

# CT Money Follows the Person Report

April 1 - June 30, 2020

UConn Health, Center on Aging

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

## MFP Benchmarks

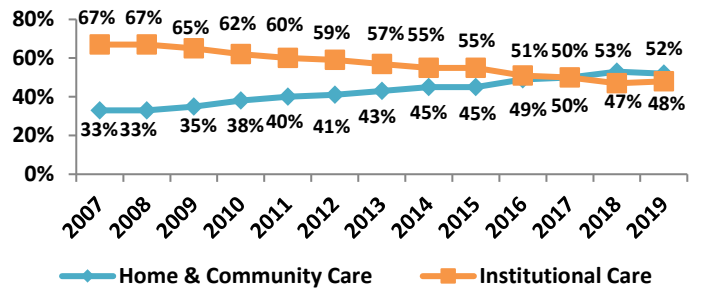
- 1) Transition 5200 people from qualified institutions to the community
- 2) Increase dollars to home and community based services
- 3) Increase hospital discharges to the community rather than to institutions
- 4) Increase probability of returning to the community during the six months following nursing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

## Benchmark 1: Total Transitions = 6,270

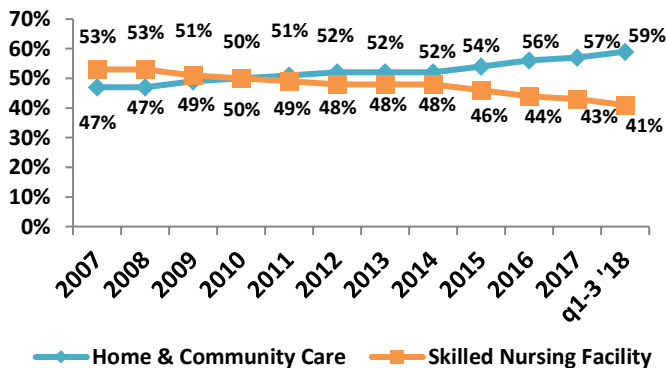
Demonstration = 5,869 (94%)

Non-demonstration = 401 (6%)

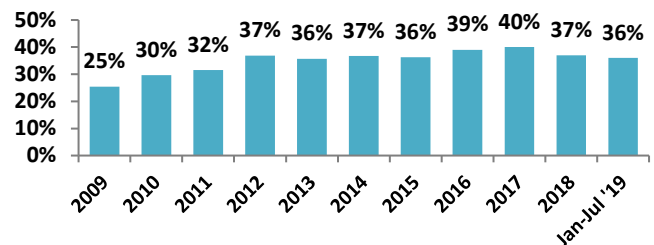
## Benchmark 2 CT Medicaid Long-Term Care Expenditures



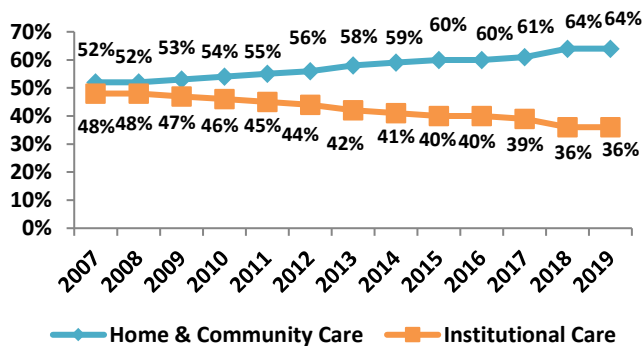
## Benchmark 3 Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility



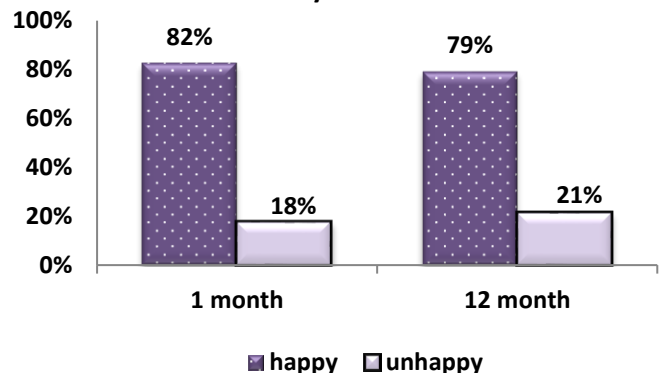
## Benchmark 4 Percent of SNF admissions returning to the community within 6 months



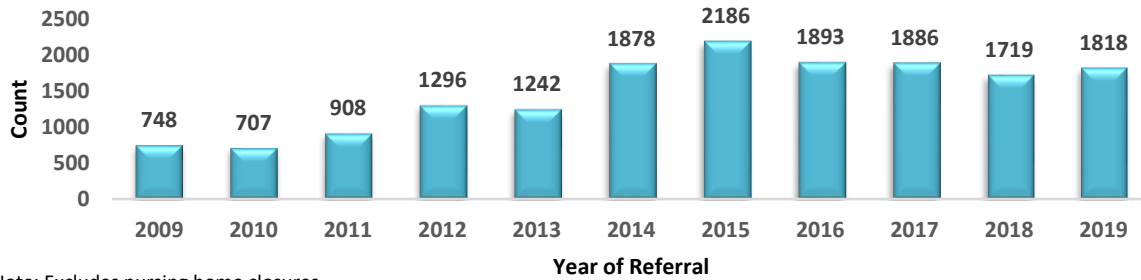
## Benchmark 5: Percent Receiving LTSS in the Community vs. Institutions



## Happy or unhappy with the way you live your life

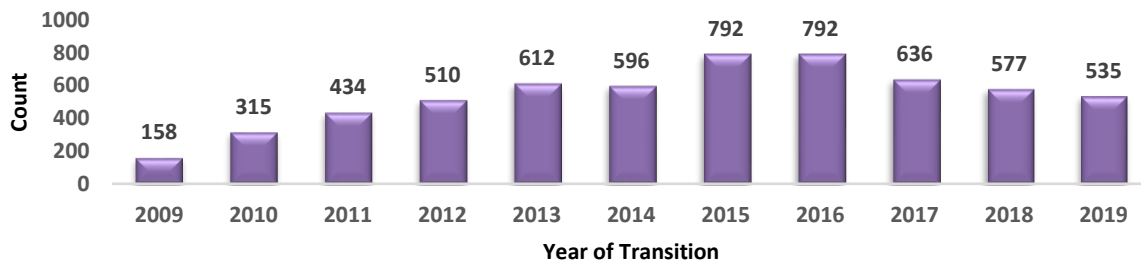


**Total Number of Referrals Assigned to the Field by Year**

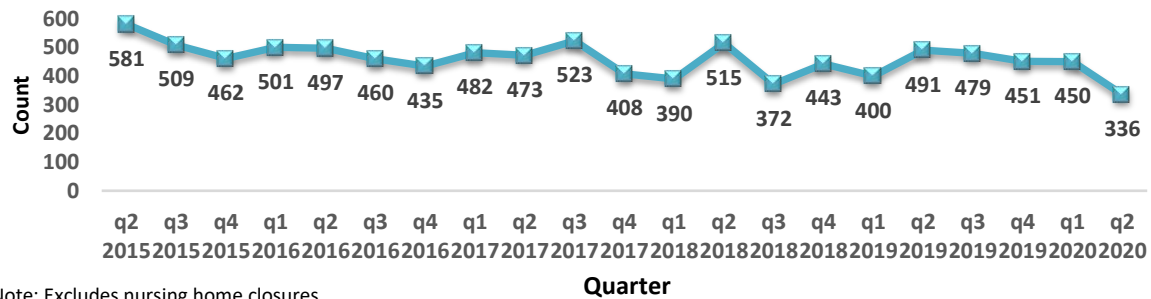


Note: Excludes nursing home closures

**Total Number of Transitions by Year**

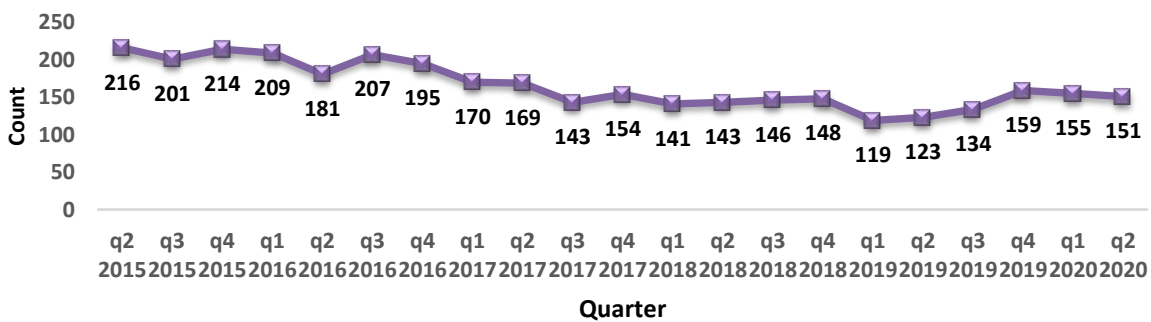


**Referrals Assigned to the Field by Quarter**

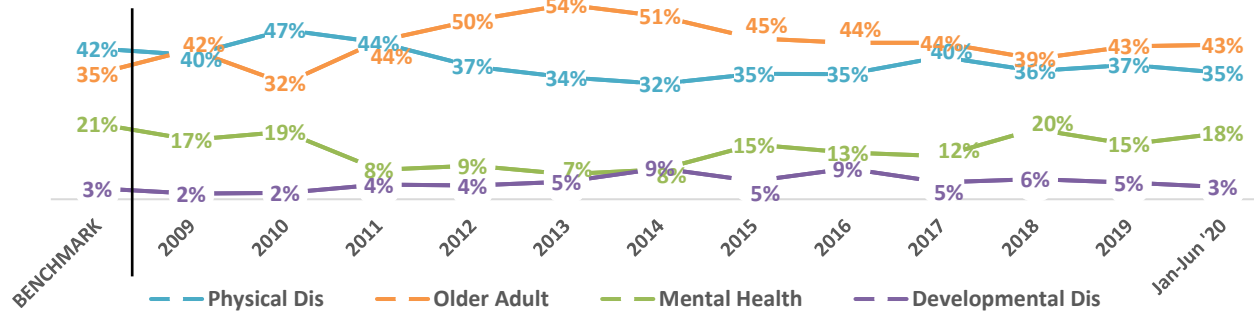


Note: Excludes nursing home closures

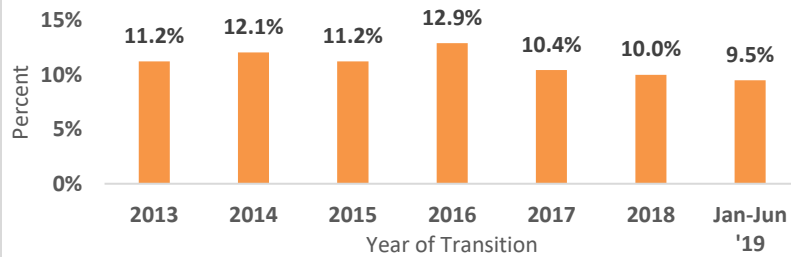
**Number of Transitions by Quarter**



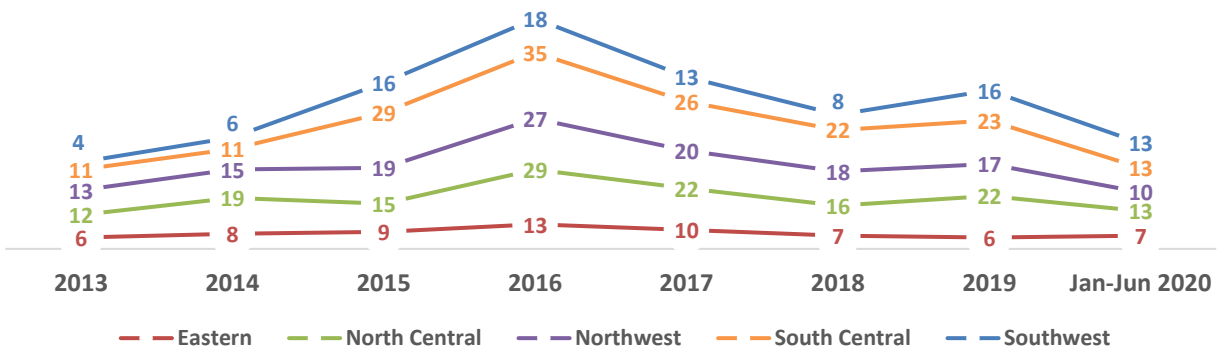
**Target Population for Transitions by Year of Transition (Demonstration Only)**



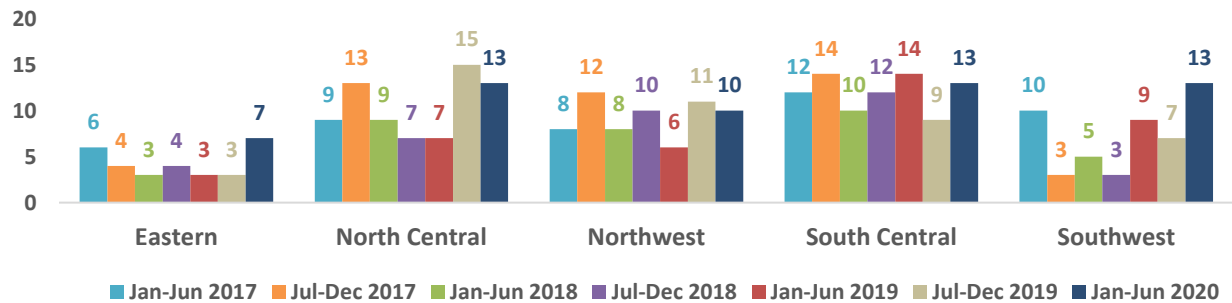
**Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay**



**Number of Participants with Home Modifications by Year Approved and Region**

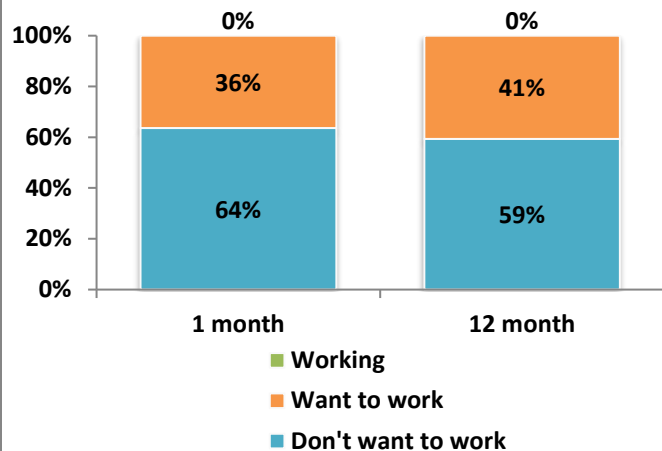


**Number of Participants with Home Modifications per 6 Months**

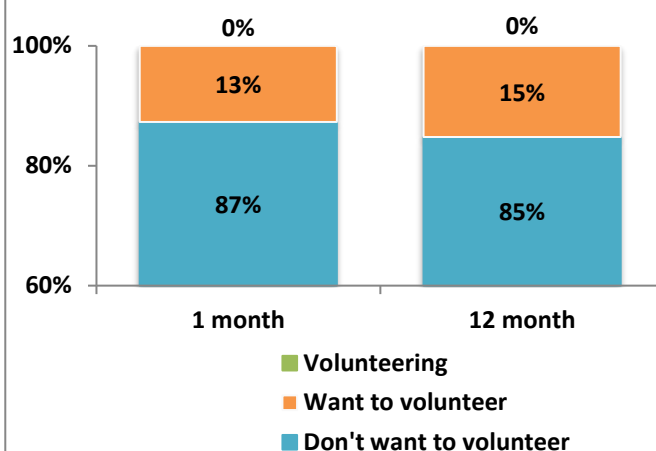


## Participants who are Working and/or Volunteering (data 4/1/2020-6/30/2020)

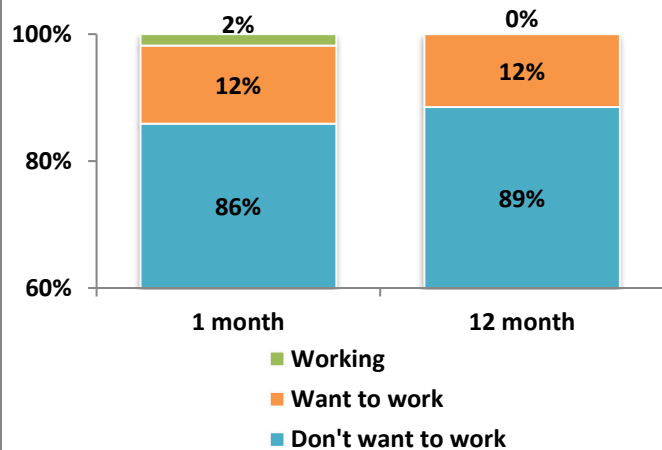
Participants under age 65 who are working and those who would like to work



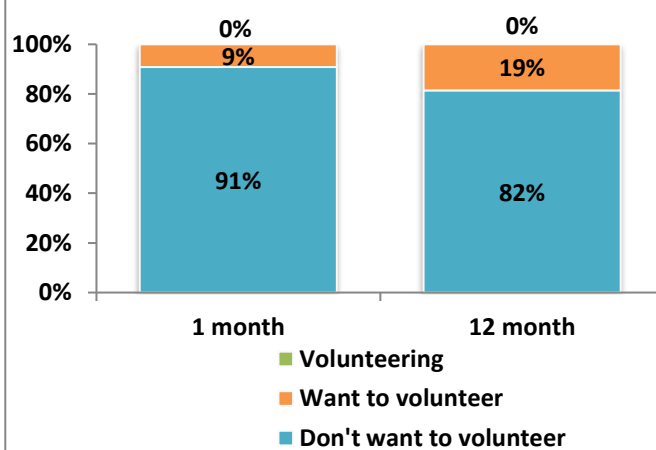
Participants under age 65 who are volunteering and those who would like to volunteer



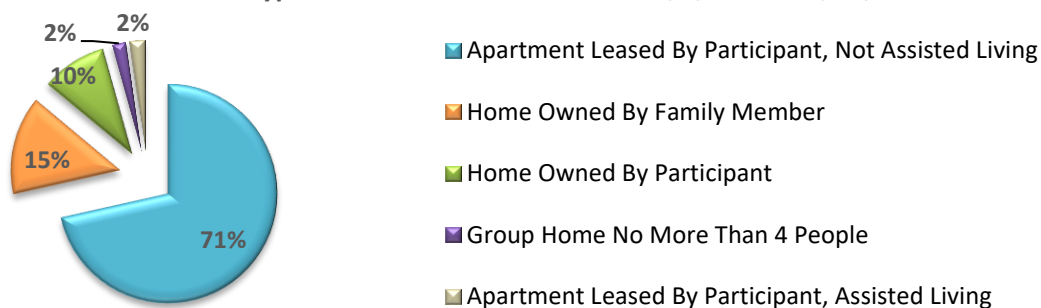
Participants 65 years and older who are working and those who would like to work



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



Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 6/30/2020



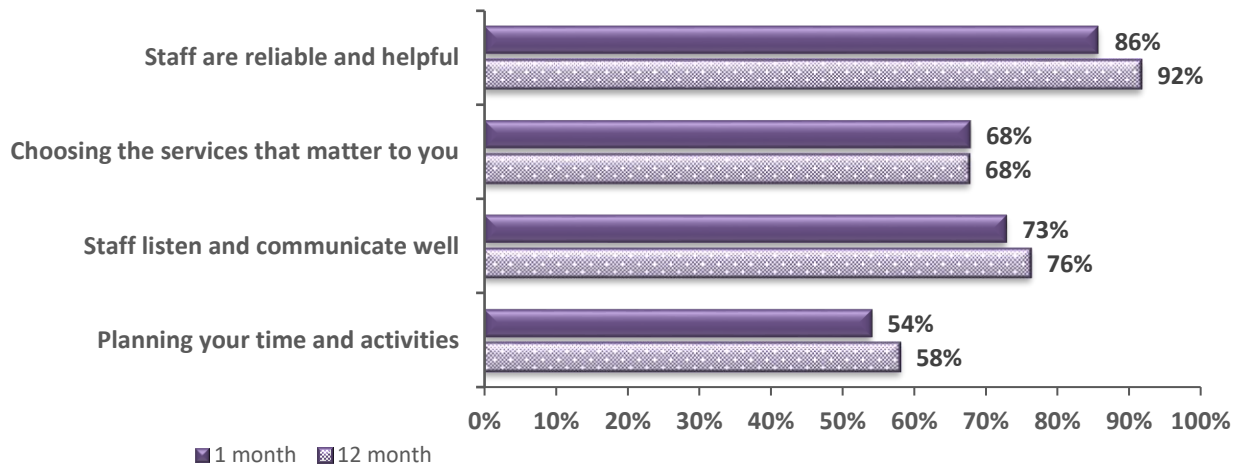
## MFP Quality of Life Dashboard

Number of Quality of Life Interviews Completed from 4/1/2020 - 6/30/2020:

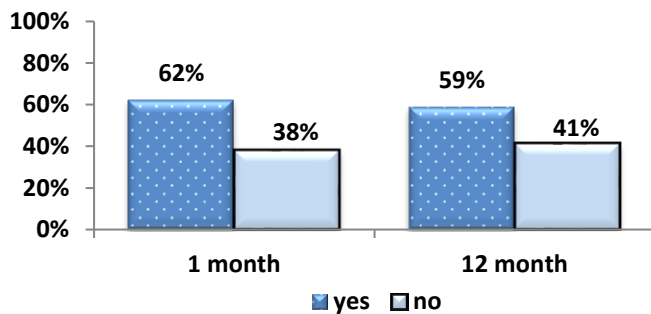
**1 month** interviews done 1 month after transition, **n=117**

**12 month** interviews done 12 months after transition, **n=70**

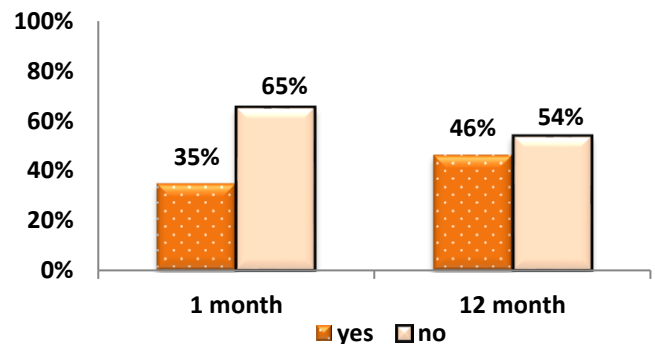
HCBS CAHPS Composite Measures: Percent with Highest Score (e.g. always, yes)



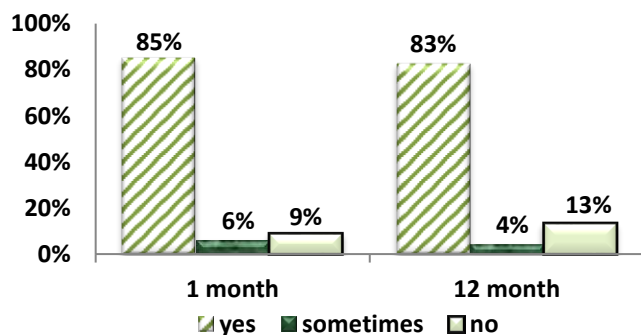
Did any unpaid family members or friends help you with things around the house?



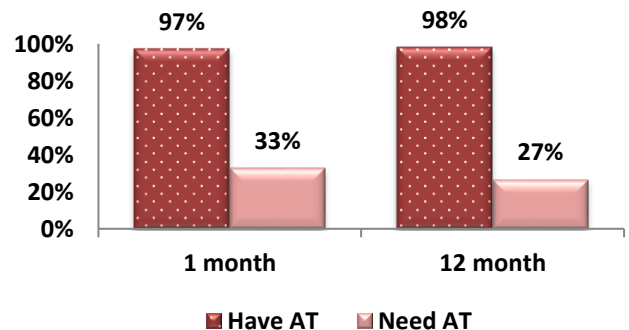
Depressive Symptoms



Do you like where you live?

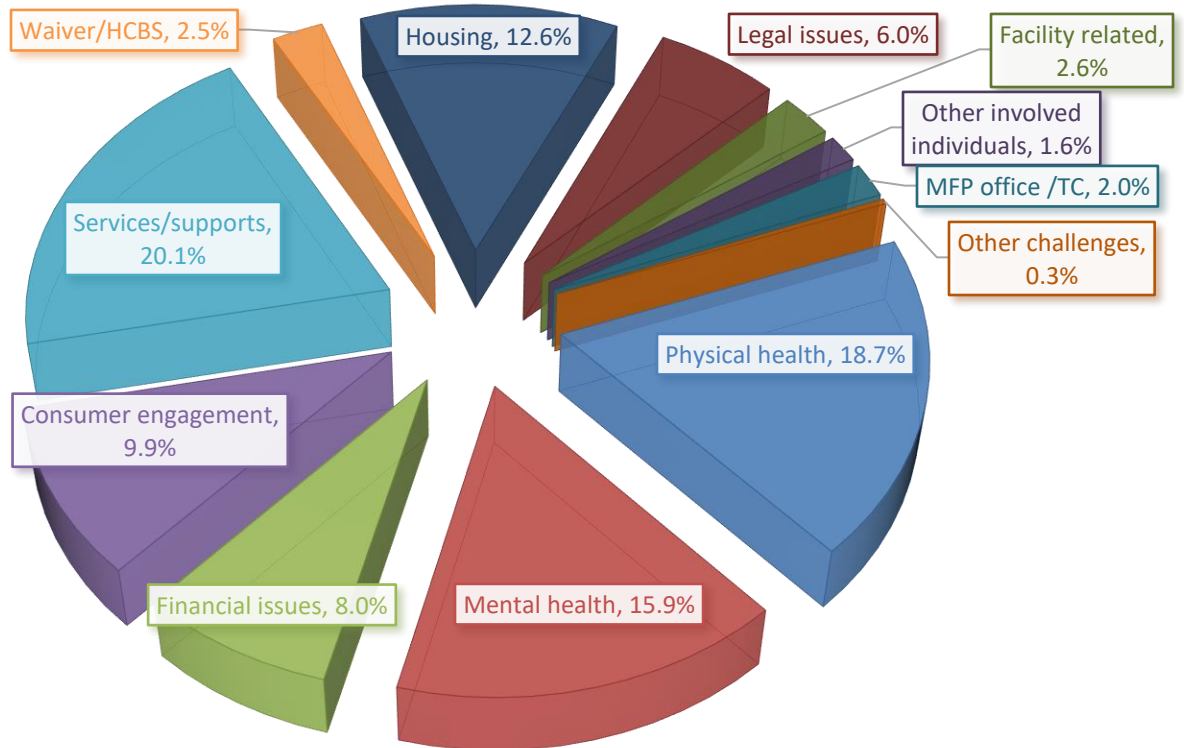


Have or Need Assistive Technology (AT)?

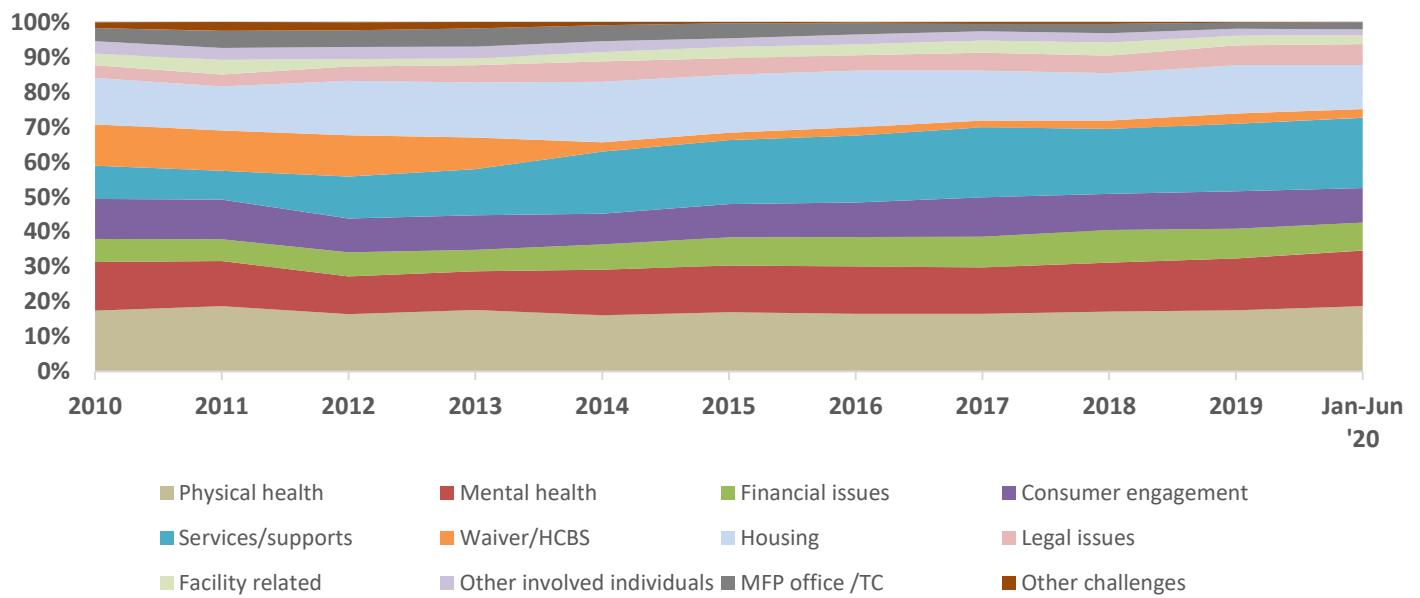


## Challenges to Transition as Recorded by TCs and SCMs

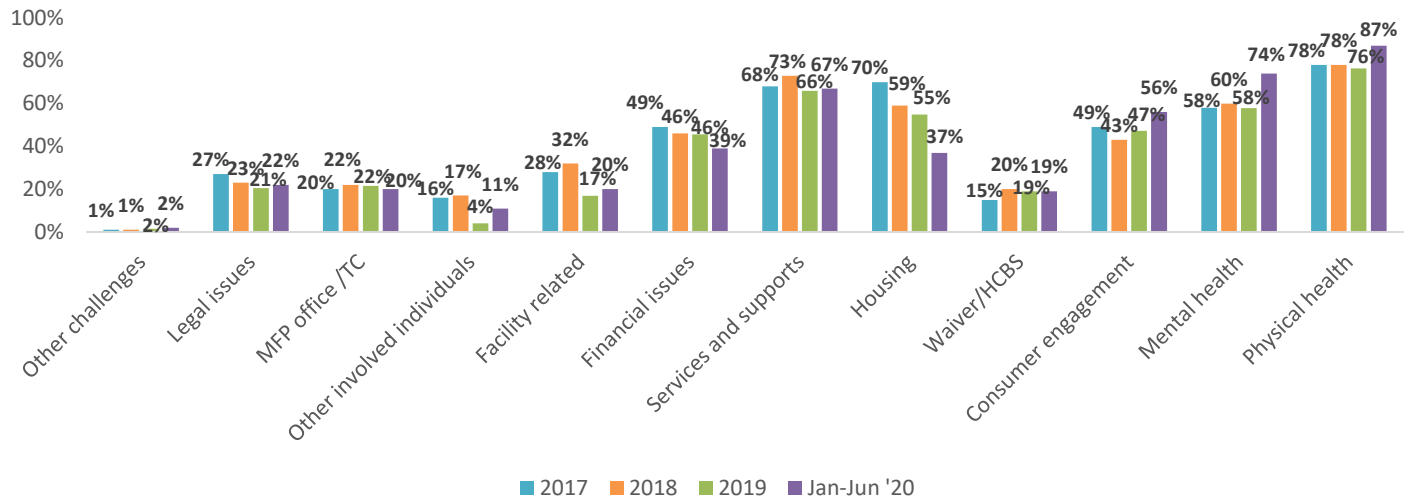
Transition Challenges for Participants Referred Jan-Jun 2020



Frequency of Transition Challenges by Year of Referral



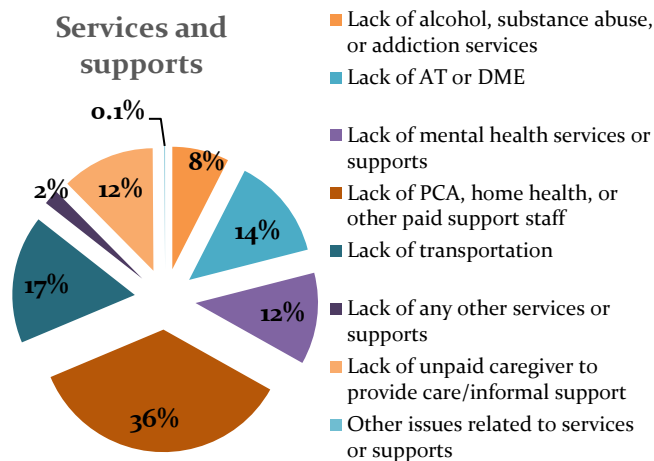
## Participants with Each Challenge who Transitioned by Referral Year



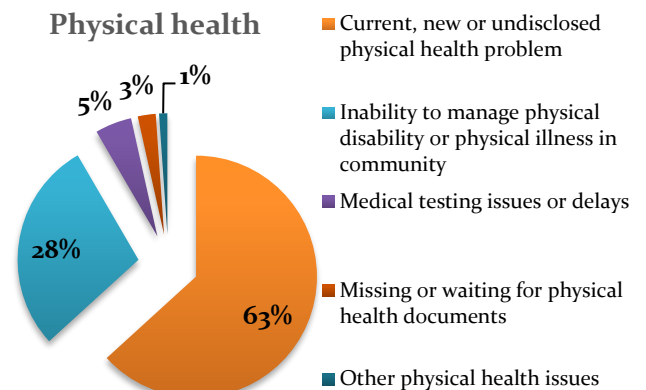
## Types of Challenges for Referrals: 1/1/2020 - 6/30/2020

*Below are the four most common challenge types for the current year*

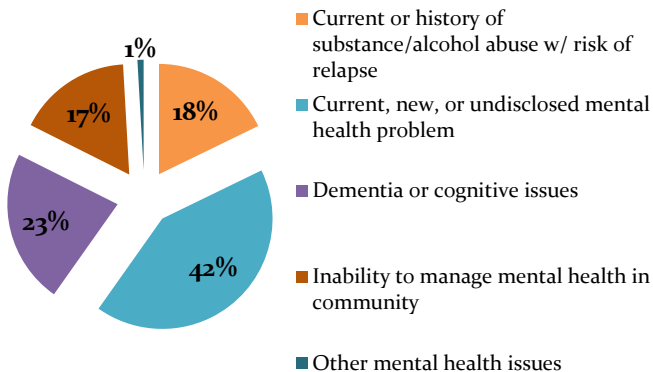
### Services and supports



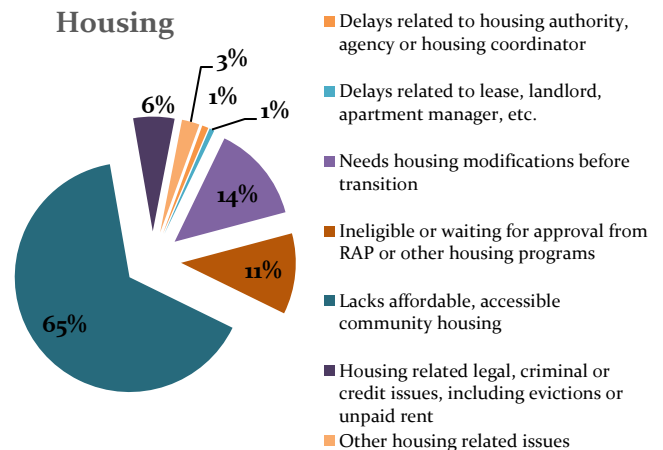
### Physical health



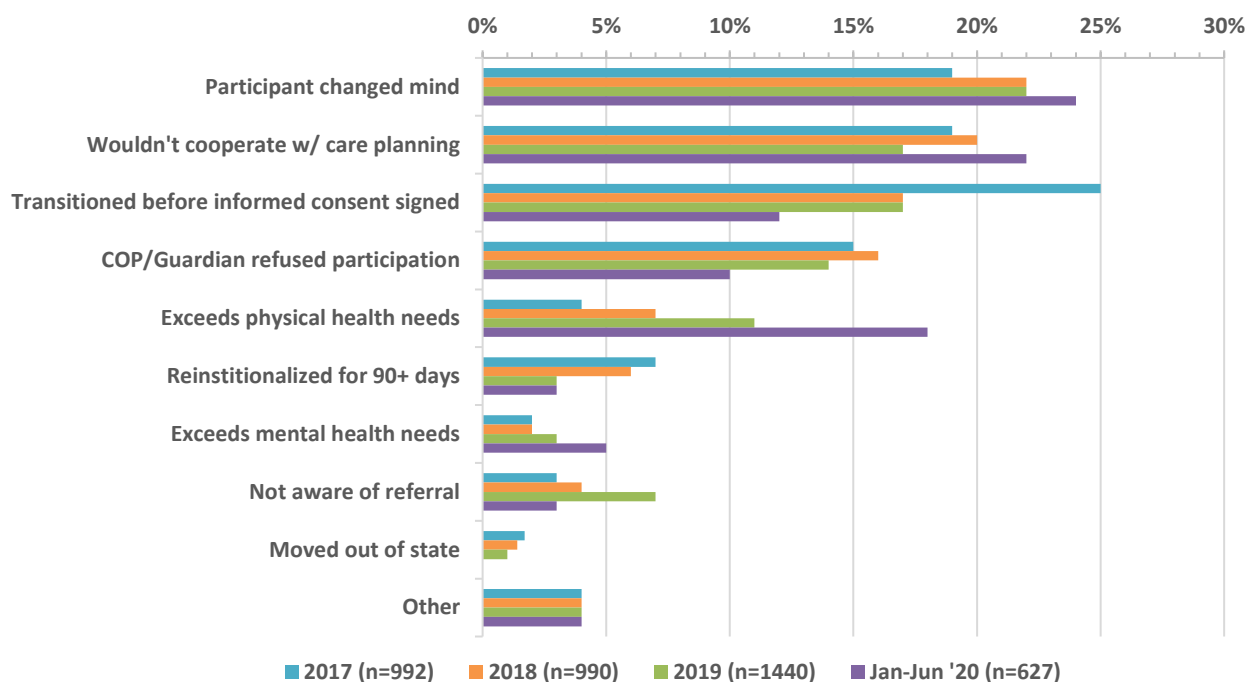
### Mental health



### Housing

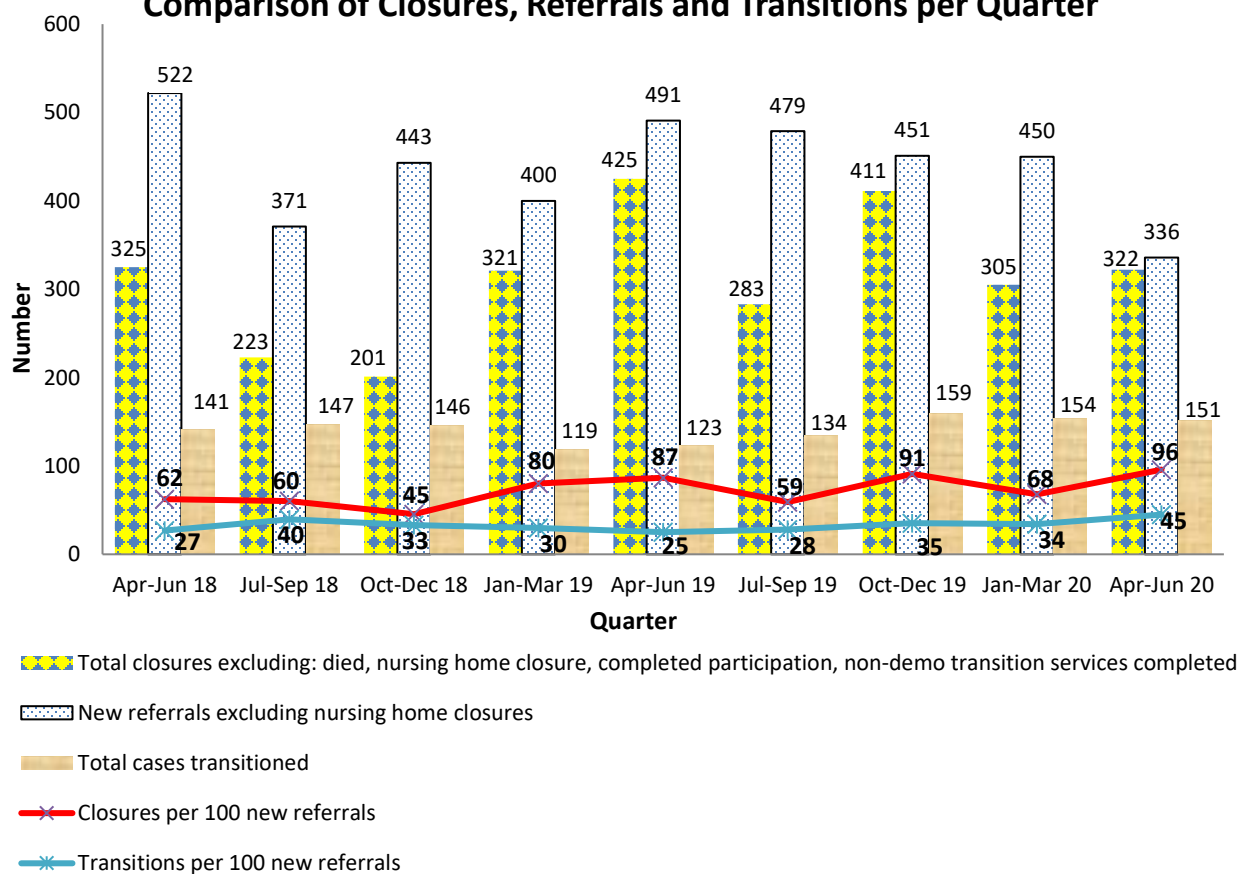


### Frequency of Closure Reason by Year of Closure



\*Excludes reasons: completed 365 days, died and non-demo transition services complete, as well as, NH closures and lawsuit facilities.

### Comparison of Closures, Referrals and Transitions per Quarter





## Christine and Joann's Story

Joann has been the primary caregiver and advocate for her younger sister for over a decade due to Christine's medical conditions. Christine has overcome severe medical challenges; she survived a stroke and kidney failure many years ago. Despite these challenges, Christine has continued to persevere with her sister's help. Christine and Joann are inseparable; their sisterly love is evident and has grown stronger, especially through the challenges they endured over the last year and a half, and resulted in Christine's return to their home in the community.

Christine spent six months in Bridgeport Hospital due to medical complications. Christine's long-term kidney failure led her to develop peripheral artery disease, which subsequently resulted in leg amputations. She had two stays in the Intensive Care Unit while in the hospital, but Christine fought through because she wanted to return to her family. The doctor called her his miracle baby. After her wounds healed, she was discharged to a rehabilitation facility.

Christine was at the rehabilitation facility for about five months before she could return home. Joann visited her every day, just as she had when her sister was in the hospital. Joann first heard about the Money Follows the Person (MFP) program at the hospital. The facility social worker told Joann and Christine more about the MFP program, and Christine enrolled. The MFP care manager and transition coordinator visited Christine and Joann several times which assured Christine that she was returning home. She was anxious to leave because she had never been apart from her family for a very long time. Christine cried a lot while at the rehabilitation facility and asked every day when she would return home. She was depressed. Joann encouraged her each day to keep her spirits up because arrangements were being made for her transition to the community. Again, Christine pushed forward and worked hard during physical therapy.

Christine and Joann's brother provided them with an apartment and made the required accommodations. After the last home modification requirement, an entry ramp, was installed, Christine transitioned on November 6<sup>th</sup>, 2019. When she arrived at her new home, her nieces and nephews welcomed her with open arms, and Christine's face lit with joy. She was very happy to be back in the care of her family, especially since the holidays were approaching and she would be able to spend more time with them. After moving home, it still took Christine a long time before she felt back to herself.

Christine continued to persevere with the help and love of her sister and family members. She received physical therapy and nursing visits at home. These services continued to strengthen her physically and emotionally. Unfortunately, since the COVID-19 pandemic began, her home-based physical therapy has been on hold. Despite this new challenge, Joann is helping Christine maintain her upper body strength by assisting with her physical therapy exercises at home. Due to the physical progress she has made, Christine has been able to go out shopping in the community with Joann's help. However, Christine has been feeling down since the stay at home order took effect, since she is not able to go out as often. Nonetheless, Christine and Joann are very grateful for the MFP program because it reunited them back home alongside their family.



*Photo credit: Family photo taken at Christine's and Joann's new home*

### 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.