# CT Money Follows the Person Quarterly Report

## Quarter 3, 2015: July 1, 2015 – September 30, 2015

*(Based on latest data available at the end of the quarter)*

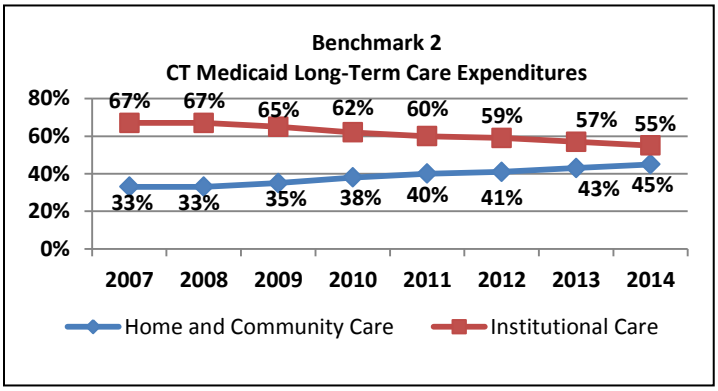
**UConn Health, Center on Aging**

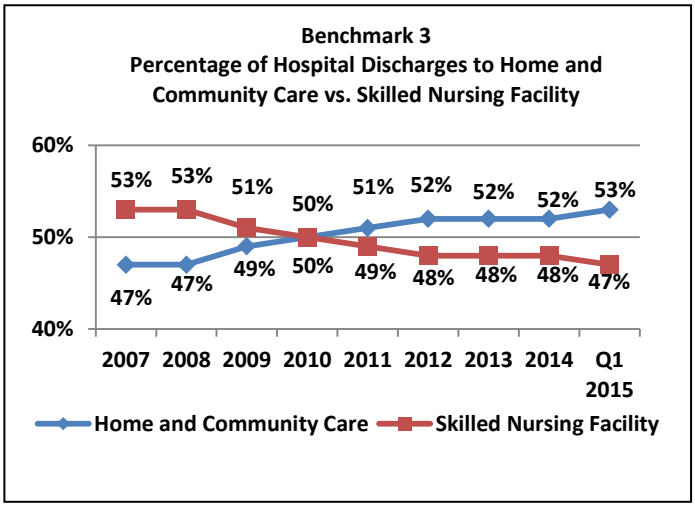
**Operating Agency:** *CT Department of Social Services* **Funder:** *Centers for Medicare and Medicaid Services*

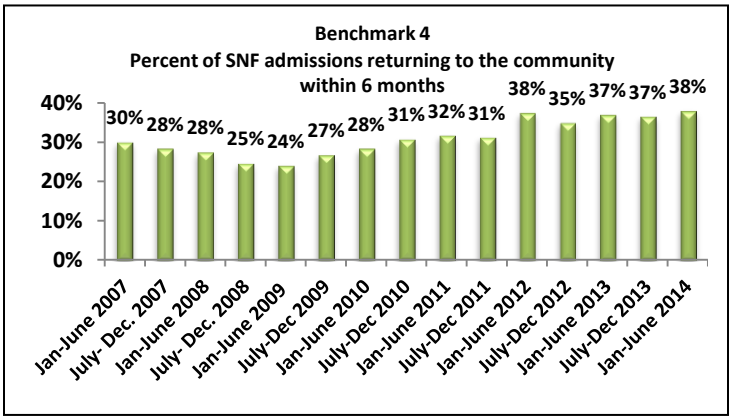
**MFP Benchmarks**

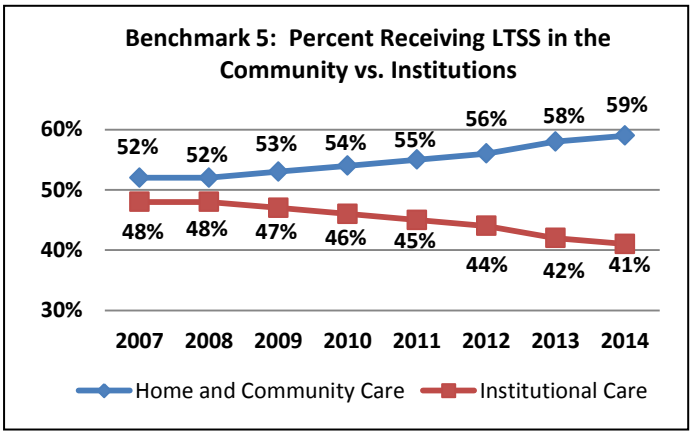
1) Transition 5200 people from qualified institutions to the community
2) Increase dollars to home and community based services
3) Increase hospital discharges to the community rather than to institutions
4) Increase probability of returning to the community during the six months following nursing home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

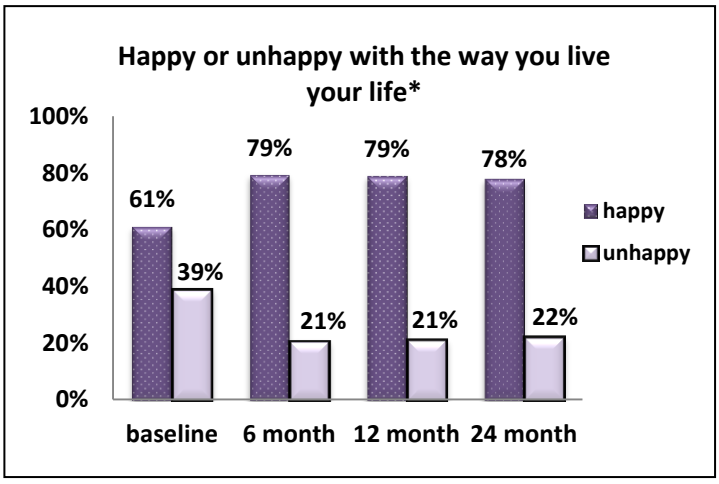
**Benchmark 1: The number of demonstration consumers transitioned = 2,961 (non-demonstration transitions = 243)**



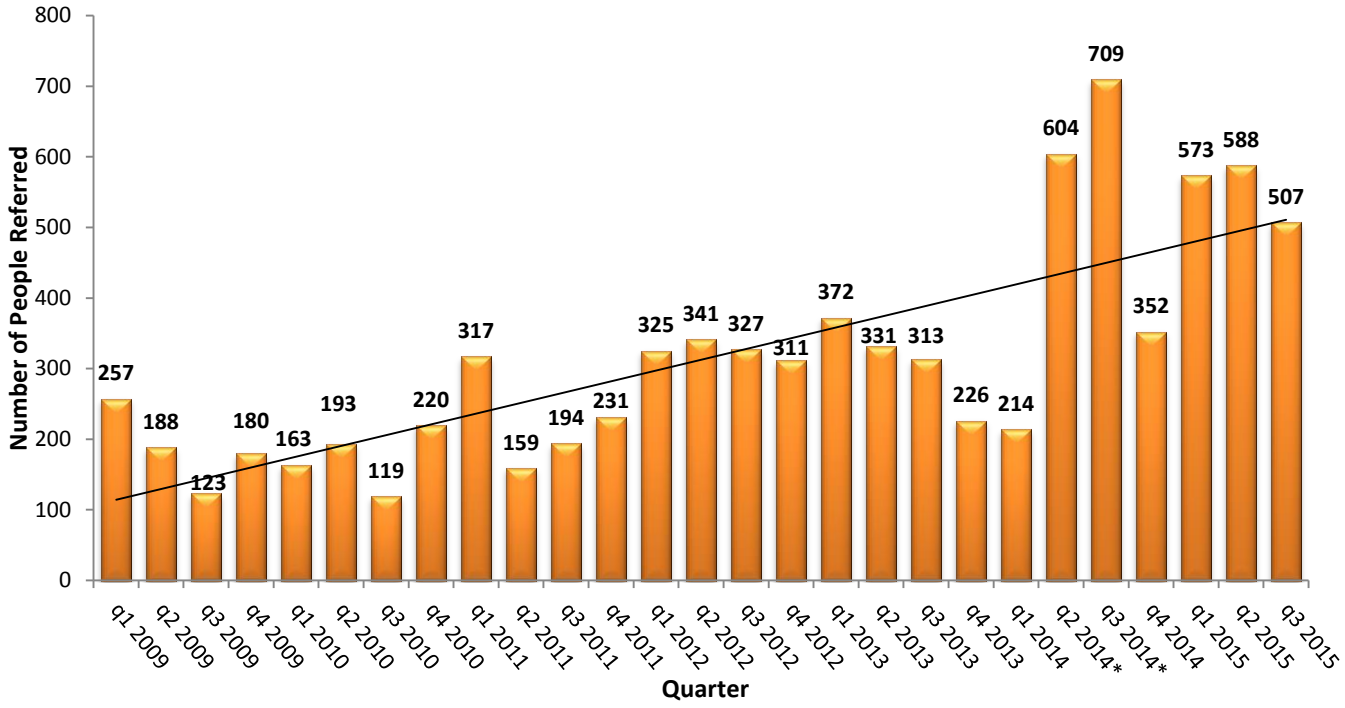



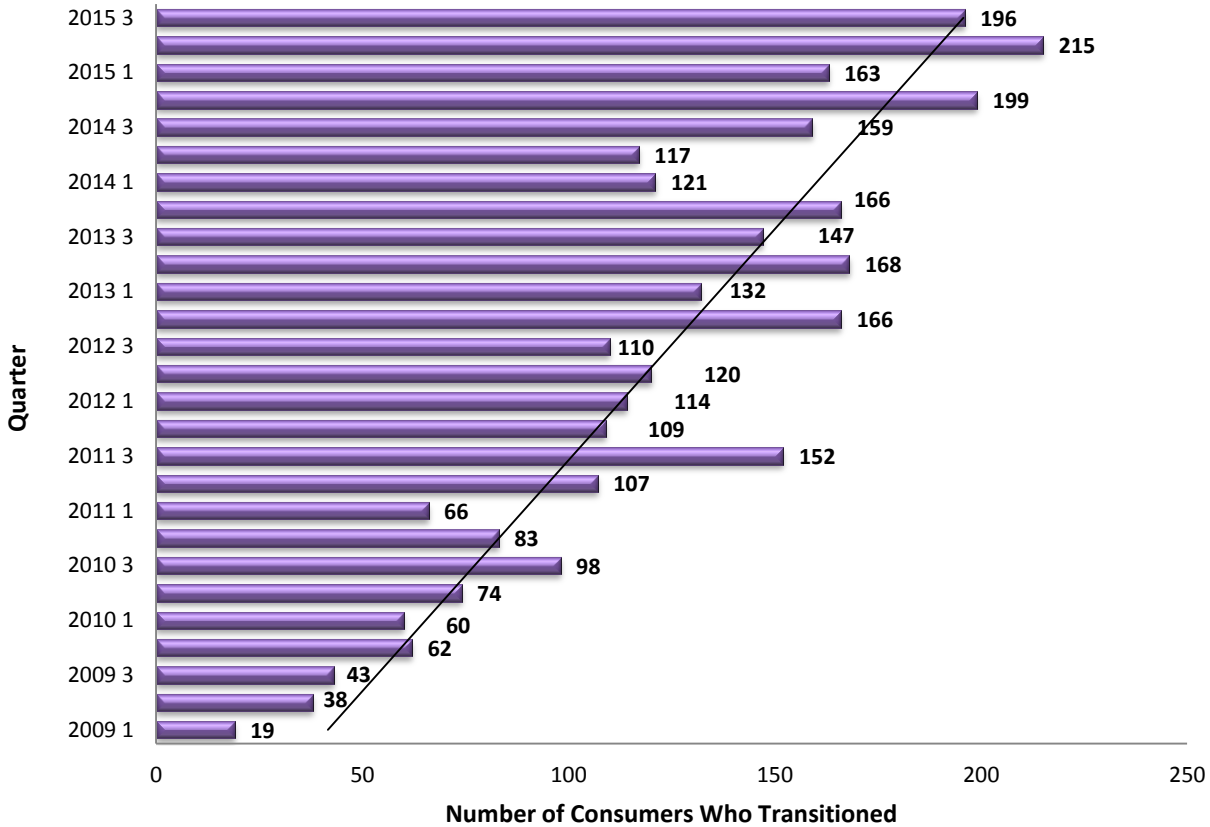



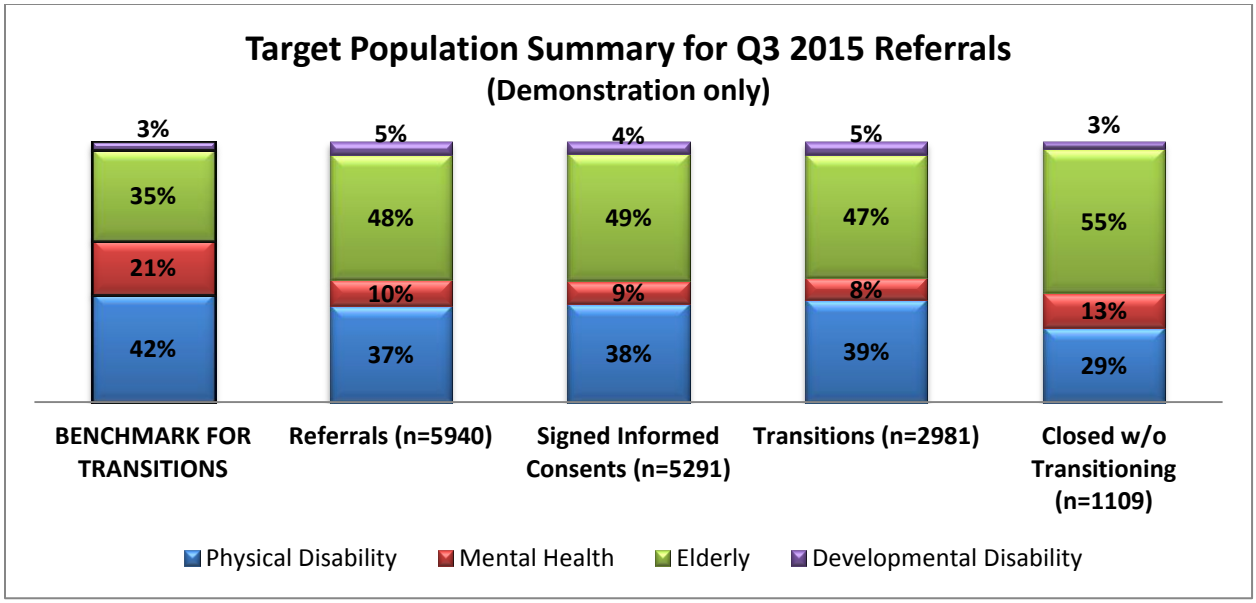
## Referrals to Transition Coordinators[t]: Q1 2009 to Q3 2015



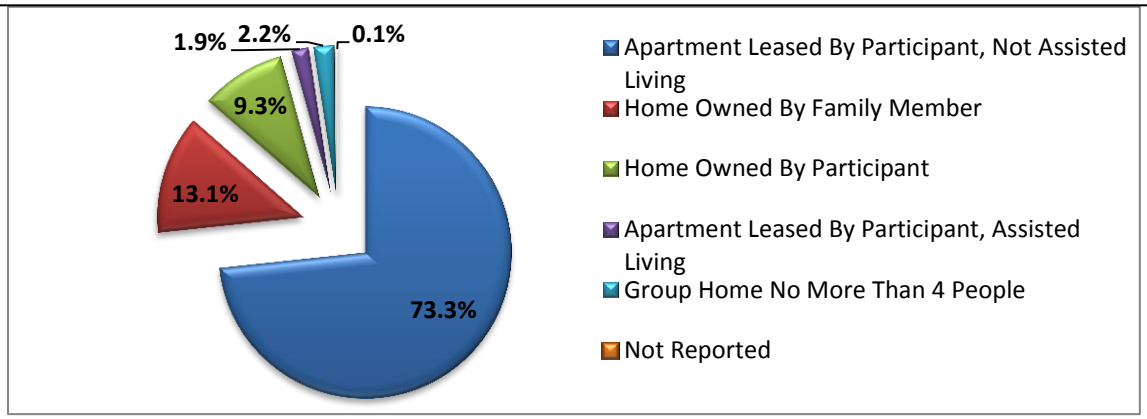

[t]Excludes nursing home closures *Inrease in referrals reflects the ongoing adjustment to MFP reorganization

## Number of Transitions by Quarter: 12/2008 - 9/30/2015

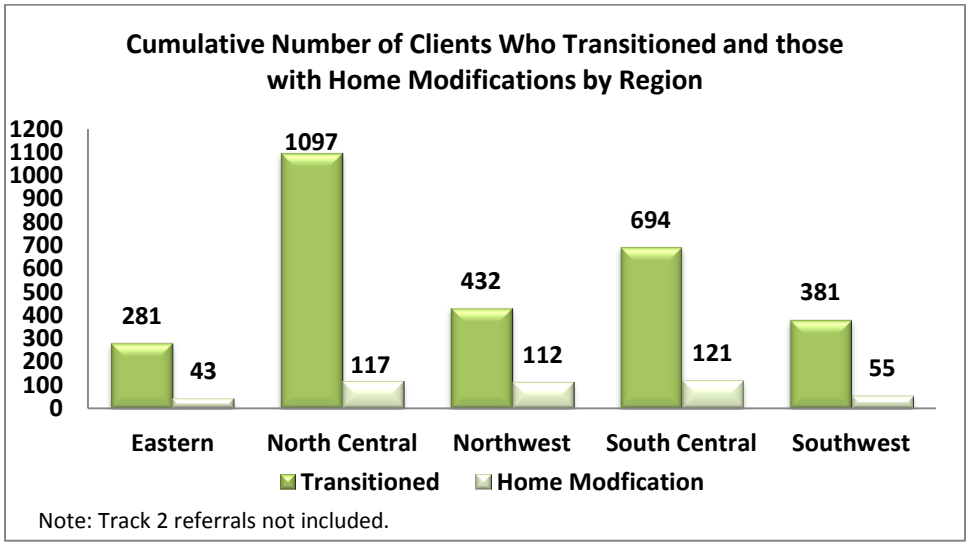




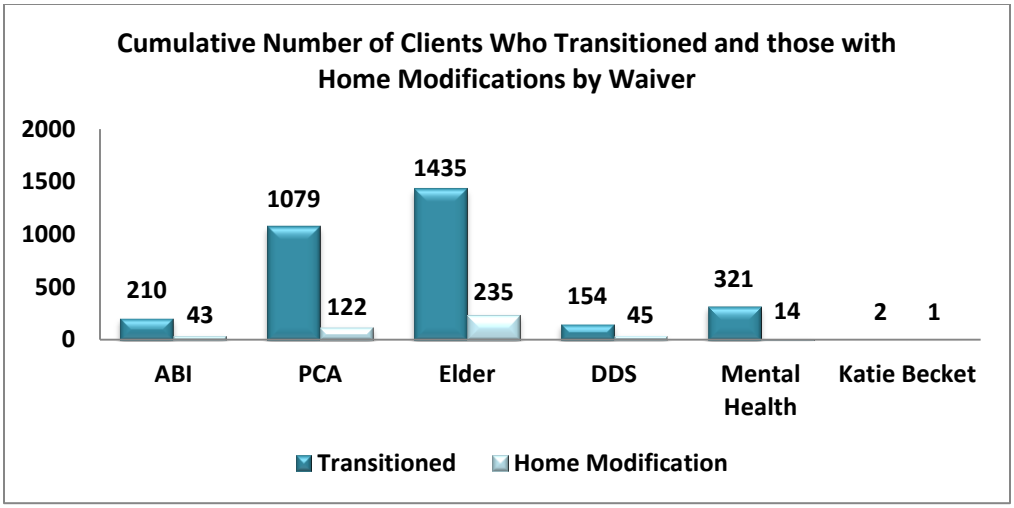

## Qualified Residence Type for Transitioned Referrals: 12/4/08-9/30/2015

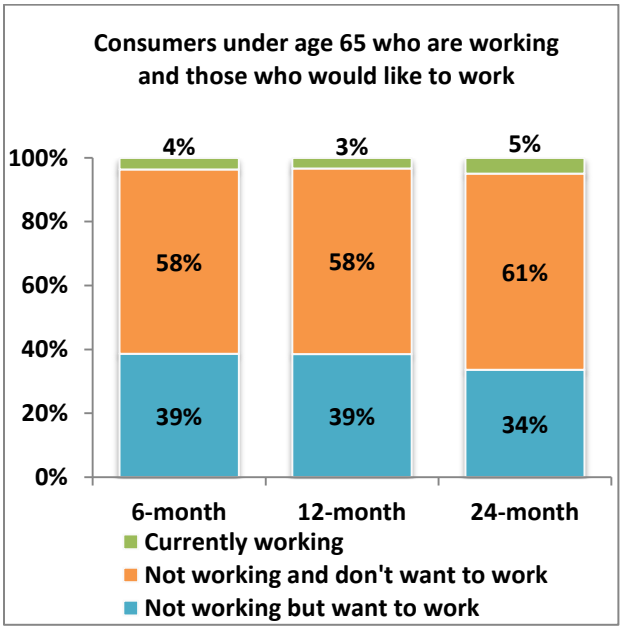


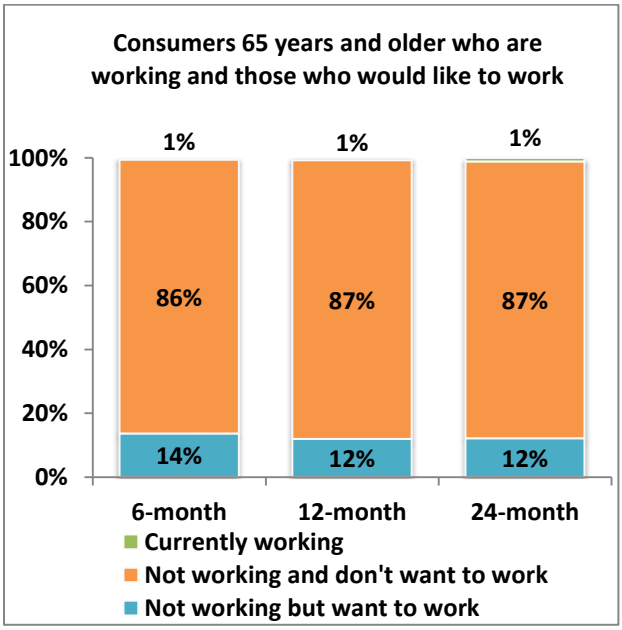

**<u>Reinstitutionalization</u>: 13% (303) of participants who transitioned by September 2014 were in an institution 12 months after their transition**

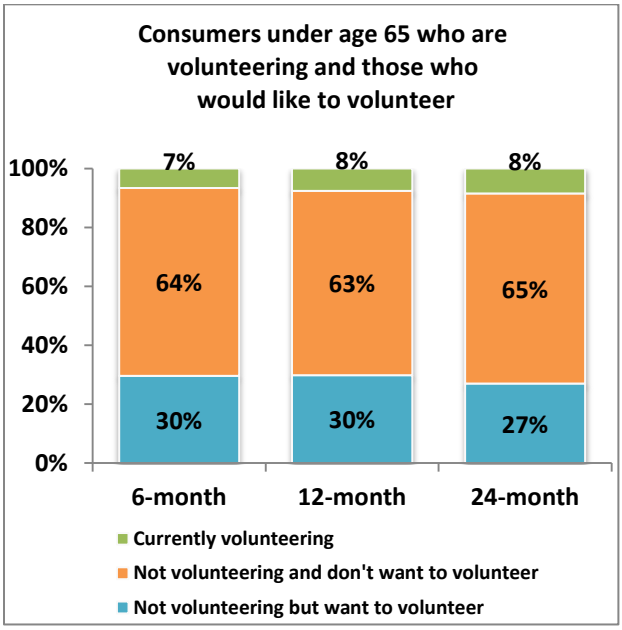


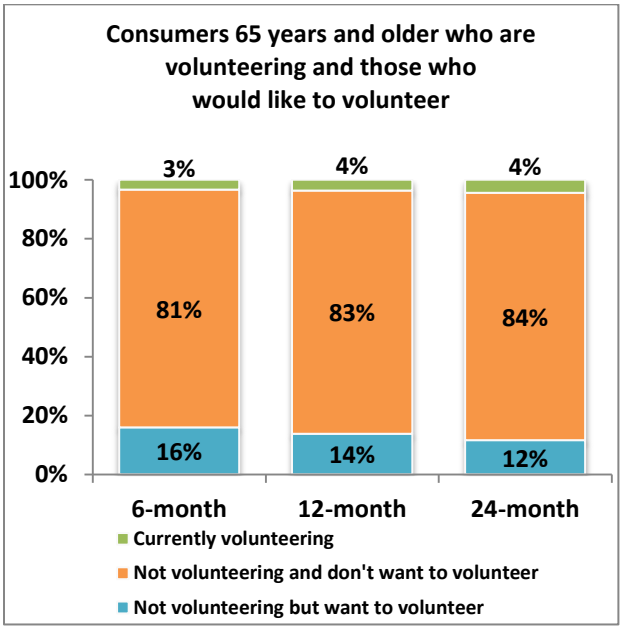

Note: Track 2 referrals not included.


Cumulative Number of Clients Who Transitioned and those with Home Modifications by Waiver
2000
1500
1000
500
0
210
43
1079
122
1435
235
154
45
321
14
2
1
ABI
PCA
Elder
DDS
Mental Health
Katie Becket
Transitioned
Home Modification

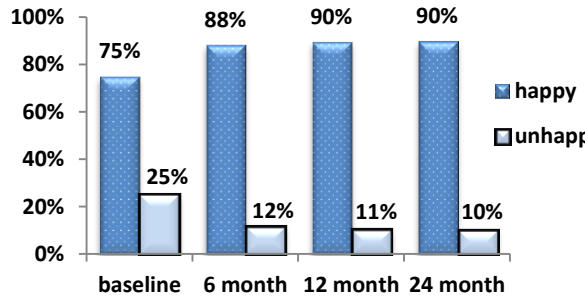

Consumers under age 65 who are working and those who would like to work
100%
80%
60%
40%
20%
0%
4%
3%
5%
58%
58%
61%
39%
39%
34%
6-month
12-month
24-month
Currently working
Not working and don't want to work
Not working but want to work

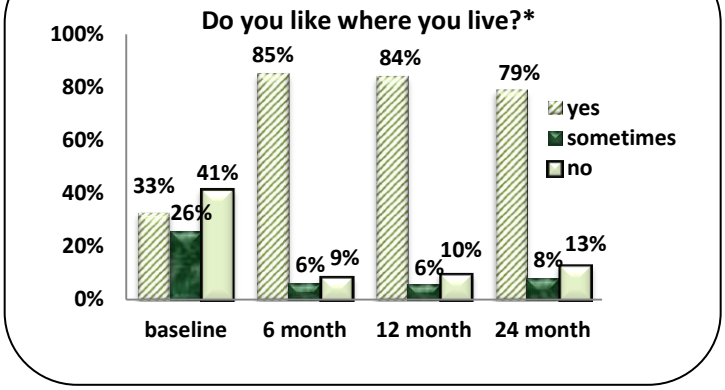

Consumers 65 years and older who are working and those who would like to work
100%
80%
60%
40%
20%
0%
1%
1%
1%
86%
87%
87%
14%
12%
12%
6-month
12-month
24-month
Currently working
Not working and don't want to work
Not working but want to work

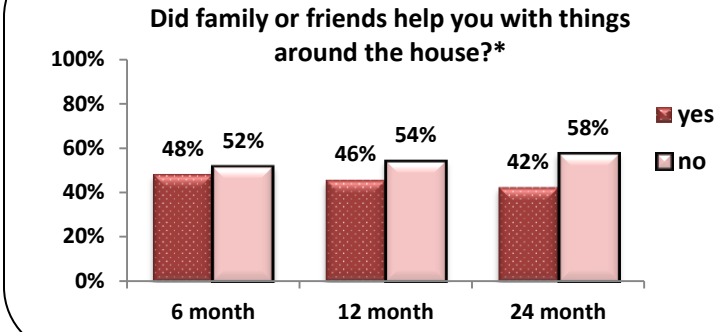

Consumers under age 65 who are volunteering and those who would like to volunteer
100%
80%
60%
40%
20%
0%
7%
8%
8%
64%
63%
65%
30%
30%
27%
6-month
12-month
24-month
Currently volunteering
Not volunteering and don't want to volunteer
Not volunteering but want to volunteer

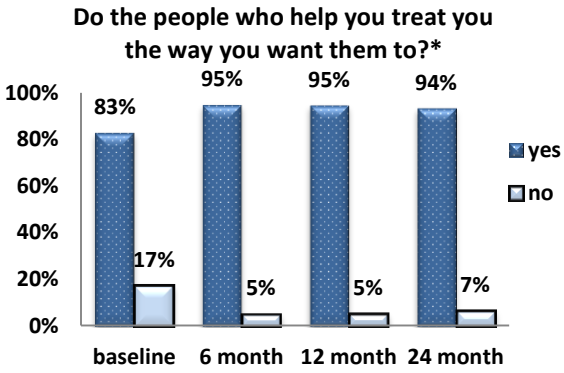

Consumers 65 years and older who are volunteering and those who would like to volunteer
100%
80%
60%
40%
20%
0%
3%
4%
4%
81%
83%
84%
16%
14%
12%
6-month
12-month
24-month
Currently volunteering
Not volunteering and don't want to volunteer
Not volunteering but want to volunteer

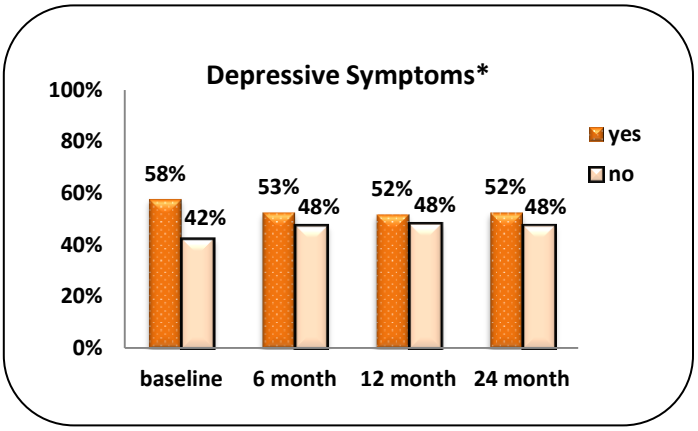
# MFP Quality of Life Dashboard As of 9/30/2015

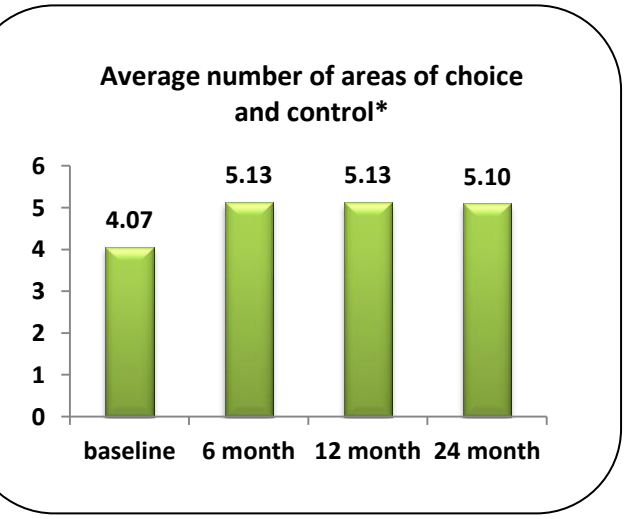


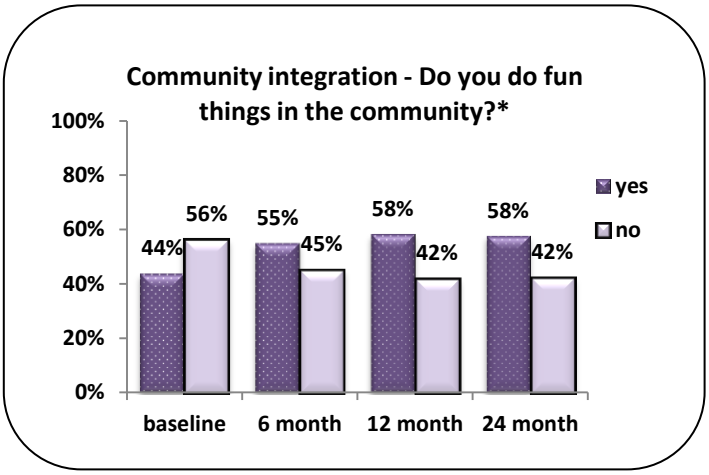




*indicates statistically significant differences

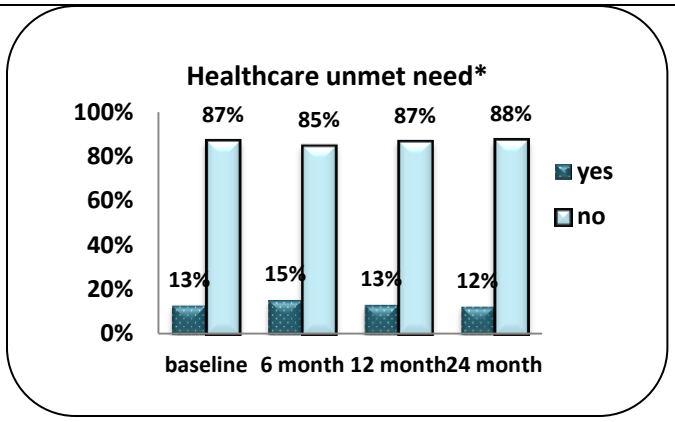
**Quality of Life Interviews Completed**
**(Cumulative data through 9/30/15)**

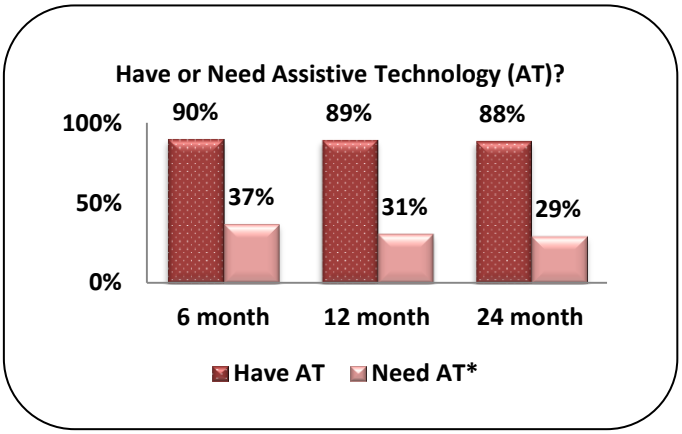
**Baseline interviews done prior to transition, n=3,254**

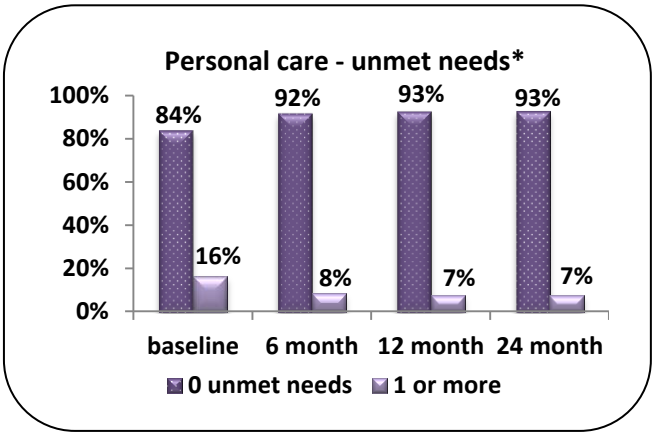
**6 month interviews done 6 mos after transition, n=2,360**

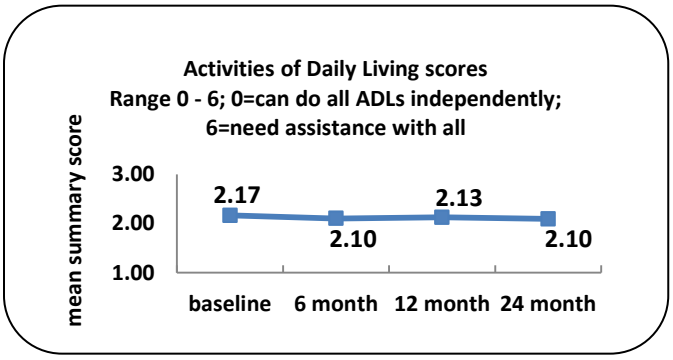
**12 month interviews done 12 mos after transition, n=2,014**

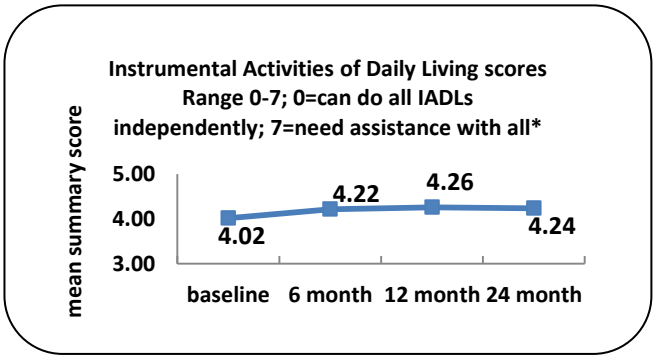
**24 month interviews done 24 mos after transition, n=1,377**

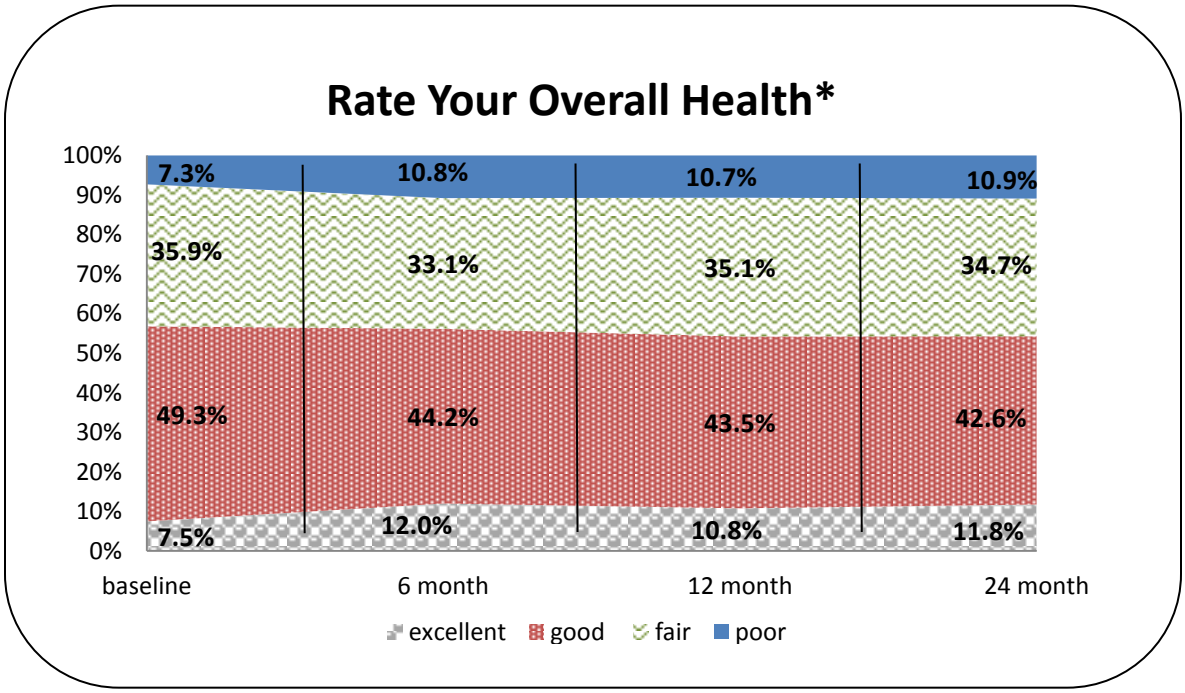


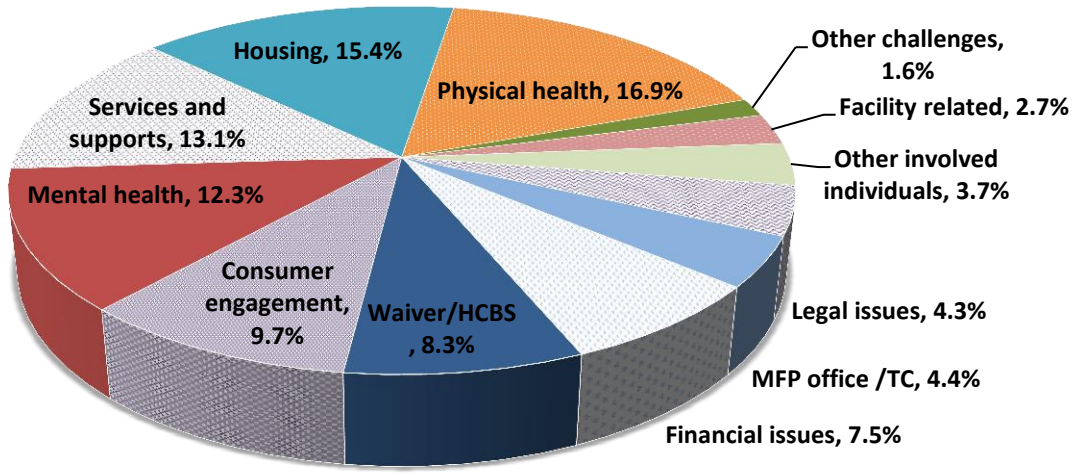






## Transition Challenges through 9/30/15

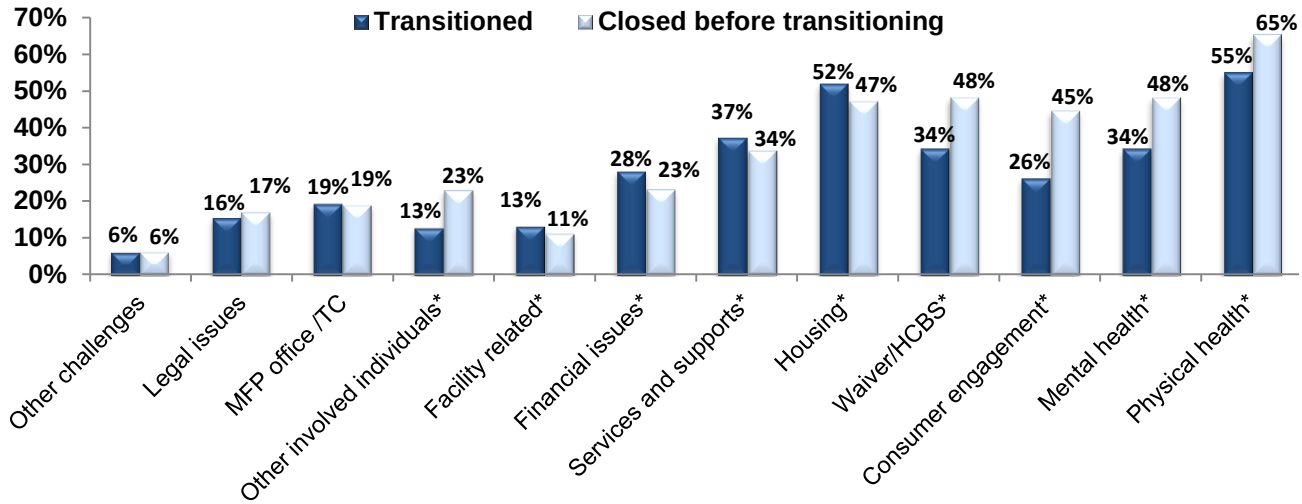
Transition coordinators and specialized care managers (SCMs) complete a standardized challenges checklist for each consumer. There were a total of 9,249 MFP referrals to SCM Supervisors. Challenges checklists were completed for 6,345 of these referrals, representing 5,892 consumers. Excluding the referrals which indicated "no challenges," the challenges checklist generated 37,101 separate challenges. Of these, the most frequently chosen challenge was physical health (16.9%), followed by challenges related to housing (15.4%), services and supports (13.1%), mental health (12.3%), and consumer engagement (9.7%).

## Type of challenge by transition status

The figure below shows the percentage of each group (those who transitioned and those who closed before transitioning) which had each challenge. For example, of the referrals that closed without transitioning, 65 percent had a physical health challenge. Conversely, 55 percent of referrals that did transition had physical health challenges.

Nine of the twelve challenge categories had statistically significant differences between the two groups.

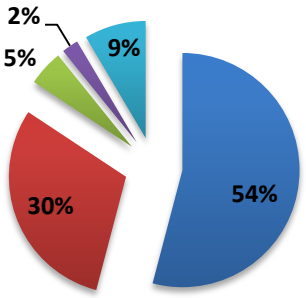
**Be sure to check the LINK to the full Transition Challenges report.**
http://uconn-aging.uchc.edu/money_follows_the_person_demonstation_evaluation_reports.html



# Types of Challenges – through 9/30/2015

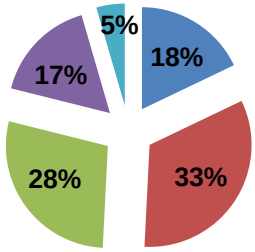
*Shown below are the six most common challenge types*

## Physical health



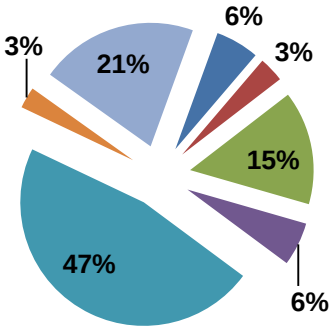

- Current, new or undisclosed physical health problem
- Inability to manage physical disability or physical illness in community
- Medical testing issues or delays
- Missing or waiting for physical health documents
- Other physical health issues

## Mental health



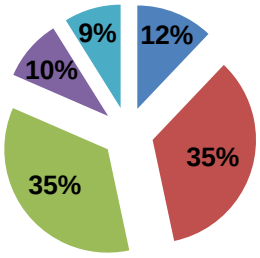

- Current or history of substance/alcohol abuse w/ risk of relapse
- Current, new, or undisclosed mental health problem
- Dementia or cognitive issues
- Inability to manage mental health in community
- Other mental health issues

## Housing



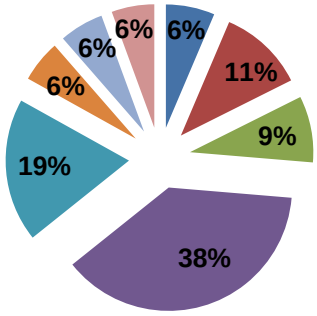

- Delays related to housing authority, agency or housing coordinator
- Delays related to lease, landlord, apartment manager, etc.
- Needs housing modifications before transition
- Ineligible or waiting for approval from RAP or other housing programs
- Lacks affordable, accessible community housing
- Housing related legal, criminal or credit issues, including evictions or unpaid rent
- Other housing related issues

## Consumer engagement



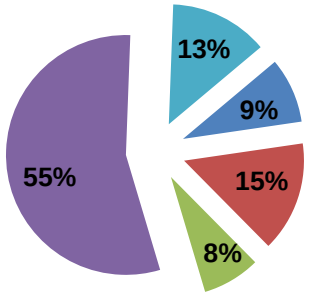

- Disengagement or lack/loss of motivation
- Lack of awareness or unrealistic expectations
- Lack of independent living skills
- Language or communication skills
- Other consumer related issues

## Services and supports



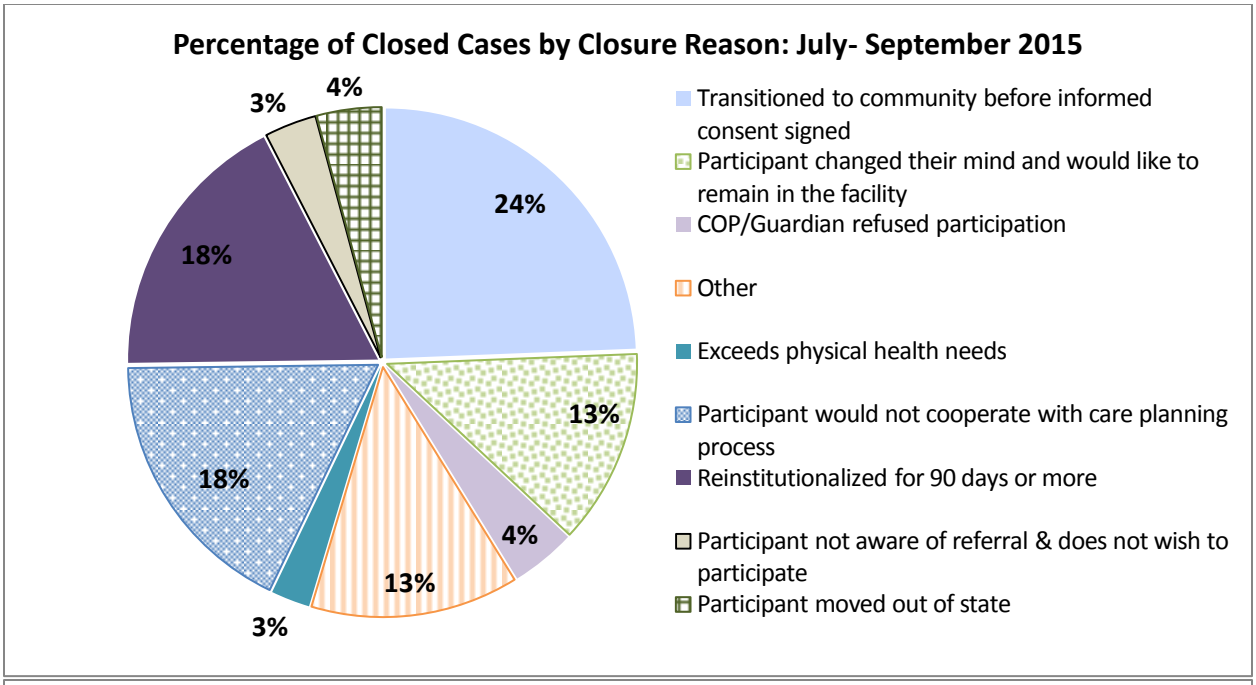

- Lack of alcohol, substance abuse, or addiction services
- Lack of AT or DME
- Lack of mental health services or supports
- Lack of PCA, home health, or other paid support staff
- Lack of transportation
- Lack of any other services or supports
- Lack of unpaid caregiver to provide care/informal support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

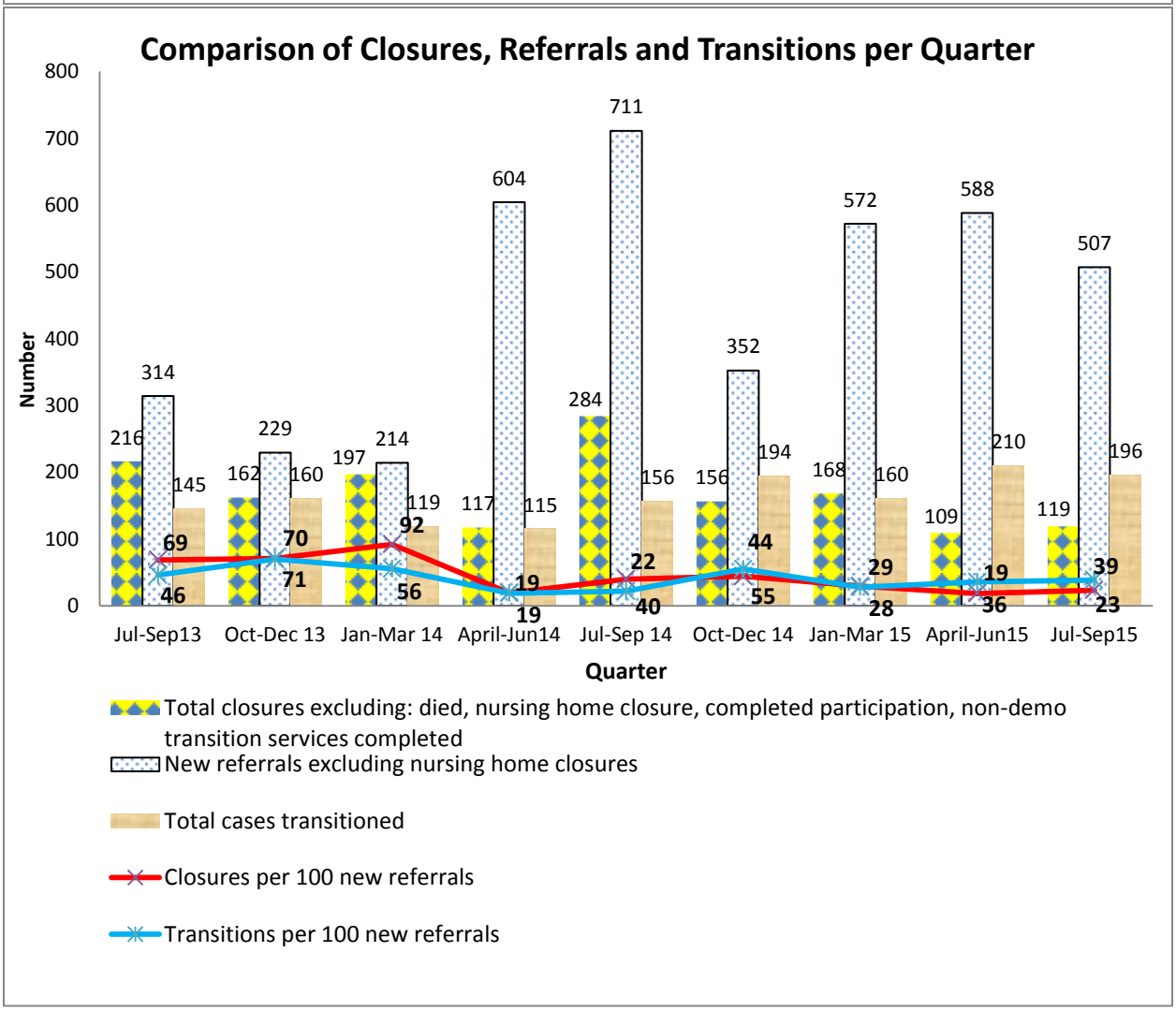
## Waiver /HCBS




- Current waivers or HCBS programs do not meet consumer needs
- Ineligible for or denial of HCBS program or waiver services
- Targeted waiver full
- Waiting for evaluation, application review from waiver or HCBS agency/contact
- Other HCBS or waiver program issues

**For the full report on transition challenges through 9/30/2015, use the link on page 7 to get to the Center on Aging website.**


Percentage of Closed Cases by Closure Reason: July- September 2015
24%
13%
4%
13%
3%
18%
18%
3%
4%
Transitioned to community before informed consent signed
Participant changed their mind and would like to remain in the facility
COP/Guardian refused participation
Other
Exceeds physical health needs
Participant would not cooperate with care planning process
Reinstitutionalized for 90 days or more
Participant not aware of referral & does not wish to participate
Participant moved out of state


Comparison of Closures, Referrals and Transitions per Quarter
Number
800
700
600
500
400
300
200
100
0
216
314
145
162
229
160
197
214
119
117
604
115
284
711
156
156
352
194
168
572
160
109
588
210
119
507
196
69
46
70
71
92
56
19
19
22
40
44
55
29
28
19
36
39
23
Jul-Sep13
Oct-Dec 13
Jan-Mar 14
April-Jun14
Jul-Sep 14
Oct-Dec 14
Jan-Mar 15
April-Jun15
Jul-Sep15
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

## Meet Christopher Danton

After spending more than 20 years at an intermediate care facility (ICF), Money Follows the Person (MFP) has helped Christopher Danton transition into the community. In May of 2014, Christopher's mother, Lucy, was approached by Community Resources, Inc. about a new group home being built that would accommodate men with Chris' level of care. Christopher and his three other housemates now live in a home in a beautiful section of Middletown. Lucy explains, "This place is a family, a real home."

Chris' mother describes the transition process as rough. Faced with long waiting lists, Lucy advocated for her son for months to get him into a home like this, and through the help of MFP, her wishes came true. Chris' family has been seriously supportive of his care, especially in the last year and a half through the transition process. Christopher has a large family including many siblings. He is particularly close with his sister, Sandy. Sandy recounts fondly of visiting her brother now that he is at the group home. They are able to have more alone time. The privacy of his own room helps the family to bond and spend time together. Because this is a home, there are no rules for family visitation, and the ease of visiting Chris has increased family comfort.

While at an ICF, the family felt he was not given the opportunities he could have. Now, Chris' life is coordinated around his control. The staff are constantly assessing Chris' desires and include him in any activity Chris chooses. If he wants to go outside, listen to the television, play music, or simply rest, he can. Because Chris is blind, he enjoys the opportunity to trail throughout the house to better sense his environment. Chris attends a day program with his other housemates, a place where he can get his energy out. Chris' life had been filled with rigid structure, sometimes leading to difficulties between workers and the family – but now this has merely disappeared. Lucy explains, "This is his normal, *whatever 'normal' really means.*"

The family described difficulties obtaining simple necessities for Chris when he was at the ICF. Lucy explains, "The process of getting small items for Chris before is so different now. If he needs a blanket, we contact the case manager of the home and we get a blanket - the anxiety has been taken away from our family." Lucy takes comfort in knowing that when she leaves, his care is top-notch and his safety is of the utmost concern.

Chris (middle) pictured with his sister Sandy (left) and mother Lucy (right) *Photo credit: Kaleigh Ligus*

Lucy reflects, "MFP is a step in the right direction, especially since they do try to follow-up. … [It is] much better for my son to be in a group home - my son is flourishing under MFP where he was not in all the years [before]." "The only goal Chris has now is having a great quality of life."

**MFP Demonstration Background**

The Money Follows the Person Rebalancing Demonstration, created by Section 6071 of the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), supports States' efforts to "rebalance" their long-term support systems. The DRA reflects a growing consensus that long-term supports must be transformed from being institutionally-based and provider-driven to person-centered and consumer-controlled. The MFP Rebalancing Demonstration is a part of a comprehensive coordinated strategy to assist States, in collaboration with stakeholders, to make widespread changes to their long-term care support systems.

One of the major objectives of the Money Follows the Person Rebalancing Demonstration is "to increase the use of home and community based, rather than institutional, long-term care services." MFP supports grantee States to do this by offering an enhanced Federal Medical Assistance Percentage (FMAP) on demonstration services for individuals who have transitioned from qualified institutions to qualified residences. In addition to this enhanced match, MFP also offers states the flexibility to provide Supplemental Services that would not ordinarily be covered by the Medicaid program (e.g. home computers, cooking lessons, peer-to-peer mentoring, transportation, additional transition services, etc.) that will assist in successful transitions. States are then expected to reinvest the savings over the cost of institutional services to rebalance their long-term care services for older adults and people with disabilities to a community-based orientation.