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Money Follows the Person Rebalancing Demonstration:

Process Evaluation Year 2 June 2009-May 2010

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Introduction

Information obtained for this report was based on key informant responses reflecting the second full year of operation of MFP, from June of 2009 until June of 2010. A process evaluation examines how a project is functioning by examining the variety of services offered and the achievements that have been realized. Connecticut's Money Follows the Person demonstration program has multiple stakeholders who are involved in the project at various levels. These stakeholders include administrative staff, provider agencies, individuals participating in workgroups, and individuals involved in the work of the transition teams. Key informant interviews were conducted with a sample representative of these diverse stakeholders. Open-ended qualitative questions were used, which can be found in Appendix A.

Key informants

Twenty-four key informant telephone interviews were conducted for this evaluation. Key informants were involved with MFP in a variety of different capacities, including program administrators, a variety of service providers, and workgroup representatives. Administrative respondents included the MFP Program Director. Workgroups were represented by the two co-chairmen of the Steering Committee and one representative from each of the following workgroups: evaluation, workforce development, transition, nominating, and hospital discharge; all five Medicaid Home and Community-Based Service (HCBS) waiver managers participated, along with a representative of the 24/7 Emergency Backup System. In addition, the directors of one Area Agency on Aging and one housing access agency, who were randomly chosen, were also interviewed. One randomly selected director of a Center for Independent Living did not respond to multiple requests for an interview. Lastly, members of two transition teams were also interviewed, including the transition coordinator, the social worker for the targeted HCBS waiver, and the social worker from the nursing home.

Each interview documented the respondents' views and experiences regarding the MFP mission and the progress of the program in its second year, from June 2009 to June 2010. Individuals reported challenges or barriers to the program, as well information regarding workgroups, communication, and partners.

All interviews were audio-taped and transcribed, then analyzed using Atlas.TI, a qualitative data analysis program. Results are grouped under four basic categories:

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

Achievements and Successes

Analyses of MFP administrative staff and service providers' responses identified six overarching achievements or successes in the second year of program operation:

- Number of individuals transitioned during the past year
- Changes in the attitudes of the public regarding people with disabilities
- Network building and collaboration
- Moving towards a single point of entry
- Recognition of MFP as a consumer driven program
- Workgroups meeting more consistently, with agendas and minutes

Number of individuals transitioned during the past year
The sheer number of individuals who actually transitioned out since the program started was mentioned multiple times as a primary success of the program. This fact was mentioned by various respondents involved in different parts of the program: those on the administrative side and also providers. It was almost with some amazement that individuals spoke about the numbers of consumers who had transitioned out of nursing homes into the community since the program started.

> *I think that the achievement is made because we got MFP, because it gives people a vehicle to leave an institution, because it provides the funding, because it provides the waivers at the end of it*.

> *Getting the person out, seeing whether it is practical, seeing whether we can put enough services in place and what extras they need. I think that it is all geared towards whether it is feasible for this person to live in the community, and then what each of us can bring to the table.*

Changes in the attitudes of the public regarding people with disabilities
Another success of the program described by many respondents was the change in attitudes that they recognized in various members of the public community. Participants described how the actual transition of individuals was not only educating the public, but also the legislature. They also acknowledged the fact that the cooperation of nursing homes in the process contributed to multiple successes as far as transitioning individuals into the community. More people now are aware of what the Money Follows the Person Project is all about, not just transitioning individuals from nursing homes into the community, but a rebalancing effort in the state of Connecticut so that more individuals can take advantage of home and community-based services as an alternative to institutionalization.

> *I think the change in thinking how people with disabilities can live in the community. The perception that people with disabilities can live in the community is growing. Growing in the public mind. So that is making it more acceptable – changing the minds of other people. And I think that home builders are becoming more involved.*

> *I think the biggest thing is finally, because of the virtue of the dollars attached to the program, that finally, on a big level, has our legislators and our state Medicaid program – folks at the state level – finally looking at rebalancing, finally looking at using Medicaid dollars differently, and it's going to be something that could potentially prove the value of keeping people in the community and move Connecticut away from that "nursing home first" sort of school of thought.*

> *With this program, and with all the help of the process, it has changed the patient's life. I'm thankful for that. Even though I'm working as a social worker in a nursing home, my goal is that if I can get someone to be discharged to a home setting, a much more comfortable setting for them, if that's what they request, I certainly, as their advocate need to do that. That's my success story.*

Network building and collaboration
Enhanced collaboration, which was also an achievement in the first year of the program, continued to lead to increased communication and joint efforts, having all parties involved

working together toward one goal. From transition teams, to the variety of individuals working together in the multiple workgroups associated with the functioning of this project, to cooperation between nursing home staff and transition teams – the whole program depends on cooperation and collaboration to achieve success, not only for the individual who is transitioning out of the nursing home, but also for Connecticut.

> *I think that the MFP program has done that, providing that extra layer of support for 12 months is working…[the program] has constantly looked at trying to make it better and done, accomplished, a great deal during a very rocky fiscal year. I think the stakeholders have been very committed to the concept and the MFP program and worked really hard.*

Another achievement resulting from involving multiple partners is the ability of partners to learn from others and the cumulative information about different types of transitions, so that some nuance discovered by one person in the field can eventually guide future processes for others.

> *I think that the Mental Health Waiver can adjust their application when they are submitting for an extension so they can address some of these issues that people who are in the trenches are telling us – these are issues like transportation for the client and some of the more logistical things – and continue with the good training of recovery assistants. I've heard a lot of good comments from the service providers for the Mental Health Waiver that the training has been excellent and a few ideas about helping them even make that cultural paradigm shift from just doing the case work to the skills building… that's a big issue.*

Transition teams spoke of the collaboration between the transition team and the nursing home staff. Even though some thought that nursing homes may be somewhat reluctant to participate in transitioning residents from the nursing home into the community, transition teams commented on the cooperation of nursing home staff. Social workers, discharge planners, and all who work at the nursing home were genuinely involved and working towards the same goal of assisting their residents to move to a situation that would be more conducive to their independence and choice.

Moving towards a single point of entry

A successful single point of entry process could help to accomplish the objective of rebalancing and any related policy changes. From the administrative level, the most notable success included centralized eligibility, which represented true systems change.

> *The biggest shift I see and the biggest impact [is]… the other one that I discussed earlier about moving towards a system where there is more of a single point of entry. One, the long-term care system, it's really more providing the services that people need, but overall, I think that everybody – we're moving. And in a lot of ways to where someone can go and say, "I have this need," and they're not going to need to be bounced around, they're going to get what they need right then and there.*
>
> *So it's moving us more towards more an ideal situation where if someone needs help, they can just call this 1-800, "I need help," and someone determines where can they get this help and how can we get this help out to them? So it's moving*

us more towards that kind of single point of entry process or system here in Connecticut.

One of the respondents felt that MFP was a driving force in changing systems, remarking that the possibility of a universal waiver and application would help to streamline the system.

I think it is a success that is forcing discussions – it is forcing changes in the system like possible universal waiver, or even if we went to two waivers and a common application for it. I think it is changing the way we look at individuals philosophically and where and how we would all want to live. That is a major attitudinal change.

Recognition of MFP as a consumer driven program
Respondents also talked about a shift in how people saw the transition process. More people from diverse backgrounds recognized the transition process as being consumer driven and client centered. Providers working with some waivers were moving away from case managing to consumer skills building.

I think it is giving control to people who wouldn't have been able to move out otherwise…MFP has changed that and that's a good thing.

I think it gives me a different perspective around how to approach care and how we can best serve the needs of the long-term care community. And I think that even from a facility-based perspective, those who need to be in facilities with long-term care, it gives me a different thought on how to better address their need for self-direction and how we can incorporate the values and mission of rebalancing on both sides.

I think we take it for granted in Connecticut as "of course we do that," and I don't think that it is a universal practice. It is the client driving the discharge process.

Workgroups meeting more consistently, with agendas and minutes
Directly as a recommendation from the previous process evaluation, workgroups were encouraged to have agendas available prior to the meetings and have someone take the minutes of the meetings and distribute them to other members of that particular workgroup. Many felt that meetings were more on track when agendas are established prior to the meeting and that keeping simple minutes would help to refresh the minds of those who are perhaps involved in many more meetings than they have time for. Also, many of the respondents reported favorably about the fact that meetings were taking place on a more consistent basis. Of course, these remarks were dependent on which workgroup they were talking about. (For a complete listing of the workgroups and comments, refer to Appendix B.)

Strengths and Supports

But as far as the strengths, I would have to say that everyone is just extraordinarily committed to the over arching goal of MFP. I think that people realize that it's not just a program, it's not just about transitions – it's about something bigger than that.

The strengths and supports of a program are items that help to facilitate positive change while at the same time overcome difficulties. There were multiple strengths in the MFP program in its second year reported by participants. While some were the same as those from the first year's process evaluation, additional new ones emerged. Many of the strengths reflect a certain maturing of the program as it enters a second year, while others are reflective of increased commitment by the various partners who often see the project as a mission. Strengths and supports in the second year recognized by respondents included:

- Commitment of people involved in the project
- Involvement of multiple partners in every phase
- Open communication
- Successful and collaborative transition teams
- Experienced transition coordinators and dedicated MFP staff
- Flexibility of the program

Commitment of people involved in the project

The strong commitment of people involved in this project was evident. That commitment is indicative of the project's goals, that is, the importance of transitioning people successfully and safely into the community, a goal which should to take precedence over any one individual's or group's agenda. Many respondents mentioned the passion of various workgroup participants who put aside their own agendas to focus on the program's goals. Others recognized how seemingly effortlessly certain individuals accomplished details of the operation of the program, and how all of the parts fit together and were synchronized so well.

> *… [T]here is good participation by people because I think they see themselves as change agents, and they see MFP and the Steering Committee as being a change agent, and they want to be a part of it rather than if I stay here in this, there may be funding or other positive benefits to come to me or my organization in the future. I think that people are there because they really want to, and to actively participate, because they really want to make a difference.*

> *I think those are the things that we might take for granted without the knowledge of the little pieces that go into the big puzzle. There are probably more of them, these little niches where there are these committed, motivated superstars who are making this behind the scenes things look so easy, but I don't really think it is.*

> *I really think that people worked enormously hard and in a way that – I think the passion of helping clients really guided people in a way that helped to overcome obstacles. It has been a good experience to be around people who really care that much, consistently. I think it is almost a self-selected group across the board of people who really care about this work.*

Involvement of multiple partners in every phase

Many of the respondents felt that involving multiple partners continued to be a great strength of the program. It is one of the main features of this project, particularly involving people with disabilities not only in the various workgroups, but as part of transition teams. A certain number of people with disabilities are required to be part of the Steering Committee, but others were involved in other workgroups, giving their input which reflected their own understanding of what it is like to live with a disability.

Definitely think that it has helped…You've really got the consumer's perspective, you've got the advocates' perspective, and then you've got the state agencies that are participating. The give and take, I think, is good. I think it does give a sense of community ownership and leveraging community resources, people who are involved, I would hope, are all working and swimming in the same directions – and that is improving the state's long-term care system.

Another one of the partners involved that was often not mentioned during the first year included the staff of the nursing homes. The involvement of nursing homes in the process of transitioning their residents, providing information about the consumer, and helping the transition team is essential. Several of the respondents commented on this unexpected ally in the transition process.

We thought that they [nursing homes] would – that that could be a tremendous barrier – that nursing homes would be just so against it that maybe this couldn't happen. And that really doesn't seem to be the case. There seems to be very good-hearted people in nursing homes trying to help people transition back into the community.

Open communication

When communication is good, things get accomplished. After a full year of collaborating, some respondents found that communication became easier because of a familiarity with the other people within their group, whether within the transition team or a workgroup. When the lines of communication are kept open, progress towards goals can be achieved more efficiently.

We appreciate everything. We appreciate any kind of system change information, any updates on potential or actual discussions about changes to waivers, because that equals MFP participant progress.

I think that the Commission on Aging has taken it on upon themselves to collect minutes and different reports and put it on...the Commission on Aging website link, and that is an improvement.

[The transition coordinators are] knowledgeable, open to my assessment, comparing it to their assessment – comparing notes and seeing where we come up with the person – what we feel needs to be done. I think that [the transition coordinators] are very open to sharing information and our perspective as well as the client.

Successful and collaborative transition teams

After a full year of experiencing the cooperative efforts of working as a team, the transition teams had matured in many ways. The experience of working with others on transitioning residents into the community is a learning curve. Many involved in the transition teams realized how certain things which were difficult before were becoming easier with experience and time. Roles which were confused during the previous year were becoming more defined, and those involved in the transition teams knew the benefits of cooperation and collaboration to get things accomplished. Many respondents of transition teams felt that it was very beneficial to have members of the transition team who themselves have disabilities. Again, it is knowledge from experience that is guiding the results.

… [T]hey have people on the team that are very knowledgeable about folks who do have disabilities, what they would need to be able to come out to live in the community successfully. And the transition coordinators, their jobs are very, very, very intense because they have to cover everything, and everything is always gone over… [in] meetings…

I would say transition teams, when they work well, are wonderful. [They] get things done, we figure out how to solve a problem, we put all of our heads together. That's what I love about teams. It's not just the TC or the care planner. It's all of us putting our heads together, figuring out how to remove a barrier, how to overcome an obstacle. That is what is the magic of teams.

Experienced transition coordinators and dedicated MFP staff

Transition coordinators are the backbone of transitioning consumers. Transition coordinators were recognized by multiple respondents for their hard work, dedication, experience, and ability to make things happen.

I have to go back to the TCs [who] at least in this region have been very strong. They are an asset to the program. I think that they are able to size up the situation and I think that, for me, the important part is that they are realistic…that the TC is realistic about a person's ability to come home safely and be maintained in the community.

The leadership, dedication, and support of the MFP Central Office were also repeatedly mentioned.

I always thought that the MFP unit worked very well. [The project director] has always been very responsive to my communications and getting back to me…and has communicated as much as possible. Overall, I thought that the MFP unit has been very responsive to my staff.

Paul Ford has regional [transition coordinator] meetings. They started out as trainings, and then they evolved more into monthly conference calls where Paul will update the TCs with the latest news of a change of protocol or procedure.

Flexibility of program

Respondents commented that compared to the first year, there was more flexibility at the administrative level how objectives were accomplished. Staff at the Central Office were more open to achieving various goals in different ways. Perhaps because the program is a demonstration, various procedures have been open to change, and a number of protocols are continually being modified. It is likely that the MFP Central Office realizes the benefits of exploring a variety of ways of accomplishing the same objective. Being open to trying things, and being flexible in any number of areas has increased the success of the program.

I think it is being flexible in responding to the needs of all participants, providers and clients. And it has been very creative in its responsibility. So it is not rigidly adhering to rules that become barriers rather than process. It's just a learning – it's willingness to change, I guess is the biggest plus.

Barriers and Challenges

> *All in all I think that this is a very exciting time. It can be scary too. Any time we're stretching systems and trying to shift things, it feels uncertain, but it's a great time…*

Barriers and challenges to the program identified by key informants are grouped into the following:

- Programmatic barriers
- Barriers specific to transitioning consumers
- Education and training
- Communication and coordination
- Multiple partners, difficulties

Programmatic barriers

Programmatic barriers included a need for additional funding and staffing, bureaucracy, and limitations of the program. Respondents indicated the need for additional staff and funding at many levels, including the MFP Central Office, the different waivers, and transition coordinator sites. Program limitations included the lack of a universal or chronic disease waiver, CMS regulations, and primary role of the state legislature in setting policies and effecting systems change.

> *The only negative thing is that they have not anticipated the additional staffing that [the waivers] need to keep it going. Because after a year [the consumers] become ours…They have the green light to get as many people out as they can get out, but we don't have the staff to do it.*

Barriers specific to transitioning consumers

Barriers specific to transitioning consumers were mentioned repeatedly and more frequently than the previous year. These included concerns regarding:

- Length of time to transition
- Transition coordinator supports
- Housing
- Community supports and integration
- Individual consumer characteristics
- Home and community-based workforce

Respondents commented upon the length of time it takes to transition a consumer, in order to work with the consumer, keep up with the paperwork, track down documents, and locate housing. Delays in obtaining waiver program assessments and care plan approvals were also mentioned.

> *I don't know if you could shorten the process. I have been told it depends on if they have a place to live in the community and all the pieces have to be approved along the way for payment. I totally understand and I agree with that. It's just my patients feel like they want to go now, that they don't want to wait the whole timeframe.*

[One waiver] is…very slow. My last referral, they told me that there are six [assessments] in line. They won't even come out here for the first meeting for several weeks.

Many respondents called for increased transition coordinator supports, such as hiring more transition and housing coordinators, increased Central Office support, and more comprehensive transition coordinator training. One respondent pointed out the absence of resources such as transition guides for consumers, family members, and nursing home staff.

Locating appropriate community housing came up multiple times as another barrier specific to transitioning consumers. Respondents remarked that getting modifications and the three bid process also takes time and follow through. Financial limitations, landlord reticence, and consumer characteristics such as credit issues and poor rental history add another layer of difficulty. As one nursing home social worker remarked, "It does seem to take an inordinate amount of time for people to locate an apartment."

The whole three bid process is a little bit time consuming especially in some of the remote areas. That's probably the biggest barrier that I can think of…home modifications - ramps and that kind of stuff.

Participants also noted the lack of community services such as transportation. Some suggested more of an effort could be made to include free existing community resources, such as senior centers and churches. Barriers also arose for consumers whose support needs exceeded the services provided by the existing waivers or state plans. In addition, some consumers were seen as more challenging than others to transition or to keep in the community, such as those with behavior issues or complex medical needs.

As far as I can see, we are so busy transitioning, that we are not looking at the longer range and making sure that people are integrated into the community.

…A lot of [consumers] do have compounding disabilities like physical, substance abuse, mental health… it is especially difficult [to transition] those with no informal supports and when the supports of the waivers available are not enough…

Finally, lack of an adequate home and community-based workforce was identified as a barrier to transitioning consumers. This is especially true for those targeted for the Personal Care Assistant [PCA] waiver. There is a great need for a workforce of trained, reliable PCAs across the state.

…I think you're going to be in a situation where you don't have the pipeline that you need to take care of the people at home and it's going to hold it up. I think you're going to have more people sitting on those waivers, sitting in their place instead of moving, if you don't have enough people to care for them.

Education and training

Respondents recognized a need for additional education and training for many of those already working in the MFP program, as well as for the greater public. This included education for workgroup or committee members, state and nursing home social workers, and transition coordinators.

I think that it's been difficult for a number of reasons to be able to help people understand what MFP is. It's an incredibly complex project, and I don't think that most people know what it is.

Additional transition coordinator education and training was requested by many respondents. Challenges to this included lack of time for transition coordinators to complete their training before being asked to work on transitions. Some mentioned a lack of training support and accessibility of Central Office staff. Potential areas for education included group dynamics and team building, physical and mental health issues, availability of services and supports, and increased waiver knowledge. Using a train the trainer model was also suggested, specifically to teach a transition coordinator how to assist a consumer in strengthening his/her independent living skills. Education was also suggested for others who play an important role in MFP, such as the nursing homes and social workers. Commented one facility social worker:

I really would like to get something in writing about the program itself, the guidelines, etc…I would like to share with my co-workers, my social worker co-workers whom I meet with regularly, what's out there for their patients who are going to be discharged.

A comprehensive transition guide would help amend this situation, especially if it included an accurate time frame for transition, as well as the consumer's role in the transition process, such as in hiring PCAs, finding a place to live, and networking with existing community supports. Several respondents specifically recommended training for consumers on hiring and using PCAs.

In general one of the challenges that we face is with folks that we are transitioning under the PCA waiver particularly. They have to be able to self direct and a lot of them are having difficulties doing that.

A question was added this year concerning the 24/7 emergency back up system, asking participants to describe it, if it were working as intended, and if they had suggestions to improve it. Only a few respondents could accurately describe the system. Others knew that it was there, but could not go any further, "It's an emergency back-up. That's all I know about it." Most respondents had various misconceptions about it. These and other respondents also indicated that it was not functioning as it was intended. There were a few respondents who indicated that the system as it is now does provide some support to consumers.

I think it's the way it was envisioned to work is that consumers under the first year of demonstration of MFP would be able to access, regardless of their services, a 24/7 triage line and someone would come to the rescue. That is not the case.

Communication and coordination

The need for better communication once again was identified as a challenge for the program. This is not surprising, given the complicated and extensive nature of the project. In particular, increased coordination and communication between the waiver staff, transition coordinators, and Central Office was requested, while some contractors wanted greater clarity regarding their roles and responsibilities. Others wanted more detailed program findings and experiences, such as challenges of transitions and gaps in the system. There was interest in greater communication between workgroups and from the Steering Committee. Key informants expressed a desire to see details in the Steering Committee minutes such as any handouts.

Others assumed all workgroups were closed to new members, or did not know that Steering Committee meetings were open to the public.

> *I am not sure that we can attend the Steering Committee meetings. If I was invited, I would surely attend.*

Overall, respondents indicated that most workgroups or regular meetings were working better than the first year of the program. More respondents reported receiving agendas and minutes, and more knew the goals of the workgroup. Some respondents noted concerns about receiving committee and workgroup minutes in a timely way and the staffing of all workgroups.

> *… there are official minutes and agendas that get out, but not always in a timely way. That's a part of the communication issue… giving committee members an opportunity to review the minutes sufficiently far in advance and knowing the agenda in advance so that they can participate more effectively.*

Steering Committee members wanted the meeting to run more effectively, but then recognized, as stated by one member, "It's a very diverse group with diverse backgrounds and interests, and to pull that together is very challenging." Respondents did voice dissatisfaction with the contractors meeting, finding that it lacked focus and centered on the concerns of the transition coordinator contractors.

Multiple partners, difficulties

Compared to the project's first year, substantially fewer respondents indicated that involving multiple partners itself was a barrier. Still, one respondent in particular noted the undercurrent of competition among some partners in this second year, while another saw a need to better utilize the existing structures and partners. As with last year, establishing a leader when working as a team was recognized as taking some effort.

> *In theory…enhancing the quality of life for folks, giving people choice…unites all stakeholders…Then when you talk about operationalizing it, and what's in it or what's not in it for your organization, then things change very quickly…We're at that point where it has become a little more challenging for these competitors to stay engaged and to continue the good will and to work well with one another.*

Changes in barriers from year 1 to year 2

Respondents reported that overall communication and workgroup processes improved over the past year, while efforts to meet other challenges need to continue.

<u>Positive changes</u>

- More workgroups are providing agendas and minutes, and more people knew the goals of workgroups.
- At least three workgroups or committees used the feedback from the first process evaluation to look at their own effectiveness and process.
- Both transition teams interviewed reported positive working relationships with the nursing homes they work with.
- More people understood MFP project goals and the roles of the State and the Steering Committee.

Efforts to continue

- There was a greater focus on barriers to and problems with transitioning consumers.
- Education of transition coordinators and others highlighted once again, including the 24/7 system.
- Programmatic issues are still a concern, including bureaucracy, need for funding, and increased MFP staff.
- Responses indicated a need for continued work on communication and coordination among all parties.

Evolution of Connecticut's MFP Program

> *I think they did a wonderful job of trying to be creative, think outside the box, willing to come to consensus, and try things and then fix them to make them work. That was very positive. I think, in general of all the different players of MFP, the public, the various providers. The whole idea is that it's a demonstration. It's working on making change, it's working on coming up with the best scenarios, the best processes that work.*

This statement captures the feelings of many of the key informants regarding the processes of MFP. All of the respondents realized that this is a demonstration project – that things will, by definition, change along the way. Respondents accepted that these changes come about through the process of trial and error and that certain things which work in one instance may not work in another. However, the overall effect reinforces the fact that the program itself is maturing over time. As mentioned previously, one of the strengths of the program is the flexibility of individuals in utilizing a variety of methods for accomplishing the various tasks and benchmarks of the program. Strength from the management of the program has reinforced the various members' abilities and decisions to do things in a way that suits their particular situations. This is the underlying strength of the program as it evolves: openness of the partners to doing things in different ways and trying to find the best solution for countless situations as they arise. This evolution of the program is evidenced by:

- Procedural changes
- Empowerment of partners
- Benefits resulting from increased experience
- More interaction between partners – sharing resources
- Potential for improvements in the future

Procedural changes

Some of the procedural changes which transition coordinators saw included a modification of the PCA waiver process and the enhanced organization of the MFP Central office with regard to the handling of care plans. The transition teams found the centralization of security deposit guarantees very helpful in expediting the various parts of the care plan.

There are also more protective service workers being employed in the project and a new program about to launch that will help people hire and train PCAs. Another change is the flexibility in the program where if a consumer wants to spend more money on a bed than to buy a couch, he or she can do that. Rental assistance, security deposit, and flexible funds were all considered very positive things by respondents. The security deposit guarantee program has also become more efficient because everything goes through a single individual at the MFP unit. Transition coordinators noted that things go a lot smoother because of that change in the process.

Empowerment of partners
Another positive change over the past year has been the empowerment of MFP partners to do things in a way that they prefer. The MFP program director demonstrated a certain amount of flexibility with regard to procedures and the way the various aspects of transitioning unfold. Certain regions might prefer a particular way of doing some of the steps that has worked well for them in the past. So they continue to be given the option of accomplishing the same goals in different ways.

> … *[S]o we prefer to have less cases, and we would prefer to do more of traditional case management role, where we would get in at day one and take a person all the way through the process and get the person the apartment, and the furnishing and out. [MFP program manager] has been very open to people doing things differently.*

Benefits resulting from increased experience
After a full year of experience, many of the players have become more familiar with working with each other, keeping the lines of communication open, and working collaboratively. Knowing the availability of others has enhanced that familiarity, and knowing somehow the possible obstacles they might anticipate in any transition has made the transition process easier for the transition teams. After a full year of transitions, their efforts have grown increasingly towards meeting the challenges of keeping people in the community. Now, after the second year, transition teams are more aware of the paper work that needs to be done and all of the procedures that need to transpire before the transition can be accomplished.

> *You learn and you adapt. The protocols are constantly evolving. I think a lot of us would agree who are involved with the program, its had its ups and downs and its challenges, but we have had a lot of growing pains. But now we are in a much better place. First of all, we've all been doing this for a year and a half now. We're all becoming more comfortable in it…A year ago our challenges might have been obstacles to getting people transitioned. Now we are moving people out and we are seeing new challenges, such as trying to keep people in the community. So as the process evolves and the program ages, there are constantly – we're also moving along this continuum and there are new challenges that come up that need to be addressed.*

> *…[W]e have a lot less headaches now that the program has been up and running longer. You know, we've actually transitioned people from MFP onto our respective waivers now and that has been a really good thing. You know our first transition was a little bit scary. Like, what paperwork needed to go where, you know that kind of thing. And now, we're a lot clearer about the procedures that need to happen. So it has been pretty successful.*

> *… I think it is becoming more efficient over time. And I can only base it on my own waiver's experience, but it has gotten easier. Even though the clients may have gotten more difficult, I think that we have learned a lot in the past year.*

In the area of communication, the familiarity of the teams working together also helped to improve communication and continued progress in their collaborative team efforts.

I think as a team with the team leads, we've kind of grown together and we've kind of learned how each other operate. It has gotten to the point where sometimes less communication was actually more, because we learned how to work with each other.

More interaction between partners – sharing resources

[MFP] is very collegial. I think it has evolved in a very positive way. I think it was more territorial a year ago. But I think that it is really feeling more and more like we're all working towards the same goal, which is helping individuals live in a less restrictive environment. It's really positive.

Certain practices have evolved over time just from experiencing a variety of different situations within the process of transitioning individuals from nursing homes into the community. Different things were learned through each of the transition processes, and everyone benefited from that knowledge. One example of sharing resources was the different waivers working collaboratively to help a person out. For example, a person on the PCA waiver is usually considered self-directing. However, in one case, there was evidence of two waivers working together to help out a consumer, a step towards the concept of the universal waiver.

So what we have been able to do. Like I will take them on my waiver and she will provide me a case manager to be the representative of the client – to manage the PCA.

Another positive collaboration that was achieved was the newly established partnership between the nursing home social worker and the transition coordinator as a team. Transition teams found that involving the nursing home at the inception of the project was the best way of ensuring their cooperation. Nursing home staff shared information about the resident, provided physical therapy assessments, and provided any pertinent medical information. Then they joined forces to accomplish the goal of successfully transitioning the resident into a new and more independent situation where the consumer would have more choices and opportunities. Instead of being resentful of MFP for taking away residents, nursing homes were often made a part of the process and joined in the collaboration of creating a new living situation for their former residents.

Potential for improvements in the future

Certain individuals mentioned practices and innovations that they saw as potentials for the future growth of the program. They recognized that steps are being made toward achieving these goals. Moving toward the goal of a single point of entry system was mentioned by multiple participants. Other potential changes included initiatives that were already in the early stages of implementation at MFP Central Office, such as a central eligibility unit, a quality improvement committee which will get information from the website and analyze the data to make improvements, the ability to triage people, and more people working at Central Office to assist in this huge endeavor.

S in the previous process evaluation there were comments about needing additional MFP Central personnel in order to do the monumental task that to date has been done by only a limited staff. Increasing the number of individuals would be a definite improvement for the coming year.

Recommendations

Workgroups
The past year has seen improvements in the numbers of meetings with assigned facilitators, agendas and minutes, and known strategic goals. A good example of this is the Transition Workgroup. Recommendation regarding workgroups include:

- Establish and staff the Housing Workgroup. Invite parties such as the directors of both housing providers and transition coordinators.
- Review timing of Steering Committee minutes. Send out minutes more quickly and include any handouts; send agendas farther in advance.
- Encourage the Steering Committee to examine its practices of educating its members in order to spend less time at meetings catching people up.
- Continue efforts to examine the contractor meeting to determine meeting goals and how to use it more effectively.
- Send out reminders to all involved in MFP that the workgroups are open to new members, and anyone can attend Steering Committee meetings.

Education, training, and outreach
Currently the MFP program provides ongoing monthly transition coordinator trainings, and education for nursing homes is provided on an informal basis by the transition coordinators. Respondents recommend expanding these efforts.

- Strengthen the transition coordinator trainings by sending out an agenda ahead of time and follow up with minutes to coordinators and their supervisors. Strongly encourage all supervisors to participate in their transition coordinator trainings. Hold a "back to basics" in-person regional training at least once a year.
- To reverse misperceptions of the 24/7 triage service, provide education to MFP stakeholders, especially the transition and housing coordinators, all the contractors, waiver managers, and the Steering Committee.
- Develop a consistent outreach and partnering plan for nursing homes and their staff. Make a concerted effort to include facilities in education and outreach.
- Develop an outreach and partnering plan for home and community-based providers, as they will be supporting consumers once they transition.
- Reach out to community organizations which might provide some community support to transitioned consumers. This might include local religious organizations and churches, senior and community centers, youth groups, and other organizations such as the Kiwanis club.

Transition guide
Lack of a transition guide is hampering efforts to educate consumers, work with social workers, and transition consumers. Create comprehensive transition guides for consumers and family members, and one modified for nursing home staff. Include:

- A realistic transition timeline.
- A description of each person's role in the process. Include for consumers their role in hiring PCAs, finding a place to live, and networking with existing community supports. Several respondents also specifically recommended training for consumers on hiring and using PCAs.
- Create an "after transition" or community integration section with suggestions and contact information for community resources such as community centers, churches, support groups, etc.

Increase consumer involvement
Respondent comments indicated a need for increased consumer involvement in their transition process. Transition coordinators and all involved in the transition process must learn to build on the consumer's current abilities so they can successfully live in the community. Encourage the consumer to take an active role in their transition process. Coach the transition coordinators to resist the temptation to do for the consumer if, with training, encouragement, or assistance, the consumer could do it him/herself. Assist the consumer in learning basic living skills. The MFP Central Office must also recognize that this may slow down or even reduce the number of transitions.

In summary, Connecticut's Money Follows the Person program continues to grow and evolve. The transition coordinators and other contractors have more experience and the processes are running more smoothly. The number of transitions is increasing. Achievements of this second year include the sheer number of individuals transitioning out of nursing homes who are subsequently living safely in the community, with increased independence and choice. This fact continues to reinforce and augment the acceptance of people with disabilities who are living in the community. The more individuals who transition out of nursing homes successfully, the more public opinion will be shifting towards accepting this as the norm rather than as the exception. These alterations will contribute to reaching the program's rebalancing goals. Not only will these developments become evident to the public, but they will become more evident to legislators and those in public office who might influence Connecticut's long-term care policies. But most importantly, legislators, the public, and the people working with Money Follows the Person recognize that MFP is a consumer driven program. Ultimately, it is the individual who decides where and how he or she wants to live. MFP has demonstrated that a variety of individuals, including people with disabilities, can collaborate and work together on continuing efforts to rebalance long-term care in Connecticut.

APPENDIX A: Workgroups June 1, 2009 – May 31, 2010

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
Steering Committee	"You really have to look at what is the role of the Steering Committee, and if you look at the by-laws and if you look at the protocol, it seems like it's an advisory body on policy decisions."	Once a month. Satisfied with frequency.	Yes	Yes	"There's good interaction – lots of participation...I think there is good participation by people because I think they see themselves as change agents and they see MFP and the Steering Committee as being a change agent…" "…there is a frustration among Steering Committee members in that they feel like perhaps they don't have all the information they would want, but I struggle with how could that even possibly be done because people are also at different levels of understanding the program itself...we need to think about to what level do we educate people about all the issues and is there a way [to do so] outside of the meetings…"
By-laws		Did not meet in second year of project.	N/A	N/A	
Contractor	"From my perspective the goal or objective of the meetings is to keep the contractors informed about how the program is going. Occasionally the goal is to get input as to our needs and what other supports we have or need. It's not always been clear. So I go there with an open mind and take whatever information they give me."	Usually once a month. Satisfied with frequency.	Sometimes	No	"I always felt like…people listened to me and that they were open to my input…That is a very positive thing about that group – that people are willing to listen." "I think if the contractor group really discussed contract issues and talked about barriers, perhaps, in meeting goals and brainstorm different approaches…[it would be] more productive along those lines…" "…it would be helpful if maybe the transition contractors had their own opportunity to meet with Dawn, to really talk about specific issues and challenges…They don't need to be

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
					monthly, but little subcontractors meetings, maybe quarterly or something."
Evaluation	"The objectives…[are] to receive feedback about measures, progress reports and to give feedback about whether something can be looked at differently…"	Every 3 months (quarterly). Satisfied with frequency.	Yes	Yes	"Essentially [we] look at the quality of the project, client satisfaction, make sure the evaluation is measuring what it needs to be measuring – the nationwide tool that we are participating in as well as the state tool." "It's been helpful, I've actually learned a lot. It is clearly a collegial effort to maximize what is right about the project and, I think, also brainstorm about getting the best feedback from clients – from all stakeholders really." "I participate primarily by telephone…I think that telephone conferencing, in and of itself, is occasionally difficult because you can't see anybody in the room. But it's really helpful as far as time management, and I think it has become a lot easier to participate without having to travel. You know, all the materials are provided up front, so it's easy to all stay on the same page, really."
Hospital discharge	"…to work on making successful discharges back to the community and avoid discharges, the quick discharge, to the nursing home…"	Not meeting on a regular basis. Would like to meet more often.	No	No	"I wish [the hospital discharge workgroup] met more consistently and had a better vision. I think that group could accomplish a lot more that it actually is." "It's a different group of people every time they get together. They don't get a consistent attendance in that group…" "The…active thing that the group was doing was…actually interviewing hospital discharge planners. And surveying them…to find out what their needs would be to make for a

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
					quicker and more successful hospital discharges."
Housing		Did not meet in second year of project.	N/A	N/A	
Nominating	"The goal is to make sure that there are no vacancies on the Steering Committee."	As needed.	No	Unclear	"[We meet] whenever there is a vacancy in the Steering Committee – whenever there is an opening in the Steering Committee. We recently nominated some people for that, and we need to always make sure we have 51% of people with disabilities. So they hold the majority. We nominated someone recently. So we only meet as needed. The goal is to make sure that there are no vacancies on the Steering Committee. The maximum number is 30." From the Steering Committee consent agenda August, 2009: "In looking for additional [Steering Committee] members, the [nominating] committee looked at issues of diversity, geography, disabilities, relevant skill bases, transition experiences and clinical experience."
Policy	"At the time, we said that we would inform Mercer [Consulting], and that we hoped to be an established group in the near future."	Met several times over a two month period in 2010. Would like to become an ongoing workgroup.	Yes	No	"We also convened…this reporting period, the policy workgroup that submitted some recommendations. I don't know if that is a temporary workgroup or not, but they submitted some directives to Mercer Consulting." "And I found that to be – kind of from my perspective because I think of policy – an area that can really be developed within the MFP Steering Committee. So I would imagine that that's a group that's going to

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
					continue on if we have the fortitude to do so."
Quality improvement		Has not met	N/A	N/A	
Transition	"The goal…has always been how do we move people out faster. How do we move out more people."	Usually monthly.	Sometimes	Sometimes	"I feel like the group is also trying to get a more specific focus as opposed to this grandiose, 'Okay, what are the obstacles and how do we move people out faster?'…the group is also trying to focus now…on what tend to be the biggest obstacles and then try to address one at a time…" "I wish we had more people that attended the group that represent the different aspects of MFP."
Transition coordinator training meeting*	To update the transition coordinators (TCs) with any change in protocol and discuss any challenging transition cases.	Monthly conference call with each of the 5 regional TC sites. Satisfied with frequency.	None formally	No	"[Paul Ford] has regional meetings. They started out as trainings and then they evolved more into monthly conference calls where Paul will update the TCs with the latest news or a change of protocol or procedures, and then also hear any challenging cases that [the TCs] may want to discuss…[in order to] to get input and feedback from Paul and our [MFP staff] team leader…" "It would be helpful if they could send us some written information… preferably ahead of time, so that we could have something in front of us during the conference call….also minutes from the meeting, too, because sometimes there are really important things discussed and there is no written documentation about it."

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
Waiver manager	"I think that the goal and objective of that workgroup is for us to get together to clarify anything that may be confusing and to get an update on how the overall initiative is going."	Unclear.	No	No	"I do wish that the waiver managers met separately from the Steering Committee. I think people who are involved because they are state employees or because they represent agencies have…a different responsibility than the Steering Committee members who are there as advocates." "…we are able to talk about successes… understanding the critical incident documents that we do, the log-in activities and everything with that, getting an understanding about different ways that we can learn about self-directed community supports…"
Workforce development	"…they have a specific [written] mission… developing and retaining a nimble and robust workforce for Connecticut to meet this booming demand of long-term care, not only in the community, but they also were mindful that this will be needed in institutions as well."	Once a month Satisfied with frequency.	Yes	No	"…I would say that the committee has done a great job at trying to understand the state structure as it pertains to workforce – the Workforce Boards, those who do workforce issues across the state – and trying to overlay the need on top of that and really leverage those professionals and resources and organizations to help us with direct service workforce needs." "Right now we're trying to identify the whole mapping process and to see what already exists before we identify any recommendations. I think that right now we are doing necessary homework, so that we don't repeat what's already been done or come up with a nonsensical recommendations that don't make sense in light of the landscape of Connecticut." "It's a standing committee monthly – but we're pretty flexible. Often, it is done by

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
					conference call and there is a lot of off-line work."
24/7 Back up system ad hoc meeting	"Overall, to design and implement the emergency backup system."	Two or three times over past year.	No	No	"…throughout the year, various ideas were implemented, tried, partially successful, some very unsuccessful, a lot of time and effort went into it...There was a lot of adjustments made in the design of the emergency backup system – [it's] still a bit in flux…We're trying things out, we're seeing what's going to work. If it doesn't work, we'll go back to the drawing table." "[There is] a lot of good interchange of ideas, brainstorming, creative ideas on what might work. There was a lot of consensus because [although] not everyone agreed on some of the choices being viable, [they] were willing to give it a shot…"

* Technically a training meeting, not a workgroup. Included to better represent the transition coordinator and provider experience.

APPENDIX B: Key Informant Interview Guide June 1, 2009 – May 31, 2010

Program goals

1. Please briefly describe the CT Money Follows the Person program and what it is trying to accomplish.

Role

2. How are you involved with the MFP program? (What is your role? Are you on any committees or workgroups?)

3. What has your experience been like? (How does it compare to your expectations? Have things gone as you have hoped? Is there anything you wish had gone differently, or that you would have changed about the process?)

Meetings/Workgroups

4. Who else is involved in the Workgroup? (What organizations or stakeholders do they represent?)

5. Describe the current workgroup or committee meetings. (How often do you meet? Is that enough? What are the meetings like in terms of interactions or process?)

6. Does your workgroup have a strategic work plan? (What are the workgroup's goals or objectives?)

7. What progress has the group made toward achieving those goals? What has facilitated or limited the progress of the group? What would you change?

Structure and process

8. How is the CT MFP program structured? Is there a person in charge and/or a governing body? What is their/its role? Is there anything you would like to see changed?

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

10. Are there things you would change about the communication processes?

Partners

11. Tell us about the different organizations or groups which are working together on this program. How has involving multiple partners or stakeholders helped or hindered the process?

12. Describe the interaction between these different partners. (How well do they work together? How do they resolve any differences when working together on the program?)

13. Are there any other groups or stakeholders who should be involved in the program but are not? (Which organizations or people are you thinking of? What would they bring to the program?)

Progress

14. In your opinion, what have been the major achievements of the MFP program over the past year (since DATE)?

15. What in particular about the program's activities has worked in the past year (since DATE)? (What are the strengths of the program? What has supported or facilitated the program's activities?)

16. What is not working well in achieving the goals or objectives of the MFP program? What barriers or challenges have you encountered in the past year (since DATE)? (What could be done to prevent or overcome these difficulties in the future?)

Program activities related to systems change

17. What MFP program activities do you feel are *most important* to promote change in Connecticut's long-term care system? (What would you recommend be included in a "Best Practice Report" on what worked in Connecticut and why it worked?)

18. What MFP program activities do you feel are *least important* to promote change in Connecticut's long-term care system?

19. Thinking about the MFP program and its role in transforming the long-term care system over the past year (since DATE), what would you change about the MFP program?

20. What is your advice to other states involved with long-term care systems change?