CT Money Follows the Person Report
Quarter 2: April 1 - June 30, 2022
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 = 7,261
Demonstration = 6,812 (94%)
Non-demonstration = 449 (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

1 month: 75% happy, 25% unhappy
12 month: 82% happy, 18% unhappy
Participants who are Working and/or Volunteering (data 4/1/22-6/30/22)

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

- Working: 69% (1 month), 66% (12 month)
- Want to work: 31% (1 month), 34% (12 month)
- Don't want to work: 0% (1 month), 0% (12 month)

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

- Working: 76% (1 month), 73% (12 month)
- Want to work: 24% (1 month), 24% (12 month)
- Don't want to work: 0% (1 month), 3% (12 month)

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

- Working: 87% (1 month), 87% (12 month)
- Want to work: 13% (1 month), 13% (12 month)
- Don't want to work: 0% (1 month), 0% (12 month)

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

- Working: 83% (1 month), 86% (12 month)
- Want to work: 17% (1 month), 14% (12 month)
- Don't want to work: 0% (1 month), 0% (12 month)

Qualified Residence Type for Transferred Referrals: 12/4/2008 to 6/30/2022

- 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 4/1/2022-6/30/2022 (n=157)

1 month interviews done 1 month after transition, n=80
12 month interviews done 12 months after transition, n=77

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

- Staff are reliable and helpful
  - 1 month: 75%
  - 12 month: 73%

- Choosing the services that matter to you
  - 1 month: 74%
  - 12 month: 66%

- Staff listen and communicate well
  - 1 month: 68%
  - 12 month: 69%

- Planning your time and activities
  - 1 month: 55%
  - 12 month: 62%

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

- 1 month: 72% yes, 28% no
- 12 month: 55% yes, 45% no

Depressive Symptoms

- 1 month: 39% yes, 61% no
- 12 month: 34% yes, 66% no

Do you like where you live?

- 1 month: 80% yes, 13% sometimes, 7% no
- 12 month: 82% yes, 12% sometimes, 7% no

Have or Need Assistive Technology (AT)?

- 1 month: 99% have AT, 39% need AT
- 12 month: 100% have AT, 23% need AT
Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred Jan-Jun 2022

- Physical health, 18.8%
- Mental health, 17.8%
- Financial issues, 7.2%
- Consumer engagement, 8.5%
- Services/supports, 20.5%
- Housing, 12.2%
- Waiver/HCBS, 1.2%
- Legal issues, 8.3%
- Facility related, 3.2%
- MFP office /TC, 1.0%
- Other involved individuals, 0.7%
- Other challenges, 0.6%
- MFP office /TC, 1.0%
- 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
- Legal issues
- Facility related
- Other involved individuals
- MFP office /TC
- Other challenges
Types of Challenges for Referrals: 1/1/2022 - 6/30/2022
Below are the four most common challenge types for the current quarter

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

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

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

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
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
Virginia’s Story

Prior to living in a nursing facility, Virginia described her life as “normal”. In her mid-90s, she was independent and living in her own home. She enjoyed designing and decorating her home, cooking for herself, making her own plans, and being able to live life on her own terms.

On a cold day in January 2020, Virginia bumped her knee on the side of the bathtub. Although it was painful, she continued through the rest of her day and didn’t think much of it. The next morning, she knew something was terribly wrong when she could not move her knee or walk on it. With few options, she went to the ER.

While in the ER, doctors drained excess fluid from Virginia’s knee and thought her sudden pain was due to gout. Although the doctors wanted to do tests on the fluid that was drained, they sent her home with a prescription from some pain meds. “I wish the story ended there,” she explained. Instead, Virginia had a bad reaction to her pain medicine that caused hallucinations and other symptoms that forced her back to the emergency room. By that time, results from the fluid in her knee showed it was not gout causing her knee pain, but instead a severe bacterial infection.

She required surgery to clear the infection from her knee. She spent about a week in the hospital recovering before transitioning to a skilled nursing facility for rehab. After having been there only a month, the COVID pandemic hit and the world began to shut down. Many people remember being stuck at home during this time; Virginia remembers being stuck in a facility.

As if her new surroundings were not hard enough to adjust to, COVID made living there a nightmare. She recalls being stuck in her room all day, forced to listen to her roommate’s TV while she tried to read. She remembers the kitchen shutting down, and the already undesirable food being served on styrofoam plates and trays, ice cold by the time it reached her. She remembers her daughter, Lestyn, driving from Vermont just to sit outside her window, the only way they could see each other. She remembers talking to Lestyn on the phone each day, explaining how desperate she was to get out. Due to COVID restrictions during this time, Virginia spent every day in her bed with no options for activities or therapies. It was detrimental to her physical abilities, including her ability to walk.

The facility social worker eventually introduced Lestyn to the Money Follows the Person (MFP) program. They submitted an application and started Virginia’s journey home. The social worker, Lestyn, and a care manager from MFP began working together to complete the necessary steps while overcoming the challenges of COVID restrictions. Virginia remembers these months as especially challenging because she could not be as involved in the planning process as she could have been pre-COVID. She had to rely on and trust her daughter to take care of it all.

Finally, in December 2020 after almost a year of waiting, Virginia was ready to transition back to her home. Through MFP, Virginia hired a live-in personal care assistant who makes sure all her needs are met. She also receives physical and occupational therapy in her own home to help regain strength and skills that she lost while living in the facility. Lestyn recalls how much she appreciated the follow up and check ins from the MFP team.

When reflecting on her first days back home, she said it was “as if I had gone to heaven”. Virginia has been back home for a year and a half, and is once again enjoying her free time reading and picking out new paint colors for her home. “I love being surrounded by my own things and feeling comfortable. I never once felt at home in the nursing home. Living at home is the ultimate for me.”

Virginia was thrilled to share that she will meet her newest great granddaughter in a few months, a moment that will be much more meaningful from the comfort of her home.

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.