CT Money Follows the Person Quarterly Report

Quarter 3 2017: July 1, 2017 – September 30, 2017

(Based on the latest data available at the end of the quarter)

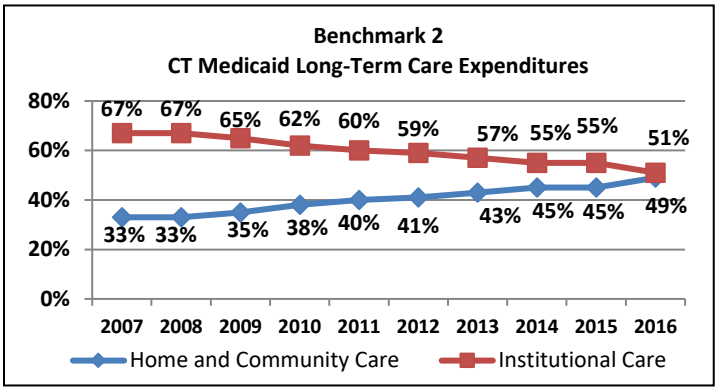
UConn Health, Center on Aging

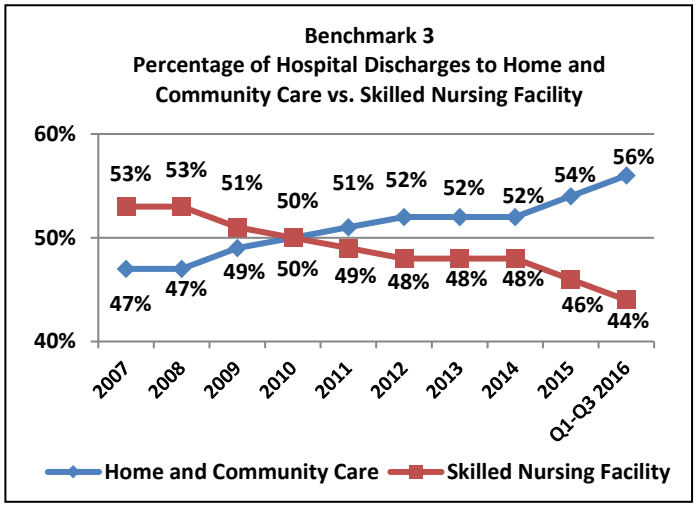
Operating Agency: *CT Department of Social Services* **Funder:** *Centers for Medicare and Medicaid Services*

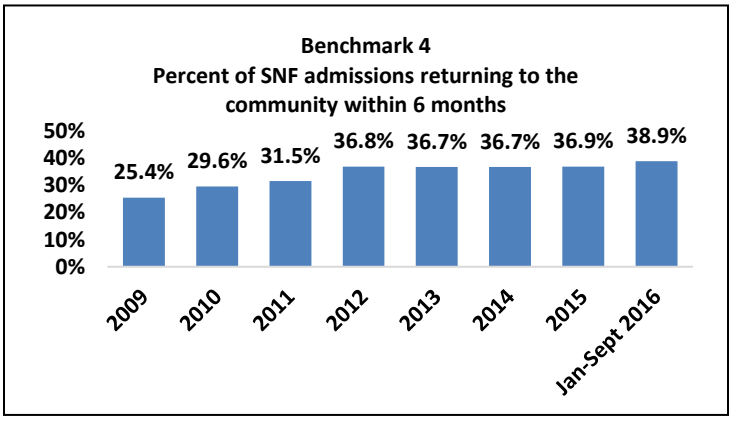
MFP Benchmarks

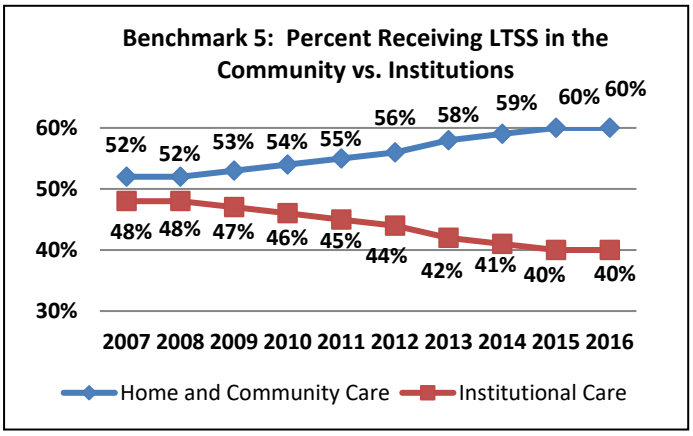
1) Transition 5200 people from qualified institutions to the community
2) Increase dollars to home and community based services
3) Increase hospital discharges to the community rather than to institutions
4) Increase probability of returning to the community during the six months following nursing home admission
5) Increase the percentage of long term care participants living in the community compared to an institution

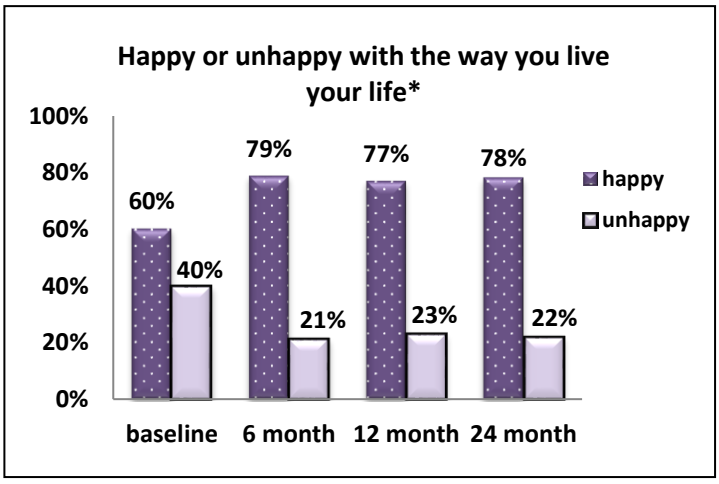
Benchmark 1: The number of demonstration consumers transitioned = 4,384 (non-demonstration transitions = 309)



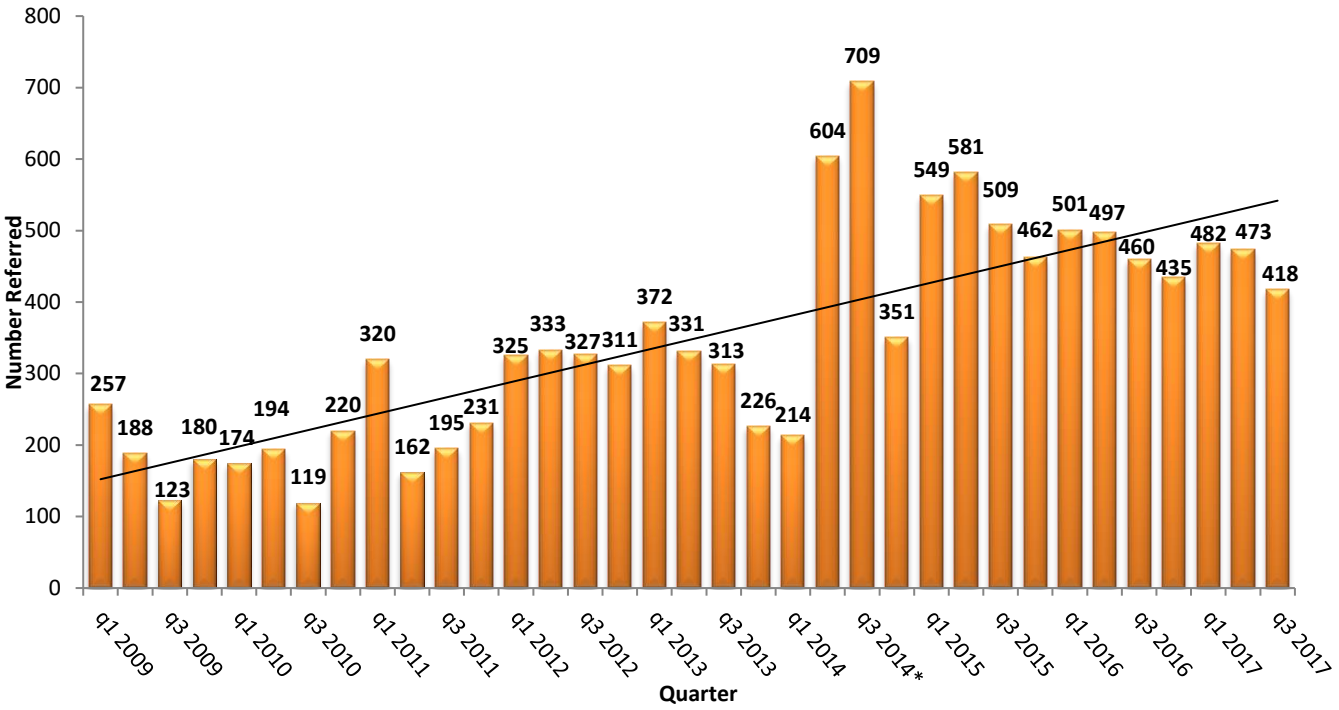






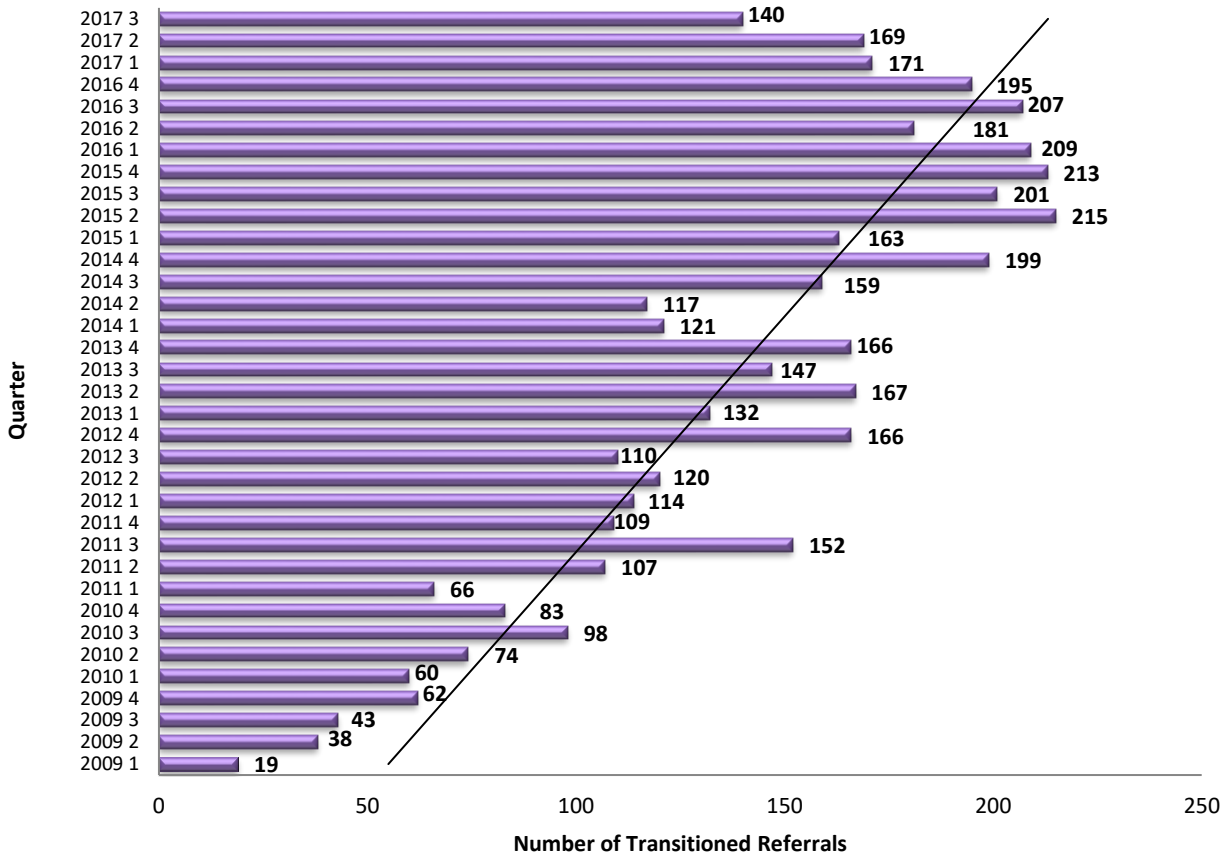


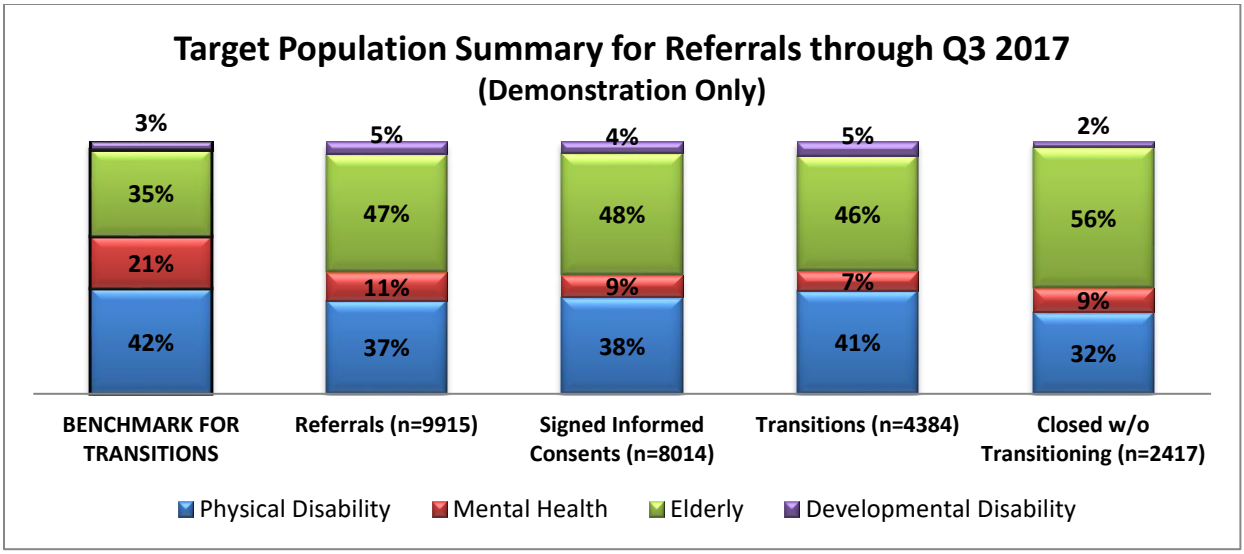
Referrals to Transition Coordinators[t]: Q1 2009 to Q3 2017

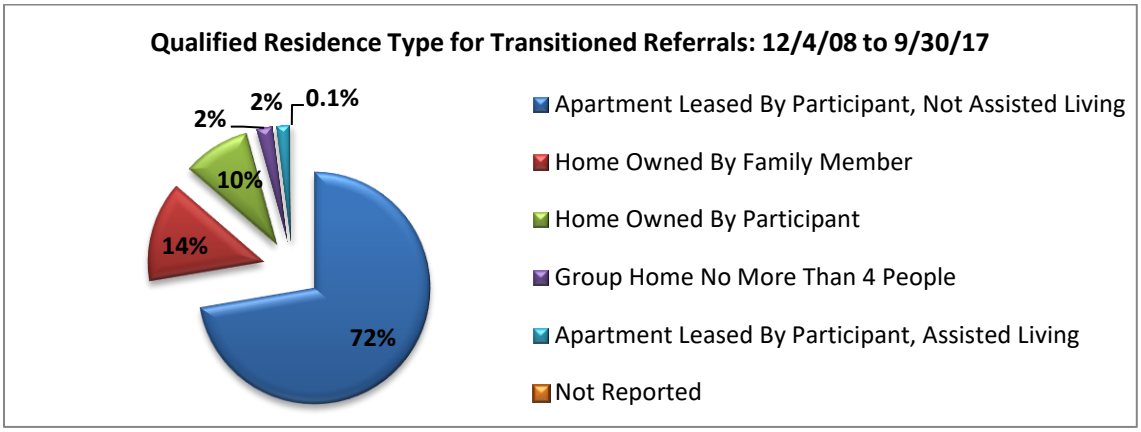


[t]Excludes nursing home closures *Increase in referrals reflects the ongoing adjustment to MFP reorganization

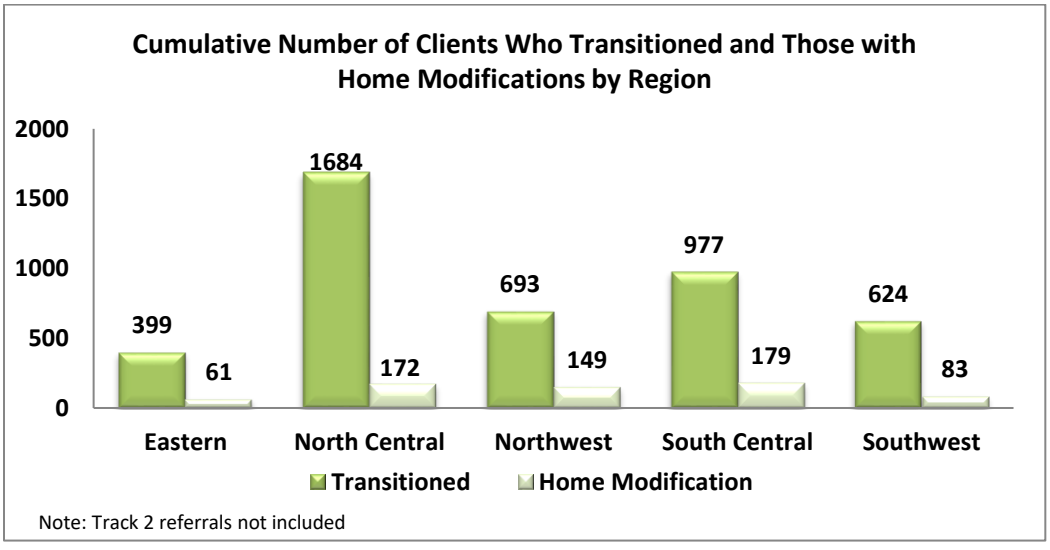
Number of Transitions by Quarter: 12/2008 - 9/30/2017



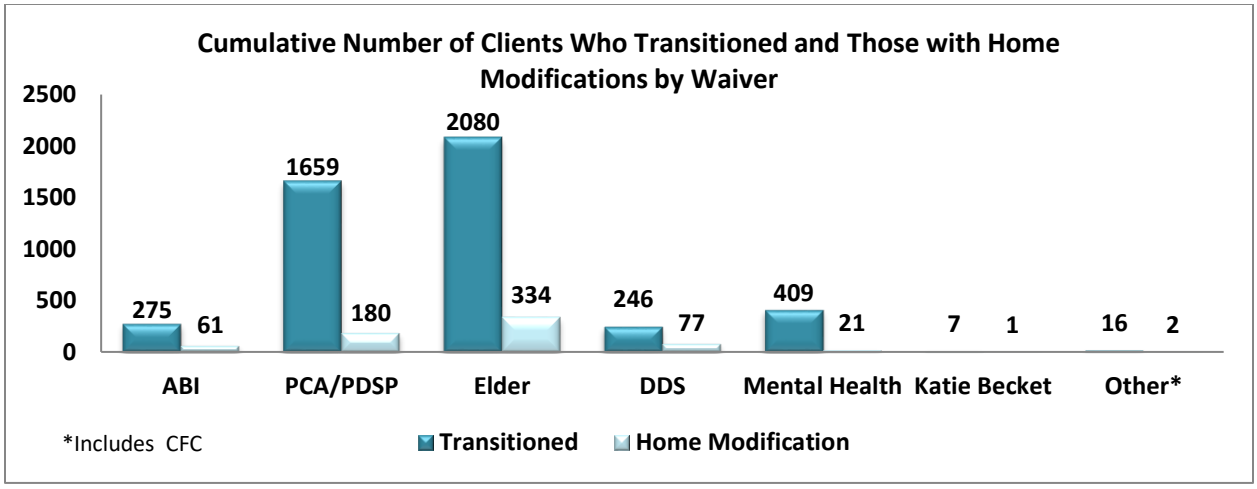


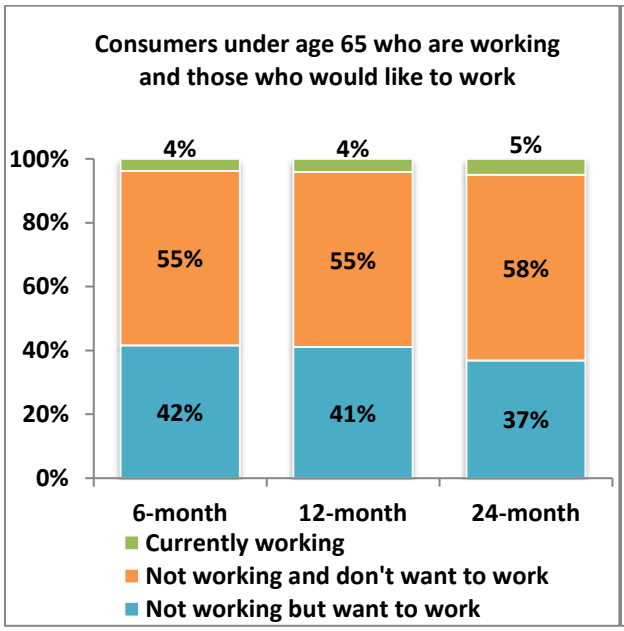


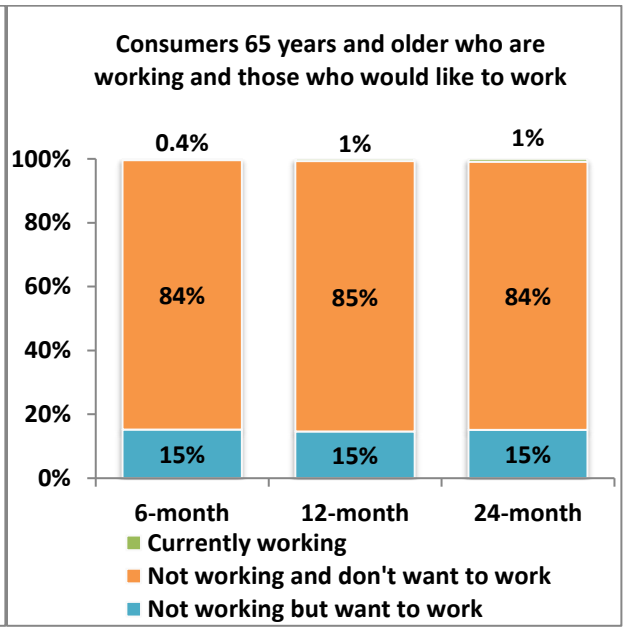
Reinstitutionalization: 12% (471) of participants who transitioned by Sept. 30, 2016 were in an institution 12 months after their transition.*

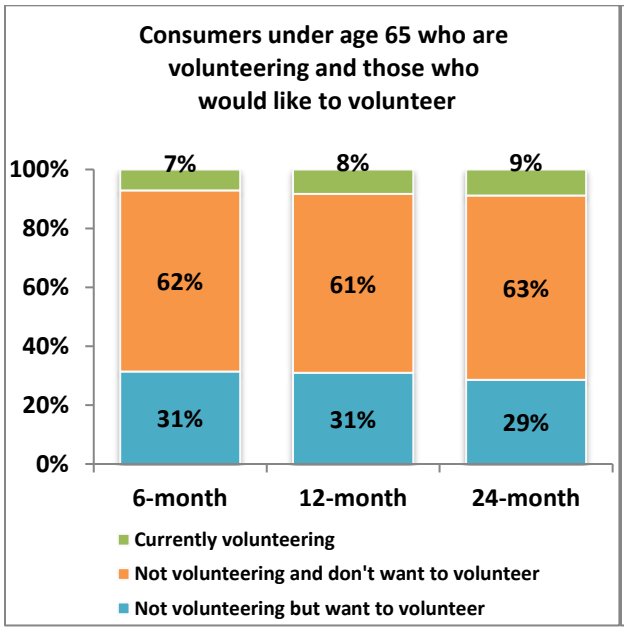


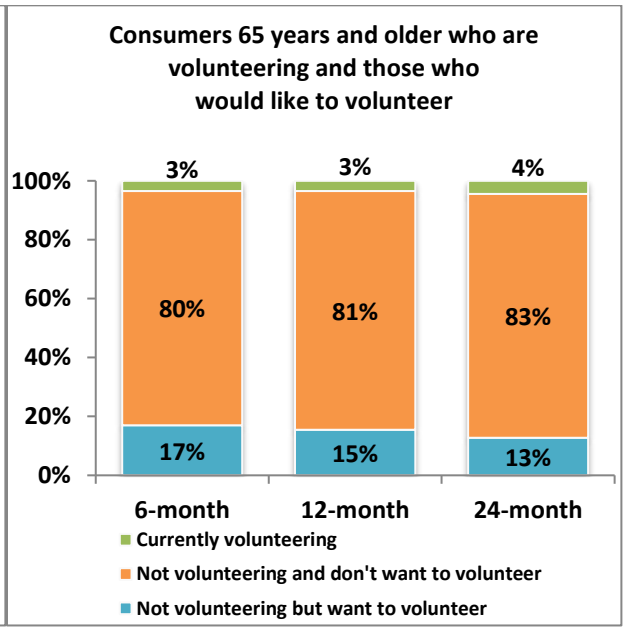
*Corrected calculation


Cumulative Number of Clients Who Transitioned and Those with Home Modifications by Waiver
2500
2000
1500
1000
500
0
275
61
1659
180
2080
334
246
77
409
21
7
1
16
2
ABI
PCA/PDSP
Elder
DDS
Mental Health
Katie Becket
Other*
*Includes CFC
Transitioned
Home Modification

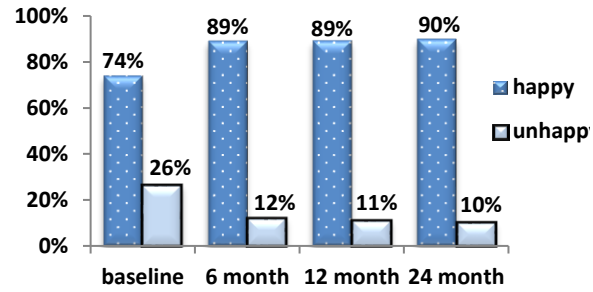

Consumers under age 65 who are working and those who would like to work
100%
80%
60%
40%
20%
0%
4%
4%
5%
55%
55%
58%
42%
41%
37%
6-month
12-month
24-month
Currently working
Not working and don't want to work
Not working but want to work

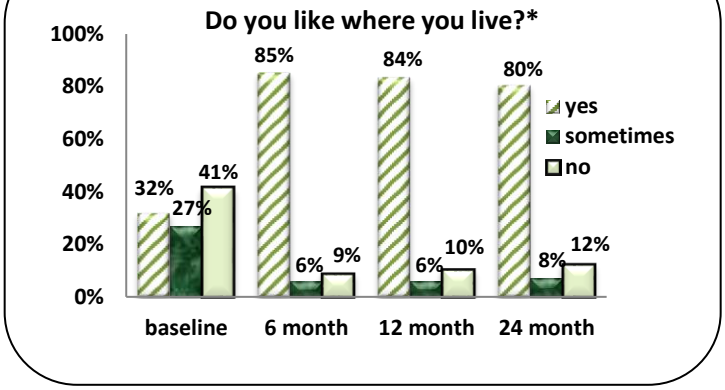

Consumers 65 years and older who are working and those who would like to work
100%
80%
60%
40%
20%
0%
0.4%
1%
1%
84%
85%
84%
15%
15%
15%
6-month
12-month
24-month
Currently working
Not working and don't want to work
Not working but want to work

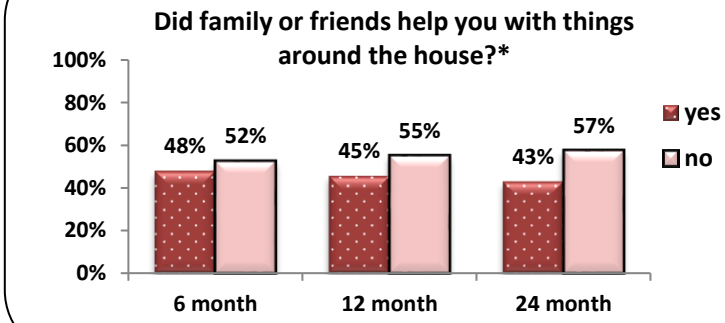

Consumers under age 65 who are volunteering and those who would like to volunteer
100%
80%
60%
40%
20%
0%
7%
8%
9%
62%
61%
63%
31%
31%
29%
6-month
12-month
24-month
Currently volunteering
Not volunteering and don't want to volunteer
Not volunteering but want to volunteer

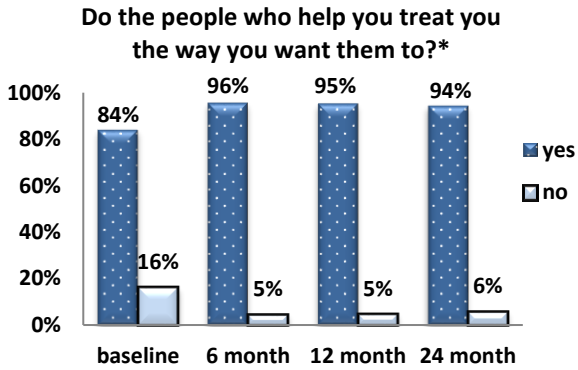

Consumers 65 years and older who are volunteering and those who would like to volunteer
100%
80%
60%
40%
20%
0%
3%
3%
4%
80%
81%
83%
17%
15%
13%
6-month
12-month
24-month
Currently volunteering
Not volunteering and don't want to volunteer
Not volunteering but want to volunteer

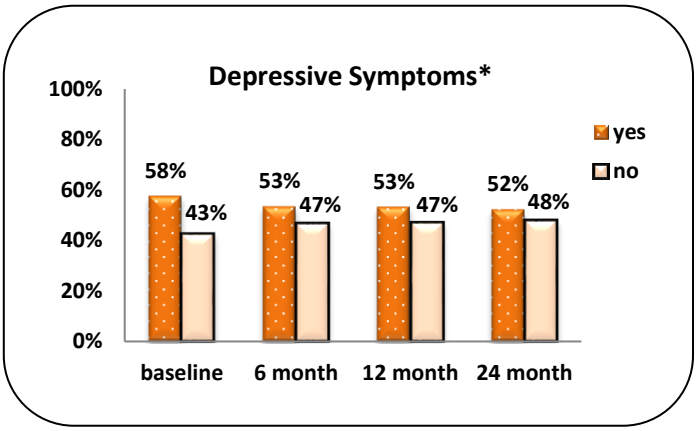
MFP Quality of Life Dashboard As of 9/30/2017

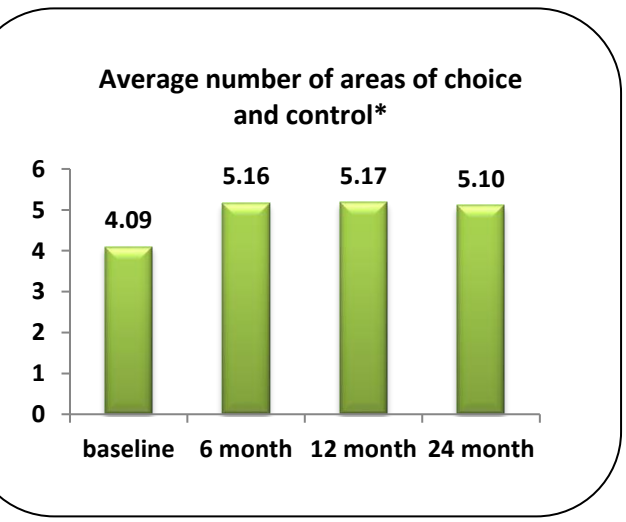


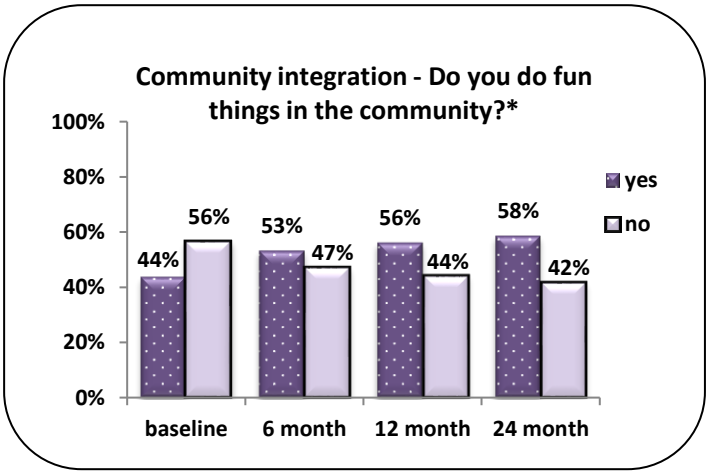












*indicates statistically significant differences

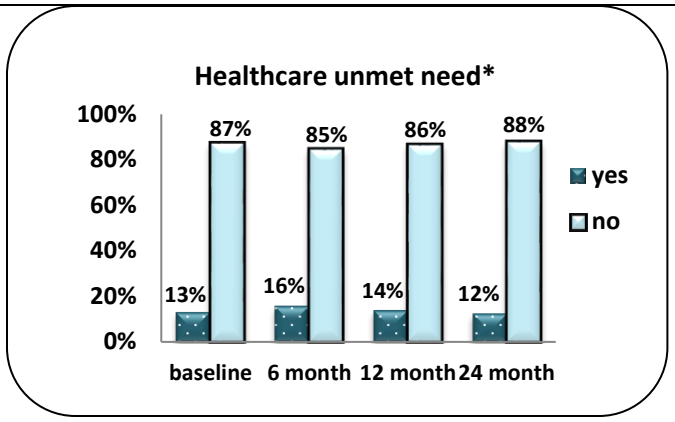
Quality of Life Interviews Completed
(Cumulative data through 9/30/17)

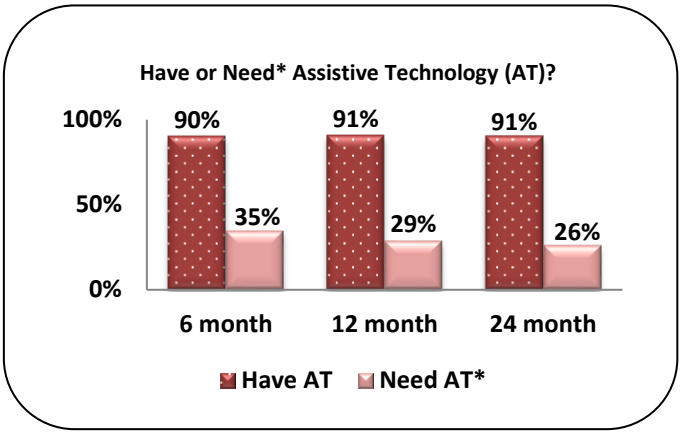
Baseline interviews done prior to transition, n=4742

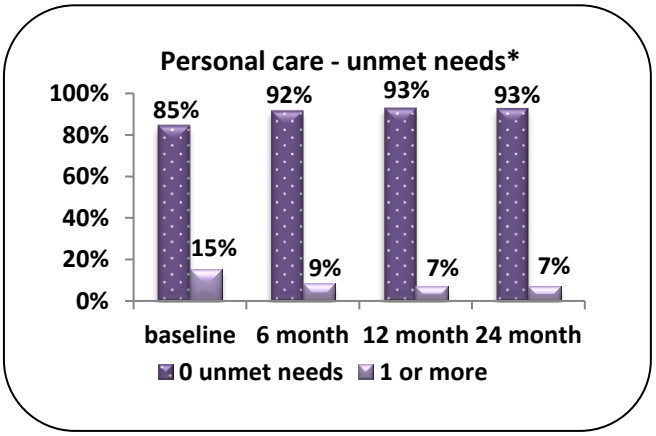
6 month interviews done 6 mos after transition, n=3613

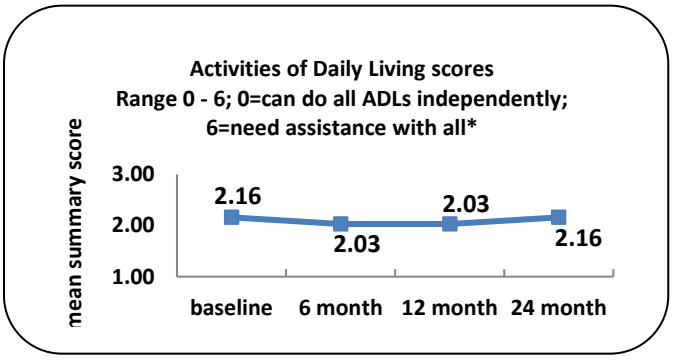
12 month interviews done 12 mos after transition, n=3207

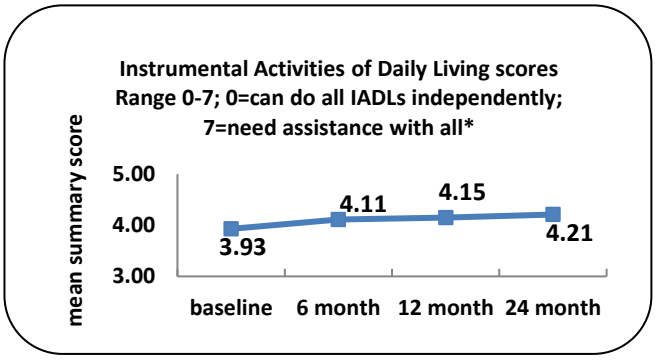
24 month interviews done 24 mos after transition, n=2263

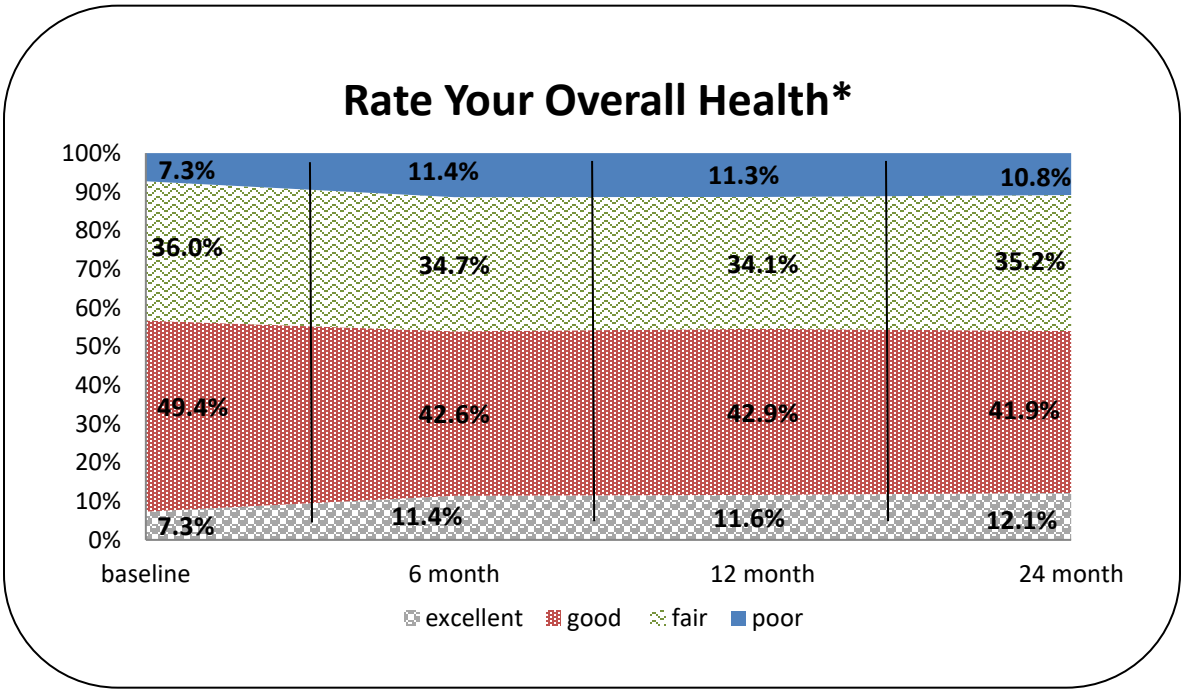


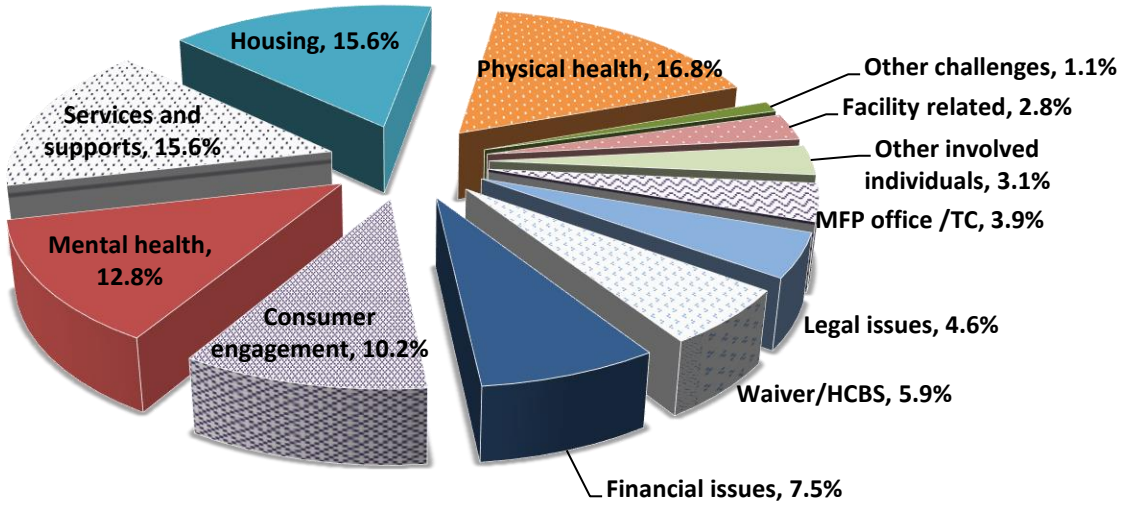












Transition Challenges through 9/30/17

Transition coordinators (TCs) and specialized care managers (SCMs) complete a standardized challenges checklist for each consumer. There were a total of 13,436 MFP referrals to SCM Supervisors. Challenges checklists were completed for 9,108 of these referrals, representing 8,368 consumers. Excluding the referrals which indicated "no challenges," the challenges checklist generated 56,032 separate challenges. Of these, the most frequently chosen challenge was physical health (16.8%), followed by challenges related to housing (15.6%), services and supports (15.6%), mental health (12.8%), and consumer engagement (10.2%).

Type of challenge by transition status

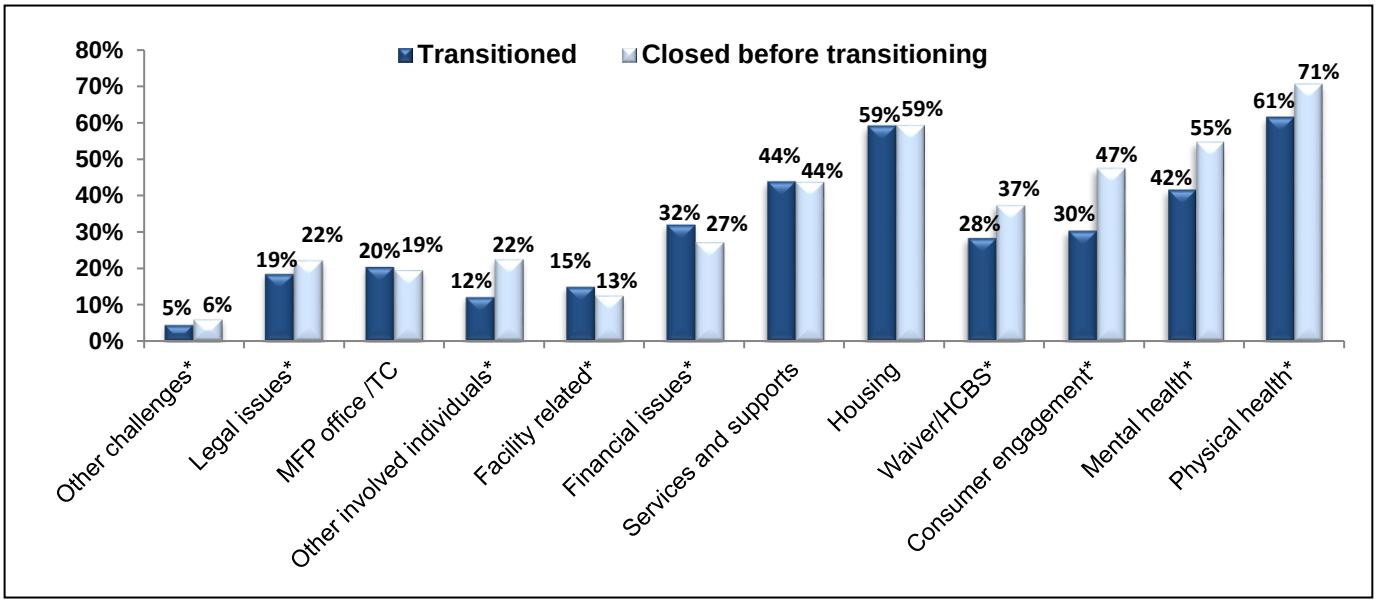
The figure below shows the percentage of each group (those who transitioned and those who closed before transitioning) which had each challenge. For example, of the referrals that closed without transitioning, 71 percent had a physical health challenge. Conversely, 61 percent of referrals that did transition had physical health challenges.

Nine of the twelve challenge categories had statistically significant differences between the two groups.

Be sure to check the LINK to the full Transition Challenges report.

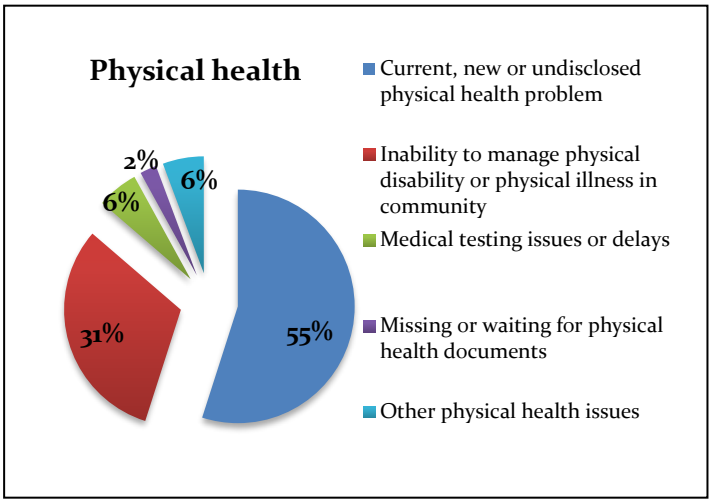
http://health.uconn.edu/aging/research-reports

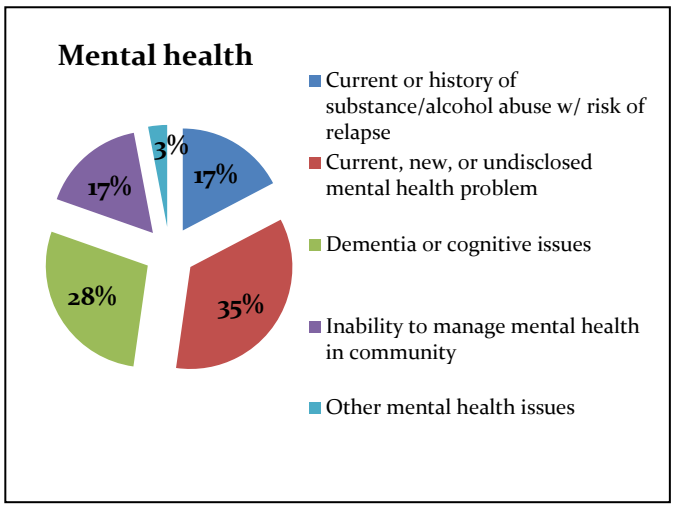
click on the Money Follows the Person tab

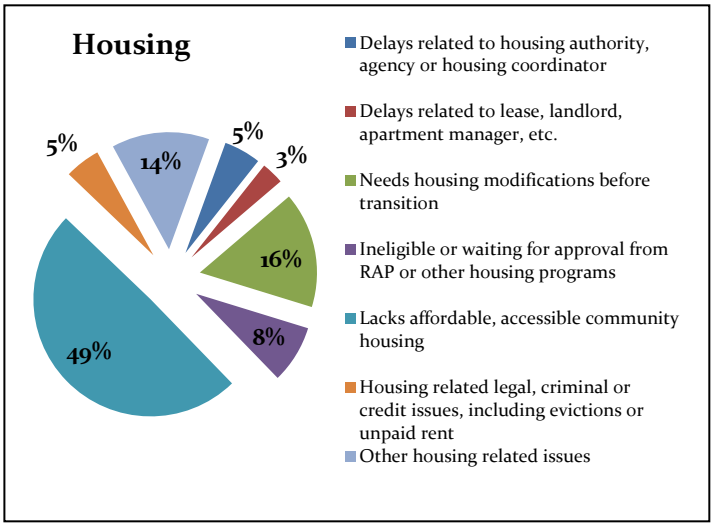


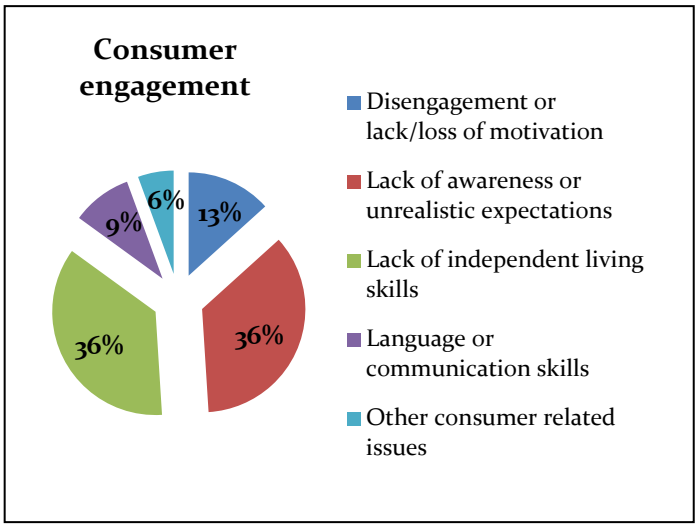
Types of Challenges – through 9/30/2017

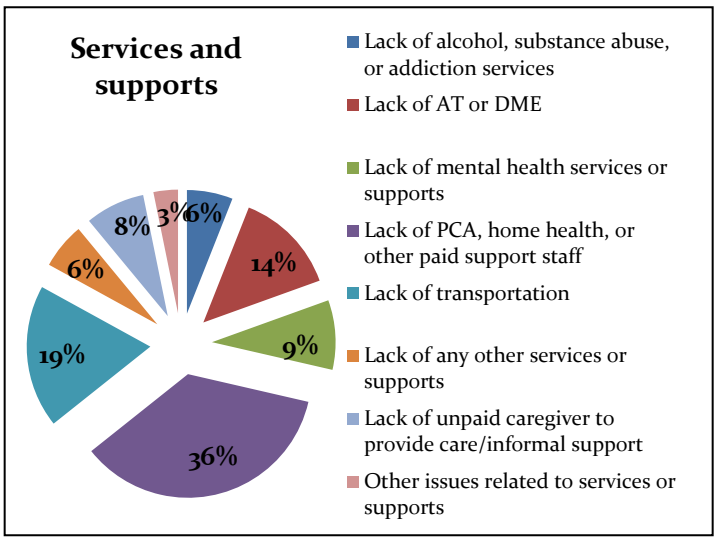
Shown below are the six most common challenge types

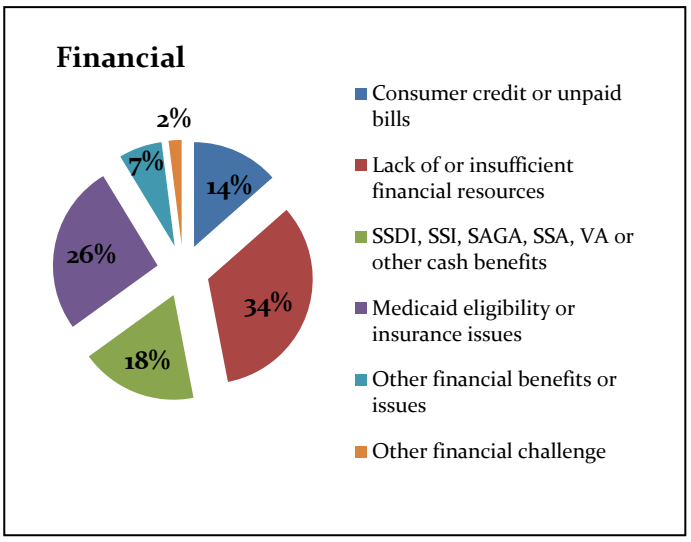






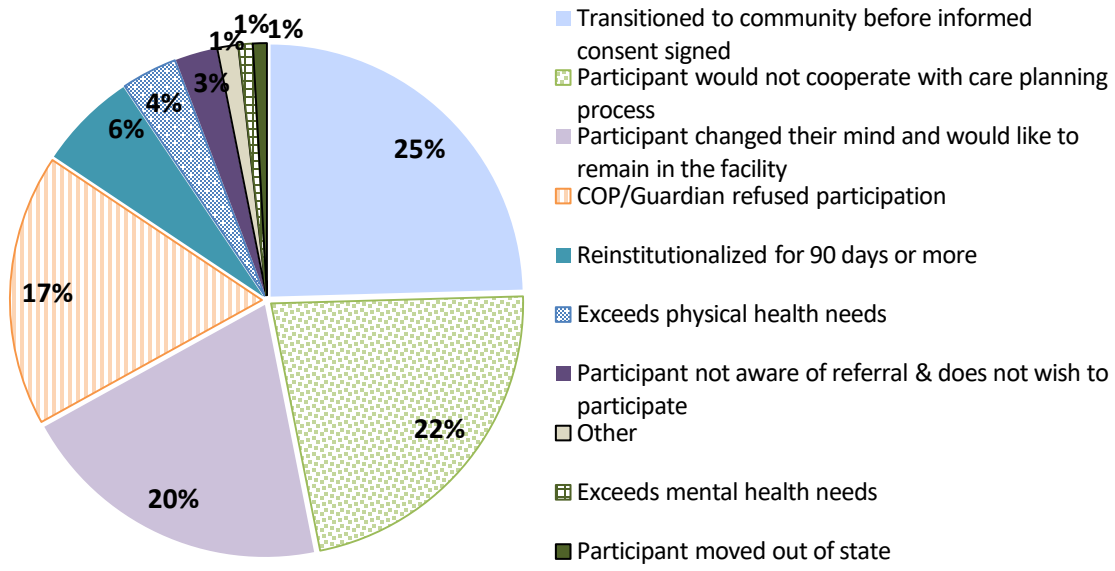






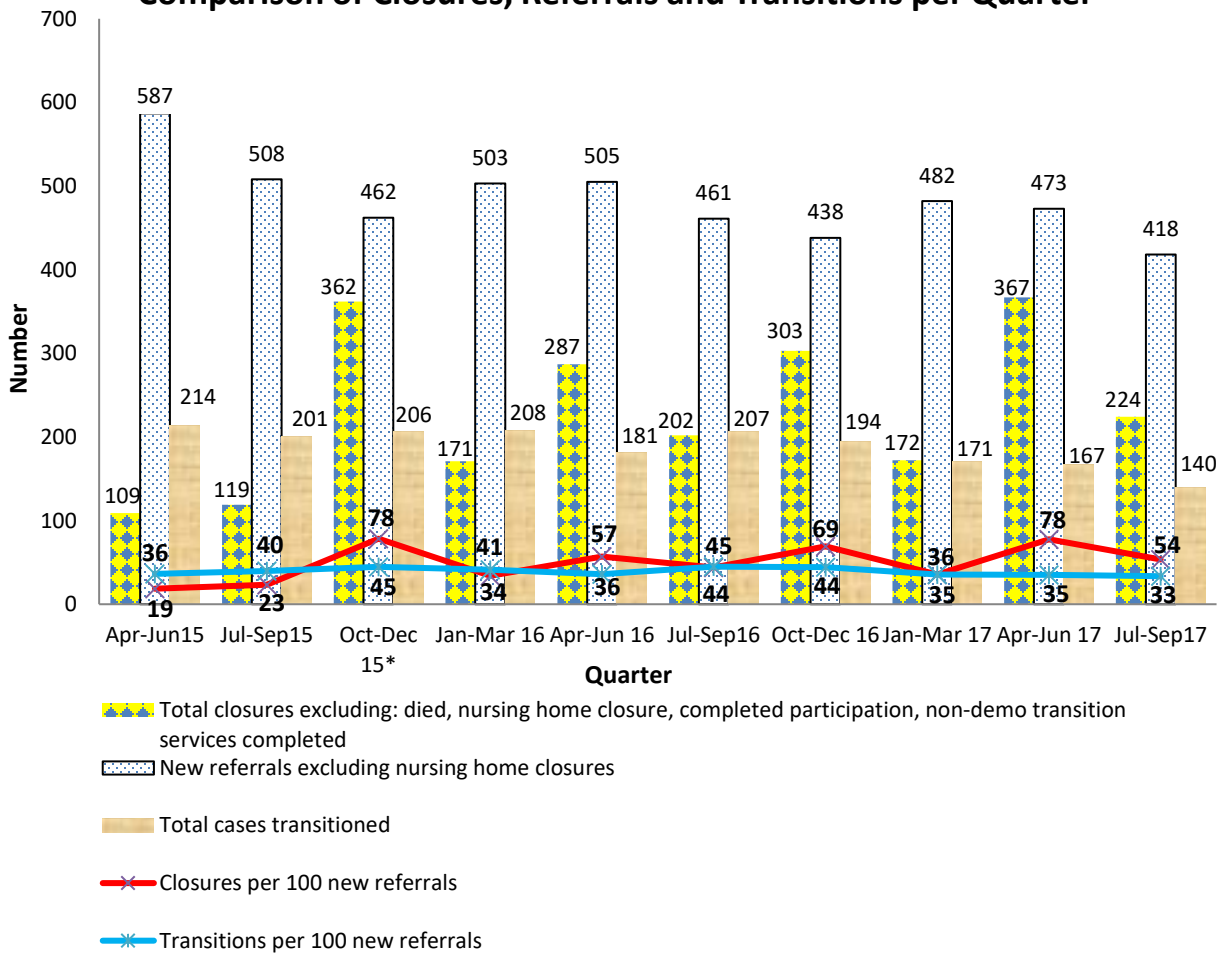
For the full report on transition challenges through 9/30/2017, use the link on page 7 to get to the Center on Aging website.

Percentage of Closed Cases by Closure Reason: Jul-Sept 2017



*Excludes NH closure and Chelsea/Touchpoints Manchester mass referrals of 12/23/16 or later

Comparison of Closures, Referrals and Transitions per Quarter



* Note: Total closures this quarter were higher due to clearing the backlog at Central Office

A Young Man with a Fresh New Start

Mathew, age 28, recalls what happened about 18 months ago. He was walking back to the sober house after work and found himself walking down the street where he bought heroin some years before. “I’d been clean for 8 months” he said. A woman appeared and made an offer he couldn’t refuse. She was giving free clean needles with a bag and an IOU until pay day. Before taking it, he said he had an uneasy feeling. He didn’t know where the drug was from nor understood the potency. He took the drug anyway and immediately fell to the floor and nearly died. He suffered from a stroke, and his liver and kidneys shut down. After three weeks in ICU, rehab, five months on dialysis and two more months in physical therapy, he left the nursing home and entered his own home for the first time.

As a resident in a nursing home, his goal was to leave in November when he could walk. November came and went, and Matthew was angry and felt trapped living in the facility. He did not see any reason that he should stay once he could walk. He said, “I hated it and felt out of place.”

Through it all, his mother was there supporting him, taking time off from work to be by his side when he was in the ICU. When Matthew learned about MFP from other nursing home residents, his mom learned all she could too. She worked with the Transition Coordinator (TC) and Housing Coordinator (HC) to help him transition to his own home.

The Rental Assistance Program provided the funds for rent. After looking at four apartments with the HC, Matthew’s Mom and uncle found an in-law apartment that proved to be perfect. He remembers the first time he walked into his new home. “I was ecstatic, I was really really happy.” Matthew proudly showed the furniture and household items purchased by his TC. His transition budget paid for a full-sized bed with a new box spring and mattress, a dresser and a night stand, a sofa, a small dinette table and two chairs. He added a few older pieces of furniture donated by his parents. His favorite painting, which he bought years ago from an artist while on vacation in the Dominican Republic, now hangs framed near the bench press he purchased on Craig’s list.

Matthew has taken advantage of many social service supports and is working hard to maintain his sobriety. Logisticare drives him to daily treatments. He attends local AA meetings. He especially likes his ABH counselor and takes pride in accomplishing tasks on his to-do list. He walks daily to the local sandwich shop and exercises a lot. Sometimes when he needs to lift his spirits he will spend the weekend with his parents.

Next on his to-do list is finding a job. He applied to a grocery store chain and they will hire him if he has transportation. He’s looking for a bicycle and also another job within walking distance.

Photo credit: Janet Caldwell-Cover

When asked how this experience and MFP has changed him, he said he’s been humbled. He is grateful to the Money Follows the Person program for giving him the opportunity to live in his own apartment, experience an authentic drug-free life and for all the medical and social support he’s received so far. He said “I don’t know where I’d be if not. I’d be on the street getting high right now.”

MFP Demonstration Background

The Money Follows the Person Rebalancing Demonstration, created by Section 6071 of the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), supports States’ efforts to “rebalance” their long-term support systems. The DRA reflects a growing consensus that long-term supports must be transformed from being institutionally-based and provider-driven to person-centered and consumer-controlled. The MFP Rebalancing Demonstration is a part of a comprehensive coordinated strategy to assist States, in collaboration with stakeholders, to make widespread changes to their long-term care support systems.

One of the major objectives of the Money Follows the Person Rebalancing Demonstration is “to increase the use of home and community based, rather than institutional, long-term care services.” MFP supports grantee States to do this by offering an enhanced Federal Medical Assistance Percentage (FMAP) on demonstration services for individuals who have transitioned from qualified institutions to qualified residences. In addition to this enhanced match, MFP also offers states the flexibility to provide Supplemental Services that would not ordinarily be covered by the Medicaid program (e.g. home computers, cooking lessons, peer-to-peer mentoring, transportation, additional transition services, etc.) that will assist in successful transitions. States are then expected to reinvest the savings over the cost of institutional services to rebalance their long-term care services for older adults and people with disabilities to a community-based orientation.