CT Money Follows the Person Report

Quarter 1: January 1 - March 31, 2025

UConn Health, Center on Aging

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

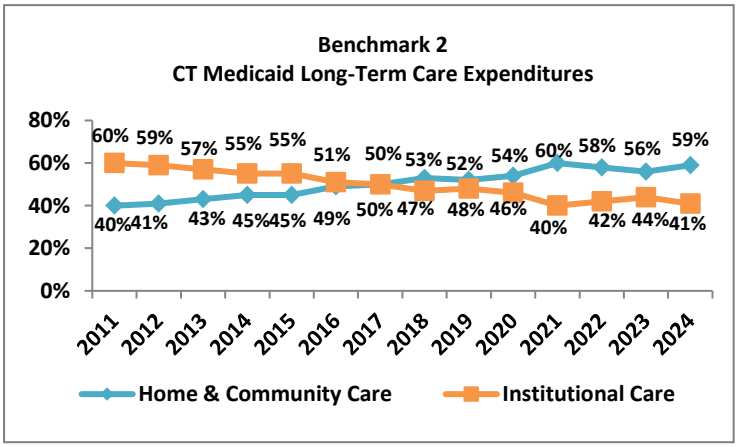
MFP Benchmarks

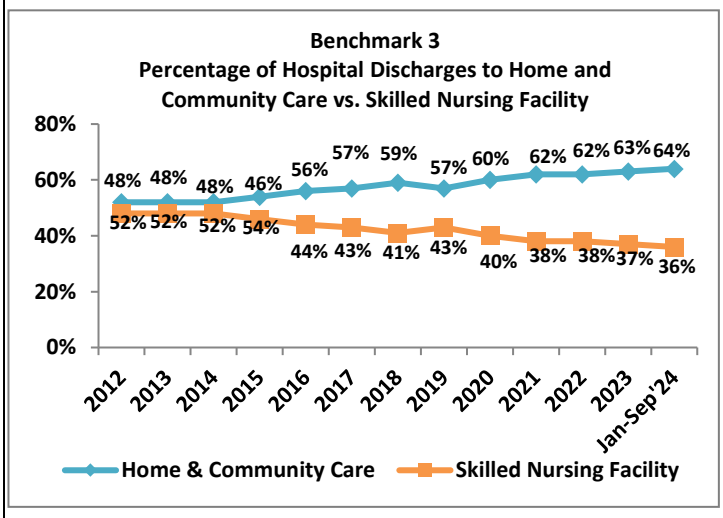
1) Transition 5200 people from qualified institutions to the community
2) Increase dollars to home and community based services
3) Increase hospital discharges to the community rather than to institutions
4) Increase probability of returning to the community during the six months following nursing home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

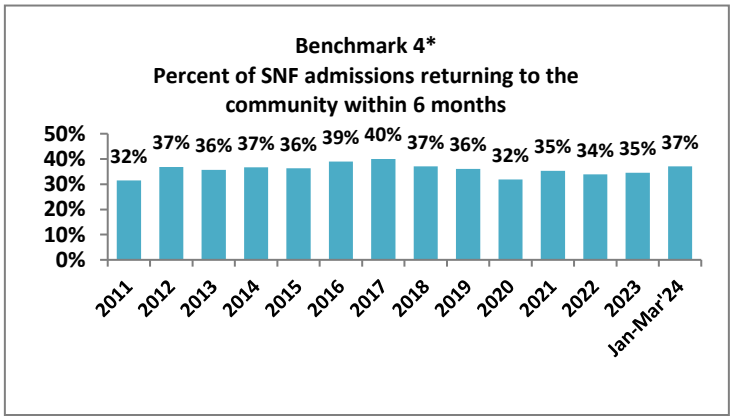
Benchmark 1: Total Transitions = 8,472

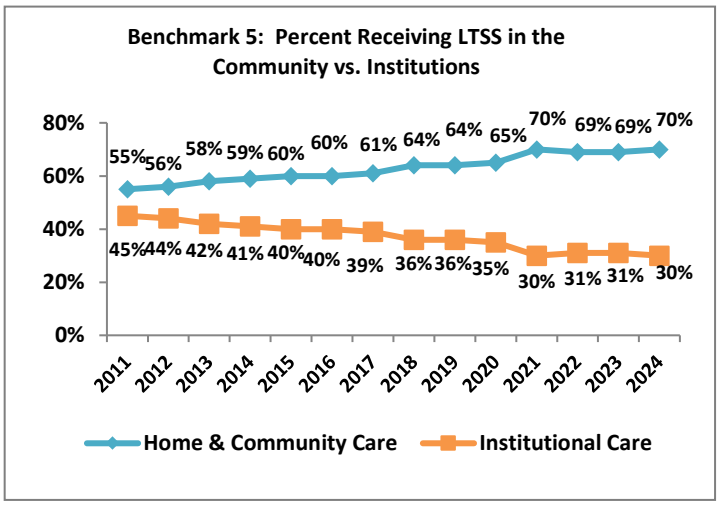
Demonstration = 7,923 (94%)

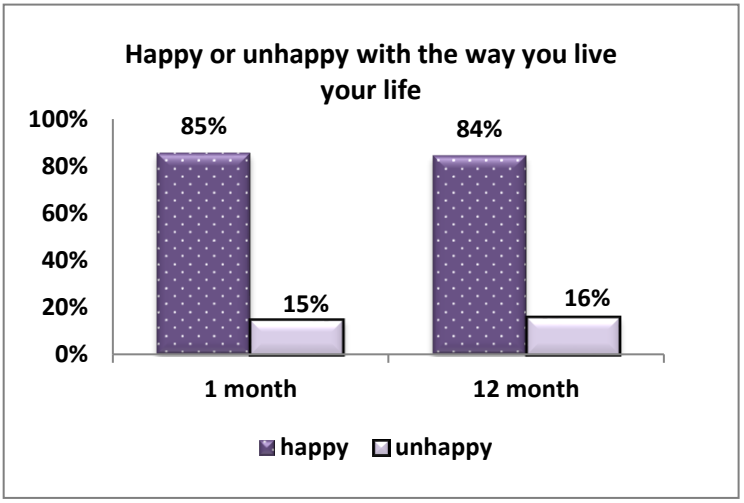
Non-demonstration = 549 (6%)











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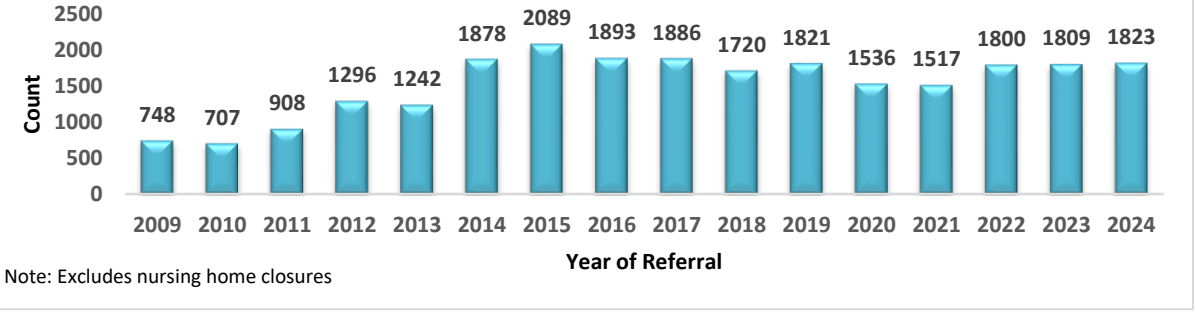
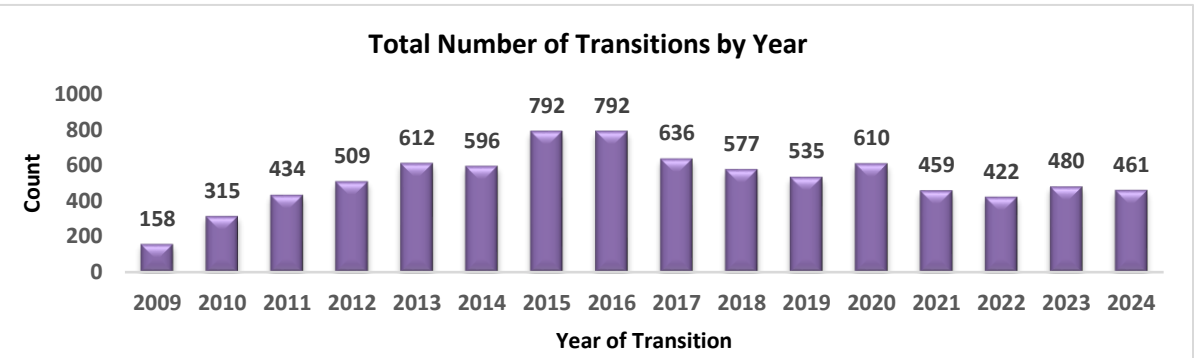
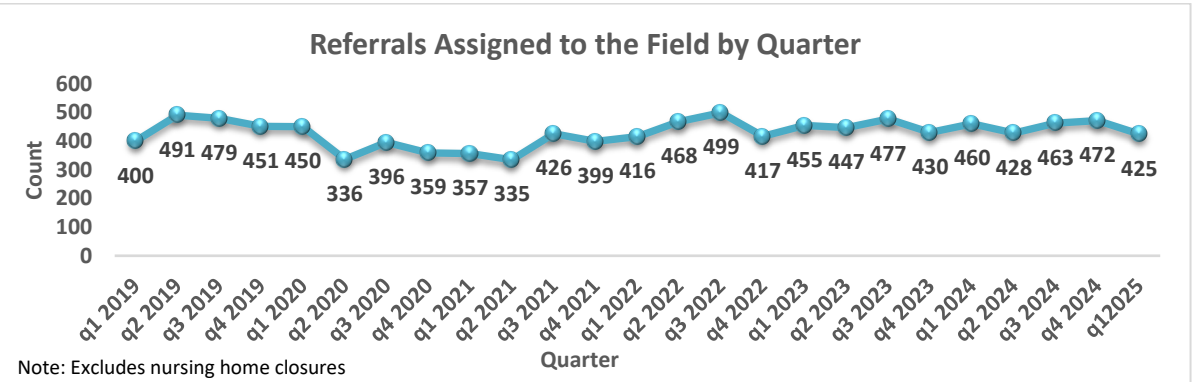


Note: Excludes nursing home closures





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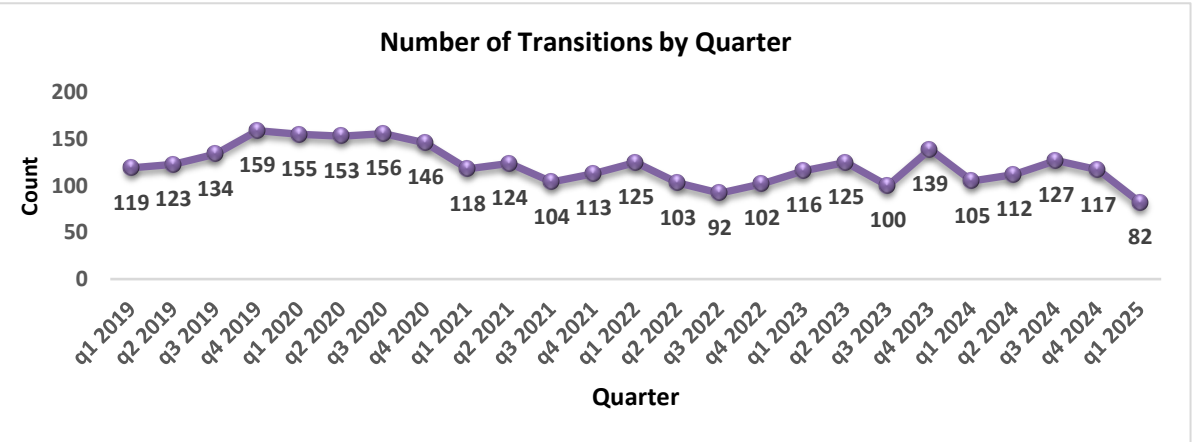

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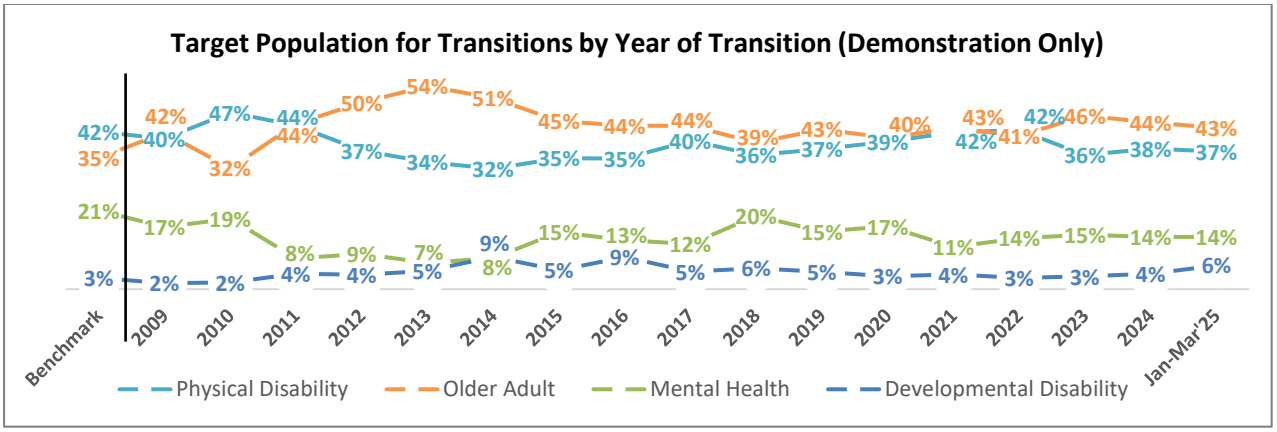

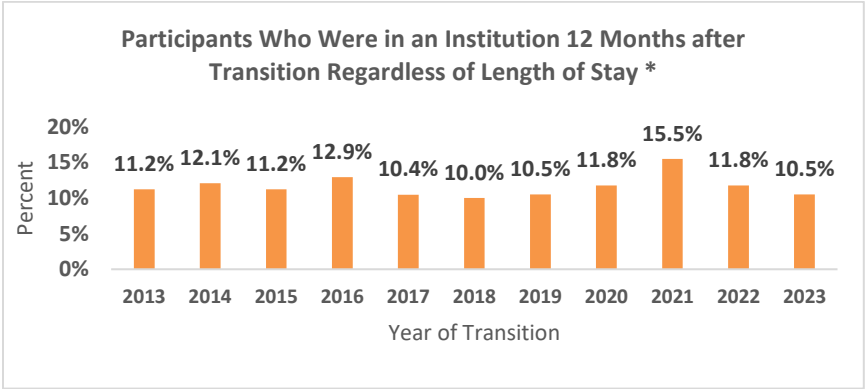

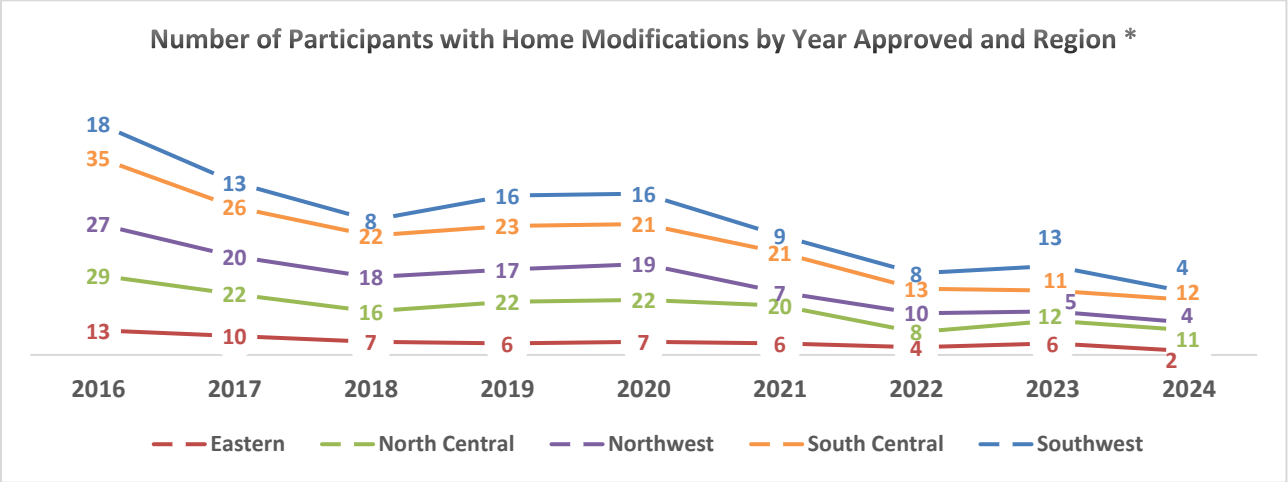

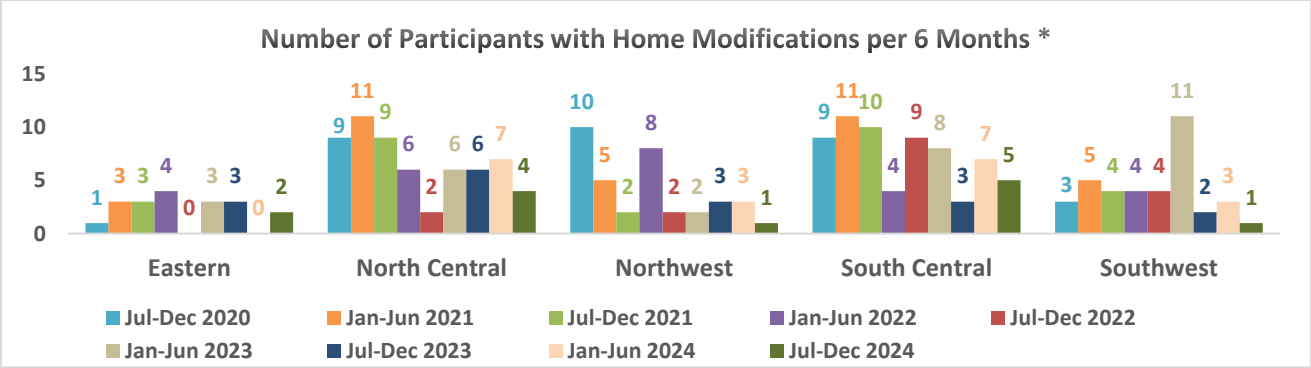

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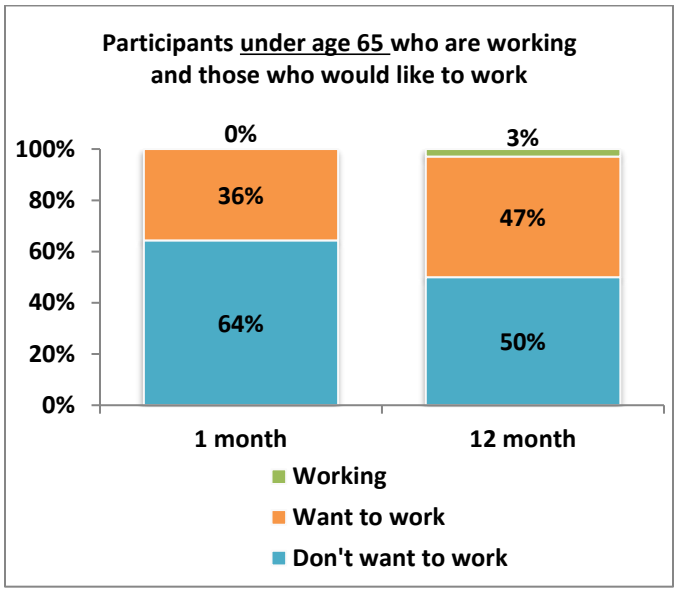
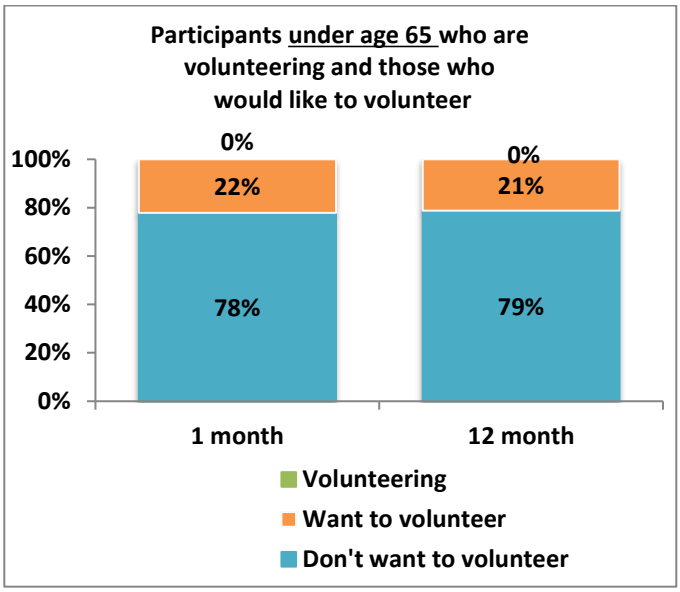
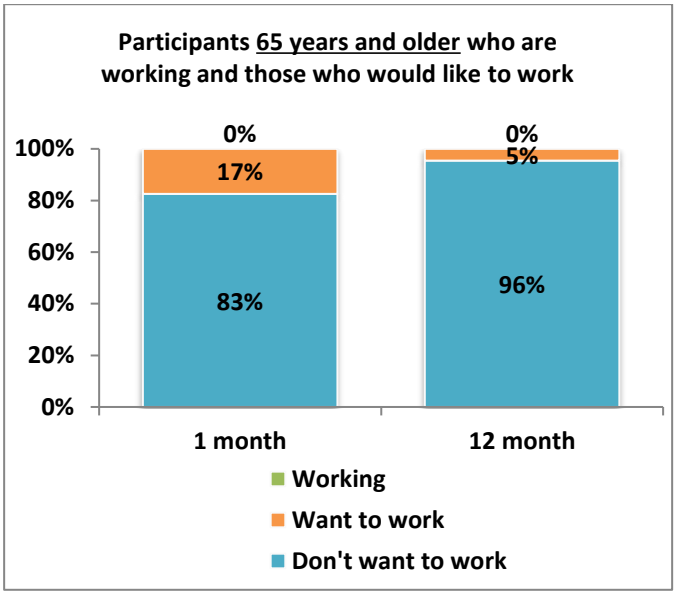
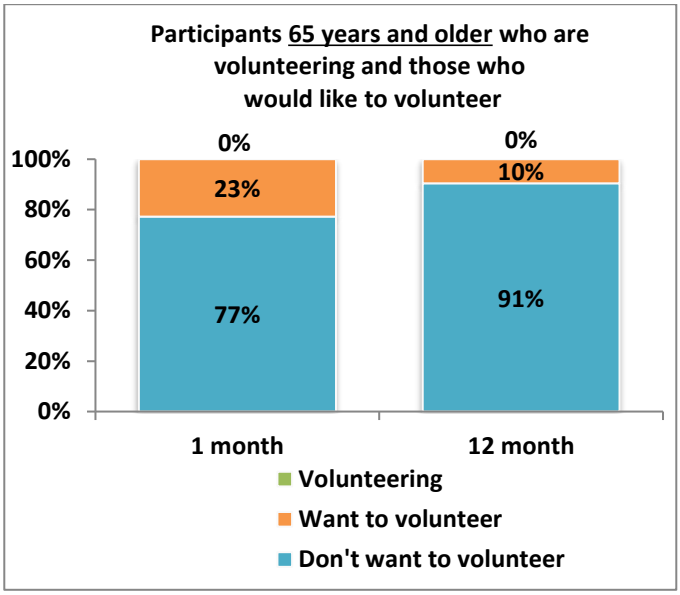
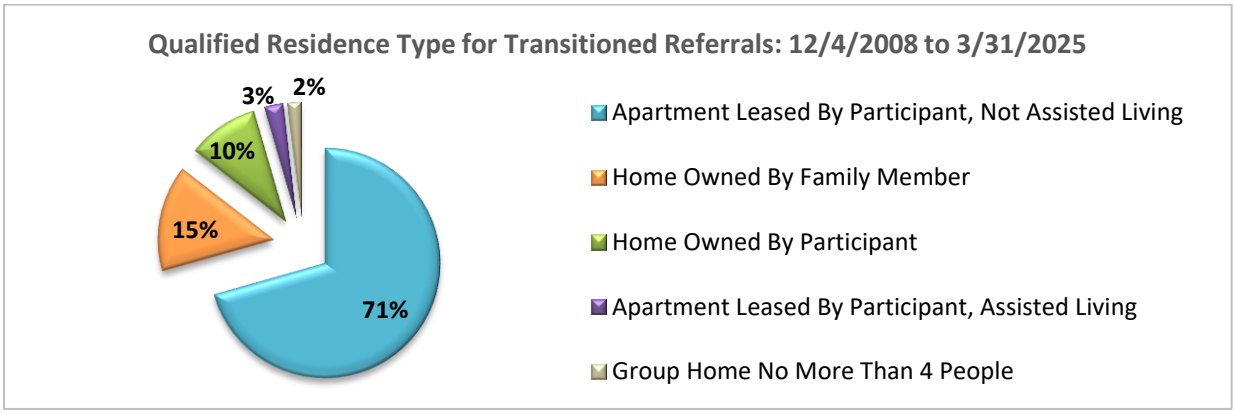
Participants who are Working and/or Volunteering (data 1/1/25-3/31/25)











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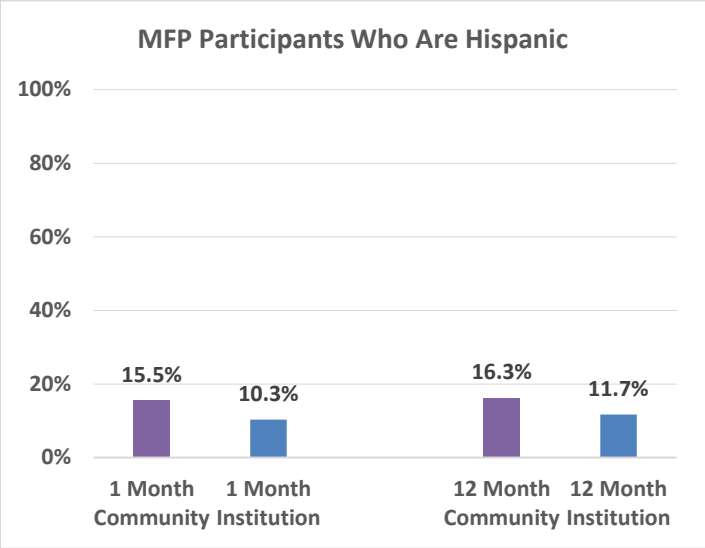
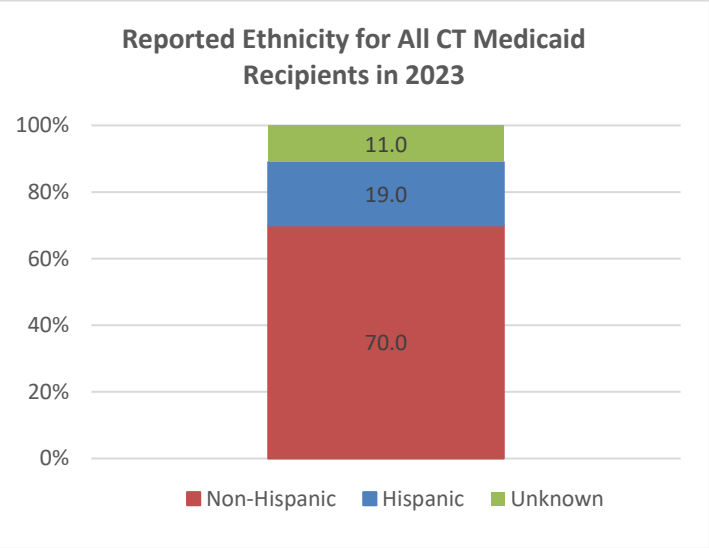
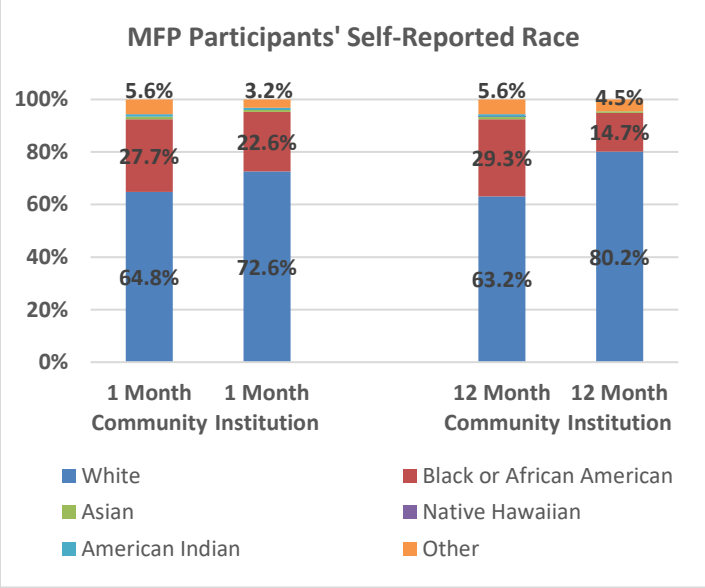
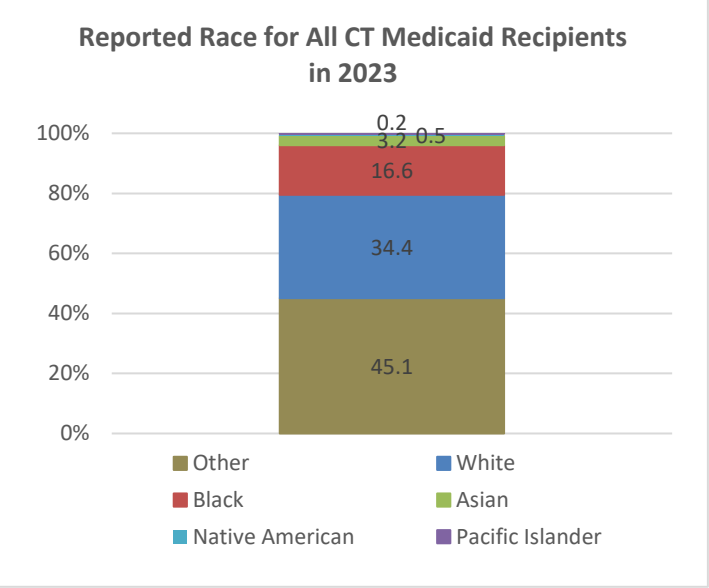
Race and Ethnicity for MFP Participants Transitioned 1/1/19 – 3/31/25 and for CT Medicaid Recipients in 2023

Note: MFP participant results are from responses to the HCBS CAHPS MFP Survey questions 87 and 89 at 1 and 12 month time points.









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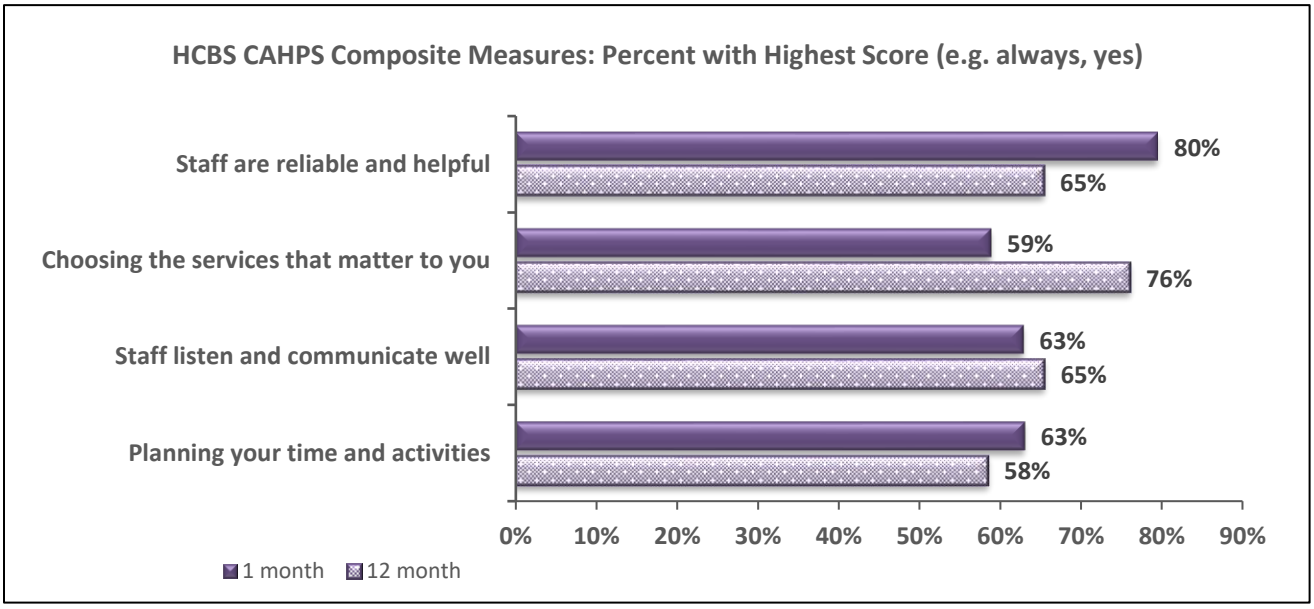
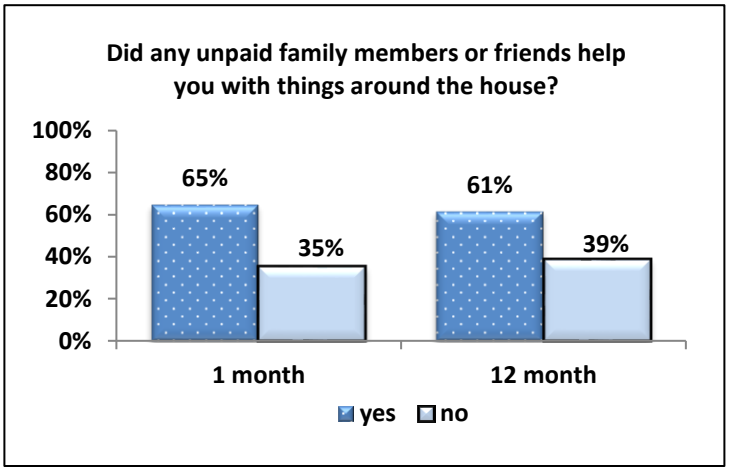
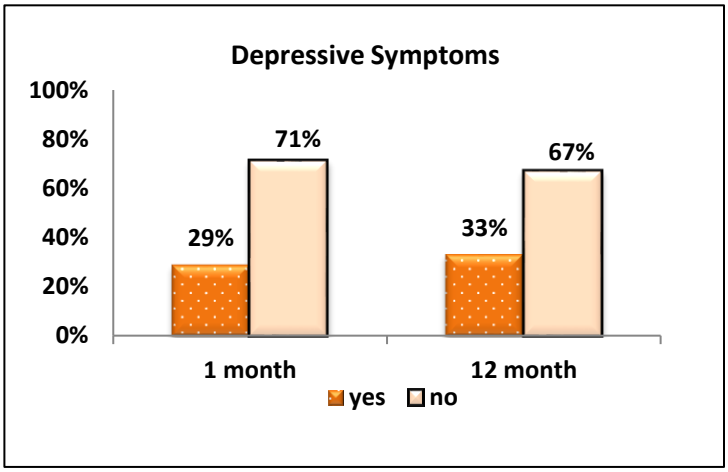
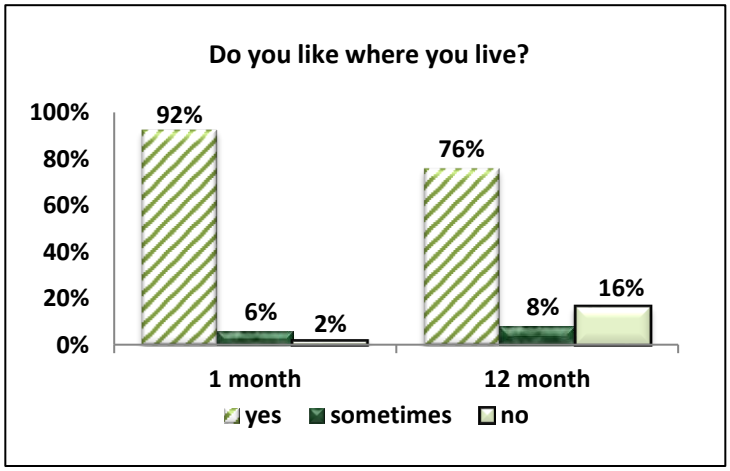
MFP Quality of Life Dashboard

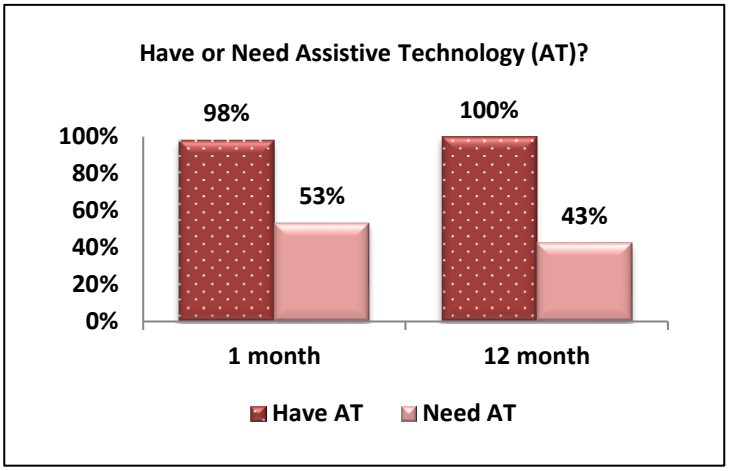
Number of Quality of Life Interviews Completed from 1/1/25 - 3/31/25 (n=116)
1 month interviews done 1 month after transition, **n=53**
12 month interviews done 12 months after transition, **n=63**











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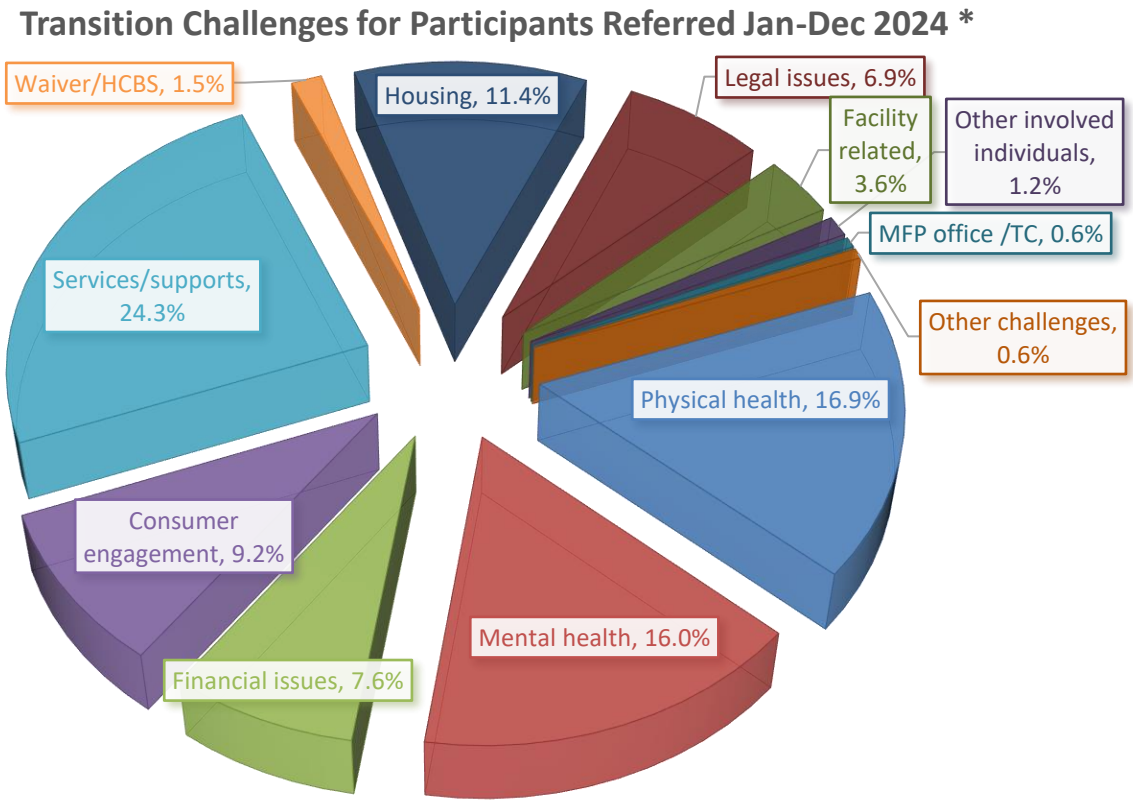
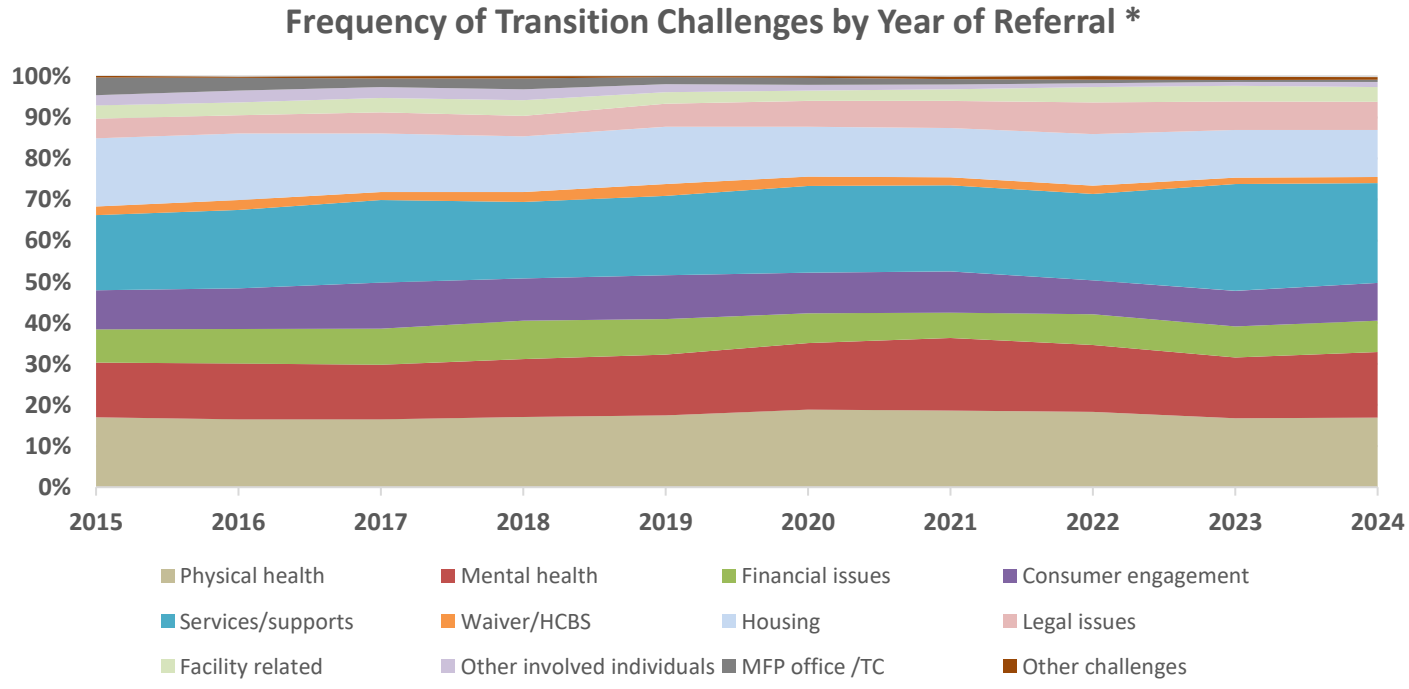
Challenges to Transition as Recorded by TCs and SCMs





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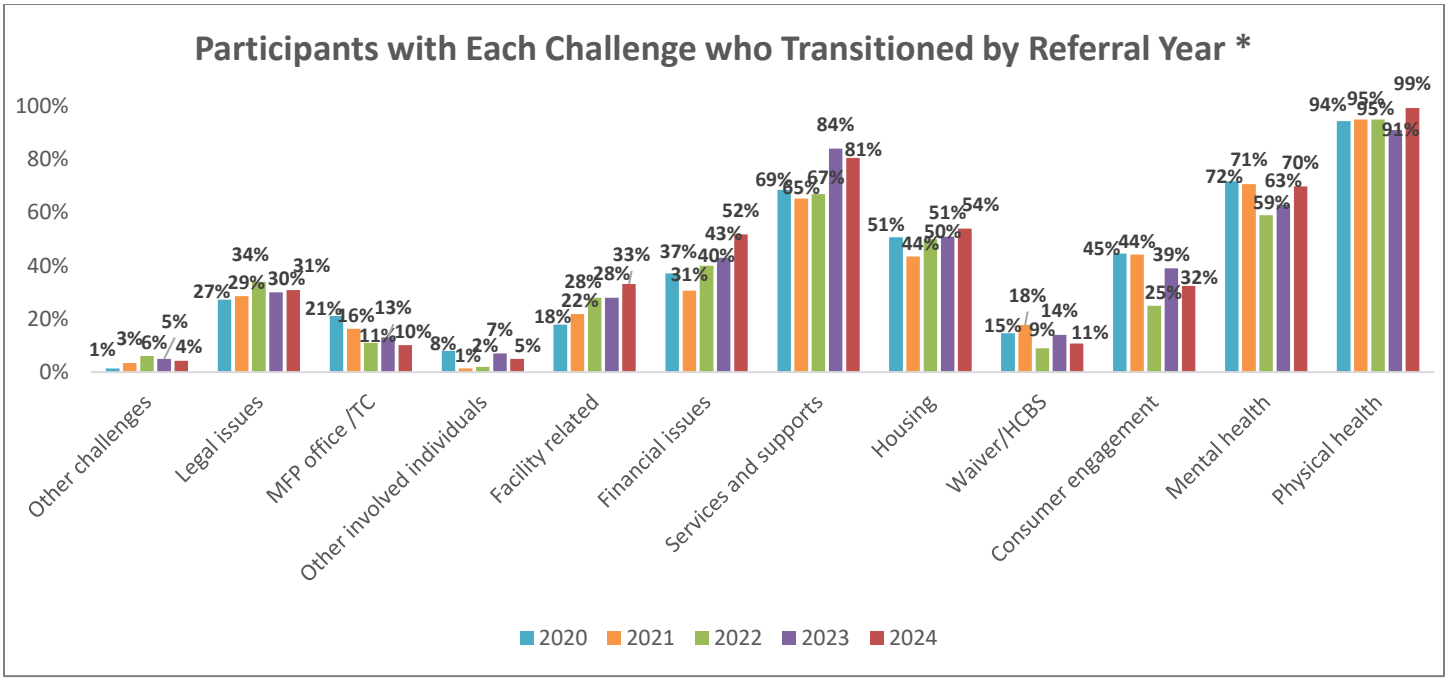
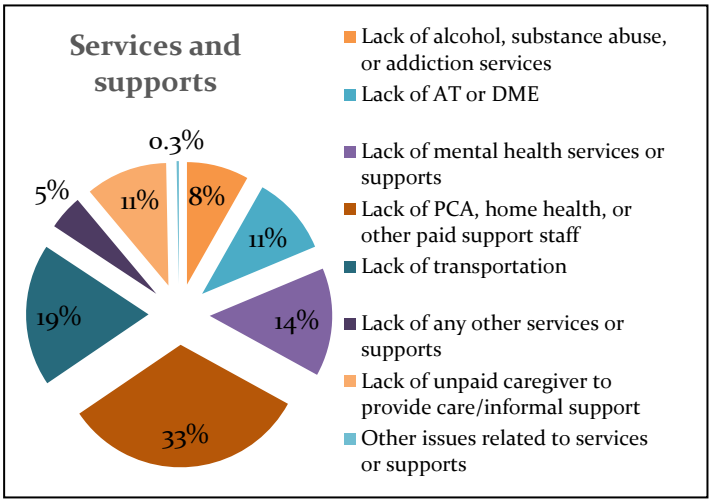
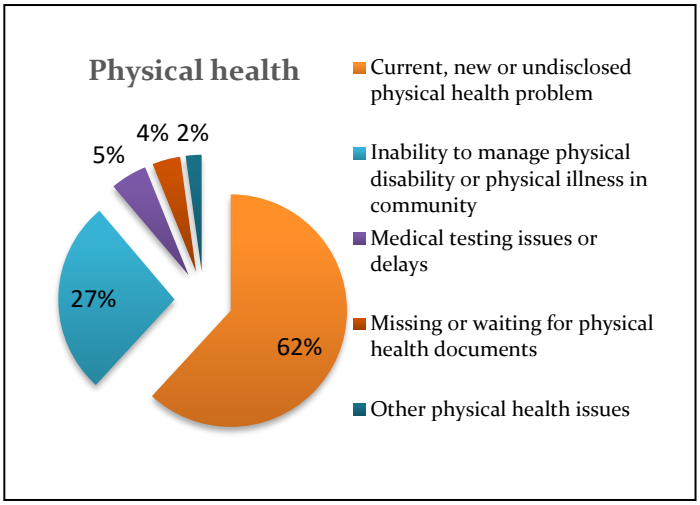
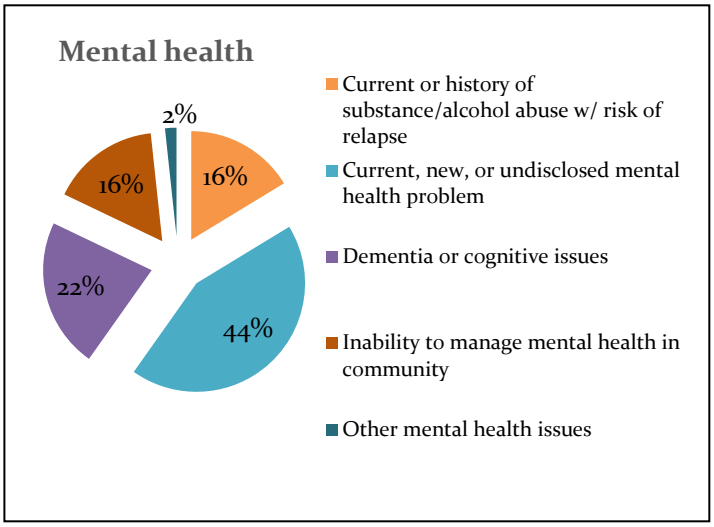


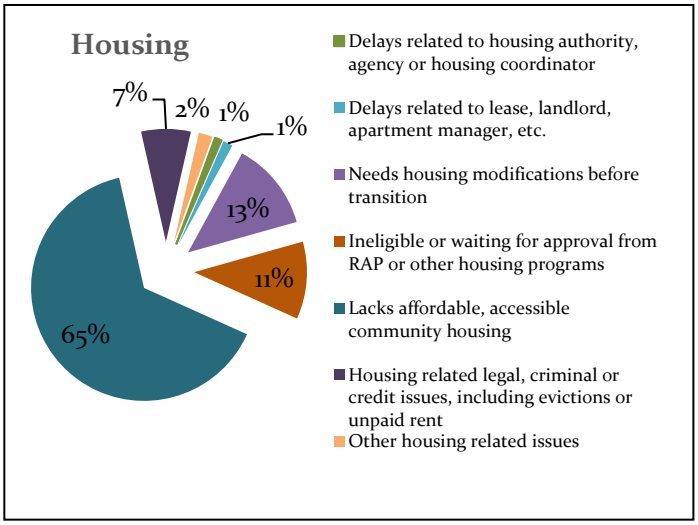
Types of Challenges for Referrals: 1/1/24 - 12/31/24 *

Below are the four most common challenge types for the current quarter









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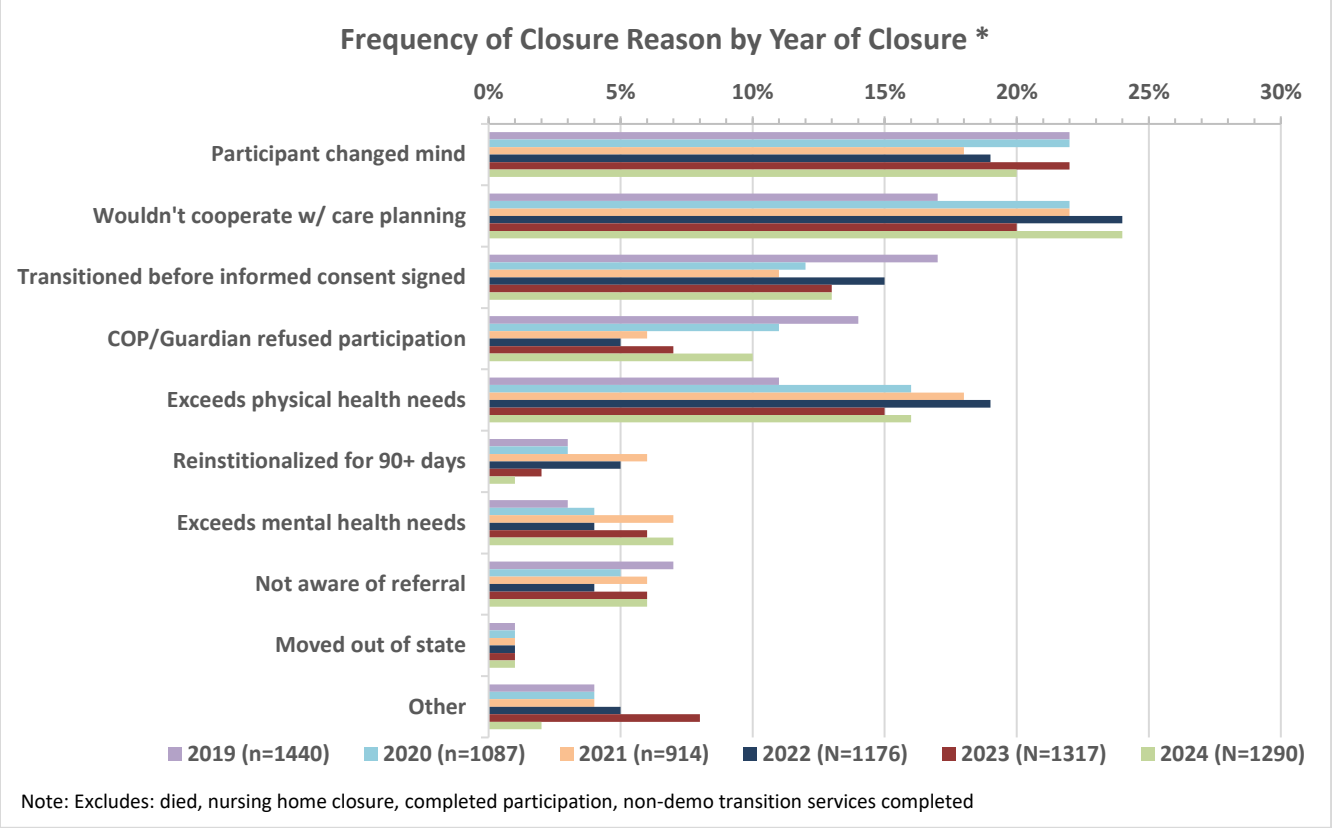
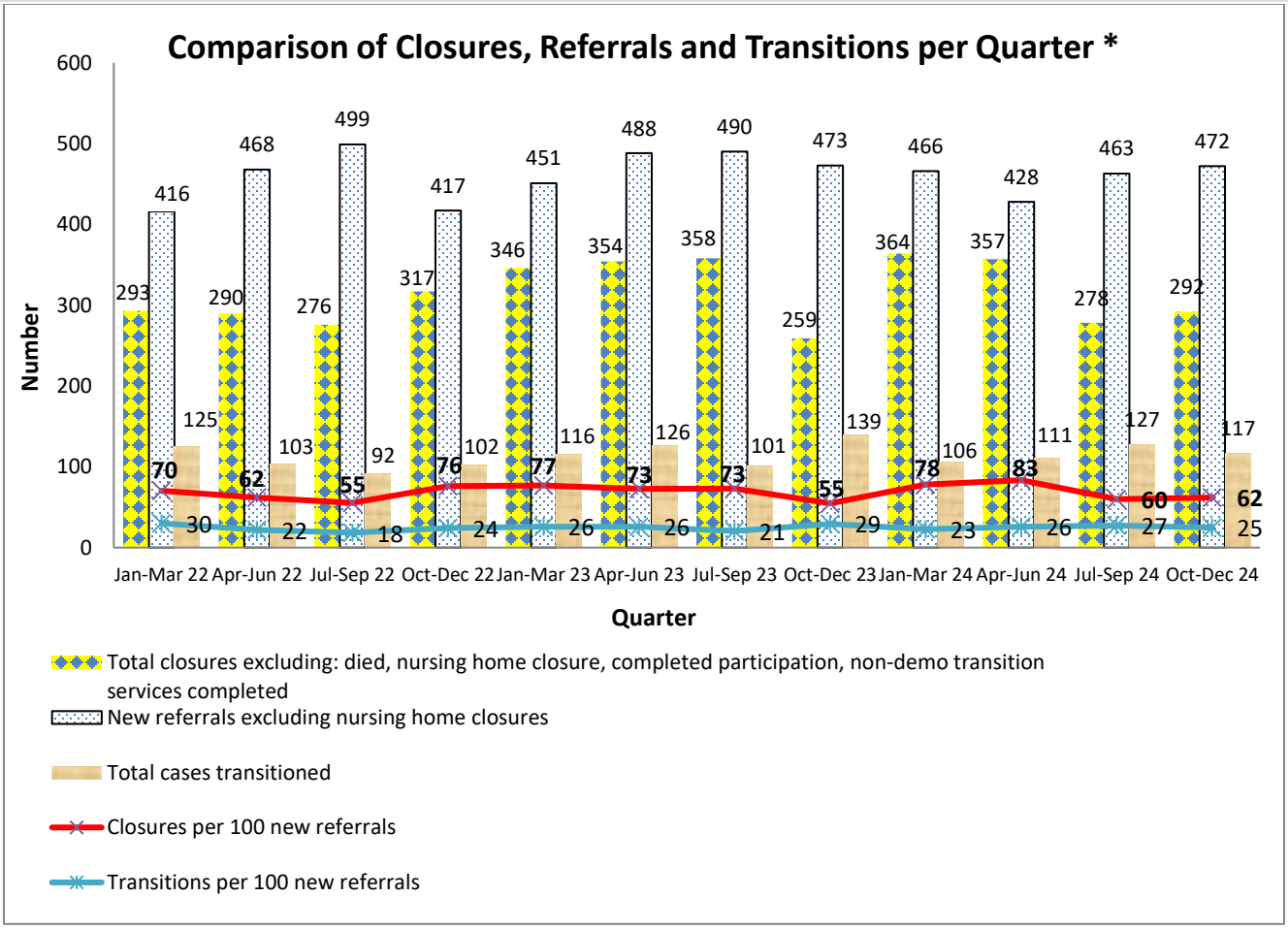


Note: Excludes: died, nursing home closure, completed participation, non-demo transition services completed



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Gary's Story

Photo Credit: Christine Bailey

Learning when to fight and when to let the little things go have been among Gary's greatest life lessons. His whole demeanor has changed from being angry and a worry wort most of the time to being more calm and accepting after surviving many losses. He owned his own business for 30 years and built his own home, but then came a divorce, the sale of the home, and a move with a new job which was going well, but ended abruptly when that business closed its doors. Starting over in a familiar town, renting a basement apartment from one of his sisters, he learned how to make surgical stents, which ironically would later be used to save his leg. When dizziness and falls occurred at work, he was let go on good terms hoping to return when his health improved. An emergency room visit and hospital stay in 2020 revealed his worsening symptoms were due to complications from COVID. His rehabiliation was not progressing due to his unsteady gait, falls, a wound on his foot, and a blood clot that went undiagnosed at the nursing home. He spent two weeks in the ICU and finally received great medical care that saved his leg from a life-threatening gangrene infection.

After almost three years in a nursing home, he gained 80 pounds from being overmedicated and in a wheelchair. He was told by the nursing home they did not have the staff to get him back on his feet and that he would never leave. Gary's reply, "We'll see about that!" Wanting to get moving and leave the nursing home, Gary advocated for himself by finding that he could receive physical therapy and transportation with the doctor's order at a nearby hospital. When the nursing home staff learned about this, they now agreed to provide PT. He experienced both fantastic, caring staff, like the nurses and aides on the day shift and the physical therapists, and terrible staff at other times. Little by little, he improved. A nursing home social worker referred him to Money Follows the Person (MFP). The MFP specialized care manager, transition coordinator and housing cooordinator worked with Gary to collect the necessary documents and find a new place to live. This took much longer than expected. When the housing coordinator showed him a photo of the apartment, he accepted and moved even though it was not easily accessible on a 2nd floor. He received the shower chair to help him transfer safely. MFP provided a bed, towels, and household supplies. A personal care assistant (PCA) would help him with housekeeping, shopping, carrying items, and safety.

There have been wonderful PCAs who have worked with Gary for years and some that stayed only days. He credits two PCAs with getting him stronger, walking with just a cane now. Gary did not leave the apartment the first year except for doctor's appointments. When one of those aide's dog had a litter of 4 puppies, he thought a puppy would be good company and give him a reason to get more exercise. Together, they go to the park and everyone is healthier and happier. Gary has learned to accept the assistance he needs with gait and balance issues, but he says, "I feel great!" His primary care doctor reduced his medications from 17 to 4. He bought himself a car and is now able to drive, regaining independence. He also does his own cooking. Gary's goals are to move closer to friends and family and return to the VFW/American Legion where he was involved as an auxiliary member. He is looking into finding senior housing and hopes to live in a quiet first floor apartment with his dog, not sweating the small stuff.

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 grantee 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.

* = Not updated for Q1 2025