CT Money Follows the Person Report
July - September 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%)

Benchmark 2: CT Medicaid Long-Term Care Expenditures
Home & Community Care
Institutional Care

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

*Data 1/1/19-9/30/19
Target Population for Transitions by Year of Transition (Demonstration Only)

Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay

Number of Participants with Home Modifications by Year Approved and Region

Number of Participants with Home Modifications per 6 Months
Participants who are Working and/or Volunteering (data 1/1/19-9/30/19)

Participants under age 65 who are working and those who would like to work

- Working: 55% (1 month), 57% (12 month)
- Want to work: 43% (1 month), 40% (12 month)
- Don't want to work: 2% (1 month), 3% (12 month)

Participants under age 65 who are volunteering and those who would like to volunteer

- Don't want to volunteer: 4% (1 month), 5% (12 month)
- Want to volunteer: 27% (1 month), 23% (12 month)
- Volunteering: 69% (1 month), 72% (12 month)

Participants 65 years and older who are working and those who would like to work

- Working: 84% (1 month), 79% (12 month)
- Want to work: 14% (1 month), 20% (12 month)
- Don't want to work: 2% (1 month), 1% (12 month)

Participants 65 years and older who are volunteering and those who would like to volunteer

- Don't want to volunteer: 1% (1 month), 8% (12 month)
- Want to volunteer: 24% (1 month), 22% (12 month)
- Volunteering: 76% (1 month), 70% (12 month)

Qualified Residence Type for Transitioned Referrals: 12/4/08 to 9/30/19

- Apartment Leased By Participant, Not Assisted Living: 2% (1 month), 2% (12 month)
- Home Owned By Family Member: 14% (1 month)
- Home Owned By Participant: 72% (1 month)
- Group Home No More Than 4 People: 10% (1 month)
- Apartment Leased By Participant, Assisted Living: 1% (1 month), 1% (12 month)
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

HCBS CAHPS Composite Measures: Percent with Highest Score (e.g. always, yes)

- Staff are reliable and helpful: 85%
- Choosing the services that matter to you: 76%
- Staff listen and communicate well: 68%
- Planning your time and activities: 60%

* Data for 1 month survey

Did any unpaid family members or friends help you with things around the house?

- Yes: 56% (1 month) 51% (12 month)
- No: 44% (1 month) 49% (12 month)

Depressive Symptoms*

- Yes: 40% (1 month) 47% (12 month)
- No: 60% (1 month) 53% (12 month)

*Questions are different at 1m vs 12m

Do you like where you live?

- Yes: 85% (1 month) 80% (12 month)
- Sometimes: 6% (1 month) 7% (12 month)
- No: 10% (1 month) 14% (12 month)

Have or Need Assistive Technology (AT)?

- Have AT: 99% (1 month) 96% (12 month)
- Need AT: 37% (1 month) 20% (12 month)
Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred Jan-Sept 2019

Physical health, 17.1%
Mental health, 14.8%
Financial issues, 8.8%
Consumer engagement, 10.5%
Services/supports, 19.3%
Housing, 13.8%
Legal issues, 5.7%
Facility related, 2.8%
Waiver/HCBS, 3.0%
MFP office /TC, 1.9%
Other involved individuals, 2.0%
Other challenges, 0.3%

Frequency of Transition Challenges by Year of Referral

Physical health
Mental health
Financial issues
Consumer engagement
Services/supports
Housing
Legal issues
Facility related
Waiver/HCBS
MFP office /TC
Other involved individuals
Other challenges
Types of Challenges for Referrals: 1/1/2019-9/30/2019
Below are the four most common challenge types for 2019

**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

**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
Frequency of Closure Reason by Year of Closure

- 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

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
- 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 more 2.

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 hurdles 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.