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

CT Money Follows the Person Report
Quarter 3: July 1 - September 30, 2021
UConn Health, Center on Aging

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

Benchmark 1: Total Transitions = 6,919
   Demonstration = 6,486 (94%)
   Non-demonstration = 433 (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

% happy vs. unhappy over time
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

Quarter
Participants who are Working and/or Volunteering (data 7/1/21-9/30/21)

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

- Working: 73% (1 month), 68% (12 month)
- Want to work: 27% (1 month), 28% (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: 93% (1 month), 90% (12 month)
- Want to volunteer: 7% (1 month), 10% (12 month)
- Don’t want to volunteer: 0% (1 month), 0% (12 month)

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

- Working: 82% (1 month), 94% (12 month)
- Want to work: 18% (1 month), 6% (12 month)
- Don’t want to work: 0% (1 month), 4% (12 month)

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

- Volunteering: 79% (1 month), 94% (12 month)
- Want to volunteer: 18% (1 month), 6% (12 month)
- Don’t want to volunteer: 4% (1 month), 0% (12 month)

Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 9/30/2021

- Apartment Leased By Participant, Not Assisted Living: 71%
- Home Owned By Family Member: 15%
- Home Owned By Participant: 10%
- 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 7/1/21-9/30/21

1 month interviews done 1 month after transition, n=78
12 month interviews done 12 months after transition, n=79

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

- Staff are reliable and helpful
  - 1 month: 91%
  - 12 month: 89%
- Choosing the services that matter to you
  - 1 month: 67%
  - 12 month: 65%
- Staff listen and communicate well
  - 1 month: 79%
  - 12 month: 74%
- Planning your time and activities
  - 1 month: 56%
  - 12 month: 62%

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

- 1 month: 54%
- 12 month: 61%

Depressive Symptoms

- 1 month: 26%
- 12 month: 31%

Do you like where you live?

- 1 month: 92%
- 12 month: 78%

Have or Need Assistive Technology (AT)?

- 1 month: 100%
- 12 month: 100%
Participants with Each Challenge who Transitioned by Referral Year

Types of Challenges for Referrals: 1/1/21 - 9/30/21
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
Frequency of Closure Reason by Year of Closure

- 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
Nancy and Charlie’s Story

In one split second, Nancy’s life changed. She was living in her own condominium with her rescue dog Charlie; active, independent and working at a job she loved. In November 2019, Nancy left her accounting job at a car dealership in Massachusetts and picked up Charlie at doggie day care. Driving onto a bridge to Interstate-91, Nancy recalled hearing a voice in her head warning her to “Stay in your lane.” It was too late. Nancy swerved into an on-coming car head on. She remembers the collision and being able to get out of the car, hearing the other driver ask, “Why did you come at me like that?” Nancy credits the police at the scene with recognizing possible signs of a stroke when they saw her left leg paralyzed. A quick response saved her life. She was only 57 years old when diagnosed with a hemorrhagic stroke. Although the stroke did not affect her ability to talk or her cognition, her entire left side was paralyzed. The shock, grief and multiple losses overwhelmed her.

After two weeks in a Massachusetts hospital, Nancy was admitted to the first of three Connecticut skilled nursing facilities to be closer to her supportive family. Nancy first heard of Money Follows the Person (MFP) from a Certified Nurse’s Aide (CNA) who urged her to look into this program. “She wanted to get me out while at the height of COVID. It sounded too good to be true when I researched it.” Concerned about her safety as COVID surged, she was discharged without MFP to her father’s home. Barely there two days, Nancy fell and broke her hip needing hip replacement surgery. Her family scrambled to find her a skilled nursing bed during COVID. In early May 2020, Nancy was at another skilled nursing facility trying to recover from both the stroke and the hip surgery. Nancy’s mental and physical health were suffering; she was in physical pain, angry, and felt like she didn’t want to live. Recalling what the CNA told her about MFP, Nancy made her application online and started to feel hopeful.

Nancy’s experience was not entirely smooth; her housing coordinator was not responsive. Nancy was proactive in finding her own apartment, with the added challenge of finding a place who accepted dogs. Her advice to anyone on MFP, “You need to be your own advocate. Be strong. Stand up for yourself. Ask a lot of questions. Ask if you have a choice for home care agencies. Make sure you are getting what you need.” Although she did not get an aide for three weeks, partly due to living in a location where they were scarce especially during COVID, she eventually got all the services she needed. Nancy says both her transition coordinator and her care manager were awesome! Not only did they buy her furniture and $180.00 of groceries to get her started in her new apartment, they were true to their word, competent and compassionate. The case manager told her about all the services she would receive, including a recovery assistant. Physical therapy at the facility provided her with a walker and transfer tub bench, and Nancy bought her own cane. She was very impressed with MFP and would definitely recommend it, and feels this program should be more widely advertised.

Now, Nancy is more mobile, able to shower, wash her hair, make simple meals and is better at dressing herself. She is adjusting to life in CT with family nearby, feeling lucky to be alive. “My sisters remind me how far I’ve come. My father tells me he is so proud of my progress.”

Nancy may have rescued Charlie, but Charlie is there for Nancy in her recovery process. “I used to whisper in his ear that we’d be back together again. My dog has been my total protector ever since.” They share unconditional love and support as they are once again reunited.

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.