



# Money Follows the Person Rebalancing Demonstration

## Process Evaluation Year 6 January-December 2014

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### Prepared by

Julie Robison, PhD

Kathy Kellett, PhD

Martha Porter, BA

Kristin Baker, BS

Pamela Higgins, MS, MPH, CPH

UConn Health | Center on Aging

263 Farmington Avenue

Farmington, CT 06030-5215

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## Introduction

The information for this process evaluation came from the analysis of interviews with key informants reflecting on the operation of the Connecticut Money Follows the Person (MFP) Demonstration from January to December, 2014 when the sixth year of program operation ended. A yearly process evaluation is useful to monitor program activities and how well they are delivered. It provides tangible evidence that important resources are benefitting consumers. An evaluation also helps determine what is not working in a program and provides information that can be used to improve implementation and strengthen program effectiveness.

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

## Key Informants

Twenty-seven key informants completed telephone interviews reflecting on their experiences in the sixth year of program implementation. Administrative respondents included the MFP Program Director, an MFP staff member (randomly chosen), Co-chairs of the MFP Steering Committee and an additional randomly chosen Steering Committee member, and the four Medicaid HCBS waiver managers. Contractors included the directors or representatives of four contractors who employed specialized care managers, transition coordinators, and/or housing coordinators, and one fiscal intermediary. Nine field staff were interviewed: three each specialized care managers (SCMs), transition coordinators (TCs), and housing coordinators (HCs). In addition, two Transition/Housing Coordinator Supervisors (TC/HC Supervisors) and two Specialized Care Manager Supervisors (SCM Supervisors) were interviewed. A facility social worker and a community provider who worked with MFP field staff on transitions were also interviewed. Information and comments from all key informants were synthesized into this report.

Each interview assessed the respondent's experiences regarding the MFP program goals and progress, meetings or workgroups, communication, education and training, achievements, and challenges. All interviews were audio-taped and transcribed. On average, interviews lasted approximately 30 minutes. All were analyzed using ATLAS.ti, a qualitative data analysis program. Similar to the previous process evaluation, overall results of the analyses fell into four basic categories, covering achievements, strengths, challenges, and program developments. An additional category to cover the New Transition Process was added for this year. Appendix A comprises information on MFP committees, meetings, and workgroups.

- Achievements and Successes
- New Transition Process
- Strengths and Supports
- Barriers and Challenges
- Related Program Developments, 2014

## **Achievements and Successes**

Achievements in 2014 identified by key informants fell under five categories:

- Implementation of New Transition Process
- Number and Speed of Transitions
- Continued Culture Change and Person-Centeredness
- Increased Housing Coordinators
- Engagement and New Demonstration Services

### **Implementation of New Transition Process**

Certainly the major achievement for many key informants was implementation of the new transition process and creation of a new field position, the Specialized Care Manager (SCM).

In March, 2014, Central Office divided the state into five regions and reorganized the field staff into cross-agency, regional teams, usually consisting of one SCM, two TCs, and an HC. The transition process itself was also redesigned. Using a targeted referral practice, a case is now first assigned to an appropriate SCM for immediate assessment and care plan development. The SCM brings in the TC and HC after the assessment is complete. Central Office staff were also reorganized to support the regional team structure, as eligibility workers, Team Leads, and nurses were all assigned to specific regions.

Year six began with a waitlist of hundreds of consumers ready for assignment to the field. Using the new process by the end of 2014, Central Office had sent the majority of waitlisted consumers to the field for initial assessment. In addition, as the first to receive the consumer's case, the SCM Supervisor could quickly determine if the consumer was a good fit for one of their programs, and if not reassign the case to another SCM Supervisor. Although releasing this backlog of consumers initially resulted in a higher number of closed cases, in the end many of these consumers were able to successfully transition through MFP.

Key informants identified many benefits of the new process, such as increased collaboration and problem-solving. Challenges were identified as well and included lack of stable teams or working with team members from different agencies. An in-depth look at the new process is provided in a separate section later in this report.

### **Number and Speed of Transitions**

As in years past, when asked to identify achievements in 2014, many key informants mentioned the number of transitions – a total of 578 consumers transitioned in 2014. Although the total number of transitions was only slightly higher than in 2013 (561 transitions), the second half of 2014 saw a large increase in transitions. There were 238 transitions in the first six months of the year, while 340 consumers transitioned from July through December.

By the end of the year, the speed of the transition process had also increased. At the beginning of 2014, it took an average of 321 days from assignment to transition. By the end of 2014, that time had decreased to an average transition time from assignment of 223 days. Many

respondents saw this as a direct result of the new team transition process implemented in March, 2014.

*I think just the sheer number of transitions was certainly significant.*

*I would say for sure a major achievement is getting patients home that prior to this program or working with this program, if you had asked me will this patient be able to go home, I probably would have said no. So, they've gotten several of our patients home with their services that I wasn't so sure in the beginning would be able to go home safely.*

*I feel like a lot more people are successfully going into the community.*

*I think like with the new changes and everything, we're definitely able to serve more people, and we have been transitioning more people out.*

*... our numbers are up and, I mean, obviously the speed of transition and the numbers going up work hand-in-hand.*

Sheer number of transitions alone does not mean the consumer's transition is a success. Connecticut's MFP program is always looking for ways to improve its transition process. When asked to define a successful transition, key informants identified several core concepts, including speed of transition, person-centeredness, remaining in the community without re-institutionalization, autonomy and choice, and quality of life after transition. The new process provides consumers in facilities with not only a choice, but the support needed to move out and live and thrive in a community environment.

*One in which the person is a part of the process. Is not just a part but a central driver in the process that's been transitioning themselves. A successful transition is when the person achieves what they set out to achieve by transitioning and not having bad outcomes when they leave. So some stability. It may be harder than anticipated, but one in which there is no harm. Their quality of life is improved, and there is no harm.*

*Certainly a transition that is person centered where the individual is able to really get into the community, community integration. It's not just bringing someone home to an apartment. It's making sure that they're hooked up with different services, different activities, that they're really being able to fully participate in their communities and doing what they want to do. So it's really looking at, at the quality of life post-transition ultimately. And what things they were able to connect to and be involved in that they wanted to.*

*Someone who's been in a nursing facility for a few years, or a number of years, who, again, either they weren't informed by the social worker what programs were out there, or the family felt, we'll use the word 'brainwashed,' that they should be in the nursing home because that's where they would be safe. So I feel like the ones that mean a lot to me – they all mean a lot to me – but the ones that I feel like I did something and I feel proud of myself and I feel proud of the process and the individuals, the ones that really didn't envision or dream of going back out in the community.*

*I define a successful transition as one where the individual established goals and objectives prior to moving out of the nursing home and that we were able to help*

*facilitate and support those goals and objectives so that when they get to the community they have that feeling of self-satisfaction and they are on their way to having the tools that it's going to take to continue to set new goals and achieve what it is that they really want to achieve... a successful transition is one that is told through the eyes of the person that we serve and that they determine for themselves whether or not it's successful based on their goals.*

*But a good transition is not only speedy, it's robust in terms of its planning and accomplishment as it relates to person-centered planning for the individual who transitions. So it's no good for somebody to move out really quickly and then not be successful, for one reason or another, or happy or whatever.*

*So to see somebody in a nursing home two years and wants to be out into the community, and MFP is there to provide him with the resources to live in the community – I mean that's a beautiful thing.*

### Continued Culture Change and Person-Centeredness

There is a growing awareness that going into a facility is not the only option. People can choose to receive home and community-based services instead. As in previous years, key informants identified MFP as a driving force behind this continued culture change in long term care. The program not only provides this choice to individuals, it also demonstrates that transitioning back to the community with long term services and supports (LTSS) is achievable.

*I think that what MFP has done is really made it clear to the community that there are choices out there, and that is very important because folks shouldn't feel like institution is their only choice. And it continues to do that.*

*And what I tried to reemphasize, a lot of times people, when you talk about talking to people about their dreams and their goals and like I very, I really never met a person that doesn't want the things that we all take for granted – being able to get up in the morning, eat what we want, cook our own foods, pick our own groceries, pick a color of our kitchen, put a bathmat in our bathroom, have our own bedspread, and pick our room.*

Person-centeredness is at the heart of MFP – in the words of one key informant, “With MFP, we are the champions of person-centered planning.” Key informants who work in the field described the incorporation of this philosophy in their everyday work.

*I tend to advocate for my consumers and really try to listen to them and find out what is it that they want, and where do they want to be, and why and who in the community or in their family is going to be near them.*

*For me, it's more of seeing the person one-on-one. You can't do it over the phone and you can't motivate a consumer over the phone; you have to be visible to them. So my philosophy is the more hands-on person-to-person approach works and is more effective in empowering that individual to want to take that responsibility in making those changes happen for them ... Most of our folks don't want to be in a nursing home. They want to be in the community. They want to be living with everybody else. I don't believe in just a normal life because everybody's version of a normal life is different. If we can get them closer to that, that's what they want and that's why we're here – to give them the resources and the assistance that they need to make this work.*

Faced with the success of MFP, the nursing home industry is slowly embracing the idea that individuals have a right to determine where they want to live. Key informants also credited the program's outreach and engagement with nursing homes, including partnering with facilities through the nursing home diversification grants. Through a competitive proposal process, Central Office awarded MFP funds to three nursing homes to expand their scope of practice to include home and community-based supports and services.

*And when [skilled nursing and rehabilitation facilities] saw that the program just continued to gain momentum and that there were, that the satisfaction is there from the clients that are placed into the community, that now it's a force to be reckoned with. And so I think that they're getting on board. I think that the attitudes are changing because it's been proven to them.*

Key informants mentioned a spillover effect of MFP, as more providers and care managers outside of MFP incorporate person-centered planning and become more comfortable with informed choice and acceptance of risk. Encouraged by MFP, there is growing realization that everyone has a right to decide for themselves where and how they want to live their lives.

*[MFP is] about people being able to make their own decisions, informed choice, like you should give people the information so they can make their own choices about what they, how they want to envision their life to be.*

### Increased Housing Coordinators

Another achievement mentioned was the increase in both field and Central Office staff, especially the infusion of additional Housing Coordinators at each TC site.

*Well the increase in the number of central office staff has helped, and the increase in the number of field staff has helped.*

*I think having housing coordinators full time assigned to 2 TCs apiece is the best thing. And in some ways, I think there could be more. That is such an enormously time-consuming job. And having them finally in a situation where they're part of the team, they're part of my staff... And we can do things that we couldn't necessarily do when it was part of somebody else's agency to contract ... But I think that that's one of the best things that has happened is increasing and knowing the value of the housing coordinators.*

*... especially having somebody dedicated to the housing. For example, we have a patient who, the only holdup was that she didn't have an appropriate place to go and they really expedited finding an appropriate housing arrangement for her.*

### Engagement and New Demonstration Services

In addition to the new process, key informants identified the addition of consumer engagement services and the new demonstration services as program achievements in 2014. Consumer Engagement services are provided by the Specialized Care Manager as he/she works with the consumer to overcome any challenges to transition. Peer Support, Informal Caregiver Supports and Addiction Services and Supports were added as new Demonstration Services in 2014. The Addiction Services and Supports comprised: Community Support Services, Peer Support Specialist, Transportation, and Transitional Supported Employment.



*I think the engagement, the additional training on engagement services for case managers.*

*I really like the idea of really digging in to people's readiness and the idea of engagement. I think having some of the new demonstration services, like the substance abuse support services, is really super, and I'm looking forward to seeing how that, what effect and what impact that has on continued stay in the community.*

*I think the addition of the supports when people transition ... Somebody who would come in and help with or supports with drug and alcohol, that kind of stuff, I think was an improvement because in the past I know that people have relapsed while they were out in the community and they actually end up going back to the nursing home without those supports. So the supports outside the nursing home when they're in the community is important, and I think that was a major thing for 2014.*

*We're fine-tuning the process by adding specialized personnel, upgrading the personnel by offering certification and having some control over the qualifications, and we're adding – as in the substance abuse – we're adding services where we can supplement what is actually within the confines of the MFP. So I think we're doing about as much as I can envision at the moment and, going forward, I guess we just have to see how it all works out.*

## **New Transition Process**

Several questions about the new transition process were added to this year's key informant interview. Almost all key informants had either direct experience with the new transition process or supervised staff members who worked in the field. Respondents also included multiple SCMs, TCs, HCs, and field staff supervisors from several different agencies across the state and from all home and community-based programs.

## **Team structure**

The new MFP structure created five regions, each with between two to eight teams, depending on the number of referrals. Most teams consisted of one SCM, two TCs, and one HC. These teams assessed consumers for the Connecticut Home Care Program for Elders (CHCPE) waivers and programs, the Personal care Assistance (PCA) waiver, and State Plan services. Referred to as "Team 2s" in this report, each region had from one to six of these teams. Each region also had one specialized team, which handled referrals for the Department of Developmental Services (DDS), the Department of Mental Health and Addiction Services (DMHAS), and the Acquired Brain Injury (ABI) waiver. Referred to as "Team 1s," these specialized teams usually consisted of three SCMs (one from each of the three programs), one to two TCs, and one to two HCs. Team 1 TCs and HCs worked with multiple SCMs from different programs.

To learn more about how the new process was working in the field, team members from one Team 1 and one Team 2 were purposely interviewed for this report. Teams were chosen so that different regions, programs, and organizations were represented. These field staff, along with their supervisors, provided much insight into working as part of an MFP team and especially informed the "Team Experience" section.



This section looks in depth at the new transition process and is organized into six areas:

- Major 2014 achievement
- Benefits from the New Structure
- Challenges to the New Transition Process
- Respondent Recommendations
- The Team Experience
- New Demonstration Tools

### Major 2014 Achievement

Many key informants saw the development and implementation of the new transition process as the defining achievement in Year Six.

*When they involved having the teams with the Transition Coordinators working as a team with the SCMs and the Housing Coordinators, I think that that's really what we were advocating for these past few years that came into fruition. I believe that that's really a big-time step, I want to say, in the right direction.*

*I think the folks here like the team structure. They say that that's working really well in getting everybody to the table and talking about stuff.*

*I think streamlining the process, making the commitments to get people assessed faster, and bringing in and really ramping up some of the staff to be able to make that happen, and I think the fact, the just overall commitment to really taking the information that has been provided, either through your evaluations, UConn's evaluations, the participant's experience and really being able to make those changes within the state system, I think, is actually remarkable.*

*I think that the things that I have suggested before – the change to the regional system ... where we divided the state into five areas. And that change in the structure of the thing, I think, really was a step forward. ... We'll have to see how it works but, certainly, the structure was good. Then adding those housing coordinators and upgrading the teams themselves...*

*Overall, it's gotten better because of the teams. I can't emphasize that enough but that's been a huge difference maker.*

Initial reaction to the new process was for the most part positive. People felt change was needed, and liked the team concept, along with the ability to target referrals to the appropriate SCM. Some key informants were initially concerned that it would confuse consumers by adding more members to a transition team or that mandatory biweekly team meetings would take away from time spent helping a consumer.

*I think it was a good plan to reorganize and restructure the work and to ramp up staffing to respond to the extraordinary backlog. So my initial reaction was very positive. It provides a generalist enough approach to get things done, but it's specialized enough in that people have the ability to have specialized transition-type experience when doing*

*the assessment and the care planning. It's generalized enough that it can be done across a couple of waivers. So yes, I think it was a really positive move and effective, I think, although we're just going to start seeing the results of that, I hope.*

*I was kind of unhappy about the change – thought it might put more hands in the pot and kind of just confuse things and confuse our consumers.*

*My initial reaction that it took a lot of getting used to because we did essentially change the program rather drastically. In the new positions we created, those people had to learn how to do it. Learn how to do their jobs. So it took some, there was certainly an adjustment period, which I think we're over with now. And in theory, the changes were a great idea; in practice, they haven't exactly turned out the way we thought they would.*

*My first initial thought was, Oh this is going to be a waste of time having to meet twice a month because we're so busy that it takes time to schedule, and it just was inconvenient to schedule something twice a month.*

*My initial reaction. Probably here we go with the MFP changes because they change a lot. But it's a fine structure. It works. It didn't change a ton for us because we already had a housing coordinator, and the two TCs that are on my team, if you want to call it that – I have worked with them in the past. So it wasn't, I don't know. I think the SCM part was the harder part to kind of ... okay, what does that mean for my role and what does that mean I have to do. Because it gave me some new responsibility. But the team part, it was fine.*

*Well, being that I was going to be an SCM, I thought it would be a little overwhelming, but I think once you get used to the process and get a pattern and a structure with your team, I think it's going quite well.*

### **Benefits from the New Structure**

Despite some initial concerns, key informants repeatedly mentioned that organizing into standard teams was a definite accomplishment which benefited the field staff as well as the consumer. Advantages of using the new transition process identified by respondents fell into two categories – advantages of working as a team and improvements to the transition process.

#### **Advantages of a team approach**

- Collaboration and problem solving
- Increased knowledge and shared skills
- Shared responsibility
- Team member support

#### **Transition process improvements**

- Earlier assessments
- Increased efficiency and speed of transitions

## Advantages of a team approach

### *Collaboration and group problem solving*

The team structure encouraged collaboration and group problem solving to overcome challenges. Collective brainstorming was mentioned by many field staff and contractors as a major benefit of the new team structure.

*I will say that I find it to be a good way, a good approach to the consumers because it's a team approach. I welcome a team approach. I think that whenever you have two people involved in trying to help a consumer, it's always better than one. There are better ideas, better suggestions, it's not just left up to one person. One person doesn't feel stuck having to come up with, and/or work through the process.*

*I think the communication and knowing we can talk about problems or issues that you have with a case with everyone, everyone can put in their input at the same time. As a group setting, I think it works better for communication.*

*I really think it's just like team work, communication. Everybody works together to kind of problem solve because obviously no two cases are the same. And there's a lot of things that we've kind of perfected and then there's things that popup that we've never experienced before but because we are working in teams there's always several people brainstorming to fix it or solve it ...*

*The whole best practice part of it would be the collaboration that has to occur between the SCM, the Specialized Care Manager, and the transition coordinator because that necessarily, before in the past with MFP was, I don't think that happened as much. And I think, to me, that's, that whole team process is really, for me, is what has really been a best practice for MFP, introducing that.*

### *Increased knowledge and shared skills*

Team members in different roles or from different agencies sometimes brought specialized knowledge and experience which all team members and their consumers could benefit from. Team members shared their skills and expertise, and learned from each other.

*I think on the provider side and for the clients, I think that it is working better because the individuals coming out just have a broader depth of knowledge. And I think instead of having the one person, you've got your specialists so that the individual responsible for housing is focusing on housing because that is certainly one of the biggest challenges. I think that some people may see it as more compartmentalized with what the role is for each individual, but I think that it makes the process more efficient.*

*I like being able to hear how, because I've only been here since July and the other TC has been here for a while, so I like when I'm like stuck on something and everyone else brings in their input because they're more experienced. So I think that's helpful because it's always new problem solving.*

### *Shared responsibility*

Working as a team meant more than one person was responsible for that consumer and his/her transition, and adding the SCM position and HCs on every team also meant more people could assist with the transition. One respondent felt that cross-agency teams in particular encouraged shared accountability.

*I think the teams. I think when people work in a team, they learn each other's strengths and they're able to help each other plan better and I think when you do approach anything as a team, you have a better outcome and people do take, look at it a little bit differently than feeling like one person's totally responsible for everything. People have their clear roles and they have to fulfill those roles, but I think when you work in a team, it does build on each. You build on each other's strengths and your capabilities and I think it's a good model because it really does put the emphasis back on it does take more than one person to move someone and it really takes away this person says they can move, this person says they can't or this person says that they need, this person says that, so it really emphasizes that cohesiveness.*

*I think some of the duties, which perhaps were a bit much for one person, have now been shared. I think we have a better relationship kind of thing set up with the specialized care manager. In other words, before we didn't really have that much to do with the care plan person, but now it seems like we're part of their team. They're like the leader of the team, and we're kind of put in where they want us to go.*

*But I do see a benefit significantly in working as a regional team instead of as a, just as a contractor because when we're looking at the issue of benchmarks, if not everyone has skin in the game, it's really not really not going to yield the benefit or the outcome that you're looking for. So I think that by incorporating a few different agencies into the teams, it gave us all some accountability and it gave us all the incentive to be more communicative and to work together. And I think that it ultimately resulted in better transitions and more of them.*

### *Team member support*

Working in teams meant that team members could support each other or help with difficult cases. Being part of a team was also empowering for some field staff who usually had a smaller role in MFP.

*So, in this case, I feel like having the teams has made it easier because we could help each other out. There's other TCs on my team that, when that person was working by themselves, they may have struggled, or maybe they worked well with other cases that maybe I don't work well with so we can kind of work together on and ... sometimes switching [a consumer case] is necessary. ... So for me, I think the team is a great thing. We kind of keep the ball rolling.*

*I know that [field staff name] felt a little bit isolated early on in the program, and now that she's a part of a team, I think she feels more supported, not only herself, but also the clients that she works with. So, I think the move to that model made a lot of sense.*

*But oftentimes we will discuss stepping outside of the box, so things that maybe the SCM should be doing, the TCs will often say, 'You know what, I'll take care of that, don't worry about it, I'll do that,' just so we can move things along.*

### Transition process improvements

#### *Earlier assessments*

People especially liked the use of targeted, specialized SCMs to do assessments and coordinate the transition process. Consumers were seen by care planners much sooner, and care plans were created and approved more quickly.

*I think that there are, in general, I think it's better for the consumer...because I think a lot of consumers are actually getting seen quicker than they were before where it would be like, "Oh, you may get somebody in the next 6 months out here." They're at least being seen quicker, but it doesn't necessarily mean that they're transitioning quicker. But I think that the feeling that they're being considered and addressed is a benefit. So they're seen quicker.*

*It definitely allows us to make the clinical determination of whether the client is appropriate for our program or not. I think what was happening is TCs were going out and seeing them and guessing what program and then trying to put them in the right place. But it seems like we're more streamlined that most of the people we get now are more appropriate for what our services.*

*I think it was a good move, and you kind of look at it from the point of view of some of the folks that we serve, needing more of a comprehensive model of care, and to have a care coordinator, someone who's responsible for all aspects, and then brings in the people with the different specialties, I think that makes a lot more sense.*

*I think the assessments are really well done. And I think the assessments across the board are really what helps to move these people into the right boxes. And I think everybody's working hard.*

#### *Increased efficiency and speed of transitions*

Overall many key informants expressed that the new transition process improved efficiency, increased transitions, and increased the speed of transitions. All of this allowed more applications to be sent to the field, reducing the backlog.

*I think [transitions] go much quicker. And we [agency] get the information we need to start the people on the program and start paying them much quicker and more accurately.*

*I think it's given it a lot more credibility because to be honest with you when we go, when we go into skilled nursing facilities, before they would say, oh, well like, they signed up for MFP but that was like a year ago.*

## Challenges to the New Transition Process

Challenges specifically tied to the new process and its implementation were also identified, falling into two broad categories: challenges related to working as a team and challenges related to the new process itself.

### Team approach challenges

The most commonly mentioned challenges related to the new team structure were:

- Establishing and sustaining consistent, stable teams
- Cross-agency teams
- Team 1 challenges
- Role clarification

### Transition process challenges

Challenges related to the new transition process were also identified, including both procedural and structural changes:

- Emphasis on fast transitions
- Larger caseloads
- Care planning challenges
- Limited role of the Transition Coordinator

### Team approach challenges

#### *Establishing and sustaining consistent, stable teams*

Field staff with less well defined team structures found the new transition process frustrating. Lack of consistency and stability among the team created confusion, was more stressful, and increased the amount of work due to duplication of efforts or poor communication. One key informant identified the problem as not enough TCs and HCs for each SCM; while another said having more stable, consistent SCMs was key.

*So what's been challenging or frustrating has been that the idea of teams works when it can happen. The reality of the situation is there are more specialized care managers than there are transition coordinators and housing coordinators so the regions can't work purely. ... There is not enough grant positions, TCs and housing coordinators, to have the pure team of SCM, 2 TCs and a housing coordinator. So TCs are having to work with multiple specialized care managers which is taking away from the purity of a team.*

*Well at first I was working with people from all over – [access agency], [access agency]. Like we had all kind of mixed-up teams because some people had been like no longer working with us. But I was still the HC. So until we could get the position filled, the consumers were kind of placed everywhere else. I think that's where a lot of the*

*confusion came from, our people, but I worked with some SCMs from [access agency] and some TCs from [access agency].*

*I think having some consistency would help the transition coordinators. One of the things that [TC] had said to me a while back was ... the SCMs have their own methods of doing things. And so one SCM will say okay, 'I'm going to take X, Y, and Z and work on those. Those are my things.' And then the next SCM will say, 'Well I'm not. I'm going to take M, W, and X.' So you don't really get the kind of, okay, here's how this person works, and I know what I need to do, I know what they need to do. And you kind of just move and kind of in sync in a way.*

Field staff turnover of SCMs, TCs, and HCs also contributed to this challenge.

*... our region ... has had a lot of turnover and vacancies in the Specialized Care Managers, so one of the difficulties that we've encountered is not one SCM to two transition coordinators. You'll have a possibility of five different SCMs that are making referrals to the transition coordinators and the housing coordinators.*

*Making things even more challenging is when you lose a team member, some regions are really experiencing high turnaround in staffing, TC staffing, HC staffing, so that also makes it difficult, trying to engage with new employees who may or may not be familiar with the process, who may or may not be as savvy and as willing to make certain that they're in contact with the entire team. That's been challenging.*

*... people come and go all the time in those roles because of entry level or whatever they might be so it's hard to have that consistency. I think that's something that we've been dealing with lately here. We're not sure who the TC is going to be because this person moved on to something else and not sure who that new person's going to be yet because they haven't assigned it or people are moving around trying to get hired or whatever.*

The increased need for more SCMs also made it difficult to keep established teams. To keep up with the expanding number of referrals and subsequent caseloads, access agencies hired more SCMs, but found it difficult to keep a balance of enough, but not too many, SCMs to complete assessments, especially when the number of referrals fluctuated.

*Hiring enough [SCMs]. Yes. So it's not like you have three positions and it's, here's the number of referrals we think you're going to have, so hire accordingly and then try to balance the caseload size or revenue coming in and making sure that we're not overstaffing or understaffing.*

*The challenge has been when there hasn't been consistency of teams. So there was a lot of ramp up for specialized care managers, so we had a lot of different people working with transition coordinators that are across our, they're in different organizations. But I would say the inconsistency was brought on because of ... [the] ramp up, and that didn't foster just the ease of regular daily contact and protocols. And it feels like it's been more challenging.*



### *Cross-agency teams*

Teams with members from two or more agencies faced some additional challenges with logistics, communication, and coordination, especially for team meetings. Supervision of TCs by SCMs from another agency was also an issue for some.

*We're not all at the same place, so...it was, I liked it much better when everyone was working in the same agency because it's just a lot easier to say 'Hey, ... I'm going to meet this guy today. I'm just giving you a heads-up' instead of having to take the time to email or make a phone call.*

*I do think it's challenging when you do have teams that are composed of people from different agencies. That makes for a supervisory challenge, a cultural challenge. It appears to be more efficient when, and not that that can't change because of course we have to have a lot of different people involved, but in terms of efficiency it does appear that when you have people who are sitting right next to you in the same agency it's certainly an advantage in terms of moving things forward – in terms of efficiency, in terms of organization.*

*I don't really have any complaints. I feel like it works well. I mean at least it's easier for me because the specialized care manager and the housing coordinator are in my office so if I ever need anything I can just walk to their desk.*

The number of TC, HC, and SCM agencies and sheer size of the North Central region was also mentioned. TCs and HCs come from three different agencies in this region, which means even a smaller agency's TCs and HCs can be fragmented across different teams. One respondent suggested that holding regular regional meetings would increase cohesion across the North Central teams, but the size of the region made it difficult and impractical.

*We actually have 2 TCs in one team and 1 TC in another team, and it really, I think, has led to some interesting dynamic there. I think, I know the team meets, but the region as a whole, I think, would benefit from meeting. So it kind of seems as though either get everybody on the same team or divide the region into 2 regions because we've got a lot of TCs and a lot of housing coordinators stretched across 3 agencies. So it just, at times it feels a little unwieldy.*

### *Team 1 challenges*

Team 1s faced some unique challenges. These teams are the most diverse, and the TCs and HCs work with SCMs from three different state programs (DMHAS, DDS, and DSS for ABI assessments). TCs, HCs, and TC Supervisors, remarked that the Team 1 SCMs did not always follow the same protocol as the access agency SCMs. For example, while the other teams interviewed held regular team meetings, the Team 1 meeting structure and process varied widely by program. In general, communication between Team 1 SCMs and the TCs/HCs was more challenging than and not as consistent as the other teams. One respondent was very frustrated that even after working together for nine or ten months, the Team 1 SCM still assigned cases to the TC very close to transition, and then expected everything to get done quickly. Some field staff also felt that Team 1 SCMs, as well as other DSS state agency case workers, were not as invested in MFP or in working as a team.

*Well, the one thing that's really challenging is the Team 1s, because of the Team 1s, the Specialized Care Managers are, either work for DDS or DMHAS or ... the ABI waiver. What's really difficult, of course, we are following a protocol that MFP has set down and, in some respects, I feel that the state agencies that're involved are not doing that ... that collaboration piece is sort of kind of missing a little bit, like with meeting with the TC that's assigned to the Team 1. So, for example, ... the care plan gets approved and within three weeks, they want the person to transition. Well, if the TC wasn't assigned, if the TC wasn't assigned to the case until the care plan's approved, then the TC really has like three weeks to get this person through the whole transition process. And on paper that doesn't seem that bad, but the thing is you've got other cases going on... So it would really benefit those particular cases especially to have ... the TC assigned early but also keep the TC abreast on, like there might be only like ten cases but I'll let you know. These six, I think, this person's probably going to be transitioning some time in a month or so. I think that that really needs to happen and I think it doesn't sometimes. Sometimes it does and sometimes it doesn't. It's very haphazard.*

On the other hand, some Team 1 SCMs did want to follow the established transition protocol, but found it difficult to remember, and then attend to, all the details, such as filling out the different forms – both on paper and the web based forms, writing progress notes on the web, using the web to update the consumer's progress, and entering critical incidents. These SCMs also had to adjust to working with a TC, including assigning the TC, and leading their Team 1 TCs and HCs.

*Just knowing everything we have to do. There's a lot of different forms. I think what also came with this process was the MFP website, which probably has always been there just we never accessed it. So just kind of knowing what all has to be done before a transition happens and what triggers what and how to just get everything to the right person. It's not the technology itself. I think the website is...well, I take that back. It's not challenging for me. I think some of my co-workers have had, 'Oh, I didn't know there was a screen on that,' and even my supervisor didn't realize there were multiple screens based on multiple MFP referrals per client. But I think it's just been more, 'Oh, I didn't know I had to do that form. Oh, I didn't know I had to do that.' We have the transition challenges checklist that we have to do for them and the Readiness Assessment that we do for them, and now there's a new form that they didn't know about. Assistive Technology. That was my newest one. And sometimes it's also knowing, well, that's a different thing, but we now have some pilot services. We can get the community support services, which is like substance abuse treatment. So how to do the modified ASSIST tool there. So I think it's just more like what do I have to have all completed to make this happen.*

### *Role clarification*

Clarifying the roles of the team members, particularly between the TC and the new SCM position, was also an issue, especially at the beginning. Many of the SCMs were new to MFP and overall less knowledgeable than the TCs about the transition process. The new supervisory role of the SCM was also a consideration, especially when the SCM was new to MFP or did not work for the same agency as the TCs or HCs on the team.

*It was a little unsettling in the beginning partially because a lot of the SCMs, when they started, didn't know as much as the transition coordinators did. And so it made it kind of difficult for the transition coordinators, I think, to figure out what their role was.*

*And it basically also provided another level of supervision, kind of, for my staff of someone who is actually external to them. So they're working very closely with their SCMs, but those SCMs are kind of functioning very similarly to supervisors, but they're not colleagues. ... So it's created a little bit of an interesting dynamic between the SCM, the TC supervisor, and the agencies that house them just in terms of role delineation and authority and that kind of thing.*

Some SCMs were more comfortable taking on the team leadership role than others.

*Everybody has a role. We usually meet and assign that role. There's usually no overlap unless somebody's helping somebody, and everybody knows what they have to do. I know some of my colleagues have struggled with that, and I could never understand why because I'm like you're the leader. ... We have a check-off list of everything that needs to be done. Assign things to people. Make sure people are being, getting them done, and just get them out.*

Another respondent's comment indicated that the confusion of roles and responsibilities extended to other agencies involved in the transition as well.

*Well one thing, it seems like there is no structure. Like there's not really defined roles between the care agencies and MFP. So that's been a challenge ... We've had like two shared housing situations that ... [the MFP housing coordinators] want to take the lead on the housing search but then they'll ask me, Well have you found anything yet?*

Others felt that the SCM role had been expanded to encompass more responsibilities than initially outlined. By going out first, the assessors found themselves spending much time explaining the MFP program to consumers and family members, and not spending it doing the assessment.

*But then it seemed like more and more duties got added to that. Like then they were responsible for getting the informed consent signed, and they were responsible for explaining to the person why an MFP application had been put in and whether the person was interested or not. ... And my staff gets very upset because they think they're going out to do their assessment, and they end up spending an hour trying to get an informed consent signed and explain what the Money Follows the Person program is and don't get their assessment done and probably have to go out again. ... we had tried to talk about using people's time appropriately. If you have licensed professionals, nurses, social workers, their specialty is doing the assessments. But now this has turned into kind of another very gray area, and it's not clear as to who's responsible. Like one of my social workers said she had a transition two weeks ago, and the TC came out, had bought the food for the client, had set up the food stamps, and that was it. My social worker ended up doing the physical move from the nursing home, and that doesn't seem appropriate either.*

## Transition process challenges

### *Emphasis on fast transitions*

Many respondents with diverse roles or affiliations with MFP felt that under the new process there was an increased emphasis to transition people more quickly than before. Respondents voiced concerns that meeting a short transition deadline was driving the process, even if the

consumer was not ready to do so or if needed supports were not yet in place. This also contributed to tension between MFP field staff and state program case managers, especially if program case managers appeared to not feel the same urgency or if they felt more time was needed to coordinate services and supports.

*So I do feel like the process, not with everybody, but there are cases where we are rushed to try to transition them, where we don't really know the individuals. And those individuals usually are the ones that don't progress well and do have a higher rate of failing in the community because we rush the cases or, again, we're getting all these cases and the TCs and SCMs can't put enough time to be able to really give the consumer the necessary tools to be successful in the community.*

*I've had some concerning cases, to be perfectly honest, as far as the timing of discharges, the lack of coordination and support. There has been some challenge, I find, on a couple of the cases of late that are a bit concerning regarding support. ... And then we've had a couple of cases where we really kind of had to step in and say look, we need to make sure that the ducks are in a row and that service reports are okay before we move forward. And sometimes MFP moves a bit quickly and excited about getting people out but not always making sure that a safety plan is in place and that adequate supports are available. ... And sometimes our staff in the regions are sometimes made to feel... that we're trying to slow the process down, that we don't want the client to be placed in the community, and that isn't the case. We just want to make sure that we've dotted our Is and crossed our Ts.*

### *Larger caseloads*

SCMs, TCs, and HCs found that under the new process their caseloads increased, making it difficult to give consumers the attention needed. Carrying high caseloads, SCMs felt pressed to complete assessments, assign a TC, and move to the next case, which in turn created larger caseloads for TCs and HCs. TCs and SCMs then found it more difficult to keep up with all their consumers, especially those who had already transitioned or who needed more support or encouragement in the transition process.

*I think part of it has to do with the way the contract's set up with the agencies that conduct the care plan assessments and creations, that they're paid to go out and assess people and create care plans and do readiness assessments. And certainly, the contract also requires them to do it in a certain amount of time. And Central Office is constantly sending out new applications to those contracts, to the agencies, so they're sort of pressured to just get out, do the assessment, create a care plan, do a readiness assessment, and move on to the next person. And I think that a certain closeness with the client isn't developed with those specialized care managers and just sort of pass on to the transition coordinator, and they're kind of in limbo because...it's a little odd because the transition coordinators don't go out and meet the client initially, not normally anyway, but certain agencies do it differently. But it's like the transition coordinators are handed a case with the approved care plans, and the specialized care managers, at least some of them, are saying well here it is, now it's your job.*

*Well what's changed is [we] definitely have more consumers to work with because things are moving along a lot quicker. So by the time they get assigned to me, they've already gone through the process, it just seems to be a lot faster and I'm getting referrals a lot*

*faster. So, of course, getting more backed up because my caseload is getting bigger and bigger.*

*I think it's good for like okay we're going to try to engage this person and do this, but quite honestly, even though it's like okay this is what's great on a piece of paper, I don't know that I have the time to really engage clients like a TC would. ... I have a case right now, and this is a prime example, I haven't seen the guy since I assessed him. I have a plan ready for him. I have to stop and see him and show him his plan so we can move forward with his discharge. I don't even know if he really wants to leave. I see that he can totally leave. He implied a sense that he needs to leave. I agree with ASCEND that he can easily live in the community, and we can provide him with a wonderful life. And I tried to reinforce that with him, but he's scared. But I haven't seen this guy since October since I assessed him. That's how busy my caseload is now. ... I just feel like I don't even have a lot of time to engage to the degree that we probably need to engage clients.*

### *Care planning challenges*

A number of respondents also identified challenges with the new care planning process. They found that overall the care plans were not as comprehensive as before or did not fully address medical or other issues which were evident to an experienced TC. This was especially voiced by some TCs and contractors who felt that one visit was not enough to explore community options with the consumer and family members, address concerns, ascertain readiness, and gather all the information necessary to develop a comprehensive, person-centered care plan for the consumer to live successfully in the community. Some felt this contributed to problems after transition which could have been avoided or lessened with more thorough and thoughtful care planning.

*... we've had a very high turnover on the SCMs. And so you've got brand new people who have never done this job going out and doing care plans, and then the TCs are looking at the care plan and saying, "Oh this isn't going to fly," because they're new. They don't have the same degree of experience that the TCs do.*

*I don't believe that you can just assess somebody that one time or two times. It has to be a series. It has to be something ongoing. And so, that's one thing that I will say that's a negative that I'm seeing with the SCMs that. ... I think there needs to be multiple visits to be able to really understand the person's needs. ... especially those cases where somebody had a prior substance abuse history or has mental health issues. Even the individuals who, they'll tell you, 'Well, I'm not that disabled. I can do my dressing, bathing, prepare meals' but it may seem on the chart that they're able to do those things but in reality, they probably can't do two out of their five ADLs ... I feel like sometimes you kind of catch these things when you're working with the consumers more often and [that's] when you start to see things.*

A related issue identified by some TCs and contractors was consumer engagement and readiness to transition. These respondents described situations where TCs were given consumers who were just beginning to explore moving out. The TCs then spent more time than expected working with consumers and their family members, which meant more consumers stayed on their caseload than was anticipated with the new process.

*I think a lot of what I was hearing is that originally the role of the transition coordinator was going to be somewhat reduced. There wouldn't be as many cases they'd have to do.*



*And what we're finding is that's not happened. And that the engagement piece, of I guess the SCM role, it seems to be an area that the TCs are still struggling with at least in my office. Trying to define the care plan is done before there's actually full engagement in wanting to transition. So when the TCs are going out, they're kind of, in some ways, 'Are you, do you really want to do this?' So it feels like that piece is missing or not as fully functional as it could be.*

Defining what engagement was and who would provide it was also problematic for some respondents.

*We kind of need to define what engagement really means. I think that that's kind of an elusive word. And how do we know that the consumer really is engaged? And how would the care planners know?*

### *Limited role of the Transition Coordinator*

Some respondents were disappointed in the limited role of the TC in the new process and limited opportunity for even experienced TCs to become SCMs. Although the SCM role was first envisioned as a way for TCs to advance in their careers, TCs from organizations which did not employ SCMs did not have the same chance for advancement as TCs from the Access Agencies which employed SCMs.

*I was a little chagrined at how the role of the SCM was limited to folks in the access agencies because I felt that I have some staff in my agency that would have been great specialized care managers, but we were unable to fill that role.*

With the new process, TCs and HCs found they did not get to know consumers and family members as well as they used to and missed this connection. It was also difficult for some TCs and HCs to get used to getting information from the SCM or written documents, not from personal interaction with the consumer and family members.

*I quite honestly don't feel that we get to know people as well as we once did because of our partial involvement. It's not that I want to be the be-all and end-all and do everything, it's just that the background information we have we usually now get through notes that have been written. ... Our involvement is different as far as which waiver we're working with. We basically now shop and deliver and negotiate what has to go into the actual transition itself as opposed to the beginning part, like I said, which I really enjoyed.*

*It's kind of hard not seeing the consumer first or on your own and getting everything from the SCM and you haven't met the consumer. That's a little challenging. But then we go out and we do eventually do our own, me as a housing coordinator, then I'll go out and do like the RAP with them and find out a little more, but that's been like the only challenge.*

Some TCs felt that by coming in late to the process, after the care plan was already created, meant their skills in figuring out what would create a successful transition were not being used. TCs found they were doing more work after transition to resolve problems. One TC commented that it made it more difficult to resolve post-transition issues when "we come in at kind of at the end, and all the decisions for this person's already been basically made."

*It seems to me, now that we do more work after the transition, it's almost like we're the back-end care manager. That's when I get all the phone calls. Oh by the way, this isn't working, and I still need this... We're not putting it in on the beginning, but we're putting it on the end.*

### *Other challenges*

Other challenges mentioned by field staff in particular included increased paperwork with the new forms, communication between team members, having too many meetings, and inconclusive program results.

*There's always challenges. Communication is a huge one, and everyone understanding the importance of communication, whether it's via a phone call, whether it's via an email, whether it's via reaching out to each other on the team using our own personal phones, and doing whatever needs to be done to get that communication out doesn't always happen.*

*Maybe the teams having specified designated times to meet, although that's challenging all in itself because we're being pulled in so many directions. So to add another meeting on top of all of the other meetings we've got going on may frazzle people, may cause added anxiety and frustration.*

*They feel like there's some busy work in, for some of the things that we're doing. ... we're doing it but it's not really clear what, because the paperwork's required, whether it has any value added to the person's life or the transition is still questionable.*

*My point of view – obviously this might not be everybody's thought – but when you get to have too many meetings, everything starts getting nitpicked and the progress kind of slows down and I think, in my perspective again is, I'd rather just get going and do my job and get it done. And if I have any questions along the way, that's where the group emails are very helpful ... So those little things along the way doesn't necessarily have to have a meeting to discuss that because it's a quick little email saying, 'This is what's going on,' and just progress notes and stuff like that, with the website as well.*

Overall program results compared to the investment in additional field staff and new processes had also yet to be determined. The number of care plans approved increased substantially, and by the end of the year number and speed of transitions had also increased. However, others noted that this had created a large number of consumers in the transition process, and that the number of transitions had not gone up as high as expected.

*Well people are being seen by care planners much sooner than they used to be, and care plans are being created and approved much faster than they used to be, but the number of people transitioning to the community hasn't increased in sort of a correlating way to the number of care plans that have been approved.*

*I think the jury's out. What I see is now, February, we're starting to see transitions pick up. I think there isn't a backlog. There's a lot of people who have care plans, but they're just not transitioned yet, so from what I understand, there's 1100 people waiting to transition or in the transition process.*



*... maybe it's still too soon to tell, but we haven't seen some of the progress that I expected as a result of the change and investment and being responsive to some of the things that they were asking for, I haven't seen that play out in increased results yet. So that's a concern. It may be too early to tell, but the reorganization cost quite a bit of money, and if we do that, then we'd like to see the results.*

### New Process – Respondent Recommendations

Respondents offered several recommendations for how to overcome some of these challenges, including:

#### Team approach respondent recommendations

- ◆ Establish consistent, stable teams.
- ◆ Hire more staff.

#### Process and protocol respondent recommendations

- ◆ Allow for a longer transition process.
- ◆ Change the assessment protocol.
- ◆ Clarify roles and team protocols.
- ◆ Clarify engagement and engagement responsibilities.

#### Other respondent new process recommendations

- ◆ Improve Communication.
- ◆ Consider dividing North Central Region into more than one region.

#### Team approach recommendations

- ◆ Establish consistent, stable teams.

Respondents liked the team structure, but also felt strongly that the team structure did not work without consistent team members.

*I think have more cohesive teams. I think the folks here like the team structure. They say that that's working really well in getting everybody to the table and talking about stuff. That's just not happening here.*

*... my experience is that if you have consistency of teams, then you have stronger expectations and responsibilities of each other and because of each other.*

- ◆ Hire more staff.

Several respondents suggested hiring more staff to cover the increased referrals, larger number of consumers already with care plans approved, and creating more consistent teams. Hiring

more TCs and HCs would create smaller caseloads and give them more time to work with their consumers to create a successful transition.

*Maybe lessen the load per transition coordinator and housing coordinator because I know there's like such a high caseload that it's kind of hard to get everybody in the way they would like us to. One person has really almost 50 people so it is a little excessive.*

*Definitely bringing on transition coordinators and housing coordinators to fill the gap where there are more specialized care managers in the region. That would be my number 1, my number 1 suggestion.*

### Process and protocol respondent recommendations

- ◆ Allow for a longer transition process.

Allowing for a longer transition process would give SCMs more time to work with each consumer. Slowing down the transition process would also allow more time to make sure all services are in place before transition and support a safer transition.

*I'd slow it down a little bit so that the specialized care managers can have more time to work with clients instead of being forced to constantly do new assessments.*

*I would say that looking at your discharge planning and ensuring that services are actually ready to go prior to discharge, particularly safety ones like nursing and home health, that folks have confirmed. And looking at the quality of the housing that we identify for folks. ... we have to understand that a lot of clients are very anxious to get out of the setting, so ... we have to seek out quality on their behalf.*

- ◆ Change the assessment protocol.

As mentioned above, some respondents suggested changing the protocol, and have the SCM meet with the consumer more than once before writing the care plan in order to really get to know the person and develop a more comprehensive care plan. More than one meeting would also give the consumer more time to process the information and understand the program, what it could and could not do, and their role in the process.

*You're talking about somebody who's an elder who's taking medication all the time, somebody with physical impairment whose got Morphine drip – how do you grasp all this information, or let's just say, how do you present all that information and have them sign something? ... So I feel like if they had that second visit to kind of go over and basically review what was at the last meeting and say, Okay, now are you ready to move forward, given what we're going to do that you've been referred for this?*

*... what I hear from other TCs is that the SCM needs to be – how can I say this? – they don't necessarily need more training but maybe the consumer is on overload when they meet the SCM because they do so much in one sitting that I notice that the consumer is very confused with the PCA program or what assistance they need or anything.*

As a related recommendation, some TCs, HCs, and Contractors were in favor of the SCM, TC, and HC going out as a whole team for the first consumer visit. This would help the team establish a rapport with the consumer and the TCs and HCs would know what to plan for. TCs

and HCs could be part of the initial assessment which might help identify needs earlier in the process.

*I guess originally there were some thoughts, and it was suggested that the TCs and the specialized care managers go out for the first meeting with the consumer together, because I think the TCs have a more practical, from having done it, they see the potential problems in a very practical way as opposed to just being a straight medical model or, if that makes sense.*

◆ Clarify roles and team protocols.

Several respondent recommendations focused on team member roles and team protocols:

- Educate everyone – from HCs to CO – about roles and responsibilities and program protocols.

*I think educating everybody as far as what their role is and what everybody else's role is, because I think that's also a little bit of an inconsistency as far as what people know and what they don't know, so I think that's part of it.*

*this kind of goes back to having policies and protocols, if there were some standardized, written protocol so that everybody really knew what their role was clearly and what their tasks were—and I think with the website set up, that would be easy to tack onto—it would make the process easier because you get people who say Oh no, that's not my job. I'm only a TC or I'm only this or I'm only that.*

- Have Team 1s follow the same protocols as the other teams do, including to assign TCs/HCs in a timely manner, hold regular team meetings, and keep TCs/HCs informed of cases which may be assigned to them.
- Create a standardized MFP Transition Process Checklist with all typical transition tasks outlined, not just the outstanding barriers.

*One of the things that have been great for us at the waiver ... is we had a checklist of everything we really needed to do, a paper checklist.*

◆ Clarify engagement and engagement responsibilities.

A few respondents felt that the process of engagement needed more clarification and a better understanding among teams. In particular, if the SCM provides the engagement, to make sure the consumer is fully engaged before handing the consumer off to a TC or HC.

*I think part of having a better understanding of the engagement process, what that's supposed to look like, who's responsible for it. Making sure that maybe we shouldn't be doing care plans unless we're really sure that the consumer's engaged in the process.*

### Other new process recommendations:

- ◆ Improve communication.

Respondent recommendations for improved communication included:

- Continue to train SCMs, TCs, and HCs on the importance of communication, regardless of what they feel may or may not be important to communicate.
- Update the Action Plan and progress notes on the web. Send a group email saying to check the web, versus writing detailed emails.

- ◆ Consider dividing North Central Region into more than one region.

Several key informants mentioned the size of the North Central region and how that made it impractical to hold one regional meeting. One suggested that creating two smaller regions would make this easier. The TCs and HCs come from three different agencies, and regular regional meetings would increase cohesion across these teams.

### The Team Experience

Using information from the field staff and supervisors interviewed, this section looks more closely at the team experience and includes descriptions of the teams, team meetings, and regional meetings. Also included are how teams were productive, some of the challenges they faced, team best practices, and mottos.

#### Team descriptions

How a team described itself varied. Team 2 members identified one SCM, two TCs, and two HCs as their team members. Some Team 1 members were part of more than one team, since team members covered distinct facilities or towns, or were statewide. In addition, the members of a particular Team 1 consistently included the nursing home staff, community providers, consumers, and family members/conservators as their team members.

*Now when you look at an entire MFP team that's serving a client, like if we were transitioning out, it's more than just them. We have our community providers, our nursing home people, the family if they're involved, friends if they're involved. Wherever, you know, it could be the team of wherever they're coming out. And eventually, it does follow them into the community, whoever's going to service them in the community. So I don't know how far you want me to go out there because to me it's more than just those 3 things. The Specialized Case Manager, the TC, and the housing people, but that's all that really MFP looks at.*

Team members also sometimes changed, and most Team members interviewed experienced some turnover.

*Since we've had a changeover, we lost one TC, and there was not one ... that TC wasn't replaced for the longest time. So we now have a new TC... I'm just trying to think. The other HC went on ... leave, so there was someone who came in to substitute, so it hasn't really been a steady flow of the same people.*

Many respondents emphasized the importance of communication among team members. Email was most commonly used; cell and office phones, conference calls, texting, scheduled meetings, and MFP website progress notes were also mentioned. Group emails and progress notes were especially helpful to give all team members quick updates.

*We do a lot of the group emails and I think those help a lot because everybody's on the email, everybody sees what's going on next, and obviously the website is also helpful because you put on updated notes, and we all have access to that so we could all see exactly what's the next steps.*

*I feel like communication is definitely key so if you're not, I think meeting in person twice a month is definitely good and then throughout the week within those, between meetings of definitely phone and email communications.*

### Team meetings

The structure and process of team meetings varied across the Teams, and Team 1 meetings differed based on program and SCM. TC and HC Supervisors interviewed provided additional feedback as they attended many Team 1 and Team 2 meetings. Overall, respondents mentioned that regular team meetings promoted accountability and kept the transition moving forward. Meeting as a team helped delegate responsibilities and clarify the roles of each MFP team member. Tasks or items that were overlooked more often got picked up at a team meeting.

Team 2 held biweekly meetings, an in-person meeting alternating with a team conference call, which all team members were expected to attend. The SCM facilitated the meeting and minutes were kept. Team members used their biweekly meetings/conference calls to give program updates, review all pre-transition cases, and address concerns for any open cases. Team members discussed cases and helped each other problem solve any challenging situations. A TC/HC supervisor interviewed from another region described a similar meeting structure for Team 2s in that region as well.

*The SCM usually chairs the meeting and just basically goes over any changes, any up-and-coming things as far as MFP goes... And we take turns going around the table as far as who has updates, what's going on, just a catch-up kind of thing.*

*We'll go one by one through every client. If we are stuck on anything or having trouble, the other teammates put in their input and we try to problem solve and then the housing coordinators will tell us where they're at and vice-versa. ... We mostly talk about the pre-transition [cases] but we'll have some post-transitions that end up needing something or some random stuff pops up, like maybe they are getting a hip replacement and now they're going to need a ramp. So sometimes we'll talk about the post-transitions.*

Team 1 meetings varied by SCM and by program. For example, similar to the Team 2 above, one Team 1 SCM held monthly in-person meetings, where all team members reviewed each pre-transition consumer case.

*I find that it works because what we do at these actually meetings... we all come with a list of consumers that are assigned to us as a team, and we discuss each one of them. We go down the list and we discuss where we're at, what needs to happen, what's the obstacles, how can we get over the obstacles, etc., etc.*

More often Team 1 SCMs held phone conferences and meetings as needed to discuss certain cases, but there were wide variations. One Team 1 SCM held an initial meeting for each consumer at the facility, with the field staff, facility social worker, consumer, and other stakeholders, but did not hold regular team meetings where multiple consumers were discussed. Another Team 1, which covered a facility whose consumers had to be assigned quickly because of a lawsuit decision, held a monthly meeting specifically to review all MFP consumers residing at that facility. Team 1 TCs and HCs who worked with more than one SCM often had quite different team meeting experiences depending on the particular SCM. The lack of consistent Team 1 meetings was frustrating for the TC Supervisors interviewed, who found that their TCs were not always kept informed but still expected to get everything done on time.

*We try to stay with one meeting. So we get a referral after they've been approved... and then we will set up that individual meeting and discuss that one client.*

One Team 1 HC, who worked with SCMs from two different waiver programs, remarked that while for one program monthly meetings were helpful, for another regular team meetings were not necessary. Instead of a team meeting with the SCM, TCs, and HCs, this HC felt that emails, discharge planning meetings, and seeing each other at the facility worked well.

*She usually will email us if she's added anyone to the caseload. ... Well, that works too because [those] consumers are mostly going into shared homes. So we see each other a lot. Like the agencies constantly want to meet, and we have a lot of meetings in the nursing homes and we're kind of always in the loop with each other.*

Discharge planning meetings continued to be held with facility social workers and other stakeholders. Team 2 members were very clear that the discharge meeting was separate from their Team meetings, unlike some Team 1 MFP staff members, who when asked to describe their Team meetings, only talked about the initial stakeholder or the discharge planning meetings for individual consumers.

*That's one of our protocols here, is we have an initial team meeting. So when we first get assigned a case, we talk to the referring agent, which is most likely our social worker or our clinician here, and then they set up a meeting with the rest of the team. So we all get together in a room, we discuss it with the client, the client's there so nobody has any misunderstandings. We try to get everybody on the same page. And like I said, at the end, we do another team meeting at the end to discuss the actual discharge and further anything else that needs to be done.*

### Regional meetings

It was not clear how many quarterly regional meetings, where all the Teams from one region would meet, had taken place. A few key informants described quarterly regional meetings held for all the SCMs, TCs, and HCs from that region; on the other hand, a Team 1 respondent was not sure how that would work. One respondent found that having quarterly regional meetings helped overcome the challenges of cross-agency teams and provided an educational component as well.

*I think it's really helpful to have the regional meetings because ... the care planner is one place and there was ... lack of collaboration that, ultimately, affected the transition because you don't have as much conferencing on what's going on. So I find the regional meetings to be helpful because there is another supervisor over at [agency] and [he/she]*

*does supervise a little differently than I do, which we're trying to always find that common ground, the things that we can all agree on.*

*One thing I know that we're supposedly doing, and I never could wrap my head around it fully and I never could finally ever understand how it was supposed to work, is we're supposed to have, like I guess, like regional team meetings or something, and I'm not real clear on those or whatever they're supposed to be.*

Most Team 1 members interviewed felt that even a meeting of all the Team 1 SCMs, TCs, and HCs for any one region would not be helpful, given the very different populations and waivers covered by the different Team 1 SCMs. Explained by one Team 1 respondent, "But the whole team for all the waivers, not so much. Because the SCMs are different too. It would be a big group, and we'd all be talking about different things."

### Team Best Practices

Field staff offered several team best practices; most encompassed specific recommendations for team meetings.

- ◆ Practice good communication.

Communication and keeping each other updated was a common theme in both team best practices and challenges.

*Communication, I think, is the best practice. And to follow up with what's going on and just keep on top of things.*

*I think communication is the biggest thing. I think that's vital to any team, communicating who's doing what, who's going to do what, and how are we going to achieve the outcome of the goal. ... Communication's still extremely vital to those so everybody knows what needs to be done or who's up next or who's covering who or whatever the issue might be.*

- ◆ Schedule standing team meetings.

Several respondents spoke on the importance of regular SCM, TC, and HC team meetings. Many, but not all, felt every two weeks was a good timeframe. Alternating in-person with conference calls made biweekly meetings more doable for some.

*The best practice would be to set a team meeting if other teams aren't doing that because I know, at an MFP get-together, people were saying they don't have time to have those meetings because the cases were getting larger and larger and that when they schedule something, they end up canceling it because things come up and they can't do it. As a best practice, you should really just set aside time. ... because that's essential to moving forward but also to being successful.*

*So a team best practice report would be first of all, all of the members being there and participating. Whether you're working with a TC and housing coordinator and specialized care manager that's internal to your agency or external, that everyone participate.*



- ◆ Respondents made some specific suggestions to help keep scheduled meetings, such as:
  - Identify a team member other than the SCM to make sure the meeting happens if one is cancelled.
  - Use a sign in sheet to keep attendance.
  - Identify someone to take meeting minutes.
- ◆ Review all consumer cases.

Use the meetings to review each consumer on the team caseload still in the transition process every two weeks. In addition to problem solving issues, use the meeting to agree on goals and set timelines.

*Just going down the caseload and figuring out for everybody where you are and what needs to be done and kind of figuring out what the challenges are going to be and getting them done.*

*I think going over each case, I think that's important. And then setting goals for... I think it's very important to set goals for the people that we think are going to leave, we set specific dates.*

- ◆ Use the Action Plan.
  - Create Action Plans for consumers to overcome specific barriers. Use the Action Plan to assign tasks with due dates, then review and update at each meeting.

*I think a best practice would be that action plans are reviewed, updated so when certain items are achieved that noted. When new things pop up they're added. So that really you use that tool to keep everyone on track.*

- ◆ Clarify roles and responsibilities.

Clarify roles and responsibilities with everyone, including stakeholders such as facility staff, community providers, and consumer.

*Well I think from what we've learned, the best practice has been to just make everyone's roles clear and to work, especially between the care agencies and MFP, and kind of combining each of our resources to best serve the client, designate who does what so it's not as confusing.*

- ◆ Meet with the consumer as a team.

One team found that going out as a team to meet the consumer helped orient the consumer to the different team members and roles.

*I think what's helped us—and we've been doing this now with our teams—going out as a team, not like individually. I think that kind of helps them see everyone's face and differentiate the roles that we all have. Because that's a big challenge too. Me, as a housing coordinator, I get all these questions for like the social worker or the TC. So by knowing, seeing us together and knowing each one, that kind of helps.*

- ◆ Discuss challenging cases.

One respondent suggested specifically setting aside time in each meeting to discuss and brainstorm more difficult cases. Another suggested that teams look more closely at consumers who were previously referred in past but the case was closed, in order to identify issues which lead to case closure or re-institutionalization and plan in advance how to meet that challenge.

*I always feel that the best practice is to set time in an agenda because there are teams that are larger so maybe they only go over the cases that are, what we call, tough cases instead of cases that you know are moving along well that maybe you don't have to put too much attention to.*

- ◆ Other suggestions included sharing success stories, providing support for each other, and adding in an educational component.

*I use that opportunity to really reinforce usually what a good job they're doing and to really promote the sustainability of not just what they're helping folks to put in place but also the sustainability of their own mental health and usually use that as an opportunity to talk to them about things that they can be doing to help themselves on a daily basis.*

### Team mottos

A couple of teams already had a team motto or slogan, and some other field staff came up with a motto off the top of their heads to describe their team:

- ◆ *Together We Can.*
- ◆ *Go Team.*
- ◆ *[It's] ... all about the consumer and having the consumer involved.*
- ◆ *Let's make it happen.*
- ◆ *Get It Done. Let's get them home wherever home is going to be.*
- ◆ *Caring for Each Client.*
- ◆ *Keep On Working It. I think that way you learn more. That way you experience more. That way maybe we can do better as we go.*
- ◆ *We're actually using the compass as a slogan for our new integrated home and community-based services, so it's been kind of what the MFP system is ... our symbol is the compass and [our slogan is] "We will support individuals or families and support staff to navigate through the DDS and DSS systems to lead the life they choose. We cannot direct the winds but we can adjust the sail."*

### Development of New Transition Tools

To assist in the new transition process, three new transition process tools were developed: the Readiness Assessment, Engagement Plan, and Action Plan. The SCM uses the Readiness

Assessment and Engagement Plan to work with the consumer, determining his/her readiness to transition, possible challenges, and engagement strategies to overcome some of these challenges. Although key informants remarked that conceptually the tools were great ideas, actual use of and response to the new tools varied.

*I have met with colleagues about them, and I think the idea sounds very good. I don't know if they're fully deployed yet on every case, but they certainly identify the elements that would support a client are good.*

Some respondents were positive about the new transition tools – although many added a qualifying comment. They saw the Readiness Assessment as a way to get to know the consumer and communicate that to the whole team. One supervisor felt that the questions on the Readiness Assessment acted as a good prompt, even for experienced assessors.

*I love the Readiness because it gets me to actually get to know a lot about a person instead of just reading what's in their chart. I had a gentleman yesterday who I assessed who, for the first time, he was able to finally let go and he broke down and he opened up to a lot of things that nobody has been able to get him to open up to. So I think it touches people in a certain way.*

*Reading through like the readiness assessments and stuff kind of gives me, as a housing coordinator, some background of things that might be an obstacle in the future.*

*I know in the beginning the readiness assessment, a lot of people complained about it a little bit. I actually thought it was great because ... as a good assessor, you're going to ask certain questions that aren't actually in the functional assessment tool anyway ... but some people aren't going to ask those ... you really need to have a good prompt for them.*

*They're good new tools. The Readiness Assessment has been adjusted so that it's shorter which has helped with the assessment process and the amount of time an assessment takes. ... The Engagement Service is definitely valuable so that we're able to work with consumers post-assessment and have reimbursement for that for continuing to visit and work them through the process. The Action Plan is a tool that the teams are using to work together on who's responsible for what, timelines. It gives, it makes for accountability for team members, so that's working well.*

*I think the Readiness and Engagement is important because it gives us an opportunity to just step back and have a regular conversation with the consumer.*

*The Engagement Plan I think, again, that's a really good tool. One piece of improvement I'd like to see is that when engagement is being sought after, which is a reimbursable activity, that there is something very clear in the website that says that the person has been approved for engagement.*

Use of, and response to, the Action Plan was very positive. Key informants found it helped delineate responsibilities, and that it gave the whole team, including the consumer, a plan to work towards transition.

*The action plan, I think of the three, is probably, for me, has probably been the most helpful and I think for a number of reasons. Number one, for the consumer because*

*we're bringing something to the consumer and saying, okay, here's all the things that have to happen for you to transition and some of these things are what you have to do, ... You need to manage your diabetes, that kind of thing ... We're going to help you but you have to understand that you're a part of this process too. ... And it's also a really great tool for the transition coordinators to see, it's kind of a good, almost like a time management tool.*

*I do know of a couple of SCMs who use the Action Plan to do that [make sure goals are met]. So that's a concrete template with what, what's listed. There's target dates. There's who's responsible, and so using that Action Plan is a way to ensure accountability.*

Respondents were less satisfied with the Readiness Assessment, finding it overly burdensome to the consumer or just additional paperwork to complete. Some of the TCs and HCs interviewed did not use the Readiness Assessment or Engagement Plan much at all.

*I hate the Readiness Assessment. I liked it and I was a huge proponent when we all saw it because I think it's got a lot of great things to it; there's a lot of not-so-great things about it too. It's very long for clients. I like the bubbles where you just like tick off ... things that are going to prevent discharge from moving forward. I love that piece. I think the questions that they ask in the beginning part and everything... I think you ask those questions as you're doing the planning; I don't know that they have to be part of the Readiness Assessment. ... I don't know that we have to do it there and then in planning too. So I would love for it to be a little smaller. It's not just for us. Yes, it's kind of a pain for us, but these clients are sitting there. ... So I think it kind of like, if there's any way to streamline, tighten up, avoid questions that might have been asked in any of the same document [or] different documents... that would be really great.*

*It's 28 pages long and we only look at 3 pages of it because a lot of it doesn't really pertain to me.*

#### Recommendations for the three tools included:

- ◆ Streamline the Readiness Assessment and align it with other forms such as the new universal assessment so the same questions are not asked over again.
- ◆ Create an Action Plan form on the web so it can be used by all team members to update their progress and new items, without additional uploading of the form.

*The Action Plan only gets submitted at the time, one time. It's not resubmitted as a working document. So I'd like to see that Action Plan become more of a tool that is part of the planning and clinical record so at all times everyone knows what's expected of them. And it should be part of the consumer's record.*

- ◆ Upload the Engagement Plan with updated engagement activities to the web so other team members can access it.
- ◆ Add functionality to the website to clearly specify when a consumer has been approved for engagement services.

## Strengths and Supports

The many strengths and supports for MFP in its sixth year of implementation were similar to those from earlier years and included strong staff and stakeholder commitment to MFP, positive communication, collaborative partnerships, and flexibility of the program. One difference from previous years was after the education and training for transition and housing coordinators was standardized, respondents considered it a strength and support of the program.

- Education and Training
- Positive communication
- Commitment of project staff and stakeholders
- Program flexibility
- Collaborative partnerships

## Education and Training

A mandatory training for Transition Coordinators (TCs) and Housing Coordinators (HCs) was developed and standardized in 2013. Transition and Housing Coordinators are currently required to complete a six module online education course covering such topics as consumer assessment, choice and control, and informal caregivers in addition to the initial training they receive at the Department of Social Services MFP Central Office. The online course was set up through a partnership with Connecticut Department of Social Services, UConn Health's Center on Aging and the Center for Aging and Disability Education and Research (CADER) at Boston University. Staff who take the training and successfully pass the final examination are awarded a Connecticut Aging and Disability Specialist Certificate. The Specialized Care Managers (SCMs), a newly created role in 2014, receive Motivational Interviewing training which consists of a two day training and additional monthly coaching sessions. There are also monthly webinars and a quarterly retreat that staff is required to attend.

Feedback about the TC and HC online training included:

- Benefits
- Challenges
- Respondent recommendations

## Benefits

Overall, respondents gave positive feedback about the 2014 online training. They felt the training was helpful and that it is needed for the continued success of the program. Many respondents thought the training provided a certain level of knowledge, expectation, and competence for staff.

*The quality of the care coordinators has increased significantly in terms of the training and so forth.*

*Everybody I've talked to has said they thought it was wonderful. It was thorough, it was well thought out, it had good information that they can use.*

*I'd just say that any, no education is wasted, and anything that we've learned, we put into our little kit of what we know. We may not even realize where it came from, but it's there. And we can refer to that or it might pop up in a certain situation. Oh by the way, this could be tried or that could be tried or this number could be used or whatever.*

*I know that I liked doing it. It really was affirmation as to why we do this work. Learning, reeducating myself about the Disability Rights Movement that was something that was, kind of learning about that now being in the work as opposed to being in school. It meant something different. It meant something more. So I think having staff really understand it and understanding who we're working with.*

## Challenges

While some respondents felt the online training was helpful for the Transition and Housing Coordinators in doing their jobs, others had concerns about the time commitment required. Many people mentioned that the training was difficult to fit in when the TCs and HCs already have a very full workload. Another stressor mentioned was the lengthy final exam.

*The one negative was trying to do the courses while still trying to do your job. That's where it gets really sticky. Because it takes a lot of time, and some of the modules are 80 pages long. So trying to kind of keep up your numbers of your transitions and doing what you need to do and taking the course at the same time, that was the problem.*

*I think the only thing that has been voiced to me is that perhaps more time should be allotted for the TC or the housing coordinator to complete it. But all of them have said that it's valuable, that it's really thought provoking, it's very well done. But given the reality of them trying to learn a new job, trying to ramp up with their cases, the time constraint has been brought to my attention as being a little bit of a tricky thing.*

*The test, I thought was ridiculous. It took people on an average of 4 hours to do it. Oh, yeah. It's paged. It's like going for the biggest bar exam or something. I mean, even people like my boss couldn't believe – and he's a former attorney – he was like, he couldn't believe it. It's a lot of questions and you don't have a lot of time ... big stress.*

As in the previous year, some field staff thought that a portion of the training was a repetition of material covered in college, particularly those in the field of social work; even so many considered it useful as a refresher. There was mention of the training being helpful in their everyday work with consumers, particularly around communication and education about persons with disabilities.

*There's like some active listening and motivational interviewing stuff and that always comes into play when we're dealing with the clients and meeting with them especially if it's, was a collaboration where we're with the family and we're with the social worker. That's been effective.*

*I could see how important it would be for someone, like I mentioned, a lot of our transition coordinators and housing coordinators are recent college graduates. Even if they have an MSW, some of this stuff is probably foreign to them unless they have like a direct personal relation to somebody that has a disability or something like that. ... prior to the Olmstead decision [community integration for everyone], [by] the Supreme Court, ... people were stuck in nursing homes and couldn't get out, so it really is a civil rights*

*issue and I think, that's what I think the benefit to taking that class is, is that it really kind of, among other things, a lot of information and education but definitely the whole philosophical pieces of it, which is really important.*

*... I feel like you benefit from the terminology, the role of Money Follows the Person, the kind of services it provides, how to work with somebody whether the person is physically disabled, elderly... it's resourceful. It's just because what you get tested on, I should say when you're going through the process, is what you do every day.*

### Respondent recommendations

Several people suggested that the CADER training should be made available to all staff, such as SCMs, in an effort to help ensure that everyone has the same information and to have more continuity within the program.

*My thoughts are I wish I'd done it myself or I wish there were other people in our organization who could take it, like our education person. And maybe they can, I just never asked until now.*

*I think they [the Specialized Care Managers] should do the CADER, actually. I think that for some care managers, they would really benefit by doing the CADER exam, especially about person-centered planning and, because that, just the idea of why is this so important*

Other respondents reiterated the need for an in-person, face-to-face component to compliment the online training and the value of mentoring.

*My philosophy, though, is that at some point, that I think it enhances the benefit of the training if there is at least some component that's face-to-face, so that there can be, and there may be on the online, there may be an opportunity for interaction or questions or whatever, but I think both components are important to support a strong training program.*

*So I may come in and try to explain that I [would] meet with the family because the person didn't know how to explain that. Again, that's something that you just don't know; you'd have to go through that process. And I've done that many times that I was confident to meet the family and go over and have the TC sit in with me so they get a feel for what to say and how to go along with that process.*

TCs and HCs also receive initial training from the Department of Social Services MFP Central Office, separate from the CADER training. This initial training focuses on overall job responsibilities and using the MFP website. TCs, HCs, and the Supervisors commented on this training, suggesting that the training be recorded as a webinar or online module form so that new TCs and HCs could get trained immediately. More practical job related training and up to date training when protocols changed was also suggested.

*The issue becomes actually having that training occur when new staff comes on board but it doesn't always happen early in their, in their start. When they start, it may be a couple months before that happens and so really the burden then rests on the supervisors at the agencies and the staff to really do an introduction to MFP and all of the job duties that occur with a transition coordinator.*



*I think rather than have someone lead it maybe if it's something that can be recorded and then the new staff can just go in, review the modules with it being recorded.*

*I do think that having an in-person sort of Central Office day going over paperwork, going over scenarios, going over the rental assistance program, that that would be helpful because that doesn't exist. So I have to rely on current staff to provide that for the new housing coordinators coming on board. And most of the housing staff is fairly new so that's been tough.*

*I think ensuring that the TCs and housing coordinators have training when programs change, the rules change, the regulations change ... But that's the one thing I can see that ensuring that they have that information ahead of time is good.*

When asked specifically about additional training for Specialized Care Managers, respondents had several suggestions, including taking the CADER training, training on topics such as current durable medical equipment and assistive technology options, mental health services, and Medicaid. Multiple suggestions focused on care planning. Respondents recommended more training on person-centered planning, complex care planning, and dignity of risk. Also mentioned was a need for overall training on the MFP transition process and practical steps of the job, and cross-training for different types of disabilities. Some of the SCM specific training comments were similar to those made about the online training for TCs and HCs, such as a need for in-person training opportunities and mentoring, as well as information sharing about the various roles and responsibilities of the TCs, HCs, fiscal intermediary, and other MFP staff.

*I'd like to see them shadow a TC for a day or a couple of days or whatever that is, so they actually see what the TCs are doing with the consumer beyond just the care plan. I think that that would give them a perspective that they may not have. I mean, ideally, it would have been great to have been able to have transition coordinators have a career path to become specialized care managers. They would have been great at it because they kind of see all of it – whereas bringing in new people that haven't necessarily served in that capacity, it creates a weak link.*

*Well, it's good for them to also know some housing stuff as well, which we have done here in DMHAS anyway. Not globally, just here inside DMHAS, we've done some collaboratives with our own clinicians, our nursing that are most likely the SCMs on cases where we've done a little collaborative on housing just to kind of discuss what are the expectations on our end and what they should be looking for to help us out and what we can do to help them out, as far as that transition period goes.*

*I always think that any opportunities to do some creative person-centered planning is always, it never goes to waste. Any of those opportunities to have people practice some of those skills so that's not really an online training, that's really a more in-person type training, and even having people mentor them through some of those processes, I think, is really important.*

*But for people new to care management, the complexity involved in care planning for those waivers that have a lot of services. So the Connecticut Home Care Program has just like 15 services you can choose from, and of course, you're merging the in-kind supports and the family supports and trying to balance respite with paid service. And it's really hard. ... We don't want people to think what service do you throw in there next, we*

*want people to think about the whole person, the whole family, the environment, and then...it's an art.*

*Training on the new demonstration services. The new demonstration service was, they were more or less kind of printed out for us but kind of, some more solid training around that would have been helpful. ... I think talking with the utilization review nurses at the MFP office about how to use them? When to use them? How to have them on care plans? Things change so much that new forms are developed frequently and they're sent out. But like some, when a new person comes on board training that may be face-to-face or a webinar, but something about the demonstration – sort of hearing it from the people who are reviewing the paperwork. What do they look for? What's required? How do you add them in a plan?*

### **Positive Communication**

As an integral component of any successful program, communication is something that respondents felt strongly about. Overall, they indicated that positive communication has increased and continued to improve across all aspects of the program. While some respondents referred to communication as a strength of the program, others reported that communication challenges still exist; these are discussed in the “Barriers and Challenges” section of this report.

Positive communication mentioned by key informants was associated with regular meetings (i.e., Steering Committee, Supervisor meetings) and staff retreats, updates and program information communicated by supervisors, the “My Community Choices” MFP website and UConn evaluations collaboration, and improved communication between MFP staff and nursing homes.

### **Regular meetings and staff retreats**

Many mentioned getting information about current activities and new initiatives through the various regularly scheduled meetings including: the Steering Committee, Central Office, a variety of workgroup and the SCM, TC, and HC Supervisor meeting, as well as the monthly webinars and the quarterly retreat that staff are required to attend.

*I don't know that perfect ever exists, but certainly for me to see the level of communication that goes on, is something I haven't seen in other committees that I've participated on through the years. I think that's a strength. I do think that's a strength. And I think it's because of the people that are in the positions, I do. I think that they're open minded and accommodating.*

*I think the communication within DSS is better. Because before you would talk to individuals that would say well whatever I think doesn't matter; nobody listens to me. Or there's no avenue to express what we're seeing or finding in the community. And I think that now there is better communication within the department for that feedback and then trying to digest it and decide what needs to be changed to try to address the needs.*

*We've had a lot of meetings. Sometimes I wonder if we really talk about what we really need to talk about at those meetings, but it's been nice having more of those meetings going on to know what's going on with MFP. And there's also the – Paul does the monthly phone call meetings [webinars] that are helpful, too. You get the updates and what's going on. So that's been, to me that's been helpful because those weren't going*

*on before. We would have occasional MFP meet-in-person kind of meetings, but we never had those like monthly 'Hey, this is the changes, this is what's going on, here's something educational and new to learn from MFP'. And I think that's been helpful.*

### Updates and program information communicated by supervisors

Some respondents reported they are kept up-to-date by their supervisor via meetings, email, phone calls and/or informal conversations. In some cases, a supervisor attended one of the larger meetings, such as the Supervisor meeting, and then facilitated getting the information back to other staff. A few mentioned agency specific staff meetings for that agency's MFP staff or field staff.

*Usually our supervisor will keep us abreast to any changes or anything that he feels that we need to know. Being an HC, I don't necessarily have to be involved in all of that. That's, to me, more of the TC's role, but he does inform us so we have a better idea of what's going on. We usually have a meeting at the office, once a month or something like that just for MFP folks.*

*Well, the team, the MFP Central Office staff meet weekly, regularly. I, for one, do appreciate those team meetings, and I have voiced that, because that is the only way for me to be able to stay in contact, stay in touch or updated as to all the stuff that's going on in the background that I may or may not be directly involved with. There's a lot going on. There's no way for me ... to be directly involved in all of that, but when we're able to meet weekly, minimally I know what's going on.*

### The "My Community Choices" MFP website and UConn evaluation collaboration

A few respondents mentioned getting information from the MFP web called "My Community Choices" and others talked about the reports generated by UConn being a valuable way to gain information about the program.

*They all use the MFP [web] system and so I think that that's something that they use a lot for communication, so I would say a lot of their communication is through the database.*

*I think two things. I think one the partnership with the University of Connecticut is a strength because we can get information that we might not otherwise get. And sometimes people will tell [UConn] things that they're not going to tell me ... but yes, they'll tell researchers things that they won't tell us because it's anonymous, and I think that's a good thing. So I think that that's a strength. And then the reports and the information that [UConn] has provided for us and reasons why cases were closing or reasons that were delaying transitions, we did put in place the changes that I just talked about.*

### Improved communication between MFP staff and nursing homes

In the past it was stated that there was a desire for improved communication between MFP staff and the nursing home social workers. This year there was some positive feedback related to this suggestion. One respondent remarked that the effect of the new process in reducing the time from application to assessment fostered a better relationship with the nursing home social worker and other community partners.

*[TC] really should get some recognition because [TC] is excellent, as well as [another TC] also part of the program who's helped us [nursing home] transition a couple of other people and I just think their work ethic and their communication is very good. I think other than that like I said once it's transitioned, once it's handed off to our regions representatives I haven't had any difficulty with communication.*

*... nursing homes have been more open to helping us where, when I first started, they'd be like, why do you need me for this case. Now they're actually making referrals because it's basically a law. They have to because the patient has a right to see what other services would enable them to be successful and move out of the nursing home. There's other options, let's just say. So, yeah, I feel like the social workers in the nursing homes – not all of them but most of them are very helpful and they're making referrals and they're taking the program serious and trying to help ... I want to say, to help others at their facilities to make this work.*

*We have heard from nursing facilities that they're happy about the response. Just a few weeks ago a specialized care manager called to setup an assessment and the social worker goes, "Wow that was quick." So I think the community, the partners are seeing that things are moving along better. There's no wait list.*

### **Commitment of Project Staff and Stakeholders**

The extraordinary commitment of MFP project and field staff was underscored during the MFP process evaluation interviews. A few respondents mentioned the unwavering commitment of Dawn Lambert, Director of the Program, as being an absolute strength. Many of the staff mentioned feeling that what they do is important and how much they enjoy helping the consumers. Also mentioned was the importance of remembering why they do what they do, and that keeping the larger picture in mind can help with the inevitable daily challenges that arise.

*I am still very much committed to the program, despite the numerous obstacles and frustrations and feeling so overwhelmed at times. But, it's rewarding, so I am very grateful and fortunate to be able to work such a demonstration, and hope to, along with the rest of the MFP folks, prove that this is actually a viable option, and go from a grant of many years to a permanent program, Medicaid program.*

*And one of the great things about it is Dawn Lambert because she has a unique ability, it seems to me, to involve people in policy decisions without abandoning the requirement that MFP be advisory and DSS be the actual policymakers. That's a very hard thing to do, which is to solicit opinion and discussion and, at the same time, move forward within the parameters of the agency. She's been able to do it so far and that's wonderful.*

*I think that there are a lot of people throughout this MFP system, including people at Central Office and the care managers and the TCs and the housing coordinators, that are fabulous. They're really good people. They're committed to this, they believe in it.*

*They, the nurse, the care managers that started out are still there and the only addition, the only changes have been new people as we've gotten more positions so and I think it's one of those areas that if you talk to the care managers, there's a very high job satisfaction. I think out of the six care managers, I think only one has looked for other opportunities. ... So I think that that's definitely a feather in MFP's cap, when you see the folks within our agency who have a lot of seniority who could really choose a lot of*

*positions and they're coming and working on MFP.*

### **Program Flexibility**

The MFP program was designed to allow for necessary changes as the needs of the staff and program participants evolved over time. Judging by the responses, people valued this flexibility and hoped it will remain as the program continues to grow. As issues came up and different needs were identified, new guidelines were proposed to meet those needs and many project staff had a chance to give their input. One respondent said it's, "A willingness to look at what's being done and find out what isn't working well and to try changes to make it work better."

*So the next thing I would say is a strength is the field staff and Central Office staff providing input into that design. That's an absolute strength. People will say, give their ideas, and then that helps inform the next day. ... We have great staff who are leading from all different levels and are willing to participate and help address the problem areas that they see and put together new tools.*

*The process change came out of strategic planning which I was actually able to be a part of and a lot of front line staff were invited too. So the fact that the leadership of the demonstration project wanted to have the input from the field and took into account what our recommendations were at a strategic planning retreat was really great.*

*And the program has changed dramatically in my four years on the Steering Committee in terms of its continually being reinvented to meet the needs of the clients, ones that they're servicing, and trying, through trial and error, and I don't mean trial and error in a negative way but just through implementing processes and a constant evaluation and feedback. And certainly, the dashboard studies that we get reports from the consumers themselves who have been placed trying to say okay, how are we addressing the needs of the population.*

*I think the fact, the just overall commitment to really taking the information that has been provided, either through your evaluations, UConn's evaluations, the participant's experience and really being able to make those changes within the state system, I think, is actually remarkable.*

### **Collaborative Partnerships**

Key informants continued to remark on the ability of MFP to bring different state agencies, community partners, providers, and advocates together, working to support change at the individual and systems level. As described earlier in this report, the use of regional teams enhanced the partnering among different community agencies. This unique approach took advantage of the diverse experiences, resources, and encouraged creative problem solving. The Steering Committee was another example where multiple stakeholders combined forces and worked collaboratively toward systems change.

*I think that's one of the things that MFP did incredibly well from the beginning was to get key people from a variety of entities, like the state agencies, to come to the table and talk about how could this all work. And I think that that's the strength of the Steering Committee.*

*I have to say, I've been in the nursing home industry in varied roles since 1984, and it is the first time that I've seen state agencies sit at the table and really work collaboratively. I'm not saying that they're perfect. ... And everybody has their turf, but I think that it's the first time I've seen a more unified approach. And I think because we have to change. This isn't, we have to make these changes, and so we need to figure out the best way to get there.*

*It's managing to coordinate with other programs like Community First Choice and other state plan amendments as well as the waivers in a way that makes the overall policy implication of the MFP pretty significant.*

## **Barriers and Challenges**

Barriers and challenges distinct from the new transition process were also identified. As in 2013, three overarching themes related to barriers and challenges were identified in 2014:

- Programmatic Barriers
- Communication Challenges
- Barriers to Successful Transitions

### **Programmatic Barriers**

Programmatic barriers mentioned by key informants during 2014 included:

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

### **Funding and staffing**

Lack of necessary funding continued to be a primary programmatic barrier in 2014 and included issues related to being underfunded for the program as well as having to work with budget limitations and the impact that has on the level of services a consumer can receive. In some cases, funding was mentioned by transition coordinators and other staff and was associated with wanting better compensation for work completed.

*Funding is always a challenge ... we are underfunded for the program, and so it takes a bit of a toll on the agency financially ... we wind up paying about \$6000 just for our participation on an annual basis. So that's a huge problem.*

*I think that the barrier of not being able to give a consumer more by way of services because of budget constrictions, to me is a huge one. Because the Medicaid rates vary throughout the state, in some instances significantly, some consumers really are not able to get what they really need by way of services. Their package does not financially support what they need to be safe, to eliminate or minimize a re-hospitalization or a re-*



*institutionalization after discharge.*

*The provider community that we're relying on to be staffing all of these waiver services and that we're relying on for providing the hands-on care, those same services, those same agencies having had COLA increases, they haven't had rate increases. So we're moving all of these people out, but we're moving them out into a rapidly fraying safety net system.*

Insufficient staffing was another programmatic barrier during 2014 and included not having enough transition coordinators, challenges related to field staff turnover as mentioned above, lapses in staff, and the need for more staff in general.

*There is a lot of turnover with the TCs and housing coordinators as it happens and I think since I've been here a year, I think I've lost seven people ... but it's because the pay isn't that great. It's just, there's a lot of reasons why, but pretty soon I'm going to start taking it personal.*

*I think, unfortunately, the access agencies have a lot of turnover because they're private nonprofits. Their wages aren't that high, so whenever you have to spend time teaching new staff, that always takes time.*

*We've had ... staffing lapses. I don't mean MFP staff but the secretary. I think, interestingly enough, the secretary has an important role because if the minutes don't get out prior to the meeting and the agendas, etc., it really is a lapse.*

*We could always use more staff. We could always have more people out in the community doing the work, but I don't see that happening. I don't see that being realistic given our state's budget.*

### Community supports and program limitations

Respondents reported continued limitations in community-based resources and the funds associated with them, such as the need for more housing and problems related to supporting people who employ PCAs or those with psychiatric disabilities. A related program limitation mentioned was the disconnect between what the MFP care planner includes in the care plan for State Plan services, versus what DSS determines is necessary.

*I'm still fearful that as much good that MFP has done for kind of changing the system, we've still got to increase the community-based resources and the dollars associated with them because it's just not enough for people to not feel as though they're struggling and living in poverty.*

*I think the main challenge is the pool of resources, housing resources available. Pretty much in every community in Connecticut I think that's an issue. And then, again, if you're talking about people with different levels of disability, finding places that either are ADA accessible or appropriate for people to live.*

*I think we're going to see a much more difficult time placing PCAs with the people that need them because I still think that there's a difficulty in that process of engaging individuals and having them understand what it means to be an employer.*

*We have been involved in the past, back in the days when people with serious psychiatric disabilities were being discharged from the state hospitals and back into the community. So, again, I think the model makes sense, but the community resources have to be there.*

*... working with people with mental health issues that don't meet the criteria of the WISE waiver for DMHAS but have significant mental health issues so if you're trying to transition them into the community like on a State plan, they don't meet the criteria for the PCA waiver, they don't need hands on help. They're not elders. Those are the challenges we have, these folks.*

*With the State Plan folks, we do make referrals to community-based services with DSS. ... What they do is they actually go out again and do another assessment. So we do an assessment and ... we put that [services] in our care plan but then ... they're [DSS] going to do their own assessment and provide services that they think, so it's sort of like when we're creating a care plan for someone in the State Plan but there's no meat to it.*

### Central Office

Concerns voiced about challenges related to Central Office included a disconnect with what happens in the field and interfacing with a waiver program after the MFP Demonstration year is over. One respondent remarked on the length of time it takes to send out new applications.

*I do think there's kind of a disconnection between DSS and what we actually do in the field sometimes. I think that they don't realize some of the people we work with really need hand holding and need more kind of support ... It's not just like old people going from a nursing home going home. It's kind of young people who have addictions, who have mental illness, maybe mental disabilities that prevent them from understanding the capacity of everything that's going on, and we have to spend a lot of time explaining and teaching, and I don't see that they kind of understand that ...*

*One of the most interesting things that I think we've had ... is getting people to realize that yes indeed, we can serve people who live at Connecticut Valley Hospital or Greater Bridgeport Mental Health or Connecticut Mental Health Center, if they're over 65. And it's been, some people at Central Office, we've had to say – "No, this is a qualified institution provided that they have Medicaid, and the only people that can have Medicaid up here are over 65."*

*When you make the initial referral online, I've found in some cases, especially one client of ours in particular, it took a long time for it to get released to the appropriate people. Because they want all the referrals done online now and that was frustrating. Because it took some time for the actual referral to get released which held up the process.*

*The only other thing that we had was communication about transition from the nursing home into the community and then being ready to come into the PCA or the ABI service as a whole. So clients would start their participation year .... [but] not really receiving notification like hey, they're coming on. They're done with their year. ... So a client will come off of, transition off of MFP, and we're not notified, and we don't know about it.*

## Policies

Burdensome policies, particularly those related to Medicaid, were mentioned as programmatic barriers as were the time limitations some staff have to be involved in policy discussions. Respondents also expressed concern about lack of written protocols for the MFP program including fiscal intermediary reimbursement.

*Medicaid itself is a barrier. It's a cumbersome system. It's convoluted. I don't think the people who designed it really thought it out or they did and, in theory, it was a great idea; in practice, it was something else.*

*I think the natural downside to any program as dynamic as this is that Dawn can't be everywhere and, insofar as that is true, the lateral development of sub-committees and policy discussions has to be limited by the amount of time she can devote to it.*

*So I think the roles are clear maybe not completely ... but like even how you do certain things, the forms, depending on who it gets submitted to you get a different answer sometimes.*

*I'm just very surprised that there aren't any, some standardized, written protocols that are given to everybody to follow, and if they change, we revise them and move forward as a process of improving it. They had developed forms and stuff, but they didn't have written protocol. So if a new person was hired, there was, I felt like there should be something to give to them that at least gives them a guideline or a structure to work out of. And there isn't any of that ... the manager basically told everybody word of mouth ... You jump into MFP, you're put on the website, and you're kind of, it's an easy website to maneuver, but it takes you a while to figure it out.*

*The only thing, I guess, the structure, which is MFP-related, I don't particularly like the way we ask for reimbursements through Allied. I feel like they are so slow with getting checks and I feel like that's a barrier sometimes to my transitions because I have to wait for the money.*

## Respondent recommendations

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

- ◆ Evaluate how the program is funded.

*At the moment, I am currently waiting for the benchmarks to be released and the success in meeting those benchmarks because I do have concerns about whether it is the intention of DSS to fund the program at a loss or at a flat rate with the expectation that these bonus payments will make up for that shortfall. But I don't believe that that adequately addresses issues of volume. I don't feel that adequately addresses issues of case mix. So if it is the expectation that the agencies need to do what they need to do in order to reach the benchmark payments that will then fully fund the program. ... I think that needs to be evaluated.*

◆ Expand and retain staff.

*If there were more staff at MFP in the role of assistant executive director – somebody that Dawn could delegate to. I'm not aware of a person of that status in the staffing of MFP ... if there were greater opportunity for her to delegate things, then maybe there would be more robust achievements and reporting, but I'm not sure that we have enough money for that ... I would love to see them have yet more money but in a plentiful way to expand and delegate and fine-tune.*

*I think I would have state-employed housing staff. And I would have either the contracted, well not the contracted field staff but state-employed staff become more of a presence in nursing homes. Because there's a lot of misinformation about our program. It's all coming from people who don't work for the state.*

◆ Provide better compensation for staff.

*The TCs and staff at the centers [Centers for Independent Living] and even at the Agencies on Aging feel like we're not getting compensated the way we should ... we do wonderful work and I just feel like – and it's not just me; it's other TCs – we feel like they could do better ... if every office lost that one person that did a great job, that's going to reflect in that office ... The DSS gets their raise, why can't we get our raise?*

◆ Increase community-based resources.

- Develop safe, affordable housing.
- Focus on workforce development.
- Increase number of service providers to reduce risk.
- Share agency/organizational resources to benefit consumers in the community.

*If we're talking about the scarcity of resources, increased resources would be the first thing I would think of, and so if further housing and development of safe and affordable housing is available for folks coming out into the community, I think that that certainly would be a plus. And I know each community approaches it differently in terms of their ability to be able to develop housing, but I think increasing the resources and the availability of appropriate housing, or community residential settings, for the individual, would be the thing that I'd think of.*

*As we look at the goals of rebalancing and as we look at the goals of nursing facility transition and diversion, I think there needs to be more done in terms of workforce development. And I think there needs to be a lot more done in terms of workforce capacity.*

*I think that, if there is some way MFP can prove that, hey, we can still save the state money, but we can still offer this person, if not 24, very close to 24 hours between the various service providers, I think it would at least reduce significantly that obstacle. It may not eliminate it because we, unfortunately, don't set those rates, but it will definitely minimize the risk for, I would say, a significant amount of consumers.*

*So I think that while MFP is bringing an awful lot of money into the state to do really good things, I think that unless that silo comes down and the spoils are shared, I think it's going to be nothing but another big silo ... I just don't see how we can continue to send more and more people into the community with fewer and fewer resources to care for them once they're there.*

- ◆ Provide better program support.
  - Improve referral feedback.
  - Increase case management for difficult cases.
  - Include and involve medical personnel when appropriate.
  - Ensure transition checks and balances are implemented.

*I think getting feedback when those referrals are sent online. You do get something that pops up that just very quickly says like your referral has been sent but it would be nice to get some feedback like the status of the referral and what's going on with it because for us it's okay your referral's gone in and then we don't know what happens until we, it's handed off and we get that initial contact from the, I forget which one it is that comes out first to do the assessment.*

*Maybe to tighten up the process a little on getting certain people out with certain histories. I think, because that also puts a lot of work on the case management piece. Very needy, needy people need a lot, call a lot, that type of thing. I think looking at the end of the process, like I said, for things that don't work out or just because people have died or gone back into a nursing home because of physical or mental needs.*

*A great addition to our MFP team is we hired a nurse ... it definitely brings that level of credibility when they're dealing with some of the medical personnel ... I didn't want to really have to have a nurse fight that fight for folks but, unfortunately, in many cases, having that nurse on board ... you can already see the impact ... I think it's really identifying once again that we do have individuals who are leery about moving. We have providers who are leery about people moving. We have families that're leery but it's the medical professionals that a lot of times they rely on to give them the thumbs up and if that medical professional is making a decision based on very limited information and then we have a nurse who is able to not just go toe-to-toe with them but really able to dispel some of the myths about people living at home with significant medical needs and not the fear that they have to live in a 24-hour setting to get those met.*

*Like I said, I think MFP is a great program, and as long as we have checks and balances and don't get so excited about transition that we forget about well-being, we'll be good .... To get discharged and then not be safe is not a good thing. And I don't mean like paternalistically safe. People have a right to make a choice, but we want to make sure that we're not putting folks in a really bad circumstance.*

- ◆ Evaluate and revise policies.
  - Standardize program processes and protocols.
  - Clarify and communicate program expectations more effectively.

- Eliminate the spend down coverage group.
- Develop a better housing policy.

*If you don't have processes standardized across the board with everybody understanding the same way to do things, things don't get done the same way, problems come up, and it's repeated over and over again. So sometimes you have to change those protocols, but it helps you to do it the right way. ... We have a protocol committee that meets quarterly to go over the policies and protocols and make sure they're up to date or if there's things we need to change.*

*Certainly I'd get rid of the spend down coverage group because it's just an awful, awful thing. I would certainly change it, and at the very least, if they still want to have some sort of coverage group that requires individuals to pay for some of their Medicaid coverage, you could make it so it's a monthly premium instead of requiring the person to spend thousands of dollars over the course of 6 months, which is, I think it would be difficult for anyone.*

*As we're working on the transition side, I really think we need to be working really hard on the diversion side so these people don't wind up in nursing homes to begin with. Because if you can keep them in their homes to begin with, that home would not be lost. It wouldn't be sold. It wouldn't be turned over to someone else. It wouldn't fall into disrepair. So I just, I feel like we've stalled on the diversion side of things.*

### **Communication Challenges**

Although many respondents reported continued improvement in communication across all aspects of the program, there were still communication challenges to overcome. These included concerns about lack of direct communication, particularly with Contractors, cessation of the Contractors' meetings, not hearing about frequent program changes in a timely way, and lapses in passing on information about program adjustments because a communication line was weak or nonexistent. Other communication breakdowns included gaps in program awareness among MFP staff. Suggestions to improve communication are provided at the end of this section.

- Lack of direct communication
- Cessation of Contractor meetings
- Gaps in program awareness
- Respondent recommendations

### **Lack of direct communication**

Some respondents indicated that lack of direct communication was a barrier to being able to being able to fully participate in the program. Additional informants shared frustration in feeling they are not as informed about program activities as they would like to be. Clearly, they would appreciate more direct, timely communication.

*There were some meetings with us at a very high level when BIP [the Balancing Incentive Program] first started, but there really has not been any ongoing communication. And then, in terms of the Universal Assessment, that has been conversation really only at the access agency level. Those of us that are not access*



*agencies really have had no real indoctrination into the process, which is unfortunate, again, because it prevents any of that intellectual capital. It prevents my agency from really participating fully and really sets up a dynamic of well, are we really intrinsic to this process at all?*

*So trying to get the time to make sure that I'm as educated as I should be is hard to do, and we're not necessarily making adequate time to do that. And then ... everything comes down through the supervisors, and it doesn't necessarily get copied to the directors of the agencies.*

*I can't say that I feel as though that I am kept informed. Those programs I knew about, because in the past, we've talked about BIP, and I knew about the legislation, and the right sizing. But we don't necessarily get that communication directly from Central Office.*

*Well I said this probably year after year in process evaluations, I feel like if we're not in every place we will not get the full picture because so much is changing day to day. And there's no one line of communication, one avenue of communication. It's like the sawed-off shotgun approach. You happen to be in the room or not. So there's, you look for what rooms are the most important to be in in order to know everything that's going on, and that's what we're doing.*

### Cessation of Contractor meetings

The cessation of Contractors' meetings made it more difficult for contractors to stay informed. Contractors stated that these meetings were valuable in helping them see the bigger picture of MFP and how they are a part of that. In some cases, the lack of meetings for other sub-committees also prevented the flow of communication and information.

*Over the last year, I have to honestly say it feels like I'm very disconnected. And some of that is in a good way. I think that there is more reliance on the supervisors, and I think that that has been helpful to a variety of the contractors. But from a contractor's perspective, not having the aforementioned contractors' meeting makes it kind of hard to know what some of the stuff is going on and the bigger picture perhaps than what we necessarily get from the supervisors. So as much as I don't really like the contractors' meetings, they were kind of valuable.*

*From my perspective as an Executive Director, there are a lot of things that I'm not invited to. So for example, I feel like a lot of the dialogue occurs when they have the retreats the staff retreats where the staff, my staff, goes to an all-day thing with Central Office staff and they hear about how things are going. I don't. My staff reports back and the supervisor that I helped fund reports back, but as a director, my involvement is very, very peripheral. Without the contractor meetings, there really is no other avenue. They have supervisor meetings, and they have these retreats, and that's pretty much it. They want to interface directly with the staff that are doing the work but not so much with the executive directors.*

*And there are some sub-committees who have never met, either because there wasn't enough staffing or because the agency position on sharing information, such as information on critical incidents, for example, has not allowed for the free exchange of information.*

### Gaps in program awareness

Gaps in knowledge about program details among CO staff that most likely resulted unintentionally were not noted as being negative but rather as an indication of the need to expand shared leadership and in so doing strengthen the overall structure of the program.

*The face of the program and the essence and the spirit of the program is all wrapped up, from my perspective, in one person being Dawn Lambert. And I think that we have limited contact with other members that are below her, and they're all very skilled at what they do. This is not a negative. But the negative being that, trying to have—and it may be just the way that DSS is structured this isn't possible—but having more ... foot soldiers for lack of a better word, that are more aware of all the different components of what is going on and how they interrelate ... Once you get past [Dawn], there's a weakness. ... it seems like a lot of the program is in her head, which is fine, but where's the depth? ... When Dawn can't be present at a meeting, and this just happened at this month's meeting, the individuals that fill in, again, are quite accommodating and certainly you can tell that they are trying their best, but there's a big gap when she's not present.*

*Dawn has enhanced the whole world of opportunities for people who come out through MFP. And it's a wonderful accomplishment, very dynamic, but it's hard to capture for people who aren't inside it, like the Steering Committee.*

*I think assumptions are made about what people know, and just for example, there was a huge mix-up with the Balancing Incentive Program, and there were people at one level who understood the way things were going to happen, and, then, there were two consecutive presentations two days in a row where it seemed like the people who were doing the presentations didn't have the full picture.*

### Respondent recommendations

When asked for suggestions regarding communication challenges, respondents provided some of the following recommendations:

- ◆ Provide better communication and more of it.

*I would ensure that the agency directors or their designee, whoever that might be in the larger agencies—it may not be the executive director. But for me, being cc'd on stuff that the supervisor gets, because I think that in some ways they're more up to date and they have more regular meetings, they have supervisor meetings. ... honestly, some of the stuff that I hear is from outsiders that are advocating for changes in DSS as a whole, not just MFP.*

*It's probably unrealistic, but it would be nice if Dawn's monthly reports were in written form and not just orally at the meeting ... there are meeting minutes but...that's after the fact rather than something that can be distributed in advance so that people have a chance to review.*

*I think communication really could be improved by the Central Office remembering that they are not the executive directors of the agencies nor do they supervise that staff.*

- ◆ Increase awareness and knowledge.

*Education is high priority as well, with communication, and continuity ... If we have those three things in place, I think that's where this program could succeed even more because the lay person doesn't really know as much about what these programs do so we have to re-educate them almost every time and that kind of takes some time away too but at the same time, it hopefully gets that person next time to know, "This is what we're doing next time and this is how we're going to do it". So overall, I think that's what we're hoping to succeed with.*

*My own personal failing in this has been my ability to see the overall structure. I know the components pretty well but where I struggle is to see it as a functioning organic thing. That's what we all struggle with so it's not exactly a criticism. It's very hard to see something as dynamic as that from sort of the – it's almost like you want to look at it from above and see how it's working but that, to the extent we can do that, I'd love to be able to see that done.*

*... there's always opportunities to continue to clarify what MFP does, what the roles are, what our objectives are around. Moving people is one part of the objective. There's many other parts to the protocol and how it's really constantly connecting so people see how those things are connected ... I think the hardest part is really getting other people to see these are not phases that DSS is going through, that these are long-term systems that're being put in place ...*

- ◆ Revise MFP's organizational structure including expanding the core leadership team.

*I just think internally, there are 22 staff on the floor ... that does create some [communication] problems just because there's not a lot of time for any one individual person. And so I think that we just need to maybe have a different organizational structure here within MFP.*

*It almost seems like we really need a second in command that really has a full command of the program.*

## **Barriers to Successful Transitions**

Housing related problems continued to be the most frequently mentioned barrier to successful transitions. The second most frequently reported transition barrier was workload barriers. This included work related expectations for contractors, transition and housing coordinators, specialized care managers, and special care manager supervisors. The length of time it took to transition was mentioned less frequently than in 2013. There were also fewer responses for other transition related barriers than in the previous year. A new barrier reported this year included challenges related to successfully staying in the community after transition.

## **Housing**

As in 2013, housing continued to be a barrier to successful transitions. Respondents reported that funding including lowering of the Maximum Allowable Rent and difficulty in getting Rental Assistance Program (RAP) certificates approved contributed to ongoing problems in securing housing. Across the state, the limited pool of resources has resulted in a shortage of affordable,

accessible, or adequate housing. Other problems related to housing included difficulty in finding places to live for people with drug or criminal records.

*Funding is always an issue for housing ... Housing has certainly been an issue. Housing, I think, and certainly the discharge planners in the hospitals have been, it's, I think, difficult for them to get their heads around discharging someone that has significant care needs back to their living setting with supportive services and working with MFP representatives.*

*There's just not enough accessible housing out there ... the affordable rent, the MAR [Maximum Allowable Rent] is lower this year than it was last year, so it's difficult to find nicer apartments in the lower price range ... [and] the exact match for consumers.*

*I mean it's hard finding accessible housing. A lot of our consumers have drug histories or criminal histories. That always can be tough. I've had to use Fair Housing a lot to help guide me through some of my challenges there ... [or] have to research town to town and see.*

### Workload

Workload barriers reported by respondents were the second most frequently mentioned barrier to successful transitions. Contractors mentioned problems related to keeping certain cases open even though a consumer was not fully invested in transitioning and that these cases took time away from consumers who wanted to transition and were ready to do so.

*The only other thing that was mentioned to me was the closing of cases because that seems to still be a little bit of a problem. If a consumer, let's say, use my original example of not necessarily being fully engaged in their transition and they decide that they really don't want to do that, there's a sense that we're supposed to kind of keep encouraging them to consider moving out. And then it ends up then you've got an open case that you can't close because you're still encouraging them, so you have to maintain them in the same way that you would an active case. So those end up taking time away from the folks that really do want to transition.*

Specialized care managers indicated that they felt overloaded by numerous waiver changes and the changes and additions in tools that were implemented during the new process.

*SCMs, such as myself, are currently so overloaded with all of the waiver changes and the tool changes and additional tools that are quickly going to be implemented to our toolbox, that they're aware that we're not so readily available ... That can be challenging, because ... we're all being pulled in so many directions that it's not a matter of achieving the goals, but we're not achieving them as fast as we would like. And so, we come back to our perspective housing to work on those goals, but then everything else, emergencies and priorities come up, that then you have to place that goal on the backseat. And that, for me in particular, is very frustrating.*

As described earlier, Transition and Housing Coordinator Supervisors reported work related barriers to successful transitions mentioning the high number of caseloads staff had and the impact that workload had on transitioning people. Some transition coordinators mentioned concern regarding the increase in their caseload, difficulty in learning the tasks necessary to do the job successfully, and challenges in working with consumers who needed more complete

assessments so they could have adequate support after transitioning to the community.

*I don't see any challenges, other than if the case load keeps getting larger, it takes away for us to do the job efficiently because there's only so many hours in a day and only so many hours during the course of a week and if we have a case load over 75 – I'm at 50 right now; it's getting tough to be able to see everybody and do everything that you need to do because you have reporting to do, you have budgets that you have to do with the individuals ... There's just so much.*

*There's been agencies that are having a hard time retaining their staff because you throw 30 cases right at them and, in this job, if you've never worked in the field of this kind of work, it's really a lot to learn.*

*Once someone assigns us we're supposed to get to see them within the week but like our schedule is so booked, everyone's obviously in a different process. Some are pre. Some are transitioning. Some are post. So if you get someone on a Monday you're whole schedule is already booked for Monday, for the week. So it's kind of hard to get to them within 7 days when you're usually booked like the next few weeks of every month ... I guess it really just depends on like where the person is. Sometimes it works in my favor as I'm already going to that nursing home so I can kind of just pop my face in and start the process. But sometimes it's really hard to squeeze them in.*

### Length of time to transition

Length of time to transition was mentioned as a transition barrier again in 2014, but less frequently than in the previous year. Transition and housing coordinators as well as specialized care managers reported concern that the transition process takes too long. Getting RAP certificates approved, lack of communication between team members, high staff turnover, and/or being overloaded by work responsibilities were mentioned as contributing factors for some of the time delays related to transitions. Difficulty gaining access to a consumer's identifying documents was also mentioned as being problematic in slowing down the time of the transition process. In some cases, a consumer struggling with his/her personal choice delayed the process, especially if they were not confident they could transition successfully. Sometimes time delays existed as a result of having to wait for funding. It was also noted that the transition process has the potential to be delayed when there is lack of consistency in communication between team members or in fulfilling roles and related tasks.

*The procedure takes a longer time than I would want it to take. In my experience, we've been able to do it a lot quicker than what is being utilized right now. We've been having some issues with getting the RAP certificates approved.*

*Then a lot of people don't have identifying documents, and it's difficult for them to get them because you have to have an, oftentimes you have to have an identifying document to get a different identifying document. And if you don't have any, you can't get any.*

*Consumers end up waiting longer when there's lack of communication or when there's a high turnaround in staffing, because we're kind of sort of starting all over again when a new face comes onboard to the team, or when there's no communication. I may be, as an SCM, working on something that the TC has already figured out or resolved, so, therefore, any one of a team member could be spinning their wheels trying to get*



*something done that another team member has already taken care of.*

*So it depends on what the consumer wants to do, too. When the case does not move quickly enough, it's usually the consumer or the circumstances that the consumer has as the reason why the process might not meet the guidelines of transition in six months ...*

### Challenges related to successfully staying in the community after transition

A new barrier reported this year included challenges related to successfully staying in the community after transition. Transition coordinators reported that because of their workload, it sometimes made it difficult to spend adequate time with consumers who had transitioned to the community and who needed additional support or services to remain there successfully. In some cases, consumers experienced a lot of anxiety during the transition process because they were not sure they liked where they were living or because there was difficulty in getting the services they thought they needed. Having a good care plan was underscored as being essential to supporting consumers in the community and making it possible for them to experience a successful transition. It was recognized, however, that it was sometimes difficult to get a good fit for people in terms of the services and supports needed for community living. This was particularly true for people experiencing addiction or substance use problems.

*... where a person moves to a place they're not so sure that they like, lacking some of the things that they think they need, and so they, in the cases I know, they manage to linger on and eventually resolve the problems ... But the person who's transitioning suffered some of the anxiety around that.*

*I think it's very difficult to put together a good fit for some people. Some people who really feel that they have to get out into the community, and then, in order to make that happen, it's very difficult when you think about equipment and transportation and modifications and hours of help ... It's wonderful to give people a chance, but if you're working on the third time up at bat, maybe you should think about it a little bit more. Maybe you shouldn't be sitting in that Probate Court meeting to see if somebody's okay to go out into the community when ... they're already at the point of all of the services and all of the things that we can do to make that happen. And we're trying it again? When we really don't have more. We don't have more tools. We don't have more services in the little package deal. So why is it going to work now if it hasn't already worked the last couple times? ... We should be able to see a little bit better what is going to happen here. And I think a certain group of people that we deal with and those in the substance abuse realm, I think we're not close to where we should be as far as helping people. And as far as the substance abuse population goes, if that person is not ready to make a change, then I think there's nothing we can put in place that's going to make that happen. Because people decide for themselves. And if we're not there, then we're already out of the picture.*

*But I do think we have to have good care plans because ... if you don't have a good care plan, a lot of times that does fall apart, like if someone really should have a lot more support like say PCA or something, and you don't write them in the care plan, then a lot of times you'll have things happen.*



## Respondent recommendations

When asked for suggestions regarding transition barriers, respondents provided some of the following recommendations:

- ◆ Increase housing resources.

*Well if I had the money, I'd offer developers incentives to create ground-floor apartments that are accessible to individuals with physical disabilities. I don't know. Tax cuts. Whatever. Whatever you can do just so new and accessible units are created. And that way they're also not in danger of being considered segregational because they'd just be on the bottom floor of regular apartment buildings as opposed to creating apartment buildings specifically made for individuals with disabilities.*

*And as far as accessible housing, I just have to research town to town and see ... I wish it would kind of be like a book or something developed with all the accessible housing. But I've kind of had to make my own database, and that's helped a lot. I have files set up for each town, and if I find something, I'll just put it in the file and just kind of mark whether it's accessible or roll-in showers.*

*I do think there needs to be more focus on the housing side and working that out ... creating partnerships or outreach with landlords ... I think there needs to be more proactive measures on the housing front.*

- ◆ Provide easier access to transition-related funds.

*I don't particularly like the way we ask for reimbursements through Allied. I feel like they are so slow with getting checks and that's a barrier sometimes to my transitions because I have to wait for the money ... I shouldn't have to get funding and then allocated and then ask for a check and then have the check sent to us and then have to be another check to go and buy a suction.. that takes a month right there when that person might need it... if I can get it within that week, that's... she shouldn't have to wait. A person waited 6 weeks to get something like that. They could've gotten it... now, my center funds the money but they can't always do that because sometimes we just don't have the funds to do that. So I wish if there was anything that MFP and Allied can work on something to make it easier to obtain funds and not have to wait weeks and weeks for it.*

Some transition coordinators mentioned concern regarding the increase in their caseload, difficulty in learning the tasks necessary to do the job successfully, and challenges in working with consumers who needed more complete assessments so they could have adequate support after transitioning to the community. Their suggestions included the following:

- ◆ Improve the efficiency of the transition process.

*The time it takes from Point A to B to C, it should be a little bit more streamlined and I think that we are in the process of talking about that anyway internally to see what we can do to help promote that.*

*I think that the paperwork should be a little bit tighter. Like I said, some things are not quite ready or done.*

- ◆ Increase transition and housing coordinator staff to support the specialized care manager's transition work and reduce transition and housing coordinator caseloads.

*So I do think that we need an increase in staff so we don't get clogged up on the transition coordinator end. We fixed one problem in waiting for assessments to happen by flipping the assessment to the front and having the specialized care manager up front, but then we need to be able to have the staff on the backend to support the front end. And if things keep moving at the pace they're moving, we absolutely are going to need some more staff at the backend to support the front end.*

## **Related Program Developments, 2014**

Over time, MFP has opened the door for other successful related initiatives such as the Balancing Incentive Payment Program, No Wrong Door, Community First Choice, Nurse Delegation of Medication Administration, and the Testing Experience and Functional Tools (TEFT) grant. With these new initiatives coming into play, some respondents mentioned a need to better understand these related initiatives and their relationship to MFP. These respondents found that the MFP Steering Committee was expanding to cover more than MFP, but were not sure what exactly the Committee's role would be with respect to each of these new initiatives. While respondents expressed excitement in the new programs, there was also some concern that MFP would be given less focus.

*... part of where we are right now as a Steering Committee is looking at because the Money Follows the Person has been really mushrooming in that the waiver programs are changing, the Community First Choice program now is expected to go live ... there's the No Wrong Door entry points, there's just so many different facets that kind of roll over into MFP, they're not specifically MFP. Right now, that's one of the things that we are looking at as a committee as where our oversight should begin and end.*

*So when I think of MFP, I think of it as having all these appendages – Community First Choice, any number of other things – that are connected, and I'd like to see the connection better. In other words, what is the relationship of Community First Choice to MFP?*

*I know that the Steering Committee is going to, last I knew, sort of be expanded to become the No Wrong Door Steering Committee and the governing body in a way. It worries me that some of the MFP either will totally take over the Steering Committee, the new one, or that it's going to get lost. And I find the latter less likely. But it does worry me that the more diverse it gets it kind of waters down that program if you have to hear about a lot of other programs at the same time in the No Wrong Door. So I do have some concerns about that.*

## **Impact on Long-term Services and Supports**

Respondents continued to see the progressive effect of the MFP program on the LTSS system in Connecticut. In its sixth year, numerous people described the positive impact of MFP in a variety of ways. Some mentioned that they saw MFP as paving the way for change, from the way nursing home staff responds to MFP staff coming into their facility, to consumers being more aware of alternatives to institutionalization, knowing that they have choices. Others mentioned the numbers of people that have been able to successfully transition to the

community. The impact of MFP on rebalancing LTSS funds and its overall effect on the nursing home industry in Connecticut was also mentioned by several respondents, as was the nursing home diversification grants, which encouraged these facilities to expand their business model to provide community-based services.

*I think it's had a very large, positive impact on it [LTSS system]. We're not where we need to be yet, but...somebody always used to say to me it's like turning the Queen Mary. There's a bunch of things that have to happen to get it to where it really works for the consumers and does the other good stuff of saving the state money. I think that that's, it's had a huge impact on making the systems start to change. We're not done, but we're getting there.*

*Transformative. Yes... it's leading the way. It's plowing down these barriers for sure. MFP is the change agent program, and it's the one that gets the most swearing at as well as...it must be doing something right because it has people who hate it and people who love it. So yes, it's a catalyst for change for sure.*

*I think MFP has significantly rattled the long-term care cage, and I think that long-term care providers are now starting to realize that residents of this state are no longer going to be forcibly institutionalized, that they have rights, and that they are being forced to make certain that they are providing those residents with their rights by merely giving them the information that they need, such as, hey, FYI, there's this program out there, you may or may not benefit from it. I think that that is going to continue in the future, affect long-term care facilities' stability of staying in business. In fact, we're seeing it currently. And it may just forcibly make them restructure their entire business model.*

*I do think that it's certainly making a difference. I do know that many of the people that we serve had they not had access to this program and access to rental assistance, they would still be in nursing facilities. We've been able to see really good outcomes. People who were told that they needed to be in a nursing facility, that they're doing just fine in the community, and not just fine – they're thriving. So it's, at a more micro-level, it's changing individual's life but at a more macro-level, it's changing, it's really changing a system.*

## **Conclusions and Recommendations**

Connecticut, as one of forty-six states and the District of Columbia currently participating in the MFP Rebalancing Demonstration Grant, has continued to make progress in the program goals of increasing the use of HCBS services and reducing the use of institutionally-based services.

In its sixth year, the MFP Demonstration had many achievements and successes. A new transition process was put into place in March, 2014, with the creation of regional, cross-agency transition teams. The second half of 2014 saw a large increase in transitions – 238 consumers transitioned in the first six months of the year, while 340 consumers transitioned from July through December. The speed of transitions also increased by the end of 2014. Other achievements included the continued culture change in Connecticut, as more people and providers embraced consumer choice and person-centeredness, enhanced housing coordinator positions, and the addition of demonstration services such as addiction services and supports.

Highlighted by respondents as a major 2014 program achievement, the implementation of the new transition process brought both structural and procedural changes. The Specialized Care

Manager position was developed, and regional teams consisting of SCMs, TCs, and HCs were created. The referral, assessment, and transition process were reinvented, and the majority of consumers waiting for assessment were sent to the field by the end of 2014. Using a team approach encouraged collaboration and problem solving and shared the responsibility of the transition. Assessments were completed earlier, and the number and speed of transitions had increased by the end of the year.

There were also many strengths and supports reported by respondents. Some were similar to previous years and included strong staff and stakeholder commitment to MFP, enhanced communication, the importance of the flexibility of the program, and the benefit of collaborative partnerships. Education and training were also emphasized as a strength and support in 2014.

In its sixth year of implementation, barriers and challenges focused on programmatic barriers, funding and staffing, community supports, communication, and barriers specific to transitioning consumers to the community. Challenges associated with the new transition process included difficulty maintaining a cohesive team structure and care planning concerns. Respondents also focused on challenges to successfully living in the community, such as insufficient community supports.

### **Recommendations from this evaluation fit into the following categories:**

- Evaluate staffing levels and address need for consistent teams
- Provide written protocols to all SCMs, TCs, and HCs
- Expand Specialized Care Manager training
- Improve team operation
- Expand MFP CO leadership structure
- Improve communication
- Focus on successful transitions
- Improve transition forms
- Analyze key metrics to inform process change

### **Evaluate staffing levels and address need for consistent teams**

- ◆ Evaluate field staff and current team structure in order to establish and sustain consistent, stable teams.
- ◆ Hire more full time or permanent SCMs and limit the use of per diem SCMs to increase team stability in regions where TCs and HCs are working with multiple access agency SCMs.
- ◆ Provide enough TCs and HCs in regions with large SCM caseloads so the SCM caseloads can stay within one team.

### Provide written protocols to all SCMs, TCs, and HCs

- ◆ Create standardized, written protocols for all field staff and supervisors, and provide to new staff as part of their initial training to explain the structure of the program.

### Expand Specialized Care Manager training

- ◆ Provide comprehensive training to all SCMs, including per diem or part time access agency SCMs, in the use of the web, MFP transition process, and working as a team. Even with more full time SCMs, TCs and HCs may still work with multiple SCMs. Having all SCMs follow the same protocol will increase team efficiency and create a more stable working environment for everyone.

### Improve team operation

- ◆ Explore ways to bring the TC and HC into the process earlier. Encourage an initial team meeting with the consumer, family members, SCM, TC, and HC to establish the team with the consumer and get everyone on the same page.
- ◆ Determine team best practices and encourage their universal use. Consider team differences, especially the specialized Team 1s, when establishing team practice guidelines.
- ◆ Clearly define roles and responsibilities in the first team meeting. Include this on the Action Plan.
- ◆ Create and continue to update an Action Plan. Give a copy to other stakeholders and extended transition team members, including the consumer, facility social workers, and community providers. Review and update Action Plan at each team meeting. When a new MFP team member or community provider is brought on, review it with him/her.
- ◆ For Team 1s: Hold regular, biweekly Team 1 meetings by program (DDS, DMHAS, ABI, other specialized teams) for SCMs, TCs, and HCs. Keep this meeting separate from any other facility or stakeholder meetings. Use similar structure as described earlier in team best practices – reviewing each case, assigning tasks, updating progress, and using shared expertise to problem solve challenges. Use the meetings to inform TCs/HCs of upcoming consumers and assign TCs and HCs earlier in the process.
- ◆ For other teams: Hold regular, biweekly meetings for each team. Establish a standard biweekly meeting day and time for the SCM, TCs, and HCs on the team. Discuss all pre-transition cases, and at least once a month review all open cases – pre and post. Keep the TCs and HCs informed of consumers who will soon be assigned to them.
- ◆ Have each team determine what method of communication works best for that team and use it consistently.

### Expand MFP CO leadership structure

- ◆ Consider creating an official Assistant Director position to expand shared CO leadership and strengthen the overall structure of the program.

### Improve communication

- ◆ Designate one CO staff member to develop and maintain one comprehensive email list to impart all MFP information to stakeholders such as SCMs, TCs, and HCs and their supervisors, contractor agency directors/designees, CO staff, and Steering Committee members. Use this to send out information such as Steering Committee and Supervisor meeting agendas, minutes, and handouts, CO MFP monthly report, UConn reports, and any CO outside presentations.
- ◆ Provide a written copy of the CO monthly report to the Steering Committee. Distribute in advance of the meeting so people can review prior to the Steering Committee meeting.

### Focus on successful transitions

- ◆ Look more closely at consumers who were previously referred in past but the case was closed with the goal of informing and improving current practice.

### Improve transition forms

- ◆ Streamline all assessments and other forms. Take a closer look at all forms required, the Readiness Assessment in particular, to see if all the information is useful for the team and if the forms can be streamlined.
- ◆ Create an Action Plan form on the web so it can be used by all team members to update their progress and new items, without additional uploading of the form.
- ◆ Upload the Engagement Plan with updated engagement activities to the web so other team members can access it.

### Analyze key metrics to inform process change

- ◆ Analyze key metrics from the first year of the new process and compare to the previous 12 month period in order to look holistically at the effect on outcomes such as number and speed of transitions, consumers in each stage of the transition process, referrals to the field, cases closed, and re-institutionalizations.



## **Appendices**

Appendix A: Committee, Meeting, and Workgroup Descriptions

Appendix B: Key Informant Interview

## Appendix A: Committee, Meeting, and Workgroup Descriptions 2014

Meeting	Meeting description	Productive	Challenging	Respondent suggestions or comments
Steering Committee	<p>"The Steering Committee is comprised of people who don't have a conflict of interest ... so they're not paid by the program. They either are people representing themselves or elders, people with disabilities or ... advocates or advocacy organizations. Nursing home [industry] is represented."</p> <p>"We're in the process of considering some changes right now because the responsibilities of the Steering Committee now go beyond MFP, to somehow integrate that into the name and the structure."</p>	<p>"They're helpful to me because it helps put into perspective the larger, higher-level policy information with the decision making on a day-to-day level."</p> <p>"That meeting is very helpful. It keeps, it's very informative of what's going on between the changes in the state and MFP and everything."</p> <p>"Certainly it gives you an immediate pulse on what is happening with the program. ... [Dawn] brings as close to real-time data to the meetings as she can in terms of the number of individuals served, what's going on in the program."</p>	<p>"I think right now our biggest challenge is looking at what programs we want to have input into or should have input into."</p> <p>"I know that the Steering Committee is going to... be expanded to become the No Wrong Door Steering Committee and the governing body in a way. ... But it does worry me that the more diverse it gets it kind of waters down that program [MFP] if you have to hear about a lot of other programs at the same time in the No Wrong Door. So I do have some concerns about that."</p> <p>"As to the last year, I'm very excited about MFP. ... [MFP is] managing to coordinate with other programs like Community First Choice ... in a way that makes the overall policy implication of the MFP pretty significant. So the only thing that worries me about the last year specifically is that so much has been going on that we have had some months in which we don't have a meeting. ... it's important to have a meeting ... once a month on something as exciting and significant as this."</p>	<p>"We do get a fair amount of healthcare providers that are not on the committee that participate, that attend the meetings ... And so we want to make sure that they have an opportunity to bring up any issues that they may have because they represent a different crosswalk of providers as well. And that's probably a weakness. ... Certainly, if a stakeholder would like something specifically addressed on the agenda, that we do address it."</p> <p>"And I think that for the Steering Committee to even realize that we need to kind of redefine the scope of what is going to come under our purview is important."</p> <p>"I just think ... it should be representative of everybody that works on Money Follows the Person. You should have some direct service staff there. You should have some managers there. Some of the private nonprofits should be represented. Some of the other state agencies that have waivers should be represented along with DSS. And then have somebody maybe that's outside of the process to facilitate it and organize it and keep it moving along."</p>
SCM/TC/HC Supervisor's Meeting	<p>"The TC, HC, SCM and representatives from the MFP office [attend]."</p> <p>"A typical meeting lasts all day. It's once a month... We discuss various changes and updates with the program, ongoing projects that are being worked</p>	<p>"I think they're helpful in the sense that we get to meet everybody. It's a very large system, and we get to meet people, supervisors, from other waivers along with the private, nonprofit access agencies that provide services for MFP as specialized care managers and TCs. And otherwise, we wouldn't</p>	<p>"You have all the managers here from all of the different agencies that are doing MFP, and we're making decisions and we're trying to clarify processes and procedures, and none of this gets written down. So we all go back to our agencies and we tell our staff about the supervisor meeting and what we talked about, I said, but</p>	<ul style="list-style-type: none"> <li>◆ Create and send out agendas prior to each meeting.</li> <li>◆ Use the agenda to keep the meeting on task.</li> <li>◆ Take minutes and send to everyone after the meeting.</li> <li>◆ Send agenda, minutes, and handouts to supervisors and</li> </ul>

Meeting	Meeting description	Productive	Challenging	Respondent suggestions or comments
	on within the demonstration. And then, of course, the contracted field staff discuss issues that arise with, out in the field. ... we discuss changes, new ways of doing things, troubleshooting."	<p>have those connections really."</p> <p>"They are helpful for me. Sometimes I feel like they're mostly held for the benefit of the contracted field staff, but occasionally we do learn things in those meetings that we weren't aware of that are going on out in the field that we just hadn't heard of."</p> <p>"I specifically hear about those at the supervisor's meetings that occur monthly at the MFP office. So we are kept up-to-date on the goings on of the initiatives, of the whole rebalancing initiative."</p>	<p>I don't know if I'm describing it the same way as [other Supervisors] or somebody else."</p> <p>"I'd certainly try to keep it more on task."</p>	<p>contractor agency directors.</p> <p>"Make sure we get minutes from the meeting sent to us."</p> <p>"But for me, being cc'd on stuff that the supervisor gets, because I think that in some ways they're more up to date and they have more regular meetings, they have supervisor meetings. They're getting more information."</p> <p>"Maybe they could have an agenda gotten together ahead of time and sent out so people could add things to the agenda. And Paul has worked on that with Karen Law, and so they've gotten ... better doing that. And sometimes it seemed like when you have a 6-hour meeting, that's an awfully long time to try and keep people focused, especially if you don't have a set agenda and people are kind of coming and going in and out of the room..."</p> <p>"The meetings are very helpful, but I believe it would be beneficial to have some break-out groups or subcommittees working on items."</p>
Contractor workgroup	"There are a number of state contractors. The different transition coordinator agencies, the agencies that have the specialized care managers, the housing. So yes, there are a number of us around the table. Allied is typically there as the fiscal intermediary, so they were well attended. They definitely were well attended, but they just, they have been very sporadic."	"But from a contractor's perspective, not having the aforementioned contractors' meeting, makes it kind of hard to know what some of the stuff is going on and the bigger picture perhaps than what we necessarily get from the supervisors. So as much as I don't really like the contractors' meetings, they were kind of valuable."	"I think it's always helpful to be in the same room for dialogue purposes. That said, they were typically frustrating. The tone of the meetings was typically quite negative. The dialogue was very controlled and polite even though we had many concerns about the contracting, the amount of time it was taking for certain things. And there always kind of seems to be either an undercurrent or just overt tension between the CO staff and the rest of the contractors. And perhaps that has led to the fact	<p>"We switched our priorities and we meet now with specific contractors that are involved in team projects that are moving ahead quickly. So an example is Community First Choice. So we meet with the contractors now who are involved in Community First Choice on a monthly basis."</p> <p>"The only [Contractor] dialogue really was for the contractors' meetings, which we really haven't been having on a regular basis. Which is really too bad, I think, because there are a lot of</p>

Meeting	Meeting description	Productive	Challenging	Respondent suggestions or comments
			that we don't have them anymore.”	pieces that I think would benefit from that contractor-level discussion. Issues of contracting, issues of future and planning and strategy just doesn't happen. I don't think we've had a Contractor Meeting in possibly a year.”
CO Staff meetings	<p>“We have a [CO] staff meeting weekly here. ... They used to be two hours, and now they generally run just a little bit over an hour. We do status updates, so I think that the staff feels they're more effective than they used to be. And then we also talk about if there are things coming up that we need input on, and the staff has the opportunity to provide input too.”</p> <p>“They are certainly more productive and helpful than they previously were. We've implemented a new structure to the staff meeting to make them more focused, more...to streamline them and to make them more informative. And it's worked so far.”</p>	<p>“The initial problem that was identified was that all of us, because there are a lot of things going on, all of the staff didn't have a good understanding of the various components of what we're working on. And so we designed the meeting to provide like as an informational form and also as an opportunity to be able to coordinate with different objectives that peers were responsible for.”</p>		<p>“Well, the team, the MFP Central Office staff meet weekly, regularly. I, for one, do appreciate those team meetings ... that is the only way for me to be able to ... stay in touch or updated as to all the stuff that's going on in the background that I may or may not be directly involved with. There's a lot going on. There's no way for me ... to be directly involved in all of that, but when we're able to meet weekly, minimally I know what's going on.”</p>
Workforce Development	<p>“I'm involved when there is action and activity with the MFP Workforce Development Group.”</p>			<p>“Just getting back to having them again.”</p>
Waiver Manager Meeting	<p>“On occasion, we have a managers' meeting that Dawn Lambert participates in related to the waiver program, and we meet quarterly on that.”</p>	<p>“Well it just kind of gives you a rundown of what's happening in each of the programs, including MFP.... I think it's just an opportunity for us to all get together and communicate about what we're doing and to make sure that we're on the same page. But I think, as far as the discussion is concerned, it really has shifted more towards</p>		

Meeting	Meeting description	Productive	Challenging	Respondent suggestions or comments
		Community First Choice, and because MFP's kind of up and running now, there's less discussion about its operation."		
Core Standardized Assessment	<p>"Different providers that do assessments for waivers and other community partners that are doing assessments for their clientele. So it's a real mix."</p> <p>"We [met] pretty much on a monthly basis."</p> <p>"[The Core Standardized Assessment workgroup] was particularly active over the last two years. I think for the first year it maybe even met weekly, and then over the past year more as needed or just by email to update documents."</p>	<p>"Deloitte ... runs the meetings now. They are very organized. They keep everybody on track. They have very good printed PowerPoint materials and handouts, and they're good at keeping us rolling along and focused ... and we've moved along in the process."</p> <p>"I think that Noreen does a fabulous job of keeping us on track ... it's pretty clear what our outcomes are and I think she does a really good job of tracking them."</p>	<p>"Those meetings are challenging. ... They could be more collaborative and open to hearing different suggestions."</p> <p>"My fear is that if we move too fast we'll make some decisions that we might regret in the future ... we need to make sure that [we're] driving the process and not the contractor."</p>	
Community First Choice	"We meet with the contractors now who are involved in Community First Choice on a monthly basis."	"And the goal of those meetings right now is to make sure that the contractors are totally informed about the roll-out plans for CFC."		

## Appendix B: 2014 Key Informant Interview Guide

### 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?

### **HCs, TCs, SCMs – Skip to question 5.**

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

### Meetings/Workgroups

4. Please describe a typical [committee, Supervisor, CO Staff, discharge, Regional, etc.] 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?
- 4d. How are the meetings productive or helpful for you?
- 4e. How do you make sure that the goals set in the meeting are met?
- 4f. What, if anything, would you change about the meeting or its structure?

### MFP Program goals and progress

5. I'd like to talk with you about the change in transition process this past year. In 2014 Connecticut reorganized the transition process into Regions and Teams. A new role, the Specialized Care Manager, was created. SCMs do initial assessments, and develop care and engagement plans. Teams were created consisting of two transition coordinators, a housing coordinator, and a Specialized Care Manager.
  - 5a. What was your initial reaction to this reorganization?
  - 5b. What do you think has worked well about this new process?
  - 5c. What has been challenging or frustrating about this new process?



- 5d. What effect has this process had on CT's MFP program?
- 5e. What suggestions do you have to make the process more effective?
- 6. Three new transition tools were developed in 2014: the Readiness Assessment, Engagement Plan, and Action Plan. Are you familiar with these new forms? What are your thoughts about them?

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

- 7. What were some of the major achievements or best practices of the MFP program in 2014?
  - 7a. What has supported or facilitated these program achievements? (Probe: What are the strengths of CT's MFP program?)
- 8. When asked about achievements, people often mention transitioning individuals out of facilities. How do you define a "successful transition?"
- 9. What MFP program barriers or challenges did you encounter or observe in 2014?
  - 9a. What could be done to prevent or overcome these difficulties in the future?

**ASK TC, HC, SCM questions 10-16. For everyone else, skip to question 17.**

TC, HC, SCM:

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

- 10. First, please tell me about the make-up of your team. For example, how many TCs, HCs, and SCMs are on your team?
  - 10a. Are you all from the same agency or different ones?
- 11. In general, do you usually work with the same people, or do your team members change?
- 12. How do your team members keep you informed about any new updates in a consumer's case?
- 13. Do you meet as a whole Team, with all the SCMs, TCs, and HCs assigned to your Team?
  - 13a. If No, Do you meet with some team members on a regular basis?
- 14. Please describe a typical Team meeting for me.

Use probes to cover the following:

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

- 14b. How often do you meet? Is that enough?
- 14c. What do you usually talk about? For example, do you review every open case, or the ones in the transition process, or something else?
- 14d. Who usually schedules and runs the meetings?
- 14e. How are the meetings productive or helpful for you?
- 14f. How do you as a group make sure that the goals set in the meeting are met?
- 14g. What, if anything, would you change about the meeting or its structure?
- 15. What would you recommend be included in a "Team Best Practice Report" on what has worked for your Team and why it worked?
- 16. If your Team had a slogan or motto, what would your Team Motto be?

#### Structure and process

- 17. Overall, is there anything (else) you would like to see changed about the organization or structure of the MFP program?
- 18. [If not yet answered]: Is there anything you would like to see changed about the process or structure of the Steering Committee?
- 19. There were several new or ongoing initiatives in 2014 include the Balancing Incentive Program, the Universal Assessment, Nurse Delegation of Medication administration, and the nursing home rebalancing grants. How are you kept informed about the current activities or new initiatives of CT's MFP program?
- 20. Are there things you would change about the communication process?

#### Education and Training

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

- 21. What are your thoughts about the online TC-HC training?

#### Only ask TCs, HCs, and TC/HC Supervisors:

- 22. What did you find most helpful about the training ?
- 23. How have you used the information you learned from the training in your everyday work?
- 24. What suggestions do you have to improve the online training?

**ASK ALL:**

- 25. If not yet answered: Overall, what training and education would be helpful for transition and housing coordinators?
- 26. Currently Specialized Care Managers receive Motivational Interviewing training. What other training or education would you recommend for SCMs?

**Systems change**

- 27. Our last question looks at the program overall. What effect do you think MFP has had on CT's long term services and supports system in general?
- 28. Is there anything else that you would like to add?