I Choose Home NJ Quality Report July – December 2023

BACKGROUND[1]

The federal Money Follows the Person program (MFP), known at the state level as I Choose Home NJ (ICHNJ), assists in the transitioning of individuals receiving long-term care services in institutions back to the community with home and community-based services. One of the goals of ICHNJ is for individuals to remain in their homes after transition, measured by the program benchmark to have fewer than 4% of all ICHNJ participants be re-institutionalized within 90 days of discharge from the nursing facility. Beginning in January 2022, the ICHNJ Quality Assurance Specialist conducted post-transition outreach, in part to identify and resolve barriers that may make it difficult for ICHNJ participants to remain in their homes. Contact with individuals post transition further serves as another level of support for individuals, opportunity for advocacy, and exploration of ways in which participants would like to connect with others and their community.

[1] *Background information originally appeared in January-June 2022 Quality Report*

DATA COLLECTION[2]

The purpose of data collection is to:

1. Allow ICHNJ participants to express their needs based on their experience;
2. Identify and provide Quality oversite for the resolution of issues for ICHNJ participants to prevent reinstitutionalization within the first 90 days of transition; and
3. Present findings and recommendations to the Director of MLTSS at the Division of Medical Assistance and Health Services (DMAHS); the Director of MLTSS at the Division of Aging Services (DoAS); the MFP/ICHNJ Executive Team; and key stakeholders in order to improve the ICHNJ program and service delivery of MLTSS.

The ICHNJ QA Specialist attempts outreach within 30 days for participants who have transitioned from a nursing home, though contact may occur after 30 days . Once the QA specialist contacts the participant, they explain the goal of the follow-up call is to identify barriers which may make it difficult to remain in their home and, if desired, coordinate with the Managed Care Organization (MCO) care team to address and resolve identified outstanding

[2] *Data Collection originally appeared in January-June 2022 Quality Report*

Due to the nature of the outreach process and data collection, the following should be noted:

- *Data is based on self-reported responses from ICHNJ participants contacted.*
- *Data is not available for all participants outreached. Sixty-four (64) could not be reached (e.g. phones out of service, no answer, no response to voicemails, etc.).*
- *Intervention with MCOs is not done in all instances where participants identify problems. Individuals choose if they want the QA Specialist to follow-up with their MCO.*
- *Due to small sample sizes, data presented cannot be indicative of greater trends across MCOs.*

need. Follow-up calls are conversational in nature and the QA Specialist uses a survey tool to help track areas of concern. These include, but are not limited to, care manager contact, availability of personal care assistants (PCA), receipt of durable medical equipment (DME), meal delivery status, and installation of emergency response systems (PERS), based on individual's need and personal preference. With consent, the ICHNJ QA Specialist contacts the individual's MCO to help resolve outstanding issues and ensure that the individual's plan of care matches their needs and preferences. *Please see Appendix A for the survey tool utilized to identify areas of concern.*

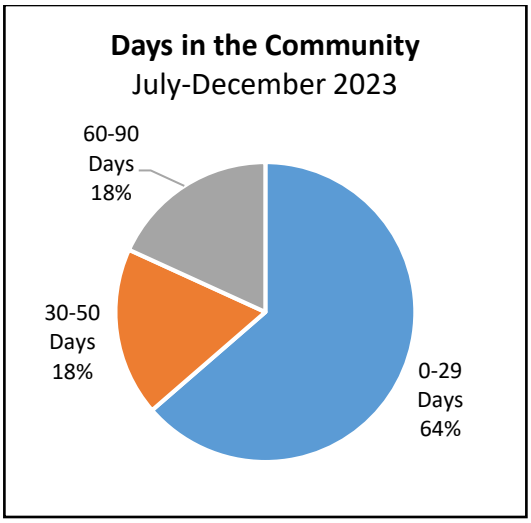
DATA REPORTED

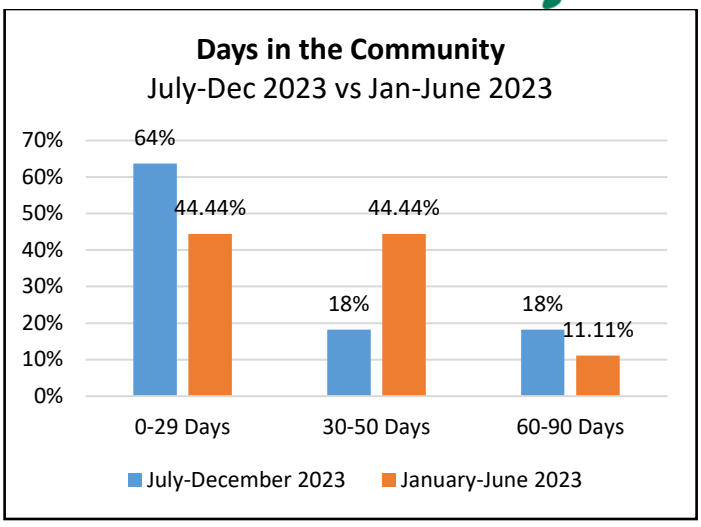
In part, outreach is conducted to assist individuals with remaining in their homes as outlined in MFP Benchmark #3:

As a result of the implementation of MLTSS by the Managed Care Organizations, fewer than 4% of MFP participants will be re-institutionalized within ninety (90) days of discharge from the nursing facility.

Reinstitutionalization within 90 days of transition					
Year	**Jan - June**	**July - Dec**	**Total Re-instit.**	**Total Transitions**	**% of Total Re-instit.**
2019	6	5	11	216	5.09%
2020	5	7	12	249	4.82%
2021	15	15	30	368	8.15%
2022	15	15	30	393	7.63%
2023	**11**	**11**	**22**	**398**	**5.53%**

In 2023, 22 of 398 (5.53%) have been re-institutionalized within 90 days of transition to the community. Reinstitutionalizations within 90 days decreased during the second half of 2023, from 6.21% to 5.4%. While the benchmark of fewer than 4% was not met, the overall reinstitutionalization rate for 2023 was lower than in 2021 and 2022.





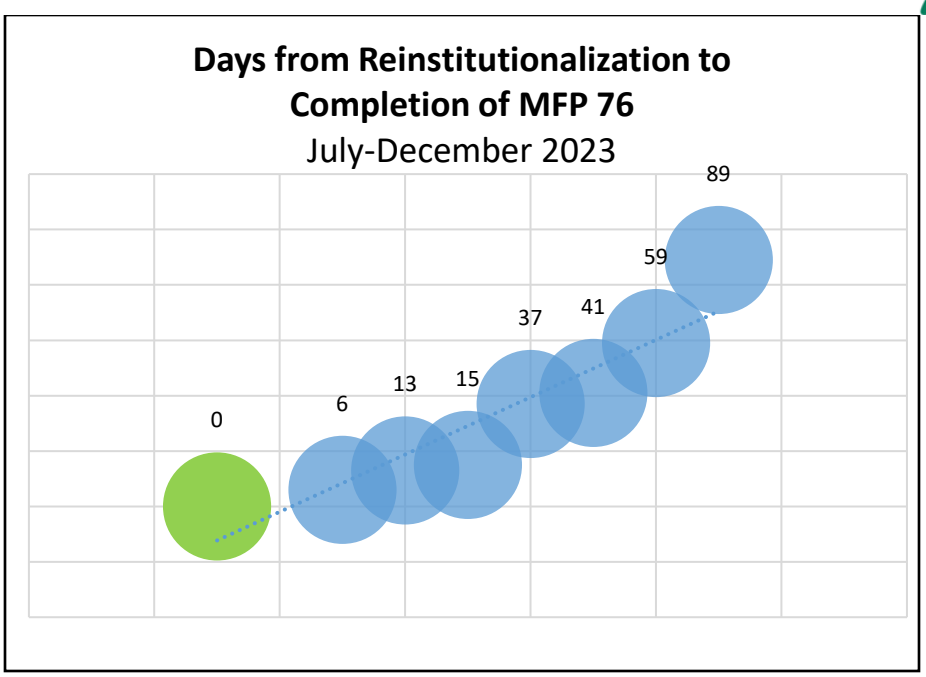
Eleven individuals were reinstitutionalized within 90 days between July and December of 2024. Seven of these individuals who returned to a nursing facility were reinstitutionalized in less than 30 days, eighteen percent (18%, 2 of 11) between 30-59 days, and eighteen percent (18%, 2 of 11) between sixty (60) and ninety (90) days. More than half those re-institutionalizations occurred within thirty (30) days in the community.

For the July-December 2023 period, additional information collected on the tracking form for nursing home readmission (MFP 76 form) indicate that three individuals reported feeling safer residing in a nursing facility, and four families of participants reported that they felt their loved one would be safer in a facility as they could not provide adequate care at home. Per the tracking forms received, the MCO's reported two individuals did not receive all durable medical

equipment ordered and two individuals who had personal care support approved did not have personal care attendants in place prior to their reinstitutionalization.[3]

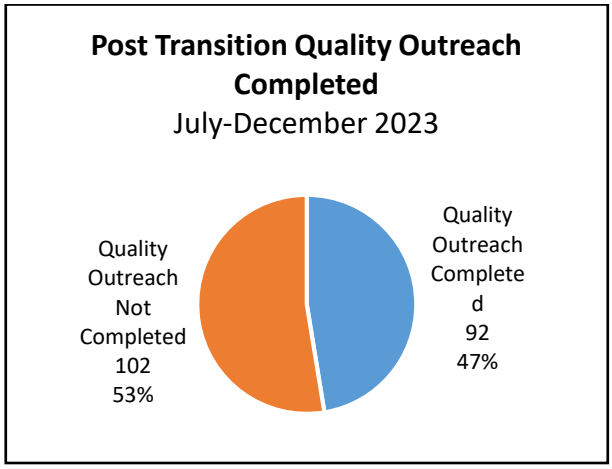
Per the contract between the state of NJ and the managed care organizations (MCOs), the MCO must notify MFP program staff, via a form, of any triggers that would stop the MFP clock or disqualify the member from participation in the MFP demonstration program within forty-eight (48) hours of a trigger event. A participant's readmission to a nursing facility is a qualifying event that must be reported. In most cases, Care Managers completing the notification form have indicated delays are due to being unaware of the member's status until the time they are completing the form.

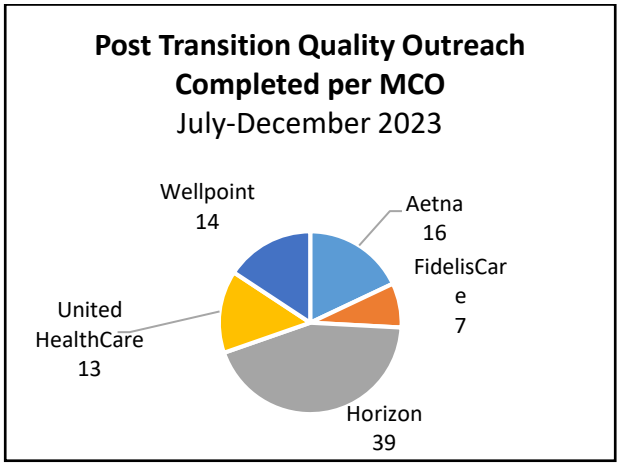
[3] Additional information as to the why personal care support was not in place prior to the individual's return to the nursing facility is not available.



Despite this requirement, the MCOs notified MFP staff of nursing home reinstitutionalization of members on average 32 days after they have returned to a nursing home, and up to 89 days later. Only one readmission was reported within the mandated 48 hour timeframe. Rationale from care managers for late submissions indicate that they were not aware of the member's reinstitutionalization until the time they completed the form. Despite the requirement for monthly contact with MFP participants, in nearly half of reinstitutionalization instances, the care manager was unaware for more than 30 days that their member had been reinstitutionalized.

POST TRANSITION QUALITY FOLLOW-UP OUTREACH





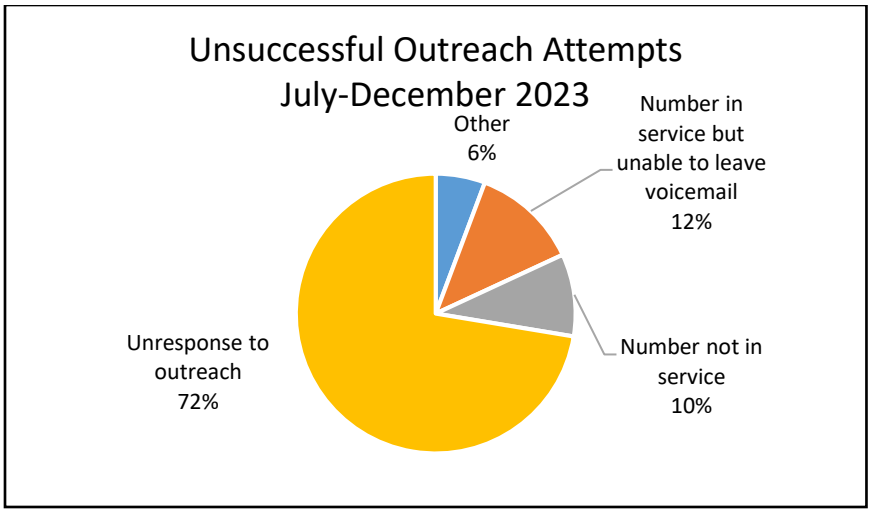
Total Participant Contact Attempts: 197

Total Participant Contacts: 92

Average length of time from transition date to follow-up contact: 27 Days

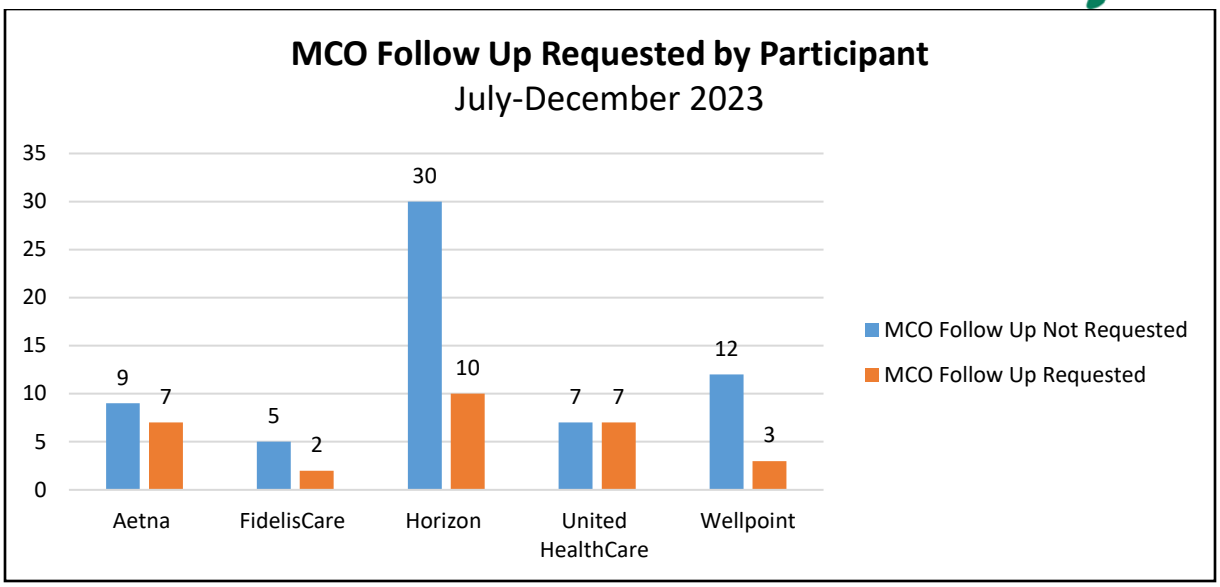
Post transition quality follow-up was completed for 92 of 197 individuals[4] (47%). Starting in October 2023, the ICH program began collecting email addresses for individuals and/or natural supports to increase the percentage of participants successfully contacted.

[4] Post transition quality outreach is completed for nursing facility transitions only. This does not include individuals who transitions under the Division of Developmental Disabilities (DDD). However, those individuals are included in the total transition number.

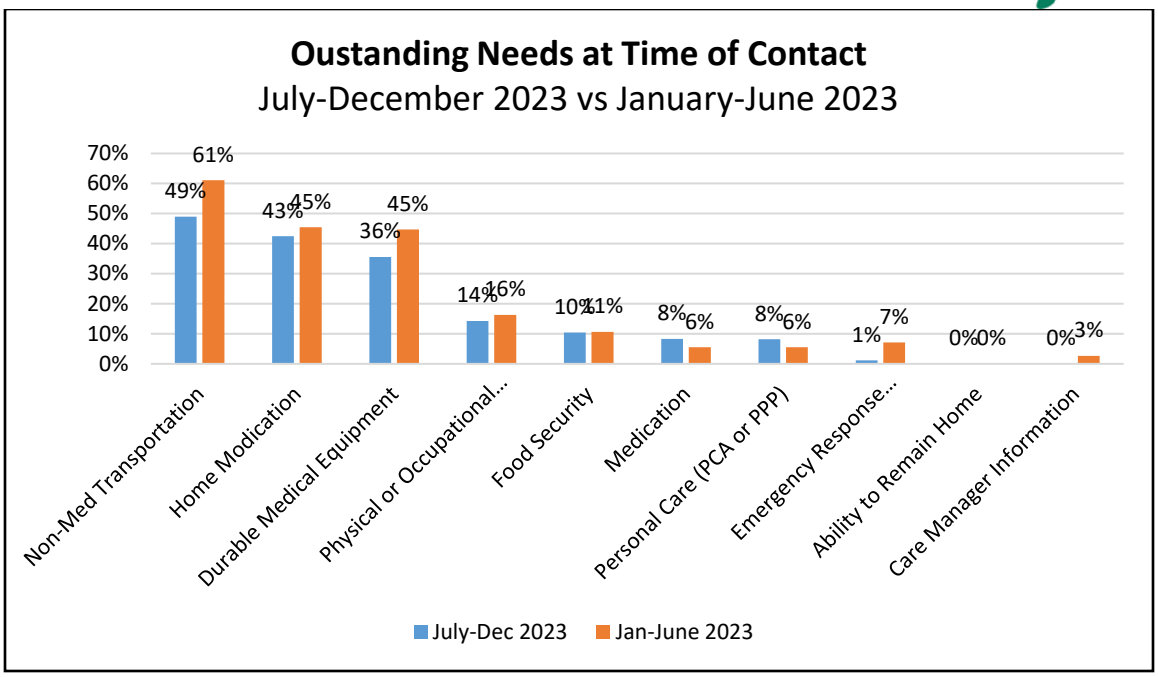


Unsuccessful Contact Attempts: 105

A majority of unsuccessful outreach efforts were due to unresponsiveness to outreach (72%). Multiple attempts are made in an effort to reach individuals. When alternate numbers or emails are provided, attempts are made through these avenues in addition to the main contact numbers. Further barriers include a small number of individuals whose numbers were not in service and an alternate number was not available after efforts to seek alternate contacts, and individuals with working numbers but without working voicemail. “Other” includes those living in assisted living program who did not answer the phone when transferred to their unit, as well as individuals who declined to engage in the follow up outreach upon successful contact.

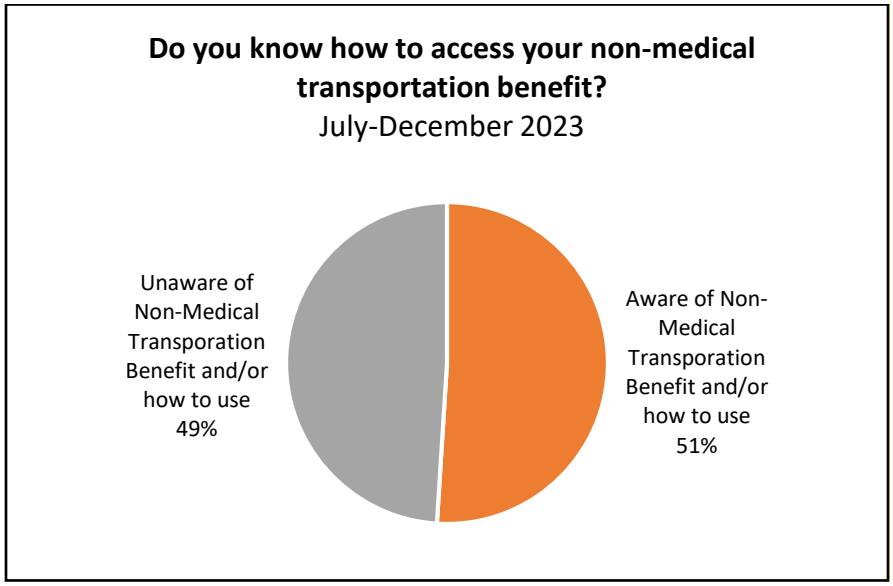


29 of 92 (32%) individuals contacted during July through December 2023 requested support with resolving unmet needs via follow up with MCOs. This is a reduction in percentage of those requesting assistance from the previous time period where 40% of individuals requested assistance. Many of the remaining 68% (62 individuals), either shared that all needs were being met or felt that they were receiving enough support from their MCO care manager to resolve their identified issues and declined further assistance.



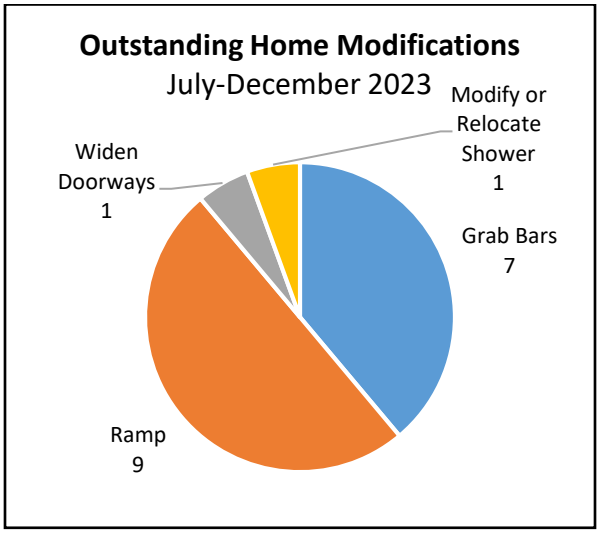
Each category of outstanding need reflects the percentage of participants who reported having an outstanding need in that area out of the 92 people that were contacted. The number of responses for each area of outstanding need is varied. The greatest outstanding needs participants reported pertain to non-medical transportation (49%), home modifications (43%), and durable medical equipment (36%). Top areas of need have remained consistent compared to data collected in January through June 2023, and all areas decreased in frequency of those reporting challenges. More individuals shared that all needs were being met and had no outstanding areas of need.

NON-MEDICAL TRANSPORTATION



From July to December 49% of individuals expressed that they either did not know that they had a non-medical transportation benefit or did not how to access it. More individuals during this time reported that they were aware of the benefit, but some did not know how to schedule transportation. The Quality Specialist shared with interested MFP participants their MCO-specific process to access non-medical transportation.

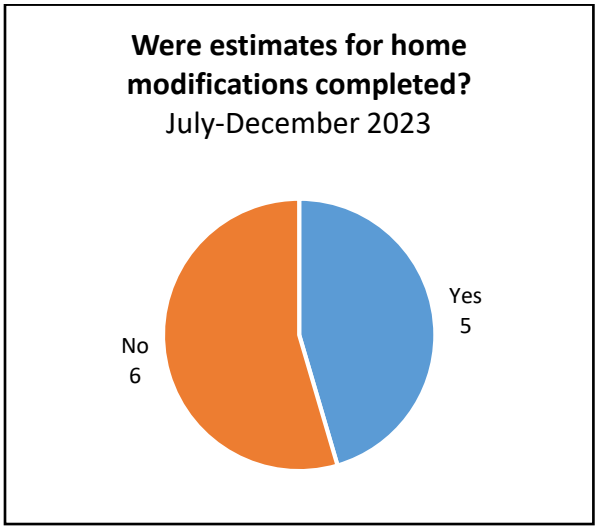
HOME MODIFICATIONS



From July to December 43% of individuals who needed home modifications (17 out of 40 participants) had outstanding needs at the time of quality follow up outreach. The most common needs were for ramps (9) and grab bars in the shower or bathroom (7). At times, participants had more than one outstanding home modification need.

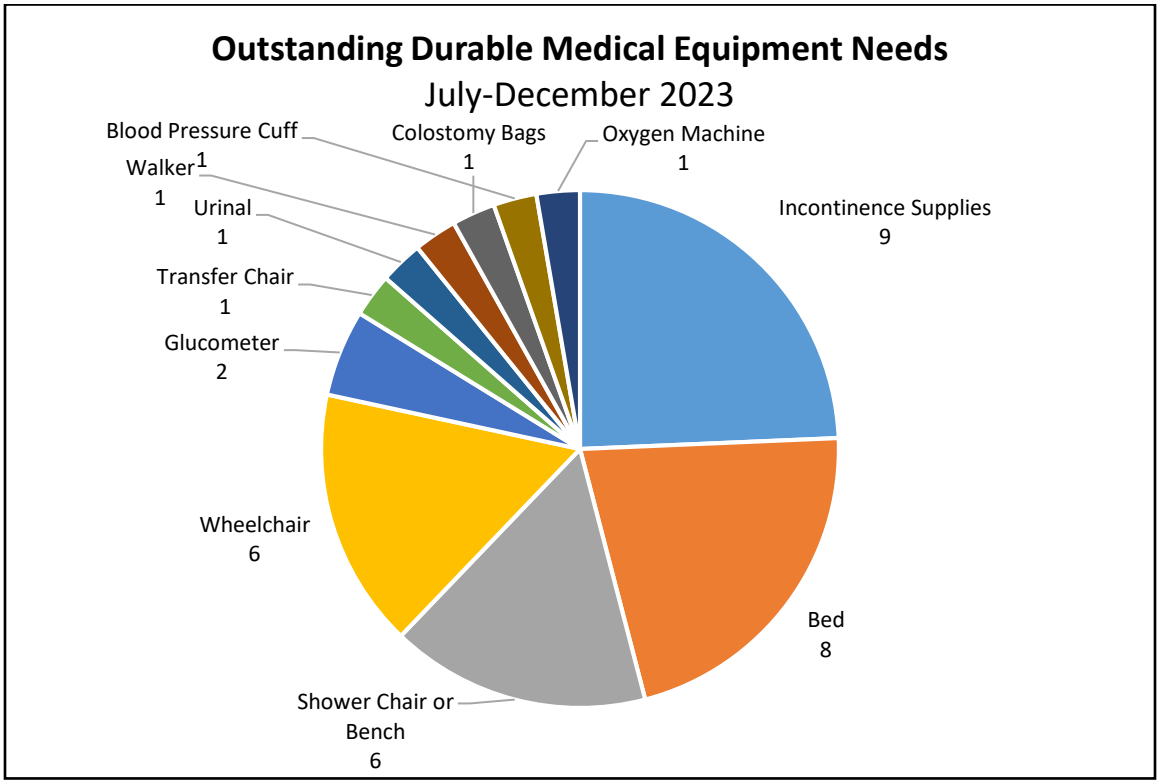
Starting September 2023, supplemental services including completion of home modifications prior to transition are available for participants. Prior to this date, individuals were not able to have home modifications completed prior to discharge. As such, delays in completion of home modification before September were anticipated. For those who required structural modifications such as a ramp or relocation of a shower, they were asked if completion of these modifications were offered prior to transition. Overwhelmingly, participants expressed that they were offered this supplemental service. However, many individuals declined the installation prior to transition to the community as there was not enough time to complete

needed home modifications prior to their anticipated discharge date. As such, individuals made the decision to complete home modifications after transition.

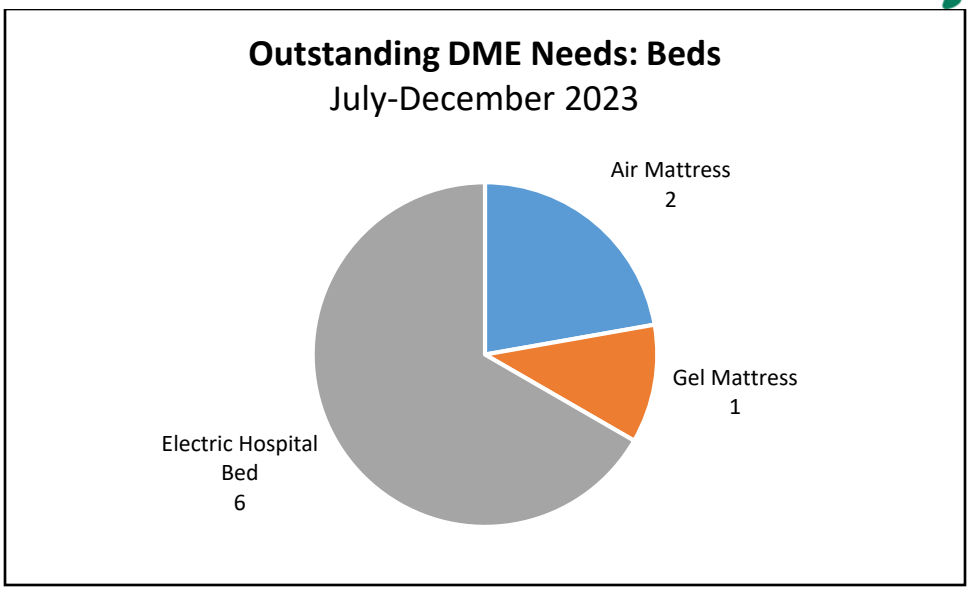


As individuals in need of structural modifications declined having modifications completed prior to transition due to time constraints, the QA Specialist asked if estimates had been completed for the work. 6 of 11 participants reported that estimates had not been completed, or that one estimate was complete but additional estimates were pending.

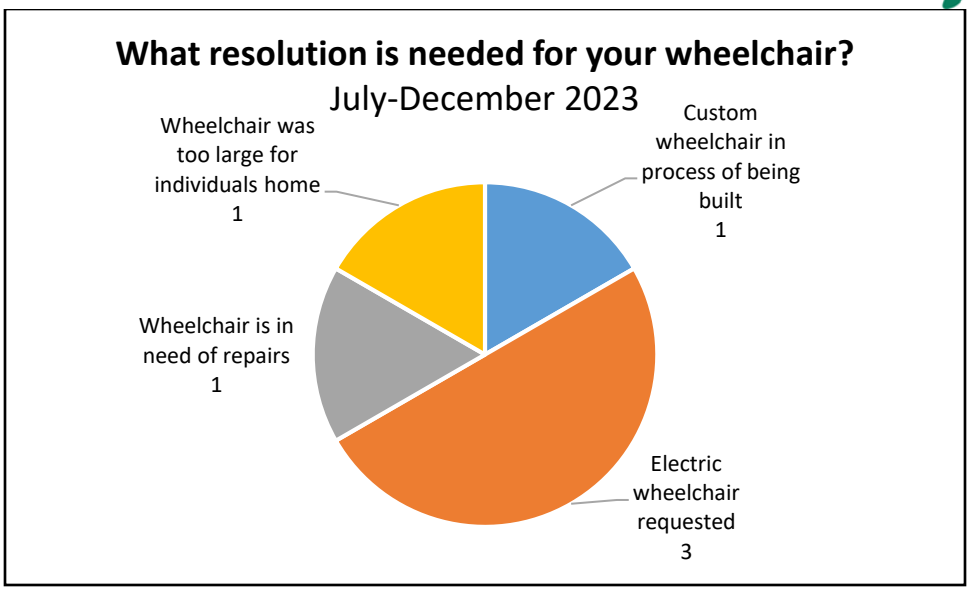
DURABLE MEDICAL EQUIPMENT



From July to December, 36% of individuals reported outstanding Durable Medical Equipment needs. The most common needs reported were for incontinence supplies (9), beds (8), shower chair or bench (6) and wheelchairs (6). Participants shared that initial incontinence supplies ordered were running low at time of outreach, on average four weeks post transition. At times, individuals identified that the supplies received were not enough to last 30 days and themselves or loved ones were paying for supplies out of pocket in addition to those received through their MCOs. Participants shared delays with receipt of shower chairs or benches, or shower chairs which did not fit in their shower, and these individuals expressed concern for their safety while using the shower.



A top area of need for durable medical equipment included beds which did not suit the individual's needs. Most often, participants reported as they could not operate beds with manual cranks on their own and expressed interest in fully electric beds. There were a few reports of individuals concerned with bed height, fearing that they would fall and injure themselves overnight.

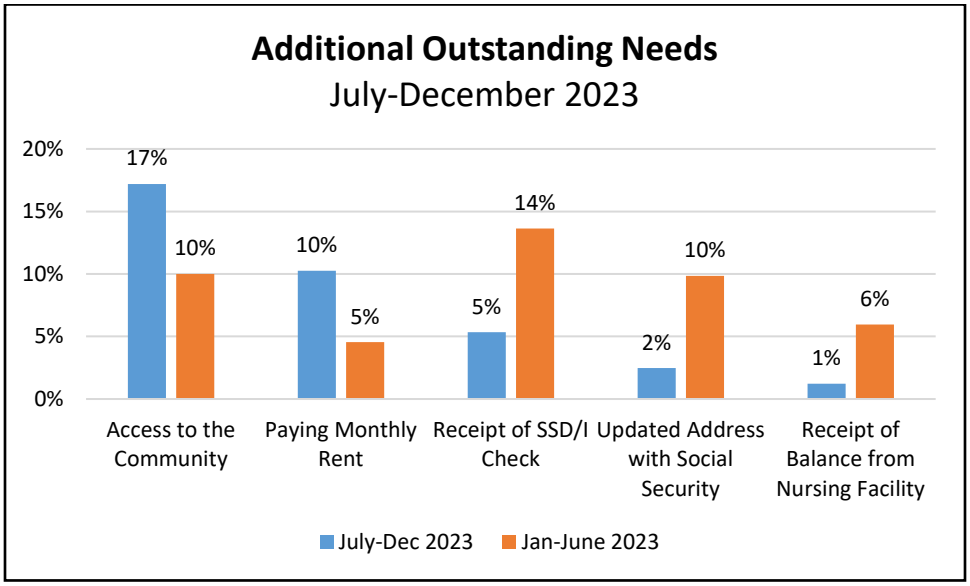


More individuals reported challenges with wheelchairs during July through December 2023 than in January through June 2023. Most commonly, individuals were waiting on electric wheelchairs to better meet their daily needs, and to navigate their homes and communities.

FOOD SECURITY

Although concern with food security was not as widespread as other outstanding areas of need (10% of individuals outreached), individuals shared challenges such as meal delivery not meeting dietary requirements, interest in applying for SNAP benefits, or being denied SNAP and having difficulty accessing their local food pantry due to transportation or limited mobility. The 2023 Supplemental Services include an increase in the Pantry Stocking amount, from $500 the previous year to $1,000. Participant have reported that while grateful for the fresh food upon transition to the community, perishable items were spoiling before they could eat them.

ADDITIONAL NEEDS



In addition to MLTSS service needs, the QA Specialist also asked about financial security and community connection. Access to the community was the most commonly expressed need during this time. Many MFP participant expressed ways in which they would like to connect with others, or to make a positive impact in their communities. Some individuals shared interest in becoming a Volunteer Advocate for nursing home residents through the Long Term Care Ombudsman (LTCO) Office Volunteer Advocate program or in returning to the nursing facility where they previously resided to visit with their peers. Participants have gotten involved with LTCO Community Engagement efforts or the MFP stakeholder group to share their experiences to improve I Choose Home services and the long term care system.

MLTSS benefits and MFP supplemental services are positioned to positively impact ones desire for community engagement, including utilization of non-medical transportation benefits and to obtain personal technology devices to reduce isolation and connect with loved ones.

SUMMARY

Throughout 2023, there has been an overall decrease in participants reporting outstanding needs. The top outstanding areas of need have remained consistent throughout this year, with non-medical transportation, home modifications and durable medical equipment remaining the highest areas of need in both January through June and July through December of this year.

More individuals remained in the community during 2023, reducing the reinstitutionalization rate to 5.36%. Delays in receipt of the change in status form (MFP 76), due within 48 hours of the event, shed light on gaps in communication and service delivery. Rationale for late submissions from care managers indicate that care managers are often not aware of the participant's reinstitutionalization for several weeks (average 32 days).

As 2023 Supplemental Services began to be offered, we began to see challenges with their intended use. Some participants are declining home modifications prior to transition because in many cases construction will not be completed by the time of their anticipated move. Some members report that food is spoiling due to greater amounts of food being delivered at one time, demonstrating the need to spread delivery over multiple weeks.

During this time, members have shared about their desire to connect with others and to get involved in their communities. Benefits offered can help participants achieve these goals and assist individuals with a more balanced life, not only focused on care or medical needs.

RECOMMENDATIONS:

Care Management Contact with Members: Review contact requirements for MFP members with care managers to ensure that members are contacted at timeframes necessitated by the contract. Create or review comprehensive procedures for when members are unable to be contacted, including number of contact attempts and additional methods to locate members, such as: contacting natural supports, verifying members are still coded as MFP recipients in internal systems, checking encounter claims to see if remember is receiving other services such as in long term care facilities and reaching out to providers such as primary care physician or PCA agencies Review documentation requirements regarding change in status to ensure tracking forms are submitted within 48 hours.

Non-Medical Transportation: Create simple consumer education materials highlighting this benefit and give to MLTSS HCBS members. Review non-medical transportation with individuals prior to transition and at first and second community contact, including specific examples of when it can be used (e.g. for shopping, errands, religious services, etc) and realistic timeframes to schedule rides. Provide written instruction on how to set up non-medical transportation and assist members until they are able to do so independently. Include instructions on how to access non-medical transportation in the member handbook. Ensure scheduling process is user friendly so members can easily schedule rides independently.

Home Modifications: Utilize 2023 MFP Supplemental Services to complete home modifications for qualified individuals prior to transition; schedule home modification estimates and construction as early in the IDT process as possible so that construction can be completed in a timely manner, including prior to transition whenever possible. Explore additional vendors for home modifications to reduce delays with scheduling estimates and construction.

Durable Medical Equipment (DME): Review DME orders during pre-transition IDT meetings, including items ordered, sizes needed, member's needs/preferences (e.g. crank vs. electric bed), and ensure all authorizations and/or prescriptions are submitted. Care managers should check at the first home visit that DME was not only received and works properly, but also meets the member's individual needs. Explore use of alternate DME vendors if DME is not received promptly. Ensure members have adequate supplies of single use items, including incontinence supplies, and that supplies ordered were received and meet their needs. Ensure that if member is unable to re-order supplies that the supplies will come on a schedule that the member is agreeable to.

Telephone Service: Confirm with members that they have working mobile or home telephones and alternate telephone numbers, when possible, prior to their transition to the community. Assist member in applying for free mobile phone services available for lower-income individuals such as Assurance Wireless or LifeLine when needed. Ensure individuals have adequate minutes on existing phones.

Food Security: Split pantry stocking into multiple orders over time so that perishable items do not spoil before they can be used. Provide a list of food pantries in the participant's community and set up non-medical transportation for the individual until they are confident scheduling the transportation independently. If the member is agreeable, set up home delivered meals and follow up to make sure Member is using them. Assist member in applying for SNAP when applicable and offer to assist in setting up home delivered groceries from local grocery stores.

APPENDIX A

I Choose Home Quality Follow-up 2023

1. MCO Transition Supports

	Yes	No	Declined or N/A
Do you feel that you will be able to stay in your home?	○	○	○
Do you know who your care manager is and have their contact information?	○	○	○
Are your aids visiting regularly and on time?	○	○	○
Are you getting enough time with your aids?	○	○	○

I Choose Home NJ

	Yes	No	Declined or N/A
Do you have the durable medical equipment (DME) or care supplies needed? (if no, question 3)	◯	◯	◯
Do you have the medications you need or will need?	◯	◯	◯
Were needed home modifications completed? - ramps, widened door frames, grab bars	◯	◯	◯
Were estimates for home modifications completed?	◯	◯	◯
Did PT/OT sessions begin as scheduled?	◯	◯	◯
Do you have enough food at home?	◯	◯	◯
Was your PERS	◯	◯	◯

	Yes	No	Declined or N/A
installed and activated?			
Do you know how to access your non-medical transportation benefit?	◯	◯	◯

2. Non-MLTSS Needs

	Yes	No	N/A or Declined
Are you able to access the community when you want/need?	◯	◯	◯
Do you have a plan for how you will be paying rent each month?	◯	◯	◯
Have your received your money owed by the nursing home? Month of d/c exemption, PNA Balance	◯	◯	◯

	Yes	No	N/A or Declined
Has anyone contacted social security to update your address?	◯	◯	◯
Did you receive your SSD/I check for this month?	◯	◯	◯

3. What DME is needed at this time?

- [ ] Blood pressure cuff
- [ ] Commode
- [ ] CPAP
- [ ] Gel Mattress Overlay
- [ ] Glucometer
- [ ] Hospital Bed
- [ ] Hospital Bed - electric
- [ ] Incontinence Supplies
- [ ] Oximeter (oxygen sensor)
- [ ] Raised Toilet Seat
- [ ] Shower chair/bench

- [ ] Wheelchair
- [ ] Other

4. What resolution is needed for your wheelchair?

- [ ] Electric wheelchair requested
- [ ] Wheelchair did not arrive
- [ ] Wheelchair was too large for individuals home
- [ ] Wheelchair is in need of repairs
- [ ] Other

5. What home modifications are needed?

- [ ] Ramp
- [ ] Grab bars
- [ ] Widen door frames
- [ ] Modify or relocate shower
- [ ] Other

6. Describe identified concerns or additional supports and services needed, summarize challanges:

Enter your answer

7. What types of things do you want to do in the community?
Examples: Religious services, library, work or volunteering, movies, cultural events, museums, sports events, supports groups (ex AA)

Enter your answer

8. Do you want any difficulties you identified to be discussed with others who are involved with your care so they can help resolve these challenges?
Such as, MCO, MFP liaison, care manager, I Choose Home team members. No information will be discussed with others without participant consent.

- ◯ Yes
- ◯ No
- ◯ N/A
- ◯ Other

9. ID

Enter your answer