CT Money Follows the Person Report
July 1 - September 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 = 6,427
Demonstration = 6,020 (94%)
Non-demonstration = 407 (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

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
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 7/1/20-9/30/20)

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

- Working: 36% (1 month), 32% (12 month)
- Want to work: 1% (1 month), 3% (12 month)
- Don’t want to work: 63% (1 month), 65% (12 month)

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

- Working: 18% (1 month), 21% (12 month)
- Volunteering: 2% (1 month), 2% (12 month)
- Want to volunteer: 80% (1 month), 78% (12 month)
- Don’t want to volunteer: 8% (1 month), 9% (12 month)

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

- Working: 83% (1 month), 87% (12 month)
- Want to work: 0% (1 month), 3% (12 month)
- Don’t want to work: 17% (1 month), 10% (12 month)

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

- Working: 17% (1 month), 18% (12 month)
- Volunteering: 2% (1 month), 0% (12 month)
- Want to volunteer: 81% (1 month), 82% (12 month)
- Don’t want to volunteer: 2% (1 month), 0% (12 month)

Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 9/30/2020

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

Number of Quality of Life Interviews Completed from 7/1/20 - 9/30/20

1 month interviews done 1 month after transition, n=141
12 month interviews done 12 months after transition, n=114

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

- Staff are reliable and helpful: 89% (1 month) vs 80% (12 month)
- Choosing the services that matter to you: 68% (1 month) vs 72% (12 month)
- Staff listen and communicate well: 73% (1 month) vs 75% (12 month)
- Planning your time and activities: 57% (1 month) vs 57% (12 month)

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

- 1 month: yes 59%, no 41%
- 12 month: yes 51%, no 50%

Depressive Symptoms

- 1 month: yes 32%, no 68%
- 12 month: yes 35%, no 65%

Do you like where you live?

- 1 month: yes 87%, sometimes 9%, no 4%
- 12 month: yes 82%, sometimes 10%, no 9%

Have or Need Assistive Technology (AT)?

- 1 month: Have AT 99%, Need AT 37%
- 12 month: Have AT 98%, Need AT 24%
Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred Jan-Sep 2020

- Physical health, 18.8%
- Mental health, 16.1%
- Financial issues, 7.4%
- Consumer engagement, 9.9%
- Services/supports, 21.0%
- Housing, 12.1%
- Waiver/HCBS, 2.4%
- Facility related, 2.5%
- Other involved individuals, 1.5%
- Other challenges, 0.4%
- MFP office /TC, 1.8%

Frequency of Transition Challenges by Year of Referral

- Physical health
- Mental health
- Financial issues
- Consumer engagement
- Services/supports
- Waiver/HCBS
- Housing
- Facility related
- Other involved individuals
- MFP office /TC
- Other challenges
Participants with Each Challenge who Transitioned by Referral Year

Types of Challenges for Referrals: 1/1/20 - 9/30/20
Below are the four most common challenge types for the current year

<table>
<thead>
<tr>
<th>Services and supports</th>
<th>Physical health</th>
<th>Mental health</th>
<th>Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Lack of alcohol, substance abuse, or addiction services</td>
<td>- Current, new or undisclosed physical health problem</td>
<td>- Current or history of substance/alcohol abuse w/ risk of relapse</td>
<td>- Delays related to housing authority, agency or housing coordinator</td>
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<tr>
<td>- Lack of AT or DME</td>
<td>- Inability to manage physical disability or physical illness in community</td>
<td>- Current, new, or undisclosed mental health problem</td>
<td>- Delays related to lease, landlord, apartment manager, etc.</td>
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<tr>
<td>- Lack of mental health services or supports</td>
<td>- Medical testing issues or delays</td>
<td>- Dementia or cognitive issues</td>
<td>- Needs housing modifications before transition</td>
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<tr>
<td>- Lack of PCA, home health, or other paid support staff</td>
<td>- Missing or waiting for physical health documents</td>
<td>- Inability to manage mental health in community</td>
<td>- Ineligible or waiting for approval from RAP or other housing programs</td>
</tr>
<tr>
<td>- Lack of transportation</td>
<td>- Other physical health issues</td>
<td>- Other issues related to services or supports</td>
<td>- Lacks affordable, accessible community housing</td>
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<tr>
<td>- Lack of any other services or supports</td>
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<td></td>
<td>- Housing related legal, criminal or credit issues, including evictions or unpaid rent</td>
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<tr>
<td>- Lack of unpaid caregiver to provide care/informal support</td>
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<td></td>
<td>- Other housing related issues</td>
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<tr>
<td>- Other issues related to services or supports</td>
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**Michael and Heidi Pitkin’s Story**

The condition of the human spirit is not defined by the moments of ease we face in life, but by what we do in the moments of obscurity, doubt, discomfort, and tribulation. It is in these times that we access a part of the human spirit that tests our strength of character and commitment to those we care for. The level of sacrifice, empathy, and love required to spend one’s life dedicated to the comfort and care of another cannot be overstated. And the sense of relief experienced by those walking tall on their path as a caregiver often make the journey worthwhile, especially when they see firsthand the difference they have made in their loved one’s life. It is through the acknowledgment of the struggles people go through that allow them to fully appreciate the peace of mind they have attained through their own determination and willingness to accept help. This part of the human spirit is no better represented than by the story of Michael and his sister/caregiver, Heidi.

Michael and Heidi, just two years apart, grew up in a loving household raised by their mother who Heidi describes as “a super mom” who put everything on her shoulders to ensure her children never lacked or wanted for anything. A strong sense of independence and responsibility was instilled in Heidi from a young age as she would be called upon to assist in the aide of her younger brother who has quadriplegia, scoliosis, and cortical blindness. Through this process they developed a bond so strong that people would often comment on the ways in which Michael seemed to brighten up whenever his sister was around.

Soon after their mother got her gall bladder removed came the realization that an alternative to addressing Michael’s care needs should be found, especially since two people are required to help him with his every day care needs. At this time, Heidi was traveling home every day from college to help care for Michael. A social worker at Michael’s day program suggested applying to get him into a group home as early as possible because the waitlists are often extensive. After 7 years, Michael was accepted into a group home and their mother sold her house to move closer to Michael’s new residence. At the time this seemed to be the best move to make sure Michael was taken care of in the event that anything ever happened to their mother.

The next 10 years were marked by a series of devastating events and challenges for the family. Over the span of time in which Michael lived in this group home he experienced a broken leg and wrist and all too often when his mother or sister would visit him, his continence needs appeared neglected. Needless to say, Heidi and her mother wanted to figure out how they could get Michael out of this location and still have his care needs addressed. Michael’s mother heard about the Money Follows the Person program in January 2016. They were initially discouraged due to a lack of follow up but they held on to the information. In August 2016, Heidi purchased a home intending for her mother to move in. They would then decide on their next steps for Michael. In October of the same year, Michael and Heidi’s mother passed away battling cancer. Around the same time, Heidi, who was raising a 3 year old son by herself, also found out that the basement area of her home had mold and asbestos. Despite this series of unfortunate events, things began to look better through Heidi’s contact with the MFP Specialized Care Manager.
After seeing the interactions between Michael and Heidi, the MFP Specialized Care Manager suggested that Michael move in with Heidi after making the appropriate accommodations to the basement. After the last home modification was installed, Michael transitioned on April 16, 2018. Upon arriving at his new home, Michael was beyond excited to be in an environment that he trusted and where felt safe. Heidi described the MFP Specialized Care Manager as a savior, and the Transition Coordinator helped to accommodate all of their needs during the first year of Michael’s transition. Even the day program that Michael attended noticed a significant change in his mood almost immediately from the time he was at the group home to the time he transitioned. Michael continues to thrive in his new environment and his spirits have remained up since living with his sister and her son. Heidi now feels at ease knowing she can hire people who she trusts and wishes she had come across the Money Follows the Person program sooner. Michael still has aides that provide home care despite the COVID pandemic, but there have been adjustments made to the operating schedule of the day program he attends. Although Michael was initially thrown off due to the change in his routine, once he realized he would be spending more time with his sister, none of that mattered anymore and he was even more excited. Heidi expressed that they are both very happy with how everything turned out. Michael now gets the kind of attention he deserves and is grateful for. Every day Michael gets cheered on and talked to in a loving manner. He also gets a chance to go outside on walks and bond regularly with his family and would not trade it for the world. Heidi expressed that people in similar situations should never give up or take the first option of care offered without being vigilant and exploring all possibilities. Although it may be challenging, and the odds may seem insurmountable, seeing her brother happy makes each day worthwhile. With the right motivation and persistence more people can access and actualize this part of their human spirit.

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.