CT Money Follows the Person Quarterly Report

Quarter 2, 2012: April 1, 2012 –June 30, 2012

University of Connecticut Health Center

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

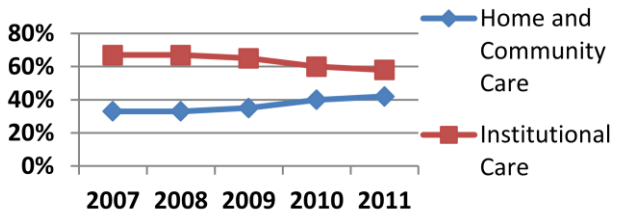
MFP Benchmarks

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 = 1000 (non-demonstration transitions = 128)

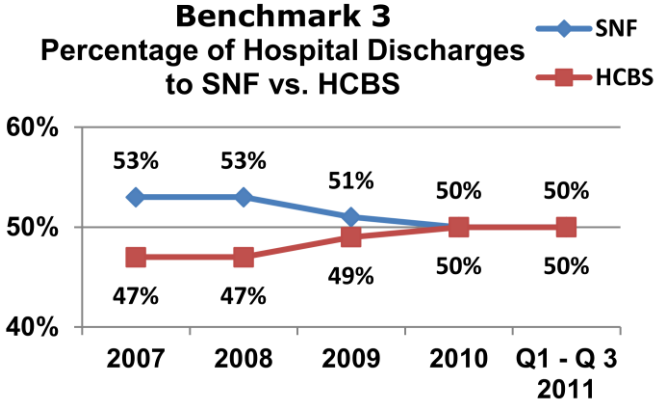
Benchmark 2

CT Medicaid Long-Term Care expenditures



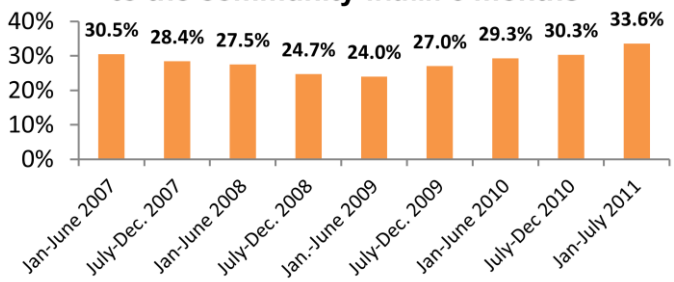
Benchmark 3

Percentage of Hospital Discharges to SNF vs. HCBS



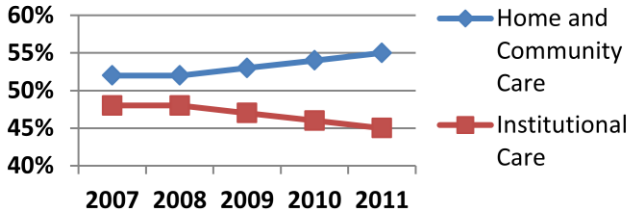
Bemnchmark 4

Percent of SNF admissions returning to the community within 6 months

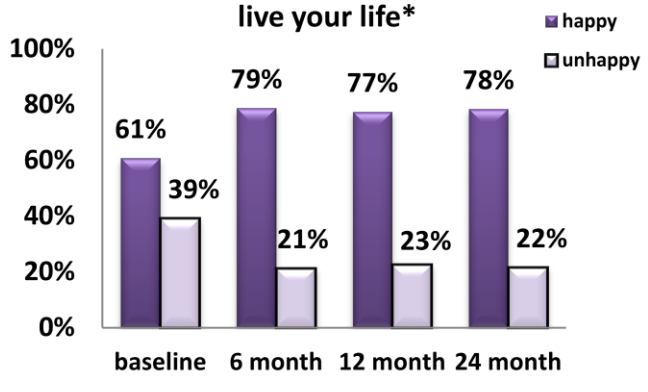


Benchmark 5

Percent receiving LTSS in the community vs. institutions

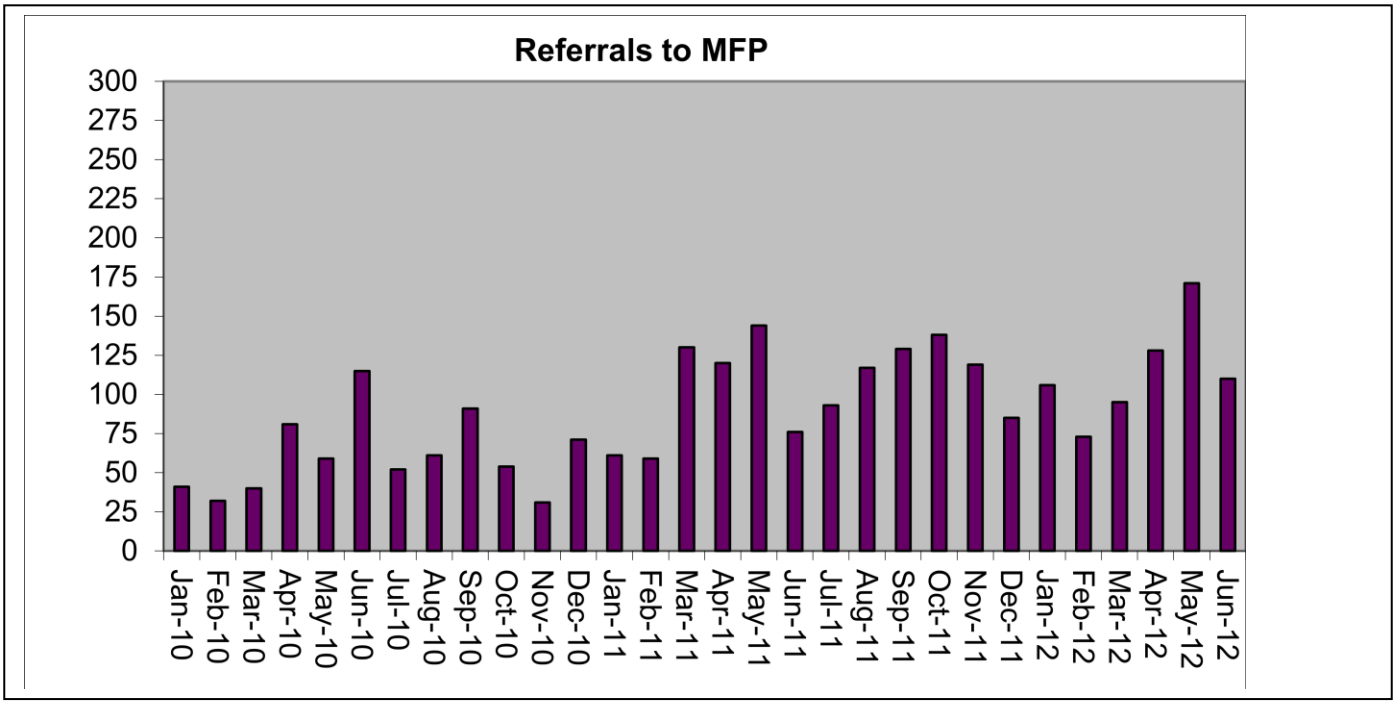


Happy or unhappy with the way you live your life*



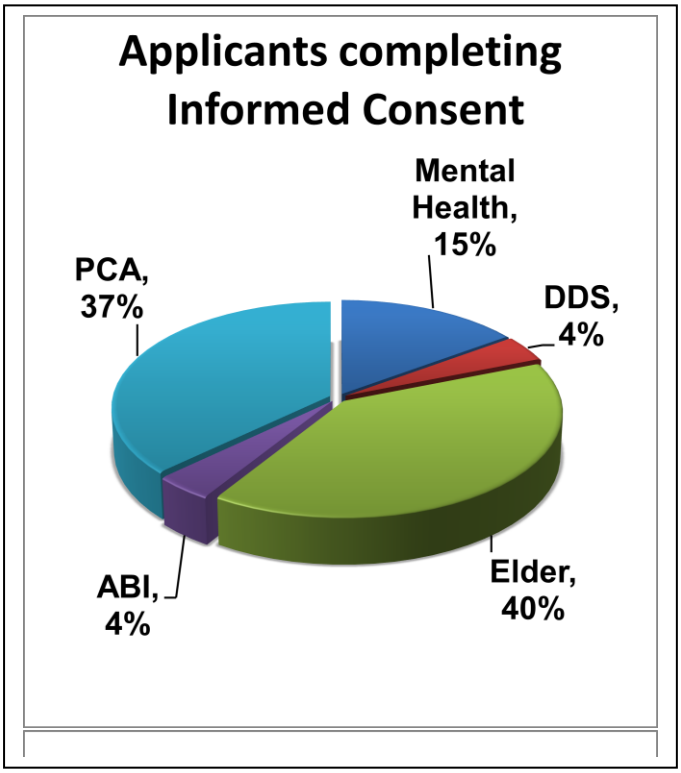
Referrals to MFP

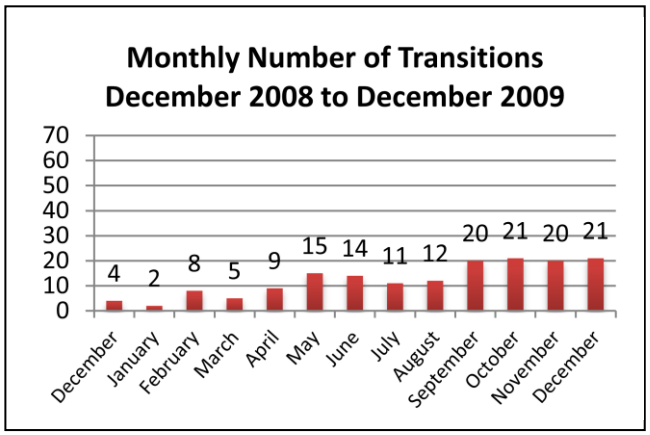
A total of 3785 applications were received by the Department of Social Services through the end of June 2012 representing approximately 17% of the total eligible institutionalized population. Demand for MFP services continues to grow. Applications came from 204 (84.35%) different skilled nursing homes 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.

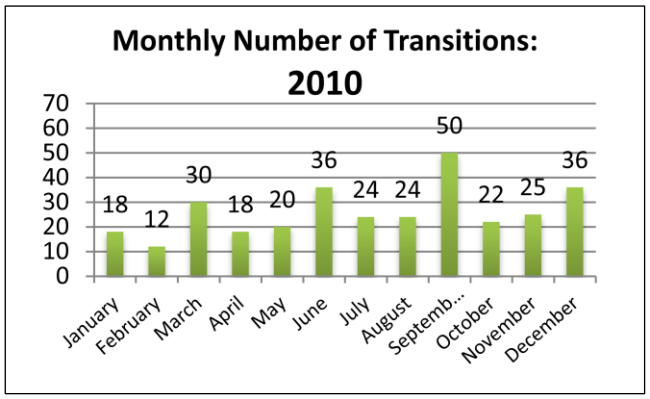


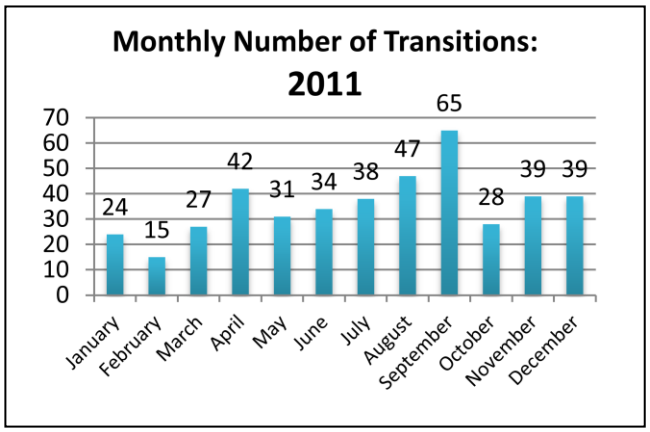
Applicants Completing Informed Consent

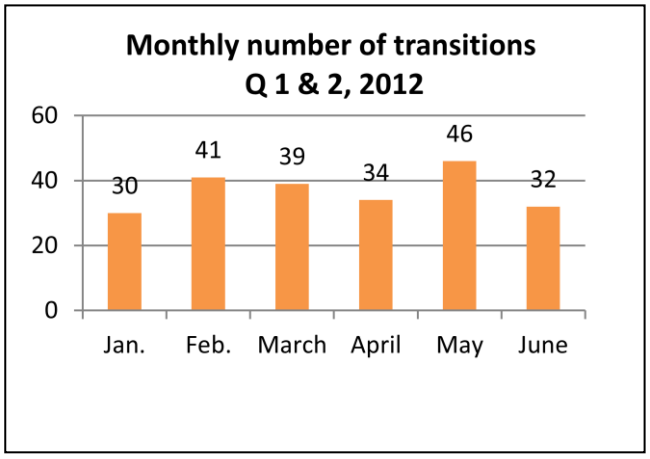
Of the 3785 applications received by the Department, 2630 were screened, assigned to the field for completion of the intake process and signed an informed consent. The screening process includes verification of the Medicaid eligibility, verification of income, verification of length of state in the institution, verification of citizenship documentation and documentation of applicant's institutional cost. The cost of the institutional placement becomes the individual cost cap for community MFP services. Field staff at local community agencies contact referrals within 3 days of assignment. A visit with the nursing home resident occurs within 2 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. Those applicants who completed the intake process were targeted for community service packages based on the initial functional assessment. The chart to the right reflects the distribution of applicants targeted for each of 5 general community services packages. While 34% of the applicants were over the age of 65, 66% were under the age of 65.



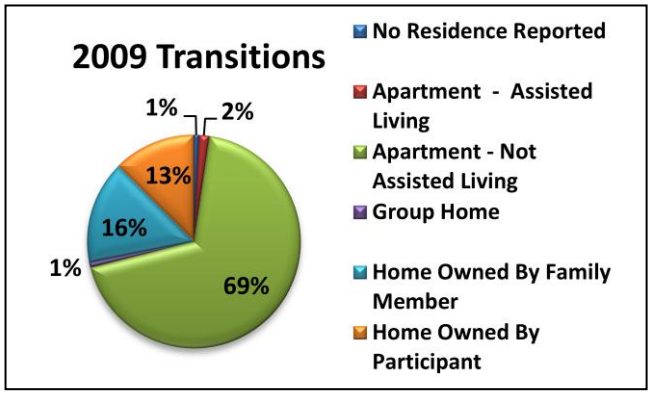


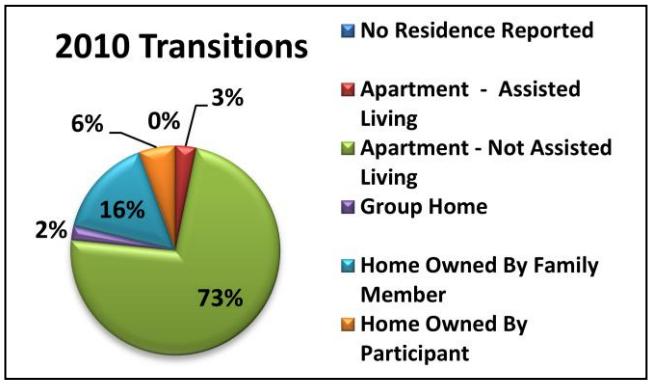


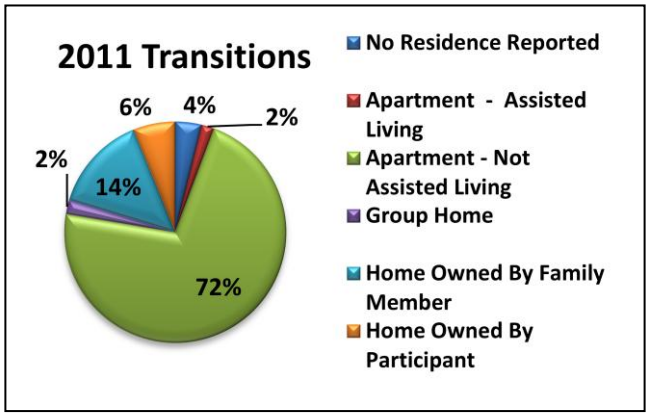


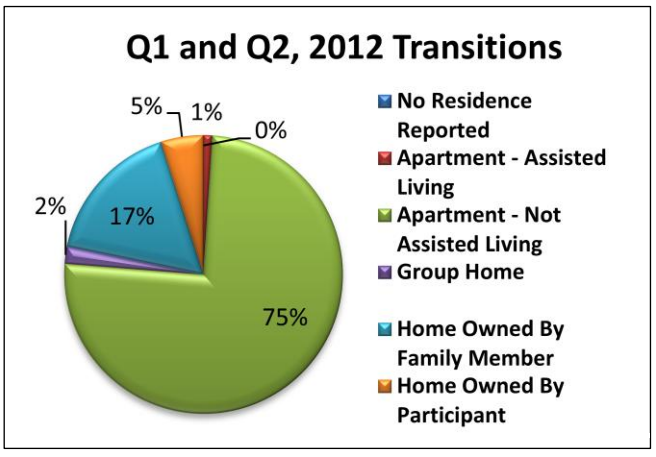


Qualified Residence Type

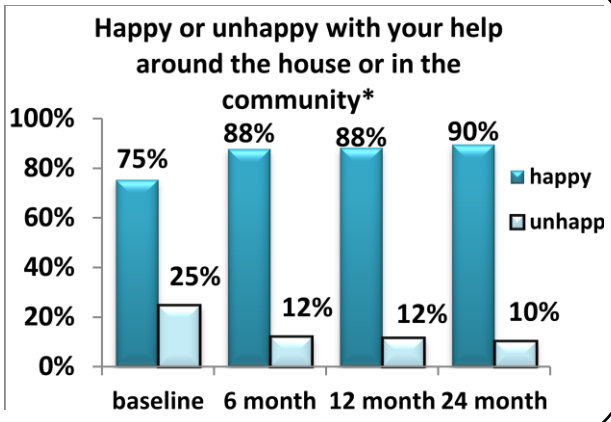


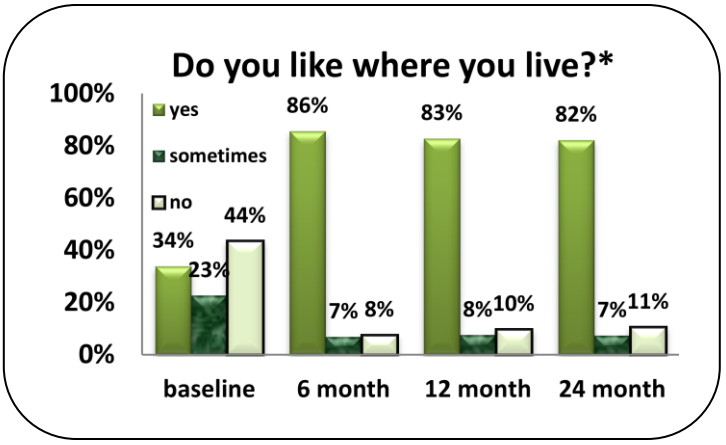


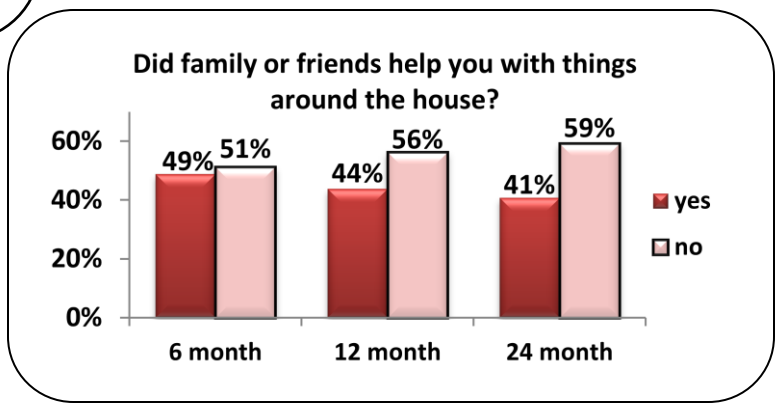


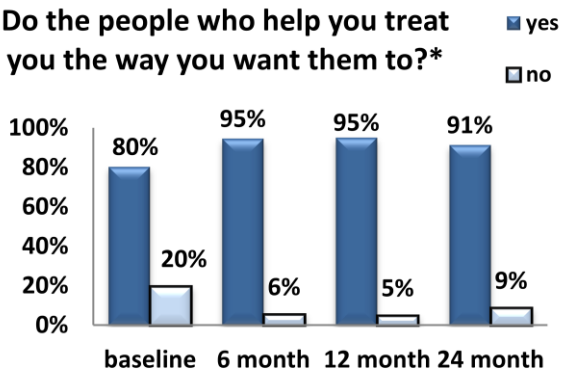


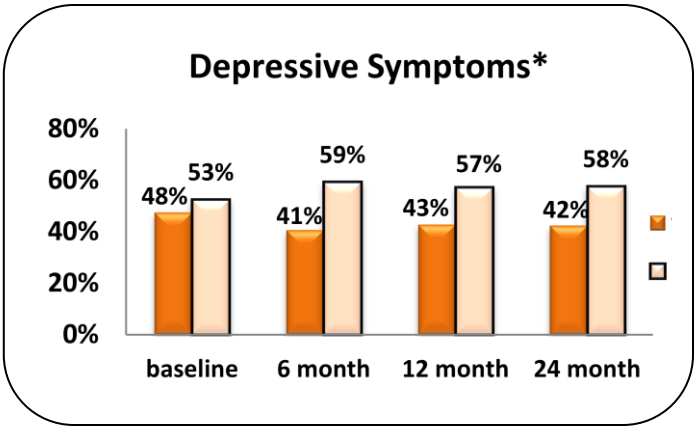
MFP Quality of Life Dashboard As of 06/30/2012

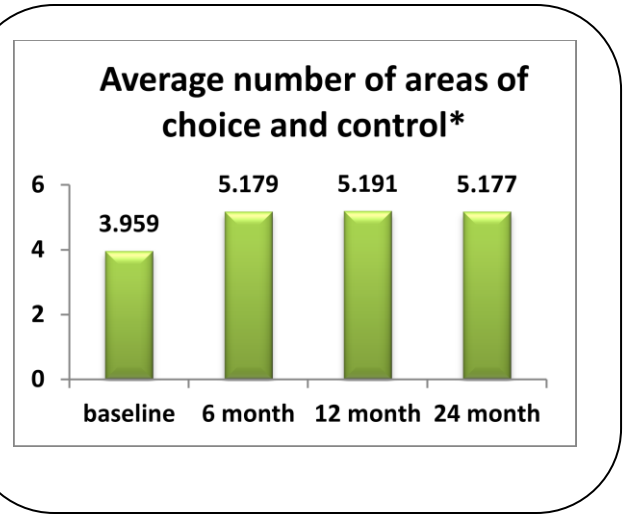


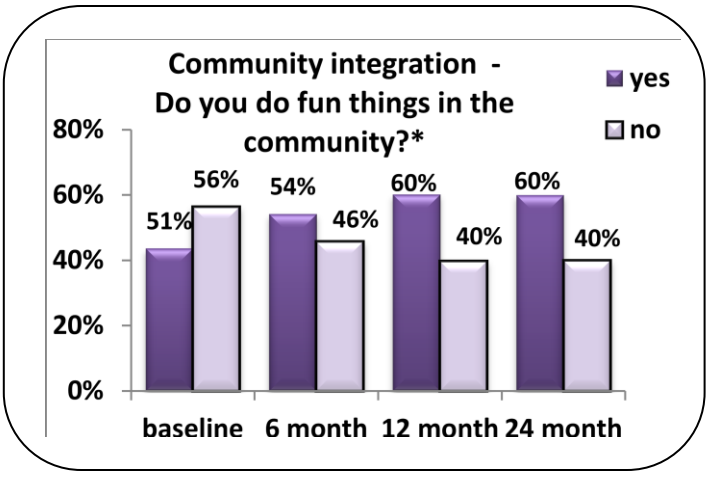












*indicates statistically significant differences

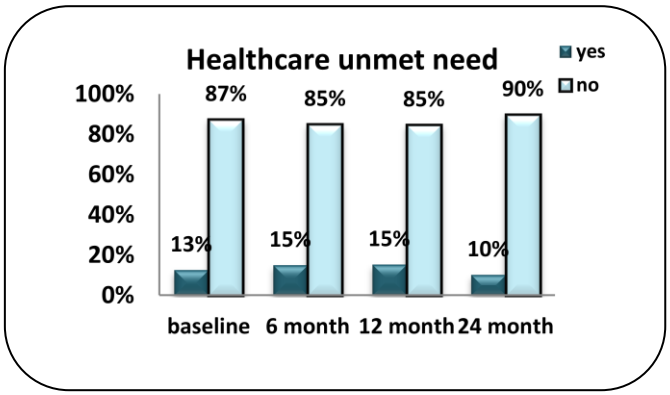
Cumulative data through 6/30/12

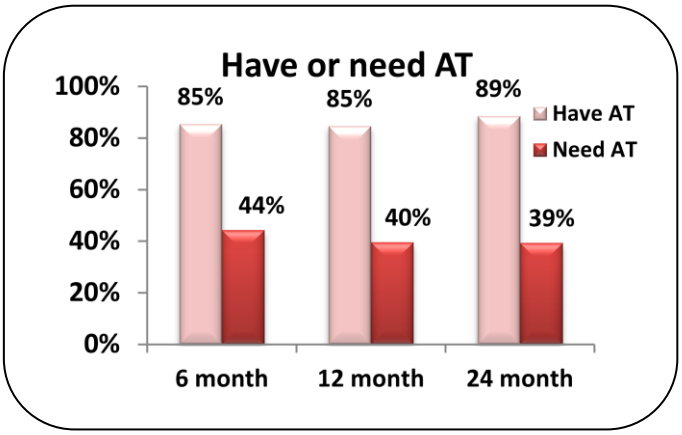
Baseline interview is done prior to transition; n=1159

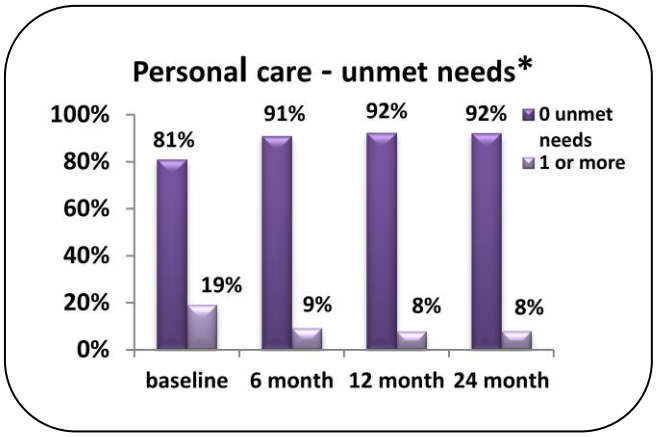
6 month interview is done 6 months after transition; n=815

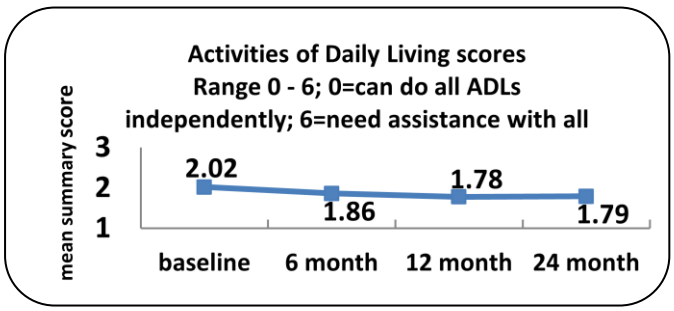
12 month interview is done 12 months after transition; n=582

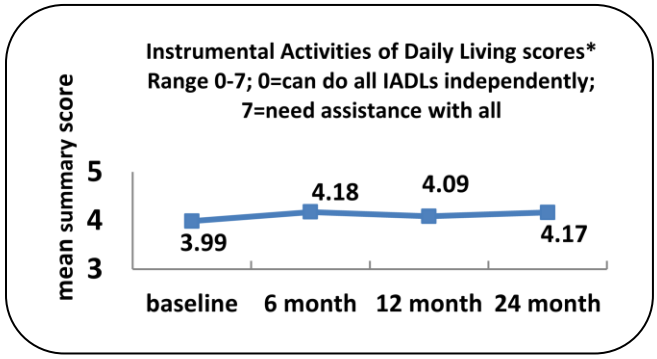
24 month interview is done 24 months after transition; n=248

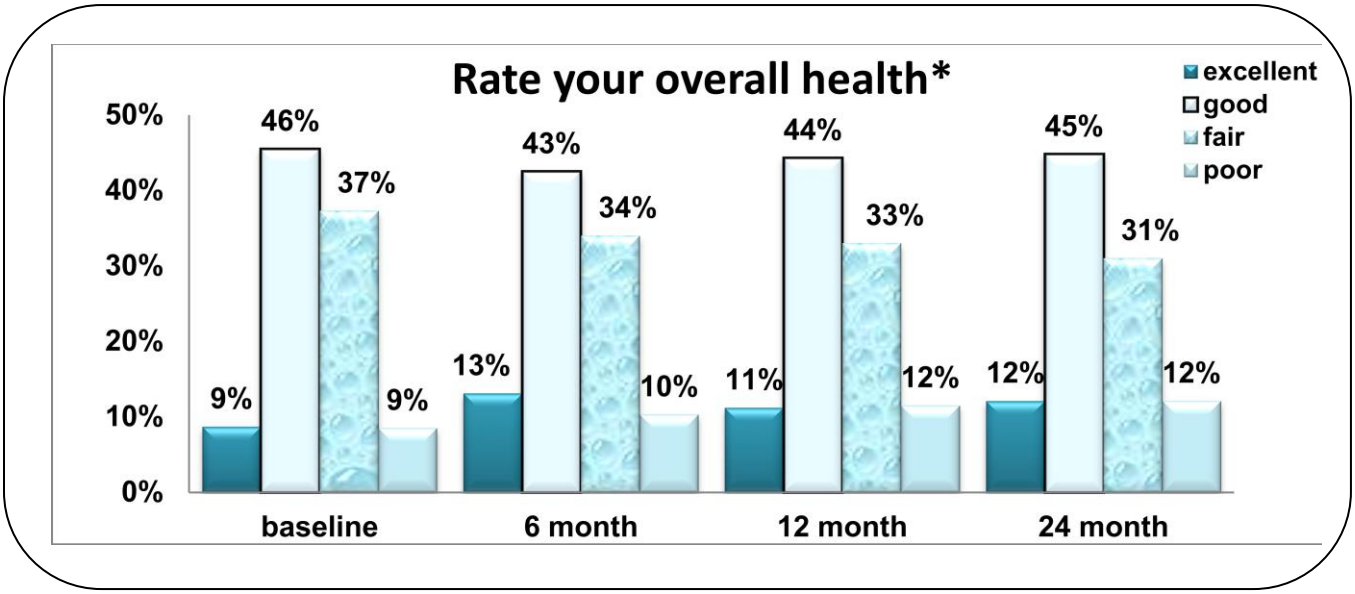












Hospital Discharges for LTSS to Institutions vs. Community, by Hospital (Benchmark 3)

Acute Care Hospitals	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							
	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	[3]CY 2011 q1-q3	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	[3]CY 2011 q1-q3
Bradley Memorial[2]	59%	59%	63%	-	-	-	-	-	41%	41%	37%	-	-	-	-	-
Bridgeport	54%	49%	47%	48%	48%	48%	47%	45%	46%	51%	53%	52%	52%	52%	53%	55%
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%	10%	97%	96%	88%	95%	91%	88%	92%	90%
Danbury	53%	52%	53%	54%	55%	54%	52%	48%	47%	48%	47%	46%	45%	46%	48%	52%
Day Kimball	51%	54%	56%	55%	52%	50%	52%	57%	49%	46%	44%	45%	48%	50%	48%	43%
Greenwich	61%	61%	49%	46%	53%	53%	54%	55%	39%	39%	51%	54%	47%	47%	46%	45%
Griffin	59%	64%	63%	63%	56%	56%	53%	52%	41%	36%	37%	37%	44%	44%	47%	48%
Hartford	49%	51%	51%	51%	52%	53%	53%	51%	51%	49%	49%	49%	48%	47%	47%	49%
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%	47%	53%	51%	51%	51%	51%	53%	56%	53%
Johnson Memorial	61%	62%	66%	63%	60%	56%	60%	51%	39%	38%	34%	37%	40%	44%	40%	49%
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%	40%	48%	48%	46%	42%	46%	49%	61%	60%
Middlesex Memorial	59%	60%	56%	59%	62%	55%	56%	57%	41%	40%	44%	41%	38%	45%	44%	43%
MidState Medical	65%	64%	65%	64%	66%	66%	61%	66%	35%	36%	35%	36%	34%	34%	39%	34%
Milford	64%	66%	68%	69%	61%	59%	53%	48%	36%	34%	32%	31%	39%	41%	47%	52%
New Milford	67%	61%	63%	61%	61%	60%	58%	68%	33%	39%	37%	39%	39%	40%	42%	32%
Norwalk	54%	54%	55%	55%	54%	56%	58%	56%	46%	46%	45%	45%	46%	44%	42%	44%
Rockville General	54%	56%	55%	61%	59%	59%	44%	51%	46%	44%	45%	39%	41%	41%	56%	49%
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%	52%	42%	45%	45%	47%	49%	48%	50%	48%
Saint Raphael	51%	50%	50%	51%	53%	50%	50%	51%	49%	50%	50%	49%	47%	50%	50%	49%
Saint Vincent's	52%	54%	53%	56%	58%	53%	55%	53%	48%	46%	47%	44%	42%	47%	45%	47%
Sharon	68%	72%	75%	78%	82%	83%	86%	80%	32%	28%	25%	22%	18%	17%	14%	20%
Stamford	55%	61%	66%	72%	60%	60%	57%	54%	45%	39%	34%	28%	40%	40%	43%	46%
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%	54%	46%	48%	43%	46%	47%	50%	51%	46%
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%	36%	60%	58%	61%	62%	60%	62%	61%	64%
Statewide	52%	53%	53%	53%	53%	51%	50%	50%	48%	47%	47%	47%	47%	49%	50%	50%

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

Transition Challenges through 6/30/12

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 2947 MFP referrals which either closed without transitioning (includes recommend closure) (61%; n=1802) or transitioned (39%; n=1145) by 6/30/12.

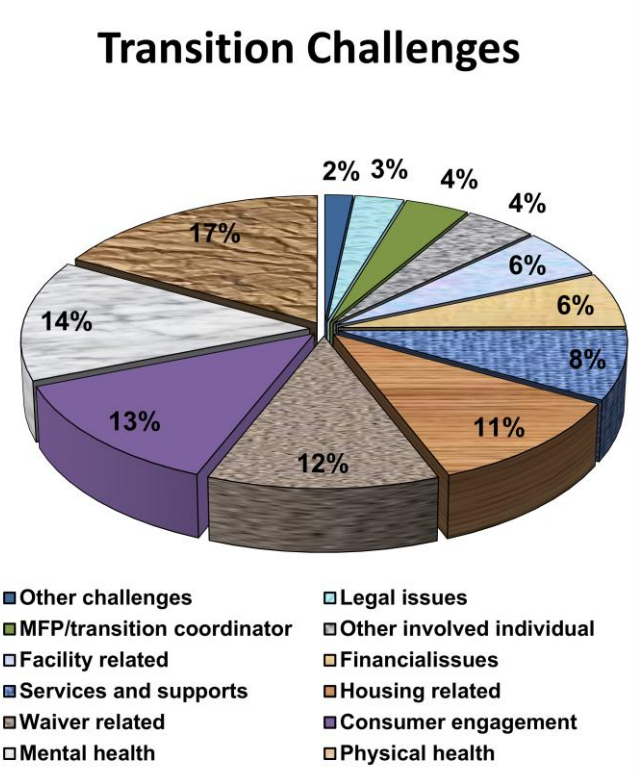
Of the 2641 referrals, 470 referrals (16%) did not have a completed challenges checklist. Data from the remaining 84% (n=2477) are reported here. Of these, 58% (n=1434) did not transition, while 42% (n=1043) did.

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.

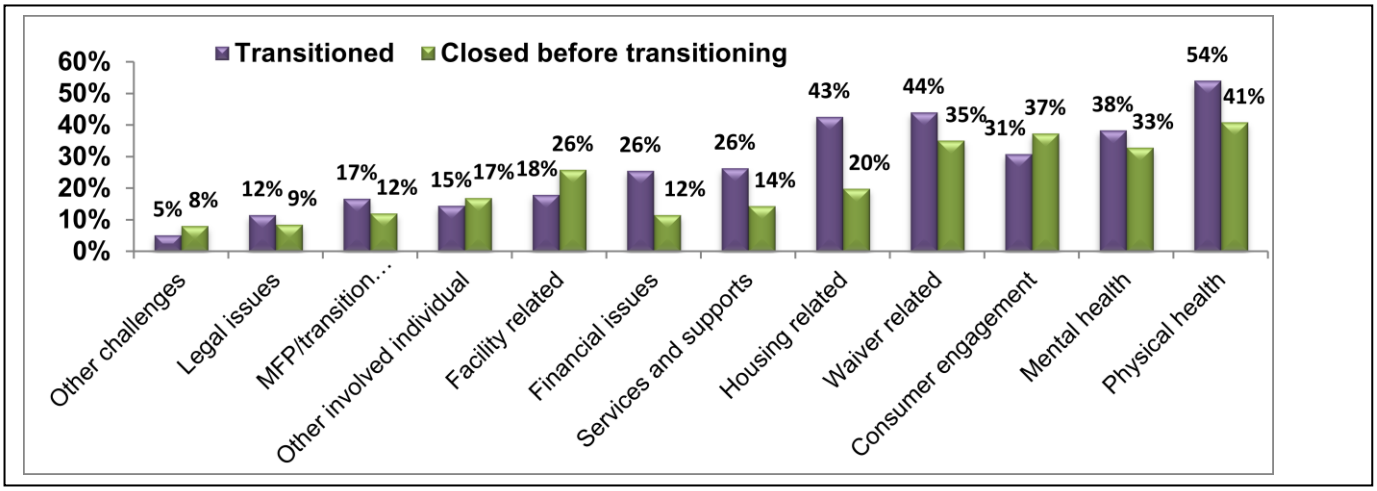
Type of challenge by transition status

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, 41 percent indicated physical health was a challenge.

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

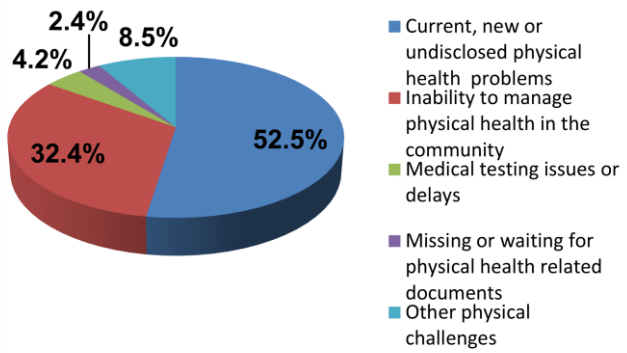


A significantly greater percentage of referrals that closed without transitioning had challenges related to consumer engagement, awareness, and skills; the facility; and "other" challenges. Although those who already transitioned faced significantly greater issues related to physical health, waiver program, 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.

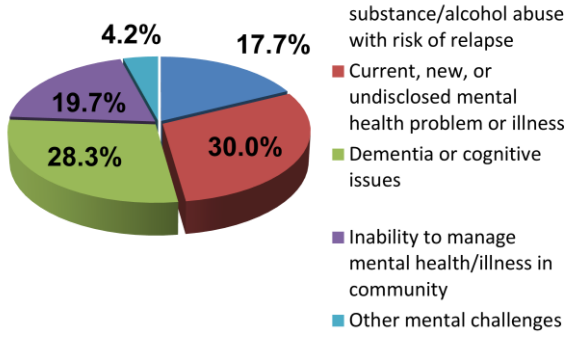


Types of Challenges – through 6/30/2012

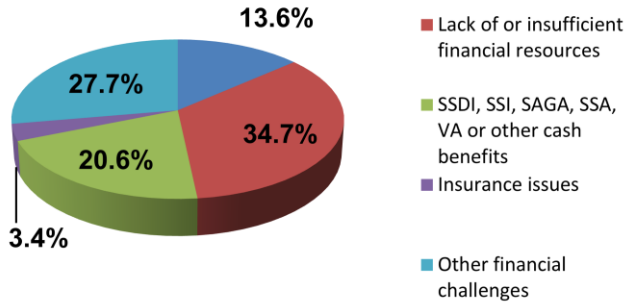
Physical health challenges



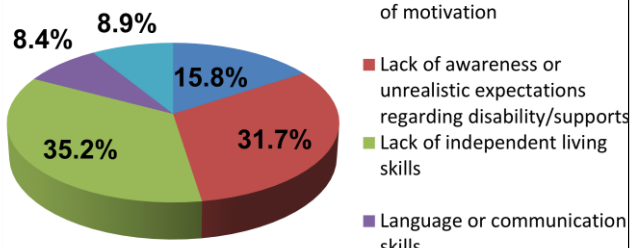
Mental health challenges



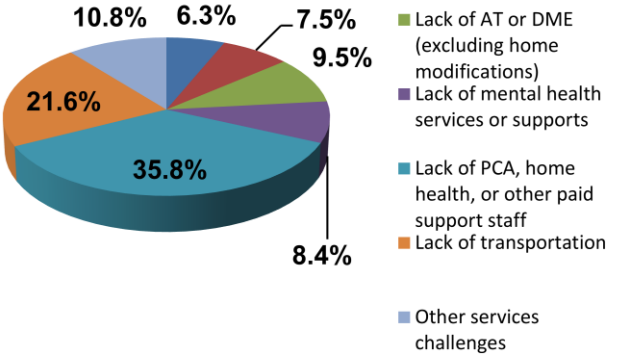
Financial challenges



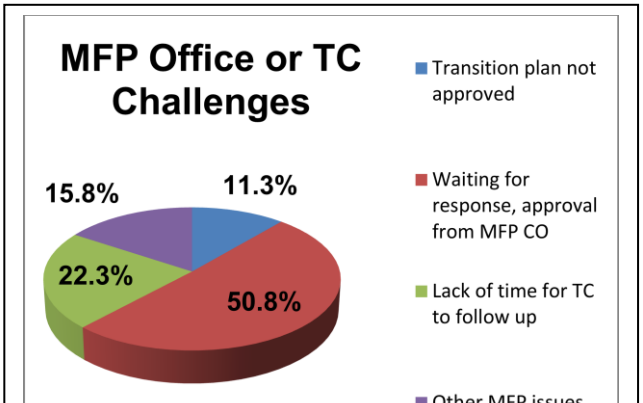
Engagement Challenges



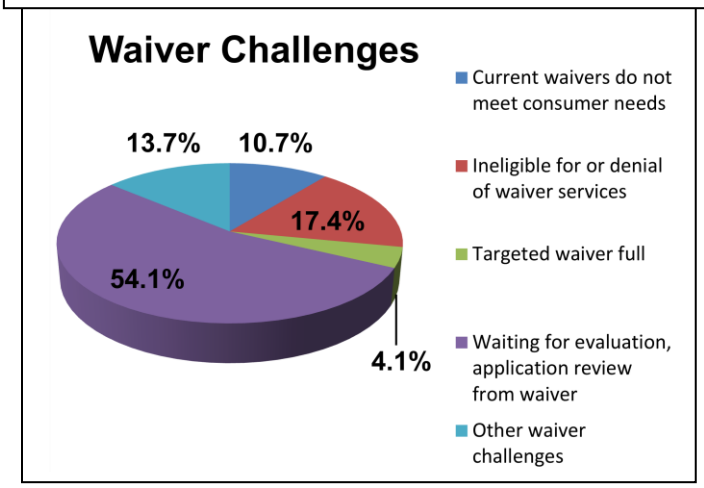
Services Challenges

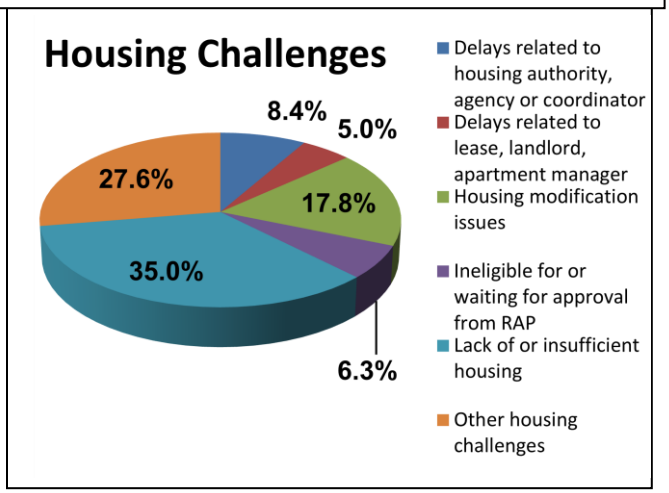


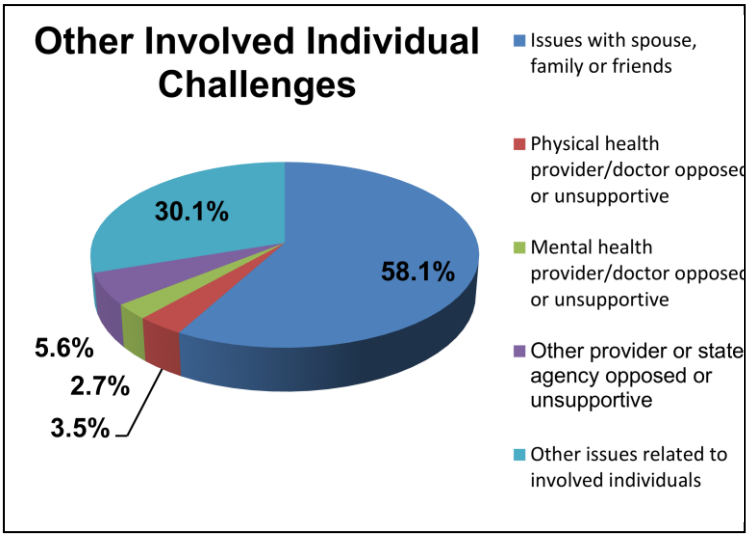
MFP Office or TC Challenges

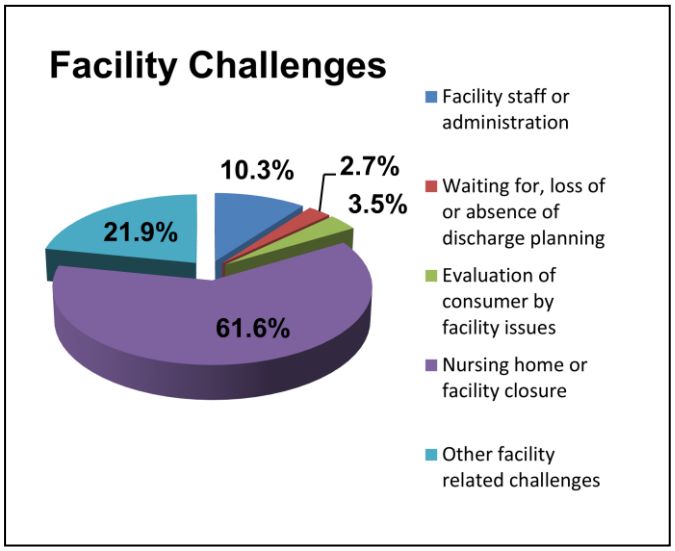


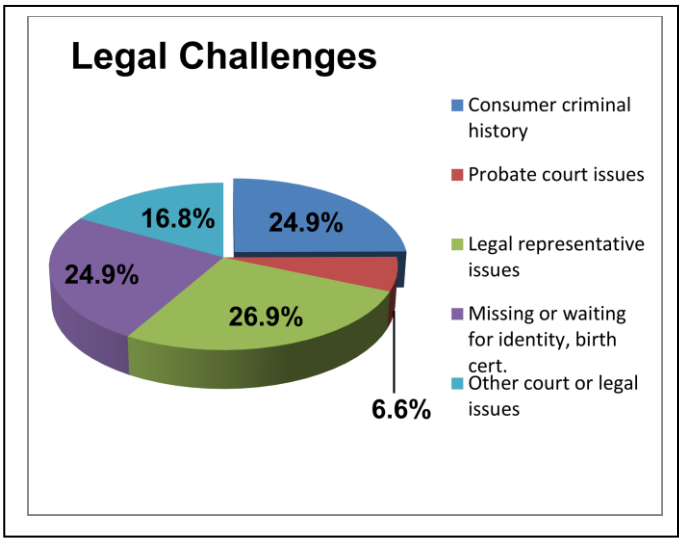
Types of Challenges – through 6/30/2012











Meet Kevin Brouwer

Kevin Brouwer is a happy person. He's thrilled to be alive and living on his own after a motorcycle accident nearly killed him. It was a long journey to recuperate, but now, with assistance from his aides, Kevin lives in his own place with his dog, Jake, a 9-year-old Italian greyhound. He enjoys lifting weights every day to keep his muscles in shape and he also enjoys going to tag sales and putting together a Christmas village for his mantel (something he did pre-accident).

While Kevin lived in the nursing home, he was always helping out. Once he began to walk on his own, he helped in the dining room and made sure that all of the dining tables had salt and pepper shakers and sugar at each and every table. He helped out with so many things, but mainly visiting some of the residents whom he knew never had any visitors. He promised them that after he got out, he would return to visit.

So every Tuesday, he packs up his dog, Jake, and with his aides makes the trip to the nursing home where he lived before Money Follows the Person (MFP) helped him to move back to the community. At the nursing home, he spends time visiting many of the residents that he knew when he was a resident there. Sometimes he brings them certain items that they requested. His dog also cheers everyone up; everyone there is so happy whenever Kevin and Jake come to visit.

One of the things that Kevin is most proud of is his happy outlook. After his accident, many of the doctors and counselors warned his family members that he would be angry and frustrated because of his losses. But he proved them all wrong. Kevin is enthusiastic and he likes doing just about everything. On one particular day, he went to Devil's Hopyard and took a four-mile walk with his aide and Jake. But going for walks has always been one of his favorite things. He enjoys many of the things that he did when he was younger. He works on "find a word" puzzles often and completes several books in a week. He also goes to the race track in Waterford with a friend. He does not race anymore, but he still enjoys himself there too. His twin sister, Karen, is also very proud of the progress that he has made. She, too, is very thankful for the Money Follows the Person program because Kevin has gained back some of his independence through MFP.

Kevin Brouwer with his dog, Jake

Photo credit: Barbara Swenson

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 the elderly and disabled population to a community based orientation.