Money Follows the Person Rebalancing Demonstration

Process Evaluation
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Introduction

Information for this process evaluation came from the analysis of interviews with key informants (KIs) reflecting on the operation of the Connecticut Money Follows the Person (MFP) Demonstration from January to December, 2016 when the eighth year of program operation ended. The goal of the annual process evaluation is to monitor program activities and determine how well they are delivered and to explore how well 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, the Long-Term Services and Supports Rebalancing Steering Committee, advocates, Medicaid Home and Community-Based Services (HCBS) waiver managers, Access Agencies, Independent Living Centers, and field staff who work to transition consumers from nursing homes and other institutions into the community. KI 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 A.

Methods and Analysis

Twenty-eight KIs completed telephone interviews sharing their experiences in the eighth year of program implementation. Administrative respondents included: the MFP Manager, Community Options Strategy Group; Director of the Division of Health Services; Director, Community Options Unit; four MFP Central Office staff; a Co-Chair of the Steering Committee, and two Steering Committee members. Other informants included the directors or representatives of three contractors, one fiscal intermediary, and three Medicaid HCBS waiver managers (some KIs held multiple roles). A total of thirteen field staff were interviewed and included: two Specialized Care Manager Supervisors, three Specialized Care Managers (SCMs), five Transition Coordinators (TCs), one Transition/Housing Coordinator (TCHC) Supervisor, and three Housing Coordinators (HCs).

To gain a better understanding of team practices and how teams function in the transition process, with the exception of the Specialized Care Manager Supervisor, field staff were selected from two Regional Teams using purposeful sampling and team members on those teams were interviewed. The teams selected met the criteria for being a stable team and had two or more team members (SCM, TC, or HC) that were part of the team throughout 2016. While there are numerous benchmarks for MFP contractors, selection of the Regional Teams was based on performance in meeting two specific benchmarks: 1) number of transitions overall, and 2) number of transitions in under 180 days. One of the teams chosen was a higher performing team and the other was a lower performing team. Based on the two benchmarks, all members of the higher performing team were high producers while the productivity of individuals on the lower performing team varied.

Each interview assessed the respondent's observations and experiences about his/her own role, the team experience, MFP program achievements/success and barriers/challenges, Community First Choice, TC/HC/SCM education and training, the Universal Assessment, and sustainability of the program. Responses from all KIs, including comments and suggestions, were synthesized into this report. With the exception of one interview, all interviews were audio-taped and transcribed. On average, interviews lasted approximately 54 minutes. All were analyzed using ATLAS.ti, a qualitative data analysis program. Overall results of the analyses fell into the following eight categories:

- ➢ People Participating in the Process
- ➢ Team Experience

- ➢ Program Achievements and Successes
- ➢ Program Barriers and Challenges
- ➢ Community First Choice
- ➢ Education and Training
- ➢ Universal Assessment
- ➢ Sustainability

People Participating in the Process

In the evaluation this year KIs were asked about their role, what makes their work meaningful to them, and how their role may change once the Demonstration ends. They were also asked how their role creates positive change in the long-term services and support system (LTSS). Responses were divided into the following subheadings.

- ➢ Meaningful Work or Role
- ➢ Future Work or Role
- ➢ Recommendations to Keep People Engaged and Motivated
- ➢ Contributions to Positive LTSS Change

Meaningful Work or Role

KIs described many reasons their MFP role was rewarding including the opportunity to: learn and develop skills, foster change in creative ways, provide a better quality of life for consumers, and help consumers be more autonomous. Respondents were passionate about being able to impact consumers' lives and described a sense of fulfillment when outcomes were positive.

> … coming in every day and having that opportunity to do something that's not necessarily in my job description and being able to learn something and continue to learn. That's incredibly meaningful to me and encourages me each time.

> I think the fact that I feel like I have the opportunity every day to make real change, to make things better, to work out a process that's been evolving for a number of years and will continue to evolve, making Connecticut a place where seniors, elders, people with disabilities can live and function in the way they want to.

> It's rewarding to be able to find a particular home that a person is happy and comfortable in and also to have them out of the nursing facility and back into the community and living independently.

> Like I said, it takes a village and especially as you grow older or if you've just been – if you're younger and have a disability, there's a lot of emphasis on keeping your independence in the community and reaching your highest potential. And so I really enjoy giving that opportunity. I really enjoy empowering others. It just provides you with a great satisfaction, and what better way to do it than to help as many people as I can.

Having a positive impact on consumers by sharing something as small as a smile contributed to satisfaction with work.

> I have this consumer – she was very difficult initially. Like the first visit, she was very mean and unresponsive but with time … you have to be patient and you have to know who you're working with … So with time and with her getting to trust me, I finally discharged her home, and she said to me, "Every time you come in here, you're smiling even when I yell at you or I tell you I don't need this or I don't need that." And with little things like that, it boosts your morale and you to do better. It's very exciting to know that the little things that you do … brightens somebody's day up and they want to do better as well.

In addition, a gift of gratitude, as expressed by consumers and families, brought meaning to a KI's role.

> *Seeing how I am able to impact someone's life and help them change their life, help them improve their quality of life by just being their eyes, their ears, giving them the motivation to move forward because sometimes I see that we have some individuals in the nursing homes that with a little help are capable of being independent and living in the community on their own. So it's very gratifying when I'm able to see someone transition and how grateful they are for the process and it's just an overwhelmingly great experience for me.*

Some respondents noted that liking their job and the team members with whom they worked added meaning to their work and role.

> *Honestly, it's the people that I work with, not just the consumers but my team as well and the people that I work with. They are wonderful. So it's nice to come into work liking what you do and not only just liking what you do, liking the people that you work with.*

Future Work or Role

For many KIs, looking to the future cast some doubt about their role as they anticipate the end of the Demonstration. However, most respondents felt they will be in the same job with only some changes to their roles.

> *Well, I don't see the advocate's role changing, that is to say representing clients will be the same as it was going forward. So I don't see any change in that. The only thing that changes is the legal strategy but the representation remains the same. The Steering Committee, likewise, has the same, I mean, the members of the Steering Committee function are the same way. The Steering Committee is advisory, but my role as I've seen it has always been to particularly look after the interests of people who are disabled, so that would continue. I don't envision that changing.*

> *I see my role changing in the future as continuing to approve the care plans and I think that that will become a primary role and there will be less of a role in creating, changing and moving policy ahead.*

> *Honestly, I do because I like what we do. I do like that things are changing. This is something that's very fast paced and nothing, not one day is the same. So I can see myself doing this a few years from now.*

> *Well, if you're talking long term, and we're talking about the future of caregiving as we know it, the increase of geriatric populations over the next 10 to 15 years, there's going to be a large role of in-kind support. So I see myself in my role, as my cases go up, I can see myself becoming more of an options counselor and support broker than a care manager because I'll be dealing with a lot of in-kind services as well as formal supports.*

> *… I don't see it changing too much. Well, I guess I see it expanding to cover more of the quality assurance role … reviewing the critical incidents and looking at the work that we do from a systemic standpoint to kind of assess whether or not there are things that we can change at a policy level. So I see it expanding more in that regard, more quality assurance-related tasks.*

Recommendations to Keep People Engaged and Motivated

Several TCs and HCs suggested that opportunities to advance in their work within their agency or at another one motivated them in their work.

I would eventually like to become a Specialized Care Manager. So that's actually why I'm currently leaving the position that I'm in right now because, just … there's no movement at the agency that I'm at.

In striving to maintain a workforce that remains engaged and motivated, several contractors recommended hiring people who demonstrate flexibility, critical thinking skills, and a high level of commitment to their work.

Adaptability, lack of preconceived notions or judgement, ability to think critically. Our waiver care managers tend to be good rule followers. That doesn't work in Money Follows the Person. You have to be able to assess risk and think critically about it but also think about a way out, the balance between consumer choice, assumed risk, and what we would typically say is unacceptable in a community setting. And it's two completely different trains of thought. And if you try and force a good rule follower into the Money Follows the Person program, they're not successful.

If you don't feel very passionately about that, as those of us in the disability community do, then you won't last long in MFP. If you just look at it as a regular social worker job or something, forget it. You'll get burned out and you'll quit. And there is a lot of turnover in the project, tremendous amount of turnover …

Contributions to Positive LTSS Change

When asked how their role created positive LTSS change, respondents suggested that being open to doing things differently and looking for opportunities to create change were important characteristics that contributed to positive change. Being able to initiate new ways of doing things and tolerating the discomfort that comes with that process were also viewed as necessary in effecting positive LTSS change.

… So I think that we're creating that positive change by being open to doing things very different, by being a change agency, an agency that instead of looks at all the negatives about changing a process, looks at it as an opportunity to better the way that we support our clients and better the way that we support our employees because there's definitely a connection between the wellness of our employees and the outcome for our clients.

But for me, the real piece of this is the systems change aspect of things – the innovation, the new services, the way structures have to change in order to make this work… Well a number of things have changed over the years with Money Follows the Person, and all change happens not because we sit around comfortably and think of how things could improve. Generally it's because of pain. And systems change is no different. When barriers are pushed and pushed, they crack, and new services, such as mental health services, substance use supports, have occurred. CFC has taken off. The support and planning coach, I see that as a very positive beginning of some systems change that really was initiated years ago, and it's still floating around and becoming a reality.

Last, but not least, being a champion in their role and promoting MFP was viewed as sending a positive and public message about the program. This included the valuable contributions of the Steering Committee and the ability of the program leadership to optimize federal initiatives in CT.

… our role is one of Champion. My role is one of Champion. I meet with a ton of people in the community, and often Money Follows the Person is not well received. It is not something that is seen as a positive thing. So I'm someone who … has the ability and the position to be able to reframe that for people and make it more personal. And I would say for me the biggest direct impact is being able to be a Champion and also on the

outside, external, in the public and then internal to the system, the long-term services and support system. It's having a voice that I believe is respected and one that in an environment where innovation is appreciated as well as creativity.

Currently what happens is I think we're pushing the envelope. We're looking and we're saying you can receive the same services and the same care in your home that you receive in a nursing home. And by consistently putting that message out there, I think that over time it does cause a change in the way people view where they can get their services and how they can get their services. So I think by every care plan that's approved by every individual that's able to move back to the community, it gives us all hope for the future.

I have worked in non-profits, worked in coalitions for well over 20 years, and I think that this Steering Committee is one of the strongest and most influential of any that I've worked with and I think it's a real, it's a very good partnership with Dawn and the MFP staff who really truly come to the Steering Committee for input and it's not just the reporting to us and kind of checking off that box of I've done what I needed to do but really taking a look at this very diverse group of professionals and consumers and advocates in terms of how things are working, how things are not and how to move forward. So I think it's made the program much stronger and we've been able to see challenges and kind of how to deal with them really as a whole team, so I think that's been really important.

… So I think we really have the opportunity not only to optimize our use of federal initiatives, which I think Connecticut has done an amazing job of, really utilizing each and every ACA [Affordable Care Act]-related LTSS feature. And then, as I said, kind of building in the plan for sustainability in support of really achieving the goals of the rebalancing plan. So I think … we're the lead agency on the rebalancing plan for the state under the governor's leadership.

Team Experience

Teams play a major role in managing Connecticut's MFP transition program and are key to the success of the program. For this evaluation, nearly half of informants were active on a Regional Team for part of 2016 as either Specialized Care Managers (SCMs), Transition Coordinators (TCs) or Housing Coordinators (HCs).

Although the focus on teams this year was to compare the team experience of a higher and lower performing team, one additional SCM from a Team One was interviewed. Team Ones are structured differently than other teams. These teams usually have one or two TCs and HCs working with multiple SCMs from three different waiver programs: DMHAS, DDS, and ABI. Feedback from Team Ones continues to be valuable in better understanding the overall process of teaming and best practices.

KIs on both the higher and lower performing teams as well as a key informant from Team One were asked about team descriptions and meetings, transition effectiveness, the regional team process, and best practices. Outcomes of team experience were organized into the following categories:

> ➢ Team Descriptions
> ➢ Team Meeting Descriptions
> ➢ Team Meeting Communication
> ➢ Team Meeting Productivity
> ➢ Team Meeting Goals

- ➢ Regional Teams
- ➢ Assigning Members to Teams
- ➢ Transition Effectiveness
- ➢ Regional Team Process
- ➢ Additional Feedback on Teaming
- ➢ Team Best Practices
- ➢ Respondent Recommendations

Team Descriptions

Teams typically consist of a SCM, at least two TCs, and one or more HCs. Field staff on the higher performing team were all from the same agency. Members of the higher performing team stated that they always worked with the same people.

> *Honestly, in the last year, I've been working with the same people. Very rarely – the only reason it changed was because our housing coordinator moved to a different region and that was only in the last month or so. So previous to the last month or so, I've been working with the same people constantly.*

The higher performing team also utilized the expertise of a TC who was not part of the official team but was described as a "float" and worked with all the agency's consumers needing bilingual services.

The lower performing team was a mixed agency team. Although this team was a Regional Team on paper, team members described it as two separate teams which shared numerous SCMs, with one team consisting of the TCs/HCs from one agency and the other consisting of the TCs/HCs from a different agency. Although the team met our criteria for a stable team, several KIs commented that their agency experienced a lot of staff turnover and struggled to become more organized or stable. Team members commented that they mostly worked with the same people, and these were within the agency they worked for and not with the other agency. It is significant that one of the TCs on this team was only acquainted with those who were located at the agency where they worked and had never met other members of the official team.

> *We have two TCs and an HC and a SCM on the team. Lately, I'm not exactly sure what the teams are because it's difficult to stay with teams because both our agencies are trying to - well, let's face it, we're trying to save money. So we're trying to keep certain teams in certain areas … I think whoever you're working with should work as a team, not necessarily a designated team because you can't do that, because of the way the referrals are spread all over the state …*

Well we are trying to restructure and to regionalize our department so that we have a little bit more consistency with who we're working with and who works in which facility, to cut down on travel, and then also, at the same time, it kind of increases the likelihood that you can collaborate on multiple cases whenever you do make contact with each other.
The Team One informant officially worked with TCs/HCs in one region, but also at times worked with field staff in a different region if asked to. People she worked with were usually the same ones and did not change unless someone left the agency and a position had to be filled.

> *I go wherever [SCM Supervisor] tells me to go. And if she says "Hey, listen, I really need help here. I know that it's way out of your way, but would you take it?" And it's like, yes, of course … I mean unless they leave the agency, I'm usually with the same people.*

Team Meeting Descriptions

Team meetings refer to the official teams that are composed of a SCM, TCs, and HCs. These are differentiated from Regional Team meetings which are discussed later in the report.

Higher performing team members described meeting once or twice a month with their whole team, but described other meetings that occurred with only the SCMs and TCs in between more formal meetings. Having a team located in one agency was underscored as advantageous because meetings and communication could take place more easily.

> *Sometimes the SCMs and the TCs would meet without the HC, and then, they would kind of fill us in when they got back to the office or vice versa. If somebody was out, they would kind of fill in as to what's going on … Because the two TCs are in the same office, we constantly, if there's an issue that comes up right away since we're all here, we just say, "Hey" and then we discuss it if they're here or send them a text or a phone call. So it's pretty regular.*

Team meetings for the lower performing team were mostly split along agency lines. The SCM had one team including field staff from two agencies, and met separately with the TCs/HCs from each agency about once a month. A striking difference between the higher and lower performing teams was that the lower performing team did not meet as an official team with staff from both agencies. Instead, all the SCMs met separately with staff from each of the two agencies.

> *We try to as often as possible … but to be honest, just with the restructuring and with multiple people out, timetables are a little tight, and so it's probably more close to monthly.*

Overall, the higher performing team meetings focused on reviewing the progress of consumers that were in the process of transitioning and any related concerns or issues.

> *We usually do the pre-transition people and sometimes it would be some of the post transition people. If we had any issues, she would usually just address primarily the pre and then after the meeting she would ask if anyone had a concern or anything about any other consumer that we did have post or pre-transition that we didn't have time to discuss.*

> *We talk about what's going on with this person and update and then the HC has an update and then we go to the next person. And if that's my consumer, I tell them what's going on with them. If I need help, I ask. If there's something that's bugging me, I tell them about it, and they can direct me on what to do with it. And we go through the whole list. And after if you have a concern, we talk about it and we meet the next week.*

Similarly, the lower performing team meetings focused on reviewing cases, providing updates, and addressing other related concerns. Additional meetings with TCs or HCs who were unable to participate in a meeting sometimes occurred as opportunities presented themselves and were described as an "informal case conference."

> *... we, actually, would have everybody go to a big kind of almost case conference, and then we'd almost cycle through each other discussing various cases here and there with almost everybody. So it's like say [Name] had a case with [Name} and [Name]. They'd talk about that case. And then [Name] would almost come talk to me about a different case. And we kind of all got together to collaborate and shoot ideas off each other. It was wonderful.*

> *And then sometimes if you don't have the luxury of having the HC involved or a TC involved, you could sometimes say, I'll meet for a discharge plan meeting at a facility, and both me and a specific TC have a little bit of time after, and we'd have almost an informal case conference about all of our cases either at that facility or in general, any updates or hot cases as it were, etc. And, so really, I like to do it as often as I can.*

Like both the higher or lower performing teams, Team One meetings with the SCM, TCs and HCs included reviewing cases and focusing on new developments. When there was an issue, a phone conference or in-person meeting was arranged.

> *We review each one of our cases, give an update, has anybody had any communication, is there any new developments of either housing or the transition part as we can look so far. But if we don't have the housing, the funding and the staffing, we're not at that stage yet.*

> *I'm continually on the phone with them, a group phone conference probably six times. Yes, when there's an issue … my to do list is to reconnect and see if we can start scheduling a phone conference or somewhere maybe meet face to face ...*

Team Meeting Communication

Team members of the higher performing team described effective communication that was enhanced by being located in one agency and having good interpersonal relationships. Communication included emails, team meetings, phone calls, text messages, updating case notes on the MFP web, and Skype. Referring to the Action Plan and team member roles/responsibilities was also mentioned as crucial in communicating about cases. The bilingual TC that assisted this team attested to regular communication with them.

> *My team was wonderful about anything. Anything that happened, we would either shoot a quick email, phone call, text message if we were out on the field or through Skype through our iPads. We were able to communicate basically anything that happens in real time. We were able to do it quickly.*

> *So because we've always worked together ... We're like family. So we're very in touch with each other. We email. We have each other's personal numbers too just in case we're not on the job and something pops up and you want to really give a call or email the person real quick. So we're kind of in tune with each other. We're friends. We hang out. So it's easier to share information and update each other on whatever is going on. And most of the time, we try to put the note [in the MFP web] until we all go to a meeting. So whoever puts it in first, we just write our names in. And then if you go – let's say you forget, so later on you go and they just add to it. We're very in touch like that. We've known each other forever.*

> *I'm very in tuned with my caseloads … If it's something on my end that I'm struggling with, whether it be a birth certificate or Social Security card that's holding up the process, I also try to communicate that with the team. Because I'm a float, I'm not a part of their team meetings …*

Overall, field staff for the lower performing team reported good communication across the agencies that made up this Regional Team. Like the higher performing team, most communication was done through emails, phone calls, and the MFP web. Communication challenges were noted when it was difficult to have in-person exchanges at team meetings.

> *We email a lot. We text. We keep the case notes up to date. And we had periodic [intra-agency] … meetings, as well, to update.*

> *And [getting to meetings] was the biggest problem. So we said, "Hey, you know what, we'll meet when we can but let's keep good communication with emails and phone calls." And it's been working … we're keeping our communications because it's very difficult to get a team meeting with all our schedules … And plus, the database is kind of self-communicative too. So that's a big help.*

Team One described communication that included the use of cell phones and texting. There was also heavy reliance on the notes in the MFP web to track the progress of cases.

> *Well, I refer daily to the notes on the MFP database because I know everybody's life is busy, and they don't have time to call me every day. Other Housing and Transition Coordinators communicate differently. I know that [Name] and [Name] in my opinion have more regular communication with me, I mean to the point that we each have each other's personal cell phones. We do texting. They're always accessible to me. And [Name] is fantastic. I mean she does the best she can, and when she doesn't know, she says "I'll get back to you," and she does.*

Team Meeting Productivity

Higher performing team members described their information sharing and problem solving as instrumental in experiencing productive meetings. This productivity was supported by in-person meetings and through other communications including texts or phone conversations. Team members described themselves as highly focused with each member of the team clearly aware of their role and responsibilities.

> *Yes, we were just very much trying to problem solve and bounce ideas off each other if one of us was kind of stuck on something or maybe come up with another way that we would look or just take a look at it from a different lens and try to go about it like in our own way.*

> *I think it's really helpful because it helps us all get on the same page. When we leave the meeting, we have a sense of what each person is responsible for and where each case stands. So it lets us know what we need to work on for the next team meeting ...*

> *So numerous ways ... but gathering information about where my HCs are at and where my TCs are at in the process of getting ready to transition someone, it's vital information. Because many times I have already completed the work that I need to do and I'm just waiting for my TC and my HC. So it's really to get updates as to what they're doing to continue to move the process along towards discharge because obviously the ultimate goal is discharge to the community.*

Most lower performing team members described meetings as productive and valued informational updates related to cases as much as higher performing team members did. The SCM for this team expressed a desire to have more regular meetings because of the potential benefits of collaboration and teaming but noted the difficulty in achieving it. This team had meetings that were segregated by agency and a meeting schedule that was less consistent and more on an as needed basis than the higher performing team.

> *… it just gives us a chance to make sure that everyone that's being touched at least once a month and that there's a note going in or something productive is happening with that case or at least trying to happen with that case.*

> *Tremendously productive. Wish there was more time in the day. Wish it was even easier to schedule to have everyone come together for case conferences and team meetings because it increases collaboration. It increases teaming … Before going into that team meeting, I didn't know exactly the dialogue that – because as much as you'd like to record in the web and via email exactly, it's these very dense legal conversations that take place and the concerns and what we see on a consumer or on a conservator or from a social worker – when you have that actual in-person team meeting, what I find is that, that TC when they came to me, they got to tell me in detail what they experienced*

*with the consumer, what their concerns were specifically with the consumer, and that
helps give me a clearer picture about the true risks for that case.*

Similar to the higher and lower performing teams, the informant for Team One highlighted the
importance of communication that occurs during meetings and the value of learning from others
as information is exchanged.

*It just keeps us, of who's talking to who. And the notes are okay, but there's so much
that's behind the scenes. Again, it's the communication and I know they're on so many
different waivers where I'm just on the [Name] waiver. And [Name] is relatively new and
is on a learning curve, but she's very knowledgeable and very helpful.*

Team Meeting Goals

On the higher performing team, meeting goals were set by the SCM and consisted of updates to
ensure consumer goals were being met. TCs mentioned the importance of the Action Plan and
clarifying team members' roles and tasks in the transition process. In addition, follow up emails
were mentioned as a way this team makes sure meeting goals are met.

*… I update her [SCM], and if there's something going on on her side because most of
the time I'm doing my paperwork and she's doing her paperwork to get her care plan
approved. So if I'm done with it … and we go into a meeting and I'm done with my
eligibility papers, all I'm going to ask her is, "Are you done with your care plan?" And
she's probably going to say "Yes" or "I have to go back and check on it." So just update
so that next time, when we meet we know if that person is discharging or the person has
a block or something going on just update, update, update – that's the most important
thing that we do in the meeting.*

*Well, we had Action Plans. So we would go through the Action Plans. So we would talk
about if one person – if the TC needed to get a lookback done that they would tell me
what they were going to do. I'm going to make contact with this family member. I'm going
to make contact with this nursing home social worker. I'm going to get the paperwork. I'm
going to set a date. So they would specifically tell me what their agenda was going to be
to reach that goal.*

*I would say with just follow up emails. If I know something is going on with the housing
coordinator, I'll make sure all my pieces are done and then I'll email her and just be like,
hey, I got this done. Do you need anything else or how can I assist? And I would just say
the next team meeting we really talk about what we've already accomplished. Because
usually we meet our goals but then we exceed them because we were doing more work
than just the goals because this is an ongoing process and you have to constantly be
moving forward.*

Overall, the lower performing team did not feel they set specific goals during the meeting, but
had instead the overall goal of moving transitions forward. As part of that process, and similar to
the higher performing team, this team described reviewing cases to determine who is
responsible to address the next steps, referring to the Action Plan, and consistently
communicating by emails and texts.

*I wouldn't really necessarily say that we set goals. I mean, we just kind of go over what
the next appropriate step is for the responsible person whether that be me showing
someone an apartment or submitting inspection paperwork to the State or Megan going
out, doing an Action Plan. Whatever it may be, I don't that we set like clear goals. We
just kind of understood that this is what you're going to work on, this is what I'm going to
work on.*

I'd say a great indicator of – that the goals at the end of the day, I think everybody has got the same goal. It is transitioning individuals to either demo or non-demo sites to get to them to their highest potential. And so I figure a direct way to measure that is individuals that we had tentative discharge dates for last month, were they discharged, was it a successful one. If they didn't discharge or if they failed soon thereafter, what barriers were not addressed appropriately? ... there's the transition checklist, making sure that items that were brought up, new barriers that were brought up last time have been addressed, have been resolved, can be unchecked.

Similar to other teams, the Team One member described following up on goals by reviewing cases and addressing issues as they arise. Meeting minutes were mentioned as a useful checklist to help keep people on task with consumer goals.

It usually is pretty much understood that we go down the list one by one and we all each know where each individual is. And if something has come up, we discuss it. Meeting minutes are taken and almost kind of like a to-do list and then we recap. So and so, you're going to call them. I'm going to do this. The guardianship has expired. We need to do that. Like in one case, I need to petition the court for a new guardian because the COP is missing, those types of things.

Regional Team Meetings

KIs on both higher and lower performing teams were asked if they participated in Regional Team meetings. A few responded affirmatively that they did, however upon further questioning it was clear that the meetings they referred to were either primary team or agency meetings, group trainings (e.g., the transition budget and CFC), or the statewide retreats. The majority of the KIs did not understand what a Regional Team meeting is or would be.

The majority who responded that they did not participate in a Regional Team meeting stated the only time they all came together for MFP was at the statewide retreats. When asked how a regional meeting could be helpful, there were mixed responses from both teams.

Some field staff on the higher performing team did not think a Regional Team meeting would be beneficial, however, several on this team suggested meeting with others from the region would be useful in gaining a better understanding of available services and would provide opportunities for collective brainstorming.

… we don't really have a meeting where all the companies are together, all the regions are together because how I do something in [Agency Name] for a Social Security card could be different from how they do it [Agency Name] and their process might be better, but I would never know about it because we don't have those meetings to have those discussions. Or I might have an issue, yes, or I might have an issue where no one but someone at [Agency] or [Agency] might know.

Similar to the higher performing team, staff on the lower performing team viewed Regional Team meetings as an opportunity to share information and network, but noted how challenging it would be to get so many staff together in one place at one time.

I think yes, to interact and share information especially with housing, just to pass on your contacts. If you're trying to look for a let's say 3 bedroom in Waterbury and you're not familiar with the area, you can contact another Housing Coordinator to say, "Hey, do you know anyone?" Just that kind of networking I find helps.

Wildly helpful. But, once again, with timetables and stuff, I just don't know how to fit it all in.

In contrast to both the higher and lower performing teams, one Team One member stated that in a Regional Team meeting there would be the potential for so much information that it would not be helpful.

> *Sometimes I think there's too much information … when you get overwhelmed or bombarded with all the different waivers, I mean it's interesting but being focused on what my job is and how I can be successful in a time manner that the agency is looking for. I don't know if that sounds rude but if I don't need to know about the Mental Health Waiver, I don't want to hear about it. I mean, it's nice at the retreat, but the DDS waiver and the individuals that work with it – and I think the retreats give me a different perspective, a positive perspective of everything that goes on.*

Assigning Members to Teams

SCM Supervisors and SCMs described practices involved with assigning members to teams. SCMs provided reasons for making assignments outside of their primary team, the challenges in doing so, and feedback on SCM meetings with those outside of their primary team.

SCM Supervisors

In general, SCM Supervisors described assigning consumers to SCMs and teams by region unless some teams did not have as many cases as others and were able to take on a case.

> *Currently, we do it as much as we can geographically. We are trying to set up our team to parallel our DMHAS and MFP regions for service provision. That contributes to efficiency so that we don't have folks running all over the state if we can avoid it. It also contributes to efficiency in terms of getting to know the service team in that region and getting to know the resources in that region so that the quality of services they provide to consumers is more reliable and valid. When we can't … Then it's based on all hands on deck and training as quickly as we can to enable the new staff to cover regions they wouldn't normally be involved in.*

Supervisors used an Excel file, the MFP web, or an internal agency database to determine staff workload and availability and to track which SCM or Team they last assigned a consumer.

> *They all have their roster. In MFP web, you can pull their workload and who they have under their name … they have a Specialized Care Manager and TC and a Housing Coordinator per team. So then, if you assign a case to Team One and that Team One person SCM will assign the case to their TC and their Housing Coordinator … I think it's a great website to keep track of all that information. It's most of the time very accurate, so we base our workload off of that.*

> *We have an internal database here at [Agency] where we track all referrals, assignments, dispositions, dates of assignment, and the location of the referral. We also have a database for the Waiver online system for the individuals who are enrolled in the Mental Health Waiver through our fiscal intermediary. And then we're trying to master the reporting system in the MFP database to be able to determine who's been assigned to specific consumers ... I've been trying to figure out how to use that MFP reporting system to determine consumers that a specific individual has assessed that may not currently have on their caseload.*

While Supervisors made every effort to assign cases to teams in a particular region, there were instances where a case had to be assigned to a TC or HC outside of his/her regular team. This mostly happened during periods of high staff turnover or when a more experienced staff person was deemed a better fit for a difficult case.

There's a lot of turnover. So for example, you may have new people coming in. If a case is extremely difficult and there's a lot of things happening with that case, you may not necessarily want to assign that to a brand new person, who started last week. So you may want to have a more senior person dealing with the case and making sure that they're keeping up to date with it until that person is up to speed and may transfer the case over or just keep that case until the client transitions home. It all depends. There's so many different scenarios with MFP that you definitely want to follow a certain way of doing things but it all depends on do we have a steady group of people, is there a turnover? And if there is, then you need to figure out where you're going to place these people so that there's coverage.

Supervisors were asked to describe some of the challenges they encountered when assigning a referral to an SCM or Team. This included some filtering issues with the MFP database, problems surrounding how assignments are made, or lack of field staff and resources. Some staff felt it was more efficient to use their own agency database when assigning a referral.

Sometimes we're aware of the particular styles in which SCMs function, their ability to assume risk, level of risk for consumers to determine what type of transitional option is appropriate and whether or not they can be serviced under a waiver program, and sometimes that does enter into an assignment if they've been assigned to a case in the past, and I feel like the disposition has not included all of the factors we'd like it to for the current referral. We may reassign that case to someone else even if it's outside the geographic area … Someone may ask why the same person is not being assigned to a case. Someone may ask why they weren't assigned to a case. Someone may be biased by the historical record. Someone may be concerned about having to travel outside the geographic area to assess someone. Those are infrequent concerns, but they've been historical concerns that have come up.

It's just that there are not enough staff. It's just the lack of resources. So you can assign a case but they won't necessarily meet the requirement of the 3 days, that timeframe, that turnaround time, which is the main thing.

I can do that more efficiently using our own database than using the MFP database. I'm still trying to master how the filters work. And it doesn't seem to be able to give me past or historical information. Most of the filters that I can find seem to be set up around current demographics.

SCMs

SCMs were asked how they decided which of their TCs and HCs they assigned a consumer to and how they kept track of how many cases each of their TCs and HCs had. In most circumstances, both teams approached assignments with a consideration for fairness in distributing caseloads as evenly as possible. The Team One member stated that the SCM Supervisor made the decision regarding what TCs/HCs would be on her team.

I try to keep track and it's every other. Sometimes I will go into my transition coordinator's work queues and just kind of see where they're at with their numbers and I'll assign that way. But usually I just do every other. **Higher performing team**

The way we first started doing it, it was more of like a – it was more haphazard. It was almost like just whoever is next in the rotation. Make sure they're all level. How many does each person have. And just kind of assigned to the next person. But now that we're more regionalized, and I have specific TCs that I'm working with more closely, I'm just like I have been regionalized to specific facilities, I'm trying to still maintain that – the fairness of how many cases each person gets, but trying to assign them by facility so

that as I go to case conferences at facilities, it makes it easier to coordinate to have the same TC and HC also at that. **Lower performing team**

Reasons for Assigning Outside of One's Primary Team

SCMs described why they sometimes assigned a consumer to a TC or HC that was part of another SCM's team. The SCM for the higher performing team mentioned they sometimes acquired a referral case from another SCM, and in that situation tried to keep the same TC/HC for that case so there would be continuity for the consumer. Other times, cases were transferred when a SCM's per diem work ended or when a TC left his/her position or was promoted to another position. In some situations cases were transferred when a TC had an unusually high caseload or if a bilingual TC was needed. On this team, communication with SCM Supervisors and other SCMs to track assignments TCs/HCs were working on was mostly done through email.

> *So I have – my TC, [Name], who is going to be leaving her position and I need to assign another TC. I need to assign a TC to the case. [Name] could not take that case because she's working on a closure so I would go to the supervisor and say, I need a TC to be assigned to this case. And then my supervisor would tell me who to assign to. So I usually get direction from the supervisor as to who to assign the case to.*

> *Maybe an email … so when this happened with – I had to assign another TC, I went to the supervisor. Then she emailed me to tell me and then I emailed the TC that I was going to assign. So I guess that would be the protocol. I would email and say, hey, I'm getting this – you're getting Mrs. Jones.*

Similar to the higher performing team, the lower performing team also acquired cases with TCs/HCs that were on other teams and viewed it as an opportunity to communicate with those outside of the team. On this team, communication with SCM Supervisors and other SCMs to track TC/HC assignments were done using various MFP web functions, through email, phone, and at weekly agency SCM meetings.

> *… I inherited a lot of cases myself, and so … many of them were already preset. And so those cases where you have other TCs and HCs … and I'm still working with these individuals and that's actually – I almost am blessed … because it gave me the opportunity to work with all the members of the team, because everyone on the team does communicate differently. For me personally, I feel like we all have a good team atmosphere over at [Agency Name], and so even if [Name] is the SCM on a case, and [Name] and [Name] have a question on a case that I'm not involved in, to be able to work with them, talk with them, case conference with them is nice.*

> *… being able to filter, search, query [on the MFP web] at first was not very easy for me. But now it's almost like you kind of have a question for yourself, you know what to plug in where, and it becomes much quicker, and so I feel like I'm getting much faster at it. So I'm doing it more and more every day. I feel like when I go to a facility and I'm just making sure that the list from last month's case conference hasn't changed substantially, I do a quick pre-population of who's in this facility, who are my TCs and HCs, where the case status is, and it's almost like just based on the information that's in the web, you could pre-populate where your cases are and possibly even what barriers are currently going on just based on what you see.*

> *We've been having weekly SCM meetings to talk about difficult cases and to kind of coordinate assessments, etc., and so I'd assume it would just kind of come up in that weekly meeting. If not, both email, phone call, and then as well in the first SCM meeting.*

The Team One SCM described working with TCs/HCs outside of the regular team. While officially assigned to one region, this SCM was assigned cases in other regions by the supervisor as needed. If assigned a case in the North Central region, the SCM was also assigned a TC/HC from the same agency in that region.

SCM Challenges in Making Assignments

Staff belonging to the higher performing team did not mention any significant challenges in making assignments because staff assigned worked within the agency and were readily available to each other.

> … it's actually really not that difficult. I guess they just wouldn't come to my team meetings. But again I've been very fortunate with other TCs that have been assigned to me that are still within my company. I just – I email, I call or I see them and it's not a real problem, honestly because they're easily accessible. We're very good with email so I don't – it's not a big problem.

In contrast, the lower performing team experienced challenges and found it difficult to communicate about cases when TCs/HCs were outside of their primary team.

> It's difficult because then you don't get to collaborate with them as much. So if I've got 25 cases right now that are pending discharge in the next 60 days, and 17 of them are with the same two people or three people, but then seven of them are with other people, you don't have the luxury then of getting the daily or bi-daily updates on that case. You have to remember to go into that chart and/or email communicate with them. And not that it's impossible, but it's not as luxurious.

SCM Meetings with Those Outside of Their Primary Team

Team members were asked if they met regularly with TCs/HCs from another team. It appears that both higher and lower performing team members met with those outside their primary team or emailed them on an as needed basis.

> Well, [a bilingual TC] handled some of my Spanish people. So I had a handful with her but … she wasn't part of my team meetings, but I would connect with her when I needed to. **Higher performing team**

> [Name] is not on my normal team, but if I have a couple cases with [Name] and I meet him for a discharge plan meeting today at a facility, I'm going to have an impromptu case conference with him on all of our cases. We're going to do the ten cases we have together right then and there. Now in two weeks from now, we're going to have another discharge plan meeting, or another family meeting, or maybe we'll have a phone call, and we will cover our ten cases again. **Lower performing team**

Transition Effectiveness

Team members described what they did as a <u>team</u> to work together successfully to transition consumers into the community. They also described what they did as <u>individuals</u> to try and increase the number of transitions.

Team Efforts in Transitioning Consumers

Members of the higher performing team described the necessity of having a good Action Plan, being aware of everyone's role, communicating effectively, and making sure the team had access to the documents needed to move the transition forward. In addition, the agency this team worked with provided outstanding support by creating basic procedure/process checklists to guide field staff and make sure nothing was overlooked in the transition process.

I honestly believe that having a good Action Plan of knowing what everybody needs to do, and everybody doing their job, and good communication as to where we're at with their process, trying to understand each other's roles because I need to know … If the housing coordinator is working on something and they're getting close to being finished with that, then that's a trigger for me that I need to start working on what I need to work on to continue the discharge planning process …

… when [SCM] goes out and meets with someone, she basically gets a lot of information that I need and the HC needs. So she informs us when we get assigned what is expected of us. So that way we know, okay, this person is going to need a pooled trust or this person wants housing in Bridgeport. So that way before we even meet with them, we can gather all the information that we need to give to the consumer. That way we're not like, okay, I'll come back and I'll bring you this information. So I feel like that cuts down on a lot of time.

The [Agency] worked really hard. They … gave us discharge meeting checklists and initial TC meeting checklists. So that way you have all the information that you need in your case notes or in your file.

Similar to the higher performing team, the lower performing team relied on the Action Plan as a checklist to help keep them on task in the transition process. Team members felt that good communication and looking to more experienced members as a resource was also helpful in working together toward the goal of transitioning consumers.

The initial meetings I think are really important, so once we – Sometimes getting IDs sometimes prolong the process unnecessarily, so now that we have the new budget process, that kind of helps because so many people, even though they say they might have the money, they take time to give us money to get the IDs. Or once we get – We can get approval for budgets really quicker now, so that initial meeting, once we find out somebody needs help getting IDs, we're able to do that much quicker.

… I believe that the fact that we work so closely together, we're in constant communication in regards to whatever the case is, even those that are difficult. The fact that we're working together and we have our supervisor who knows a lot of the resources out there and who has a lot of experience, it really helps us to be able to increase the transitions ...

As a new member to the team and I guess in MFP land, everyone says after six months you're a veteran. But I would prefer if they said I feel like experience is what really helps, and having new team members collaborate with experienced team members to resolve some barriers and some issues that are more common. How to address certain character types, certain dynamics, certain legal issues. Because when you get caught up into the legality of it, sometimes you'll freeze up and say I don't really want to make a move for fear that I'm not going to take the right necessary steps. But if you have that experienced field member to kind of give you the pat on the back and say, no, don't worry, we've had transitions just like this, this is exactly what we did, and it was a great success – and so I feel that's great … Everyone has different specialties. Everyone has different backgrounds. And so an individual who might not know about one particular area might actually be more experienced in a certain realm. And so even a more experienced team member might learn a new trick.

Similar to both higher and lower performing teams, the Team One member underscored good communication as essential in the transition process. Having a structured schedule was also mentioned as a preference for getting work done and moving transitions forward.

I think it comes right back down to simple communication, like accountability and communication. Where are you at in this, how can I be of assistance, or can I be, and where do we go from here? And the follow up, are you going to get back and … I like saying "Okay, we're discussing this. If I don't hear from you by Wednesday, I'll call you back." I like having a structured schedule because we can all get pulled in different directions very easily.

Individual Efforts in Transitioning Consumers

Individuals interviewed for the evaluation had varying strategies to increase the number of transitions on their team. Members of the higher performing team mentioned keeping up with necessary paperwork, using the MFP web consumer list, ipad, and a personalized consumer and computer-based checklist that was prioritized and allowed for tracking transition status.

Working hard to be timely with getting my assessments conducted, going out assessing people, getting the paperwork turned in on time. If somebody has housing and is ready to go, making sure that the approval for the care plan gets done right away … I keep a checklist of things that need to get done – of – personally of things that I need to get done and just continue to work off my checklist to make sure that we're getting things done in a timely manner … So it's informal. I don't really create a spreadsheet … I prioritize that person and create a little checklist and then just go down the line, get it done and move on to the next person.

... I have my to-do list. So I check it. Whatever I have to do, I do it on my list for the day, update, to make sure I did it and then I put reminders on the ones that I have to do. And I always have my iPad with me, so wherever I go, I have my consumers with them … So it goes according to priority, who's going next and what I'm doing. So I just put – and there's this icon on the thing, it's like an emoji, so I just put – I have different colors for whichever action I'm taking. So let's say number one is discharging tomorrow. I just put the check sign there and I put the time of discharge and the date and what I'm doing for the person. So it's right there on my screen everywhere I go. It's very easy to do.

Lower performing team members described the importance of initial meetings for informational purposes, reviewing cases, referring to the Action Plan, identifying transition barriers, brainstorming, communication, being available to and supportive of team members as much as possible, and reaching out to Central Office as an important resource. To increase transitions, HCs on this team described being aware of housing opportunities, reaching out personally to landlords, and encouraging consumers to look on their own.

What I usually do is – so I look at the Action Plan because I really think the Action Plan – knowing the major barriers really helps … If I haven't gotten an ID in two months, I'll bring it up to my care manager and be like, "[Name], this case has been sitting but it can move forward. What can we do?" So then we start brainstorming. So it's like I plan it out. If something doesn't happen, then I go to someone else for help to try to figure out a different approach.

A lot of times, too, I'll send an email to Central Office for advisement because I'll be stuck and everyone around me doesn't know either. I'm like, all right, well, maybe Central Office will know. So just keep brainstorming and getting ideas from other people. I think eventually you'll overcome any transition obstacles.

Well, I am constantly looking for housing, everywhere, driving into work. As I'm driving, I'm always looking for rental signs or I'm always out meeting landlords, potential landlords to just make connections. So when somebody does, is ready to transition and

they want to go to a certain area, I have a few people that I can contact to see if they have availabilities and constantly just networking.

I like to encourage my clients to look on their own. I have 65 clients right now and it's difficult to be in all the different places at once. If they can look on their own on the internet or even physically go out to go look at the apartment, let me know that it was a good fit for them and then I complete the paperwork. That essentially helps a tremendous amount. But I mean I'm just constantly on Zillow, on Trulia, on Craigslist looking for appropriate apartments for clients.

For the Team One member the most important factors in achieving transitions included the importance of communication, developing relationships, staying in touch with the consumer and family members, and being an active listener.

It's communication, but it's more so on my part individually is communicating with the family and the individual and getting the transition done. It is developing relationships as well. I have to be flexible and accepting sometimes when different personalities are challenging, and how do we keep communicating? What's the goal? Can we just please stay focused on the goals? … The communication and being an active listener … I try to keep the human in it … The first thing I say is, how would you like me to help you? How can I be of service to you? What would you like me to do? I'm not saying I can get it all done, but I want to hear what your hopes are from me instead of me telling them, this is what I can offer, this is what we can do …

Regional Team Process

KIs described what worked or did not work and what was difficult for the <u>team</u> as well as <u>individually</u> in the regional team process.

Challenges Working as a Team

The greatest <u>team</u> challenges for the higher performing team were finding adequate housing, having difficulty getting the proper documents for consumers, people with criminal backgrounds, those who are conserved, or those who developed an illness or had other medical issues. Not having the MFP web updated in a timely manner was also noted to make it difficult to transition people quickly.

Housing is a huge issue. Other issues people who have a criminal history can – is a big challenge. People who have credit issues can slow down the – that slows down the process. There's some things that can't be controlled, like people's health may turn. Everything seems to be going along fine and then something medically happens to that person, which can delay. So there's some things that are – I feel like is out of our control, we've done everything that we can do, and a lot of times it's just finding that apartment or waiting for that person to get through whatever medical issue that they're going through.

I honestly think that has to do with things not being updated in the web system. So I have one instance where I have a consumer that should have transitioned by now but I just – it just got flagged a couple weeks ago that they need a pooled trust. And there was no information in the web under income – saying how much their income was, so I didn't know. Oh that's what they need, they need a pooled trust. So it delayed things and it's still delaying things. So I think just not having the accurate information and having to go back and do something that you could've done sooner.

If the person is conserved that's another thing that holds up transition because now we're having to wait on paperwork from the conservator.

Similarly, challenges encountered by the lower performing team included lack of housing choices, Maximum Allowable Rent (MAR) restrictions, a record of evictions, getting the appropriate paperwork from consumers (e.g., IDs), dealing with Medicaid eligibility, and Ascend issues. In contrast to the higher performing team, this team underscored that staff turnover and communicating about procedures to new hires made the regional team process challenging. Not having care plans approved and consumers that are not prepared to assume some personal responsibility in the transition process were additional challenges that were mentioned.

> *I'm going to say housing is always the biggest issue. The lack of choice, the lack of accessibility … We are not allowed to go over the MAR. We have to ask for special permission, get approval before and that's put a damper on us finding housing …*

> *We're getting more and more cases of people who aren't even Medicaid eligible, so I'm dealing with redeterminations. I'm dealing with look backs at the last minute for people who have homes to go to …*

> *Staff turnover is always difficult because … you're overburdening individuals on your team that are good workers, that are slowing them down … Communicating to the staff members about these procedures because if someone is new and they don't feel comfortable doing a role, even if it is their role, you've got to have another team member kind of guide them and assist them and tell them what they should be doing.*

> *A lot of people are coming with care plans that are not yet approved … they don't have any IDs, and sometimes it's really difficult to get the IDs. And a lot of the consumers I'm noticing as much as they want to get out, they don't know how to take on their own responsibility in helping that move forward, so they're completely dependent on the TCs and HCs, and sometimes they're not really cooperative … their focus is getting out, but they're not willing to help in the process, and sometimes it makes the process even harder.*

The Team One member mentioned that the dynamics of MFP and the rules and regulations are the most challenging issue in working together as a team.

> *It's the dynamics of MFP, the rules and the regulations and the challenges. I mean for me, a lot of the time, the needs of the individual, a lot of them that we deal with, need to do private hiring because the funding won't allow it to do agency-based things, and that – and I'm not sure if you know about self-determination – but that's a whole different animal. And it's very time consuming.*

Challenges Working as an Individual

Higher performing team members described what was challenging for them individually when working to achieve team goals, particularly increasing transitions in under 180 days, and what made it difficult to work successfully with other team members. Respondents described not having clear policies and procedures or a lag in communication when forms change. Other challenges that impacted movement on a case included not hearing back from provider agencies and Central Office, and gaps in information when the web was not updated.

> *… we don't have a lot of policies and procedures. And I find that to be a little bit frustrating at times. Forms change and we don't get a lot of direction. So I feel as though I don't always feel efficient in the work that I do. So I feel as though that slows down time. Or something that I should've known with the paperwork that I was supposed to be doing and I didn't know. I didn't know until the nurse at the MFP office notified me that my paperwork is incorrect. And I felt as though that was something that I should've known before getting to her so that I could have made that process more efficient.*

… I've had a lot of issues with outside companies … we contract with [Agency] to hire the PCAs. I've had issues with them not getting back to me, not returning phone calls … I've had people that have had care plans approved for months and [Agency] hasn't scheduled the employer training. There was one instance where … I called the supervisor. I called the team leader. I called all of the employer trainers. I must've left at least, in total 20 voice mails asking them to call me back or call this individual to setup the employer training and it took months. And there was no reason for that. And I was just so frustrated. I went to my supervisor and we emailed the Central Office, but then they never responded. So I was just at a loss and I felt so bad because this person should've transitioned and she didn't because she didn't get the employer training in a timely manner.

… This happens frequently, I'll get phone calls from family members or from clients and they're like, so where are we in the housing process? And I can't answer that because I don't do that job. So that can be a little bit of a challenge. Thankfully my TCs and my HCs are working in-office. We have the same basic work ethic, but sometimes notes don't always get put into the web. So even if somebody does call me with a housing question, that information may not have been updated yet. So I can't communicate that information with an update to the client or the family member.

Lower performing team members described what was challenging for them <u>individually</u> when working to achieve team goals, and what made it difficult to work successfully with other team members. HCs mentioned the cost caps for housing, less availability within certain price ranges, and the state's rental constraints. They shared frustration in locating accessible housing and finding landlords willing to work with them. Other individual challenges included adjustments to a program in which a lot of flexibility is required and working with consumers who needed more care in the community than what could be provided by the program or consumers who lacked motivation to be involved in the transition process. It was also difficult to work successfully as a team when overwhelmed by the workload and when members on the team were resigned or promoted to another position.

… If someone wants an apartment in [Town] … they need a one bedroom, the maximum including utilities is $1186. So say I find an apartment for $1200 including everything. So that's a little bit over the allowable rate. I would have to contact Central Office and write a request and explaining why I think that this person needs this housing especially if it's accessible. That's always the issue. And sometimes, the request gets denied for multiple reasons and that is just the difficulty of wording the request properly in order for it to be accepted or just finding that perfect apartment under that minimum or Maximum Allowable Rate.

The biggest obstacle I think is #1 finding something that is accessible and will work for them but #2 trying to find a landlord that is willing to work with us ... And when I went to put the application in, the landlord said, "Sorry, we don't want to work with the program." So sometimes, it's a lot of doors in our face and we just need to try and continue to keep going and figure out other options. It's not easy. It's not an easy job at all, but it's rewarding once you actually see that transition through and someone is in their apartment.

… I came from [the] homecare [waiver program], and it was not nearly as comprehensive, and so it's more of like a very black-and-white program. You're either eligible or you're not. If you don't have the support, it's not really something I provide. Whereas MFP, the roles, the boundaries get so gray, and each individual has a different

working style … What's difficult for me is knowing what the true limits are in a case or making sure you don't spend too much time on one case because some cases get pretty hot … I feel like a lot of our team members are similar to me in the sense that they like to know that the job is done, and when you're putting in an extra hour or two, and you know you're still so far from that light at the end of the tunnel, it's hard to stay positive sometimes … I mean you're looking at all that there is to be done and what's still left.

… if a consumer doesn't have support in the community that makes it difficult because I feel like I'm on my own. If the client isn't motivated, there's so many factors that would make a transition difficult compared to doable … But I would say really having support and having a client motivated are two big things … so if the consumer isn't motivated, it makes my job more difficult because I have to push them because they don't realize that going home is a process and you can't just go home.

For the Team One member, individual challenges included the dynamics involved in interpersonal relationships when working together to achieve team goals.

I think it's all the dynamics, all the players, administratively. I mean like I said I have a fantastic supervisor and [Name] is always accessible to me. But there's so many things that I don't know about that I can't explain to a family. I'm kind of like the waitress that brings the food out from the kitchen. I didn't cook it, but here it is, and if they like it that's great but it's burnt, they are yelling at me … it may sometimes feel like we're passing the buck, but we're all not and we can't know each other's jobs, but I can answer the questions a lot. And when I have, sometimes, I've been wrong which has caused more animosity.

Experience of Teaming Outside of One's Primary Team

Overall, both teams had members that worked with others outside of their primary team. Communication with those outside of their primary team was a common area that required additional attention and effort.

I mean it's really not too bad for me because most of my cases are with [Name]. I've only had four other cases with different SCMs. But – I mean I wouldn't say it's challenging but it's definitely different to have to constantly email someone or call them to let them know what's going on in a case instead of telling them during a monthly meeting. Because I just have to be more aware of, okay, this happened with this case so I need to update this SCM. But honestly, it hasn't really been much of a difficulty. It's just a matter of reminding myself to do it. **Higher performing team**

Sometimes they're not available to speak to … we communicate through email mostly but I would like to meet them in person just like I do with the TCs here. Yes, communication is always an issue. **Lower performing team**

… Instead of just going and talking to one person about everything, you have to go to everybody else. I think that's a challenge just because it can get a little mixed up. If you have that one designated person, like say if I had all my cases with [Name] or all my cases with [Name] or anyone … it's just more helpful because you could just touch base on every case all at once. **Lower performing team**

Additional Feedback on Teaming

Additional feedback on teaming challenges was primarily provided by non-team members. The most frequently mentioned factors that impacted teaming were staff turnover and vacancies, shifts in referrals and workload, or when teams were not co-located.

I think the problem I do see is just the turnover. It's a lot … it is a starting position for a lot of people. And so, the pay is not the best. So you do have people just graduated from college and this is their first job and then they stay here for a year or so and then move on. So it's tough to keep Transition Coordinators and Housing Coordinators in place for long periods of time. So I think that's always an issue.

… we're seeing incredible turnover because of promotions. And the good news again, it's because of promotions, but it makes for an unstable team if there ever were really a team … I think you can't ever create a structure that is reliant upon people because people will change, and I'm a big believer in you've got to create a system that's about trusting the system and the process, not the people. So I think putting a lot of stock into the stability of people in a team is kind of a set up for failure.

I think in some areas teaming is perceived as too difficult to do because there are so many players in the region … I think the Team Ones have been a particular challenge. It seems to go fairly well with the ABI cases working with our social workers here out of Central Office, but with DMHAS and DDS … the TCs tend to be brought in late in the process. So I think all of those have been kind of a challenge to effective teaming.

The lack of teaming I think. Even though they're in the same region and they have knowledge of the providers, they still in many ways work in silos and they are not communicating as well as they can to hand off the baton to kind of let their team know when to pick up and when to move forward with the next part of their process. So everyone is kind of working together independently, which doesn't quite work well and it can actually slow up a transition because everyone is doing something and there's a lack of communication.

The importance of being goal directed and always having a designated person moving the transition forward was underscored in an analogy of driving a car.

I think that team has great success in moving individuals out. But I do think there has to be a driver in that driver's seat and they have to be goal directed and they have to drive that car to that goal with the person in the back seat taking them along … as soon as someone gets out of that driver's seat and there's nobody driving that car, the car slows down … So I think the team is very important – that the team stays engaged and moving towards the goal together. Think of it as a car.

Using TCs or HCs from a different agency and trying to interact when agency cultures vary was a significant challenge to working as a team, especially with those outside of the primary team.

We actually use TCs from a different agency, and I think that becomes a real struggle in that the culture of the two agencies are very different, and so the expectations that perhaps my staff would have from a team member have to change when they're working with a team member from a different organization because their culture doesn't hold them to the same standard or accountability, and I think that is extremely frustrating for some of our team members and works actually to the detriment of the team.

… our team members are asked to take on cases that are way across the state somewhere. And that's a whole different Specialized Care Management team and a different agency that we're not normally working with. So it's challenging, but I think it hasn't been proven practically that the team concept as it was envisioned really works … basically you have to have accountability, you have to have frequent communication and you can do that within an entity, within a contractor ... But as soon as you introduce somebody into the mix from outside that you have no control over, there's no accountability necessarily with others, then it creates all kinds of problems … So

basically, we work well within our own agency, but when you start introducing people, that's a problem.

Respondents described challenges associated with roles and the importance of team members being able to be flexible in those roles throughout the entire transition process.

Well I think sometimes role identity is somewhat of an issue, but … we've thought long and hard about what we could do about that … there are times when the TC's role is going to extend a little further into what may traditionally be an SCM role or vice versa … I will say that if your team does not get along and communicate, the team is doomed for failure because there's no checklist for transition. There really isn't. Every person's life is so different. The supports that are coming from the outside will change the path of the care plan greatly. The support or lack of support from the nursing home is going to change it. The skilled agency that you're bringing in, depending on the preconceived notions of the nurse that's going in, that's going to change it. So the variables are so great that you cannot say as long as you've done this, you have done your job and done it well. You have to say each and every transition is this unique thing that you need to be touching, communicating, changing the path maybe 100 times within especially those two weeks, the week before transition to the week after for it to be successful.

And I perceive that my clients and sometimes I have trouble understand who's who and that's important because particularly when … it's trying to be determined whether the client is eligible for a waiver, sometimes the waiver staff gets involved too. So I think if I were to say that there should be better delineation between staff member functions and roles and names. Somewhere along the line, people who are being served by MFP have to know a little bit more about the process and who's doing what. Otherwise, it's kind of overwhelming.

Challenges with roles included working with others when there was not agreement among those involved and striving to standardize team processes and systems.

… it's been a challenge … when there's not consensus among all parties, so providing some degree of clinical supervision as well as administrative supervision and negotiation with the Central Office staff in terms of process and systems use and trying to standardize those for our team.

Weaknesses associated with the Team One structure were noted to impact the transition process.

… the TC is overworked and that TC is unable to really focus and concentrate on a select number of consumers at one time. It's really difficult to have a good transition where all of the pieces are put together very well when you have three different SCMs working off of three different waivers, asking that one person for, holding that one person accountable to complete tasks for their person on a particular waiver because that's three different populations that the person has to not only know about and be informed but also be involved and know how to be involved with the consumer of that particular population because they all have varying needs.

Similarly, weaknesses in the leadership structure of the program were noted and suggestions made to provide more support from the state level to encourage leadership and accountability at local levels.

… I think natural leadership sometimes doesn't emerge. I think that we try to set up leadership structure, but I don't think that that necessarily is working everywhere ... Where there is a leader in the group, it's working really well. Where maybe somebody needs more skills or could be supported with more assistance in terms of leadership and

making sure communication is there, I think that's the weakness. And so just making sure that we put more support in place from a state level to ensure the leadership and the accountability is occurring at a local level.

Lack of documentation in the MFP web was underscored as a challenge that impacted the transition process.

The lack of documentation in the Web is also a big thing. Just trying to catch up and piece together what everyone is kind of doing is also a challenge to making it a seamless transition.

Team Best Practices

Team members on both the higher and lower performing teams and the Team One member described best practices that were demonstrated by their teams.

Higher Performing Team

Working in the same agency and location, being easily accessible to each other, having familiarity with the agency culture, use of the Action Plan, timely updating of the web progress notes, and having regular team meetings were strong best practices for this team.

I think the biggest thing for me is I have – my team is – everybody works for [Agency]. We're all in-house and I have worked with some TCs that are outside of our company. And I really feel as though working together in the same company with the same supervisors, with the same work ethic that the company expects of you … I think that's a really key piece as to why we do so well. And we see each other more often. We're in the office. We have team meetings … I really feel that that lends to better camaraderie and better communication …

This team's agency developed face sheets or task lists (e.g., flow charts) and then incorporated information from the Action Plans to inform team members what responsibilities they had in transitioning a consumer.

… So what we did … we broke down the entire MFP process by role and we have that in a word document. So I know, okay, this person needs home modification so these are the three things I need to do before they have their employer training because the employer training is pretty quick and they can hire PCAs. So it just – it's a breakdown of everything that is required as part of the MFP process, and then I use that and the Action Plan to make a flow chart of what each individual needs to get done.

Timely communication, recognizing everyone's role, and mentoring new team members were additional best practices for the higher preforming team.

I help train the new people that come in and give them tips and things like that try to make it as easy for them as it is for the consumer to kind of make it all go organically.

Lower Performing Team

Consistent communication, documentation, team meetings and/or case reviews, knowing your team role as well as having flexibility were mentioned as best practices by members of the lower performing team.

I think it's regular team communication via phone conference or meeting.

Best practices, I guess having the TC and HC role clearly defined, and flexibility as well. Once you have the team, sometimes we might have to – the TCs might help the HCs in getting the paperwork done, especially if the caseloads are all piling up. And sometimes

the TCs are getting the paperwork completed for like housing for the HCs sometimes helps to speed up the process because if they have to – the paperwork takes time to explain to the consumers and stuff like that. So in my initial meeting, if I know that definitely that this person is going to need RAP, or if this person has a specific place in mind where they want to move to and there's an application for that, I will just do that at the initial meeting, and that kind of helps so that we don't have to take another trip back up to manage that, if those paperwork are already in place. When the time comes, we could just have it submitted for them. And the team meetings and the openness of the team members to communicate honestly with each other definitely makes a difference.

I think just being on the same page knowing that … having those team meetings just to go over all the cases before a case review happens at a nursing home, making sure that something was at least done, just constant communication. And I think that we're all very good at documenting everything that has occurred that we would need to pass off the information to someone else.

Additional best practices for this team included collaboration that included the consumer and his/her family or friends.

… everyone has their own roles and responsibilities, but at the end of the day, we all have to share a goal of transitioning the consumer. And so if I'm at a facility and a consumer has a housing question, it would be – I would feel remiss to not spend five minutes telling them about the housing process instead of telling them that's not my role and you're going to have to please call this individual and leave a voice mail, and they'll have to call you back in 48 hours. I feel like although we all have our own unique roles and responsibilities, it would really benefit the whole process for all individuals to at least know the other's roles and responsibilities and what that process may look like to help assist consumers who want to empower themselves to take on roles … if you have a consumer that's ready to undertake some of these responsibilities, to not take the time to empower them to take advantage of it, I feel like that would be silly.

… normally, when we have family or friends who are really supportive [and] involved, it helps ... And sometimes explaining it [the process] to them in detail, sometimes a lot of them are like okay, they're ready and willing to take on their role as a consumer in the process and do what they have to do …

Other Staff

Other staff who weighed in on best practices suggested the importance of making sure a team has a good mix of ability and experience so that those with more tenure can mentor more recently hired team members.

And then I think there's the teams that we put together … as I think about it, it seems to make sense to maybe be a little bit more strategic about it so that a team has a good mix of somebody who's seasoned and has been with the program for a while, and that might be the Housing Coordinator, the Transition Coordinator, the Specialized Care Manager, along with new people to help bring them along.

Respondent Recommendations

Recommendations in this section were made by team members and non-team KIs and were associated with team meetings and the transition process that is supported by teams.

Higher Performing Team

➢ Continue team meetings

… [Meetings are] always something that we always kind of look forward to because that was our time to kind of discuss with our SCMs because we know how busy they are.

➢ Prioritize cases at meetings and focus on those that TCs and HCs are struggling with

… not everyone on the caseload needed to be discussed. Maybe it was more of the SCM taking the lead and picking out who were the priorities and who is going to be moving out sooner and kind of lead the discussion that way and maybe she can also have input from the HCs and the TCs to who they want to discuss and who they're struggling with …

➢ Update notes on the web during team meetings

… what we did at our team meetings is we updated the notes on [the web] – while we were in the meeting. And it stated what the TC was going to work on, what the HC was going to work on so that way if you ever forgot what you were supposed to do it was right there on the web.

➢ Embrace new technology (e.g., Skype) to encourage better time management

… So we're going to be trying to embrace new technology and see how that goes. To encourage efficiency of time.

Lower Performing Team

➢ Continue team meetings

I really wouldn't change anything [about the meetings] to be honest. I find them incredibly productive.

➢ Schedule more one-on-one meetings and only review cases in team meetings that are current or need attention

… it's so time consuming to go over every case, I think if it happened more often with a one-on-one basis more than a whole team because it just, because our time is so limited, if we did it just individually I think it would be easier … not every single case, maybe just ones that are pending or have issues.

… I think to save time or maybe make the time more meaningful, if the SCMs were able to manage having separate meetings where … the specific TCs and HCs involved in certain cases would meet with them separately, and then we'd meet, we'd talk about the issue and then move forward. Maybe we could do that, and then have like a big team meeting where everyone who's involved with that same care manager could meet. But I feel sometimes having those meetings and having to sit on the other cases, are not always that beneficial to us.

➢ Develop an interactive web-based Action Plan that can be edited by all team members not just the SCM

… I like to get a really good comprehensive Action Plan, because not only does it address the barriers that are on the challenge checklist for this particular consumer, but they also identify strategies and outcomes that you'd like to see. And so what I think would be helpful is as a way to have my eyes and ears, my TCs and HCs, be able to notify me of new barriers, without me having to put them in – because it seems kind of silly that if a new barrier comes up that's related to the TCs/HCs that they're going to

have to resolve anyway, for them to have to report it to me, for me to then have to enter it, for them to have to report that it's done, for me to have to enter that it's done … Because when we all have that working document, I really like that idea, that we could all pull up that working document for each consumer and see oh, well it looks like on 2/5 you got the identifications and then on 2/15 you managed to submit the new RAP application. You notified me on 2/16 to make sure that I reviewed the care plan. I reviewed it, got a status review out of it. We're good to go.

Team One

Since monthly team meetings have not been occurring, staff suggested there should be regular team meetings.

➢ Schedule monthly team meetings to review cases

I think just maybe a monthly meeting similar to the staff meeting my supervisor provides, just a touch in.

Other KIs

Other KI recommendations included the importance of taking time to communicate effectively with everyone involved in the transition process and to provide team member training using standardized protocols.

➢ Communicate effectively

… develop scenarios and throw those scenarios out to the teams and that folks would meet as teams to determine how they would manage a case, and it became very clear in the one I participated in that folks on the clinical team had absolutely no understanding of how we operate or what we can do or what resources are available to us. So it was clear that the communication between team members was inadequate. So I think … that process needs to be encouraged, promoted, cultivated, reinforced because I think that's what's going to lead to better outcomes for the folks that are transitioning.

➢ Provide team member training using standardized protocols

In 2016, they did not have the resources to train SCMs, TCs, and HCs consistently and with standardized protocols. In 2017, they've begun a system to do that. I don't know how long their limited resources will hold out, and, frankly, I think it should be mandatory because you always pick up a little nugget of information that you didn't have before. I don't know if it's worth a whole day of in-servicing for some people, but consistency in processing, consistency in policy, consistency in training would be fabulous, on how the MFP database works, what the documentation expectations are, how people need to network with other providers, how they mesh their roles with roles of TCs and HCs on a team, the Universal Assessment process. All of those pieces need to be consistently trained as people come on board. Currently they may have to wait for months and get it from supervisors who may have been inconsistently trained, and that's a problem for consumers, I'm sure.

Program Achievements and Successes

Respondents were asked what the major achievements, strengths or best practices of the MFP program were in 2016 and what supported those program achievements. Responses were separated into the following categories:

- ➤ Major Achievements

  - Community First Choice
  - Transition Budget System
  - Successful Transitions
  - Positive Role of MFP within LTSS Rebalancing in State of CT
  - Other Achievements

- ➤ Major Achievement Supports

Major Achievements

Community First Choice

Several KIs identified Community First Choice as a major achievement and noted that overall the program was positively received. Please see the section on CFC for a more complete evaluation of that program.

> *CFC in the last year has actually become operational on time, which is amazing even if operational not in the fullest possible sense, nonetheless, up and running. And that I think was a significant achievement that at least is under the umbrella of MFP.*

> *It was really hard to think of something specific in 2016. I had my hands on so many different things since I've been here and I did struggle with that but [CFC] was one thing that stood out in my mind. And, although it wasn't just that it affected Money Follows the Person, but that it was a change throughout the entire system for the betterment of individuals who are accessing, not just the PCA waiver but, Community First Choice also without the waiver or with other waivers.*

Transition Budget System

The new web-based transition budget system was applauded for its speed and efficiency. A TC illustrated how this auto approval system has the potential to speed up the discharge process.

> *But now they have this new transition budget where things are auto approved unless you need a special request. But with the auto approve budget of $2,000 per person for certain items, it's a lot quicker. I can go in the day before and be like, this person's discharging last minute, I need this transition budget. And I don't have to freak out because I know I could just send this to something that's auto approved. So I really like that. I think that was a really good best practice for them.*

Successful Transitions

A fundamental goal of the MFP program is to successfully transition people out of facilities to the community. Again this year, KIs were asked to define a successful transition. Similar to 2015, the number of transitions were noted to be a major achievement. While transitions were 20% higher in 2015 than in 2014, they remained about the same in 2015 and 2016 (784 versus 791, respectively) (See Figure 1).

Figure 1. Total Number of Consumers Who Transitioned in 2014, 2015 and 2016

Number of Transitions by Year
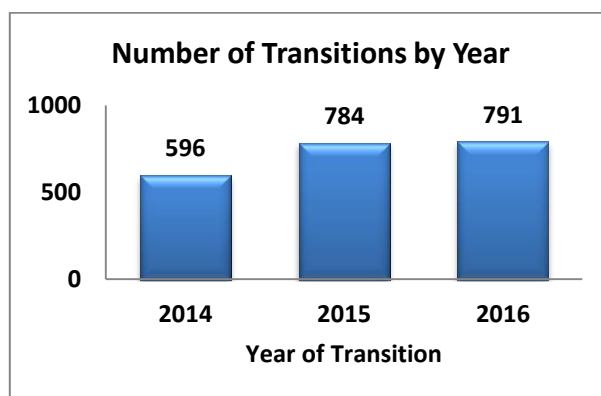
It was suggested that the team process contributed in a significant way to the number of transitions that occurred.

> *I think one of the major achievements was all those transitions we had … And I think having set teams and it was really organized … that's what made more transitions happen.*

The speed of transitions, or average length of time, from referral (i.e., initial assignment) to transition decreased from 270 days in 2014, to 230 days in 2015, and to 179 days in 2016 (See Figure 2). This decrease in average length of time to transition was considerably less than it was prior to using the team process for transitions and was also considered an important achievement.

Figure 2. Average Number of Days from Referral to Transition

Average Number of Days from Referral to Transition by Year
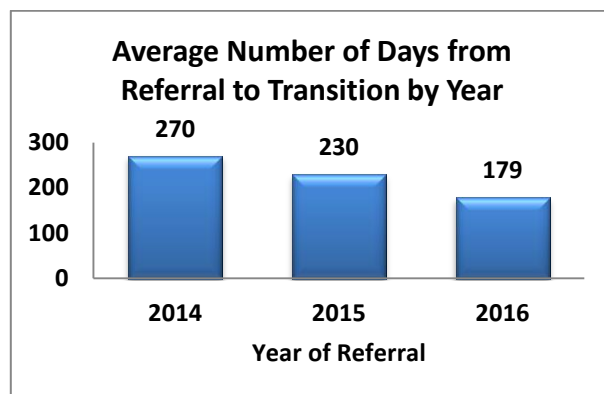
Field staff suggested that a successful transition was one that happened quickly with limited delays in obtaining the necessary documents.

> *I would say one that happens fast from getting assigned to the Transition Coordinator and the Housing Coordinator. One that doesn't have any evictions; that has all of their documents. We could get them into an apartment as fast as possible and one that is successful and safe and the nursing home doesn't have any hesitations, we don't have any hesitations on our part and if they stay in their apartment without having any hospitalizations.*

Communicating expectations before and during the discharge planning meeting with all the stakeholders was also deemed important in achieving a successful transition. In addition, it was suggested that discussions include a back-up plan, particularly the importance of supporting

informal caregivers and in so doing assure that consumers who are transitioned have every opportunity to remain in the place of their choosing.

> *Communicating the expectations, like, "Mom, you said you're going to be able to cook for him every weekend. Let's confirm that in a team discharge planning meeting. This is what you said you're going to do, and what would happen if you get sick, Mom, who's going to provide food for the weekend?" … a successful transition is one where every member of the team, both at the nursing facility as well as the community-based team, is discussing and committing to their role prior to transition … Secondary to that is the backup plan … There has to be some discussion and some plan should something fall apart. We've had discharges where a wife has come back home to live with the husband, and the husband has had a heart attack a couple days later. Well he was the primary support. Did anyone think about what would happen if he's not available for the support, and if we did and we have a plan?*

Respondents described a successful transition as one in which the consumer had a choice and was able to experience what they hoped for. In some cases, KIs described a successful transition as one in which the consumer expressed they were, "Happy to be home" or they were pleased with the services they received.

> *A successful transition would be a transition whereby a person, a consumer who has decided to move out of the facility into the community, feels comfortable and feels empowered that they are able to kind of create their own destiny in the community regardless of what their health conditions may be.*

> *I mean we do transition folks who are going home on hospice, and what they really want to do is to be able to pass at home with their family, and that's a good outcome for them.*

> *Well, it is consistent in alliance with that person's values and preferences – their health goals, their integration goals, that there are effective supports in place at the time of transition so it doesn't have to be kind of an adaptive or an evolutionary curve once they are at home in the community.*

Integration into the community or reengagement was also a common description of a successful transition.

> *But what does that mean when you actually get to the community? Are you just staying in your apartment all day? Are you actually a part of community? But I want to know are you going to the grocery store? Do you go to your library and take advantage of these free services and classes and have you navigated the bus system? Are you really a part of society again? That's what I would define as successful transition.*

> *… some of the most successful transitions seem to be those people who either engage in something that they like or reengage in something that they were doing previously, whether that's a faith community or going back to work or renewing a hobby or reintegrating or reconnecting with family. You know it's very unique. But something that gives them purpose above and beyond just being outside the nursing home.*

Positive Role of MFP within LTSS Rebalancing in State of CT

KIs were asked what effect they thought MFP has had on Connecticut's LTSS system. With over 4,500 transitioned cases in ten years, the effect of the state's rebalancing program has not only impacted people in positive ways, but has been demonstrated in the growing signs of culture change.

MFP has changed the way people think about long term care. It has changed people's mindset about when nursing home care is needed and when it is not.

So it's like there's a nursing home in my town, I drive past every single day on my way home and they recently changed names, maybe in the last year or two. And then they have a new slogan underneath, it's like – get sick, come here, go home. And they didn't have that before. So it's just interesting that that's something that's sort of moving – that people are moving that way.

We're looking and we're saying you can receive the same services and the same care in your home that you receive in a nursing home. And by consistently putting that message out there, I think that over time it does cause a change in the way people view where they can get their services and how they can get their services. So I think by every care plan that's approved by every individual that's able to move back to the community, it gives us all hope for the future.

Some KIs spoke to person-centeredness and self-determination or the importance of self-direction and that the program has promoted autonomy. In particular, the program's dignity of risk process has allowed consumers to make informed decisions and was identified by respondents as an important systems change.

… I think the change has become more person centered. The change has allowed for more individual autonomy around their – around all aspects of their life, the person's life, and … though that can come with challenges as well. And so on one hand, I think it's pushing us as a system and as people participating in the system to a newer extreme of self-direction, more autonomy, more choices. The challenge associated with that is more confusion. More choices means more confusion and new things to have to navigate because now you're autonomous, you can be autonomous in making decisions, but there's a lot to know, but we'll come to the middle if we all have the chance to at some point.

Well I think the rebalancing has really changed the paradigm, which is a wonderful thing. It's allowed people to live in the least restrictive environment. It's offered hope to people who I think never had hope before, and it think it has changed what was more of a paternalistic system of care – I'm providing care for you and you're going to do it my way – to a situation where care is defined by the individual, and the supports, the system is going to transform to support the person rather than the person transforming to fit into the system.

I see people have a different attitude about who can live in the community and who can't. I think that's definitely changed people's perspective on that…It's an informed decision they're making. So basically how I would explain it to someone is they have the right to make the same good and bad choices that you and I get to make every day.

It was noted that, as a model, MFP has been influential in encouraging better care in nursing homes. In addition, the program was described as another option nursing homes can suggest to residents needing long term care. The awareness promoted by nursing homes was said to increase consumer confidence and hope in MFP's ability to assist them.

For those facilities that actually care about people, [MFP] opens their eye to making sure that they're providing quality services and helping the people in the nursing home. The residents know that they have options, that going into a nursing home is not the end for them, that they actually have other options available to them. I think is one of the positive things that MFP provides.

KIs made a number of suggestions to further positive change in the LTSS system. It was mentioned that while MFP has had a positive role in the rebalancing process, there is the potential for the system to reverse itself and that more time is needed to ensure that the change hoped for will be lasting. Another suggestion was the need for a nursing home diversion program.

> *… I think we're talking a generation to make the change in thoughts and ideas that needs to occur in society in order for society to look and say, an individual can receive their supports and services just as easily in a nursing home as they can in the community. I don't think we're anywhere near making that change. I think it takes a generation or more to instill that type of a change in a society, in a view. So have we started? Yes. Have we scratched the surface? Oh yes. Is there a potential to reverse? Definitely.*

> *I would personally like to see a nursing home diversion program be separate from MFP. I don't mean separate in like in a separate silo and never talk to each other because that's ridiculous because everyone should be cooperating and talking to each other. But what I mean is I think somebody else needs to shoulder the responsibility of doing that. I think MFP is so big. I don't think you can do that and nursing home diversion. That's just my gut feeling.*

Other Achievements

Retreats were mentioned several times in the interviews when asked to identify strengths and best practices.

> *I think definitely the retreats are really helpful for us to come together I think as a whole and just make sure everyone's on the same page.*

> *I think some of the major strengths have been the fact that we continue to step back and do periodic retreats to bring everyone together to talk about what's going on and to do training. I think there's a high level of enthusiasm and commitment from the leadership, and I see that both at Central Office and in the various agencies that we work with.*

The Section 811 Project-based Rental Assistance (PRA) program for low-income persons with disabilities was an additional achievement identified by respondents. In particular, the 811 Grant gave leadership the opportunity to improve coordination with HUD's resources. Respondents also recognized the Medicaid Innovation Accelerator program (IAP), or IAP Grant, and the repurposing of HUD 232 funds.

> *What we call the IAP Grant, which is the grant that really focused on making sure that services and supports are available in coordination with housing for some of the people who might not be at nursing-home level of care, which is a gap in our state. I think that that work was really important this past year… The work that we did with HUD on trying to look at how we can partner better on the repurposing of HUD 232 mortgages. I think that that's amazing work.*

Major Achievement Supports

The Director of MFP was mentioned throughout the process evaluation by many KIs for her inspiration and superb leadership skills in bringing all stakeholders together, such as through the Steering Committee, to move things forward. Central Office staff were also praised for their open door policy and willingness to help all staff, including field staff, problem solve when questions or problems came up.

I think that it was the commitment of Dawn Lambert and some others to get the thing out. Also, I would add that Claudio was the chairman of the CFC committee, and he was very diligent and kept people's nose to the grindstone. And there were very talented and committed people that worked on that but were also members of MFP. That's another thing I must say, I mean, I really think that one of the great achievements of 2016 or any year for that matter but increasingly, maybe 2016's a good example, is that the commitment of the people on the Steering Committee is remarkable. And then, of course, Dawn Lambert is a superb leader and so she does what is a very difficult thing to do, which is to balance the transparency concerning policy making and outcomes, and shares it with people without disillusioning them and making them mad, so that we all pull together and are, I would say, colleagues in our effort to make the thing work as opposed to a bunch of disgruntled and disappointed people. A part of that is I say her balance in telling us and bringing us into the process but not so far in that the thing can't work. I mean, we aren't governing after all.

I think there's a high level of enthusiasm and commitment from the leadership, and I see that both at Central Office and in the various agencies that we work with.

To further underscore the strengths of Central Office and the willingness to support field staff, one CO KI had a unique way of describing how he/she moved stalled or difficult cases forward to transition.

It's giving them advice; maybe they're stuck on a certain thing. It could be any one of a number of different things that the plan – everybody could be stuck on it. It's maybe giving some advice as to how to move the car forward. How to step on the gas. And sometimes it's bad. Sometimes it's going to somebody else and saying, okay, I have this problem. Can you help me fix it? But sometimes it takes me a little bit getting in front of the car and saying, wait a minute, we need to put the car back on the road and somebody needs to get in the driver's seat and here's what you need to do.

Other respondents described providing much needed support to field staff and cases assigned to them by sharing suggestions and best practices, such as what has worked in the field, with CO colleagues and in general for communicating clearly, succinctly, and respectfully.

… it provides opportunity to consult directly with our staff. I get to obviously speak with the Housing Coordinators, TCs, SCMs who've had cases previous to my receiving them. So being able to offer varying perspectives to understand what they do and how they do it, and incorporate some of those practices that they do into the work that we all do, I think is a great opportunity to then share with Dawn and others here in Central Office other alternative ways to meeting the same goal. So it's the opportunity to empower and praise the staff that I work with and also provide some direction and guidance just from my own experience and knowledge of the various programs to the staff that's working with us.

Communication I think on any level, whether it's family, my immediate supervisors. It's clear, concise, and respectful communication. I like that they try to include everybody, the support I think they try to give and their passion for the mission statement and their devotion. We have some tough obstacles to overcome and I find that they're really supportive on trying to do but being realistic and staying within funding and guidelines.

A best practice in consistent communication identified the TC monthly call from CO to review various challenges involved in transitioning consumers.

There's a TC monthly call from Central Office and they just go over different topics, different issues that we've had. They kind of make their own agenda and … they send it

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out just to tell us what's going on. And then they ask us if we have any questions? Do we need more clarification, stuff like that and usually the things that are covered in there are DME or Medicaid or how pooled trust works and stuff like that. So those are informative. They definitely help because we can talk about what issues we're having or we've come up against and they will take those into consideration and usually bring them up the next time we have the monthly meeting.

Program Barriers and Challenges

The most frequently mentioned barriers and challenges were those associated with successful transitions. KIs also described program specific barriers and many underscored one problematic area or process that they suggested needs to be overcome.

- ➢ Barriers and Challenges to Successful Transitions
- ➢ Programmatic Barriers
- ➢ Most Important Barrier to Overcome
- ➢ Respondent Recommendations

Barriers and Challenges to Successful Transitions

Similar to 2015, KIs described multiple program barriers and challenges that made it difficult to successfully transition a person. The top four barriers and challenges were:

- Housing
- Length of Time to Transition
- Post Transition Barriers
- Team Workload or Expectations

Less frequently mentioned transition barriers and challenges included:

- Problems Involving Legal Documents
- Lack of Informal Supports
- Criminal History
- Medicaid Eligibility
- Consumer Expectations

Other Barriers and Challenges to Successful Transitions were:

- State Culture
- Insufficient Community Support for Behavioral and Mental Health
- Medication Management
- Gaps in Provider Services
- Inadequate Workforce in Rural Areas
- Hiring and Managing of Individual Supports

Housing

Housing and housing-related challenges were mentioned as the greatest barrier to successful transitions. Housing-related challenges included: lack of accessible, affordable housing; the Rental Assistance Program (RAP); the Maximum Allowable Rent (MAR) and restrictions on rent, modifications and the time needed to put those into place, and finding landlords who were willing to work with the program.

> *Housing is hard to find in certain areas of the state, accessibility issues, legal issues, history of homelessness, addictions. All of that is absolutely real.*

Depending on what the issue is, when the person is denied a RAP, they can't get housing. And if they can't get housing, there's so little we can do because a lot of the people that need housing, they don't need PCA or nursing or anything. They just need a place to get into. So if what they really need is denied, there's so little we can do.

I would say the state's constraint on rental now. I use this one particular property in [town] because they actually had water and electricity included in their rent. So for individuals that don't have any income, this is the only place that they can go. And I've put probably five people here and they're just a good option for us because if you don't have any income, you're not going to be able to go anywhere. And now, the state is telling me that the amount that they're requesting in rent – they can't approve it. It's not worth that much money, which is frustrating because they give us the MAR, the maximum allowable rent, to go by in terms of finding appropriate housing and it falls underneath the MAR, but yet the State is still saying that they won't pay it. It's been pretty frustrating ever since in November since they had changed all of this on us. It's difficult to be able to secure housing.

It is the Maximum Allowable Rate that the Housing Authority will allow to pay for a rental cost. And right now – we used to be able to request a percentage over that and the Housing Authority would approve it. But I guess because it happened so often that Central Offices now control of approving that. So it's been – and we have to write a written request and why we feel that it needs to be over that MAR and that's been a difficult situation.

We got a guy who's 500 pounds. He's an amputee. He needs 42-inch wide doorways. Show me an apartment that has 42-inch wide doorways, okay? … And I think the project needs to recognize that and say "Hey look, maybe in this guy's case, we need to pay more money than we would normally pay." So that's an obstacle and it's only going to get worse because as we've all been told, the rental assistance program and the RAP is coming to an end. So I think we're going to go way back to what we used to encounter when we got very few people out because there was no housing. Truth of the matter is, a lot of people in nursing homes are stuck in nursing homes because of housing.

… Anyone who needs housing for more than one bedroom, it becomes difficult. And the modifications also can prolong the process because not all landlords agree to doing the home modifications, and if we do get approval, then they have to wait sometimes to get, to start the modifications. So all of that delays the transition.

The biggest obstacle I think is #1 finding something that is accessible and will work for them but #2 trying to find a landlord that is willing to work with us. I found a gorgeous two bedroom, handicap accessible apartment … I mean, literally it was a Housing Coordinator's dream … it was the perfect apartment. And when I went to put the application in, the landlord said "Sorry, we don't want to work with the program."

Length of Time to Transition

A range of challenges impacted length of time to transition including working with staff in other agencies, conservators, consumers with psychiatric histories, brain injuries, or unexpected illnesses. In some cases, trying to keep consumers engaged and motivated in the process or finding the appropriate providers also delayed transition.

… it just takes longer, and it's more difficult to do a transition when you're trying to get a partner agency. I can't tell staff from another agency that they must be at a meeting at a certain time, only their administration can, and if that's not the culture of that agency, then even though the SCM is responsible ultimately for that transition, he or she doesn't

have the control over it. And I think the worst position we could put people in is to hold them accountable at 100 percent but not give them the tools.

You can see when you look at the timelines of someone who has DMHAS or DDS involvement in their transition versus someone who does not, you can clearly see that the time is extended, prolonged, and the one common denominator is that we're dealing with a state agency.

If the person is conserved that's another thing that holds up transition because now we're having to wait on paperwork from the conservator. A prime example now, I have a conservator that isn't willing, I've contacted them weekly for the past two months because we need them to follow-up with the nursing home and she hasn't done so. So that holds up my time …

… if someone is on psychotropic medication, that is definitely going to cause a hold in the transition just because we need to set up a psych doctor in the community, and they need to see them a certain number of times. So I know that that just brings a lot more challenges to the transition. Someone that needs special durable medical equipment – that will make the transition sometimes a little bit more difficult.

… I have an individual who's very, very behaviorally symptomatic, may not be stable in the community. He wants to return to the community at all costs, exhibits very little insight into how behavioral symptoms might impact others in the community. And legal representatives who have been through very challenging times in the community with individuals and who have taken up a lot of their time and energy and resources because of their inability to manage effectively in the community. Those kinds of challenges make it difficult to determine a residential option that's going to be rich enough to address the individual's needs on a 24-hour basis. For those folks, sometimes quality of life is what we look for, and it may or may not be for a lengthy period of time as they may cycle through their symptoms. Those kinds of challenges are hard to overcome.

There are also things, health or medical issues that can affect the speed of the transition, just overall engagement and interest … Also, finding providers willing to take the case in the community is another example of why it may take a little bit more time for someone on the ABI waiver to transition … more importantly people with an ABI, they take a longer time to process information. So the length of time, for example to complete a UA, many of our clients can't sit through that in one or two settings. It could take three potential visits to go back and complete that, and then going back to explain what happened particularly with this population that has memory loss, memory recall issue. So it's just a slower process …

… There's some things that can't be controlled, like people's health may turn. Everything seems to be going along fine and then something medically happens to that person, which can delay [transition] … we've done everything that we can do, and a lot of times it's just … waiting for that person to get through whatever medical issue that they're going through.

… right now a lot of my clients are PCA waiver and a lot of them are self-directed instead of agency based … it's a great opportunity for clients because they hire their own PCAs, but that also has been slowing down transitions … Because sometimes clients aren't motivated to do that or don't want that responsibility …

Post-Transition Barriers

Respondents described numerous barriers and challenges to successfully remaining in the community after transition. These included consumers who were medically unstable or those with behavioral health (e.g., addictions) or psychiatric conditions and the associated challenges of getting adequate support for them in the community. Ensuring that Medicaid was active was key to enabling consumers to remain successfully in the community. In some cases, difficulty reaching a consumer's care manager for post-transition issues was problematic and was a barrier to successfully staying in the community.

> *We have people who have addiction issues. They get out. One guy, all he wanted to do was drink, and he lived with his parents and all he did was get drunk every day. And his parents died and he ended up in a nursing home. We did all this tremendous work. He had lousy credit, criminal history, everything else besides, got him out … All he wanted to do was go to the bars to drink and then go to the liquor stores to buy more and drink vodka straight from a bottle in his apartment. He would get drunk. He wouldn't let his caregivers in. He was so drunk, the landlord said "I'm very nervous about this. I think something's going to happen to him." And sure enough, he was coming back from a bar … got hit by a car, shattered his pelvic bone, a whole bunch of other bones, ended up in the hospital and a nursing home, never to come out again. Something needs to be done there.*

> *… It's very difficult to get on the WISE Waiver, very difficult. Either they're not persistent and serious enough in their mental illness or they are but DMHAS does not feel they'll be safe – with their care plan package – so they're bumped over to the PCA Waiver program, and that doesn't have the supports, for sure. There may be local mental health organizations, but … they work independently, so they're not required to work or be overseen … I think there's a lot of breakdown there … Connecticut could do a better job in that arena and probably every other state in the nation.*

> *Making sure that the Medicaid is active so that there's no delay in a client having access to a practitioner or, most importantly, his medications. Is the person leaving with a solid supply of medications until they can see their community-based provider and make sure that they can get that next round of prescriptions, because if not, there's going to be a health issue that puts them back into the hospital and really jeopardizes the success of a transition.*

> *Sometimes I would need to contact the care manager, but it was very difficult to get in contact with them ... I've had a few cases where the consumers really needed to get feedback from whoever their care manager is because they needed to make some changes or have issues with their homecare agency, and a lot of the times, the care managers would not return their call.*

Team Workload or Expectations

Numerous comments were made regarding team workload or expectations. These included frequent changes in field staff, leadership challenges in agencies with low staffing levels, a high number of caseloads per field staff, eligibility issues, and the challenging nature of many of the cases. In particular, closures impacted teaming by creating heavier workloads for other team members when people were pulled off their own teams to form a closure team and their regular caseload became the responsibility of the remaining team members.

> *Some agencies with lower capacity don't have the ability to really lead their teams, and I think that results in problems because you need strong leadership and strategy, and you need to spend time working with the team and helping them to learn how to*

communicate with the other team members. So that's definitely an area of major challenge.

… if you don't have all the players it's hard to do your part, and then you end up picking up the slack of someone else, which people do, but then once you do that one or two times, then people are like are they necessarily in a rush to fill that position if people keep picking up the slack? I think that can be discouraging to people.

The caseloads, the unusual demands, the ineligibility pieces we're always finding out, and sometimes we don't find out until - we applied for housing …

Frustrations were expressed by SCM Supervisors, SCMs, TCs and HCs about the difficulty of the work and expectations that were deemed unreasonable and time consuming.

You have a hundred cases, and seven are discharging within the next two weeks, and you've got to get your three to four assessments a week in. And every time you go to assessment … you can tell it's just another hot mess … Very complex. And you don't know until you're there, and you only have an hour … and I'm already like stressed about that case because that case – I did that last week and it was tough, but I have to go follow up on it, and then you get there, and it's just a disaster …

… sometimes, I go above and beyond and do extra work. I try to get people to doctor's appointments. I try to find family to assist – try to get them bank accounts. I try to get them their IDs. There's a whole lot of little things that we add to a job that we have to do in order for the process to happen. And if we don't do it, the whole process wouldn't happen.

… We're supposed to be doing rent reasonableness tests. If we think the apartment's going to be over the MAR, we have to automatically go search for those areas and get rent calculations and what other rents are going for in the area. Alright. Could it be just a Google search? Sure. It still is an hour of my HC's time … when the Housing Authority does that anyway because they have to see what the rent's going for in that area before they approve it. Why are we doing that job? Because they think that it's going to save time and it doesn't because now it's taking time away from my HCs for actually looking.

Less Frequently Mentioned Transition Barriers and Challenges

Less frequently mentioned transition barriers and challenges included problems obtaining required legal documents (e.g., IDs), lack of informal supports, criminal history, Medicaid eligibility, and consumer expectations. Although mentioned less often than other barriers and challenges, respondents noted that these still have the potential to significantly delay the transition process.

Problems Involving Legal Documents

It's very difficult to go to the Social Security office and tell them you want a social security card when the person doesn't have an ID. And you cannot go to the DMV and tell them you want an ID when the person doesn't have a social security card. And you can't go to the town hall and tell them you want a birth certificate when you don't have an ID … We need all of this to get housing and it takes forever to find housing. You don't want to lose housing because you don't have a social security card and an ID. That doesn't make sense.

Lack of Necessary Informal Supports

It's difficult because, informal supports are always going to be key … people are more successful when they have their informal supports, like their granddaughters, their

daughters, their cousins, someone, an exterior family member there visiting and checking up and doing that sort of stuff … that's when they're more successful, when they have that family piece. As far as us being able to provide that, I don't see it.

If you are on IDDM management, if you have diabetic management, and you don't have a family member that's willing to go and administer that insulin, then I can't get you out. There is no safe discharge for this person because they don't have the capacity to manage that themselves.

Criminal History

… there are many very specific barriers to transitions. For example, a criminal history that makes it difficult to find housing. Or a financial history that perhaps makes it very difficult to get credit or get utilities or get a lease, etc.

Medicaid Eligibility

… as far as our team goes, I don't think we were very successful in transitions. Yes, we had a lot of people … our numbers were not up to what we're supposed to be doing ... there's a maximum or a minimum that's required and we, as a whole, didn't do that well … because there were barriers such as people needing specialized needs trust. They were over income in order to qualify for Medicaid. There were housing issues where there were some things that took longer to build like ramp and special modifications. That sort of thing, so it kind of put a damper on our numbers.

… I'm battling with … trying to get them eligible before I can even concentrate on discharge. My last six referrals, four of them have homes to go to, have Ascend issues, which means I can't get a care plan if the facility's not getting paid. They're not MFP eligible if the facility's not getting paid the day before they leave. And then, maybe two of them out of those four that have eligibility issues, it's not an Ascend issue, it's a redetermination or a look-back issue.

Another main presenting concern is individuals whose complex behavioral health profile makes some particular cohort of people who do not meet level of care for nursing facilities, and that has presented some real issues in gaps and challenges for us in terms of them not meeting the requisites for Medicaid coverage that is a threshold requirement for MFP … that they, in general, individuals with behavioral health conditions and SUDs [substance use disorders] just in terms of effectively serving them and enabling transitions that are actually likely to be successful.

Consumer Expectations

Barriers to transition … Yes, sometimes the consumer might want to move, but the family is not supportive, so then we have to find a way around that and to see if it's … what the family is saying, if it's valid and see if the consumer actually wants to do what the family wants or actually still wants to pursue in moving out on their own, then we'd have to help them. If they're conserved, we have to help them change their conservatorship, and sometimes that takes time as well. So if the family is not on board, then that could be a barrier.

And a lot of the consumers I'm noticing as much as they want to get out, they don't know how to take on their own responsibility in helping that move forward, so they're completely dependent on the TCs and HCs, and sometimes they're not really cooperative, they just want, they want – their focus is getting out, but they're not willing to help in the process, and sometimes it makes the process even harder.

If it's a PCA waiver, even if they have a home to go to, we're looking at very close to 180 days because it's how do you get the consumer motivated to do their part? I can't hire their PCAs for them. I can train them on how to do it… sit with them maybe for the first few interviews when they're interviewing their PCAs, and maybe we'll even write down certain questions or work with them together … I would rather take a year to get somebody out knowing that I gave them the skills and we did it together rather than do it for them to get them out in 180. Because I know when they get out, I'm not going to get that phone call, "My PCA quit. What do I do?" Because that's going to delay me with getting to new people.

Other Barriers and Challenges to Successful Transitions

Respondents described other barriers and challenges to successful transitions. These included the State culture and predominance of the medical model versus a person-centered model that emphasizes the right to make one's own choices. Other areas noted to be problematic included poor teaming, insufficient community support for those with behavioral and mental health conditions, medication management issues, gaps in provider services (e.g., transportation), insufficient workforce – particularly in rural areas, and challenges associated with the hiring and managing of individual supports.

State Culture

I think that the culture of the state continues to be a problem. I think that the medical paradigm is absolutely still prevalent, and the medical paradigm is so different than the person – I guess I'll call it the independent living paradigm, where we don't all see through the same eyes the amount of risks that someone should be able to choose for themselves.

… they [consumers] have the right to take that risk. If they're cognitively intact and they understand what the risks are, they have that right. And sometimes we need to take a step back. We can't protect people from themselves. And people get to make bad choices or they need to make the choice that's right for them, even if it's not right for me or you. So I think that that's a huge challenge and a huge barrier that's across the entire system.

Insufficient Community Support for Behavioral and Mental Health

… mental health issues, not having enough mental health help out there in the community. I think we all know that's a challenge. And just having … for example people that want to hire their own PCAs, having enough PCAs out there or a pool of PCA services that they can pull from to hire their own caregivers. Just the education part of it, and I think that we can help them a little bit more in how to manage their care and that's something that we can do. But there's a lot of mental health issues that I think are sometimes out of our control.

Medication Management

A lot of times they see individuals who are unwilling, are unable to do their own medication administration, especially individuals with diabetes who are on insulin. I think that that is becoming an increasing challenge for us.

The biggest barriers that I'm dealing with right now that like just really grind my gears – morphine, opioids – whether it be prescription or recreational – mental health counseling, psychotropics, and by that I mean the difficulty in having a hard enough time getting community agencies, getting diabetic management under control, getting any kind of supports to agree to do the whatever it be … we also have to make sure that the

pain management clinics start prior to discharge, which means that the facility has to stop prescribing, and then have them start going, but then you run into … it's like a house of cards because there's so many variables and then any one of them could push a discharge back.

Gaps in Provider Services

… Also services – there are not enough community resources. Finding quality providers.

There are delays with different providers, which can be frustrating … I've had issues with LogistiCare – just like doesn't show up or just frustrating headaches with them and then it pushes things back.

Inadequate Workforce in Rural Areas

Out here, I mean, you have towns that, where are you going to get an employee? You're not going to get them from Norwich or Hartford or Mystic. You got a very small pool. And again, when employees are told to go to a work site, they're not being paid the transportation time to and from.

Hiring and Managing of Individual Supports

… self-determination is the preferred way to go, self-hiring, which I understand gives the individual and the family more hours. But there's an awful lot more that goes with that, which is being the employer, finding employees ... Teaching somebody how to be an employer. Not a lot of oversight. With agencies, they have inspections, regulations, and audits, and self-hire does not. So that has its benefits but it also – I have some concerns with the oversight.

Programmatic Barriers

Similar to 2015, most programmatic barriers were associated with funding and staffing, policies, and program limitations.

- Funding and staffing
- Policies
- Program limitations
- Other programmatic barriers

Funding and Staffing

Funding and staffing continued to be a challenge for the MFP program in 2016. Respondents described concerns about the budget and the current fiscal condition in CT and how that impacts the program. Many shared frustrations about the lack of cost of living raises and that the regional performance benchmarks for bonuses are difficult to meet. Stressful job situations, heavy workloads, and low compensation were noted as contributory factors in high staff turnover.

… the funding we have to do independent living skills … was largely taken away from us. And in fact, we're down to our last $40,000 a year in funding and the governor wants to take that away from us … So we used to have two people on staff. All they did was independent living skills for people. Now we have nobody on staff doing independent living skills …

… it's a very stressful, overwhelming job. It really is, honestly. And the pay does not match up with it. But the project has always said, "Well, these are just entry level positions." So people come in, they do the job and then they leave. If you're fine with that kind of turmoil and change over, then great but don't come running after people and say

*"Why is this taking so long to transition people out? Why are transitions slowing down?"
… how are we supposed to function when people are constantly leaving? … So as soon
as a new job offer comes, you leave. And in fact, a lot of the people aren't even waiting
for new job offers. They're just leaving and going on unemployment or whatever because
they can't take it anymore. So this is a serious problem that needs to be addressed.*

*If you don't feel very passionately about that as those of us in the disability community
do, then you won't last long in MFP. If you just look at it as a regular social worker job or
something, forget it. You'll get burned out and you'll quit. And there is a lot of turnover in
the project, tremendous amount of turnover … But we're not doing it for the money. The
money's terrible. Even by non-profit standards, the money is terrible. The workload is
tremendous. And so, you have to have that passion. Otherwise, you're just not going to
last.*

Policies

Respondents expressed frustration with an ongoing MFP program barrier the lack of written
policies and procedures, frequent changes in rules and regulations and inconsistencies in
guidelines about what protocols to follow. Protocols were also noted at times to create new
barriers and challenges in transitioning consumers.

*… I don't have a policy book … I wasn't given one … I don't really think that there are
real policies or procedures put in place for MFP … I've read online that there's things
that we should be doing and I have a job description, but I think it's so big and so vague
that anything goes and anything doesn't go kind of thing.*

*So now they came up with this new budget thing … but they basically said look, the
budget level is going to be this and you're going to have all this freedom and flexibility
within that … but because Community First Choice has to be kept at this amount, and by
the way, transportation and this and that and everything has to go in there. So what
we're finding is the flexibility might be there in theory but in practice it's not there
because now you included more costs that are eating up this budget, sometimes you
end up not giving people like basic household items they need because otherwise they
exceed their budget. So in practice, it hasn't worked out. So there's an example of how
MFP Program and protocols can create new barriers and new challenges in working
people to get them out.*

Program Limitations

Respondents described a range of program limitations that included challenges associated with
diverting people from nursing homes, working with state systems, and putting person-centered
planning into practice.

*… why aren't we doing anything to stop people from losing their housing in the first
place? Why do we require people to go to the nursing home, be there for 90 days, pray
and hope that they did an income diversion, so they can save their apartment? And then
we're going to go and find them housing? Why aren't we diverting people from the
nursing home and keeping them in the housing they had first off? And then we won't
have this problem later on. And there still is no real diversion program in Connecticut.
We started it with Aging and Disability Resource Centers, but there wasn't really any
continued funding for that. So that diversion - diverting people from nursing home is
critically important to enable them to keep their housing.*

*Working with the state systems, the DMHAS and the DDS, the Developmentally
Disabled. Again, maybe some of it is culture, the way our organization works versus*

those departments. It's very laissez-faire, I'll get there when I get there, so my staff is sitting with the client for an hour waiting for the care manager who was supposed to be there at 9 o'clock from DMHAS to get there, who strolls in at 10:30. And very difficult to get return phone calls. And these clients are dependent on the Waiver Services from that state agency, and I understand contractors get held to a different accountability or requirement than a state worker, but it's just simply unfair, unfair to the client first of all, not productive, not efficient for our staff.

… project leadership I think is very committed and very passionate about person-centered planning and activity. But I don't think we put it really into practice. I think sometimes the need to move people out and move them out fast takes a priority over what the person's needs really are.

Other Programmatic Barriers

Other programmatic barriers described were associated with determining eligibility, the long Medicaid application process, and inconsistent training of all staff in processes that change frequently or in new programs, such as the CFC program.

… just making sure that people are actually eligible and should be on our program. That sort of thing. I think maybe that's prescreening. I mean, it's difficult because I know that we want to offer this to everyone. But sometimes, there are just – are people that aren't appropriate for it.

But absolutely Medicaid for long-term services and supports, the application process is incredibly long and difficult and I don't know how people do it. And when you really sit down and read the application, you're like, wow. I'm having a hard time figuring this out.

… they really should've sat us down and explained to us how the CFC program works … I went to a training with DSS for the CFC planning and support coach and because I did that I would be able to better understand how the CFC paper worked and what I needed to do as a Transition Coordinator. And a lot of TCs didn't realize what they had to do for the CFC paperwork as a Transition Coordinator until after the fact. So they would have to redo the CFC paperwork.

While integration of the HCBS Unit in MFP and the implementation of CFC were seen as improvements, it was noted that the time invested in these shifted attention and efforts away from MFP. Other operational challenges included the integration of the MFP team and waiver team.

… I think what they did was they shifted focus and took time and energy from MFP, and that was the integration of the HCBS Unit in MFP and the implementation of Community First Choice. So there are kind of pros and cons. But I think during 2016, both of those took focus and energy that would have otherwise been clearly directed towards MFP ... I don't necessarily see them as bad. I haven't necessarily felt like they've created huge improvements or efficiencies. I think it's yet to be seen. But certainly when you take two different groups and make them into one, that's always a challenge.

The integration of the MFP team with our long-standing waiver team is definitely a work in progress just in terms of blend of cultures, applied practice, and we're continuing to work on that. But that definitely was a kind of major operational challenge.

Most Important Barrier to Overcome

Respondents were asked to identify the most important barrier that needs to be overcome and how to overcome it. Similar to the programmatic barriers that were described in the previous

section, respondents mentioned a broad range of barriers. These included: inadequate written guidelines and standardization of practices, weak common culture between agencies, inadequate funding, and insufficient housing access and availability.

> *… it sure would be nice to have a handbook or policy or protocol that all staff are required to refer to. That would help in the education piece, and I think it would standardize practices to some degree so that consumers and facility social workers could count on a more standardized way of MFP service provision and transition planning.*

> *I think that there's still too much discrepancy from agency to agency at a local-level, organization to organization … I don't think we've created a common culture in the field for Money Follows the Person. I think that there are still agencies that have their own cultures that somehow or other become prevalent, and it's destructive to the MFP process. It has to be a single culture, and we haven't quite gotten there yet. But certain entities that have been identified as teams exemplary best practices, absolutely are demonstrating the culture that we want to see.*

> *It's got to start at the grassroots level. We need to change the way society looks at elders and disabled. We need to increase funding to programs and federal funding, Medicare, Medicaid. We need to protect the rights of these individuals and we need to keep them.*

Insufficient support and planning coaches to assist with the CFC toolkit was also mentioned as a most important barrier to overcome.

> *… The Community First Choice becomes a difficult issue because we don't have the support and planning coaches to help people with the toolkits. It is really supposed to be self-directed, but quite frankly, you could have an MBA and have trouble filling out the toolkit, and most of our transitioning clients do not …. The Specialized Care Managers and Transition Coordinators have been told unequivocally that they cannot help with the toolkit … We have to either perhaps find a way so that each region could train other people and let it get paid as part of a social-work visit from one of the homecare agencies … but we need somebody in the community to take on this role, and they're probably not going to do it for free …*

Additional most important barriers described by respondents included inadequate services to support consumers in the community, difficulty obtaining required documentation, and working to resolve processes associated with people with behavioral health that don't meet nursing home level of care.

> *We need to have more of a community living focus rather than a transition from a nursing home focus.*

> *So most important thing is the ID ... I really feel like there has to be some coordination between the state and the MFP and DMV whereby – especially the elderly don't have to go through all that struggle just to get an ID.*

> *One operational process – I think finding some resolution to the phenomenon as an individual with various behavioral health conditions who doesn't meet nursing home level of care being foreclosed from MFP eligibility. That is something we should be doing something about procedurally.*

Some respondents stated that greater awareness regarding self-referral to MFP is needed, and communication was underscored as an area that still needs improvement.

I think the thing that I've been thinking about most recently is a way that consumers and families can self-refer … They always have been able to, but I'm not so sure that the average person is a nursing facility or their family is aware of that right now. We've made efforts in the past to make them aware. There is information on My Place, but I think by and large our referrals tend to come through facility social workers. That can be very good because it can provide a lot of information, but it also can put them in somewhat of a gatekeeper role as to who gets referred.

Respondent Recommendations

Respondents shared numerous recommendations to address the transition barriers and challenges and programmatic barriers they described. Recommendations for transition barriers and challenges are listed first followed by recommendations for programmatic barriers.

Transition Barriers and Challenges Recommendations

➢ Provide more affordable, accessible housing options

I think it's a systemic problem that's not going to be solved by MFP. But we should take the data that MFP gives us and we should be advocating in the state legislature and in the state congress for laws that require residential buildings especially apartment building to have more accessibility. That would go a long way. And when the developer comes to town, they said "I'm going to build this apartment building and it's going to have 80 units in it and eight of them are going to be for disabled or elderly who need some accessibility and those same eight are going to be the below market rate ones. And oh by the way, all of our units are going to be studios or one bedroom." That's the kind of development we don't need. We need more two bedrooms, three bedrooms type of things, more accessible apartments … We need to bring that to them, and we need to do advocacy to make sure we're going to have some kind of rental assistance.

➢ Promote awareness and education about MFP

I think that there are a couple things. One is telling the stories and helping people see that the life experience of the individual is something other than what naysayers thought it would be, and we just start to demonstrate through that, everybody being part of it, that we're overcoming some of the myths or some of the mindsets that would have yesterday led to continued institutionalization for that person … And I think then also the data, on the data side, being able to show the quality of life improved, medical utilization of acute care didn't go up, that in many cases people's health actually improved, and these are individuals who otherwise wouldn't have even been discharged because we thought it wasn't safe.

The state needs to either take a more active role or allow their regional contractors to better educate the community and spend some more time talking about what the initiatives are, what Money Follows the Person can and cannot do, what is the role of the community. So I think there's always areas that we can improve. Even when we look at discharge planning from a hospital perspective, clients in MFP who come home and then end up in the emergency room, are we communicating back to that Specialized Care Manager so that we're maybe increasing their care plan and giving them the additional support because they have pneumonia now or because they fell back and perhaps started drinking again. Let's get the supports in sooner rather than later.

➢ Strengthen teaming

I think just keep trying to look at different approaches until you find a solution because there are so many – especially if you talk to your coworkers and team members, there's

always a way to do it, even if it's not the obvious one. I think if you keep taking different approaches, you'll eventually figure out what you should do. A lot of times, too, I'll send an email to Central Office for advisement because I'll be stuck and everyone around me doesn't know either. I'm like, all right, well, maybe Central Office will know. So just keep brainstorming and getting ideas from other people. I think eventually you'll overcome any transition obstacles.

… I think if that team and the nursing facility team can begin to see themselves as one team, that's better.

➢ Improve communication

… I think more communication would help … I think that sharing more information and, like I said, maybe a conference call between the State and the Access Agencies and Allied, so that … when we have the issues, we can all talk about them together, so it's the same together. So we all hear it the same way …

I think taking the time to effectively communicate within the team, within all the partners, whether it's a formal team or just the group of individuals that are around somebody who's seeking to transition. I think that's absolutely vital to keep everybody on track. And, again, to manage those expectations about how quickly things will happen and what can be done and what can't.

… I'm not really sure how those supports are presented to them in those initial encounters with the care managers, but … a lot of the consumers even though they might have need for such support, they seem to kind of want to stay away from them … I don't know if there's a way to have those better explained to the consumers, but they haven't really been receptive. But I would think it would be beneficial.

➢ Increase flexibility in considering living situations for people with behavioral and mental health issues

I think there needs to be a recognition that sometimes folks benefit from settings that can provide structured 24-hour supervision cyclically. I think that DSS Central Office sees a residential-care-home level of care as a failure, when for folks in our population, it's actually a stepdown from an institutional setting into a community setting and can provide time for them to continue to stabilize and learn how to function in an independent setting in the community when the waiver program becomes more appropriate for their needs … the state is reimbursed for individuals who … go out on waiver programs as opposed to folks who go out on state-planned transitions with no reimbursement for individuals who go out into residential care homes, and Central Office staff have to be concerned with that mission, which is understood. But it may conflict with an individual's need for a more structured setting at various times in their lives and to be able to use those settings as a foothold to step off into more independent settings down the road.

Provide better transitional support

… a number of individuals have serious, serious substance use and addictions and certainly a history of that. And I would say to successfully transition a person, sometimes I worry that people aren't getting the transitional support that they need in that area. There's a – such a hard focus on living independently that I wonder … if there's possibly more of a transitional program or transitional housing that would help people who need that extra level of support until they can really get on their feet and be independent. A lot of people just jump right back into their addictions even if they didn't plan on it. They're addictions; it's hard.

I really liked what Independence Unlimited did in the past and that maybe others did as well. They had a support group for people who had just transitioned or who wanted to transition. Now even though they provided transportation, everybody had to truck themselves to the office for that support group … it could be done through the web. It can be done through lots of different ways. That kind of preparation time and peer support and problem solving, that is a need, and I don't know that that is something that the state needs to tackle, but our communities – It'd be great if we could inspire that kind of an opportunity for people to work together on these common issues.

➢ Increase recruitment of service providers

… I think just recruitment of more providers … service providers.

➢ Improve medication management procedures

And so when you do an initial … you better put in your write-up that the consumer is on pain medications and will need a pain specialist in the community. It better be on the Action Plan because that way when the – and when you send that Action Plan over to the facility, you want to make sure you note social worker at facility will ensure pain medications can be reduced or eliminated or will set up pain management specialist, and you make it clear to them and make it clear to everybody.

➢ Integrate assistive technology

I think there's a lot of emphasis on getting people out as fast as possible, but if you don't take the time to have someone assessed for assistive technology, you could really be over-serving them and giving them way too much support … And I think that because a lot of folks have been in a nursing home, people assume they can't use technology, and I just think that it's one of those areas that as a state we need to get better at. It's not just MFP. It's across all our services. But I think, once again, MFP has the opportunity to be a model for the rest of the state.

➢ Improve access to credit or criminal reports

But I think overall for housing cases, you have a lot of people that have criminal backgrounds or bad credit and the HC won't find out about that until they apply them to an apartment complex. So the HC is wasting money and time. If they had some access to look up their credit report or look up if they have a criminal background in the system, then they would know, okay, I'm going to have to talk to this landlord beforehand so that way they get – they know this is the situation they're going into.

➢ Encourage consumer choice for options in waivers

… I think that waiver-wise that should be an option. I think they should … pick whether they want to do self-directed or agency based. That's the one waiver thing I think should change.

Programmatic Barriers Recommendations

➢ Increase funding to hire staff

Well, it would be very nice if there was much more money to hire staff. That would be helpful for practically every program I know but that certainly would presumably add to the ability to move people out as there would be more transition teams working …

➢ Improve field staff salaries

… you can't have a good working relationship and team structure if the team members are constantly coming and going, and you don't even know what their name is. And you don't know what their email is. It's very frustrating. We go to the retreat and we look around and say who are these people?

➢ Strengthen nursing home diversion and integrate it with MFP

… We've never thought we would come to the point where we would actually advise someone who doesn't want to go into a nursing home to please go into a nursing home so that we can help you get out of a nursing home ... there needs to be a diversion program, a very strong one and very strong Aging and Disability network. That and MFP together needs to be funded by the State.

➢ Improve communication and continued education regarding MFP program changes

I would think communication can always be better about changes. But I think they do the retreats, which I think are really beneficial to the staff, giving them those opportunities to meet, and I know the supervisors meet. But I think that you can never do enough communication or outreach before you roll something out or change a process.

➢ Cross-train agency staff as CFC support and planning coaches

… Agencies are not going to let go of staff for a couple of days to do that [CFC training]. So teach us what you want a support and planning coach person to know. Let us hold regional trainings for it, and sprinkle at least a half dozen support and planning coaches at various homecare agencies as part of the social-work function and let them help the individual because it truly is a barrier.

➢ Simplify MFP procedures

… I think the project has gotten too complicated, too unwieldly, too many rules, too many protocols, too many steps. Everything is getting very hard. There are some things have happened over the years that made things easier initially and then harder, for example, the introduction of a web-based data system. That was great in the beginning because we finally had a way to put all our data in a simple way and all of us could do it and anybody could go look at somebody else's data and we thought it was great. But then … they decided as long as we have that, let's add this on and let's do this, and let's make this protocol and say you have to do that and you have to do this and you have to do that … Things need to be made more simple.

➢ Implement "pods" to strengthen existing teams

I think it's helpful to work in teams. I think it would be helpful to understand why it hasn't worked, and I'm not sure what the answer is there. One of the ideas that I've been toying with is maybe teams of teams – in some places, that might be what they call pods – where you have a couple of teams that work together. So as people leave, you have more than just that little four-person team that's familiar and you can sort backfill and support, and I think you can also better mix seasoned staff with new staff to support everyone.

➢ Explore an expedited Medicaid process

… we've identified the Medicaid application as being a barrier or a difficulty for people. And you look at Washington State who does have that – has an expedited process and most of their Medicaid – their long-term service Medicaid recipients start to receive services in the community first as opposed to nursing home first where that is in Connecticut … we need to figure out some presumptive or expedited process. And we've

talked about that too as hospital discharge planning as well … you don't have a payment source in place and you're discharging from a hospital, chances are getting services back in the community – from a waiver … Well one, there's – there's a wait list so you might not get services right away. And two, if your Medicaid's not done, those services aren't going to start so you're likely to be discharged to a nursing facility. But I think Community First Choice has helped with that too. And I would like to see that furthered in discharge planning. So that's my barrier and my suggestion is we should do something about that Medicaid process.

➢ Focus more on quality of life and less on dollar amounts in transitioning consumers

… I think there's still some folks that are still evaluating the cost of the care in the institution versus the community, and that's within state government, and I still think that we have a long way to go to really – for people to really understand what a quality of life means. And, like I said before, it's not my definition or your definition but that family's quality of life. And I just think that decisions shouldn't be made just on dollar amounts.

➢ Expand the development of shared protocols for individuals with disabilities and complex medical needs

… the need for development of shared protocols for individuals who have both disabilities and also complex medical conditions. So we've just been doing some protocols around how to do that in a more comprehensive way. But opening up that effort and not operating in parallel is something that we really could use. It would be, I think, extremely meaningful.

➢ Develop a wider range of consumer supports

I think we never did a great job of getting a lot of people interested in becoming recovery assistants. It's difficult to find agencies that have those supports, so I think we need to continue to do that. They're very, very helpful to someone in need.

➢ Promote more awareness regarding choice and control

I think it's an education – I think it's a society change and I don't think it's anything that happens quickly … society has to change how it views risk and … what we're willing to let somebody else take as a risk to their own life and make their own choices … society, as a whole, has to understand you're allowed to take risks with your life, with the choices of where you live and how you receive services …

➢ Promote more awareness about MFP

I think continuing outreach, making people aware of Money Follows the Person and how it works and how it can benefit people, and also, realistically, what it can and can't do in managing expectations.

Community First Choice

The newly available program, Community First Choice (CFC) allows any Medicaid member that can self-direct services and meets Institutional Level of Care to receive services and supports in their home. Respondents shared their thoughts and experiences about the program, its impact on the transition process, program challenges, and recommendations.

Experiences with CFC

Overall, CFC was described by respondents as a work in progress and a huge culture shift to include self-direction under the Medicaid state plan. Respondents described participation in rolling out the new Medicaid entitlement program as "incredibly exciting." Some shared that in the beginning, identifying those eligible for the program and then coordinating everything with DDS was a tedious process. Others described the startup as good but challenging because of the level of confusion in the community about the program, consumer expectations, and the cost involved in implementing it.

> I think it's an incredible program to have something like this in this state where not many states have Community First Choice …

> … it definitely has grown from when we first rolled out CFC in 2015 … There's been so many changes with how we started things and how things are being done now. I think it's moving in the right direction … there's things that we need to work on, the toolkit and things like that. But I have confidence that working together and kind of explaining what's working out there for the clients, what's not, what's lacking, what things we should all be working on, will change the program for the better.

> It's definitely growing. Referrals keep coming in. I think expectations have been a real challenge, expecting that Community First Choice will bring far more additional services than people had. I think some of that's been promoted by advocates. So I think, again, a lot of it comes back to helping people understand the reality of the program, that it can do a great deal for people, and it has the potential to make people's lives much better, but it's not going to solve everything for everybody.

> Just that there's a lot of community confusion about what is Community First Choice. I don't think that our community partners understand it or know what it is. So I think we could help more people if people understood what it is.

> … I don't really know intimately the forms and all of that to speak to the consumer-level experience of that. I just know from a bigger perspective, it's costing us money as it is. There's a lot demand for answers from consumers and guidance that is unreimbursed. So we're losing a lot of money.

A few respondents expressed frustration with CFC because the packet and paperwork were unclear and it was difficult to help consumers with care planning when they were confused. For at least one respondent, the process of getting care plan packets returned was a slow process and created more work in following up on outstanding packets.

> Very frustrating. I'm not pleased with the CFC packet. I think it's very long. I think figuring out how to do the calculations is very confusing. I mean I'm not supposed to be doing the calculations, but I have to do the calculations so I know if the numbers are correct. And I find this to be very difficult to understand … So I feel that this paperwork needs to be revised … I do understand the purpose of people being responsible for figuring out what they need for themselves. I think having to leave this packet with the people, frequently people are confused. They don't know what to do, and I think it's delaying the process … I just find it to be kind of a cumbersome process … I can't submit my care plans to the state for approval until this packet is done.

TCs participating in this evaluation described their experiences with CFC primarily as an informant to raise consumer awareness about the program and follow up with assistive technology if it was requested. In some cases when consumers wanted more services, a TC provided the appropriate paperwork to initiate a change in the care plan.

… I just tell them that Community First Choice is an option … I just tell them that CFC is available and that it's self-directed, but I can't really go into detail. I can just give them the contacts for the care managers and ask that a broker be given to them if they want one.

… my role is just to make sure that the assistive technology is done because that's something that I would have to purchase. And then … if I go out to a post-transition interview and the individual is like, oh I need more services. Then, I would have to inform them, okay, you have to change your care plan. So then I'd have to bring them out all the new paperwork, have him change his care plan and then give it to the SCM. The only other thing I'm kind of responsible for is just following through to see the care plan is approved and that Allied contacts the consumer to set up the employer training. But because CFC is so self-directed, the consumer is responsible for hiring their own PCAs. That's not really something I step into unless they need help creating ads or making up interview questions and just kind of suggesting where they can send the PCAs.

Impact of CFC on the Transition Process

Overall, CFC was described as another resource with great potential to give consumers more options and to help meet their needs in the community. Several respondents underscored that giving people greater choice and control in their life is a significant strength of the program.

I think the strength is that it is an option that gives people the maximum degree of choice and control in their life, including self-hiring their own staff, determining the qualifications for their staff, and developing and managing their own budget for all the service delivery system. Those are the absolutely great things about Community First Choice.

I think [CFC] puts the person or the family members in the driver's seat …

The benefits, if the consumer and their family can manage their paperwork and really take on that responsibility of self-directing … that control really helps because they get to pick who is working with them and how, the hours, and they'll get more, I believe more flexibility with the hours that they want. Sometimes that works better because not all families want a specific agency providing the PCA services and with them self-directing, sometimes that's helpful, especially if sometimes they have – they already have family and friends in mind willing to provide those services. Sometimes it works for their benefit.

In particular, CFC was noted to be a benefit for consumers on the PCA waiver because it allowed individuals to have modifications and assistive technology as part of their plan.

… Community First Choice allowed … home modifications and assistive technology as part of a plan for individuals – that didn't exist previously … it made a huge change for individuals who needed a ramp to access their home and I think that that's a huge change that is now easier to fund and easier to have.

I think it's wonderful in a way that covers the PCA Waiver because … I think it's good that it gives the consumer more of a choice to make their own care plan and so they actually see where their money is going and they're more responsible for it instead of having someone like a Specialized Care Manager oversee everything …

Some respondents noted that CFC processes impacted and slowed the transition process.

There are delays in getting Allied to come out and talk about services, in particular with CFC, and if the person is coming out with CFC services. Now, I haven't had that except recently. So Allied has not been an issue for me in the past until CFC has been on the team.

CFC Challenges

While most respondents applauded the design of CFC, many described a disconnect between the conceptual and operational designs of the program.

> *I think there are field-capacity challenges. I think that there have been some design challenges as we've tried to coordinate across all departments and maintain a single coordinated budget that's a total budget across all departments for long-term supports and services without the adequate technology and like a centralized case-management system. So we don't have that. When CFC was designed, we were supposed to have that. So what we have is a great design in program that is really hard to operate because we don't have the tools to do it. So that has been challenging. I think some of our budget allocations have to be revisited because of that.*

> *The setup for integration with our waiver program was not and is not complete, and the assessors for CFC and our clinical staff who function as SCMs and community support clinicians have found it challenging … We are not allowed … to assess an individual and say but for his personal-care needs being met, the individual would be eligible for the Mental Health Waiver. Instead we have to find the individual ineligible for the waiver and refer to the Access Agency for an assessment for self-directed services and then determine whether or not we could wrap around waiver services or community mental health services with the individual, depending on how far they get with CFC. That is not an ideal system.*

In many cases, not having field-capacity or the necessary tools to implement CFC effectively made it difficult for contractors and impacted transitions by delaying them.

> *There was a very long trajectory for the development of the operational materials – I think that could have been more efficiently handled in terms of clarity to our external contractors who would be implementing [CFC] …*

> *… But as great as Community First Choice is, it's really designed conceptually and not practically … a transition is slowed down when someone is using CFC because they don't know how to manage and coordinate their own budget. It generally requires some hands-on training and assistance of a support and planning coach, and by the time a support and planning coach gets involved, another month has gone by. It's just – There's just too many stops in the process that slows everything down. That could be changed.*

Challenges related to effectively implementing the program included lack of appropriate CFC training, deficiencies in experienced staffing resources, and the learning curve involved in a new program.

> *My thoughts about CFC for 2016 is that it felt very scattered and it felt very piecemeal to an extent that information wasn't very clear. It wasn't shared and there wasn't appropriate training on CFC for the people that would be, not only carrying it out, but for the individual staff that were not actually going to actually deliver the service but just having that broad understanding and knowledge as to exactly what CFC is and how might it affect your particular role. It kind of felt like you learned about CFC if and only a question came to you but that there was not a reach out to just say, "Hey, let's kind of talk about what it is and what it means for you exactly." I mean, there was some training, there was some workshops on it, but I just think that the service, the information sharing on that could've been a lot better distributed.*

… having staff split their time between both MFP and Community First Choice… It's incredibly stressful because you want to make sure you are taking care of all the cases … we need staff … dedicated DSS staff to Community First Choice …

Some respondents described the need for a better understanding of CFC, particularly in conjunction with waiver services.

Well, I think the regional teams and the waiver teams are yet to be fully at ease with the CFC and that's a way overstatement. That is to say no one really seems to understand what's going on very well. And in a way, that's to be understood because CFC hasn't been around for all that long. But it's an issue. If CFC is supposed to be a reliable or a robust alternative, then it has to be better understood and put forward by both MFP and the waiver services because after all we know that CFC can be used in conjunction with waiver services. And in my experience, there are waiver people who don't know that much less MFP. So I mean, everyone needs to come up to speed a little bit better than that.

Many respondents expressed concern about consumers who do not want to self-direct or those lacking in capability for self-direction. This included frustrations with not being allowed to assist the consumer during the process.

… the major challenge, which is one that the Committee foresaw coming, I mean this is not news to anybody who worked on the thing from the very start, and that is self-direction is frightening and not possible. We always knew that there would be people who didn't want to self-direct. Even if they could, they didn't want to. And so for these people, that group of people, this is not their program. And then, there are people for whom self-direction is tough … even those with conservators, because the hiring and firing and worker's comp and all the other things that go wrong with self-direction are tough for people with mental health challenges or even for people without them … there's a large group of people who can do it and once they've done it for a certain amount of time, they'll be fine. But at first, it's like learning to drive ... it's frightening and they don't know … the hope is that as they hire their staff, get used to the problems that they after a while it just comes naturally …

And then there's … participation from people on the DDS waitlist who don't really meet the profile of individuals that we'd originally anticipated targeting for CFC, both from the standpoint of interest and capability of self-direction and then just the service need, which is predominantly for a residential service that is not satisfied by CFC. So that's definitely been a challenge.

It's tough. It's like a blessing and a curse to not be legally allowed to complete a toolkit. It's like I love the idea self-direction, love it, but it really stinks to have a consumer that maybe needs a little bit more help ... I think the ability to complete a CFC toolkit is a good indicator of if an individual can self-direct their own care, in general. And so if you give a CFC toolkit to somebody, and they say I got it, and 30 days goes by and they are still sending you incomplete or incorrect care plans, that's a sign. That's a big sign.

Respondents noted that lack of awareness about CFC and how it operates in different agencies contributed to the challenges associated with the program. In particular, having a silo mentality and not all being on the same page contributed to difficulties in effectively operating the program.

… the Department of Social Services, those waiver people and to some extent MFP people, they don't understand what Community First Choice is and how it can work. For example … I spoke to people at the Mental Health Waiver and they were dubious that

CFC services could be combined with waiver services when I knew … that surprised me … it may be that there are silos. The waiver people are one silo, the MFP people are another silo, the CFC people are another silo. And that's one of the reasons I'm so apprehensive about yet another major silo or separation between policy and operations. People don't see the overall picture, and in a case like MFP where there are so many nuances, it's important that all the different threads be able to be brought to bear on individuals who need services maybe from several different silos …

Well they all have a different way of assessing people. They have all different ways of seeing things and what the budgets are like. DDS is the advocate for their clients. They have different budgets. Budgets are really big. Trying to get that communication and explaining this program that it's not a waiver and how it's going to work with or be implemented with their waiver could be difficult at times … CFC is going to take obviously some time for everyone to get used to of what CFC does and how it's implemented within their waiver. It's not a service that is an addition to what they're receiving. It's a combination of with what they're receiving. So I think that's been the struggle. There was a lot of misinformation and miscommunication …

Other challenges associated with CFC included issues with accounts receivable, billing, rebilling, and having an adequate cash flow.

… once again the CFC, is all the issues with billing, so our role of accounts receivable – and doing a lot of rebilling and everything has changed a lot, the focus to get cash flow so we can pay these people timely … there's tons of billing issues right now with CFC.

Respondent Recommendations

Respondents made numerous suggestions to strengthen CFC.

➢ Promote greater awareness of the program through education

If CFC is supposed to be a reliable or a robust alternative, then it has to be better understood and put forward by both MFP and the waiver services because after all we know that CFC can be used in conjunction with waiver services.

➢ Target specific services and develop educational materials to explain them more fully

… there's some pieces of [the toolkit] that can be a little bit complicated, and although I think they're well covered in the toolkit that we've developed, I think breaking some of those out so that people have a specific tool that they can go to just for that one piece. Some of them are around home modifications, around assistive technology, around the whole process, around Workers' Compensation … They're all covered in one service-planning tool, but I think sometimes it's helpful just to have … a separate pamphlet or a place to go to or a – that when you're focusing on this one thing, it's just focused on that.

➢ Provide more complete CFC training and regular updates about the program

… I think there should be a CFC intensive training on it because outside of knowing that there's a long waitlist and outside of knowing that the cases are kind of assigned by region and a few are given per week to whatever Access Agency, I personally don't know very much … we should all at a very basic level have the same knowledge base in order to explain to anyone that answers the phone with a very general question, we should be able to answer that with some confidence without always having to get a phone number and send the question by email or look for someone to answer the question, call this person back. It gets a little chaotic doing it in that fashion.

More training, not only for the employees but also there needs to be more information given to the consumers … there needs to be more education and training regarding CFC … there needs to be more information given to the employees and the individuals that are accessing the program instead of it coming up after the fact.

➢ Reconsider CFC budget allocations

We have to revisit the budget allocations. We're not going to have a centralized case-management system in the near future, so we have to create a different process other than what we're using right now to do that.

➢ Provide better implementation of CFC

… Central Office at DSS needs to determine how to integrate these two programs [CFC and MFP] if they can be, needs to determine efficient referral processes for doing that, needs to have negotiated those processes with their access agency contractors before marketing the program and asking us to market it. It's very frustrating for our staff to market a program that they can't integrate with successfully or to tell family members, legal representatives, and other supports that the program exists and then not be able to refer to it.

➢ Create a unit dedicated to CFC that has a clear leader and stronger policies and procedures

… there's so many people out there hanging on by a thread and they really need services … We absolutely need the DSS staff dedicated to that … We need a unit devoted to CFC.

[CFC] needs a leader and stronger definition, policies, procedures.

➢ Increase consumer access to assistance with the toolkit

… It also seems at times like it would be great if there was a helpline that people could call.

I think frontloading the system with some extra help would be great … We've talked about non-profit groups that would offer free advice …

… since the family or the consumers are having a hard time getting a hold of the brokers, I don't know if maybe when the SCMs present the CFC paperwork with them and ask the family right then and there if they want a broker and call the broker right then and there and set up an initial meeting for the people – the family … if that initial visit with the broker, even if it's an hour that they can provide, if that could be free that maybe that would help the process …

Education and Training

To help inform processes related to the education and training of new hires and to provide additional employee learning opportunities, more in-depth questions were asked this year. Respondents were asked how effective the online CADER training was in creating a standardized approach for TCs and HCs, how the training impacted consumers, if they felt it was a good investment for the state, and how helpful the training was. In addition, SCM Supervisors were asked what training was needed to effectively do their jobs.

TC/HC/SCM Training or CADER

At the time of the evaluation, all TCs and HCs completed a standardized, 6 module online education course from Boston University's Center for Aging and Disability Education and

Research (CADER). The course covers topics such as consumer assessment, choice and control, and informal caregivers.

When field staff were asked whether or not they took the CADER training, most recalled taking the training, however a few KIs noted it had been a few years since they completed the course and, as a result, they could not offer thoughts about the training. Of those that provided feedback, the course was described as informative and provided an introduction to numerous topics.

> *It gives you a lot of information about Title 19. It's Medicaid and Medicare … If you don't know anything about that, like Medicaid, Title 19, that training gives you a – it introduces you to what that is. And it makes you want to ask more questions because you ask "What is this? Why are they saying that?" And then, you get familiar with it. That's what I got out of it.*

KIs were asked if the CADER training was a good investment of time and money for TCs and HCs and if it was worth the state's investment. Responses were mixed depending on their role and previous education and included some yes but mostly no answers. One HC described the CADER training as a review of classes she had taken in college and liked that it was a refresher, but felt it would be more beneficial if it tied in more with MFP. The following is an example of a yes response.

> *I took it when I was a HC. I thought the course was really informative. I liked it just because I'm interested in that kind of stuff. And it kind of taught you how to – not taught you but reminded you this is - how you're supposed to be respectful. You need to understand that they are dealing with different issues than you're dealing with and just to treat them as human beings and understand some of the issue that they face and … I thought it was a good training. I think it puts everyone at the same level of like this is what you should know.*

There were numerous reasons why KIs felt the training was not worth the state's investment including: difficulty absorbing the information; too nerve-racking; not able to interpret material and process it into a real work experience; spending dollars on CADER training for an entry level position when the money should go to salaries. One respondent suggested that new hires did not appreciate the training because they did not understand why they were doing it and that they need an opportunity to put it into practice. The following are examples of "no" responses, with the first quote from a TC wishing for more interactive training.

> *No, because … you want to be in the field and you could really have your heart here but if you don't pass this test, they said you couldn't work in the field, it's not, I don't know. Because then they want to test you to make sure that you could do it instead of going through modules of examples or trainings as, as trainings of what you should not do as a TC or when you're breaking barriers or when you're overstepping boundaries, some sort of interaction like that I think it's, it'll be different but I don't see how that BU training is beneficial to the MFP process.*

> *The only reason I say that is because I think a lot of what this job is - it's experience based. So for the amount of time that I put into that BU course, I put a lot of time in, I think it was 6 hours. It was a long time. I would say most of what I've learned, I've learned from experience shadowing people or just watching how people – how my coworkers interact with clients. You're going to find your own groove and way to talk to people and read people but honestly, if I'm being honest, I don't think the amount of time and effort I put into that course gave me anything more than I could've gotten from just shadowing or my own personal experiences.*

KIs had conflicting thoughts about the time needed for the training. Some underscored the necessity of making time for it while others expressed concern that additional training would be burdensome.

> … I think [TCs are] so overwhelmed with all the different hats they wear with the different waivers, I'm not sure if I'd want to put any additional training on them. I don't know how they do what they do.

Other concerns included CO not being up to date in training and in issuing certificates for completed training. One TC underscored that field staff hired more recently have not received CADER training.

> Let me put it to you this way, we have two people who did the course, took the test, we don't know if they passed or failed … I don't know if it's something different but I can tell you whatever CADER courses our TCs took, they still don't know if they passed or failed. And when they took the test, 90 days after they were hired, believe me for about six months later, we've been emailing back and forth. "Well, what's up?" Nothing.

> I took the training when I first started. However, ever since then, not one person, not one TC or HC has taken it since I have started here. So I mean, no, I don't think that it's effective then if people aren't taking the course.

Suggestions for improving CADER training included a need for optional delivery methods to address different learner styles and provide certification that people can use in other jobs.

> I think it was a good intention on part of the project leaders should do it in this way and do it with the university because not only does it make it more credible but also this is something that will be actual certification that people can use in other jobs or when they move on to other positions. They could use it and say by the way, I'm a certified Aging and Disability Specialist. So I think the intention was really good as far as that goes.

When asked how the CADER training has impacted consumers or their families, most KIs responded in general terms suggesting that better trained TCs/HCs have the potential to improve consumer outcomes. Many KIs also noted that they did not know how to measure the impact of the training on consumers or their families without a way to evaluate it or without data.

Motivational Interviewing Training

At the time of the evaluation, all SCMs received Motivational Interviewing training. Although they were asked to describe how the training impacted consumers or their family members, most focused on the value of the training and suggested it should be offered to everyone involved in MFP, from HCs to CO Staff.

> I think it is something that everyone should take. And my reasoning behind that is you don't have to be an SCM to learn proper engagement. And because we're all interacting with that same consumer in some capacity or another, we have to know how to engage and speak and appropriately motivate someone to do the things that they themselves say that they want to do. And by not offering that as a standard training, I think that we're doing not only the consumer but our staff a great disservice because we're not having core training across the board for MFP staff.

Other Suggestions

Consistent Core Training for TCs, HCs, and SCMs

Respondents raised concerns about inconsistencies in the training of newly hired TCs/HCs/SCMs, and noted the training they received was dependent upon the Access Agency or location of the team within the state.

> *I came into this job and I had no one to train me. My boss had no idea how to do my job at all. So I had to kind of just learn it along the way...I had no idea what anything was. I didn't know what Money Follows the Person was or – I never knew what SNF stood for. It was difficult at times. I mean I remember my first couple months here, I hated it because I just didn't feel like I had support, didn't feel like I had the appropriate tools to be able to do my job effectively or anything like that. So I think definitely having a mandatory training for the TCs and the HCs is necessary.*

Job Shadowing

Job shadowing was suggested as an effective way to teach roles and responsibilities to new hires because it promotes hands-on learning from more experienced staff in the field.

> *So what we do, since I've actually been doing some of that training, is we – in the past I – shadow – or someone has shadowed me for maybe three months. So they come out with me on assessments. So I go through with them learning how to collect data out of a chart and what information and where to go to find that information. They watch me how I do the Universal Assessment tool and what types of questions that I ask, and how I ask them when I'm talking – doing an assessment. I sit down with them. I go over all the paperwork that's necessary. They go through the discharge planning process with me. They go to discharge planning meetings. So – and, yes that's been really – I'll meet with them one-on-one if they have questions, if they're not sure. My supervisor has had me train I think maybe three or four people in the past few years and they haven't – they keep coming back to me so I'm assuming that they're liking what I'm doing.*

> *In general, I'd say just shadowing people, seeing how people interact with others and being able to understand this is who you are and this is how you're going to come across. And every individual is different because I really just think our role – HC and TC is not a role that you could read from the book and then be like, okay, I can do it now. It's something that you have to be immersed in, that you have to experience.*

In addition to job shadowing, TC/HC respondents suggested education and training topics they would like exposure to. This included training on:

♦ Roles (e.g., SCM, TC, HC)

♦ CFC

♦ Medicaid

♦ Waiver programs

♦ How the transition budget works

♦ Care plans and understanding complex needs of clients

♦ Understanding Informed Risk with reduced cognitive ability

♦ Brain injuries

♦ Assistive technology

- ♦ Completing a Universal Assessment

- ♦ Motivational Interviewing

- ♦ Critical case conferences

- ♦ How to resolve barriers with nursing homes and guardians

In particular, HCs requested training with Housing Authorities and on specific housing programs (e.g., RAP, Section 8, and 811).

Suggestions for SCM Supervisor Training

One SCM Supervisor described the overwhelming challenge of trying to learn about the various waiver programs and MFP processes at the same time and suggested that it was not productive for consumers.

> *I just had to wing it, figure it out as time goes, stumble into errors and wait to be called on and given a process to clean it up. I mean it was just terribly inefficient for our consumers.*

Exchanges during the monthly MFP SCM and TC/HC Supervisor meetings were noted to be beneficial in learning about each person's role in MFP and how some of the processes worked.

SCM Supervisors suggested a number of training topics for people in their position. This included training on:

- ♦ Roles (e.g. SCM, TC, HC, Fiscal Intermediary)

- ♦ MFP (e.g., program overview, CO training manual, database and online web system)

- ♦ Processes related to how cases are transferred including how to communicate with other SCM Supervisors about transferring a case

- ♦ Waiver programs (e.g., have waiver managers present their program)

- ♦ Best practices for supervising staff

- ♦ Utilization of available teaching and communication resources

- ♦ Discharge planning and budget allocations

- ♦ A consumer's right to self-determination

Education and Training Challenges

High staff turnover and trying to meet the needs of both new hires and more seasoned staff were identified as the greatest education and training challenges.

> *Well it's always been one of the challenges to offer training and meet the needs of, because there's been so much turn over, new folks while at the same time providing training that is challenging, interesting, relevant for more seasoned individuals, kind of advanced learning. We have explored providing access. Boston University (CADER) has offered opportunities to do outside learning, and we've explored paying for the courses and giving people access to them. They wouldn't be able to do them on the job, but it's something that they could take for extra credit or for their own learning. Unfortunately, what comes back again is we don't have the time to do that. I think finding some creative ways to support, particularly existing staff, people who've been with us a while and offering training opportunities that would be valuable to them.*

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Insufficient resources to train staff were another challenge that contributed to inconsistent training.

> *In 2016 they did not have resources to train SCMs, TCs and HCs consistently with standardized protocols. In 2017 they've begun a system to do that … they may have to wait for months and get it from supervisors who may have been inconsistently trained, and that's a problem for consumers.*

New Trainings

A meeting at CO toward the end of 2016 was noted to provide hope for the development of new trainings to benefit staff and support ongoing MFP efforts.

> *It was a meeting at the Central Office. I was the only Housing Coordinator that was chosen to be in attendance and we were asked to go over everyone Specialized Care Managers, Supervisors, Transition Coordinators, to go over each step of your job and how we can be more effective in training and communication amongst everyone and how we can get our documents to be more of a working document more of a guiding tool from someone getting assigned to transitioning out into the community. That was a great meeting. I'm glad that I was actually able to be a part of it because I think that from that they have now developed new trainings and such to be able to benefit everyone that works for Money Follows the Person.*

Universal Assessment

KIs were asked about their involvement with the implementation of CT's Universal Assessment (UA). Many reported that they never completed any assessments or reassessments themselves as that was not part of their role. A few informants mentioned that they supervised people who completed assessments or reassessments, and some of these felt they could not answer questions about the UA because they were not familiar enough with the tool or the process. Those that had used the tool or were familiar with it commented on both the strengths and challenges of the UA, and made recommendations. A few respondents had some comments and suggestions about UA training.

Strengths of the UA

The UA was applauded for numerous reasons including the collaboration that occurred between agencies to create a comprehensive, standardized tool. Some who used the UA or had staff that completed assessments described the UA as user-friendly, not difficult to administer, and found the numerous questions helpful. For at least one informant, the UA provided the evidence needed to produce reports.

> *… the tool itself I think was a remarkable collaborative process and really is an example of how we were able to transcend agencies and populations to really produce something really cool.*

> *I love the Universal Assessment … it has so much information in it and it collects so much information … I think it gives us a great look at the individual … I think it gets me a great snapshot of the picture, the individual …*

> *… I think it has great questions. I think once you complete the assessment and you do gather the information you need to have a clear picture of the client, things like what are their preferences and what they don't like, they like, what would they do in case of an emergency … there's a lot of good questions there that can definitely paint a clear picture of what the client is like, what their support system is, what their needs are, what their deficits are, and what they're able to do …*

I think it's user-friendly. I don't think it's difficult. You just select the answers and the questions. I just think that it's lengthy. But it's not a difficult assessment.

Respondents that commented on the usefulness of the various UA sections, noted that getting a deeper level of detail had its advantages but contributed to challenges as well. The most useful sections of the UA included those that focused on level of care, ADLs, and IADLs. At least one respondent liked the cognitive questions and felt that while asking more specific questions required additional time, it was worth it.

I think every section is helpful. Every section has its place depending on the consumer. And I think that's what is difficult about it, is it is kind of all-encompassing in the fact that it's really kind of digging into what are the medications, what are the diagnoses, what are the behavioral disturbances, what's the cognition level, what are the IADLs, ADL capacities and functionals, and how many falls and whatnot. I like every part of it …

… But I think that the sections that they find most helpful are those that are on medication and things around level of care, hands on needs, or lack of tend to be the most helpful.

I like the ADLs and IADLs. I mean it seems long, but I really like how they get more – they get detailed with upper body dressing, lower body dressing, only because we – in past assessment tools that I have used, we didn't get that specific …

Challenges of the UA

A number of respondents described the UA as too long, very time consuming to complete, and not user-friendly. While some did not find the UA difficult to complete, others found it extremely difficult to finish and were frustrated by questions that seemed unnecessary. Some challenges were associated with the way in which medications had to be entered and that it significantly contributed to the length of time it took to complete the assessment. At least one respondent compared the DDS Level of Need assessment with the UA stating that the UA was more burdensome to complete.

I just know it's very long. And if I was a consumer, I'd be telling you never mind. I'm staying where I am.

… I think it's extremely difficult, and it asks questions that we don't really have an answer for. Do you have a gun? Well what do we do if they say yes? … It seems like if you're going to ask a question like that, there should be some follow-up. We should be teaching the care managers what to do if they get that. Do you use drugs? Yes, I do. Okay, well … Is that just a knowledge point? Why does the state want to know that? … Do we then have a requirement to let the homecare agencies that are going to be supporting that person know that? I think that a little more needs to be done there for sure.

I prefer the [DDS] Level of Need … it goes over a 12-month period with sections for comments and explanations, and it doesn't always match up to the needs of the individual. What I've seen over time is DDS has revamped and redone it as the need is known. So the Universal Assessment is pretty cumbersome for me and I prefer the Level of Need …

Concerns about the length of time needed to complete an assessment also focused on consumers who take longer to process information and those on multiple medications.

… people with an ABI, they take a longer time to process information. So the length of time, for example to complete a UA, many of our clients can't sit through that in one or two settings. It could take three potential visits to go back and complete that, and then

going back to explain what happened particularly with this population that has memory loss, memory recall issue. So it's just a slower process.

Other challenges mentioned included the time it took to get consumers access to be an authorized user of the UA and the loss of connectivity once they had access to the system. At least one respondent was concerned about the lack of "humanness" in the UA.

… once they have access to the system, I think that it's relatively easy to navigate. I think their ongoing problem is if they lose connectivity. That's definitely a problem. And that's – It's a lot of paper to complete if they have to do it on paper.

… I think it [UA] was more, in my opinion, clinical and statistical, and I think just the humanness is out of it … I just think that's the way of the world. Everything is data and nobody's got a face. We only have numbers.

Several of the respondents looked to the future and to possible resolutions of some of the challenges in the updated UA.

… I think there are little things that are being addressed that may be difficult, but they are being addressed with the second version.

Well I know [staff] were frustrated because they were doing it by hand. But I honestly, I know they're working on the next phase of it, so … I haven't heard too many complaints about it recently.

Reassessments Using the UA

A few respondents that were familiar with reassessments using the UA offered positive feedback including its potential to foster improved service plan development.

… they love the reassessment … It lets you have a baseline. If nothing has changed, you can just validate the results and focus on the areas that somebody has improved in or weaknesses, and it focuses the discussion and the care planning as well. So I think it can be a very, very focused discussion that leads to a better service plan development.

I like the Reassessment … It's great. I love it. It only takes me – depending how on easy the client is, it only takes me a half an hour to go through it instead of – I just have to go in and modify and change what needs to be changed. But I like it. It's really good.

Fewer were familiar with how the reassessment compared to the process as it existed in the past using the Modified Community Assessment.

It's obviously a lot lengthier because the UA is longer and they do have to go through the entire thing to make sure nothing has changed. With the modified tool that we had for the Elder Waiver, it's right there, a paper tool and you just answer right next to it and it is shorter.

Respondents familiar with pre-populating the next assessment liked the idea and felt it would save time and be an additional strength of the UA.

… Love it. Love it. Love it … Depending on how little the consumer's life has changed, you could – because it pre-populates, so everything that you did last time comes right back. And so now instead of having to type all the little medications again, if only one of the 25 medications changed in milligrams, you just click edit, and change one number and then boom, 57 minutes are saved right there. If their ADLs haven't changed, I don't even need to change anything. I just click next.

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[Pre-populating] helps. If there's any changes, you can see the changes. You can see how the client was in that point in time when they were assessed and how they are right now. I mean if there were drastic changes, you can see that.

Well just from a technology point of view, don't forget this new Universal Assessment tool is supposed to be done on mobile computer, and we have many areas in Fairfield County, as I'm sure the same happens in Eastern Connecticut or Litchfield County, where you don't have Wi-Fi, and so you're going to do all this on paper, and then you're going to come back, and you're going to become a data entry specialist and do all that. So if it's pre-populated that should help us get through that data entry piece a little more quickly.

Respondent Recommendations

Respondent recommendations included making the UA shorter, making it more user-friendly, expanding its use across all waivers, and including optional sections, such as Behavioral Health, in the algorithm to determine level of need and budget. It was also recommended that an integrated administrative process be promoted among agencies serving a targeted population.

➢ Shorten the length of the assessment or base it on a particular waiver

I think it would just be nice if it was just somehow shorter, but I understand that it's very comprehensive and covers various waivers and various waivers need different information. But, if we could still work to get it down, to get the length of questions down, that would be so incredibly helpful and I think folks would be more receptive to using it … I mean they get an opportunity to do it over a couple of visits but that's still time consuming.

➢ Expand use of the UA across all waivers

… I would like to see it across all waivers eventually, just have a standardized process. If you think about LTSS as a whole of the big picture, just getting everything coordinated across all agencies that would be great, especially for a person on the person level - having everything just standardized …

UA Training

A few respondents made comments about the training they received on the UA and noted that the training in general was good, but would have been more useful if it were closer to the time the UA was rolled out. Some KIs emphasized the importance placed on engaging people and how motivational interviewing was helpful in that process.

I thought it was good. I thought it was a little preliminary. I do remember doing the training and I remember doing it in February and we didn't actually use the UA until …sometime over the summer and … I was trying to remember from five months before. So I mean the training … was good. I think the timing was just slightly off.

… in the training we do talk a lot about the importance of engaging people in a conversation about their support needs and where they are functionally now and what informal supports they have … I hear people saying, "Oh, this is a great way to engage people." … And so the motivational interviewing sort of reinforces that, but I think it's something you need ongoing, about how to structure those conversations to draw out the information without just firing 127 questions at people and documenting the answers … building that skill of how you talk with people and pull the answers out without just firing off questions, it's a real art.

Suggestions for UA training included having dedicated staff to do the training and the availability of retraining to address changes in the new version of the UA.

> *So training on the UA we now have in place for folks coming on board, the expectation is that we will train people on that, but not doing it on a regular basis, it's very challenging for us to be the trainer. And so we end up having to rely on other staff who are doing it to train, which isn't ideal … having somebody who does … staff development and training for the MFP staff would be wonderful …*

> *Every year, everyone should be retrained to make sure that everybody maintains the same knowledge of what the UA is trying to accomplish.*

Sustainability

Respondents were asked to provide feedback on the long-term sustainability of CT's MFP program as it moves from a Demonstration to full integration into Medicaid. Responses were divided into the following subheadings.

➢ Restructuring MFP

- Demonstration Services to Continue
- Regional Transition Team Structure

➢ Policies or Programmatic Changes Needed to Streamline MFP
➢ Administrative Processes Needed to Make Program Changes
➢ Future Program Concerns

Restructuring MFP

As the MFP Demonstration transitions into a permanent component of the CT Medicaid LTSS system, KIs were asked to describe how the program could be reorganized or restructured. The majority of respondents provided little feedback stating they did not know. Of the KIs who responded, some were emphatic that there is no need to restructure the program. Other KIs offered suggestions for programmatic changes that may require restructuring.

Some respondents who provided feedback regarding how MFP could be restructured, referred to the purpose for funding demonstration projects and described it as an important process to test and measure the impact of potential program changes. It was suggested that with a focus on outcomes, any need to restructure would be evident during the Demonstration and going forward the emphasis should be on sustaining what was demonstrated.

> *I don't know that we would necessarily be looking to restructure. I mean I think there has been abundant evidence – there's so many data points that suggest what are instrumental factors in transitions and avoiding recidivism that I wouldn't really be looking to change structure. I think what we have to do is try to optimize as best as possible what we can cover and … we did pretty much map that out in the Sustainability Plan ...*

Other KIs were in favor of restructuring MFP by moving away from multiple waiver programs to a universal waiver or one waiver system.

> *This business of pigeoning people into this waiver is ridiculous. And then keeping all the data and all the individual waivers. We know the costs of each waiver and know each individual in the waiver. That's all great. But does that really matter? And people change when they're out in the community. Sometimes they have different needs … it should be a universal type waiver.*

> *Whether it's a Universal Waiver, I think more options and services, kind of like one service, one package of services that everybody could access, not if you're ABI you get*

this, but if you're an Elder you get that. I think getting our systems to talk to each other. We've kind of developed a model with MFP where people can fill out the application online, and then the application … can come right into our system, and the more that we're able to do those sorts of things, I think that's going to help improve things.

At least one KI suggested restructuring hospital discharge planning during the Demonstration. It was also recommended that a nursing home diversion program be supported by the State.

I would like to see us to be able to demonstrate things in a more proactive level instead of reactive as we generally are. So think about hospital discharge planning and how we could give people their first services in the community as opposed to a nursing home. I would like to see us be able to figure those things out in the last few years so those can translate over. I think Connecticut has the capacity to be one of the leading states in this. I just want to make sure we get there before we can't get there. When we don't have flexibility – as much flexibility as we do right now in the Demonstration.

Demonstration Services to Continue

Respondents were asked which services or parts of the MFP Demonstration would be important to continue. Most agreed it would be important to continue transition and housing coordination, rental assistance, home modification services, assistive technology, and the utilization of systems that offer consumers choice.

Certainly the rental assistance, the assistance with housing, the assistance with home modifications and assistive technologies, the support of a Transition Coordinator and Housing Coordinators so important to the success of the actual transition. Making sure that we're using the PASRR system and that nursing homes are expected to ask the question of clients about whether or not they'd like to entertain community living again. I think those are all very important pieces that we have to institutionalize if the success of MFP is to continue.

Several KIs underscored a need for Recovery Assistants (RAs), and one KI provided an example of a consumer with a history of drug and alcohol abuse to support the need for RAs. The need for nursing assistants, PCAs, care management, and continuous care transition supports that follow a consumer from the nursing facility to the community were also emphasized.

We know that there are a lot of people who're in a nursing home because they've had a long-standing alcohol abuse problem or drug abuse problem and while they're in a nursing home of course they can't feed the habit and sometimes it's years. And we know that the first day we move them out, they go running to their old habits. We literally had a guy, an elderly man, who was transitioned from a nursing home, who was an alcoholic. Had not had not a drop of alcohol in the nursing home for eight years … with the Transition Coordinator standing right there outside the apartment, waiting, watching the guy's van pulls up. The guy alighted off the van and took off like a shot, despite his mobility problems, straight to the corner to a liquor store and spent whatever money he had in his pocket buying liquor. Do you think he lasted in the community? No.

You need nursing assistance in the community. You need the PCAs. That needs to be continued in the community. The care management aspect in the community must be continued.

Addiction services and supports are already available as state services. The mindset that transitioning people out of facilities is now embedded in the way we think. We need to

provide continuous care transition supports, which follow people from facility to community and throughout the care continuum.

Some respondents suggested important services that may be more challenging to continue.

I would love to continue every bit of it. What I think we will likely lose is the ability to kind of capitalize innovation because we don't have a vehicle through which to do that. In Connecticut under Medicaid, we don't have an 1115 waiver like some states have, and I think that's probably going to be the area we don't have a solution for. But the transition work and the other pieces I think that definitely there's clear vehicles for that. And then some of the other pieces around sustaining the website and the workforce pieces.

I think CFC, if we're able to continue it, was like a step in that direction, and I still think that without the housing subsidy, it doesn't matter what you have in your waivers or what services you have under your state plan if people can't get out of the institution. So I think a lot of it does hinge on housing opportunities for people.

Regional Transition Team Structure

KIs were asked whether or not the current regional transition team structure should continue. While most supported the current structure and would like it to continue, some respondents were concerned about the challenges cross agency teams have had and that those issues might be difficult to resolve in the future.

I would love to see it continue the way it is, the teaming down from the field staff up to the CO staff. So that can continue post ending of the Demonstration. That would be nice.

If we have to work with other agencies, we are going to continue to struggle with the cultural differences between agencies. In so many ways it would be so much easier to have everything under one roof … I think in these cases that the outcome for the clients is often challenged because we don't have everything under one roof because the communication is not as strong.

Policies or Programmatic Changes Needed to Streamline MFP

KIs were asked what policies or programmatic changes might be needed to streamline the MFP program. Suggestions did not warrant any drastic changes and included some operational improvements for efficiency, promoting an informed choice process for consumers, and using process mapping to understand all the administrative costs involved in managing the MFP program.

… the biggest challenge … is getting it right the first time and having enough personnel both on the frontline and in Central Office to process things in real time so that we don't have a backlog ... So I think that kind of streamlining, touch it once, automate it as much as possible, and have enough people. It's kind of that right number to be able to handle things as it comes in, whether those are referrals and getting them out to the field, having staff in the field to be able to deal with the referrals as they're coming their way, getting the assessments and the care plans back, processing those as they come in, along with all the supporting pieces like the rental assistance and security deposit and home modification and AT and DME [Durable Medical Equipment] and all of it.

… It has taken me months to figure out who the most appropriate person is to send questions related to MFP, either protocols or database, and every day it is still a challenge on that. I can send a question out to utilization nurses and get one response. I can send it out to the liaison and get another response. I can send it out to one of the –

somebody who oversees the database and get a third response. That inconsistency is frustrating, and it doesn't contribute to efficiency in the transition planning process.

So how could we make a decision about your life, telling you to sell your house if you don't even know what options are available. So I think we need to do a better job explaining that to people, empowering them with that information… And we're trying to move forward with that and we have legislation – the 180 day legislation where if somebody's admitted to the nursing home and likely to be Medicaid eligible within the 180 days that they should be reporting that to MFP. But I think we need to be more proactive in every Medicaid - long-term care Medicaid application that comes in, we should let them know, this is your benefit package.

I think the whole transition, trying to get all the housing supplies and everything for the consumer is a process that has been very difficult, home modification processes. For the most part, it just looks like stuff needs to be process mapped, and we never seem to have the right people at the table to process map them ... We understand you have to go out and shop for the consumer. But really if there's a toaster on sale at another Walmart, do we really have to travel to the other Walmart because we could get it a dollar cheaper? Some of those kinds of policies need to be relaxed a little bit in favor of expediency… All the billing processes for home modifications are extraordinarily painful, and they lead to a lot of confusion on the part of the community provider that's actually doing the modification or the home alteration. I think those could definitely be streamlined … The billing requirements, they use these random dates, and we have to wait until things are approved by one person who often is out on leave…and it takes six, seven, eight months to get paid for a transition …and so that is all delayed. And what they don't see is that a finance department tracks that receivable for six, seven, or eight months, and all of those touches equal time, and all that time equals money. So at some point, the cost of running the program is so far above the reimbursement that it will become a problem.

Administrative Processes Needed to Make Program Changes

KIs were asked to describe what administrative processes they thought would be needed to streamline MFP. Some respondents suggested adding transitional services through a State Amendment Plan. Other KIs underscored the importance of making transitional services federal and/or an entitlement.

I think that in order to streamline it, we do have to submit some State Plan Amendments, and beyond that, I don't know that in terms of sustainability there's that much more that we need to do.

Because I remember back at the beginning, you couldn't do the MFP Demonstration unless you were on a waiver. And then they switched it so that as long as you were leaving the facility under Medicaid whether you were a waiver or just regular state planned services, meaning you didn't meet the level of care for a waiver, then now you're a demo. It shouldn't be just part of a waiver because then there's people who might not meet the level of care for a waiver who aren't going to, who still might need services, home modifications, rental assistance in order to get them out. So I think it would need to be an entitlement.

Future Program Concerns

When asked about potential barriers or risks that might be associated with the administrative processes needed to make program changes, KIs described several concerns including the need for education, culture change, and flexibility depending on what happens in Congress.

When the Demonstration is over, people will go immediately from a nursing home environment to a formal Medicaid system, and I think in order to make sure that that's effective, we're going to have to start to do some education and some culture change across the entire system. Right now that change and the instability that occurs the first couple of days, first couple of weeks is all within the MFP Demonstration, with people who have been specially trained to address those kinds of – that type of instability in a proactive way in a team … I mean the traditional Medicaid system doesn't work as a team, and so there will be a disconnect if we can't figure out how to help that formal Medicaid structure do what needs to be done in order to stabilize people who are moving out of nursing homes.

Well, yes. I mean there's maybe not risk, but there's obviously balancing factors I think in terms of whether they are matched or not. The ACA-enhanced match has been a very significant motivator for our choices. We don't, as I said, have an 1115 waiver, so that definitely is – that would be a big decision to make to go that route. We obviously are not using any managed, capitated managed care arrangements. That would be a big change if the state has new political leadership and they decide to go in that direction. So there's some of those pieces that would be a real departure from how we're handling those things.

I guess my only concern would be, would we be creating a more or an increasingly dependent population if we just say you can get this, you can get that, you can get this under a State Plan – if it's just an entitlement?

… if we get block granted as approving them, it will be a very different scenario, and none of the federal proposals now really have clarified whether the LTSS work, whether the waivers or anything like that, is included or not … we made specific recommendations in the Sustainability Plan around what authorities we'd use, so we did map that, and it's our typical process, but I think we'll have to examine that depending on what happens in Congress.

Conclusions

Connecticut continues to make progress as a demonstration program for rebalancing its long-term services and supports system and providing individuals with the opportunity to experience maximum independence and freedom of choice about where they live and receive services.

Participants in this year's process evaluation described many reasons their MFP role was rewarding including the opportunity to learn and develop skills, foster change in creative ways, and provide a better quality of life for consumers. Respondents were passionate about being able to impact consumers' lives and described a sense of fulfillment when realizing positive outcomes. Flexibility, critical thinking skills, and a high level of commitment to their work were mentioned as important attributes contributing to maintaining an engaged and motivated MFP workforce. KIs suggested that exploring opportunities for change and implementing new ways of doing things were necessary in effecting positive LTSS change. In addition, being a champion in their role and promoting MFP was viewed as sending a positive and public message about the program.

Teams play a major role in managing Connecticut's MFP transition program and are vital to the success of the program. For this evaluation, nearly half of informants were active on a regional team for part of 2016 as either SCMs, TCs or HCs. The focus on teams this year was to compare the team experience of higher and lower performing teams and the evaluation sought feedback about team meetings, team meeting communication, productivity, and goals. It also asked questions about regional teams, how members were assigned to teams, transition effectiveness, the regional team process, teaming, and team best practices.

While it is unclear the role each factor contributed to team transition performance, some differences between the higher and lower teams are noteworthy. In team performance, each member of the higher producing team was a high performer with respect to sheer number of transitions while transition performance of the lower producing team varied among different team members. In regard to teaming, the higher producing team described working together more cohesively as a team than the lower producing team. This cohesion was reflected in participation in true team meetings with all the members assigned to the team (i.e., the team's SCM, TCs, HCs). Most of the higher producing team's transitions were done with members of their primary team (i.e., within their team), while several of the lower producing team members frequently worked on transitions with field staff assigned to other teams. The higher producing team also described themselves as a more focused team, particularly in awareness of their roles.

As in past years, respondents stated that co-location of all team members enhances team cohesiveness, communication, and overall effectiveness. While it makes sense that being physically located in the same place has the potential to facilitate teaming, it should be noted that half of the lower producing team functioned as a same-agency team, and overall their number of transitions was lower and transitions took longer than the higher producing team. Therefore, other factors aside from being in the same agency may also contribute to team effectiveness or lack thereof. With regard to the effect of team stability, the instability of the lower producing team, particularly within the SCM position, may have contributed to overall team performance. Earlier MFP evaluation research demonstrates that team stability was correlated with transition performance. From this year's evaluation, it appears that consistent SCM leadership may have impacted the lower producing team's effectiveness. For future analysis, it may be important to redefine what a "stable" team is, especially with regard to SCM turnover, and to take into account the number of staff on a team. Most likely all of the above factors above played some role in the transition performance differences between the two teams – team cohesion, working together more frequently, co-location, true team meetings, focus, and team and SCM stability.

Major achievements during 2016 were identified by respondents and included the newly available Community First Choice (CFC) program and its benefits of self-direction as part of the Medicaid State Plan, the new web-based transition budget system and its potential to improve the discharge process, successful transitions, and the Section 811 Project-based Rental Assistance Program for low income persons with disabilities. Similar to 2015, the number of transitions in 2016 were identified as a major achievement. The average length of time from referral to transition decreased from 230 days in 2015 to 179 days in 2016 and was also noted as an important achievement. This decrease in average length of time to transition was considerably less than it was prior to using the team process for transitions and was how some respondents described a successful transition. The positive role of MFP within CT's LTSS system, a growing shift in culture change, an emphasis on person-centeredness, self-determination, and the dignity of risk process were mentioned as additional achievements. Other achievements included recognition of the Medicaid Innovation Accelerator program, the plans for repurposing of HUD 232 funds, and the retreats. Respondents noted that the

outstanding leadership skills of the Manager of the Community Options Strategy Group were visionary and generated a high level of enthusiasm and commitment among staff and partnering agencies.

Similar to 2015, some of the same barriers and challenges persisted and made it difficult to successfully transition a person. These included housing, length of time to transition, and post transition barriers, such as consumers who were medically unstable or those diagnosed with behavioral health or psychiatric conditions. Frequent changes in field staff, leadership challenges in agencies with low staffing levels, a high number of caseloads per field staff, performance expectations, eligibility issues, and the challenging nature of many of the cases created additional barriers and challenges for teams. Less frequently mentioned barriers and challenges were noted to impact the transition process and included problems involving legal documents, lack of formal supports, criminal history, Medicaid eligibility, the State culture, poor teaming, inadequate community support for those with behavioral and mental health conditions, medication management issues, gaps in provider services (e.g., transportation), an insufficient workforce and difficulties associated with the hiring and managing of individual supports.

The majority of programmatic barriers and challenges were related to concerns about the budget and current fiscal condition in CT in terms of how that impacts the program. Stressful job situations, heavy workloads, and low compensation were mentioned as contributory factors in high staff turnover. In addition, frustration was expressed regarding the lack of written policies and procedures, frequent changes in rules and regulations and inconsistencies in guidelines about what protocols to follow. Program limitations described by respondents included challenges associated with diverting people from nursing homes, working with state systems, and putting person-centered planning into practice.

Respondents identified a number of different barriers that were deemed the most important to overcome. These included inadequate written guidelines and standardization of practices, weak common culture between agencies, inadequate funding, and insufficient housing access and availability.

KIs described CFC as an important additional resource with great potential to provide consumers with expanded community options and greater choice and control in their life. Respondents noted that rolling the program out was tedious in terms of the learning curve and putting in into practice. Challenges related to effectively implementing CFC included: a disconnect between the conceptual and operational designs of the program; lack of appropriate CFC training; deficiencies in experienced staffing resources such as lack of support and planning coaches; inadequate collaboration between agencies, particularly when consumers need services from several different sources; and issues with accounts receivable, billing, and rebilling.

TC/HC/SCM online training, provided by CADER, covered numerous consumer-related topics. There were mixed responses regarding whether or not the courses were a good investment of time and money for those participating in it. Some described it as informative while others found it difficult to interpret material and process it into a real work experience. Complaints associated with the training included CO not being up to date in training and in issuing certificates for completed training. Respondents were unsure how to measure the impact of the training on consumers or their families without a way to evaluate it. KIs familiar with the Motivational Interviewing training were positive about it and suggested it should be offered to all MFP staff. Overall, the greatest education and training challenge identified was being able to meet the needs of both new hires and more seasoned staff and having sufficient resources to conduct training including shadowing of experienced staff.

The Universal Assessment (UA) development was described as a collaborative process between agencies to create a comprehensive, standardized tool. Some who used the UA or had staff that completed assessments described the UA as user-friendly, not difficult to administer, and found the numerous questions helpful. Others described it as too long, very time consuming to complete, and not user-friendly. A few respondents familiar with reassessments offered positive feedback regarding the reduced time to complete reassessments due to pre-populating and its potential to improve service plan development. The few respondents who made comments about UA training suggested it would have been more useful if it were closer to the time the UA was rolled out, and some emphasized the importance placed on engaging people and how motivational interviewing was helpful in that process.

As CT's MFP program transitions into a permanent component of the CT Medicaid LTSS system, most respondents had little or no feedback regarding the long-term sustainability of the program. A few underscored the purpose of a demonstration, the importance of testing and measuring the impact of potential program changes during the project, and the subsequent goal of focusing on sustaining what was demonstrated. A small number of KIs were in favor of restructuring MFP by moving away from multiple waiver programs to a universal waiver or one waiver system. Most respondents suggested that the following Demonstration services be continued: transition and housing coordination; rental assistance; home modification services; assistive technology, and the utilization of systems that offer consumers choice. Most KIs supported the current regional transition team structure and would like it to continue, but some were concerned about the challenges cross agency teams have had and that those issues might be difficult to resolve in the future.

Overall, respondents did not suggest any radical programmatic changes. A few, however, were in favor of streamlining some operational improvements for efficiency, promoting an informed choice process for consumers, and using process mapping to understand all the administrative costs involved in managing the MFP program. KIs mostly favored adding transitional services through a State Plan Amendment, and a few underscored the importance of making transitional services federal and/or an entitlement. Future concerns about the sustainability of MFP included the need for education, culture change, and flexibility depending on Congressional outcomes.

Recommendations

Key Informants provided numerous recommendations for improving MFP and related LTSS rebalancing work in CT. A selection of these KI recommendations are summarized below, organized into the following categories:

  ➢ Funding and Staffing
  ➢ Teaming
  ➢ Transition Processes
  ➢ Programmatic Processes
  ➢ Community First Choice
  ➢ Education and Training
  ➢ Universal Assessment
  ➢ Sustainability

Funding and Staffing

Evaluate funding and staffing levels and address related needs across the program

  ❖ More closely monitor and address staff retention needs including factors associated with high staff turnover (i.e., stressful job situations, heavy workload, low compensation and lack of cost of living raises).

❖ Investigate fair wage for field staff (i.e., entry level for social workers or target recruitment for agencies and compare to the market salary with benefits).

Teaming

Continue to evaluate and improve teaming

❖ Recognize the primary challenges experienced in teaming and track success in addressing these as a team.

❖ Strengthen team spirit and cohesion through regular meetings that include all team members. For cross-agency teams, focus on team-specific meetings, not agency-specific meetings with multiple SCMs.

❖ Improve and maintain communication systems to transfer knowledge and keep the entire team informed.

❖ Implement best practices by updating notes on the web during team meetings to promote efficiency and reduce delays associated with transitions.

❖ Recognize cultural variances that exist when teams are located at different agencies and strive to maximize each agency's strengths.

❖ Emphasize the value of teamwork and encourage staff to collaborate as they focus on common team goals to maximize their effectiveness.

❖ Set up and implement a job shadowing or mentoring program to foster the development of roles, responsibilities, and skills in newly hired people by more seasoned staff. Promoting hands-on learning through the program could include creating certificates of achievement/completion for new hires participating in the program and an evaluation of the program upon completion of the program to improve its effectiveness and/or to inform programming decisions.

❖ Promote team models that strengthen teaming. For example, whenever possible, consistently assign consumers to an SCM, TC, and HC from the same team. Consider how many TCs and HCs are assigned to each SCM. If it is a large team, perhaps pair up two TCs with one HC to encourage stable partnering.

Transition Processes

Expand MFP's transition effectiveness

❖ Encourage a focus on both pre-transition tasks and post-transition community integration, or reengagement, efforts to increase successful transitions.

❖ Increase post-transition support for consumers through a peer support program (i.e., consumers who successfully transitioned supporting consumers in the process of transitioning: peer/MFP consumer – run).

❖ Create and regularly disseminate an information sheet of best practices associated with the number and speed of transitions and/or successful transitions. For example, spotlight particularly successful field staff and/or teams, and share their best practices.

Implement processes to facilitate the location of consumer housing

❖ Develop a process in the system to gain quicker access to a consumer's credit report and/or criminal background to help prevent delays in locating housing.

❖ Encourage HCs to engage consumers in independently searching for housing when they are able in an effort to help prevent transition delays.

Improve communication

❖ Continue the TC monthly call from CO to review various challenges involved in transitioning consumers and ensure this useful practice will continue under the Sustainability Plan (i.e., include this is in CO budget).

Conduct a quarterly conference call with all the Access Agencies and the State to discuss existing issues and recommendations to resolve them.

❖ Encourage consistent communication between field staff and skilled nursing facilities to facilitate smoother transitions and minimize delays in transitioning consumers to the community. Communication should include timely updates or progress reports during regular case reviews and include all who are involved.

Streamline transition and data tracking processes

❖ Create simpler transition and data tracking processes so staff can focus more equally on the tasks involved in these different responsibilities.

Programmatic Processes

Develop an expedited Medicaid eligibility process

❖ Develop a reasonable process to accelerate the activation of Medicaid and avoid delays that impact transitions (i.e., financial review, five year look-back).

Community First Choice (CFC)

Promote greater awareness of CFC throughout CT

❖ Create and disseminate a one-page fact sheet and infographics regarding what CFC is, who is eligible, the benefits of self-direction and informed choice, and options such as the of hiring family members.

❖ Provide more complete CFC training for field staff, clearly defining each position's roles and responsibilities.

Education and Training

Expand education and training opportunities

❖ Review current education and training practices and address inconsistencies between agencies and regions in newly hired SCMs/TCs/HCs.

❖ Provide team member training using standardized protocols and shadowing of experienced field staff.

❖ Provide SCMs with training to help them better understand the various waivers (i.e., CHCPE, PCA, ABI, DDS and DMHAS) or other programs they do not typically work with and the services offered under those waivers.

❖ Develop a comprehensive, quarterly training on the use of the MFP web and related functions. Design one training for SCM Supervisors/SCMs and a separate one for TCs/HCs. An important area of focus for SCMs and Supervisors would be the use of filters so staff can more easily view caseloads.

❖ KIs recommended evaluating the effectiveness and impact of CADER training to identify what was gained during the course, determine costs versus benefits, and determine justification for continuing the course. Assessing satisfaction with the course, knowledge or skills acquired, how those are transferred to the workplace, and the impact on

consumers and their family might also be beneficial. Note: CADER already provides CO and UConn with an annual evaluation report that includes several of these elements. This report could be shared with other MFP stakeholders to demonstrate the impact of the program to a wider audience.

❖ Continue MI training and offer it to all CO and field staff in an effort to more successfully engage consumers and minimize challenges or delays that impact length of time to transition.

❖ Explore ways to modify the structure of MI training to make it more cost effective. For example, shorten the number of follow-up coaching sessions (currently is 6), or have some of the coaching sessions be led by other staff who are proficient in MI.

❖ Offer MI refresher training (i.e., coaching sessions) led by CO and other staff who are proficient in MI at retreats as breakout groups for a limited number of participants and encourage them to bring a specific case to discuss.

Universal Assessment (UA)

Provide more complete UA training

❖ Clearly define the responsibilities of homecare agencies that are supporting a person, particularly when follow-up to questions asked in the UA may be required (e.g., if a consumer responds they have a firearm, what if anything the care manager is required to do with that information).

Sustainability

Communicate sustainability information to MFP staff and stakeholders

❖ KIs demonstrated some confusion and misinformation about the end of the MFP Demonstration program and MFP sustainability in CT. Inform MFP CO staff and other stakeholders that the MFP program will continue after the Demonstration ends and clarify what the sustained program will include.

Provide field staff support as part of the Sustainability Plan

❖ Provide sustained TC support for up to a year.

❖ Increase availability of Support and Planning coaches.

Appendix A: 2016 Key Informant Interview Guide

<u>Role</u>

First I'd like to talk with you about your role with the MFP program in 2016.

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

2. How do you see your role in MFP changing in the future?

3. Do you see yourself in this position two years from now?

   If No – Why?

4. What makes your work or role with MFP meaningful to you?
   4a. What motivates you to work with MFP?

5. How does your role as a _____ create positive change in the long-term services and supports system?

Ask SCMs, TCs, & HCs, questions 6 – 25.
SCM Supervisors – Skip to question 26.
Everyone else, skip to question 28.

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

6. First, please tell me about the makeup of your team. For example, how many SCMs, TCs, HCs are on your team?

   7a. Are you all from the same agency or different ones?

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

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

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

   10a. **If No** – Do you meet with some team members on a regular basis?

10. Please describe a typical Team meeting for me.

    10a. Who usually attends the meetings? I'm not looking for names, just the roles they play.

    10b. How often do you meet as a full Team, with your SCM, TCs, and HCs? Is that enough?

    10c. What do you usually talk about? For example, do you review every open case, or the ones in the transition process, or something else?

10d. How are the meetings productive or helpful for you?

10e. How do you as a team (group) make sure that the goals set in the meeting are met?

10f. What, if anything, would you change about the meeting or its structure?

We'd like to better understand how <u>teams</u> work together to successfully transition consumers into the community.

11. What does your <u>team</u> do to increase the number of transitions in under 180 days?

12. What makes it <u>difficult</u> for your <u>team</u> to increase the number of transitions in under 180 days?

13. What does your <u>team</u> do to support your working together as a team?

We'd also like feedback on what you do <u>individually</u> as a team member to successfully transition consumers into the community.

14. What do you do <u>individually</u> to increase the number of transitions in under 180 days?

15. What makes it <u>difficult</u> for you to increase the number of transitions in under 180 days?

16. What makes it <u>difficult</u> for you to work successfully with your team?

17. Thinking about your team, what would you recommend be included in a "Team Best Practice Report" on what has worked for your Team in successfully transitioning consumers and why it worked?

18. In 2016, did you have any regional team meetings where all the teams in your region met together?

    If Yes – How was that helpful for you?

    If No – How would this be helpful for you?

Ask Specialized Care Managers:

19. As a Specialized Care Manager, you assign your consumers to TCs and HCs. How do you decide which of your TCs and HCs to assign a consumer to? Is there a standardized protocol that you follow?

    Probes:
    19a. How do you keep track of which TC or HC you last assigned a consumer to?

    19b. How do you keep track of how many cases each of your TCs and HCs have?

20. SCMs often have some cases with a TC or HC who is not part of his/her regular team. How does this come about?

> *Probe*:
> 20a. What are some of the reasons an SCM may assign a consumer to a TC or HC outside of his/her regular team?

21. Is there a standard communication process between Specialized Care Managers to notify each other when one SCM assigns one of his/her consumers to a TC or HC who is part of another SCM's team?

> *Probe:*
> 21a. How do you keep track of what other consumers your TCs or HCs are working with other SCMs or on other teams?

22. What are some of the challenges you find when you have some cases with TCs or HCs outside of your regular team?

23. If you have some cases with a TC or HC from another team, do you meet separately with that TC/HC, or does that TC or HC come to your regular team meetings as well as his/her own team meetings?

Ask Transition Coordinators:

24. [Unless answered already] Do you work with just one Specialized Care Manager, or do you have consumers with more than one SCM?

> **If Yes** – How many different SCMs do you have open consumers with?

> 24a. What are some of the challenges of working with multiple teams and SCMs?

> 24b. Do you attend the meetings of all the different teams you work with or just your primary team's meetings?

> 24c. [If just attend the primary team meetings] How do you communicate with the other SCMs you work with outside your regular team?

Ask Housing Coordinators:

25. [Unless answered already] Do you work with just one Specialized Care Manager or Team, or do you have consumers with more than one SCM?

> **If Yes** – How many different SCMs do you have open consumers with?

> 25a. What are some of the challenges of working with multiple teams and SCMs?

> 25b. Do you attend the meetings of all the different teams you work with or just what you consider your primary team's meetings?

> 25c. [If just attend the primary team meetings] How do you communicate with the other SCMs you work with outside your regular team?

Ask Specialized Care Manager Supervisors:

26. As an SCM Supervisor, you assign referrals to SCMs and their Teams. How do you determine which SCM or Team to assign a consumer to? Is there a standardized protocol that you follow?

    Probes:
    26a. How do you keep track of which Team or SCM you last assigned a consumer to?

    26b. How do you keep track of how many cases each of your SCMs and each of your Teams have?

27. What are some of the challenges you encounter when assigning a referral to an SCM or Team?

MFP Program Goals and Progress:

28. [Only ask SCMs, TCs, HCs if they did not address these in 7-27]. Thinking broadly, I'd like to talk with you about the current transition process which uses regional teams. Teams usually consist of one Specialized Care Manager, two Transition Coordinators, and one Housing Coordinator.

    28a. What do you think has worked well with using this SCM/TC/HC regional team process?

    28b. What has been challenging or frustrating about this process?

29. One goal of MFP is to successfully transition people out of facilities to the community. How do you define a "successful transition?"

30. What do you think makes it difficult to successfully transition a person? What are the barriers to transition?

31. What suggestions do you have to overcome these barriers?

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

32. What were some of the major achievements, strengths, or best practices of the MFP program in 2016?

    32a. What has supported or facilitated these program achievements?

33. In addition to _____ you mentioned above, what MFP program barriers or challenges did you encounter or observe in 2016?

34. If there is one area or process that you feel needs to change to help the client, what is it and how can it be changed?

35. What could be done to prevent or overcome any of these program difficulties in the future?

<u>Community First Choice</u>

We'd like to talk with you about Community First Choice (CFC) which is now active in Connecticut.

36. Have you worked with Community First Choice? This could be in any capacity, such as a Community Options staff member, MFP field staff, care manager or assessor, or in the evaluation or design of the program?

    If Yes:
    36a. What is your role in Community First Choice?

    36b. What has your experience been like in 2016?

    36c. What challenges have you experienced with Community First Choice?

    If No:
    36d. What are your thoughts about Community First Choice?

37. [If not yet answered], How (else) do you think Community First Choice could be improved?

    Probe:
    37a. What specific actions or changes would you suggest?

<u>Education and Training</u>
Now I'd like to ask you about training and education. Currently all Transition and Housing Coordinators complete a standardized, 6 module online education course covering topics such as consumer assessment, choice and control, and informal caregivers.

38. Do you think this online training is effective in creating a standardized approach for Transition and Housing Coordinators to take with consumers?

    Probe:
    38a. Can you tell me more about that?

39. How do you think the online TC/HC training has impacted consumers or their family members?

40. In your opinion, is the online training a good investment of time and money for what the Transition and Housing Coordinators get out of it? In other words, is the state getting its money's worth out of the training?

    Probe:
    40a. Can you tell me more about that?

41. [If not yet answered] Did you take the online 6 module TC/HC training?

    If No – Go to question 42

    If Yes – Continue to 41a

41a. What did you find most helpful about the training?

42. [If not answered] What other training and education would be useful for Transition and Housing Coordinators?

43. Currently, Specialized Care Managers receive Motivational Interviewing training. How do you think this training has impacted consumers or their family members?

44. Besides Motivational Interviewing training, what additional training or education would you recommend for SCMs?

Ask SCM Supervisors. Otherwise skip to question 48:

45. What training is needed to effectively do your job as an SCM Supervisor?

45a. Who should provide this training?

Ask Central Office staff. Otherwise skip to question 49:

46. What training is needed to effectively do your job as a Central Office staff person?

46a. Who should provide this training?

Universal Assessment

47. Have you, or people you supervise, completed any <u>assessments</u> using the Universal Assessment (UA)?

If No – Go to question 51

If Yes – Continue to 48

48. What questions or sections do you, or do your staff, find most helpful? Least helpful? How are these questions helpful (not helpful)?

49. Do you have any comments about the training you or your staff received on the UA?

Probe:
49a. Do you have any suggestions to improve the training?

50. How easy or difficult is it to use the UA?

51. Have you, or people you supervise, completed any **Reassessments** using the UA?

If No – Go to question 53

If Yes – Continue to 52

52. How does the <u>reassessment</u> process under the Universal Assessment compare with the reassessment process as it existed in the past, using the Modified Community Assessment?

52a. Is the UA Reassessment process faster or more efficient?

52b. What advantage do you see in having answers from the previous assessment prepopulate the next assessment?

Sustainability Questions
The Federal MFP Demonstration is in the process of transitioning into a permanent component of the CT Medicaid long-term services and supports system. We'd like your feedback on the long-term sustainability of Connecticut's MFP program as it moves from a demonstration to full integration into Medicaid.

53. As it makes this transition, how can the MFP program be reorganized or restructured?

   Probes:
   53a. What services or parts of the MFP Demonstration are important to continue?

   53b. [If not yet answered previously] Should the current regional transition team structure continue? If not, what changes do you suggest?

54. What policies or programmatic changes are needed to streamline or restructure the MFP program?

55. Do these program modifications require state plan amendments or would they be written into the state's Medicaid administration plan?

56. What are the potential barriers or risks that might be associated with these suggestions?

Systems Change
Our last two questions look at the program overall.

57. What effect do you think MFP has had on Connecticut's long-term services and supports system in general?

58. What else do you think MFP should be doing to effect a positive change in the long-term services and supports system?