I Choose Home NJ Quality Report January – June 2025

BACKGROUND[1]

The federal Money Follows the Person (MFP) program, known at the state level as I Choose Home NJ (ICHNJ), helps individuals transition from receiving long-term care services in institutions to living in the community with the support of home- and community-based services. One goal of ICHNJ is for individuals to remain in their homes after transition, measured by the program benchmark to have less 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 and offers opportunities 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 oversight to resolve issues for ICHNJ participants and prevent re-institutionalization within the first 90 days of transition; and
3. Present findings and recommendations to the Director of Managed Long-Term Services and Supports (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 to improve the ICHNJ program and 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

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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, please note:

- *Data is based on self-reported responses from ICHNJ participants.*
- *Data is not available for all participants because 64 individuals could not be reached.*
- *Intervention with managed care organizations (MCOs) is not automatic. Participants who identify problems choose if they want the QA Specialist to follow up with their MCOs.*
- *Due to small sample sizes, data presented cannot be indicative of greater trends across MCOs.*

with the Managed Care Organization (MCO) care team to address and resolve identified 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 personal emergency response systems (PERS), based on the 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.*

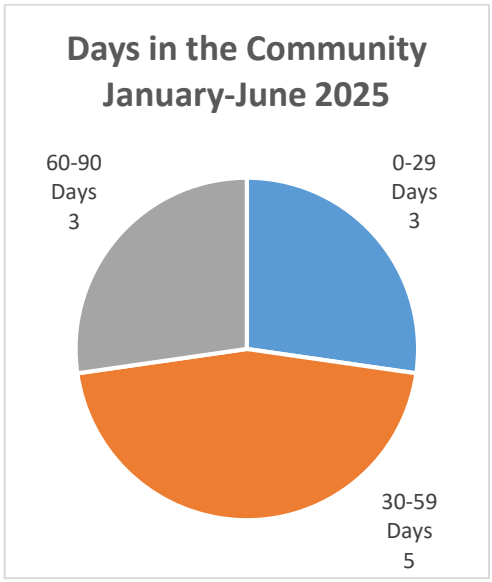
DATA REPORTED

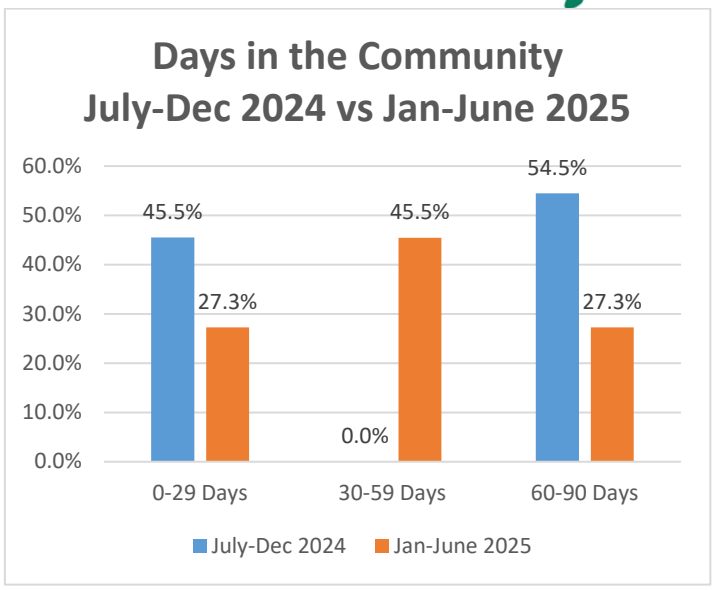
In part, outreach is conducted to help people remain in their homes as outlined in MFP Work Plan Initiative on Quality Measurement and Improvement.

Objective: Reduce re-institutionalizations within 90 days of transition date to 4% of MFP participants by 2027 by identifying barriers and collaborating with MCOs on resolution to help participants remain in their homes through quality follow-up outreach.

Re-institutionalization within 90 days of transition					
Year	**Jan - June**	**July - Dec**	**Total Re-instit.**	**Total Transitions**	**% of Total Re-instit.**
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%
2025	**11**		**11**	**237**	4.64%

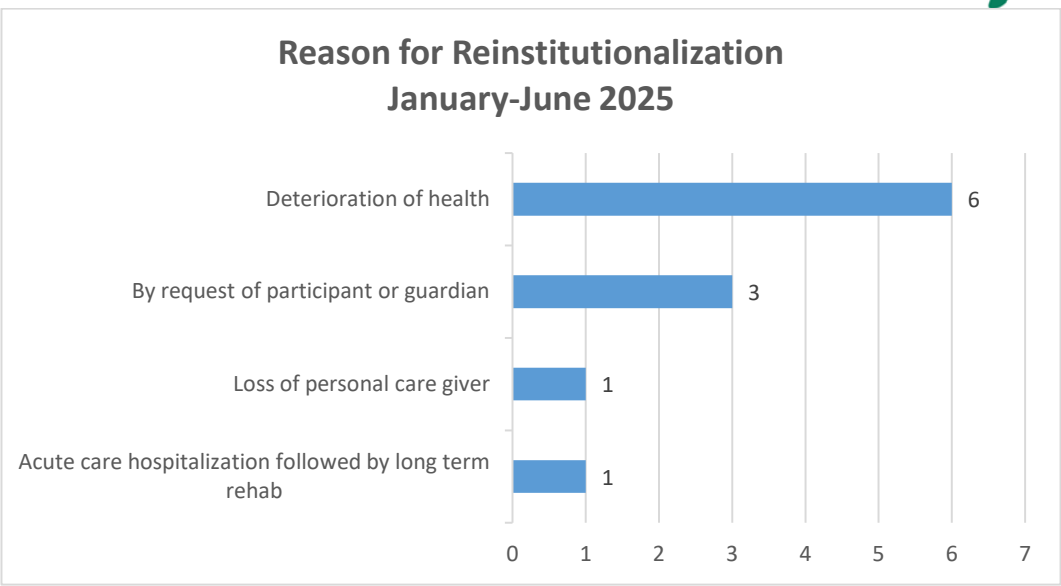
From January through June 2025, 11 MFP participants, 4.66% of 237 transitions, were re-institutionalized within 90 days. The re-institutionalization rate has decreased slightly from 2024, based on current available data. However, due to delays in managed care organizations' notification of re-institutionalization, this rate is subject to revision when more data becomes available.





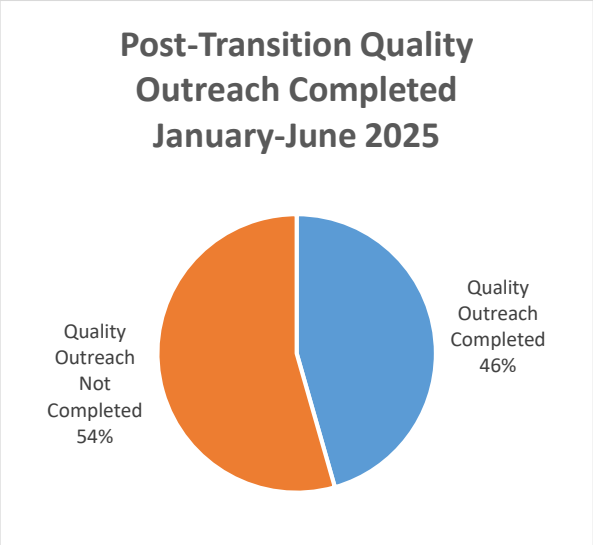
Eleven MFP participants were re-institutionalized within 90 days from January through June 2025. The length of time spent in the community prior to re-institutionalization did not show significant difference between the three timeframes. Three individuals (27.3%) were re-institutionalized within 30 days, five individuals (45.5%) were re-institutionalized between 30 and 59 days, and three (27.3%) were re-institutionalized between 60 and 90 days.

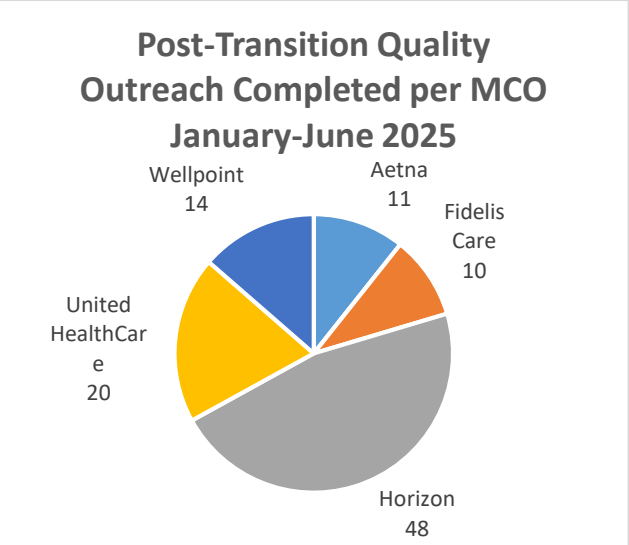
Re-institutionalization rates did not significantly differ between those living with family (six out of 11, 54.5%) and individuals not living with family (five of 11, 45.5%). Similarly, five of 11 individuals were age 65 or older, five of 11 were individuals age 18 to 64 with physical disabilities, and one individual has been diagnosed with an intellectual/developmental disability.



Reasons for re-institutionalization were varied, with the most common being deterioration of health, leading hospitalization and subsequent return to a nursing facility, and requests by the participant or guardian to return to an institution.

POST-TRANSITION QUALITY FOLLOW-UP OUTREACH



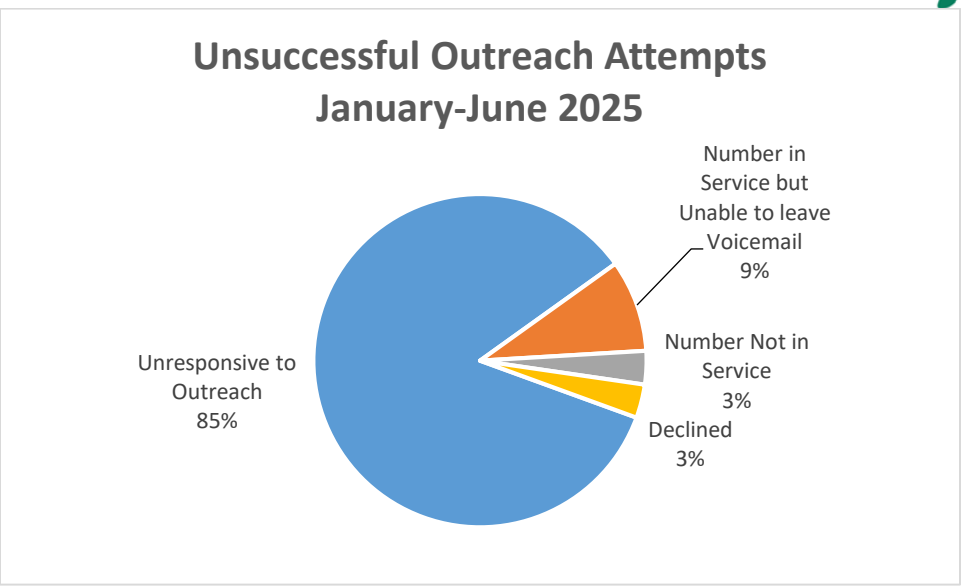


Total Participant Contact Attempts: 226

Total Participant Contacts: 103

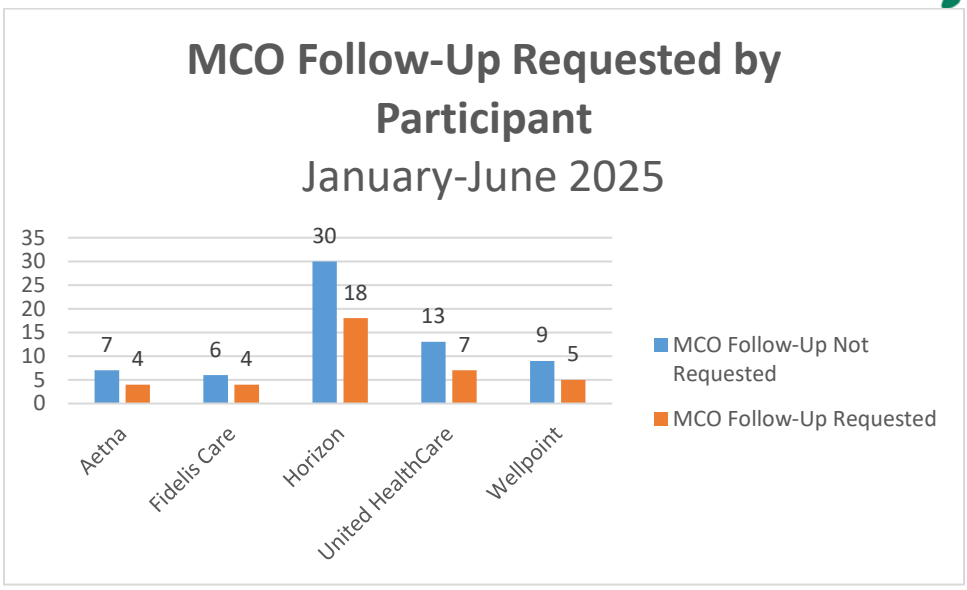
Average length of time from transition date to follow-up contact: 27 Days

Post-transition quality outreach was completed for 103 of 226 (45.6%) individuals. Outreach strategies included attempting contacts at different times of the day, calling primary and alternate phone numbers and emailing all addresses provided by the individuals, as well as outreaching MCOs for additional contact numbers when given phone numbers are incorrect or not in service.

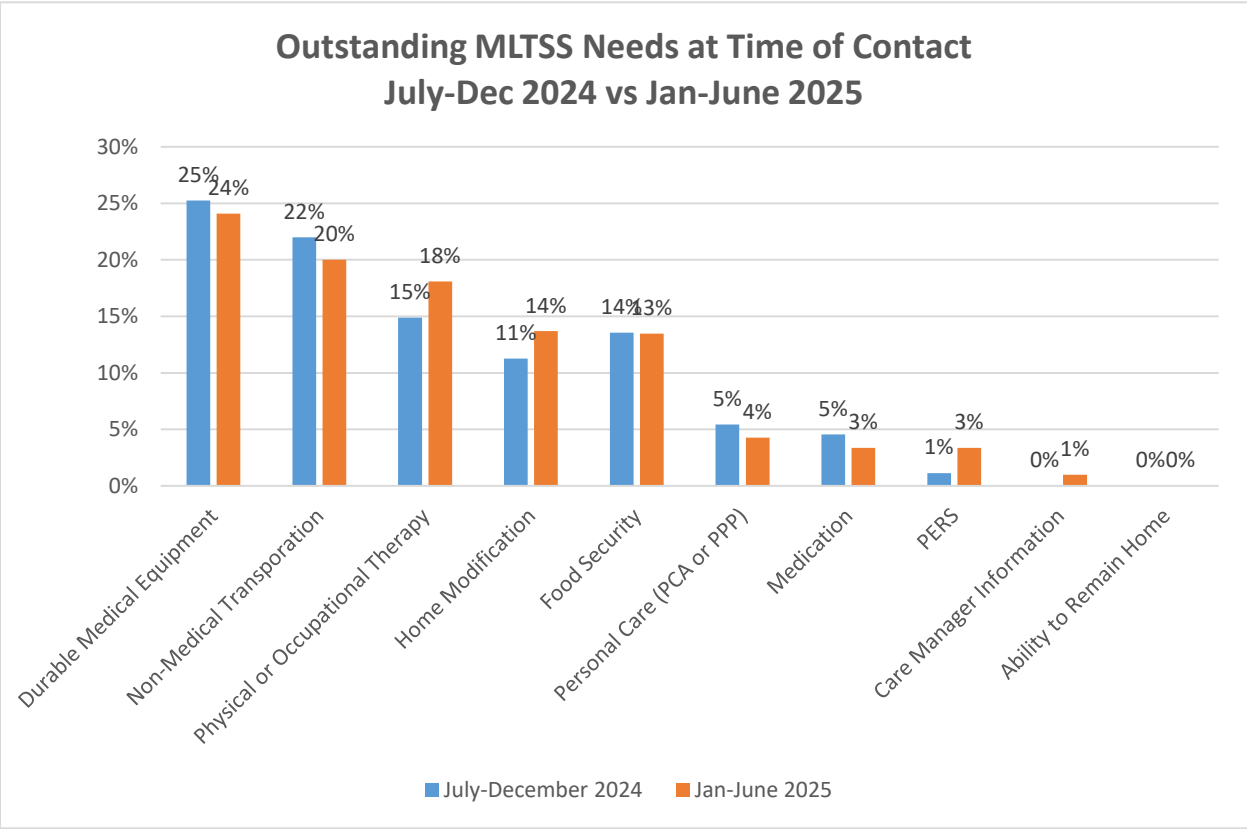


Unsuccessful Contact Attempts: 123

The primary reason for unsuccessful outreach (85%) was that participants did not respond to multiple phone calls or emails. In a small number of cases, individuals had numbers that were not in service or voicemails that were full and not accepting messages. Four individuals were successfully reached and declined to participate.

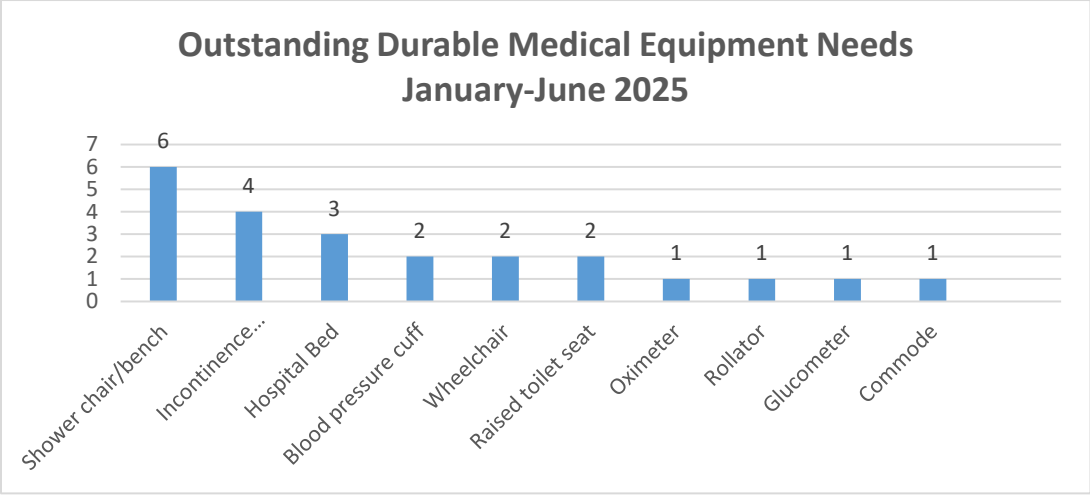


From January through June 2025, 38 of 103 (37%) individuals reported unmet needs for which they requested support to resolve. The rate of individuals with outstanding needs is consistent with 2024, when 36% of individuals requested support to resolve outstanding needs. Since 2024, one-third of MPF participants have had unmet needs that could impact their ability to remain in the community.



Participants reported durable medical equipment (24%), non-medical transportation (20%), and physical or occupational therapy (18%) as the top unmet needs related to MLTSS benefits from January through June 2025. Home modifications (14%) and food security (13%) also had substantial rates of unmet needs. Top outstanding needs have changed only slightly compared to July through December 2024. Outstanding needs are based on MFP participants' reports of experiences that have impacted their transition to the community.

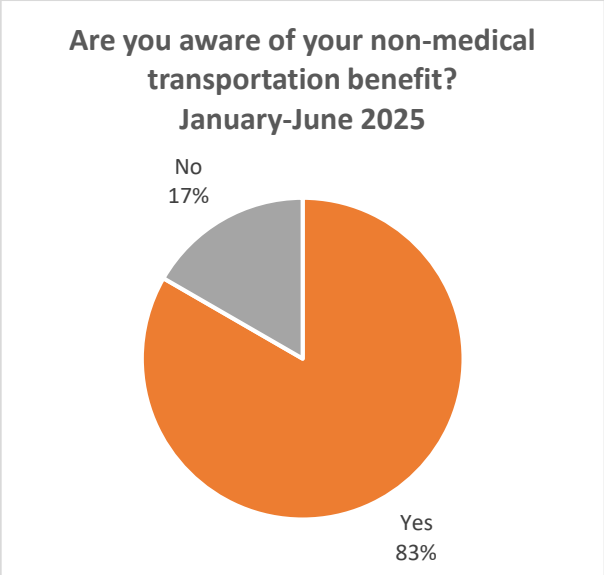
DURABLE MEDICAL EQUIPMENT

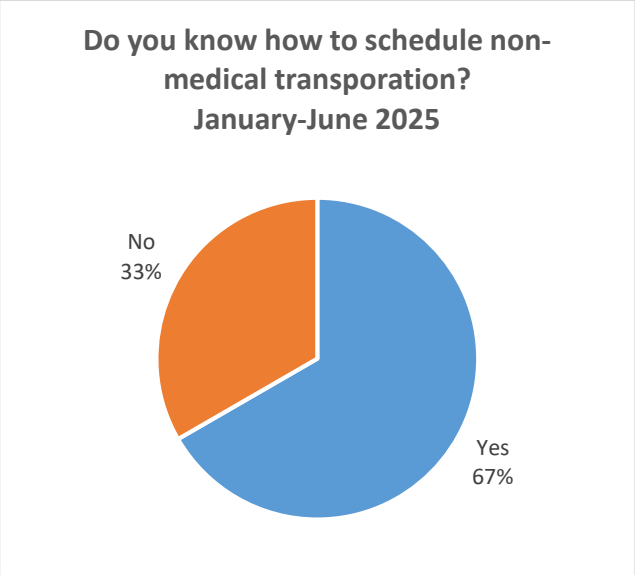


Among participants outreached from January through June 2025, 24% had unmet durable medical equipment (DME) needs. A lack of shower chairs or benches was the most common durable medical equipment need. Delays often occur for individuals who are dually eligible (who have Medicare and Medicaid), due to a longer process of obtaining durable medical equipment when Medicare is their primary insurance. Partners at MCOs have been encouraged to explore alternate routes to procure shower chairs for participants, such as using discretionary funds. Individuals have shared how the lack of shower chairs can present a fall risk and results in injuries requiring medical attention or hospitalization. Incontinence supplies continue to be another common need, with four participants reporting being out of supplies at time of outreach. Nursing facilities provide initial supply of incontinence products, and MCOs have been encouraged to supplement when needed. Three individuals reported needs related to

hospital beds, including needing a fully electric beds without manual cranks, a bariatric bed, and a gel overlay.

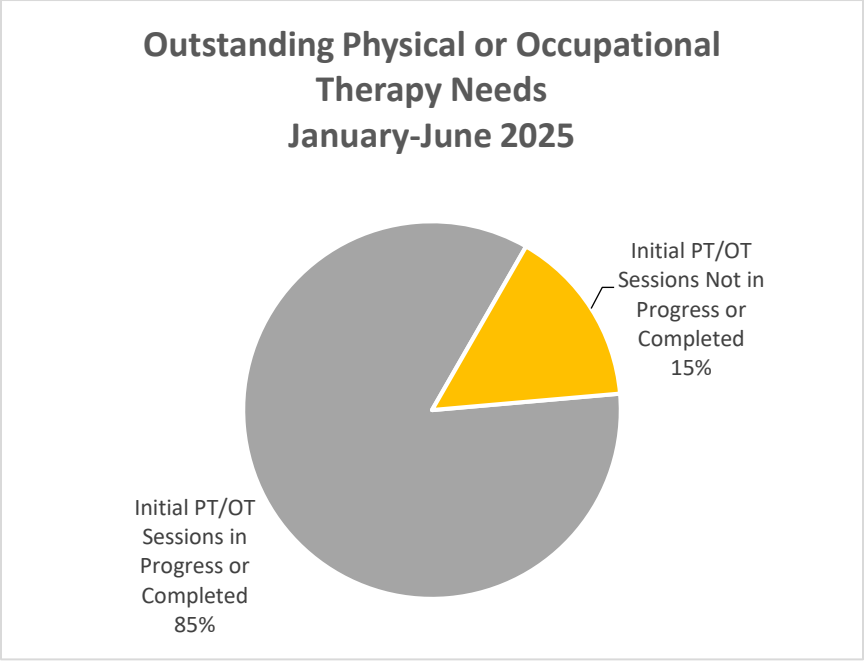
NON-MEDICAL TRANSPORTATION

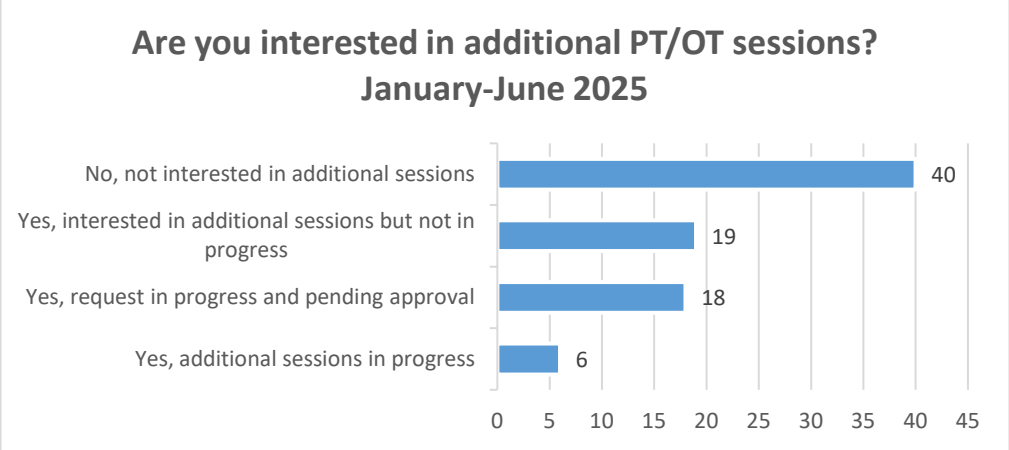




Seventeen percent of individuals reported that they were unaware of their non-medical transportation benefit through MLTSS. Among the 83% who were aware of this benefit, 33% reported that they were not aware of how to schedule transportation. A lack of information about non-medical transportation or how to schedule the service presents a barrier to accessing one's community, meeting daily needs, and reducing isolation.

PHYSICAL OR OCCUPATIONAL THERAPY

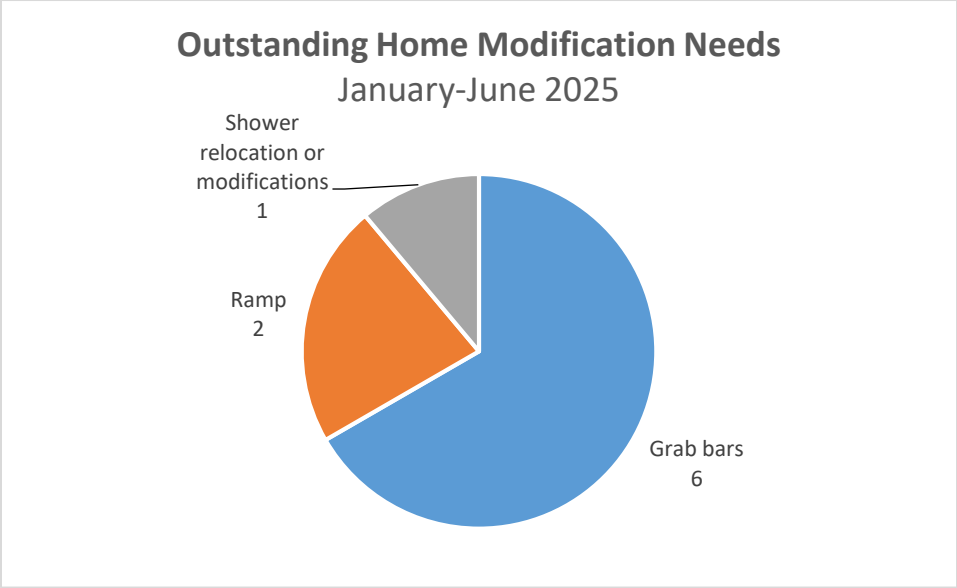




Fifteen percent of individuals with physical or occupational therapy needs reported that initial sessions had not begun by the time of outreach. Physical and occupational therapy is limited to a set amount of approved sessions initially. Participants expressed that additional sessions to gain strength would be beneficial in completing daily needs and accessing their home and

communities. More than half (52%) of individuals who completed initial physical or occupational therapy sessions expressed interest in obtaining additional sessions or had subsequent sessions in progress at time of outreach. Participants were often knowledgeable about the process to obtain additional sessions, with some individuals in the process of working with their care managers and primary doctors on obtaining approval prior to outreach. Several participants reported that delays in approval for additional therapy sessions were due to lack of follow-through from primary care physicians.

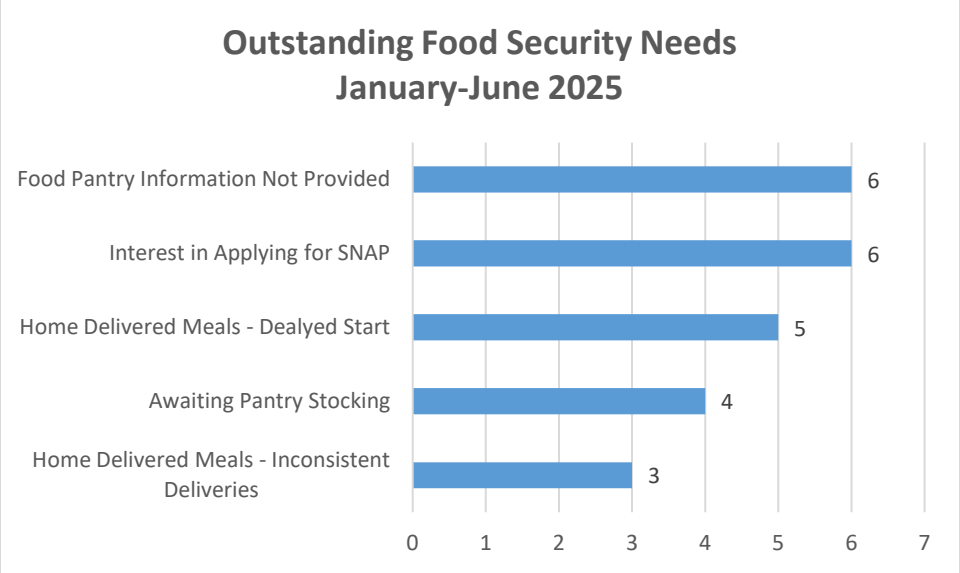
HOME MODIFICATIONS



At time of outreach, 14% of individuals who reported needing home modifications were still waiting for completion of those modifications. Six individuals were awaiting grab bars in the bathroom or shower. Three of these individuals rent their homes in apartment complexes, which may cause installation delays due to maintenance protocols. However, in most instances there had not been further communication with the participant from MCO care managers or apartment complex staff about the status of their need. For individuals who were in need of ramps, all reported that estimates had been scheduled or at least one estimate was completed, though an installation date had not yet been set. Largely, home modifications prior to transition to the community, available through MFP supplemental services during this reporting period, had been offered to individuals and were declined by the participants due to concern of

delaying their discharge. Home modifications prior to transition were discontinued as a supplemental service in July 2025.

FOOD SECURITY

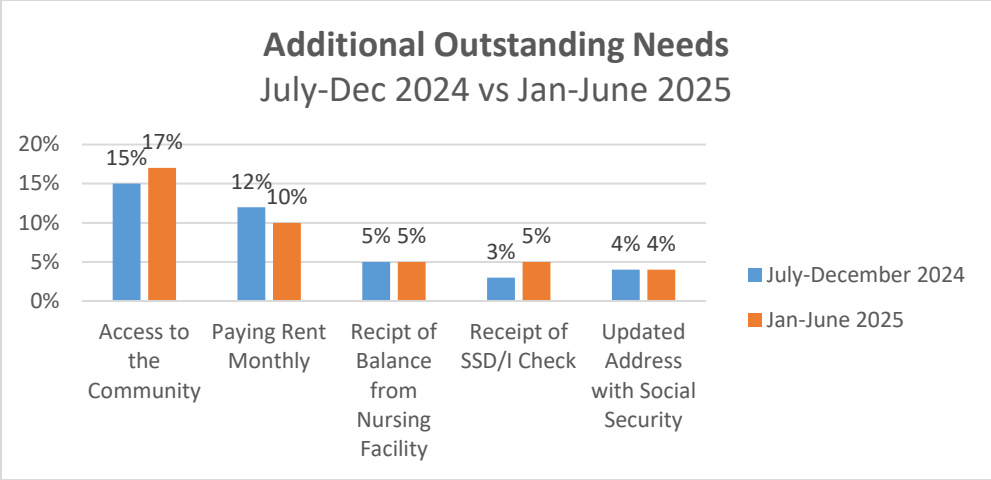


Food security continues to be a top need, with 13% of individuals reporting unmet needs in this area. The most common outstanding needs related to food security included lack of information about local food pantries provided, as well as interest in applying for SNAP benefits. Several individuals had challenges with their home delivered meal benefit as well, with five individuals experience delays in the start of meal delivery, and three participants who had an initial delivery of meals, but did not receive subsequent deliveries. Delays in receipt of pantry stocking were reported as well, with four participants sharing that they had received their initial order of groceries through MFP supplemental services but had not received

subsequent deliveries. Supplemental pantry stocking has been encouraged to be provided in multiple deliveries within the first 30 days so that food provided does not spoil prior to the individual being able to consume all items.

Provisions to increase food security for those residing in the community have been included as an 1115 waiver, which provided an array of services for Medicaid recipients, benefit beginning in July 2025. These benefits, available to those who meet the USDA definition of food insecure, provide not only stocking of groceries upon initial return to the community from an institution, but include supplying food in subsequent months as well. All MFP participants will be screened for the pantry stocking benefit, with the MFP supplemental pantry stocking available to all those who are deemed not to meet the necessary USDA food insecurity criteria.

ADDITIONAL NEEDS



Outstanding needs that are outside the scope of MLTSS have largely remained consistent compared to experiences shared in 2024. Access to the community remains the most reported outstanding need (17%), as other unmet needs may serve as barriers to this pursuit such as delays in mobility aids, home modifications, or desire to gain more strength via physical or occupation therapy.

Further interest in community access and integration was explored in the follow-up outreach survey starting in 2025. At the time of contact, participants most commonly reported interest in accessing their community in the future to partake in resources and community events such as visiting their local libraries, attending religious services and socializing with friends and family. Participants often shared that at time of contact, they were still adjusting to the transition back to the community, with many having outstanding care needs as well.

SUMMARY

Revisions were made to the quality follow-up outreach survey tool in 2025 for increased accuracy of data in anticipation of the development of a comprehensive database for MFP. The MFP Salesforce application launched in early July 2025, serving as a centralized hub of data for MFP participants from the time of referral through the time of their dis-enrollment from MFP.

January through June 2025 demonstrates a slight decrease in re-institutionalization rate within 90 days compared to 2024. However, all data may not be available due to delays in MCOs' notification of return to an institution. While re-institutionalization rates have decreased, MFP participants continue to report outstanding needs at a similar rate compared to 2024, with nearly one-third of individuals having an unmet need three to four weeks after transition to the community.

Quarterly meetings with managed care partners began in 2025 to discuss progress of individual MCO transition goals, and address quality concerns. Strategies for improving gaps in service delivery, similarly shared as recommendations below, have been discussed during these times in hopes of mitigating common unmet needs reported by MFP participants in the future.

RECOMMENDATIONS:

Durable Medical Equipment (DME)

- Review DME orders during pre-transition interdisciplinary team (IDT) meetings, including items ordered, sizes needed, member's needs/preferences (e.g. crank vs. electric bed), and ensure all authorizations and prescriptions are submitted.
- Check at the first home visit that DME was received, works properly, and meets the member's individual needs.
- Explore use of alternate vendors if DME is not received promptly.
- Ensure members have adequate supplies of single-use items, including incontinence supplies. If the participant is unable to reorder supplies, ensure that supplies will be delivered on a schedule that works for the individual.
- Work closely with nursing facilities to ensure adequate incontinence supplies are provided upon transition.
- 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 all members receiving MLTSS.

- Review non-medical transportation with individuals prior to transition and at first and second community contact, providing 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.

Home Modifications

- Schedule home modification estimates and construction as early in the IDT process as possible so that construction can be completed in a timely manner, prior to transition whenever possible.
- Explore additional vendors for home modifications to reduce delays with scheduling estimates and construction.

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