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 = 7,697
Demonstration = 7,217 (94%)
Non-demonstration = 480 (6%)

Benchmark 2: CT Medicaid Long-Term Care Expenditures
- Home & Community Care
- Skilled Nursing Facility

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% happy, 16% unhappy
- 12 month: 82% happy, 18% unhappy
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
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 4/1/23-6/30/23)

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

<table>
<thead>
<tr>
<th></th>
<th>1 month</th>
<th>12 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working</td>
<td>49%</td>
<td>69%</td>
</tr>
<tr>
<td>Want to work</td>
<td>49%</td>
<td>31%</td>
</tr>
<tr>
<td>Don't want to work</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>1 month</th>
<th>12 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteering</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Want to volunteer</td>
<td>45%</td>
<td>24%</td>
</tr>
<tr>
<td>Don't want to volunteer</td>
<td>55%</td>
<td>72%</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>1 month</th>
<th>12 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working</td>
<td>32%</td>
<td>11%</td>
</tr>
<tr>
<td>Want to work</td>
<td>68%</td>
<td>83%</td>
</tr>
<tr>
<td>Don't want to work</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>1 month</th>
<th>12 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteering</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Want to volunteer</td>
<td>44%</td>
<td>16%</td>
</tr>
<tr>
<td>Don't want to volunteer</td>
<td>56%</td>
<td>84%</td>
</tr>
</tbody>
</table>
Race and Ethnicity for MFP Participants Transitioned 1/1/19 – 06/30/23 and for CT Medicaid Recipients in 2022

Note: MFP participant 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 4/1/2023-6/30/2023 (n=139)

1 month interviews done 1 month after transition, n=85
12 month interviews done 12 months after transition, n=54

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

- Staff are reliable and helpful: 80% (1 month), 64% (12 month)
- Choosing the services that matter to you: 68% (1 month), 63% (12 month)
- Staff listen and communicate well: 65% (1 month), 49% (12 month)
- Planning your time and activities: 65% (1 month), 59% (12 month)

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

- 1 month: 70% yes, 30% no
- 12 month: 60% yes, 40% no

Depressive Symptoms

- 1 month: 38% yes, 62% no
- 12 month: 46% yes, 54% no

Do you like where you live?

- 1 month: 88% yes, 2% sometimes, 9% no
- 12 month: 80% yes, 11% sometimes, 9% no

Have or Need Assistive Technology (AT)?

- Have AT: 100% (1 month), 100% (12 month)
- Need AT: 49% (1 month), 60% (12 month)
Participants with Each Challenge who Transitioned by Referral Year

Types of Challenges for Referrals: 1/1/2023 - 06/30/2023
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

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

Comparison of Closures, Referrals and Transitions per Quarter

Legend:
- 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
Jon’s Story

Jon has always been passionate about helping others. Throughout his life, he has always tried to give back what was given to him. Whether it was teaching locals kids how to carry themselves, how to have confidence, how to prepare for interviews, or teaching them home improvement skills, he always felt rewarded knowing he was making a difference. When he wasn’t inspiring the local youth, Jon worked several security jobs and also had a home improvement business on the side. In his free time, he would practice his ping pong skills, even participating in tournaments in Boston and New York.

On May 31st, 2023, Jon remembers telling a friend he felt off. Something wasn’t right. Soon afterwards, his left arm became numb, and he lost consciousness. That friend called 911, and Jon was quickly transported to the hospital for treatment of a stroke. When Jon awoke, he remembers being surrounded by tubes and medical equipment, things that would become familiar over the next 21 days that he spent in the ICU. Although he was happy to be alive, these days proved treacherous, as Jon could not speak or move much. Writing on a whiteboard became his only form of communication.

During Jon’s time at the hospital, a nurse pulled his sister and main supporter, Pam, aside to tell her about Money Follows the Person program. Because Jon was living with Pam prior to his stroke, she had a lot of concerns about what his life was going to be like and if he would be able to live independently again. After learning more about the program, she applied on Jon’s behalf and started working with a case manager, transition coordinator, and housing coordinator. They immediately began developing a plan that would eventually allow Jon to live in the community again.

After 9 more days in a step-down unit, Jon was ready to transition to a rehabilitation facility. He spent 25 days with a team of specialists learning how to talk, walk, and use his left hand again. He was extremely dedicated to his rehab, exercising at least 5, and sometimes 6, days a week. Jon was also doing exercises on his own, outside of time he spent with the therapy staff. As always, but especially during this time, Jon relied on his faith, praying to God every day and believing that God would allow him to recover fully.

Jon does not recall his time at the nursing home fondly. He remembers feeling like a nuisance to staff even though their job was to help him. Poor bedside manner and terrible food became his expectation. Pam recalls a specific time when Jon had a seizure and was sent to the hospital, and she did not find out until she called to speak with him the following day. During this time, Jon lost about 100 pounds because of the terrible food, and he continued to pray that he would become well enough to leave.

Like many people in the Money Follows the Person program, Jon’s team struggled to find appropriate housing for him. Eventually, it was Pam who knew someone that had a unit opening up, and this stroke of luck finally allowed Jon and his team to plan his discharge from the nursing home. The MFP team helped to provide some furniture, home goods, toiletries, kitchen essentials, and groceries for Jon upon moving in. They even helped move everything into the apartment, which Jon and his family are beyond grateful for. Jon was set up with a PCA, Connie, to help him with cleaning, laundry, grocery shopping, medication management, cooking, and more. He was quick to mention that Connie is a great cook, and he doesn’t take that for granted.

Pam did a lot of the back-and-forth communication with Jon’s MFP team. She expressed her immense gratitude towards them, recalling how much they cared about Jon as a person. The staff had passion for their jobs and therefore passion about giving Jon the best outcome they could. They were responsive, professional, and knowledgeable. Pam described how supported she felt throughout this process; the staff would remind her why she was doing this for Jon, and why it was worth all this work on top of her own life and full-time job responsibilities.

Now that Jon is happily living in the community again, he hopes his story will help and inspire others. He was not happy living in a facility, but now has the freedom to live life on his terms again. MFP has given him the opportunity to take back his health and independence, two things he takes very seriously. Jon till takes his recovery very seriously too, by staying active and eating healthily. He is once again enjoying home workouts, outdoor walks, going out to eat, and of course, ping pong.