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%)

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
- 84%
- 16%

12 month
- 81%
- 19%
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

Number of Transitions by Quarter
Participants who are Working and/or Volunteering (data 7/1/22-9/30/22)

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

- **Participants under age 65 who are working and those who would like to work**
  - **1 month**
    - Working: 62%
    - Want to work: 38%
    - Don’t want to work: 0%
  - **12 month**
    - Working: 57%
    - Want to work: 39%
    - Don’t want to work: 4%

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

- **Participants under age 65 who are volunteering and those who would like to volunteer**
  - **1 month**
    - Volunteering: 58%
    - Want to volunteer: 38%
    - Don’t want to volunteer: 5%
  - **12 month**
    - Volunteering: 61%
    - Want to volunteer: 39%
    - Don’t want to volunteer: 0%

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

- **Participants 65 years and older who are working and those who would like to work**
  - **1 month**
    - Working: 90%
    - Want to work: 10%
    - Don’t want to work: 0%
  - **12 month**
    - Working: 93%
    - Want to work: 7%
    - Don’t want to work: 0%

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

- **Participants 65 years and older who are volunteering and those who would like to volunteer**
  - **1 month**
    - Volunteering: 95%
    - Want to volunteer: 5%
    - Don’t want to volunteer: 0%
  - **12 month**
    - Volunteering: 77%
    - Want to volunteer: 23%
    - Don’t want to volunteer: 0%
Qualified Residence Type for Transitioned Referrals: 12/4/2008 to 9/30/2022

- Apartment Leased By Participant, Not Assisted Living
- Home Owned By Family Member
- Home Owned By Participant
- Group Home No More Than 4 People
- Apartment Leased By Participant, Assisted Living

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

Participants Who Are Hispanic

- 1 Month Community: 15.0%
- 1 Month Institution: 10.8%
- 12 Month Community: 15.1%
- 12 Month Institution: 13.6%

Participants' Self-Reported Race

- White
- Black or African American
- Asian
- Native Hawaiian
- American Indian
- Other
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

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

- Staff are reliable and helpful: 84% (1 month), 76% (12 month)
- Choosing the services that matter to you: 68% (1 month), 74% (12 month)
- Staff listen and communicate well: 72% (1 month), 68% (12 month)
- Planning your time and activities: 53% (1 month), 60% (12 month)

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

- 1 month: 60% yes, 40% no
- 12 month: 66% yes, 34% no

Depressive Symptoms

- 1 month: 37% yes, 63% no
- 12 month: 29% yes, 71% no

Do you like where you live?

- 1 month: 78% yes, 10% sometimes, 12% no
- 12 month: 84% yes, 4% sometimes, 11% no

Have or Need Assistive Technology (AT)?

- 1 month: 100% have AT, 44% need AT
- 12 month: 100% have AT, 29% need AT
Challenges to Transition as Recorded by TCs and SCMs

Transition Challenges for Participants Referred Jan-Sep 2022

- Physical health, 18.5%
- Mental health, 17.2%
- Financial issues, 7.4%
- Consumer engagement, 8.2%
- Services/supports, 20.6%
- Housing, 12.6%
- Waiver/HCBS, 1.8%
- Legal issues, 7.8%
- Facility related, 3.4%
- Other involved individuals, 0.9%
- MFP office /TC, 0.8%
- Other challenges, 0.6%

Frequency of Transition Challenges by Year of Referral

- Physical health
- Mental health
- Financial issues
- Consumer engagement
- Services/supports
- Waiver/HCBS
- Facility related
- Housing
- Legal issues
- Other involved individuals
- MFP office /TC
- Other challenges
Participants with Each Challenge who Transitioned by Referral Year

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
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
Jashaud's Story

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.”