

# CT Money Follows the Person Quarterly Report

Quarter 4 2018: October 1, 2018 – December 31, 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

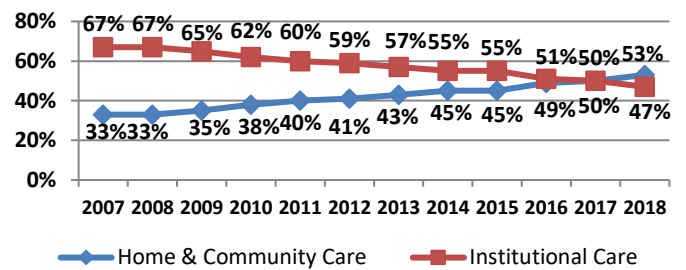
### MFP Benchmarks

- 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

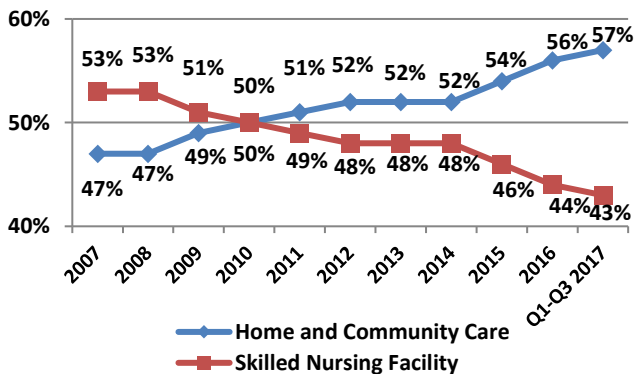
**Benchmark 1: The number of demonstration consumers transitioned = 5,074 (non-demonstration transitions = 351)**

### Benchmark 2

CT Medicaid Long-Term Care Expenditures

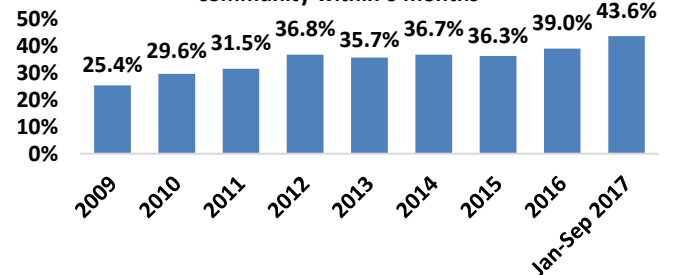


### Benchmark 3 Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility

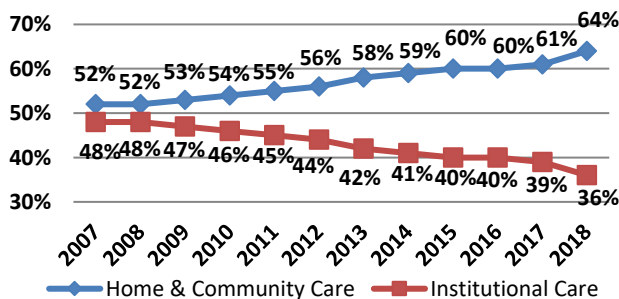


### Benchmark 4

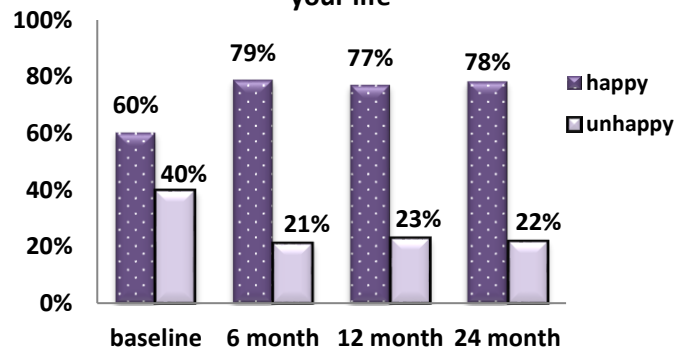
Percent of SNF admissions returning to the community within 6 months



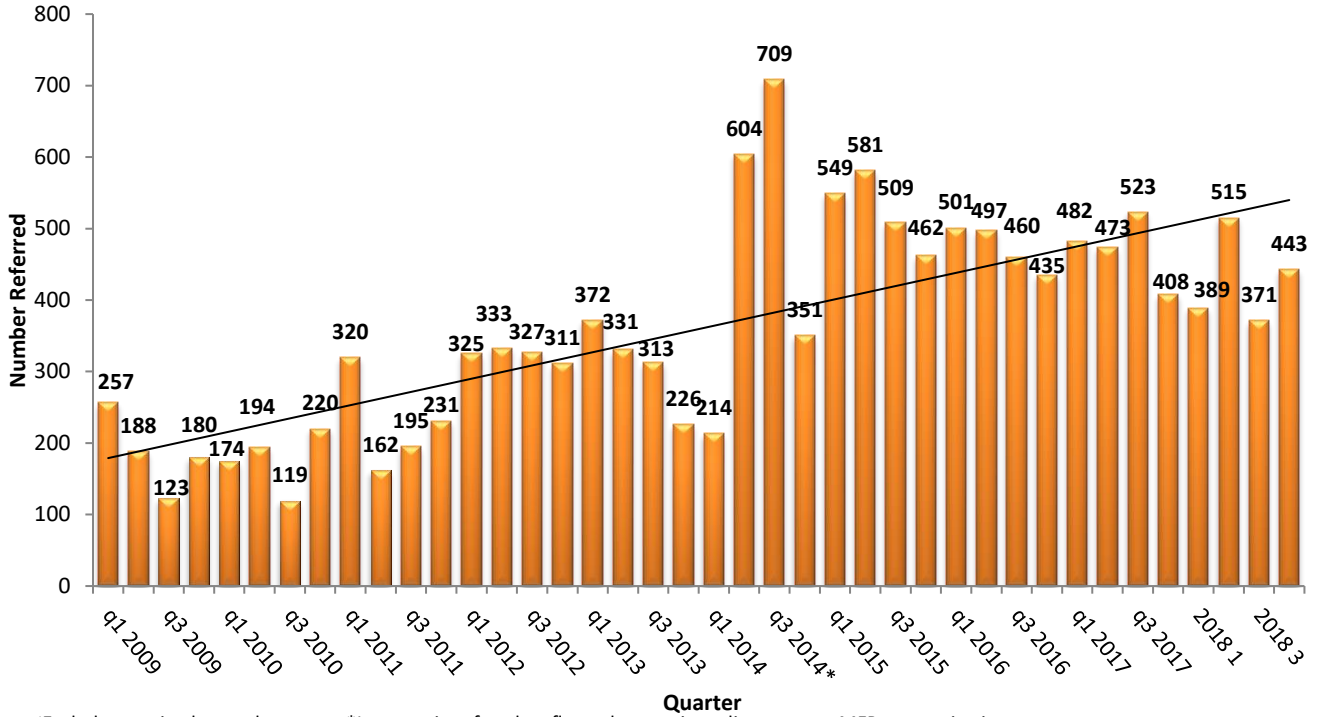
### Benchmark 5: Percent Receiving LTSS in the Community vs. Institutions



### Happy or unhappy with the way you live your life\*

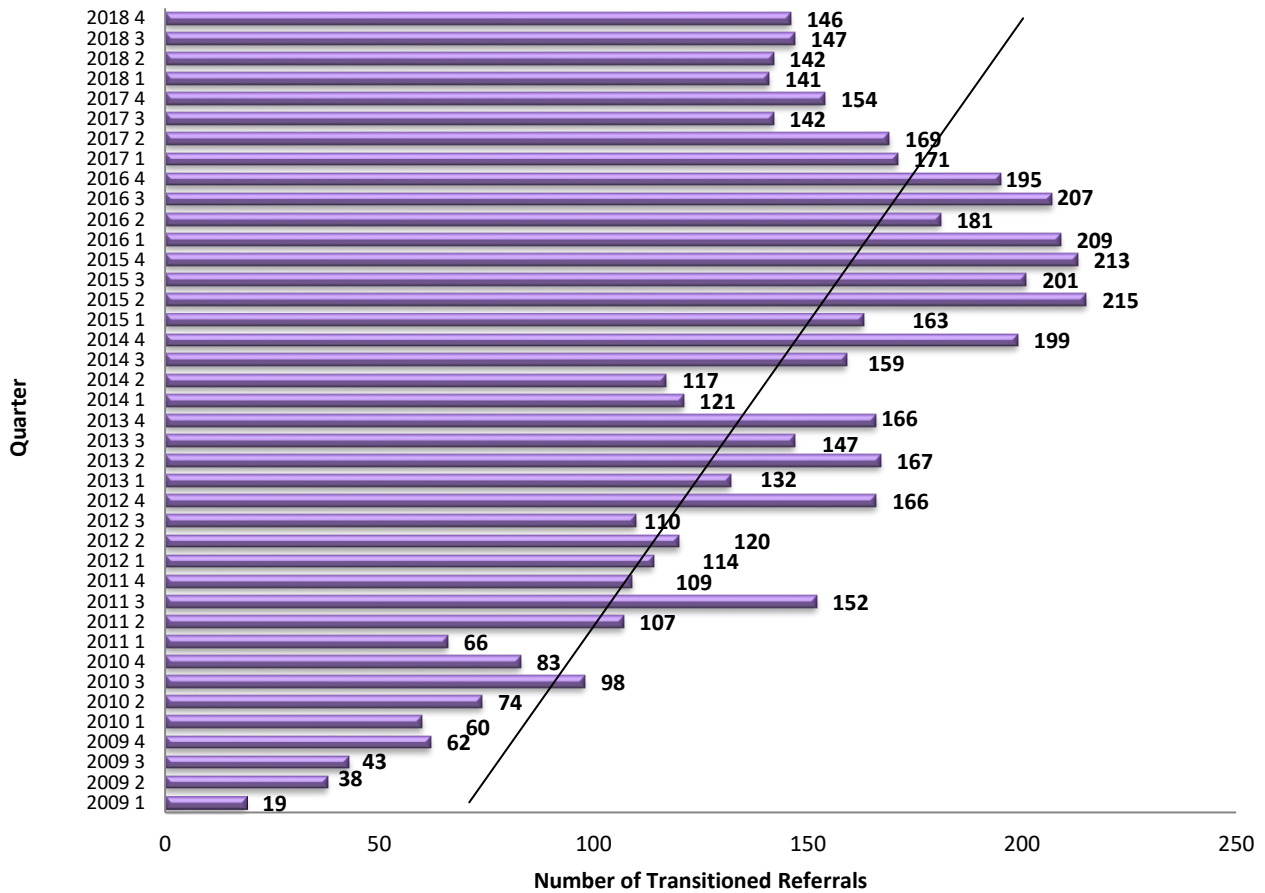


## Referrals to Transition Coordinators<sup>t</sup>: Q1 2009 to Q4 2018

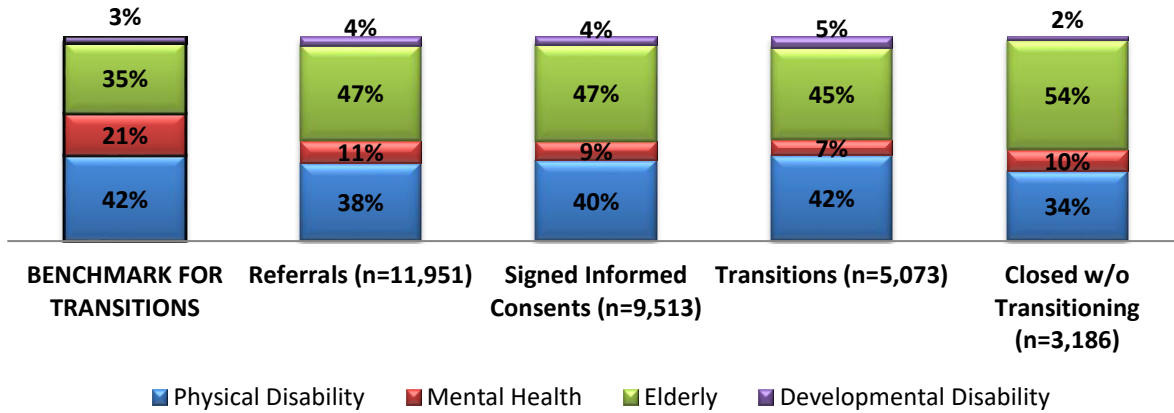


<sup>t</sup>Excludes nursing home closures    \*Increase in referrals reflects the ongoing adjustment to MFP reorganization

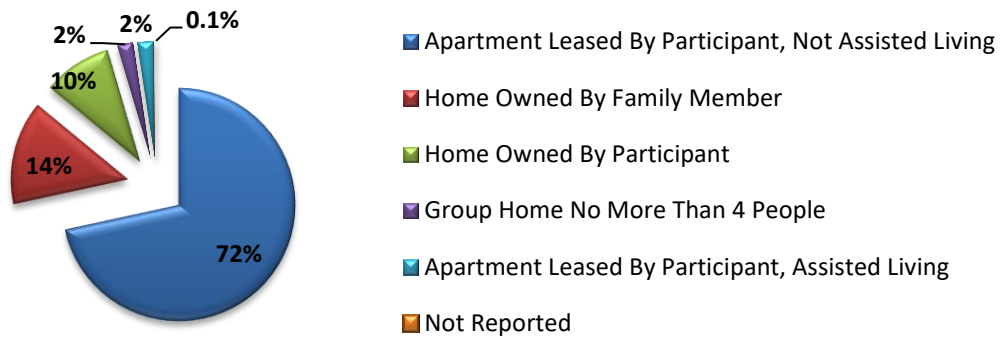
## Number of Transitions by Quarter: 12/2008 - 12/31/2018



### Target Population Summary for Referrals through Q4 2018 (Demonstration Only)

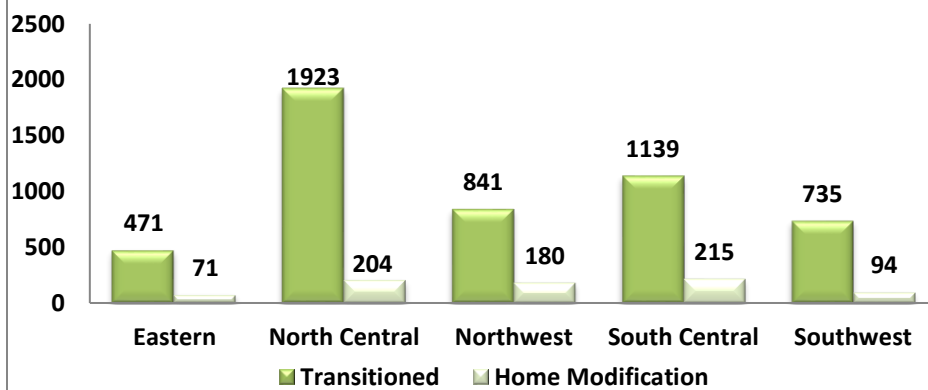


### Qualified Residence Type for Transitioned Referrals: 12/4/08 to 12/31/18

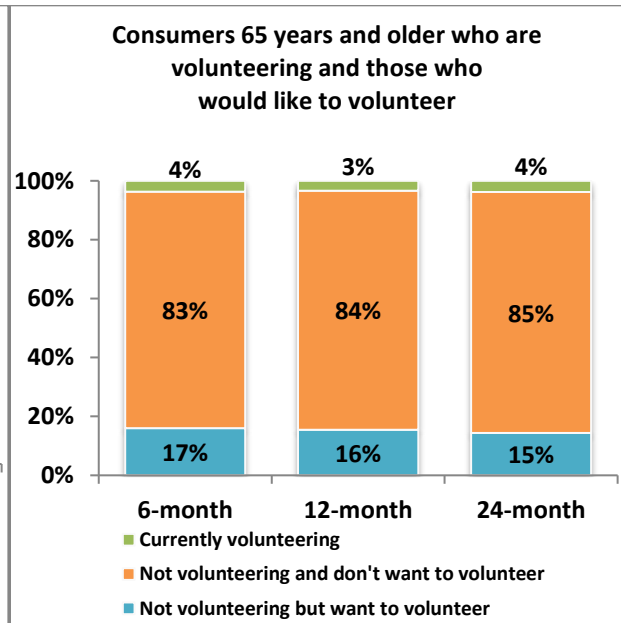
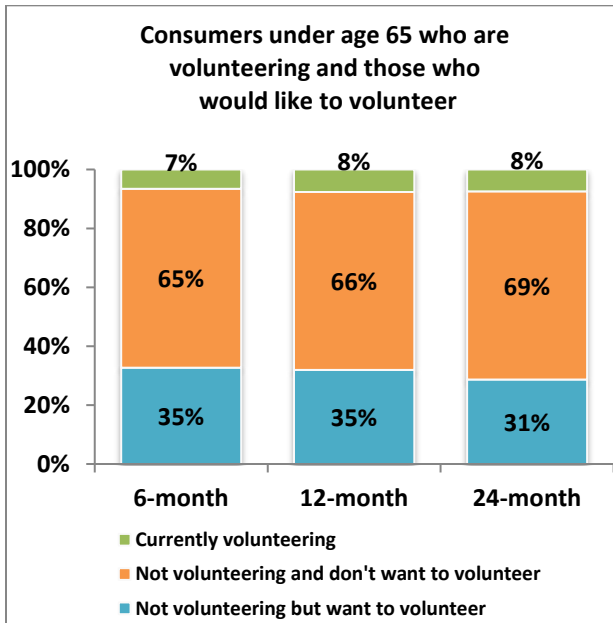
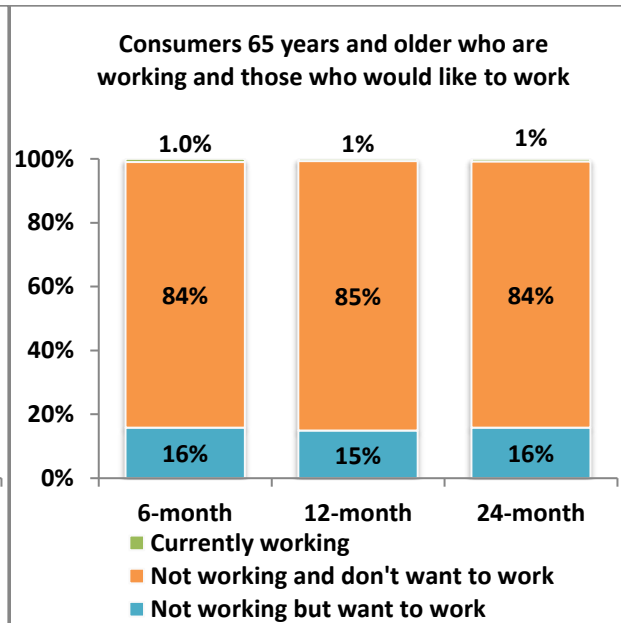
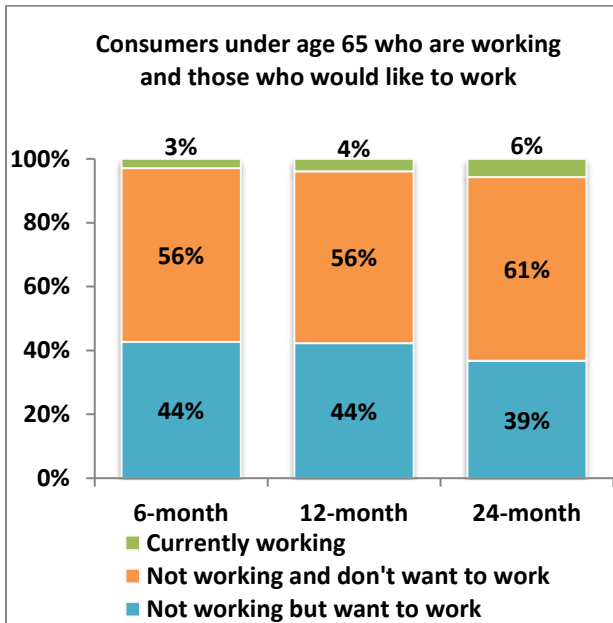
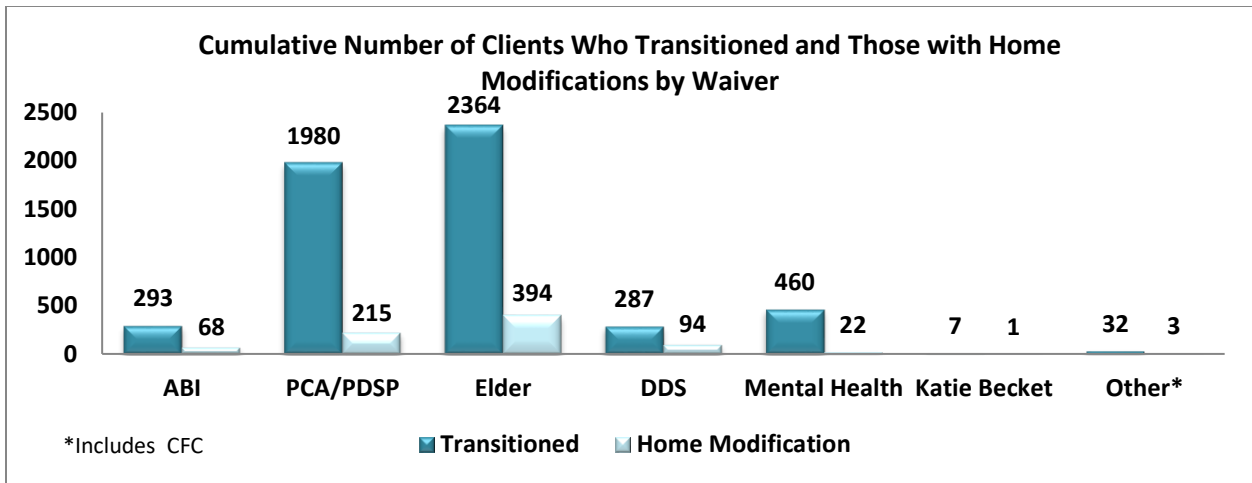


**Reinstitutionalization:** 12% (558) of participants who transitioned by December 31, 2017 were in an institution 12 months after their transition.

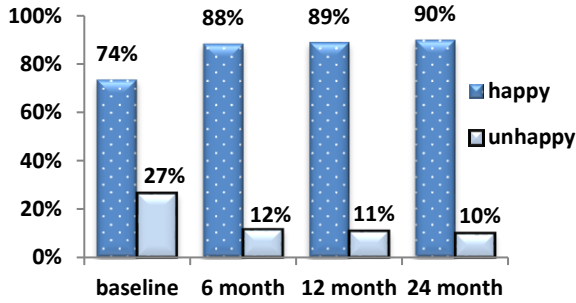
### Cumulative Number of Clients Who Transitioned and Those with Home Modifications by Region



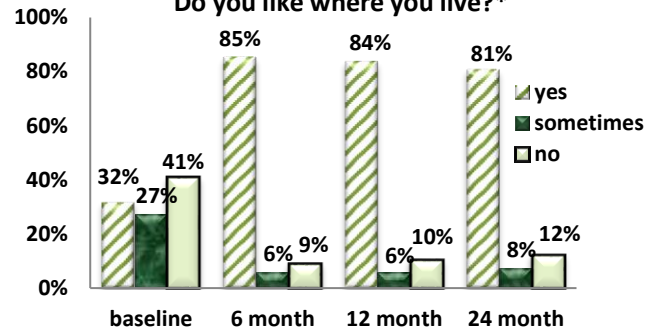
Note: Track 2 referrals not included.



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

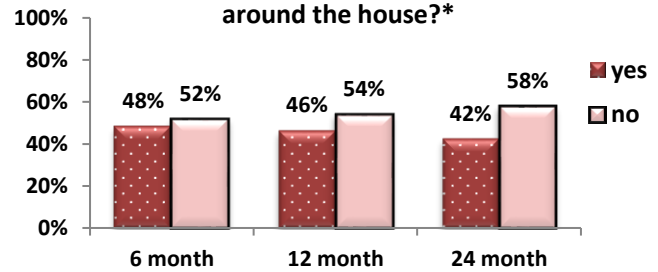


**Do you like where you live?\***

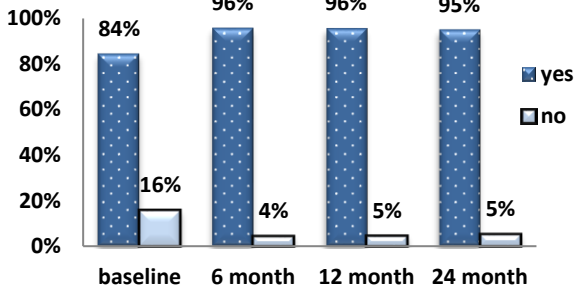


**MFP  
Quality of Life  
Dashboard  
As of  
12/31/2018**

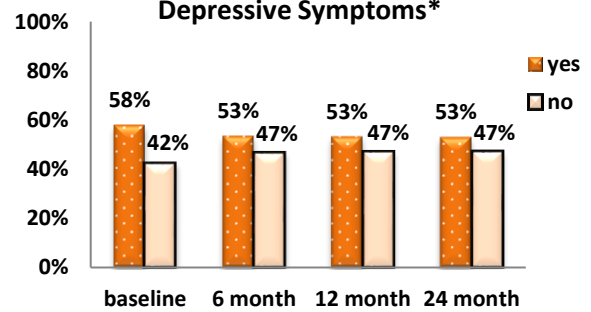
**Did family or friends help you with things around the house?\***



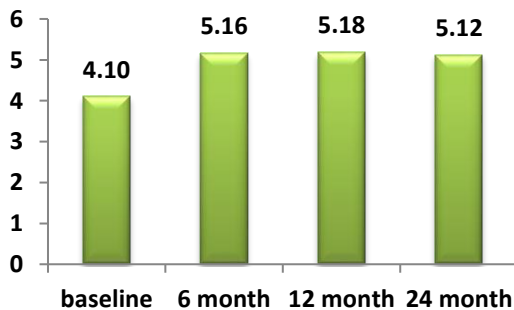
**Do the people who help you treat you the way you want them to?\***



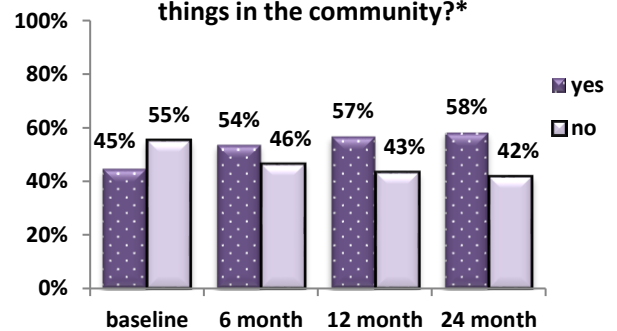
**Depressive Symptoms\***



**Average number of areas of choice and control\***



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



\*indicates statistically significant differences

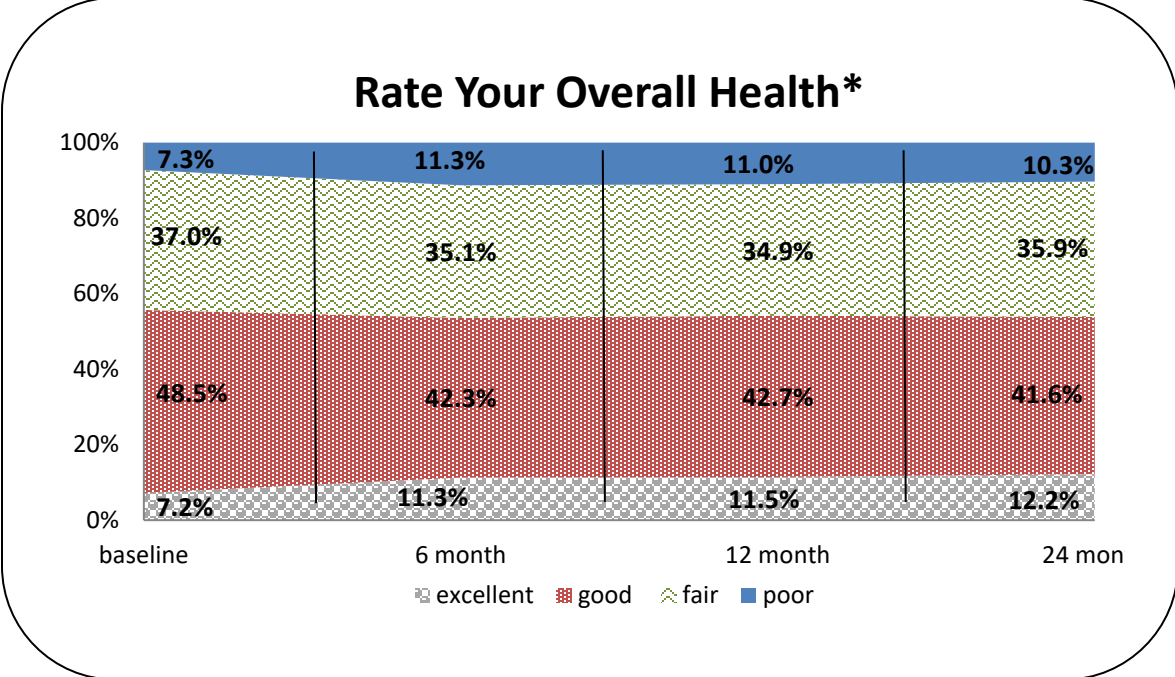
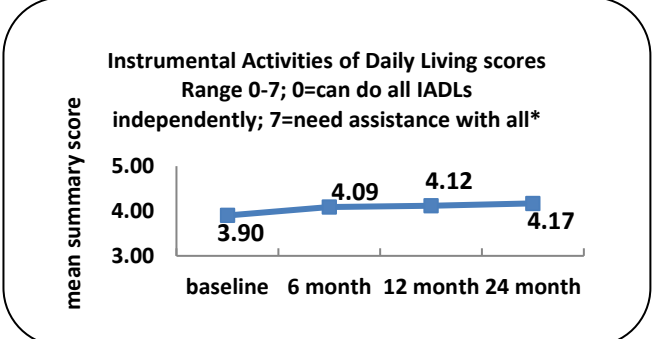
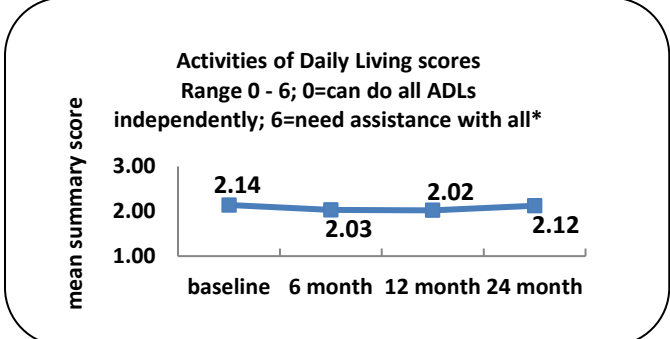
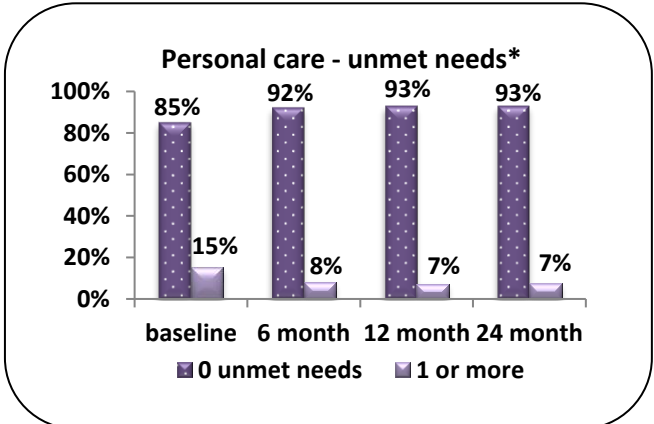
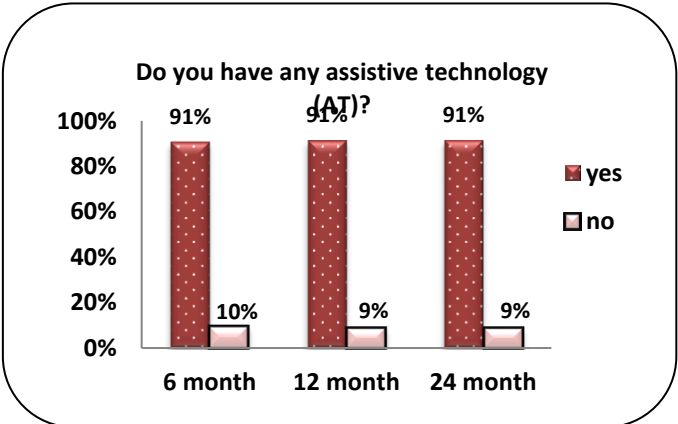
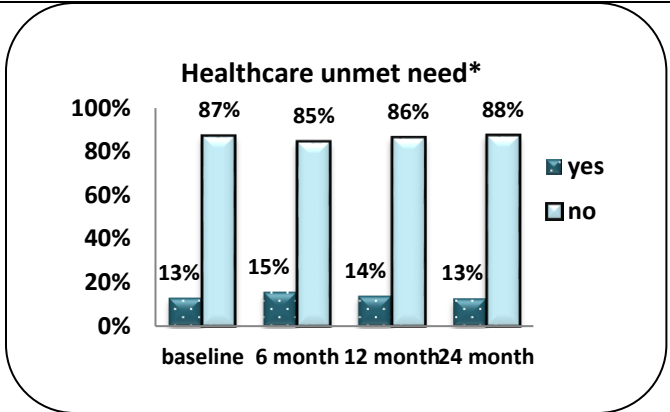
**Quality of Life Interviews Completed**  
(Cumulative data through 12/31/18)

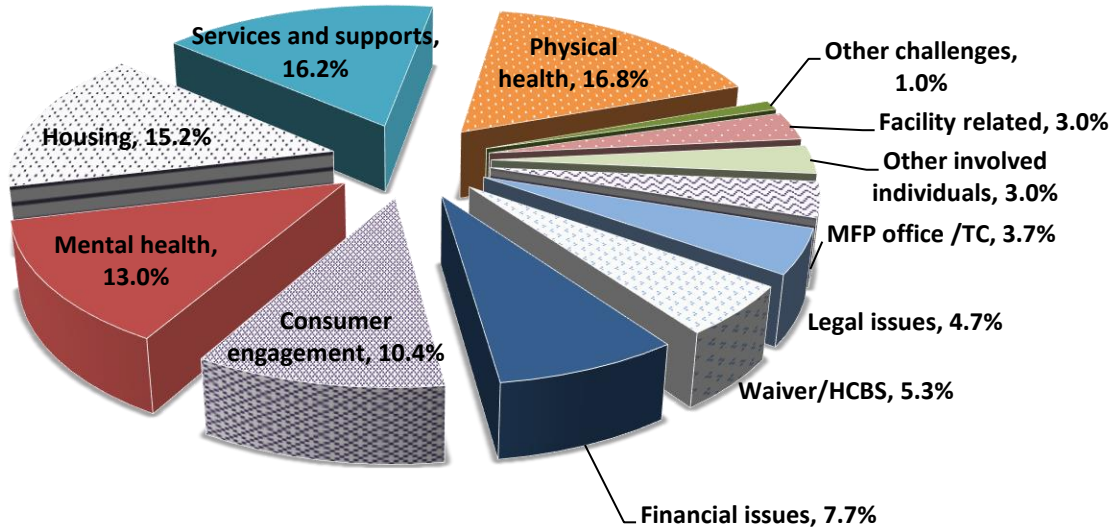
**Baseline interviews** done prior to transition, n=5460

**6 month interviews** done 6 mos after transition, n=4220

**12 month interviews** done 12 mos after transition, n=3824

**24 month interviews** done 24 mos after transition, n=2906





### Transition Challenges through 12/31/18

Transition coordinators (TCs) and Specialized Care Managers (SCMs) complete a standardized challenges checklist for each consumer. There were a total of 15,667 MFP referrals to SCM Supervisors. Challenges checklists were completed for 10,532 of these referrals, representing 9,627 consumers. Excluding the referrals which indicated “no challenges,” the challenges checklist generated 66,665 separate challenges. Of these, the most frequently chosen challenge was physical health (16.8%), followed by challenges related services and supports (16.2%), to housing (15.2%), mental health (13.0%), and consumer engagement (10.4%).

### Type of challenge by transition status

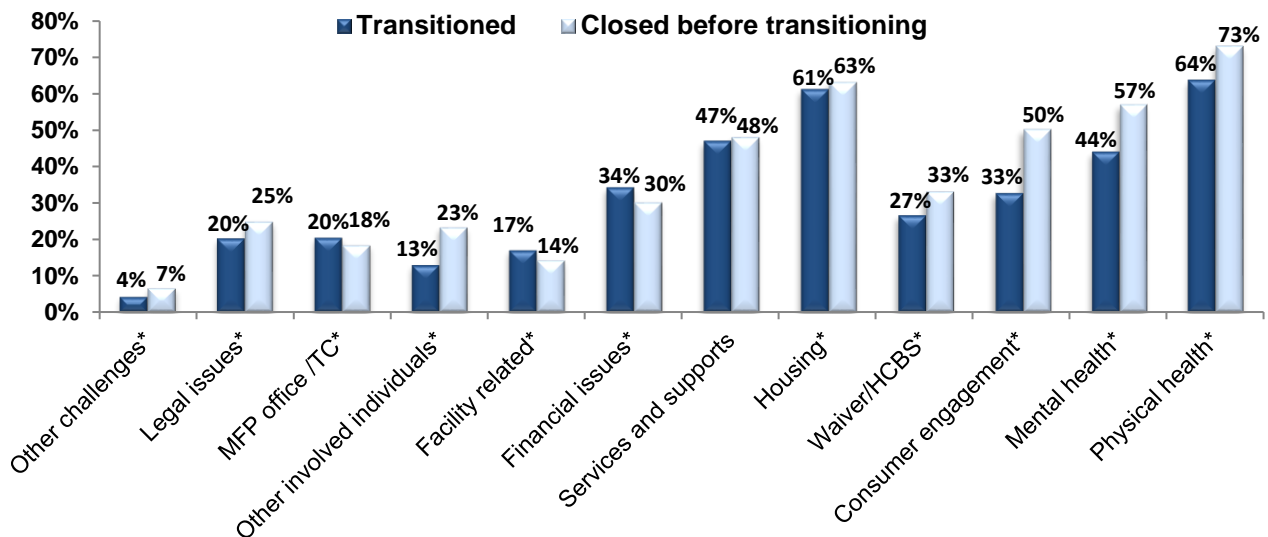
The figure below shows the percentage of each group (those who transitioned and those who closed before transitioning) which had each challenge. For example, of the referrals that closed without transitioning, 73 percent had a physical health challenge. Conversely, 64 percent of referrals that did transition had physical health challenges.

Eleven of the twelve challenge categories had statistically significant differences between the two groups.

Be sure to check the [LINK](http://health.uconn.edu/aging/research-reports) to the full Transition Challenges report.

<http://health.uconn.edu/aging/research-reports>

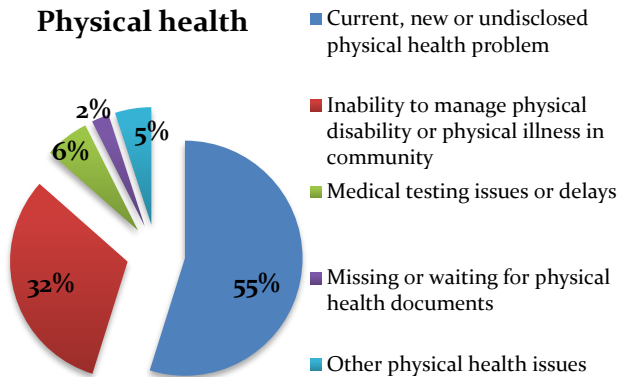
click on the Money Follows the Person tab



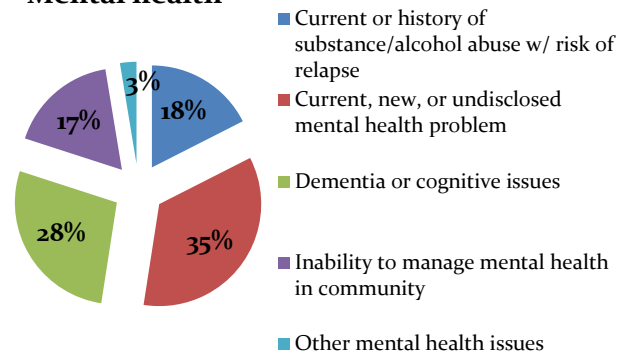
# Types of Challenges — through 12/31/2018

Shown below are the six most common challenge types

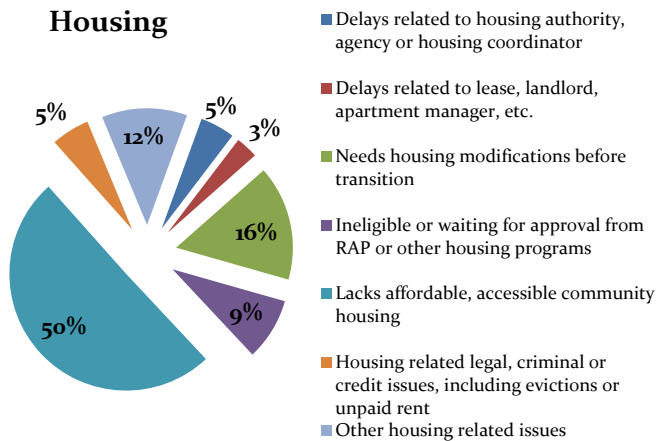
## Physical health



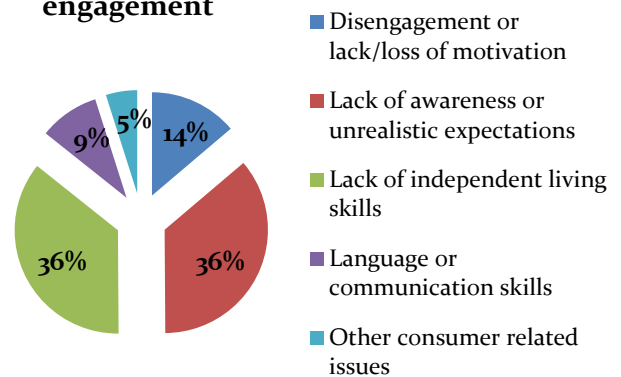
## Mental health



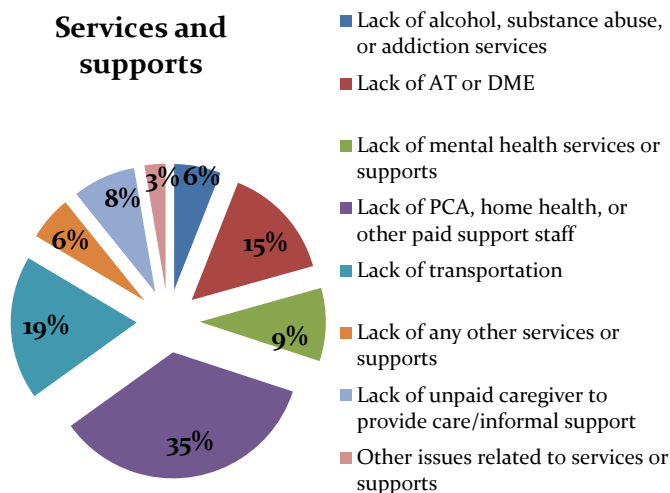
## Housing



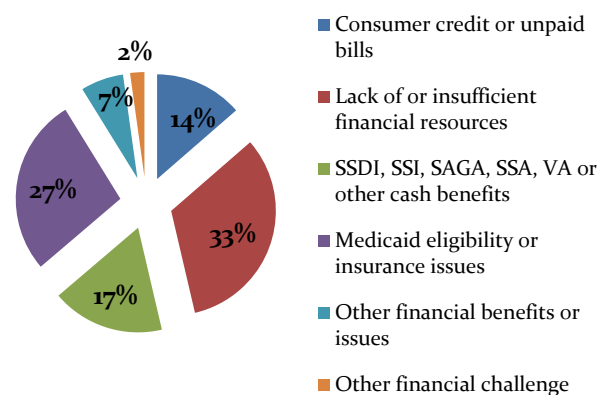
## Consumer engagement



## Services and supports



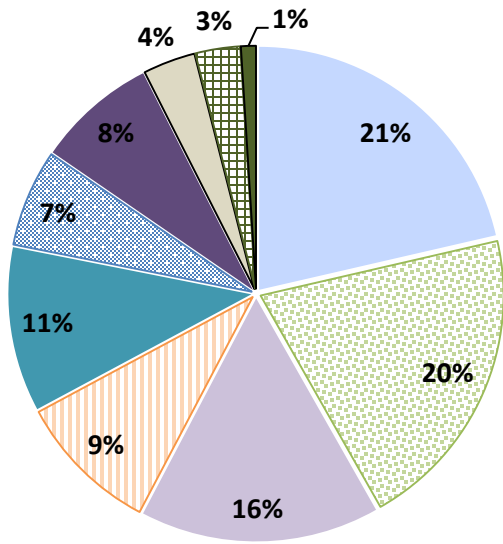
## Financial



For the full report on transition challenges through 12/31/2018, use the link on page 7 to get to the Center on Aging website.



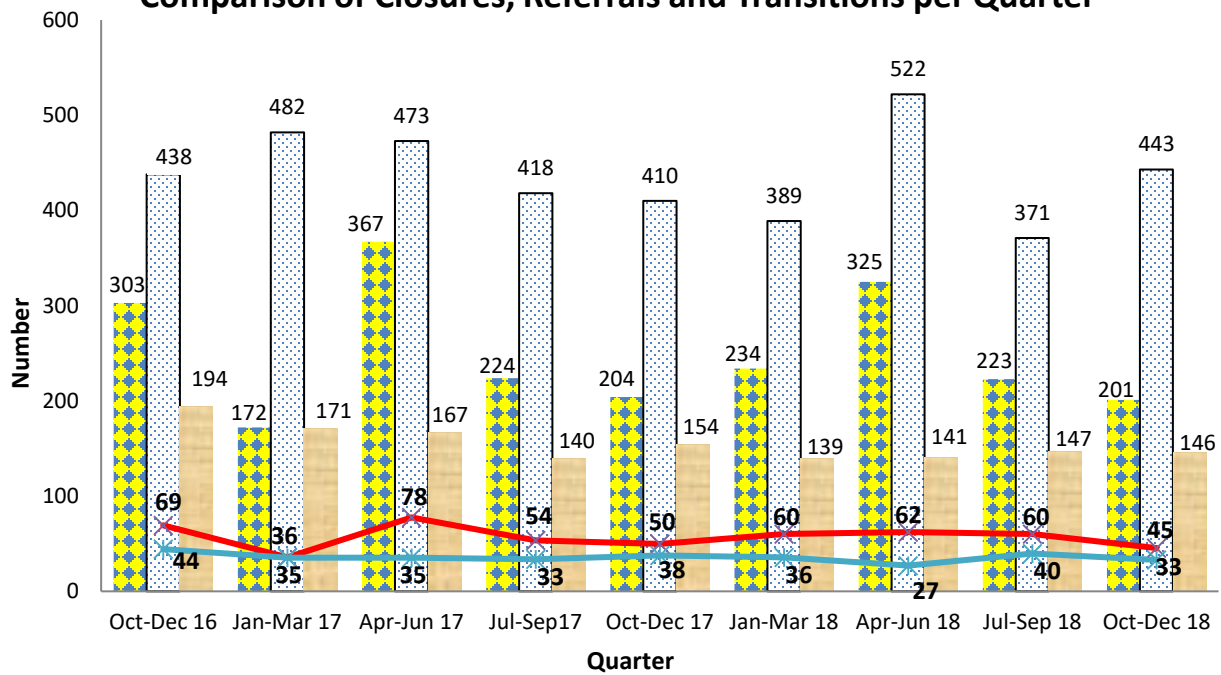
### Percentage of Closed Cases by Closure Reason: Oct-Dec 2018



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

\*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
- x— Closures per 100 new referrals
- \*— Transitions per 100 new referrals

## Susan Blaszczak's Story

Susan Blaszczak, former Emergency Room nurse at Brigham and Woman's hospital in Boston, found herself on the other side of the healthcare system after being diagnosed with stage 4 breast cancer. "Although I shared compassion with patients as a nurse, it is humbling to find yourself a patient. It's tough to be on the other side. It lead me to a deeper spirituality and I've learned to be more patient." She became "so sick" from the chemotherapy that her deconditioned body needed 24/7 care and she was admitted to a skilled nursing facility. For eleven months she spent up to 3 hours a day working with the physical therapists in the rehabilitation gym determined to get stronger. Susan also helped others through the bible study group there.

Her deeply held faith in God stems from her upbringing in Massachusetts where both parents were leaders in the church as youth and adult lay music ministers and she attended two weekly services all of her young life. Susan continues to use prayer, creative writing, gardening and painting as pathways to help her heal.

As Susan was gaining her strength, a housing coordinator from Money Follows the Person (MFP) introduced her to how this program could help her transition back to her town with supports. "I was so incredibly blessed when MFP identified themselves and their plans to transition me from the skilled nursing facility back into the community and find me an apartment. I did not know what to expect. I was afraid I may not be able to see the end, given my diagnosis." In just 4 short months Susan's MFP transition team had found her a beautiful apartment close to her fiance Rich, whom she met while living at Green Grove, a residential care home nearby. Another key person has been the care manager at Advanced Behavioral Health, coordinating Susan's care plan. Susan credits her recovery assistant (RA) from Compassion N Care as being a dynamic and important team member. From the moment Susan met her RA, they "just clicked" and have been close companions ever since. Her RA knows Susan so well that she recognized that something was not right one day and convinced her to go the ER. She continues to be so instrumental in helping Susan with anything she needs. She goes beyond helping with daily tasks, driving and filing important paperwork, but also getting much needed hearing aids and oral chemo medication. Searching out grants with community organizations, she motivated Susan to write an essay with a non-profit in New Haven at the 11<sup>th</sup> hour, and Susan was awarded \$350.00 to order new art supplies.

Susan and Rich have recently been reunited and they start each day baking and praying together. Susan shares that the "apex of our relationship is God, with friends and family in the middle." Rich is an incredible baker and as he gives Susan her morning medications, she engages her sense of smell to guess what he has baked that morning. Fellowship and faith are also shared with several different health and spiritual wellness ministries they either host or attend every week. Susan not only has been the recipient of gracious donations, but gives back, sharing piles of books on spirituality with Smilow cancer center.

Susan's healing gifts extend to her plants, whom she counts as her "babies." They represent life to her. Friends bring her their neglected plants and they thrive with her nurturing.

"MFP was the answer to all my prayers. MFP stayed with me the whole time. I was so overwhelmed with what MFP provided me!"

Susan's life philosophy has changed tremendously from her days working in the ER. She now lives simply so others may simply live.



Photo credit: Diane Taha, Mintz and Hoke

### 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.