CT Money Follows the Person Report

November 2019

UConn Health, Center on Aging

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

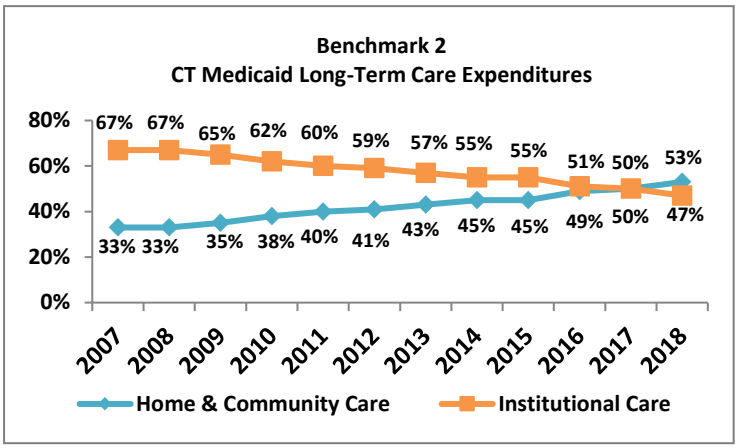
MFP Benchmarks

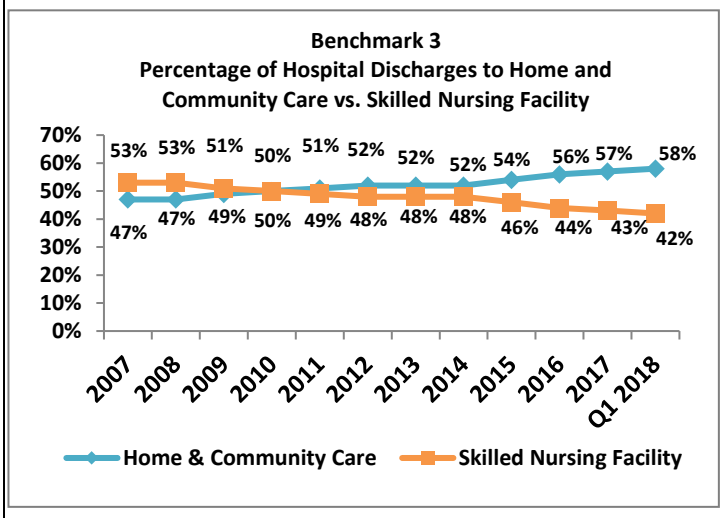
1) Transition 5200 people from qualified institutions to the community
2) Increase dollars to home and community based services
3) Increase hospital discharges to the community rather than to institutions
4) Increase probability of returning to the community during the six months following nursing home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

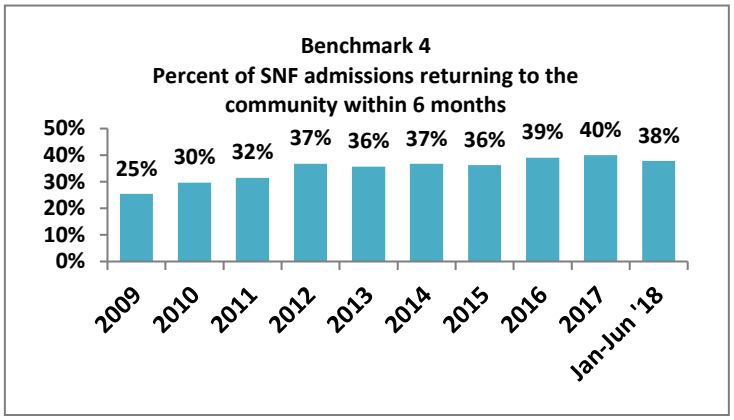
Benchmark 1: Total Transitions = 5,805

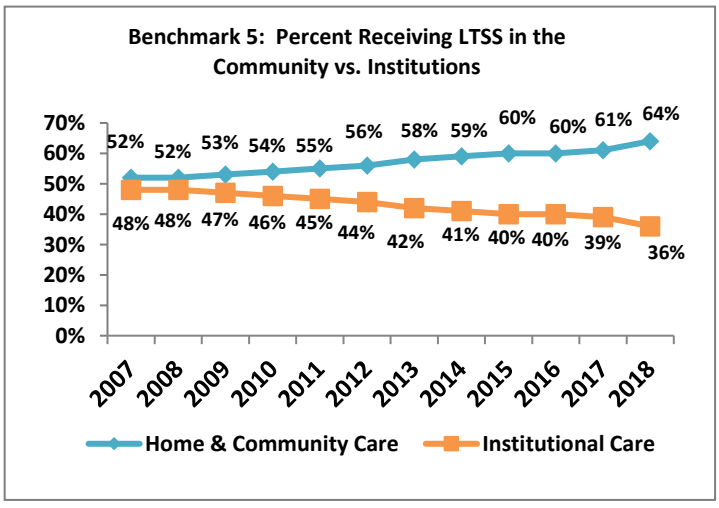
Demonstration = 5,425 (94%)

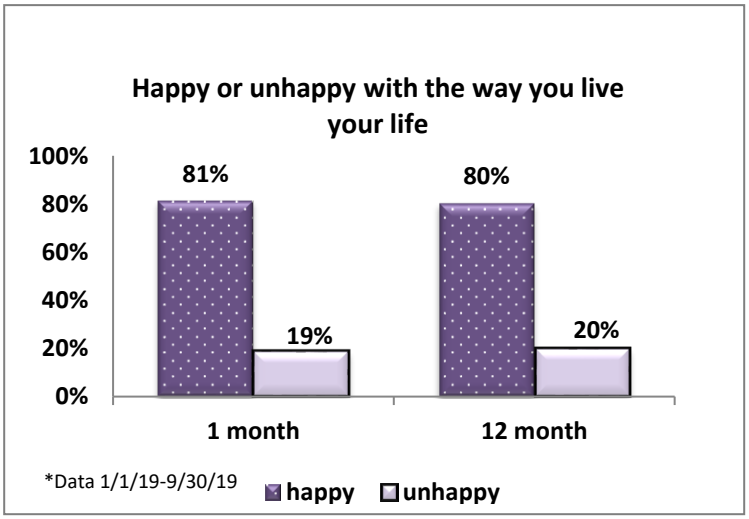
Non-demonstration = 380 (6%)

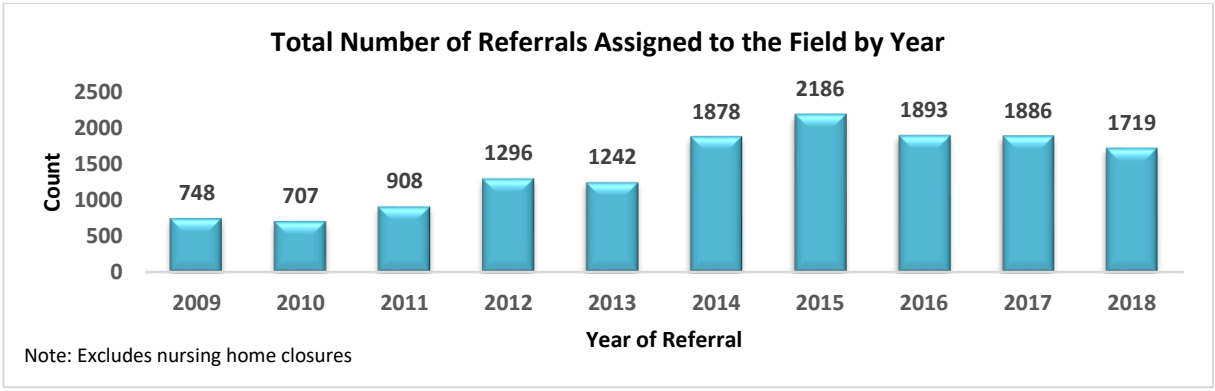




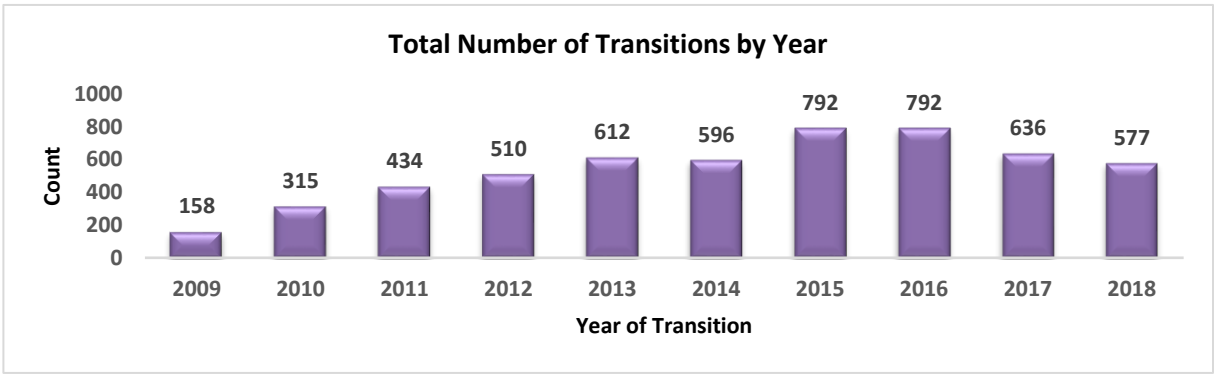


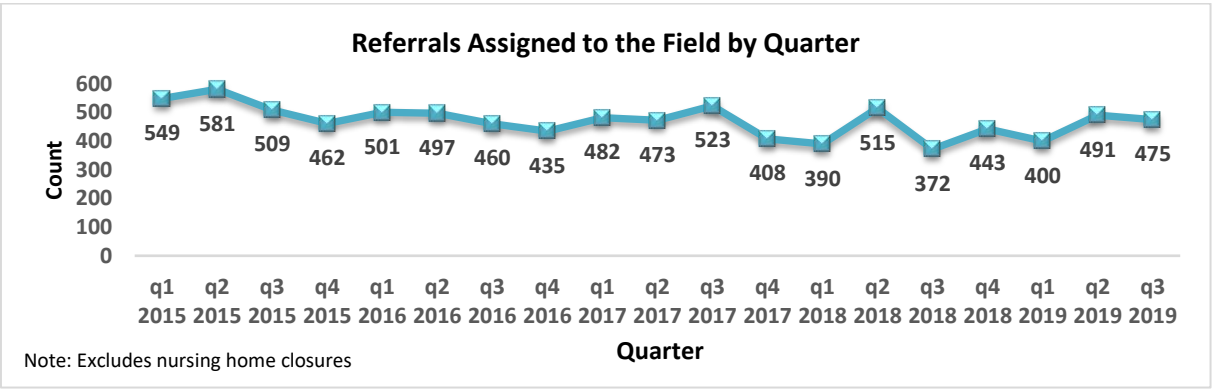






Note: Excludes nursing home closures





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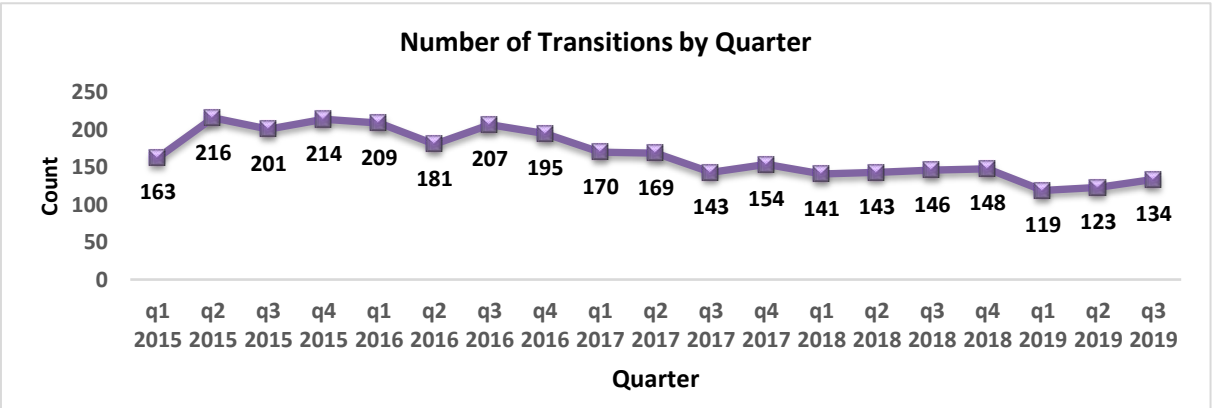
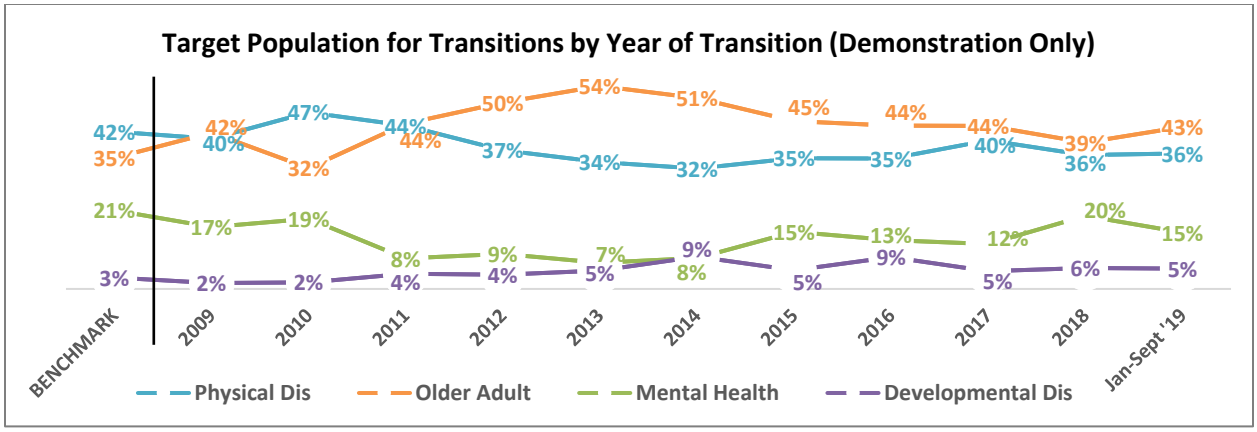
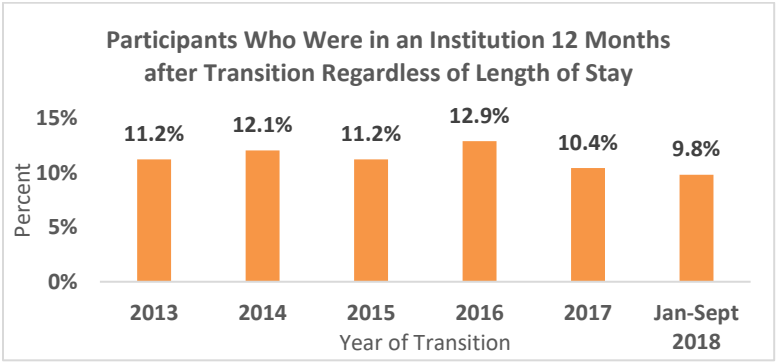
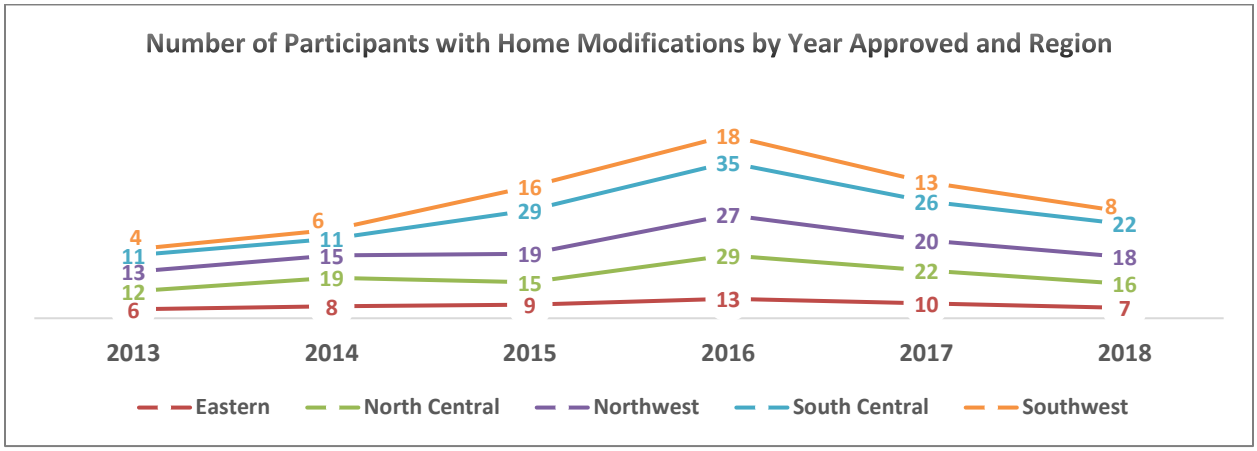
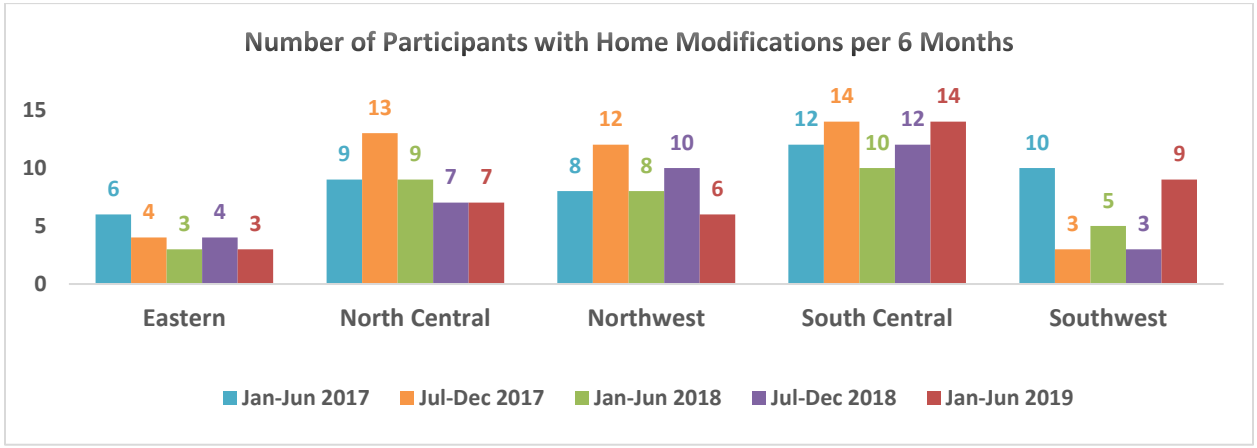


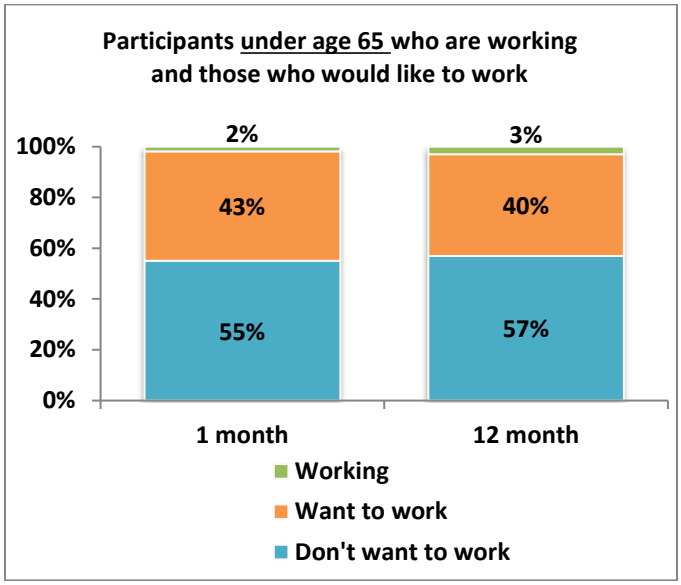

Target Population for Transitions by Year of Transition (Demonstration Only)
BENCHMARK
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Jan-Sept '19
Physical Dis
Older Adult
Mental Health
Developmental Dis

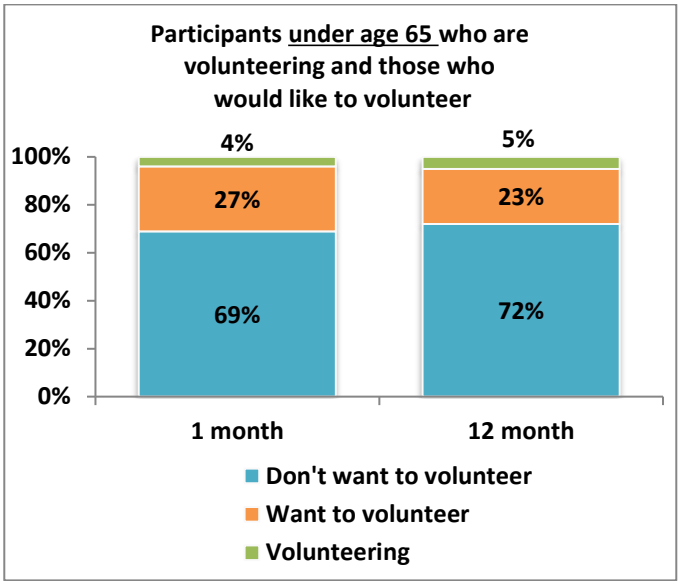

Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay
Percent
15%
10%
5%
0%
11.2%
12.1%
11.2%
12.9%
10.4%
9.8%
2013
2014
2015
2016
2017
Jan-Sept 2018
Year of Transition

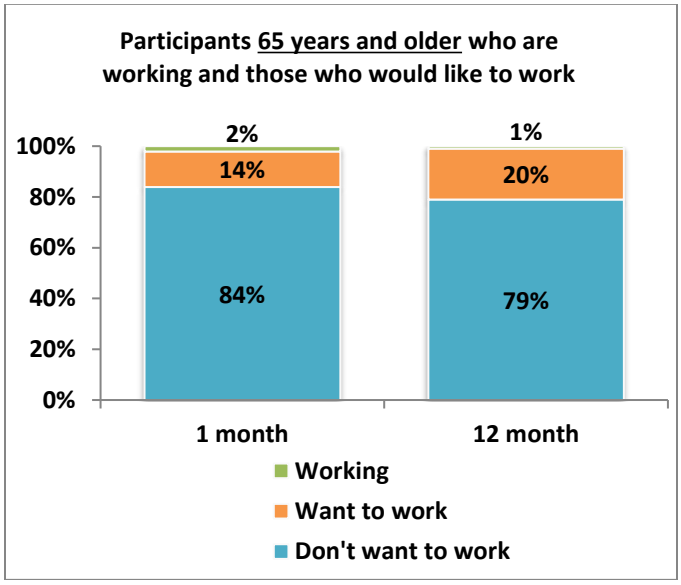

Number of Participants with Home Modifications by Year Approved and Region
2013
2014
2015
2016
2017
2018
Eastern
North Central
Northwest
South Central
Southwest

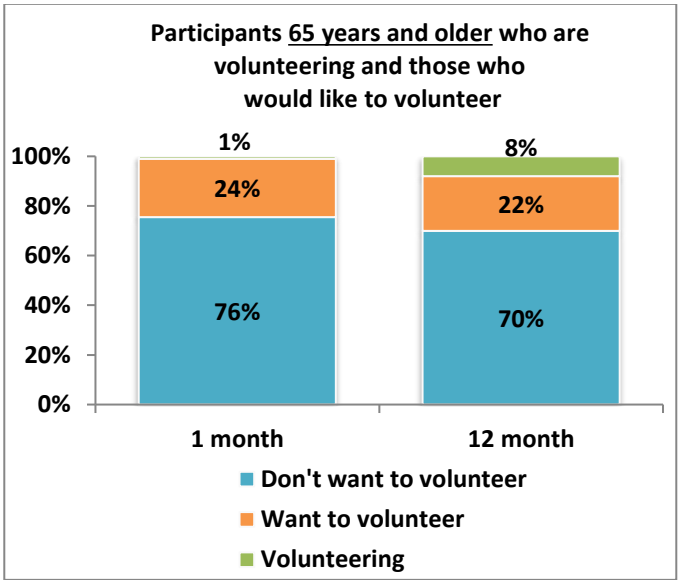

Number of Participants with Home Modifications per 6 Months
Eastern
North Central
Northwest
South Central
Southwest
Jan-Jun 2017
Jul-Dec 2017
Jan-Jun 2018
Jul-Dec 2018
Jan-Jun 2019

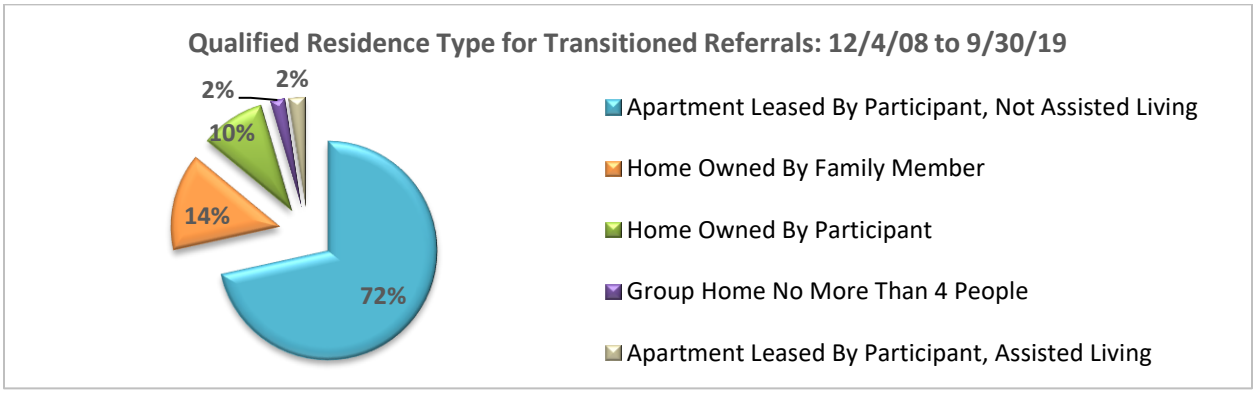
Participants who are Working and/or Volunteering (data 1/1/19-9/30/19)





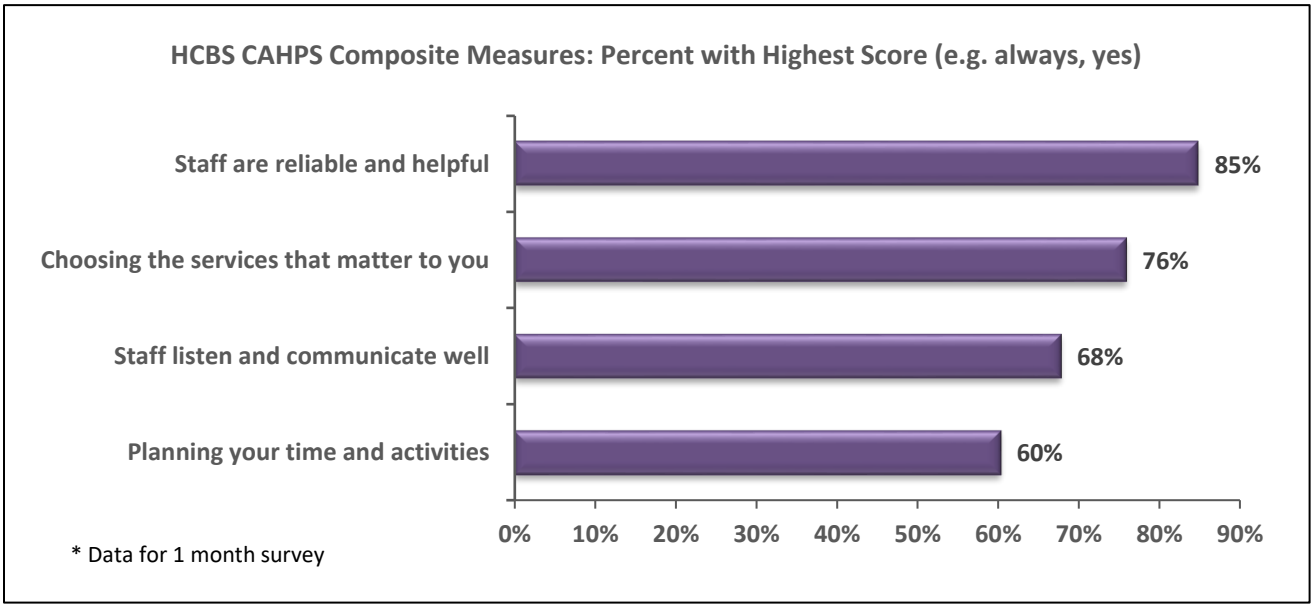


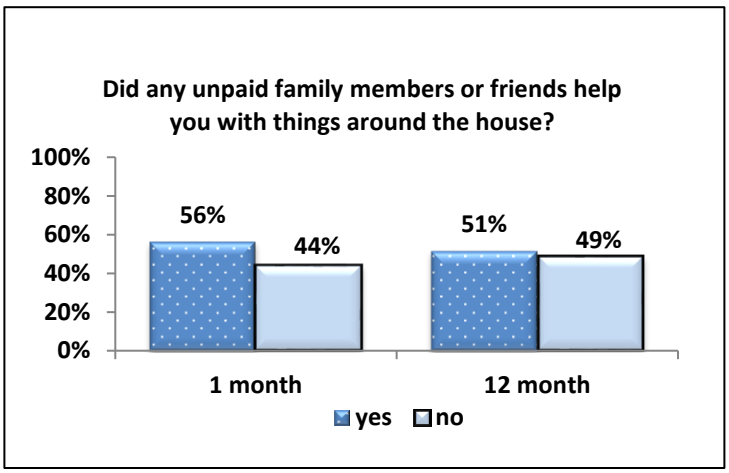


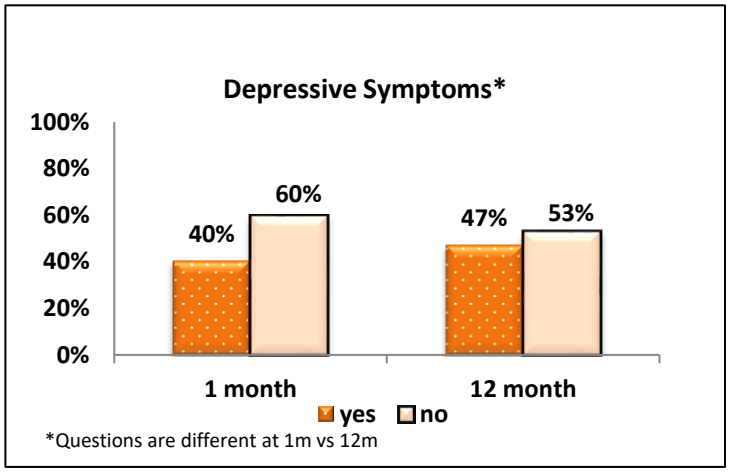


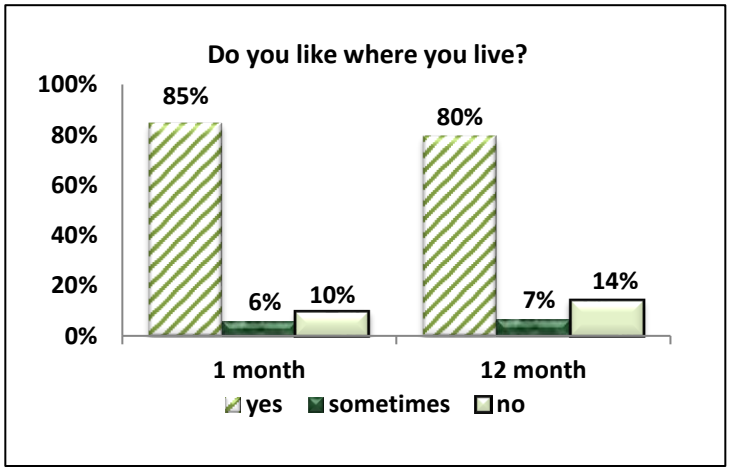
MFP Quality of Life Dashboard

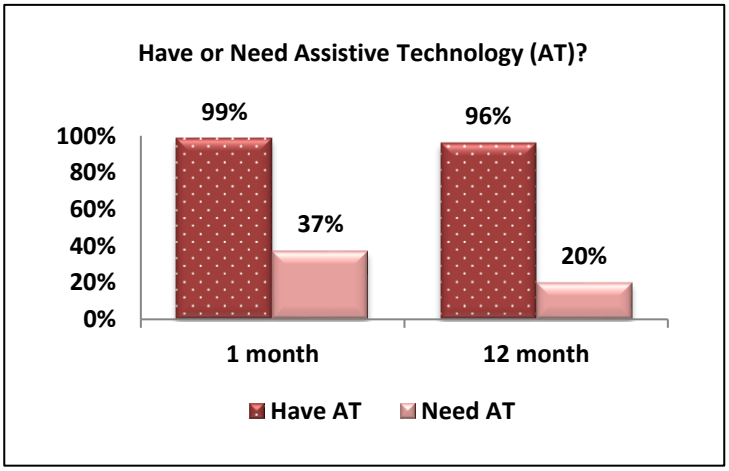
Number of Quality of Life Interviews Completed from 1/1/19 - 9/30/19:
1 month interviews done 1 month after transition, **n=237**
12 month interviews done 12 months after transition, **n=295**





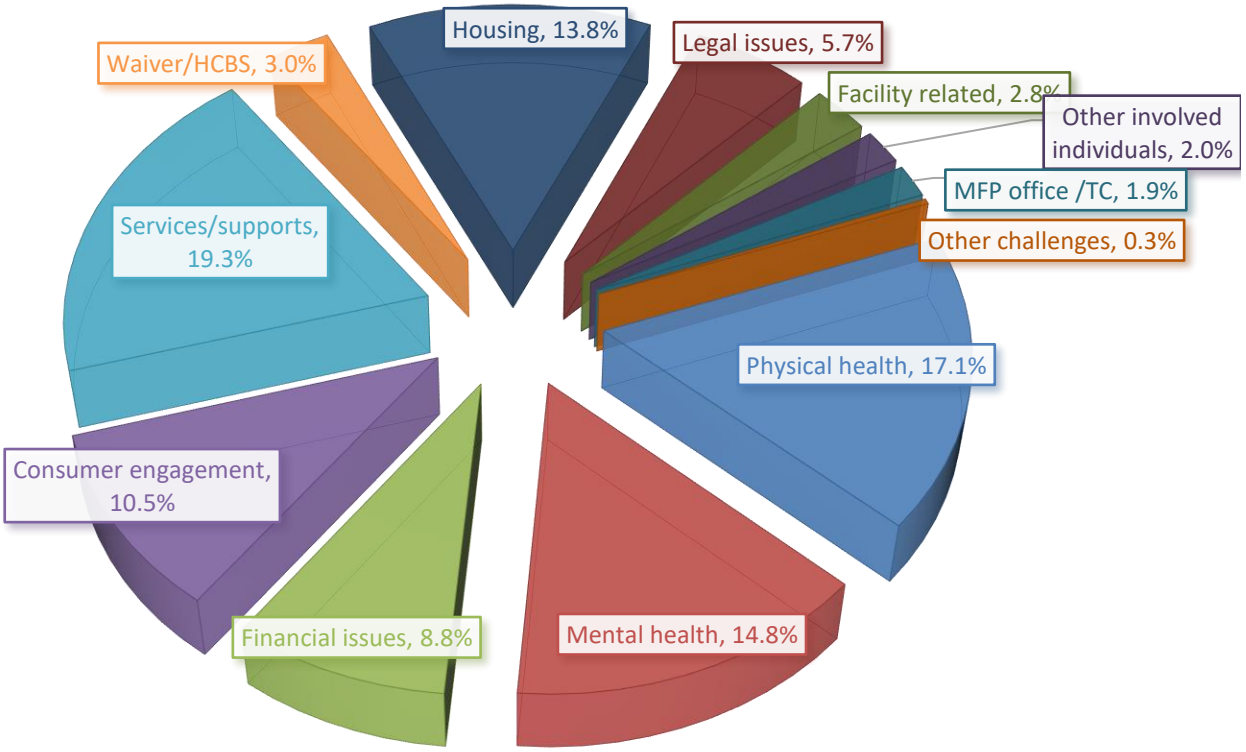




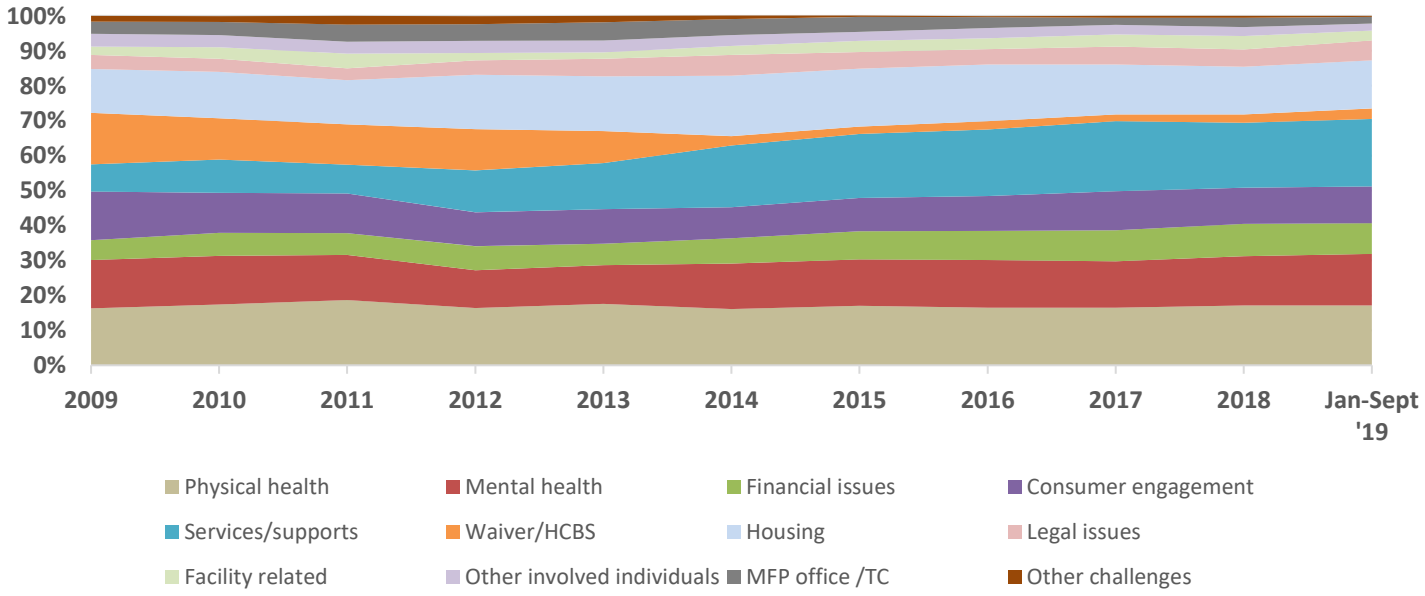


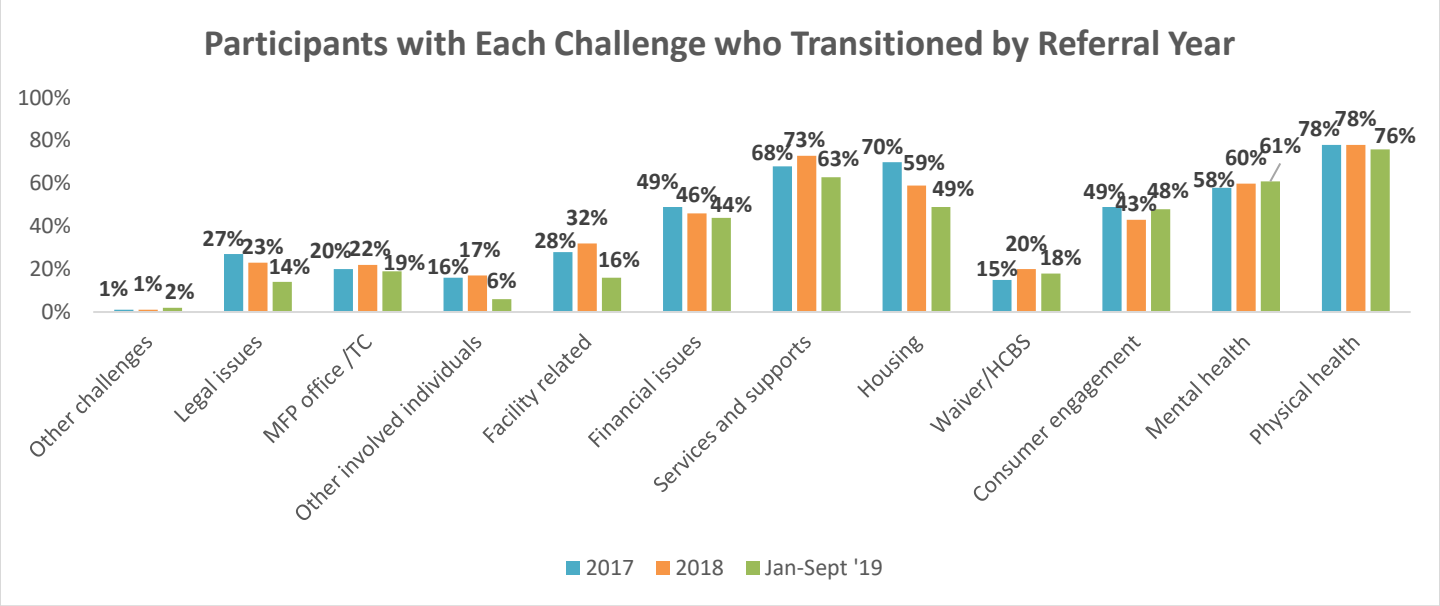
Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred Jan-Sept 2019



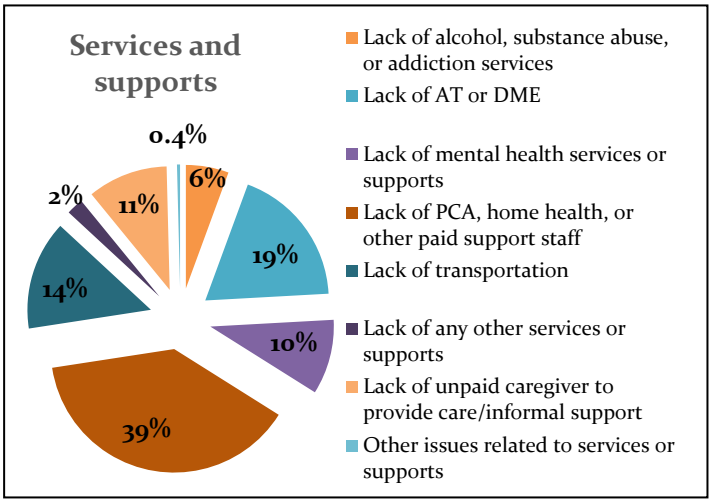
Frequency of Transition Challenges by Year of Referral

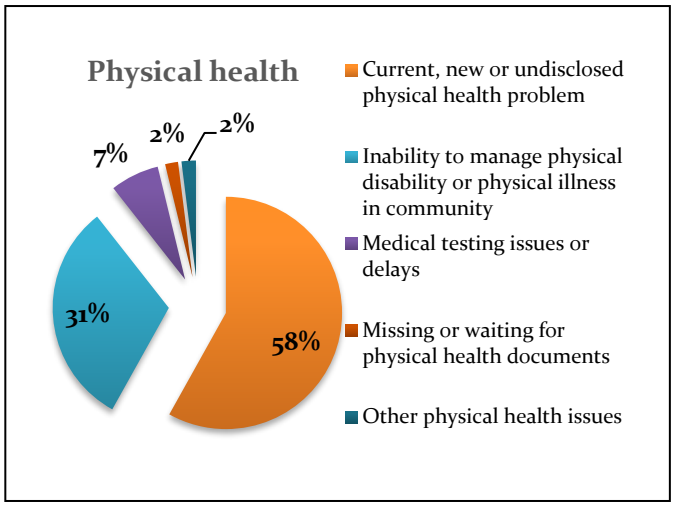


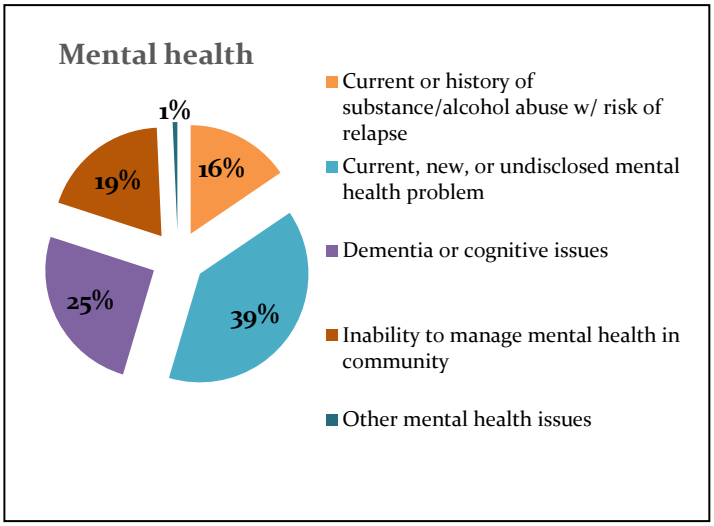


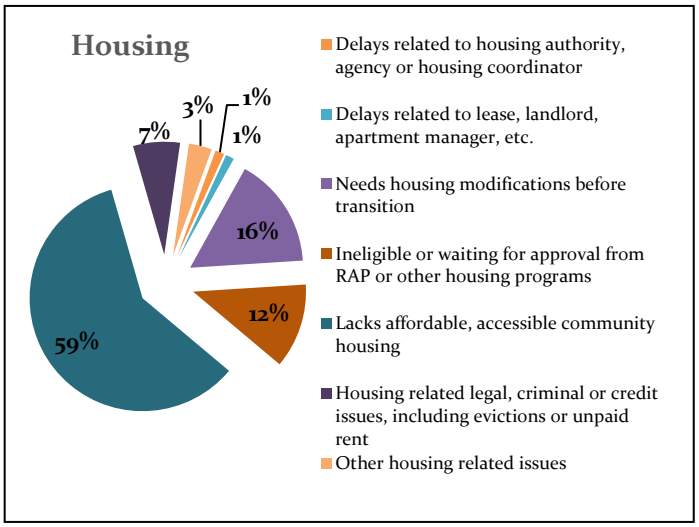
Types of Challenges for Referrals: 1/1/2019-9/30/2019

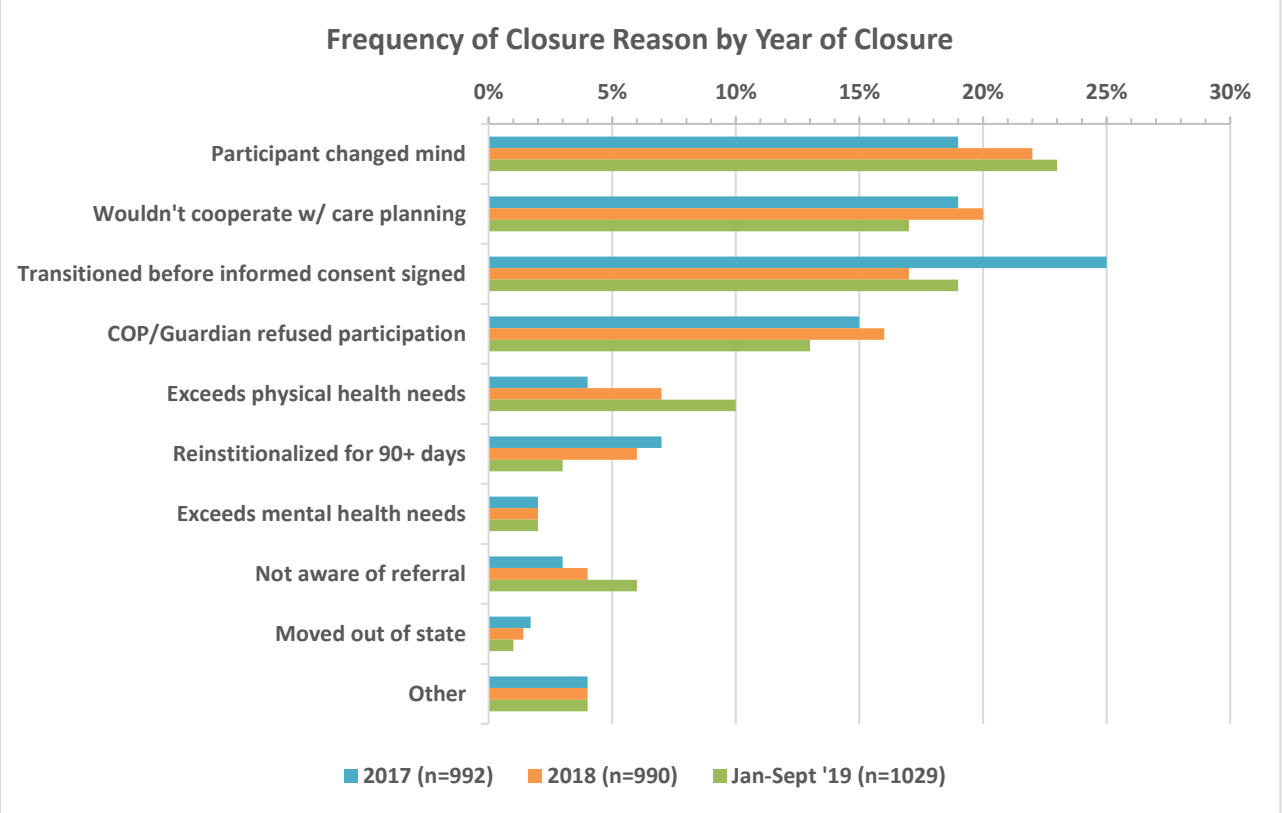
Below are the four most common challenge types for 2019

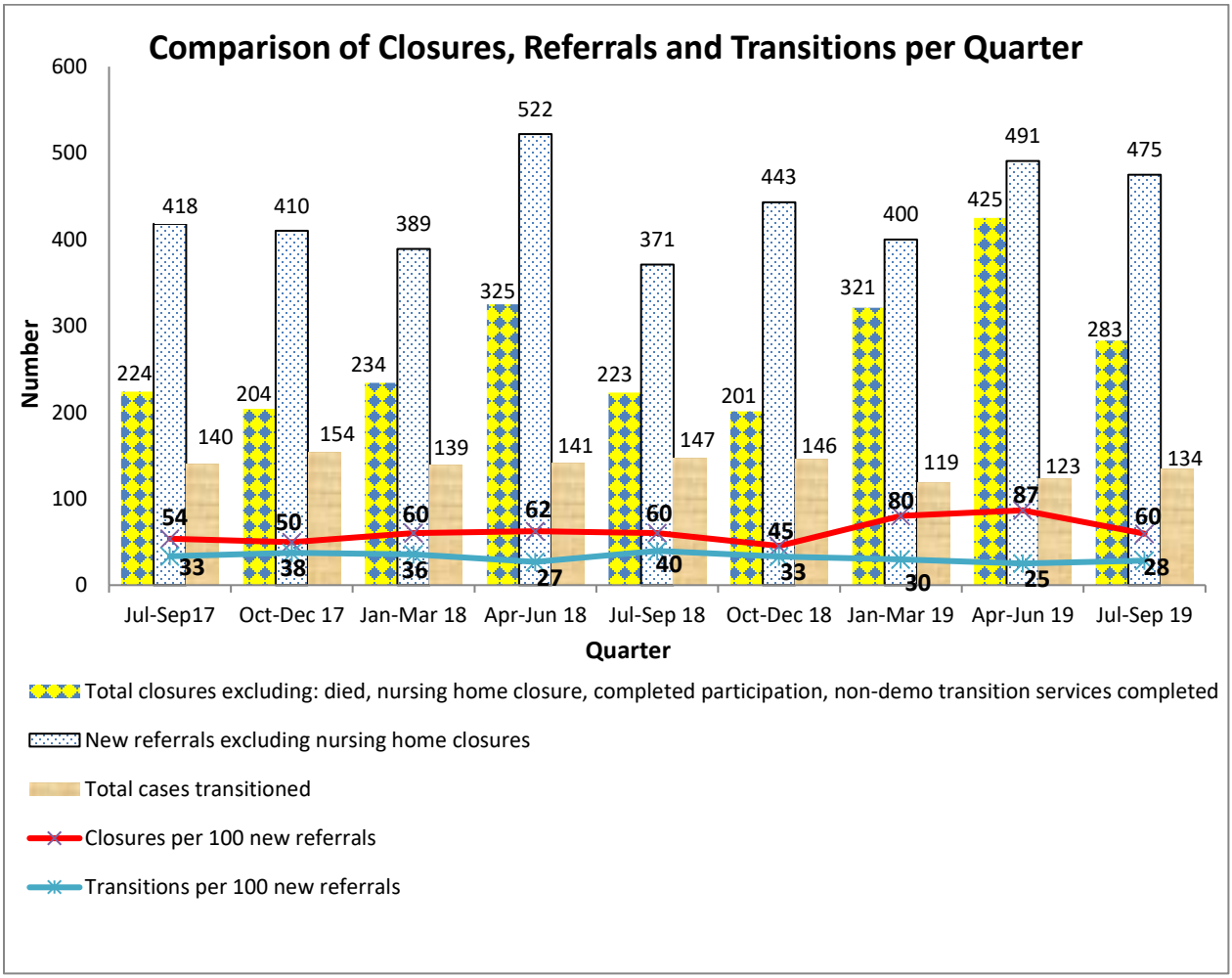









Frequency of Closure Reason by Year of Closure
0%
5%
10%
15%
20%
25%
30%
Participant changed mind
Wouldn't cooperate w/ care planning
Transitioned before informed consent signed
COP/Guardian refused participation
Exceeds physical health needs
Reinstitutionalized for 90+ days
Exceeds mental health needs
Not aware of referral
Moved out of state
Other
2017 (n=992)
2018 (n=990)
Jan-Sept '19 (n=1029)


Comparison of Closures, Referrals and Transitions per Quarter
Number
600
500
400
300
200
100
0
224
418
140
54
33
204
410
154
50
38
234
389
139
60
36
325
522
141
62
27
223
371
147
60
40
201
443
146
45
33
321
400
119
80
30
425
491
123
87
25
283
475
134
60
28
Jul-Sep17
Oct-Dec 17
Jan-Mar 18
Apr-Jun 18
Jul-Sep 18
Oct-Dec 18
Jan-Mar 19
Apr-Jun 19
Jul-Sep 19
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

Andrew Butkiewicz' Story

The first thing you notice when entering Andrew's home environment is the hardy welcome you receive from Lola and Laila, teacup Pomeranian sisters, and Brody "Bear," a Bernese Mountain dog. There is also a very quiet, but very old (100 years) turtle.

Three major motorcycle accidents in the last 16 years may have altered Andrew's body and mind, leaving him to struggle daily with pain, short-term memory loss and PTSD, but he retains a wonderfully positive outlook on life. As his t-shirt says, "He is hooked on life." Andrew works hard to maintain his physical health in order to enjoy his family and his animals. He hopes he will find a way to enjoy fishing again as he continues to recover. After his 2011 accident, he was officially brain dead, deprived of oxygen for over 6 minutes, and in a coma for 5 days on a ventilator. However, he did ultimately return to work as a manufacturing engineer for auto, air and spacecraft components. In July 2018, after working a 19 hour day on a project, he was hit by a car while on his motorcycle. Thrown into a telephone pole, he suffered tremendously on that 100+degree day resulting in a severed foot, fractures of the leg, arm, ribs and spine, and third-degree burns that are still healing after 16 months. He has had 14 surgeries since that day and may need 2 more.

Andrew has held very physically demanding jobs such as a ski patroller, fireman, paramedic, and high angle ropes instructor for the county's fire department. His fierce determination and desire to help others remain strong. He and four other family members work as a team to home school his teenage daughter. He called everyone rejoicing when he conquered certain hurtles like getting out of bed and not relying on people to help him use the bathroom.

Life in the skilled nursing facility (SNF), although necessary for his rehabilitation, was also extremely difficult. He had little control over his life, but he engaged with other residents, especially the veterans, in recreational activities. Andrew felt the nurses and aides provided "phenomenal" care, giving credit to one particular nurse whom he felt saved his life. It was this nurse who told him about the Money Follows the Person program. He followed through on his own with the process and, with help from the transition coordinator, Andrew was discharged from the SNF after 4 months, on the day before Thanksgiving, to be with his wife and daughter.

The transition coordinator was there to help Andrew make his environment safer by getting assistive technology to help him with activities of living. After working intensely with the physical therapists at Gaylord Specialty Healthcare, Andrew continues to do his PT exercises on his own. No longer fully dependent on the wheelchair, he has made great progress in his rehabilitation and is working on strengthening his legs to prevent falls. A visiting nurse and a physical therapist are available if needed. However, given his training as a paramedic, he is comfortable changing his wound dressings. The burns are now 85-90% healed.

Andrew has recently been able to climb the stairs and enjoy the backyard gazebo with family, friends, and Brody. He has learned to never stop seeing the positive aspects of his life.

Photo credit: Vanessa Woy, Mintz & 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.