

CT Money Follows the Person Report

August 2019

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

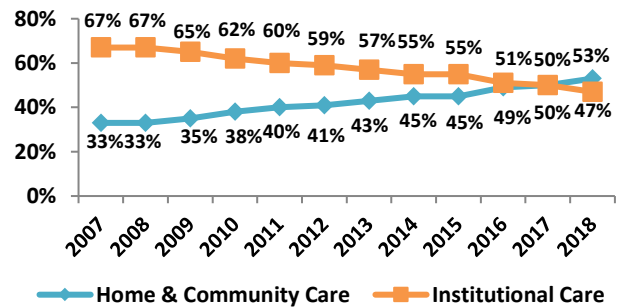
Benchmark 1: Total Transitions = 5,671

Demonstration = 5,298 (94%)

Non-demonstration = 373 (6%)

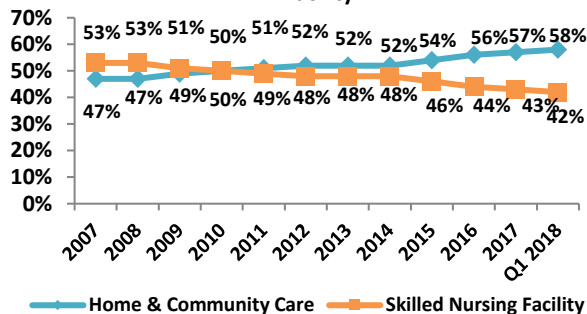
Benchmark 2

CT Medicaid Long-Term Care Expenditures



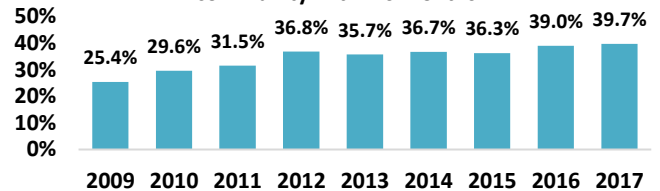
Benchmark 3

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

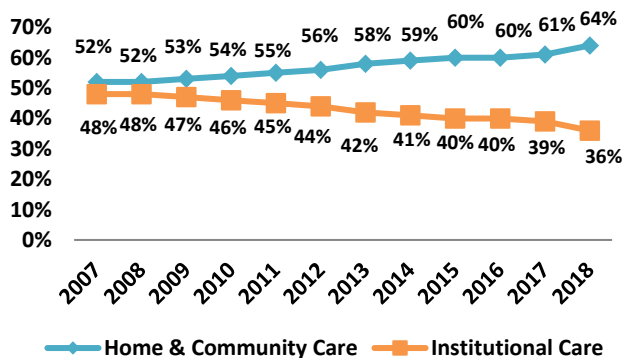


Benchmark 4

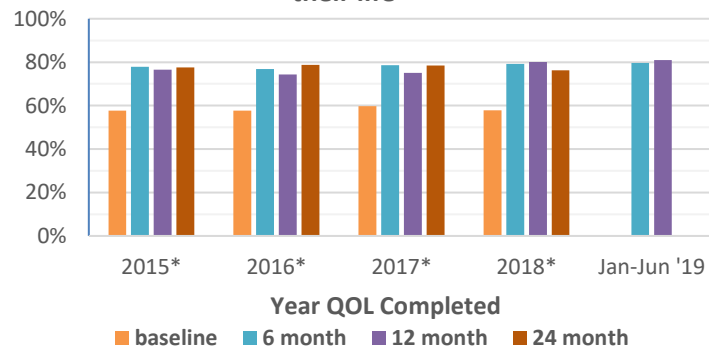
Percent of SNF admissions returning to the community within 6 months



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

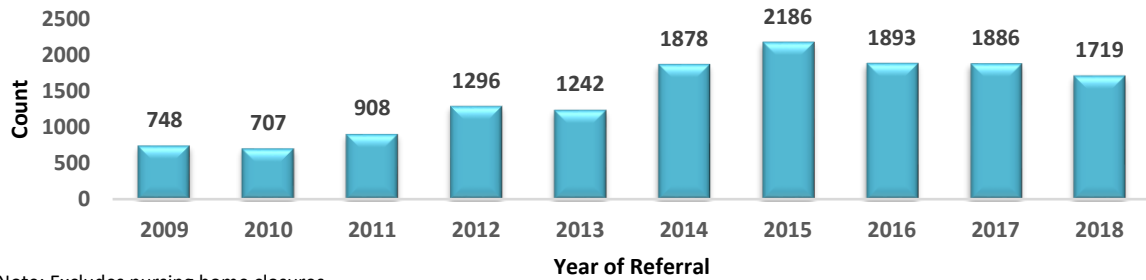


Participants happy with the way they live their life



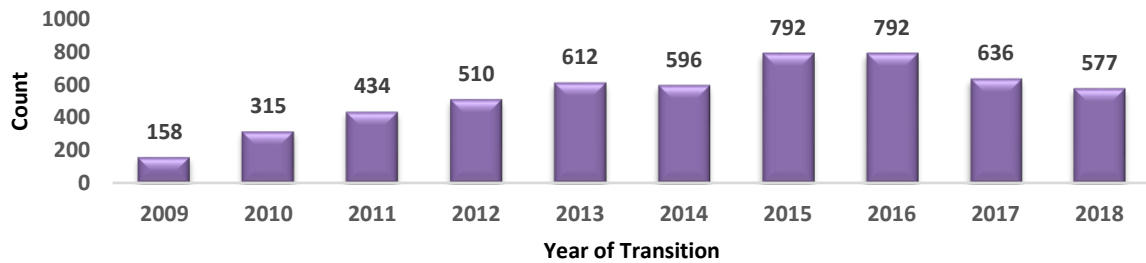
* Indicates statistically significant differences

Total Number of Referrals Assigned to the Field by Year

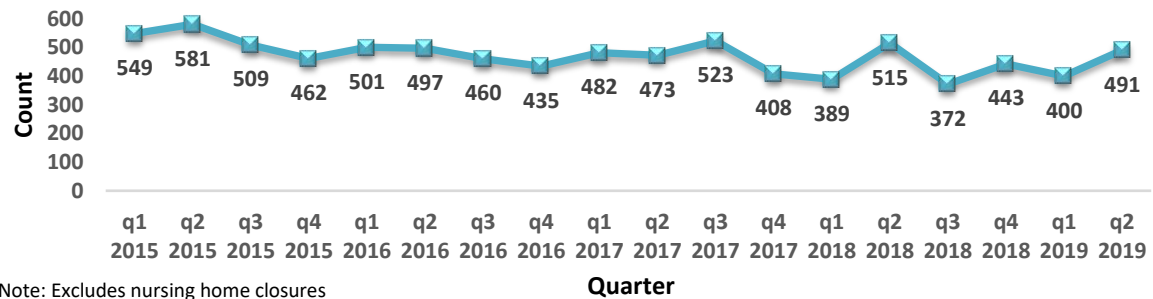


Note: Excludes nursing home closures

Total Number of Transitions by Year

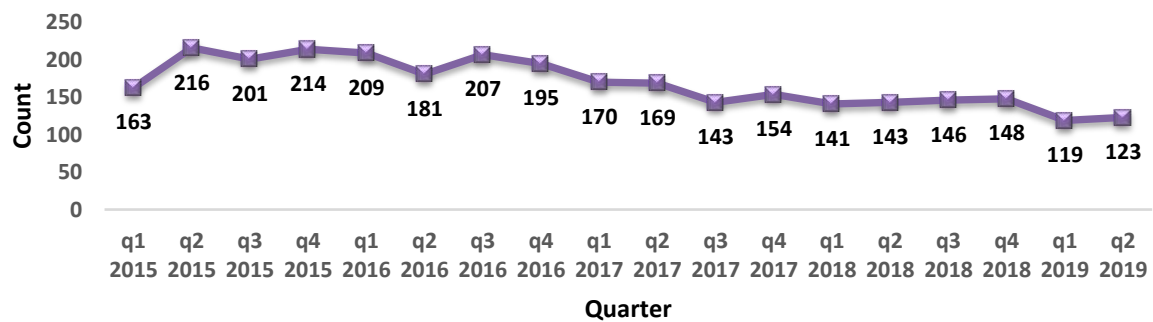


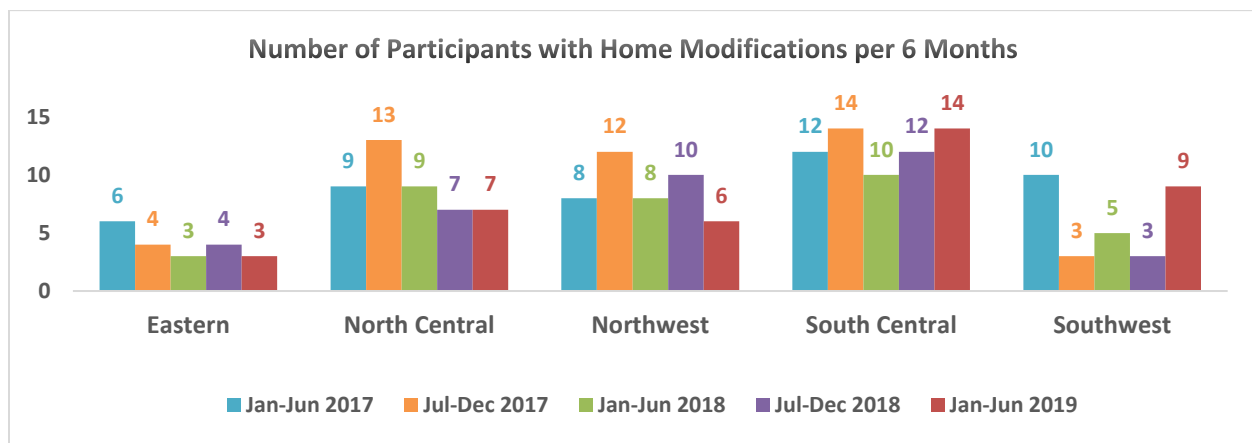
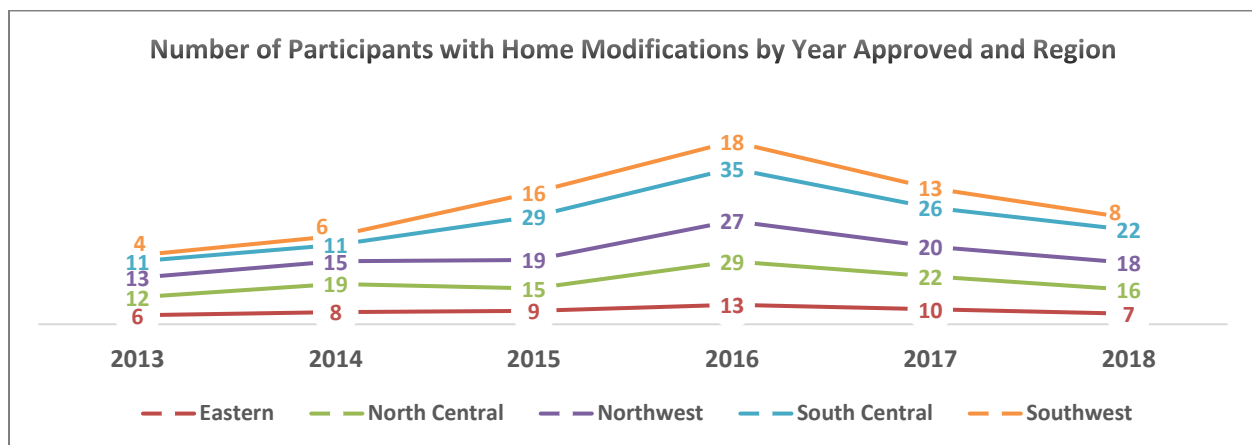
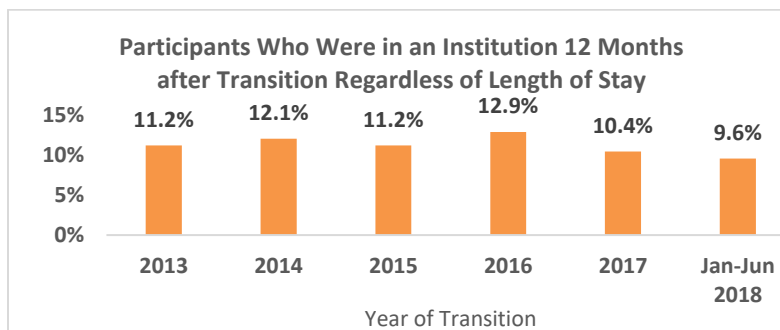
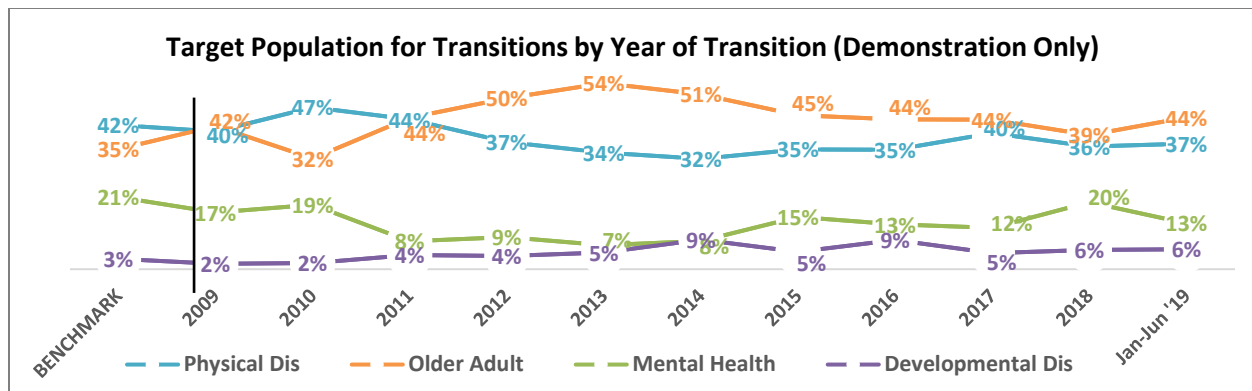
Referrals Assigned to the Field by Quarter



Note: Excludes nursing home closures

Number of Transitions by Quarter

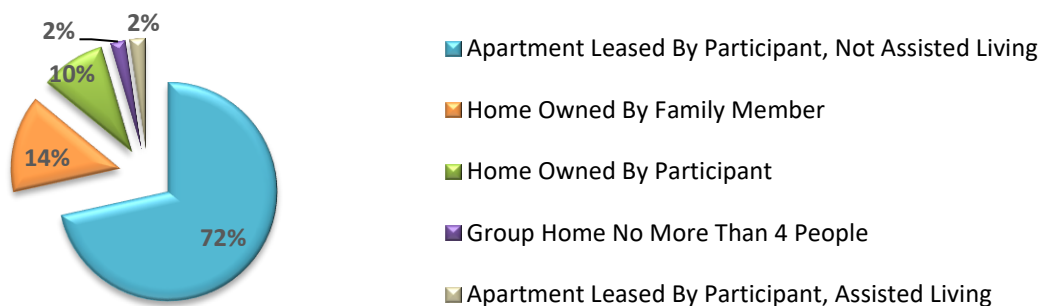




Participants who are Working and/or Volunteering (cumulative data 12/2008-present)



Qualified Residence Type for Transitioned Referrals: 12/4/08 to 6/30/19



MFP Quality of Life Dashboard

Number of Quality of Life Interviews Completed by Timepoint (cumulative through 06/30/19)

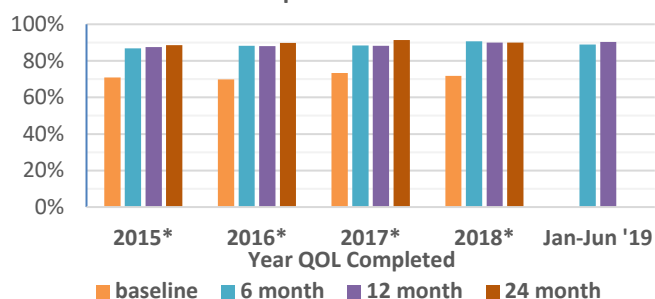
Baseline interviews done prior to transition, **n=5463**

6 month interviews done 6 months after transition, **n=4407**

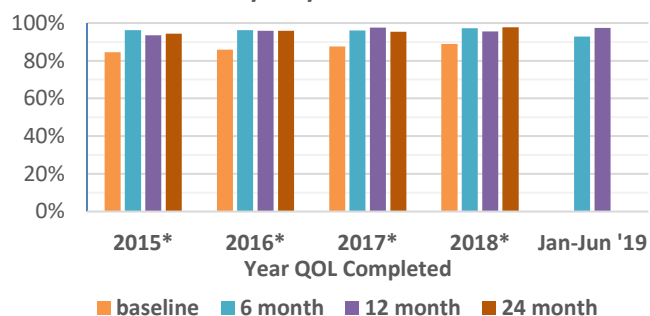
12 month interviews done 12 months after transition, **n=4018**

24 month interviews done 24 months after transition, **n=2907**

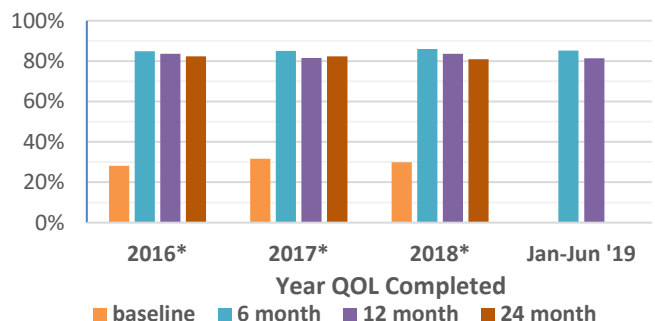
Participants happy with the help they got in the past week



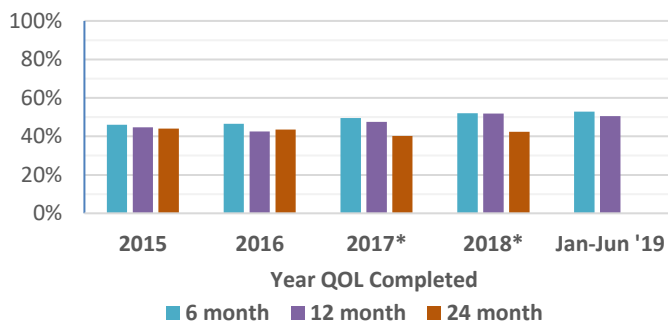
Participants who felt their staff treated them the way they wanted them to



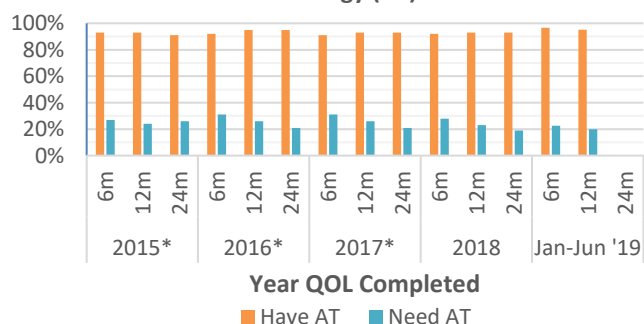
Participants who like where they live



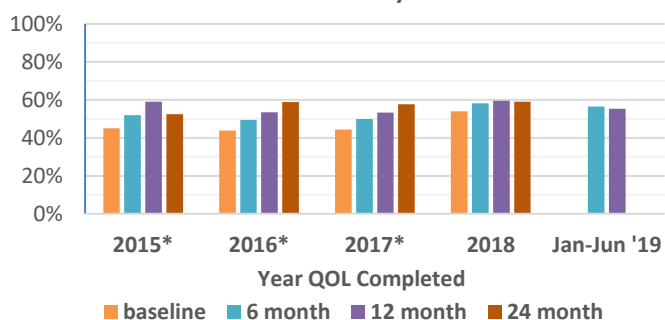
Participants who had help from family or friends in the past week



Participants who have or need assistive technology (AT)

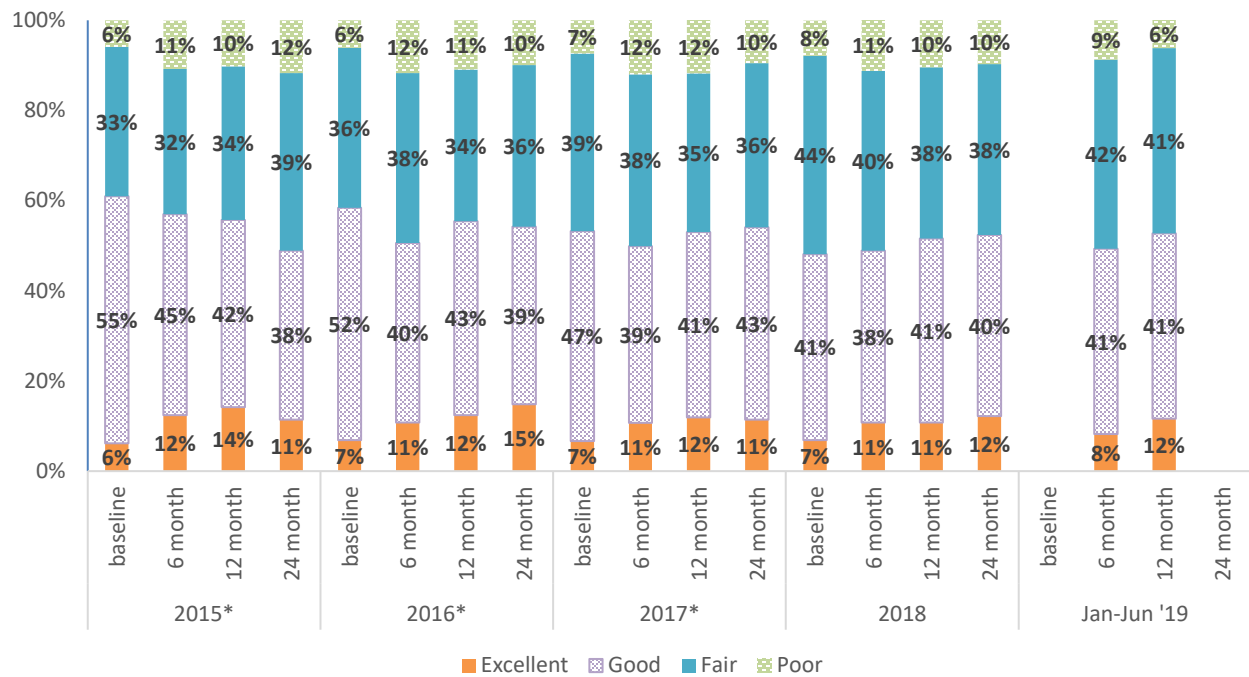


Participants who go out to do fun things in the community



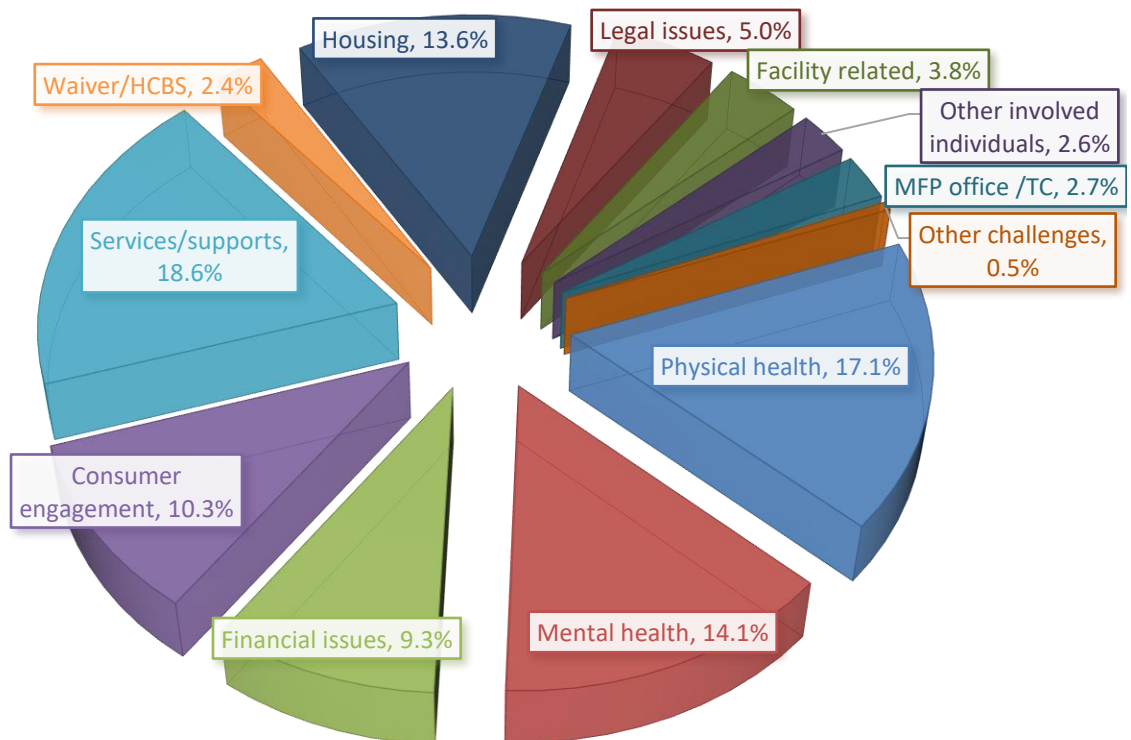
* Indicates statistically significant differences

Participant rated overall health by year QOL completed

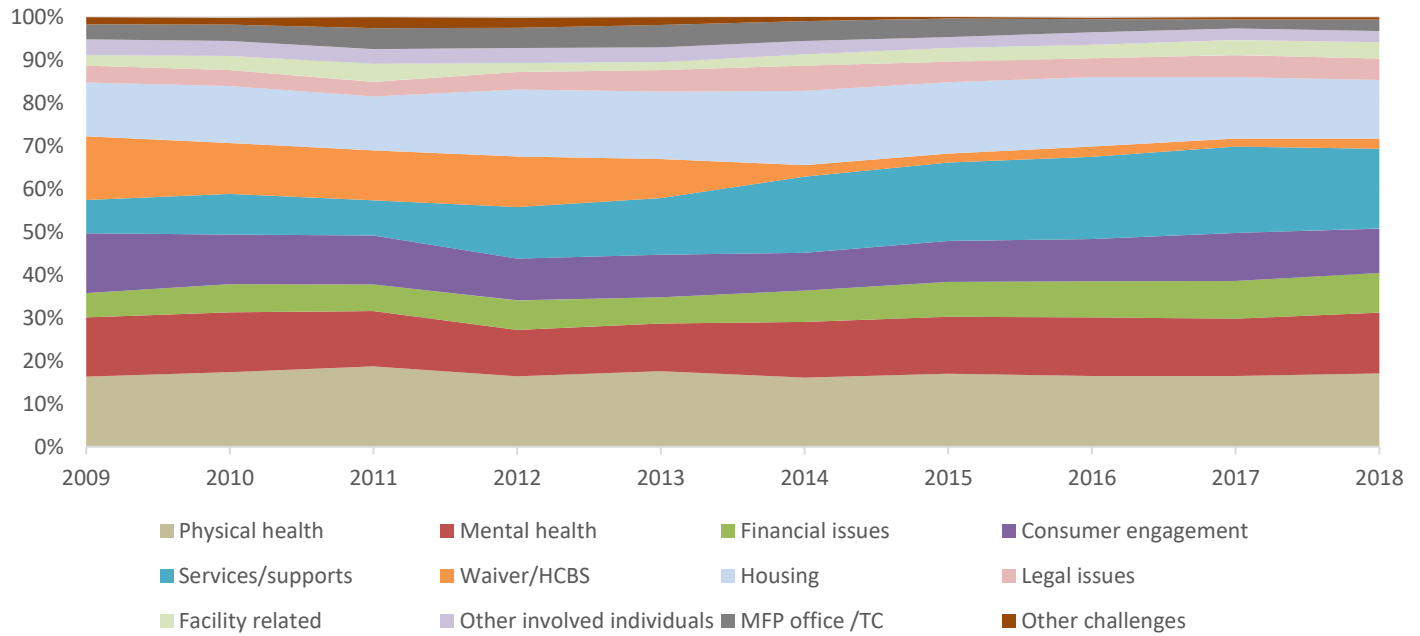


Challenges to Transition as noted by TCs and SCMs

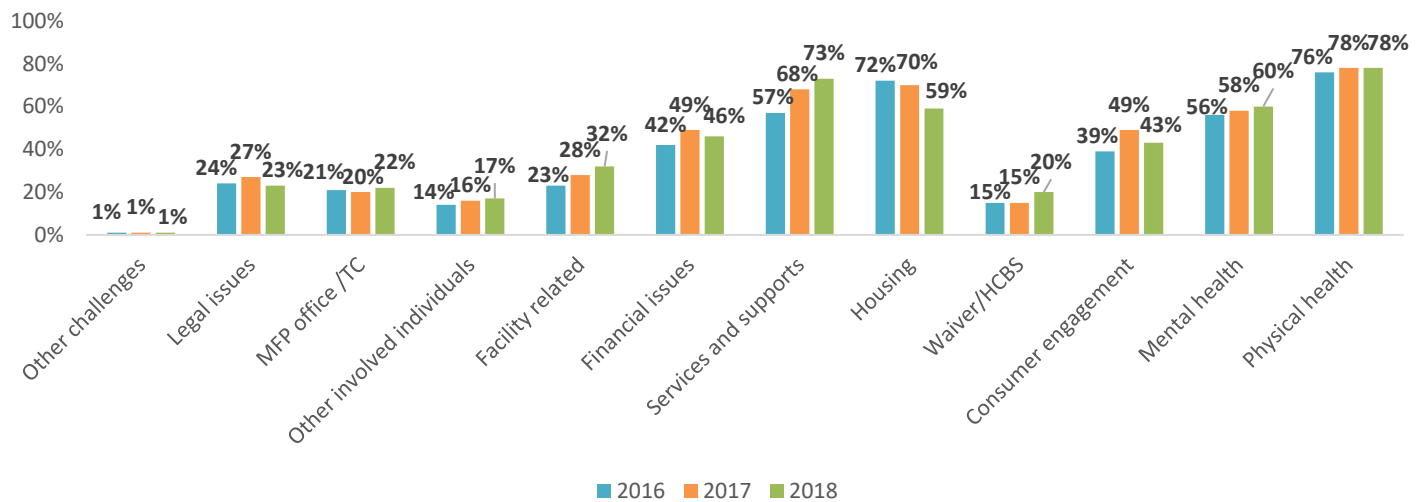
Transition Challenges for Participants Referred in 2018



Transition Challenges by Year of Referral



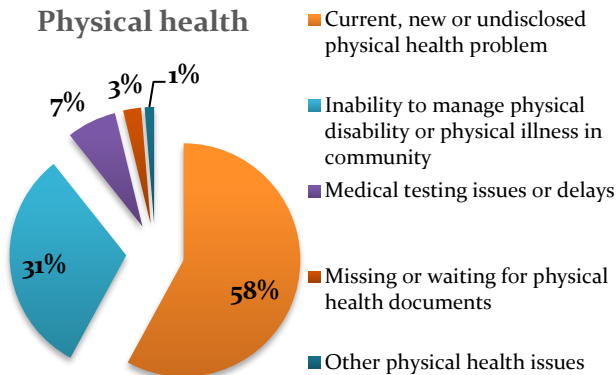
Participants with Each Challenge who Transitioned by Referral Year



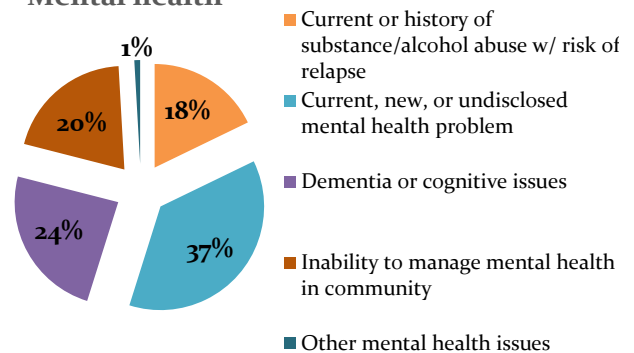
Types of Challenges for Referrals: 1/1/2018-12/31/2018

Below are the six most common challenge types from 2018

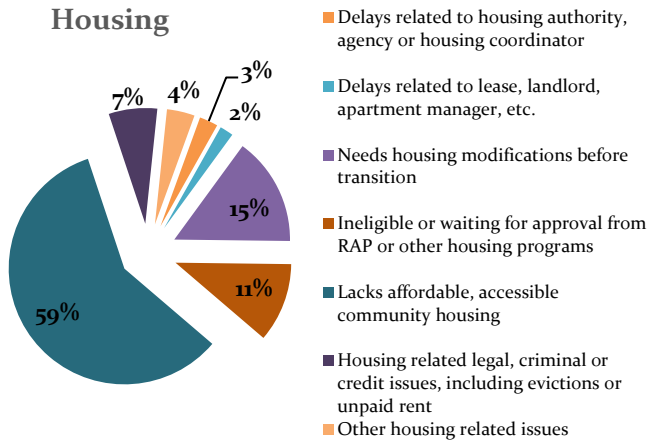
Physical health



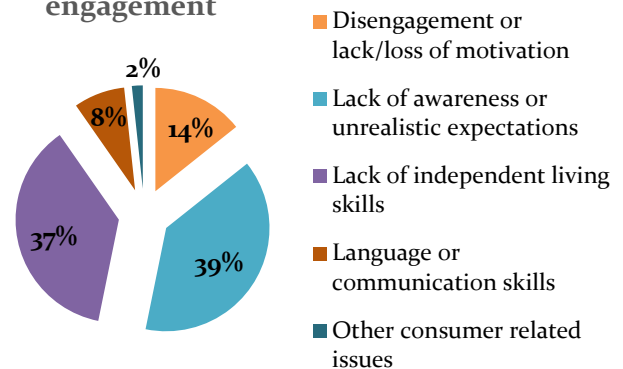
Mental health



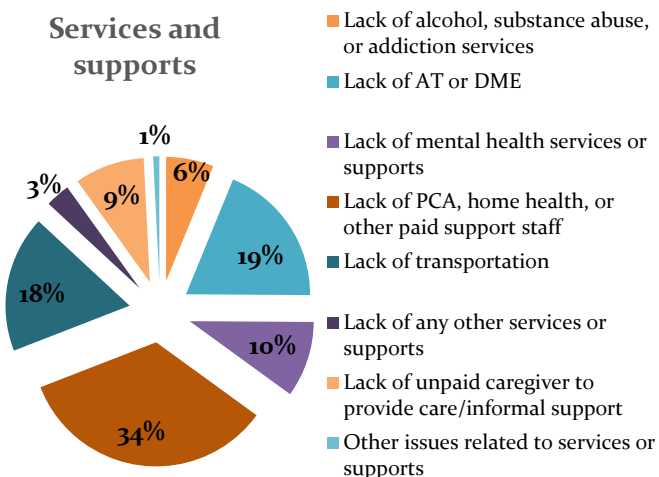
Housing



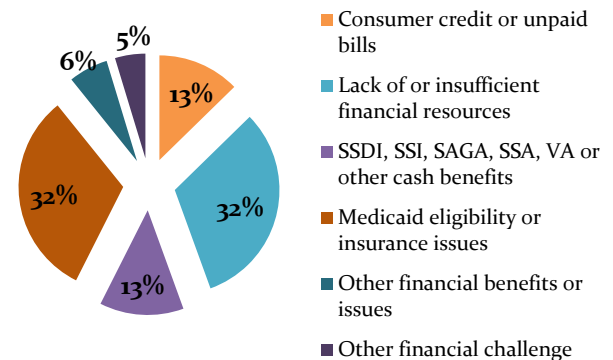
Consumer engagement



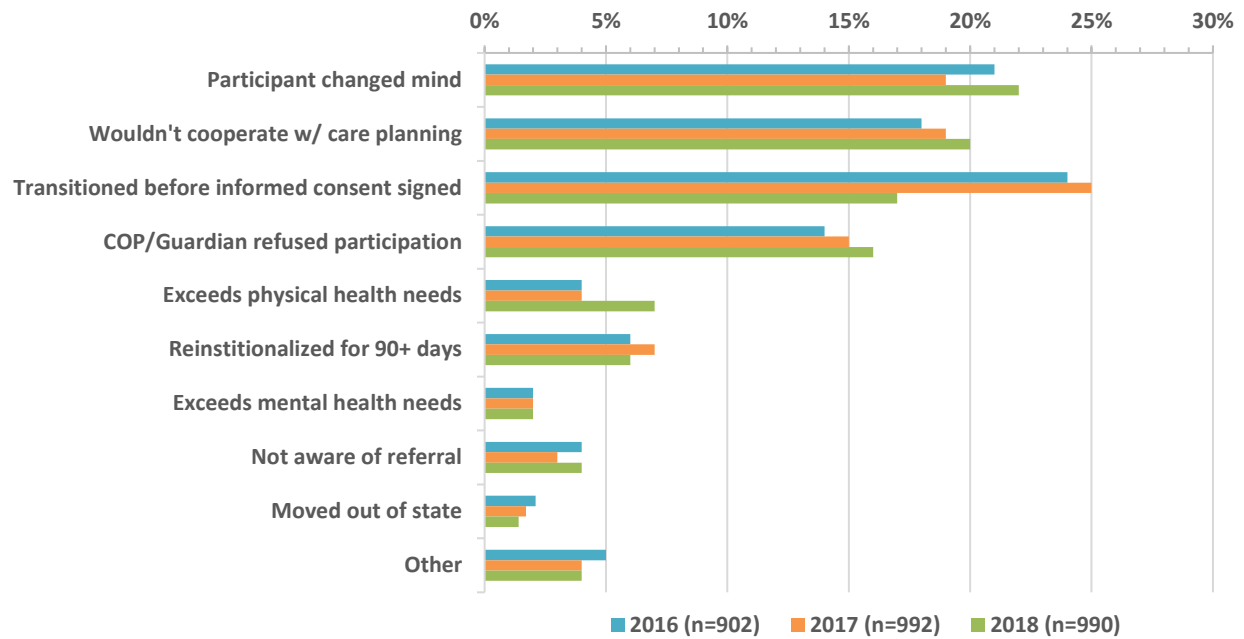
Services and supports



Financial

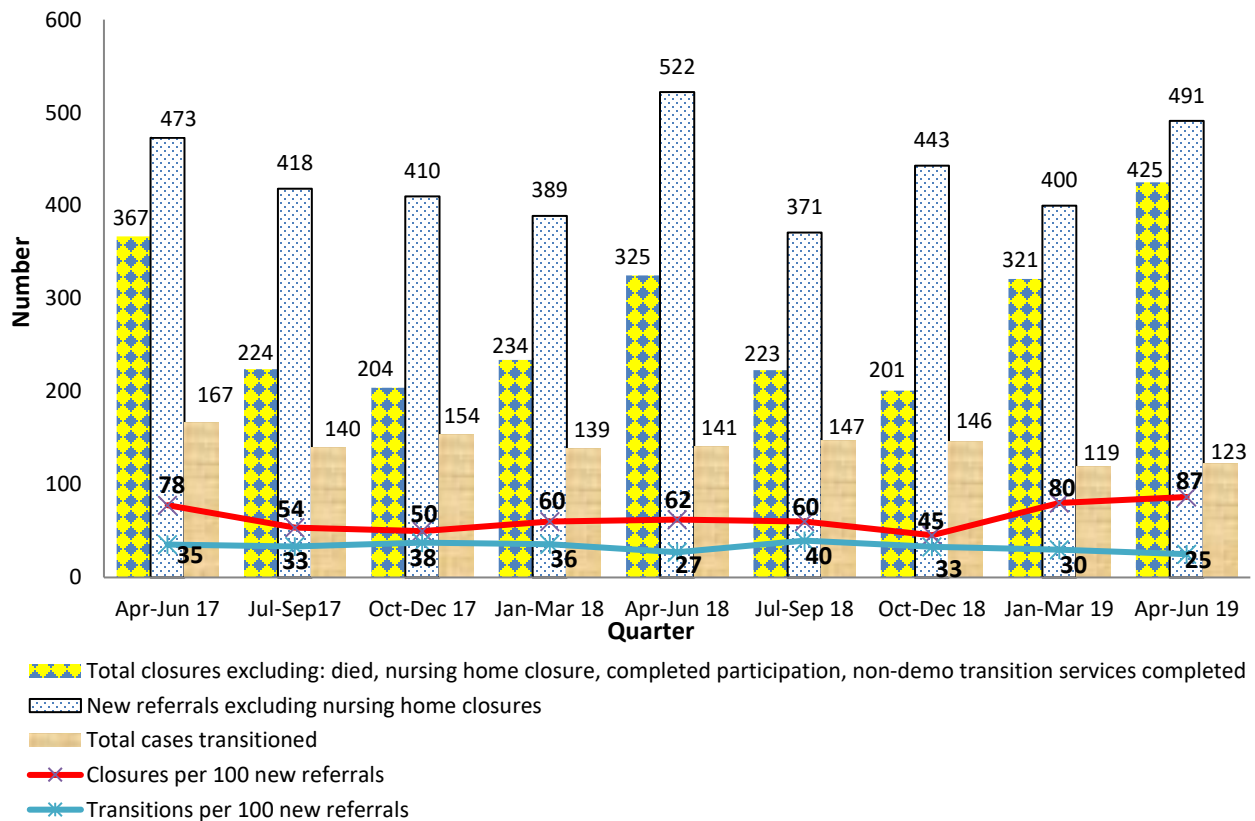


Closure Reason by Year of Closure



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

Comparison of Closures, Referrals and Transitions per Quarter



Doug Lagasse's Story

Doug Lagasse is a goal setter and hard worker. He worked in the service and sales industries for over twenty years. He achieved the height of success, owning his home and his car. But he worked over twelve hours per day, ate for convenience, and did not prioritize exercise, social events and family time. Things changed two years ago when his lifestyle caught up with him and an illness put Doug in the hospital for a lengthy stay. When he was in the hospital, he was unable to walk. Doug knew he needed rehab and went to a nursing home.

His time in the nursing home lasted longer than he expected. He went from being financially and physically independent to being waited on and reliant on staff. He says being at the nursing home is "not reality when you're there, they do everything for you. You get used to the level of care and you don't have to 'adult'. It's easier for them to leave someone in bed then to get them up, bathe and dress. It's easier for them to just let [residents] chill. I got up and fought every day. I went to recreation and tried to keep myself occupied because otherwise I'd melt into the background like everybody else."

Doug was lucky to have a social worker (SW) at the nursing facility who suggested the Money Follows the Person (MFP) program to him. "[While in the hospital] I had lost my house and everything in it, the only place I had to live was [the nursing facility]." The SW thought he would be a good candidate for MFP and worked with him directly to introduce the MFP team. The first time he met his care manager she spent two hours laying out a transition plan including a goal analysis for his physical and mental progress and outlining the program. He says the care manager gave him a lot of direction and encouraged him to pursue life in the community again. The housing coordinator found him an apartment immediately: "The housing search was non-existent. That's how good [the housing coordinator] was." Because Doug had lost everything while he was at the nursing facility, he had no possessions. His transition coordinator provided him with "everything they thought I needed to get started. It was a big help." He adds, "Without the program, I would have figured it out, but it wouldn't have been solid. I have a home now."

When he first moved into his apartment, Doug used the local paratransit service to attend doctor's appointments and other community events. However, he now is able to drive his own car in the community. Doug has lost over 150 lbs since leaving the nursing facility. He attributes much of his success to a membership at a local wellness center where he uses the pool. Doug estimates that he swims for about four hours a day, five times a week (including water aerobics, laps and walking). Doug says his exercise routine not only has strengthened his weight loss goals but also is beneficial to his mental and emotional health. He says he never thought he would be able to go to a public pool but his goals keep him focused. At home, Doug focuses on his hobbies like playing guitar and singing.

Doug says his mental health has improved significantly since settling into his apartment. "The program has been an amazing tool to get back on my feet. Without the help I would have gotten out of the hospital and failed and ended up back at the hospital and it would have been a revolving door. Now I can move forward." Doug looks forward to losing weight in the future. He doesn't have a number in mind but knows he wants to feel good. "I now have a path to success instead of a path to failure. [MFP] helped me in ways that allow me to focus on my health and get better. I don't want to stay disabled forever."



Photo credit: Alyssa Ciaciosci, 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.