of all of them because it determines the date when a client transitions home." <br><br> "… I normally lead the meetings. If the consumer's capable, I kind of instruct them on what needs to be done. They could lead the meeting. I think it should come, if possible, from their request. In many cases when the SCM has been there, I think it's kind of a co-leading situation, co-chair, if you want to call it that, situation." |

| Meeting | Meeting description | Productive | Challenging | Respondent suggestions or comments |
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| Retreat | "… the primary reason for the retreat is to try to intentionally touch base with the entire field workforce at least once every 4 months to provide information and also to try to establish a central point for the development of a common culture. So everybody works in different organizations and different companies, and so it's really hard – nonprofits – and so it's really hard to establish a common culture when everybody day to day is surrounded by a different work culture. So the real primary objective of that retreat is for it to kind of take on a culture of its own that's specific to Money Follows the Person and build synergy from that common goal that everyone has as they gather there."<br><br>"Most of the times I get updated about that either through emails or at the retreats that we have four times a year. So they updated us a lot about CFC and like how that was working, and we had a lot of break-out sessions about that."<br><br>"I believe at the last one it was decided they're going to be cut back to 3 times a year, once every 4 months instead of once every 3. It's hard to set aside a whole day every quarter. It's a whole-day meeting, and it's usually in some somewhat centralized location." | "… I like learning about the things at the retreats because they go more in depth and it's easier than reading like an email or something like that because you can ask questions and go back and forth."<br><br>"And also with our quarterly updates [retreats], I guess. Hearing how well we're doing compared to other states is also a huge inspiration, I guess, that we're doing well for such a small state in so far as the number of transitions we've had."<br><br>"… They're helpful. They're always packed with info, and it's a good chance to network with people you don't often come into contact with. So they've been very helpful."<br><br>"So we talk about different issues, different problems that we have. … it's usually one day, whole day long of different trainings and different groups and brainstorming and problem solving and some activities to maybe connect us. … We have some main goals. … everybody has to discuss the cases. It's helpful I think." | "Sometimes it's a little too far for us to travel, but I guess since it's only quarterly I shouldn't – it's not that bad, but sometimes we're going all the way like an hour away."<br><br>"… people didn't go to breakouts at one point; they stayed in the central gathering room. So how can we make sure that more people feel committed to going to workshops that they signed up for, making sure that people are really using the time effectively? We talked about the structure of Keeney Center and whether or not we thought that it was still effective for our purposes. We talked about specific workshops and like who might be invited back and where maybe there were weaknesses. So we'll be making improvements based on all of those things." | "We just had an after action report about the retreat, about ideas that we could implement to make it better based on what we hear."<br><br>"The MFP retreat … those are really great because we do a lot of networking. You see a lot of other MFP staff throughout the state so that's really good. And they do have breakout sessions on various topics which I think is really good. It's one of my favorite parts. You get to pick what breakout sessions you want to attend. It could be something on housing. It could be something on the ABI waiver. It's different every quarterly meeting."<br><br>"… Last retreat they introduced CFC to us which is Community First Choice. … We went through the whole process. They demonstrated, they give us example of how to fill out the forms, how to explain the program to us. So I guess it's – I don't know how to say it. I guess it's like – information, like it's learning experience for me. I go and I learn something new and then I try to implement that." |

# Appendix C: 2015 Key Informant Interview Guide

<u>Role</u>

First I'd like to talk with you about your role with the MFP program in 2015.

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

2.  What has your experience been like?

**HCs, TCs, & SCMs – Unless a TC or SCM Supervisor, Skip to question 5.**

3.  *[If not yet answered]* Do your regularly participate in any MFP committees or meetings, including any MFP Supervisor, staff, or Discharge meetings?

<u>Meetings/Workgroups</u>

4.  Please describe a typical [committee, Supervisor, CO Staff, discharge, etc.] meeting. (*If necessary add:* We cover the SCM-TC-HC team meetings later in the interview.)

    Use probes to cover the following:

    4a.  Who usually attends the meetings? I'm not looking for names, just the roles they play.

    4d.  How are the meetings productive or helpful for you?

    4f.  What, if anything, would you change about the meeting or its structure?

<u>MFP Program goals and progress</u>

5.  I'd like to talk with you about the current transition process which uses regional teams. Teams usually consist of a Specialized Care Manager, two Transition Coordinators, and a Housing Coordinator. This SCM/TC/HC team process was used throughout 2015, and we would like your feedback on it.

    5a.  What do you think has worked well with using this SCM/TC/HC team process?

    5b.  What has been challenging or frustrating about this process?

    5c.  What effect has this process had on CT's MFP program?

    5d.  What suggestions do you have to make the transition process more effective?

6.  In 2015 there was a lot of activity in creating, testing, and implementing the new Universal Assessment, or UA. The Universal Assessment was designed to be used across all home and community based programs to evaluate an individual's need for services and supports.

    6a.  Were you involved in the process of creating or testing the Universal Assessment instrument?   Yes / No

    6b.  Have you used the Universal Assessment to assess anyone for Money Follows the Person or for Community First Choice?  Yes / No

<u>If Yes to either a or b:</u>

    6c.  What are your thoughts about the **process** of developing and implementing the Universal Assessment?

<u>If No to both a and b:</u>

    6d.  Are you familiar with the Universal Assessment? What are your thoughts about it?

Next, I'd like to talk with you about Connecticut's MFP program overall.

7. What were some of the major achievements or best practices of the MFP program in 2015?

   7a. What has supported or facilitated these program achievements? (Probe: What are the strengths of CT's MFP program?)

8. When asked about achievements, people often mention transitioning individuals out of facilities. How do you define a "successful transition?"

9. *In addition to _____ you mentioned above,* what MFP program barriers or challenges did you encounter or observe in 2015?

   9a. What could be done to prevent or overcome any program difficulties in the future?

**ASK TCs, HCs, & SCMs questions 10-15. For everyone else, skip to question 16.**

TC, HC, SCM:

Next I'd like to talk with you more about the MFP Team you are part of.

10. First, please tell me about the make-up of your team. For example, how many TCs, HCs, and SCMs are on your team?

   10a. Are you all from the same agency or different ones?

11. In general, do you usually work with the same people, or do your team members change?

12. How do your team members keep you informed about any new updates in a consumer's case?

13. Do you meet as a whole Team, with all the SCMs, TCs, and HCs assigned to your Team?

   13a. **If No,** Do you meet with some team members on a regular basis?

14. Please describe a typical Team meeting for me.

   *Use probes to cover the following:*

   14a. Who usually attends the meetings? I'm not looking for names, just the roles they play.

   14b. How often do you meet? Is that enough?

   14c. What do you usually talk about? For example, do you review every open case, or the ones in the transition process, or something else?

   14e. How are the meetings productive or helpful for you?

   14f. How do you as a group make sure that the goals set in the meeting are met?

   14g. What, if anything, would you change about the meeting or its structure?

15. What would you recommend be included in a "Team Best Practice Report" on what has worked for your Team and why it worked?

Structure and process

16. Overall, is there anything (else) you would like to see changed about the organization or structure of the MFP program?

17. [If not yet answered]: The MFP Steering Committee is now called the Medicaid Long Term Services and Supports Rebalancing Initiatives Steering Committee. Is there anything you would like to see changed about the process or structure of the Steering Committee?

18. There were many new or ongoing initiatives related to MFP in 2015, including Community First Choice, TEFT, MyPlaceCT website, Balancing Incentive Program or No Wrong Door, the Universal Assessment, Nurse Delegation of Medication administration, and the nursing home rebalancing grants. How are you kept informed about the current activities or new initiatives of CT's MFP program?

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

<u>Education and Training</u>

Now I'd like to ask you about training and education.

20. Currently Transition and Housing Coordinators complete an online education course covering topics such as consumer assessment, choice and control, team approach, and informal caregivers. What other training or education you would recommend for TCs and HCs?

21. Currently Specialized Case Managers receive Motivational Interviewing training. What other training or education you would recommend for SCMs?

<u>Systems change</u>

22. Our last question looks at the program overall. What effect do you think MFP has had on CT's long term services and supports system in general?

23. Is there anything else that you would like to add?