I Choose Home NJ Quality Report July – December 2022

BACKGROUND

Background information originally appeared in January-June 2022 Quality Report:

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]

Data Collection originally appeared in January-June 2022 Quality Report:

The purpose of data collection is to:

[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. Ninety-seven (97) 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.*

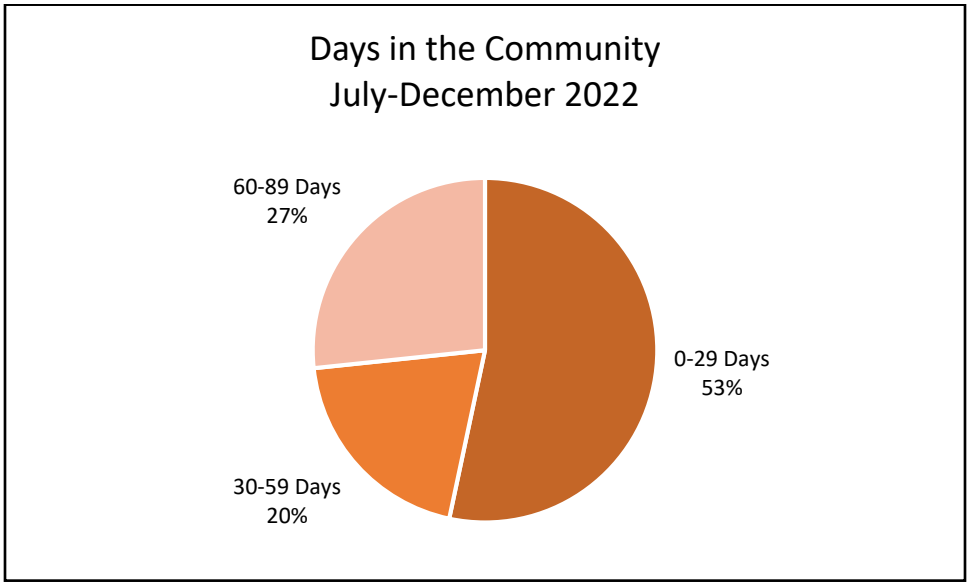
1. Identify and resolve issues for ICHNJ participants to prevent re-institutionalization within the first 90 days of transition; and
2. Present findings and recommendations to the Director of MLTSS at the Division of Medical Assistance and Health Services (DMAHS) and the Director of MLTSS at the Division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

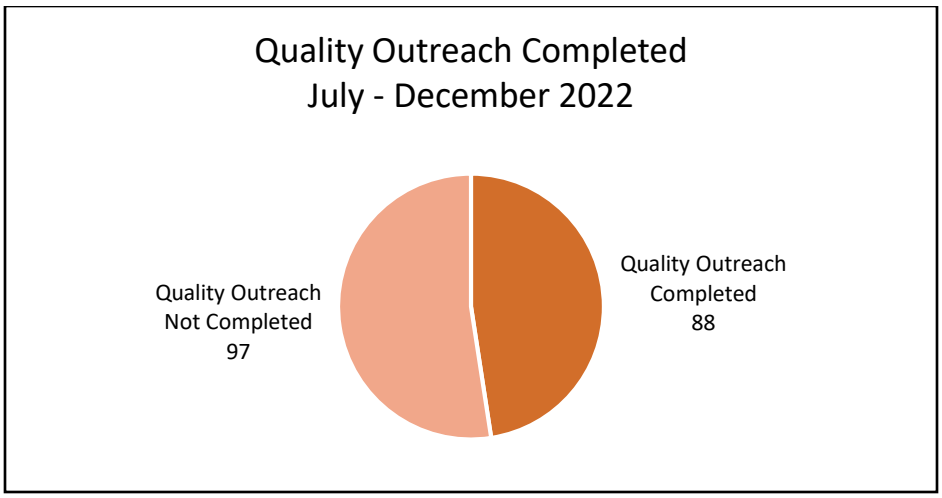
DATA REPORTED

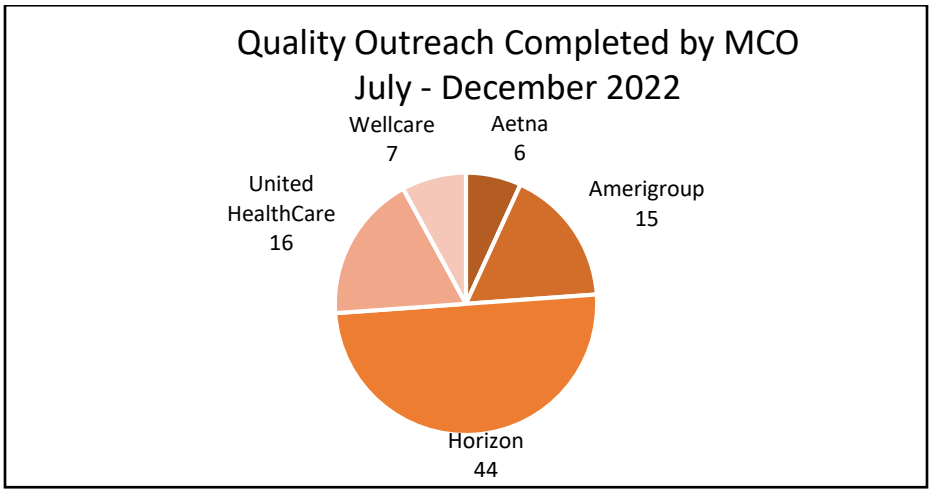
MFP Benchmark #3: As a result of the implementation of MLTSS by the Managed Care Organizations, fewer than 4% of MFP participants will be re-institutionalized within ninety (90) days of discharge from the nursing facility.

Re-institutionalization within 90 days of transition.					
Year	Jan - June	July - Dec	Total Re-instit.	Total Transitions	% of Total Re-instit.
2017	4	7	11	294	3.74%
2018	6	6	12	270	4.44%
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%**



MFP Benchmark #3 was not met in 2022. The number of re-institutionalizations was consistent from 2021, however, the overall percentage was lower due to an increase in total transitions in 2022. From July through December 2022, 53% of re-institutionalizations occurred within less than 30 days of community transition, with 33% occurring within 15 days.

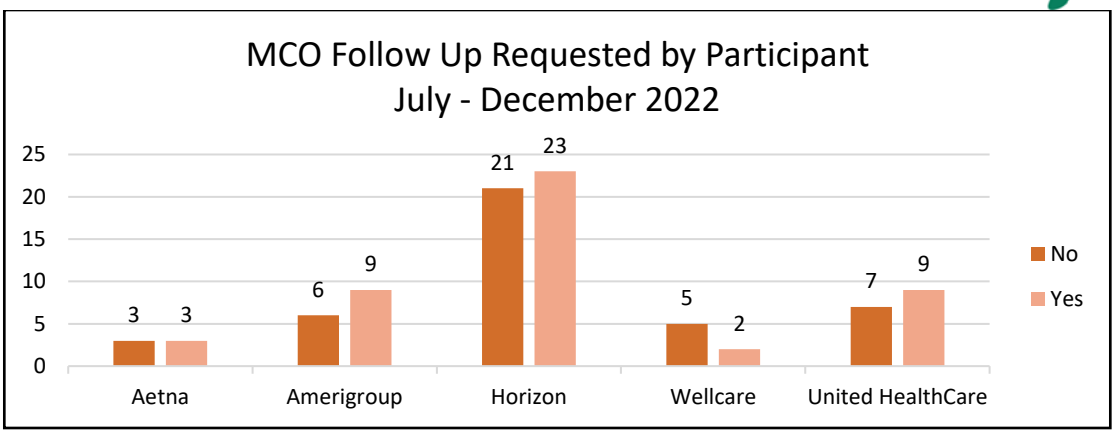




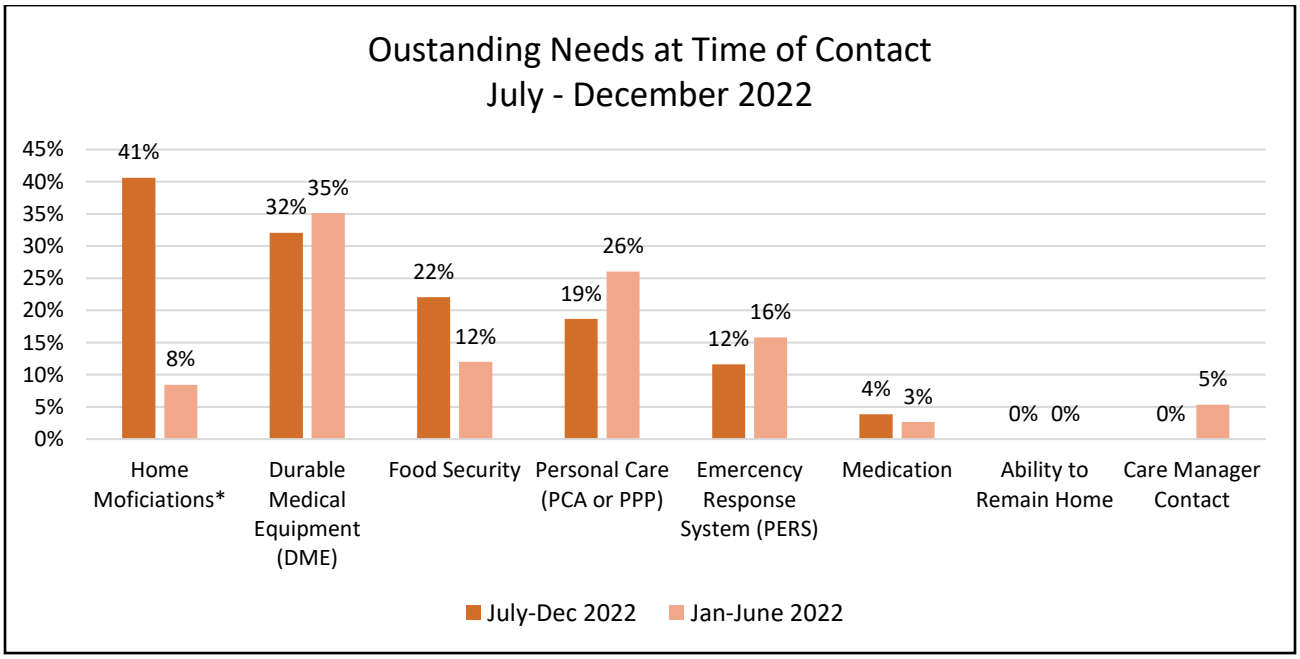
Total participant contacts: 88

Average length of time from transition date to follow up contact: 29

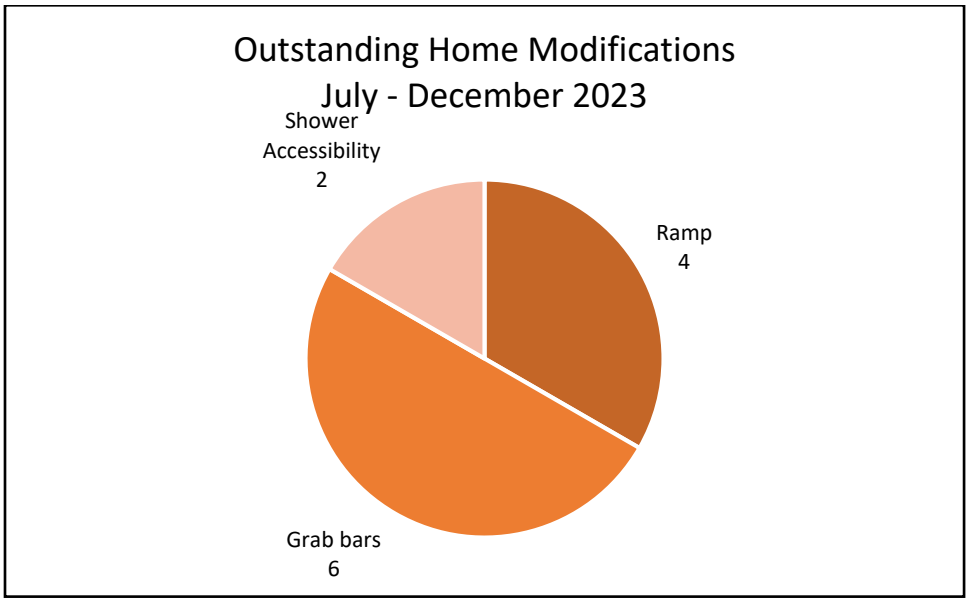
Data was not collected for 97 of 185 individuals due to unsuccessful outreach attempts. Barriers included provided phone numbers which were not in service at time of contact, incorrect contact numbers or lack of response to voicemails describing follow up efforts. Participants provide phone numbers during IDT meetings prior to transition and are often the number of family members or other natural supports. Only 40% of residents contacted during this time had alternate phone numbers; the QA Specialist called these numbers when provided.



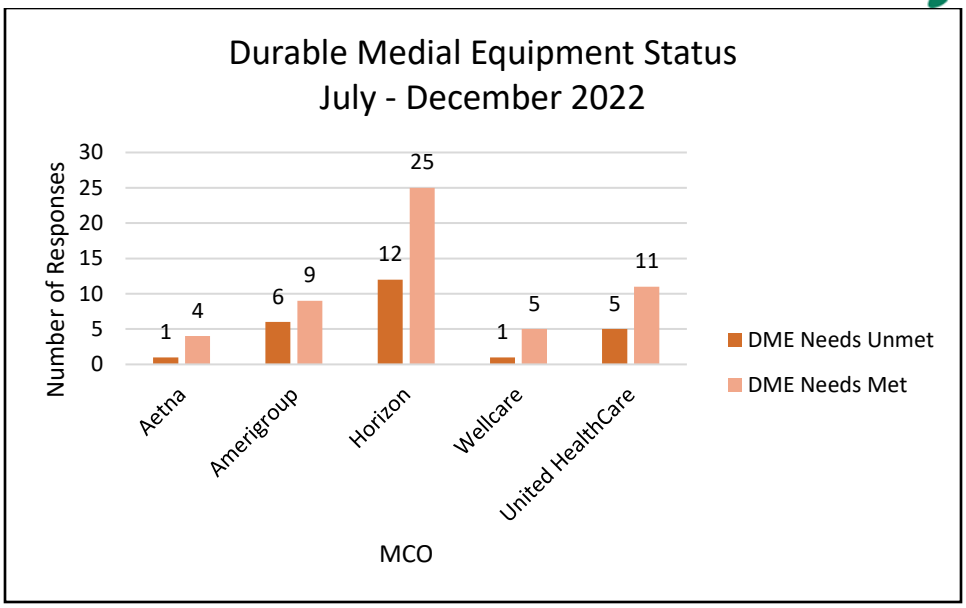
46 of the 88 participants who were contacted requested follow up with their MCO to address outstanding issues. Some participants with outstanding needs declined this assistance; many of these identified having ongoing contact with MCO Care Managers and feeling as though they were able to work with their Care Managers directly. The percentage of individuals who requested MCO follow up from July through December 2022 (52%) was consistent with the percentage of individuals requesting MCO follow up from January through June 2022 (53%).

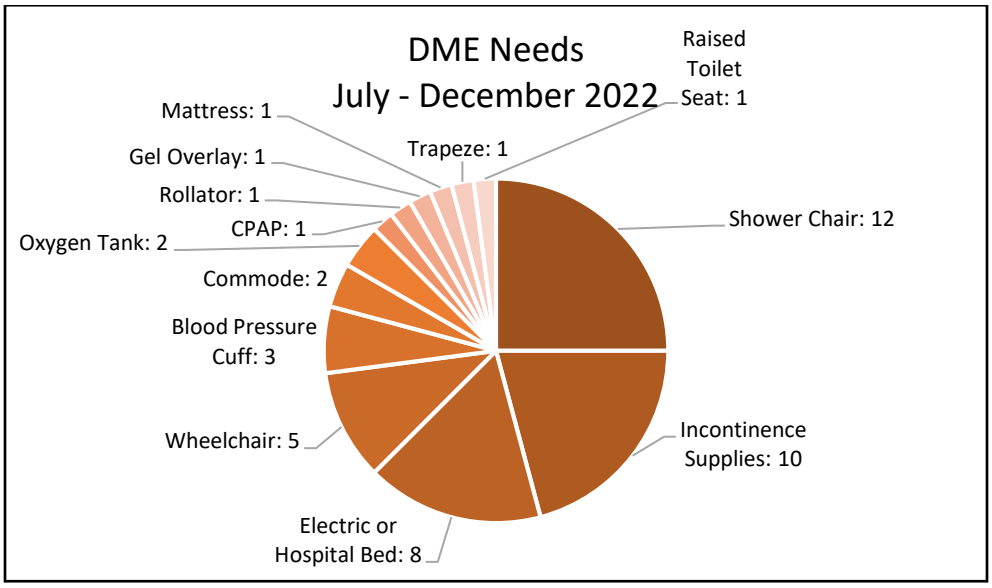


Each category of outstanding need reflects the percentage of participants who reported having a need for follow up. The number of responses for each area of outstanding need is varied. The greatest challenges participants faced are home modifications (41% of individuals who were in need of modifications), obtaining durable medical equipment (32%), food security (22%) and support for personal care (19%).

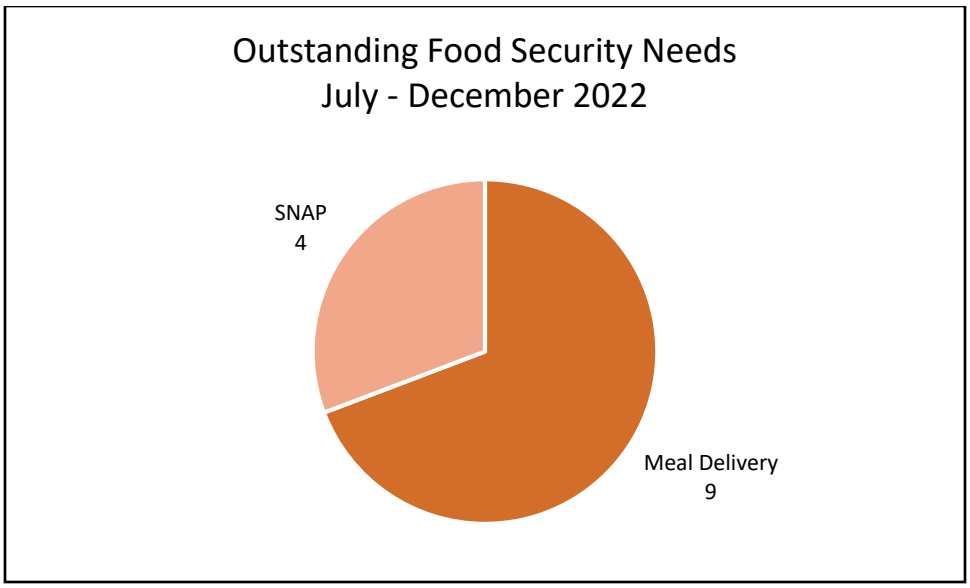


A change in data collection regarding home modifications was made as a result of the January through June 2022 Quality Report. Individuals who were not in need of home modifications have since been marked as "Declined or N/A", as such, fewer responses were collected regarding home modifications. 41% (12 out of 29) of individuals who needed home modifications had outstanding modifications to be completed. Structural modifications, such as installation of ramps or renovation of showers for accessibility currently cannot be paid for until individuals' transition to the community. As such, delays in this area are anticipated. However, all participants awaiting ramps had not yet had estimates for the modification completed at the time of follow up approximately 30 days after transition to the community.

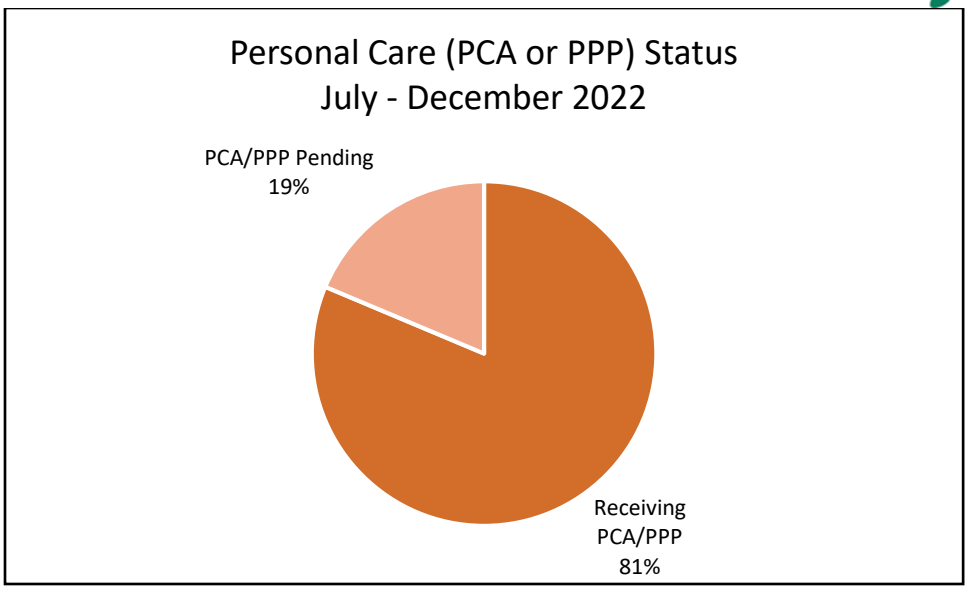


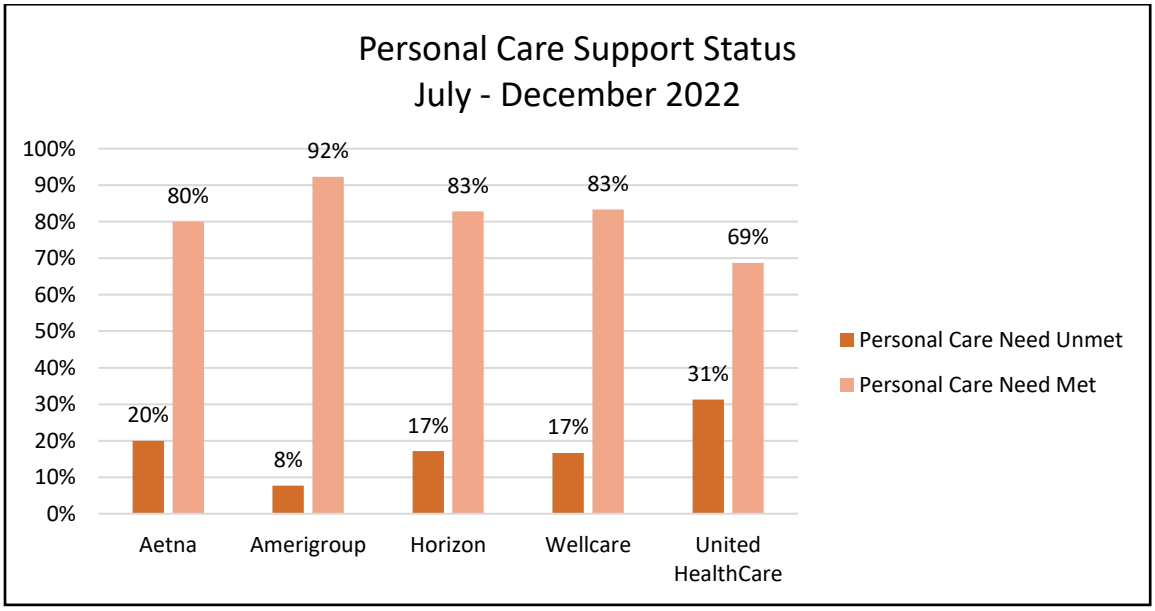


Durable medical equipment remained one of the highest areas of need for July through December 2022, with 32% of individuals surveyed awaiting DME. Shower chairs, incontinence supplies and beds were the most common needs reported. Individuals reporting issues with bedding included members waiting for different equipment and members who felt bedding supplied did not meet their need (e.g. inability to crank a manual bed due to limited strength, unsupportive mattresses contributing to inadequate sleep, etc.).

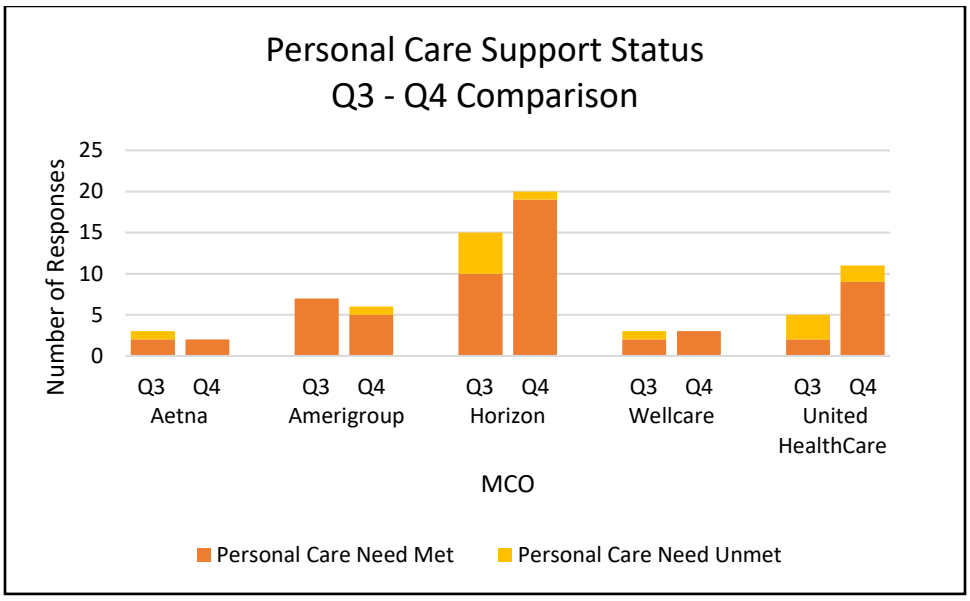


There was an increase in individuals who reported challenges with Food Security in July through December 2022, up to 22% from 12% in January through June 2022. Members reported delays with the start of home delivered meals, primarily through the Moms Meals vendor, or reported meals had initially been received but subsequent deliveries had not been received. More MFP participants identified interest in exploring SNAP benefits and some individuals reported that no one had discussed eligibility for SNAP benefits with them.

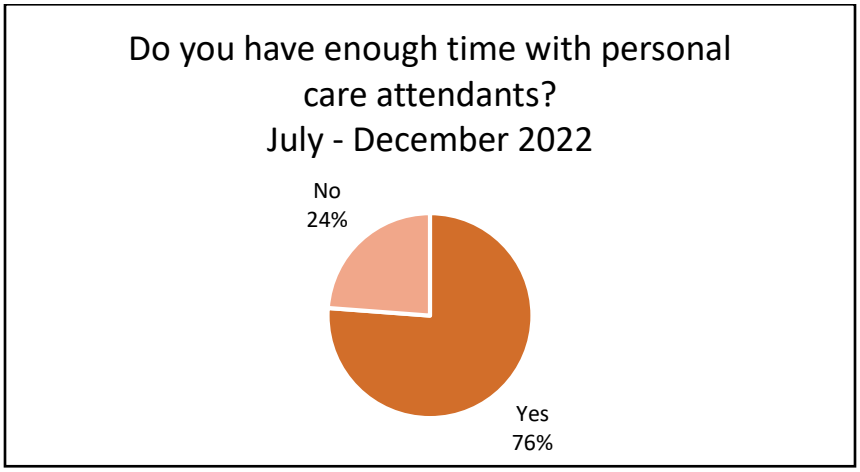




Data reflects a positive change in personal care support throughout 2022. There was a decrease in the percentage of individuals without personal care support in place at the time of follow up calls for July through December, down to 19% from 26% in January through June 2022. Fewer individuals reported challenges with the Personal Preference Program (PPP) than during the January through June time period. Those with PPP pending had PCA in place more consistently from July through December 2022 per reports.

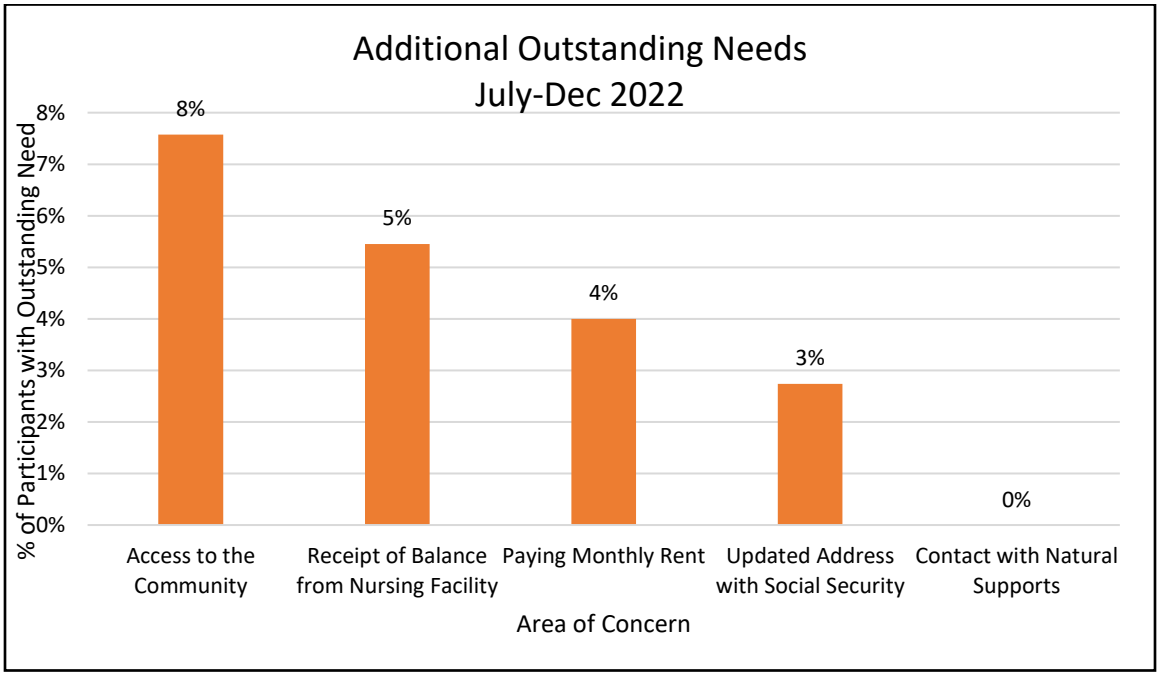


Further progress is noted when comparing July-September (Q3, 22%) and October-December (Q4, 15%) of 2022. Incremental changes between Q3 and Q4 are significant due to the small number of responses per quarter for each MCO.



Despite positive changes for those with personal care support between July and December, 24% of individuals receiving these services state that hours provided are not enough to meet their need. This is an increase from 20% of respondents from January through June 2022 who

reported the same. Many participants indicated that although approved PCA hours were often met, hours provided are ending in early afternoon and/or that they do not have personal care support on weekends. For example, some participants reported being transferred back to bed around 3PM or 4PM when PCA hours end for the day, long before going to sleep. This serves as a barrier to community integration and independence. Similarly, participants reported challenges with relying on natural supports such as friends or family on weekends as natural supports may have limited availability to provide needed care.



Consistent with reports in January through June, access to the community was the most significant barrier faced for individuals in July through December of the above additional needs. ICHNJ participants report challenges with delayed home modifications such a ramps and significant issues with Modivcare medical transportation as barriers to community access.

In addition to data collected from follow up surveys, trends were noted with regards to Physical Therapy (PT) and/or Occupational Therapy (OT), including delays in start of therapies or denial of additional sessions which participants felt would be beneficial in gaining strength, remaining

in their home and integrating fully in their communities.

Furthermore, individuals increasingly reported challenges with resuming Social Security benefits upon transition to the community. At times, Social Security checks had gone to prior facilities despite members having changed their address with the Social Security Administration. Participants cited inability to get someone at the Social Security Administration (SSA) on the phone to resolve challenges, and reported barriers to accessing the SSA building including lack of non-medical transportation, support persons to provide assistance, and long wait times interfering.

SUMMARY

Ongoing feedback collection from ICHNJ participants provides insight into the continued challenges faced, and has reflected on service improvements throughout the course of the year. Data presented in the January through June 2022 Quality Report was shared with MCOs to bolster collaborative efforts and identify areas of ongoing improvement, as well with MFP stakeholders.

Responses from participants throughout July to December of 2022 have shown ongoing difficulties with durable medical equipment (DME), increased challenges with home modifications and food security upon transition to the community. Positive change is evident in the area of Personal Care support. Those with PPP pending have had more consistent PCA gap services until PPP can begin.

In an effort to increase percentage of responses, the QA Specialist will take additional steps to contact MFP participants, such as attempting other contact methods and attempting subsequent follow up at different times of day, etc. Changes to the ICHNJ Quality Follow Up tool were made and implemented in January 2023. Revisions allow for ease and accuracy of collecting data, measurement of participant satisfaction and being able to address community integration.

RECOMMENDATIONS

Home Modifications: Schedule estimates for structural modifications such as ramps or needed renovations once a transition date has been set. Explore use of additional funding streams to expedite home modifications.

Food Security: Ensure food delivery has started and remains consistent, assess if participant may be eligible for SNAP, provide a list of food pantries in their community and assist recipients with use of non-medical transportation for access.

Telephone Service: Guarantee members have working mobile or home telephones and alternate telephone numbers when possible prior to transition to the community, apply for free mobile phone services available for lower income individuals such as Assurance Wireless or LifeLine when needed, and ensure individuals have adequate minutes on existing mobile plans.

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.

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

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 care managers discuss use of non-medical transportation for trips to the grocery store, movies, religious services, 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