CT Money Follows the Person Quarterly Report

Quarter 1, 2012: January 1, 2012 – March 31, 2012

University of Connecticut Health Center

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

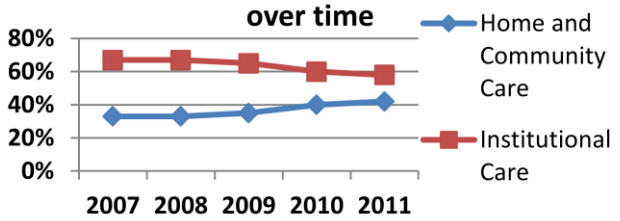
MFP Benchmarks

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 = 910 (non-demonstration transitions = 120)

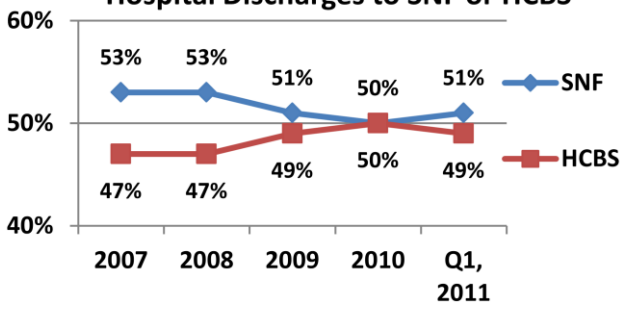
Benchmark 2

Proportion of CT Medicaid Expenditures for Long-Term Care over time



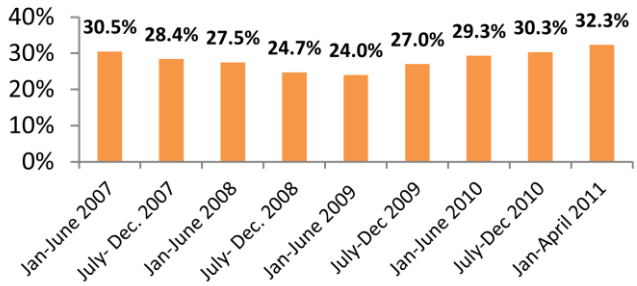
Benchmark 3

Percentage Share of Acute Care Hospital Discharges to SNF or HCBS



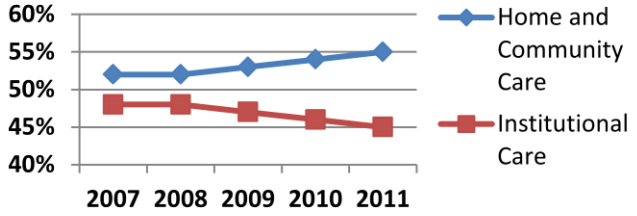
Benchmark 4

% Admissions not in a Nursing Home or Hospital after 6 months

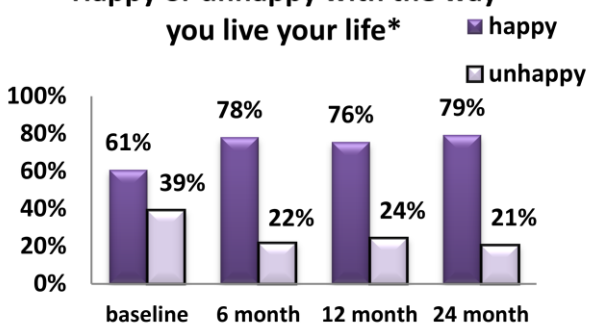


Benchmark 5

Proportion of CT Medicaid Long-Term Care Clients over time



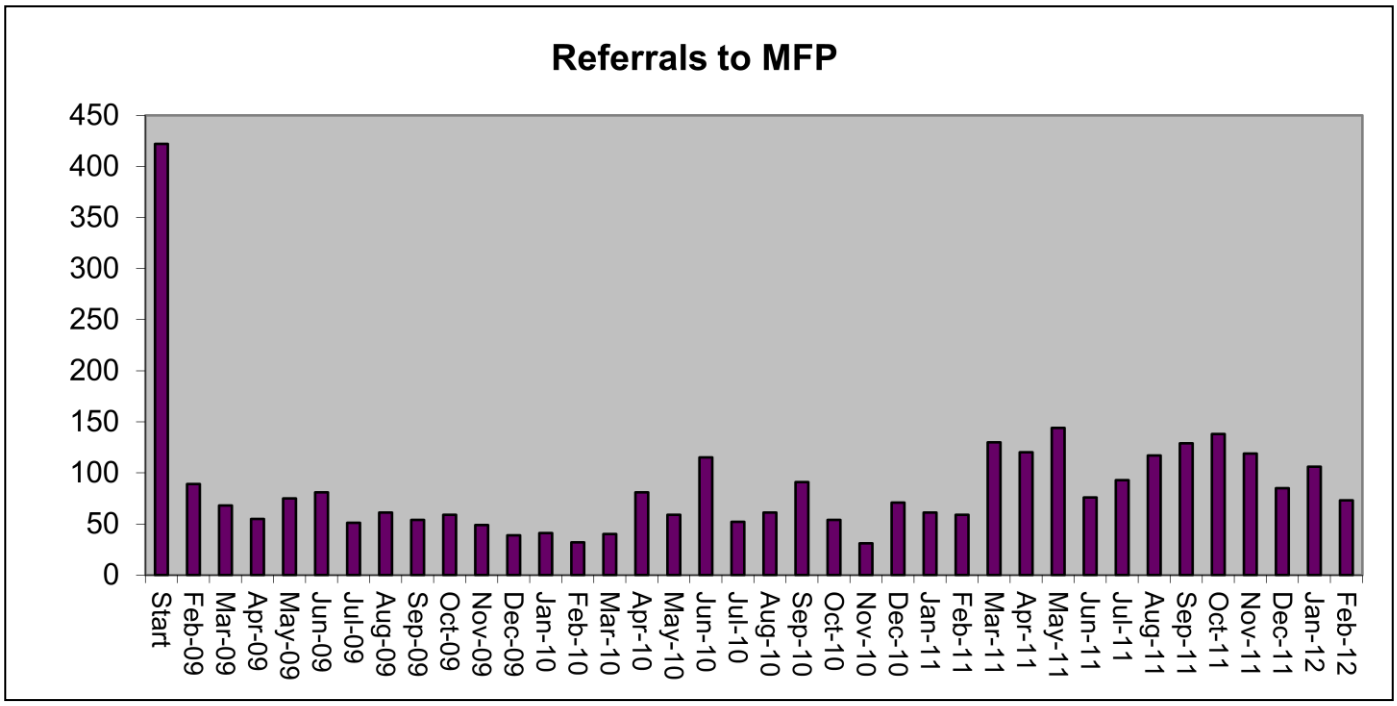
Happy or unhappy with the way you live your life*



Permanent Re-institutionalization – 86 participants (9.5% of all demonstration transitions)

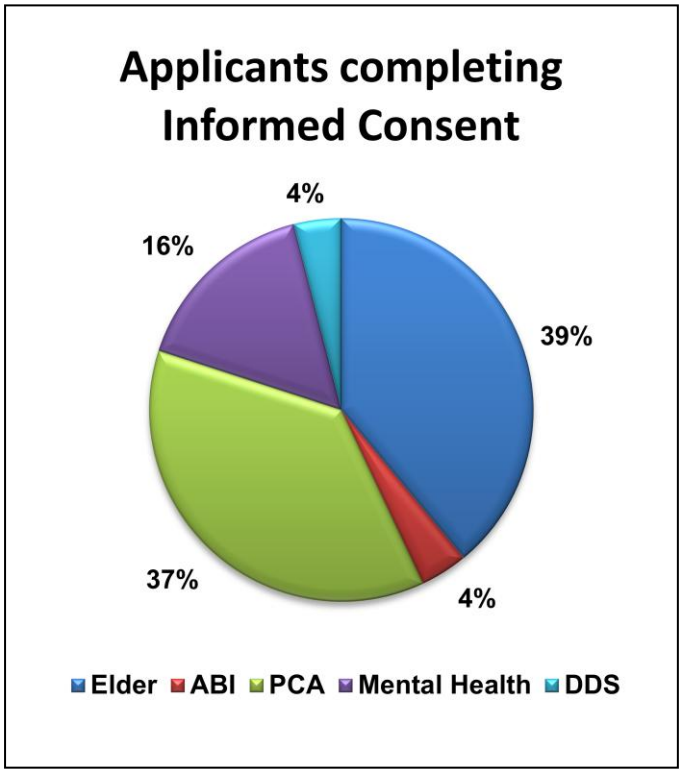
Referrals to MFP

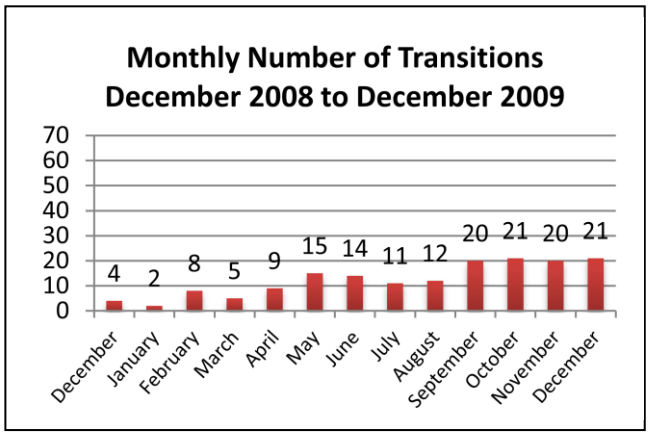
A total of 3281 applications were received by the CT Department of Social Services through the end of February 2012 representing approximately 17% of the total eligible institutionalized population. Demand for MFP services continues to grow. Applications came from 204 skilled nursing homes and other institutions across the state. Demand for MFP services exceeded initial estimates; therefore outreach activities were postponed. The most frequent source of referrals for MFP services came from family members, social workers and Ombudsmen.

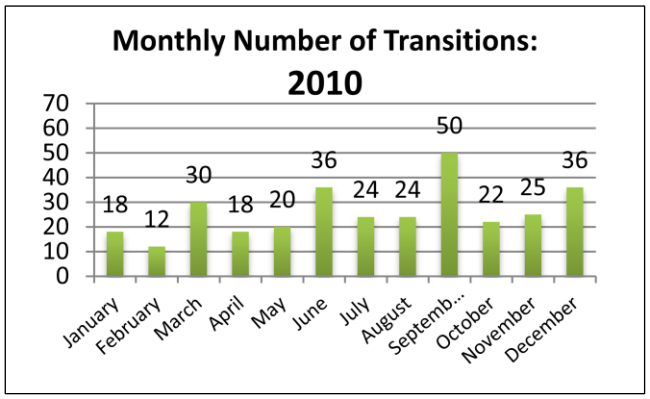


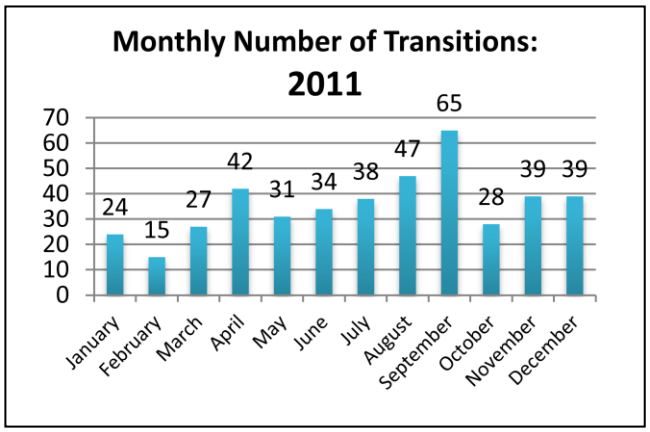
Applicants Completing Informed Consent

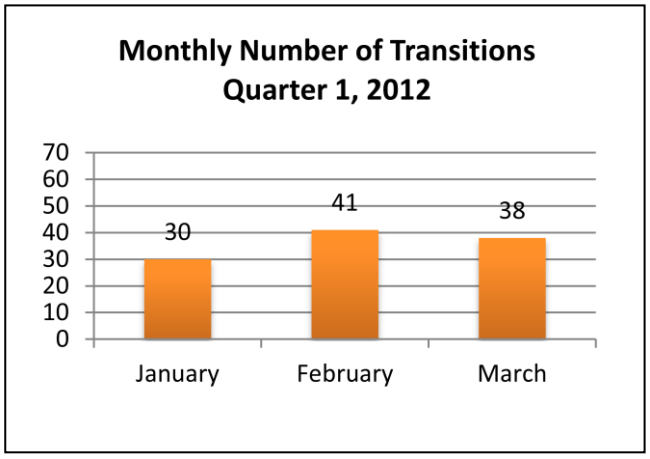
Of the 3281 applications received by the Department of Social Services, 2302 were screened, assigned to the field for completion of the intake process and signed an informed consent. The screening process includes verification of the Medicaid eligibility, verification of income, verification of length of stay in the institution, verification of citizenship documentation and documentation of applicant's institutional cost. The cost of institutional placement becomes the individual cost cap for community MFP services. A visit with the nursing home resident occurs within two weeks of referral. During the first few visits the intake process is completed. The intake process includes completion of a functional and self assessment, completion of application for MFP community services, and completion of informed consent to participate in the MFP demonstration. The chart to the right shows the distribution of the 2302 applicants targeted to each of 5 general community service packages.



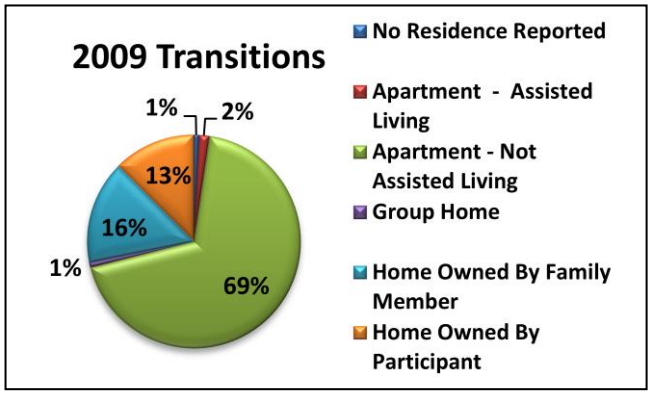


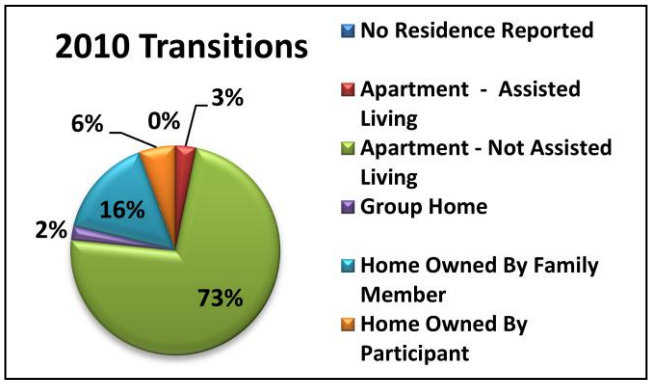


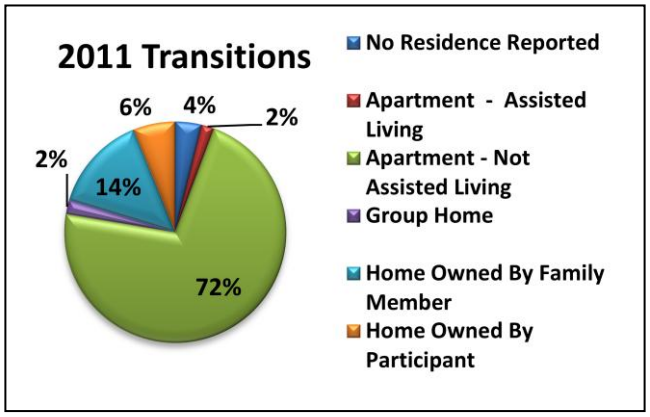


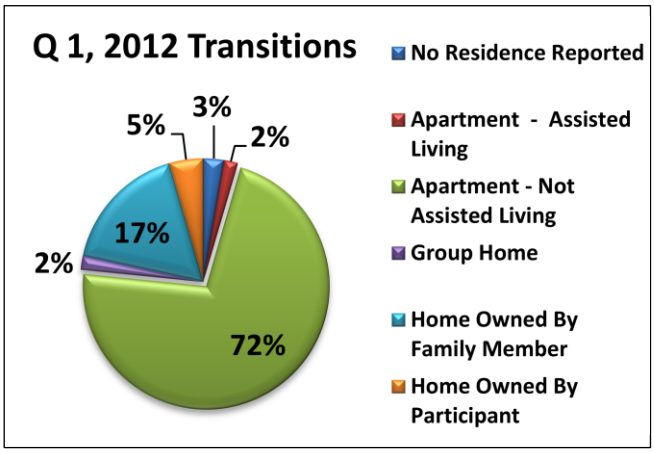


Qualified Residence Type

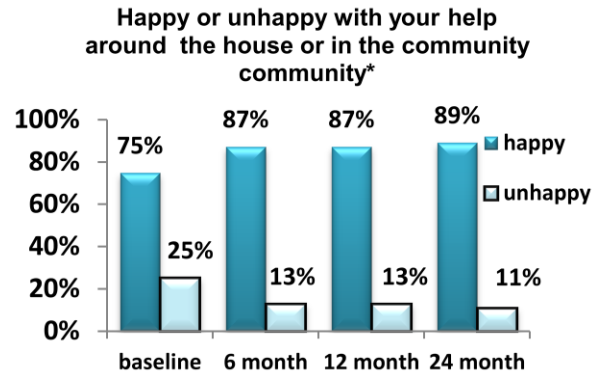


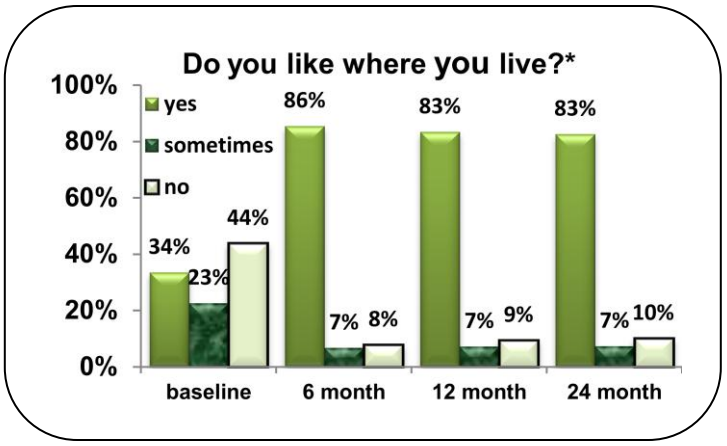


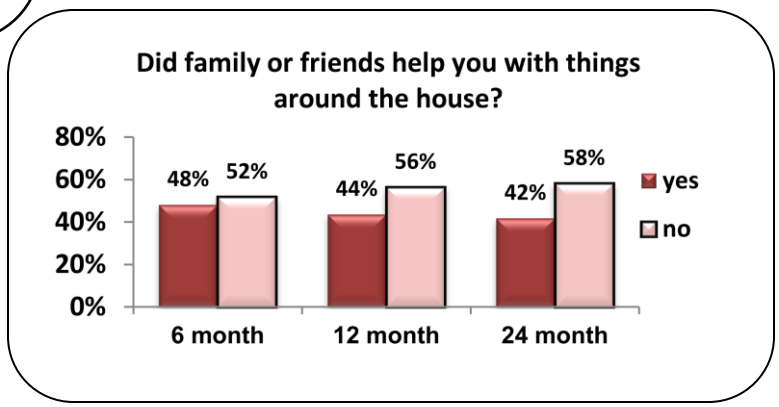


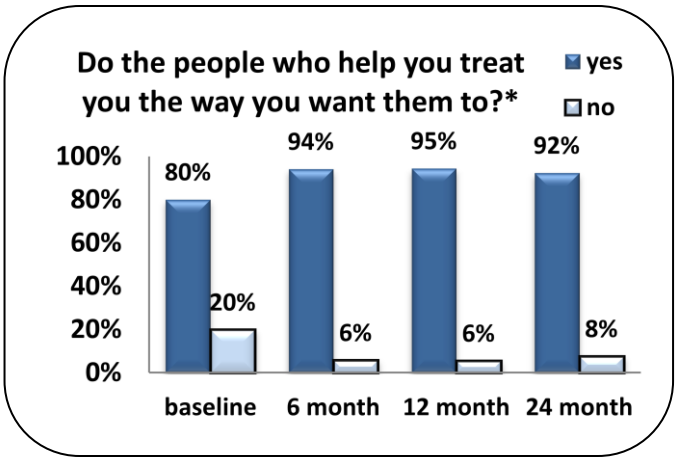


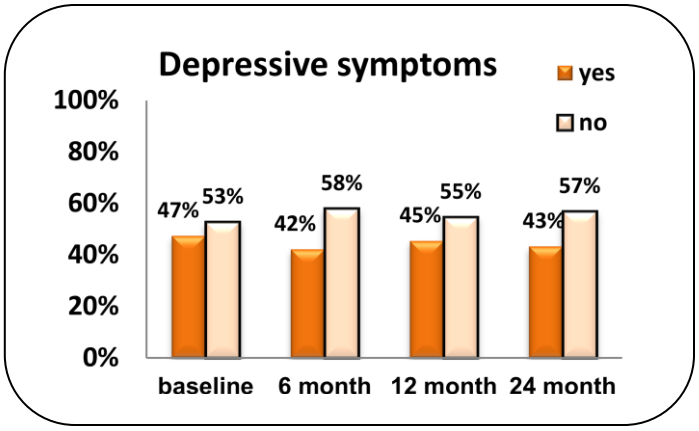
MFP Quality of Life Dashboard As of 03/31/2012

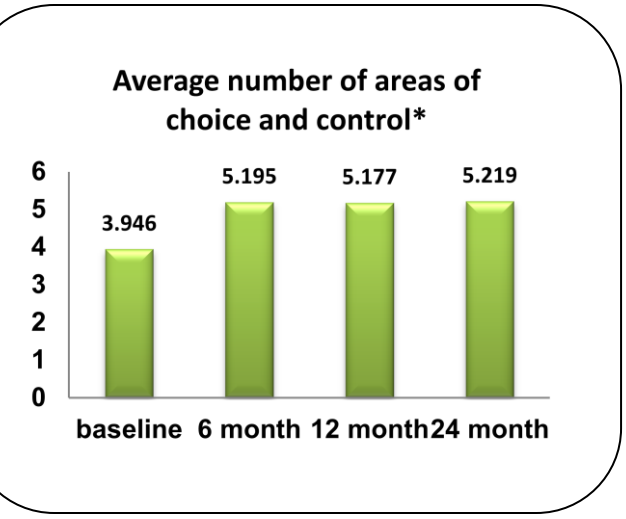


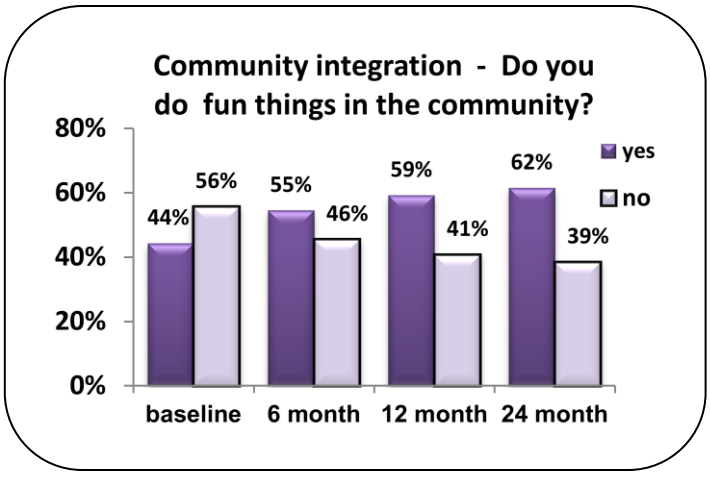












*indicates statistically significant differences

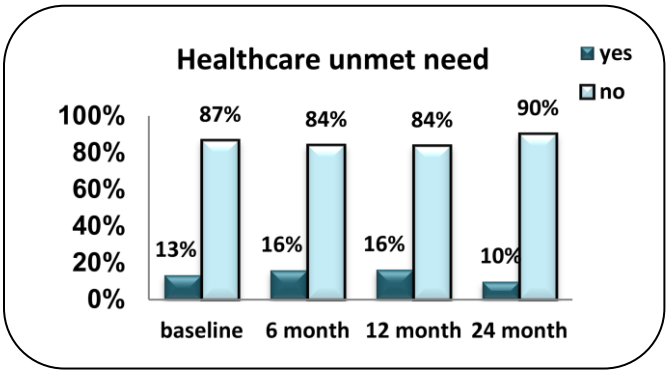
Cumulative data through 3/31/12

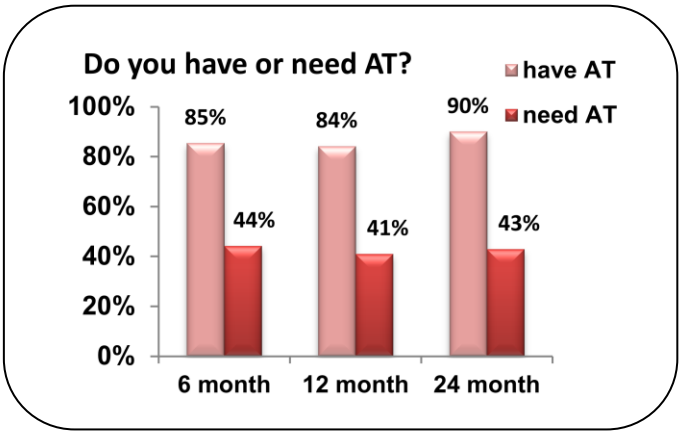
Baseline interview is done prior to transition; n=1055

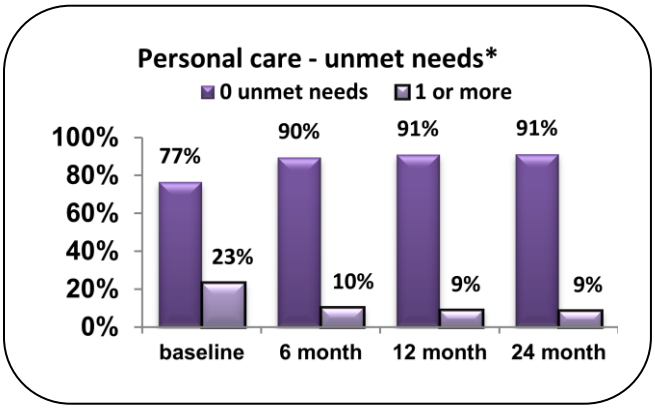
6 month interview is done 6 months after transition; n=709

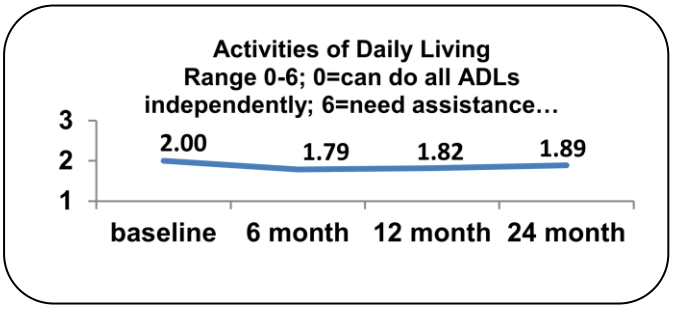
12 month interview is done 12 months after transition; n=494

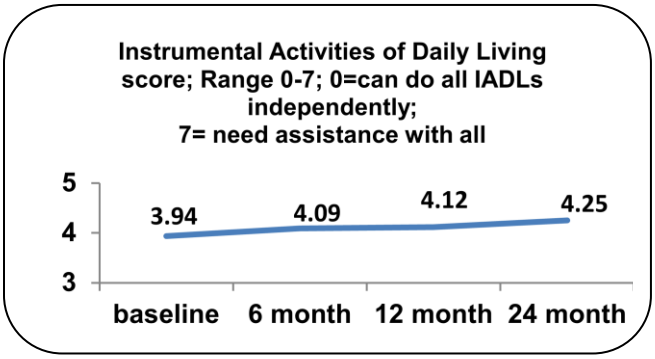
24 month interview is done 24 months after transition; n=178

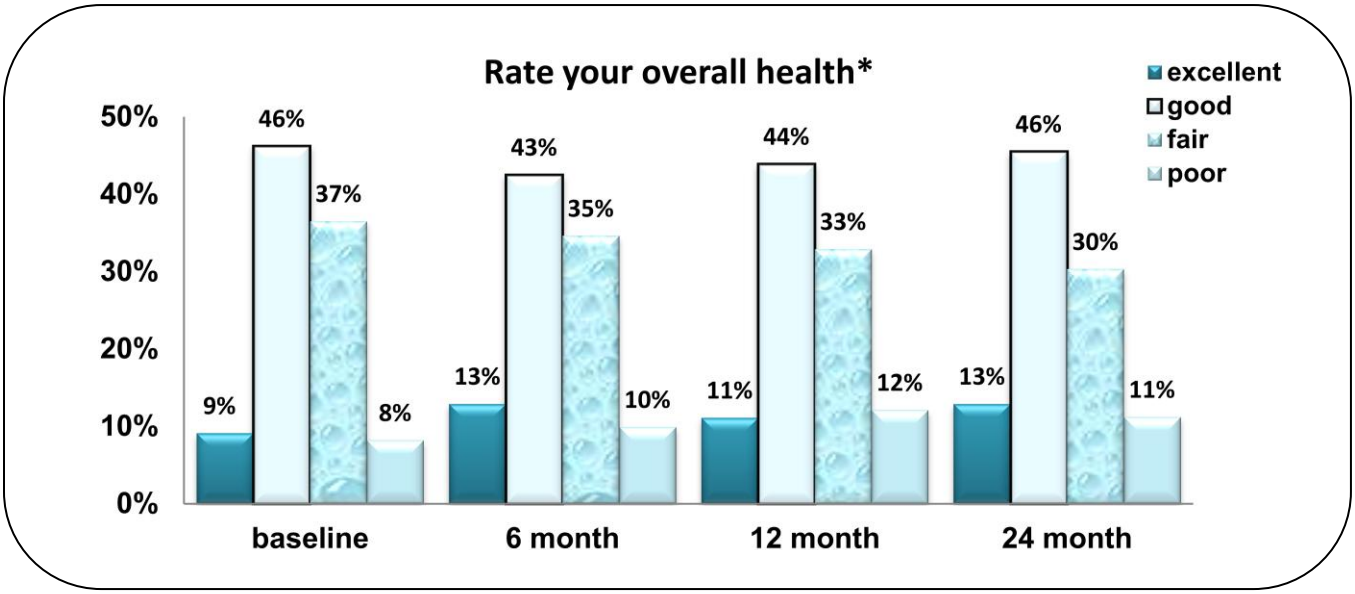












Hospital Discharges for LTSS to Institutions vs. Community, by Hospital (Benchmark 3)

	Percentage Share of Acute Care Hospital Discharges to Skilled Nursing Facility/Intermediate Care Facility								Percentage Share of Acute Care Hospital Discharges to Home Health Services							
Acute Care Hospitals	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	[3]CY 2011q1	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	[3]CY 2011 q1
Bradley Memorial[2]	59%	59%	63%	-	-	-	-	-	41%	41%	37%	-	-	-	-	-
Bridgeport	54%	49%	47%	48%	48%	48%	47%	46%	46%	51%	53%	52%	52%	52%	53%	54%
Bristol	52%	55%	58%	57%	57%	55%	57%	63%	48%	45%	42%	43%	43%	45%	43%	37%
Charlotte Hungerford	50%	55%	55%	56%	45%	45%	43%	43%	50%	45%	45%	44%	55%	55%	57%	57%
CT Children's	3%	4%	12%	5%	9%	13%	8%	-	97%	96%	88%	95%	91%	88%	92%	-
Danbury	53%	52%	53%	54%	55%	54%	52%	49%	47%	48%	47%	46%	45%	46%	48%	51%
Day Kimball	51%	54%	56%	55%	52%	50%	52%	54%	49%	46%	44%	45%	48%	50%	48%	46%
Greenwich	61%	61%	49%	46%	53%	53%	54%	57%	39%	39%	51%	54%	47%	47%	46%	43%
Griffin	59%	64%	63%	63%	56%	56%	53%	57%	41%	36%	37%	37%	44%	44%	47%	43%
Hartford	49%	51%	51%	51%	52%	53%	53%	54%	51%	49%	49%	49%	48%	47%	47%	46%
Hospital of Central CT[2]	56%	59%	59%	61%	59%	61%	60%	61%	44%	41%	41%	39%	41%	39%	40%	39%
John Dempsey	47%	49%	49%	49%	49%	47%	44%	48%	53%	51%	51%	51%	51%	53%	56%	52%
Johnson Memorial	61%	62%	66%	63%	60%	56%	60%	50%	39%	38%	34%	37%	40%	44%	40%	50%
Lawrence & Memorial	47%	51%	53%	58%	56%	53%	53%	55%	53%	49%	47%	42%	44%	47%	47%	45%
Manchester Memorial	52%	52%	54%	58%	54%	51%	39%	43%	48%	48%	46%	42%	46%	49%	61%	57%
Middlesex Memorial	59%	60%	56%	59%	62%	55%	56%	58%	41%	40%	44%	41%	38%	45%	44%	42%
MidState Medical	65%	64%	65%	64%	66%	66%	61%	65%	35%	36%	35%	36%	34%	34%	39%	35%
Milford	64%	66%	68%	69%	61%	59%	53%	49%	36%	34%	32%	31%	39%	41%	47%	51%
New Milford	67%	61%	63%	61%	61%	60%	58%	62%	33%	39%	37%	39%	39%	40%	42%	38%
Norwalk	54%	54%	55%	55%	54%	56%	58%	57%	46%	46%	45%	45%	46%	44%	42%	43%
Rockville General	54%	56%	55%	61%	59%	59%	44%	50%	46%	44%	45%	39%	41%	41%	56%	50%
Saint Francis	53%	56%	56%	55%	45%	41%	42%	44%	47%	44%	44%	45%	55%	59%	58%	56%
Saint Mary's	58%	55%	55%	53%	51%	52%	50%	57%	42%	45%	45%	47%	49%	48%	50%	43%
Saint Raphael	51%	50%	50%	51%	53%	50%	50%	53%	49%	50%	50%	49%	47%	50%	50%	47%
Saint Vincent's	52%	54%	53%	56%	58%	53%	55%	55%	48%	46%	47%	44%	42%	47%	45%	45%
Sharon	68%	72%	75%	78%	82%	83%	86%	83%	32%	28%	25%	22%	18%	17%	14%	17%
Stamford	55%	61%	66%	72%	60%	60%	57%	52%	45%	39%	34%	28%	40%	40%	43%	48%
Waterbury	53%	51%	49%	50%	47%	48%	49%	44%	47%	49%	51%	50%	53%	52%	51%	56%
William W. Backus	54%	52%	57%	54%	53%	50%	49%	56%	46%	48%	43%	46%	47%	50%	51%	44%
Windham Community	54%	52%	53%	52%	51%	48%	46%	50%	46%	48%	47%	48%	49%	52%	54%	50%
Yale-New Haven	40%	42%	39%	38%	40%	38%	39%	37%	60%	58%	61%	62%	60%	62%	61%	63%
Statewide	52%	53%	53%	53%	53%	51%	50%	51%	48%	47%	47%	47%	47%	49%	50%	49%

Source: CT Office of Health Care Access Acute Care Inpatient Discharge Database

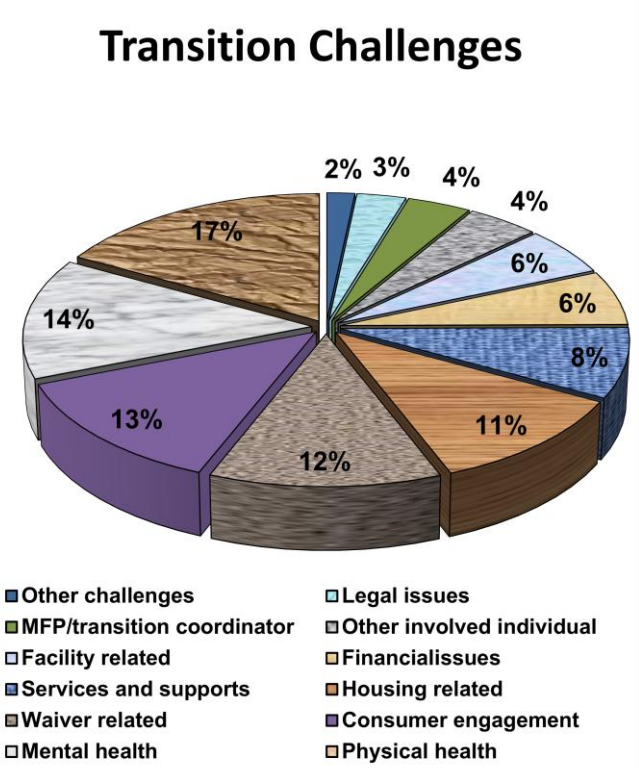
Transition Challenges through 3/31/12

Transition coordinators complete a standardized challenges checklist for each consumer. The consumer's challenges to transition are recorded up until the consumer transitions, or if not transitioning, until the consumer's case is closed. The data reported here is cumulative and reflects a combination of demonstration and non-demonstration consumers.

There were a total of 2641 MFP referrals which either closed without transitioning (includes recommend closure) (61%; n=1611) or transitioned (39%; n=1030) by 3/31/12.

Of the 2641 referrals, 349 referrals (13%) did not have a completed challenges checklist. Data from the remaining 87% (n=2292) are reported here. Of these, 59% (n=1347) did not transition, while 41% (n=945) did.

Comparisons of type of challenge by transition status and disability types are examined. The categories are not mutually exclusive; referrals can experience multiple types of challenges.

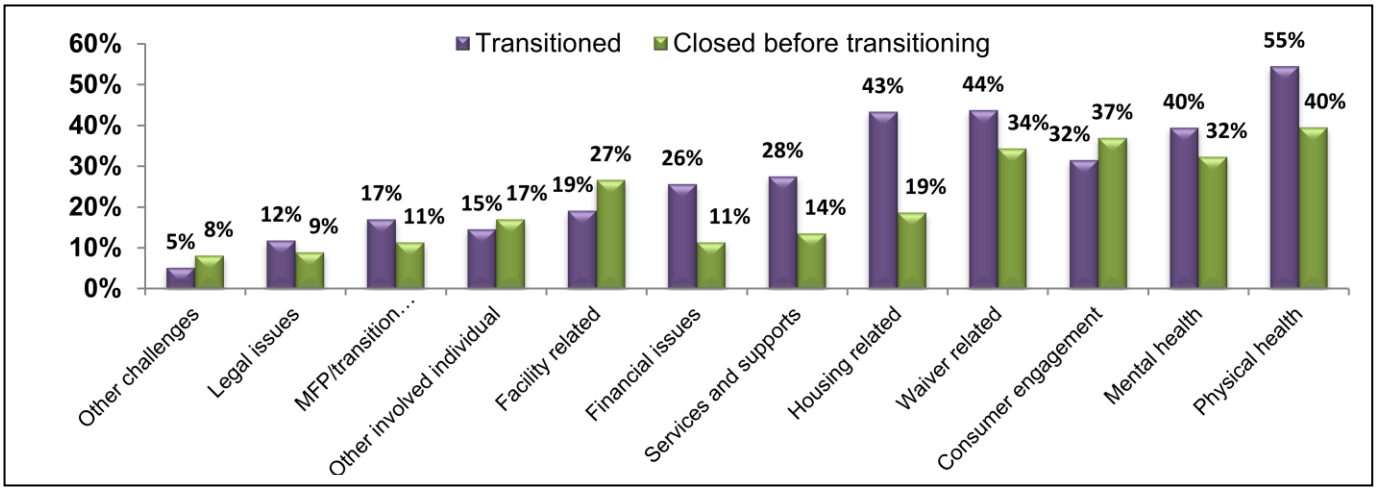


Type of challenge by transition status

The figure below shows the percentage of each group (those closed before transitioning and those who transitioned) which indicated presence of the challenge listed. For example, of the referrals which closed without transitioning, 40 percent indicated physical health was a challenge.

Almost all (n=11) of the twelve listed challenges showed statistically significant differences between the two groups.

A significantly greater percentage of referrals that closed without transitioning had challenges related to consumer engagement, awareness, and skills; the facility; and "other" challenges. Although those who already transitioned faced significantly greater issues related to physical health, waiver program, housing, mental health, community services and supports, financial issues, the MFP Central Office or transition coordinator, and legal concerns, these challenges did not prevent these consumers from transitioning.



MFP Year 3 Process Evaluation

Each year researchers from the UConn Health Center, Center on Aging complete a process evaluation of CT's MFP program. Researchers interview people who work on different parts of the program – such as the Program Director, Steering Committee and workgroup members, transition coordinators and members of their transition teams, and various contractors. The evaluation examines program structure and process, strengths and weaknesses, communication, and changes in CT's provision of long term supports and services. Some interviewees commented on the personal gratification from being part of the program and seeing it make a difference in people's lives:

> *"Every person has the right to live at home. And services such as the PCA per diem program have made this more possible. MFP is an absolute blessing. The client is happier, and even family members would more likely want to visit their family member in a home setting as opposed to visiting them in a nursing home."*

> *"I'm proud to be part of this program and look forward to continuing to make progress in helping people live in the community."*

CT's MFP program noticeably changed and grew in the third year, including:

- The program continues to grow and meet the needs of individuals who desire to live in the community. That consumers are now asked periodically, "Where would you like to live?" is the first step towards offering the benefits of MFP to every single resident of a nursing home, a truly person-centered decision.
- The MFP program initiated the informed risk policy, enlisting the support of the Department of Public Health and reaching out to community providers.
- CT became the first state to be funded for rightsizing in this year. This funding is in part targeted to support nursing homes as they shift their focus beyond providing long-term, chronic care.
- More and more individuals continue to successfully transition from nursing homes into the community – this feature alone is causing systems change in Connecticut.
- Culture change is becoming more evident, as public opinion continues to shift, accepting that people who were living in nursing homes are capable of living in the community safely with supports and services.
- CT's leaders and legislature are becoming more aware of the MFP program and its success, and increasingly see the multi-level value of rebalancing the long term supports and services system.

"…that we can move [someone] out and surround them with supports and services and see that individual flourish does more to change the long term care system than to talk about the principles and the values and risk. To see it actually happen provides us with real life experiences and stories to tell… So it's not so much the number of people that we move out, it's the successes and the stories, and seeing what happens when people have that opportunity to choose

The full report can be accessed online at: http://www.uconn-aging.uchc.edu/Process%20Evaluation%202010-2011%20Final%20Report.pdf

Meet Joe Luciano

Joe Luciano is a person with high optimism and enthusiasm for life since he began independent living that was made possible by a pilot program, Money Follows The Person (MFP), which is administered by the Connecticut Department of Social Services.

"All in all, I am very happy, satisfied, if not thrilled every day to be living an independent life. My apartment even has a view of a Naugatuck River waterfall just a few hundred yards outside my dining and living room windows. Money Follows the Person made it possible! Even as a one-handed person, I am becoming more and more independent. I'm in charge of my own life—eating what I want when I want, sleeping, and active when I decide, and am free to go where I want when I want. I *feel* healthier in body and in mind. In fact, I *am* healthier in body and in mind."

Currently he is rehearsing to perform piano concerts at Connecticut's long term care facilities, senior centers, and also at various community and church events. He has volunteered as a mentor in the music curriculum of Seymour Public Schools, and has been asked to give lecture-demonstrations to COTA students about ADLs (activities of daily living) and ADCs ("activities of daily cooking") that can be done with one hand.

Joe Luciano at the piano. [photo credit: Michael Kabelka]

Joe found a low-cost way to create an accessible kitchen for himself and other wheelchair users who want to cook for themselves safely: he designed low-profile kitchen and cooktop counters that cabinetmaking-carpentry students at Wilcox Technical High School built and are installing this week. He has a forthcoming cookbook, *Wheelchair Cooking"—A Cookbook for One-Handed Persons & Others with Disabilities.* He is also getting ready to upload his one-handed piano jazz recordings to YouTube.

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 Program Announcement, pp. 32, Application Review Information, Review Criteria, Section A, Rebalancing). 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 the elderly and disabled population to a community based orientation.

IMPORTANT NOTICE

This is our first release of this comprehensive CT MFP Quarterly Report – please send suggestions for improvement to this evolving project to ireed@uchc.edu.