

CT Money Follows the Person Quarterly Report

Quarter 3 2018: July 1, 2018 – September 30, 2018

(Based on the 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

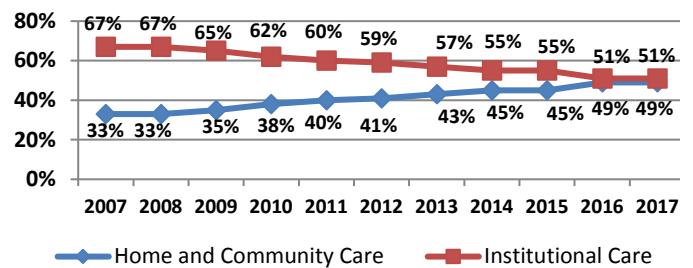
MFP Benchmarks

- 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 = 4,932 (non-demonstration transitions = 346)

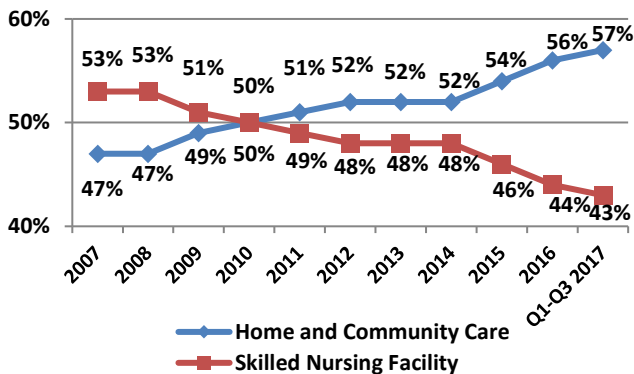
Benchmark 2

CT Medicaid Long-Term Care Expenditures



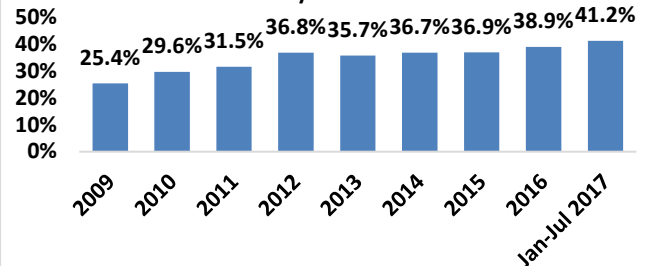
Benchmark 3

Percentage of Hospital Discharges to Home and Community Care vs. Skilled Nursing Facility

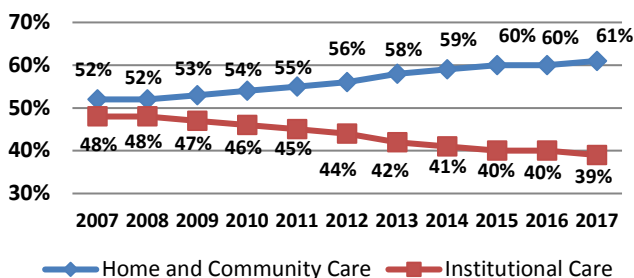


Benchmark 4

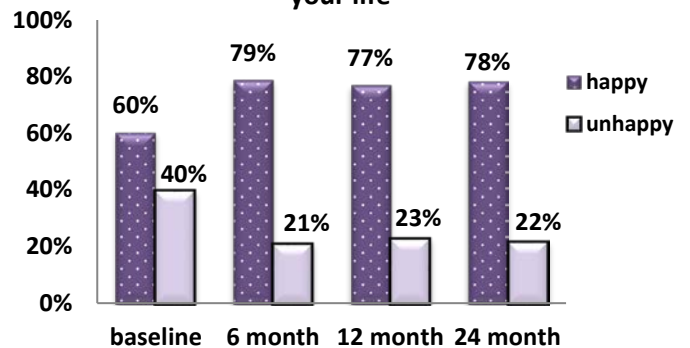
Percent of SNF admissions returning to the community within 6 months



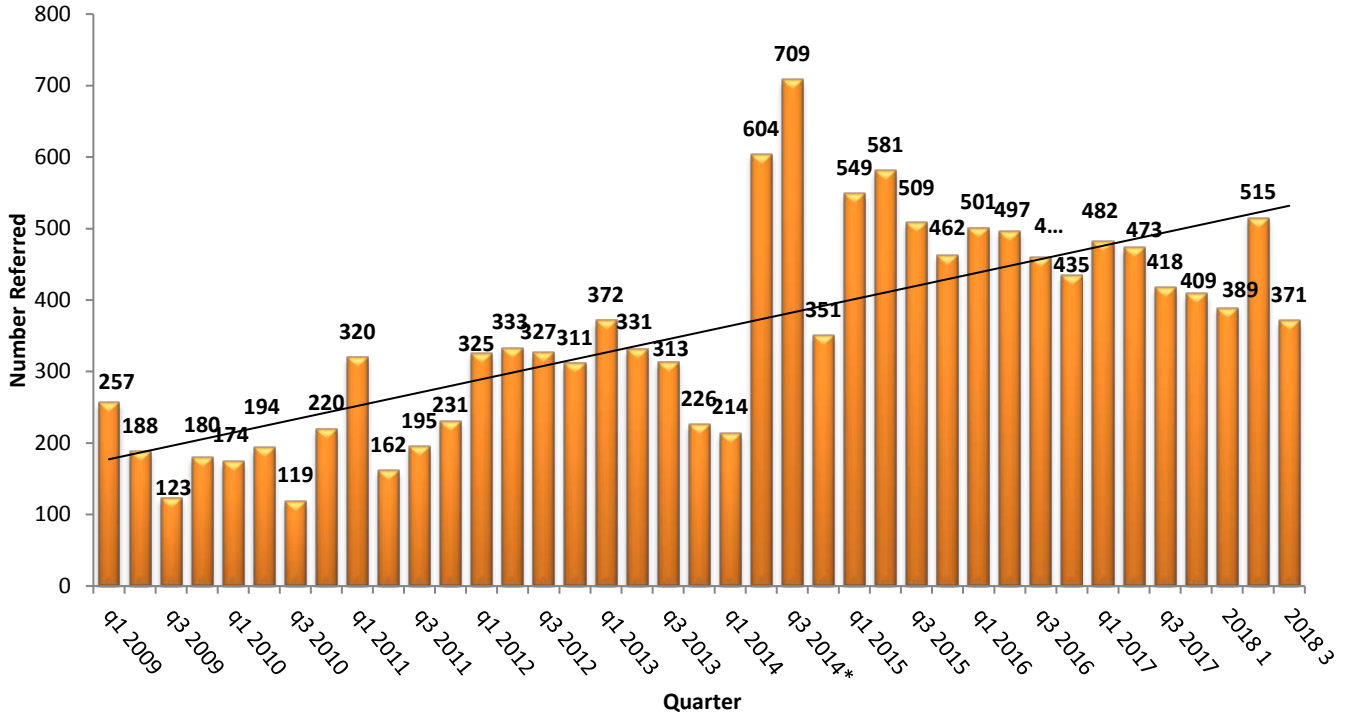
Benchmark 5: Percent Receiving LTSS in the Community vs. Institutions



Happy or unhappy with the way you live your life*

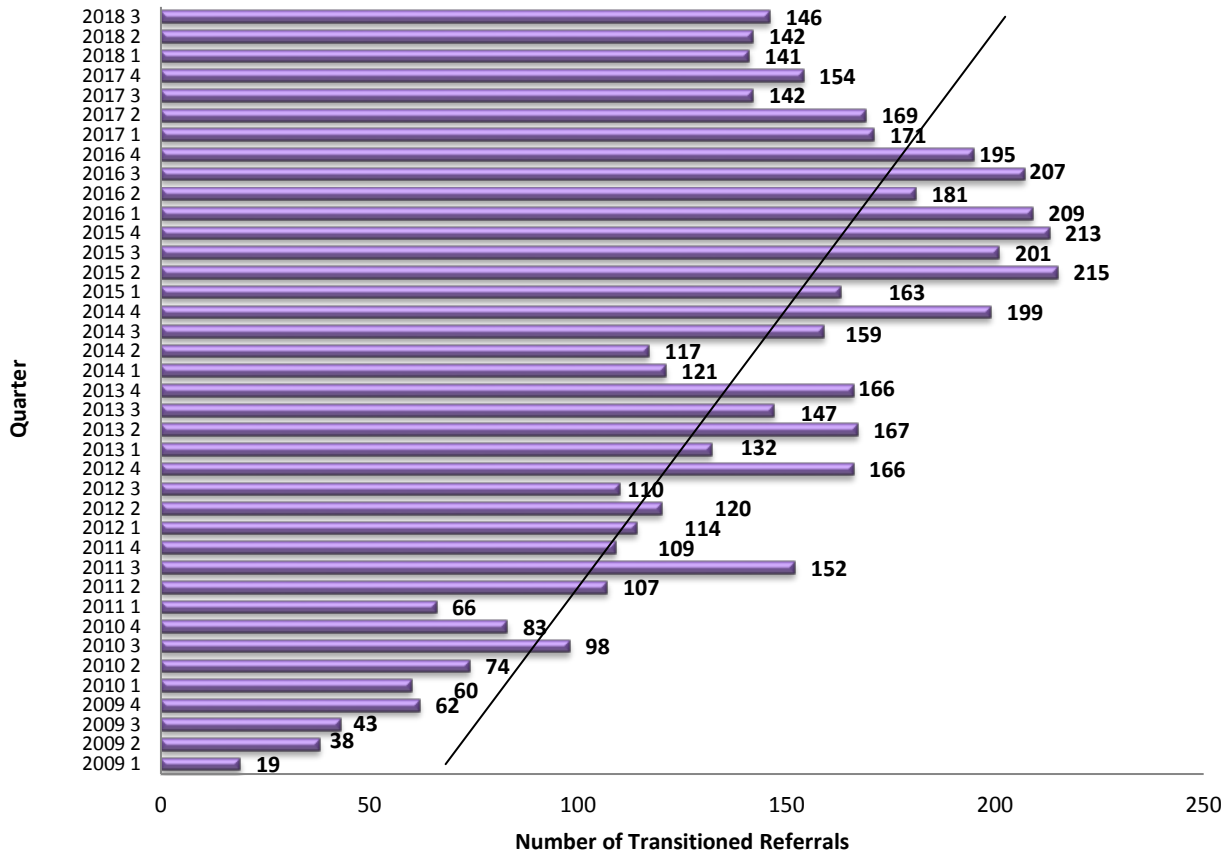


Referrals to Transition Coordinators^t: Q1 2009 to Q3 2018

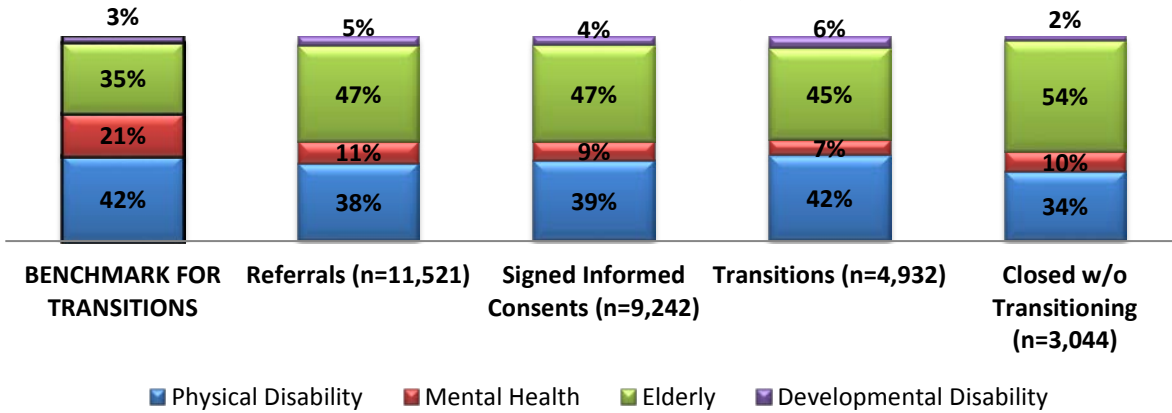


^tExcludes nursing home closures *Increase in referrals reflects the ongoing adjustment to MFP reorganization

Number of Transitions by Quarter: 12/2008 - 9/30/2018



Target Population Summary for Referrals through Q3 2018 (Demonstration Only)

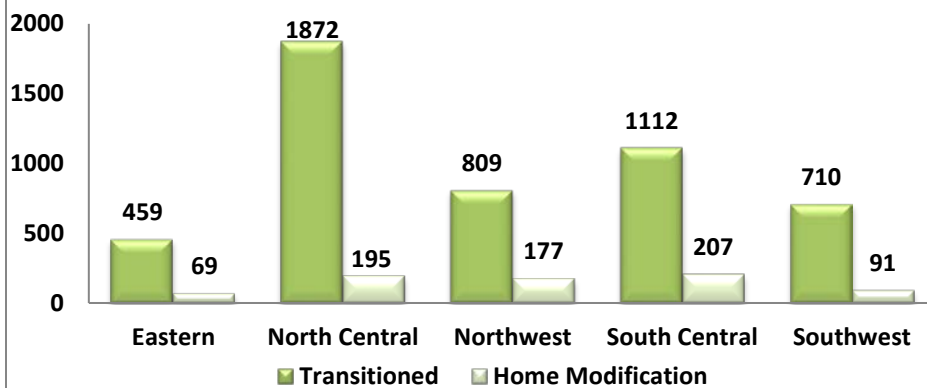


Qualified Residence Type for Transitioned Referrals: 12/4/08 to 9/30/18

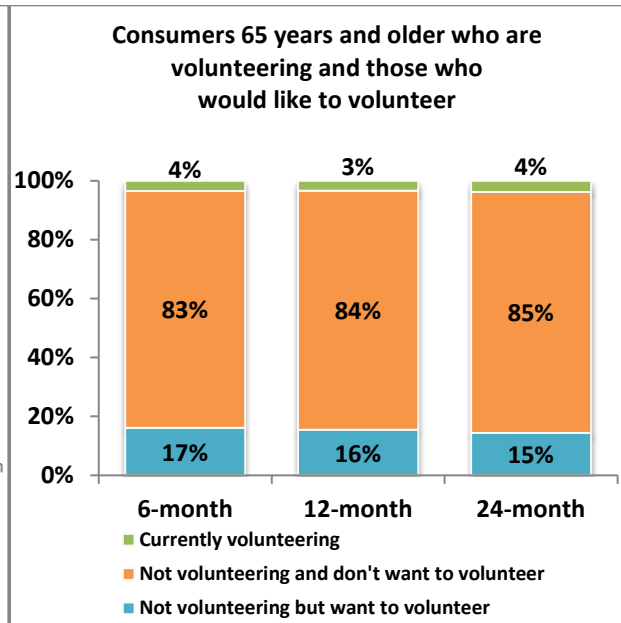
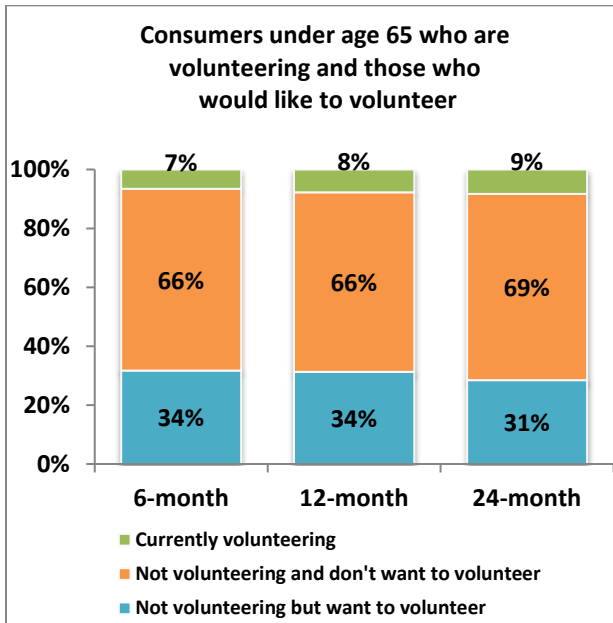
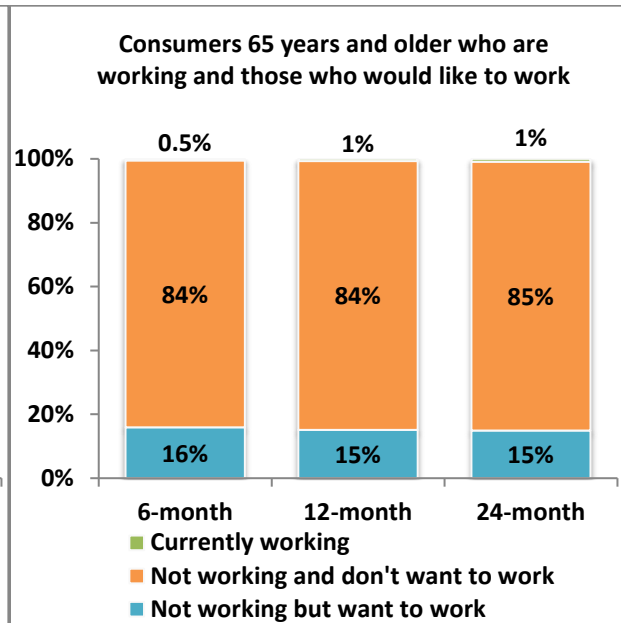
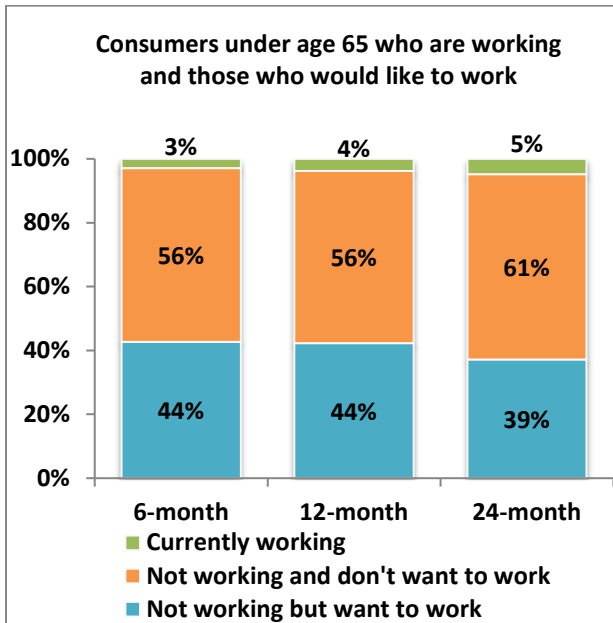
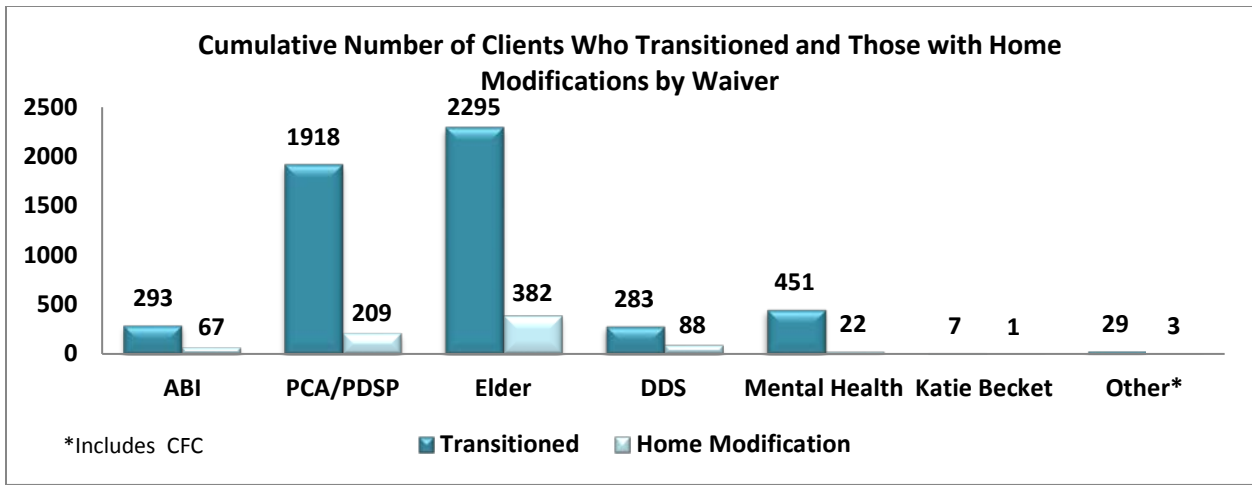


Reinstitutionalization: 12% (551) of participants who transitioned by Sept 30, 2017 were in an institution 12 months after their transition.

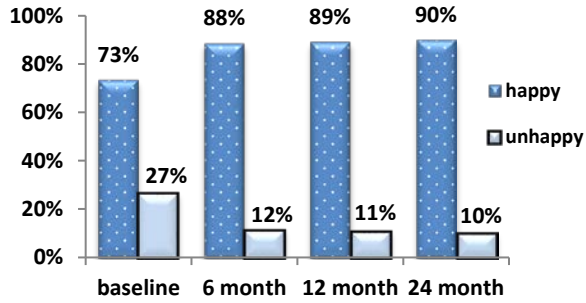
Cumulative Number of Clients Who Transitioned and Those with Home Modifications by Region



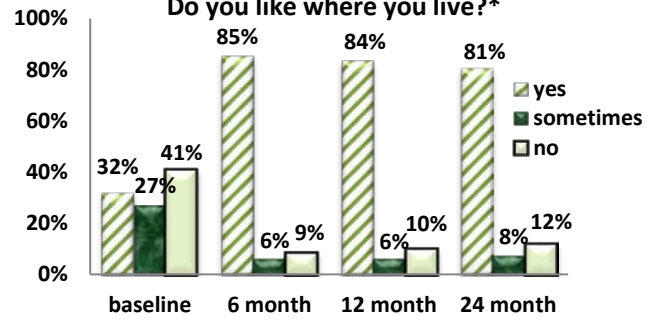
Note: Track 2 referrals not included.



Happy or unhappy with your help around the house or in the community*

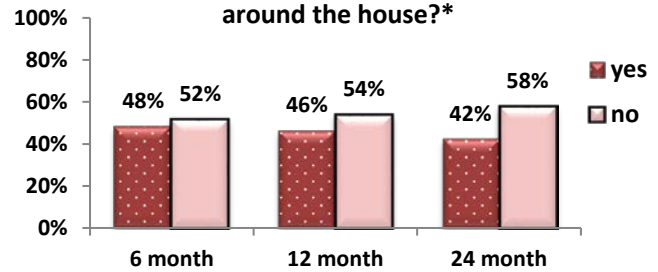


Do you like where you live?*

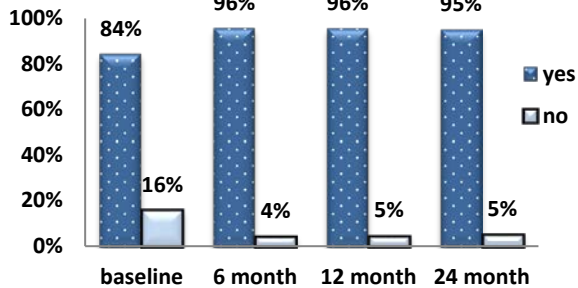


**MFP
Quality of Life
Dashboard
As of
09/30/2018**

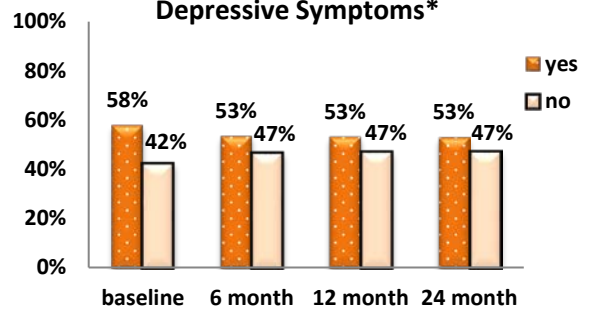
Did family or friends help you with things around the house?*



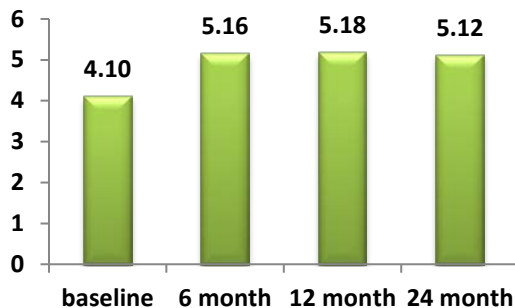
Do the people who help you treat you the way you want them to?*



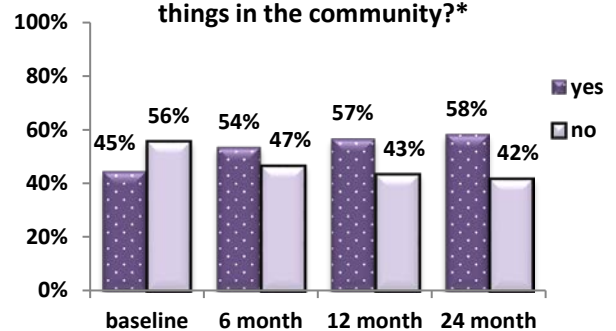
Depressive Symptoms*



Average number of areas of choice and control*



Community integration - Do you do fun things in the community?*



* indicates statistically significant differences

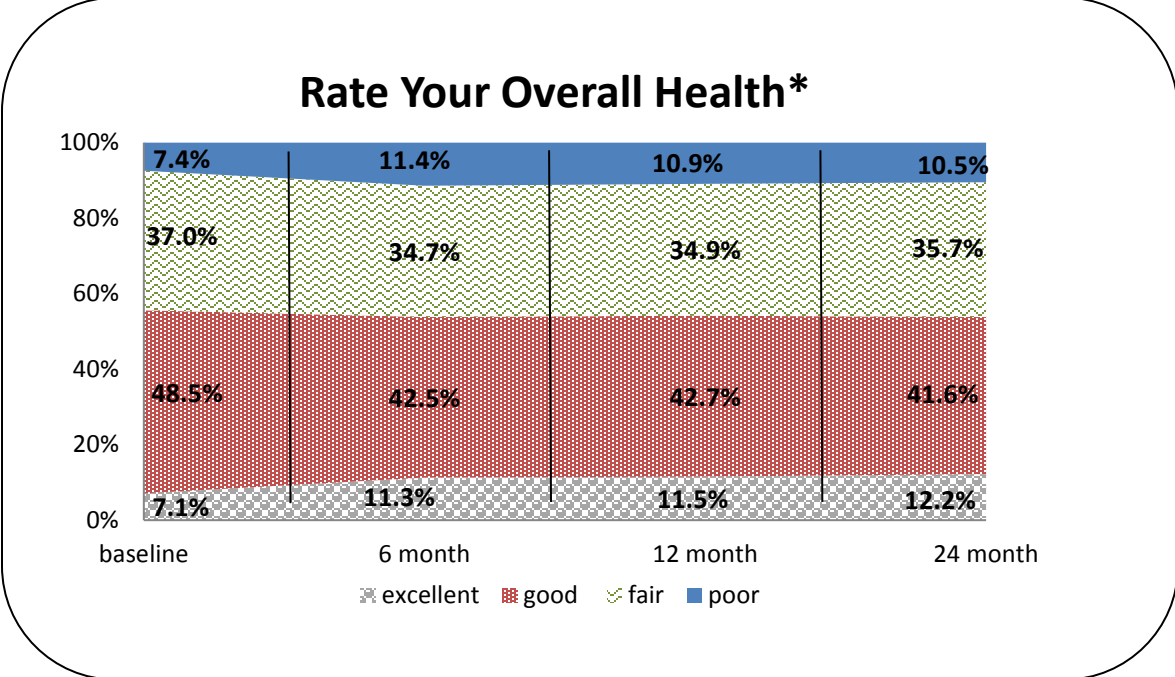
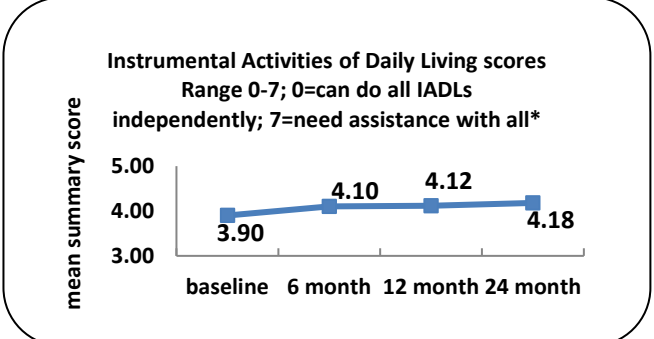
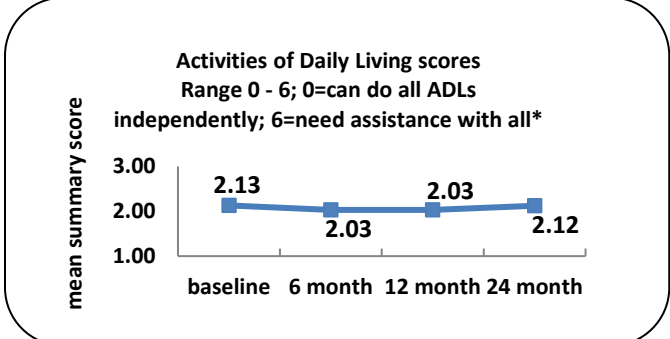
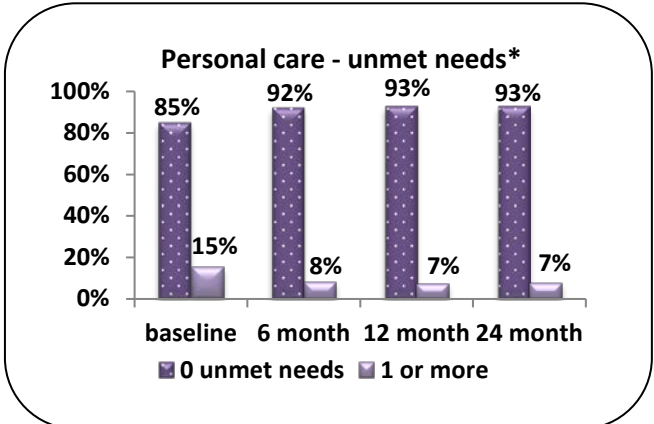
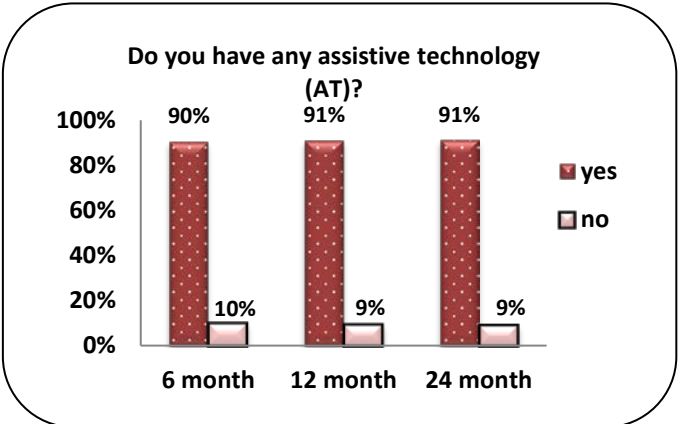
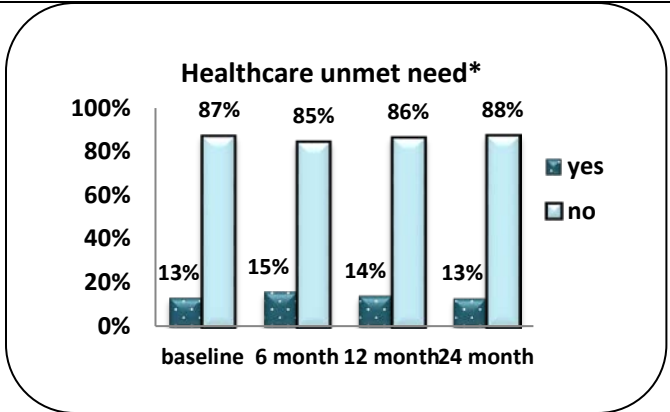
Quality of Life Interviews Completed
(Cumulative data through 09/30/18)

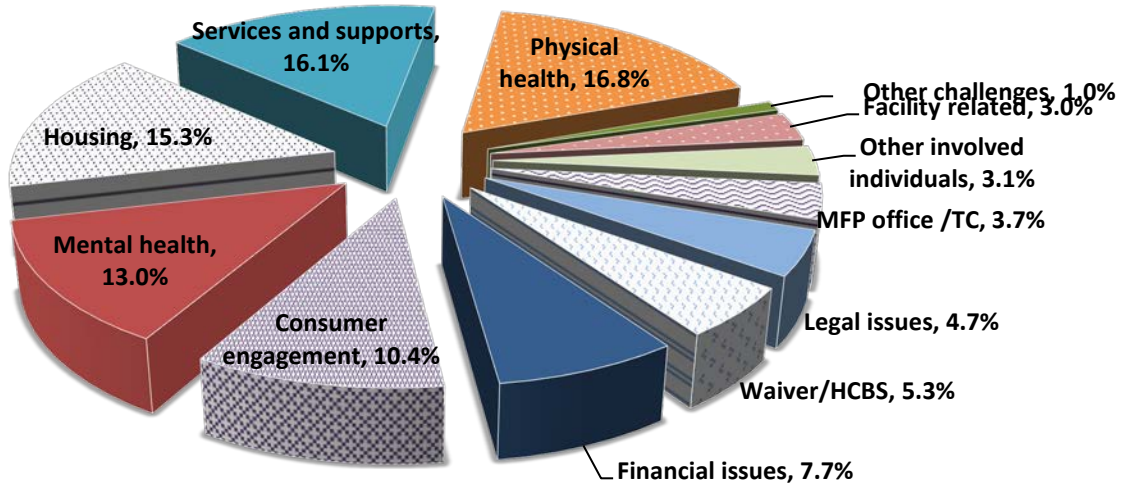
Baseline interviews done prior to transition, n=5323

6 month interviews done 6 mos after transition, n=4092

12 month interviews done 12 mos after transition, n=3700

24 month interviews done 24 mos after transition, n=2796





Transition Challenges through 9/30/18

Transition coordinators (TCs) and Specialized Care Managers (SCMs) complete a standardized challenges checklist for each consumer. There were a total of 15,227 MFP referrals to SCM Supervisors. Challenges checklists were completed for 10,245 of these referrals, representing 9,373 consumers. Excluding the referrals which indicated “no challenges,” the challenges checklist generated 64,658 separate challenges. Of these, the most frequently chosen challenge was physical health (16.8%), followed by challenges related services and supports (16.1%), to housing (15.3%), mental health (13.0%), and consumer engagement (10.4%).

Type of challenge by transition status

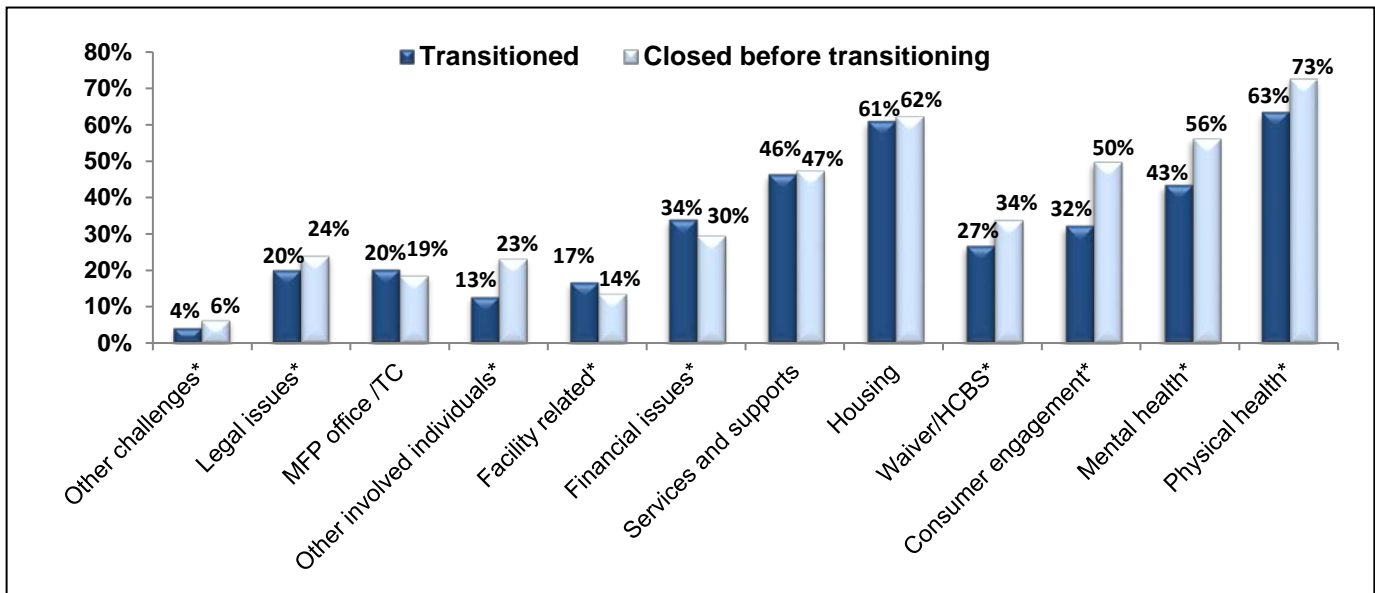
The figure below shows the percentage of each group (those who transitioned and those who closed before transitioning) which had each challenge. For example, of the referrals that closed without transitioning, 73 percent had a physical health challenge. Conversely, 63 percent of referrals that did transition 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://health.uconn.edu/aging/research-reports>

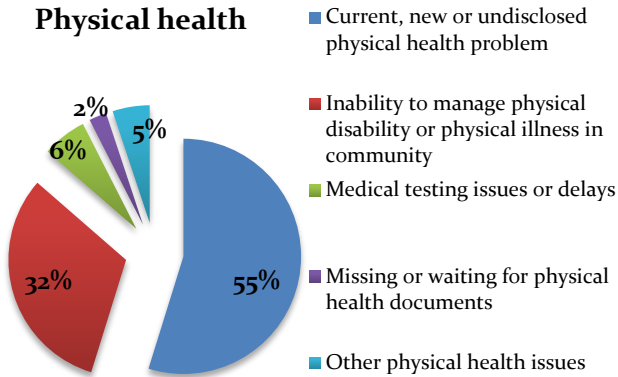
click on the Money Follows the Person tab



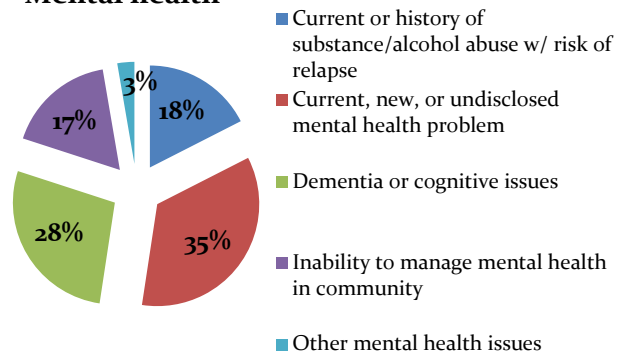
Types of Challenges — through 9/30/2018

Shown below are the six most common challenge types

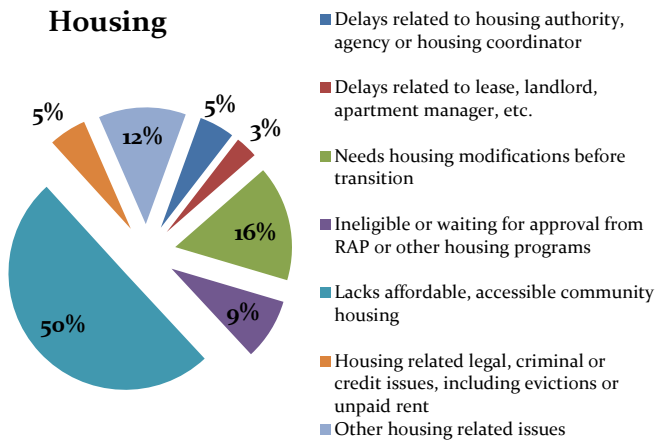
Physical health



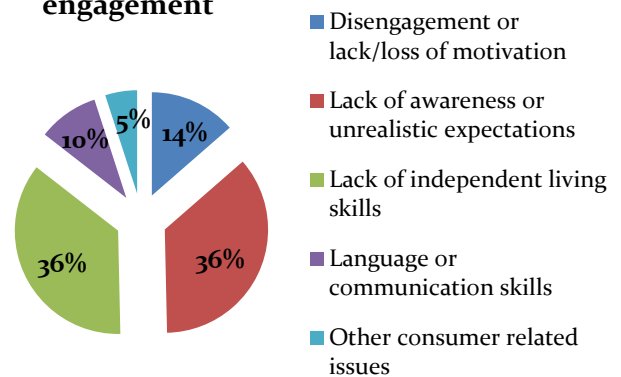
Mental health



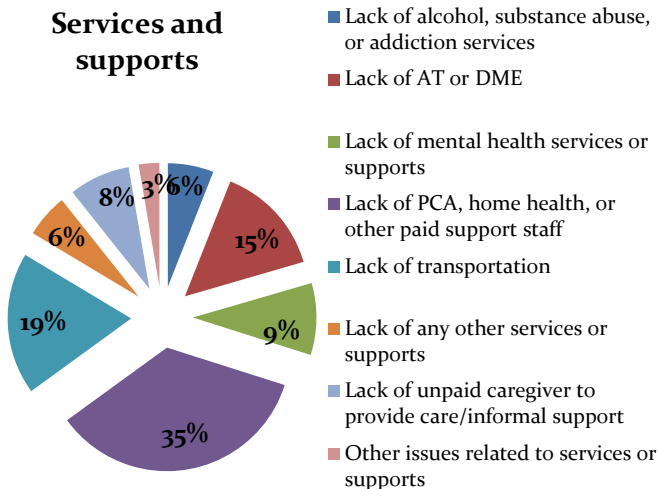
Housing



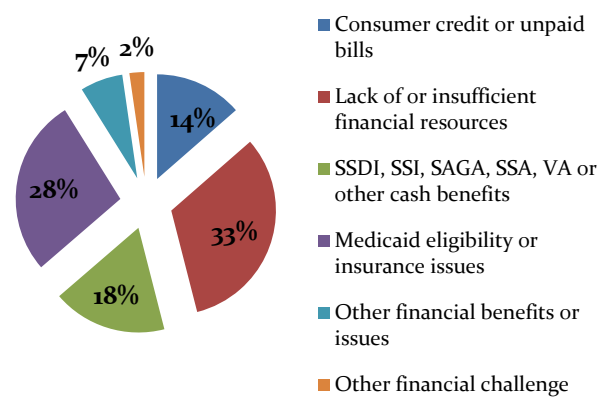
Consumer engagement



Services and supports

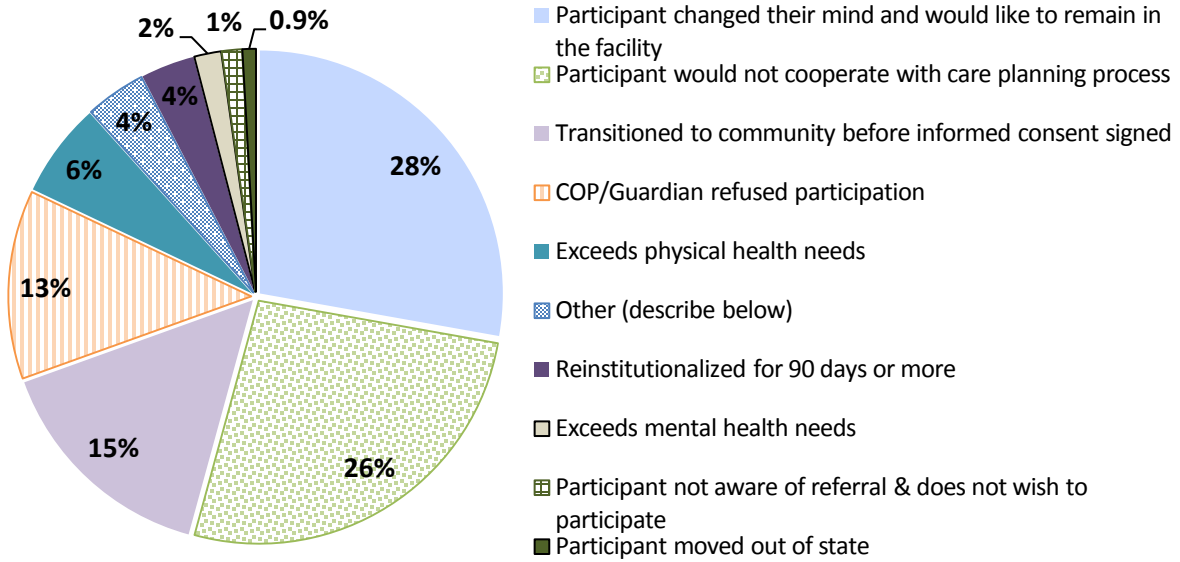


Financial



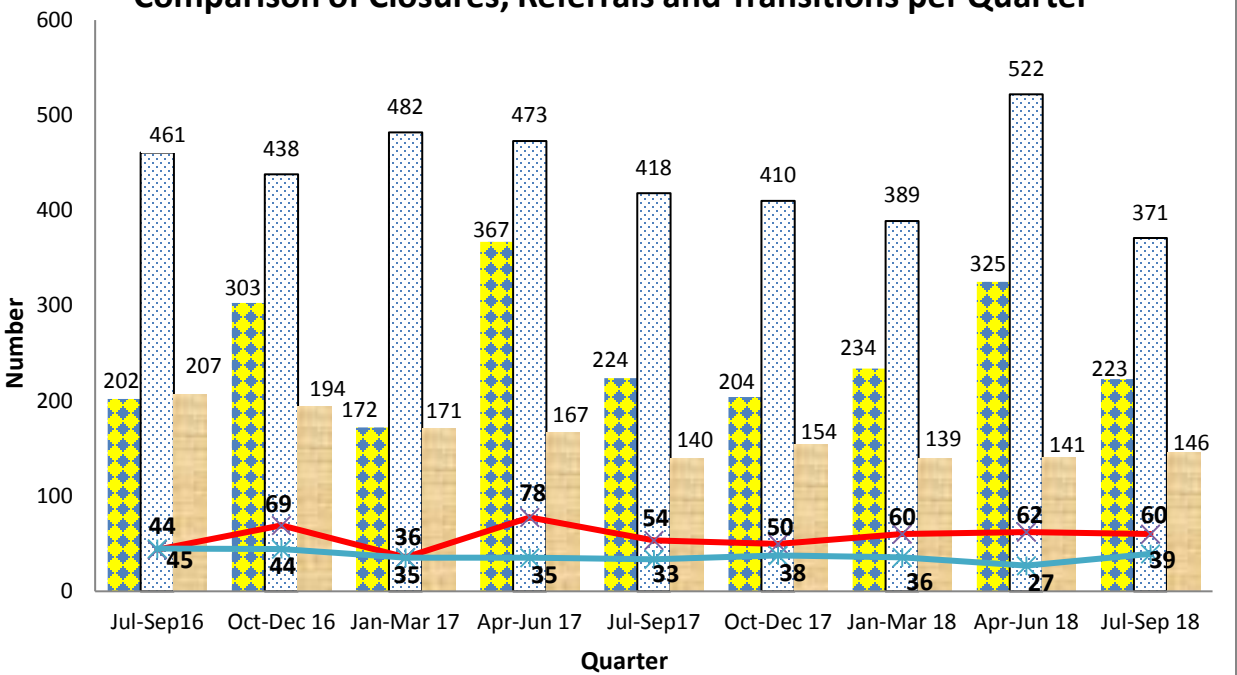
For the full report on transition challenges through 9/30/2018, use the link on page 7 to get to the Center on Aging website.

Percentage of Closed Cases by Closure Reason: July-Sept 2018



*Excludes NH closure and Chelsea/Touchpoints Manchester mass referrals of 12/23/16 or later

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

Nancy Dalton's Story

Nancy Dalton is what many would refer to as a warrior. In the years prior to her admission to a skilled nursing facility, she endured a divorce from an abusive husband and without the support of her family. As a result, Nancy was left with a lack of finances and post-traumatic stress disorder. This dramatically affected her ability to get a job and cope with her life circumstances. She suffered from debilitating panic attacks multiple times a day, and found herself going in and out of the hospital fighting severe depression. As if life couldn't get any tougher for Nancy, she soon found herself facing another challenge; a stroke that placed her in the hospital and eventually into a nursing facility.

It was in that nursing home that Nancy decided she wasn't going to live this way anymore. She worked hard to recover from her stroke, physically and mentally. After many months of tirelessly working with physical therapy and pushing her limits, Nancy was able to walk without a walker and regained function of her impaired hand. Through therapy and a wonderful social worker from the facility, Nancy began to challenge all the negative, self-hatred thoughts that routinely entered her mind. She also decided to start each day by making a list of 10 things she was grateful for. Every day, Nancy made a choice to focus on the positive, the things she could change, and how she could help others at the facility. As an artist, she drew pictures for residents to hang as decoration for different seasons, and pictures that could easily be colored in for entertainment. Helping others at the facility became very therapeutic for Nancy as she was beginning to feel her sense of purpose again.

After many months of hard work and recovery, the facility social worker introduced Nancy to MFP. She applied, was accepted and began the process of finding a place to live and determining what services she would need. She soon had an apartment of her own, a budget to help buy personal care items, and a SNAP card to buy groceries every month. In addition, Nancy was set up with recovery assistants who would come to her home a few hours a day to help complete daily activities and provide rides for necessary and leisure activities. Before she eventually obtained a car, the assistants were Nancy's only mode of transportation.

Since returning to the community, Nancy has continued to vigorously work on her happiness and takes each day as it comes. She continues to make her gratitude lists, focus on the positive, and challenge every negative thought that tries to seep in. She keeps busy by finishing art projects that she had started long ago, including intricate paintings and quilts. When the weather is nice, she loves going outside and taking care of her yard and garden, something she missed so dearly while living in the nursing home.

Nancy worked tremendously hard to turn her life around before she was introduced to MFP. The MFP program then gave her the opportunity to expand her success into the community. MFP perfectly supplemented Nancy's "work hard" attitude, and she is so grateful for how everything turned out.



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.