Connecticut Money Follows the Person Evaluation
UConn Health Center, Center on Aging

Analysis of MFP cases closed between January 1, 2012 and June 30, 2012

Introduction

Money Follows the Person (MFP) aims to transition residents in long term care facilities to the community. By 2016, Connecticut seeks to transition over 5,000 long term care (LTC) residents 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. Unfortunately, CT has experienced a relatively high number of cases closed compared to cases transitioned (Figure 1). Therefore, 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.

In Connecticut, during 2012 cases were closed for one of the following 17 reasons:

1. Transitioned to community before informed consent signed
2. Exceeds mental health needs
3. Exceeds physical health needs
4. Completed 365 days of participation
5. Died
6. Hospitalized 90 days with no discharge date
7. Left without approved transition plan
8. Non-Demo: transition services complete
9. Nursing home closed and moved to another facility
10. Other
11. Re-institutionalized for 90 days or more
12. Withdrawal, conservator of person (COP)/Guardian requested closure
13. Withdrawal, participant changed their mind and would like to remain in the facility
14. Withdrawal, participant declines to agree with program requirements
15. Withdrawal, participant declines assessment
16. Withdrawal, participant moved to another state without MFP transitional services
17. Withdrawal, participant would not cooperate with care plan development

For the purposes of this analysis, cases closed under four closure codes were excluded: completed 365 days of participation, died, non-demo: transition services complete, and nursing home closed and moved to another facility. Also excluded were referrals from nursing home closures independent of the case closure reason.

Methods

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

tracking system. In-depth analysis of cases closed was conducted by using case notes from the CT MFP website and from individuals' paper files at the CT Department of Social Services. Finally, two focus groups with MFP transition coordinators from across the state were conducted; 12 transition coordinators participated in the first one and eight in the second.

First we compare data from 2009-12, the first four years of the MFP program. The remainder of the report focuses on cases closed between Jan 1, 2012 and June 30, 2012, presenting a detailed analysis of cases closed for each of the 13 closure codes included in the analysis. We provide a further breakdown of each reason code by demographic characteristics and by which home and community-based services (HCBS) program the consumer was targeted for. We then examine transition challenges (selected by the transition coordinators from a standardized checklist) and other common characteristics among the closed cases.

Comparison of 2009-2012

In three of the four years, case closures exceeded transitions, while in 2011 transitions exceeded closures slightly, 434 to 395, respectively. New referrals exceeded both in all years (Figure 1).Compared to the year 2011, in 2012 there was a 48.5% increase in referrals, 70.6% increase in cases closed and a 16.8% increase in cases transitioned (Figure 1). Comparing the two halves of 2012, despite a decrease in referrals in the second half, there was a large increase (36%) in closures and only a modest increase (17%) in transitions (Figure 2).

Figure 1. Comparison of Closures, Referrals, and Transitions per Year

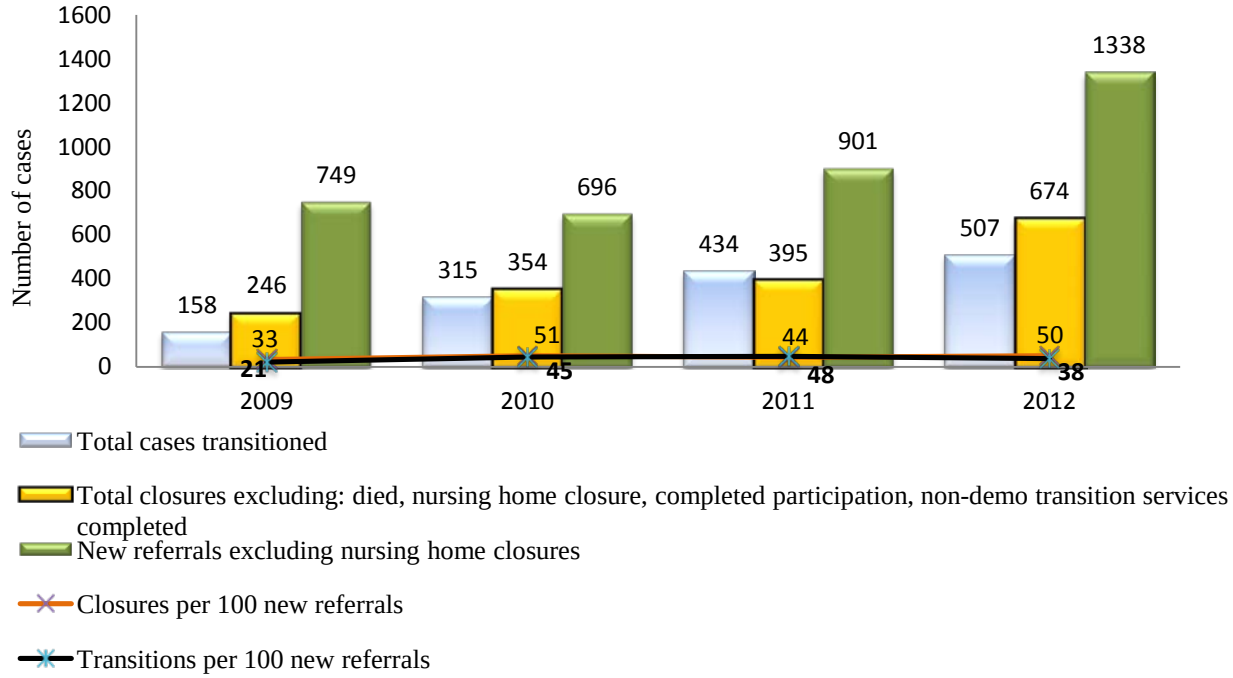
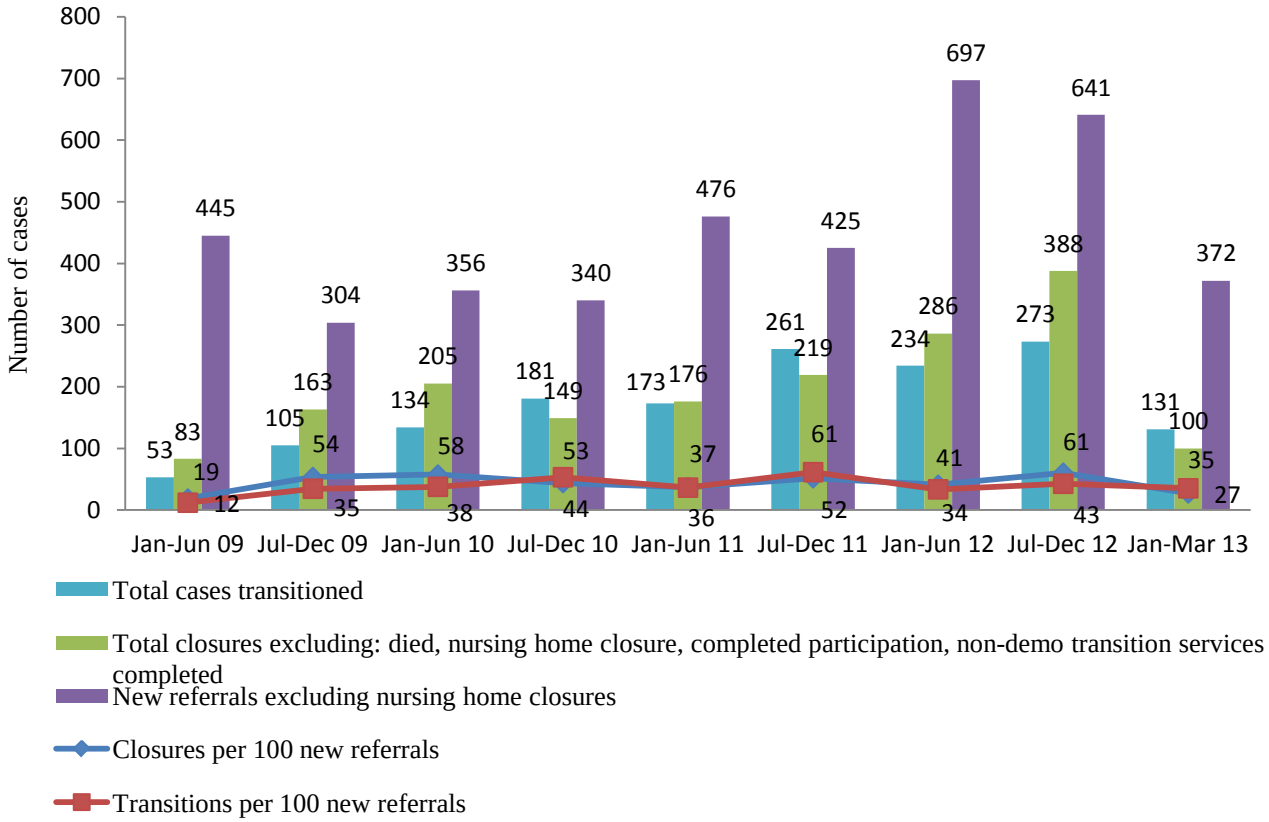


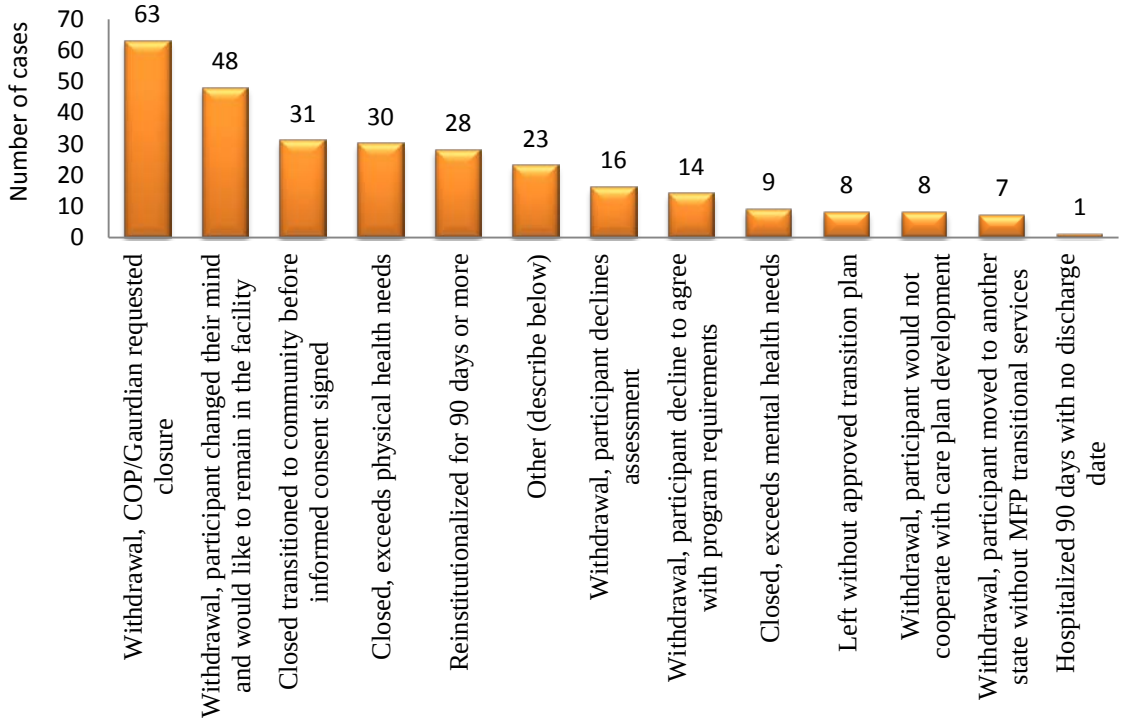
Figure 2. Comparison of Closures, Referrals and Transitions per Six month period



January 1, 2012 through June 30, 2012

Out of the 286 cases closed during this time period, the top four closure reasons accounted for 172 (60%) of the closures: Withdrawal, COP/guardian requested closure 63 (22.0%), withdrawal, participant changed their mind and would like to remain in facility 48 (16.8%), closed transitioned to community before informed consent signed 31 (10.8%) and exceeds physical health needs 30 (10.5%) (Figure 3).

Figure 3. Closed Cases January through June 2012



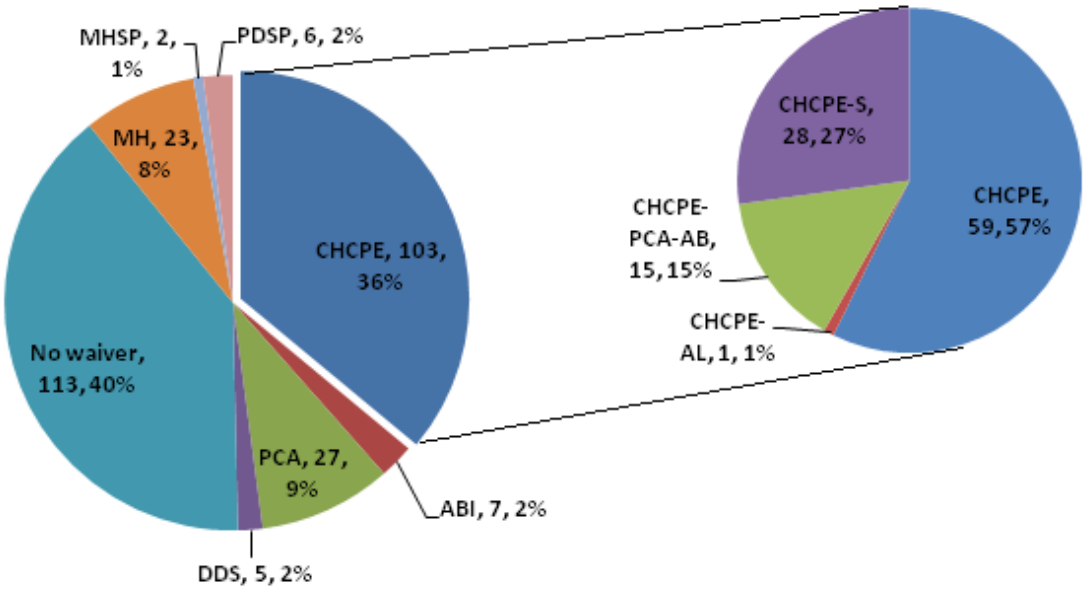
Closed cases by HCBS program and closure reason

There are ten HCBS programs, including Medicaid waivers and state-funded programs, for which persons transitioning under MFP may be targeted in order to meet their continuing needs. These programs, and their abbreviations, include:

Abbreviations for the HCBS programs:
CHCPE: CT Home Care Program for Elders
CHCPE-AL: CT Home Care Program for Elders, Assisted Living
CHCPE-PCA-AB: CT Home Care Program for Elders, Personal Care Assistance Agency-Based
CHCPE-S: CT Home Care Program for Elders, State funded
ABI: Acquired Brain Injury Waiver
DDS: Department of Developmental Services Waivers
MH: Mental Health Waiver
PCA: Personal Care Assistance Waiver
PDSP: Physical Disability State Plan
MHSP: Mental Health State Plan

Almost 113 (40%) of the 286 cases closed during the first half of 2012 were not targeted for any of the available HCBS programs. The largest percent of the other cases closed, 103 (36%), had been targeted for a least one of the available types of the elder waiver. The next waiver with most cases closed was the PCA waiver with 27 (9.4%), followed by the mental health waiver with 23 (8.0%) (Figure 4).

Figure 4. Distribution of closed cases by waiver: January through June 2012



Of the 113 cases that had not been targeted for any waiver, 30 closed due to the individual transitioning to the community before informed consent signed, 33 due to COP/guardian requesting closure, 14 due to the participant changing their mind, and the remaining 36 cases were distributed amongst the other closure reasons. Of the 59 targeted for the CHCPE waiver, 14 closed due to exceeding physical needs, another 14 closed due to COP/guardian requesting closure, 10 closed due to the participant changing their mind, and the remaining 21 cases were distributed amongst the other closure reasons. Additionally, half of the 28 cases targeted for the CHCPE-S waiver closed due to reinstitutionalization for 90 days or more (Table 1).

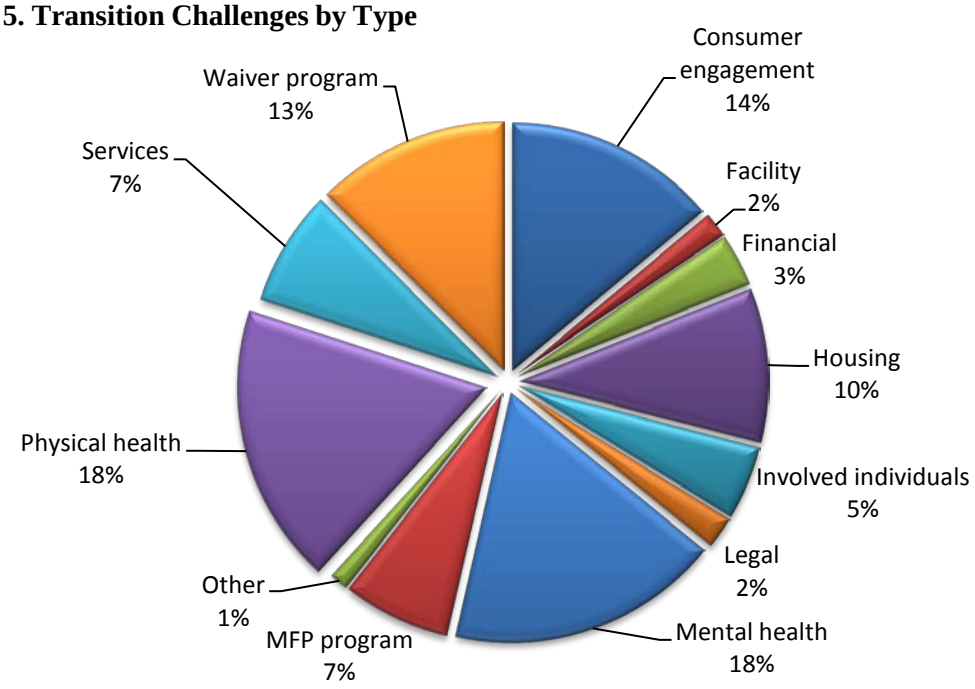
Table 1. Distribution of closed cases by waiver and reason

	No Waiver	ABI	CHCPE	CHCPE-AL	CHCPE-PCA-AB	CHCPE-S	DDS	MH	MHSP	PCA	PDSP
Transitioned to community before informed consent signed	30	0	1								
Exceeds mental health needs	1	1						7			
Exceeds physical health needs	3	2	14			1	1	1		8	
Hospitalized 90 days with no discharge date	1								1		
Left without approved transition plan	1		1		1			1		3	1
Other (describe below)	15		4		1		1			2	
Reinstitutionalized for 90 days or more		1		1	4	14		2		2	3
COP/Guardian requested closure	33	2	14		2	4	1	2		4	1
Participant changed their mind, would like to stay at nursing facility	14		10		6	7	2	4	1	4	
Participant decline to agree with program requirements	3	1	4			2		3			1
Participant declines assessment	8		7							1	
Participant moved to another state without MFP transitional services	3		1		1			1		1	
Participant would not cooperate with care plan development	1		3					2		2	
Total	113	7	59	1	15	28	5	23	2	27	6

Transition challenges of closed cases

During the first half of 2012, individuals whose cases were closed had multiple transition challenges, the most common of which were: physical, mental health, engagement and waiver issues (Figure 5). More specifically, such challenges included: lack of awareness or unrealistic expectations regarding disability or needed supports, lack of independent living skills, disengagement or lack/loss of motivation, inability to manage physical or mental health or illness in community, dementia or cognitive illness, waiting for evaluation, application review, or response from waiver agency/contact, lack of time for transition coordinator to follow up and waiting for response, approval, etc. from MFP office.

Figure 5. Transition Challenges by Type



Analysis by closure reason

The following sections of this report provide an in-depth analysis of each closure reason. Table 2 summarizes the gender distribution, age, and days from referral to closure of cases closed under each closure reason. Cases closed due to excess physical needs, COP/guardian requesting closure and participants changing their mind were more likely to involve female participants, while cases closed due to the participant leaving without an approved transition plan, declining to agree with program requirements, and not cooperating with care plan development were more likely to be male. Cases where the COP/guardian requested closure had the oldest average age, while cases closed with the youngest average age exceeded mental health needs or left without an approved transition plan.

Table 2. Characteristics of cases closed

Closure Reasons	Closures (N) (%)	Female (%)	Male (%)	Age Range	Age Average	65 or older (%)	Range of number of days from referral to closure	Average number of days from referral to closure
COP/Guardian requested closure	63 (22)	60.3	39.7	45-98	73.7	69.8	8-932	247.9
Participant changed their mind and would like to remain in the facility	48 (16)	60.2	39.6	34-93	72	71	5-1082	250
Transitioned to community before informed consent signed	31 (10.8)	48.4	51.6	36-86	63	45	1-628	83.7
Exceeds physical health needs	30 (10.5)	66.6	32.3	41-88	65	56.6	26-1186	403
Reinstitutionalized for 90 days or more	28 (9.79)	57.1	42.9	25-91	69	75	N/A	N/A
Other	23 (8.04)	69.6	30.4	7-94	66	65	0-887	183
Participant declines assessment	16 (5.59)	50	50	62-86	74	87.5	1-650	167
Participant decline to agree with program requirements	14 (4.9)	35.7	64.3	46-92	68	50	8-948	409
Exceeds mental health needs	9 (3.14)	55.6	44.4	42-60	56	0	7-807	249
Left without approved transition plan	8 (2.8)	25	75	21-87	56	37.5	0-522	199
Participant would not cooperate with care plan development	8 (2.8)	37.5	62.5	47-93	68	50	92-848	459
Participant moved to another state without MFP transitional services	7 (2.45)	28.6	71.4	44-81	62	42.9	18-1276	345
Hospitalized 90 days with no discharge date	1 (0.35)	100	-	52	-	-	-	-

Withdrawal, COP/Guardian requested closure: 63 closures

HCBS program: About 32 (50.7%) cases were closed before informed consent was signed and only 10 consumers had care plans approved at the time of closure. The distribution of consumers targeted for the different waivers was as followed: 35 consumers were not targeted for any waiver, 2 ABI, 14 CHCPE, 2 CHCPE-PCA-AB, 4 CHCPE-S, 1 DDS, 2 MH, 4 PCA, and 1 PDSP. The 2 consumers targeted for the MH waiver were denied compared to 4 denials out of the 20 targeted for the elder program.

Challenges and Characteristics: The most common transition challenges of these individuals were physical, engagement and mental health challenges. These included: lack of awareness or unrealistic expectations regarding disability or needed supports, lack of independent living skills, inability to manage physical or mental health or illness in community. Common characteristics of the consumers whose cases were closed under this reason included: dementia, diabetes, behavioral issues and non-compliance with medications, diet, or physical therapy at the nursing home. Many underestimate their physical limitations, and many suffered a decline in health during the process. Most of these consumers were described as needing 24/7 care or supervision according to conservators, relatives, facility social workers or physicians.

The most common reasons for requesting closure were: concern for consumer's safety if living independently in the community; fear by relatives and/or COPs that caring for the consumer will entail too much responsibility; lack of back-up plan as most families/conservators would not agree to be part of it; and past experience of consumer failing to live independently.

> ***Case 1:*** *"Consumer has history of non -med compliance and alcoholism. Consumer also reported that he would like to cook in the home. COP had informed TC (transition coordinator) that the consumer is not capable of cooking due to forgetfulness and fire risk. Former apartment had multiple carpet burns caused by lit cigarettes […] At this time the consumer's family is not able to participate as the emergency backup system or provide a room in their home due to the presence of minor children; including foster children […] Consumer at this time will not be allowed to rent with the […] Housing Authority due to the unlivable conditions that his recent apartment was left in."* ***64 year old male consumer with diagnosis of dementia, alcoholism and strokes***
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> ***Case 2:*** *"Although the family is heartbroken they are not able to bring their mother home and feel the n/f can provide the best care. The consumer's elderly children have been taking care of her for 7 years since her multiple strokes and now consumer needs even more care."* ***98 year old female consumer***
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> ***Case 3****: "TC explained MFP and CHCPE services and that consumer could pursue own apartment. Daughter states that the consumer has declined mentally and physically to a point where NF placement is best for him and that her main goal is to move him from current NF to one where the care will be better for him. TC met with consumer in his room and attempted to discuss with him his referral to MFP. Consumer did not understand who TC was and stated that TC should speak with his dtr regarding any questions about his care."* ***88 year old male consumer***

Case 4**: "TC received call from [X] confirmed she spoke with COP who has decided to withdraw CL (client) from MFP at this time. [X] reports the decision was made due to inability to provide CL with a safe community option. [X] indicated she is willing to write up document stating she spoke to CLs COPE who made decision that CL should no longer be on MFP at this time. TC asked for document to be faxed to TC." **61 year old female consumer with diagnosis schizophrenia and HIV

Withdrawal, participant changed their mind and would like to remain in the facility: 48 Closures

HCBS program: More than half of the participants, 32, had informed consents signed before closure and at least 9 consumers had care plans approved at the time of closure. Consumers were distributed into the different waivers as followed: 14 no waiver, 10 CHCPE, 6 CHCPE-PCA-AB, 7 CHCPE-S, 2 DDS, 4 MH, 1MHSP, and 4 PCA. All 4 consumers targeted for the MH waiver were denied, and only 1 consumer out of the 23 targeted for the elder waiver was denied.

Challenges and Characteristics: The most common transition challenges in these cases were physical, mental health, engagement and waiver challenges, more specifically these were: current, new, or undisclosed physical health problem or illness, dementia or cognitive illness, inability to manage mental health in the community and waiting for evaluation, application, review, or response from waiver agency/contact. Participants who decided to withdraw their referral suffered from several health issues, including but not limited to, morbid obesity, anxiety, respiratory and heart problems, and depression. Many of these consumers did not follow through with physical therapy, diet adherence or medication training as recommended by the transition team. Some of these participants changed their minds after talking to their family members and others were never interested in leaving the nursing facility.

Case 1:** "The Rn on the floor reports that the consumer has not worked with PT or OT since before Christmas. The consumer does not get out of bed and does not get dressed. She stated that MH works with him and he is showing no progress at this time. She stated that he enjoys the girls (CNA's) taking care of him. CM and TCS met with the consumer […]The consumer reports that he can't work with PT or OT as he has been sent out for medical appointments in a wheelchair that hurts him and then he is in pain and unable to move. He reports going to two appointments in two weeks. He reports that his body is also not stable enough to participate in PT he says he "Knows his body". TCS stated that the case has been sitting for a long time with no forward progress. TCS stated that TCS could close the case at this time so that TC's or CM's are not requesting more out of him at this time. TCS stated that he could be re-opened if his function increases. The consumer stated that he feels relieved by that statement he doesn't feel so pressured." **68 year-old male with morbid obesity and other co-morbidities

***Case 2:** "Talked to consumer about the program with the social worker. Discussed the risks involved in living in the community and how there was a cost cap to the program*

which did not always fit the needs of the consumer. Consumer's family and the social worker did not think that a community placement would fit the needs of this person. She is at the SNF level of care and admitted that at the end of the conversation." ***75 year old female***

Case 3*: "Writer met with consumer this morning at facility. Consumer informed writer, with social worker present, that she did not want to leave facility. Consumer stated that she is not well. Writer replied in the affirmative"* ***82 year old female***

Case 4: *"Care plan assessment was held. Stressed that she would need to work hard on transfer to be able to fit into a safe plan […]Consumer has made no progress towards becoming independent. She stated she was not interested. Confirmed she is withdrawing from demo."* ***73 year old female with diagnosis of amputation, morbid obesity, and other co-morbidities.***

Case 5: *"This writer spoke with [consumer's son] prior to meeting who stated that he took consumer to her home for a visit this past weekend to see if this was really what she wanted to do. He noticed that she became very anxious and they had a very long talk and Irma decided that she did not feel safe returning to her old home and would prefer to stay in the nursing facility where she has friends. This writer explained to X that if she changes her mind the case can always be reopened. Consumer signed case closure paperwork."* ***90 year old female with diagnosis of generalized anxiety disorder, spinal stenosis, depressive disorder, and other co-morbidities.***

Closed transitioned to community before informed consent signed: 31 closures

Very limited information was available about consumers in this category. Most consumers had transitioned by the time transition coordinators attempted to contact them, which for many was about three to four months from the date application for the program was completed.

Case 1: *"…Nurse Reviewer from the MFP Central Office called the CLS to inform the CLS that she spoke with the consumer's daughter as of today and learned that the consumer discharged from the SNF on 4/3/2012 due to poor health care received. As of 4/10/2012 through 4/24/2012 the consumer has been admitted to Yale Hospital for different medical exacerbations a few times already. The consumer's daughter informed [nurse reviewer] from MFP that she is looking into in-home services for her mother at this time because she does not feel comfortable placing her mother in another SNF due to her mother being in several SNF over the course of the year"* ***83 year old female***

Case 2: *"CLS called the client and was informed by the client that she was being discharged from the facility as of today. I asked the client was there any in-home services she may need once she settles in at home. The client informed the CLS that she will need a companion/homemaker to assist with cleaning the house and to have company. I told the client that I would look and see what is available to her in the community and I would call her with some information."* ***59 year old female***

Closed, exceeds physical health needs: 30 closures

HCBS programs: 27 consumers had signed the informed consent and 7 consumers had approved care plans at time of closure. The distribution of the consumers into the different programs was as followed: 2 ABI, 14 CHCPE, 1 CHCPE-S, 1DDS, 1MH, and 8 PCA. 10 out of the 15 consumers who applied for the elder waiver were denied, 3 of 8 consumers who applied for PCA were denied and the mental health waiver was also denied for the one consumer who applied.

Challenges and Characteristics: As expected most consumers in this category had a physical challenge to transition, mainly, inability to manage physical health or illness in the community; waiver related challenges were also common, more specifically, waiting for evaluation, application review, or response from waiver agency/contact and delay in neuropsychiatric evaluation; also common were housing, engagement and mental health issues. These cases were characterized by the need for 24/7 care, lack of family or informal support in the community, a decline in health during the transition process, and inability to independently manage personal care assistants. Many of these participants suffered from dementia and/or other debilitating conditions such as multiple sclerosis and heart conditions.

> ***Case 1:*** *"I met with the family last Tuesday and it's clear, they don't want to be responsible for consumer's care. They do not mind assisting but not to be a back-up/primary care person should an emergency come up. Also, they feel that they cannot train aides on how to use a lift and do not want to use the lift themselves, since they feel that they are not qualified enough to use a lift."* ***69 year old female with diagnosis of Alzheimer's disease, diabetes and stroke***
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> ***Case 2:*** *"Received call from social worker at DSS in Bpt. said he doesn't think he can approve [consumer] for the PCA waiver. She will need help with 5 of her ADL's, can eat on her own but nothing else. Needs help with toileting which will be an issue during the overnight hours, also does not have family to live with or help with her care"* ***54 year old female with diagnosis of chemical dependency, stroke secondary to chemical dependency and depression.***
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> ***Case 3****: "It seems that there are some very real concerns about consumer being able to be discharged safely into the community. Contrary to what client tried to convey to us, he is total care. He does need someone to help him bathe, but consistently will wear soiled clothing sometimes for several days. There are times that he refuses to get out of bed. His memory, it seems is much worse than he conveyed the other day… There is mild depression, but no suicidal ideations. The Doc administered CAGE which is an alcohol screening test. The results indicated that client has at risk of becoming 'greatly disabled should he return to the community to live independently primarily due to the likelihood he would resume excessive alcohol consumption'… Based upon this information, I do not feel that a safe discharge plan can be developed and I intend to recommend to my supervisor that this case be closed. I will send notification to the client"* ***43 year old consumer with diagnosis of acquired brain injury***

Re-institutionalized for 90 days or more: 38 closures

Challenges and characteristics: The consumers were targeted for the different HCBS programs in the following manner: 1 ABI, 1 CHCPE-AL, 4CHCPE-PCA-AB, 14 CHCPE-S, 2 MH, 1 MHSP, 2 PCA and 3 PDSP. Consumers had multiple challenges for transition, although they all did transition for some time prior to their re-institutionalization and closure. The average number of days elapsed between referral and transition for these consumers was 202.8 days with a range of 20 to 572 days. Additionally, the average number of days elapsed from the transition to closure date was 309 days with a range of 95 to 588 days, with 13 (46.4%) of the participants being reinstitutionalized within six months of transition. The challenges were all recorded before transition, not at the time of re-institutionalization. These challenges included but were not limited to physical and mental health problems, services and waiver related issues, and engagement issues. More specifically, these challenges were: lack of awareness or unrealistic expectations regarding disability and needed supports, lack of independent living skills, dementia or cognitive issues, current or history of substance abuse or dependence, lack of PCA, home health, or other paid supports, and waiting for evaluation application review, or response from waiver agency.

These consumers were characterized by experiencing various adverse events after having transitioned including loss of caregiver in the community. For example, a consumer's husband who was caring for her in the community passed away and the consumer's daughter decided to place the consumer back in a nursing facility. Another consumer's caregiver abandoned the apartment leaving the consumer alone until he was found and taken to the hospital due to abuse and neglect. Most consumers also experienced a health related episode such as pneumonia which often led to a hospitalization followed by nursing home admission. Many consumers experienced a fall at their community dwelling upon transition, for example, one consumer fell during the night and was found the following day by the nurse after having spent eight hours on the floor. Finally, at least two consumers had drug related issues and were hospitalized after having been found intoxicated.

> ***Case 1:*** *"Called consumer's apartment and the OT person answered. He was very concerned about the lifestyle of this consumer - his bed is wet, he cannot ambulate, had been using an unsafe rolling seat and appears to be in a weakened state. Called his CM to discuss this situation and she reiterated that he signed a "risk agreement" and that I would be surprised how many people live like this gentleman does. She said that he is not a harm to himself and won't take any more time offered him. He has the right to make poor choices. Writer called New X and the supervising nurse was also very concerned about this situation. She said that someone should always go out ahead of the transition and make sure that everything is O.K. and functional for the person returning to an apartment of his/her own […] DSS called to say that a nurse found consumer laying in a pool of urine with high blood pressure - he had fallen two times. He is at Hartford Hospital.* ***75 year old male consumer with diabetes, renal failure, and cardiac compromises***

Case 2: *"07-19 On July 08, TC received phone call from said consumer's daughter. She stated her father died on July 06. She stated she does not really know what to do with her mother, the consumer she requires too much care for her and she is sick herself. Writer stated to her that MFP could increase her services. Daughter stated her mother gets up many times during the night to go to the bathroom. She could spend a couple of nights but she would not be able to sleep. TC called the consumer's case manager. Writer stated to her that the consumer's husband and caretaker have died. CM stated she would increase her service in the home. On July 19, 2011 writer received phone call from CM, she stated that said consumer retuned to facility. She stated that even with the increase service in the home it did not work out. The consumer's daughter had a break down and the consumer was returned to the nursing home on July 10-2011.* ***87 year old female consumer***

Other: 23 closures

The most common reason cited for closing a case was eligibility issues related to the individual not being active on Medicaid, for example, having Medicare as a paying source for their nursing facility stay or having to sell assets such as a house in order to be eligible for Medicaid. One consumer changed her mind and should have been coded accordingly; others were referrals from Ascend, which determines level of care of nursing home residents. These individuals were referred due to the possibility of being denied long term services at the nursing home at their upcoming Ascend evaluation, but once they were granted nursing home level of care they withdrew from the program and should have also been coded as changed their mind. Other cases cited reasons such as not being able to contact consumer's conservator, having transitioned to a residential care home without MFP services, having legal issues such as being arrested; and perception that discharge to the community would be unsafe.

Challenges and characteristics: Six individuals had signed the informed consent by the time of closure and one had a care plan approved. The most common transition challenges of individuals in this category were mental health, physical, housing, and services issues. These challenges included: dementia, previous or current substance abuse, housing modification issues, lack of transportation, lack of paid support staff and lack of substance abuse support services. As suggested by the transition challenges these consumers were characterized by having mental health or cognitive issues, having substance abuse issues and lack of informal support in the community.

Case 1: *"T/C received return call from social worker at snf. t/c reviewed the referral with her. she confirmed she was told by Ascend to make referral to MFP while LTC approval was pending. t/c was informed that LTC was approved. Jessica also confirmed that consumer was not aware of the referral and the consumer does NOT want to leave the n/f. t/c did NOT confirm with consumer since consumer is NOT aware of the referral. t/c changed status on web, recommended closure on web and notified team lead to close"* ***75 male consumer***

Case 2: *"Tel. call to facility, social worker reports consumer's husband does not want consumer back home. Consumer needs 24 care and has behaviorial issues. SW states consumer cannot communicate by phone. SW stated since consumer said "yes" to wanting to go home, she sent the MDS referral to MFP. CLS explained to SW consumer would need to be on T.19 in order to qualify for MFP. CLS to follow up with spouse. Tel. call to spouse, confirms he does not want consumer to return to his home. Spouse states consumer is dependent with all IADL's …Spouse reports he has durable POA for consumer. Spouse also reports consumer will not be eligible to apply for T.19 for approx. 1 yrs. Consumer has LTC insurance and has assets. Spouse saw elder law attorney and transferred his home and other assets in his name. CLS explained role and informed spouse will report information to MFP CO."* ***77 year old female consumer***

Withdrawal, participant declines assessment: 16 closures

Challenges and characteristics: At least seven participants had signed the informed consent before case closure; as expected, none of the consumers had an approved care plan. Many of these consumers had engagement, housing, mental, physical, MFP and waiver related transition challenges, mainly the inability to manage mental/physical health/illness in community, lack of independent living skills, and waiting for response, approval, etc. from MFP office. Some of these consumers stated they had never wanted to move to the community, many had mental health problems and many had family or conservators who did not support transition to the community. Finally, some of these consumers considered too much time had elapsed from time of application to being contacted by the transition coordinator.

Case 1: *"DSS SW met with consumer to conduct eval on 11/3. Today she left VM that she received a call from fac SW reporting that consumer has changed his mind and does not want to participate in MFP. She has sent a withdrawal form to him and will close the case when she receives the signed document."* ***63 year old male with diagnosis of depression, anxiety, and other co-morbidities***

Case 2: *"I met with X to complete the intake/waiver paperwork. X stated she is not interested in moving into the community. She was curious about the program and only wanted information. I explained MFP program and the transition process. I talked about some of the MFP success stories with hopes of alleviating any fear X may have. X insisted she does not want to move nor did she express she wanted to move"* ***82 year old female***

Case 3*: "TC received a VM from care manager … According to [care manager], the consumer refused the assessment for the CHCPE waiver on 1/25. Care manager stated that the consumer has "different expectations of the program and has misunderstood what he has been told". Naomi informed this TC that she will be closing the consumer's case. This TC also contacted the SW at Westfield Health & Rehab. SW confirmed the consumer's refusal to do an assessment. This TC asked SW what the consumer has discussed about his expectations. According to SW, the consumer thought that he was going to have all the services that he wanted. For example, SW stated that the consumer*

thought he would have someone to prepare him three meals a day. SW stated that the consumer is capable of doing many things for himself such as preparing his breakfast. After speaking to the SW, this TC contacted the consumer directly. TC confirmed the refusal with the consumer and asked consumer if he wanted to participate in MFP. Consumer stated no. After the information obtained from the care manager, SW and the consumer, this TC will be recommending closure at this time" ***77 year old male***

Withdrawal, participant decline to agree with program requirements: 14 closures

Challenges and characteristics: All consumers, except for one, had signed the informed consent by time of closure; however, only three had care plans approved. Consumers were targeted for the different waivers in the following way: 3 CHCPE, 1 CHCPE-S, 1 ABI, 2 MH, and 1 PDSP. Consumers had various transition challenges including mental health and physical, waiver and service related, and engagement issues. More specifically, these challenges included dementia or cognitive issues, current or past substance abuse or dependence, lack of paid support staff and lack of mental health services or supports. The cases closed under this reason were characterized by unsuccessful attempts to communicate with the consumers' conservators and therefore not being able to move forward with the process; in addition, some consumers refused services in the community, and other consumers did not follow through with signing required MFP paperwork or other requirements such a neuropsychological evaluations.

Case 1: *"Spoke with nurse whom reported that she did go and visit with consumer. Stated that she had several concerns. Consumer had stated to her that he wanted to go back home to drink and continue to be non compliant. She stated that she spoke with COP and she stated that she was relieved that there were others that felt he would not be appropriate to leave the facility. Nurse stated that she found him not to be eligible. Made him an assessment only. TC will recommend closure."* ***69 year old male consumer with diagnosis of personality disorder, major depression and anxiety***

Case 2:*"This Tc spoke with consumer this afternoon. He thanked for me for the services that were provided by all team members, when assisting him with his transition to the community. He would just like to live by himself and feels that he does not need the services of the state, since he figures that the state will save 50,000 a year from not serving him. He just feels that over the past few months, he never left the NF, since people are always checking on him and wants to "live life" to the fullest and that is doing what he wants to do and when he wants to do thing, which require no assistance overseeing from another person. Tc stated, he understood but tried to explain the challenges […] Tc asked consumer to call him if he should change his mind and he could always call CDR, should he have questions about services in the future. Tc will notify DMHAS about his conversation with consumer and will request closure on his case."* ***65 year old male consumer***

Case 3: *"I asked what he was going to do after the day he would have to leave snf. He does not know. I advised him that if the MFP paperwork were signed almost two months ago, there might have been a possibility something could have been available for his*

discharge – however, in nearly two months the signatures were not obtained, I noted that I do not believe he was interested in MFP, preferring to live at the facility instead. I said I was sorry for the fire, and my final point to consumer was that there are persons living in nursing homes that desperately want to be discharged. He made no comment beyond he 'needed more time'. I said goodbye, and left." ***60 year old male consumer***

Case 4: *"TC explained to consumer why he would not be eligible for the MFP program. She stated that since he is unwilling to do a pool trust his income is too high. Consumer stated that he could not afford a pool trust for $1,000 and mthly fees to maintain it. TC explained that is why she had [X] from Plan of CT to come out in order to explain how he could benefit from the Pool trust…TC indicated that she was recommending closure of consumer's case due to the fact that the consumer refused to do a pool trust and that his income was too high which made him ineligible for MFP."* ***92 year old male consumer with diagnosis of chronic heart failure, depressive disorder, hypertension and other co-morbidities.***

Closed, exceeds mental health needs: 9 closures

Challenges and characteristics: Except for two cases, all cases were closed after informed consent signed, almost all consumers were targeted for the DMHAS waiver and all were denied. Consumers had multiple transition challenges including: inability to manage mental health/illness in the community; current or history of substance abuse; lack of mental health services supports; lack of alcohol, substance abuse, or addiction services; lack of independent living skills; and lack of awareness or unrealistic expectations regarding disability or needed supports. These consumers were characterized by severe behavioral issues, previous failed attempts to live in the community, lack of informal support in the community, and the need for 24/7 supervision.

Case 1: *"According to consumer COP/COE Attorney who was also present at the appointment, along with consumer's social worker, consumer is not able to safely return to her home in the community. This writer met with consumer briefly who understands English but prefers to communicate in Polish. Per her history when she was out on her own she was impulsive, non-compliant with treatment, and rapidly decompensated and the most effective way to manage these symptoms has been close supervision, monitoring both behavioral and medical issues, and medicating consistently […] Received a call from DMHAS who stated that she assessed consumer and feels like she is misdiagnosed as she feels that she is Bi-polar and not being treated as such. She discussed with social worker, who is working on have Neuropsychological testing done to confirm. At this point she determined that consumer requires 24/7 Care and will faxed disposition to this writer and the nursing facility."* ***60 year old female***

Case 2: *"TC explained [to conservator that consumer] was denied the DMHAS waiver program. He explained why and that there was another program, called the PCA waiver program, which might help consumer, while getting mental health services as well. However, it was also explained that consumer would need to have someone to assist her*

with hiring PCAs, keeping track of hours worked as well as duties that the PCAs would be responsible for, regarding consumer's needs. TC thought that conservator had stated in a prior conversation that the family as well as conservator would not be able to assist consumer with managing her care on the PCA program, if consumer was to be accepted onto the program. Conservator also stated that she receives updates from facility monthly and consumer has tantrums and behavior disturbances, which have to be confronted by staff at facility. Conservator stated, she be interested if there a 24/7 program that would be least-restrictive than the nursing home but at this time, there is not a program and she feels that facility is sufficient in meeting her consumer's needs. TC stated, he would request closure from the MFP office at this time." ***59 year old female***

Left without approved transition plan: 8 closures

These consumers differed slightly on their reasons for having left without an approved transition plan. For one consumer the events were not clear. Two consumers had other plans, one moved to a residential care home and the other moved to an assisted living facility. Two consumers were taken home by their caregivers, one was a 21 year old consumer taken home by his mother and the other one was a fast track 87 year old consumer taken home by her daughter to pass away at home. Two consumers left the nursing facility against medical advice. Finally, one consumer was discharged from the nursing facility due to an Ascend deadline.

Case 1: *"She is withdrawing from the MFP program. She was having a lot of trouble finding a PCA and in the meantime her mother was declining and on hospice so she decided to take her home (to die basically) and was going to private pay for care for her until her last days."* ***From consumer's daughter. Consumer was 87 year old female.***

Case 2: *"On 2/24 Incoming call from consumer stating he is not able to live with his cousin and a discharge would render him homeless. He will speak with the cousin again to inquire if temporary housing could be accomplished until MFP finds suitable housing. On 2/25 incoming call from consumer stating he is not able to temporarily reside with his cousin. Consumer stated he is scheduled to have surgery on 3/15 and does not understand why he being 'kicked out' of the facility. I left a message for facility social worker to return my call to discuss the surgery. On 3/1 Consumer was discharged from the SNF back in 3/2011 without a bed hold. He had the surgery which was scheduled on 3/15/11. Depending upon the need for rehabilitation and his re-admittance to Park Place, another referral will be submitted."* ***25 year old male consumer***

Withdrawal, participant would not cooperate with care plan development: 8 closures

Eight cases were closed under this reason, five males and three females. The average age at the time of referral of these consumers was 68 years old, with a range of 47 to 93 years old, half of the individuals were 65 years or older. The average number of days elapsed from referral to closure was 459 days with a range of 92 to 848 days. One consumer in this category exceeded mental health needs, one consumer decided to stay at nursing facility and one consumer left

facility against medical advice. The other five consumers had different issues including: refusal of 24 hour care, refusal of any assistance in the community, refusal to use Hoyer lift, verbal abuse towards staff, and another consumer was denied PCA waiver services due to lack of need for assistance with daily living activities and inability to manage a PCA; this consumer also refused voluntary conservatorship. Most of these consumers presented various transition challenges, especially, current or history of substance abuse with risk of relapse, inability to manage mental health/illness in the community, dementia or cognitive issues; and many had physical in addition to their mental health challenges; this group also had financial challenges including outstanding debt and insufficient financial resources.

> ***Case 1:*** *"Met with [consumer], DSS SW and facility SW spoke to [consumer] in regards to moving back into the community. Consumer feels he doesn't need any help from anyone and refuses to hire any PCA's. It was explained that the doctor wouldn't be able to sign off on a discharge he believe to be unsafe. Consumer signed a withdrawal form saying he no longer wants to live in the community." 58 year old male consumer with diabetes and heart problems*
>
> ***Case 2:*** *"Spoke with social worker about the conservator question. She said that consumer will not agree to a voluntary conservator and that appointing a conservator on the basis of someone making very poor decisions and exhibiting poor judgment would not be enough to get an appointment. Some days conservator wants out (with inappropriate goals) and other days, he doesn't. We will stilll proceed and see if he can get on the PCA waiver and then get an assessment that will delineate what has to be done. Consumer was denied the PCA waiver services - he has not enough ADLs and was not a good candidate for hiring and keeping track of PCAs."* ***63 year old male consumer with diagnosis of stroke and amputation***
>
> ***Case 3:*** *"TC, FYI, I've completed writing up my assessment for this client and my recommendation to … is that [consumer] is not appropriate for MFP transition to home. This is based on the fact that she requires and has been ordered by the probate judge to accept 24/7 care, but adamantly refuses to let anyone stay with her. She also does not have a BUP, as her only support in the area is her goddaughter, who states she shops for client weekly, but she cannot be responsible for providing care in the event formal services are interrupted."* ***94 year old female consumer with dementia***

Withdrawal, participant moved to another state without MFP transitional services: 7 closures

The number of days elapsed from referral to closure ranged from 18 to 1276, with an average of 345 days; however, four cases were closed within 73 days of referral. Only three of these consumers presented transition challenges which included lack of PCA, home health, or other paid support staff and waiting for evaluation, application review, or response from waiver agency/contact. No significant process issues were apparent in these cases, it appears the consumers just desired to move to another state.

Hospitalized 90 days with no discharge date

Only one case was closed under this reason. The participant was a 52 year old female with mental health issues. Apparently, the participant was not mentally stable as she had frequent hospitalizations; however, she did not qualify for long term care. The transition coordinator did not attempt to contact consumer or conservators for months, eventually finding consumer had been discharged from facility to hospital five months prior to the transition coordinator's call.

Findings from transition coordinator focus groups

When asked to recall under which categories they were most likely to closed cases, transition coordinators reported conservator or consumer requesting closure and care plan being over cost cap (exceeding physical or mental health needs). Transition coordinators reported the most common issue they encountered during the initial meeting with the consumer was inappropriate expectations about MFP, such as expecting to return to the community within three months or expecting the same services they are currently receiving at the long term care facility. When asked what the main reasons were for consumers changing their minds, most transition coordinators agreed it was most likely due to the time elapsed from referral to initial meeting and the length of the transition process which can take six to 12 months. When asked the same question about conservators, coordinators reported a request for closure was mainly due to a significant decline in consumer's health after referral had been made. Most transition coordinators reported having a conservator opposing a potential transition was not a common situation, unless the conservator is an attorney and the consumer plans to transition with PCA waiver services, which conservators describe as too much work. Finally, almost all transition coordinators reported lack of services and supports to successfully transition consumers with a history or current substance abuse/dependence problem.

Discussion

After analyzing cases closed between January 1 and June 30, 2012, it is evident the areas in need of improvement are various. With withdrawal from the program due to conservator or participant requesting closure accounting for almost 40% of the total cases closed during this time period, it makes sense to address the underlying issues in these categories. In the case of conservators requesting closure, it would be helpful to develop a system where the family/conservators are not the only viable back up plan; likewise, it is necessary to develop a system in which a third party can manage PCAs in cases where the consumer is unable or the conservator refuses to do so. Finally, for many consumers the lack of PCAs or other paid supports and the lack of transportation were noted as transition challenges; efforts to address these services gaps would benefit those consumers.

Most of the consumers in the categories reported here are 65 years old or older. While the transition coordinators reported not experiencing any major issues when interacting with the

consumers, it is beneficial for personnel involved in the transition process to not only understand how to interact with an older adult, but also to understand the potential dynamics among the consumer's relatives that might affect the likelihood of the transition occurring. Understanding the family dynamics will provide a better idea of how much informal support can be expected, it will also provide an opportunity to start addressing family/conservators' fears about the consumer's transition, needs for support and training, and most importantly, an opportunity to truly engage them in the transition process.

Consumers with a history of or current problems with substance abuse were identified by transition coordinators as more likely to experience case closures, mainly due to the lack of adherence with recommended counseling. A support system that focuses specifically on this population is needed. Additionally, some individuals with mental health issues could benefit from a service that offers 24 hour supervision.

Another area in need of improvement is the delay of the transition process. Through the analysis of case notes and the transition coordinator focus groups, it is evident that the time elapsed between referral and initial meeting with the consumer needs to be shortened. This interval of time has detrimental consequences, such as an opportunity for a significant decline in the health of the consumer, or a decline in consumer's morale, and it affords the consumers a window of time to become comfortable at the long term care facility.

A closure reason that warrants attention is reinstitutionalization for more than 90 days. With many of these reinstitutionalizations being due to falls of the consumer at his or her dwelling it is important to implement a system that will seek to minimize the likelihood of falls. For example, in some instances the community dwellings were inappropriate for the consumer to navigate without the risk of falling, and in other cases, the consumer transitioned without the appropriate supports such as a lifeline system or adequate hours of home aid.

Finally, it is important for transition staff to know how to keep consumers, relatives and conservators engaged throughout the transition process, especially during challenges. For example, transition staff needs to know how to manage a situation where finding adequate housing is taking longer than expected, or how to interact with a consumer who does not seem motivated to comply with required steps for their transition such as substance abuse counseling, diet or physical therapy adherence. These consumers may need an additional transition support that will keep them engaged and committed to their transition plans.

Conclusion

Since 2008, Connecticut has transitioned over 1,500 individuals from long term care facilities to community settings. However, much work is needed to increase the likelihood that individuals who would like to live in the community and are 65 years or older, or struggle with substance abuse/dependence, and/or have mental health issues, are able to do so.