CT Money Follows the Person Report

Quarter 3: July 1 - September 30, 2022

UConn Health, Center on Aging

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

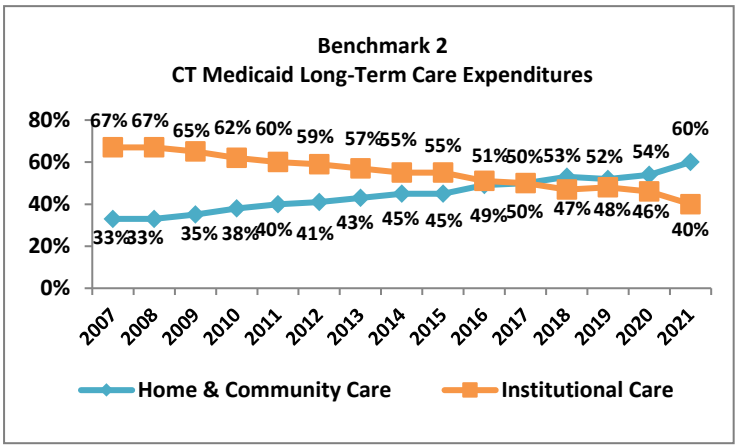
MFP Benchmarks

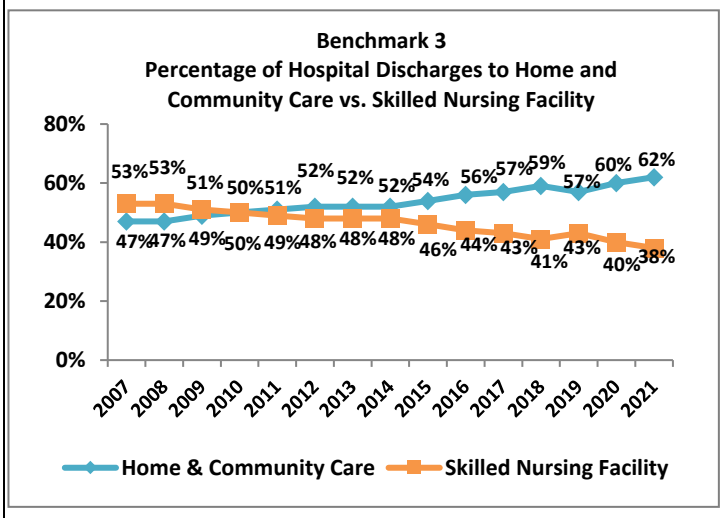
1) Transition 5200 people from qualified institutions to the community
2) Increase dollars to home and community based services
3) Increase hospital discharges to the community rather than to institutions
4) Increase probability of returning to the community during the six months following nursing home admission
5) Increase the percentage of long term care participants living in the community compared to an institution

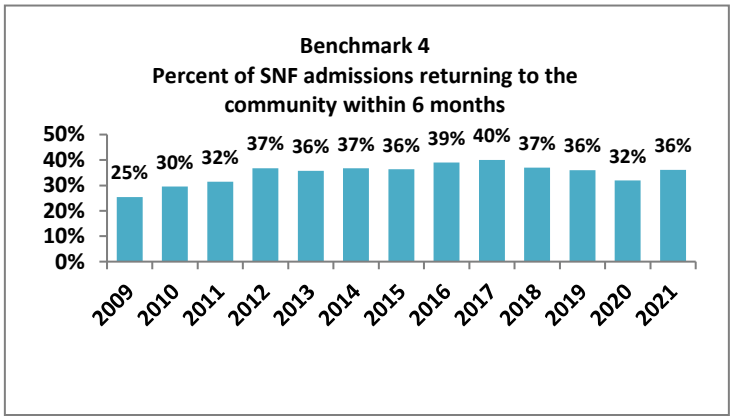
Benchmark 1: Total Transitions = 7,353

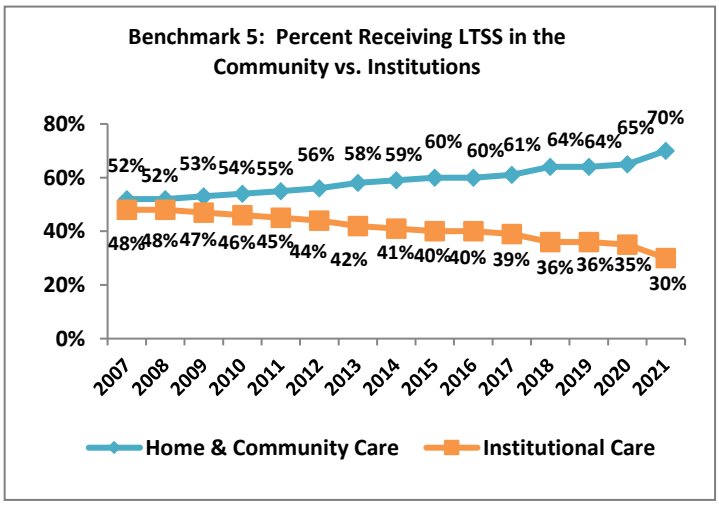
Demonstration = 6,896 (94%)

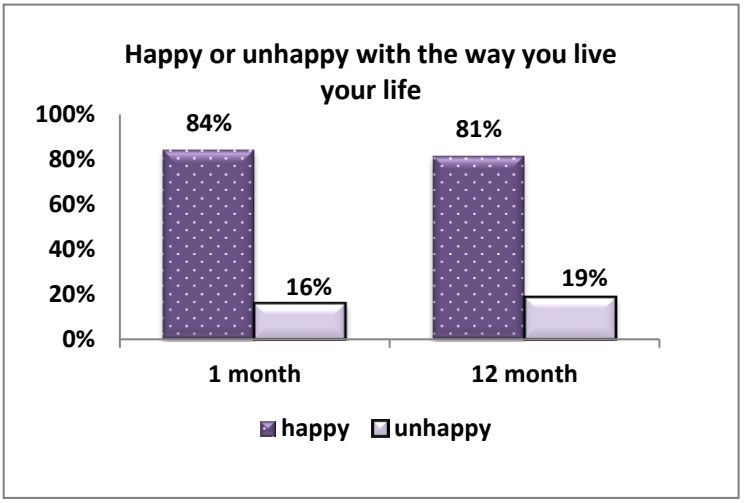
Non-demonstration = 457 (6%)

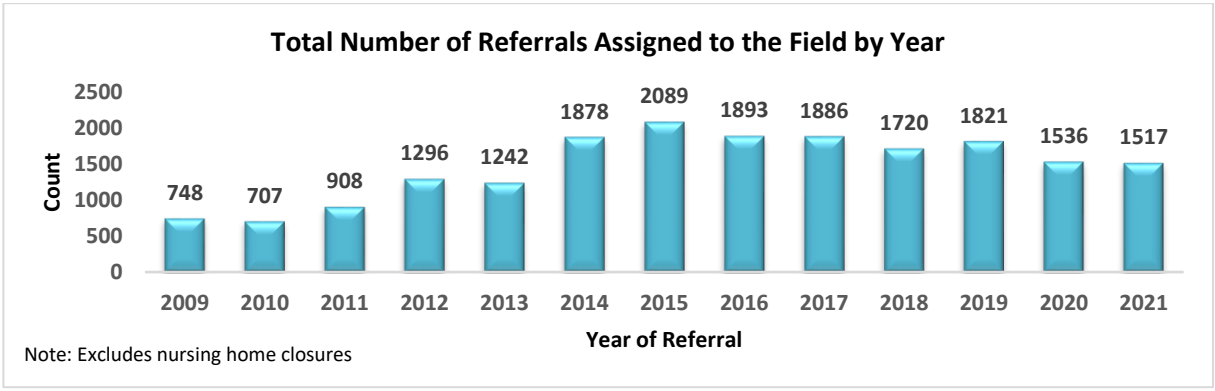




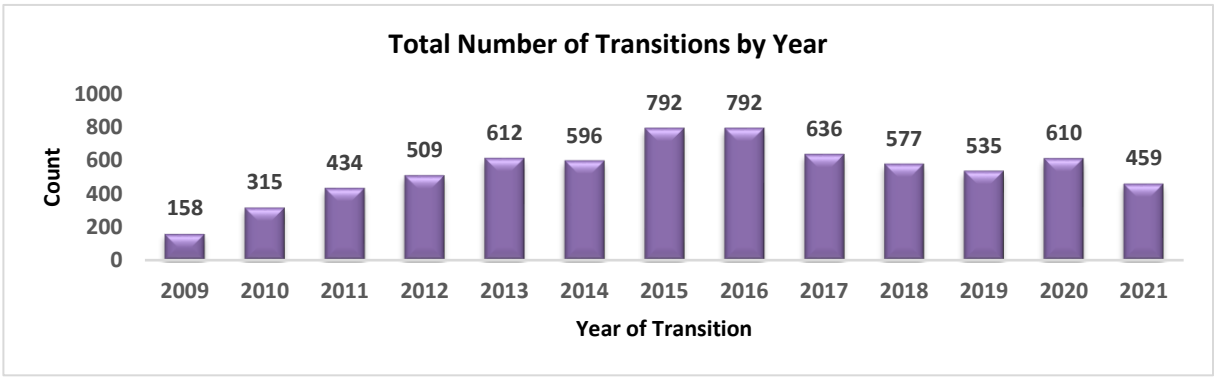


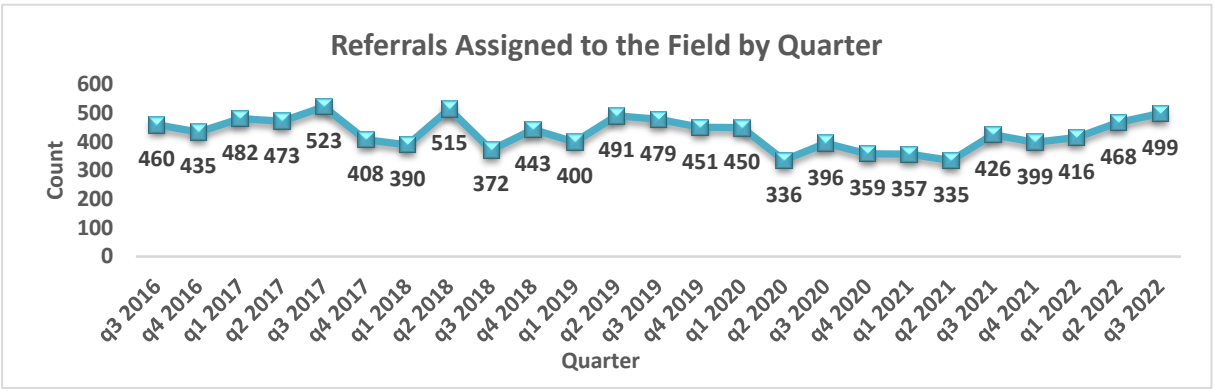


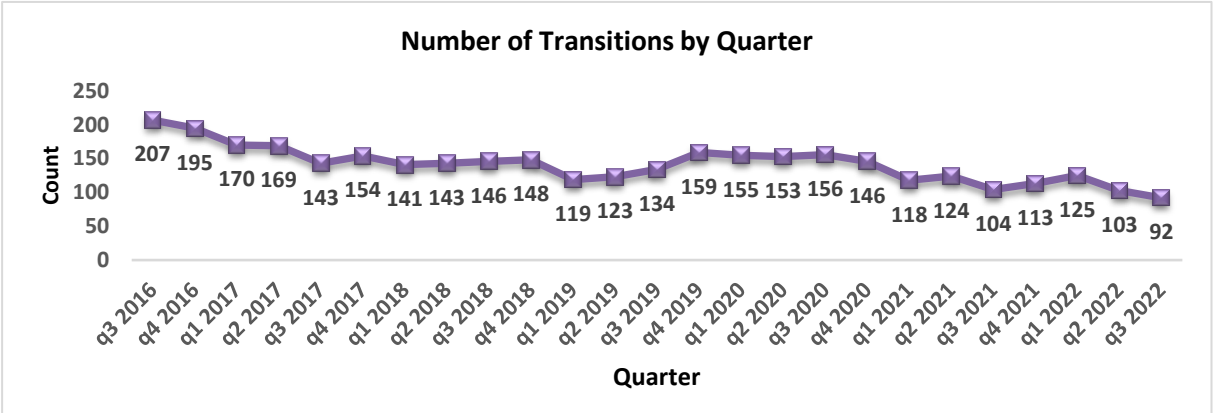


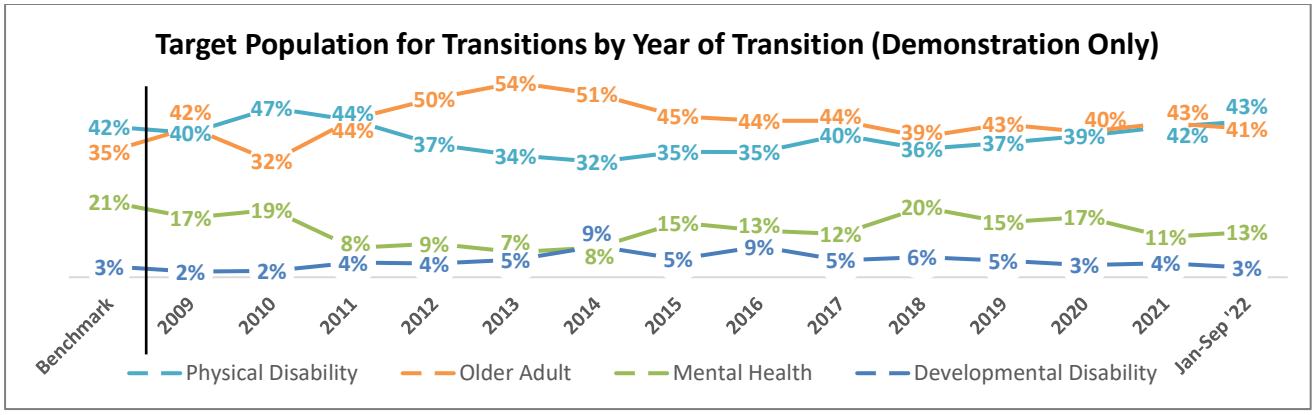


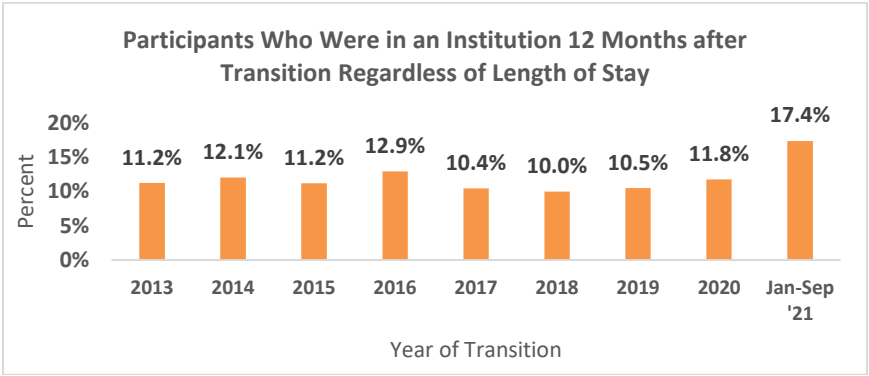
Note: Excludes nursing home closures

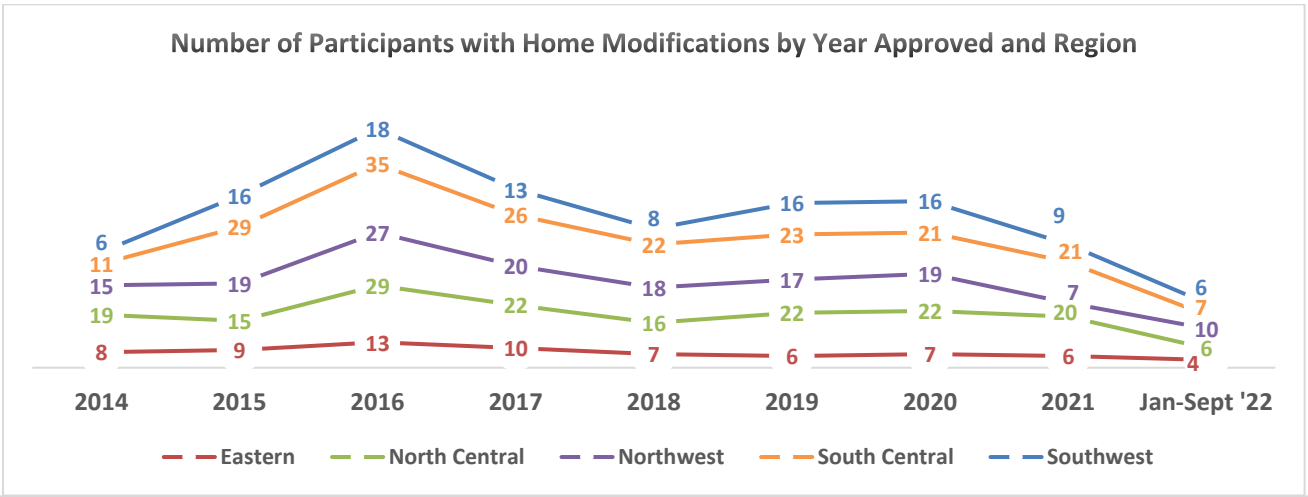


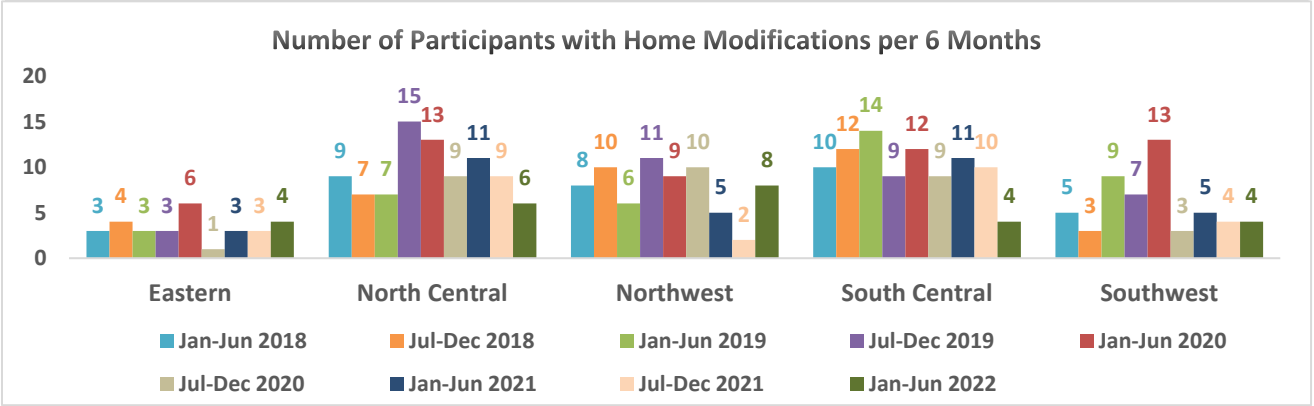




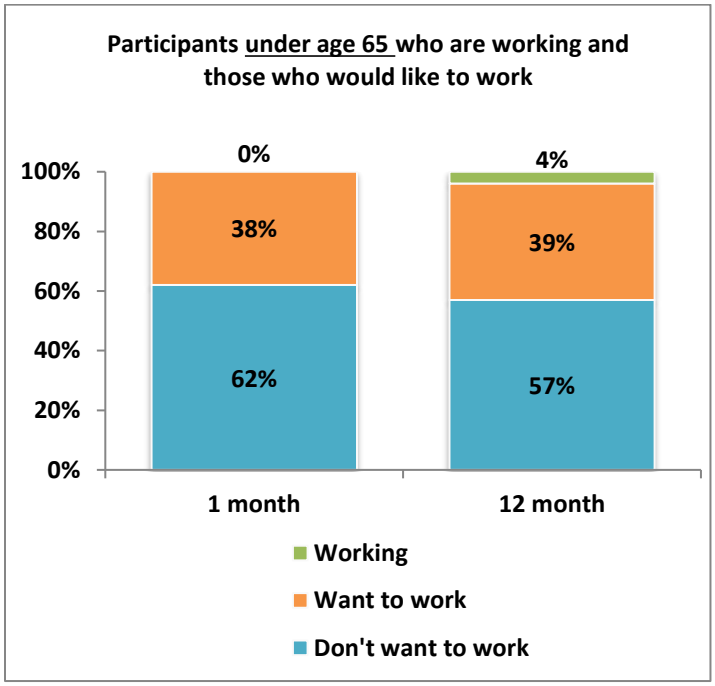

Target Population for Transitions by Year of Transition (Demonstration Only)
Benchmark
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
Jan-Sep '22
Physical Disability
Older Adult
Mental Health
Developmental Disability

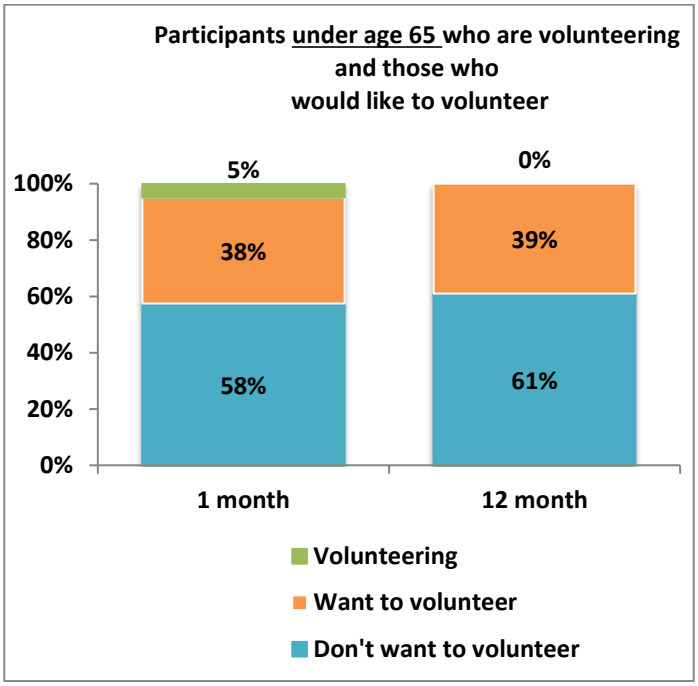

Participants Who Were in an Institution 12 Months after Transition Regardless of Length of Stay
Percent
20%
15%
10%
5%
0%
11.2%
12.1%
11.2%
12.9%
10.4%
10.0%
10.5%
11.8%
17.4%
2013
2014
2015
2016
2017
2018
2019
2020
Jan-Sep '21
Year of Transition

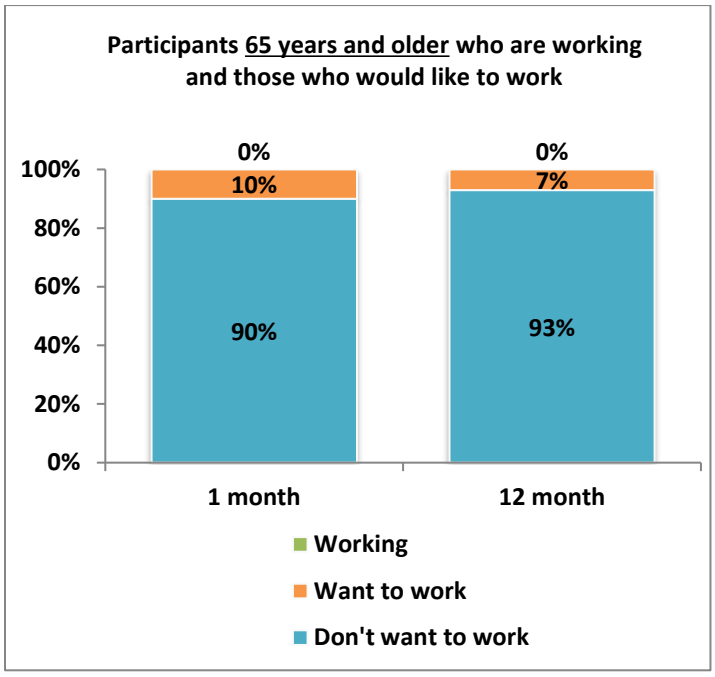

Number of Participants with Home Modifications by Year Approved and Region
2014
2015
2016
2017
2018
2019
2020
2021
Jan-Sept '22
Eastern
North Central
Northwest
South Central
Southwest

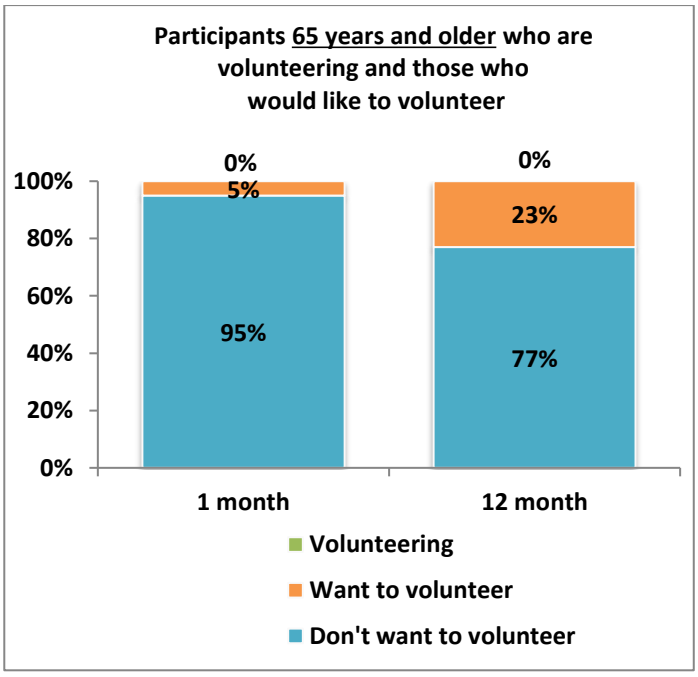

Number of Participants with Home Modifications per 6 Months
Eastern
North Central
Northwest
South Central
Southwest
Jan-Jun 2018
Jul-Dec 2018
Jan-Jun 2019
Jul-Dec 2019
Jan-Jun 2020
Jul-Dec 2020
Jan-Jun 2021
Jul-Dec 2021
Jan-Jun 2022

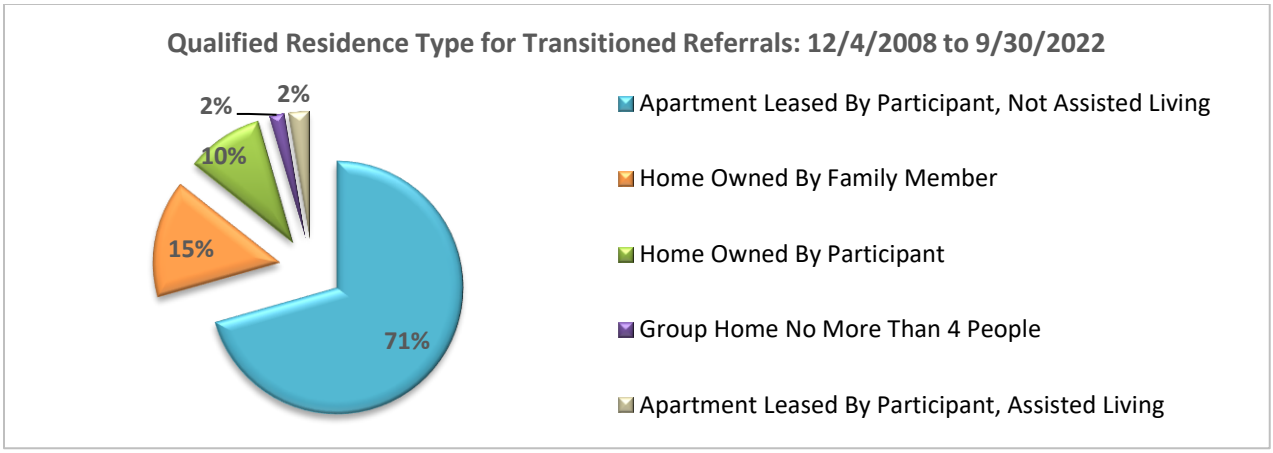
Participants who are Working and/or Volunteering (data 7/1/22-9/30/22)



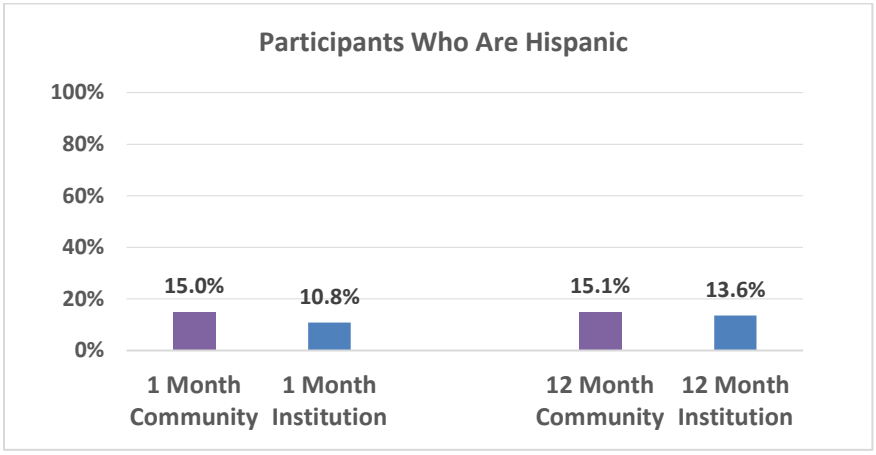


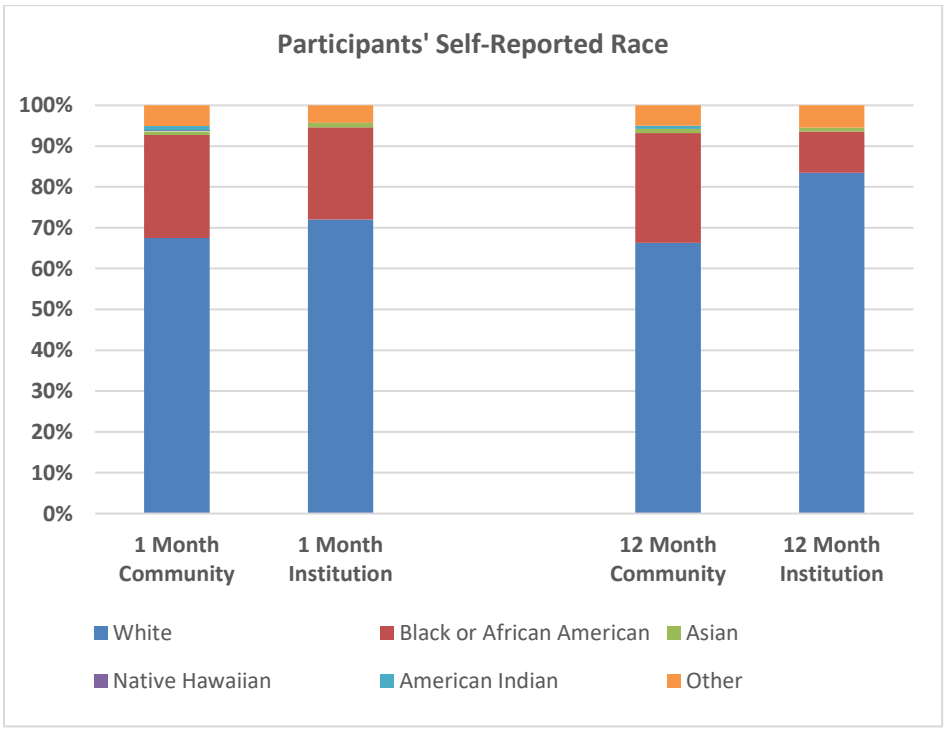






Race and Ethnicity for Participants Who Transitioned 1/1/19 to 9/30/22



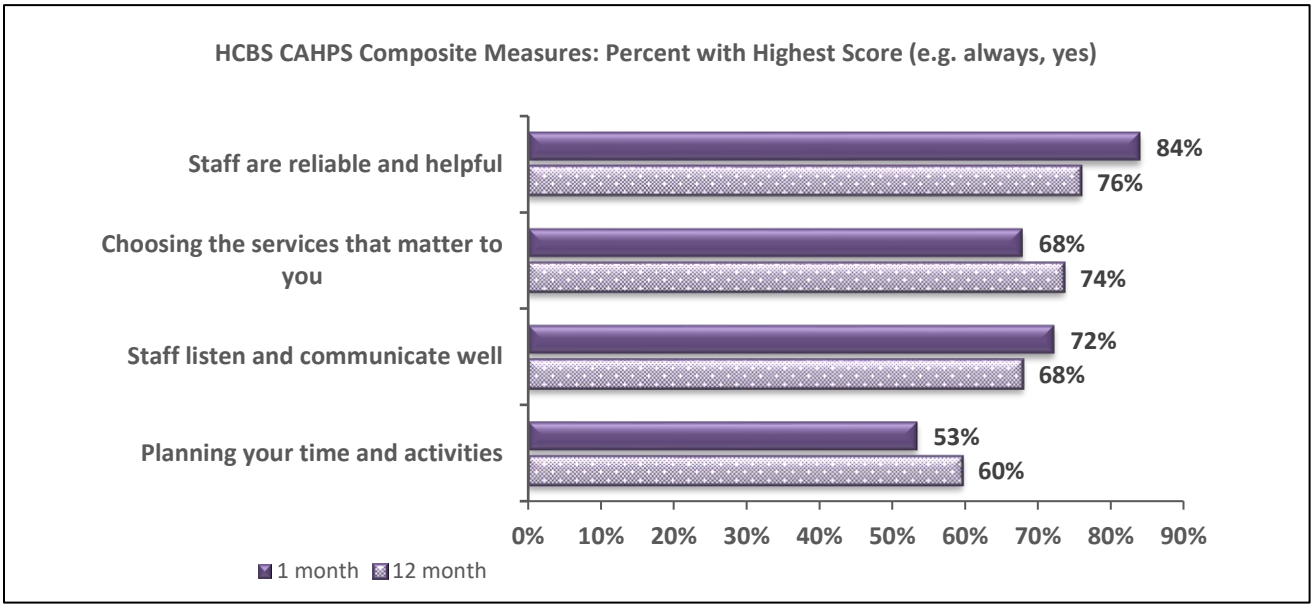


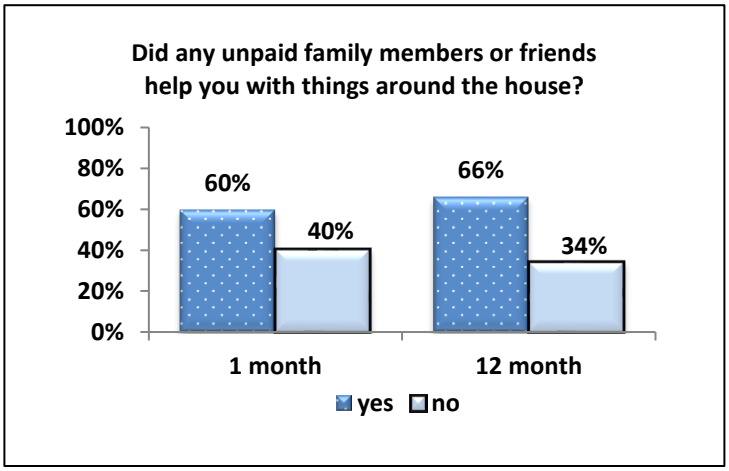
MFP Quality of Life Dashboard

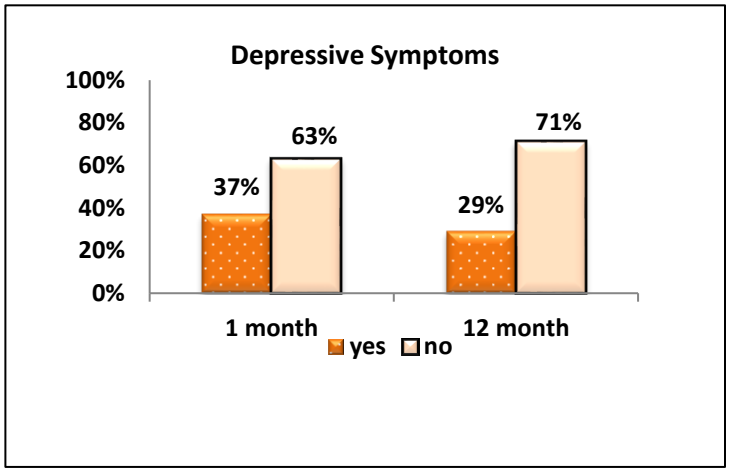
Number of Quality of Life Interviews Completed from 7/1/2022-9/30/2022 (n=113)

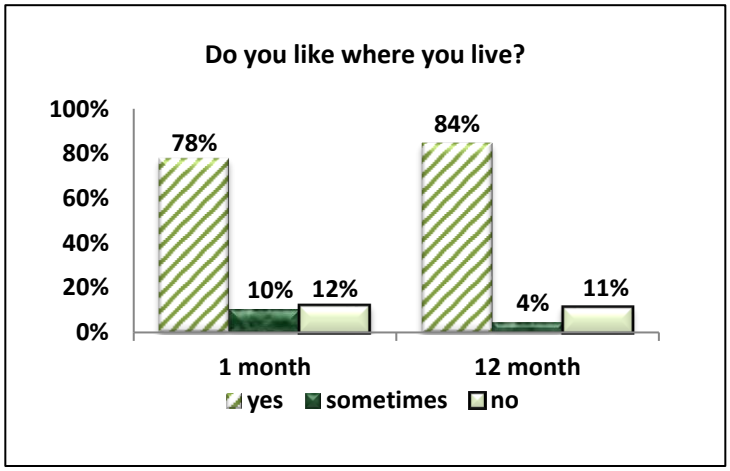
1 month interviews done 1 month after transition, **n=68**

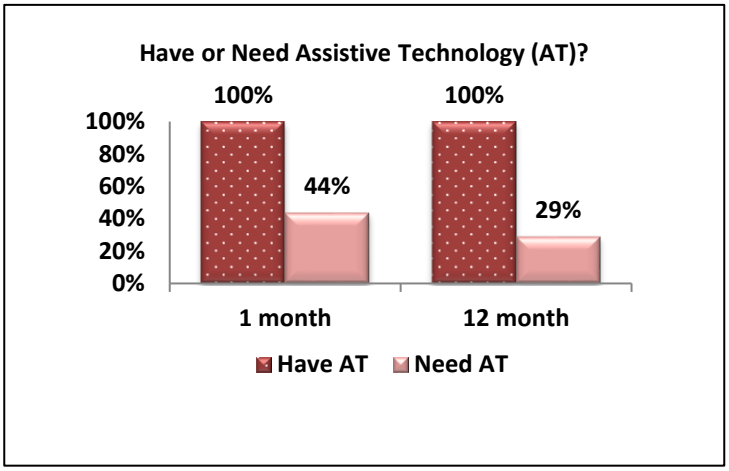
12 month interviews done 12 months after transition, **n=45**



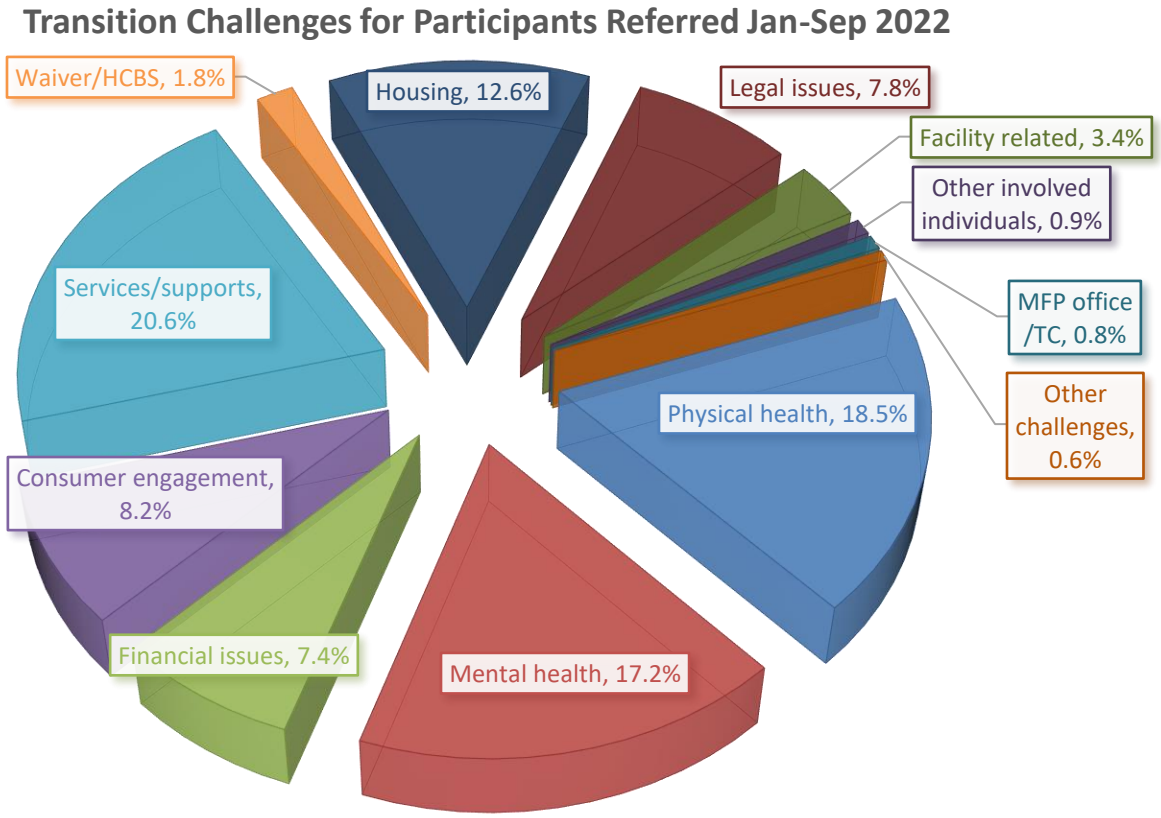


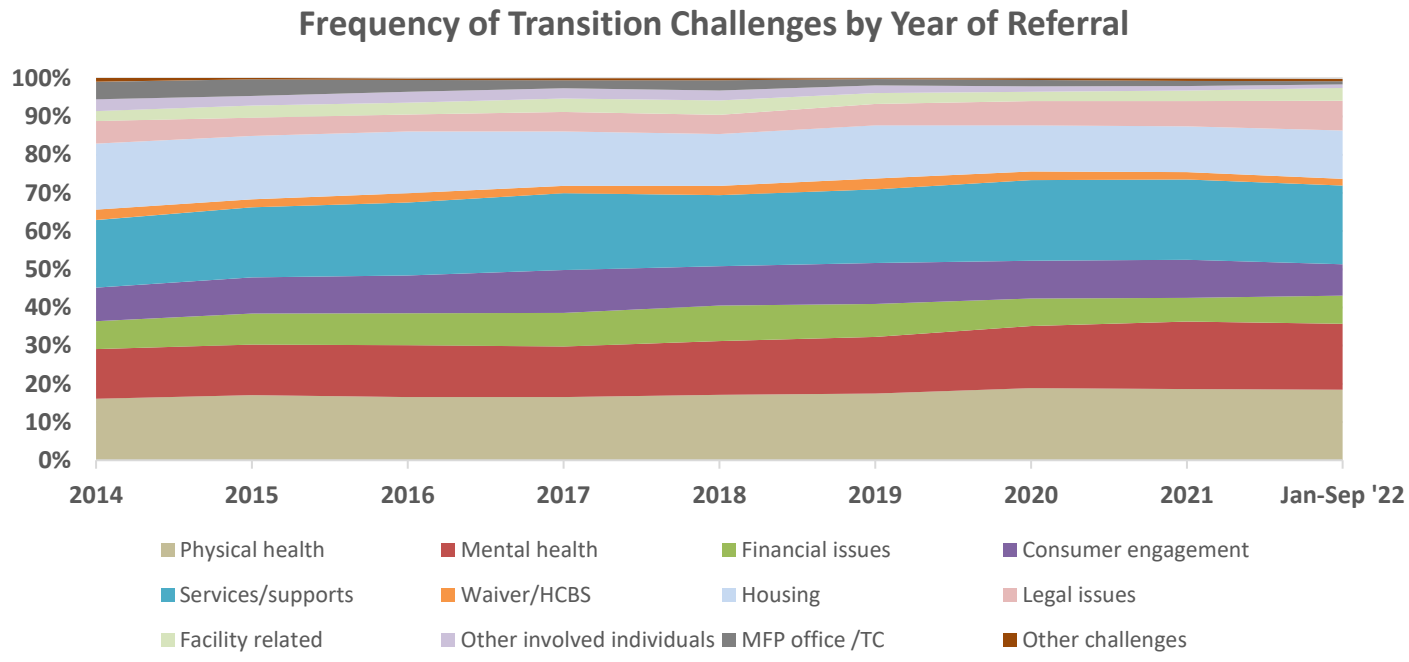


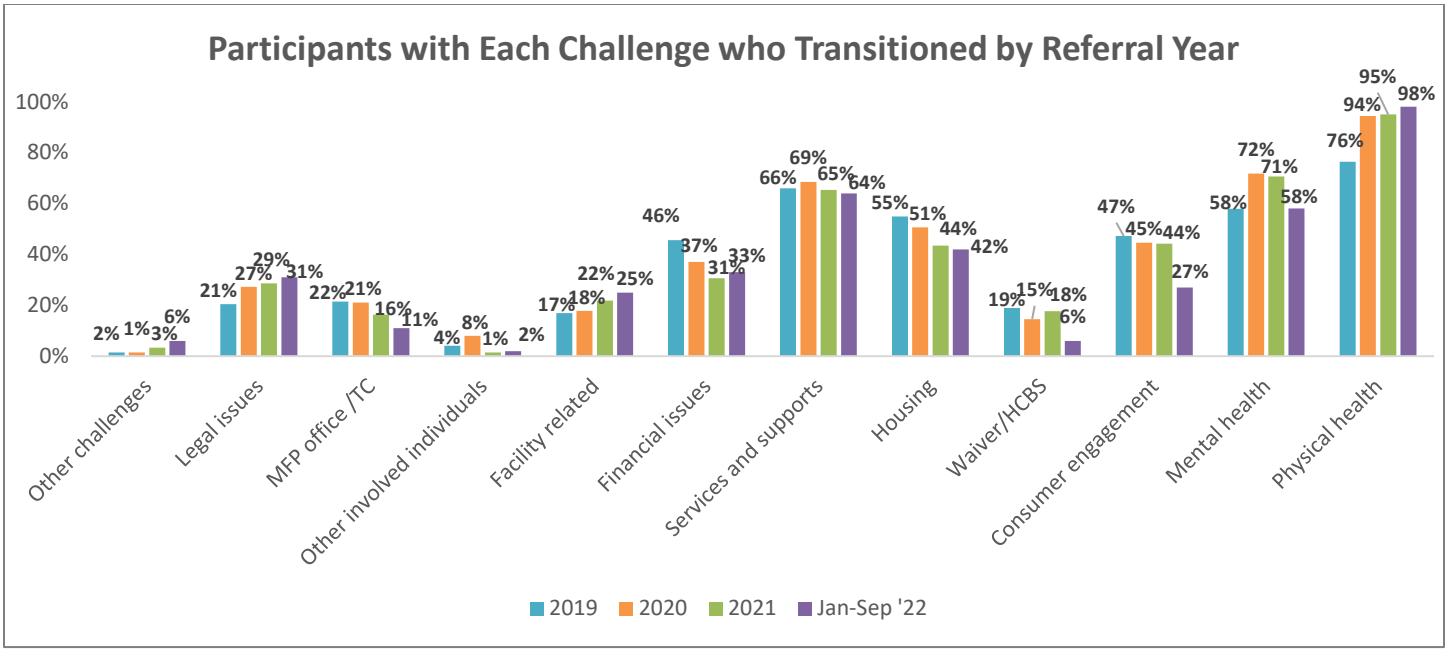




Challenges to Transition as Recorded by TCs and SCMs



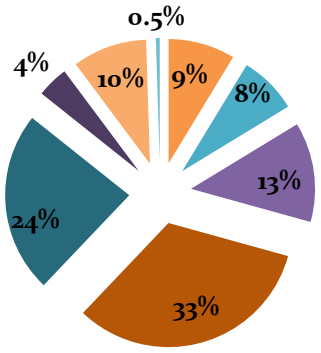




Types of Challenges for Referrals: 1/1/2022 - 9/30/2022

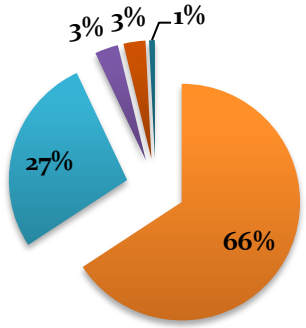
Below are the four most common challenge types for the current quarter

Services and supports



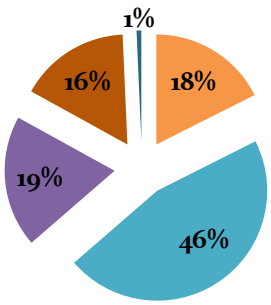
- Lack of alcohol, substance abuse, or addiction services
- Lack of AT or DME
- Lack of mental health services or supports
- Lack of PCA, home health, or other paid support staff
- Lack of transportation
- Lack of any other services or supports
- Lack of unpaid caregiver to provide care/informal support
- Other issues related to services or supports

Physical health



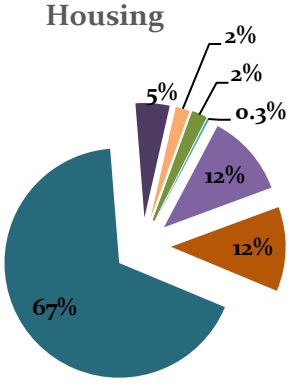
- Current, new or undisclosed physical health problem
- Inability to manage physical disability or physical illness in community
- Medical testing issues or delays
- Missing or waiting for physical health documents
- Other physical health issues

Mental health

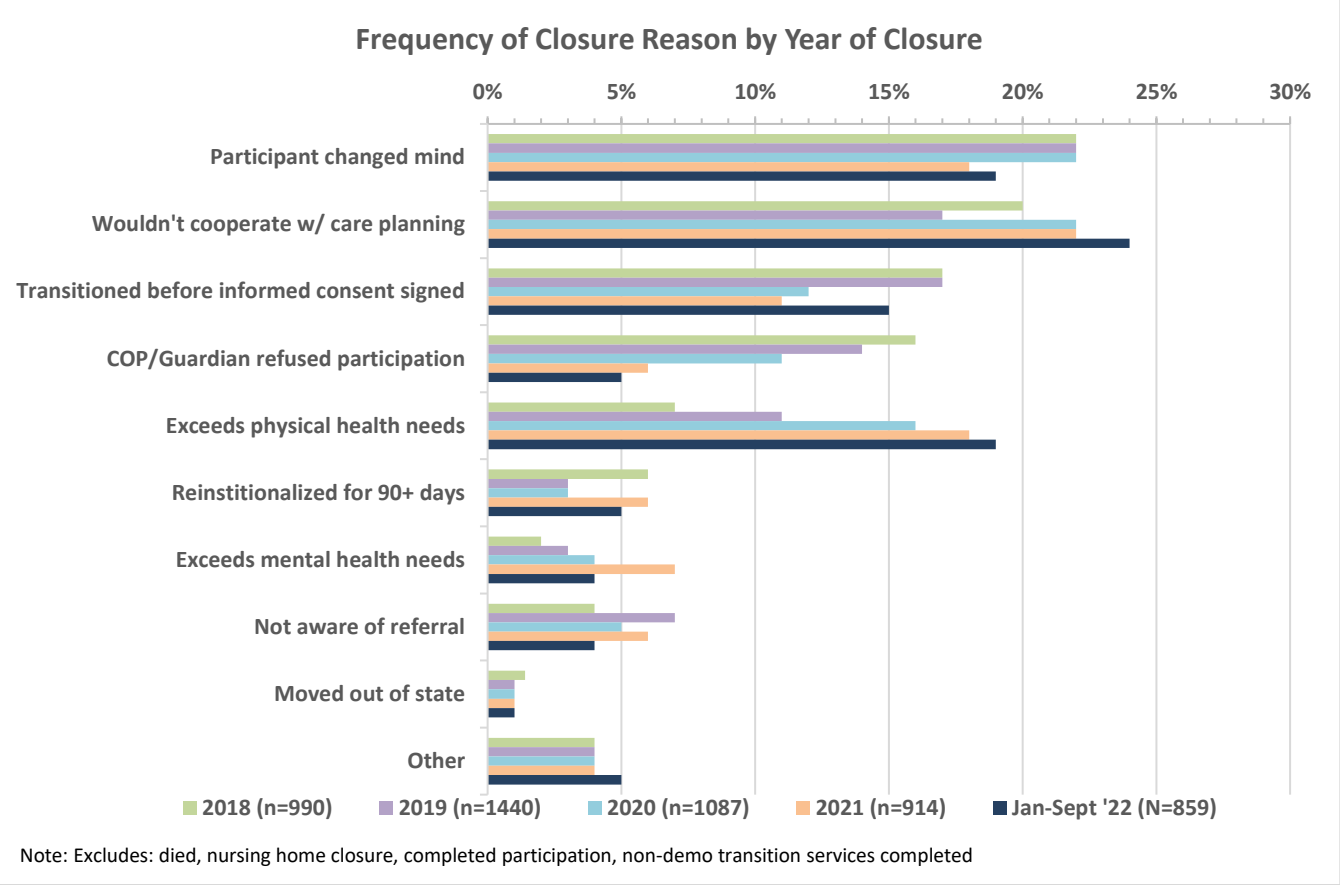


- Current or history of substance/alcohol abuse w/ risk of relapse
- Current, new, or undisclosed mental health problem
- Dementia or cognitive issues
- Inability to manage mental health in community
- Other mental health issues

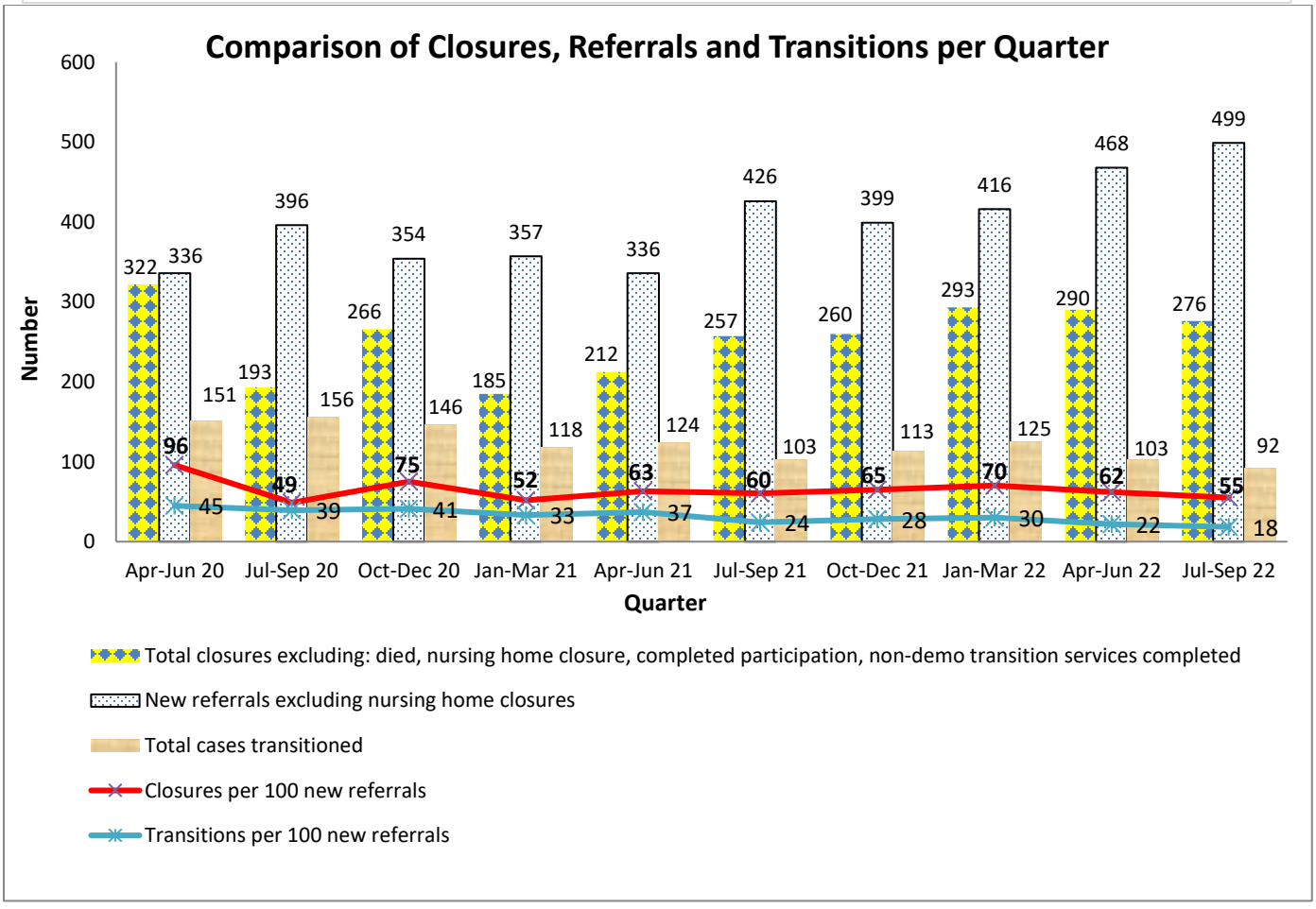
Housing



- 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



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



Jashaud's Story

Photo credit: Chloe Browdy

In 2020, you could find 20 year old Jashaud Jenkins at the basketball court, hanging out with friends, or practicing his skills behind the wheel with his newly acquired learner's permit. You might find him spending time with family, teaching his little brother about sports or goofing off. No matter where he was, Jashaud was always the life of the party.

On March 28th, 2021, Jashaud was the backseat passenger in a car with three other friends. In an instant, a seemingly normal day transitioned to a nightmare when another vehicle ran a red light and struck their car. Once first responders had arrived, it took 25 minutes to get Jashaud out of the car. By this point, he had no pulse and EMTs were told that he was gone. Despite this, they decided to give him CPR for 33 minutes, which saved Jashaud's life.

Jashaud was sent to Hartford Hospital where his long road to recovery began. His prognosis was grim, and the chance of permanent brain damage was extremely high. They found bleeding in his brain, two collapsed lungs, a fractured pelvis, and a complete spinal cord injury. He was consciously sedated for almost two weeks and on a ventilator, while doctors let his body recover and kept him stable. After 10 days, Jashaud woke up but unfortunately was unable to communicate. He stayed in the ICU for over a month.

On May 7th, Jashaud was transferred to a long-term acute care hospital at Hackensack University Medical Center in Westwood, NJ, a unit uniquely designed to serve patients who have complex medical needs and require a lengthy stay in an acute care setting. While recovering here, Jashaud was weaned off the ventilator with supplemental oxygen, something doctors originally said he would never be able to do. He was paralyzed but began working on speech therapy. After more than two months, doctors felt there was nothing more that could be done at that facility and Jashaud was transferred to the Hospital for Special Care in New Britain.

The Hospital for Special Care in New Britain is where Jashaud's mother, Chloe, learned about the Money Follows the Person program (MFP). Although he has quadriplegia (paralysis of both arms and legs) and needed around the clock care, Chloe's main goal was always to have her son back home. MFP was her first glimmer of hope, and she was ready to do whatever was necessary. She met with a care manager from the program and began working with a transition coordinator to outline their next steps.

Chloe described the MFP team as amazing and incredibly supportive. Seeing her son in the hospital every day was extremely overwhelming, as was dealing with his new condition. She felt as though doctors were too quick to give up on him or failed to see the progress Jashaud was making. MFP never made her feel that way, and instead always encouraged her confidence in Jashaud's ability to successfully live in the community again. The plan was underway as MFP helped get a ramp installed at Jashaud's home and provided his family with medical supplies. MFP also acquired an iPad that Jashaud could use in various ways to help him communicate. Chloe hired a contractor to modify a bathroom that would meet Jashaud's needs. Since he would also need around the clock care, Chloe and four other family members were trained to become paid PCAs.

Through MFP and the dedication of his family, Jashaud returned home on September 8th, 2022. He is so happy to be surrounded by family once again. Chloe mentioned, "We are a tight family unit; holidays and birthdays were not the same without Jashaud. We needed him home."

Jashaud can now work on his independence in the setting that is best for him. He constantly has friends over and is getting good at using his cell phone again. He and his family are looking forward to seeing all the progress he will continue to make. Chloe finished our interview with mentioning the impact MFP has had. "We have had the opportunity to meet so many amazing people throughout this journey, and our hearts are forever grateful, thankful and blessed."

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.