CT Money Follows the Person Report
Quarter 4: October 1 - December 31, 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 = 7,454
Demonstration = 6,992 (94%)
Non-demonstration = 462 (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: 86% happy, 14% unhappy
12 month: 81% happy, 19% unhappy
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 10/1/22-12/31/22)

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

- Working: 50% (1 month), 55% (12 month)
- Want to work: 45% (1 month), 41% (12 month)
- Don’t want to work: 5% (1 month), 5% (12 month)

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

- Volunteering: 26% (1 month), 65% (12 month)
- Want to volunteer: 71% (1 month), 6% (12 month)
- Don’t want to volunteer: 3% (1 month), 13% (12 month)

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

- Working: 71% (1 month), 96% (12 month)
- Want to work: 5% (1 month), 6% (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

- Volunteering: 26% (1 month), 14% (12 month)
- Want to volunteer: 74% (1 month), 82% (12 month)
- Don’t want to volunteer: 0% (1 month), 0% (12 month)

Participants who are Working and/or Volunteering (data 10/1/22-12/31/22)
Race and Ethnicity for Participants Transitioned from 1/1/19 - 12/31/22
Note: Results are from responses to the HCBS CAHPS MFP Survey questions 87 and 89 at 1 and 12 month time points.
MFP Quality of Life Dashboard

Number of Quality of Life Interviews Completed from 10/1/2022-12/31/2022 (n=145)

1 month interviews done 1 month after transition, n=74
12 month interviews done 12 months after transition, n=71

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

- Staff are reliable and helpful: 78% (1 month), 86% (12 month)
- Choosing the services that matter to you: 71% (1 month), 71% (12 month)
- Staff listen and communicate well: 71% (1 month), 73% (12 month)
- Planning your time and activities: 61% (1 month), 60% (12 month)

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

- Yes: 65% (1 month), 50% (12 month)
- No: 35% (1 month), 50% (12 month)

Depressive Symptoms

- Yes: 34% (1 month), 44% (12 month)
- No: 66% (1 month), 57% (12 month)

Do you like where you live?

- Yes: 84% (1 month), 81% (12 month)
- Sometimes: 16% (1 month), 9% (12 month)
- No: 0% (1 month), 10% (12 month)

Have or Need Assistive Technology (AT)?

- Have AT: 99% (1 month), 98% (12 month)
- Need AT: 39% (1 month), 47% (12 month)
Participants with Each Challenge who Transitioned by Referral Year

Types of Challenges for Referrals: 1/1/2022 - 12/31/2022
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 undiscovered 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
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
Randy’s Story

Randy continues to be a fighter after the many challenges life has dealt. For nearly a decade, Randy advanced in his positions at Peapod, worked hard, made a good salary, and took annual trips to Disney World. One day in 2016 he wasn’t feeling well and discovered he had an infection in his back. What followed was major back surgery, months of being bedridden, and learning how to walk again. One doctor said it was a miracle he was still alive. He was alive but unable to work. For six years, he was frequently hospitalized, due to major health issues such as a blood clot in the brain and complications from diabetes, edema, and obesity. During this time, he lived with a roommate and her dog and enjoyed the company of doing things together. Unfortunately, he was challenged once again when his roommate died following a surgery. Randy could no longer afford the two-bedroom apartment and could not find an apartment he could afford on his own, forcing him to live in his car for 2 weeks. Depression and homelessness led to a serious decline in his health. After 8 months, including another hospitalization, and transfer to two nursing facilities, Randy finally transitioned with the help of Money Follows the Person (MFP) to an accessible apartment which he loves!

Prior to living in the nursing facility, he had called towns to be placed on their affordable housing wait lists. Once he connected with a nursing facility ombudsman, the process of applying for MFP started. The facility social worker then connected him with a case manager and transition coordinator (TC) at MFP. Because Randy was proactive and already on several housing lists, he was called quickly when an apartment reserved for older adult or people with disabilities became available. “The TC was awesome! She furnished the new apartment, making sure it was clean and the bed was made. Every week she calls and every month she checks up on me.”

His two personal care assistants (PCAs) have been wonderful, supporting Randy with housekeeping, laundry, transportation to appointments, grocery shopping, cooking if needed, and “keeping me company.” “They get me out of the house to walk around the park, sometimes go to movies, and shop.” The apartment is located close to the police station, pool, library, and community center where he goes to relax or attend a get together. Living in the community, he hears children playing baseball or soccer. There is also a walking trail. Now he has an accessible apartment with a pull cord for safety, support from the PCAs, and community connections. These supports, along with managing his medication and eating healthier food, have helped Randy lose 100 pounds! He is no longer depressed and is in control of his health issues. Before he describes himself being “close to the edge.” Last year, he didn’t know when his next meal was going to be. Now his refrigerator is filled with chicken and other healthy food. Randy finally celebrated this past Thanksgiving with his cousins and uncle for the first time in two years. His family is very proud of his achievements, which means so much to him.

He visits his friends in the nursing facility, encouraging those who are wondering if they, too, can transition to the community. Randy found the hardest changes were adjusting to being alone, not having a routine, making sure to not run out of medication, getting used to cooking, and meeting new people. He wants others to know that they are not alone. MFP will help set you up and will check on you once you are out of the nursing facility.

Randy has already rented a car and traveled to VT and the casinos. His next goal is to revisit the magical land called Disney World once again.

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 grants to 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.