CT Money Follows the Person Quarterly Report

Quarter 2 2018: April 1, 2018 – June 30, 2018

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

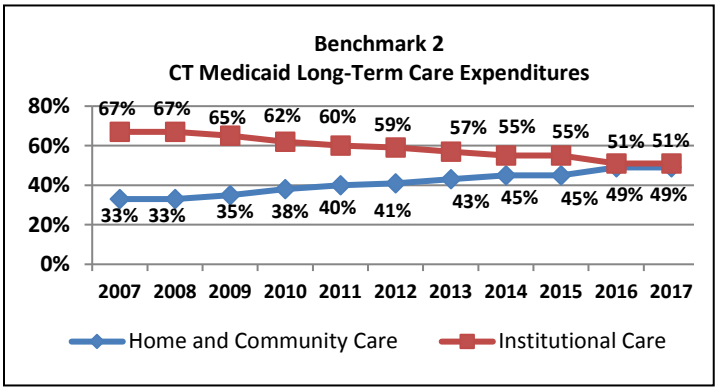
UConn Health, Center on Aging

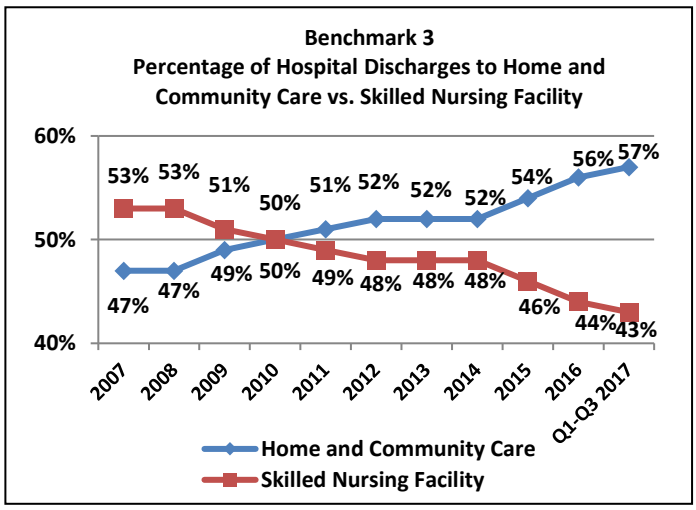
Operating Agency: *CT Department of Social Services* **Funder:** *Centers for Medicare and Medicaid Services*

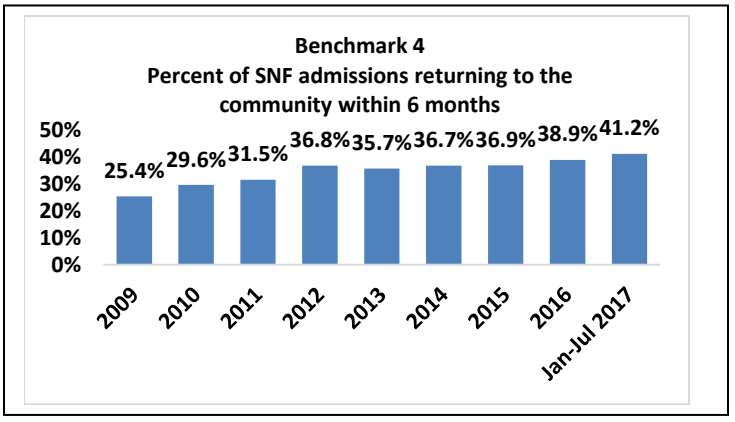
MFP Benchmarks

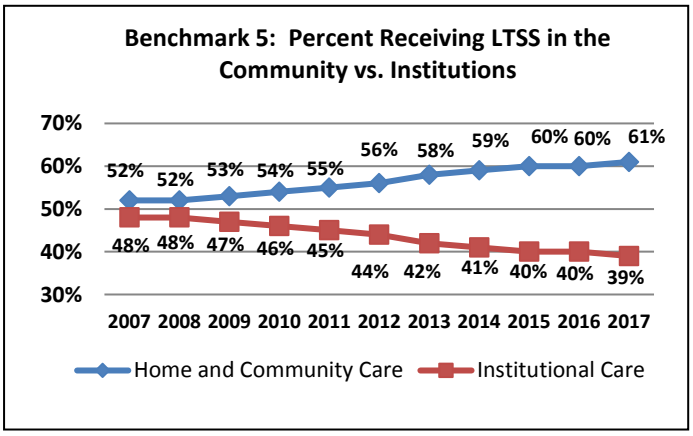
1) Transition 5200 people from qualified institutions to the community
2) Increase dollars to home and community based services
3) Increase hospital discharges to the community rather than to institutions
4) Increase probability of returning to the community during the six months following nursing home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

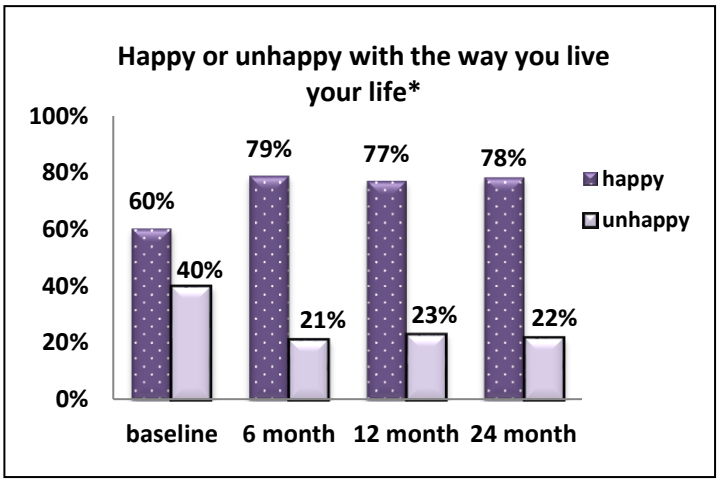
Benchmark 1: The number of demonstration consumers transitioned = 4,800 (non-demonstration transitions = 330)



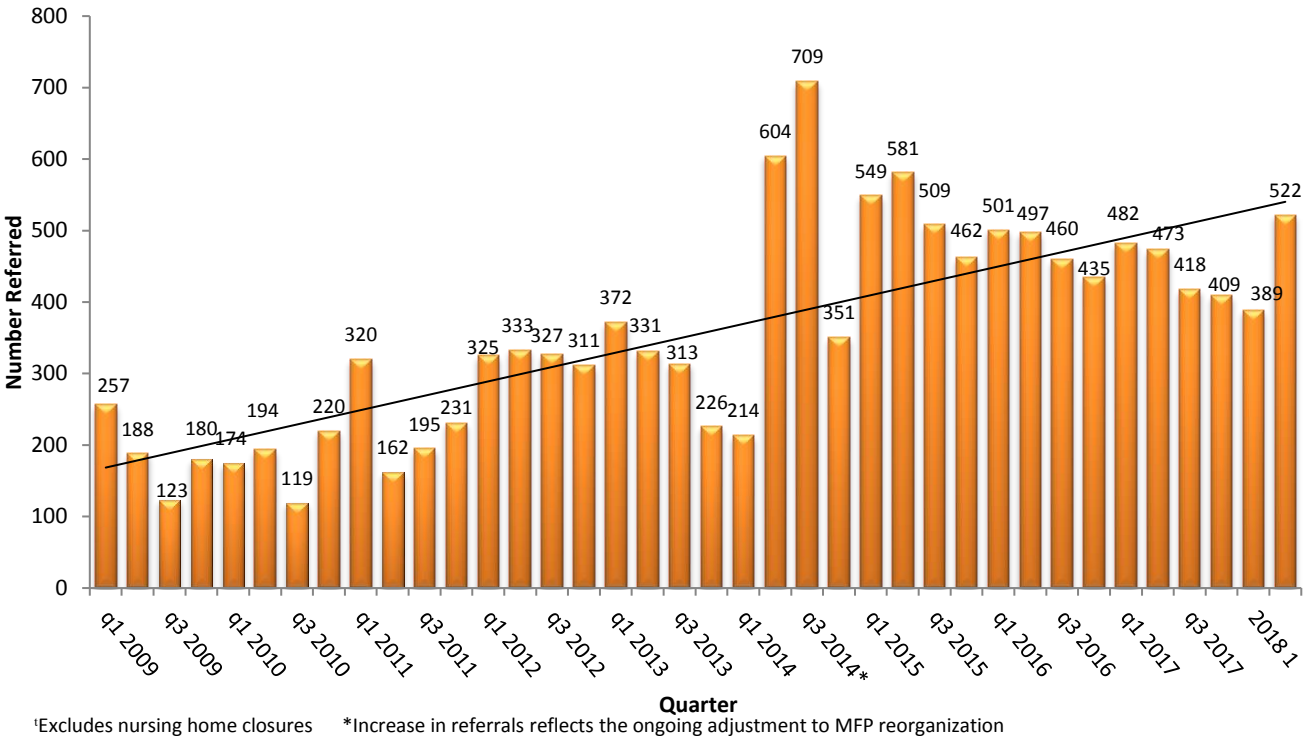






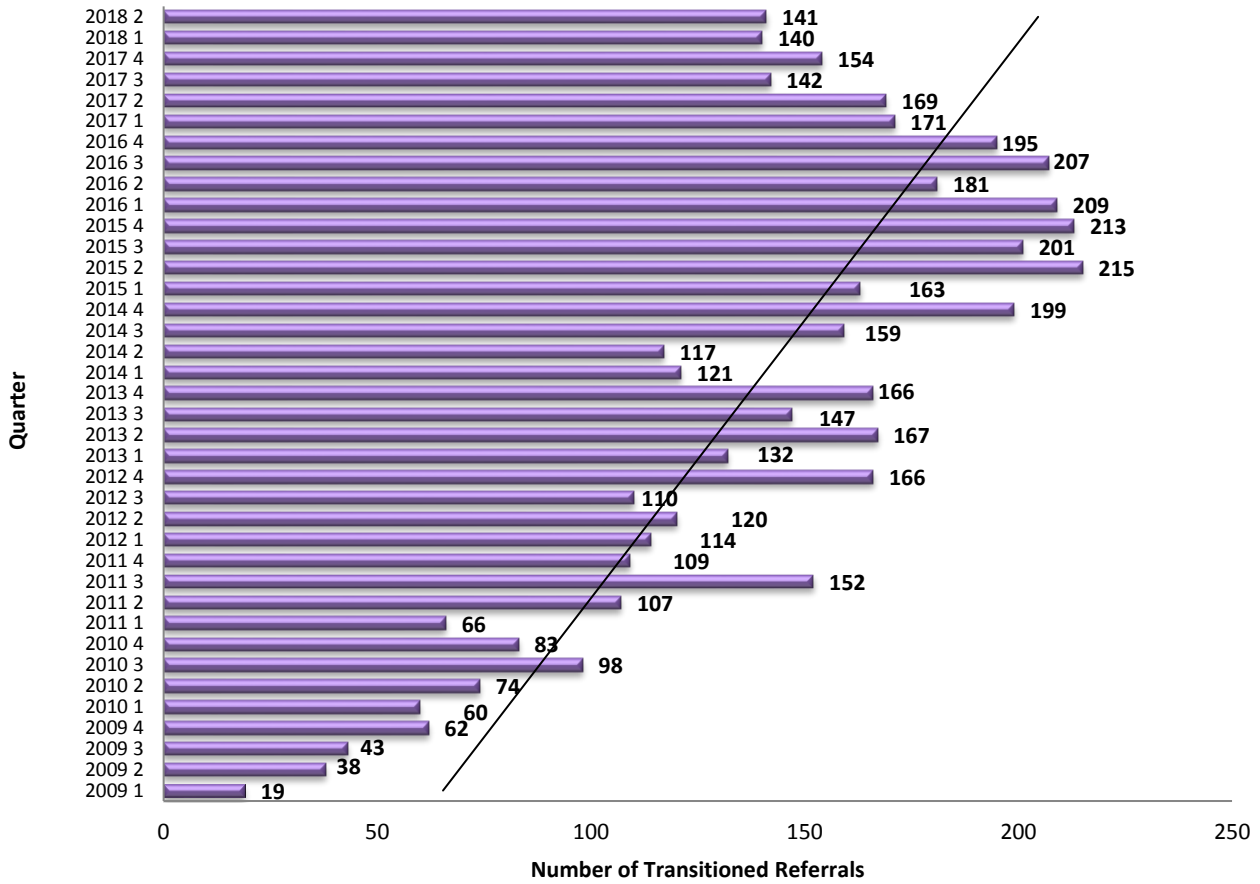


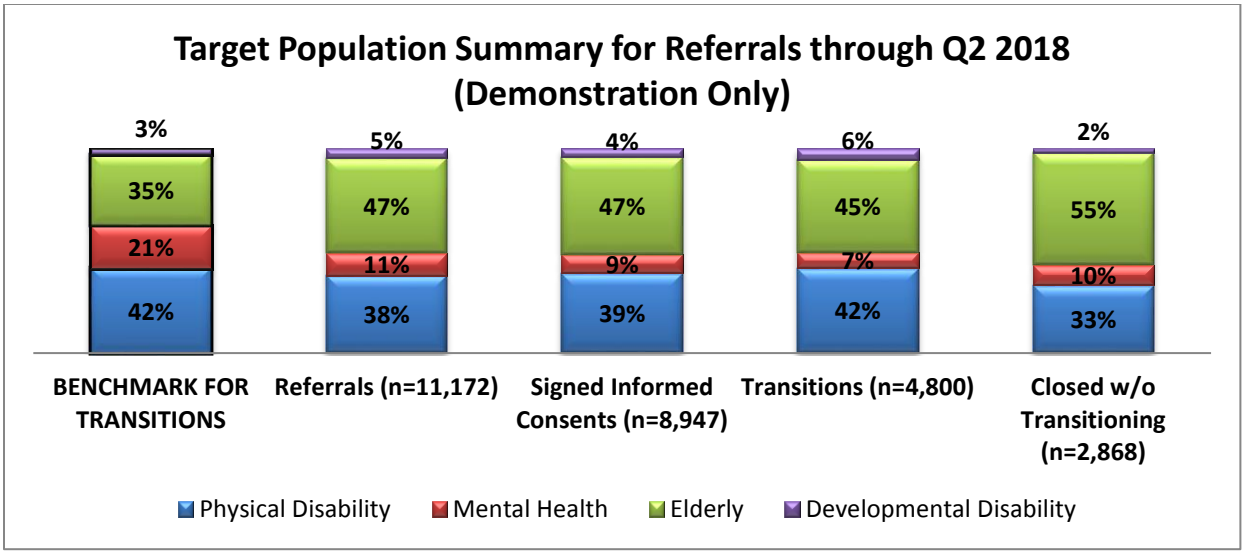
Referrals to Transition Coordinators[t]: Q1 2009 to Q2 2018

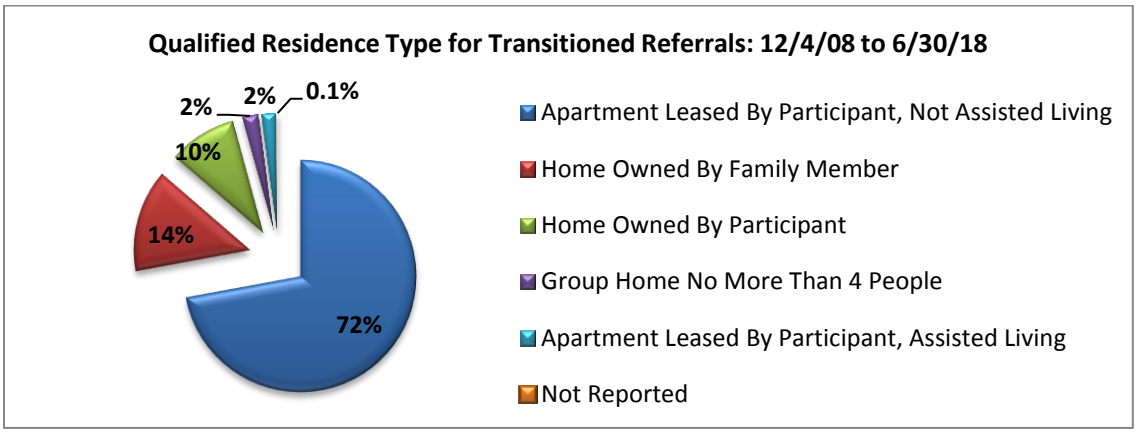


[t]Excludes nursing home closures *Increase in referrals reflects the ongoing adjustment to MFP reorganization

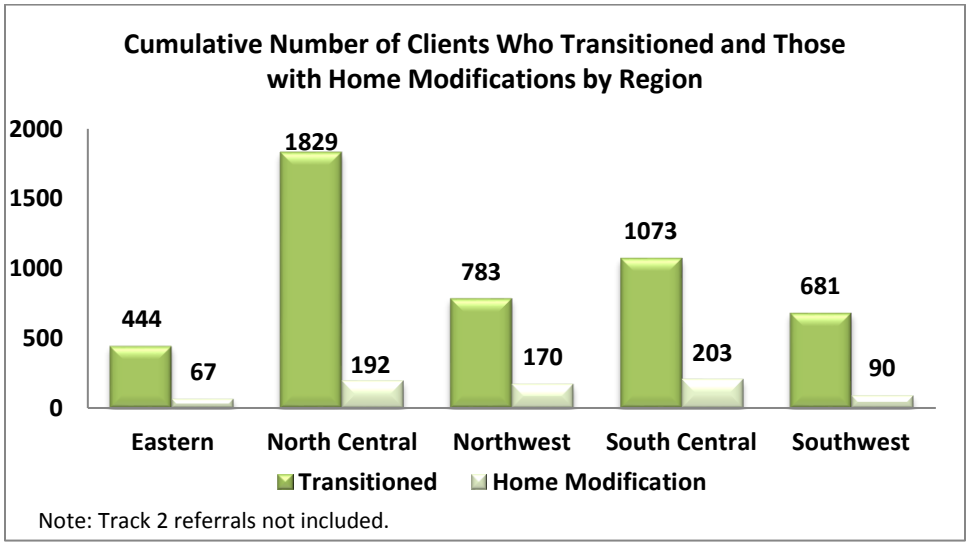
Number of Transitions by Quarter: 12/2008 - 6/30/2018



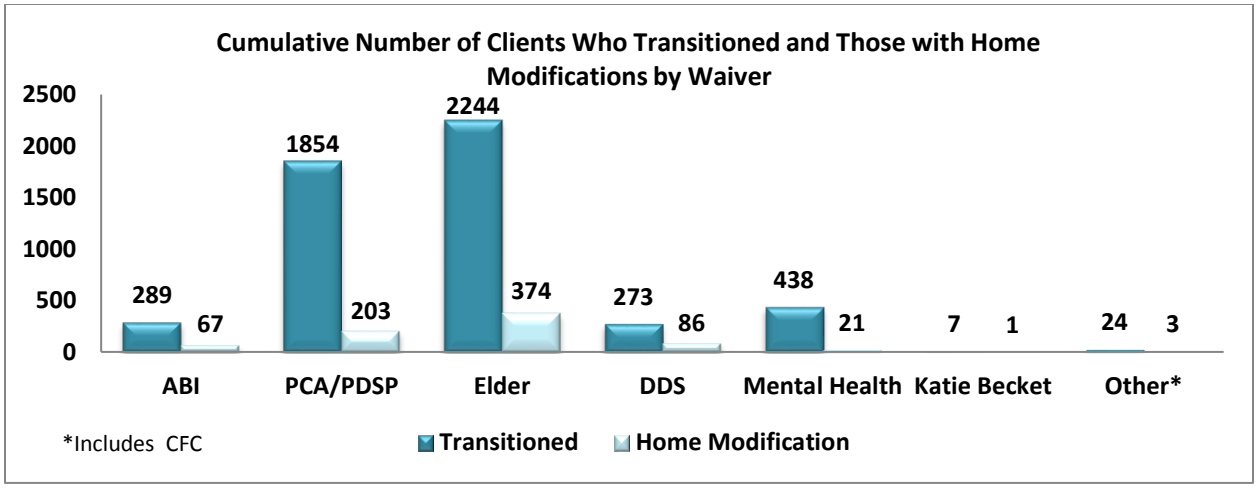


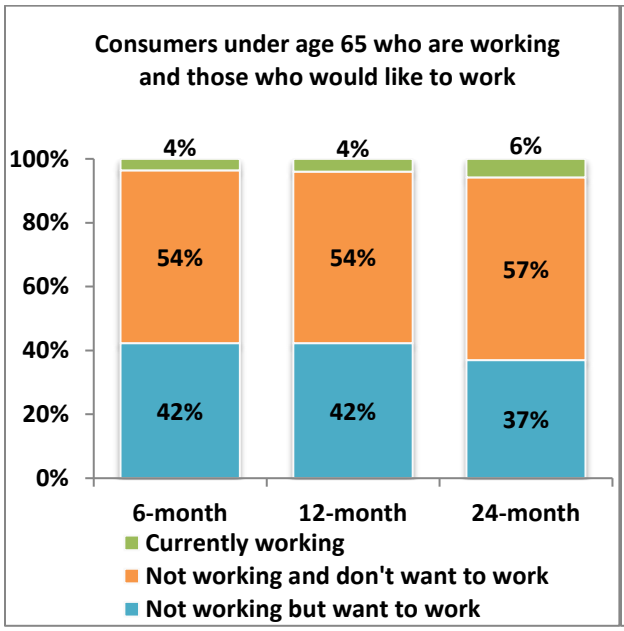


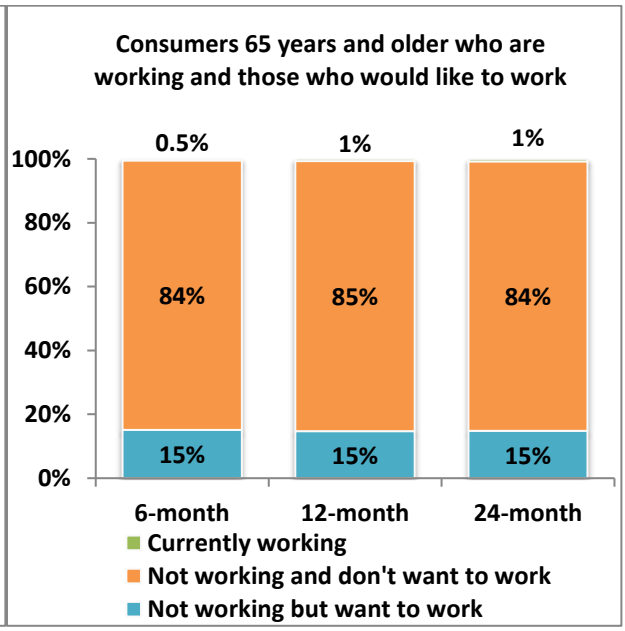
Reinstitutionalization: 12% (532) of participants who transitioned by June 30, 2017 were in an institution 12 months after their transition.*

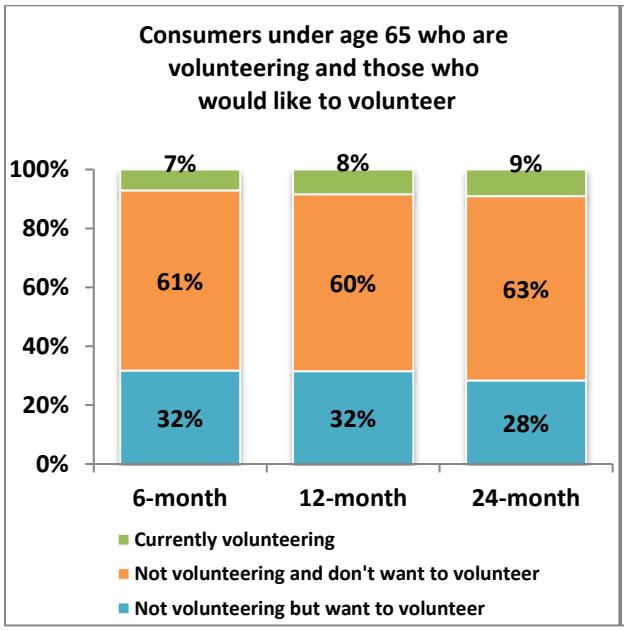


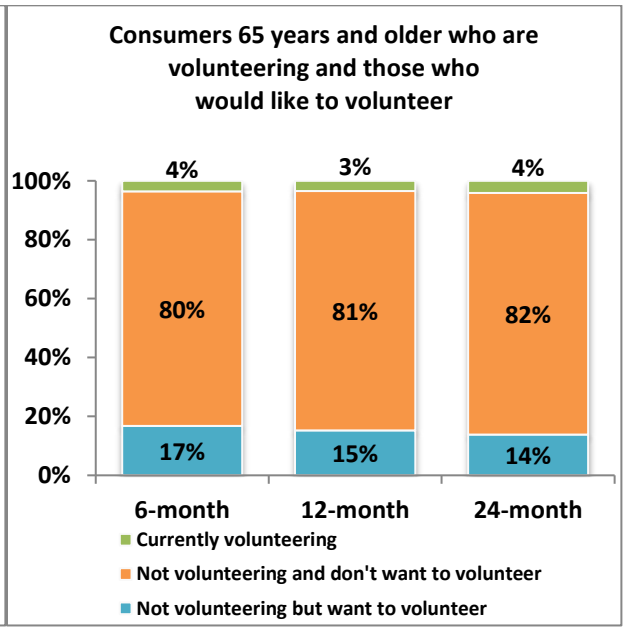
*Corrected calculation


Cumulative Number of Clients Who Transitioned and Those with Home Modifications by Waiver
2500
2000
1500
1000
500
0
289
67
1854
203
2244
374
273
86
438
21
7
1
24
3
ABI
PCA/PDSP
Elder
DDS
Mental Health
Katie Becket
Other*
*Includes CFC
Transitioned
Home Modification

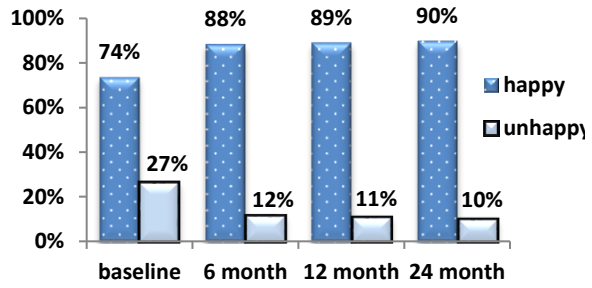

Consumers under age 65 who are working and those who would like to work
100%
80%
60%
40%
20%
0%
4%
4%
6%
54%
54%
57%
42%
42%
37%
6-month
12-month
24-month
Currently working
Not working and don't want to work
Not working but want to work

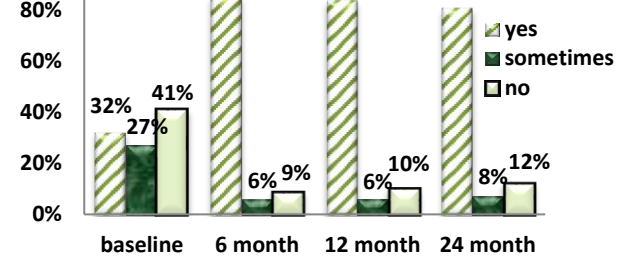

Consumers 65 years and older who are working and those who would like to work
100%
80%
60%
40%
20%
0%
0.5%
1%
1%
84%
85%
84%
15%
15%
15%
6-month
12-month
24-month
Currently working
Not working and don't want to work
Not working but want to work

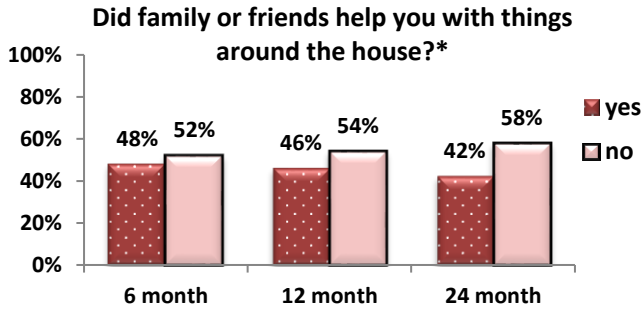

Consumers under age 65 who are volunteering and those who would like to volunteer
100%
80%
60%
40%
20%
0%
7%
8%
9%
61%
60%
63%
32%
32%
28%
6-month
12-month
24-month
Currently volunteering
Not volunteering and don't want to volunteer
Not volunteering but want to volunteer

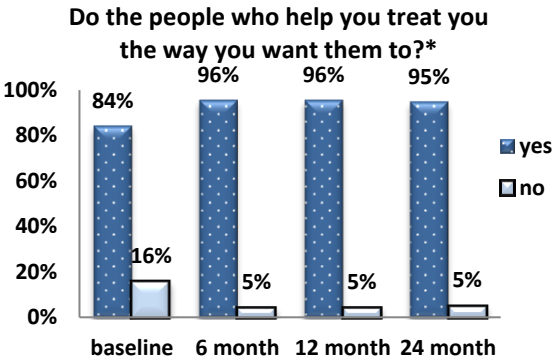

Consumers 65 years and older who are volunteering and those who would like to volunteer
100%
80%
60%
40%
20%
0%
4%
3%
4%
80%
81%
82%
17%
15%
14%
6-month
12-month
24-month
Currently volunteering
Not volunteering and don't want to volunteer
Not volunteering but want to volunteer

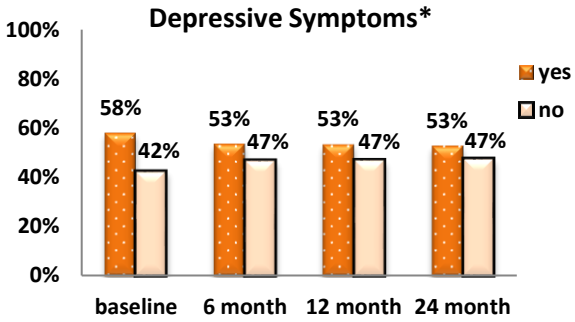
MFP Quality of Life Dashboard As of 06/30/2018

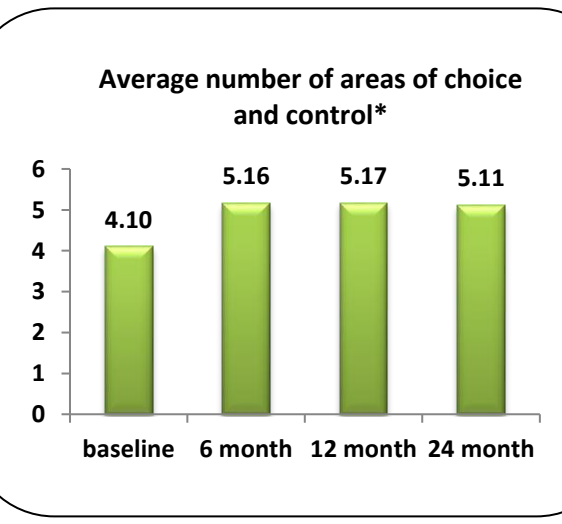


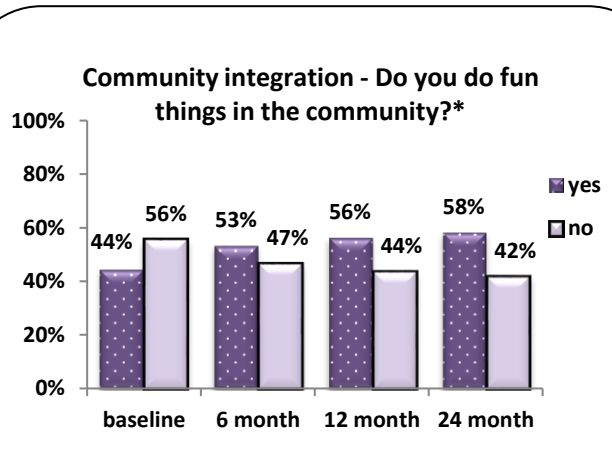












*indicates statistically significant differences

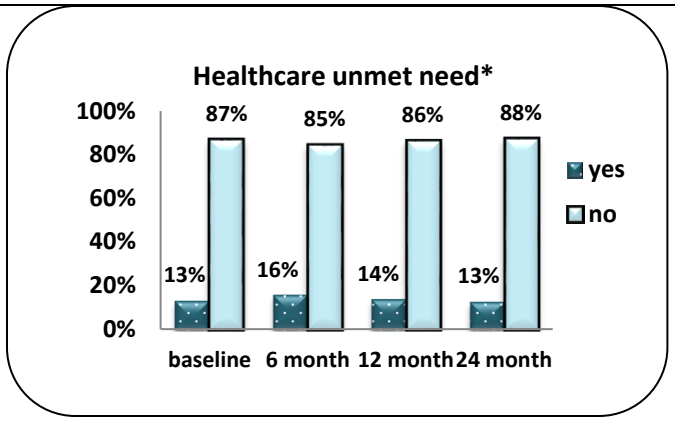
Quality of Life Interviews Completed
(Cumulative data through 06/30/18)

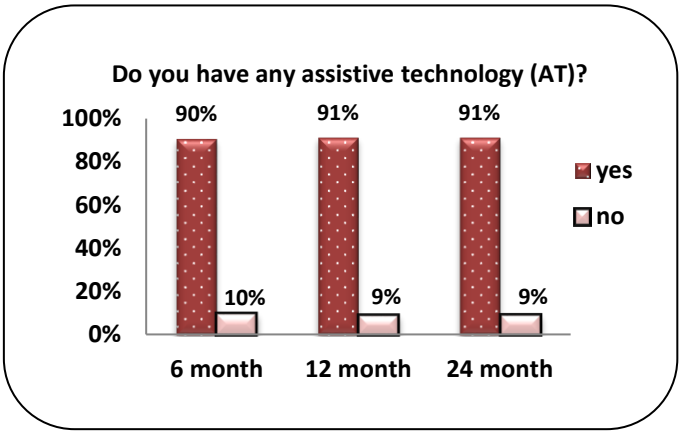
Baseline interviews done prior to transition, n=5193

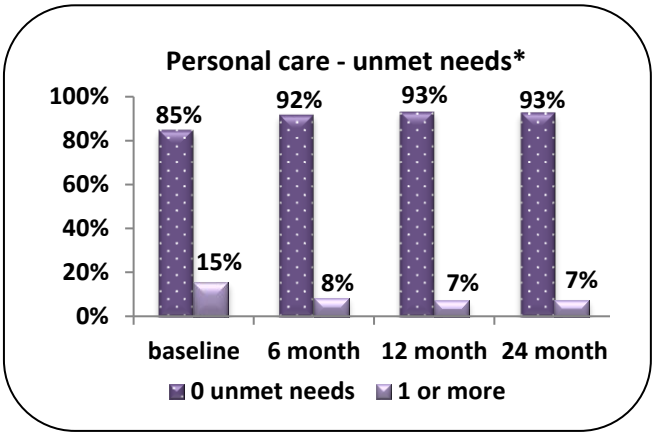
6 month interviews done 6 mos after transition, n=3977

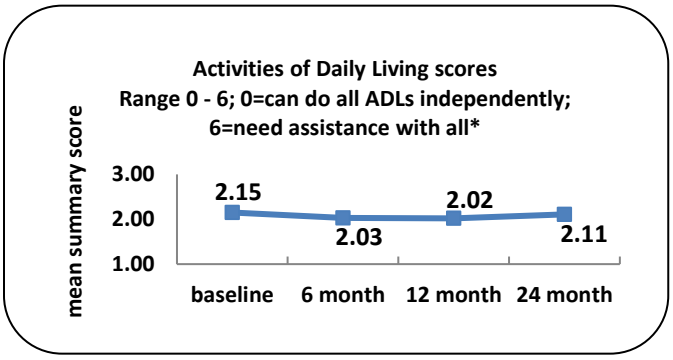
12 month interviews done 12 mos after transition, n=3589

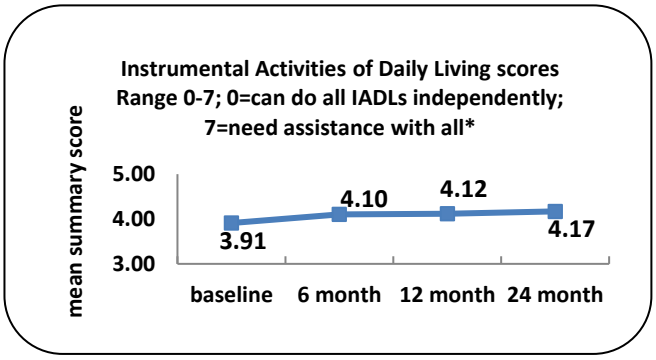
24 month interviews done 24 mos after transition, n=2673

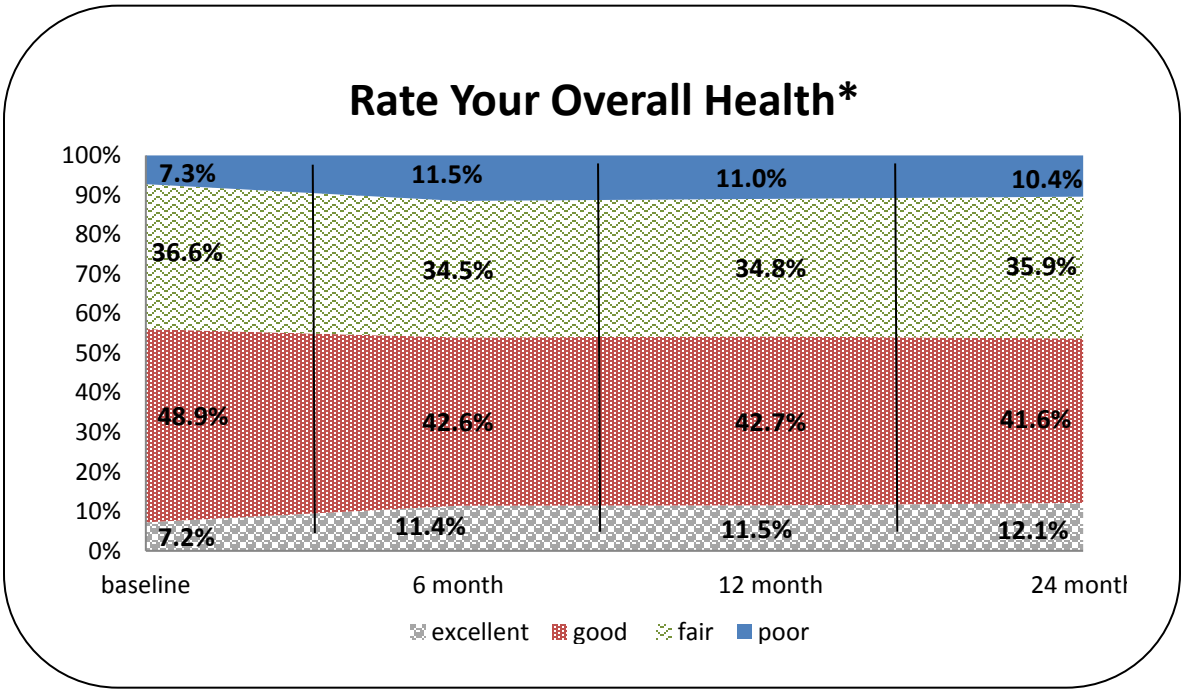


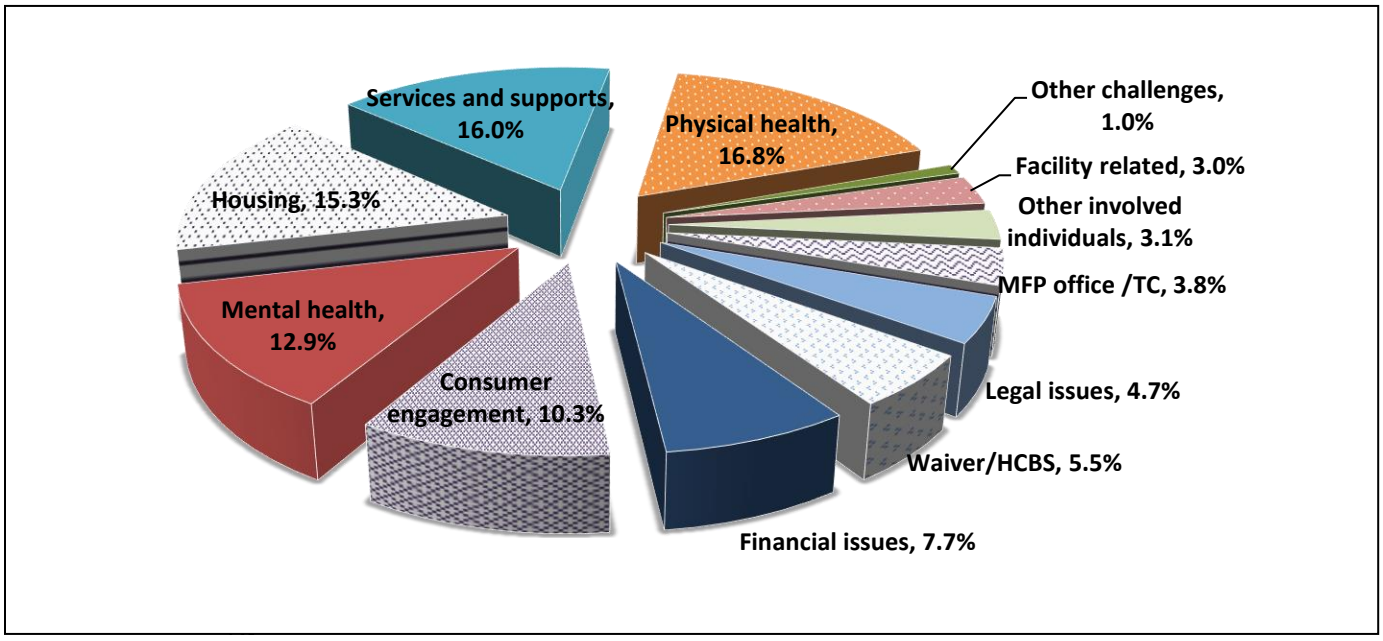












Transition Challenges through 6/30/18

Transition coordinators (TCs) and specialized care managers (SCMs) complete a standardized challenges checklist for each consumer. There were a total of 14,842 MFP referrals to SCM Supervisors. Challenges checklists were completed for 9,953 of these referrals, representing 9,120 consumers. Excluding the referrals which indicated "no challenges," the challenges checklist generated 61,867 separate challenges. Of these, the most frequently chosen challenge was physical health (16.8%), followed by challenges related services and supports (16.0%), to housing (15.3%), mental health (12.9%), and consumer engagement (10.3%).

Type of challenge by transition status

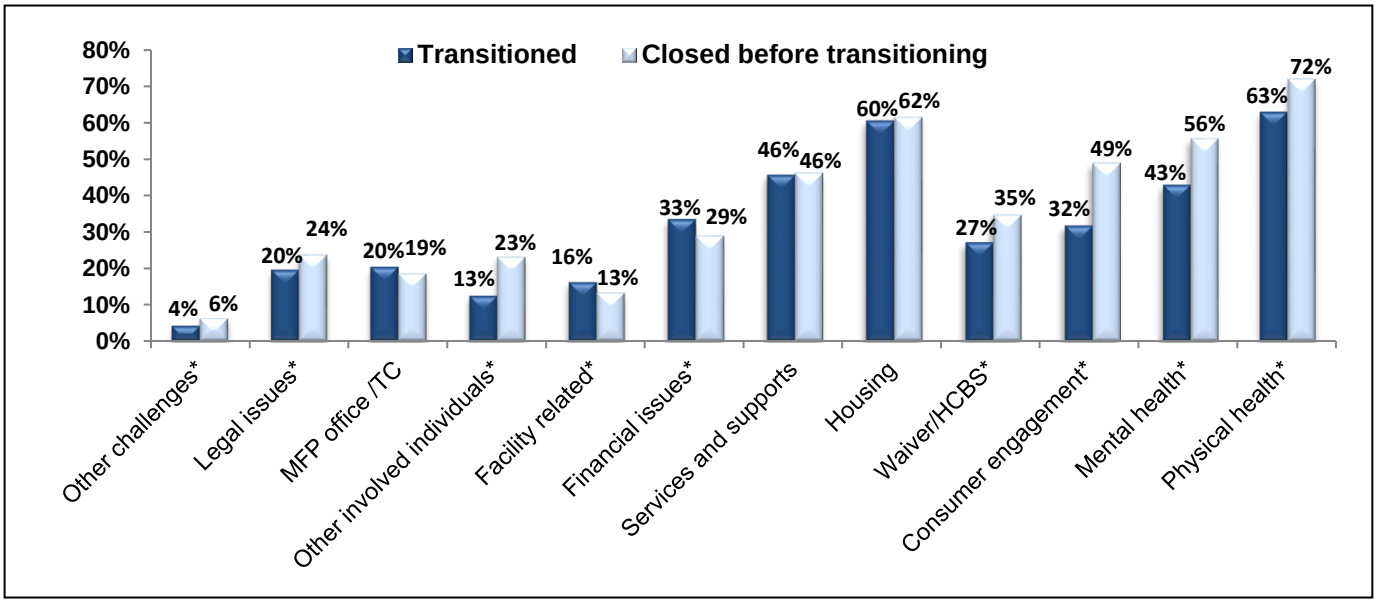
The figure below shows the percentage of each group (those who transitioned and those who closed before transitioning) which had each challenge. For example, of the referrals that closed without transitioning, 72 percent had a physical health challenge. Conversely, 63 percent of referrals that did transition 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

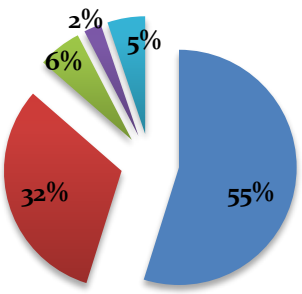
click on the Money Follows the Person tab



Types of Challenges – through 6/30/2018

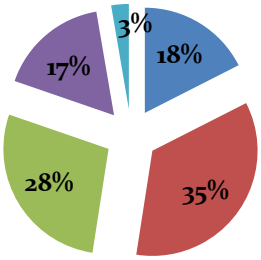
Shown below are the six most common challenge types

Physical health



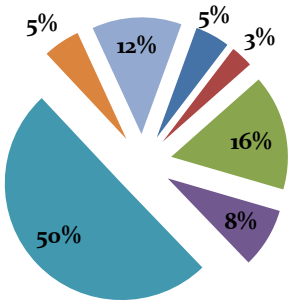
- Current, new or undisclosed physical health problem
- Inability to manage physical disability or physical illness in community
- Medical testing issues or delays
- Missing or waiting for physical health documents
- Other physical health issues

Mental health



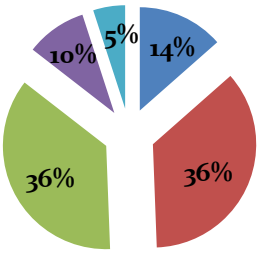
- Current or history of substance/alcohol abuse w/ risk o relapse
- Current, new, or undisclosed mental health problem
- Dementia or cognitive issues
- Inability to manage mental health in community
- Other mental health issues

Housing



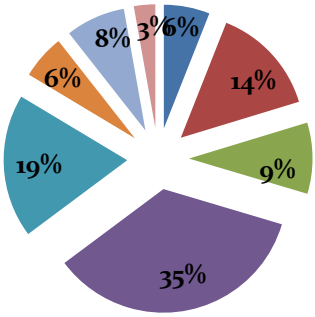
- Delays related to housing authority, agency or housing coordinator
- Delays related to lease, landlord, apartment manager, etc.
- Needs housing modifications before transition
- Ineligible or waiting for approval from RAP or other housing programs
- Lacks affordable, accessible community housing
-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

Consumer engagement



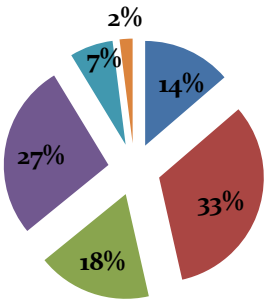
- Disengagement or lack/loss of motivation
- Lack of awareness or unrealistic expectations
- Lack of independent living skills
- Language or communication skills
- Other consumer related issues

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

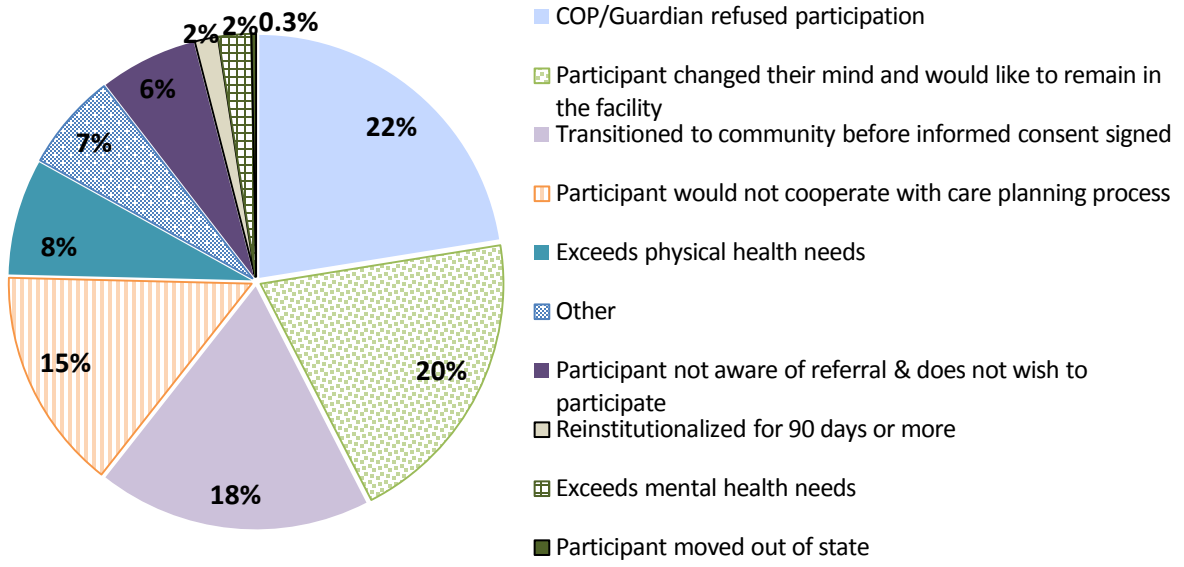
Financial



- 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

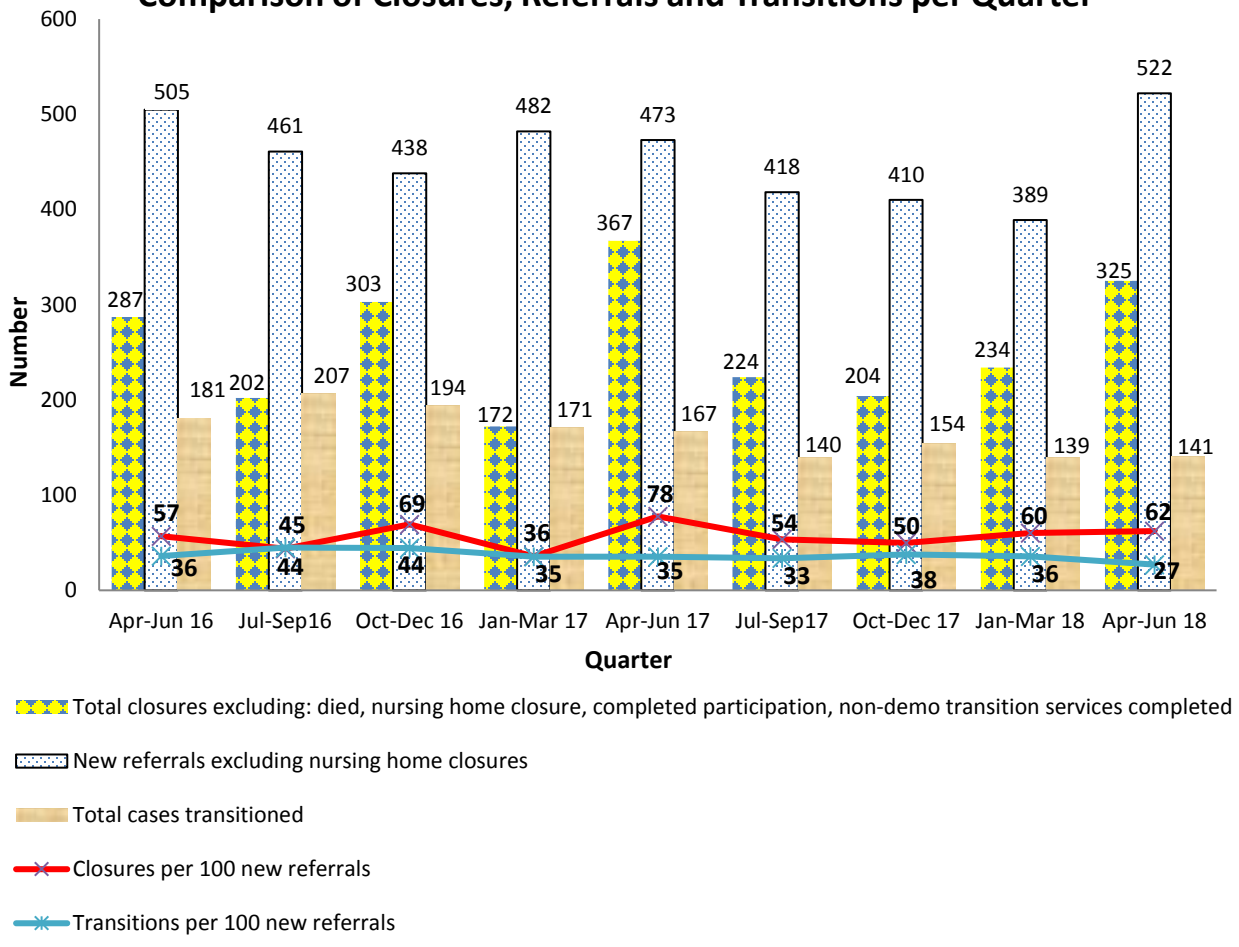
For the full report on transition challenges through 6/30/2018, use the link on page 7 to get to the Center on Aging website.

Percentage of Closed Cases by Closure Reason: April-June 2018



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

Comparison of Closures, Referrals and Transitions per Quarter



Rosalyn Reid's Story

Four years ago Roslyn Reid was living with her husband in the state of Pennsylvania. She was surrounded by an extensive network of friends, many of whom she met through her involvement in the local church. Unfortunately while living here, Roslyn lost her husband and her family and friends began noticing changes in her speech, walking, and behaviors. Eventually, it was determined that Roslyn had been having mini strokes and multiple aneurisms in her brain. The many medications combined with her daily symptoms were hard to manage on her own.

Roslyn's family was living in New York and Connecticut, and knew she needed to be with them for her safety and well-being. Upon moving here, she lived with her brother Kevin and his wife but it soon became clear that Roslyn was in need of 24 hour care, which they were unequipped to provide at the time. In a pinch, it seemed they had no choice other than for Roslyn to move into a skilled nursing facility for the time being.

Despite her satisfaction with the care she received, Roslyn found herself in a state of sadness with a diminished sense of independence. Towards the end of her stay at the nursing home, she was even treated for depression. She wanted to live in her own home again where she could be free to come and go and make choices for herself. Roslyn's family wanted nothing more than to see her happy and to bring out the vibrant woman Roslyn was once again. They began discussing Roslyn's discharge with the facility social worker and were introduced to the Money Follows the Person program. She qualified for the acquired brain injury waiver which provides multiple services including respite care, hours for a personal care assistant, and even monetary compensation for Roslyn's daughter who would be living with and caring for her mother every day. Most recently, the program provided an iPad that allows Roslyn to play games and do exercises that help strengthen her brain. Fortunately for Roslyn, her brother Kevin is a realtor and while these services were being arranged, he was able to find her a beautiful apartment.

With the help of a care manager and transition coordinator from Money Follows the Person, the transition into her new apartment instigated an immediate change in Roslyn's attitude and personality. She has found a new sense of independence and motivation that has improved her overall happiness ten-fold, even allowing her to stop taking the anti-depressants that she was prescribed at the nursing home. She can now do the things she really enjoys such as shopping for herself, adding personal touches to her apartment, going for walks, and hanging out at the park. She is able to visit specialty doctors for things that could not be addressed before and as a result her overall health and well-being have also improved. Most importantly to Roslyn, she is also now surrounded and cared for by her family and has the option to visit those who live in other areas. Kevin summed up his sister's success with the program stating, "This program has provided a significant quality of life change that is night and day."

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.