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Connecticut's 'Money Follows The Person' Yields Positive Results For Transitioning People Out Of Institutions

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ABSTRACT A centerpiece of federal and state efforts to rebalance long-term services and supports to enhance consumer choice and contain costs, the federal Money Follows the Person Rebalancing Demonstration helps qualified individuals living in institutions make the transition to life in the community. The Connecticut Money Follows the Person program is an unusually rich source of data, with information on the 2,262 people who transitioned to the community under that state's program during 2008–14. Responses to participant surveys completed before and six, twelve, and twenty-four months after transition indicate that, for the majority of respondents who remained in the community, quality of life and life satisfaction improved significantly after transition, and they stayed high. About half of the participants visited hospitals or emergency departments after transition; however, only 14 percent had returned to an institution one year after transition. Predictors of reinstitutionalization included some not previously observed: mental health disability, difficulties with family members before transition, and not exercising choice and control in daily life. These and other findings suggest multiple ways in which policy makers can target efforts to strengthen transition programs that can meaningfully improve people's lives while containing costs.

People with disabilities of all ages prefer to live in community settings and receive community-based long-term services and supports instead of living in isolating institutions such as nursing homes, rehabilitation hospitals, or intermediate care facilities.[1,2] According to the Centers for Medicare and Medicaid Services (CMS), a community living setting is one that is integrated into and supports full access to the greater community. It provides meaningful choice and control over one's living environment and services according to one's preferences.[3]

Since the 1980s the proportion of people receiving community-based long-term services and supports has increased significantly.[4] Providing such services and supports costs less per capita than institutional care.[5,6] In 2013 long-term services and supports spending of $146 billion accounted for 34 percent of all Medicaid spending; 48.7 percent of these dollars went to institutions.[7]

Given the rare confluence of personal preference and economic efficiency, policy makers have developed initiatives to rebalance the long-term services and supports system to reduce the historical institutional bias and expand home and community-based services. The availability

of such services allows people with support needs to stay in community settings and return to communities after an institutional stay.[8]

Medicaid pays for the majority of long-term services and supports not provided by families.[9] Thus, the increased proportion of Medicaid long-term services and supports dollars spent in community versus institutional settings reflects progress in both national and state-specific rebalancing. Between 1995 and 2013 Medicaid spending on home and community-based services increased from 18 percent to 51 percent of total long-term services and supports spending.[7] However, this national statistic masks significant variation in the proportion of long-term services and supports spending devoted to home and community-based services across states that year, which ranged from 26 percent in Mississippi to 79 percent in Oregon.

The federal Money Follows the Person Rebalancing Demonstration, funded under the Deficit Reduction Act of 2005 and expanded by the Affordable Care Act, is a centerpiece of rebalancing strategy. In 2007, in the first round of Money Follows the Person, CMS provided funds for thirteen states, including Connecticut. The program currently operates in forty-six states and the District of Columbia.

The program has two arms: One focuses on increasing voluntary transitions from institutions to community-based settings, the other on improving states' home and community-based services infrastructure. Institutions from which people may transition under Money Follows the Person include nursing homes, hospitals, institutions for people with mental diseases, intermediate care facilities for people with developmental or intellectual disabilities, and group homes for five or more residents. Destination community settings include private homes and apartments, assisted living facilities, and group homes for four or fewer residents.

Policy discussions about long-term services and supports often center on ensuring safety and mitigating risk. Moving people with significant disabilities out of institutions that provide staff and services raises concerns for the people being moved, their family members, and policy makers. Will the people be safe in the community? Will they be able to stay in their community homes? Will they feel isolated? Will they be happy?

Before the implementation of Money Follows the Person, outcome data for large-scale transition programs were not available. The national Money Follows the Person evaluation has reported sustained increases in quality of life and life satisfaction after transition.[10] Furthermore, participants had lower total Medicaid and Medicare expenditures in the first year after transition.[11]

Quality of life for people remaining in institutional settings over time varies based on both resident and facility characteristics.[12] The national guiding principles of Money Follows the Person are based on person-centeredness, including the principle of choice. People in institutions are offered the choice of receiving services in the community instead. An operating premise is that quality of life is improved for institutionalized people who, empowered with the choice to return to the community, subsequently choose to make that transition. For residents of institutions who prefer to live in their communities, community living contributes to global life satisfaction (that is, feeling generally happy given all aspects of life at a particular time), and that satisfaction is a function of enhanced quality of life across multiple domains.[10]

Each person who transitions through Money Follows the Person completes a survey assessing quality of life and global life satisfaction, before transition and at regular intervals for two years afterward. The national evaluation tracks six specific quality-of-life domains: quality of and access to care, being treated well by providers, sense of autonomy, satisfaction with living arrangements, community involvement, and health and well-being. These domains align with other quality-of-life research in populations of people using long-term services and supports.[13,14]

This article describes the more than 2,000 people who transitioned from institutions to community settings through the Connecticut Money Follows the Person demonstration and discusses their quality of life, global life satisfaction, and health services use after transition. Specifically, we examined changes in indicators for each quality-of-life domain from before transition to six, twelve, and twenty-four months after transition. Then, with the goal of informing policy makers and program staff members across the United States who are involved in creating and managing transition programs, we identified the independent effects of these quality-of-life domains on global life satisfaction and reinstitutionalization one year after transition.

Global life satisfaction and avoiding reinstitutionalization are two key indicators of a successful transition to the community, indicating both quality and stability over time. CMS evaluates all states' Money Follows the Person programs on these measures. However, the national evaluation has not identified independent predictors of these outcomes that states can use for targeted program improvement.

Research comparing life satisfaction between nursing home and community residents demon-

strates clear detriments for residents of nursing homes.[15] Predictors of life satisfaction in frail older adults include physical health, emotional health, social support, and locus of control (that is, the extent to which individuals believe that they can control events affecting them).[16,17] No previous study has investigated the independent effects of quality-of-life domains on global life satisfaction for people of all ages and disabilities who have moved from institutions to community settings.

Previous research has identified multiple factors related to risk of nursing home admission for older adults, including older age, race and ethnicity, living alone, poor self-rated health, functional and cognitive impairment, falls, previous nursing home admission, and multiple medications.[18,19] However, previous research has not examined whether this constellation of factors also predicts readmission to institutional settings after a transition to the community. Furthermore, previous research has focused on the institutionalization of older adults.

The Connecticut Money Follows The Person Demonstration

Connecticut was selected for this study because of its productive transition and rebalancing programs, and because its state-level Money Follows the Person evaluation incorporates several enhancements to the national version. Connecticut's program includes all disability groups and has transitioned more people to the community than all but three other states, which is attributable to its early start and strong stakeholder support from legislators, other policy makers, consumers, and providers. The Connecticut evaluators added questions to the national evaluation survey.

Moreover, Connecticut is the only state that administers the survey at four time points instead of three. An additional survey collection at six months after transition allows an earlier look at participant outcomes than the national evaluation, which requires only surveys before transition and at twelve and twenty-four months after it.

Connecticut began transitioning residents from institutions to the community in December 2008 and will continue through 2018. Consistent with national program rules, enrollees must have been institutionalized for at least ninety days, have Medicaid as the institutional payer, and want to move to a community-based setting. There are no health or functional eligibility criteria, but the costs of the community care plan cannot exceed the individual's institutional costs.

States use a range of strategies to identify and enroll participants. In Connecticut, referrals to the program come from many sources, including residents themselves, family members, and facility social workers. After confirming eligibility, a care manager from an agency partner explains the program and gets signed informed consent. Following national guidelines, the consent describes all program components, including the evaluation surveys.

Money Follows the Person transition team members and procedures vary across states, to integrate Money Follows the Person with each state's unique home and community-based services program. In Connecticut each resident undergoing transition works with a team that consists of him- or herself, involved family members, a specialized care manager and transition coordinator, a facility social worker, a housing coordinator, and home and community-based service providers. This team develops a community-based, person-centered plan for each participant, drawing on a wide range of possible services such as home health, case management, and employment supports, and transitions the person to a community home. The University of Connecticut's Center on Aging conducted the program evaluation.

Study Data And Methods

STUDY DESIGN AND DATA SOURCES Staff members of Connecticut's Money Follows the Person program enter demographic and other information about participants—including living arrangement, disability category, and medical diagnoses—into a web-based data system. Field staff members complete a transition challenges checklist and an in-person baseline survey before each transition.

Following the state's augmented national evaluation protocol, evaluators complete follow-up interviews at six, twelve, and twenty-four months after transition at the current place of residence (community or institution), either by telephone or in person, based on participant preference (see the "Study Variables" section for interview components). Interviewers conduct assisted or proxy interviews if needed in English or Spanish (see the online Appendix for more details);[20] translators assist with interviews in other languages. The UConn Health Institutional Review Board approved this study.

STUDY PARTICIPANTS As of September 30, 2014, 2,339 people had transitioned to community living through Connecticut's Money Follows the Person program. Survey response rates were high: Of those eligible for interviews at each point in time, 93–97 percent completed the inter-

The wide range of outcomes measured tell a consistent story of improved quality of life.

views. During the two year follow-up time, 327 (14 percent) participants died (see the online Appendix).[20]

This analysis includes data from 2,262 people who transitioned before October 2014 and completed at least the pretransition survey. Differences in sample sizes between time points are primarily attributable to participants' not yet having reached due dates for follow-up surveys.

STUDY VARIABLES All of the variables used in the study come from the national evaluation protocol, except where specified as Connecticut-only variables. Participant characteristics include age, sex, race (white, black, or other), Hispanic ethnicity, disability category (age sixty-five or older with a physical disability, younger than age sixty-five with a physical disability, any age with a mental health disability, or any age with a developmental disability), dementia diagnosis (Connecticut only), housing type, and living arrangement (see the Appendix).[20]

The six quality-of-life domains include multiple measures assessed at the time of each survey. The domain of quality of and access to care includes satisfaction with services, unmet need for personal care assistance, and unmet need for medical or mental health care (see the Appendix).[20] The domain of being treated well by providers includes being treated with respect and dignity and experiencing physical, verbal, or financial mistreatment.

The domain of sense of autonomy uses a six-item scale to assess choice and control over daily life (see the Appendix).[20] A survey question asking, "Do you like where you live?" is used for the domain of satisfaction with living arrangements. The domain of community involvement includes a five-item community integration index[10] (see the Appendix)[20] and whether participants moved between two of the survey times.

And the health and well-being domain includes needing assistance with six activities of daily living and seven instrumental activities of daily living (Connecticut only), self-rated health (1 = excellent, 4 = poor), whether the participant had a fall since the previous survey (Connecticut only), and depressive symptoms (see the Appendix).[20] Participants also responded to a single question assessing global life satisfaction: "Taking everything into consideration, during the past week have you been happy or unhappy with the way you live your life?"

Finally, respondents reported their use of selected health services at each follow-up interview (Connecticut only): whether or not they had visited the emergency department (ED), stayed overnight in a hospital, or returned to an institution since the previous interview, and whether or not they were reinstitutionalized at the time of the follow-up interview.

STATISTICAL ANALYSES Statistical differences in quality-of-life indicators from before transition to after it (at six, twelve, and twenty-four months) were assessed with McNemar's tests for the categorical measures (such as satisfaction with services) and with paired *t*-tests for the continuous measures (for example, the number of deficits in activities of daily living). These analyses were conducted for the whole sample as well as for the subgroup of people who remained in the community at the time of each follow-up survey.

Descriptive statistics indicate the use of health services after transition. Logistic regression models identify quality-of-life and demographic predictors that increase or decrease the odds of two key outcomes: global life satisfaction and being reinstitutionalized twelve months after transition.

The logistic regression models included all independent variables with significant bivariate relationships with the dependent variables (see the Appendix).[20] More parsimonious models might be more useful in achieving the ultimate goal: helping program planners identify key risk and protective factors to target in the future.

The model predicting global life satisfaction included all participants who had completed six- and twelve-month surveys and included reinstitutionalization as an independent predictor. The logistic regression predicting reinstitutionalization at twelve months after transition excluded 173 people who were institutionalized at six months after transition, to ensure that the six-month predictors included in the model described community-based experiences (see the Appendix).[20] A p value of less than 0.05 indicates significance in all analyses.

LIMITATIONS Our study had several limitations. First, the data we analyzed came from one state's Money Follows the Person program and did not include a comparison group, and our results might not be generalizable to all Money Follows the Person or other transition programs.

However, all state Money Follows the Person programs operate under the same set of CMS program rules, with minor operational differences described above. Given these national program standards and the exceptional response rate, this prospective cohort provides an excellent participant population for other states to learn from.

Second, the national evaluation protocol dictated the majority of the variables examined in Connecticut's evaluation and called for the inclusion of proxy respondents. The use of dichotomous variables for some outcomes might not be ideal for purposes of data analysis. However, as reliable and easily understood measures, they are preferable to more complex measures when surveying a population that includes participants with cognitive disabilities. Because proxy responses could differ from participants' responses, all analyses were also conducted without proxy respondents. Except for the predictors of reinstitutionalization, statistical results did not differ. Moreover, excluding proxy responses from the current analysis would eliminate the perspectives of the most vulnerable program participants and skew the results regarding reinstitutionalization. Therefore, both proxy and participant surveys were included (see the Appendix).[20]

Study Results

Demographic characteristics of all participants who completed a pretransition survey appear in Appendix Exhibit 1.[20] Participants' ages ranged from under 1 year to 104 years. The average was 63 years; 9 percent of the participants were ages 85 and older, and 11 percent were younger than age 45. The sample was 52 percent female, three-quarters white, and 11 percent Hispanic.

Primary disability categories were ages sixty-five and older with a physical disability (45 per-

EXHIBIT 1

Quality-Of-Life Indicators And Global Life Satisfaction Before Transition From An Institution To A Community-Based Setting Compared To Six, Twelve, And Twenty-Four Months After Transition For Participants In Connecticut's Money Follows The Person Program, 2008–14

	Before transition (n = 2,262)		Months after transition					
			6 (n = 1,605)		12 (n = 1,328)		24 (n = 770)	
Quality-of-life domains and measures	% or mean	No. or SD	% or mean	No. or SD	% or mean	No. or SD	% or mean	No. or SD
QUALITY OF AND ACCESS TO CARE								
Satisfied with services	76.3%	1,103	90.9%****	1,314	91.6%****	1,096	92.9%****	645
Unmet need for personal care assistance	20.8%	332	7.2%****	115	7.1%****	94	6.4%****	49
Unmet need for medical or mental health care	18.3%	289	18.3%	289	18.2%	238	15.7%***	120
TREATED WELL BY PROVIDERS								
Treated with respect and dignity	72.2%	1,052	95.0%****	1,384	95.1%****	1,136	95.6%****	655
Physical, verbal, or financial mistreatment	28.0%	429	6.0%****	92	6.2%****	78	6.4%****	46
SENSE OF AUTONOMY								
Choice and control over daily life[a]	4.07	1.55	5.37****	1.04	5.34****	1.07	5.37****	1.05
SATISFACTION WITH LIVING ARRANGEMENTS								
Like where you live	58.3%	914	95.3%****	1,494	94.1%****	1,226	92.9%****	697
COMMUNITY INVOLVEMENT								
Score on community integration index[b]	3.01	1.26	3.55****	1.21	3.57****	1.18	3.68****	1.16
Community move since last survey	—[c]	—[c]	5.6%	84	4.9%	63	10.7%	80
HEALTH AND WELL-BEING								
Number of ADL deficits	2.04	2.13	1.93**	2.08	1.92	2.08	1.82	2.06
Number of IADL deficits	3.96	2.14	4.08***	2.03	4.08****	2.07	3.99**	2.06
Self-rated health[d]	2.44	0.73	2.41	0.84	2.43	0.82	2.38	0.84
Fall since the previous survey	19.8%	309	25.8%****	403	24.2%***	312	24.9%***	189
Depressed mood	57.6%	899	50.5%****	788	50.0%****	645	47.4%****	356
Global life satisfaction								
Global life satisfaction	63.0%	921	83.9%****	1,227	82.8%****	1,001	83.3%****	589

SOURCE Authors' analysis of data for 2008–14 from the Connecticut Money Follows the Person Demonstration. **NOTES** Of the 2,262 study participants, those who were back in an institution at the time of the six-, twelve-, or twenty-four-month survey were excluded from those respective comparisons. Percentages reflect number of respondents with complete data for each bivariate comparison. Global life satisfaction is feeling generally happy given all aspects of life at a particular time. ADL is activity of daily living. IADL is instrumental activity of daily living. [a]On a scale of 0 to 6. [b]On a scale of 0 to 5. [c]Not applicable. [d]On a four-point scale (1 = excellent, 2 = good, 3 = fair, and 4 = poor). **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

cent), under age sixty-five with a physical disability (40 percent), mental health disability (11 percent), or developmental disability (4 percent). Thirteen percent of the sample had a diagnosis of dementia.

Upon transition from an institution, 71 percent of the sample moved into leased apartments, and 21 percent moved into a house owned by either the participant or a family member. The remaining 8 percent moved to an assisted living facility, a residential care home, or a group home. Just under half lived alone after the transition, a third moved to the home of a spouse or other family member, a small number (3 percent) lived with friends or roommates, and 21 percent lived with a paid support person or in supervised housing.

For people who remained in the community at each point in time, a remarkably consistent pattern emerged in the first five quality-of-life domains: Responses on virtually all indicators improved from baseline (before the transition) to six months after the transition and stayed consistently high over two years for quality of and access to care, being treated well by providers, sense of autonomy, satisfaction with living arrangements, and community involvement (Exhibit 1). Between each survey, 5–11 percent of the participants moved, demonstrating housing stability within the community.

Results were mixed in the health and well-being domain (Exhibit 1). Deficits in activities of daily living decreased, but deficits in instrumental activities of daily living increased slightly after the transition, although neither change (from 2.0 to 1.9 deficits in activities of daily living and from 4.0 to 4.1 deficits in instrumental activities of daily living) reached a clinically meaningful level. Self-rated health remained at 2.4 across all four points in time, which falls between good and fair on the four-point scale.

The incidence of recent falls increased from 20 percent before transition to 26 percent six months after transition, and it remained above the pretransition levels. Notably, this was the only indicator to worsen in the community.

Symptoms of depression declined significantly after transition, although close to half of the respondents at each interview still had depressive symptoms. For global life satisfaction, the share of respondents who reported being happy with the way they were living their lives increased from 63 percent before transition to 84 percent at six months afterward and remained at 83 percent for the rest of the two-year follow-up period.

These results for participants who remained in the community at the time of each survey do not differ markedly from analyses of the full sample that also included people who had returned to institutions. However, subanalyses show that the group of people who remained in the community accounted for the improvements after transition described above. For purposes of comparison, the analyses of the full sample appear in Appendix Exhibits 2 and 3.[20]

Participants remaining in the community reported relatively high use of some health services after transition (Exhibit 2). About half had visited the ED, and about one-third had been hospitalized since each previous interview. At the time of each interview after transition, 12–19 percent of all the participants were currently in an institution, and 15–24 percent had returned to an institution for some period of time between interviews. The subgroup of reinstitutionalized participants had higher rates of ED visits and hospitalizations than those who remained in the community.

Several factors were found to be independently related to global life satisfaction at the twelve-month interview (Exhibit 3). Participants who

EXHIBIT 2

Health Services Use By Participants In Connecticut's Money Follows The Person Program At Six, Twelve, And Twenty-Four Months After Transition From An Institution To A Community-Based Setting, 2008–14

	Months after transition					
	6		12		24	
	Percent	Number	Percent	Number	Percent	Number
ED visit[a]	44	565	45	574	54	400
Overnight in hospital[a]	29	374	31	394	38	286
Currently in an institution[b]	12	215	14	216	19	175
Ever institutionalized since last survey[b]	15	278	20	315	24	227

SOURCE Authors' analysis of data for 2008–14 from the Connecticut Money Follows the Person Demonstration. **NOTES** People who were back in an institution at the time of the six-, twelve-, or twenty-four-month survey were excluded from the emergency department (ED) and hospitalization numbers but not from the reinsitutionalization numbers. [a]There were 1,605 respondents with complete data in the six-month group, 1,328 in the twelve-month group, and 770 in the twenty-four-month group. [b]There were 1,820 respondents with complete data in the six-month group, 1,544 in the twelve-month group, and 945 in the twenty-four-month group.

EXHIBIT 3

Predictors Of Global Life Satisfaction At Twelve Months After Transition From An Institution To A Community-Based Setting By Participants In Connecticut's Money Follows The Person Program

Independent variable (months after transition)	Odds ratio	95% CI
Unmet need for personal care assistance (12)	0.59**	0.36, 0.97
Unmet need for medical or mental health care (12)	0.61***	0.42, 0.86
Treated with respect and dignity (12)	1.94**	1.12, 3.38
Physical, verbal, or financial mistreatment (12)	0.98	0.58, 1.66
Fall since last survey (12)	0.82	0.59, 1.14
Like where you live (12)	2.11****	1.71, 2.60
Choice and control over daily life (12)	1.18**	1.04, 1.34
Score on community integration index (12)	1.53****	1.34, 1.73
Reinstitutionalized (12)	0.67*	0.44, 1.03
Constant	0.09	—[a]

SOURCE Authors' analysis of data for 2008–14 from the Connecticut Money Follows the Person Demonstration. **NOTES** The dependent variable and the independent variables were measured at twelve months. This logistic regression was applied to 1,544 participants. Model summary statistics: chi square statistic = 270.68; degrees of freedom = 9, $p < 0.001$; −2 Log likelihood = 1,154.84; Nagelkerke $R^2 = 0.28$. Global life satisfaction is feeling generally happy given all aspects of life at a particular time. CI is confidence interval. [a]Not applicable. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

reported unmet need with personal care or with medical or mental health care were only about 60 percent as likely as those who did not report such need to report feeling happy with how they were living their lives. By contrast, people who said they were treated with respect and dignity and those who liked where they lived were twice as likely to be happy with their lives than people who were not well treated or liked where they lived, respectively. People with greater choice and control over their daily lives and people with higher levels of community integration were also significantly more likely to report life satisfaction, compared to those with less choice or integration, respectively.

When these quality-of-life factors are taken into consideration, other factors such as mistreatment, falls, and reinstitutionalization, which were significant bivariate predictors, did not significantly relate to life satisfaction. Overall, these factors explained about 28 percent of the variance in global life satisfaction.

Fourteen percent of participants had returned to an institution at the time of their twelve-month interview. Logistic regression results show several significant predictors of reinstitutionalization, including higher age and worse self-rated health (Exhibit 4). People with mental health disabilities were two and a half times more likely than others to return to an institution. Recent falls and challenges with family members before the transition doubled the likelihood of being reinstitutionalized. In contrast, people with choice and control in their daily lives at six months were only 78 percent as likely as others to be back in an institution at twelve months. The following six-month measures were significant bivariate predictors but were no longer related to reinstitutionalization at twelve months in the multivariate model: global life satisfaction, unmet need for personal care assistance, and liking one's home. The logistic regression model predicting reinstitutionalization explained 13 percent of the variance for being reinstitutionalized at twelve months.

EXHIBIT 4

Predictors Of Reinstitutionalization At Twelve Months After Transition From An Institution To A Community-Based Setting By Participants In Connecticut's Money Follows The Person Program

Independent variables (months after transition)	Odds ratio	95% CI
Age at transition	1.03****	1.01, 1.05
Mental health disability	2.52***	1.31, 4.82
Self-rated health (6)	1.41**	1.03, 1.91
Global life satisfaction (6)	0.60*	0.34, 1.08
Unmet need for personal care assistance (6)	1.85*	0.89, 3.82
Fall since last survey (12)	1.99***	1.20, 3.30
Like where you live (6)	0.87	0.41, 1.83
Choice and control over daily life (6)	0.78**	0.64, 0.96
Challenges with family before transition	1.98**	1.08, 3.64
Constant	0.01	—[a]

SOURCE Authors' analysis of data for 2008–14 from the Connecticut Money Follows the Person Demonstration. **NOTES** The dependent variable was measured at twelve months. Most of the independent variables were measured at six months, in order to examine the effect of quality-of-life measures on reinstitutionalization. This regression analysis was applied to 1,544 respondents to the twelve-month survey, minus 173 respondents who were reinstitutionalized at the six-month survey. Model summary statistics: chi square statistic = 57.80; degrees of freedom = 9, $p < 0.001$; −2 Log likelihood = 502.39; Nagelkerke $R^2 = 0.13$. CI is confidence interval. [a]Not applicable. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

Discussion

This study investigated long-term outcomes of transitioning from institutions to community living over six years of the Money Follows the Person program, 2008–14, in Connecticut. Participants included people of all ages with any type of disability and came from diverse racial and ethnic groups.

Despite needing assistance with an average of two activities of daily living and four instrumental activities of daily living, almost three-quarters of the participants moved into their own apartments. The wide range of outcomes measured tell a consistent story of improved quality of life, which led to higher rates of global life satisfaction for people who remained in the community. Participants who returned to institutions did not report the same improvements.

Although the results indicate improvement after transition on nearly every indicator for par-

Connecticut's Money Follows the Person program has largely succeeded in addressing concerns about safety, quality of life, and life satisfaction.

ticipants who remained in the community, they nevertheless highlight several opportunities for ongoing program improvement. About half of those participants reported symptoms of depression after transition, and a notable minority (16–18 percent) reported unmet needs for medical or mental health care in the community. Six percent experienced physical, verbal, or financial mistreatment after transition, whereas well over a quarter reported such mistreatment before transition. The incidence of falls increased after transition, with a fourth of the participants reporting recent falls. These falls could lead to ED visits, hospital stays, or reinstitutionalization.

Global life satisfaction and reinstitutionalization are of particular interest to a range of stakeholders—including policy makers, advocates, families, and individuals who might transition—which warranted in-depth multivariate analyses. The significant independent predictors of life satisfaction that we found are important, even if not surprising, such as being treated with respect and dignity and experiencing integration into the community. Equally notable are the factors that were not significant (mistreatment, recent falls, and reinstitutionalization), although in bivariate analyses they were related to life satisfaction.

To enhance life satisfaction, planning for care after transition should focus on addressing personal medical and mental health care needs and ensuring that people select a home that they truly like and from which they can participate in their communities. Person-centered planning is key to ensuring that people exercise choice and control over decisions in daily life and that caregivers treat them with respect and dignity.

Although only 14 percent of participants were back in an institution twelve months after transition, identifying triggers for reinstitutionalization highlights risk factors to consider when risk mitigation plans are being developed at the time of transition. Some of the predictors that we identified, such as older age, lower self-rated health, and experiencing falls, are consistent with the results of previous research.[18,19] Other predictors identified are new and may be unique to a population that has made a transition: having a mental health disability, experiencing difficulties with family members before transition, and not exercising choice and control in daily life.

Although related in bivariate comparisons to reinstitutionalization, the factors of life satisfaction, liking one's home, and unmet need for personal care assistance did not independently predict a return to an institution. Several additional factors did not relate to reinstitutionalization even in bivariate analyses. These included functional status, a diagnosis of dementia, mistreatment, unmet need for medical or mental health care, and community integration.

Our study results suggest several areas to explore in future research. The next steps include investigating differences in outcomes for specific subgroups, such as the different disability groups. For example, do older adults with physical disabilities have different experiences after transition than their younger counterparts? Do people with mental health disabilities have a different set of risk factors for reinstitutionalization than other people, in addition to their higher overall risk that our analyses uncovered? The data on reinstitutionalization could be explored in more depth to determine whether risk factors differ for short stays versus long stays or permanent returns.

Such targeted explorations of reinstitutionalization could shed light on the relatively low variance explained in the logistic regression model by identifying additional factors associated with reinstitutionalization under specific conditions. Outside the scope of this article, but also of interest, is the identification of any specific services or community programs that might help prevent a return to an institution or improve the quality of life for people who transition out of an institution to the community. Finally, future analyses should examine mortality, recognizing that for some participants, death might not be an unexpected, or even a negative, outcome.

Conclusion

The results of this study show that Connecticut's Money Follows the Person program has largely succeeded in addressing concerns raised by poli-

cy makers, advocates, families, and residents of institutions about safety, quality of life, and life satisfaction following a transition to the community. More than 2,000 people in the program returned to community living, where the vast majority of them have thrived. National and state policy makers can gain insights from these findings to identify areas to target that could prevent the use of acute care services and reinstitutionalization after transition, as well as to ensure high quality of life and global life satisfaction for older adults and people with disabilities living in the community. ■

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NOTES

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20 To access the Appendix, click on the Appendix link in the box to the right of the article online.