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)

Benchmark 2: CT Medicaid Long-Term Care Expenditures

Benchmark 3: Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility

Benchmark 4: Percent of SNF admissions returning to the community within 6 months

Benchmark 5: Percent Receiving LTSS in the Community vs. Institutions

Happy or unhappy with the way you live your life*

*happy
unhappy
Referrals to Transition Coordinators*: Q1 2009 to Q3 2017

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

Number of Transitions by Quarter: 12/2008 - 9/30/2017
Target Population Summary for Referrals through Q3 2017 (Demonstration Only)

<table>
<thead>
<tr>
<th>BENCHMARK FOR TRANSITIONS</th>
<th>Referrals (n=9915)</th>
<th>Signed Informed Consents (n=8014)</th>
<th>Transitions (n=4384)</th>
<th>Closed w/o Transitioning (n=2417)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Disability</td>
<td>35%</td>
<td>47%</td>
<td>48%</td>
<td>56%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>21%</td>
<td>11%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Elderly</td>
<td>42%</td>
<td>37%</td>
<td>38%</td>
<td>32%</td>
</tr>
<tr>
<td>Developmental Disability</td>
<td>3%</td>
<td>5%</td>
<td>5%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Qualified Residence Type for Transitioned Referrals: 12/4/08 to 9/30/17

- Apartment Leased By Participant, Not Assisted Living: 72%
- Home Owned By Family Member: 14%
- Home Owned By Participant: 10%
- Group Home No More Than 4 People: 2%
- Apartment Leased By Participant, Assisted Living: 2%
- Not Reported: 0.1%

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

Cumulative Number of Clients Who Transitioned and Those with Home Modifications by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>399</td>
</tr>
<tr>
<td>North Central</td>
<td>1684</td>
</tr>
<tr>
<td>Northwest</td>
<td>693</td>
</tr>
<tr>
<td>South Central</td>
<td>977</td>
</tr>
<tr>
<td>Southwest</td>
<td>624</td>
</tr>
</tbody>
</table>

Note: Track 2 referrals not included

*Corrected calculation
Cumulative Number of Clients Who Transitioned and Those with Home Modifications by Waiver

*Includes CFC

Transitioned  Home Modification

Consumers under age 65 who are working and those who would like to work

Consumers 65 years and older who are working and those who would like to work

Consumers under age 65 who are volunteering and those who would like to volunteer

Consumers 65 years and older who are volunteering and those who would like to volunteer

ABI  PCA/PDSP  Elder  DDS  Mental Health  Katie Becket  Other*

275  61  1659  180  2080  334  246  77  409  21  7  1  16  2

6-month  12-month  24-month

Consumers 65 years and older who are volunteering and those who would like to volunteer

Consumers 65 years and older who are volunteering and those who would like to volunteer
MFP
Quality of Life Dashboard
As of 9/30/2017

Happy or unhappy with your help around the house or in the community*

- 74% happy, 26% unhappy at baseline
- 89% happy, 12% unhappy at 6 month
- 89% happy, 11% unhappy at 12 month
- 90% happy, 10% unhappy at 24 month

Do you like where you live?*

- 32% yes, 27% sometimes, 41% no at baseline
- 85% yes, 6% sometimes, 9% no at 6 month
- 84% yes, 6% sometimes, 10% no at 12 month
- 80% yes, 8% sometimes, 12% no at 24 month

Did family or friends help you with things around the house?*

- 48% yes, 52% no at 6 month
- 45% yes, 55% no at 12 month
- 43% yes, 57% no at 24 month

Do the people who help you treat you the way you want them to?*

- 84% yes, 16% no at baseline
- 96% yes, 5% no at 6 month
- 95% yes, 5% no at 12 month
- 94% yes, 6% no at 24 month

Depressive Symptoms*

- 58% yes, 43% no at baseline
- 53% yes, 47% no at 6 month
- 53% yes, 47% no at 12 month
- 52% yes, 48% no at 24 month

Average number of areas of choice and control*

- 4.09 at baseline
- 5.16 at 6 month
- 5.17 at 12 month
- 5.10 at 24 month

Community integration - Do you do fun things in the community?*

- 56% yes, 44% no at baseline
- 53% yes, 47% no at 6 month
- 56% yes, 44% no at 12 month
- 58% yes, 42% no at 24 month

*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

Healthcare unmet need*

<table>
<thead>
<tr>
<th></th>
<th>baseline</th>
<th>6 month</th>
<th>12 month</th>
<th>24 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>13%</td>
<td>16%</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>no</td>
<td>87%</td>
<td>85%</td>
<td>86%</td>
<td>88%</td>
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</table>

Personal care - unmet needs*

<table>
<thead>
<tr>
<th></th>
<th>baseline</th>
<th>6 month</th>
<th>12 month</th>
<th>24 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 unmet needs</td>
<td>85%</td>
<td>92%</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>1 or more</td>
<td>15%</td>
<td>9%</td>
<td>7%</td>
<td>7%</td>
</tr>
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</table>

Have or Need* Assistive Technology (AT)?

<table>
<thead>
<tr>
<th></th>
<th>Have AT</th>
<th>Need AT*</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 month</td>
<td>90%</td>
<td>35%</td>
</tr>
<tr>
<td>12 month</td>
<td>91%</td>
<td>29%</td>
</tr>
<tr>
<td>24 month</td>
<td>91%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Activities of Daily Living scores
Range 0 - 6; 0=can do all ADLs independently; 6=need assistance with all*

<table>
<thead>
<tr>
<th></th>
<th>baseline</th>
<th>6 month</th>
<th>12 month</th>
<th>24 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>mean summary score</td>
<td>2.16</td>
<td>2.03</td>
<td>2.03</td>
<td>2.16</td>
</tr>
</tbody>
</table>

Instrumental Activities of Daily Living scores
Range 0-7; 0=can do all IADLs independently; 7=need assistance with all*

<table>
<thead>
<tr>
<th></th>
<th>baseline</th>
<th>6 month</th>
<th>12 month</th>
<th>24 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>mean summary score</td>
<td>3.93</td>
<td>4.11</td>
<td>4.15</td>
<td>4.21</td>
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Rate Your Overall Health*

<table>
<thead>
<tr>
<th></th>
<th>excellent</th>
<th>good</th>
<th>fair</th>
<th>poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>baseline</td>
<td>7.3%</td>
<td>11.4%</td>
<td>11.3%</td>
<td>10.8%</td>
</tr>
<tr>
<td>6 month</td>
<td>36.0%</td>
<td>34.7%</td>
<td>34.1%</td>
<td>35.2%</td>
</tr>
<tr>
<td>12 month</td>
<td>49.4%</td>
<td>42.6%</td>
<td>42.9%</td>
<td>41.9%</td>
</tr>
<tr>
<td>24 month</td>
<td>49.4%</td>
<td>42.6%</td>
<td>42.9%</td>
<td>41.9%</td>
</tr>
</tbody>
</table>

Rate Your Overall Health*
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

Physical health
- Current, new or undisclosed physical health problem
- Inability to manage physical disability or physical illness in community
- Medical testing issues or delays
- Missing or waiting for physical health documents
- Other physical health issues

Mental health
- Current or history of substance/alcohol abuse w/ risk of relapse
- Current, new, or undisclosed mental health problem
- Dementia or cognitive issues
- Inability to manage mental health in community
- Other mental health issues

Housing
- Delays related to housing authority, agency or housing coordinator
- Delays related to lease, landlord, apartment manager, etc.
- Needs housing modifications before transition
- Ineligible or waiting for approval from RAP or other housing programs
- Lacks affordable, accessible community housing
- Housing related legal, criminal or credit issues, including evictions or unpaid rent
- Other housing related issues

Consumer engagement
- Disengagement or lack/loss of motivation
- Lack of awareness or unrealistic expectations
- Lack of independent living skills
- Language or communication skills
- Other consumer related issues

Services and supports
- Lack of alcohol, substance abuse, or addiction services
- Lack of AT or DME
- Lack of mental health services or supports
- Lack of PCA, home health, or other paid support staff
- Lack of transportation
- Lack of any other services or supports
- Lack of unpaid caregiver to provide care/informal support
- Other issues related to services or supports

Financial
- Consumer credit or unpaid bills
- Lack of or insufficient financial resources
- SSDI, SSI, SAGA, SSA, VA or other cash benefits
- Medicaid eligibility or insurance issues
- Other financial benefits or issues
- Other financial challenge

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-Sep 2017

- Transitioned to community before informed consent signed (6%)
- Participant would not cooperate with care planning process (4%)
- Participant changed their mind and would like to remain in the facility (3%)
- COP/Guardian refused participation (1%)
- Reinstitutionalized for 90 days or more (22%)
- Exceeds physical health needs (25%)
- Participant not aware of referral & does not wish to participate (20%)
- Exceeds mental health needs (17%)
- Other (4%)
- Participant moved out of state (1%)

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

Comparison of Closures, Referrals and Transitions per Quarter

- Total closures excluding: died, nursing home closure, completed participation, non-demo transition services completed
- New referrals excluding nursing home closures
- Total cases transitioned
- Closures per 100 new referrals
- Transitions per 100 new referrals

*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.

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.