I Choose Home NJ Quality Report July – December 2024

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 based on individuals lived experience. Contact with individuals post transition 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 re-institutionalization 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 Data and Quality Analyst attempts outreach within 30 days for participants who have transitioned from a nursing home, though contact may occur after 30 days. Once the Data and Quality Analyst contacts the participant, they explain that the goal of the follow-up call is to identify barriers that 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

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[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.*

outstanding needs. Follow-up calls are conversational in nature and the Data and Quality Analyst uses a survey tool to track areas of concern. These areas 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 expressed needs and preferences. With consent, the ICHNJ Data and Quality Analyst 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.*

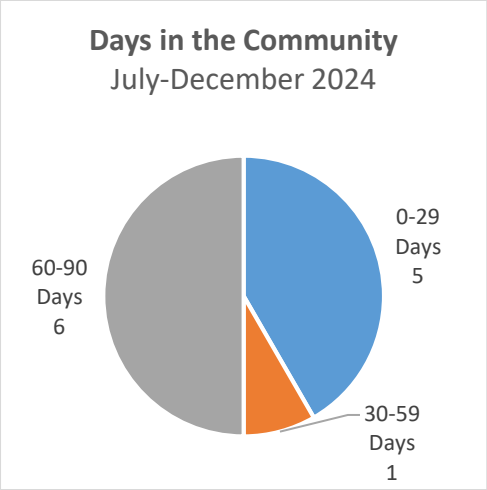
DATA REPORTED

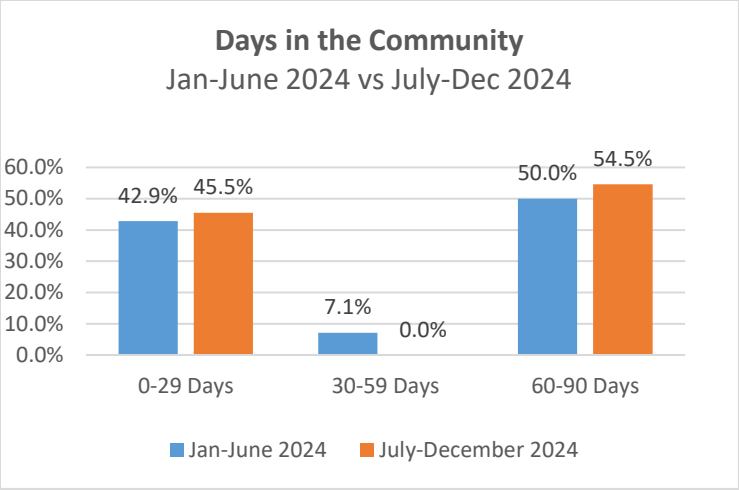
In part, outreach is conducted to assist individuals with remaining in their homes as outlined in MFP Benchmark #3:

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.

Re-institutionalization within 90 days of transition					
Year	**Jan - June**	**July - Dec**	**Total Re-instit.**	**Total Transitions**	**% of Total Re-instit.**
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%
2024	**14**	**14**	**28**	**438**	**6.39%**

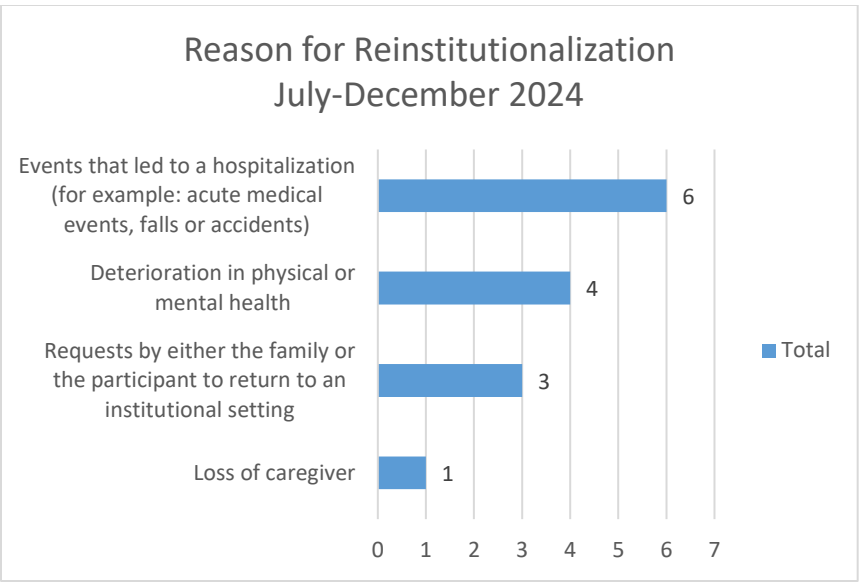
In 2024, 28 MFP participants, 6.39% of 438 total transitions, were re-institutionalized within 90 days. The rate of re-institutionalization increased slightly from 2023, exceeding the 4% target benchmark.





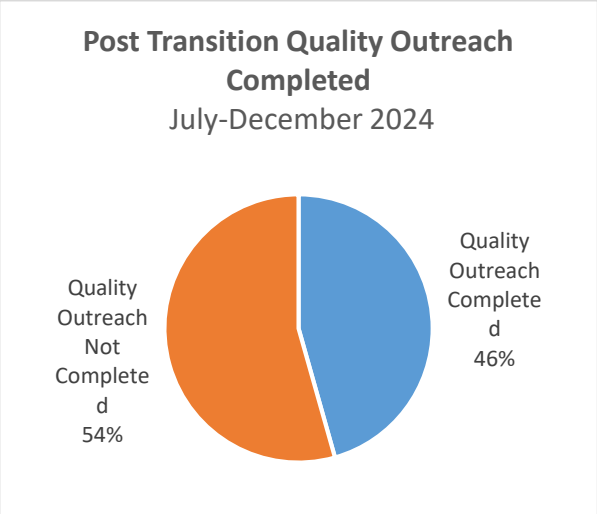
14 individuals were reinstitutionalized within 90 days in July through December 2024. 5 individuals (42.86%) were reinstitutionalized within 30 days, 1 (7.14%) individual was re-institutionalized between 30 and 59 days, and 6 (50%) were re-institutionalized between 60 and 90 days. When compared to January through June 2024, there was no signficiant change in the length of time individuals spent in the community prior to reinstitutionalization within 90 days.

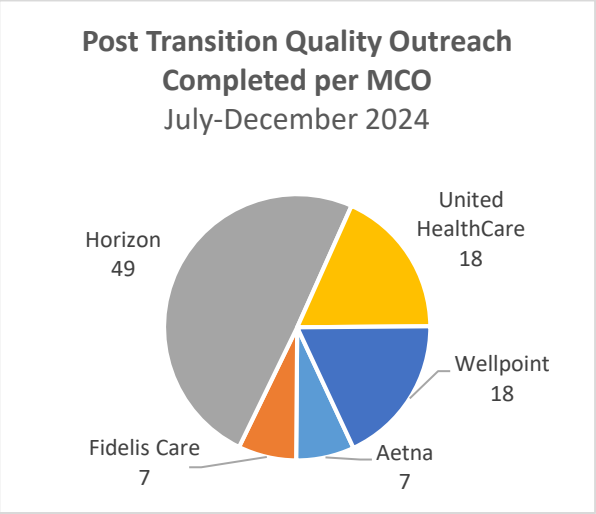
10 out of 14 individuals (71%) re-institutionalized within 90 days during July through Decemeber 2024 were living with family. However, throughout all of 2024, 17 of 28 individuals re-institutionalized (61%) lived with family. Of those who returned to an institution within 90 days of transition in the second half of 2024, 64% (11 of 14) were older adults 65 or older. This is consistent when including data for those reinstitutionalized in January through June of 2024.



Reasons for re-institutionalization were varied, with the most common being events that lead to a hospialization (e.g. acute medical problems, falls, accidents). Request by the MFP participant or their family to return to insitutional care were less frequent during this time period.

POST TRANSITION QUALITY FOLLOW-UP OUTREACH



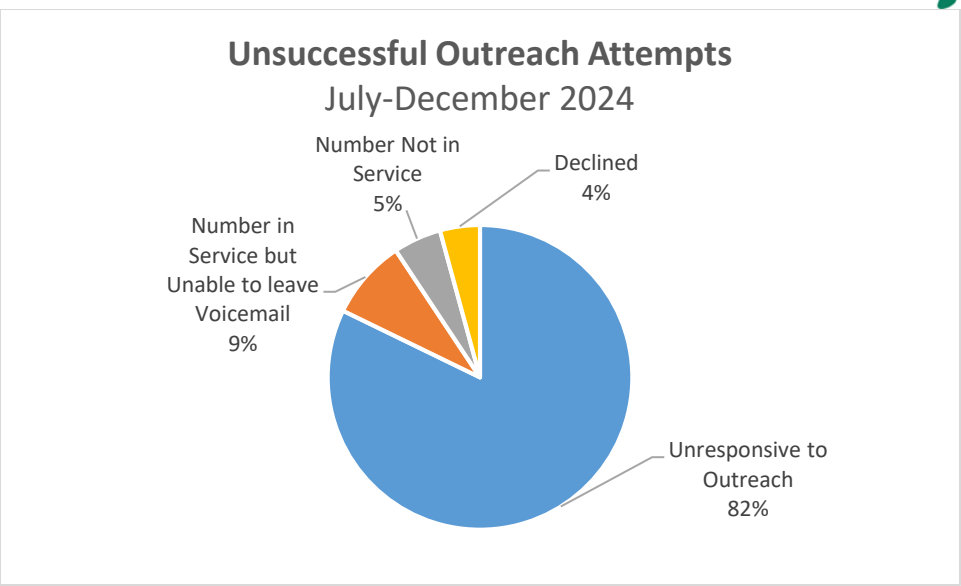


Total Participant Contact Attempts: 217

Total Participant Contacts: 99

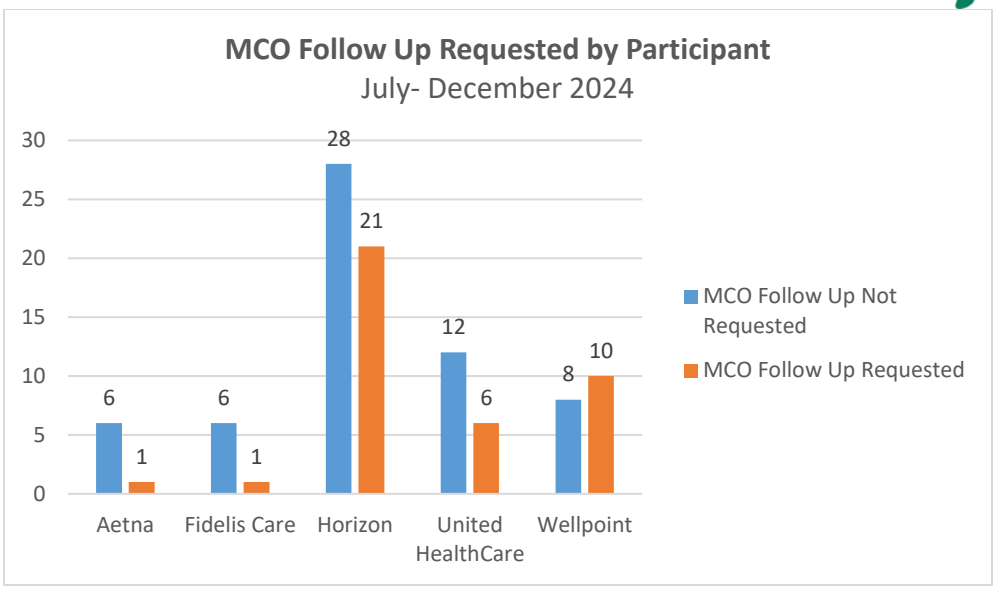
Average length of time from transition date to follow-up contact: 27 Days

Post transition quality outreach was completed for 99 of 217 (45.6%) individuals where contact was attempted. Throughout 2024, the Data and Quality Analyst implemented additional strategies in efforts to increase this percentage, including collecting email addresses and emailing individuals, in addition to calling all phone numbers provided and making multiple outreach attempts at different times of the day.

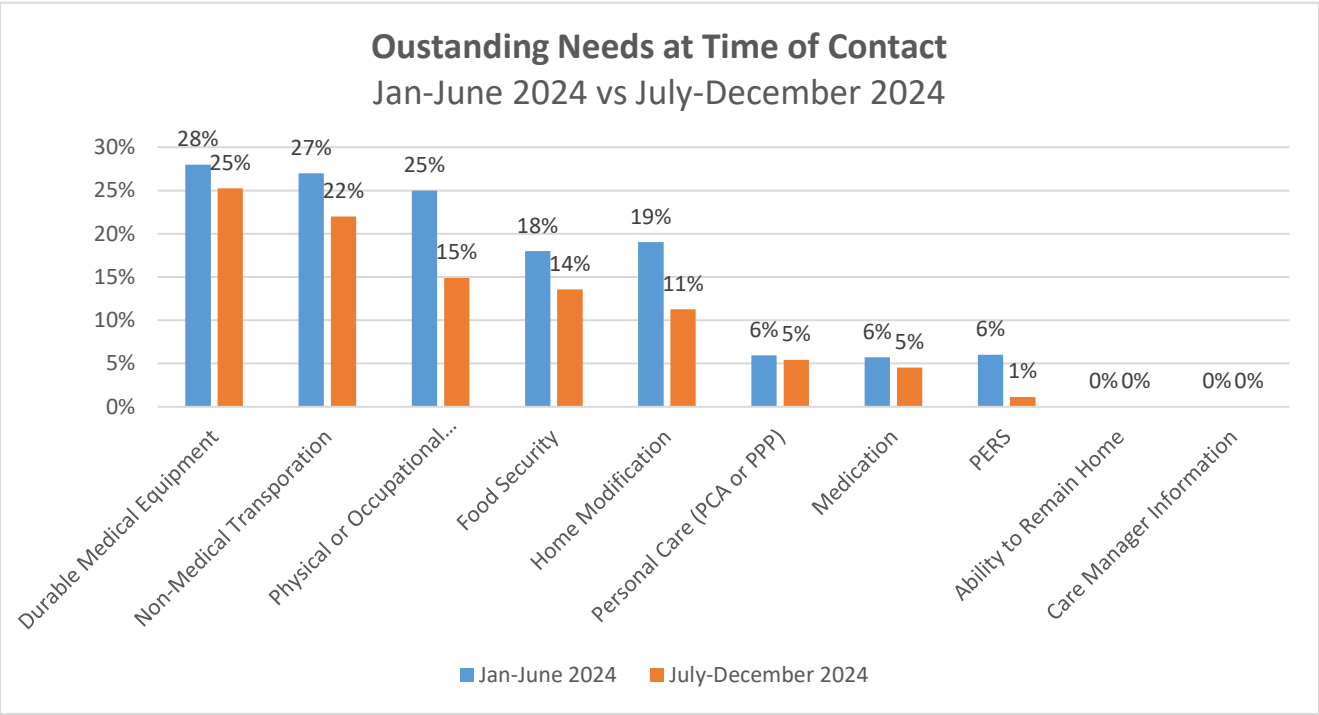


Unsuccessful Contact Attempts: 118

The primary reason for unsuccessful outreach (82%) was that the participant did not respond to multiple phone calls and/ or email. In a small number of cases, individuals had numbers that were not in service or voicemail boxes that were full or not in service. Five (5) individuals were successfully reached and declined to participate.

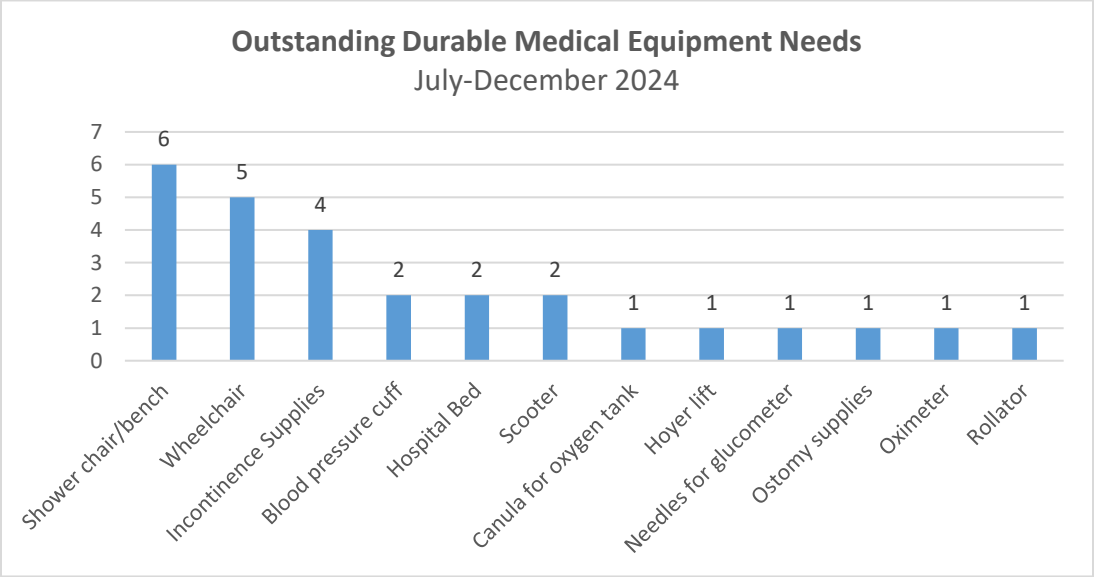


In July through December 2024, 36 of 99 (36.4%) of individuals requested support to resolve unmet needs related to their transition to the community. This was consistent throughout 2024, with 36% of those outreached in the first half of the year requesting this support. While 64% of participants outreached reported all needs were being met, over one third of individuals identified unmet needs that were impacting their experience post-transition.

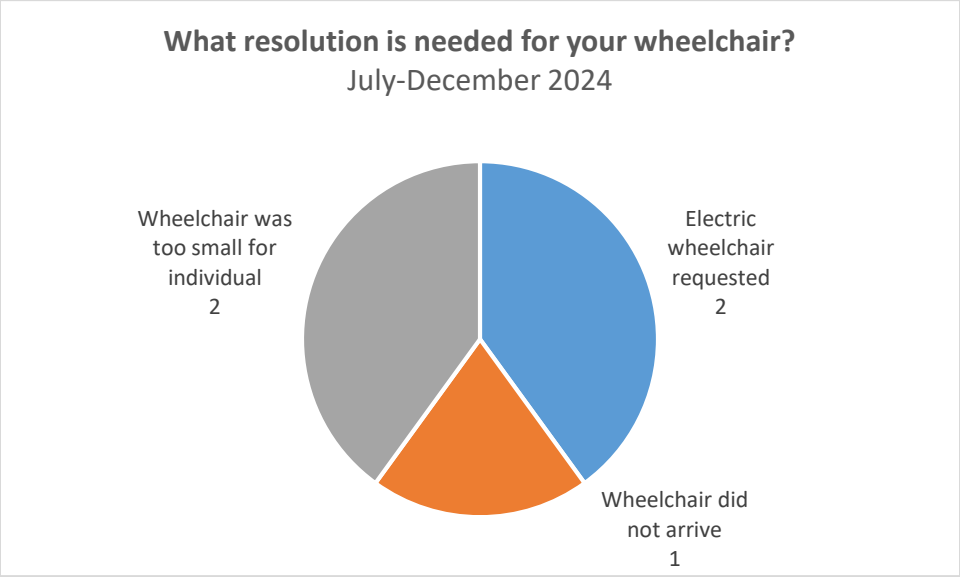


The top areas of outstanding need were consistent throughout 2024. Outstanding needs are self-reported by MFP participants based on their experience. The most frequent outstanding needs identified within the scope of MLTSS during this time period were: durable medical equipment (25%), non-medical transportation (22%), physical or occupational therapy (15%), and food security (14%), with decreases in the percentages of individuals reporting outstanding needs in these identified areas compared to January through June 2024.

DURABLE MEDICAL EQUIPMENT

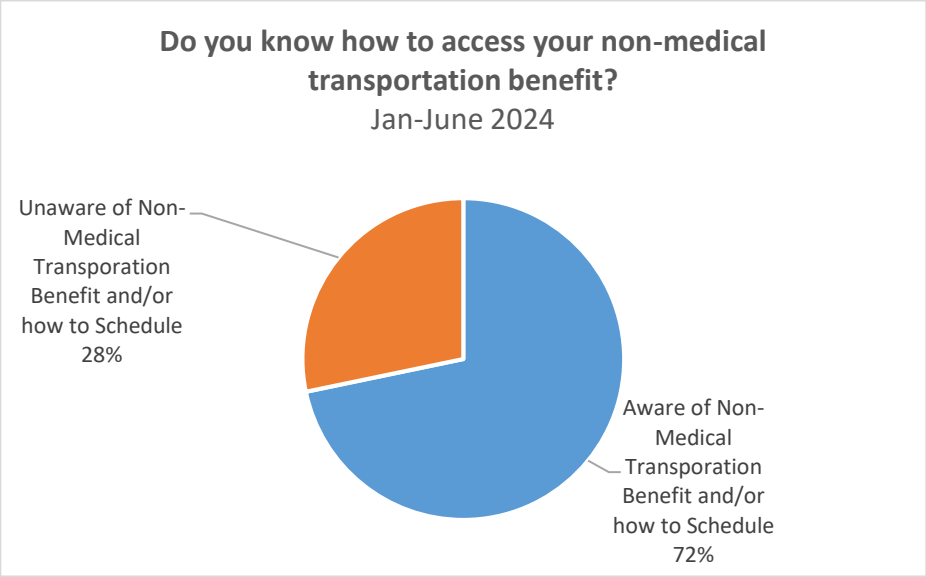


25% of MFP participants outreached in this period reported outstanding durable medical equipment needs. While outstanding durable medical equipment needs decreased in 2024 compared to 2023, one out of four individuals continued to report outstanding DME needs. Top DME needs included shower chairs or benches (6), wheelchairs (5) and incontinence supplies. Individuals shared concerns for their safety while bathing while awaiting receipt of a shower chair.



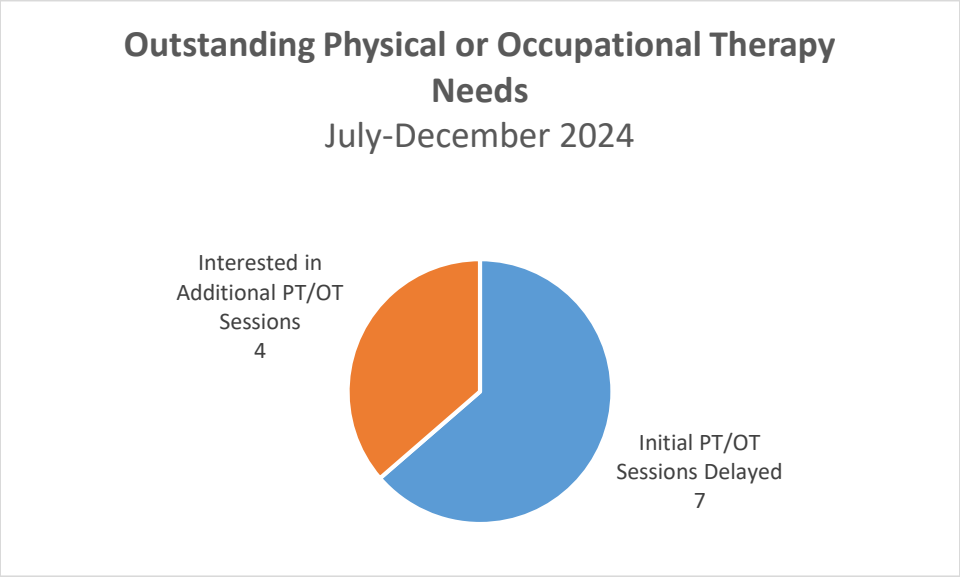
Outstanding needs regarding wheelchairs were varied during this time. Two individuals expressed that received wheelchairs were too small for their bodies, two expressed interest in obtaining an electric wheelchair to better access their homes and communities, and one reported that receipt of their custom wheelchair remained pending. Delays in mobility aids, or those which do not suit the individual's needs (e.g. wheelchairs that were too small for the person's body) were reported to have negatively impacted participants' ability to meet their daily needs, in addition to serving as a barrier to accessing their communities.

NON-MEDICAL TRANSPORTATION



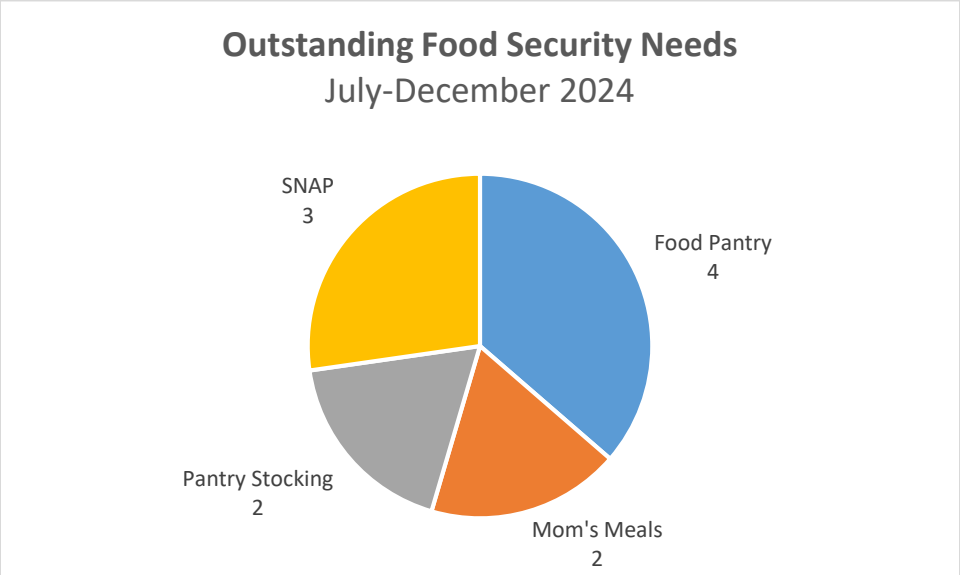
22% of MFP participants outreached identified that they were either unaware of the non-medical transportation benefit or were aware of it but did not know how to access/schedule it. Though there was a decrease in the number of individuals reporting outstanding non-medical transportation issues in 2024 compared to 2023, one out of five individuals outreached reported barriers in this area.

PHYSICAL OR OCCUPATIONAL THERAPY



Outstanding needs relating to physical or occupational therapy included individuals who were anticipating start of physical or occupational therapy and experienced delays (7 of 11, 63%), while others had completed initial sessions and expressed needing additional therapy. Most often, participants understood how to obtain additional therapy sessions, and in some instances had begun the process and were awaiting approval. Individuals shared how delays in receipt of initial physical or occupational therapy sessions or in obtaining approval for additional sessions impacted their day-to-day lives. MFP participants shared concerns about lack of strength impacting completing daily needs, increased concerns for their safety due to weakness, and how limited strength building has served as a barrier to visiting loved ones and/or exploring their communities.

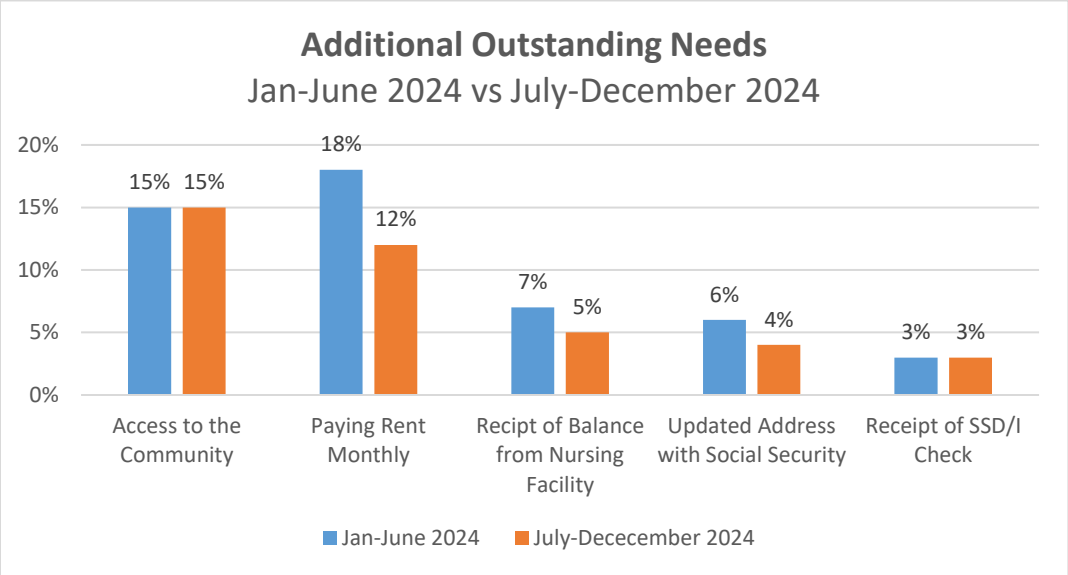
FOOD SECURITY



Food security remained a top need throughout 2024, with 14% of those outreached citing concerns about having enough food in their home. Outstanding needs with regards to food security varied, including delays in receiving home delivered meals (2) and interest in applying for SNAP benefits (3). Some participants expressed concern about food security despite having home delivered meals and/or SNAP benefits. In some instances, individuals shared that they had not been provided with a list of local food pantries in their area (4) or were unaware that non-medical transportation could be used to access them. MFP supplemental services include pantry stocking of 30 days upon transition to the community. Pantry stocking can be split into multiple deliveries to prevent spoiling of fresh foods, such as dairy and produce, a concern which participants reported in the past. During this time, some individuals expressed that while

they had received an initial pantry stocking supplied by the MCO, they were still waiting on a subsequent delivery.

ADDITIONAL NEEDS



Access to the community was the most common outstanding need outside of the scope of MLTSS shared by MFP participants during this time. Barriers to accessing the community have remained consistent, with individuals sharing barriers such as mobility aids that do not suit their needs, lack of transportation or knowledge of about how to utilize their non-medical transportation benefit, and delays in completing home modifications.

Reports of delays in Social Security benefits decreased during this time though still remained a concern. Long wait times for appointments to reapply, around 6-8 weeks after transition to the community, were still common. MCO nursing home transition staff reported successes in obtaining SSA appointments once the member's nursing home transition date was set, which alleviated this income gap for some participants.

SUMMARY

Participants' outstanding needs remained quite consistent throughout 2024. The percentage of individuals outreached who had outstanding needs was 36% during both reporting periods (Jan-June and July-December). Top outstanding needs from the first reporting period through the end of the year remained consistent as well, including durable medical equipment, non-medical transportation, physical and occupational therapy and food security, with a slight decrease of those reporting outstanding needs in all areas. However, more than one third of MFP participants identified that all of their needs were not met based on their lived experience of community transition.

Delays in receipt of medical equipment, limited access to or knowledge of other supports and services have impacted individuals' day to day lives, at times causing concern for their safety.

Data on re-institutionalization throughout 2024 demonstrates disparities across populations when comparing rates of reinstitutionalization for younger adults with physical disabilities (18-64 year olds) to older Adults (65 years or older). The rate of reinstitutionalization for older adults, 8.9%, is twice that of younger adults with physical disabilities, 4.4%. Older dults comprised 43% of MFP transitions for 2024, though accounted for 61% of reinstitutionalizations.

A robust data system for MFP is anticipated to launch in 2025. This data system will serve as a centralized hub utilized by all state entities and MCOs who collaborate on I Choose Home and will allow for continuity of data and information - from the time of referral to the MCO, through IDT meetings and concluding with the quality follow up outreach. The system will have increased capacity for collecting detailed information about participant needs based on their self-reported experience of the transitions, as well as data provided by MFP and MCO staff who have assisted participants throughout the transition process. Increased data integrity will provide opportunity to more swiftly identify and communicate trends in outstanding needs as they arise to better serve MFP participants and work collaboratively to resolve barriers in order

for individuals to remain in their homes.

RECOMMENDATIONS:

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. Work closely with nursing facilities to ensure adequate incontinence supplies are provided upon transition and provide additional supplies to cover the first 30 days if needed.

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 the scheduling process is user friendly so members can easily schedule rides independently

Physical and/or Occupational Therapy (PT/OT): Ensure that PT/OT prescriptions are provided by the nursing facility physicians when appropriate. Verify that the prescription has been received and sessions are scheduled during initial face-to-face contact. Inform participants of the process to obtain additional PT/OT sessions from their primary care physician.

Food Security: Split pantry stocking into multiple orders over the first 30 days of transition 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 the member is using them. Assist the member to apply for SNAP when applicable and offer to help set 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