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 = 7,033
- Demonstration = 6,596 (94%)
- Non-demonstration = 437 (6%)

Benchmark 2: CT Medicaid Long-Term Care Expenditures
- Home & Community Care vs. Institutional Care

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
- 1 month: 82% happy, 18% unhappy
- 12 month: 86% happy, 14% unhappy
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 10/1/21-12/31/21)

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

<table>
<thead>
<tr>
<th></th>
<th>Working</th>
<th>Want to work</th>
<th>Don't want to work</th>
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<tbody>
<tr>
<td>1 month</td>
<td>71%</td>
<td>29%</td>
<td>0%</td>
</tr>
<tr>
<td>12 month</td>
<td>51%</td>
<td>47%</td>
<td>2%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Volunteering</th>
<th>Want to volunteer</th>
<th>Don't want to volunteer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month</td>
<td>85%</td>
<td>15%</td>
<td>0%</td>
</tr>
<tr>
<td>12 month</td>
<td>79%</td>
<td>17%</td>
<td>4%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Working</th>
<th>Want to work</th>
<th>Don't want to work</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month</td>
<td>88%</td>
<td>13%</td>
<td>0%</td>
</tr>
<tr>
<td>12 month</td>
<td>85%</td>
<td>15%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

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</thead>
<tbody>
<tr>
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<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>12 month</td>
<td>86%</td>
<td>14%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

- 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 10/1/21-12/31/21

1 month interviews done 1 month after transition, n=81
12 month interviews done 12 months after transition, n=86

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

- Staff are reliable and helpful: 81% (1 month), 85% (12 month)
- Choosing the services that matter to you: 63% (1 month), 68% (12 month)
- Staff listen and communicate well: 71% (1 month), 75% (12 month)
- Planning your time and activities: 56% (1 month), 56% (12 month)

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

- 1 month: 62% yes, 38% no
- 12 month: 51% yes, 49% no

Depressive Symptoms

- 1 month: 34% yes, 66% no
- 12 month: 43% yes, 58% no

Do you like where you live?

- 1 month: 84% yes, 6% sometimes, 10% no
- 12 month: 75% yes, 16% sometimes, 10% no

Have or Need Assistive Technology (AT)?

- 1 month: 99% have AT, 31% need AT
- 12 month: 99% have AT, 23% need AT
Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred Jan-Dec 2021

- Physical health, 18.6%
- Mental health, 17.7%
- Financial issues, 6.2%
- Consumer engagement, 10.0%
- Services/supports, 21.0%
- Housing, 12.0%
- Waiver/HCBS, 1.9%
- Facility related, 2.8%
- Other involved individuals, 1.2%
- MFP office/TC, 1.3%
- Other challenges, 0.6%

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

Challenges to Transition as Recorded by TCs and SCMs
Types of Challenges for Referrals: 1/1/21 - 12/31/21

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
Frequency of Closure Reason by Year of Closure

Comparison of Closures, Referrals and Transitions per Quarter

Note: Excludes: died, nursing home closure, completed participation, non-demo transition services completed
Joann’s Story

In February of 2020, Joann was doing some routine grocery shopping when she collapsed. The fall resulted in a broken back, and required her to enter a rehabilitation facility before she could return to the home she shared with her daughter. Joann, unfortunately, was no stranger to the facility. She had been there many times before as a result of a wide array of health issues. Although she was used to the staff and enjoyed their support, the facility was not a place she wanted to stay long.

The following month, COVID began running rampant and lockdowns were put in place. Those living in skilled nursing facilities were greatly affected and required to use extreme caution. Most people, including Joann, were not allowed to leave their rooms. She was already experiencing loneliness due to not having anyone at the rehab facility that she could connect with. Being of a very sound mind, Joann felt the only people she could have a real conversation with were staff. Over the next few months, her condition improved but COVID made it hard to leave.

Thankfully, during this time, a social worker from the rehab facility introduced Joann and her family to the Money Follows the Person program. Because Joann was still very independent, she was a great candidate for the program. She was very excited at the idea of having her own apartment rather than living with her daughter. It was a piece of independence that she could not wait to have back. Even with many complications due to COVID, over the next year, Joann, her family, and the MFP team were able to find her a beautiful apartment.

Finally, on Oct. 4th, 2021, Joann was discharged from the rehab facility and began the next chapter of her life. She immediately fell in love with her apartment. She met her PCA, Georgina, who would spend a few hours with her Monday through Friday to make sure all her needs were met. Her family and MFP team made sure she had everything she needed, including medical equipment like a shower chair.

Joann loves her new sense of independence. Although she sometimes gets down about the things she can no longer do, she feels so grateful that the Money Follows the Person program was able to provide her with the most independence possible. She thinks back to her time in the facility, and explained what a joy it is to be able to decide when you want to get up, and when you want to go to bed. She can decorate her place how she pleases, and light a candle without needing permission. Joann can now enjoy the peace and quiet of her apartment with a good book, with no need to worry about the facility’s rules or time constraints.