I Choose Home NJ Quality Report January – June 2023

BACKGROUND[1]

The federal Money Follows the Person program (MFP), known at the state level as I Choose Home NJ (ICHNJ), moves people receiving long-term care services in institutions back in the community with the home and community-based services they need to thrive. 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-eligible individuals receiving Managed Long Term Services and Supports (MLTSS) 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 to identify and resolve barriers that may make it difficult for ICHNJ participants to remain in their homes.

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

DATA COLLECTION[2]

The purpose of data collection is to:

1. Identify and resolve issues for ICHNJ participants to prevent re-institutionalization within the first 90 days of transition; and
2. Present findings and recommendations to the Director of MLTSS at the Division of Medical Assistance and Health Services (DMAHS) and the Director of MLTSS at the Division of Aging Services (DoAS) to improve service delivery of MLTSS.

The ICHNJ QA Specialist attempts outreach within 30 days for participants who have transitioned from a nursing home, though contacts may occur more than 30 days later based on participant availability. Once contact is made, the goal of the follow-up call is explained: to identify and help resolve barriers which may make it difficult to remain in their home and to advocate for them with their Managed Care Organization (MCO) if desired. Follow-up calls are conversational in nature and a survey tool is used to help track areas of concern. This includes, but is not limited to, care manager contact, availability of personal care assistants (PCA), receipt

[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.*

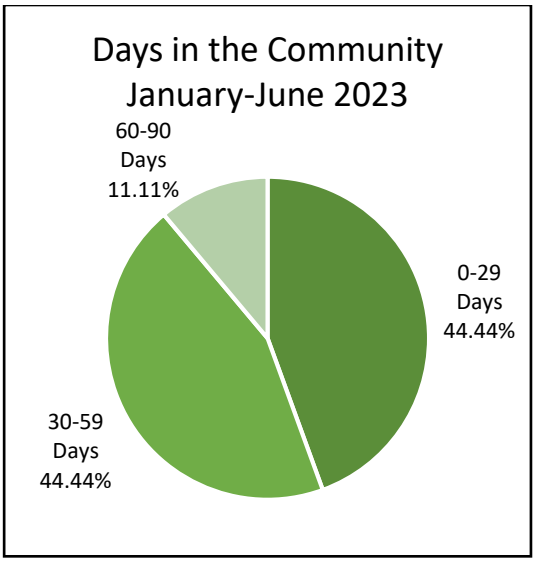
of durable medical equipment (DME), meal delivery status, and installation of emergency response systems (PERS). With consent, the ICHNJ QA Specialist contacts the individual's MCO to help resolve outstanding issues. *Please see Appendix A for the survey tool utilized to identify areas of concern.*

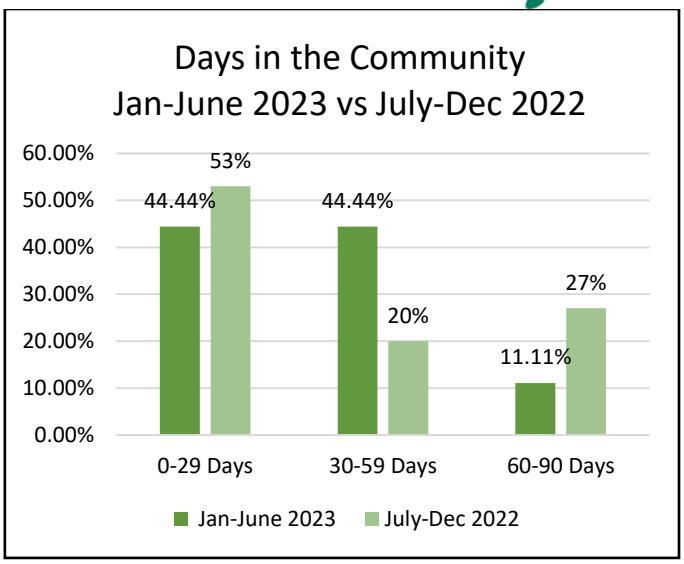
DATA REPORTED

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.**
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**	**177**	**6.21%**

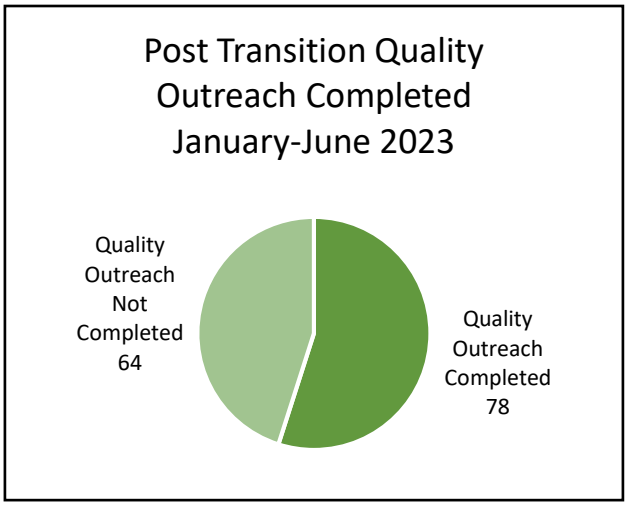
To date, 11 of 177 participants (6.21%) have been reinstitutionalized within 90 days. Although the 4% benchmark was not met in the first half of 2023, there is reduction in the number of individuals reinstitutionalized in this period compared to the previous two years.

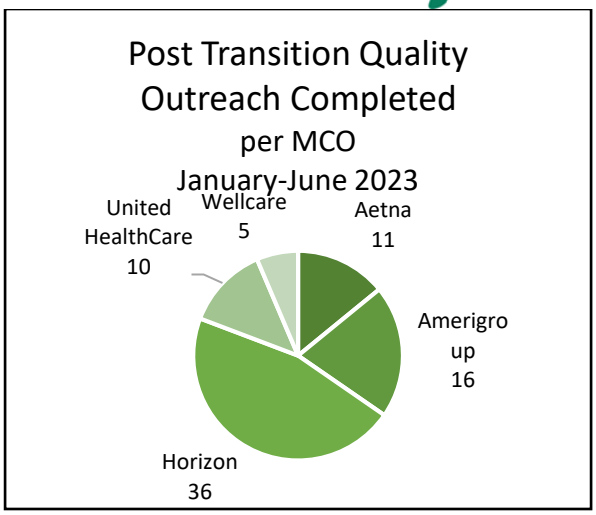




Of those who had been reinstitutionalized, 44.4% (5 of 11) of were reinstitutionalized in less than 30 days, 44.4% (5 of 11) between 30-59 days, and 11% (1 of 11) between 60 and 90 days. While fewer individuals returned within 30 days than the previous period, a majority (89%) of participants who had been reinstitutionalized were in the community for less than 60 days.

In March 2023, reporting on change in MFP status was revised to include additional information of contributing factors to reinstitutionalization. Changes include information of transition needs such as care management contacts, PCA, DME and home medication status, as well as a brief description of the events leading to reinstitutionalization. In some instances, family members providing care support reported that they were not able to provide a sufficient level of care or declined to have the individuals return to their home after a hospitalization.





Total Participant Contact Attempts: 142

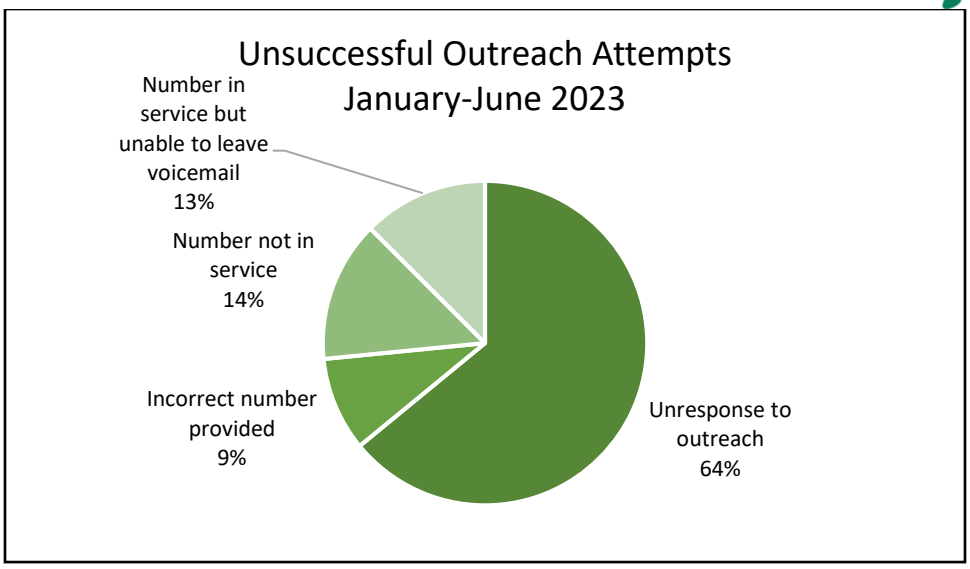
Total Participant Contacts: 78

Unsuccessful Contact Attempts: 64

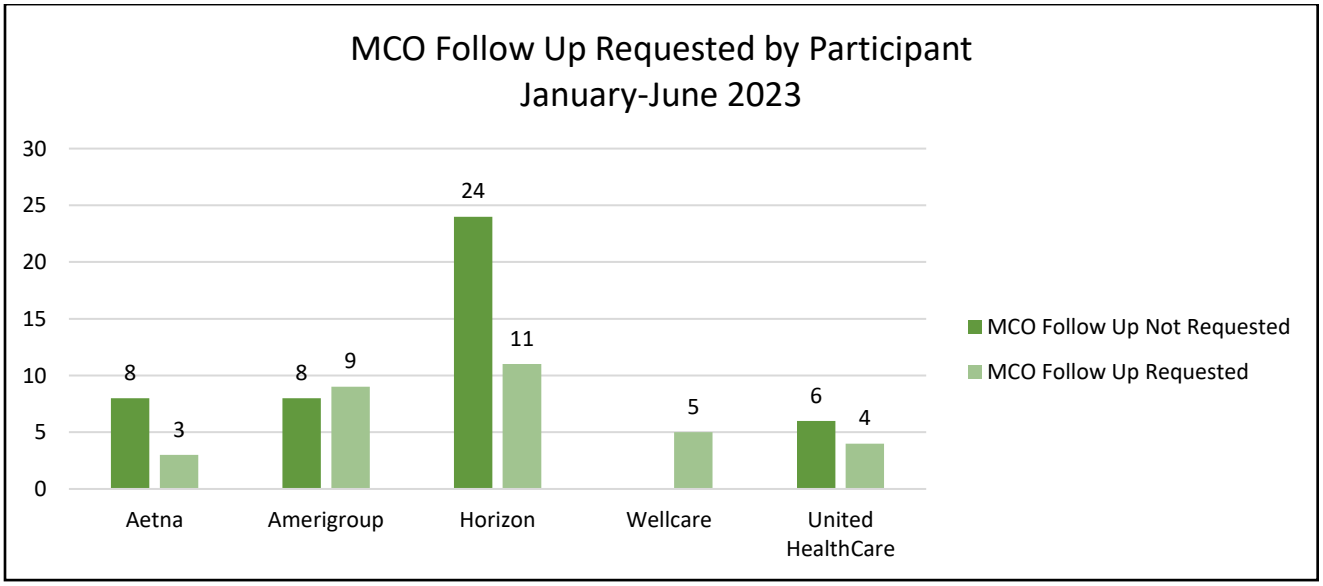
Average length of time from transition date to follow-up contact: 28

Post transition quality follow-up was completed for 78 of 142 individuals[3] (55%). While the number of individuals has decreased in this reporting period relative to 2022, the percentage of successful contacts remains consistent. During this reporting period, changes were made to outreach approaches, which included attempting contact earlier and employing text messaging in efforts to increase the percentage of individuals outreached. To date, this has not yielded a change in percentage of successful outreach attempts and alternate strategies to increase engagement in the quality follow-up process will continue to be explored.

[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.



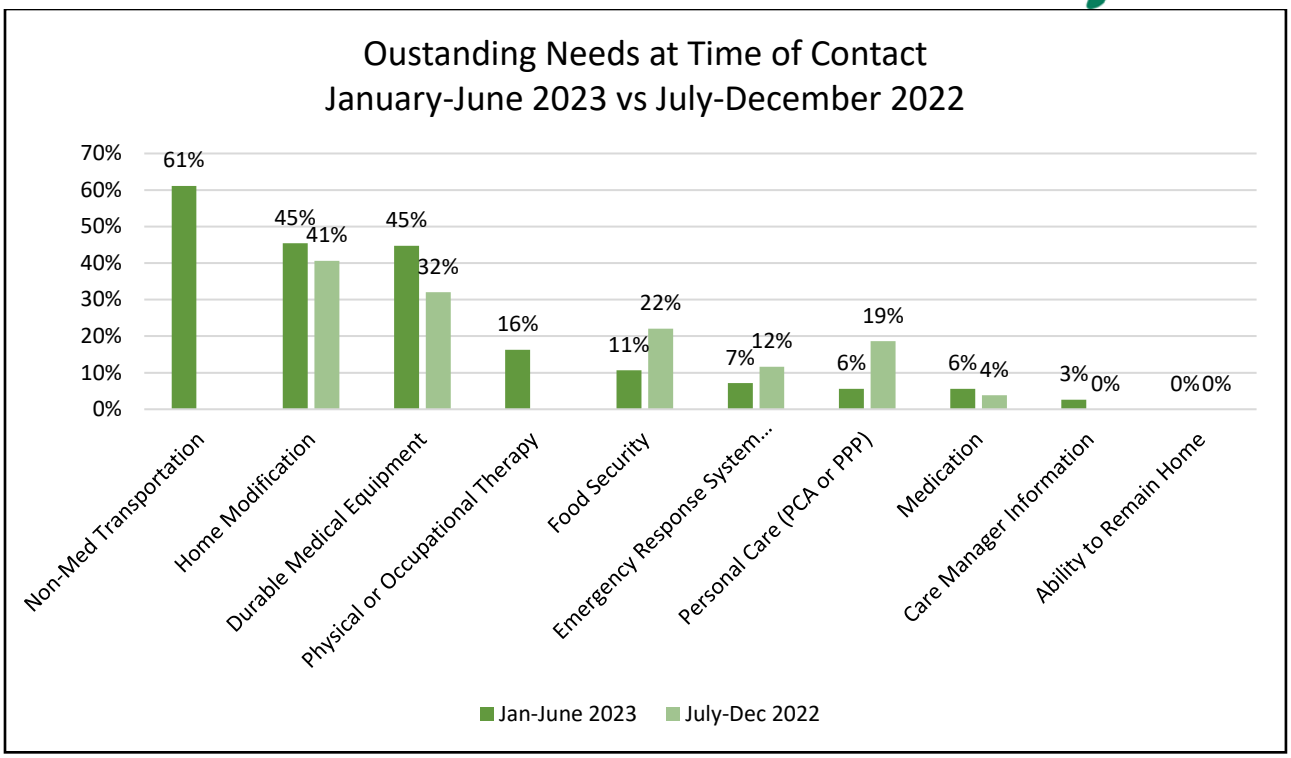
Unsuccessful outreach attempts were due in large part to lack of response to outreach from participants (64%). At times, contact numbers were incorrect, were not in service, or could not receive voicemail.



31 of 78 participants outreached from January through June 2023 requested support with resolving unmet needs via follow-up with participant MCOs. Overall, fewer individuals reported having outstanding needs requiring MCO follow-up. 40% of individuals requested assistance during this period.

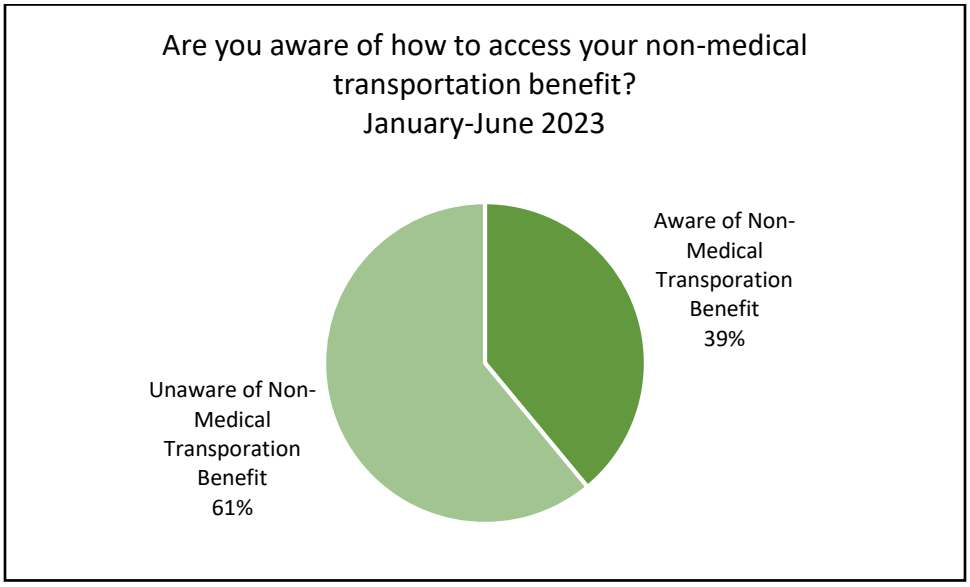
Changes were made to the quality outreach survey in 2023. Questions included in 2022 remained, while new additions were added for accuracy of data collection and reporting.

Changes include questions pertaining to home modification estimates, detailed collection regarding outstanding DME and home modification needs, non-medical transportation knowledge, and an open-ended question about how participants would like to engage in their communities.



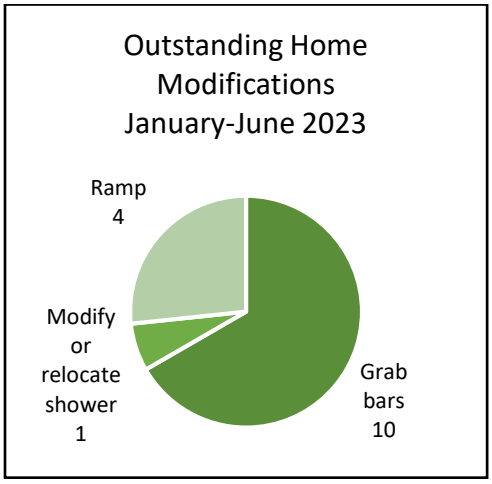
Each category of outstanding need reflects the percentage of participants who reported having a need for follow-up. The number of responses for each area of outstanding need is varied. The greatest outstanding needs participants reported pertain to non-medical transportation (61%), home modifications (45%), and durable medical equipment (45%). There was a significant reduction in outstanding needs for Personal Care Support, continuing positive trends noted in the latter half of 2022.

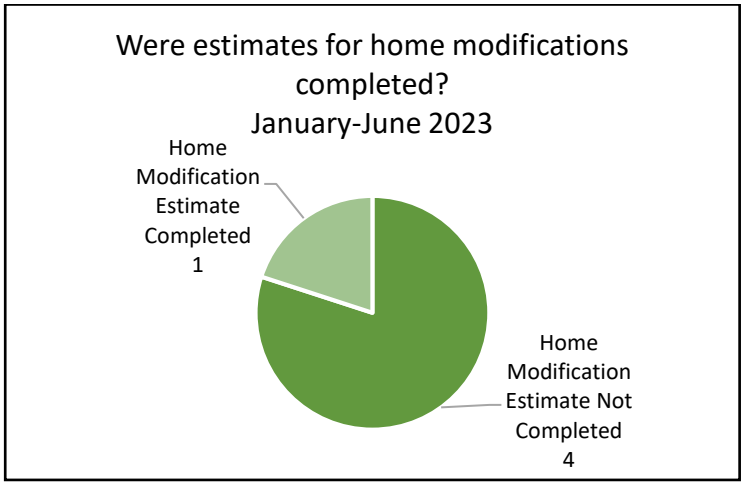
NON-MEDICAL TRANSPORTATION



61% of individuals reported they were not aware of their non-medication transportation benefit and/or did not understand how access it. Although non-medical transportation benefits are commonly explained at transition meetings in the nursing home, the large gap in knowledge of this benefit highlights the need to review this benefit once individuals have transitioned to increase community utilization and integration.

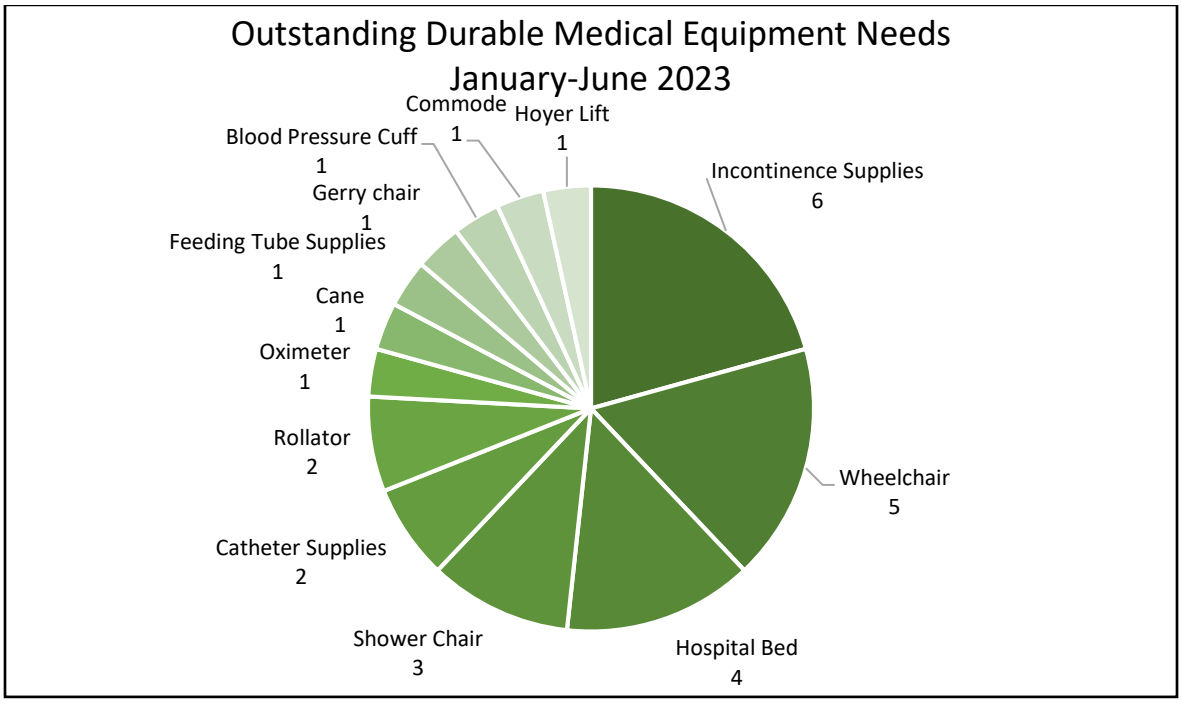
HOME MODIFICATION



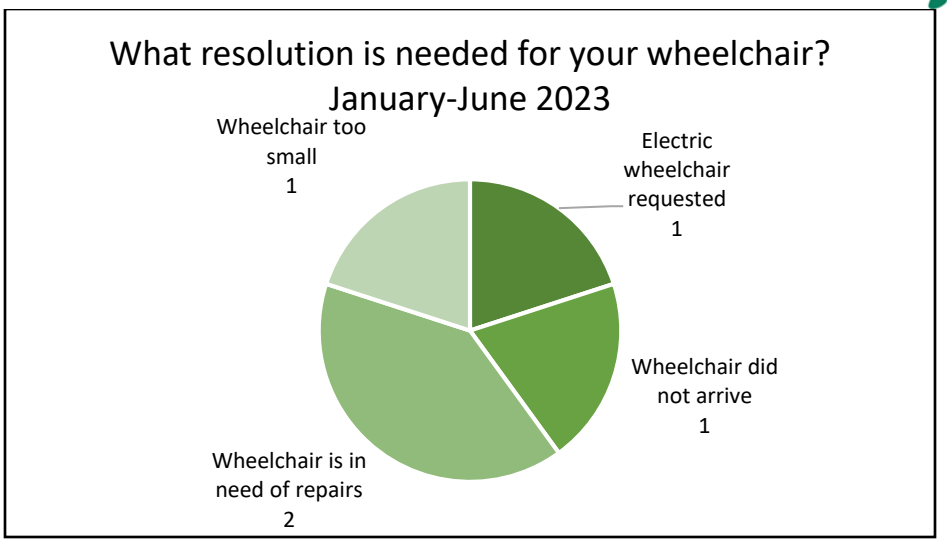


45% of individuals needing home modifications had outstanding needs when quality outreach was completed. Participants who had home modifications completed by the time of quality outreach most often had grab bars installed in their homes and did not require structural changes. During this reporting period, substantial modifications, including renovation or relocation of showers and installation of ramps could not be completed until individuals transitioned to the community. As such, delays in installation are expected. For these structural modifications, 4 out of 5 individuals reported that estimates needed to begin renovations had not been complete at the time of follow-up contact, around four weeks from the date of transition. Beginning in July 2023, MFP Supplemental Services include provisions to complete home modifications prior to an individual's transition to the community.

DURABLE MEDICAL EQUIPMENT

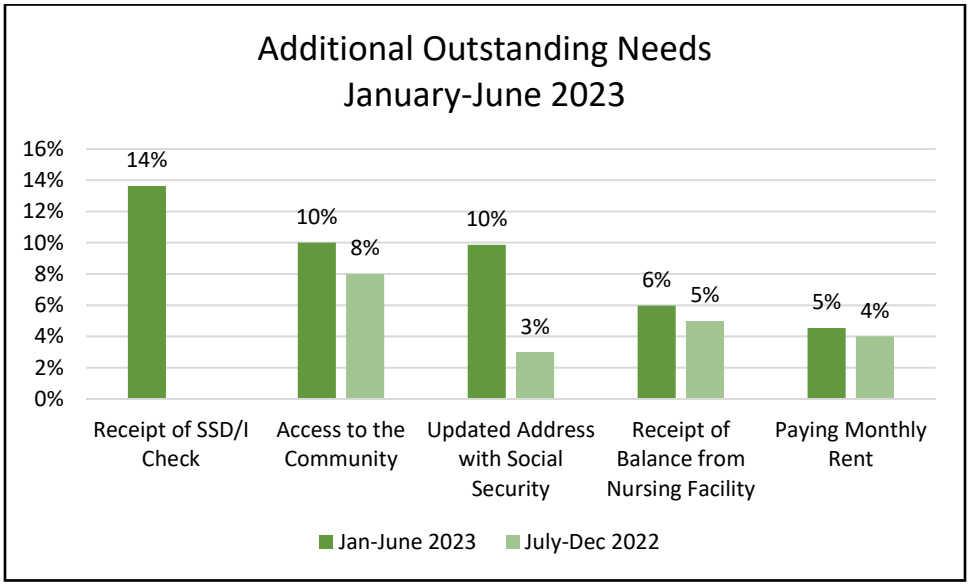


45% of individuals had outstanding durable medical equipment needs during this time. The most common needs were incontinence supplies, wheelchairs or other mobility aids, beds, and shower chairs. As follow-up contacts occurred on average four weeks post-transition, members reported running low on incontinence supplies initially provided. At times, participants stated supplies provided were the wrong size, or that they or their family members paid for incontinence supplies due to delays obtaining them through insurance. Some individuals stated that their beds did not meet their needs. In some instances, they still had not received hospital beds that had been ordered, while other members reported beds with manual cranks were not adequately meeting needs and expressed interested in electric beds.



Participants shared about mobility aids that did not meet their needs, the most prevalent of which were wheelchairs. Challenges were varied, including wheelchairs that did not arrive, wheelchairs too small for the individual, the need for a motorized wheelchair, and two participants that needed wheelchair repairs.

ADDITIONAL NEEDS



Needs outside of MLTSS benefits addressed during follow-ups include financial security and community connections. A question about the receipt of social security income checks post-transition was added in survey revisions for 2023. 14% of individuals reported that they had not received their SSD/I check following their community transition. In many of these cases, the address had been changed with the Social Security Administration prior to transition, although some changes of address had not been completed by the time of contact. Individuals report challenges with reaching the Social Security Administration without having to go personally to a local SSA office, which can be difficult for those with limited mobility. Attempts at phone contact are often met with long wait times or are unsuccessful.

Community access remains a barrier for many as well. Limited mobility or inadequate mobility aids, income restrictions and lack of knowledge about community resources and/or non-

medical transporation benefits are contributing factors for those who identify difficulties with accessing their community.

Revisions to the 2023 quality outreach survey include an open-ended question regarding participants' aspirations of community access and integration: "What types of things do you want to do in the community?"

Individuals often reported that they remained focused on medical and care needs at the time of contact, consistent with the 41% of individuals who expressed still having some type of outstanding need. Many individuals did not have concrete ideas of places they would like to visit in their communities at time of contact. Some individuals had ideas of what they may like to do in the future, including connecting with others in social settings or doing activities they enjoy such as bowling or going to the movies.

Responses relating to community access demonstrate the extensive changes that occur when transitioning to community living. Outstanding care needs may impact community integration including lack of knowledge of how to access non-medical transportation, lack of suitable mobility aids and limited knowledge about community resources one could utilize.

SUMMARY

January through June 2023 demonstrated some shifts in outstanding needs identified in 2022 and also reflected some consistent concerns/issues. For examples, far fewer participants reported problems with personal care assistance (6% in January-June 2023, compared to 26% in January-June 2022). However, durable medical equipment remains a high area of need (45%).

Barriers to community integration came into greater focus in this period. Participants' lack of knowledge of non-medical transportation benefits, continued outstanding medical/clinical needs (ex. DME), challenges to receipt of continued social security benefits, , and needed home modifications are precursors to people being able to safely leave their homes and access their communities. As online resources and opportunities become more prevalent, digital connection is also increasingly important in reducing isolation and addressing unmet needs. Lack of adequate phone numbers or phones for individuals also serves as a barrier to completing quality follow-up, contact with care management and medical teams, and meaningful social connection.

MFP Supplemental Services beginning in July 2023 align with many of the needs identified in quality follow-up contacts during this time period and in those prior. Supplemental services will allow for home modifications prior to individual transition, increased food pantry stocking and additional food support after hospitalizations, provision of a personal technology device for reduced isolation and increase community connection.

RECOMMENDATIONS:

Non-Medical Transportation: Review non-medical transportation benefits again with individuals during the second community contact. Assure that care managers discuss use of non-medical transportation for trips to the grocery store, movies, religious services, etc. Provide written instruction on how to set up non-medical transportation and assist individuals with scheduling the transportation until members are trained on doing so independently.

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. Apply 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.

Durable Medical Equipment (DME): Review DME orders during pre-transition IDT meetings, including what has been ordered, sizes needed and review member preferences such as a crank or electric bed and ensure all proper authorization or prescriptions are obtained. Make sure care managers are checking at the first visit to ensure all DME was received, works properly, and meets the member's needs. Explore use of alternate DME vendors if DME is not received promptly. Ensure members have adequate supplies of single use items, including incontinece supplies, and supplies order were received and are meeting their needs.

Home Modifications: Utilize 2023 MFP Supplimental Services to complete home modifications prior to individuals' transition for qualified individuals, schedule home modification estimates and construction once an address is identified for individuals in the transition process.

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