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 = 4,537 (non-demonstration transitions = 313)

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*

*Based on the latest data available at the end of the quarter

CT Money Follows the Person Quarterly Report
Quarter 4 2017: October 1, 2017 – December 31, 2017
(Operating Agency: UConn Health, Center on Aging)
Funder: Centers for Medicare and Medicaid Services
Referrals to Transition Coordinators\(^t\): Q1 2009 to Q4 2017

\(^t\)Excludes nursing home closures  \(^*\)Increase in referrals reflects the ongoing adjustment to MFP reorganization

Number of Transitions by Quarter: 12/2008 - 12/31/2017
Target Population Summary for Referrals through Q4 2017 (Demonstration Only)

<table>
<thead>
<tr>
<th>BENCHMARK FOR TRANSITIONS</th>
<th>Referrals (n=10,329)</th>
<th>Signed Informed Consents (n=8,374)</th>
<th>Transitions (n=4,537)</th>
<th>Closed w/o Transitioning (n=2,540)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Disability (%)</td>
<td>35%</td>
<td>11%</td>
<td>46%</td>
<td>56%</td>
</tr>
<tr>
<td>Mental Health (%)</td>
<td>42%</td>
<td>37%</td>
<td>41%</td>
<td>33%</td>
</tr>
<tr>
<td>Elderly (%)</td>
<td>21%</td>
<td>39%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Developmental Disability</td>
<td>3%</td>
<td>72%</td>
<td>47%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Qualified Residence Type for Transitioned Referrals: 12/4/08 to 12/31/17

- 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: 0.1%
- Apartment Leased By Participant, Assisted Living: 2%
- Not Reported: 2%

Reinstitutionalization: 12% (498) of participants who transitioned by Dec. 31, 2016 were in an institution 12 months after their transition.*

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

- Eastern: 425 Transitioned, 62 Home Modification
- North Central: 1735 Transitioned, 180 Home Modification
- Northwest: 726 Transitioned, 162 Home Modification
- South Central: 1006 Transitioned, 188 Home Modification
- Southwest: 641 Transitioned, 84 Home Modification

Note: Track 2 referrals not included.

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

<table>
<thead>
<tr>
<th>ABI</th>
<th>PCA/PDSP</th>
<th>Elder</th>
<th>DDS</th>
<th>Mental Health</th>
<th>Katie Becket</th>
<th>Other*</th>
</tr>
</thead>
<tbody>
<tr>
<td>283</td>
<td>61</td>
<td>190</td>
<td>353</td>
<td>257</td>
<td>415</td>
<td>21</td>
</tr>
</tbody>
</table>

*Includes CFC

Transitioned  
Home Modification

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

<table>
<thead>
<tr>
<th>6-month</th>
<th>12-month</th>
<th>24-month</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>54%</td>
<td>54%</td>
<td>57%</td>
</tr>
<tr>
<td>42%</td>
<td>41%</td>
<td>37%</td>
</tr>
</tbody>
</table>

Currently working  
Not working and don't want to work  
Not working but want to work

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

<table>
<thead>
<tr>
<th>6-month</th>
<th>12-month</th>
<th>24-month</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.4%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>84%</td>
<td>85%</td>
<td>84%</td>
</tr>
<tr>
<td>15%</td>
<td>14%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Currently working  
Not working and don't want to work  
Not working but want to work

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

<table>
<thead>
<tr>
<th>6-month</th>
<th>12-month</th>
<th>24-month</th>
</tr>
</thead>
<tbody>
<tr>
<td>7%</td>
<td>8%</td>
<td>9%</td>
</tr>
<tr>
<td>61%</td>
<td>60%</td>
<td>63%</td>
</tr>
<tr>
<td>32%</td>
<td>31%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Currently volunteering  
Not volunteering and don't want to volunteer  
Not volunteering but want to volunteer

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

<table>
<thead>
<tr>
<th>6-month</th>
<th>12-month</th>
<th>24-month</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>80%</td>
<td>82%</td>
<td>83%</td>
</tr>
<tr>
<td>17%</td>
<td>15%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Currently volunteering  
Not volunteering and don't want to volunteer  
Not volunteering but want to volunteer
MFP
Quality of Life Dashboard
As of 12/31/2017

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

<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>happy</td>
<td>74%</td>
<td>89%</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>unhappy</td>
<td>26%</td>
<td>12%</td>
<td>11%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Do you like where you live?*

<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>89%</td>
<td>85%</td>
<td>84%</td>
<td>80%</td>
</tr>
<tr>
<td>sometimes</td>
<td>9%</td>
<td>9%</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>no</td>
<td>2%</td>
<td>6%</td>
<td>7%</td>
<td>12%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>6 month</th>
<th>12 month</th>
<th>24 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>48%</td>
<td>52%</td>
<td>58%</td>
</tr>
<tr>
<td>no</td>
<td>52%</td>
<td>48%</td>
<td>42%</td>
</tr>
</tbody>
</table>

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

<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>84%</td>
<td>96%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>no</td>
<td>16%</td>
<td>5%</td>
<td>5%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Depressive Symptoms*

<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>58%</td>
<td>53%</td>
<td>53%</td>
<td>53%</td>
</tr>
<tr>
<td>no</td>
<td>43%</td>
<td>47%</td>
<td>47%</td>
<td>47%</td>
</tr>
</tbody>
</table>

Average number of areas of choice and control*

<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>4.09</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<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>44%</td>
<td>56%</td>
<td>56%</td>
<td>58%</td>
</tr>
<tr>
<td>no</td>
<td>56%</td>
<td>44%</td>
<td>44%</td>
<td>42%</td>
</tr>
</tbody>
</table>

*indicates statistically significant differences
Quality of Life Interviews Completed
(Cumulative data through 12/31/17)

Baseline interviews done prior to transition, n=4884
6 month interviews done 6 mos after transition, n=3738
12 month interviews done 12 mos after transition, n=3345
24 month interviews done 24 mos after transition, n=2412

Healthcare unmet need*

Personal care - unmet needs*

Have or Need* Assistive Technology (AT)?

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

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

Rate Your Overall Health*
Transition Challenges through 12/31/17

Transition coordinators (TCs) and specialized care managers (SCMs) complete a standardized challenges checklist for each consumer. There were a total of 13,931 MFP referrals to SCM Supervisors. Challenges checklists were completed for 9,364 of these referrals, representing 8,594 consumers. Excluding the referrals which indicated “no challenges,” the challenges checklist generated 56,907 separate challenges. Of these, the most frequently chosen challenge was physical health (16.8%), followed by challenges related services and supports (15.8%), to housing (15.5%), mental health (12.9%), and consumer engagement (10.3%).

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

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, 62 percent of referrals that did transition had physical health challenges.

Nine of the twelve challenge categories had statistically significant differences between the two groups.
Types of Challenges — through 12/31/2017
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 12/31/2017, use the link on page 7 to get to the Center on Aging website.
Percentage of Closed Cases by Closure Reason: Oct-Dec 2017

- 34% Transitioned to community before informed consent signed
- 20% Participant would not cooperate with care planning process
- 14% Participant changed their mind and would like to remain in the facility
- 9% Reinstitutionalized for 90 days or more
- 7% COP/Guardian refused participation
- 5% Other
- 5% Exceeds physical health needs
- 5% Participant not aware of referral & does not wish to participate
- 3% Participant moved out of state
- 2% Exceeds mental health needs

*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.
Meet Keith Bullock

I stepped into an apartment filled with the aroma of homemade sauce simmering on the stove at my interview with Keith Bullock, age 59, and a former chef. As a graduate of the Culinary Institute of America, he spent the later part of his career cooking for the NY Yankees and serving 25,000 fans “much more than just hot dogs,” he says with pride. Then in 2014, osteoarthritis and peripheral neuropathy in his right foot made it too difficult to stand all day. An operation to fuse his ankle led to complications with an infection post-surgery and he needed to have his foot amputated in 2015. During the year he spent in nursing homes, he was finding it hard to “wrap my head around the amputation” and the dramatic change in his once active life. At the nursing home, he found himself sinking into depression, despair and hopelessness in an environment with those who were much older and sicker.

He is extremely grateful to the director of the nursing facility who first gave him the Money Follows the Person (MFP) information. He said that MFP “stepped in at the right time to rescue me. This program is a God-send, a true life saver where I saw my only alternative was living in a homeless shelter.” He was “overjoyed” with the first apartment that his housing coordinator found, which was only 2 blocks from his former apartment and felt like his prayers had been answered. His transition coordinator made the process of moving to his new apartment easy by providing furniture, household goods and two weeks of food. They also told him about ordering his food on-line and the delivery service through Stop & Shop’s Peapod. He did not need any home modifications, although his landlord would have obliged. He feels that people in a nursing home need to know about this program. For him, it was like “an angel had swooped down and rescued me from doom.”

Keith continued out-patient physical and occupational therapy. Once he was fitted with his prosthetic leg & foot, he worked hard to find his “footing.” He lost 40 pounds in 8 months by walking on his new limb and eating healthier. He drives himself everywhere. In fact, he and his son, whom he had not seen due to his enlistment in the navy, drove across the United States together stopping at the Grand Canyon and Monument Valley this past April/May for Keith’s birthday. He said good-bye to his son who is based in San Diego and drove himself back to CT. He is also father to three daughters, who are now living together in Philadelphia, finishing college and starting new careers.

Keith spoke about wanting to volunteer with the Wounded Warrior Project and returning to the workforce. His former professors at the Culinary Institute of America have inspired him to now think about teaching as a way to reenter the workforce. He will receive his second prosthetic, another challenge to master, but I have no doubt Keith will realize his goals with a positive attitude and the faith that lead him to MFP.

Keith Bullock feels like he has emerged from despair to a new life. His analogy is one from nature, “I feel like I went from a caterpillar to a butterfly.”

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.