I Choose Home NJ Quality Report January – June 2022

BACKGROUND

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 into 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 with the goal of identifying and resolving barriers which may make it difficult for ICHNJ participants to remain in their homes.

DATA COLLECTION[1]

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

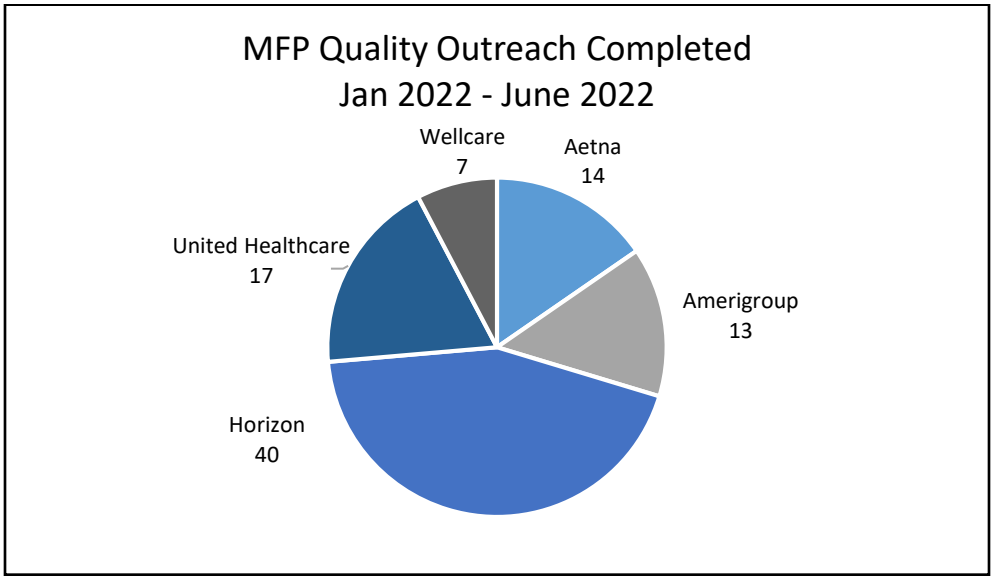
[1] *Due to the nature of the outreach process and data collection, the following should be noted:*

- *Data is based on self-reported responses from ICHNJ participants contacted.*
- *Data is not available for all participants outreached. Seventy-six (76) 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.*
- *Some calls made in January were more than 30 days after day of transition, due to timing of hiring of the new ICHNJ Quality Specialist.*
- *Changes to the follow up survey tracker have been made during this period and, due to these changes, information is not available across all participants for all areas.*

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.

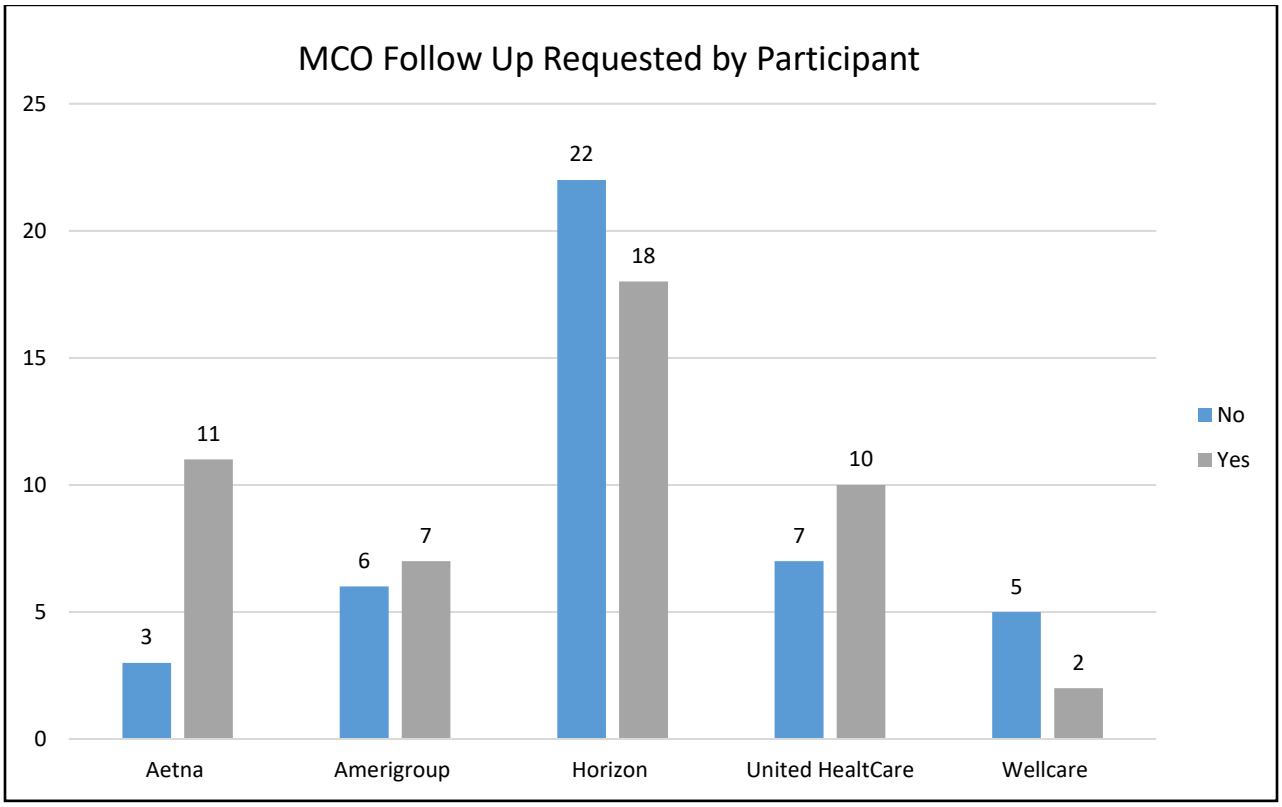
The ICHNJ QA Specialist attempts outreach within 30 days for participants who have transitioned from a nursing home, though contacts may occur more than 30 days later based on participant availability. Once contact is made, the goal of the follow up call is explained: to identify and help resolve barriers 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 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

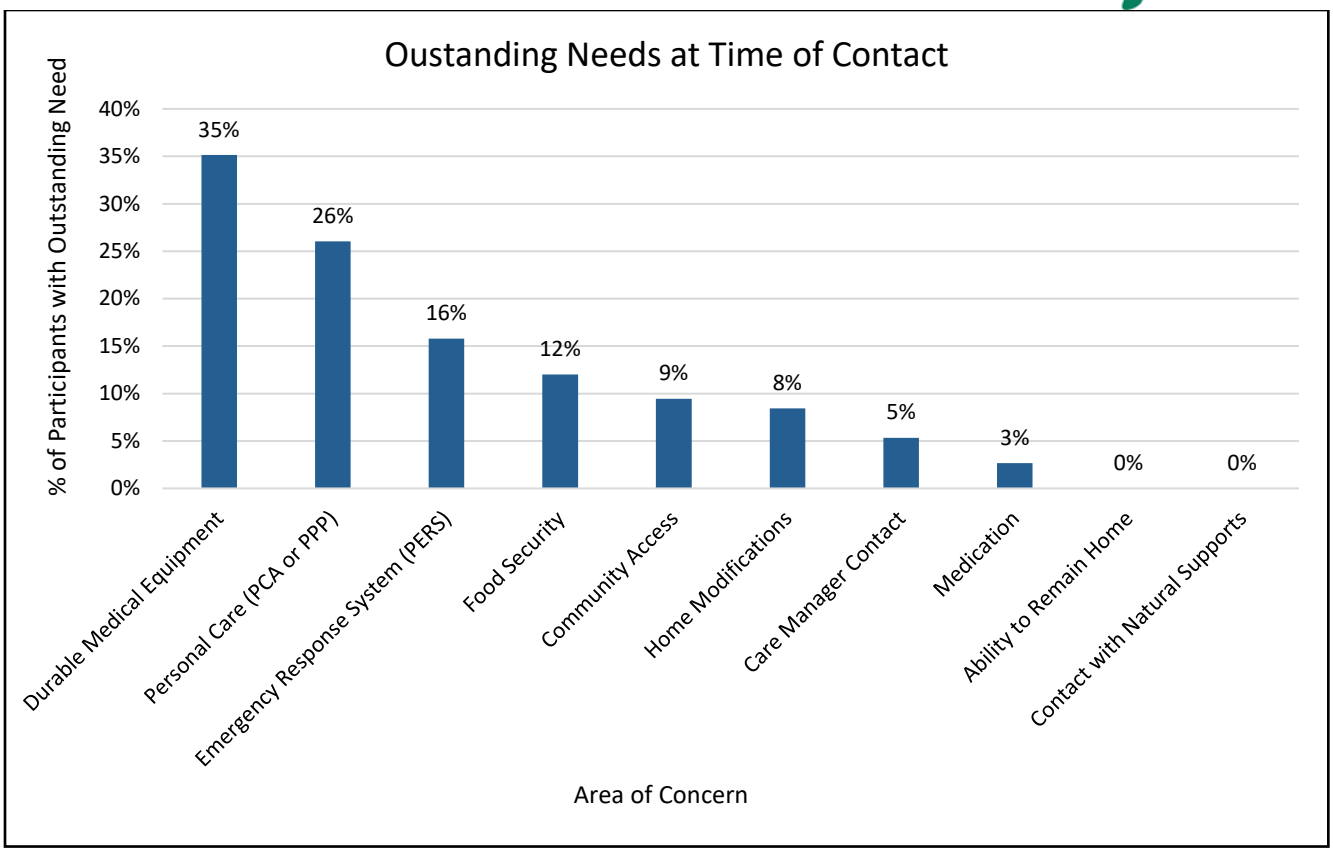


Total participant contacts: **91**

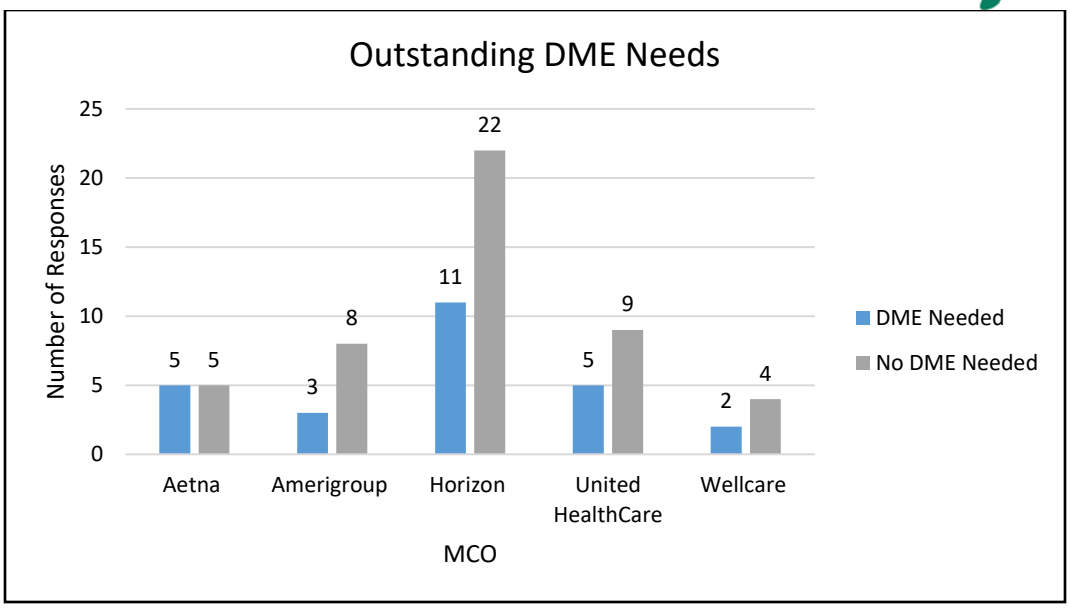
Average length of time from transition date to follow up contact: **26 days**



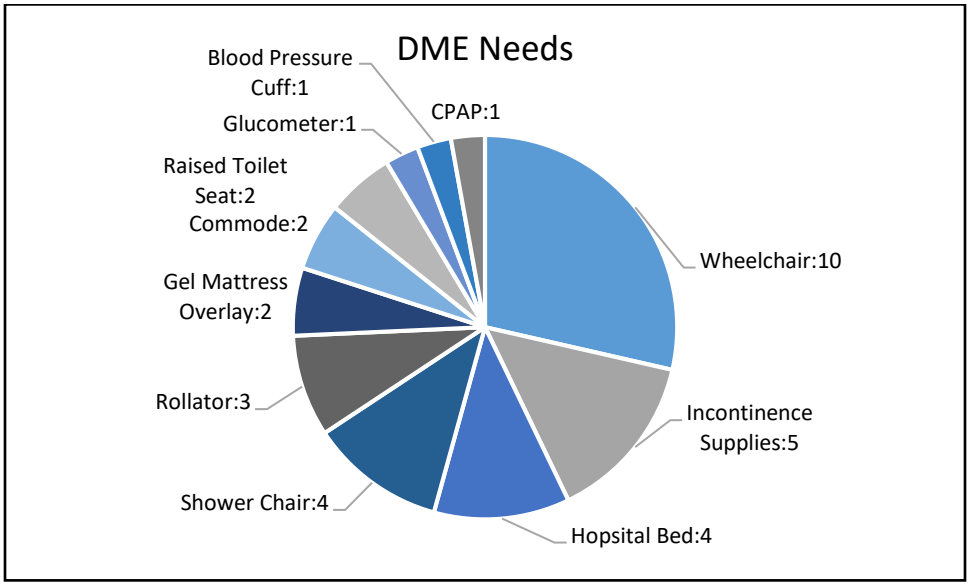
The ICHNJ QA Specialist followed up with MCOs on behalf of 48 participants (of 91 contacted) who requested this assistance. Typically, this occurred when areas of need were not yet met that had previously been discussed with the individual and their care team, such as if PCA services were not in place after transition. At times, participants identified areas for assistance of which their care managers may not have been aware (e.g. need for non-medical transportation).



Areas of concern reflect percentage of participants who reported having an outstanding need in that category. As individuals have different needs, the number of responses for each area of concern is varied. The greatest challenges participants faced are obtaining durable medical equipment (35%) and support for personal care (26%).

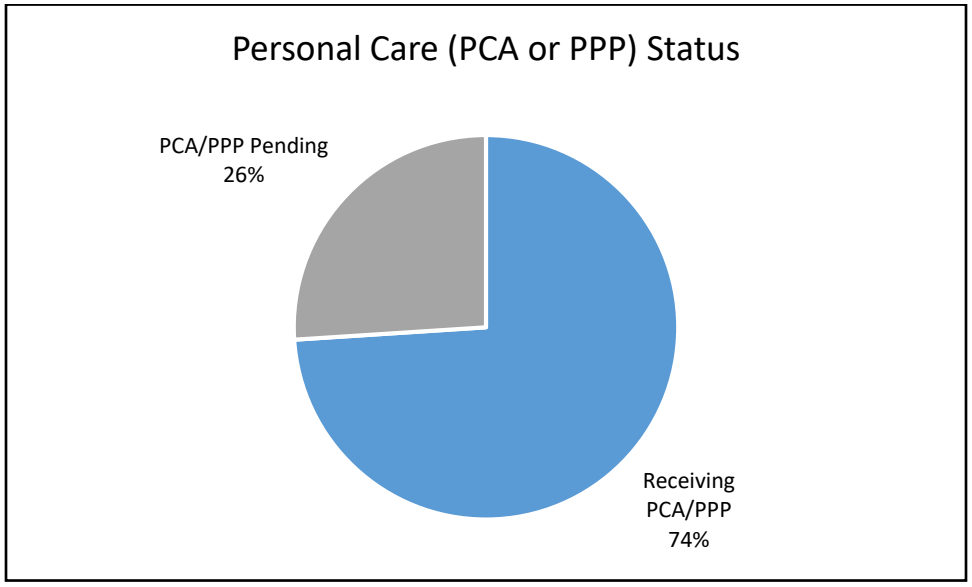


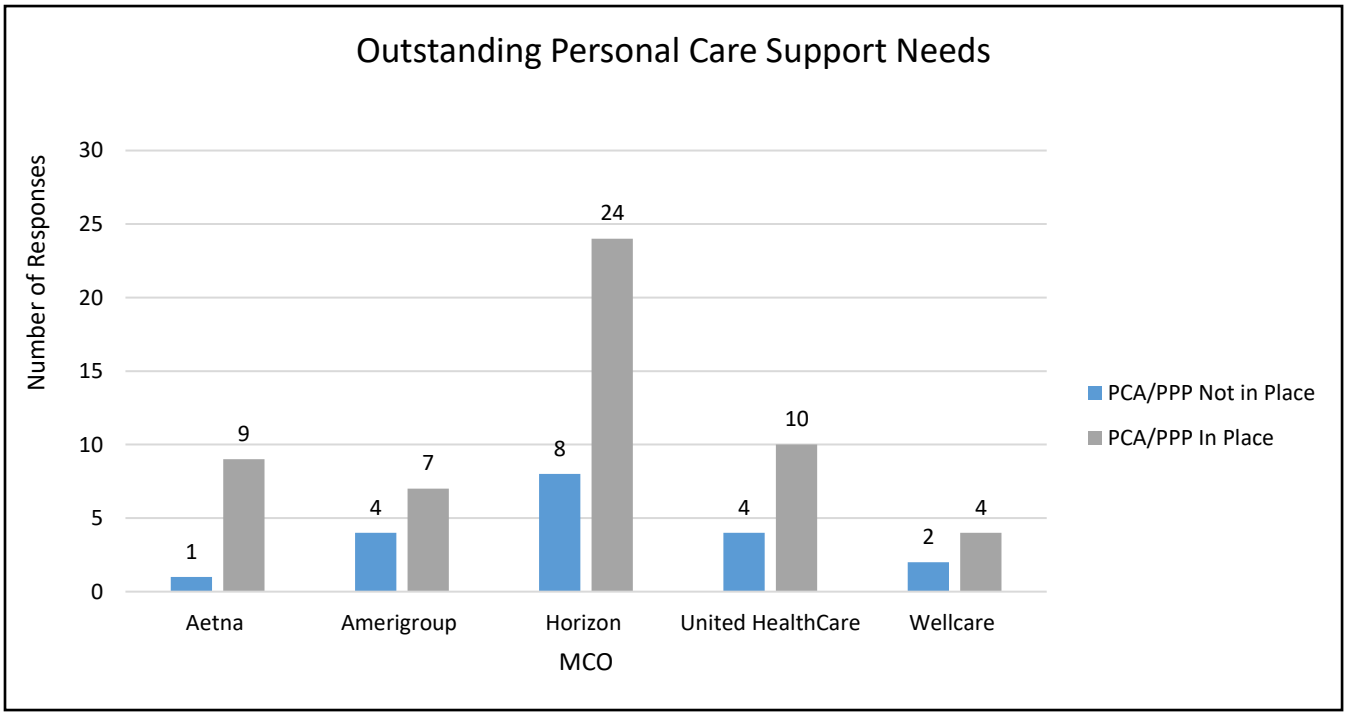
Due to small sample sizes, data presented cannot be indicative of greater trends across MCOs.



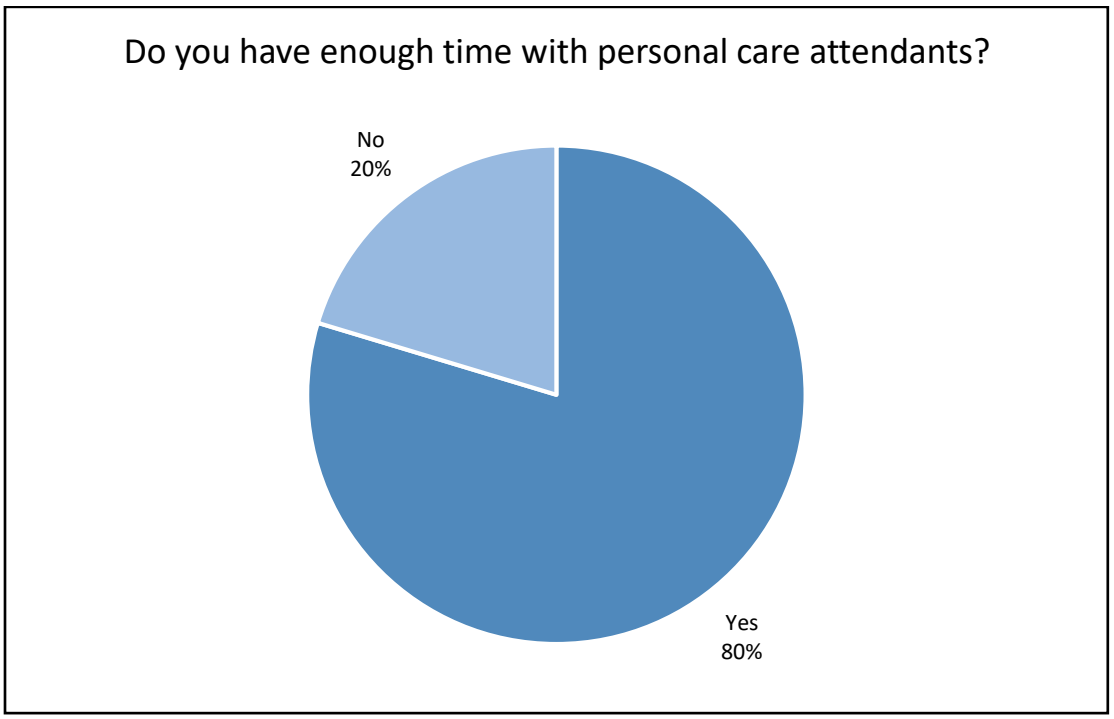
Durable medical equipment was the area with the highest percentage of individuals with outstanding needs. Wheelchair problems were the most common and included: outstanding

repairs needed, interest in power wheelchairs, and wheelchairs that did not suit their living space due to size.





Outstanding care needs include challenges with personal care assistants (PCA) and the Personal Preference Program (PPP). More than one quarter of participants reached reported problems with PCA and/or PPP services. In talking with members and their families about the lack of support with care needs, it is evident that there is significant strain on ICHNJ participants and caregivers when PCA or PPP is not in place for the first weeks of transition. Often times, individuals have identified that while they were advised that PCA would not start immediately upon transition to the community, they were not aware of the possibility to be without support for 3-4 weeks. Access to care support is a crucial step in an individual's ability to remain home. Without transparency regarding the length of time before PCA hours would start, individuals are making uninformed decisions to return home in what could be an unsafe or unsustainable situation.

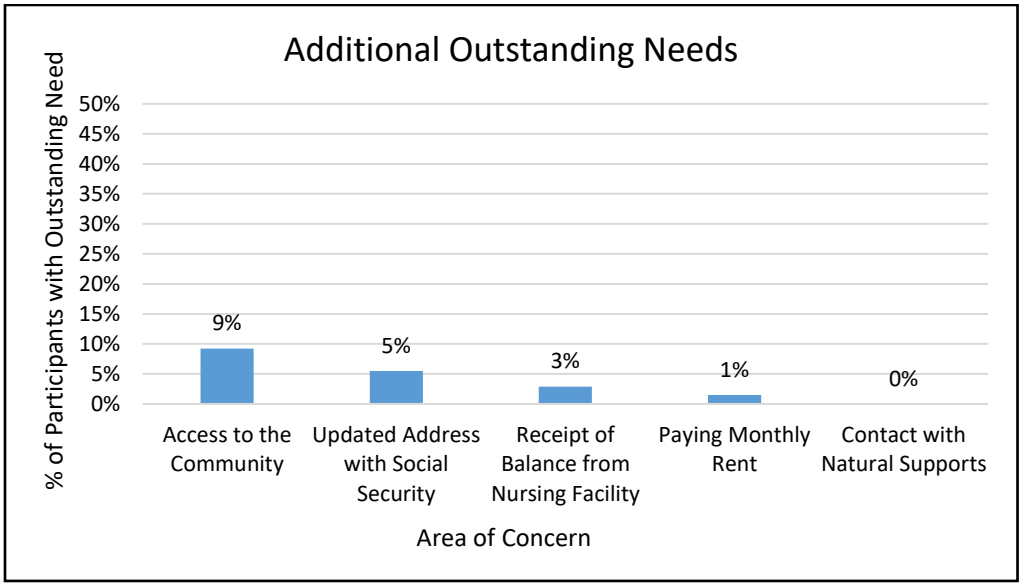


For ICHNJ participants who did have PCA in place at the time of follow up contact, 20% identified that they did not have enough time with care assistants. Some individuals identified that aids were not attending consistently, hours provided ended in early afternoon, individuals

were being transferred to bed at inopportune times, or that their primary aid was unavailable and an alternate was not provided.

Many individuals who have family or other supports and are applying for PPP were still pending at the time of follow up calls. In some cases, PCA had been discussed to bridge care needs until PPP begins, however, PCA was not in place. Several participants and/or caregivers stated that providing care while PPP is pending has been a financial strain, as caregivers have had to reduce hours of employment or leave jobs to fill the gap in care.

During outreach calls, some areas are addressed which do not directly relate to services currently coordinated by MCOs. These include the individual's ability to pay rent, return of income from nursing facilities (when applicable), and change of address with Social Security.



Barriers to accessing the community often overlapped with above areas of concern, including pending home modifications such as a ramp and lack of access to a power wheelchair. Further challenges in this area included difficulty with transportation. Individuals have discussed inconsistencies with Modivcare for medical appointments, and several were not aware of the MLTSS non-medical transportation benefit.

SUMMARY

ICHNJ participant feedback gathered from January to June 2022 has made clear gaps in the transition and follow up process and has identified areas for improvement in MLTSS services received.

Data shows that support for care needs, including Personal Care Assistants (PCA) and Personal Preference Program (PPP) services, and obtaining durable medical equipment (DME) were the biggest challenges faced by ICHNJ nursing home transition participants contacted. Although trends in outstanding needs across participants were limited, nearly half of those successfully outreached had services which were not in place at time of contact. The vast array of unresolved needs highlights the importance of providing quality outreach targeted to each individual. Outreach, advocacy and collaboration with MCOs by the ICHNJ QA Specialist provides an avenue for identifying and resolving outstanding needs unique to each ICHNJ participant to bolster a successful transition to the community.

In addition to data collected from follow up surveys, throughout the course of completing follow up outreach with ICHNJ participants it is evident that individuals are not always aware of how to resolve problems. While participants have overwhelmingly identified that they have been contacted by their care manager, some expressed frustration that their care manager changed since they moved home. Participants have identified that newly assigned care managers, whether because the member moved from a facility to the community or for any other reason, are not always aware of ongoing needs that were previously discussed. Individuals have noted that they feel that having their care manager changed caused delays in resolving known problems.

Transitions, as well as follow up outreach, has appeared to largely focus on medical and other care needs. For some individuals, behavioral health and/or substance use support has not been integrated into their transition or care plans.

And, while access to the community is discussed during post transition outreach, further emphasis could be placed on community integration, before and after transition, to ensure that individuals flourish in their community.

Changes to the survey tool are needed to gather more data about the scope of challenges, participant satisfaction and community inclusion. Revisions will be made to the tool for the 2023 calendar year.

RECOMMENDATIONS

Personal Care Assistance (PCA): Provide realistic and honest timelines for PCA anticipated start dates. Authorize single case agreements when warranted.

Durable Medical Equipment (DME): Make sure care managers are checking at the first visit to ensure all DME was received, works properly, and meets the member's needs.

Change of Care Manager: Assure that the member has their care manager's name and contact information. If the care manager changes, the outgoing care manager should communicate pending issues with the incoming care manager (either directly or via other internal process) to ensure continuity of follow up.

Behavioral Health/SUD: Assure these needs are discussed and integrated into the member's transition or care plans.

Non-Medical Transportation: Community inclusion is of major importance once an individual transitions to the community. Assure that their care manager is discussing the availability of non-medical transportation for trips to the grocery store, movies, church, etc.

Appendix A

I Choose Home Follow Up Tool

1. Identify areas of further need by asking the following:

"No" response indicates further support or assistance is needed in this area

	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?	○	○	○
Do you have a plan for how you will be paying rent each month?	○	○	○
Do you have the medications you need or will need?	○	○	○
Do you have the medical or care supplies needed? - wheelchair, shower chair, incontinence supplies	○	○	○

Were needed home modifications completed? - ramps, widened door frames, grab bars	◯	◯	◯
Do you have enough food at home?	◯	◯	◯
Are you having contact with friends and/or family?	◯	◯	◯
Are you able to access the community when you want/need?	◯	◯	◯
Have your received your money owed by the nursing home? Month of d/c exemption, PNA Balance	◯	◯	◯
Has anyone contacted social security to update your address?	◯	◯	◯
Was your PERS installed and activated? (added Apr 2022)	◯	◯	◯

2. If answering "no" above, describe additional support or services needed.

Enter your answer

3. 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

4. MCO

Select your answer

5. ID

Enter your answer

Submit