I Choose Home NJ Quality Report January – July 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. 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 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 that 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

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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.*

needs. Follow-up calls are conversational in nature and the QA Specialist uses a survey tool to help 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 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.*

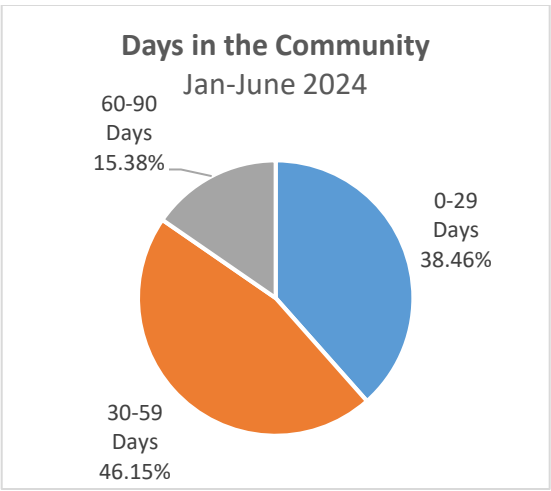
DATA REPORTED

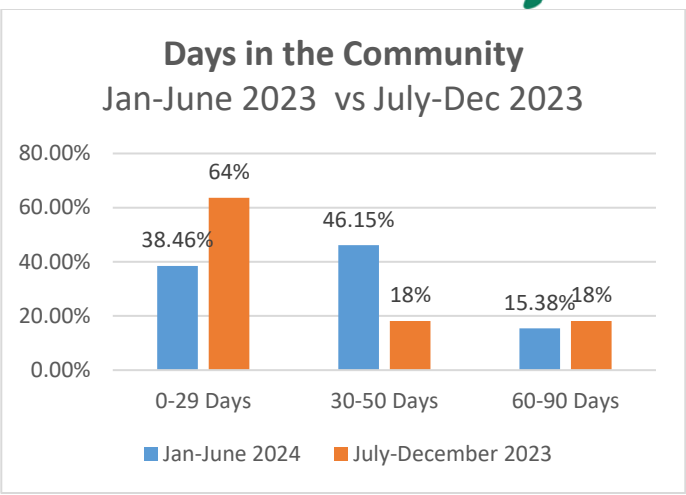
In part, outreach is conducted to assist individuals with remaining in their homes as outlined in MFP Benchmark #3:

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.

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	**13**		**13**	**219**	**5.93%**

In January through June 2024, 13 of 219 (5.93%) individuals were re-institutionalized within 90 days of transition to the community. While the 4% benchmark has not been met, re-institutionalization rates have not increased significantly from 2023.



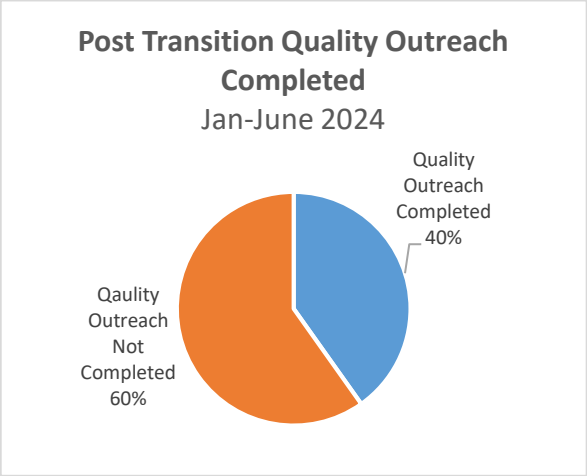


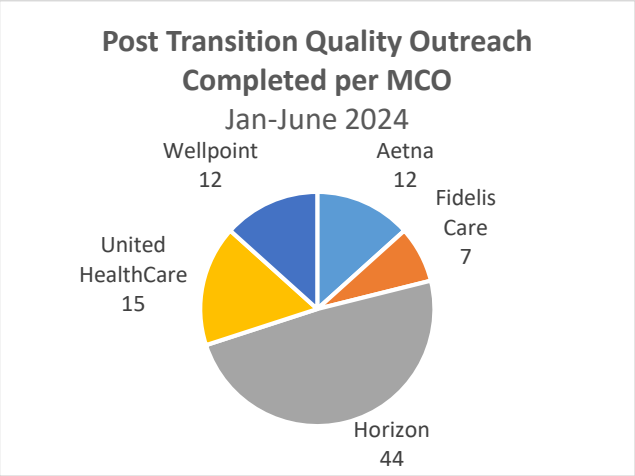
Of the 13 individuals who were reinstitutionalized, 5 (38%) were within 30 days of living in the community, 6 (46%) were reinstitutionalized between 30 and 59 days, and 2 of 13 (15%) were reinstitutionalized between 60 and 90 days. Reasons for reinstitutionaliation provided included precipitating events which required medical attention, and requests from participants or loved ones such as family to return to a nursing facility. In 10 of 13 instances, concerns for safety were cited as contributing factors for seeking institutional care. In 7 cases, MFP participants requested to return to a nursing facility, and in 3 instances families sought readmission to a nursing facility due to difficulty providing adequate care at home. In 12 of 13 instances, personal care support was in place, and the remaining individual was in the community for one day only with prior knowneldge that PCA would not be in place at time of transiton. Durable medical equipment was received in 12 of 13 instances; the outlying individual was unable to accept the delivery of a hospital bed.

January through June 2024 demonstrates a shift in reinstitutionalization data and contributing factors which lead to readmission. Previously, at least 50% of individuals who were reinstitutionalized returned within 30 days, whereas during this time, more than 50% of readmissions occurred after 30 days. Rationale for returning to a nursing facility also shifted during this reporting period, with a decrease in family reports of not being able to provide care and an increase in individuals identifying concerns for safety and requesting to return to a nursing facility.

In February 2024, the timeframe for submission of notification of an individuals reinstitutionalization to a nursing facility was increased from 48 hours to 30 days based on feedback received from Managed Care Organization partners. Since that time, 77% (10 of 13) of reports were received on time. Of those remaining (3 of 13), details provided indicate that care managers were not aware that they had to complete the form.

POST TRANSITION QUALITY FOLLOW-UP OUTREACH





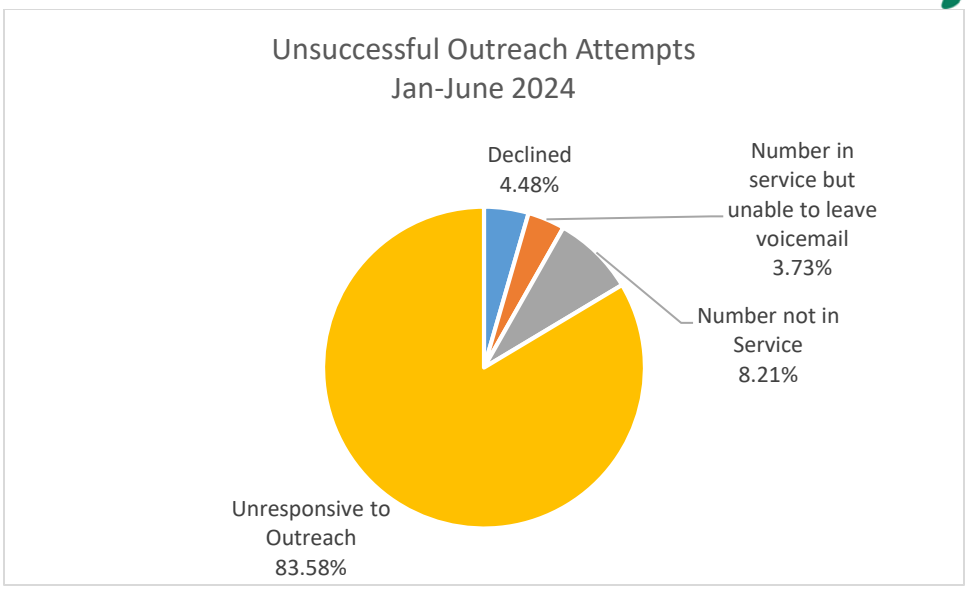
Total Participant Contact Attempts: 224

Total Participant Contacts: 90

Average length of time from transition date to follow-up contact: 28 Days

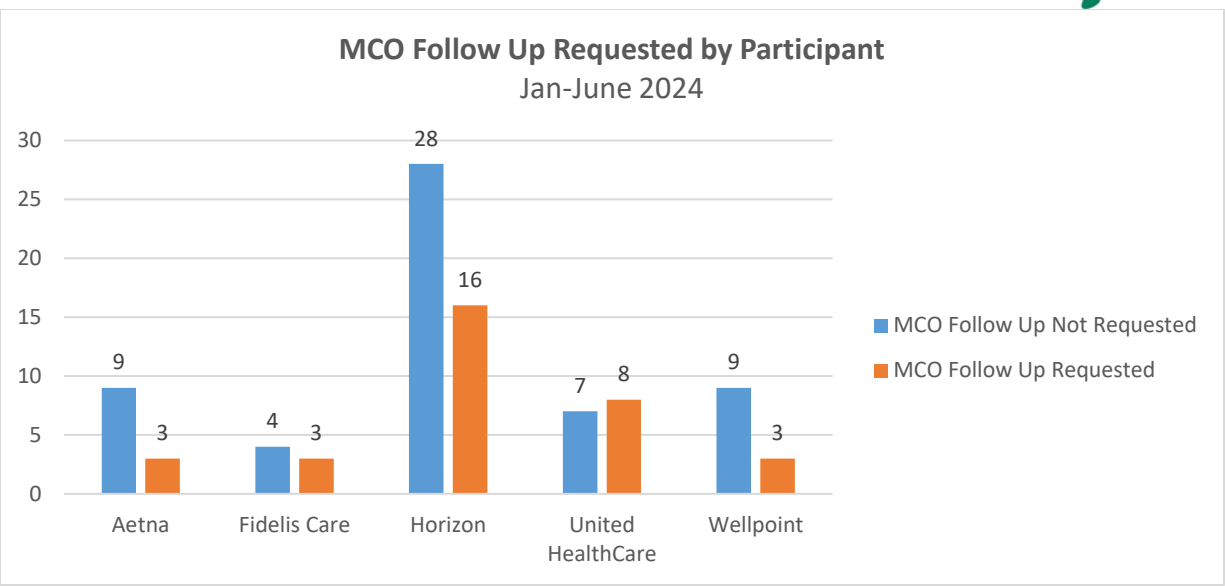
Post transition quality follow-up was completed for 90 of 224 individuals[3] (40%). Efforts to increase successful outreach were implemented in late 2023, including collecting email addresses (when available) and emailing participants and/or their care partners, as well as the continued practice of making multiple outreach attempts.

[3] 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.

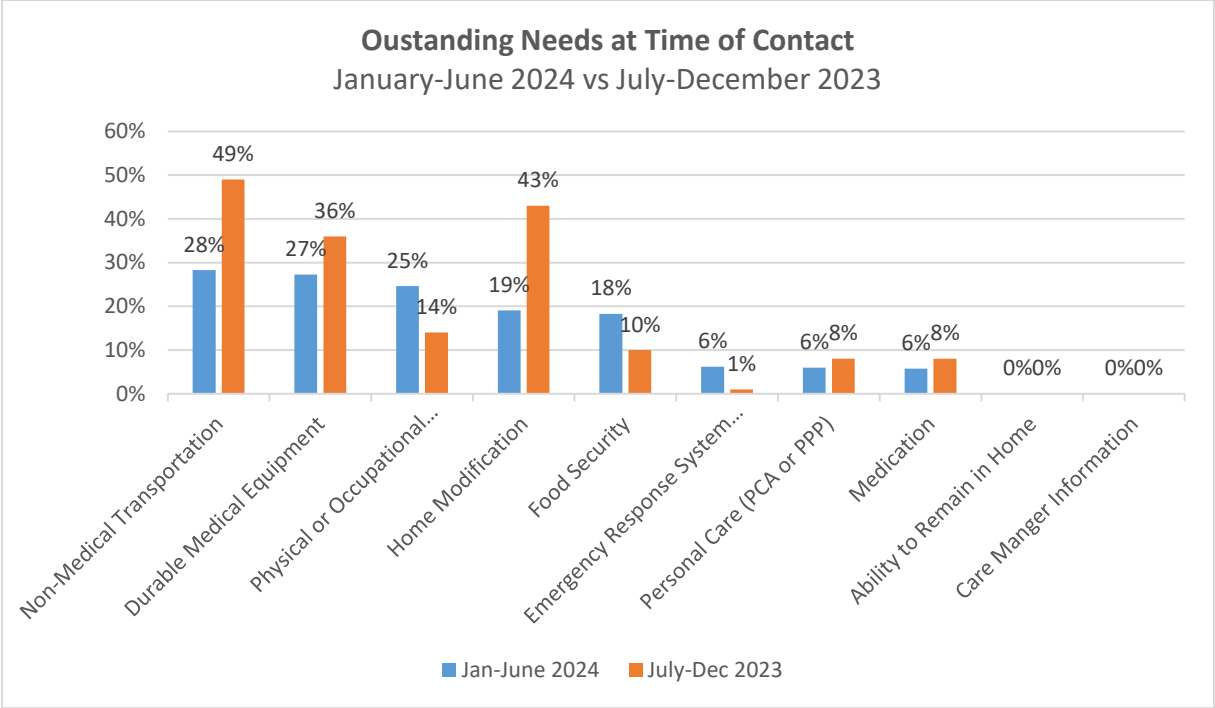


Unsuccessful Contact Attempts: 134

Unsuccessful outreach attempts were largely due in part to unresponsiveness to outreach (83%) after multiple phone contact attempts and email outreach when email addresses are provided. In a small number of cases, individuals had numbers which were not in service, or were not accepting voicemails to request follow up contact. Four (4) individuals were successfully reached and declined to participate.

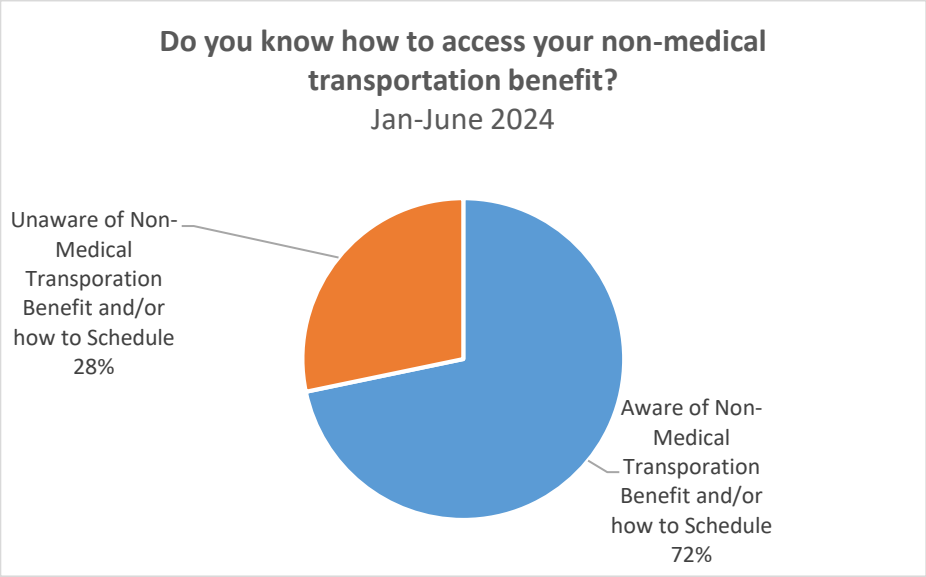


33 of 90 (36%) of individuals outreached during January through June 2024 requested support to resolve unmet needs, a slight increase compared to July through December 2023 (32%). 64% of those outreached either reported that all needs were being met at the time of contact, or outstanding needs were pending resolution, or they expressed receiving enough support to resolve challenges from their Care Management team and declined outreach be made.



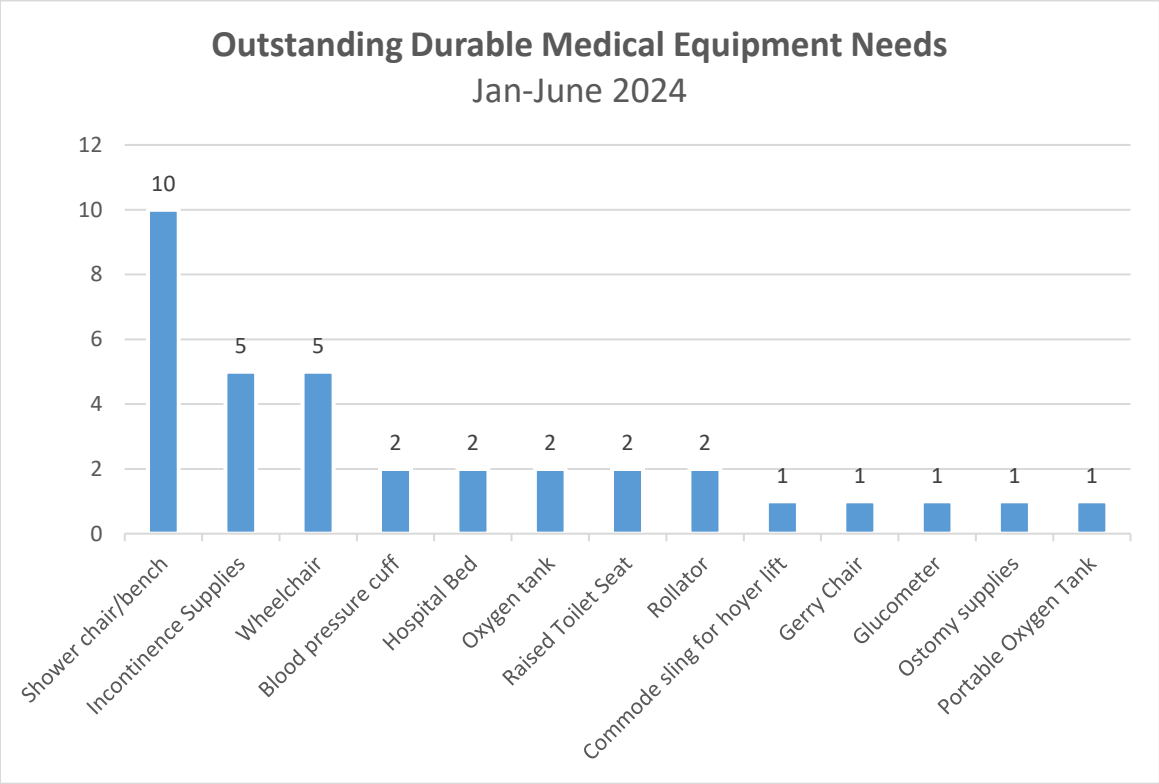
Each category of outstanding need reflects the percentage of participants who reported having an outstanding need in that area out of the 90 people that were contacted. The number of responses for each area of outstanding need is varied. The greatest outstanding needs MFP participants reported from January through June 2024 pertain to non-medical transportation (28%), durable medical equipment (27%), and physical or occupational therapy (25%). While non-medical transportation and durable medical equipment remain in the top needs, the percentage of individuals reporting concerns in these areas is lower than July-December 2023. Unmet needs relating to Physical or Occupational Therapy and Food Security have increased.

NON-MEDICAL TRANSPORTATION



While Non-Medical Transporation remains a top unmet need (28%), there was a substantial increase in the percentage of people reporting that they are aware of this benefit and how to access it (72%), up from only 49% in the previous period. However, while progress in this area is positive, many MFP participants still do not know how that this benefit exists or how to schedule transportation. I Choose Home state staff have shared that some nursing home resident participants are still paying out of pocket for transportation that could be covered under this benefit, such as taking taxis or ride share services to obtain vital records such as social security cards or birth certificates, which are often required for individuals moving to an apartment complex.

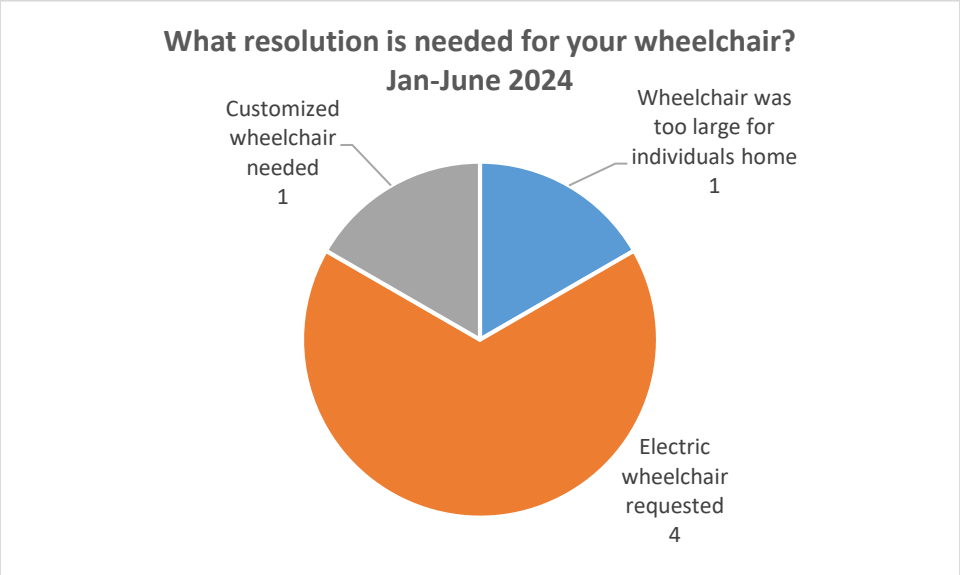
DURABLE MEDICAL EQUIPMENT



28% of individuals outreached reported outstanding Durable Medical Equipment (DME) needs. This is a reduction from 36% of participants with unmet DME needs during the prior reporting period. The most commonly reported needs were for shower chairs or benches (10), incontinence supplies (5), and wheelchairs (5). There were fewer individuals during this time who identified outstanding needs related to beds (2), which was a common unmet need in July through December 2023.

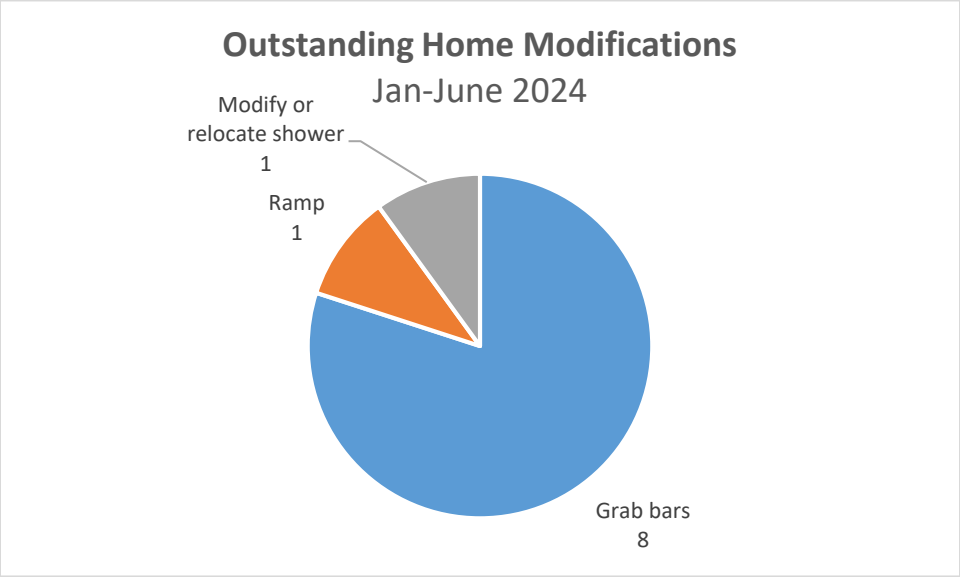
Upon transition to the community, initial incontinence supplies are provided by the nursing facility. Individuals who received additional supplies by Managed Care Organizations have had

fewer unmet needs in this area. Delays in receipt of shower chairs or benches has contributed to safety concerns, as participants shared fears of falling and being injured while bathing.



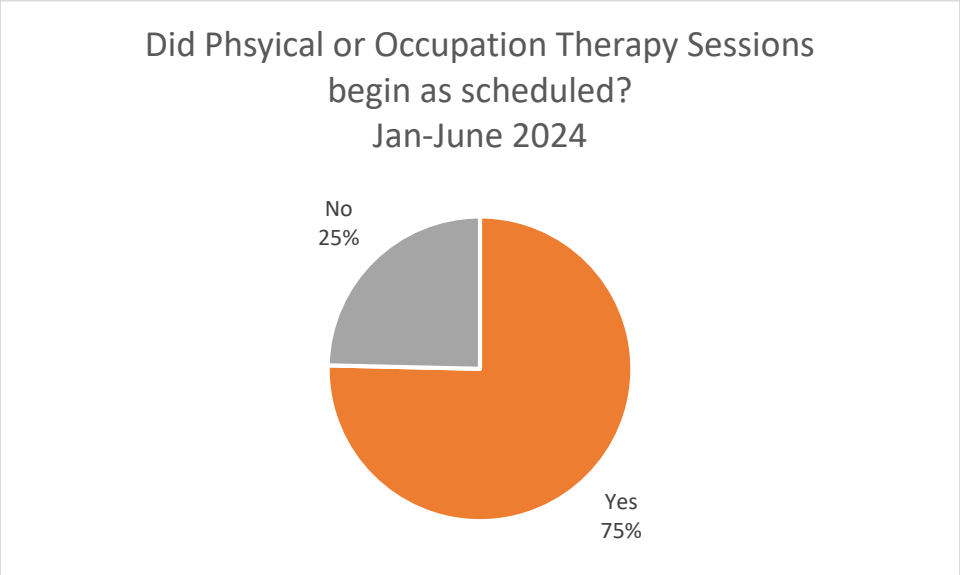
For individuals with unmet needs regarding wheelchairs, 4 of 6 expressed that they were interested in or waiting on an electric wheelchair. Individuals discussed the ways in which having a manual wheelchair (versus an electric one) impacted their day to day life. Primarily, they shared how using a manual wheelchair made accessing medical care in the community more difficult (e.g. doctor's appointment) and that they did not feel that they could fully integrate into their communities or access community.

HOME MODIFICATIONS



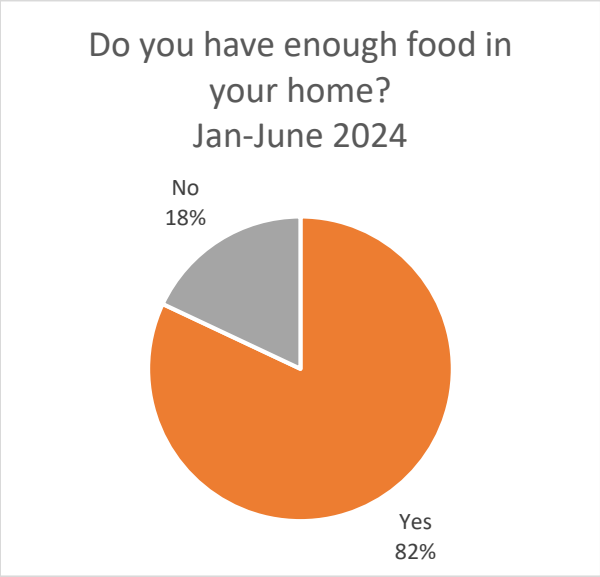
For January through June 2024, there was a decrease in outstanding home modification needs. 81% of those contacted who were in need of home modificaitons had their needs met, including those requiring ramp installation. In prior reporting periods, all participants who were in need of ramps had outstanding needs. Grab bars were needed in 8 of 10 cases (80%) where participants had unmet Home Modification needs. One individual reported that they were in need of a ramp, and while estimates were not fully completed, they had received one estimate by the time of outreach contact and had another scheduled for the folliwing week. One participant expressed need for modification of the shower for accessibility, which had not been previously addressed with their care team.

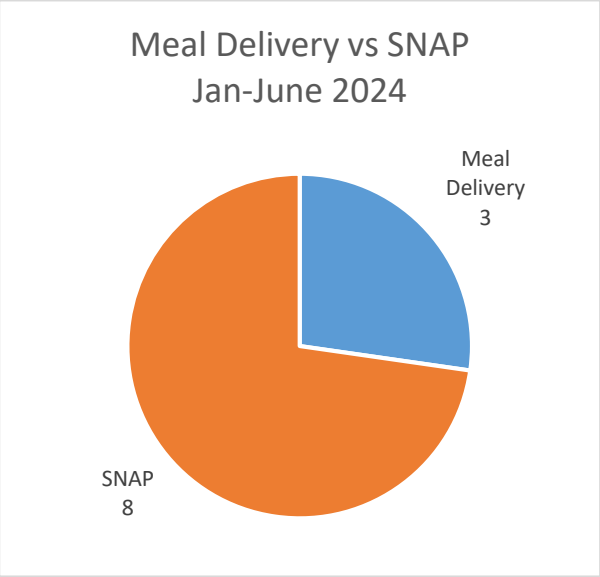
PHYSICAL OR OCCUPATIONAL THERAPY



25% of participants outreached reported that either physical or occupational therapy (PT/OT) had not begun at the time of follow up outreach, or that sessions had started and concluded with interest in having additional sessions. Participants shared how physical and/or occupational therapy is essential to living as independently as possible and gaining strength to engage in leisure activities which help them feel fulfilled. The nursing home provides initial authorization for PT/OT via prescription prior to discharge. Additional sessions could be prescribed by the individual's primary care doctor should they have further room for improvement. Care manager support and follow up could make a positive impact in this area to ensure sessions begin as scheduled and to help the member explore the possibility of additional PT and/or OT sessions.

FOOD SECURITY





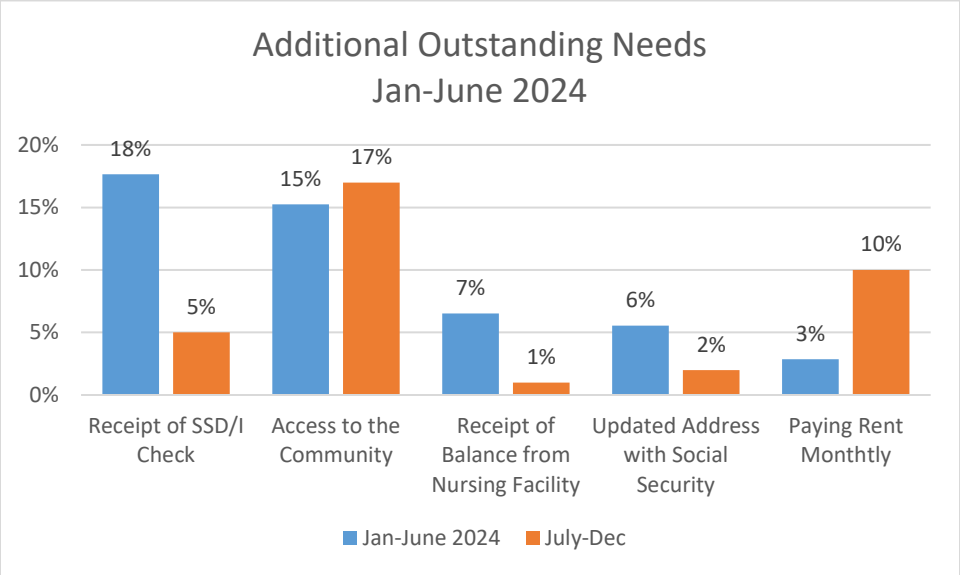
There was an increase in individuals reporting concerns with food security in January through June 2024, with 18% of participants having unmet needs in this area, compared to 10% in the prior reporting period (July-December 2023). While individuals shared that they had received initial pantry stocking as part of the MFP supplemental services, they expressed concern for ongoing food security. Three of 11 individuals shared challenges with meal delivery via Mom's Meals. Two participants were awaiting the start of deliveries, while one individual had received meals, but not consistently.

Eight of 11 participants concerned with ongoing food security expressed interest in applying for the Supplemental Nutrition Assistance Program (SNAP). Two individuals had submitted their applications and were waiting approval, while six had not started the application process. Those expressing concern for food security largely reported that they had a list of food pantries in

their area. However, they expressed barriers to accessing them, including difficulties getting to the location and/or carrying groceries to their homes while using mobility aids.

In July through December 2023, there were reports that some of the food provided as part of the MFP supplemental services upon transition had spoiled due to the volume of food provided. During this time, there were no further reports of food spoilage.

ADDITIONAL NEEDS



The most significant outstanding need outside of MLTSS scope in January through June 2024 was receipt of Social Security income upon transition to the community. Challenges in this area were varied. While a few individuals reported that they did not change their address with Social Security by the time of follow up outreach, a majority had done so and remained without income since moving to their homes. Participants have reported that even when going to the Social Security Administration (SSA) office in the days after their community transition, they were given appointments with SSA to renew benefits 6-8 weeks from that time. Those with delays in Social Security Income have expressed fear of losing their housing due to lack of income until the appointment is completed.

As with prior reporting periods, participants' access to the community continues to be limited by mobility aids which do not meet the individual's needs; underutilization of non-medical

transportation; concerns of strength or stamina in the community due to delays in physical or occupational therapy; and concerns with financial security and delays in receipt of income. Some of those outreached continue to express interest in giving back to their communities, including by supporting others still residing in nursing homes.

SUMMARY

January through June 2024 demonstrated a continued increase in participants reporting that all of their needs were met (64%), but 36% of participants did report outstanding needs and request assistance to meet them. Tops areas of need largely remained the same from prior reporting periods, including non-medical transportation and durable medical equipment, while there were increased unmet needs for physical and occupational therapy. Respondents tended to be more aware and better able to access non-medical transportation and farther along with home modifications than in July through December 2023.

More respondents reported not having enough food in their homes. They also reported concerning delays in accessing their social security income and related fears about housing stability, ability to afford goods and services outside of MLTSS, and the ability to do anything in the broader community.

Re-institutionalizations have increased slightly during in the first half of 2024, with 5.9% of individuals readmitted to a nursing facility within 90 days of community transitions. January through June 2024 demonstrated a shift to increased time in the community prior to re-institutionalization, with the highest percentage readmissions occurring within 30-59 days. Overwhelmingly, re-institutionalized individuals and their families reported feeling safer in a nursing facility. While outstanding needs have decreased with time, nearly one third of MFP participants contacted reported outstanding needs which impact their care and wellbeing, and there are ongoing concerns from MFP participants on feeling safe in their homes.

RECOMMENDATIONS:

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. Encourage use of non-medical transportation for individuals to obtain vital records if needed for their transiton, such as for housing or voucher opportunities.

Home Modifications: Utilize 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. 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.

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