Money Follows the Person Rebalancing Demonstration

Closed Cases Report For 2015

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Introduction

As part of Connecticut's rebalancing efforts, the Money Follows the Person (MFP) Demonstration transitions residents in institutional facilities to the community. By 2018, Connecticut (CT) seeks to transition 5,200 people from qualified institutions to approved community settings. To achieve this goal, it is important to enable the transition of most individuals who express a desire to return to the community. In the early years of the demonstration, CT experienced a relatively high number of cases closed compared to cases transitioned. Therefore, in 2012 an analysis of case closures was undertaken to identify practices, service needs, and other areas in which improvements may assist the state in reducing case closures and increasing transitions. This is the fifth report produced from the analysis of closed cases. For the previous reports, which analyzed closures January through June 2012 and July through December 2012, as well as reports for 2013 and 2014, please visit: UConn Health Center on Aging

In order to comprehensively cover the closed cases data, this report is divided into three sections. Section I is an overall picture showing the current status, as well as number and percent of transitioned and closed cases for *referrals made during 2015*. Section II shows a comparison of *cases closed during each of the seven years* of the MFP program (2009-2015), and Section III provides specifics on *all cases closed during 2015*, regardless of the year in which the case was referred. In addition, Section III provides a detailed account of the specific reasons cases closed in 2015 in order to inform practice and allow program managers to make programmatic changes that decrease the number of preventable closures. There is a list of acronyms and abbreviations at the end of this report for reference.

There are currently 14 reasons a case can be closed:

1. Participant not aware of referral and does not wish to participate
2. Participant would not cooperate with care planning process
3. Participant changed their mind and would like to remain in the facility
4. COP/Guardian refused participation
5. Participant moved out of state
6. Exceeds mental health needs
7. Exceeds physical health needs
8. Transitioned to community before informed consent signed
9. Reinstitutionalized for 90 days or more
10. Other
11. Nursing home closed and moved to another facility (excluded from analysis)
12. Died (excluded from analysis)
13. Non-demo: Transition services complete (excluded from analysis)
14. Completed 365 days of participation (excluded from analysis)

Methods

Numerical data for cases closed, cases transitioned and new referrals were obtained through Microsoft Access queries of MFP program data in the My Community Choices web-based tracking system.

For the purposes of this analysis, cases closed under the last four closure codes (11-14 above) were excluded because programmatic changes would not affect their occurrence: nursing home closed and moved to another facility, died, non-demo: transition services complete, and completed 365 days of participation. Also excluded were any additional referrals from nursing home closures regardless of the case closure reason.

Section I: Status of Referrals made between January and December 2015

A total of 2,110 referrals were received during 2015. After excluding referrals that closed due to the following reasons: died (121), completed 365 days of participation (2) and non-demo: transition services complete (2), the number of total referrals to be analyzed from 2015 is 1,985, an increase of 16% over 2014. As of February 24, 2016 (the date the data was downloaded from the MFP website), the current status of these referrals is distributed as follows:

Table 1: Current Status for 2015 referrals compared to 2014 (as of 2/24/2016)

Current Status	**2015 Cases**	***2015 %***	**2014* Cases**	***2014 %***
Closed (w/out transitioning)	**442**	***22***	**460**	***27***
Recommend Closure Approved (w/out transitioning)	**99**	***5***	**82**	***5***
Recommend Closure Initiated (w/out transitioning)	**18**	***0***	**20**	***1***
Transitioned (total)	**456**	***23***	**406**	***24***
- Open cases	444	*22*	384	*22*
- Closed	10**	*1*	9**	*1*
- Closure recommended	1	*0*	12	*1*
- Closure initiated	1	*0*	1	*0*
In Progress (total)	**970**	***49***	**750**	***44***
- Assigned to Field	284	*14*	164	*10*
- Informed Consent Signed	300	*15*	163	*10*
- Care Plan Approved	354	*18*	395	*23*
- Transition Plan Submitted	20	*0*	17	*1*
- Transition Plan Approved	12	*0*	11	*1*
Total	**1985**		**1718**	

* Statuses from referrals in 2014 are as of 4/6/15, 6 weeks later than for the 2015 referrals.
** These cases transitioned and closed and are included in the total closed cases.

Of the 1,985 referrals made in 2015, 23 percent (452) are now closed and another 119 (6%) are in the closure process (closure recommended, initiated, or approved). 456 (23%) of the referrals from 2015 transitioned (Table 1). Twenty-two percent (444) are referrals that transitioned and are still open; the remaining 49% (970) are still active in the transition process. Cases referred in

2015 that transitioned (456) or closed (452) by February 24, 2016 were categorized by region, Home and Community-Based Services (HCBS) package, and target population (Tables 2, 3, 4). Closures are shown by the reason they closed in Table 5.

Regional variations in percentage of referrals transitioned were relatively low, ranging from 20% in the Southwest to 25% in the Northwest region (Table 2). Regional differences in the percentage of referrals closed were more notable. The South Central region closed 16% of its referrals, while the Southwest region closed 29% of referrals, a trend that continued from 2014, when South Central had the lowest closure rate (20%) and Southwest the highest (32%).

Table 2: Transitions and closures of referrals from 1/1/2015 to 12/31/2015 by region

Region	Referrals	Transitioned #	Transitioned % (of refs. in each region)	Transitioned % of total transitions (n=456)	Closed #	Closed % (of refs. in each region)	Closed % of total closures (n=452)
Eastern	237	52	22	11	65	27	14
North Central	722	173	24	38	176	24	39
Northwest	307	78	25	17	63	21	14
South Central	448	100	22	22	70	16	16
Southwest	271	53	20	12	78	29	17
Total	1985	456			452		

Over 90 percent of referrals transitioned under one of three HCBS packages: the Physical Disability State Plan (PDSP), one of the CT Home Care Program for the Elderly (CHCPE) waivers/plans, or the Personal Care Assistance (PCA) waiver (Table 3). Another 5 percent transitioned under the WISE Mental Health waiver (MH-WISE). By contrast, cases closed without transitioning came primarily from those accepted to the CHCPE (46%); the PCA waiver (27%), and the WISE waiver (10%). Two percent of closed referrals did not have an assigned HCBS package.

Table 3: Transitions and closures of referrals from 2015 by HCBS package

HCBS Package	Transitioned	*%*	Closed	*%*
ABI	5	*1*	16	*4*
CHCPE	5	*1*	161	*36*
CHCPE-AFL	6	*1*	2	*0.5*
CHCPE-AL	4	*1*	1	*0.2*
CHCPE-C5	2	*0.4*	2	*0.5*
CHCPE-L1	0	*0*	1	*0.2*
CHCPE-PCA-AB	75	*16*	19	*4*
CHCPE-PCA-LI	67	*15*	12	*3*
CHCPE-PCA-SD	12	*3*	5	*1*
CHCPE-S	60	*13*	6	*1*
DDS	0	*0*	2	*0.5*
DDS-C	9	*2*	0	*0*
MH-WISE	23	*5*	45	*10*
MHSP	3	*0.6*	2	*0.5*
OTHER	0	*0*	3	*0.7*
PCA/PCA-S	67	*15*	123	*27*
PDSP	117	*26*	44	*10*
Total*	455		444	

* There were an additional 1 transitioned case and 8 closed cases missing an HCBS package.

The greatest number of transitions (51%) and closures (47%) were adults 65 years and older (Table 4). It is worth noting that more of the older adults transitioned (51%) than closed (47%) this year, which is the opposite of 2014 where a larger percent closed (64%) than transitioned (50%). A higher percentage of referrals in the mental health target population were closed (11%) versus transitioned (6%) which was also true in 2014. Both the developmental and physical disability target populations had a slightly higher number of transitions than closures.

Table 4: Transitions and closures of referrals from 2015 by target population

Target Population	Transitioned	%	Closed	%
Developmental Disability	9	*2*	2	*0.5*
Elderly (age 65+)	231	*51*	209	*47*
Mental Health	26	*6*	47	*11*
Physical Disability	189	*42*	186	*42*
Total*	455		444	

* There were an additional 1 transitioned case and 8 closed cases missing a target population.

Table 5: Closures of referrals from 2015 by reason compared to 2014

Closure Reason	2015 cases	2015 %	2014 cases	2014 %
Transitioned to community before informed consent signed	161	*36*	182	*39*
Participant changed their mind and would like to remain in the facility	68	*15*	91	*19*
COP/Guardian refused participation	65	*14*	86	*18*
Exceeds physical health needs	14	*3*	30	*7*
Participant would not cooperate with care planning process	67	*15*	24	*5*
Other	34	*7*	21	*5*
Exceeds mental health needs	4	*0.8*	14	*3*
Participant not aware of referral & does not wish to participate	26	*6*	11	*2*
Reinstitutionalized for 90 days or more	5	*1*	5	*1*
Participant moved out of state	8	*2*	5	*1*
Total	452		469	

As seen in Table 5, the percentage of referrals that closed in 2015 due to transitioning before the informed consent was signed (36%) was very similar to 2014 (39%). This number is very

different from 2013 (12%) largely due to the mass referral of the backlog of applications which happened in 2014 and was still being addressed in 2015 – some of those people had left the facility before the case was even assigned to the field. The relative percentage of referrals closed because the participant changed their mind went down even further in 2015 (15% vs. 19% in 2014), and continuing a downward trend from a high of 33% in 2013. However, the percentage of referrals which closed because the participant would not cooperate with care planning increased (15% vs. 5% in 2014), and was even higher than the 11% in 2013. While the engagement services added in 2014 appear to have had a salutary effect on closures due to participants changing their minds, the increase in participants not cooperating with the care planning process strikes a note of caution. Engagement services for participants who disagree with their care plan or proposed services should be examined.

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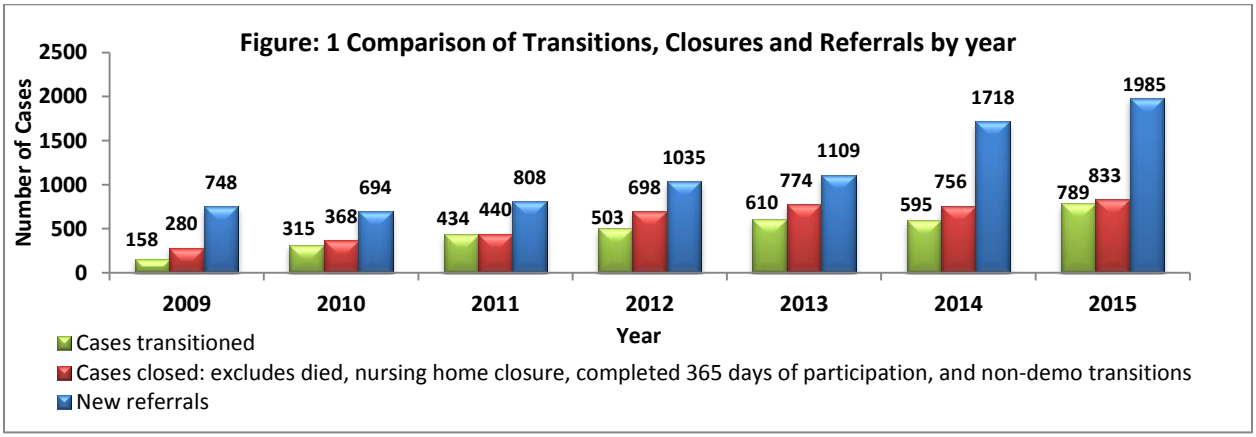
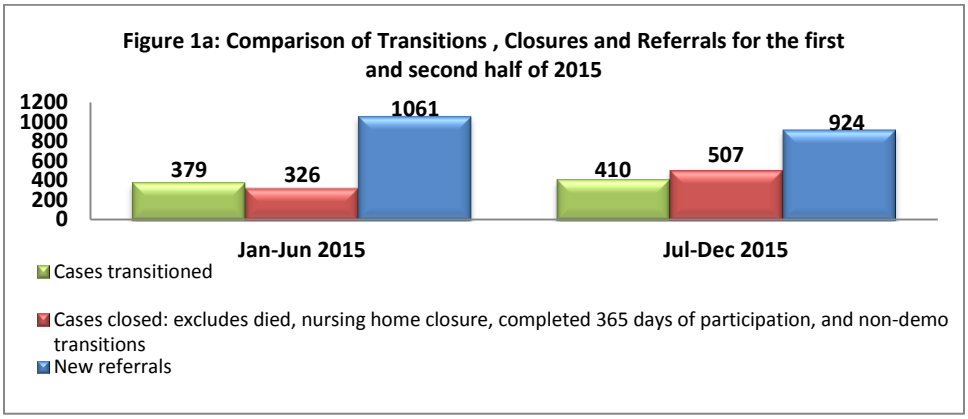
Section II: Comparison of Closed Cases by Year, 2009-2015

During 2015 MFP experienced 1,985 referrals, 789 transitions and 833 closures (referrals and closures exclude those that closed due to the 4 excluded reasons; transitions and closures are regardless of referral year). In 2015, there was a 16% increase in new referrals, 34% increase in transitions, and 10% increase in closures. The increase in referrals over the last two years reflects a revised transition process begun in March of 2014, including the creation of a new Specialized Care Manager position and reorganization of field staff into regional teams. This new process allowed Central Office to refer to the field many of the consumers who had applied to MFP but were waiting to be assigned to the field due to lack of assessment staff.

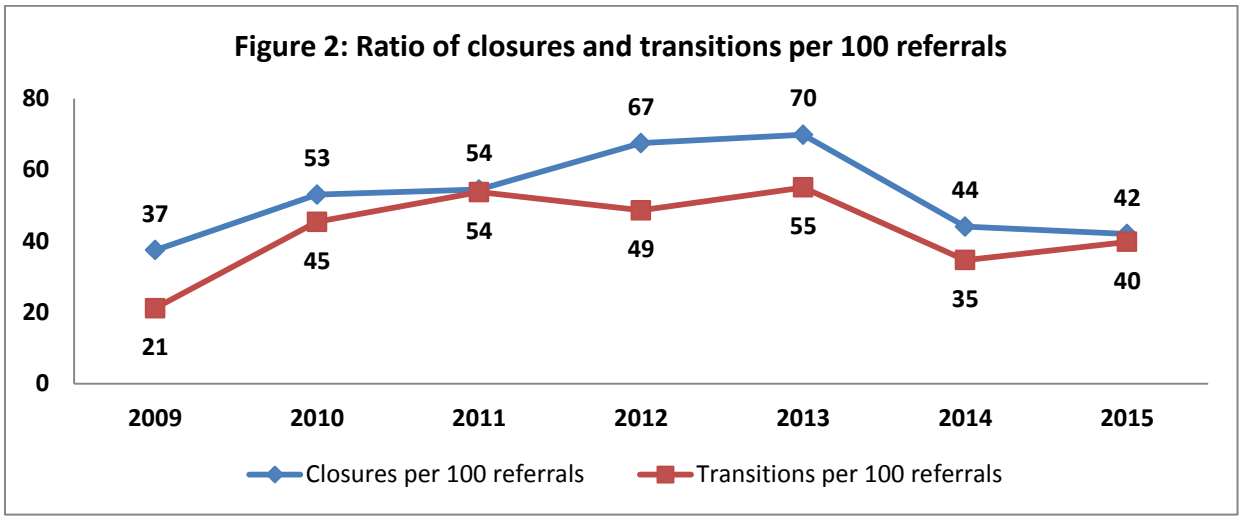


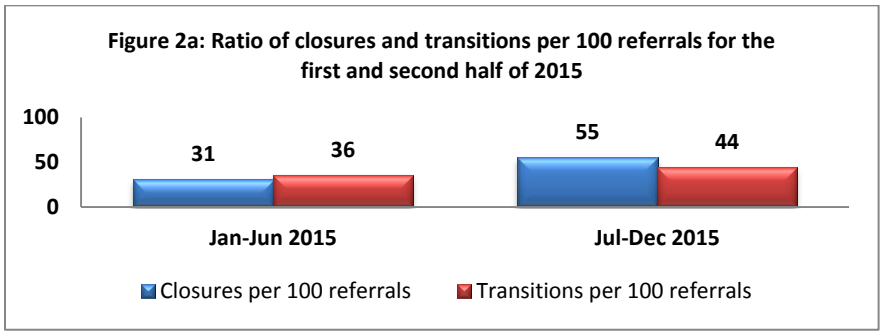
Whenever there are a large number of referrals, the number of transitions often drops or slows down as Transition and Housing Coordinators are working with these new referrals to get them transitioned, as in 2014 when transitions decreased by 3%.

Comparing transitions, closures and referrals between the first and second half of 2015 (Figure 1a), it is interesting to note that there were more referrals in the first half of the year, and more transitions and closures in the second half. The increase in transitions represents progress, while the higher number of closures in the second half is likely due to the mass closure of backlogged "recommended closures" by MFP Central Office late in the year.



Continuing the trend of prior years, in 2015 the CT MFP program closed relatively more cases than it transitioned (see Figures 2 and 2a), although the gap is narrowing, with the ratio of closures to transitions per 100 referrals closer than it has been in the last three years. For the year, closures per 100 referrals are down from 44 to 42, and transitions per 100 referrals are up from 35 to 40. Dividing the year into halves, however, shows that closures per 100 referrals was up substantially in the second half, from 31 to 55. The reason for that significant increase is due to the mass closure of backlogged recommended closures as noted above.

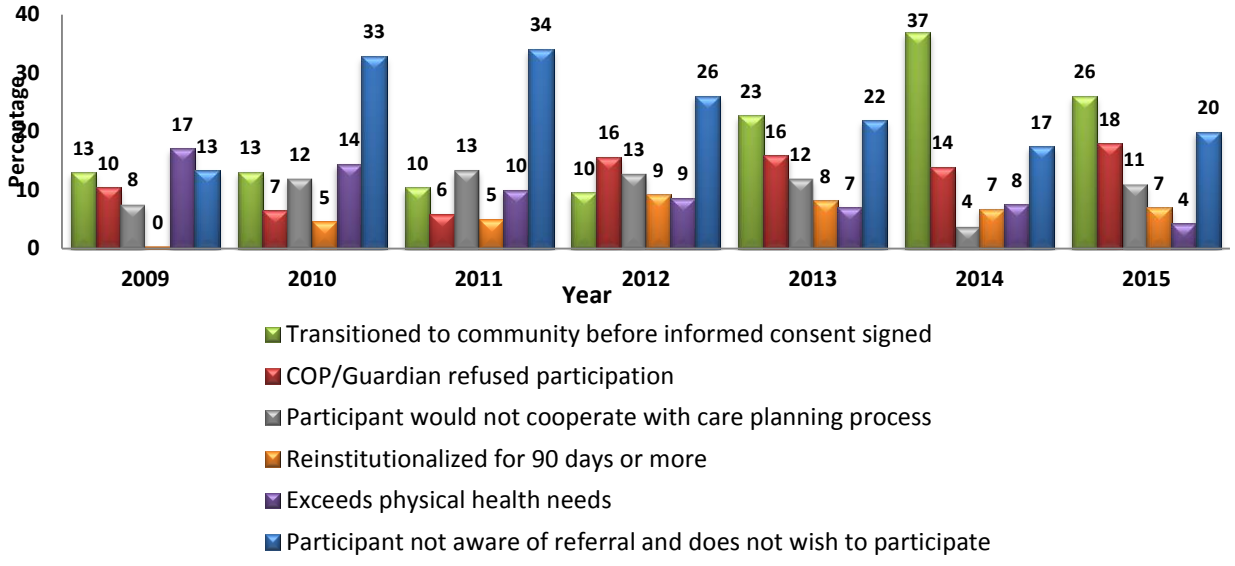




Considering all cases that closed during 2015 regardless of referral year (n=833, without the 4 excluded closure reasons), the three most frequent reasons cases closed accounted for about two-thirds of closures and were the same as the top three reasons in 2014 (see Figure 3). The

top reason was “Transitioned to community before informed consent signed.” This reason accounted for 26% (n=217) of closures during 2015, an 11% decrease from 2014. The second most frequent reason for closing a case during 2015 was “Participant changed their mind and would like to remain in the facility,” accounting for 20% (n=166) of closures, a three percent increase from 2014. The percentage of cases closed upon request of the COP or guardian also increased from 2014 (14% to 18%). Cases closed due to re-institutionalization of 90 days or more was the same as the previous year at 7%. The percentage of cases closed in 2015 because of high physical health needs (4%) was half what it was in 2014 (8%). On the other hand, the percentage of cases closed because the participant would not cooperate with the care planning process increased this year, from 4% in 2014 to 11% in 2015. A different reason was in the top seven this year – instead of “Exceeds mental health needs” the seventh top reason in 2015 was “Participant not aware of referral and does not wish to participate” (3%).

Figure 3: Percentage of cases closed under the top seven reasons for 2015



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Section III: Analysis of Cases Closed Between January and December 2015

A total of 1580 cases closed during 2015 for any reason regardless of the year they were referred to MFP. Cases that closed due to the following reasons were excluded: died (266), completed 365 days of participation (454), non-demo transition services complete (24) and nursing home closed and moved to another facility (3), leaving 833 closed cases for further analysis in the remainder of this report (see Table 6). Table 6 shows basic characteristics of cases that closed for each reason. More detailed analysis was completed by reviewing the case notes and other “My Community Choices” web information for a random sample of cases for each closure reason.

Table 6: Characteristics of consumers whose cases closed in 2015

Closure Reasons	Closures N (%)	Female N (%)	Male N (%)	Age Range	Age Avg	% 65 or older	Days from referral to closure Range	Days from referral to closure Avg
Transitioned to community before informed consent signed	217 (26)	104 (25)	106 (26)	22-97	61	37	0-1720	n/a*
Participant changed their mind and would like to remain in the facility	166 (20)	91 (22)	74 (18)	29-101	72	68	3-1865	382
COP/Guardian refused participation	149 (18)	77 (19)	72 (18)	32-103	73	71	14-1758	325
Other	66 (8)	30 (7)	33 (8)	28-93	61	33	3-1223	291
Exceeds physical health needs	35 (4)	17 (4)	18 (5)	41-86	68	63	22-2507	450
Reinstitutionalized for 90 days or more	58 (7)	39 (9)	18 (5)	20-96	70	69	n/a	n/a
Participant would not cooperate with care planning process	92 (11)	38 (9)	54 (13)	25-92	60	35	26-1343	274
Exceeds mental health needs	6 (1)	2 (1)	4 (1)	36-64	56	0	38-751	344
Participant not aware of referral and does not wish to participate	29 (3)	13 (3)	15 (4)	53-93	71	52	16-345	114
Participant moved out of state	15 (2)	6 (1)	9 (2)	32-79	60	33	42-925	294
Total	833**	417	404	X	X	X	X	X

Note: Percent totals may not equal 100 due to rounding.
*The average days to closure cannot be accurately calculated for this closure reason due to missing referral dates. Cases missing referral dates (n=31, 14%) were never assigned to the field, often because they already transitioned to the community between applying to MFP and when their case was ultimately going to be assigned to the field.
** Gender information was missing for 12 participants.

For the most frequent closure reason, "Transitioned to community before informed consent signed" (n=217, 26%) cases were often closed because the client discharged from the facility prior to meeting MFP eligibility requirements or left the facility against medical advice. Fourteen percent of these cases (n=31) were never assigned to the field because they left the institution before assignment, leaving few notes on their activity. Consumers who closed for this reason were more likely to be younger compared to consumers in most other categories, with an average age of 61, and only 37 percent age 65 or older (see Table 6). As mentioned above, it should be noted that the cases that were never referred to the field lack referral dates.

This year there was a 3% increase for cases that closed because the participant changed their mind and wanted to stay in the facility, from 17% to 20% (n=166), which represented the second most common reason. Similar to previous years, an in-depth analysis of these cases showed the main reasons participants changed their mind were: acclimation to the facility – feeling comfortable living there, the perception by participants that their physical or mental health needs were significant and would be better met at a facility, and participants feeling happy with the socialization at the facility. The average length of time from referral to closure was 382 days, with a range of 3-1,865 days. The average age of participants closed for this reason in 2015 was 72 years, the same as 2014.

Below are a few quotes from case notes that highlight common explanations of why participants changed their mind and decided to stay in the facility:

- *"[Participant] reported he liked it there. He likes the activities they have. He states his wife visits him several times a week."*

- *"[Participant] said that for right now, she wants to stay at SNF. However, she did say that if she becomes more stable physically, then she would tell her [social worker] to put in another MFP Referral for her."*

- *"The only reason he applied for MFP was because he thought he would not be approved for long term care."*

- *"Participant's brother [name] was hesitant to sign any TPOC [transition plan of care] documents because [participant] is not physically where they would [want] her to be at transition. After discussing with TC, [participant] and family decided they would prefer to wait until she is age 64 to discharge with MFP CHCPE."*

Cases closed because the "COP/Guardian refused participation" accounted for 18% (n=149) of overall closures in 2015, an increase of 4% from 2014. As in years prior, the main reasons COPs and guardians cited for their decision were a decline in consumer health from the time of the referral and the belief that the consumer needs 24-hour care to ensure his/her safety in the community. Two other common reasons were that the legal representative did not want to be either part of the back-up plan or to manage the consumer's personal care assistants (PCAs). In addition, many of these consumers had mental health and/or memory issues and were unable to manage other health issues, such as diabetes, on their own. Some illustrative case notes include:

- *"Both children/conservators live at least 2 hours away and he will lack community support. SCM informed her that Live-in PCAs are available if it is warranted by the assessment. She [daughter/conservator] stressed that he has dementia with severe cognitive loss and they live too much of a distance to be readily available."*
- *"COP who is no longer in favor of participant [name] returning to the community, due to unsafe behaviors and having to be hospitalized numerous times due to the behaviors."*

- *"Son states that they feel quality of life would be better in SNF setting versus a home with a caregiver."*

Eleven percent (n=92) of cases closed in 2015 because the participant would not cooperate with the care planning process, a 7% increase from 2014. Only 35 percent of this group was over age 65 in 2015, a significant decrease from 2014, when 59 percent were over age 65. Lack of cooperation in establishing Medicaid eligibility for participants who were over income or assets played a role in many of these cases. Additionally, there were some participants who left the facility before eligibility to transition with MFP was established.

- *"Durable Power of Attorney [name] states that she met with Attny [name] and she does not want to pursue a Pooled Trust because participant [name] is on hospice and she does not want to spend that much money when participant [name] does not have that much time left."*
- *"…the client discharged back to his community residence before [date]. The exact date is unknown, and there is no discharge notice in Ascend at this time. Medicaid eligibility was not established prior to discharge. The pending L-01 has been denied."*
- *"He left SNF AMA and was homeless for a week before he was admitted to the hospital [name]. Client knew what he was doing and chose to leave SNF anyway."*
- *"T/c to SNF SW [name] who states consumer's wife took consumer home on [date] without completing the T-19 and Pooled Trust."*

Similar to 2014, re-institutionalization for 90 days or more accounted for 7% of overall closures (n=58). A variety of reasons contributed to participants needing to be re-admitted to an institution including: a long-term hospital stay or multiple hospitalizations, declining health, diabetes, mental health, stroke, and substance use problems.

Three percent of referrals were closed for the reason "Participant not aware of referral and does not wish to participate" (n=29). These participants had an average age of 71 with 52% age 65 years or older. The average number of days from referral to closure was 114, the lowest of all the closure reasons. A couple of representative quotes include:

- *"SCM met with consumer [date] who states he is not staying in the SNF past [date]. For the consumer to qualify for MFP he would have to stay until [date] to meet the 90 day criteria. Consumer refused program."*
- *"SW, Consumer, and Family would like the MFP Referral to be put on hold for the moment. SCM has asked SW to re-refer [participant] at a later time if and when [participant] is ready. Her son is not ready to have her back home yet but once he is well enough, he is open to her returning home. [Participant] does not wish to speak with SCM without her family and does not wish to live anywhere but her son's home. SCM has not been able to do the UA. Each time SCM has met [participant] she says she "isn't ready". SW said she doesn't mind being at SNF while her son recuperates."*

Exceeding physical health needs accounted for 4% of closures (n=35) which is half the percentage it was in 2014 (8%). In addition, nearly two thirds of this group (63%) were over age 65 in 2015, a significant increase from 2014, when only 26 percent who closed for this reason were over age 65. Representative quotes from cases closed for this reason include:

- *"DDS [Department of Developmental Services] has denied her and she is too medically and cognitively impaired to be home on state plan services. Participant [name] requires structure 24/7 care and supervision. "*
- *"Client cannot independently check his blood glucose level nor administer his insulin. This client is therefore not eligible for the MH Waiver as he would need 24/7 care and his health and safety cannot be assured on the Waiver."*

Finally, reasons for closing a case due to exceeding mental health needs accounted for 1% of overall closures (n=6). Similar to findings from 2013 and 2014, these participants mainly had a diagnosis of anxiety, depression, post-traumatic stress disorder, and/or schizophrenia. The main health issues were mental health issues, uncontrolled diabetes, and dementia.

- *"Caseworker contacted social worker [name]. Caseworker informed her that because client was overspending and recently suicidal in the structured supervised environment, client was not stable enough to transition to the community without 24 hour supervision. Client exceeds MFP cost cap..."*
- *"There are no current safe options for community living. He has no one he can live with and he requires 24 hour care. His mental health needs exceed what PCA and State offer (wouldn't be eligible for PCA Waiver because he does not require any hands-on assistance). ALFs are out of the equation because they won't [accept] anyone who is an AWOL risk. RCHs - the same thing. Maybe when consumer turns 65 he could be assessed again but for the Elder Waiver. However, participant [name] does not want to live with anyone and there is still a huge risk that, even if he did live with a Companion, that he would elope and go AWOL."*
- *"…it is very unsafe for this client transition into the community due to his history of violence and drug use."*

Another noteworthy point was that 239 (29%) of the cases closed in 2015 (excluding cases without referral dates and those closed for the four excluded closure reasons) were closed more than one year after referral, an increase over 2014 when only 19 percent were closed more than one year after referral. It is likely that the concentrated work of CO in 2015 to address the backlog of cases that had been recommended for closure much earlier contributed to this trend.

The closure reason with the lowest average amount of time from referral to closure was "Participant not aware of referral and does not wish to participate" at 114 days, and the highest was "Exceeds physical health needs" with an average of 450 days. Participants who changed

their minds and decided to remain in the facility due to feeling happy and/or comfortable there had the second longest average time from referral to closure at 382 days.

Transition Challenges

Compared to the previous year, the distribution and order of transition challenges for cases closed in 2015 differed only slightly (see Table 7), with the top four challenges the same in both years. Physical health was the biggest challenge in both years: 17% (n=1126) in 2015 and, 18% 2014. Field staff identified housing as a close second challenge in both years, also representing 17% (n=1122) of cases. The next most common challenges included services and supports (16%), mental health (12%), consumer engagement (8%), financial (7%), and waiver/HCBS package (6%).

Table 7: Transition challenges by category for cases closed in 2015 and 2014

Transition Challenges	2015 %	2014 %
Physical health	17	18
Housing	17	15
Services and supports	16	12
Mental health	12	11
Consumer engagement	8	9
Financial	7	8
Waiver/HCBS package	6	10
Legal	5	4
MFP Central Office	4	5
Involved others	4	4
Facility	2	2
Other	2	2

Over half (54%) of those with physical health challenges had the sub-challenge “Current, new, or undisclosed physical health problem or illness,” similar to 2014 (53%). As in 2014, almost half (49%) of consumers with housing challenges did not have affordable, accessible community housing. Consumers with services and supports challenges most often faced problems related to a lack of PCA, home health, or other paid support staff (39%) and a lack of transportation (16%). While challenges related to PCA, home health, or other paid support staff increased by 1%, challenges related to lack of transportation went down 6% this year compared to last. Consumers with mental health challenges most often faced difficulties related to current, new, or undisclosed mental health problem or illness (32%) and dementia or cognitive issues (31%).

Conclusion

Many of the 2015 findings were similar to those in previous years, and the characteristics of consumers for 2015 were similar to those last year. For example, consumers whose cases closed due to changing their mind and deciding to stay in the facility had an average age of 72 years, the same as last year. However, this year the highest average age (73) was for consumers whose case closed due to COP/guardian refusal to participate. Cases closed due to exceeding mental health needs had the lowest average age (56), similar to 2014 (54). The two major differences were in the percentage of persons over age 65 whose case closed due to exceeding

physical health needs (increase from 26% to 63%) or due to not cooperating with the care planning process (decrease from 59% to 35%). Percentages for male and female consumers were similar for most closures reasons. There were slightly more females (9% vs. 5% males) whose cases closed due to being re-institutionalized for 90 days or more, and slightly more males (13% vs. 9% females) for the reason "Participant would not cooperate with care planning process."

Closures due to prolonged re-institutionalization remained the same (7%) as in 2014. Effective prevention of re-institutionalization remains a key priority, and identifying and mitigating the risk of falls leading to hospitalizations is one critical factor. This year the combined percentage of cases that closed because the consumer's mental or physical health needs exceeded allowable cost (5%) was less than half of what it was in the prior year (11%), a sign that the program may be finding ways to provide more services at decreased cost, such as Adult Family Living. In fact, this year cases closed due to exceeding mental health needs was not in the top seven closure reasons. It accounted for just 1% of cases closed, lower than previous years (3% and 4%). The percentage of cases closed due to consumer's exceeding physical health needs (4%) was also lower in 2015 compared to previous years (8% in 2014 and 7% in 2013).

As described earlier, a revised transition process began in March of 2014 which allowed Central Office to refer to the field many of the consumers who had applied to MFP but were waiting to be assigned to the field. Directly related to this change, 2014 saw a large increase in older referrals sent to the field, which corresponded with an increase in the percentage of cases closed because the consumer had already left the facility without the assistance of MFP. Only 14% of cases closed in 2015 were never assigned to the field, compared to 39% in 2014. Related to this shift, fewer cases closed this year because a consumer transitioned to the community before signing an informed consent (26%) than in 2014 (37%), though it is still a large percentage of closed cases. This is likely due to the mass referral of waitlisted cases, many of which then closed because they already left (transitioned before IC signed). With such a large percentage increase in cases closed for this reason, it is reasonable that there would be an overall decrease in the relative percentages of the other top three closure reasons; the top three account for 68% in 2014 and 64% in 2015 of all closures.

Only the relative percentage of closures due to participants' lack of cooperation in the care planning process rose significantly from 4% in 2014 to 11% in 2015. Possible reasons for this change and ways to address it, such as earlier Medicaid eligibility screening or continued work with motivational interviewing, should be explored with MFP Central Office staff. Closures due to COP refusing participation also rose four percent, from 14% to 18%. Many of these family members had concerns about safety or getting 24 hour care in the community; MFP should also consider ways the SCMs and TCs could respond to these concerns, perhaps using motivational interviewing techniques. Family members were also concerned about taking on caregiving tasks and management responsibilities, especially for consumers who could not manage their health or PCAs on their own. Utilizing Support and Planning Coaches and developing more Adult Family Homes could help address these concerns. Making use of caregiver respite hours or caregiver training might also decrease burden for these caregivers and, therefore, make it possible for these consumers to move out.

Progress was made during 2015 in narrowing the gap between closures per 100 referrals (42) and transitions per 100 referrals (40), and there were almost as many transitions (789) as closures (833), the closest gap since 2011. That progress may be due to an additional year's experience with the new transition process begun in March 2014 and increased transitions of the waitlisted applicants who were mass referred during 2014. The new process implements a structured team approach with rapid assessment and community care plan development, ideally leading to shorter transition times.

Acronyms and Abbreviations

The list below provides an explanation of abbreviations and acronyms used for the waivers and other terms in this report.

ABI	Acquired Brain Injury Waiver
AMA	Against Medical Advice
BIP	Balancing Incentive Program
CHCPE	CT Home Care Program for Elders Waivers or Programs
CHCPE-AFL	CT Home Care Program for Elders Waivers (Adult Family Living)
CHCPE-AL	CT Home Care Program for Elders Waivers (Assisted Living)
CHCPE-C5	CT Home Care Program for Elders Waivers (Category 5)
CHCPE-L1	CT Home Care Program for Elders Waivers (Level 1 State Funded)
CHCPE-PCA-AB	Personal Care Assistance Waiver (Agency-Based)
CHCPE-PCA-LI	Personal Care Assistance Waiver (Live-in)
CHCPE-PCA-SD	Personal Care Assistance Waiver (Self-Directed)
CHCPE-S	CT Home Care Program for Elders Waivers (Standard)
CO	Central Office
COP	Conservator of Person
DDS	Department of Developmental Services Waiver
DDS-A	Department of Developmental Services (Autism Waiver)
DDS-C	Department of Developmental Services (Comprehensive Waiver)
DDS-IFS	Department of Developmental Services (Individual and Family Support Waiver)
DSS	Department of Social Services
HC	Housing Coordinator
HCBS	Home and Community Based Services
KB	Katie Beckett Waiver
LCSWs	Licensed Clinical Social Workers
MFP	Money Follows the Person
MH	Mental Health Waiver
MHSP	Mental Health State Plan
PCA	Personal Care Assistance Waiver
PCA-AFL	Adult Family Living
PCA-S	Standard
PCAs	Personal Care Assistants
PDSP	Physical Disability State Plan
SCM	Specialized Care Manager
SNF	Skilled Nursing Facility
SW	Social Worker
TC	Transition Coordinator
UA	Universal Assessment
WISE	Working for Integration, Support, and Empowerment – DMHAS MH Waiver