University of Connecticut
Health Center

September 2013

Money Follows the Person
Rebalancing
Demonstration:

Process Evaluation
Year 4
July 2011-
December 2012

Prepared by

Julie Robison, PhD
Kathy Kellett, PhD
Martha Porter, BA
Yesmel Bodden, MA

Center on Aging
University of Connecticut
Health Center

263 Farmington Avenue
Farmington, CT 06030-5215

Table of Contents

Introduction

The information for this report came from the analysis of key informant interviews reflecting on 18 months of operation of the Connecticut Money Follows the Person (MFP) Demonstration, from July, 2011 to December, 2012 when the fourth year of program operation concluded. The report focuses particularly on calendar year 2012. A process evaluation focuses on the program's intended goals, what is delivered in reality, and the gaps between program design and delivery. MFP involves multiple stakeholders at various levels, including administrative staff, MFP contractors, MFP workgroup members, Medicaid Home and Community-Based Services (HCBS) waiver care managers, and field staff who work to transition consumers from nursing homes and other institutions into the community. A sample of these stakeholders completed key informant interviews with the University of Connecticut Health Center's Center on Aging MFP evaluation team. Questions for the key informant interviews are found in Appendix B.

Key Informants

Twenty-four key informants completed telephone interviews reflecting on their experiences in the fourth year of program implementation. Administrative and workgroup respondents included the MFP Program Director, an MFP staff member (randomly chosen), Co-chairs of the MFP Steering Committee; one representative from each of the three active workgroups (evaluation, workforce development, and contractor), and the four Medicaid HCBS waiver managers. Providers included the directors or representatives of three transition and/or housing coordinator contractors (randomly chosen). In addition, members of two separate transition teams were interviewed, including the transition coordinator, the housing coordinator, the case manager or social worker who did the assessment, and the social worker and/or discharge nurse from the nursing home. Each interview assessed the respondents' experiences regarding the MFP mission and progress, meetings or workgroups, communication, partners, education and training, risk mitigation, participant risk agreement, challenges, and achievements.

All but one interview was audio-taped and transcribed; the remaining interview was completed as a written questionnaire. On average, interviews lasted approximately 30 minutes. All were analyzed using ATLAS.ti, a qualitative data analysis program. Similar to previous process evaluation, results of the analyses fall into four basic categories:

- ➢ Achievements and Successes

- ➢ Strengths and Supports

- ➢ Barriers and Challenges

- ➢ Program Developments, 2011-2012

Achievements and Successes

Analysis of the key informant interviews identified six overarching achievements and successes in the fourth year of program operations:

- ➢ Number and Impact of Transitions

- ➢ Increased Staff
- ➢ Culture Change

- ➢ Program Leadership

- ➢ Enhanced Training and Education

- ➢ Website Development

<u>Number and Impact of Transitions</u>
As of December, 2012, 1421 consumers had transitioned from institutions into the community. In the fourth year of program implementation, this fact remained one of the primary accomplishments mentioned by key informants.

> *Well, probably just the numbers of people we've moved out. I mean I think that's been probably certainly the most visible and it's created a whole chain reaction with the nursing homes reducing beds and having to be willing to repurpose themselves.*

> *I think transitioning people out of nursing homes leads to everything else. And it gives examples of…textual examples of where others felt somebody couldn't live in the community but in fact they did and it tells us information about where the key areas are and…so I think that's transitioning people.*

New funding has helped facilitate the number of transitions and contributes to this extraordinary achievement. The support of family and friends was also mentioned as a contributing factor in the many successful transitions.

> *Well I think the fact that being, for our folks, for us it's new funding. To be able to take the cost of care that's already being spent on them and making it what I call portable, making it actually follow the person. The money is key and them having waivers that have enough flexibility in them to meet the diversity of needs that people have out there.*

> *Family and friends supports. Circles of supports. I was just telling a co-worker about that. The most successful transitions that I have seen is when there is a circle of support. That they have family. They have friends. They're huge. Absolutely huge.*

For key informants who work directly with consumers, setting people up with waivers, moving them into their own home in the community, and the impact that has on people and their families was listed as another primary achievement of MFP.

> *It's really exciting to see them believe and begin to think they can live independently, that they can move, that they can overcome some barriers, and that you're the person…that brings them to that place.*

> *Getting the young people out into the community and remembering how happy the families are and that I was able to help them was major.*

> *It's been nice to see people that who otherwise in the past would not have returned to the community, being able, giving them the opportunity to do so.*

The program made it possible for people who lack support from family and friends to live in the community where they prefer to live. It also enabled people who have been in a nursing home for many years, to reenter the community and live there safely.

> *I think it's a positive program for a lot of people. It gives them the opportunity to live back in the community. It's allowed a lot of people who didn't have a lot of supports from family or friends to move from the nursing home where the population is trending to the younger side and allow them the freedom of being back in the community, so I'd say it's a positive thing.*

> *I think the greatest satisfaction are some of the people who have been in the nursing home for 20/30 years and people kept telling them they could never live in the community. I could tell you at least ten stories but one story is a gentleman who had a wound on his leg for over 10 years and people kept telling him he couldn't leave the nursing home until it healed. He's been out of the nursing home for a year and the wound is gone.*

Increased Staff

A newly recognized achievement in the implementation of the program is the increase in staff in Central Office as well as the hiring of additional transition coordinators and expanding field staff to include full-time housing coordinators.

> *Whereas it relates to my role, it was probably about a year ago, well around this time I think. We got five additional staff members and so they have, things I used to do, now they do, which is a good thing because the stuff that's on my desk has expanded to the point that I still, ya know, I just can't do everything. So that was a huge achievement.*

> *I think some of the things that were helpful were that we did get housing coordinators whereas originally the TCs [transition coordinators] had to take on that role, looking for housing, talking with landlords or agents that represent housing, getting the paperwork done for the housing, which is a lot of extra work. Having the housing coordinators in place has helped, but it's still not perfect.*

Providing funding to each transition and housing coordinator contractor to pay for transition and housing coordinator supervision was an important and long sought after achievement in 2012. Central Office began to hold mandatory monthly supervisor meetings in the fall of 2012 chaired by a dedicated MFP staff member, which cover topics especially relevant to field staff, such as changes in the transition process, working with different waiver systems, and home modifications.

Culture Change

Many key informants agreed that the cultural shift from facility-based to community-based care is positive and continues to be an important achievement of the MFP program.

> *I think the main achievement has been a greater awareness of the opportunities for folks to have community living…but the attention that MFP receives helps to*

inform the system about our abilities to support people in different ways and the more awareness we have, the [more] opportunities we have to offer choices.

I think that the program has opened people's eyes a little bit about the ability of individuals to live in the community, even individuals who require a great deal of support or who have medically very severe conditions. I think that a lot of individuals have some pessimism about whether folks can live in the community or not and I think that MFP has been terrific in sort of overcoming some of that pessimism.

It's a paradigm shift to embrace an individual's right for self-autonomy and living in the less restrictive environment and to be in control over their life and the things they want to have control over and for us to provide a supportive environment in which they can achieve that.

I think it's a systems change and looking at our system differently and how we can serve people in less group settings and congregate settings and more integrated into their individual community.

Program Leadership

There is a high regard for the MFP program that continues to contribute to its success and this reflects on the standards and commitment of the leadership. It also includes the manner in which the leadership addresses challenges and resolves those through policy changes.

A big factor is the reputation for CT that Dawn Lambert has built with the folks at CMS and also with other government agencies.

I think the management of the program has done a good job in addressing barriers, looking at policy and changing policy that needs to be changed. Finding wrap-arounds. I think that has worked really, really well.

Central Office has initiated the establishment of bench marks and performance standards. We have facilitated the advocacy and technical assistance to communities for barrier removal.

And I think it has been a learning program. It's been a program that has been willing to look at its own structure and tried to change and improve.

Enhanced Training and Education

One shift seen this past year was in the realm of education and training. Compared with previous process evaluations, more respondents felt the current training for field staff was going well, with Central Office providing more timely and consistent transition coordinator training. Respondents pointed to the monthly conference calls and webinars as successful ways to provide training for coordinators from across the state. Another spoke of how the case scenarios on the MFP transition coordinator blog were really good learning tools.

I think it's excellent. I think they've done a good job in developing training; they really keep the TCs and housing coordinators up-to-date and fully apprised of what's going on. But again, it has been a work in progress.

Since I've been on board let me see, I've been to two trainings; very informative. I wouldn't really change anything. Because like I said before we have a blog, we do have a blog that we can go on. We have webinars that we can go on and be educated on certain things, and we get emails, so I wouldn't change anything. We are well informed on things.

[On the blog] they have case discussions, and they're very good. They're complicated cases typically.

Others pointed to the important role of the new transition coordinator supervisor position in enhancing the cross-training among different Contractors and their partners of their own procedures and roles in Connecticut's MFP program.

[The field staff training] is working better than it was. They do a supervisors meeting once a month now and we're included in that, so we get to hear their issues and they get to better understand our role.

From what I know it sounds like they are provided with some pretty good training – especially more recently. I think that the supervision, the fact that they are now getting a little bit more supervision. Perhaps they always were and I just became more aware of it now… That seems to be working out well.

Website Development
Through the leadership of the Commission on Aging, significant work has been accomplished this year in the development of the long-term services and supports website. This work has been recognized and incorporated into MFP for its benefit. Respondents also praised the MFP web-based tracking system as a facilitator of communication.

We probably spent at least 60 hours in helping them make that a reality and at the same time we've connected them with the existing website of which we lead and they're taking that information and that structure and it's going to become this new, you know, highly evolved website.

Improving on the long-term care website that already existed and using that as a resource and improving that and moving that over to the website as an information and referral source, I think those are all really positive.

The web is great… technology is underutilized. So I think the more we're able to utilize that process, and that level of way of communicating with Central Office and things.

Strengths and Supports

Many of the same strengths and supports established in the early years of the program continued during this fourth year of project implementation.

➢ Commitment of Project Staff and Stakeholders

➢ Support for Community Living

- ➤ Collaborative Transition Teams and Partners

- ➤ Positive Communication

<u>Commitment of Project Staff and Stakeholders</u>
Project staff and stakeholders continue to exhibit their extraordinary commitment to MFP starting with the Director of the demonstration project. This commitment and exuberance to embrace the many facets of transition is one of the strengths of the program and has helped create an environment that supports the growing number of successful transitions for a diverse population of people with disabilities.

> *I think that Dawn has done an exceptional job of picking people and also creating a sort of a culture of cooperation and collaboration and um, the team aspect is really great here.*

> *There are many staff that care deeply about what they do and it shows in their work.*

> *Having the commitment of the steering committee, the project manager, the staff of MFP, to do this work and even all the up to, really up to the government to support it.*

<u>Support for Community Living</u>
Support for community living is particularly important for this program as it has evolved and continues to be significant. Several respondents underscored the tremendous value of families, friends and staff who are supportive of community living and by doing so have helped facilitate the successful transition of individuals from a nursing facility to the community.

> *Families definitely, families and friends, having people in the community who are receptive to that. Having social workers in the nursing homes who understand the process and are supportive of people going to live in the community and realizing that people have the right to make, not ideal choices but you now, if they chose to go be in a community with less supports than they would receive in a nursing home but be happy then that should be their goal, people should honor and respect that.*

<u>Collaborative Transition Teams and Partners</u>
Teamwork and partnering is an additional strength of MFP. In the fourth year of the demonstration, transition teams exhibited continued success in working together to meet the goals necessary for consumer transitions. In addition, waiver programs built on existing partnerships to seek the resources required to support a growing number of individuals transitioning to the community.

> *We work together and I think that's helped. When we're all team players and we're all on board. Even though I'm looking for housing and that's my role, I still do other stuff and so does the transitional coordinator and we work together as a team and I think that's what has helped.*

> *Our transition coordinator is very good and interacts with us a lot. They speak to us about the residents and we collaborate a lot...Our building, our transition coordinators are excellent.*

It was an individual who did not fit into a waiver and we were able to work with Dawn and with the waiver that she went with and we were able to get her assessed and get her on it, so it took a lot of collaborative work to be able to get her to be able to come to the community and it put the department of DSS and other waivers working together and the caregiver and the transition coordinator together to make this accomplished, and we moved mountains, it's a wonderful thing

Positive Communication

Although some challenges still exist, respondents noted that communication has improved during this fourth year of program implementation. The major opportunities for positive communication revolve around opening the lines of communications so all parties are kept informed and updated on current initiatives and any new changes to the program. Open communication is an essential part of the success of any program and respondents felt strongly about it.

The communication with the staffing has been very good. Central Office staff communicates with the line staff very well.

Any mailings that are going out, if things are changing, and they are sending out any letters, these talk about the changes in the program and what's going on.

We have a process here…that if there is a problem with a partner agency, a sister agency, who we are working with, that we go directly to that supervisor or director and if there isn't any resolution then we go to the contractor, the department of social services. Its' a good process, I'm glad we put that in place.

Barriers and Challenges

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

➢ Programmatic Barriers

➢ Barriers Specific to Transitioning Consumers

➢ Education and Training

➢ Communication Challenges

Programmatic Barriers

Programmatic barriers mentioned by key informants during the fourth year of the project include:
- Funding and staffing

- Community supports and program limitations

- Policies and procedures

Even with an increase in MFP Central Office staff and the addition of transition and housing coordinators, lack of necessary funding and staffing remained the primary programmatic barrier during the fourth year of implementation. This challenge includes frustration in not being able to provide resources for items MFP does not pay for, an inability to reward workers through an increase in wages, and more staff in Central Office to process care planning assessments so these can be completed in a more timely fashion.

> *Appropriate fees need to be worked on and developed. Can't expect community-based agencies to do services and not be covered for the total cost, that's a problem when you're banking a whole system on that. That's a challenge. I think community-based agencies are doing that right now, but how long will they be able to do that if it's not covering the cost of the service. I think the dollars need to make sure they're covering these extra services, I really do. Here at this agency, we are paying below average wages for the services that we're providing for our TC and our housing coordinators. The dollars are not available. They do it because they believe in the program. They believe in the system, not because they are making any significant dollars out of it. There is not anything comparable to change staffing positions and that's unfortunate.*

> *Resources and TC morale. Finding resources for items MFP does not pay for and finding incentives for staff since they have not had an increase in pay for a few years. There was no increase in our contract so we did not have the funds to increase the pay rate. The increase promised a few years ago from CO did not materialize so we are challenged in finding ways to reward our staff.*

> *So when they're doing – when they're doing care planning assessments, those are – there are two people in central office that write those care plans for the whole entire state. And so I would say one of them, absolute one of the biggest barriers to the whole entire program, is that they don't have more people writing care plans and assessing people. And they don't have people who are doing that regionally.*

> *Just more people involved to speed up the process and make sure the supports are maintained in the community once they're out there.*

Other limitations of the program that were perceived as barriers include issues related to Home and Community-Based Services and the different waivers, whether the lack of service options, allocation of money, or different supports among packages.

> *If you write down PCA Waiver on that sheet and fax it over to Central Office, you know there's going to be a wait before the person is assessed. You're talking months before a local DSS worker goes out to assess that person for a PCA waiver. Or you know if someone goes out on an ABI waiver, you know the whole process will take at least a year or longer. You can't get anyone out with a brain injury sooner than a year. Transition usually is supposed to take about 6 months, but on an ABI waiver, it's much longer.*

> *Where the person is going to live can become an issue if they need home modifications and it becomes an issue if they go under a particular waiver that has a cost cap that's low (like PCA waiver). On the PCA waiver there's a limit to home modifications – just over $2,000. On an ABI waiver, the budget is bigger,*

around $10,000.

Additional challenges mentioned include limitations in MFP information, such as standardized policies and procedures that change rapidly making it difficult to stay current with them.

> *I think there's been some frustration as far as procedures go within MFP because it's thinking out of the box, we change so rapidly that sometimes I am not sure what the procedure for today is.*

When asked for suggestions regarding these barriers, respondents gave multiple recommendations, including:

♦ Increase funding and staffing.

> *I think it would help the project in trying to make decisions and keep moving forward… Dawn is trying to keep track of so many things. Sometimes it's hard to keep her focus on things because she's just… she's got so much going on. And I think it's probably hard for staff to keep up with her. And so if there was somebody or something, a right hand person that could help her with that would be really beneficial to the management of the program.*

> *An increase in the contract so salaries could be increased would be awesome.*

> *There's been great education out there so I really think that if we had more staffing resources and a little bit more structure we'd be unstoppable.*

♦ Allow more accessibility to a variety of consumer supports across programs.

> *We need to bring down the silos of networking and programming. Like you only fit into this program, this specific one. We need more working blurring of some of those boundaries that say, this is the person and the need and these are the multiple funding sources that will pay for that as opposed to, this is the person and this is what they need and we need to fit them into the options that are available for them. That doesn't work. This gives us more freedom to solve their issues.*

♦ Provide policy and procedures information in a centralized location that's easily accessible.

> *If there was a standardized policy or manual for things like prior authorizations saying you know, for assistive technology this is the code and just having that, either everyone having the same book or having access to the information on a centralize website where we could go and type in what we're looking for and have the instructions there for us.*

> *I think that one of the things is, you know, we've started to gain more clarity but it would be nice if there were more written procedures from the MFP unit about what they're doing and what the programmatic expectations are. I know it's a demonstration project so it's hard for it to be structured as kind of like our more established programs. But really the only kind of written procedures, which currently need updating, that were written about how social work interacts with*

MFP were written by our unit.

♦ Create opportunities for information sharing to increase awareness and strengthen the program.

I would like to be a part of the planning process on things that affect or significantly impact our agency or how we operate our program. I realize this is a state program and we are not a state agency, however, we could really problem solve as a group. The resources and knowledge of some of the people who have been involved in transitioning people to community based living for many years prior to MFP are not being tapped. I would also like to have "official" communications about important issues so we are all on the same page.

I think minutes of meetings would be helpful to be disseminated to all the participants, I think if there is a policy or program change an e-mail to everyone, I don't know if they'll ever develop policies and procedures and I know some of the reasons is because it's an ever changing paradigm shifting program that as soon as you write it, it could change, but something in between of what we got and that is needed, I don't know how else to explain it, even like an e-mail in bold that stands out "MPF change" that would highlight it, that would be great.

Barriers Specific to Transitioning Consumers
The barriers to transitioning consumers include:
- Length of time to transition

- Housing

- Community supports

As in year three, the length of time to transition continues to be a challenge. Even with the increase of field staff in the fall of 2012, respondents still saw long waits for consumers to be first seen by a transition coordinator from when the consumer was referred to the program. Housing barriers, especially finding housing or getting modifications done, also often lengthened the time to transition. If targeted for the Acquired Brain Injury (ABI) or Personal Care Assistance (PCA) waiver, there was additional time waiting to be assessed by MFP, given there were only two MFP social workers covering the state. Getting a neuropsychological assessment done often caused even more delays for those applying to the ABI waiver.

If we identify a client in the facility that wants to be back in the community, may or may not have housing, but we offer up the program to them... by the time we make the referral to the time we're able even have them come out for first interview, it could be quite an extensive period of time. The clients on this end are, they hear about this wonderful program that's out there to assist them with the transition, but it seems like it takes them forever to even start talking to people about it.

Successful transitions depend on finding the best suited community housing for that individual. Many housing barriers exist and were mentioned, including locating affordable and accessible housing, getting home modifications, and regional issues. Some respondents also reported the

need for more structured or supported housing, especially for people with alcohol or substance use issues.

> *Well, even from the beginning starting to find vendors who are willing to come out and do the assessment, once they do the assessment getting them to get back to me with the information that I need to submit, for the… you know, home modifications that they put in place. Unfortunately a lot of my folks once I've had the home modification, you know, the estimates done they then decided not to return home to the community or their health it's changed so it's not feasible for them to come out back to the community at this time.*

Insufficient community services and supports remains a key barrier to transition such as, not enough hands on support, no transportation in the area, or lack of mental health supports, support brokers for PCA clients, or any other support necessary for the person to live in the community successfully. This barrier was especially difficult to overcome if the consumer had little or no informal supports.

> *I think that in some cases we are trying to conduct transitions…when the infrastructure isn't as ready. You know, in terms of whether it's housing, or whether it's some of the services that are really needed, or whether it's supportive housing, or whether it's mental health treatment and capacity. I think our community based capacity and systems are lacking, you know, in some cases.*

Other barriers mentioned by respondents include legal issues, family members opposed to the transition, transportation to view apartments, unsupportive facility staff, finding a home care agency willing to take a client with a challenging past, and transition coordinator workload. Another respondent spoke of the need for culture change in both the nursing home and homecare agencies.

> *Again, social workers from nursing homes not willing to let…. Be willing to allow people to accept risk. And not having the 24 hr. supervision that would be ideal for them, have the ideal situation. Nurses in the community again, also not willing to allow people, be willing to accept that people can have the right to make choices that wouldn't, might not exactly be the perfect solution but that's the solution for them. And you're giving the people the opportunity to be in the community and what… normally would be a risky situation but them just being able to… that's their choice and them embracing that client choice.*

Respondents had various suggestions on how to overcome or prevent some of these barriers, some of which will be implemented in 2013:
- Provide for a step down unit or transitional living where consumers would learn self-care and life skills

- Have a clinician or care manager do an initial screening and assessment before transition coordinator assignment, to determine if transition is feasible for this individual

- Provide greater mental health and substance use community support

- Create better support services for family members or informal caregivers

- Create a position which would take over the home modifications piece

Education and Training

Although respondents were pleased with the improvements in the training, specifically of the field staff, they also felt there was room for further improvement. Once again respondents saw the need for a consistent, standardized curriculum and training program.

> *People should be on the same page and the training consistent around the state. First we had trainers, then no trainers with CO doing some training. I hope the new training program evens the playing field.*

> *I think it needs to be more standardized, and we're working on that right now. But I think it needs to be more standardized, and it needs to be a level of accountability for having achieved competencies.*

Care managers and social workers expressed a desire for more training on the procedures of the MFP transition process, and other stakeholders mentioned the need for more care manager training as well.

> *…for people in our office, we have dedicated assessors. If there was a training to go through the process with us, explaining, you know, going through what paperwork needs to be done, why it needs to be sent, to whom it needs to be sent, and walking us through the process so we kind of have a better idea going into it of what is expected of us. And the reasons for doing things, I think that would be very helpful. Definitely more trainings on the Home Modifications process, what we need, who we need to send it to, where we need to send it to, and you know, the whole process would be beneficial.*

The continued need for education of staff working in long term supports and services and the larger public was also noted.

> *I think there's a definite lack of education, not education… a lack of knowledge on behalf of social workers about what the MFP program is. I don't think consumers in the nursing homes are made aware that of the possibility often that the MFP program exists for them and what it can offer them.*

When asked for recommendations regarding future training, respondents gave multiple suggestions, including:

♦ Archive the current trainings as webinars, for the benefit of both new and veteran field staff.

> *I would like to see it archived. So that if a new TC or Housing coordinator came down the pike, they could go back and look at the archived training and be able to either start there or refresh there. Through webinars. So if they could do that, archive those types of training, that would be ideal. Just so that anybody could go back, a new TC or someone who's been here for a while who says, I hadn't done this for a while, whatever the topic may be, to go back just as a refresher and go back and look at the webinar again.*

- Provide clear expectations regarding the roles and responsibilities about each team member, including the transition and housing coordinators and waiver care managers. *Where a role ends and where another one begins and having respect for that and expectations about that so that the TC doesn't ever feel like they are having by default having to do something. And there are very clear expectations of who should be doing that and they should be held accountable for that…*

- Provide ongoing, up to date training regarding the changes to the website and MFP policies and procedure changes.

    Training regarding the changes to the MFP system, or training on the database and changes in it is important.

- Conduct skill development training for all field staff, including care managers covering personal development skills, working with ambivalent consumers, family members with disagreements, nursing home staff, and other partners involved in the transition process.

    How do you work with the nursing home staff? Whose role is to do what? Who do you get involved to provide decision support for ambivalent people? And how do you work with family members that have a disagreement? And I don't think that's education necessary just for TCs, I think that should be a group education you know for TCs and for case managers who are working on transitions. There are a lot of skills needed.

Other trainings requested by respondents included education regarding consumer direction, person centeredness, working with specific types of disabilities, unique procedures of the different waiver programs, and the participant risk agreement. One respondent mentioned the need for disability awareness training for facility staff, while another suggested specialized training, including home modifications, for waiver care managers who assess or work with MFP consumers. One novel idea was to have joint training for social workers and transition coordinators and using it as a way to build rapport and understanding.

    I think one other thing that would benefit training is to have them listen to the voices of the families and the individuals that they transitioned themselves. Have them tell their stories, what worked really well… what didn't. I think that would be most effective training.

The housing coordinators interviewed reported similar needs with respect to education or training. Both expressed a desire for more in depth training mirroring that given to transition coordinators, in order for the housing coordinators to participate fully as a member of the transition team. Housing coordinators also requested specialized training beyond filling out RAP forms, such as working with different disabilities, or perhaps have housing staff from other waivers, specifically the Department of Developmental Services (DDS) and the Department of Mental Health and Addiction Services (DMHAS), conduct a training on what they have found to be successful for their consumers. Other housing specific topics included fair housing and ADA policies, working with landlords, and working with unique geographic challenges. One housing coordinator suggested including complicated housing case scenarios on the MFP online blog.

[Housing coordinators] should have some connection to the person-centered training and to the pieces, like even quality of life. Like how is this – don't just find an apartment because you have a benchmark coming up or you have a date. Try to find a home for this person…[not] just looking for an apartment…. Where there is quality of life, where there is a connection. Like there, there is a library around the corner because this person loves to read.

Some of these recommendations are already being incorporated into the 2013 year – in particular standardized modular training for all field staff and specialized engagement training for a newly developed field position.

<u>Communication Challenges</u>
Although some respondents felt that the communication process already in place works well, others described the communication as fragmented and untimely across various agency levels. Many respondents expressed that the occasional emails that they get with bits and pieces of information were not enough for them to feel fully aware of all the changes and ongoing initiatives within the program. Participants often felt that they were only informed of different situations and plans after it had already occurred, leaving them frustrated and confused. Thus, respondents expressed wanting the communication process to become more consistent so they would not receive information second hand. This lack of coordinated efforts in communication further complicates already complex situations.

I think communication could be much improved. Coordination could be improved. We've had a number of situations that have not gone smoothly that could have if communication had been better. Too much room for breakdown; I don't feel I'm kept up to date on programmatic changes. There are no regular emails with this information.

Respondents suggested putting in place a more effective communication system. Currently, most communication is done through emails but have to look for alternative sources of information; usually supervisors or other staff who work directly with Central Office. Other respondents echoed this feeling by stating that they are not kept in the loop. This communication breakdown seems to be more prominent across organizational levels; for example, those individuals closer to the nucleus of the program mentioned fewer gaps in communication whereas line staff reported a greater disconnect. The coordinated and purposeful dissemination of information seems to be minimal, at best.

My supervisor shares some information from the steering committee but I don't get much from anywhere else. I think the TCs and housing coordinators are kept in the loop but the rest of us don't get enough information.

There's monthly supervisors meetings but what comes down to it they'll say, "here's what happened and well, you don't have to know that, it's not related to housing"; so they'll basically give you the snippet of what might be related to housing or not. So it doesn't let you, as a housing person, know what the whole program is about.

I would like more direct communication back to the facilities whether it's through letters. I mean we only have the intake line where we make the referrals and we do call back to see where they're at but other than that my only other contact with

the program is through a Transition Coordinator who usually hunts down the information and gets back to me.

Additionally, those involved in different parts of the program described a re-occurring situation where things would change quickly and many times they would not be informed of the changes. Although some of those quick changes can be attributed to the nature of the demonstration program itself, the fact that staff is not aware of such shifts leaves them feeling frustrated and discouraged. As the program continues to grow, efforts need to be made to find ways to better include all those involved in the program.

If there's a change in direction for whatever reason…and if something happens right after the last steering committee meeting, by the time the next one comes around, it doesn't get communicated so things move fast and that makes it hard.

I think about the 24/7 triage… we're not considered a part of the transition team, which is a bit unfortunate. I think that often I do not know what changes are happening, even if it pertains to transportation or some changes… durable medical equipment or personal care. There really isn't… I have not been a part of that listserv, that group. I often have to hear it from another way.

Sometimes I think that, you know, I'd like to know as things change at Central Office, but my experience has been – and [CO staff person]… would say, "What I'm telling you today holds true until 5:00pm today."

Respondents made suggestions to improve communication including:

♦ Increase the frequency of emails that are sent out and make sure all staff get the same information at the same time.

But I don't' think that it's necessarily that the vision is unclear or that the broad expectations of the program are unclear across the system. I think folks are very much aware of the goal and intent of MFP and the benefit of this enhanced retention of community based support. But I think that again on the line staff level there need to be more communication; we need to continue to stress that as managers across the system. And if we continue to do that I think we'll be fine.

♦ Publish a newsletter or have a centralized bulletin board for bridging some of the current communication gaps.

I would also like to have "official" communications about important issues so we are all on the same page.

I would like to hear something about what we have done well. Just a little something good I can pass on.

♦ Ensure better coordination of meetings to support a more effective communication process, making sure agendas are sent prior to the meeting and that all the parties are informed of the topics to be discussed at meetings so attendees can prepare beforehand.

Sometimes contractors meetings are a little frustrating; there's never an agenda, we never know what we're walking into. When we walk into a contractors meeting, we don't know what the current topic might be. I'd rather be prepared to go and attend the meeting. No agenda given ahead of time.

♦ Strengthen communications between staff and communication with the nursing home facilities. Supporting these relationships is crucial to prevent duplication of efforts and to create a more cohesive team.

As simple as if the MFP coordinator would send a tickler and update the social worker. It's as simple as that – update the social worker. Another case, I have, a gentleman has been approved for a year and he's still in the nursing facility and I had to go back and say: what's the status? I heard but not officially and didn't get anything in writing. There's been a status change and I had to inquire to find out that the family decided that they're withdrawing because there's not enough care for him at home and he's digressed medically. The follow-up should be consistent.

♦ Reinforcement of already established procedures and protocols are needed to make sure processes are being implemented the same by all. This will eliminate some of the questioning back and forth and crease some consistency across the program. Efforts should be made so that everyone is on the same page and everyone feels included.

If there was one person up in the main office that could be a contact to answer any questions or disseminate information back to. If there was somebody specific that could be appointed to have contact with the nursing homes and people who have clients in the process of transitioning.

♦ Create an assistant director position. A person in this position would work closely with Dawn Lambert and assume some of the programmatic responsibilities she's been overseeing, including a focus on more consistent communication.

Dawn should have somebody under her who is responsible for the operations so she could be responsible for the outreach and new issues, new items; broader picture. Someone who could devote part of their time to keeping communication a little more consistent.

Program Developments, 2011-2012

Program developments for 2011-2012 involved the following:

➢ Program Expansion

➢ Performance Standards

➢ Dedicated Care Management Position

➢ Participant Risk Agreement

➢ CT Strategic Rebalancing Plan

Program Expansion
Year four was one of expansion for Connecticut's MFP program. Almost 500 consumers transitioned in 2012, including 127 Track 2 transitions. Three more nursing homes also closed in 2012, and by the end of the year, 379 long-term care beds had been removed from the state (334 beds from closures and 45 additional reductions). Several program enhancements were also initiated in 2012. Increased funds in the second half of the year facilitated the hiring of approximately 20 new field staff positions, including providing housing coordination for each transition coordinator site, and the creation of a new transition coordinator contractor to cover northwestern Connecticut. In response to transition coordinator contractor requests, Central Office redirected some of these funds to pay for transition and housing coordinator supervisor time at each site, and monthly transition coordinator supervisor meetings were implemented in September, 2012. Respondents were pleased with this change and felt this would provide an opportunity for direct communication from Central Office to field staff focusing on MFP procedures and new developments.

> *… the things that I do learn are probably from the Supervisor meetings. If I'm going to learn it anywhere, I'm going to learn it there.*

> *It seems sometimes, one thing that we have done which I think is going to help make things more consistent is we have appointed supervisors at each agency, and once a month the supervisors come for a meeting. So I think that having other people kind of responsible – they're the ones who come and sort of get into our culture, and then it's their job to keep the transition coordinators hopefully moving and everything. I think that's going to help…*

Performance Standards
The fourth year of implementation also included the initial implementation of the transition coordinator contractor performance standards or benchmarks, which are tied both to monetary bonuses and, if the baseline standards are not met, continued funding as a transition and housing coordinator contractor. These were met with mixed reactions from contractors already concerned about transition coordinator workload and relatively low pay, although one expressed that setting standardized performance expectations was an achievement for the MFP program.

Dedicated Care Management Position
One program development, initiated not by MFP but by two of its partners, was the creation of dedicated MFP care managers for their clients. This should create greater cohesion between the transition coordinators and the care managers in those programs, with the goal of a smoother, successful transition.

> *I think we can always do a better job of that. I think there always needs to be more understanding of our systems and how they work and there can be a lot of misunderstanding about how people are doing things without really understanding our systems. I think by us having dedicated staff it's making it easier so it's not like every time they get a person for MFP from [state waiver] they have a whole new case manager to deal with. They're getting used to and they're working out relationships, so I think from our advantage having a dedicated staff is definitely an advantage for our folks.*

Participant Risk Agreement
This fourth year was also the first full year of implementation of the participant risk agreement. In 2012, 101 consumers (20%) who transitioned had signed a participation risk agreement,

compared with just five percent (n=18) the previous year. Overall, respondents were pleased with the incorporation of the participant risk agreement into MFP and felt that it was a good way to support self-determination and empower the consumer. Some respondents felt it encouraged culture change, while others wanted community providers such as home care agencies to have a larger role in the process.

> *I would say that at least having that discussion and talking about risk has started to change how people think about it, and that it's about allowing people a choice. And I think that's positive. I think that just even, you know, having those conversations and really starting to change how we view that is really important.*

> *Well, I think it's changed the culture a little bit. And hopefully a little bit closer to person centered planning than the medical model, and I think it's achieved that to a certain degree and I think that… it's a reflection of the fact that, you know, we are changing the way of thinking at least a little bit.*

There were a few concerns expressed. Several people felt it should always be the care manager or a clinical staff person, not the transition coordinator, who completed the form, while other respondents wanted more training on it. Two of the three nursing home staff interviewed expressed concerns about the process, and felt that for some particularly vulnerable consumers, signing a risk agreement just to get out of the nursing home was not always a good option decision.

> *Well, I think there are certain levels of risk, absolutely, that you can allow to return to the community on but I think there has to be kind of a line that can't be crossed. Somebody who isn't physically able to get themselves out of bed or into a wheelchair or out of the house should not be allowed to sign a risk agreement saying they're aware of the risk but their desire to be home outweighs their the risk of being home alone. Versus somebody, you know a diabetic who is very unstable often falls, into goes extremely high or low, has a diabetic crisis, or something who is young and alert and oriented I guess they have a little more physical ability and there may be other options out there to assist them with that kind of thing that would allow them to be safe in the community.*

CT Strategic Rebalancing Plan
During this past year, there was an even greater inclusion of MFP programs and initiatives into the Governor's strategic rebalancing plan. For example, the Governor incorporated verbatim the workforce strategic plan created by the Workforce Workgroup under the leadership of the Commission on Aging. The right-sizing strategic plan was also announced in 2012, and in 2012 the nurse delegation law passed, which will allow medication administration by unlicensed personnel. All of these initiatives support the vision and work of the MFP program.

Conclusions and Recommendations

The fourth year of MFP was characterized by expansion and included numerous achievements and successes. Nearly 500 individuals were transitioned. An increase in funding enabled the hiring of 20 new field staff including transition and housing coordinators. Respondents also reported a growing awareness of culture change, effective program leadership, enhanced training and education, and website development. Many of the same strengths and supports established in the early years of the demonstration were reported to facilitate these

achievements and successes and include the commitment of staff and stakeholders to the project, support for community living, collaboration among transition teams and partners, and positive aspects of communication in the partnering process.

Overall, the following areas of successful development continue to contribute to the efficacy of the program and are enabling the systems change the project seeks and supports:

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

➢ Increasingly more individuals continue to successfully transition from nursing homes into the community – this feature alone is causing systems change in Connecticut.

➢ Culture change is more apparent as people realize that individuals who were living in nursing homes are capable of living in the community safely with supports and services.

➢ Connecticut's leaders and legislature are becoming increasingly aware of the MFP program and its achievements and are demonstrating their support in rebalancing the long term supports and services system.

As with any program, there were barriers and challenges and these centered primarily on certain programmatic barriers, barriers involving the transitioning of consumers, education and training, and communication. Although there weren't nearly as many nursing home closures as in year 3, there still were some that tested the resources of the system. While the addition of housing coordinators greatly enhanced the program, there remained the challenge of finding appropriate housing for individuals and getting necessary modifications completed where required. Communication regarding updates in policies and procedures and more consistent communication overall was also reported to be an ongoing challenge.

Recommendations from this evaluation include:

➢ Provide standardized training and updates regarding the MFP program and its practices.

➢ Provide enhanced community supports specifically for alcohol and substance use issues.

➢ Increase self-direction supports for consumers under age 65 transitioning on the PCA waiver.

➢ Improve communication of program and policies changes.

➢ Evaluate workgroup structure.

Provide standardized training and updates regarding the MFP program and its practices
Respondents recommended that MFP provide standardized training to field staff and others with accountability for achieved competencies. Further, respondents requested updates regarding the MFP program and its practices; the dedicated care managers from the Home and Community-Based waiver programs particularly expressed this request. It was also suggested

that joint trainings, for example with transition coordinators and social workers, would be helpful as part of the learning process and understanding the roles of various people in the program. In addition, some respondents suggested that specialized training would be beneficial and that learning more about risk would defuse some of the anxieties that exist about the Risk Mitigation policy. Learning from the stories of individuals and families involved in transitions was suggested as another effective approach to helping staff learn about the program.

Provide enhanced community supports specifically for alcohol and substance use issues
Creating a continuum of care for people experiencing alcohol and substance use problems is challenging, but necessary. Collaborating with community providers to create a coordinated, systematic response to the complex issues of addiction and delivering essential supports are elements of new approaches to develop a framework for integrating treatment services for substance abuse issues and co-occurring mental health disorders and would be useful for individuals in the MFP program. These supports might also potentially reduce some of the risks people are concerned about, particularly with this subset of consumers. The new substance abuse demonstration service should address these issues.

Increase self-direction supports for consumers under age 65 transitioning on the PCA waiver
People with disabilities seek to live their lives in the same way as individuals without disabilities, but are often frustrated by barriers created by the cultural environment, such as discrimination. Although social service systems cannot eliminate all the obstacles arising from society's stereotypes and cultural norms, it is possible to provide services and supports in a way that give control to those receiving services. This fosters greater independence and autonomy among service users.

Self-directed supports are a facet of the larger self-determination philosophy. At the very least, systems should not create barriers that prevent individuals from participating in the various aspects of family and civic life, but should support and enable them to participate in directing their care to the degree that they want to. Attributes of direction and control that would be important to promote include factors such as: person-centeredness, enriched life opportunities, respect, valued roles, and legal rights. The new support broker service in the PCA waiver should increase consumer direction and enable a consumer to make a significant difference through his or her own actions in the type of services he or she is receiving. Such support would also enable them to be involved in key decisions regarding the design and operation of the services they receive.

Improve communication of program and policies changes
Communicating program and policy changes is fundamental and vital to programs like MFP. The exchange of information is essential to run a program efficiently as well as to build and maintain relationships. Sharing information through electronic mail and computer-aided communication has dramatically improved the efficiency of communication, but as suggested by several respondents, needs to be focused on programmatic changes and be more consistent.

Respondents reported that intraorganizational information flows downward, upward, horizontally, or diagonally, but that going forward, it would be most beneficial to make sure that when there's a program or policy change, everyone who needs to know about it is informed in a standard way.

One respondent suggested designating a specific person at Central Office to coordinate information dissemination and answer programmatic questions. Developing a standard format

and mode of communicating program and policy changes could potentially help overcome the barriers to communication currently being experienced.

Evaluate workgroup structure

Similar to last year, only a few workgroups met regularly during the fourth year of the program (See Appendix A). Members wanted to meet more frequently for continuity, especially those in the contractor and evaluation workgroups. Respondents also suggested that they would like more information about the development of policies and procedures and opportunities for feedback related to them. In addition, advance agendas would be appreciated and enable workgroup members to be more prepared for the meetings that do occur.

Appendices

Appendix A: Workgroup Descriptions

Appendix B: Key Informant Interview

Appendix A: Workgroup Descriptions

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
Steering Committee	"Yeah, I mean we're supposed to be a policy setting entity, and it's impossible if you're not fully informed about what's happening. So I feel like the Steering Committee is usually trying to run to catch up with what Dawn knows and experience." "The Steering Committee meetings provide information related to the program and any new issues or developments." "I attend the Steering Committee meeting and find them very helpful. They're well organized, and it's helpful to hear what's going on. They do a good job explaining different things and giving input on what's happening in the future for MFP."	Once a month. Satisfied with frequency.	Yes	Yes	"I think that they're necessary in that these are stakeholders in the community and this is the only way that they can understand what's happening with the project. And how it changes from week to week. Aside from that, I think there's tremendous value from – you want the stakeholders to be educated and informed and to remain positive. I mean. There are challenges that come with this program, and it does give them an opportunity to discuss any concerns that come up, so I do think it's productive for that end." "We've been struggling with involvement from actual consumers…We have a 51% benchmark that we must meet, and that's something that we're trying to address right now as far as involvement…But I feel that we've done a disservice to the very folks that we're saying we hope they have a voice by… you know, getting them as members to come to a monthly meetings. I think there are far more meaningful ways that we could get input from participants or adults or persons with disabilities beyond dragging them to these meetings." "I would like to see [it] focused more on spending time on the policies and, you know, important initiatives that are happening than some of the discussions that sometimes occur."
Contractor	"For the Contractor's meeting, it's mostly for the	Quarterly	Sometimes	No	"Sometimes Contractor's meetings are a little frustrating; there's never an agenda,

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
	transitional coordinators and agencies. It's informative to know what the issues are for the TCs and the agencies so when we get the payments, if we don't get all the right information from them, we have a better understanding of what's going on their end and can adjust accordingly."				we never know what we're walking into. When we walk into a Contractor's meeting, we don't know what the current topic might be. I'd rather be prepared to go and attend the meeting. No agenda given ahead of time."
Evaluation	"The first one that I attended we were looking at proposed benchmarking in a performance measurement aspect… that's been the primary focus. We've taken a look at the quality dashboard… I think that's really been it."	Quarterly "I think it meets quarterly, and at least one meeting has been cancelled. So I would say that I would be happy to meet more often."	Yes	Yes	"I think that the quality dashboards that have been produced are terrific. I think that's great data and important and helpful; and I think, you know, these type of process evaluation and taking a look at what does help and what does interferes are also very helpful data."

"They are generally productive and interesting."
"I think it is helpful to know what kind of measures or evaluation tools are being used, so I think that's helpful. I think it's also helpful to… have a varied group that's sort of looking at that and talking about that so I would say that that is helpful… I'm not sure that I see all of the steps in between. So if a tool is presented and the group has to provide feedback on it, I don't see what happens to that feedback before the next iteration; so that would be the only thing that I would say that would be perhaps more helpful." |
| TC Supervisor's | "I think that there's an | Monthly | Yes | Not | "I've never walked out of there |

Workgroup	Strategic goal	Meeting frequency	Agendas provided	Minutes provided	Comments
meeting	agenda based on questions and concerns that come from Central Office, and they're addressed."			consistently	disappointed and not, you know, [had] any questions that are asked are answered so, no, I don't think anything's not been helpful." "I like them a lot. I really do and I always come away with something and I know Rome wasn't built in a day, but I think they're beneficial. I always walk away with something."
Workforce development	"During the development of the workforce strategic plan development the workgroup was productive. Since then the workgroup has lately been serving as an advisor to the development of the MyPlace workgroup…"	Workforce subcommittees meet monthly	Yes	No	"Usually, there is an agenda developed before the meeting. And we follow through the agenda. We usually try to end with next steps." "We have not met as a full group in quite a while, but we have had smaller break-out subcommittees from the larger committee meet almost once a month during the development of the MyPlace website." "I would say that is very well organized, it's driven purposefully. We only meet when there is something to meet about. And with strong leadership by the Commission on Aging."

Appendix B: Key Informant Interview

Role

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

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

2.   What has your experience been like in that role?

3.   [If not yet answered] Are you on any committees, workgroups or transition teams?

Meetings/Workgroups (only ask steering committee, active workgroup or transition team members)

4.   Please describe a typical [workgroup, committee, or transition team] meeting.

      Use probes to cover the following:
4a.   Who usually attends the meetings? I'm not looking for names, just the roles they play.

4b.   How often do you meet? Is that enough?

4c.   Who usually schedules and runs the meetings? Are there agendas or official minutes?

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

4e.   How do the [transition team, workgroup] members make sure that the goals set in the meeting are met?

4f.   Are there ways in which the meetings are not helpful (or impede the transition process)? What would you change to overcome this?

MFP Program goals and progress

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

5.   What are the goals or objectives of Connecticut's MFP program?

6.   What have been the major achievements (as they relate to your role) of the MFP program over the past year?

6a.   What has supported or facilitated these achievements?

7.   What barriers or challenges have you encountered in your role with the MFP program encountered in the past year?

7a.   What could be done to prevent or overcome these difficulties in the future?

Structure and process

8. What do you think about the way Connecticut's MFP program is currently organized or structured?

    Use probes to cover:
    8a. How well do you think the current structure works?

    8b. Is there anything you would like to see changed about the organization or structure of the MFP program?

9. [If not yet answered]: What do you think of the way the Steering Committee is structured?

    Use probes to cover:
    9a. How well do you think the current Steering Committee structure works?

    9b. Is there anything you would like to see changed about the organization or structure of the Steering Committee?

10. How are you kept informed about the current activities or new initiatives of CT's MFP program?

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

12. Please describe the interaction between the different organizations or groups which are working together on this program.

     Alternate Question:
     Is there anything you would like to add about how the different organizations or groups work together on this project?

     Probes if needed:
     12a. How well do they work together?

     12b. How do they resolve any differences?

13. What are your thoughts about the education and training of the MFP field staff, such as the transition and housing coordinators?

     Probes if needed:
     13a. What would you say is working well?

     13b. Are there things you would change about the education and training process?

14. [If not yet answered]: What would you like future trainings to focus on?

Risk mitigation

15. What are your thoughts about the risk mitigation policy and the Participant Risk Agreement? (If they don't know what it is say, "The form signed by the consumer and care manager that lists potential risks in their care plans and steps to mitigate the risk, which is

backed by the CT Departments of Social Services and Public Health." If they still don't know about it, just record that).

16. What impact has the Participant Risk Agreement had on Connecticut's MFP program?

<u>Program activities related to systems change</u>

17. We are interested in any changes in CT's long term services and supports system. In your opinion, what MFP program activities have had the biggest impact on rebalancing Connecticut's long term services and supports?

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