Money Follows the Person Rebalancing Demonstration

Closed Cases Report For 2017

July 2018

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This project was funded by the Centers for Medicare and Medicaid Services and the Connecticut Department of Social Services, Money Follows the Person Rebalancing Demonstration CFDA 93.779.

Introduction

As part of Connecticut's rebalancing efforts, the Money Follows the Person (MFP) Demonstration transitions residents in institutional facilities to the community. By the end of 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. As of March 31, 2018 there were 5,036 MFP participants who transitioned. In the early years of the demonstration, CT experienced a relatively high number of cases closed compared to cases transitioned. Therefore, in 2012 the first 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 seventh report produced 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, 2015, and 2016 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 2017*. Section II shows a comparison of *cases closed during each of the nine years* of the MFP program (2009-2017), and Section III provides specifics on *all cases closed during 2017*, 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 2017 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. Data for this report was downloaded on May 4, 2018 from My Community Choices.

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.

Section I: Status of Referrals made between January and December 2017

A total of 1,782 referrals were received during 2017. After excluding referrals that closed due to the following reasons: died (129), completed 365 days of participation (10), and non-demo: transition services complete (2), the number of total referrals to be analyzed from 2017 is 1,641, a decrease of 7% from 2016. As of May 4, 2018, the current status of these referrals is distributed as follows:

Table 1: Current status for 2017 referrals compared to 2016 (as of 5/4/2018)

Current Status	2017 Referrals	*2017 %*	2016* Referrals	*2016 %*
Closed (w/out transitioning)	**499**	***30***	**450**	***26***
Recommend Closure Approved (w/out transitioning)	**117**	***7***	**88**	***5***
Recommend Closure Initiated (w/out transitioning)	**58**	***4***	**41**	**2**
Transitioned (total)	**319**	***19***	**388**	***22***
- Open cases	301	*18*	368	*21*
- Closed	9**	*1*	13**	*1*
- Closure approved	3	*0*	4	*0*
- Closure initiated	6	*0*	3	*0*
In Progress (total)	**648**	***40***	**790**	***45***
- Assigned to Field	129	*8*	223	*13*
- Informed Consent Signed	224	*14*	362	*21*
- Care Plan Approved	274	*17*	182	*10*
- Transition Plan Submitted	11	*1*	10	*1*
- Transition Plan Approved	10	*1*	13	*1*
Total	**1641**		**1757**	

* Statuses from referrals in 2016 were as of 3/27/17

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

Of the 1,641 referrals made in 2017, 30 percent (508) had closed as of 5/4/18 and another 184 (11%) were in the closure process (closure recommended, initiated, or approved). 319 (19%) of the referrals from 2017 had transitioned (Table 1). 301 of these transitioned referrals were still open

and living in the community, and 18 had subsequently closed. As of May 2018, 41% (674) of referrals from 2017 had either closed without transition or were in the process of closing without transition. The remaining 40% (648) are still active in the transition process. Compared to referrals made in 2016 and analyzed in March of 2017, this year shows an increase in percentage of referrals closed or in the process of closing without transition (33% 2016), and a decrease in referrals still in the transition process (45% 2016). A small part of this difference may be due to the date the data were pulled – the 2017 referrals had an additional five weeks to progress towards transition or closure. The percentage of referrals which transitioned (19%) decreased from the previous year (22% 2016).

Cases referred in 2017 that transitioned (319) or closed (508) by May 4, 2018 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 5%, ranging from 18% in Eastern, North Central and Southwest to 22%-23% in South Central and the Northwest (Table 2). Regional differences in the percentage of referrals closed was greater this year with 23% in the Eastern region to 36% in the Southwest. In 2016 the range of variation was less, from 22% Eastern to 29% in the Northwest.

Table 2: Transitions and closures as of 5/4/18 for referrals made in 2017

		Transitioned			Closed		
Region	Referrals	#	% (of refs. in each region)	% of total transitions (n=319)	#	% (of refs. in each region)	% of total closures (n=508)
Eastern	163	30	18	9	37	23	7
North Central	633	112	18	35	204	32	40
Northwest	286	66	23	21	96	34	19
South Central	301	66	22	21	78	26	15
Southwest	257	45	18	14	93	36	18
Total	1640*	319			508		

* An additional one referral was from an out of state facility that was not assigned to a region in CT

About 88 percent of referrals transitioned by means of one of three HCBS packages: one of the CT Home Care Program for the Elderly (CHCPE) waivers/plans (45%), the Physical Disability State Plan (PDSP) (25%), or the Personal Care Assistance (PCA) waiver (18%) (Table 3). Another 5 percent transitioned under the Mental Health waiver (MH) or Mental Health State Plan (MHSP). This pattern is similar to 2016, when 90 percent of transitions came from either CHCPE (50%), PDSP (22%), or PCA (18%). By contrast, cases closed without transitioning came primarily from those accepted to CHCPE (39%); the PCA waiver (26%), or the MH waiver or MH state plan (19%). This distribution is different from last year, when 39 percent of closures without transition were from CHCPE, 34 percent from PCA, and another 10 percent from MH/MHSP. Almost 5 percent of closed referrals (n=24) did not have an assigned HCBS package.

Table 3: Transitions and closures of referrals from 2017 by HCBS package

HCBS Package	Transitioned	%	Closed without transition	%
ABI	4	*1*	26	*5*
CHCPE	1	*0.3*	140	*29*
CHCPE-AFL	3	*0.9*	2	*0.4*
CHCPE-AL	4	*1*	0	*0*
CHCPE-C5	1	*0.3*	0	*0*
CHCPE-PCA-AB	69	*22*	28	*6*
CHCPE-PCA-LI	40	*13*	14	*3*
CHCPE-PCA-SD	8	*3*	0	*0*
CHCPE-S	13	*4*	6	*1*
DDS	0	*0*	10	*2*
DDS-C	13	*4*	2	*0.4*
DDS-IFS	3	*0.9*	0	*0*
KB	1	*0.3*	0	*0*
MH/MHSP	17	*5*	94	*19*
OTHER	3	*0.9*	2	*0.4*
PCA/PCA-S/PCA-AFL	58	*18*	127	*26*
PDSP	81	*25*	33	*7*
Total*	319		484	

* There were an additional 24 closed cases missing an HCBS package.

When analyzed by target population, the greatest percentage of transitions (46%) was for participants with a physical disability who were under 65 years of age, followed closely by adults 65 and older (44%); together these HCBS packages account for 90 percent of transitions. This is similar to 2016, when 90% of transitions were for adults age 65 and older (47%) or physical disability under age 65 (43%). Overall, the greatest percentage of closures without transitioning was 39% for two target populations, adults age 65 plus and participants with a physical disability under age 65 (Table 4).

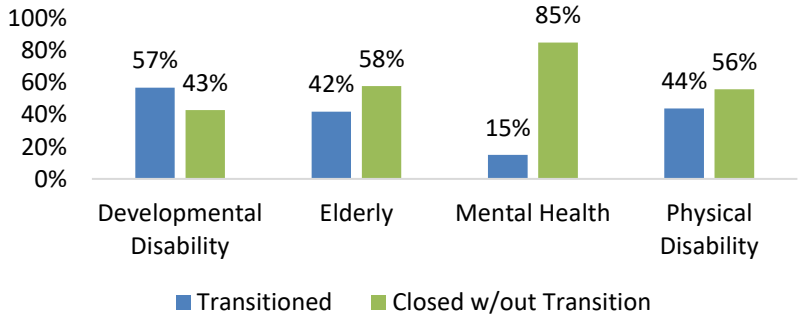
Table 4: Transitions and closures of referrals from 2017 by target population

Target Population	Transitioned	%	Closed without transition	%
Developmental Disability	16	*5*	12	*3*
Elderly (age 65+)	139	*44*	190	*39*
Mental Health	17	*5*	94	*19*
Physical Disability (< 65)	147	*46*	188	*39*
Total*	319		484	

* There were an additional 24 closed cases missing a target population.

There were striking differences with respect to percentage of referrals within each group which transitioned or closed without transition (see Figure 1). The developmental disability target group transitioned 57 percent of referrals, while 44 percent of physical disability under age 65 and 42 percent of older adult referrals transitioned. Meanwhile, only 15 percent of referrals in the mental health target population transitioned.

Figure 1: Percentage of Referrals that Transitioned or Closed without Transitioning by Target Population



As seen in Table 5, 40% of referrals closed in 2017 due to transitioning before the informed consent was signed which was a small increase from 38% in 2016. After rising significantly from 2014 (5%) to 2015 (15%) and 2016 (24%), the percentage of referrals closed because the participant would not cooperate with the care planning only increased by one percent from 2016 to 2017 (25%). In 2017 cases closed due to participants changing their mind was 15%, similar to 2016. In 2017 there was also a decrease in the percentage of closures due to the COP/guardian refusing participation, 6% in 2017 compared to 8% in 2016, 14% in 2015, and 18% in 2014. The ongoing engagement services added in 2014 appear to have a continued beneficial effect on closures due to participants changing their minds and is likely part of the steady decrease in cases closed due COPs/guardians refusing participation.

Table 5: Closures from 2017 referrals by reason compared with 2016

Closure Reason	2017 Cases	2017 %	2016 Cases	2016 %
Transitioned to community before informed consent signed	205	*40*	178	*38*
Participant changed mind & would like to remain in the facility	74	*15*	72	*16*
COP/Guardian refused participation	32	*6*	37	*8*
Exceeds physical health needs	14	*3*	7	*2*
Participant would not cooperate with care planning process	126	*25*	112	*24*
Other	22	*4*	21	*5*
Exceeds mental health needs	1	*0.1*	2	*0.4*
Participant not aware of referral & does not wish to participate	20	*4*	26	*6*
Reinstitutionalized for 90 days or more	5	*0.9*	5	*1*
Participant moved out of state	9	*2*	3	*0.7*
Total	508		463	

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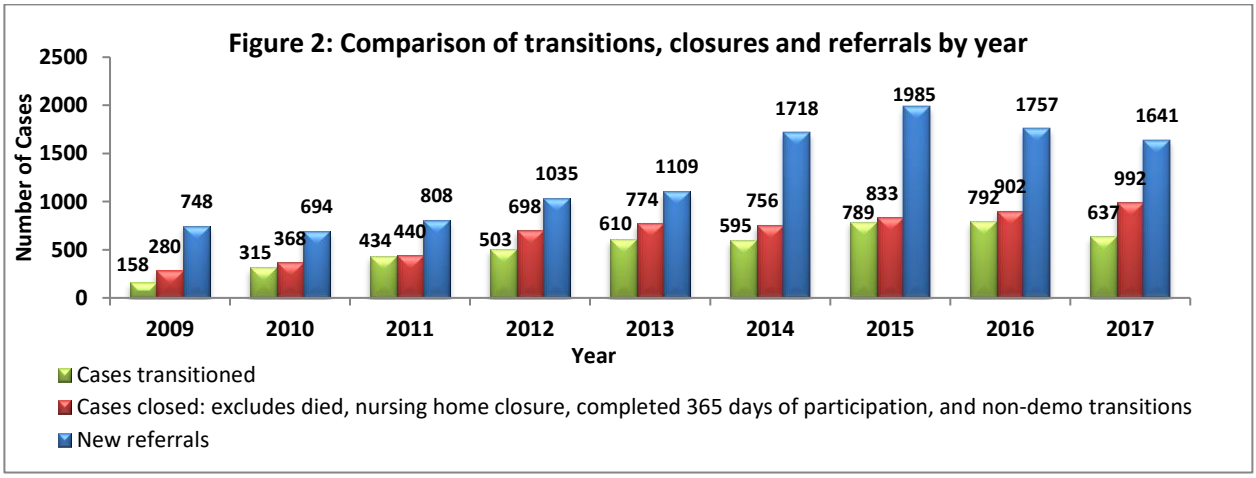
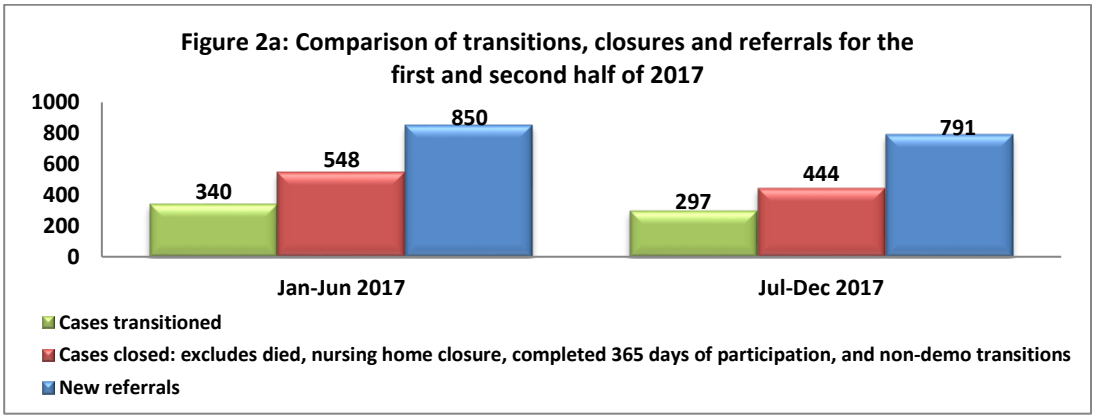
Section II: Comparison of Closed Cases by Year, 2009-2017

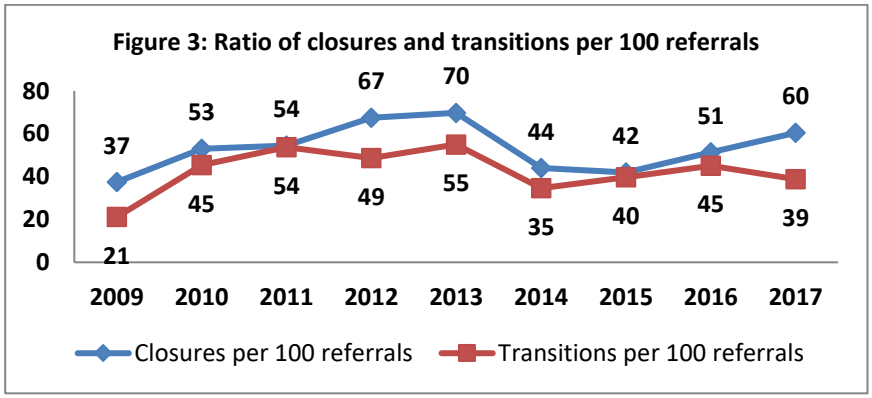
During 2017, MFP experienced 1,641 referrals, 637 transitions and 992 closures (referrals and closures exclude those that closed due to the four excluded reasons; transitions and closures are regardless of referral year). In 2017, there was a decrease in both new referrals and transitions, and an increase in closures. In 2017 the total number of referrals decreased, as in 2016, which may indicate they have started to level out after the process change has been in place for a few years (see figure 2).

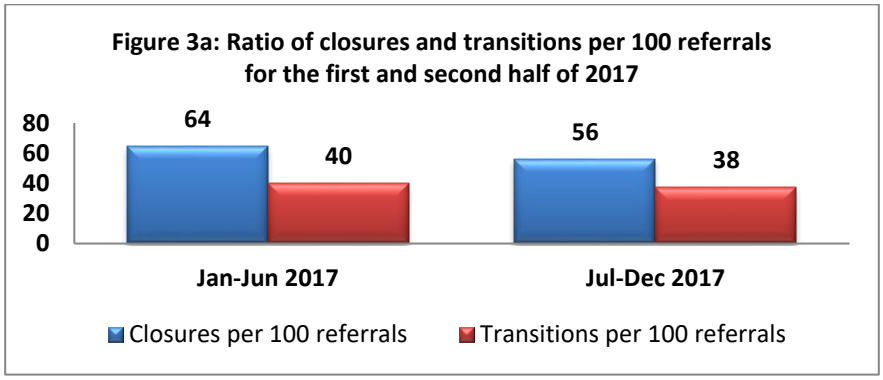


Comparing transitions, closures and referrals between the first and second half of 2017 (Figure 2a), it is interesting to note that this year there were more referrals, transitions and closures in the first half of the year, which is different from 2015 and 2016 when there were more referrals in the first half of the year and more transitions and closures in the second half.



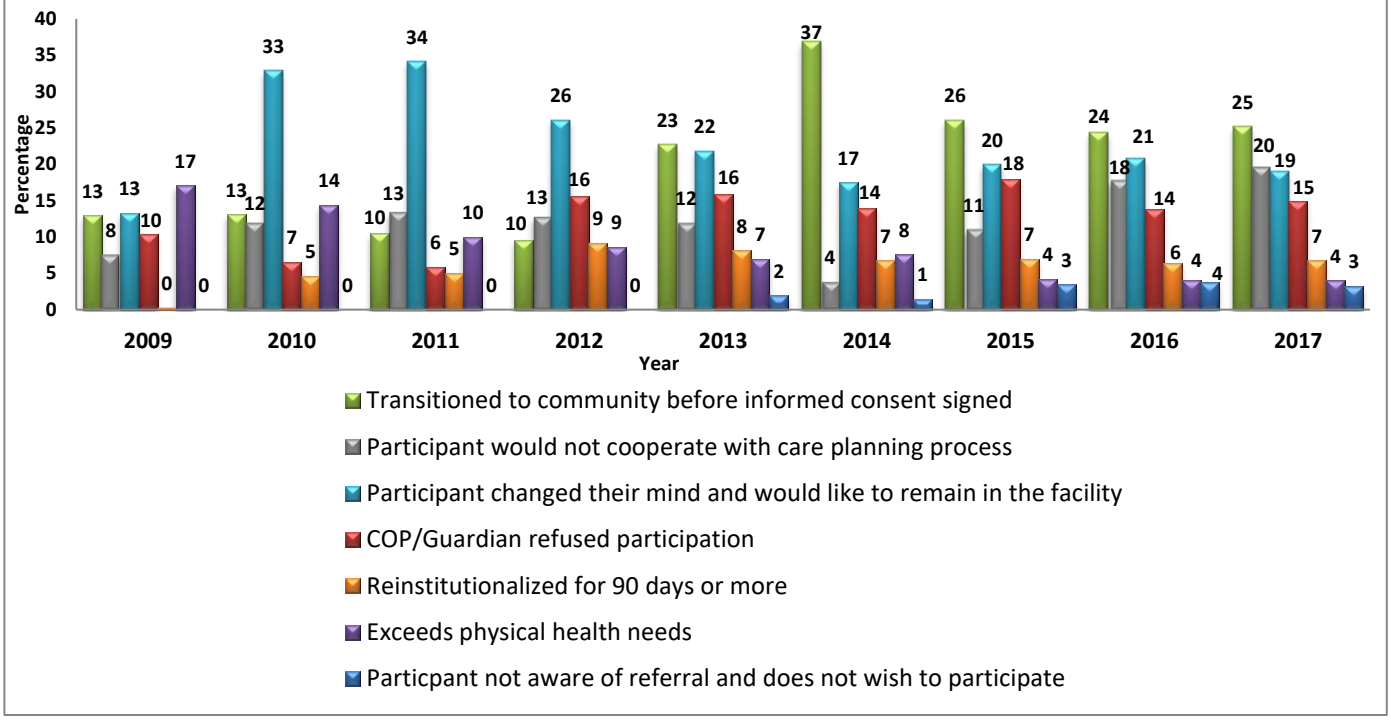
Continuing the trend of prior years, in 2017 the CT MFP program closed relatively more cases than it transitioned (see Figures 3 and 3a). For the year, closures per 100 referrals were up from 51 to 60, and transitions per 100 referrals went down from 45 to 39. Dividing the year into halves shows closures per 100 referrals was up substantially in the first half, 64 compared to 56 in the second half.





Considering all cases that closed in 2017 regardless of referral year (n=992, without the four excluded closure reasons), the three most frequent reasons cases closed accounted for nearly two-thirds of closures. As in the previous four years, the top reason closed in 2017 was "Transitioned to community before informed consent signed," which accounted for 25% (n=250) of closures during 2017, a one percent increase from 2016 (see Figure 4). The second most frequent reason for closing a case during 2017 was "Participant would not cooperate with care planning process," accounting for 20% (n=194) of closures. This closure reason has steadily climbed over the past several years (18% 2016, 11% 2014, and 4% 2014). The percentage of cases closed because the participant changed their mind and would like to remain in the facility decreased slightly this year, from 21% in 2016, to 19% in 2017. The other top four reasons cases closed remained stable, within one percent from 2016. The percentage of cases closed upon request of the COP or guardian increased by one percent to 15% in 2017. Cases closed due to re-institutionalization of 90 days or more was one percent more than the previous year at 7% for 2017. The percentage of cases closed in 2017 because of high physical health needs (4%) was the same as the two years prior. The final closed reason in the top seven in 2017 was "Participant not aware of referral and does not wish to participate" (3%) which is down one percent from last year.

Figure 4: Percentage of cases closed under the top seven reasons of 2017



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Section III: Analysis of Cases Closed Between January and December 2017

A total of 1887 cases were closed during 2017 for any reason, regardless of the year they were referred to MFP. Cases that closed due to the following reasons were excluded: died (344), completed 365 days of participation (520), non-demo transition services complete (30) and nursing home closed and moved to another facility (1), leaving 992 closed cases for further analysis in the remainder of this report. 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 2017

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	250 (25)	119 (23)	131 (27)	1-97	56	23	0-1113	132
Participant would not cooperate with care planning process	194 (20)	86 (17)	108 (23)	20-90	61	34	20-1976	305
Participant changed their mind and would like to remain in the facility	189 (19)	123 (24)	66 (14)	28-100	71	66	30-2060	509
COP/Guardian refused participation	148 (15)	78 (15)	70 (15)	15-101	69	65	46-1789	614
Reinstitutionalized for 90 days or more	67 (7)	39 (8)	28 (6)	3-96	66	54	n/a	n/a
Exceeds physical health needs	40 (4)	17 (3)	23 (5)	40-96	65	45	24-1575	584
Other	37 (4)	18 (3)	19 (4)	20-99	63	44	7-1967	367
Participant not aware of referral and does not wish to participate	32 (3)	16 (3)	16 (3)	34-98	72	70	0-1161	307
Exceeds mental health needs	18 (2)	10 (2)	8 (2)	27-85	63	44	260-2088	785
Participant moved out of state	17 (2)	9 (2)	8 (2)	45-84	64	41	65-929	378
Total	992	515	477	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=250, 25%), cases were often closed because the client discharged from the facility prior to meeting MFP eligibility requirements or left the facility against medical advice without signing an informed consent. Four percent of these cases (n=10) were never assigned to the field because they left the institution before assignment, which was a 2% increase from 2016. Consumers who closed for this reason were more likely to be younger compared to consumers in other categories, with an average age of 56, and only 23 percent age 65 or older. The average length of time from referral to closure was 132 days, which was the shortest length of time for all the closure reasons (see Table 6).

Twenty percent (n=194) of cases closed in 2017 were because the participant would not cooperate with the care planning process, a 2% increase from 2016. A little more than one third of this group were over age 65 in 2017, a large increase from 2016, when 25 percent were over age 65. Lack of cooperation in establishing Medicaid eligibility played a role in many of these cases. Additionally,

there were participants who left the facility against medical advice as well as those who left before eligibility to transition with MFP was established, though they had signed an informed consent.

- "Client has no Medicaid Coverage, would not follow through with Medicaid Process and is no longer residing in a SNF."
- "Consumer refused to participate in financial planning in order to be eligible for T-19."
- "Consumer left SNF AMA effective [date]."
- "Consumer has not been participating in the care planning process. Consumer and facility [social worker] were informed that this case will be closed. Case has been open for over two years. Daughter and consumer will not help the professional team get IDs thus stopping housing search."
- "Client still active CHCPE and discharging on CHCPE before she reaches her 90th day."

This year there was a two percent decrease in the percentage of cases that closed because the participant changed their mind and wanted to stay in the facility (n=189, 19%), which represented the third most common reason. Similar to previous years, these cases indicated 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 much longer at 509 days, with a range of 30-2,060 days. This group was the second oldest, with an average age of 71 years for participants closed for this reason in 2017.

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:

- "Consumer decided that her needs are better met in a SNF."
- "Due to consumer's multiple physical and cognitive comorbidities coupled with the lack of informal support and need for financial assistance, consumer states that she is happy and would prefer to remain in the facility at this time with the understanding that she can re-refer to the program at any time if her status and feelings do change."
- "[Client] goal prior to completion of this assessment was to live independently in the community. After completing this screening [client] stated that he is not ready at this time to leave the SNF, stating "I don't think I could handle that" (own apartment alone, loneliness). He states that he has medical and mental health issues that need to be resolved before leaving."
- "Client stated would like to lose weight at SNF, get surgeries needed, and once rehab is complete, discharge with MFP in about 1.5 years."

Cases closed because the "COP/Guardian refused participation" accounted for 15% (n=148) of overall closures in 2017, a slight increase of 1% from 2016. As in years prior, two of the main reasons COPs and guardians cited for their decision were a decline in consumer health from the time of the referral and the perceived inability to have appropriate care provided for the consumer at home. Another reason given was the legal representative did not want to pursue the required financial requirements, such as establishing a pooled trust. Closures for this reason had the second highest average number of days (n=614) from referral to closure. 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. Some descriptive case notes include:

- "Family reports that after speaking with elder law attorney they have decided to remain in the facility at this time. They did not realize the financial eligibility requirements of CHCPE and are going to continue and work toward facility LTC [long term care] approval. POA reports she understands the process in more detail now and states that if their decision as a family changes and they do wish to pursue community transition they can re-refer at any time."

- "Dtr/POA requesting case be closed as the consumer and spouse are together at [facility name] SNF and no plans to return to the community. Consumers spouse would have been informal supporter providing supervision for consumer in the community. Consumer stated at time of assessment only interested in living with the spouse again in the community."

- "TC shared email with SCM and SCM followed up with CL [client] daughter/COP. CL daughter who is the COP would like the cl to stay in the SNF at this time, as cl would not be able to live with her, and COE does not want to establish a pooled trust."

- "SCM spoke with clt's mother [name]. [Name] Client's mother has requested to close clt's case stating that she is unable to bring clt home at this time due to his medical decline."

Similar to the last two years, in 2017 re-institutionalization for 90 days or more accounted for 7% of overall closures (n=67). This group was a year older on average (66) this year than in 2016 and younger than the average age of 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, and mental health concerns.

- "[Participant] was admitted to the SNF on [date] for rehab following a hospitalization. [Participant] has diagnoses of COPD, muscle weakness, CHF, HTN, hypertensive heart disease w/o heart failure and acute respiratory failure."

- "MFP case was closed on [date] due to being institutionalized for over 90 days. TC will inform facility SW and [participant]. [Participant] is not able to safely manage his diabetes on

his own consistently. Due to this, [participant] would not be able to live independently in the community."

- "…he reported that he has been home and to the hospital several times. He reported that every time he goes home he gets sick."

- "Client was recently at [hospital] from [dates] and then sent back to [facility name] (SNF) and then was re-admitted to [hospital] on [date] and is scheduled to go back to the SNF on [date]. [Hospital nurse] stated that the client came to the hospital with an altered mental status and unresponsive with very low stats. She also stated that she does not think that it is safe for the client to return to the community."

Exceeding physical health needs accounted for 4% of closures (n=40) which is the same percentage as it was in 2016. Forty-eight percent of consumers closed for this reason were in one of the CHCPE HCBS packages (n=19), 33% were in PCA/PDSP (n=13), 10% were in a MH package (n=4), 8% were in ABI (n=3), and 3% had a DDS package (n=1). Average age for this group was 65, up from age 62 in 2016. The average number of days from referral to closure was 584 for cases closed for this reason, the third highest length of time for all cases closed in 2017. Representative quotes from cases closed for this reason include:

- "At this time SCM is unable to put a plan together for the community that would be safe to support his care needs. Consumer needs assist of 2 for most of his ADL needs, consumer is at very high risk for further skin breakdown and on aspiration precautions. Consumer has no family/friends to assist with personal care or a [back-up] plan."

- "Consumer is deemed incompetent, he has advanced dementia. He is on insulin 4x [a day], he is incontinent of bowel and bladder, requires total care, Hoyer lift. He is on special pureed diet and needs to be feed. His needs exceed program cost caps."

- "Consumer remains an assist of 2 due to inability to participate in self-turning and transfers primarily due to obesity. Consumer has stopped PT and is now on hospice. Family aware that if situation changes and improvements are made a re-referral can be submitted for MFP."

Three percent of referrals were closed for the reason "Participant not aware of referral and does not wish to participate" (n=32). These participants had an average age of 72, the highest for all the closure reasons, with 70% age 65 years or older. The average number of days from referral to closure was 307 days. A couple of representative quotes include:

- "Consumer stated his dtr was working on helping him move home. SCM explained assessment is the next step in the process. SCM explained MFP program. Consumer did not want to participate in the assessment. Consumer stated "I do not want to participate in the program." SCM described MFP in many ways and tried multiple approaches to offering to complete the assessment. Consumer did not want to participate in assessment or MFP

process. SCM informed consumer that he can be re-referred to the program if he changes his mind in the future."

- "She refused to be part of MFP and refused to sign the informed consent. Said that she was discharging back to her home in a few days with services and did not need MFP. This was confirmed by the Social Worker who also said that she was independent with all of her ADLs except for medication management and was going home with VNA Services. "

Reasons for closing a case due to exceeding mental health needs accounted for 2% of overall closures (n=18). In 2017 this group had the longest average number of days between referral and closure (n=785) with a range of 260-2,088 days. This represents a large increase in average number of days between referral and closure from 2016, when it was 595 days for this group. In 2016, those closed due to exceeding physical health needs had the highest average number of days from referral to closure at 684 days. Similar to findings from past years, these participants mainly had a diagnosis of depression, anxiety, bipolar disorder, and/or schizophrenia. The main health issues were mental health issues, dementia, and diabetes.

- "SCM discussed reassessment with clt's COP [name]. SCM explained that clt is exceeding mental health needs – client's behaviors are difficult to manage at SNF, he is resistive towards all care and combative towards residents and staff. SCM recommending closure, safe care plan cannot be developed for the community. COP acknowledges and agrees."

- "Testing states that the client would do best at a group home or assisted living facility where there would be 24 hour supervision available. The MH waiver is unable to provide 24 hour supervision within the cost cap."

- "[Assessor name] indicated that due to the client's very complex medical regime, requiring intermittent hands on care and her mental health diagnosis of level 2 schizophrenia and severe anxiety, she would need 24 hour supervision. [Assessor name] also indicated that the consumer would not be able to hire and manage PCAs."

- "Met with consumer today. Status remains the same and he remains unsafe to be in an apartment in the community without 24/7 supervision. Speech is pressured and thoughts appear disorganized. He continues to fight with others on the locked unit."

Finally, two percent of cases closed because the consumer moved out of state (n=17). In 2016 the percentage was the same with a total of 19 cases. The average age for participants whose cases closed because they moved out of state was 64 years of age, and the percent 65 or older was 41%. A quote from cases closed for this reason:

- "[Participant] contacted this writer while he was in transit to South Carolina. He is permanently moving down south to be with his family. This was always a goal for him post-transition."

Another noteworthy point was that 418 (43%) of the cases closed in 2017 (excluding cases without referral dates and those closed for the four excluded closure reasons) were closed more than one year after referral, an increase from 2016 when 35 percent of cases were closed more than one year after referral.

The closure reason with the lowest average amount of time from referral to closure was "Transitioned to community before informed consent signed" at 132 days, followed by participants who would not cooperate with the care planning process (305 days), and participants who were not aware of the referral and did not wish to participate (307 days). The closure reasons with the highest average amount of time from referral to transition were "Exceeds mental health needs," with an average of 785 days, and "COP/guardian refused participation," with an average of 614 days. These were followed by Exceeds physical health needs (584 days) and "Participant changed their mind and would like to remain in the facility" (509 days).

Transition Challenges

Compared to the previous year, the distribution of the transition challenges for cases closed in 2017 differed somewhat, although the order did not change. (see Table 7). Service and supports was the greatest challenge in 2017, 19% (n=1851) compared to 18% in 2016. In 2017, physical health was the second greatest challenge for 17% (n=1677) of cases; it was also a challenge for 17% of cases in 2016. Field staff identified housing as a close third challenge this year, representing 16% (n=1542) of cases which is a slight decrease from 17% in 2016. Mental health was the fourth most common challenge, which at 13% stayed the same as in 2016. The next most common challenges were consumer engagement (10%) up from 8% in 2016, financial (8%), and legal (5%).

Table 7: Transition challenges by category for cases closed in 2017 and 2016

Transition Challenges	2017 %	2016 %
Services & Supports	19	18
Physical health	17	17
Housing	16	17
Mental health	13	13
Engagement	10	8
Financial	8	8
Legal	5	5
MFP	3	4
Involved others	3	3
Facility	3	3
Waiver	2	3
Other	1	1

Consumers with services and supports challenges most often faced problems related to a lack of PCA, home health, or other paid support staff (34%; down from 38% in 2016) and a lack of transportation (19%, up from 16% in 2016). Over half (58%) of those with physical health challenges had the sub-challenge "Current, new, or undisclosed physical health problem or illness," similar to 2016 (59%). Just over half (54%) of consumers with housing challenges did not have affordable, accessible community housing which is up 1% from 2016 (53%).

Conclusion

In 2017 there were 637 transitions, 992 closures, and 1641 referrals (referrals and closures exclude those that closed due to the four excluded reasons; transitions and closures are regardless of referral year). 2017 had the highest number of closures to date (n=992), a figure that has grown nearly every year since 2009. While the relative frequency of closure reasons has shifted over time, transitions before the informed consent was signed has remained the top reason for the last five years, accounting for at least a quarter, or nearly a quarter, of closures in these years. The gap in the ratio of closures per 100 referrals (60) and transitions per 100 referrals (39) increased in 2017 as it had in 2016 as well. One factor that might have contributed to the increased gap in early 2017 was the loss of two utilization review nurses from August 2015 through September of 2016.

The 2017 findings were similar to those in previous years, and the characteristics of consumers for 2017 were overall similar to 2016. There were some differences. In 2017 consumers' cases closed due to the participant not being aware of the referral and not wishing to participate had the highest average age (72), compared to an average age of 64 in 2016. The highest average age in 2016 (72) was for cases closed due to the reason participant changed their mind and would like to stay in the facility which had the second highest average age in 2017 (71). Cases closed for the reason transitioned to the community before informed consent signed had the lowest average age (56), which was different from 2016 when exceeds mental health needs had the lowest average age (54). In 2017, cases closed because exceeds mental health needs were much older (average age 63).

This year the highest percentage of persons over age 65 was for cases closed due to the participant not being aware of the referral and not wishing to participate (70%), whereas in 2016 it was due to participants changing their mind and choosing to remain in the facility (71%). Again this year the percentages for male and female consumers were similar for many of the closures reasons. As in 2016, notable exceptions were "Participant changed their mind and would like to remain in the facility" which in 2017 had a much greater percentage of female consumers (24%) compared to male consumers (14%). As in 2016, the closure reasons "Transitioned to community before informed consent was signed" and "Participant would not cooperate with care planning process" had greater percentages of males than females.

Similar to 2016, one quarter of cases closed because the participant transitioned to the community before informed consent was signed. Similar to 2016, these cases often did not meet the MFP 90 day length of stay requirement before leaving the facility or left the facility against medical advice prior to signing an informed consent. Twenty percent of cases closed because the participant would not cooperate with the care planning process which is up from 18% in 2016. Lack of cooperation in establishing Medicaid eligibility played a role in these cases as did some consumer's leaving the facility against medical advice and consumers who left the facility before becoming eligible for MFP, even though they had signed an informed consent. In 2017, 19 percent of cases closed because the participant changed their mind and would like to remain in the facility, which is less than the 21% closed for this reason in 2016. Socialization and familiarity with life at the facility were two common reasons participants mentioned for changing their mind. Developing ways to connect consumers with community resources before they transition, such as connecting consumers to community centers in the towns being considered for transition, may have helped to decrease this reason. Seven percent of closures in 2017 were due to prolonged re-institutionalization, similar to the 6% in

2016. Effective prevention of re-institutionalization remains a key priority. As in 2016, this year the combined percentage of cases that closed because the consumer's mental or physical health needs exceeded allowable cost was 6%, which is a drop from 2015 (7%) and 2014 (11%). The decrease in recent years 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 three years "Closed due to exceeding mental health needs" was not in the top seven closure reasons, accounting for just 2% of cases closed. However, given how long these cases were open, it is likely these two percent of cases are especially challenging. The percentage of cases closed due to consumer's exceeding physical health needs was lower the last few years (4% for 2015, 2016 and 2017) compared to previous years (8% in 2014 and 7% in 2013).

Four percent of cases closed in 2017 were never assigned to the field, compared to 1% of cases in 2016, 14% in 2015, and 39% in 2014. Cases closed because a consumer transitioned to the community before signing an informed consent also showed a large decrease from 2014 (37%) to 2015 (26%); since then it has been stable at about 25%.

The relative percentage of closures due to participants' lack of cooperation in the care planning process rose again this year and became the second top reason cases closed, going from 11% in 2015, to 18% in 2016, and 20% in 2017. Possible ways to address this might be to increase assistance with Medicaid eligibility and to continue the work with motivational interviewing. Closures due to COP refusing participation increased by one percent, from 14% in 2016 to 15% in 2017. Similar to previous years, many of these family members had concerns about safety or getting 24 hour care in the community. MFP could consider ways the SCMs and TCs might respond to these concerns, such as motivational interviewing techniques and increasing access to both Support and Planning Coaches and Adult Family Homes.

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
ADL	Activities of Daily Living
AMA	Against Medical Advice
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)
Cl/Clt	Client
CHF	Congestive Health Failure
CO	Central Office
COE	Conservator of Estate
COP	Conservator of Person
COPD	Chronic Obstructive Pulmonary Disease
DDS	Department of Developmental Services Waiver
DDS-C	Department of Developmental Services (Comprehensive Waiver)
DSS	Department of Social Services
Dtr	Daughter
HC	Housing Coordinator
HCBS	Home and Community Based Services
HTN	Hypertension (high blood pressure)
LTC	Long Term Care
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
POA	Power of Attorney
SCM	Specialized Care Manager
SNF	Skilled Nursing Facility
SW	Social Worker
TC	Transition Coordinator
VNA	Visiting Nurse Association