

# CT Money Follows the Person Report

Quarter 4: October 1 - December 31, 2020

UConn Health, Center on Aging

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

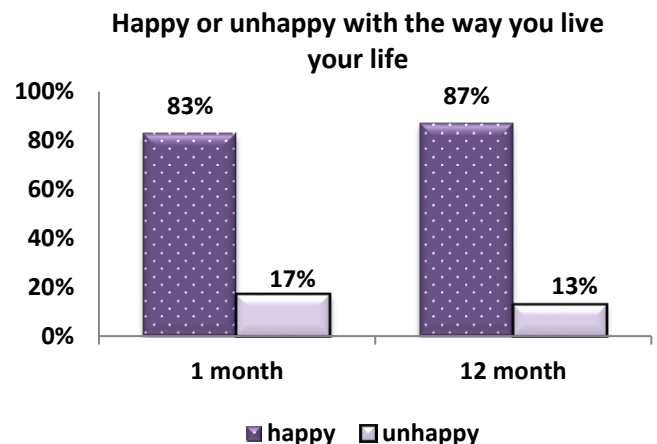
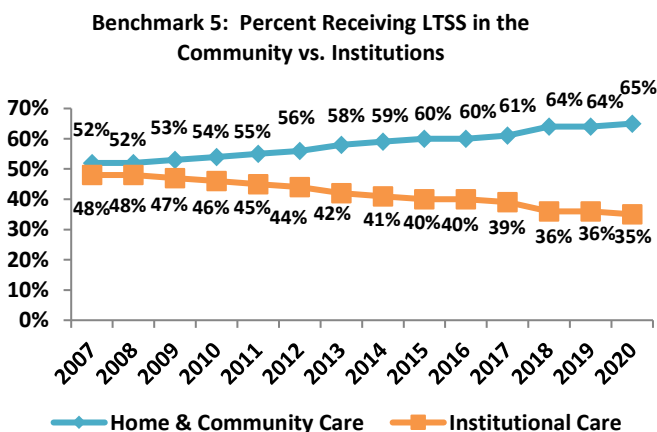
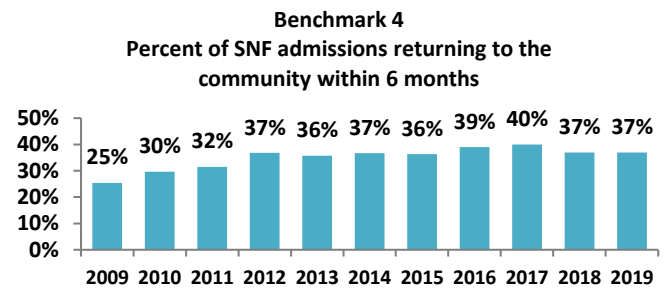
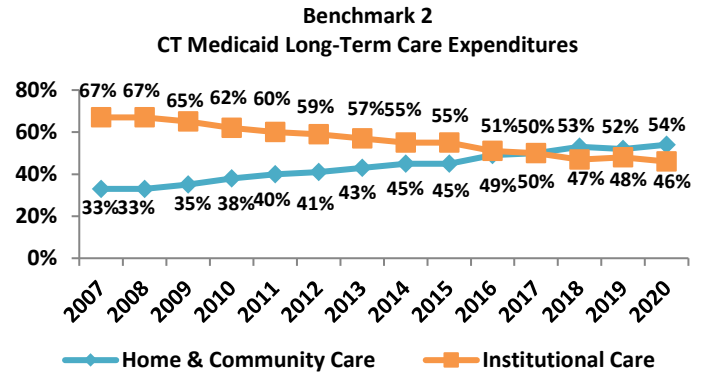
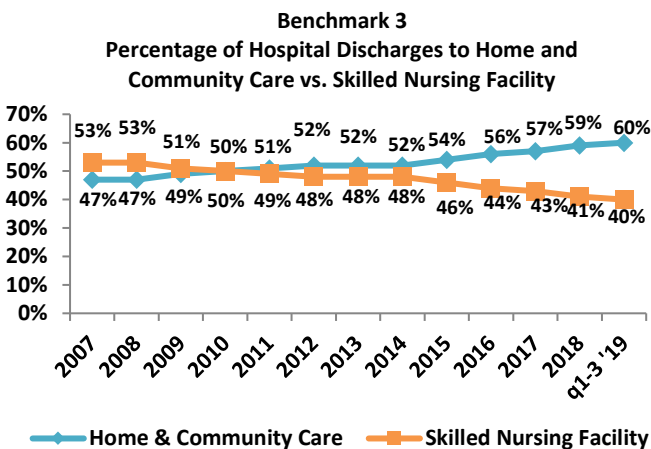
## MFP Benchmarks

- 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

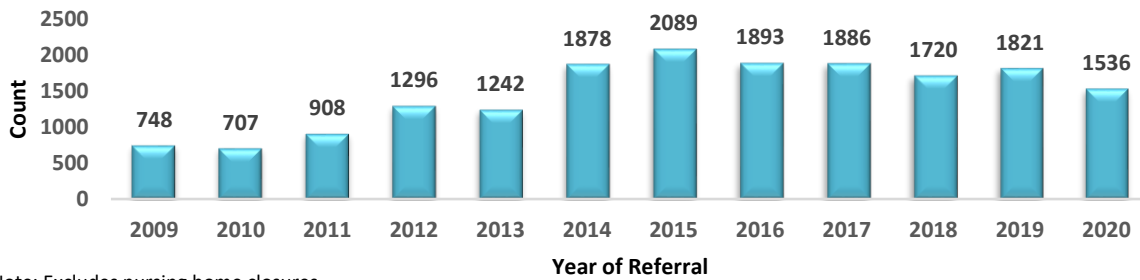
## Benchmark 1: Total Transitions = 6,574

Demonstration = 6,162 (94%)

Non-demonstration = 412 (6%)

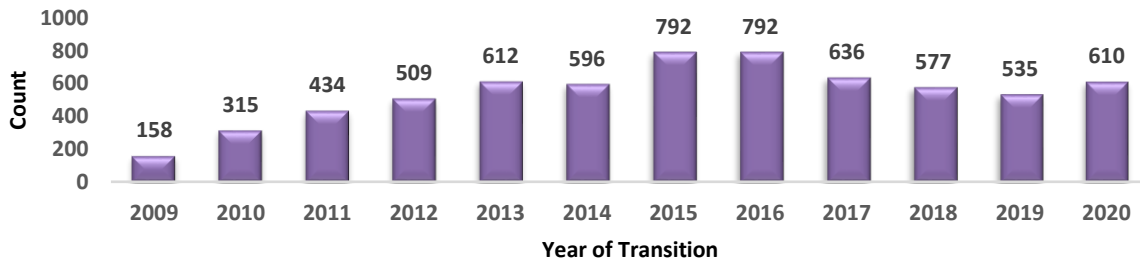


**Total Number of Referrals Assigned to the Field by Year**

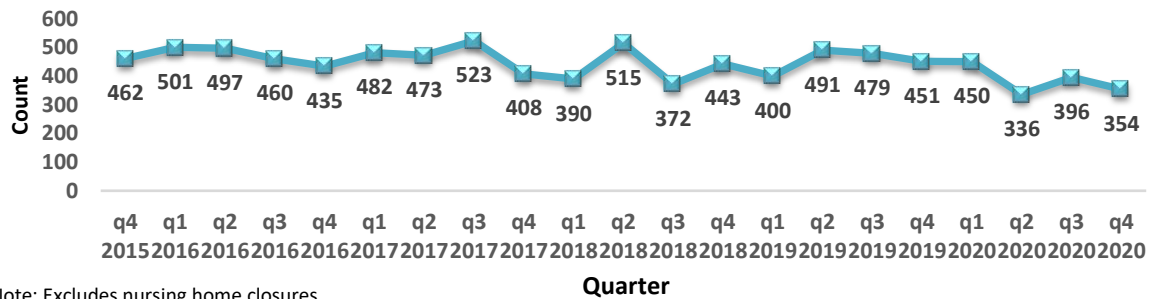


Note: Excludes nursing home closures

**Total Number of Transitions by Year**

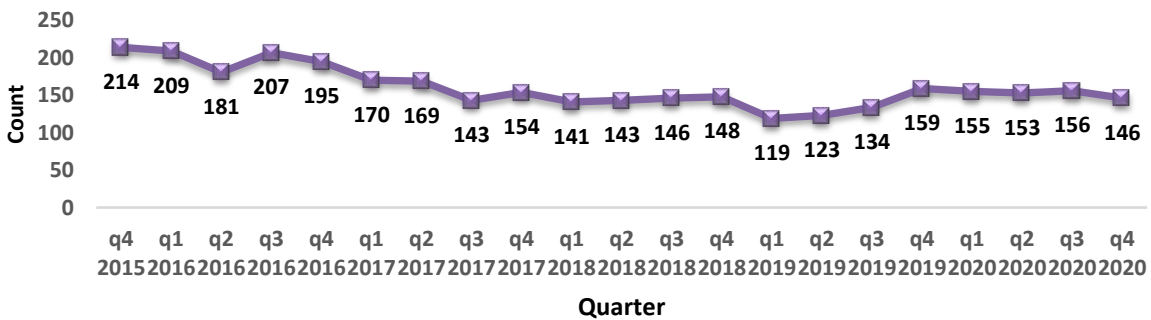


**Referrals Assigned to the Field by Quarter**

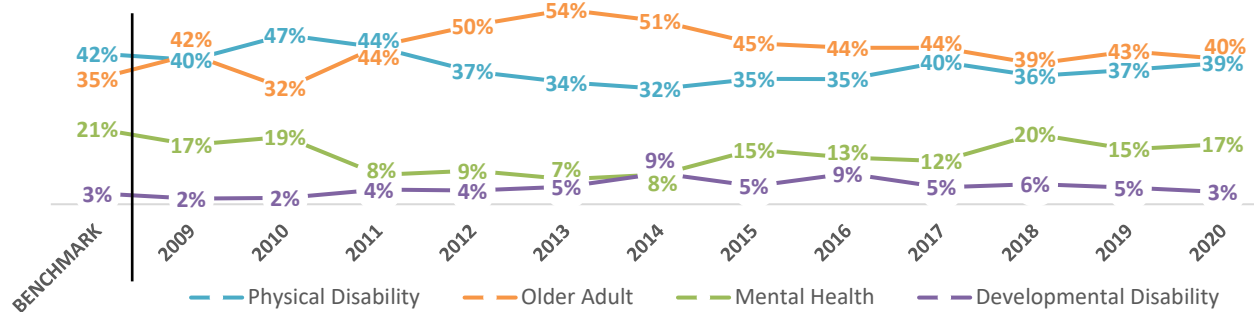


Note: Excludes nursing home closures

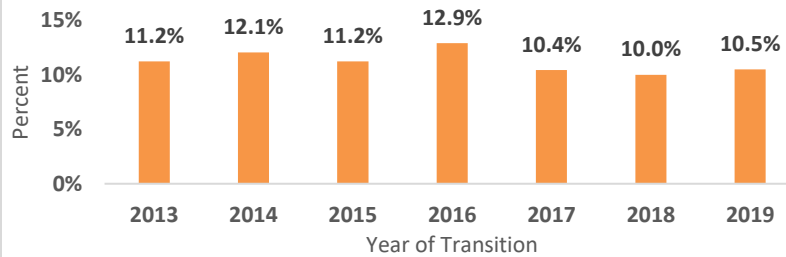
**Number of Transitions by Quarter**



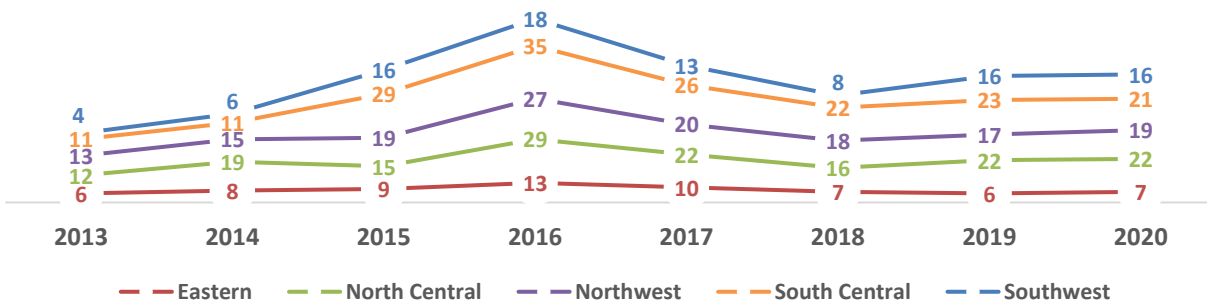
**Target Population for Transitions by Year of Transition (Demonstration Only)**



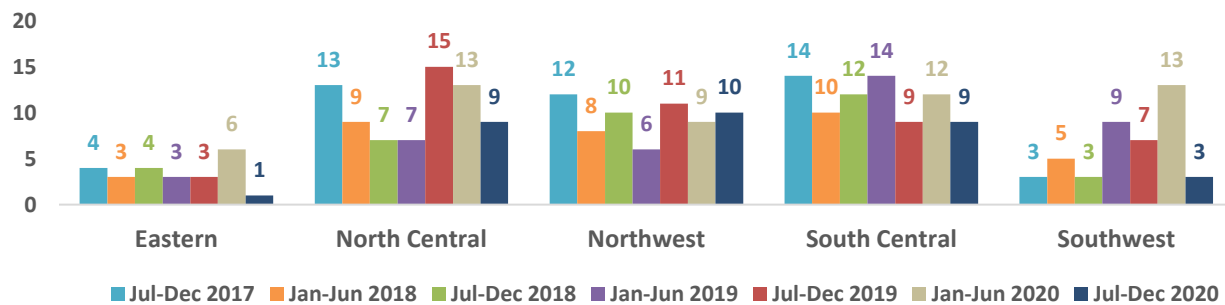
**Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay**



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

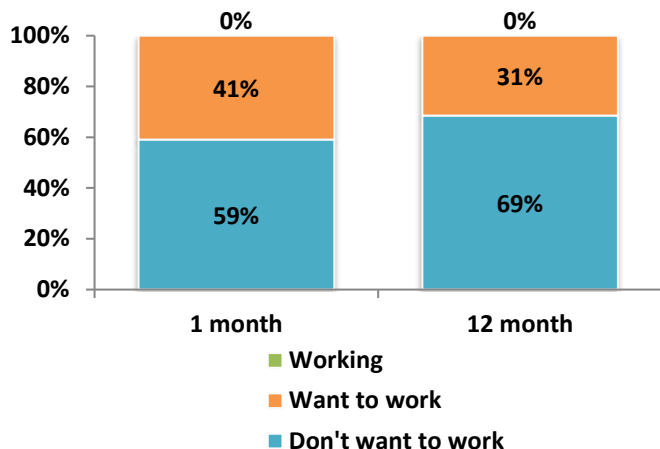


**Number of Participants with Home Modifications per 6 Months**

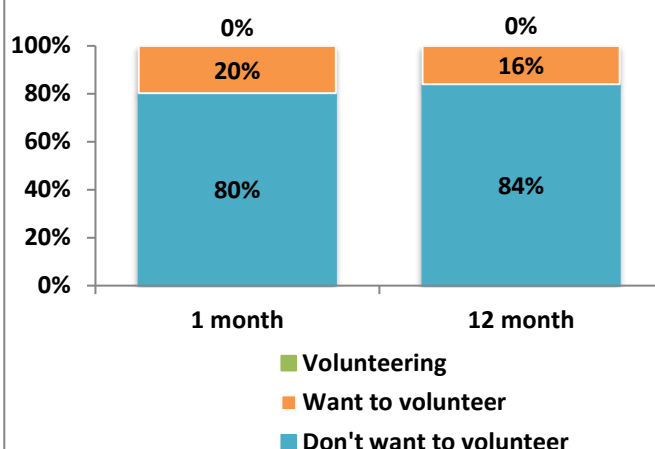


## Participants who are Working and/or Volunteering (data 10/1/20 - 12/31/20)

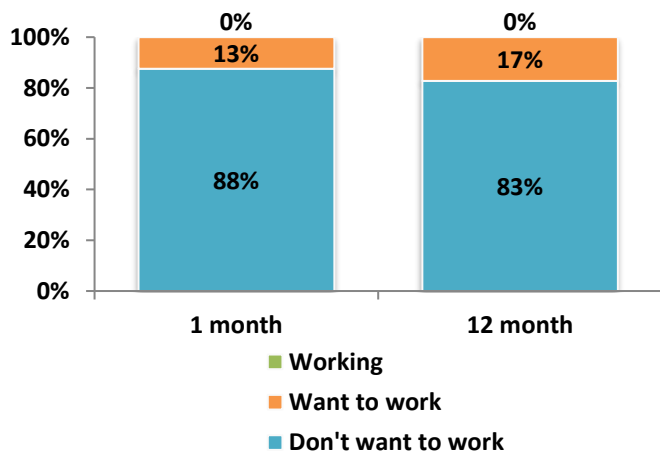
Participants under age 65 who are working and those who would like to work



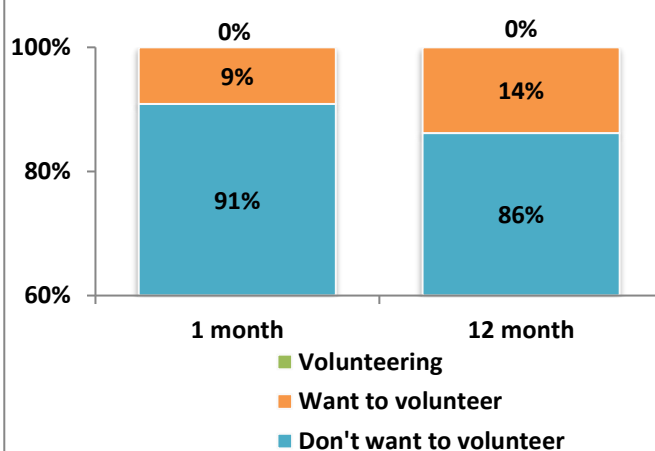
Participants under age 65 who are volunteering and those who would like to volunteer



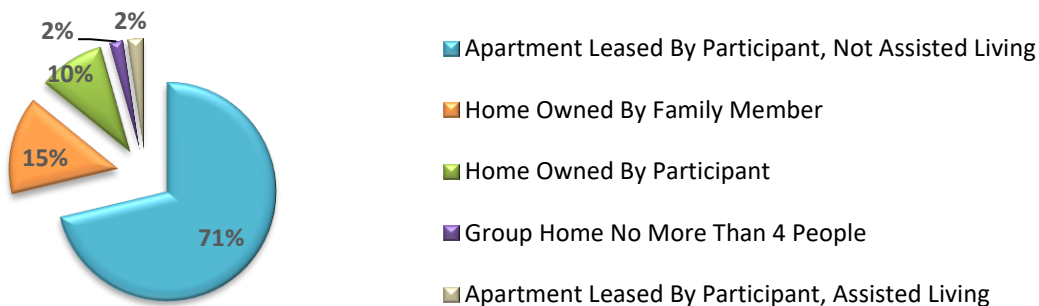
Participants 65 years and older who are working and those who would like to work



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 12/31/2020



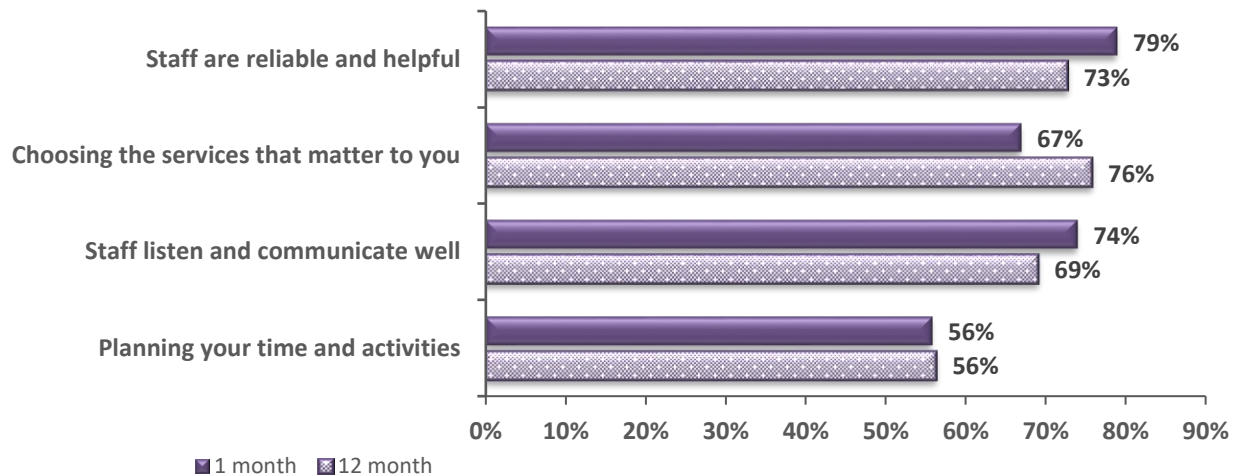
## MFP Quality of Life Dashboard

Number of Quality of Life Interviews Completed from 10/1/20 - 12/31/20

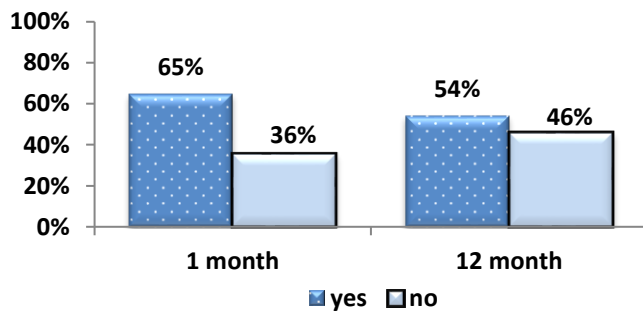
**1 month** interviews done 1 month after transition, **n=111**

**12 month** interviews done 12 months after transition, **n=96**

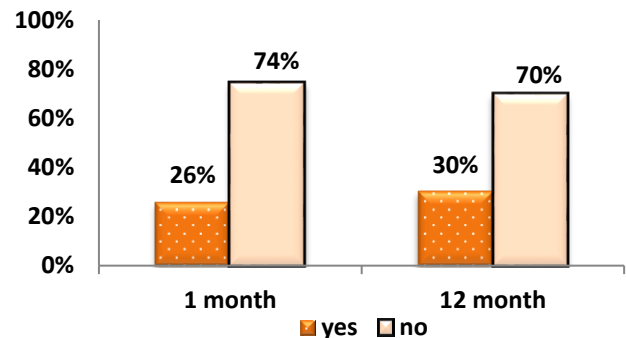
HCBS CAHPS Composite Measures: Percent with Highest Score (e.g. always, yes)



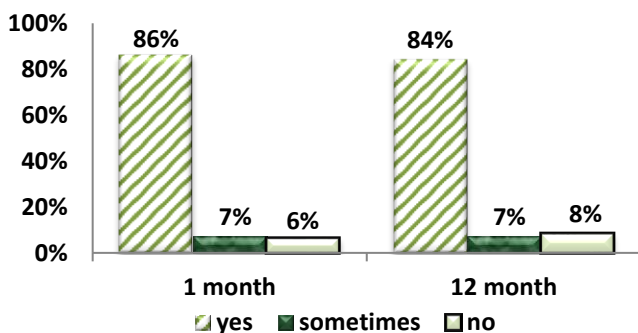
Did any unpaid family members or friends help you with things around the house?



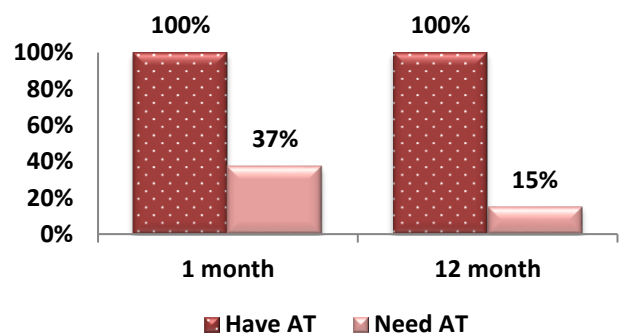
Depressive Symptoms



Do you like where you live?

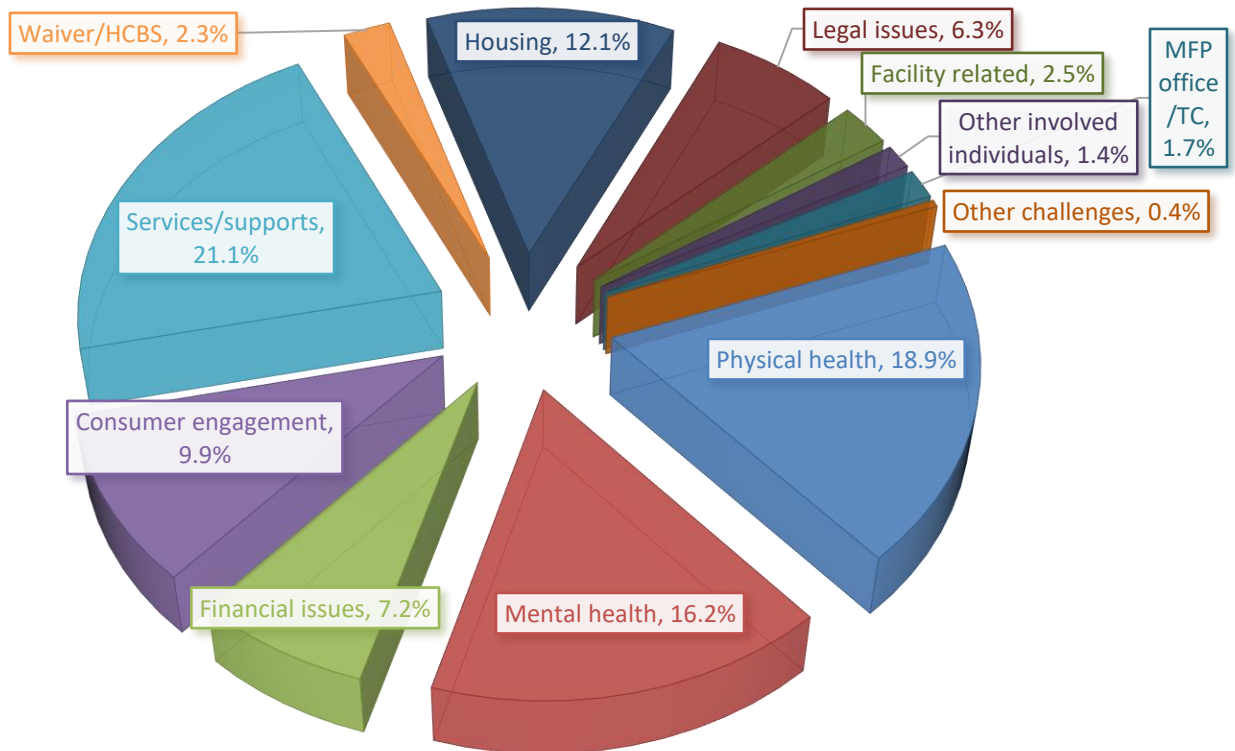


Have or Need Assistive Technology (AT)?

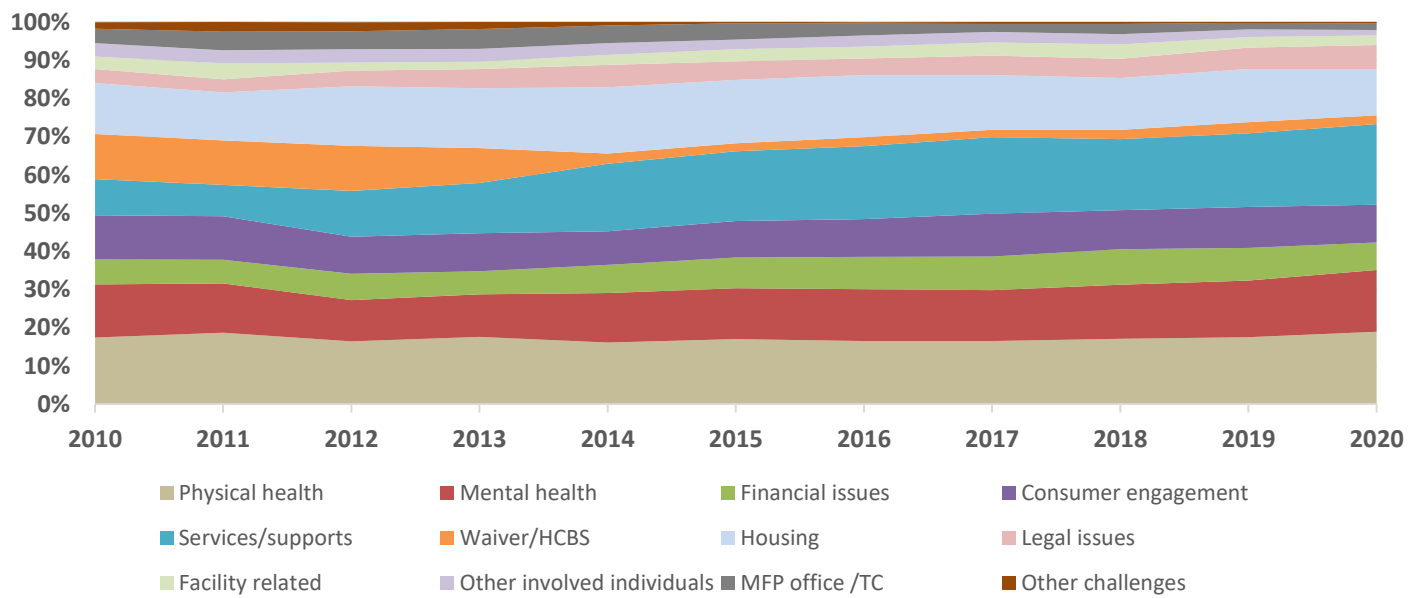


## Challenges to Transition as Recorded by TCs and SCMs

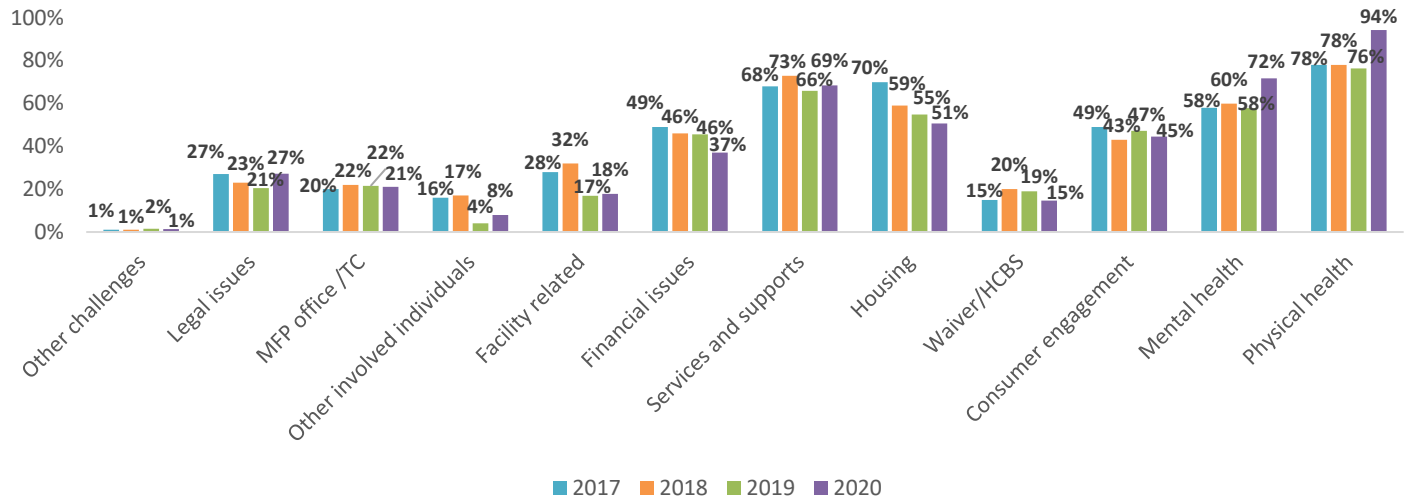
Transition Challenges for Participants Referred Jan-Dec 2020



Frequency of Transition Challenges by Year of Referral



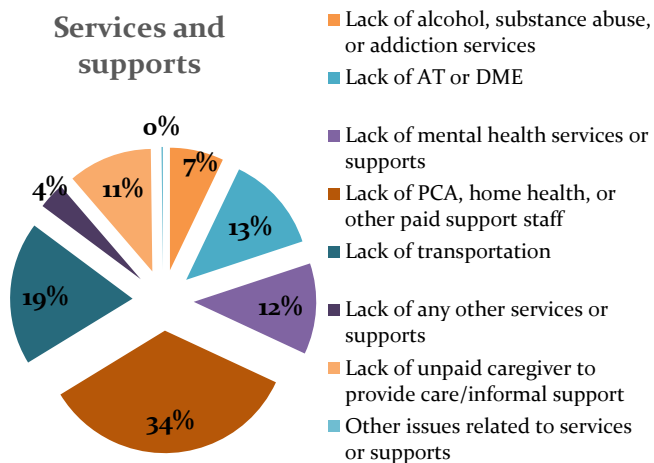
## Participants with Each Challenge who Transitioned by Referral Year



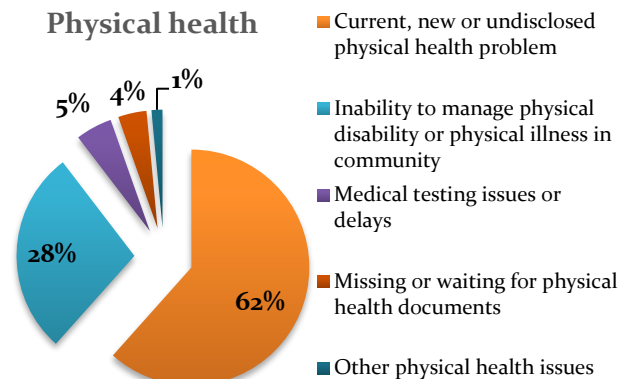
## Types of Challenges for Referrals: 1/1/20 - 12/31/20

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

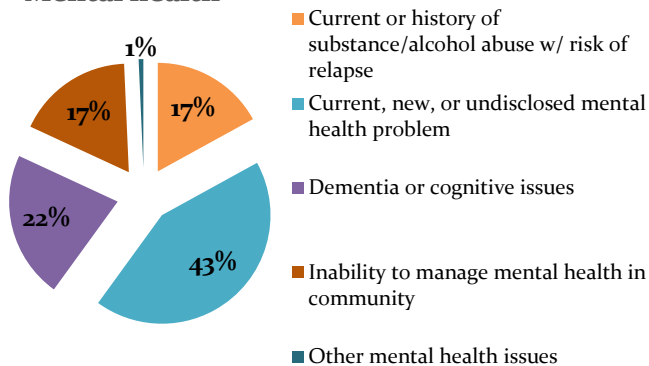
### Services and supports



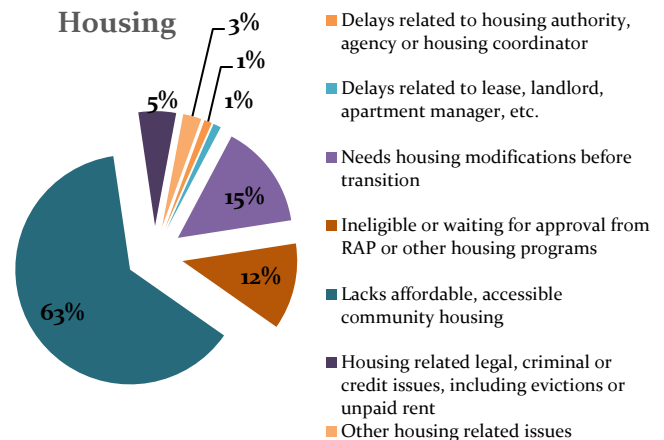
### Physical health



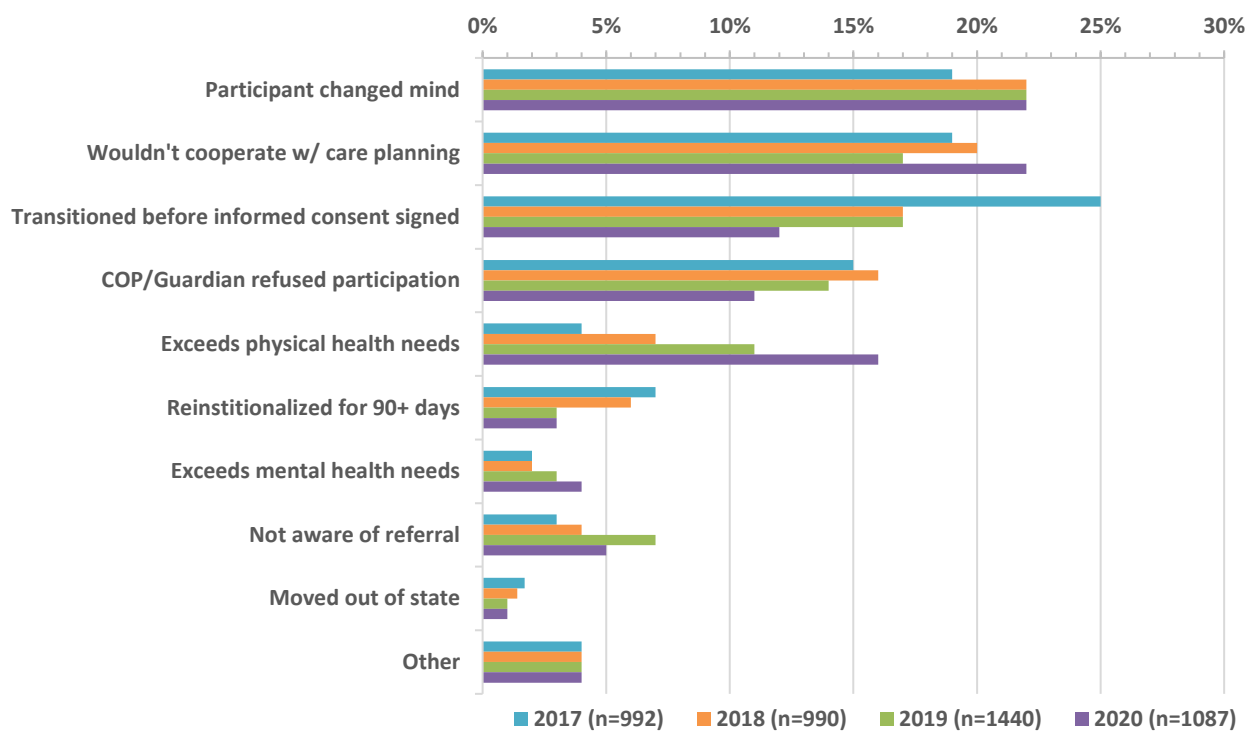
### Mental health



### Housing

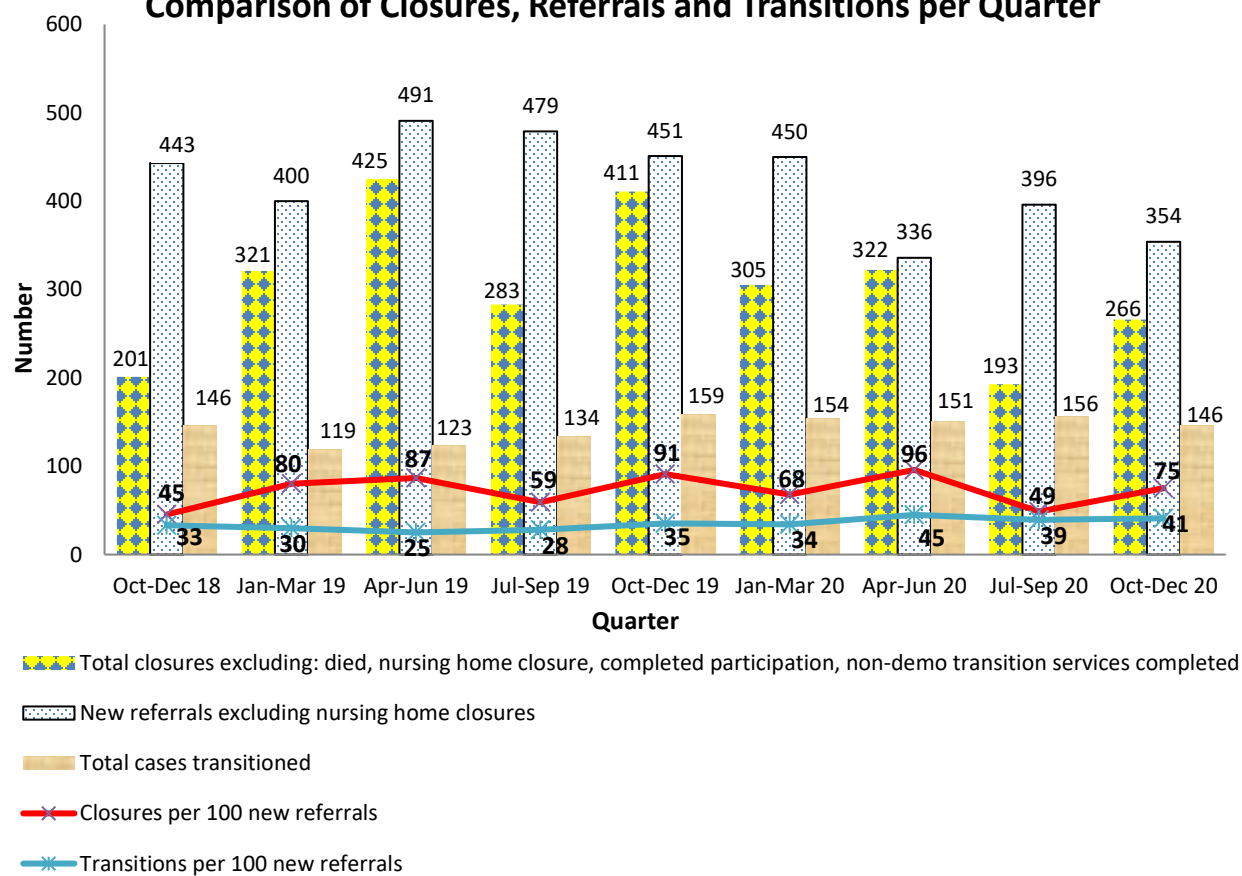


### Frequency of Closure Reason by Year of Closure



Note: Excludes: died, nursing home closure, completed participation, non-demo transition services completed

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





## Karen Dowou's Story

Karen Dowou experienced a life of independence, as most people do. This independence allowed her to work at St. Francis Hospital for 16 years serving the community. It allowed her to make the everyday choices we often take for granted: when to get up, what to pack for lunch, and what to do over the weekend.

In 2015, Karen's health took a turn and she needed to start dialysis three times a week. Unfortunately, dialysis was just the start of other health issues that eventually forced her to leave her job. She needed to focus on her health. Even during this time, Karen continued living independently.

Karen's life took another turn in 2018 when a wound on her foot became badly infected. Based on her doctor's recommendation, she chose to have it amputated. Following the surgery, Karen was admitted to a nursing facility for short term rehab. Her stay started as a four-month plan to adjust to life after amputation and wait for a prosthetic to be made. She attended rehab and made friends, but dreamed of going back to the place she called home.

She described her time in the nursing home as living by someone else's schedule. The facility was clean, and the staff were nice, but she craved privacy and independence. She recalled, "I was one of the youngest in there, and it felt like I wasn't supposed to be there. I wanted more independence. I hated being told when to go to bed and when to eat. And the food was terrible." She even mentioned not being allowed to go to the bathroom on her own, often causing her to wait an uncomfortable amount of time.

Karen was introduced to the Money Follows the Person (MFP) program by her sister. Together, they brought it up to the facility social worker who was able to facilitate the process of getting Karen back home. Even with rehab and a new prosthetic, Karen would need help to live in her home again. Money Follows the Person was her key to getting out of the nursing home while still receiving the daily assistance she needed.

Through MFP, she met with a care manager and transition coordinator who made sure her apartment was adapted to her needs. This meant obtaining equipment that would foster Karen's independence such as grab bars, a shower chair, and a personal emergency response system. She also learned how to hire personal care assistants so she could receive a nursing level of care in the comfort of her own home. Finally, in January of 2020, she was ready to make her transition. Karen described her transition as smooth. As to be expected, she was nervous about spending her first night alone in over nine months, but was comforted by knowing her next aide would be there first thing in the morning. With some time and help from the PCAs, she settled back into her own routine. Karen described how it used to feel when getting picked up from dialysis. "When they picked me up, I would usually be down about going back to the nursing home. Now, I get picked up and can look forward to going back to my actual home!" Upon reflecting on her transition, Karen thanked God first for her success. Behind Him, she thanks her MFP team who were always on top of any issues that she had and followed up in a timely manner. Last but certainly not least, she thanks her PCAs who've been there for her each and every day. She added, "They don't just help with personal care or cooking, they provide companionship too. We have great communication and I can talk to them about anything. It doesn't feel like I'm their boss, it's more like they're my friends and I'm so thankful for that."



### 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.