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 = 5,964
Demonstration = 5,576 (94%)
Non-demonstration = 388 (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

- 1 month: 85%
- 12 month: 80%

happy: 15% 20%
unhappy: 85% 80%
Total Number of Referrals Assigned to the Field by Year

Note: Excludes nursing home closures

Total Number of Transitions by Year

Note: Excludes nursing home closures

Referrals Assigned to the Field by Quarter

Note: Excludes nursing home closures

Number of Transitions by Quarter

Note: Excludes nursing home closures
Participants under age 65 who are working and those who would like to work

- **1 month**
  - Working: 56%
  - Want to work: 43%
  - Don't want to work: 2%
- **12 month**
  - Working: 58%
  - Want to work: 40%
  - Don't want to work: 2%

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

- **1 month**
  - Volunteering: 68%
  - Want to volunteer: 29%
  - Don't want to volunteer: 4%
- **12 month**
  - Volunteering: 71%
  - Want to volunteer: 24%
  - Don't want to volunteer: 6%

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

- **1 month**
  - Working: 82%
  - Want to work: 17%
  - Don't want to work: 1%
- **12 month**
  - Working: 81%
  - Want to work: 18%
  - Don't want to work: 1%

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

- **1 month**
  - Volunteering: 76%
  - Want to volunteer: 23%
  - Don't want to volunteer: 1%
- **12 month**
  - Volunteering: 74%
  - Want to volunteer: 20%
  - Don't want to volunteer: 7%

Qualified Residence Type for Transitioned Referrals: 12/4/08 to 12/31/19

- Apartment Leased By Participant, Not Assisted Living: 72%
- Home Owned By Family Member: 14%
- Home Owned By Participant: 10%
- Group Home No More Than 4 People: 2%
- Apartment Leased By Participant, Assisted Living: 2%
MFP Quality of Life Dashboard

Number of Quality of Life Interviews Completed from 1/1/19 - 12/31/19:
1 month interviews done 1 month after transition, n=347
12 month interviews done 12 months after transition, n=377

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

- Staff are reliable and helpful: 82%
- Choosing the services that matter to you: 72%
- Staff listen and communicate well: 70%
- Planning your time and activities: 61%

* Data for 1 month survey

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

- 1 month: 55% yes, 45% no
- 12 month: 53% yes, 47% no

Depressive Symptoms*

- 1 month: 37% yes, 63% no
- 12 month: 50% yes, 50% no

*Questions are different at 1m vs 12m

Do you like where you live?

- 1 month: 87% yes, 5% sometimes, 9% no
- 12 month: 80% yes, 6% sometimes, 13% no

Have or Need Assistive Technology (AT)?

- 1 month: 99% have AT, 38% need AT
- 12 month: 96% have AT, 22% need AT
Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred in 2019

- Physical health, 17.5%
- Mental health, 14.8%
- Financial issues, 8.6%
- Consumer engagement, 10.7%
- Services/supports, 19.3%
- Waiver/HCBS, 2.9%
- Housing, 13.9%
- Legal issues, 5.6%
- Facility related, 2.8%
- Other involved individuals, 2.0%
- MFP office/TC, 1.7%
- Other challenges, 0.2%
- Other involved individuals, 2.0%
- MFP office/TC, 1.7%
- Other challenges, 0.2%

Frequency of Transition Challenges by Year of Referral

- 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

Types of Challenges for Referrals: 1/1/2019 - 12/31/2019
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
- Transformed before informed consent signed
- COP/Guardian refused participation
- Exceeds physical health needs
- Reinstitionalized 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
Betty Lichtenstein’s Story

Betty describes herself as an active, “never been a sitting around” type of person. After graduating from Western Connecticut State University, having a career in human resources, creating a home for her family and enjoying her hobbies, life took a downward turn. Complications from diabetes led to a stroke and a single leg amputation 8 years ago followed by two years living in a skilled nursing facility. While in the nursing facility, Betty experienced more than physical losses. Her mother and brother died and she could not attend the funerals due to lack of suitable transportation.

The rehabilitation department at the nursing facility suggested Money Follows the Person (MFP) to assist her in transitioning back into the community. Although excited, Betty was fearful and anxious, having to begin again. Betty just wanted a place that felt like home and had two requests when it came to finding housing: a place where she could garden and a place where her grandsons, “the light of her life,” could visit freely. Since 2014, Betty’s MFP transition team (the housing coordinator, the transition coordinator and care manager) continues to work with her. The MFP housing coordinator was able to find Betty an end unit, which provided her with a bigger yard. Now, she looks out her bedroom window to a lovely bird feeder and raised garden beds, where she grows carrots and tomatoes. She enlists her grandsons to help and now they can visit her in an environment where they can play outside. The apartment is not only wheelchair accessible with wider doorways, and a roll-in shower, but the MFP team were instrumental in finding special medical equipment, like a Rifton transfer lift, assistive technology for her vision loss and environmental controls for greater independence to control the lights and fan.

Betty has adjusted well to “the new normal.” She continues to stay active and involved in her community. Utilizing transportation provided by Ability Beyond, she is able to attend her grandsons’ basketball and football games, concerts in town, and nearby shopping centers. Due to her central location and level of independence, she is also able to take herself downtown and to her alma mater, WCSU’s campus to get some fresh air. Betty enjoys giving back to her community, crocheting for charities. Every year she donates 25-30 hats to homeless shelters and 10-20 infant hat and blanket sets to Birthright, an organization that helps single mothers. Betty continues on a path of self-improvement and staying positive in her life. She enjoys attending a free all-day retreat at a Buddhist Monastery in New York, which brings her comfort and strength. She also visited the family plots at the cemetery to find closure with her losses.

Both Betty and the MFP team admit to having a rocky start, with lots of staff turnover. Betty’s advice to others who have to hire their own Personal Care Assistants (PCAs) is to go by word of mouth and know someone who has worked with an aide and trusts them. Betty self manages PCAs for over 80 hours a week and has learned to juggle PCA and Independent Living Skills Training (ILST) worker hours within her budget. Over the past four months, Betty has undergone 4 surgeries, including a second leg amputation. “MFP has changed my life!” Having the aides in place after her surgeries allowed her to go back home where she received in-home and then outpatient services. “I don’t see any reason I should ever have to go to a nursing home again.”

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 grantees 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.