Money Follows the Person Rebalancing Demonstration

Closed Cases Report For 2016

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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 year of reporting on 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, 2014, and 2015 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 2016*. Section II shows a comparison of *cases closed during each of the eight years* of the MFP program (2009-2016), and Section III provides specifics on *all cases closed during 2016*, 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 2016 in order to inform practice and allow program managers to make programmatic changes that decrease the number of preventable closures. A list of acronyms and abbreviations appears 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 (NH) 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, as well as the mass upload of referrals from Chelsea Place and Touchpoints of Manchester in December, 2016 which were part of the Department of Mental Health and Addiction Services (DMHAS) lawsuit.

Section I: Status of Referrals made between January and December 2016

A total of 1,896 referrals were received during 2016. After excluding referrals that closed due to the following reasons: died (129), completed 365 days of participation (5), non-demo: transition services complete (3) and NH closed moved to another facility (2), the number of total referrals to be analyzed from 2016 is 1,757, a decrease of 11% from 2015. As of March 27, 2017 (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 2016 referrals compared to 2015 (as of 3/27/2017)

Current Status	2016 Referrals	*2016 %*	2015* Referrals	*2015 %*
Closed (w/out transitioning)	**450**	***26***	**442**	***22***
Recommend Closure Approved (w/out transitioning)	**88**	***5***	**99**	***5***
Recommend Closure Initiated (w/out transitioning)	**41**	***2***	**18**	***0***
Transitioned (total)	**388**	***22***	**456**	***23***
- Open cases	368	*21*	444	*22*
- Closed	13**	*1*	10**	*1*
- Closure recommended	4	*0*	1	*0*
- Closure initiated	3	*0*	1	*0*
In Progress (total)	**790**	***45***	**970**	***49***
- Assigned to Field	223	*13*	284	*14*
- Informed Consent Signed	362	*21*	300	*15*
- Care Plan Approved	182	*10*	354	*18*
- Transition Plan Submitted	10	*1*	20	*0*
- Transition Plan Approved	13	*1*	12	*0*
Total	**1757**		**1985**	

* Statuses from referrals in 2015 were as of 2/24/16

** These cases transitioned and closed and are included in the total closed cases.

Of the 1,757 referrals made in 2016, 26 percent (463) had closed as of 3/27/17 and another 136 (8%) were in the closure process (closure recommended, initiated, or approved). 388 (22%) of the referrals from 2016 had transitioned (Table 1). 368 of these transitioned referrals transitioned were still open and living in the community, and 20 had subsequently closed. As of March, 2017, one third (579) of referrals from 2016 had either closed without transition or were in the process of closing without transition. The remaining 45% (790) are still active in the transition process. Compared to referrals made in 2015 and analyzed in February, 2016, this shows an increase in percentage of referrals closed/in process of closing without transition (27% 2015), and a decrease in referrals still in the transition process (49% 2015). Percentage of referrals which transitioned was comparable between the two years.

Cases referred in 2016 that transitioned (388) or closed (468) by March 27, 2017 were categorized by region, Home and Community-Based Services (HCBS) package, and target population (Tables 2, 3, 4). Table 5 shows closures by reason closed.

The regional variation in percentage of referrals transitioned was as much as 8%, ranging from 17% in Eastern and South Central to 25% in the Northwest (Table 2). Regional differences in the percentage of referrals closed were comparable. The Eastern region closed 22% of its referrals, while the Northwest region closed 29%, which is different from 2014 and 2015 when South Central had the lowest closure rate (20%) and Southwest the highest (32%).

Table 2: Transitions and closures as of 3/27/17 for referrals made in 2016

		Transitioned			Closed		
Region	Referrals	#	% (of refs. in each region)	% of total transitions (n=388)	#	% (of refs. in each region)	% of total closures (n=463)
Eastern	144	25	17	6	32	22	7
North Central	683	164	24	42	188	28	41
Northwest	280	69	25	18	82	29	18
South Central	368	64	17	17	90	25	19
Southwest	282	66	23	17	71	25	15
Total	1757	388			463		

Just over 89 percent of referrals transitioned by means of one of three HCBS packages: the Physical Disability State Plan (PDSP) (22%), one of the CT Home Care Program for the Elderly (CHCPE) waivers/plans (50%), or the Personal Care Assistance (PCA) waiver (20%) (Table 3). Another 5 percent transitioned under the Mental Health waiver (MH) or Mental Health State Plan (MHSP). By contrast, cases closed without transitioning came primarily from those accepted to CHCPE (42%); the PCA waiver (34%), or the MH waiver or MH state plan (10%). Less than 1 percent of closed referrals did not have an assigned HCBS package.

Table 3: Transitions and closures of referrals from 2016 by HCBS package

HCBS Package	Transitioned	%	Closed without transition	%
ABI	2	*0.5*	29	*6*
CHCPE	4	*1*	181	*39*
CHCPE-AFL	3	*0.8*	1	*0.2*
CHCPE-AL	1	*0.3*	1	*0.2*
CHCPE-PCA-AB	75	*19*	6	*1*
CHCPE-PCA-LI	72	*19*	5	*1*
CHCPE-PCA-SD	8	*2*	0	*0*
CHCPE-S	19	*5*	5	*1*
DDS	1	*0.3*	5	*1*
DDS-C	19	*5*	0	*0*
MH/MHSP	19	*5*	48	*10*
OTHER	5	*1*	0	*0*
PCA/PCA-S/PCA-AFL	76	*20*	158	*34*
PDSP	84	*22*	20	*4*
Total*	388		459	

* There were an additional 4 closed cases missing an HCBS package.

When analyzed by target population, the greatest percentage of transitions (47%) was for adults 65 years and older, while the greatest percentage of closures without transitioning was for those under age 65 with a physical disability (45%) (Table 4). A greater percentage of referrals in the physical disability and mental health target populations were closed versus transitioned. The developmental disability target population had a higher number of transitions than closures (5% vs. 1%).

Table 4: Transitions and closures of referrals from 2016 by target population

Target Population	Transitioned	%	Closed without transition	%
Developmental Disability	20	*5*	5	*1*
Elderly (age 65+)	182	*47*	199	*43*
Mental Health	18	*5*	47	*10*
Physical Disability (< 65)	168	*43*	208	*45*
Total*	388		459	

* There were an additional 4 closed cases missing a target population.

Table 5: Closures of referrals from 2016 by reason compared to 2015

Closure Reason	2016 Cases	2016 %	2015 cases	2015 %
Transitioned to community before informed consent signed	178	*38*	161	*36*
Participant changed their mind and would like to remain in the facility	72	*16*	68	*15*
COP/Guardian refused participation	37	*8*	65	*14*
Exceeds physical health needs	7	*2*	14	*3*
Participant would not cooperate with care planning process	112	*24*	67	*15*
Other	21	*5*	34	*7*
Exceeds mental health needs	2	*0.4*	4	*0.8*
Participant not aware of referral & does not wish to participate	26	*6*	26	*6*
Reinstitutionalized for 90 days or more	5	*1*	5	*1*
Participant moved out of state	3	*0.7*	8	*2*
Total	463		452	

As seen in Table 5, the percentage of referrals that closed in 2016 due to transitioning before the informed consent was signed (38%) was up from 36% in 2015. The backlog of care plans waiting for approval due to unfilled Central Office utilization review nurse positions may have contributed to this increase. The percentage of referrals which closed because the participant would not cooperate with care planning increased again in 2016 (24%), compared to 15% in 2015 and 5% in 2014. In 2016 cases closed due to participants changing their mind was 16% and for 2015 it was 15%, which are both down from 19% in 2014. The engagement services added in 2014 appear to have had a beneficial effect on closures due to participants changing their minds. In 2016 there was also a large decrease in the percentage of closures due to the COP/guardian refusing participation, 8% in 2016 compared to 14% in 2015.

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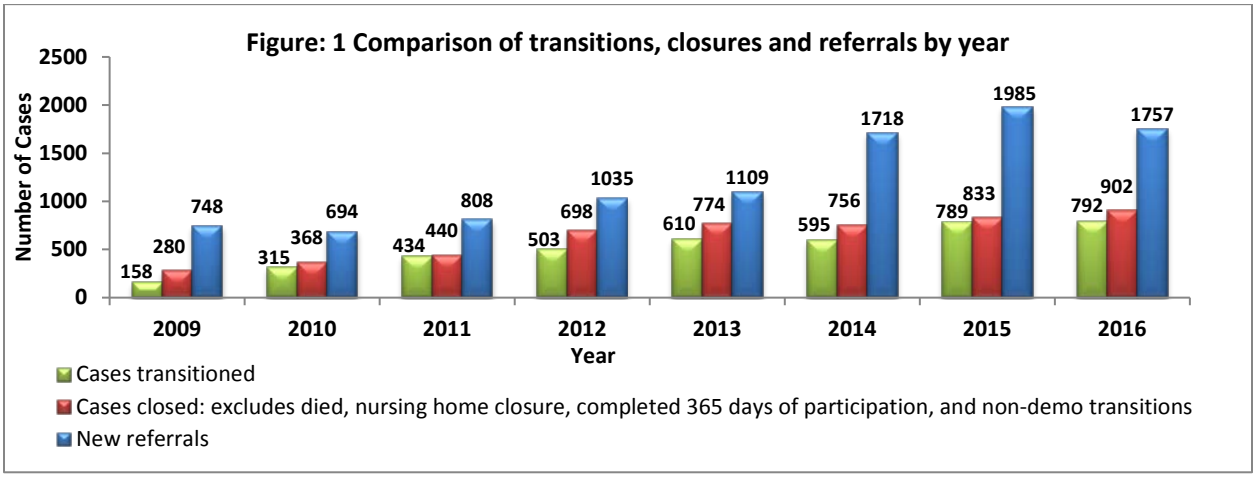
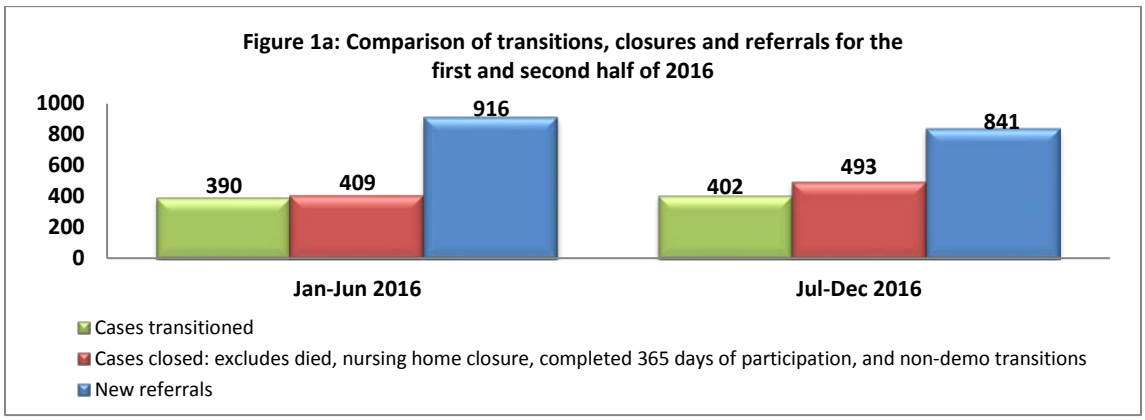
Section II: Comparison of Closed Cases by Year, 2009-2016

During 2016, MFP experienced 1,757 referrals, 792 transitions and 902 closures (referrals and closures exclude those that closed due to the 4 excluded reasons; transitions and closures are regardless of referral year). In 2016, there was an 11% decrease in new referrals, a slight increase (0.4%) in transitions, and an 8% increase in closures. The increase in referrals during

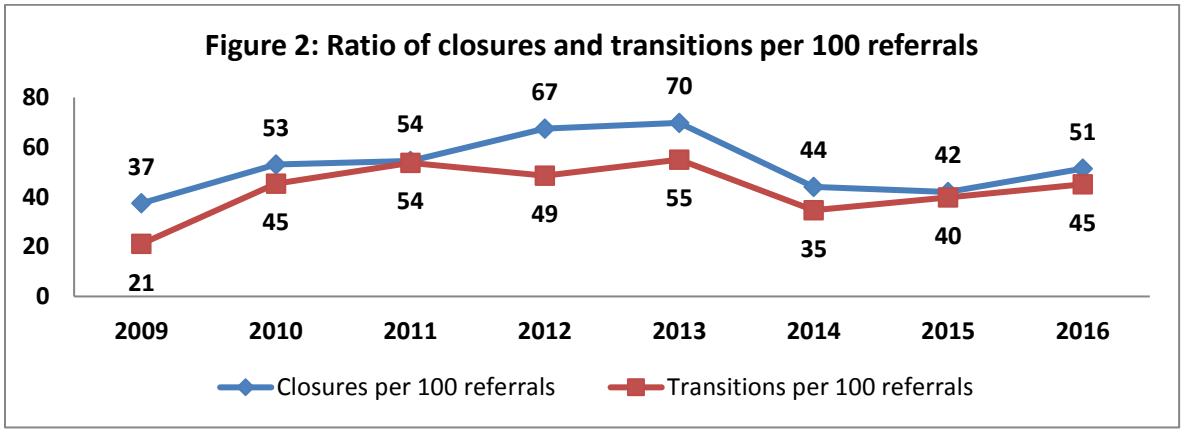
the previous two years likely reflected the revised transition process beginning in March of 2014. This new process allowed Central Office to refer to the field many of the consumers who had applied to MFP but were waiting to be assigned to the field due to lack of assessment staff. In 2016 the total number of referrals decreased which may indicate they have started to level out after the process change has been in place for a couple years.

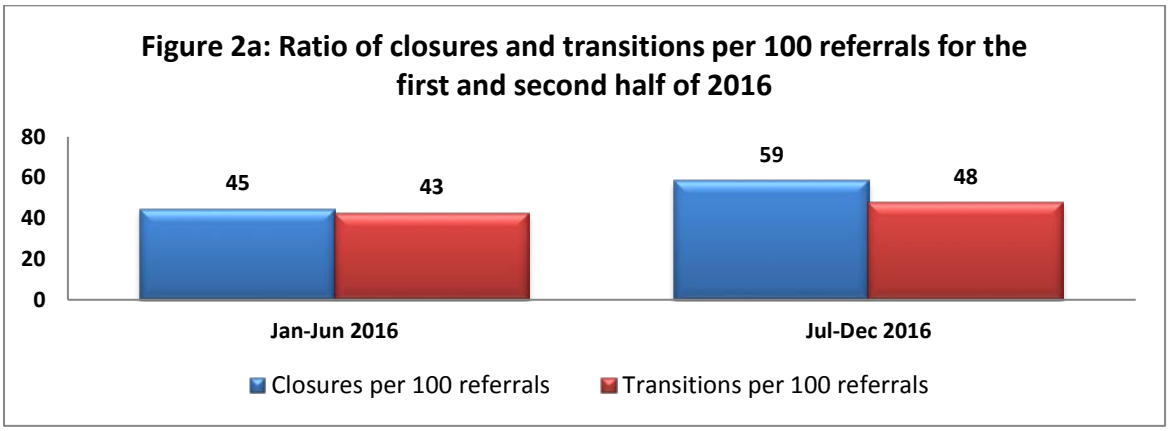


Comparing transitions, closures and referrals between the first and second half of 2016 (Figure 1a), it is interesting to note that there were more referrals in the first half of the year, and more transitions and closures in the second half, as was the case in 2015 as well.

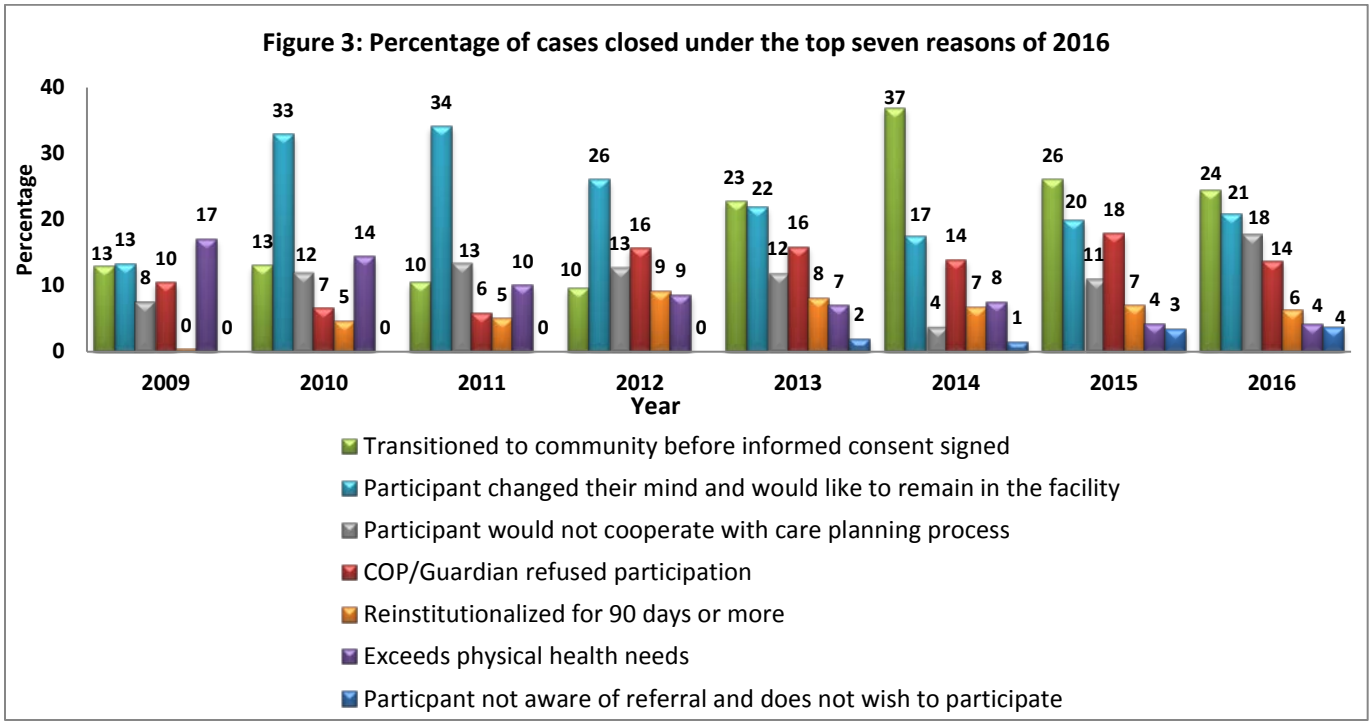


Continuing the trend of prior years, in 2016 the CT MFP program closed relatively more cases than it transitioned (see Figures 2 and 2a). For the year, closures per 100 referrals are up from 42 to 51, and transitions per 100 referrals are up from 40 to 45. Dividing the year into halves, however, shows closures per 100 referrals was up substantially in the second half, from 45 to 59.





Considering all cases that closed during 2016 regardless of referral year (n=902, without the 4 excluded closure reasons), the three most frequent reasons cases closed accounted for nearly two-thirds of closures. This year the top two reasons remained the same as 2015 though the third was different (see Figure 3). As in the previous three years, the top reason closed in 2016 was "Transitioned to community before informed consent signed." This reason accounted for 24% (n=220) of closures during 2016, a two percent decrease from 2015. The second most frequent reason for closing a case during 2016 was "Participant changed their mind and would like to remain in the facility," accounting for 21% (n=188) of closures, a one percent increase from 2015. The percentage of cases closed because the participant would not cooperate with the care planning process increased again this year, from 4% in 2014, 11% in 2015 to 18% in 2016. On the other hand, the percentage of cases closed upon request of the COP or guardian decreased from 2015 (18% to 14%). Cases closed due to re-institutionalization of 90 days or more was one percent less than the previous year at 6% for 2016. The percentage of cases closed in 2016 because of high physical health needs (4%) was the same as the previous year. The final closed reason in the top seven in 2016 was "Participant not aware of referral and does not wish to participate" (4%).



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Section III: Analysis of Cases Closed Between January and December 2016

A total of 1796 cases closed during 2016 for any reason regardless of the year they were referred to MFP. Cases that closed due to the following reasons were excluded: died (308), completed 365 days of participation (546), non-demo transition services complete (38) and nursing home closed and moved to another facility (2), leaving 902 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 2016

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	220 (24)	100 (22)	120 (26)	<1-96	59	29	0-842	121
Participant changed their mind and would like to remain in the facility	188 (21)	104 (23)	84 (18)	<1-102	72	71	7-2596	371
Participant would not cooperate with care planning process	160 (18)	72 (16)	88 (19)	21-91	59	25	11-1821	292
COP/Guardian refused participation	124 (14)	64 (14)	60 (13)	23-98	70	65	19-1764	450
Reinstitutionalized for 90 days or more	57 (6)	33 (7)	24 (5)	1-92	65	51	n/a	n/a
Other	45 (5)	18 (4)	27 (6)	<1-85	55	24	2-1295	436
Exceeds physical health needs	37 (4)	19 (4)	18 (4)	31-82	62	41	28-2391	684
Participant not aware of referral and does not wish to participate	34 (4)	19 (4)	15 (3)	30-91	64	44	6-783	161
Participant moved out of state	19 (2)	12 (3)	7 (2)	25-90	62	47	157-824	418
Exceeds mental health needs	18 (2)	5 (1)	13 (3)	19-72	54	12	160-1371	595
Total	902	446	456	X	X	X	X	X

Note: Percent totals may not equal 100 due to rounding.

For the most frequent closure reason, “Transitioned to community before informed consent signed” (n=220, 24%) cases were often closed because the client discharged from the facility prior to meeting MFP eligibility requirements or left the facility against medical advice. Two percent of these cases (n=4) were never assigned to the field because they left the institution before assignment, which is down from 2015 when it was 14% of 217 of these cases that were not assigned to the field. Consumers who closed for this reason were more likely to be younger compared to consumers in most other categories, with an average age of 59, and only 29 percent age 65 or older. The average length of time from referral to closure was 121 days, which was the shortest length of time of all the closure reasons (see Table 6).

This year there was a slight increase (1%) for cases that closed because the participant changed their mind and wanted to stay in the facility (n=188, 21%), 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: adapting 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 371 days, with a range of 7-2,596 days. This group was the oldest, with the average age of participants closed for this reason in 2016 was 72 years, the same as in 2015.

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] stated that after a lot of consideration, he decided that he would rather stay in SNF placement because that is where he feels the most comfortable."*

- *"Consumer reports that she is actually satisfied at the SNF at this time. When asked, consumer reports that at this time she would like to remain in the facility due to the supports she receives. Consumer states she has good care and good care workers at the facility. Consumer also states that although she doesn't smoke cigarettes she enjoys going out and sitting with the other smokers and enjoys socializing with them daily. Consumer states that due to these two main factors she has decided to remain at the SNF at this time."*

- *"[Client's] health has declined and is now on hospice. [Client] and husband/POA were explained the program, but [client] wants to stay at [SNF] until she passes."*

- *"[Follow-up] call to [daughter] on this day for discussion about moving forward with MFP Program. [Daughter] was in the consumer's room while discussing on phone and SCM heard consumer and [daughter] agree that she (consumer) would like to stay in the SNF at this time as this is where she feels most safe."*

- *"[Consumer] has adjusted to facility life, volunteering for the rec. dept. and attending activities. He does not feel physically or emotionally ready to leave and live in the community."*

Eighteen percent (n=160) of cases closed in 2016 because the participant would not cooperate with the care planning process, a 7% increase from 2015. Only 25 percent of this group were over age 65 in 2016, which was a decrease from 2015, when 35 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 participants where deciding upon housing was an issue, and some left the facility before eligibility to transition with MFP was established, though they had signed an informed consent.

- *"Transitioned home before approved care plan and does not have T-19."*

- *"Client, family and COP were not able to agree on client's living arrangements. All places that HC and TC recommended family and client were not satisfied. Client's parents (step-dad and mom) did not agreed to independent living for client and COP agreed with*

them. At this moment client is pending for two RCH and waiting list for those places are 2 years. There is no transition plans for this client."

- *"Consumer has been connected with legal aid attorney and continues to not engage in sorting out issue with identification. Birth certificate, SS card and picture ID needed to move forward with housing. Consumer has not cooperated and understands his case will be closed until this corrected. Consumer aware the re-referral can be submitted at any time."*

- *"SCM attempted to complete IA [individual assessment] with client again. Client did not want to participate in IA. SCM attempted to engage with client about the options available in the community. Client again did not want to speak with SCM about options in the community other then moving back to her house (which is not hers anymore) and living with her daughter (which is not an option at this time); she does not want to talk to SCM about leaving. SCM recommending closure at this time."*

Cases closed because the "COP/Guardian refused participation" accounted for 14% (n=124) of overall closures in 2016, a decrease of 4% from 2015. 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, some of these consumers had memory and/or mental health issues and were unable to manage other health issues, such as diabetes, on their own. It should be noted that this reason for closure includes consumers with legally appointed COPs, legal guardians and POAs and in some cases a family member who is making medical decisions due to consumer's inability, though that person has not legally been appointed. In addition, these legal representatives could be family members (44%) or professionals (38%); and in some cases it is unknown which one (18%). This group was the second oldest, with an average age of 70 for participants closed for this reason. Some descriptive case notes include:

- *"SCM spoke with client's daughter/POA [name]. [Daughter] reports that client and family have decided for client to remain long-term at SNF. POA [daughter] requested that client's MFP case be closed at this time."*

- *"Family and legal representative are no longer interested in consumer living in the community."*

- *"POA wants client to remain at facility due to unstable health and requested closure."*

- *"Consumer has diagnosis of dementia. SCM again reached out to POA. He stated that neither he nor his grandmother had the desire to work with the MFP program. He would follow up if they …changed their mind. He stated he could find her care and an apartment when they desired. SCM recommended closure."*

Similar to the last couple of years, in 2016 re-institutionalization for 90 days or more accounted for 6% of overall closures (n=57). This group was younger than last year, with an average age of 65, compared to 70 in 2015. 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.

- *"Consumer is in [hospital name] and expected to stay as nursing cannot be obtained at the level she requires in the community."*

- *"Consumer has been in and out of hospital and nursing facilities since he returned home. He has been at [facility name] since [date]."*

Exceeding physical health needs accounted for 4% of closures (n=37) which is about the same percentage as it was in 2015 and is half the percentage it was in 2014 (8%). Forty-one percent of consumers closed for this reason were in one of the CHCPE HCBS packages (n=15), 27% were in PCA/PDSP (n=10), 24% were in ABI (n=9), and 8% were in a MH package (n=3). In addition, under half of this group (41%) were over age 65 in 2016, a decrease from 2015, when 63 percent which closed for this reason were over age 65. Representative quotes from cases closed for this reason include:

- *"Consumer's physical care needs exceed the limitations of the PCA waiver. Consumer needs 24/7 care, cannot afford the cost of private providers to compensate for the hours not covered by the PCA waiver and is disinterested in having a roommate."*

- *"Client requires 24/7 services for cueing and physical and to address aggression and risk of wandering. SCM cannot implement a plan of care that is both cost effective and reasonably ensures the client's health, welfare and safety."*

- *"Consumer exceeds physical health needs. MHW services are not sufficient to maintain safety in the community. Physical limitations and chronic medical conditions include hypertension, chronic bronchitis (COPD), asthma, respiratory failure, diabetes mellitus (DM), morbid obesity, wheelchair dependence, chronic pain and fall with injury to right knee [date]."*

Four percent of referrals were closed for the reason "Participant not aware of referral and does not wish to participate" (n=34). These participants had an average age of 64 with 44% age 65 years or older. The average number of days from referral to closure was 161 days with a range of 6-783 days. A couple of representative quotes include:

- *"Client's daughter made referral without client's knowledge and is requesting referral be closed."*

- *"SCM met with consumer and met with FSW [name]… Consumer states she is happy at the SNF and does not want to participate in MFP. Upon further discussion & engagement, consumer stated she feels it would be too stressful for her to return to the community. She reports she had 3 falls prior to the hospitalization in May. She states her glucose is unstable at times & she doesn't want to worry about falling. Also does not want to worry about caregivers coming and going and would not want someone to live with her. … Consumer reports feeling safe with nursing staff available x24 hours and is adamant she does not want to consider MFP at this time. Possibility of Re-referral discussed if/when she is ready. SCM updated [FSW name] who advises referral was made because staff is now concerned about Ascend/level of care."*

Two percent of cases closed because the consumer moved out of state (n=19). In 2015 the percentage was the same with a total of 15 cases. The average age for participants whose cases closed because they moved out of state was 62 years of age, and the percent 65 or older was 47%. A quote from cases closed for this reason:

- *"Consumer transferring to SNF in Mass to be closer to family."*

Finally, reasons for closing a case due to exceeding mental health needs accounted for 2% of overall closures (n=18). As in 2015, this group was overall the youngest, with an average age of 54, and only 12 percent age 65 or older. Similar to findings from past years, these participants mainly had a diagnosis of depression, post-traumatic stress disorder, and/or schizophrenia. The main health issues were mental health issues, uncontrolled diabetes, and dementia.

- *"Service plan cannot be developed that does not exceed available funding for ABI waiver program and reasonably ensure health, welfare and safety in the community."*

- *"Met with [participant] at SNF for assessment. There are grave concerns for [participant's] safety in community due to behaviors, poor judgment, and poor insight. Additionally he has a reportedly poor memory, is a fall risk, and has a history of noncompliance with medications and treatment. Although smoking has resulted in health issues, a building catching on fire, and second degree burns to his neck/shoulder/chest, [participant] voices no desire or intention to quit smoking. He has had numerous inpatient psych admits and suicide attempts. ... [Participant's] behaviors pose a threat to himself and others in the community. Unable to create a safe community recovery plan that does not include 24 hour supervision."*

- *"Client has been in an inpatient psychiatric setting since 2009 when she was admitted to [hospital]. She transferred to [another hospital] on [date] at the request of her family who reside in CT. Her behaviors include but are not limited to: physical aggression, verbal aggression, urinating on the floor, screaming, disrobing, command auditory hallucinations, extreme paranoia and delusions. She has required frequent IM psychotropic medications in order to manage her behaviors. She is diagnosed with a cognitive disorder in addition to her mental illness and will require 24/7 supervision in order to be safe if her extreme behaviors were not present."*

Another noteworthy point was that 319 (35%) of the cases closed in 2016 (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 2015 when 29 percent were closed more than one year after referral. This increase may have been affected by the loss of two of the utilization review nurses at Central Office from August 2015 until September 2016.

The closure reason with the lowest average amount of time from referral to closure was "Transitioned to community before informed consent signed" at 121 days, and the highest were "Exceeds physical health needs," with an average of 684 days, and "Exceeds mental health needs," with an average of 595 days. Participants who were not aware of the referral and did not wish to participate had the second shortest average time from referral to closure at 161 days.

Transition Challenges

Compared to the previous year, the distribution and order of transition challenges for cases closed in 2016 differed somewhat, with the top challenge type changing this year (see Table 7). However, the top four challenge categories stayed the same as in 2015: services and supports, physical health, housing, and mental health. Service and supports was the greatest challenge in 2016: 18% (n=1597) compared to 16% in 2015. In 2016, physical health was the second greatest challenge for 17% (n=1492) of cases; it was also a challenge for 17% of cases in 2015. Field staff identified housing as a close third challenge this year, also representing 17% (n=1491) of cases. The next most common challenges included mental health (13%), financial (8%), consumer engagement (8%), and legal (5%).

Table 7: Transition challenges by category for cases closed in 2016 and 2015

Transition Challenges	2016 %	2015 %
Services	18	16
Physical health	17	17
Housing	17	17
Mental health	13	12
Financial	8	7
Engagement	8	8
Legal	5	5
MFP	4	4
Waiver	3	6
Involved	3	4
Facility	3	2
Other	1	2

Consumers with services and supports challenges most often faced problems related to a lack of PCA, home health, or other paid support staff (38%) and a lack of transportation (16%). Over half (59%) of those with physical health challenges had the sub-challenge "Current, new, or undisclosed physical health problem or illness," similar to 2015 (54%). Just over half (53%) of

consumers with housing challenges did not have affordable, accessible community housing which is up by 4% from 2015 (49%).

Conclusion

In 2016 there were 792 transitions, 902 closures and 1757 referrals (referrals and closures exclude those that closed due to the 4 excluded reasons; transitions and closures are regardless of referral year). While the total number of referrals decreased from 2015 (n=1985), 2016 still had the second highest number of referrals since 2009. 2016 also had the highest number of closures to date (n=902), a figure that has grown nearly every year since 2009. The ratio of closures to transitions increased from 2015, although when all years are considered, 2016 had the third closest ratio since MFP began. While the relative frequency of closure reasons has shifted over time, transitions before the informed consent was signed and participants changing their mind have remained the top two for the last 4 years, accounting for half or nearly half of closures in these years. The gap in the ratio of closures per 100 referrals (51) and transitions per 100 referrals (45) increased from 2015, when it was the closest it had been since 2011. One factor that might have contributed to the increased gap was the loss of two utilization review nurses from August 2015 through September of 2016.

Many of the 2016 findings were similar to those in previous years, and the characteristics of consumers for 2016 were overall similar to 2015. For example, in both years consumers whose cases closed due to changing their mind and deciding to stay in the facility or whose case closed due to COP/guardian refusal to participate had the highest average ages, although in 2015 the average age of consumers whose cases closed due to COP/guardian refusal to participate was higher (average age 73 vs. 70 in 2016). Cases closed due to exceeding mental health needs had the lowest average age (54), similar to 2015 (56). This year the highest percentage of persons over age 65 was for cases closed due to the participant changing their mind and wanting to remain in the facility (71%). Again this year the percentages for male and female consumers were similar for most closures reasons, although the closure reason “Participant changed their mind and would like to remain in the facility” had a greater percentage of female consumers (23%) compared to male consumers (18%). Conversely, the closure reasons “Transitioned to community before informed consent was signed” and “Participant would not cooperate with care planning process” had a somewhat greater percentage of males than females this year.

Sixteen percent of cases closed because the participant changed their mind, as did 15% in 2015. Socialization and familiarity with life at the facility were two common reasons participants mentioned for changing their mind. Developing a way to connect consumers with community resources before they transition, such as connecting consumers to community centers in the towns being considered for transition, might help to decrease these reasons. Six percent of closures in 2016 were due to prolonged re-institutionalization, similar to the 7% in 2015. 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 was 6%, which increased by 1% from 2015, though was 5% lower than the 11% in 2014. This could be an indicator that the program is finding ways to provide more services at decreased cost, such as Adult Family Living. In fact, for the last two

years “Closed due to exceeding mental health needs” was not in the top seven closure reasons, accounting for just 2% of cases closed. The percentage of cases closed due to consumer’s exceeding physical health needs, 4% for 2015 and 2016, was also lower than the previous two years compared to previous years (8% in 2014 and 7% in 2013).

Only 1% of cases closed in 2016 were never assigned to the field, compared to 14% of cases in 2015 and 39% in 2014. Related to this shift, fewer cases closed this year because a consumer transitioned to the community before signing an informed consent (24%) compared to 26% in 2015 and 37% in 2014.

Only the relative percentage of closures due to participants’ lack of cooperation in the care planning process rose significantly, from 11% in 2015 to 18% in 2016. Possible reasons for this change and ways to address it, such as increased assistance with Medicaid eligibility or continued work with motivational interviewing, should be explored with both MFP Central Office and field staff. Closures due to COP refusing participation decreased by four percent, from 18% to 14%. Similar to previous years, 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, such as motivational interviewing techniques. Family members continued to be concerned about taking on caregiving tasks and management responsibilities, especially for consumers who could not manage their health or PCAs on their own. Increasing access to both Support and Planning Coaches and Adult Family Homes, and utilizing caregiver respite services may help address these concerns.

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
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-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-C	Department of Developmental Services (Comprehensive Waiver)
DSS	Department of Social Services
HC	Housing Coordinator
HCBS	Home and Community Based Services
MFP	Money Follows the Person
MH	Mental Health Waiver
MHSP	Mental Health State Plan
PCA	Personal Care Assistance Waiver
PCA-AFL	Personal Care Assistance Waiver (Adult Family Living)
PCA-S	Personal Care Assistance Waiver (Standard)
PCAs	Personal Care Assistants
PDSP	Physical Disability State Plan
SCM	Specialized Care Manager
SNF	Skilled Nursing Facility
SW	Social Worker
TC	Transition Coordinator