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 = 6,692
Demonstration = 6,272 (94%)
Non-demonstration = 420 (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

<table>
<thead>
<tr>
<th>Time</th>
<th>Happy</th>
<th>Unhappy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month</td>
<td>86%</td>
<td>14%</td>
</tr>
<tr>
<td>12 month</td>
<td>89%</td>
<td>11%</td>
</tr>
</tbody>
</table>
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

Quarter

Count

Year of Referral

Count

Year of Transition

Count

Quarter

Count

Quarter
Participants who are Working and/or Volunteering (data 1/1/21-3/31/21)

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

- Working: 66% (1 month), 69% (12 month)
- Want to work: 34% (1 month), 27% (12 month)
- Don’t want to work: 0% (1 month), 4% (12 month)

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

- Volunteering: 89% (1 month), 93% (12 month)
- Want to volunteer: 9% (1 month), 7% (12 month)
- Don’t want to volunteer: 2% (1 month), 0% (12 month)

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

- Working: 85% (1 month), 94% (12 month)
- Want to work: 15% (1 month), 6% (12 month)
- Don’t want to work: 0% (1 month), 2% (12 month)

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

- Volunteering: 89% (1 month), 96% (12 month)
- Want to volunteer: 11% (1 month), 2% (12 month)
- Don’t want to volunteer: 0% (1 month), 2% (12 month)

Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 3/31/2021

- Apartment Leased By Participant, Not Assisted Living: 10%
- Home Owned By Family Member: 15%
- Home Owned By Participant: 71%
- 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 1/1/21-3/31/21

1 month interviews done 1 month after transition, n=108
12 month interviews done 12 months after transition, n=119

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

- Staff are reliable and helpful: 82% in 1 month, 90% in 12 month
- Choosing the services that matter to you: 65% in 1 month, 72% in 12 month
- Staff listen and communicate well: 71% in 1 month, 75% in 12 month
- Planning your time and activities: 55% in 1 month, 53% in 12 month

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

- Yes: 60% in 1 month, 55% in 12 month
- No: 40% in 1 month, 46% in 12 month

Depressive Symptoms

- Yes: 33% in 1 month, 38% in 12 month
- No: 67% in 1 month, 62% in 12 month

Do you like where you live?

- Yes: 83% in 1 month, 79% in 12 month
- Sometimes: 10% in 1 month, 7% in 12 month
- No: 8% in 1 month, 13% in 12 month

Have or Need Assistive Technology (AT)?

- Have AT: 97% in 1 month, 100% in 12 month
- Need AT: 32% in 1 month, 14% in 12 month
Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred Jan-Mar 2021

- Services/supports, 23.9%
- Physical health, 18.0%
- Mental health, 17.8%
- Financial issues, 6.1%
- Consumer engagement, 7.5%
- Housing, 11.6%
- Facility related, 2.6%
- Other involved individuals, 1.1%
- MFP office /TC, 1.7%
- Other challenges, 0.4%
- Waiver/HCBS, 3.0%

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
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- 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: 1/1/21-3/31/21
Below are the four most common challenge types for the current year

**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

**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

**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

**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
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

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

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
Marsha Culver’s Story

Marsha Culver’s life as a former dementia-care nurse manager at a skilled nursing facility would come full circle when she became a resident in the same facility. Marsha enlisted in the navy after graduating from high school and served as a certified nursing assistant in a hospital, inspiring her to pursue a career in nursing years later, when she was a single mother raising her son. Describing herself as a self-sufficient person, she had been living with her sister in a duplex where her granddaughter lived too. She fondly reminisced about driving to Hammonasset Beach State Park to meet up with friends and play cards, until the morning she awoke with severe back pain and was unable to get out of bed. She went to the emergency room and was given two options: do nothing for her lumbar spinal stenosis or have a very risky surgery to reconstruct her spine. After a ten-hour surgery in which she needed resuscitation, she requested transfer to the familiar nursing home in which she worked. She would not only have to adjust to feeling a loss of freedom, but also to the dramatic changes in skilled nursing facilities during the pandemic. The reduced staffing was evident in aides trying to care for patients’ daily needs as quickly as possible. Marsha felt the dependence on aides doing for her rather than with her, which required more time and restricted her growth towards regaining independence. She did not think she would ever leave the facility.

Through her roommate, she heard about Money Follows the Person (MFP). She initiated the application process and immediately started researching accessible housing on her own. Marsha, being a proactive person, was fortunate to have found the accessible housing located near her family. MFP staff determined she was qualified for assisted living level of need and helped her get the rental assistance program certificate needed to transition. She exclaimed, “Oh my God, I was lucky to get out when I did!” The MFP transition coordinator assisted Marsha to set up her new apartment, buying furniture and transitional food items. “I felt like a queen!” Being a veteran, the VA assisted her to get medical supplies, a wheelchair, and a walker. Now, she can see her own VA healthcare team again.

Her advice to others thinking about this program, is to not be too choosy to find the “ideal” housing. She encourages others to make sure to check in often with both the facility social worker and MFP case manager on the progress of their case status to assure clear communication, understanding of your eligibility, and expectations.

Marsha, who lives with diabetes, is now able to check her own blood sugar levels and monitor her diet, sometimes even cooking for herself although the food at her assisted living is great. Slowly, COVID-19 restrictions are being lifted at the assisted living, allowing residents to once again share a meal together and join in activities.

“I feel like a real person, once again having the privilege of making up my own mind. MFP helped me get here. My family and I both agree I am more alert now and interested in engaging in life again.” After two years, Marsha was able to see her son who lives in Hawaii for a wonderful family reunion! Recently, the residents had unusual visitors, alpacas from a nearby farm. In the coming months, Marsha looks forward to more enjoyable activities, hoping to return to the beach once again this summer.

MFP Demonstration Background

The Money Follows the Person Rebalancing Demonstration, created by Section 6071 of the Deficit Reduction Act of 2005, supports States’ efforts to “rebalance” their long-term support systems, so that individuals can choose where to live and receive services. One of the major objectives of Money Follows the Person (MFP) is “to increase the use of home and community based, rather than institutional, long-term care services.” MFP supports this by offering grantee States an enhanced Federal Medical Assistance Percentage on qualified services. MFP also offers states the flexibility to provide supplemental services, such as assistive technology and enhanced transition services, to assist in successful transitions. States are then expected to reinvest the savings over the cost of institutional services to rebalance their long-term services and supports for older adults and people with disabilities to a community-based orientation.