CT Money Follows the Person Report

October – December 2019

UConn Health, Center on Aging

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

MFP Benchmarks

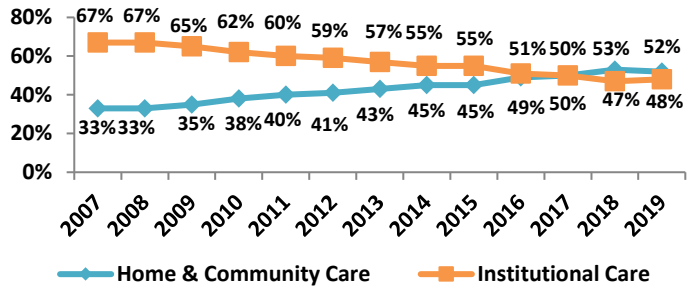
1) Transition 5200 people from qualified institutions to the community
2) Increase dollars to home and community based services
3) Increase hospital discharges to the community rather than to institutions
4) Increase probability of returning to the community during the six months following nursing home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

Benchmark 1: Total Transitions = 5,964

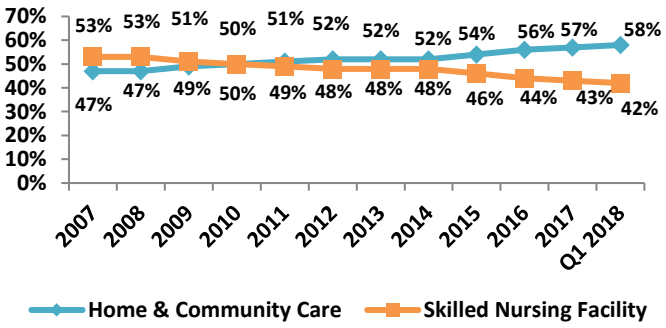
Demonstration = 5,576 (94%)

Non-demonstration = 388 (6%)

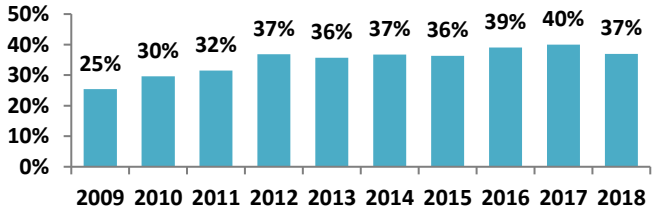
Benchmark 2
CT Medicaid Long-Term Care Expenditures



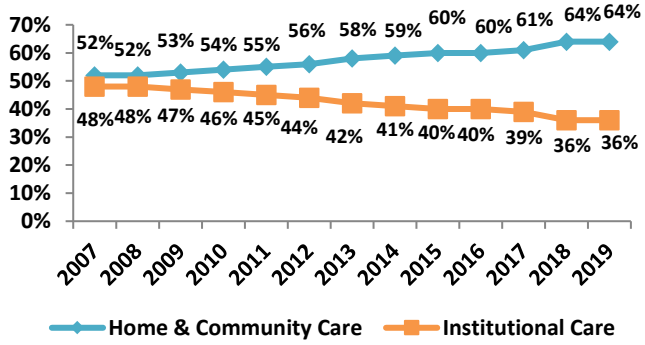
Benchmark 3
Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility



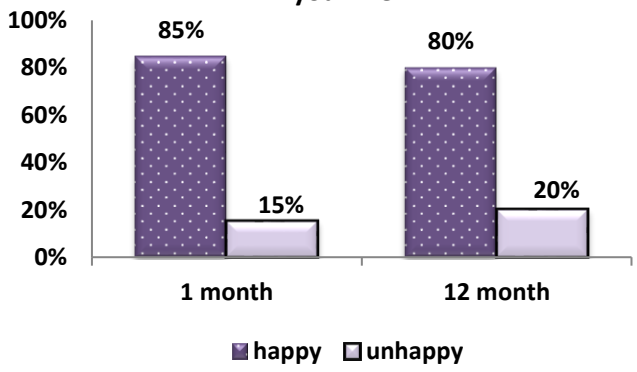
Benchmark 4
Percent of SNF admissions returning to the community within 6 months

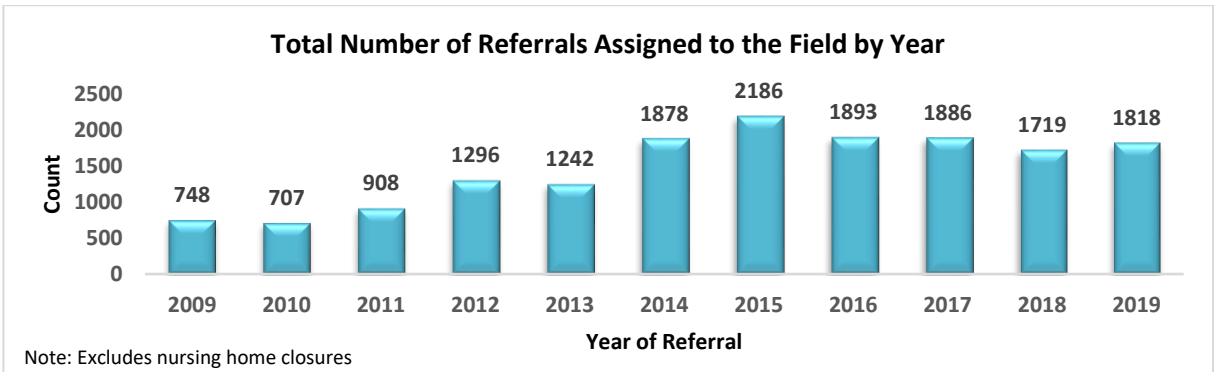


Benchmark 5: Percent Receiving LTSS in the Community vs. Institutions

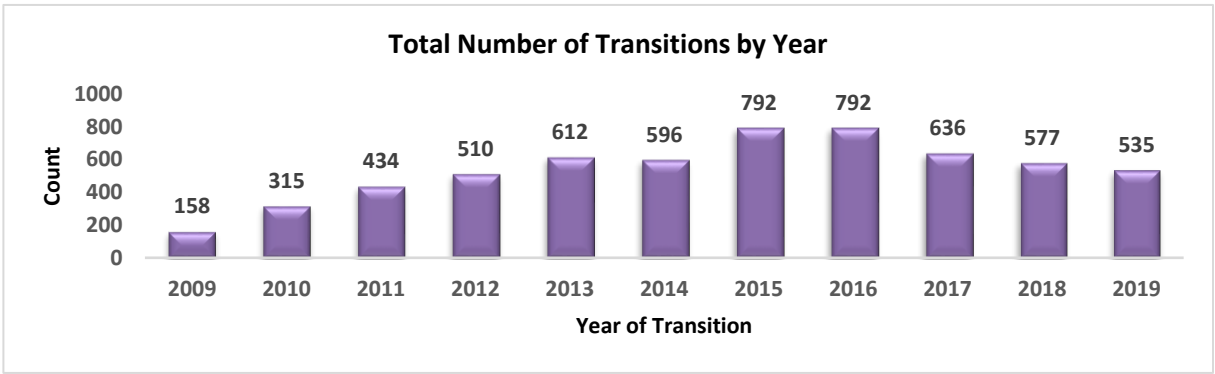


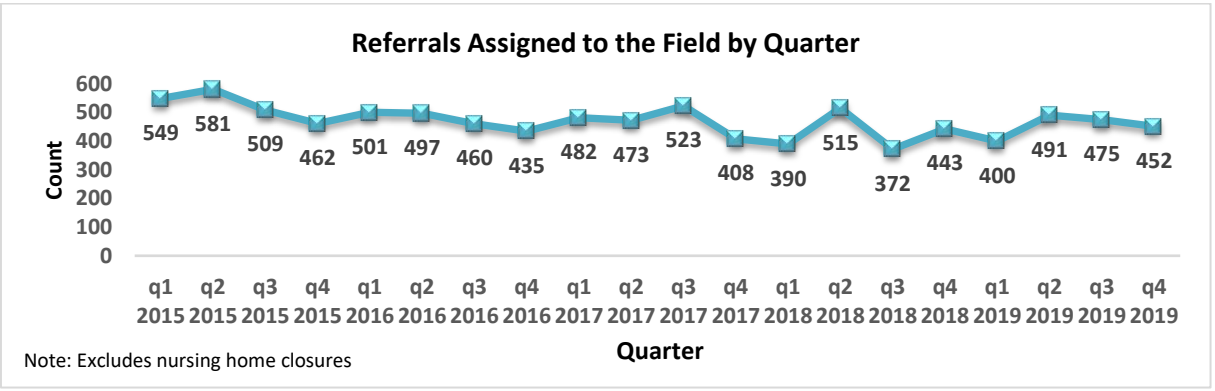
Happy or unhappy with the way you live your life





Note: Excludes nursing home closures





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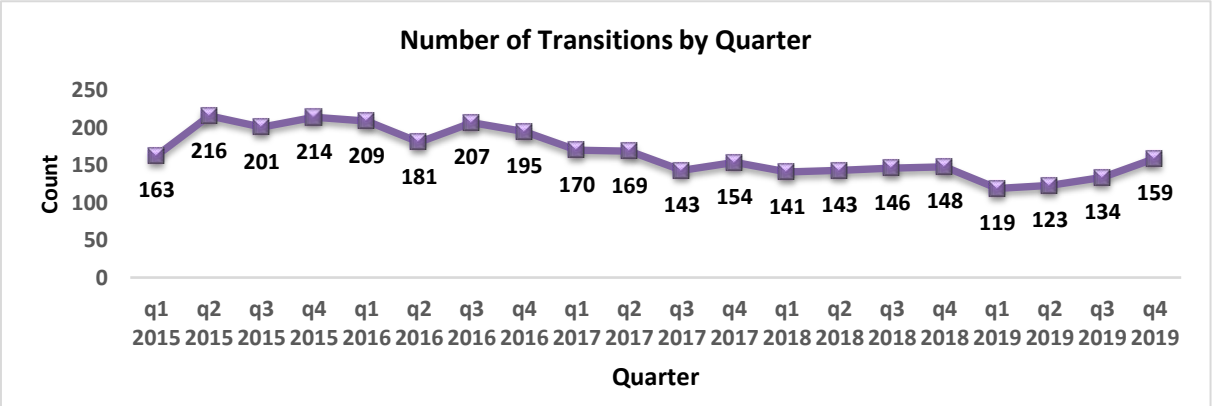
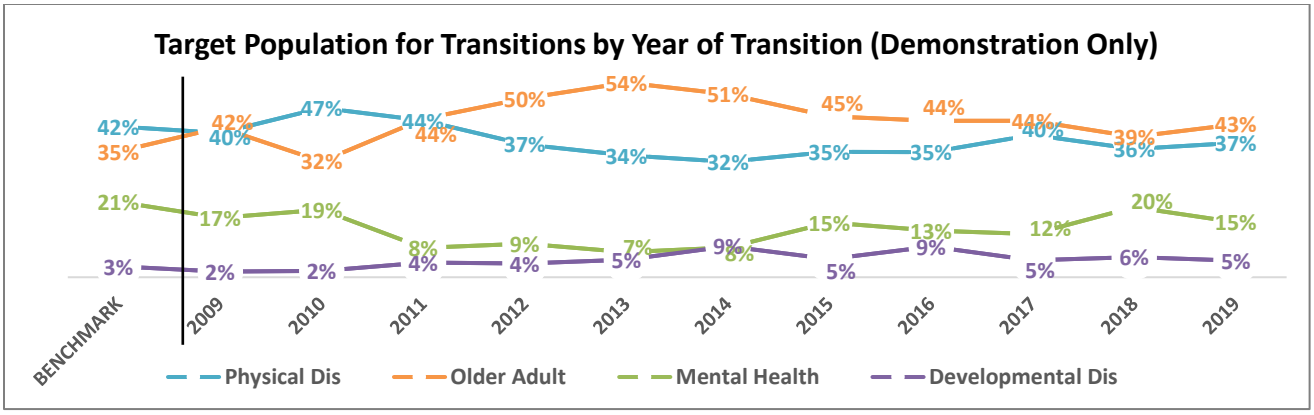
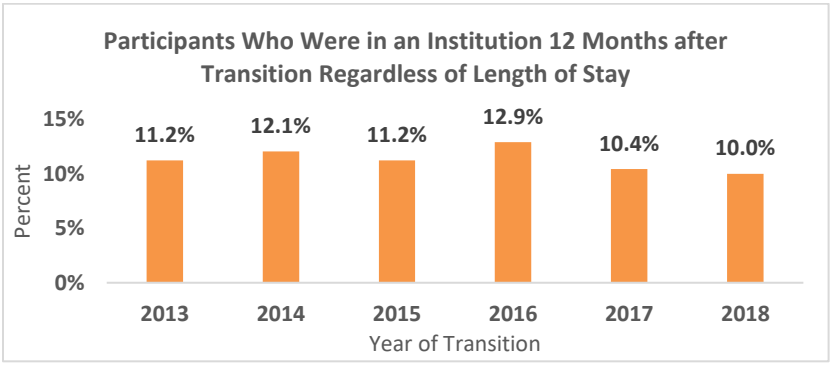
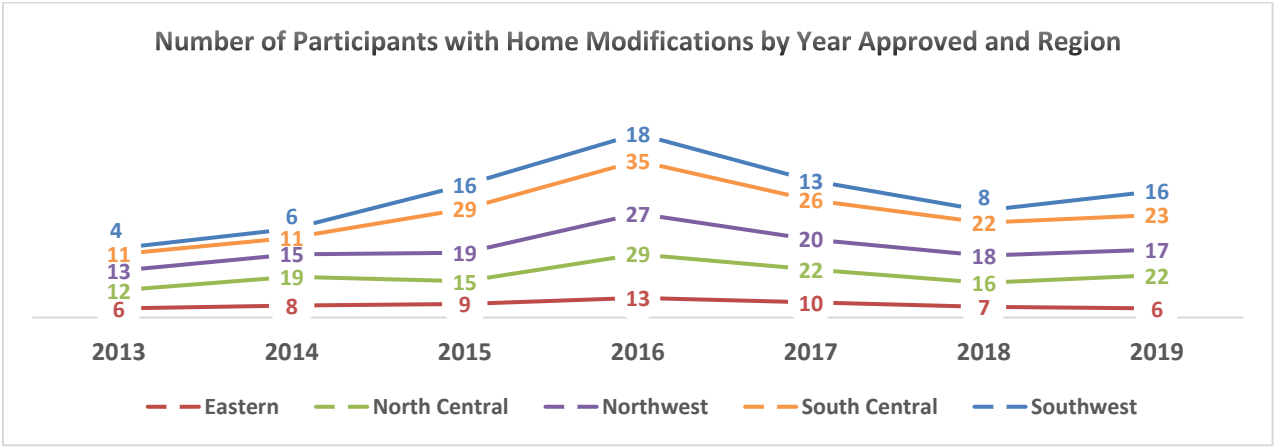
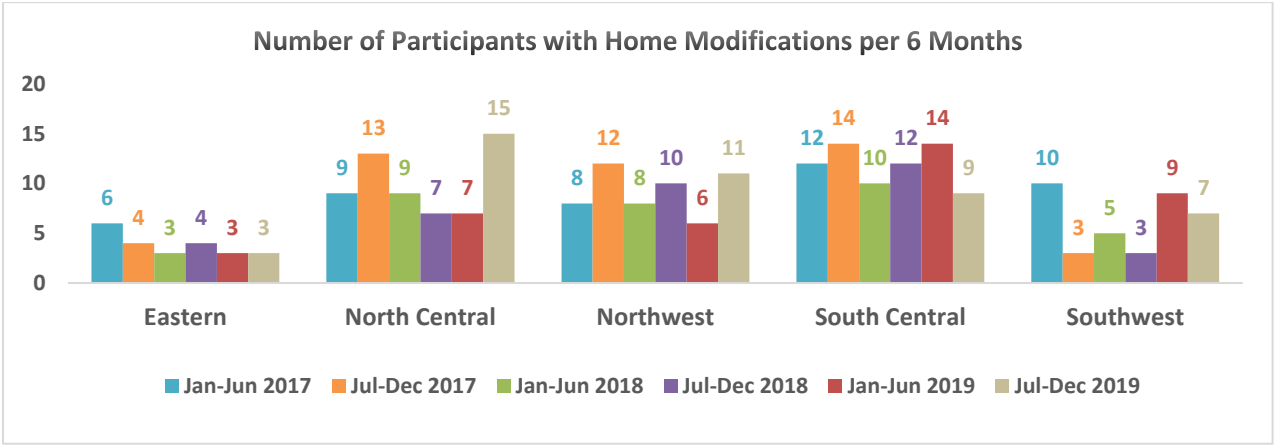


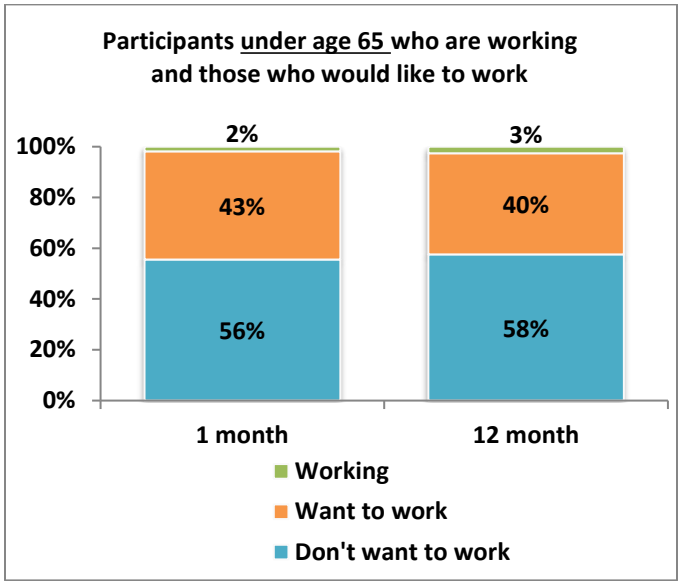

Target Population for Transitions by Year of Transition (Demonstration Only)
BENCHMARK
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
Physical Dis
Older Adult
Mental Health
Developmental Dis

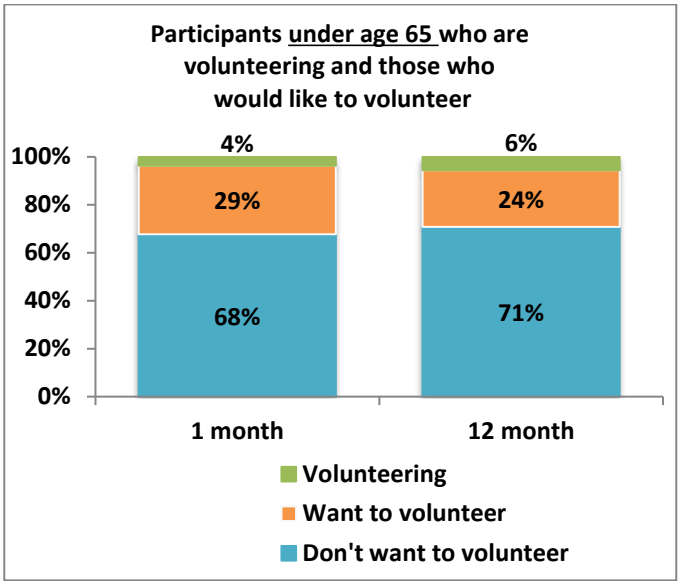

Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay
Percent
15%
10%
5%
0%
11.2%
12.1%
11.2%
12.9%
10.4%
10.0%
2013
2014
2015
2016
2017
2018
Year of Transition

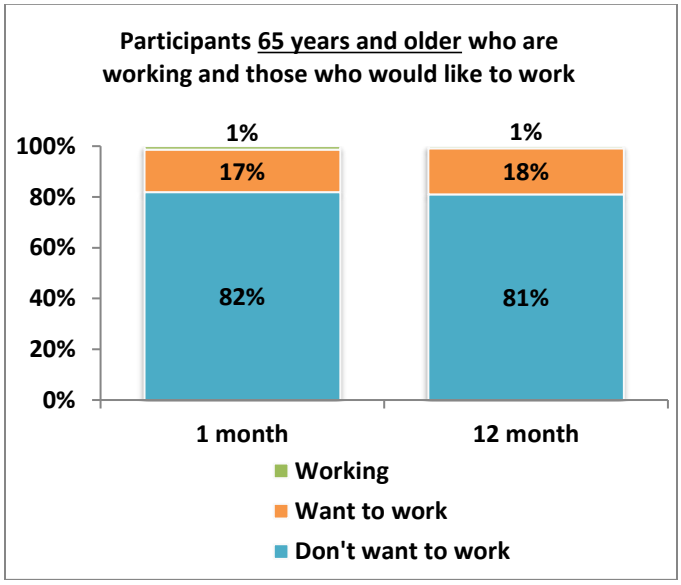

Number of Participants with Home Modifications by Year Approved and Region
2013
2014
2015
2016
2017
2018
2019
Eastern
North Central
Northwest
South Central
Southwest

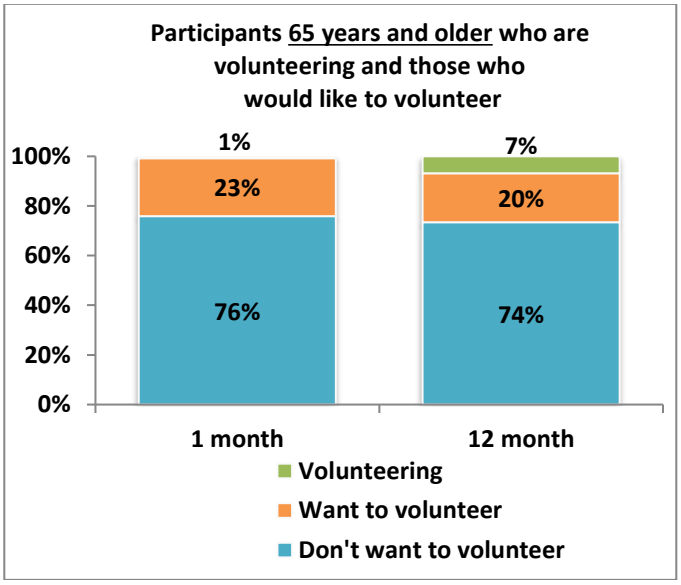

Number of Participants with Home Modifications per 6 Months
Eastern
North Central
Northwest
South Central
Southwest
Jan-Jun 2017
Jul-Dec 2017
Jan-Jun 2018
Jul-Dec 2018
Jan-Jun 2019
Jul-Dec 2019

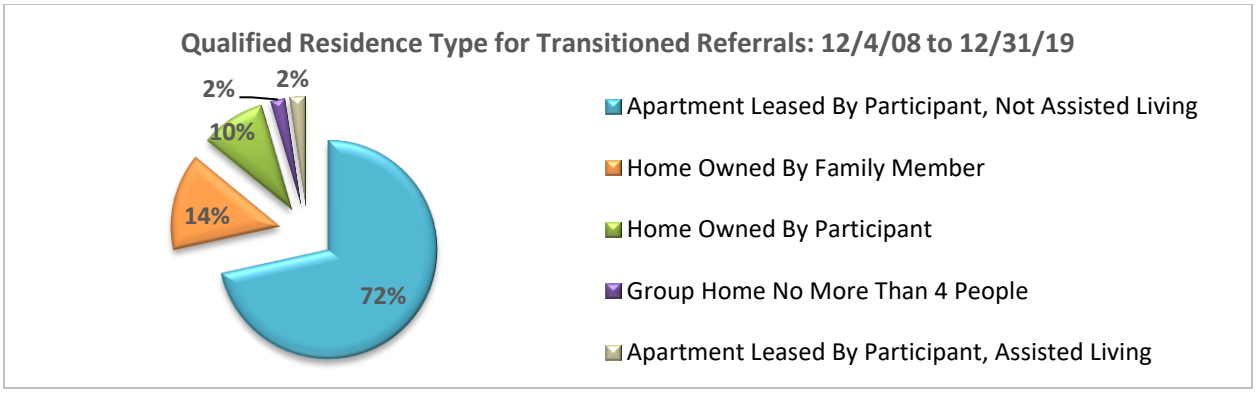
Participants who are Working and/or Volunteering (data 1/1/19-12/31/19)









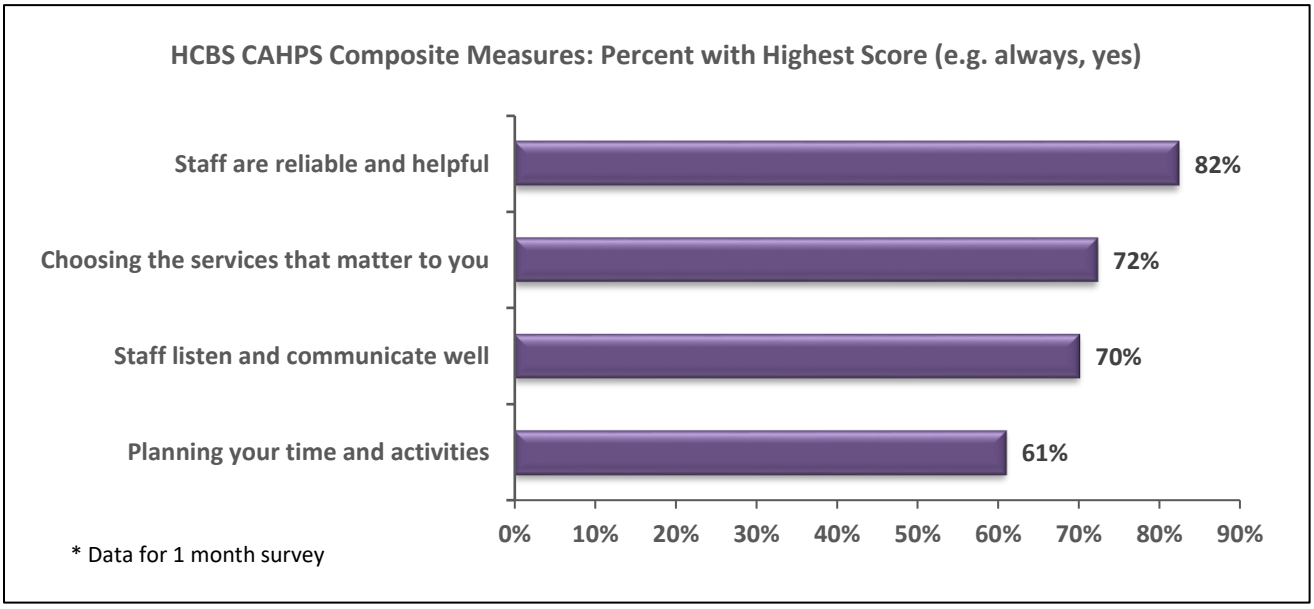


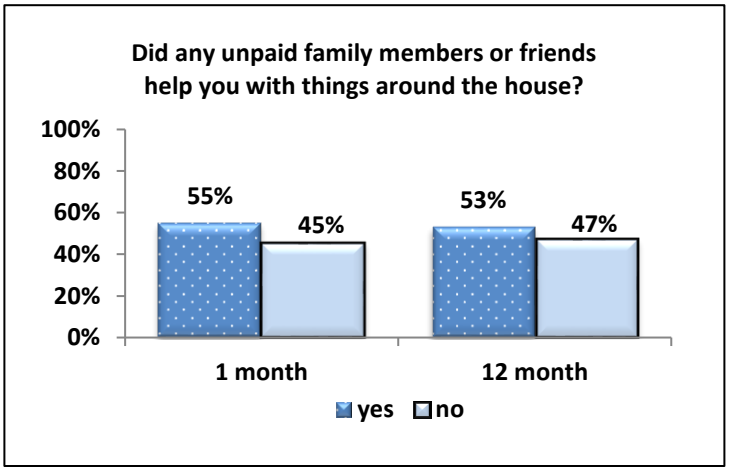
MFP Quality of Life Dashboard

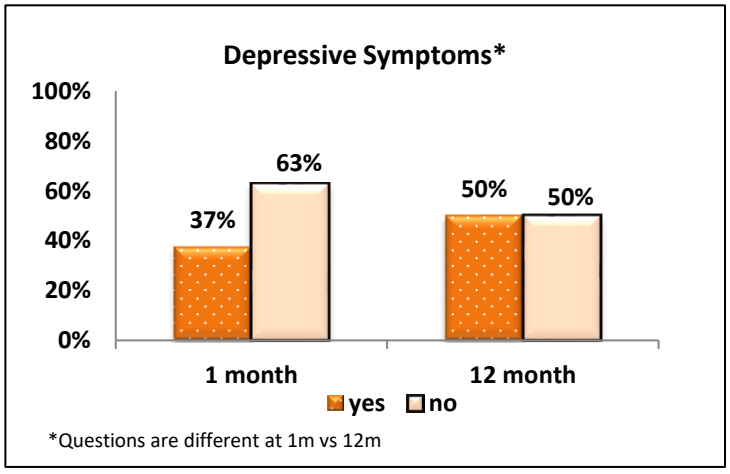
Number of Quality of Life Interviews Completed from 1/1/19 - 12/31/19:

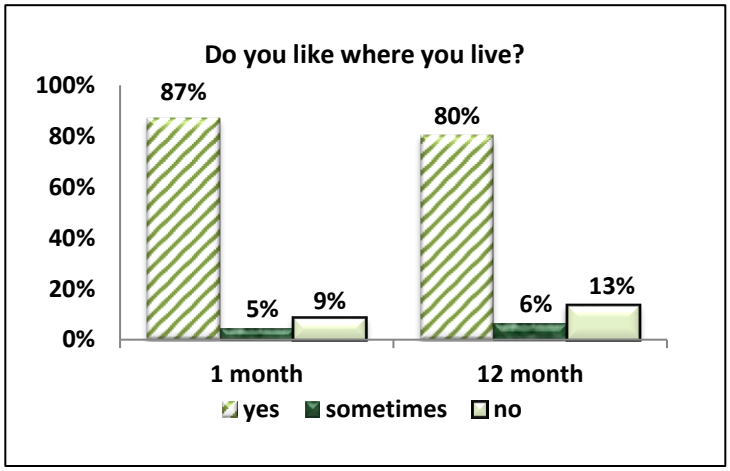
1 month interviews done 1 month after transition, **n=347**

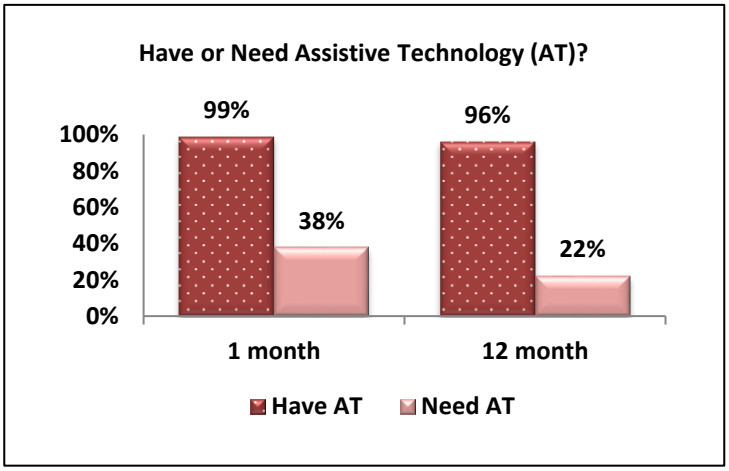
12 month interviews done 12 months after transition, **n=377**



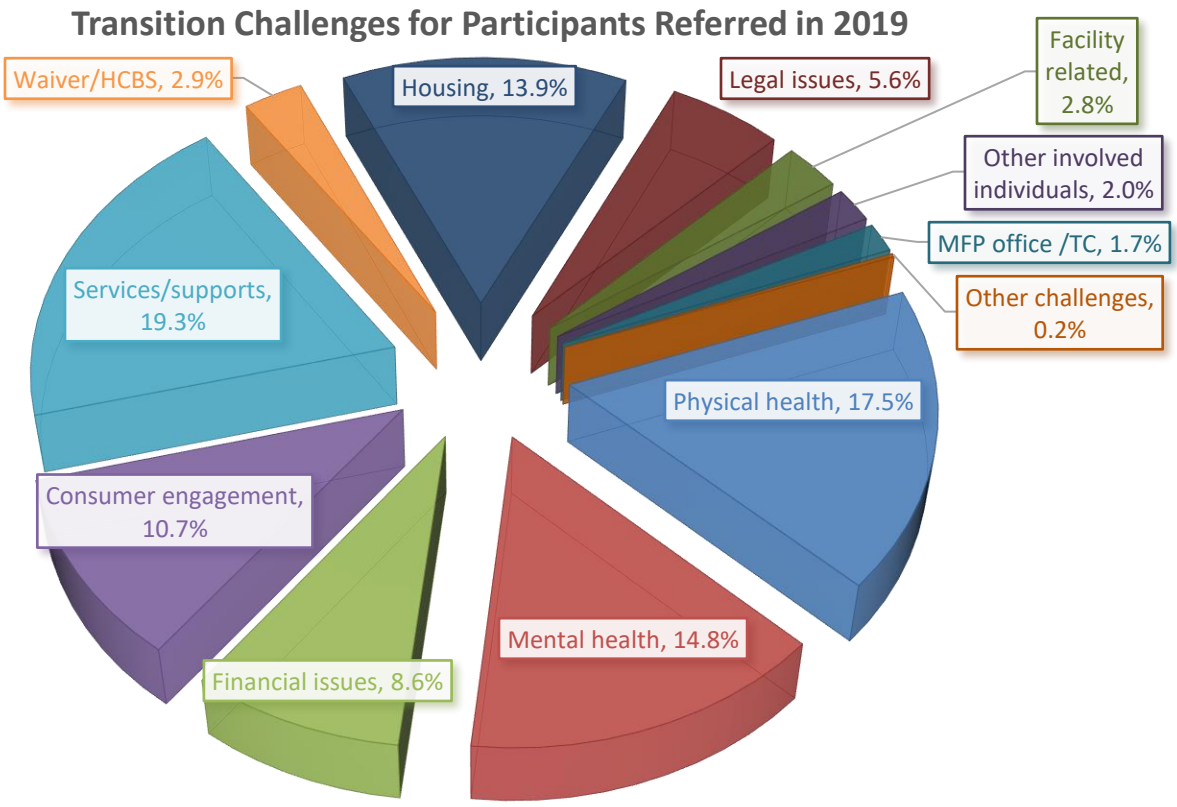


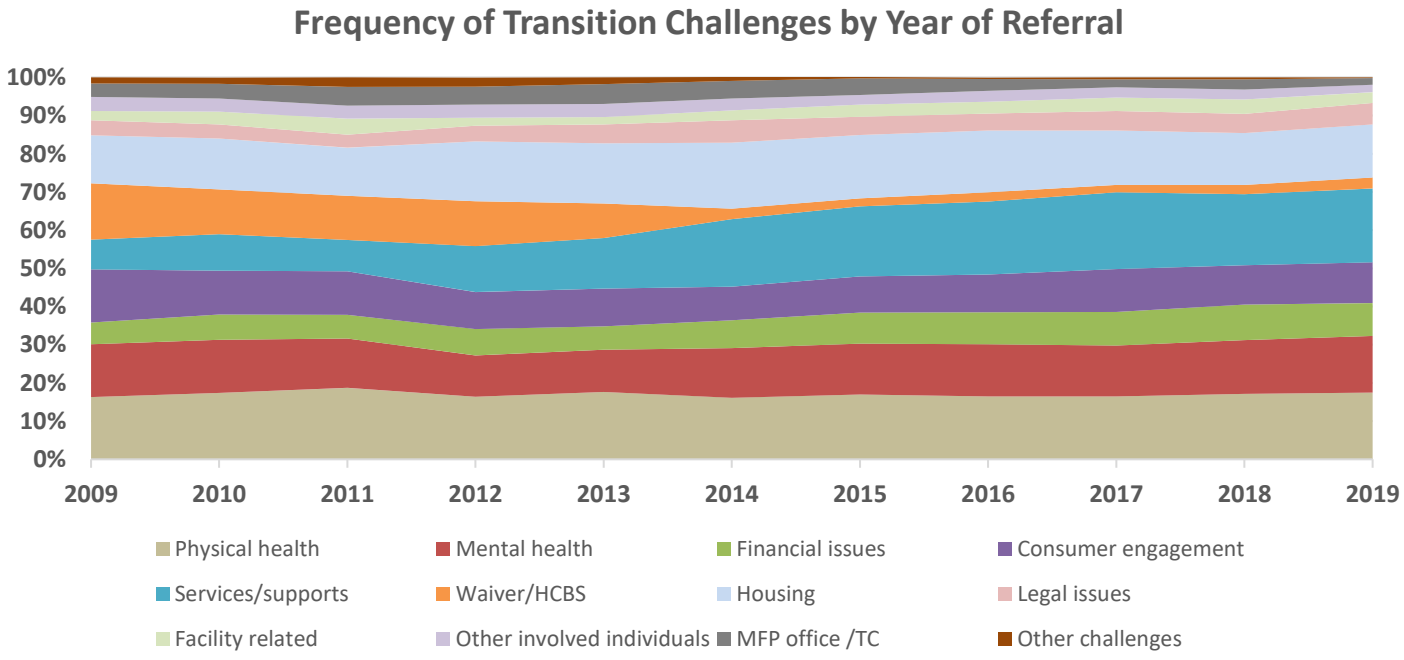


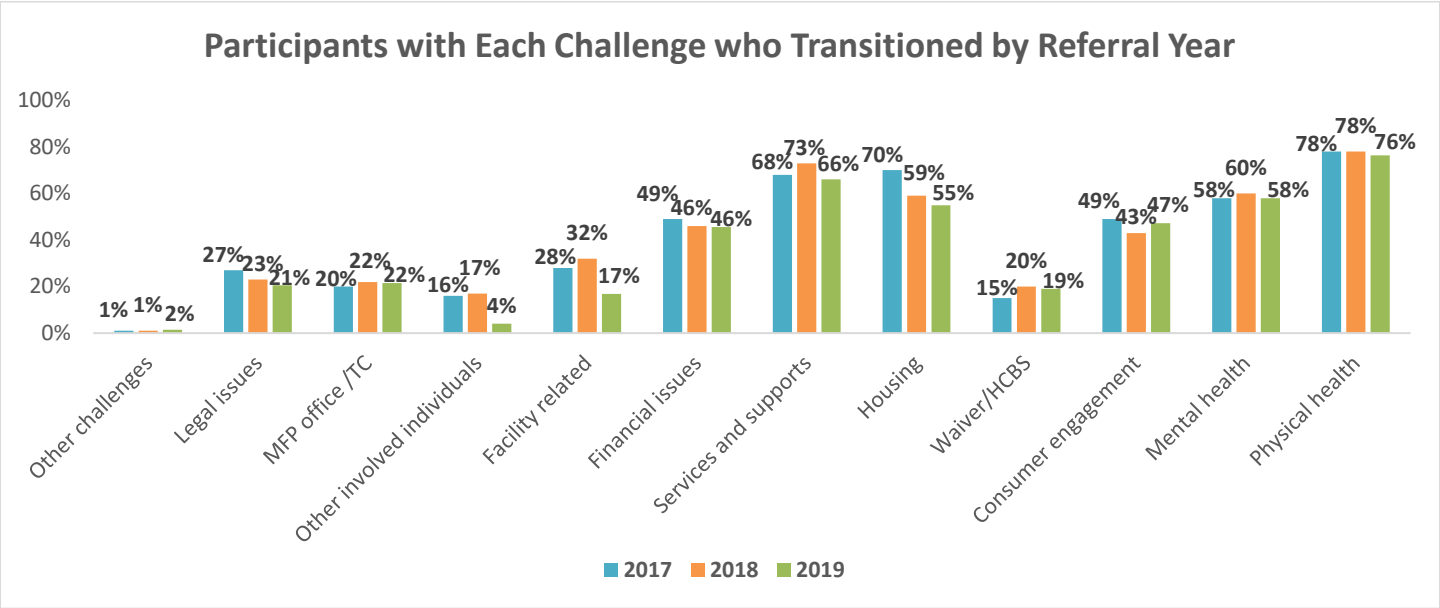




Challenges to Transition as Recorded by TCs and SCMs

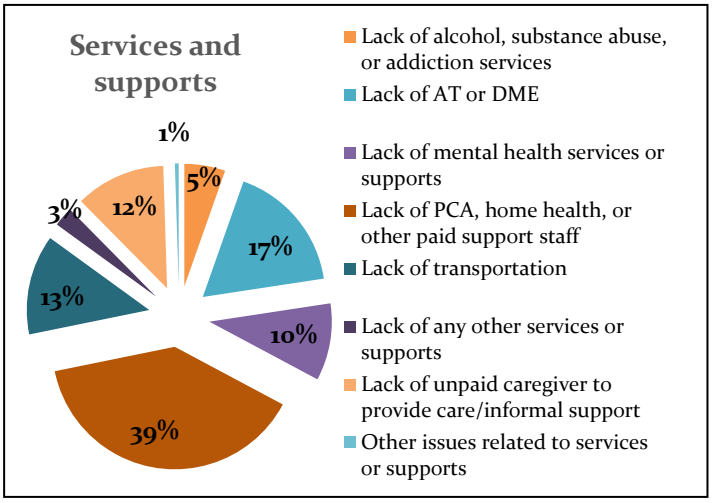


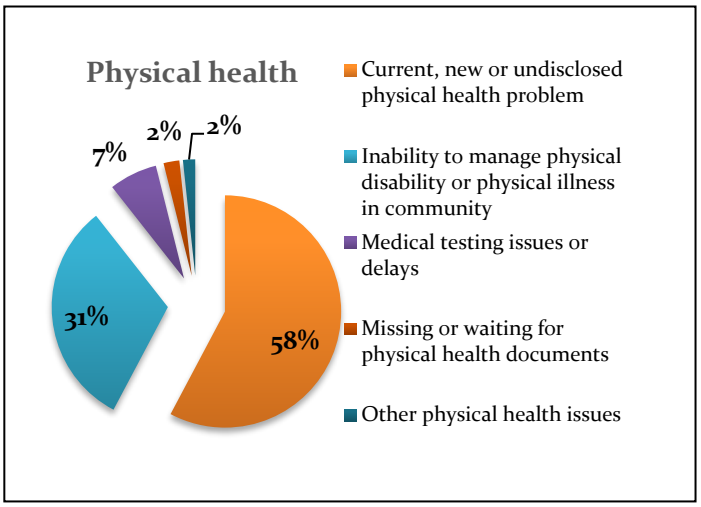


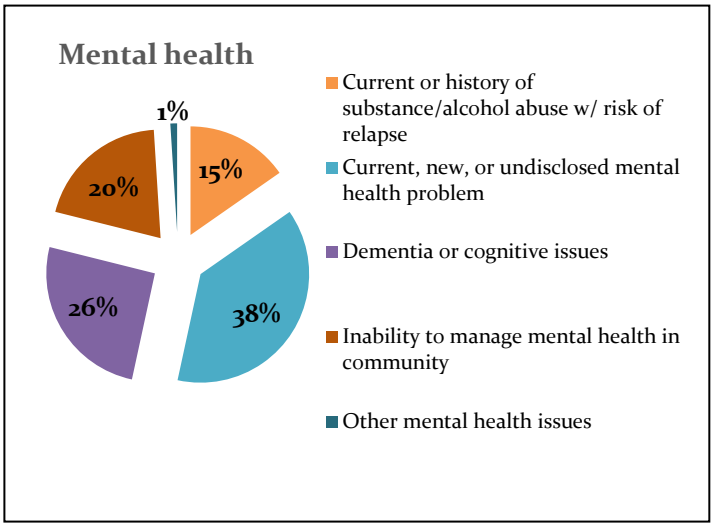


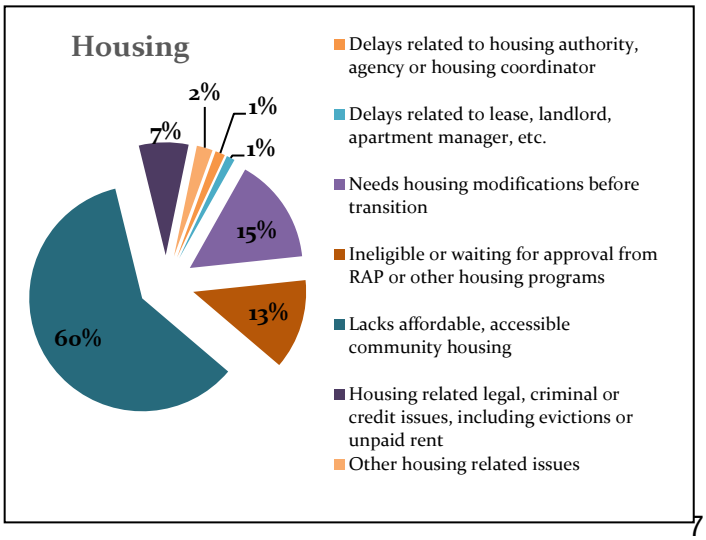
Types of Challenges for Referrals: 1/1/2019 - 12/31/2019

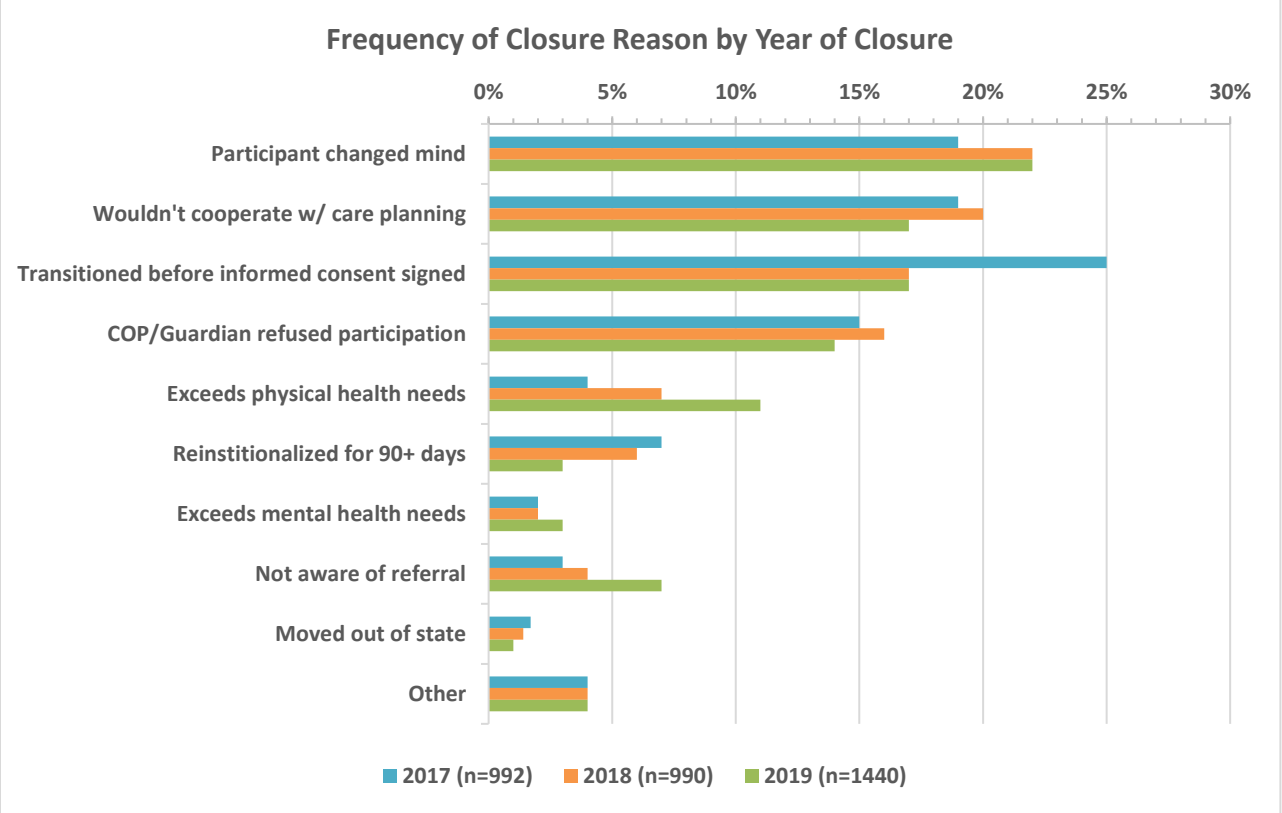
Below are the four most common challenge types for 2019

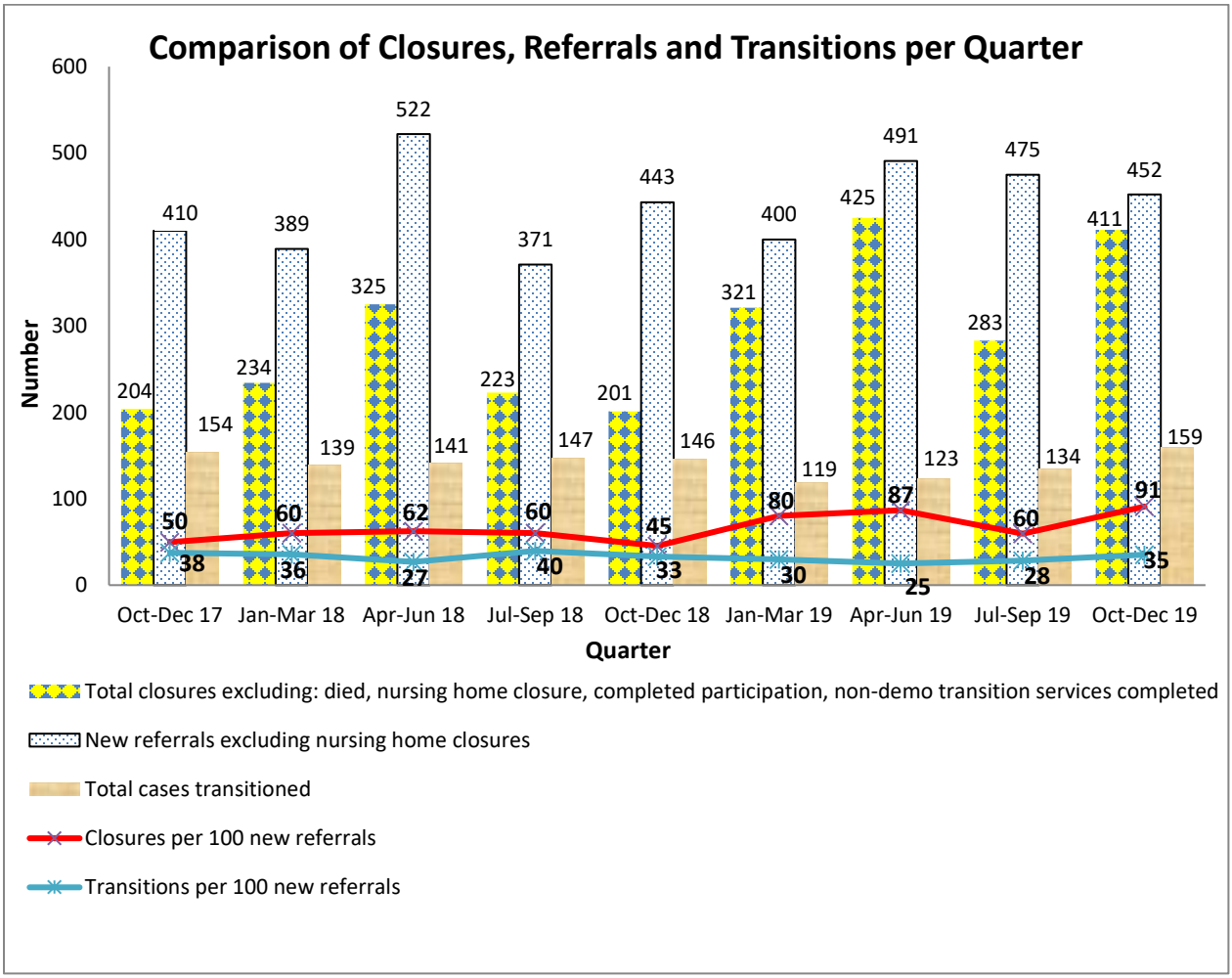









Frequency of Closure Reason by Year of Closure
0%
5%
10%
15%
20%
25%
30%
Participant changed mind
Wouldn't cooperate w/ care planning
Transitioned before informed consent signed
COP/Guardian refused participation
Exceeds physical health needs
Reinstitutionalized for 90+ days
Exceeds mental health needs
Not aware of referral
Moved out of state
Other
2017 (n=992)
2018 (n=990)
2019 (n=1440)


Comparison of Closures, Referrals and Transitions per Quarter
Number
600
500
400
300
200
100
0
204
410
154
234
389
139
325
522
141
223
371
147
201
443
146
321
400
119
425
491
123
283
475
134
411
452
159
50
60
62
60
45
80
87
60
91
38
36
27
40
33
30
25
28
35
Oct-Dec 17
Jan-Mar 18
Apr-Jun 18
Jul-Sep 18
Oct-Dec 18
Jan-Mar 19
Apr-Jun 19
Jul-Sep 19
Oct-Dec 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

Betty Lichtenstein's Story

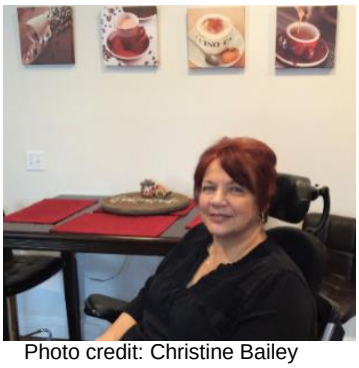


Photo credit: Christine Bailey

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.


Photo credit: Betty Lichtenstein


Photo credit: Betty Lichtenstein

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.


Photo credit: Betty Lichtenstein

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 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.