CT Money Follows the Person Quarterly Report

Quarter 3, 2012: July 1, 2012 –September 30, 2012

University of Connecticut Health Center

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

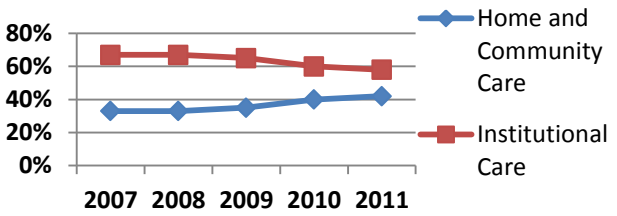
MFP Benchmarks

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 = 1107 (non-demonstration transitions = 134)

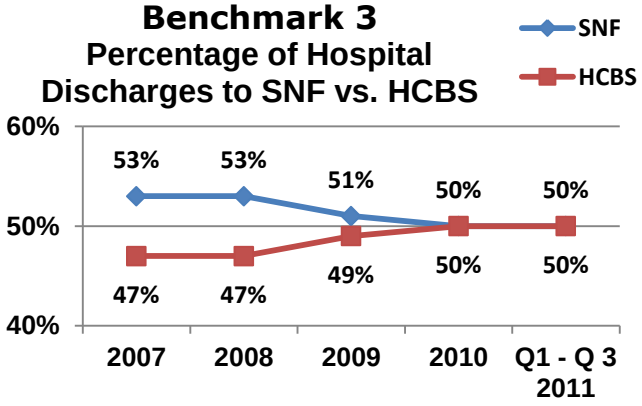
Benchmark 2

CT Medicaid Long-Term Care expenditures



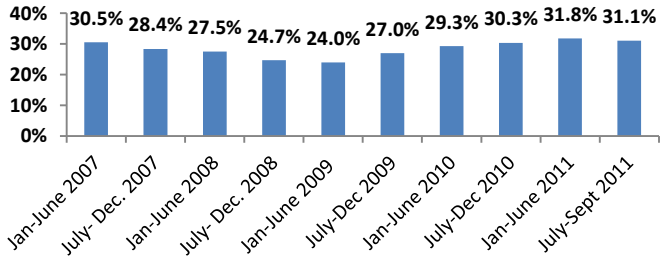
Benchmark 3

Percentage of Hospital Discharges to SNF vs. HCBS



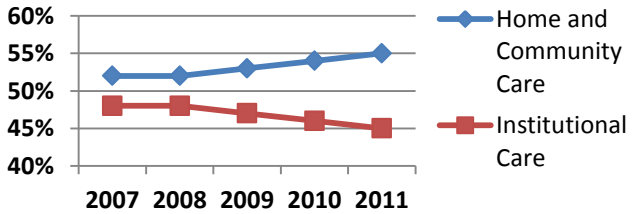
Benchmark 4

Percent of SNF admissions returning to the community with 6 months

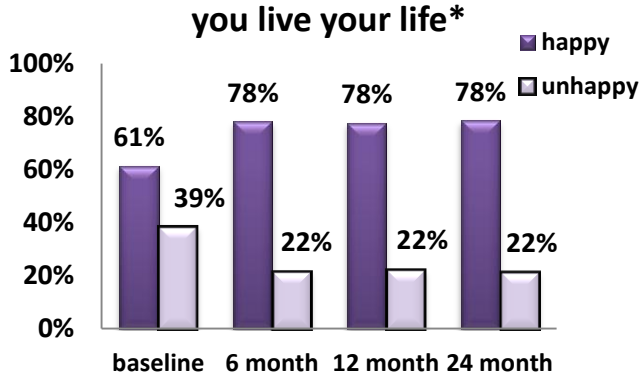


Benchmark 5

Percent receiving LTSS in the community vs. institutions

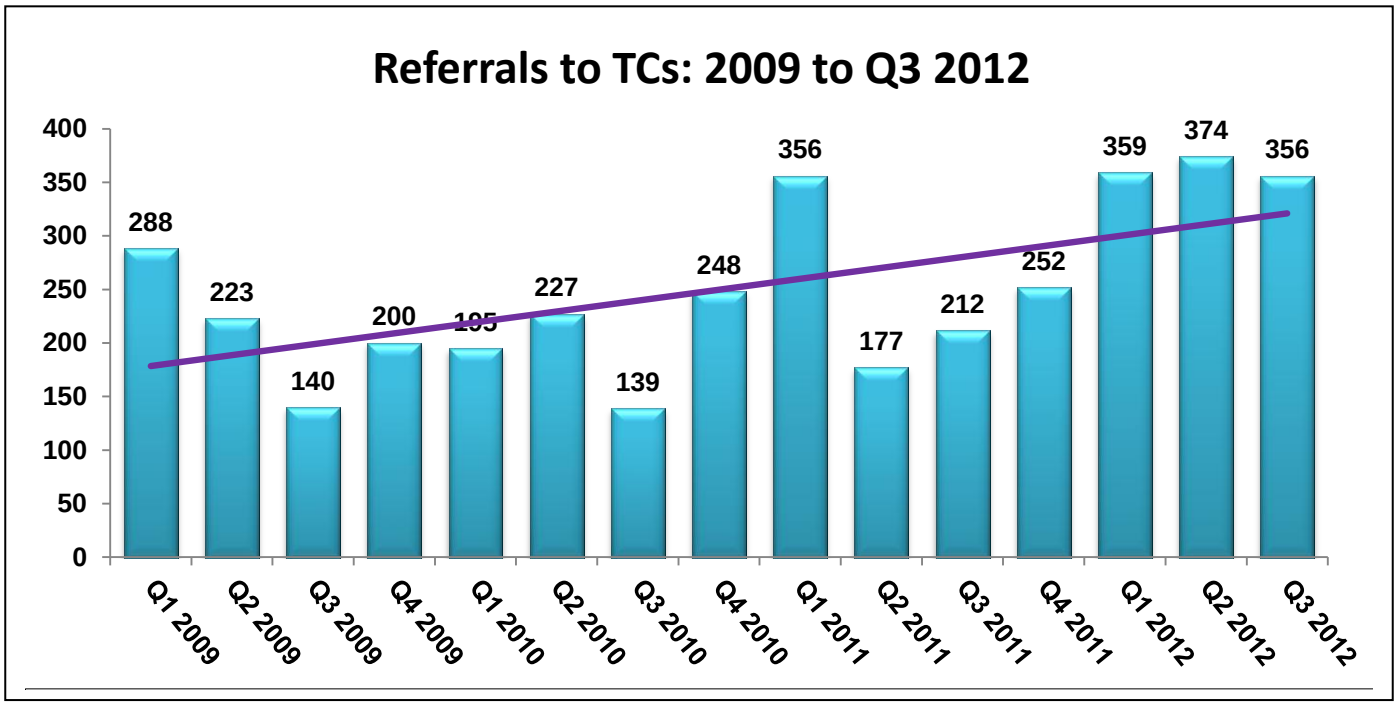


Happy or unhappy with the way you live your life*



MFP Applications and Referrals to Transition Coordinators

A total of 4194 applications were received by the Department of Social Services through the end of September 2012 representing approximately 17% of the total eligible institutionalized population. Applications came from 210 (89%) different skilled nursing homes and other institutions across the state. The most frequent source of referrals for MFP services came from family members, social workers and Ombudsmen. Between 1/1/09 and 9/30/12, 3,746 referrals went to Transition Coordinators from MFP Central Office (nursing home closure referrals excluded).

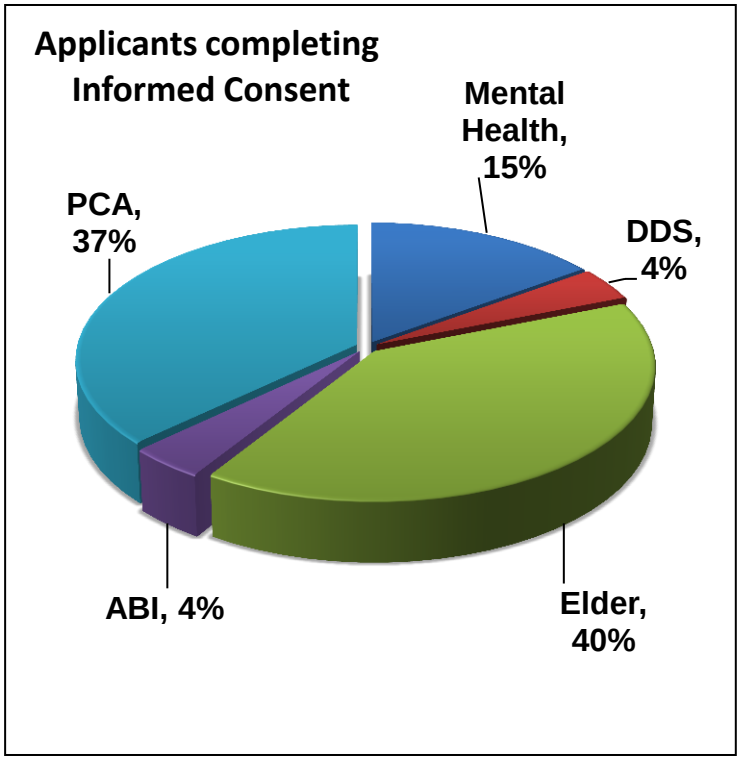


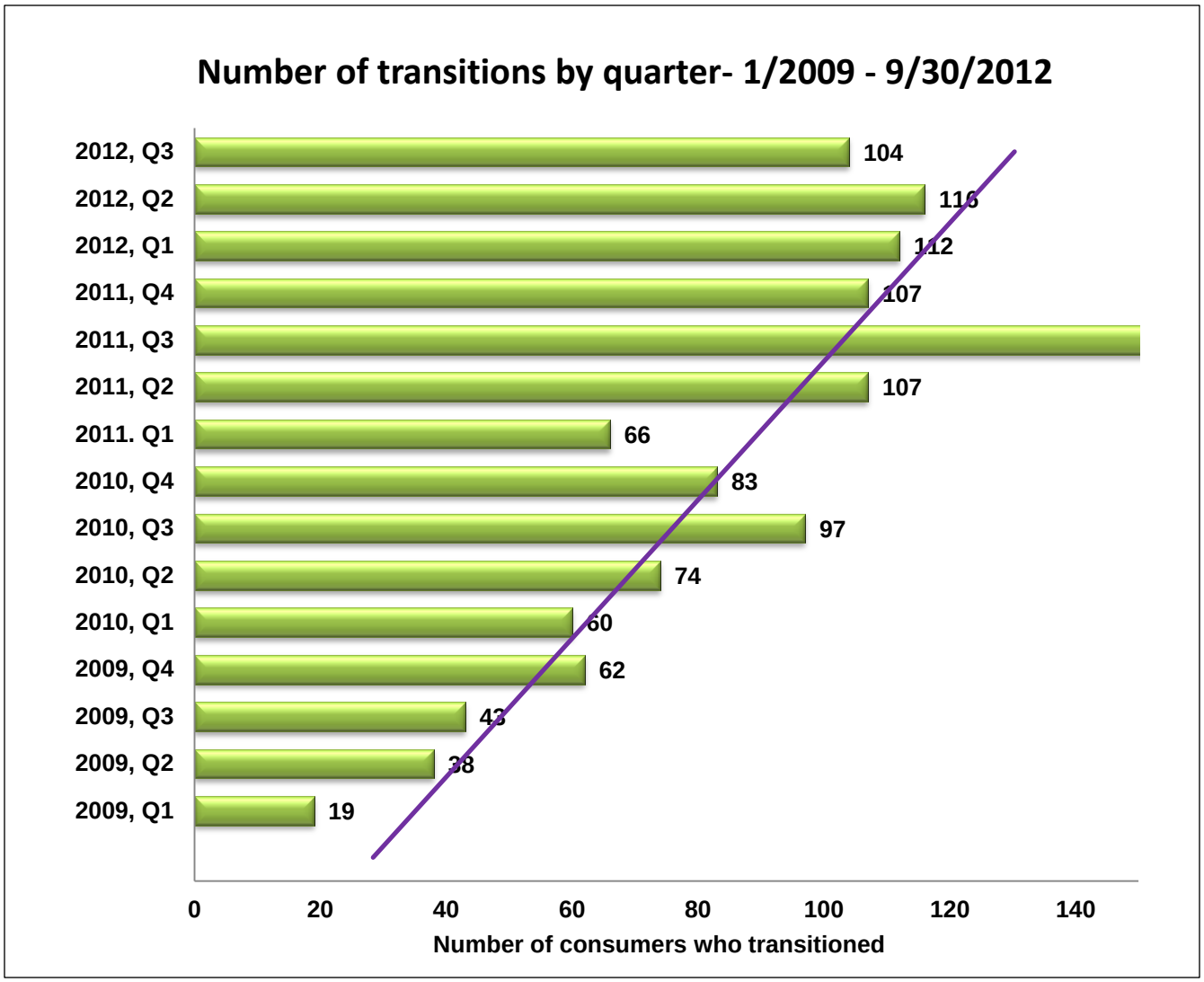
Applicants Completing Informed Consent

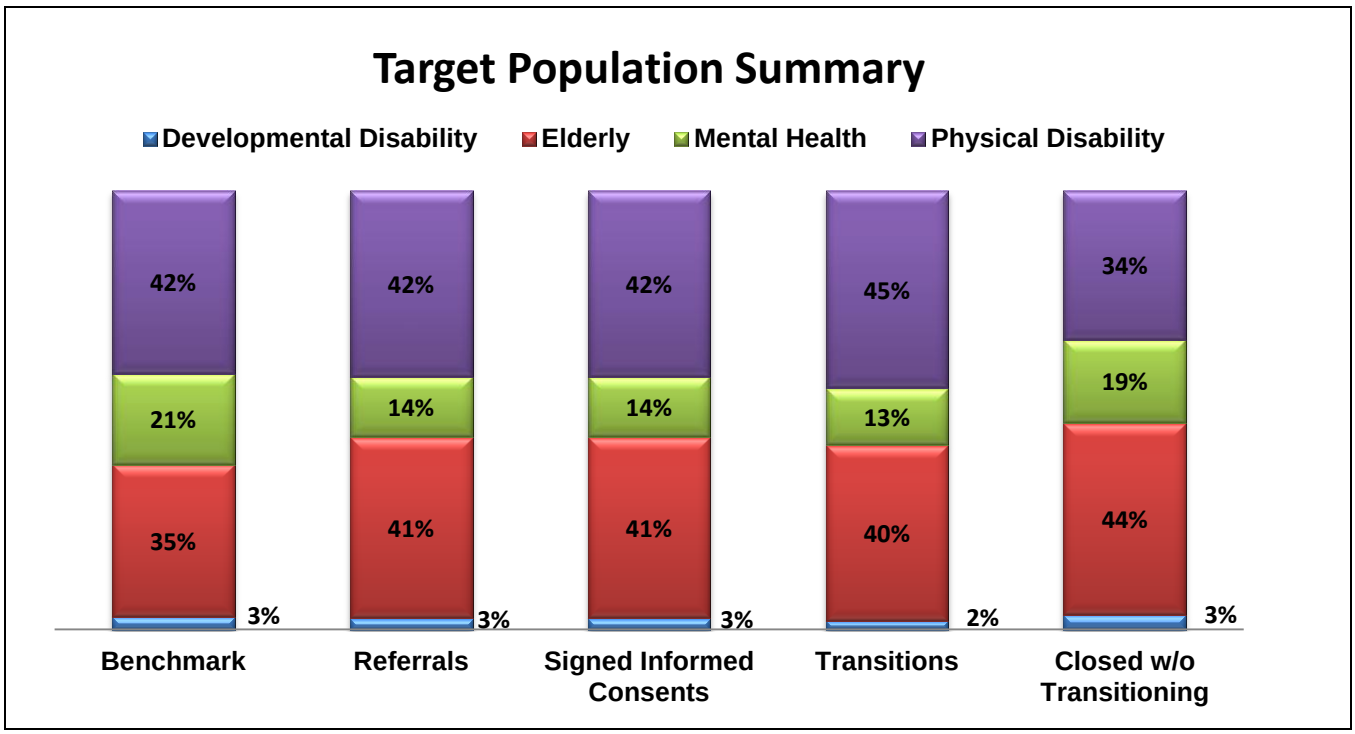
Of the 4194 applications received by the Department, 2884 were screened, assigned to the field for completion of the intake process and signed an informed consent. The cost of the institutional placement becomes the individual cost cap for community MFP services.

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.

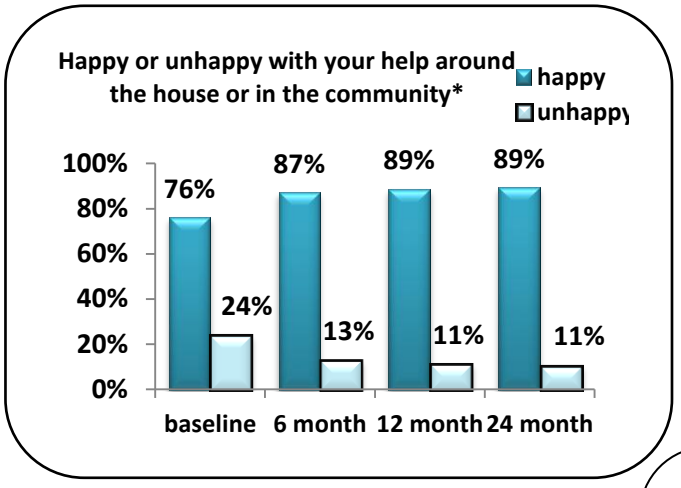
Those applicants who completed the intake process were targeted for community service packages based on the initial functional assessment. The chart to the right reflects the distribution of applicants targeted for each of 5 general community services packages.

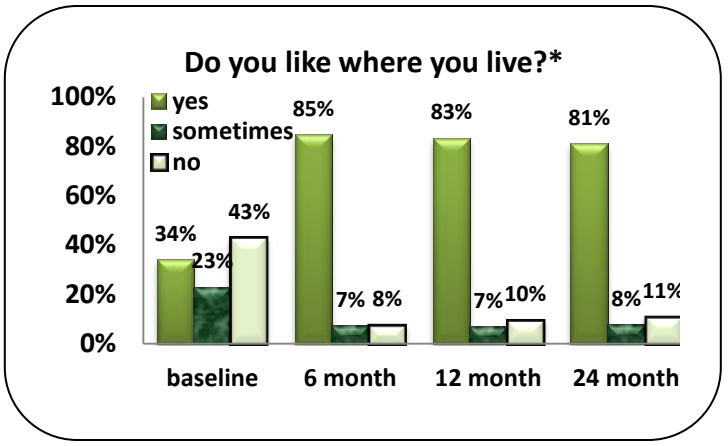


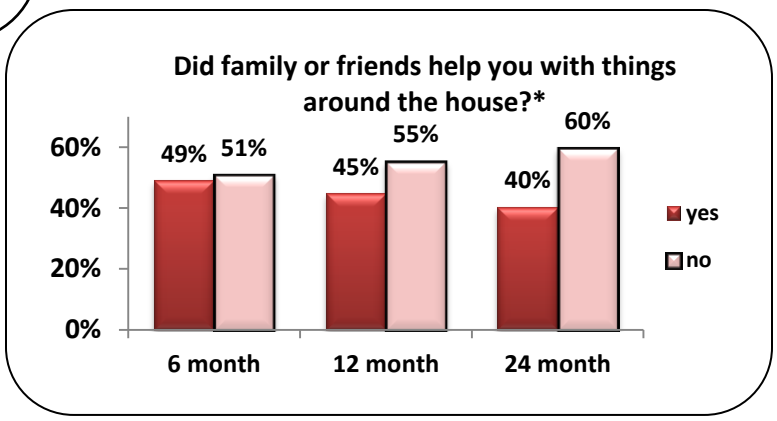

Number of transitions by quarter- 1/2009 - 9/30/2012
2012, Q3
2012, Q2
2012, Q1
2011, Q4
2011, Q3
2011, Q2
2011. Q1
2010, Q4
2010, Q3
2010, Q2
2010, Q1
2009, Q4
2009, Q3
2009, Q2
2009, Q1
104
116
112
107
107
66
83
97
74
60
62
43
38
19
0
20
40
60
80
100
120
140
Number of consumers who transitioned

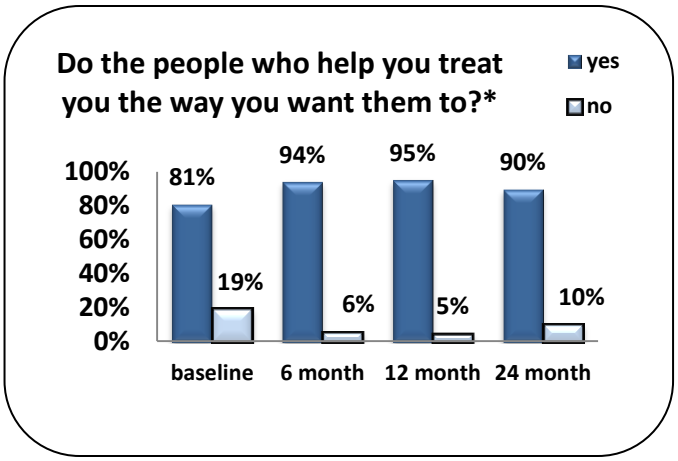

Target Population Summary
Developmental Disability
Elderly
Mental Health
Physical Disability
42%
21%
35%
3%
42%
14%
41%
3%
42%
14%
41%
3%
45%
13%
40%
2%
34%
19%
44%
3%
Benchmark
Referrals
Signed Informed Consents
Transitions
Closed w/o Transitioning

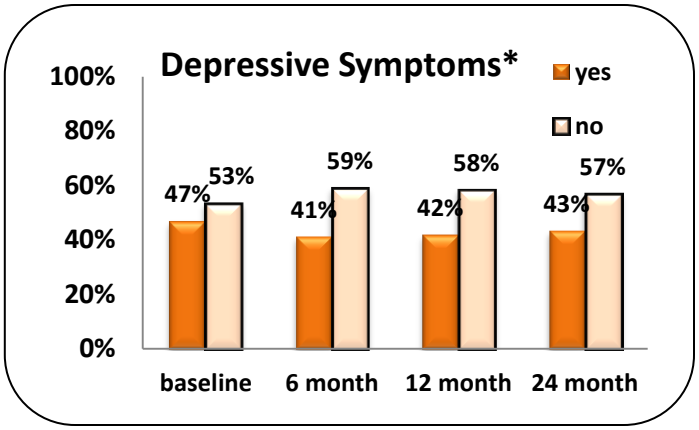
MFP Quality of Life Dashboard As of 09/30/2012

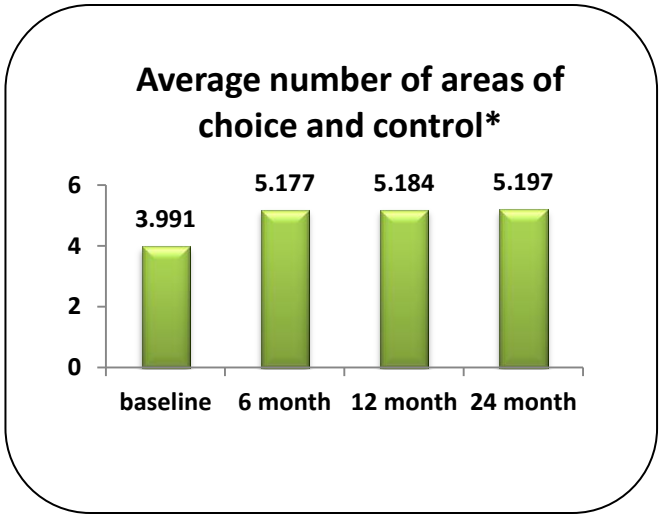


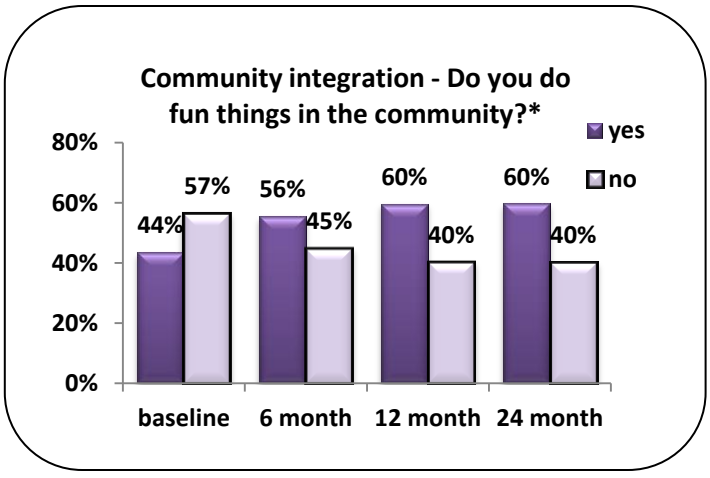












*indicates statistically significant differences

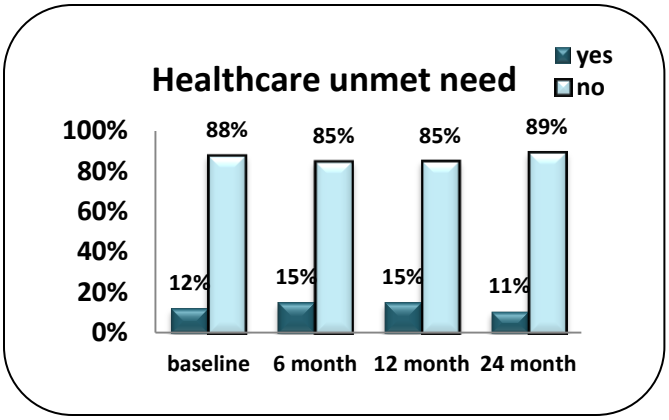
Cumulative data through 9/30/12

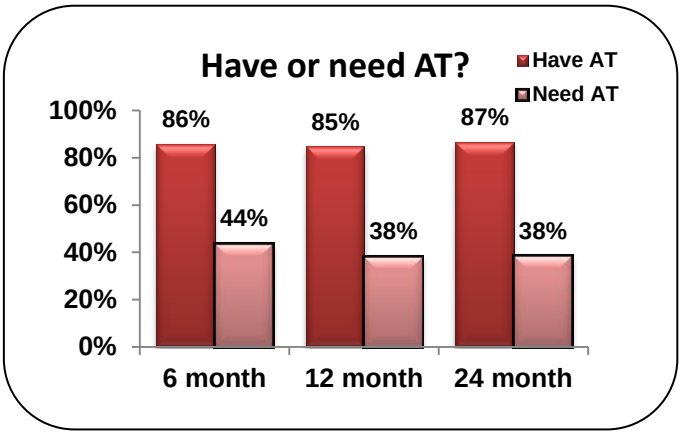
Baseline interview is done prior to transition; n=1283

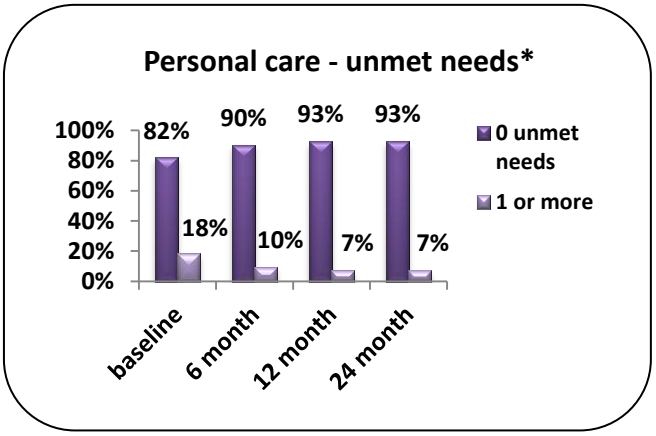
6 month interview is done 6 months after transition; n=916

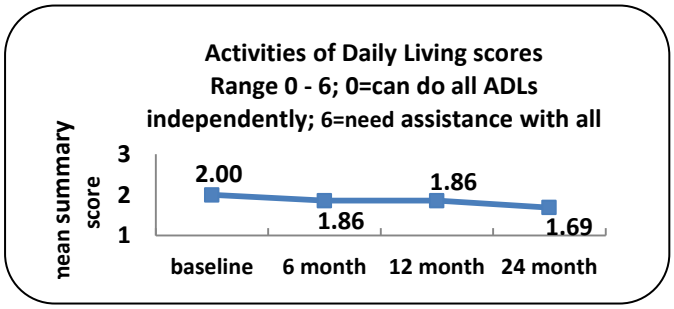
12 month interview is done 12 months after transition; n=687

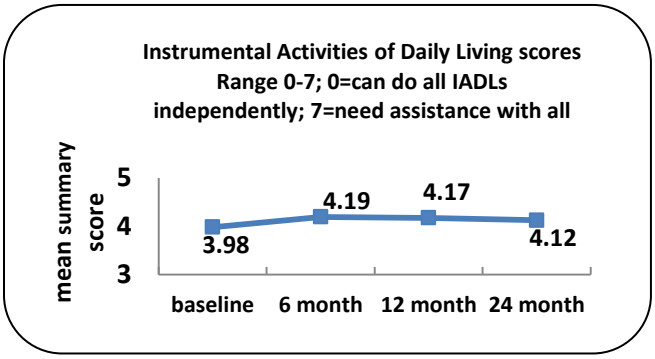
24 month interview is done 24 months after transition; n=315

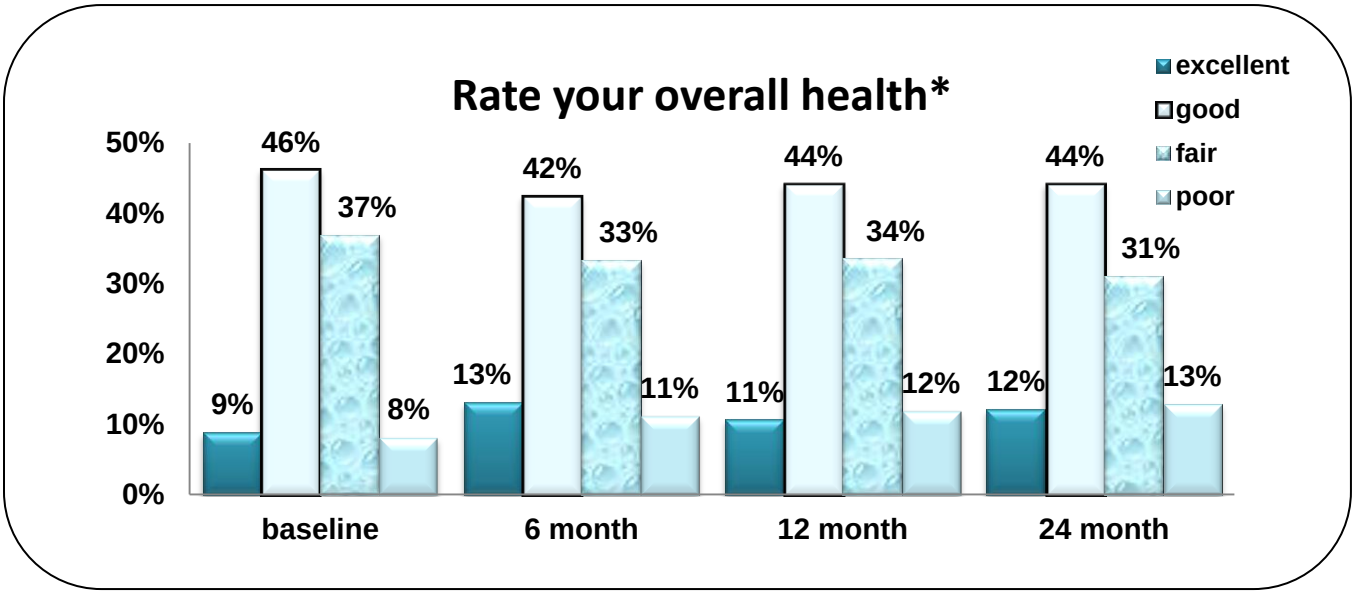


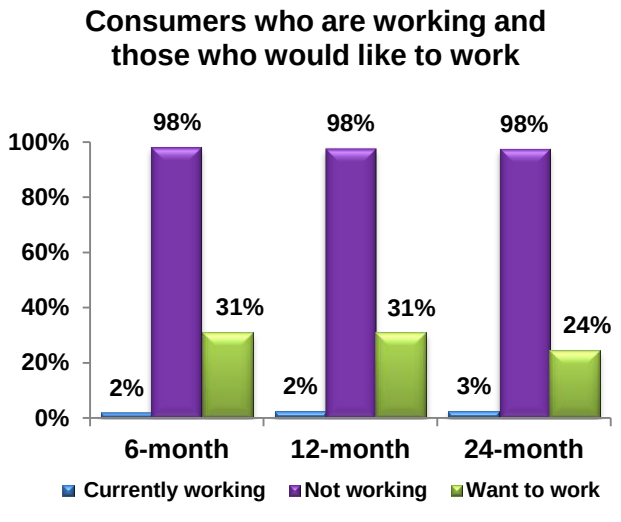


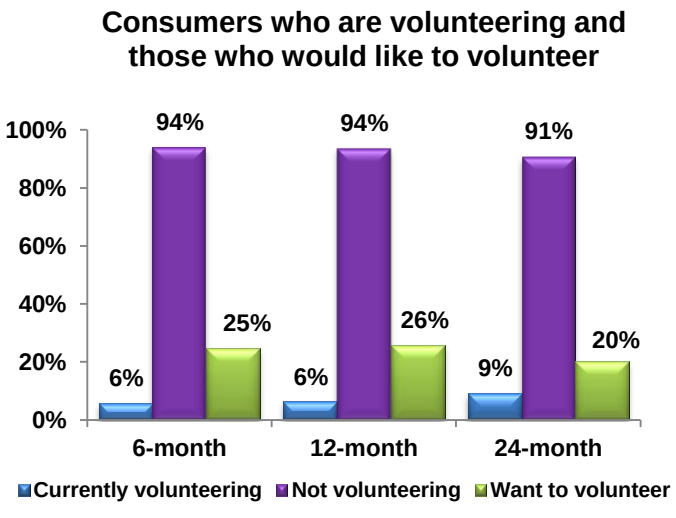




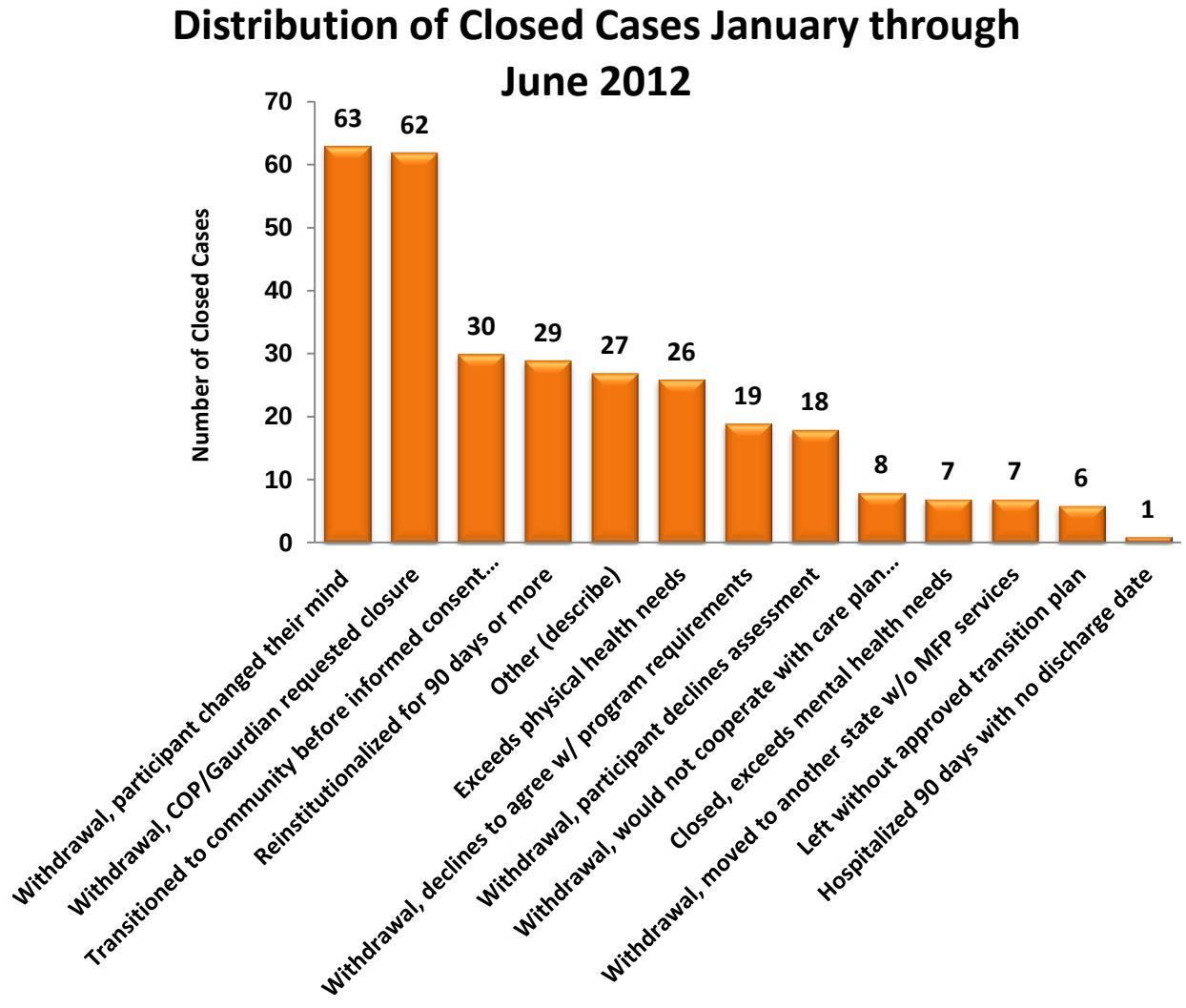


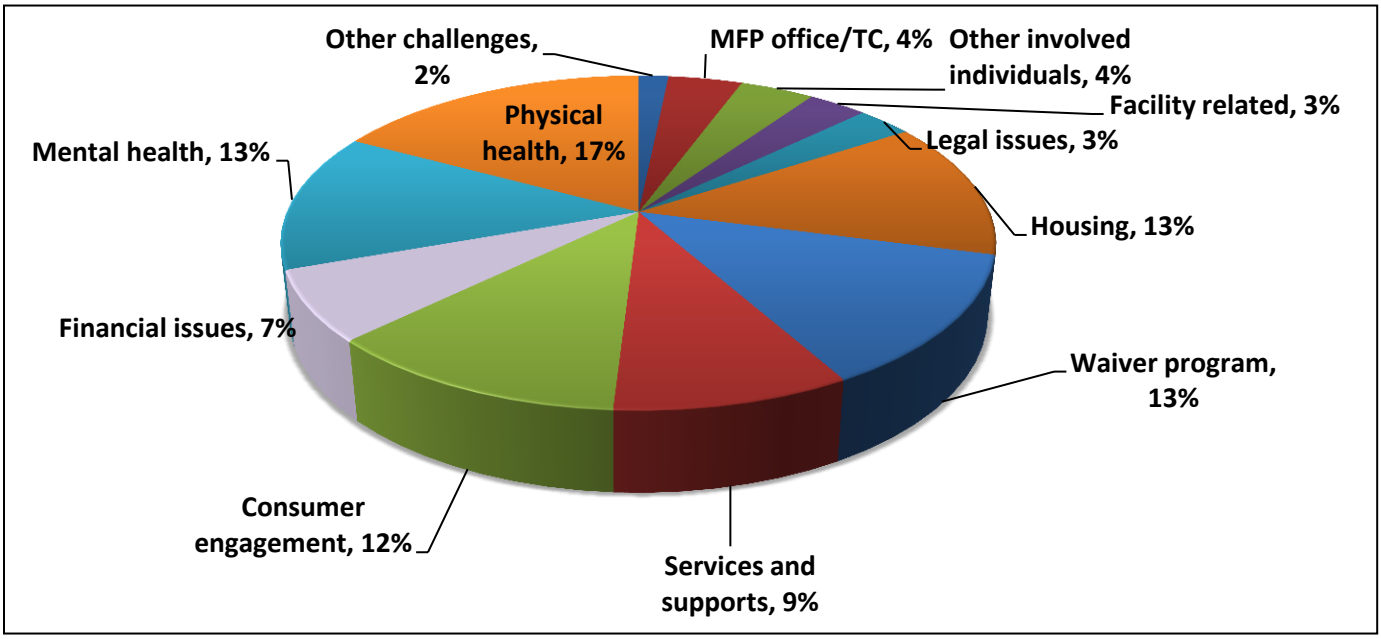






Closed Cases





Transition Challenges through 9/30/12

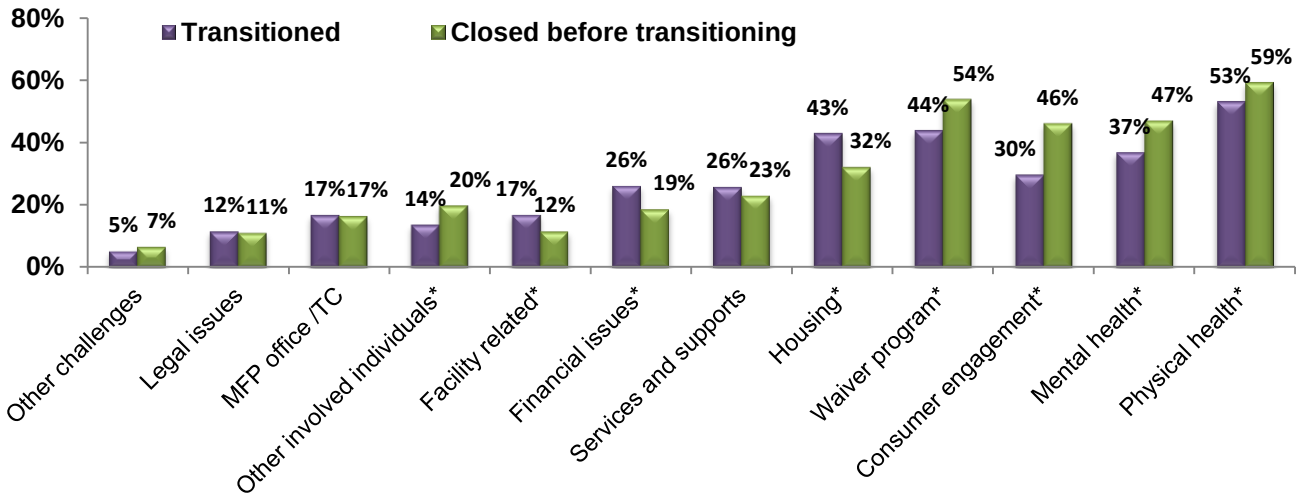
Transition coordinators complete a standardized challenges checklist for each consumer. There were a total of 4039 MFP referrals to TCs. Transition coordinators had completed challenges checklists for 2702 of these referrals, representing 2597 consumers. Excluding the referrals which indicated "no challenges," the challenges checklist generated 13,025 separate challenges. Of these the most frequently chosen challenge was physical health (17%), followed by challenges related to mental health, housing and waiver program (13% each) and consumer engagement, awareness or skills (12%).

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 indicated each challenge. For example, of the referrals which closed without transitioning, 59 percent indicated physical health was a challenge. The challenges and sub-challenges are checked off by the individual transition coordinator who is working with that consumer.

Eight of the twelve listed challenges indicated 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

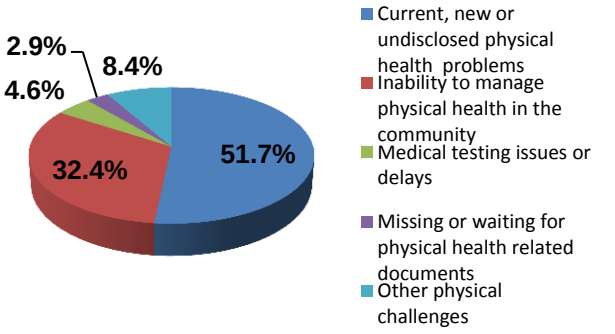


*indicates statistically significant differences

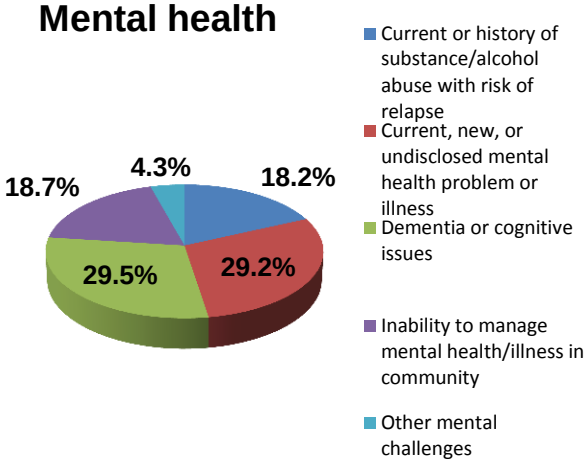
Types of Challenges – through 9/30/2012

Shown below are the five most common challenge types

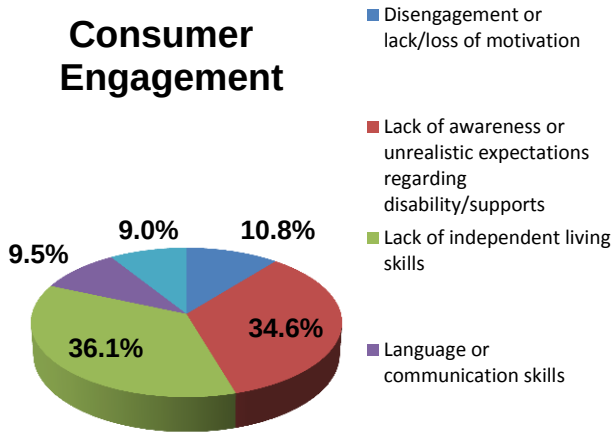
Physical health



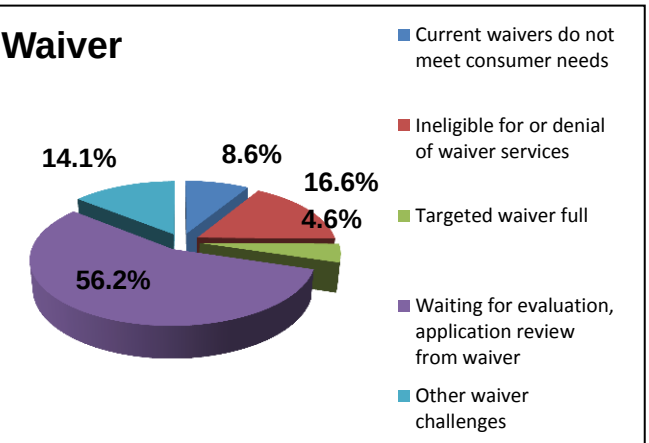
Mental health



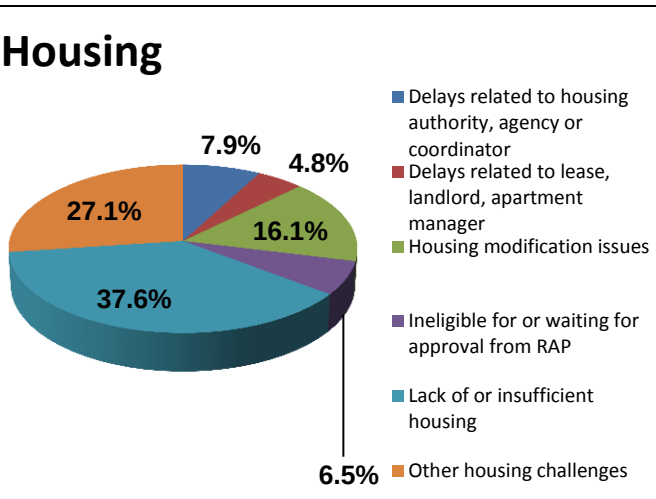
Consumer Engagement



Waiver

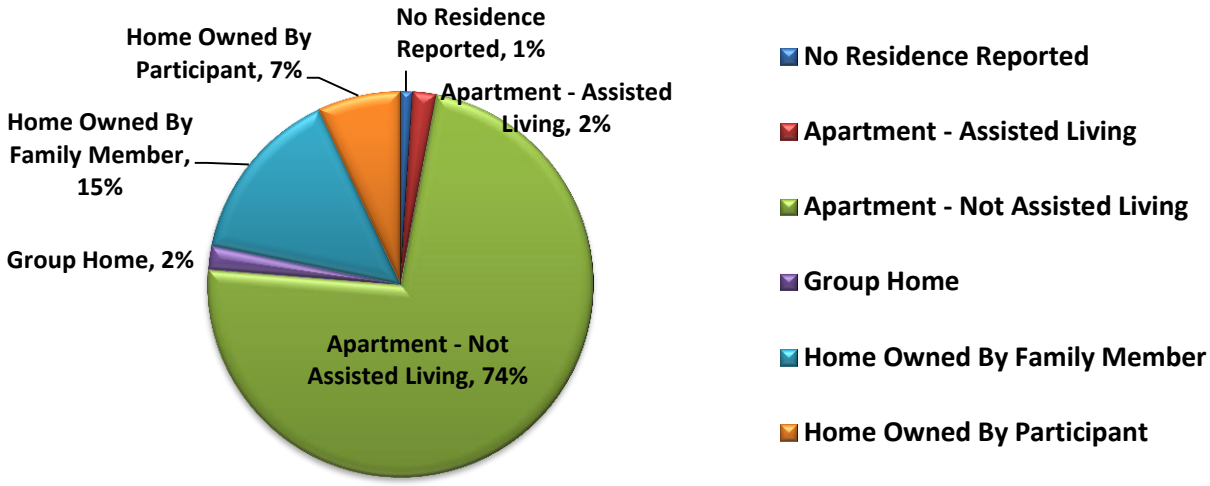


Housing

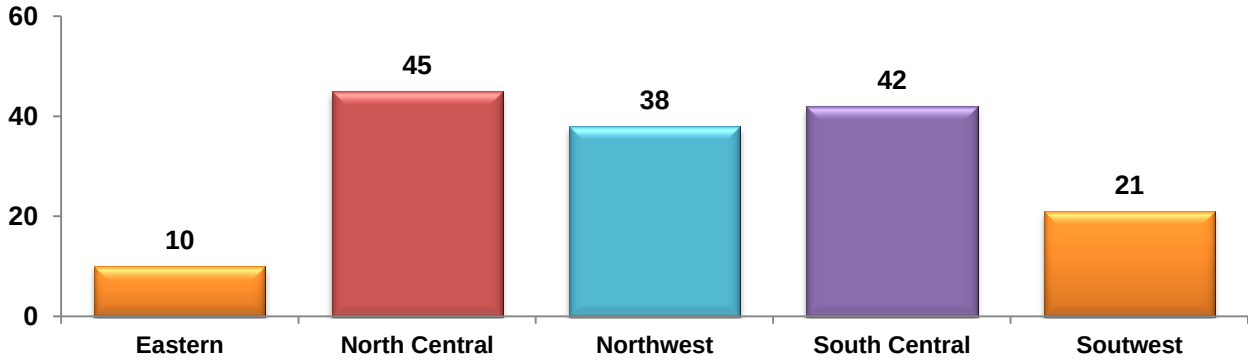


For the full report on transition challenges through 9/30/2012, use the link on page 7 to get to the Center on Aging website.

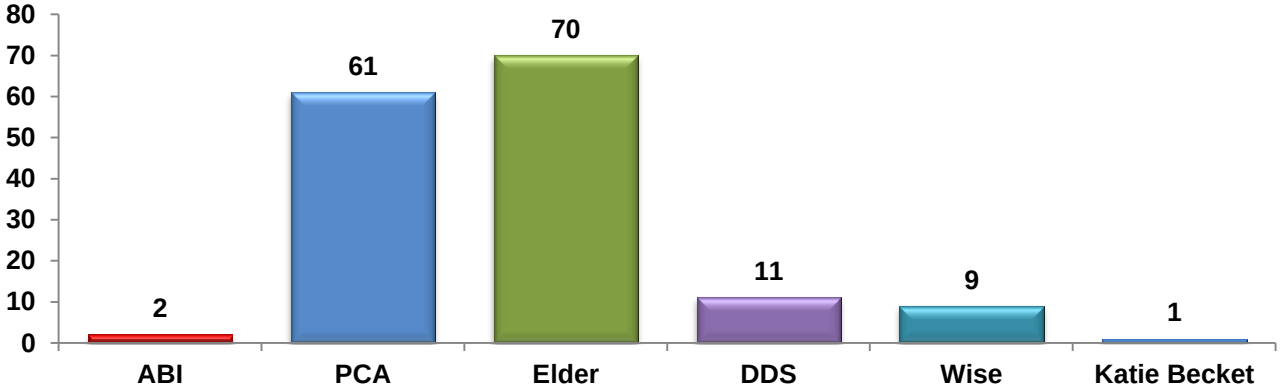
Qualified Residence Type – Cumulative 12/4/08-9/30/2012



Number of home modifications - by region



Number of clients with home modifications by waiver



Meet Lucille Webber

Lucille Webber may be chair-bound by health issues, but she has a welcoming spirit, enthusiasm for life and passion for creativity in spite of her disabilities. Approaching ninety, she lives in an accessible converted basement with the help of family and professional caregivers. For all of her life, she has been an artist; teaching, learning, making and selling her work. She views her multiple physical problems as just interruptions in her art. Having learned to conserve her limited energy to "fun things," she daily works at her lifelong passion of creativity including painting, music, origami, scrapbooking, needlepoint, quilting, knitting and crafts from which she derives much joy and purpose.

A current passion is jewelry making. Her worktable is laden with ongoing projects, design trays and boxes of brightly colored beads soon to be gifts for her family. As a quilter, she designs and makes tote bags and small purses of fancy material and beads. Open to new creativity she learned origami, designing unique gift cards and Christmas cards to delight her friends and family.

Looking to expand her mind, Lucille uses her computer to integrate technology into her art. She creates embroidery designs on her sewing machine then moves her designs from the sewing machine to disk to computer and back to the sewing machine. It pleases her to personalize the items she makes for others. Seeing them smile as she presents a gift to them gives her incentive and hope.

Music is another passion. Moving from her mobile chair to her organ bench, she adeptly pushes buttons and stops on her organ to produce integrated sounds for every genre of music. Using two keyboards, she produces her own organ concerts to entertain and enrich family and friends as well as lifting her own sprits in "down times."

Helping is another passion. Desiring to help others who have become handicapped as a result of surgery, Lucille shared her experiences when she participated in a panel presentation to professional caregivers. She helped educate them as a care recipient; hoping that through her story, they become more aware of the needs of people with new disabilities.

With the help of programs and her caregivers, Lucille adapts to ongoing changes and health crises. Although she can't walk anymore, she feels her best assets are her eyes and hands. They allow her to continue to be creative, filling her with joy, meaning and hope, and bring a smile to her face as she works to make others happy.

Lucille Webber
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.