CT Money Follows the Person Report

April-June 2019

UConn Health, Center on Aging

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

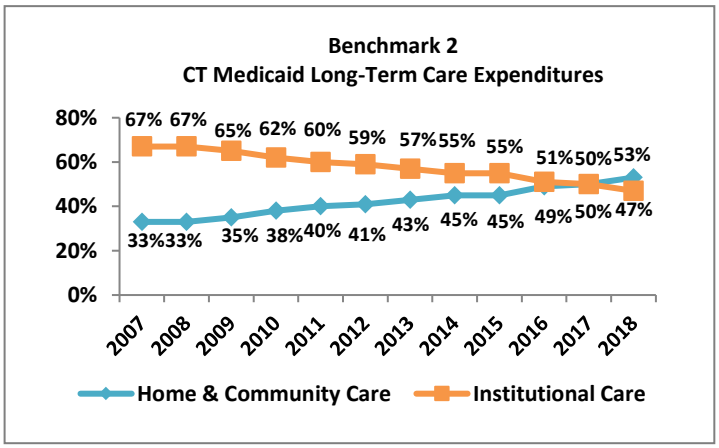
MFP Benchmarks

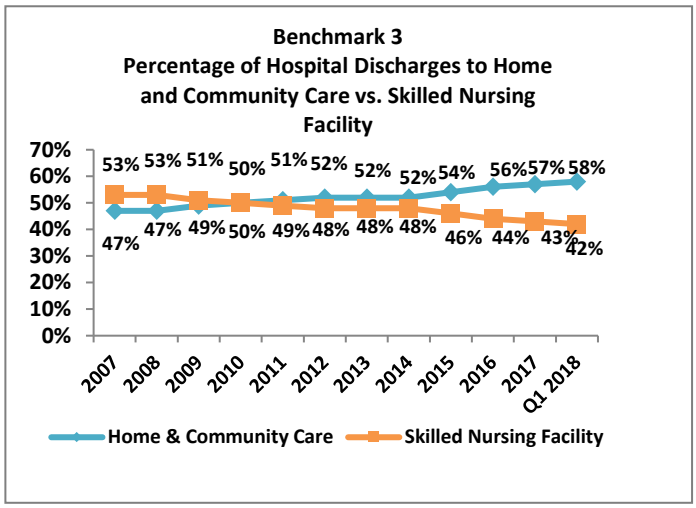
1) Transition 5200 people from qualified institutions to the community
2) Increase dollars to home and community based services
3) Increase hospital discharges to the community rather than to institutions
4) Increase probability of returning to the community during the six months following nursing home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

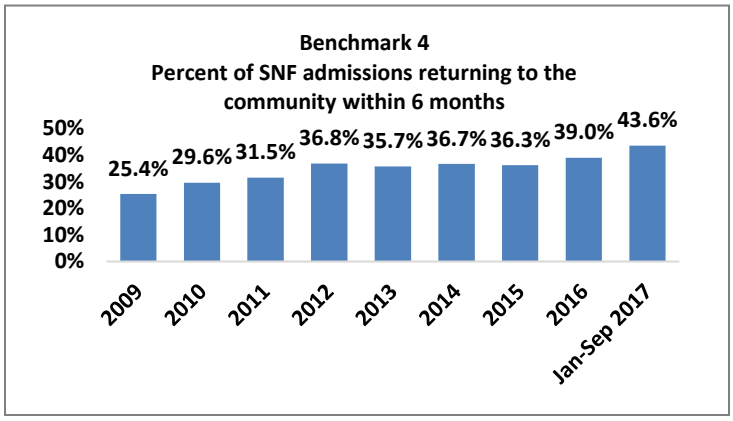
Benchmark 1: Total Transitions = 5,671

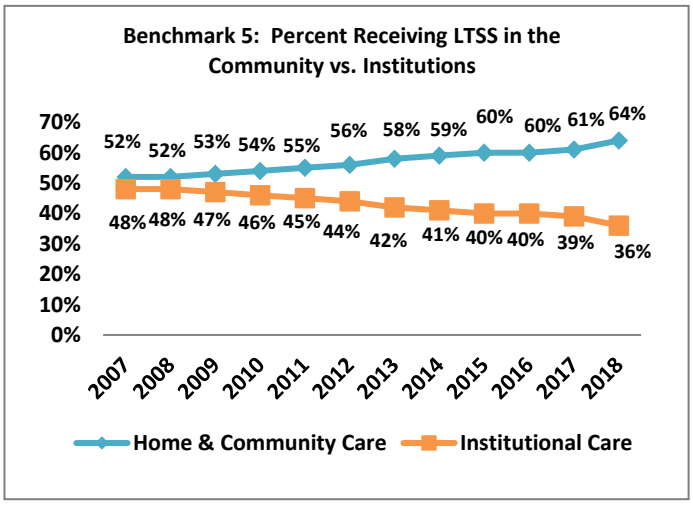
Demonstration = 5,298 (94%)

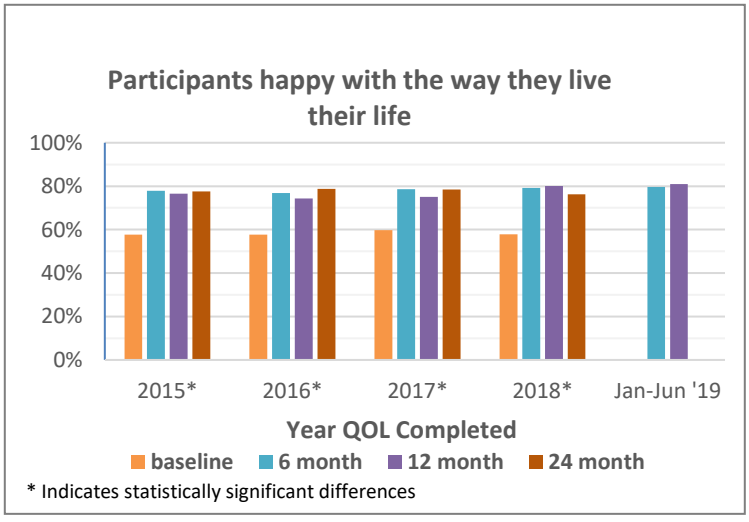
Non-demonstration = 373 (6%)



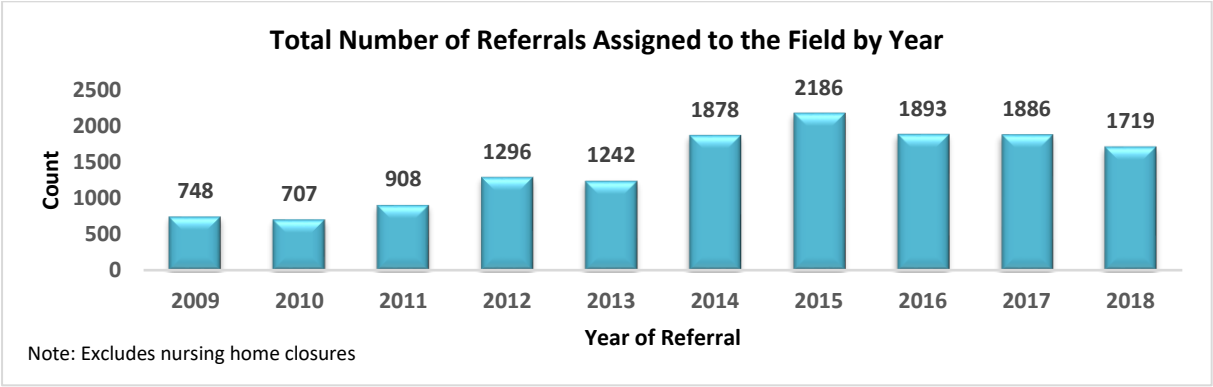




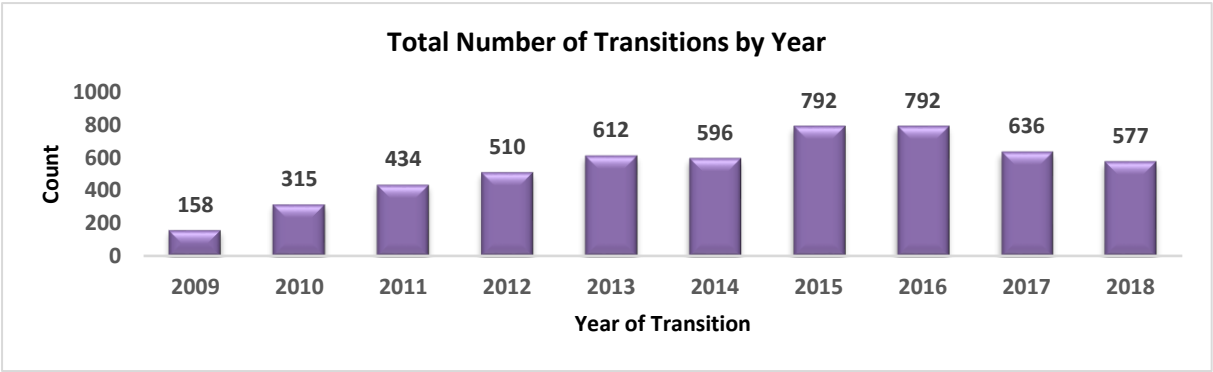


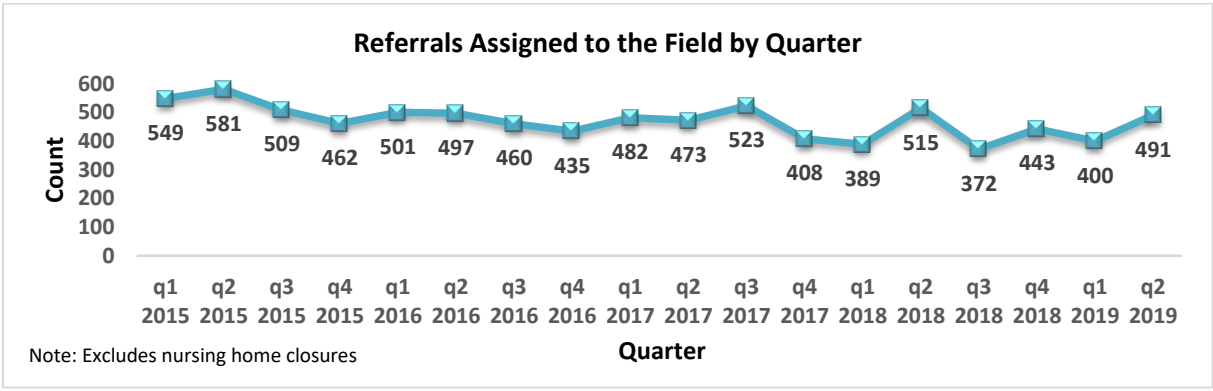


* Indicates statistically significant differences



Note: Excludes nursing home closures





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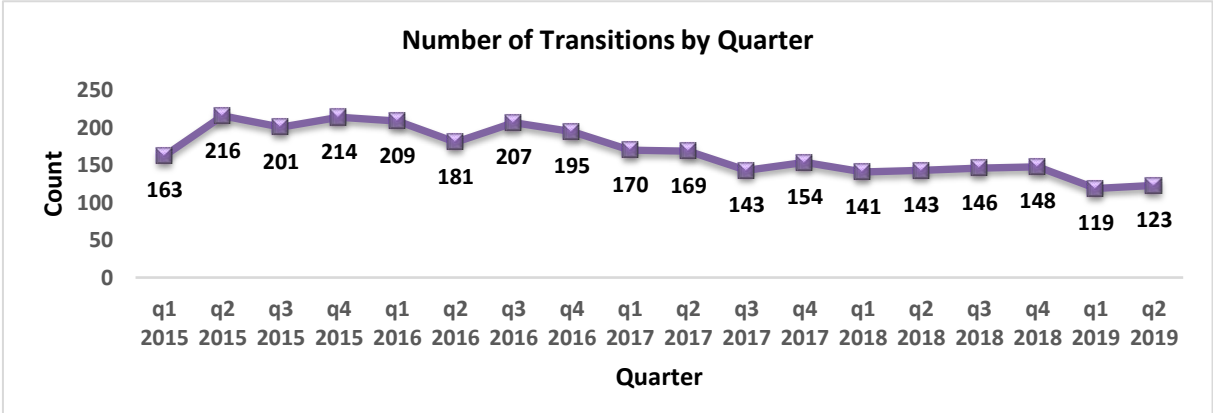
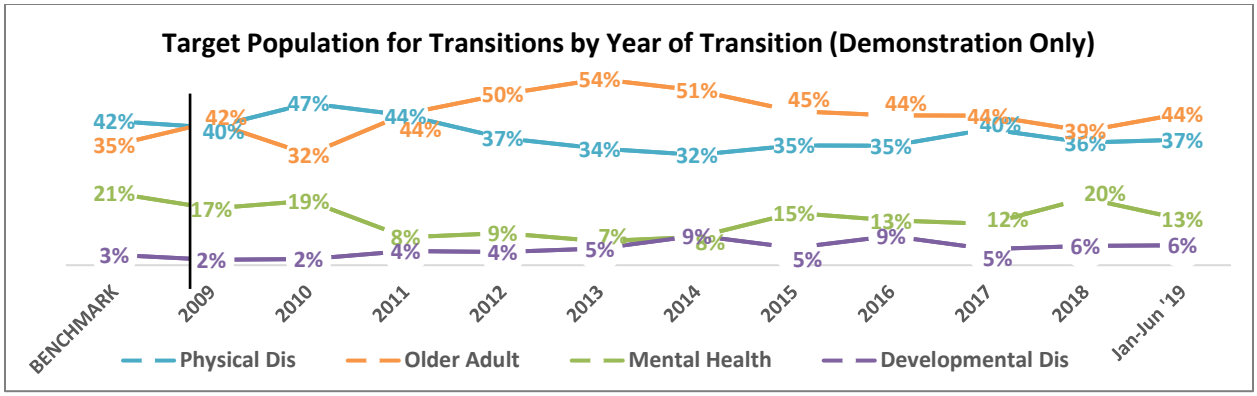
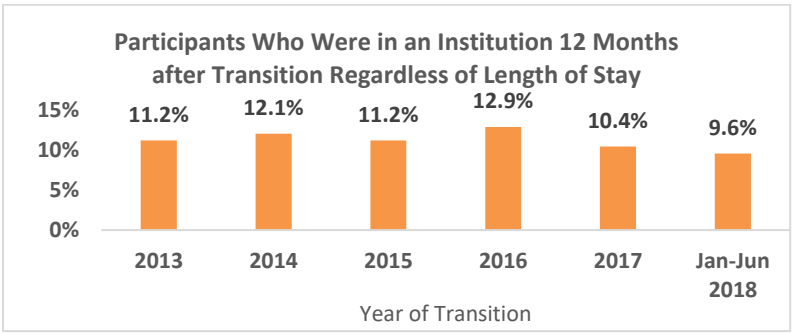
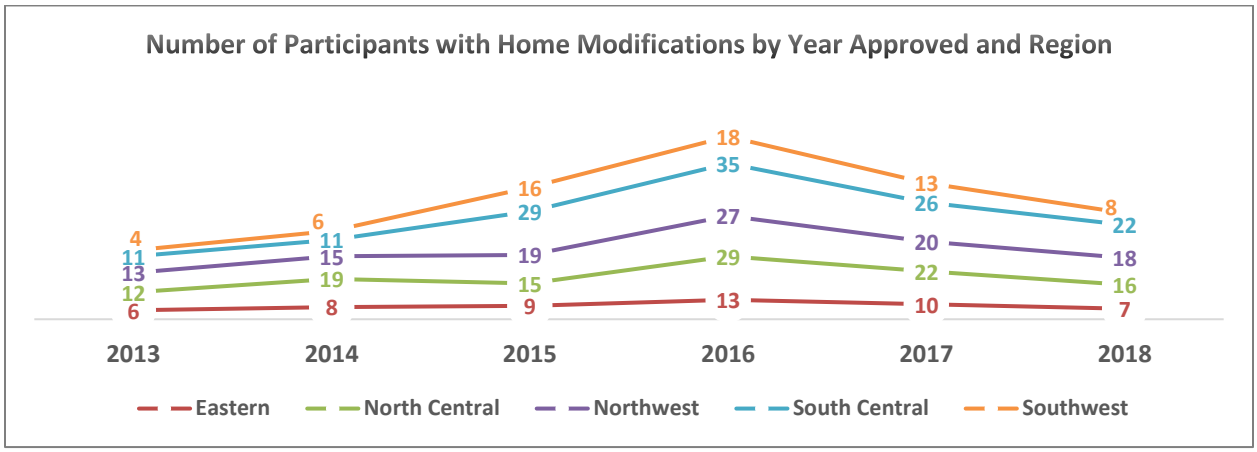
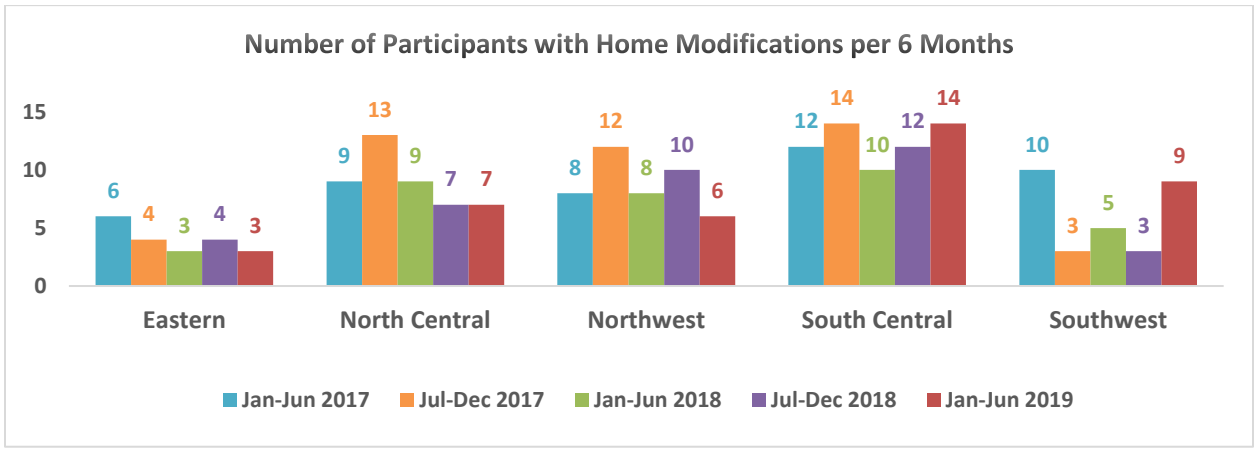


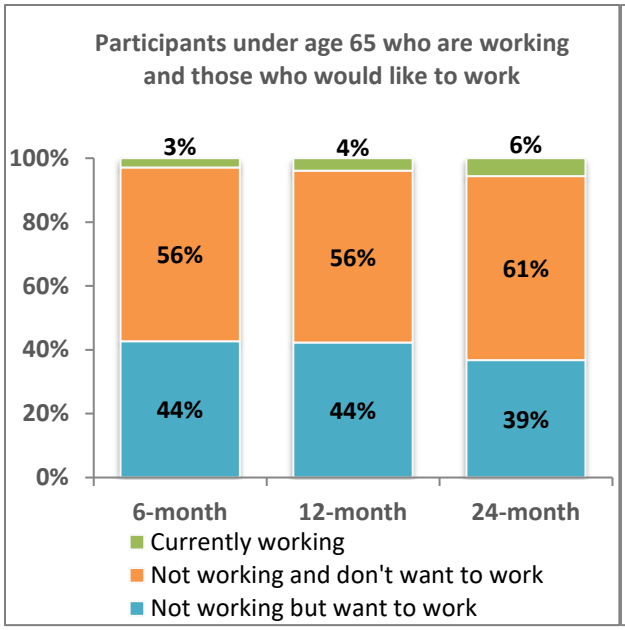

Target Population for Transitions by Year of Transition (Demonstration Only)
BENCHMARK
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Jan-Jun '19
Physical Dis
Older Adult
Mental Health
Developmental Dis

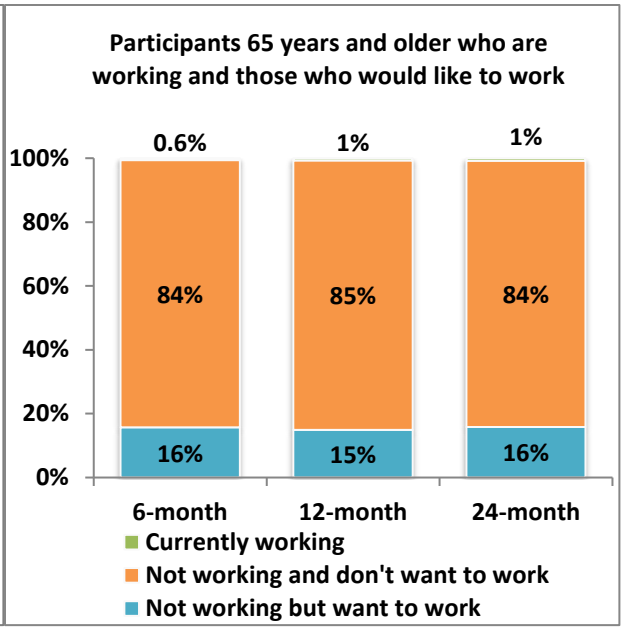

Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay
15%
10%
5%
0%
11.2%
12.1%
11.2%
12.9%
10.4%
9.6%
2013
2014
2015
2016
2017
Jan-Jun 2018
Year of Transition

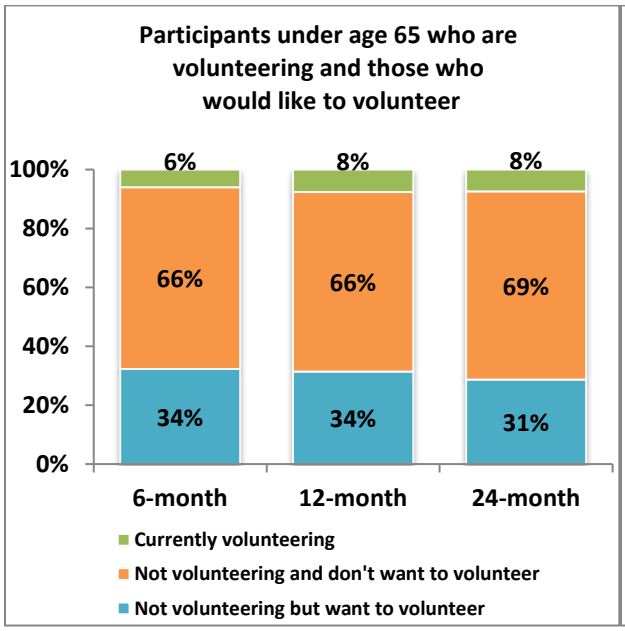

Number of Participants with Home Modifications by Year Approved and Region
2013
2014
2015
2016
2017
2018
Eastern
North Central
Northwest
South Central
Southwest

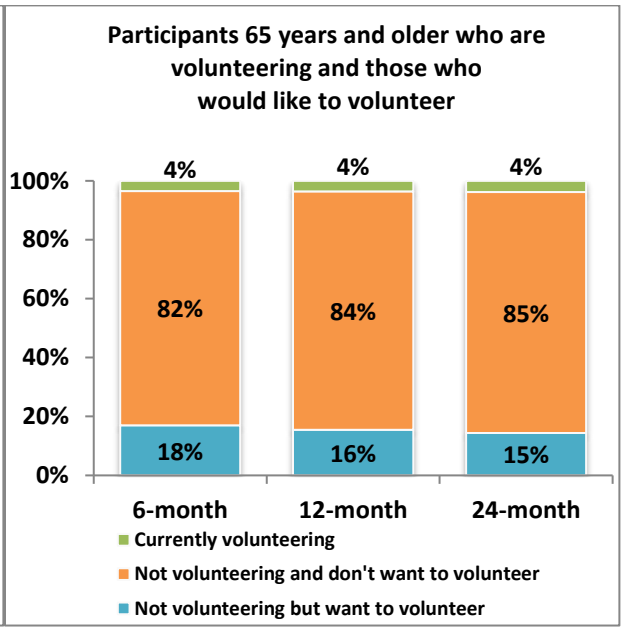

Number of Participants with Home Modifications per 6 Months
15
10
5
0
Eastern
North Central
Northwest
South Central
Southwest
Jan-Jun 2017
Jul-Dec 2017
Jan-Jun 2018
Jul-Dec 2018
Jan-Jun 2019

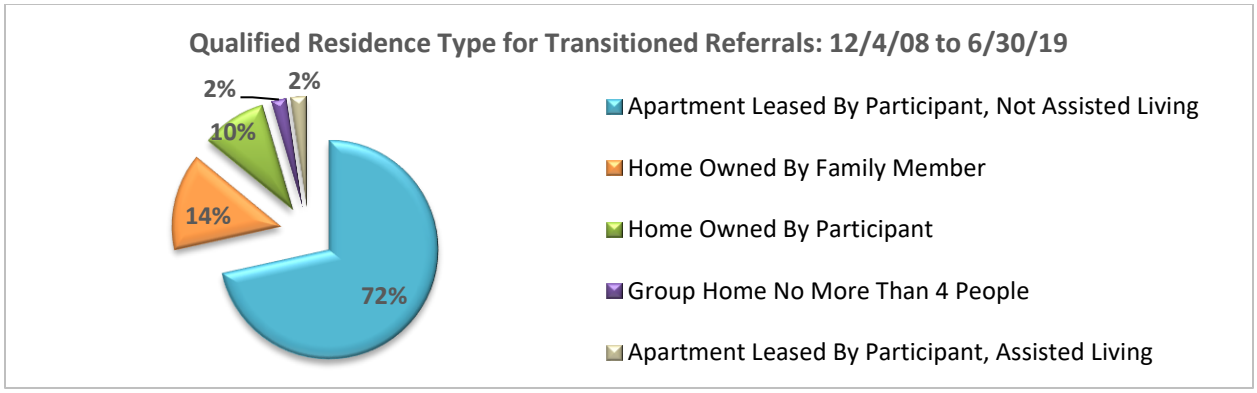
Participants who are Working and/or Volunteering (cumulative data 12/2008-present)





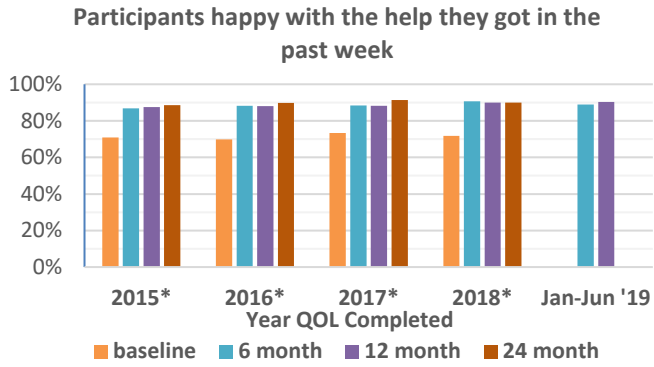


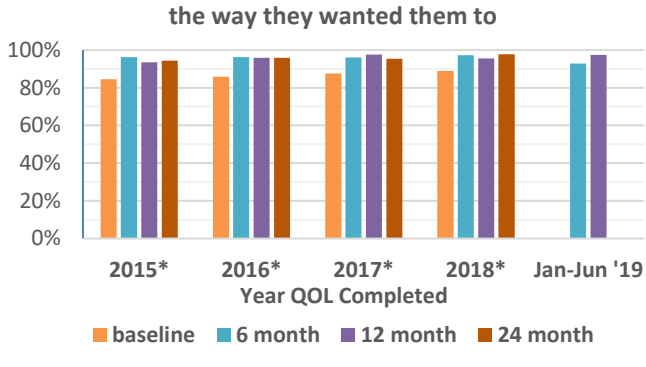


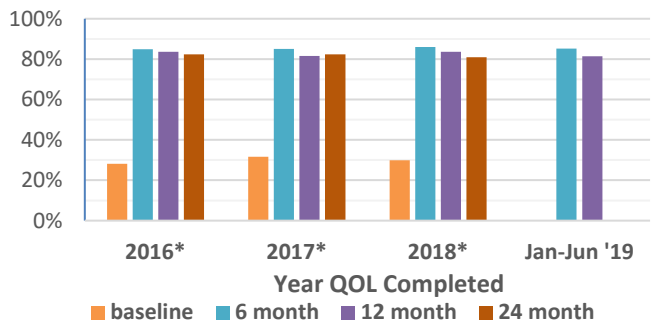


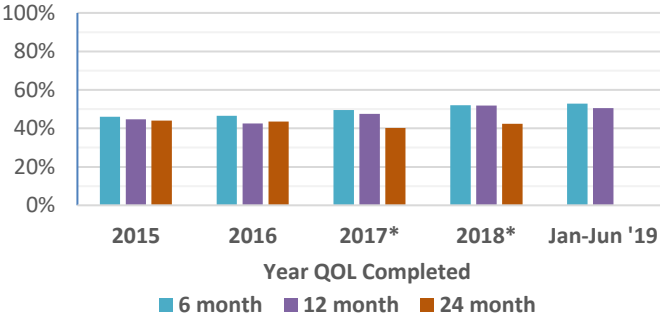
MFP Quality of Life Dashboard

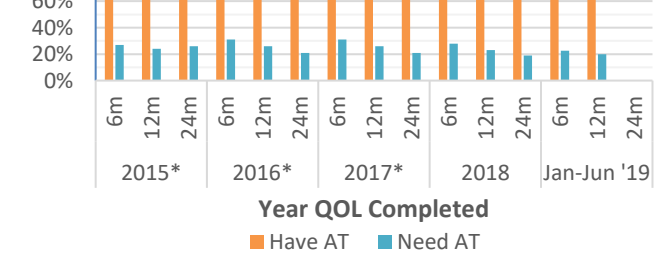
Number of Quality of Life Interviews Completed by Timepoint (cumulative through 06/30/19)
Baseline interviews done prior to transition, **n=5463**
6 month interviews done 6 months after transition, **n=4407**
12 month interviews done 12 months after transition, **n=4018**
24 month interviews done 24 months after transition, **n=2907**

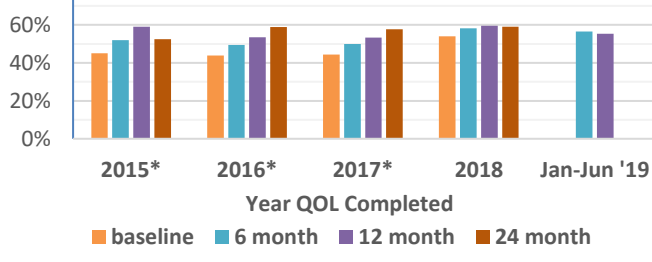












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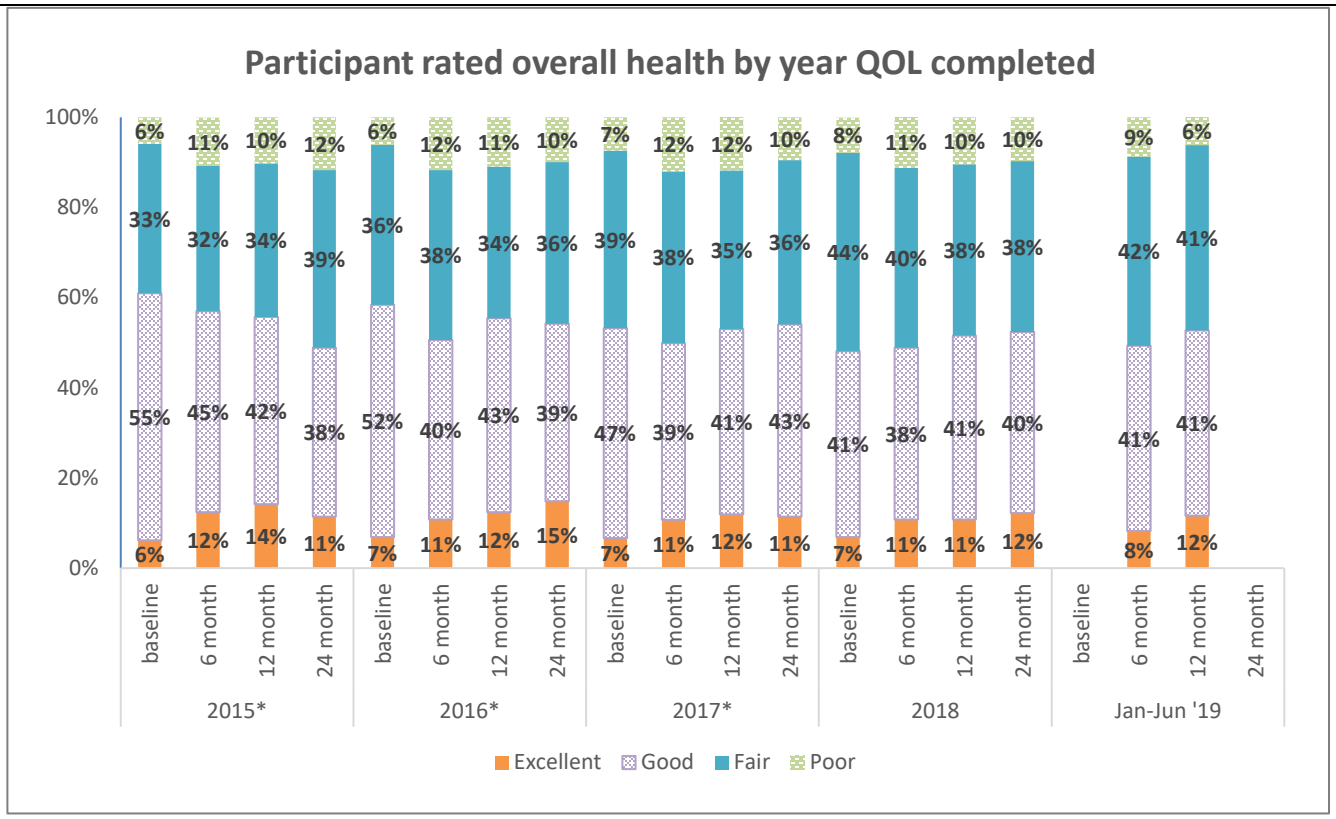
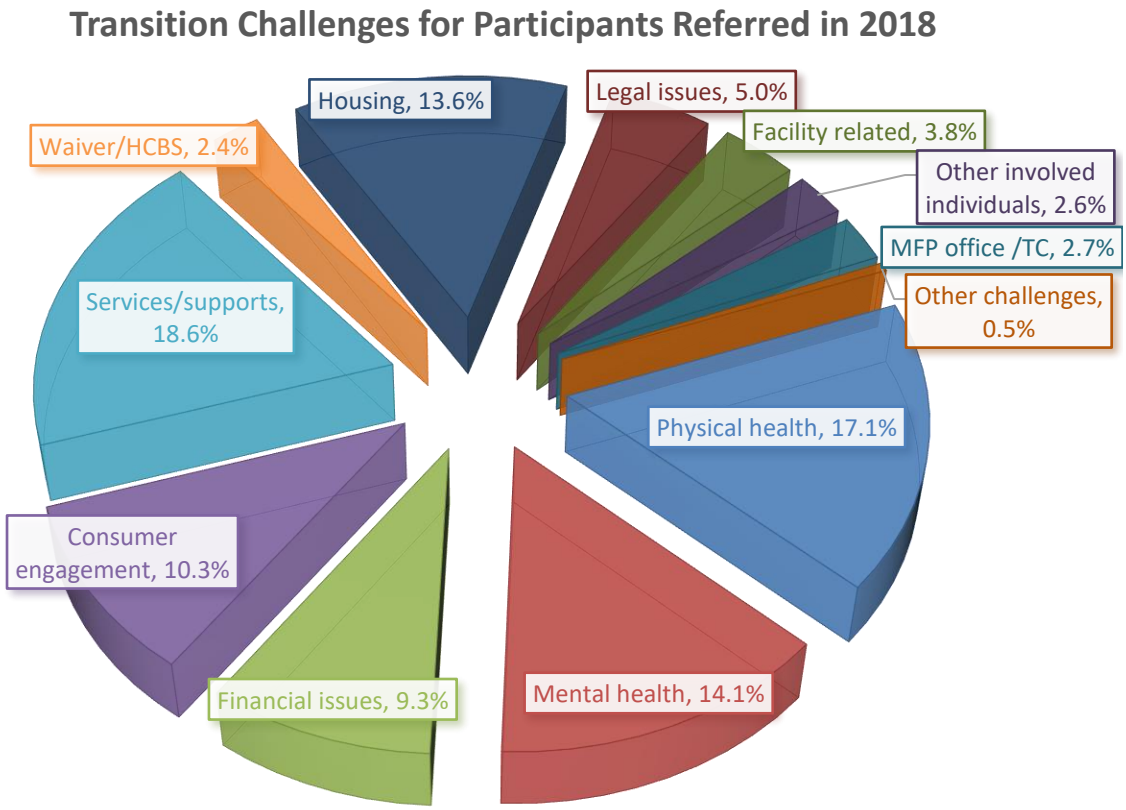
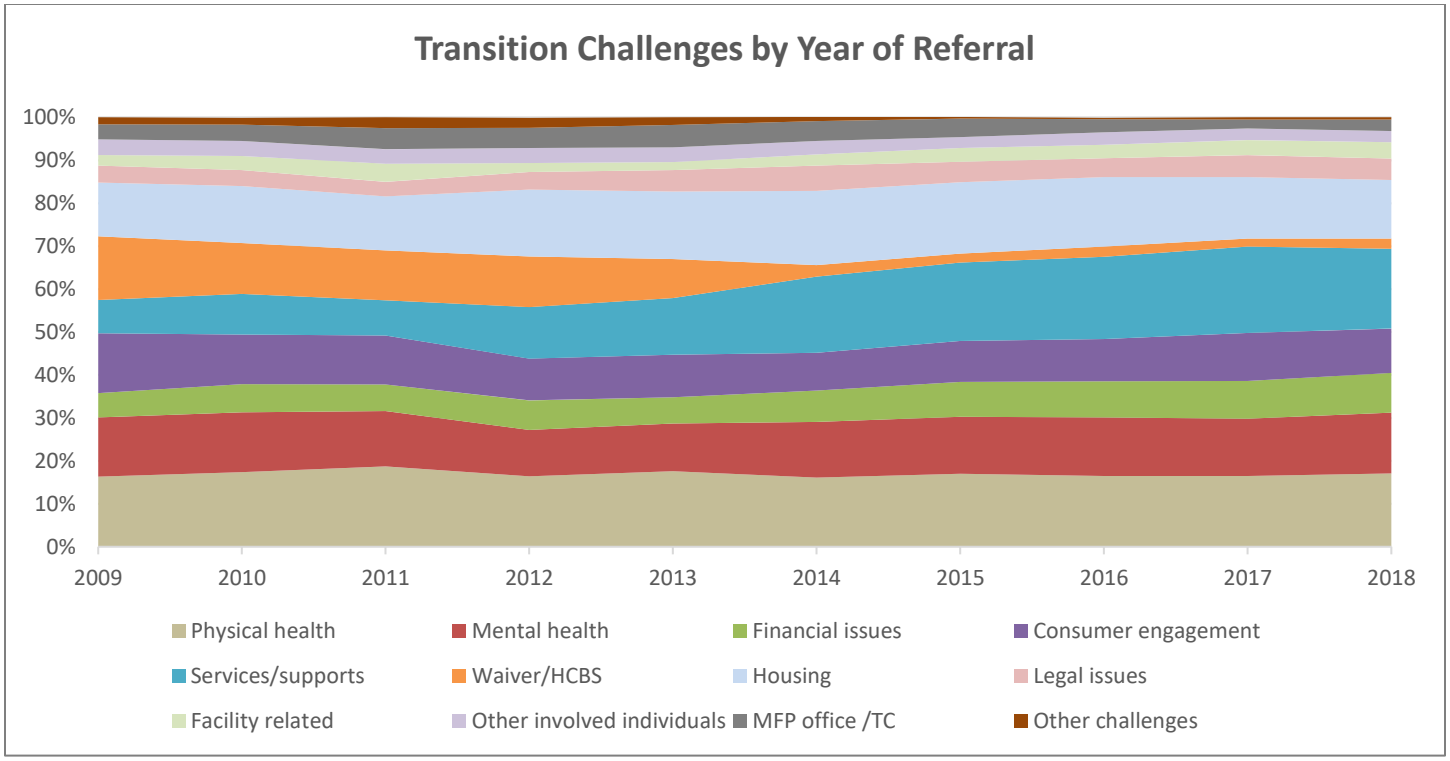
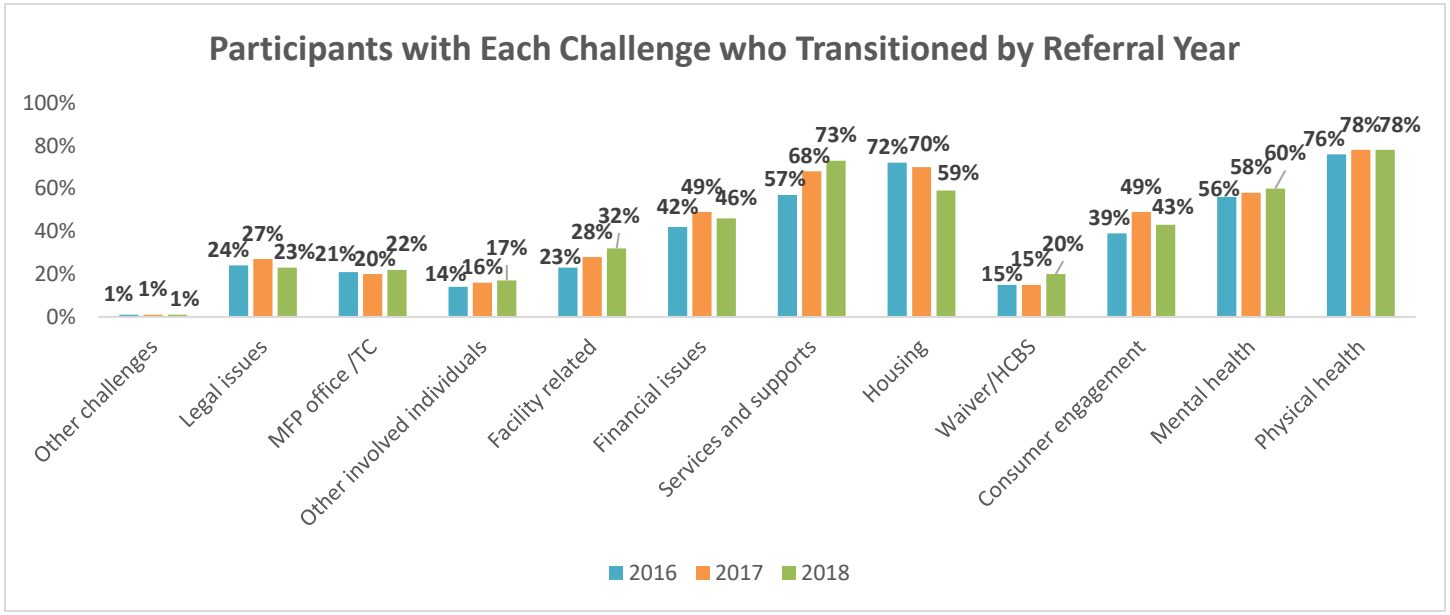


Challenges to Transition as noted by TCs and SCMs



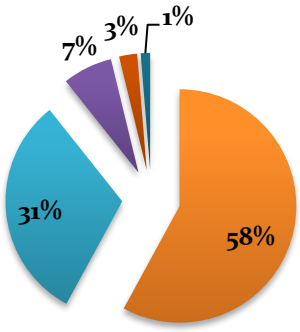

Transition Challenges by Year of Referral
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Physical health
Mental health
Financial issues
Consumer engagement
Services/supports
Waiver/HCBS
Housing
Legal issues
Facility related
Other involved individuals
MFP office /TC
Other challenges


Participants with Each Challenge who Transitioned by Referral Year
100%
80%
60%
40%
20%
0%
1% 1% 1%
24% 27% 23%
21% 20% 22%
14% 16% 17%
23% 28% 32%
42% 49% 46%
57% 68% 73%
72% 70% 59%
15% 15% 20%
39% 49% 43%
56% 58% 60%
76% 78% 78%
Other challenges
Legal issues
MFP office /TC
Other involved individuals
Facility related
Financial issues
Services and supports
Housing
Waiver/HCBS
Consumer engagement
Mental health
Physical health
2016
2017
2018

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

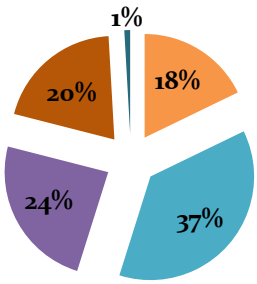
Below are the six most common challenge types from 2018

Physical health



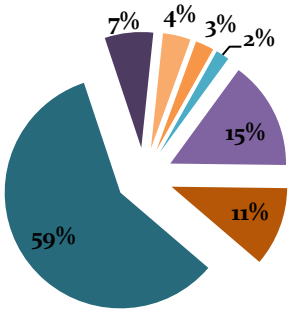
- Current, new or undisclosed physical health problem
- Inability to manage physical disability or physical illness in community
- Medical testing issues or delays
- Missing or waiting for physical health documents
- Other physical health issues

Mental health



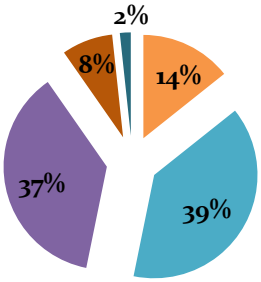
- Current or history of substance/alcohol abuse w/ risk of relapse
- Current, new, or undisclosed mental health problem
- Dementia or cognitive issues
- Inability to manage mental health in community
- Other mental health issues

Housing



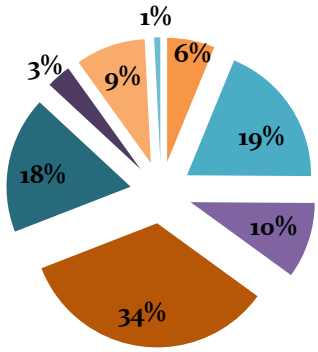
- Delays related to housing authority, agency or housing coordinator
- Delays related to lease, landlord, apartment manager, etc.
- Needs housing modifications before transition
- Ineligible or waiting for approval from RAP or other housing programs
- Lacks affordable, accessible community housing
-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

Consumer engagement



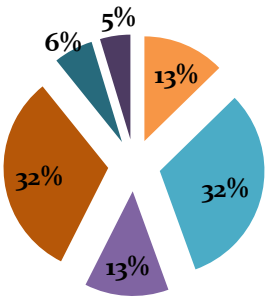
- Disengagement or lack/loss of motivation
- Lack of awareness or unrealistic expectations
- Lack of independent living skills
- Language or communication skills
- Other consumer related issues

Services and supports

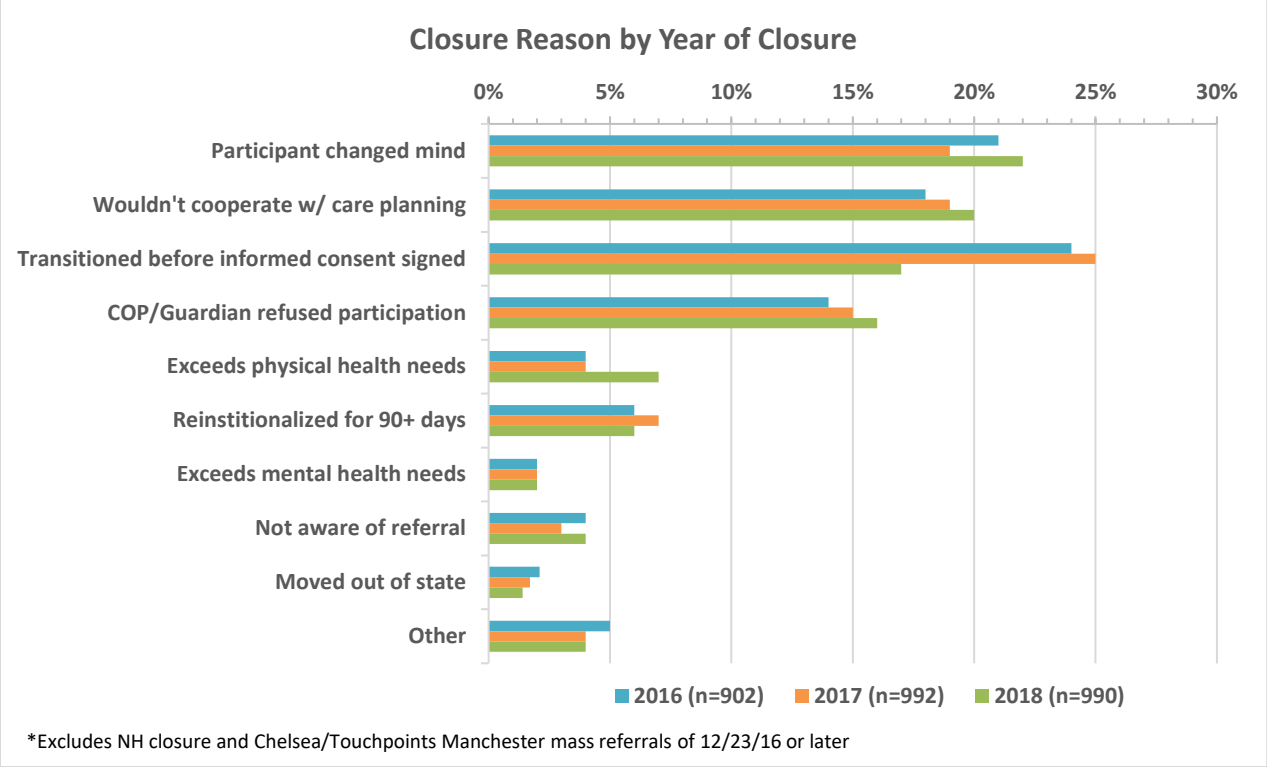


- Lack of alcohol, substance abuse, or addiction services
- Lack of AT or DME
- Lack of mental health services or supports
- Lack of PCA, home health, or other paid support staff
- Lack of transportation
- Lack of any other services or supports
- Lack of unpaid caregiver to provide care/informal support
- Other issues related to services or supports

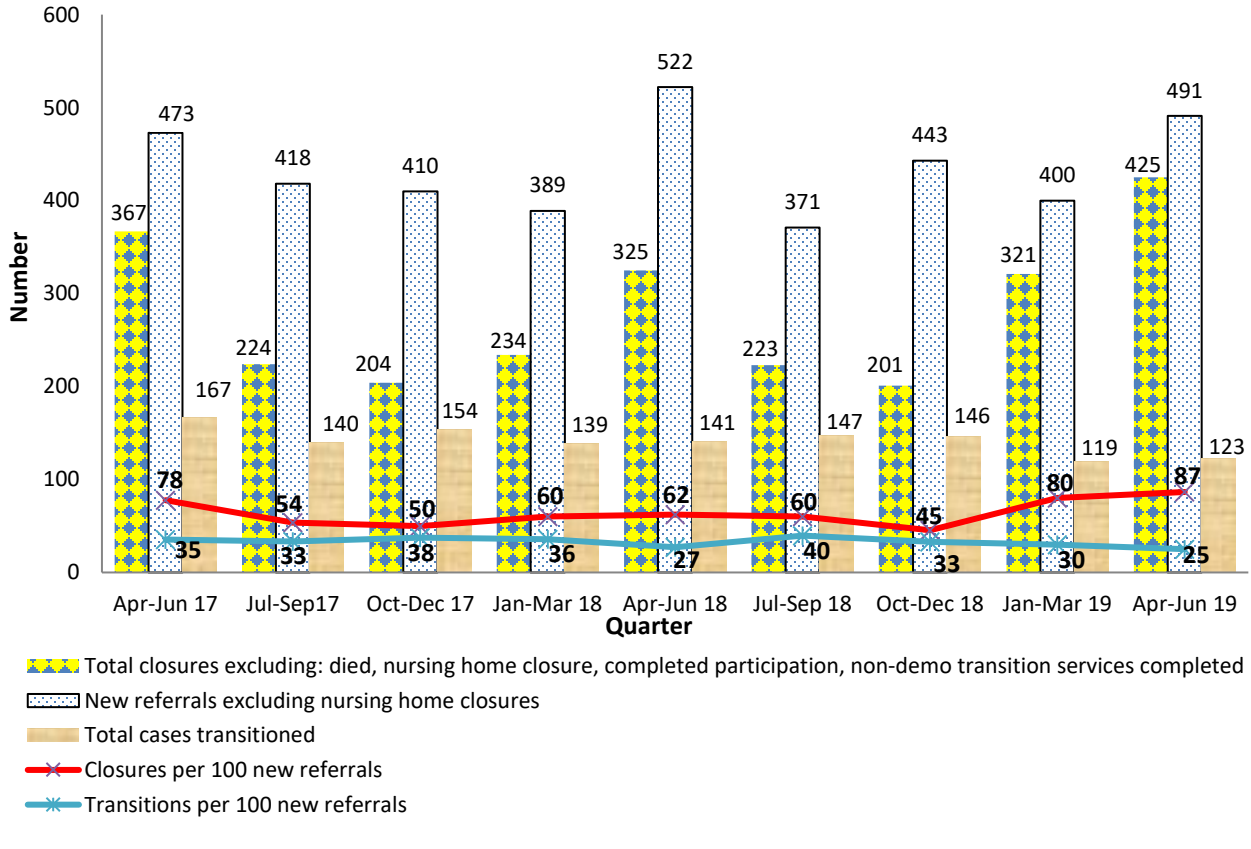
Financial



- 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



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



Doug Lagasse's Story

Photo credit: Alyssa Cianciosi, Mintz and Hoke

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."

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.