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VIA ELECTRONIC DELIVERY

December 15, 2019

W. Charles Smithson
Secretary of the Senate
State Capitol Building
Des Moines, Iowa 50319

Meghan Nelson
Chief Clerk of the House of Representatives
State Capitol Building
Des Moines, Iowa 50319

RE: Iowa Return to Community Initiative-Progress Report

Dear Mr. Smithson and Ms. Boal,

The Iowa Department on Aging submits this Progress Report on the Pilot Initiative to Provide Long-Term Care Options Counseling, pursuant to HF 766, Section 1.

Please feel free to contact me if you need additional information.

Sincerely,

Angela R. Van Pelt

Angela R. Van Pelt
Legislative Liaison and Public Information Officer

cc: Kim Reynolds, Governor

Progress Report on the Pilot Initiative to Provide Long-Term Care Options Counseling

House File 766 Section 1

12/15/2019

Linda J. Miller, Executive Director
Iowa Department on Aging

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HOUSE FILE 766 LEGISLATIVE MANDATE

Of the funds appropriated in this section, $250,000 shall be used by the department on aging, in collaboration with the department of human services and affected stakeholders, to expand the pilot initiative to provide long-term care options counseling utilizing support planning protocols, to assist non-Medicaid eligible consumers who indicate a preference to return to the community and are deemed appropriate for discharge, to return to their community following a nursing facility stay. The department on aging shall submit a report regarding the outcomes of the pilot initiative to the governor and the general assembly by December 15, 2019.

IOWA RETURN TO COMMUNITY OVERVIEW

The Iowa Department on Aging (IDA), in accordance with Senate File 2418, collaborated with stakeholders to design a pilot initiative to provide long-term care options counseling utilizing support planning protocols. This pilot initiative assists consumers, age 60 or older, who are not Medicaid-eligible, who indicate a preference to return to their community, and are deemed appropriate for discharge following a nursing facility or hospital stay. The initiative is called Iowa Return to Community (IRTC).

Using evidence-informed interventions, Iowa's Return to Community (IRTC) initiative provides long-term care support planning to assist non-Medicaid eligible seniors who want to return to the community following a hospital or nursing facility stay. By providing the coordination of wrap-around services and supports for these individuals, they are able to live safely and comfortably at home. The IRTC initiative will provide increased quality of life by ensuring consumer choice; and produce cost savings for older Iowans and the State by preventing or delaying an individual's enrollment in Medicaid.

The Iowa Return to Community (IRTC) Program is a collaborative effort with a variety of partners that include hospitals, long-term care facilities, Area Agencies on Aging (AAA), home and community based service providers, Iowa Legal Aid, and other organizations that assist non-Medicaid individuals age 60 or older following long-term care facility or hospital stays. Person-centered planning and coordination of services is critical in assisting individuals and their families in navigation of the health care system and to ensure that services are in place to meet their care needs and preferences. Major components of the IRTC include the following:

GOALS:

- Help seniors to maintain their independence by keeping them in their homes with a comprehensive set of wrap around services and supports.
- Achieve person-centered planning by enabling seniors to have the information and assistance they need to stay in their homes if they so choose.
- Integrate services through care coordination and management.
- Increase access to primary and preventative care.
- Reduce unnecessary facility placement, unnecessary hospital admissions and readmission, emergency department use.

OBJECTIVES:

- Implement evidence informed interventions for older Iowans who are transitioning from hospitals or nursing facilities by formalizing key referral sources and increasing access to person-centered counseling.
- Connect to other programs and resources such as family caregiver program to fully optimize available resources.
- Develop and implement a consumer satisfaction survey to document the quantitative and qualitative benefits and outcomes.

PERFROMANCE METRICS:

- Total Number of Referrals
- Total Number of Successful Transitions
- Total Number of Transitions to the Community
- Average Length of Time in the IRTC Program
- Results From Customer Satisfaction Surveys

OUTCOMES:

- Ensure consumer choice in a care setting by assisting in transitioning consumers to a community setting.
- Increase access to person-centered planning.
- Achieve cost savings for the consumer and the Medicaid program by delaying or avoiding enrollment in the Medicaid Program.

Types of services provided by the Area Agencies on Aging or their subcontractors to IRTC consumers include:

- Assistive Devices
- Case Management
- Homemaker
- Home Delivered Meals
- Home / Vehicle Modification
- Material Aid
- Emergency Response System
- Transportation

IRTC consumer referrals made to local partner providers for services not available through the Area Agencies on Aging or their subcontractors include:

- Behavioral Health Supports
- Companion Services
- Housing Assistance
- Insurance Counseling / SHIIP Services
- Legal Assistance
- Veterans Benefits

CONNECTIONS AAA IRTC PILOT FY 2019

PROGRAM OVERVIEW

Iowa Return to Community (IRTC) has completed its first year which began July 1, 2018 in three Counties: Pottawattamie, Cass, and Mills-Woodbury County joined later in October.

Implementation and Delivery: Service delivery started simultaneously with implementation due to high consumer interest prior to full implementation of the program. The services are intensive in nature and involve case screening, planning and coordination in conjunction with actual service delivery and average around 31 days of service per consumer. Caseloads fluctuate between 25 – 30 consumers at a time depending on level of need.
Implementation activities included:

- Infrastructure and staffing development in each of the four pilot counties;
- Development of standardized protocols and tools;
- Determination of data collection methodologies and;
- Establishment of baseline data.

Stakeholder Engagement: 20 Community meetings were held in the four project counties with engagement from targeted stakeholders such as discharge planners and administrators from hospitals, long-term care facilities, skilled nursing facilities, and community providers. These meetings will continue to occur every other month. Continued development will focus on consumer engagement, education, and public awareness.

Summary of Data: In the first 12 months of the pilot, 595 cases were screened, 260 were determined eligible for the program and 89 have been admitted. As the program is voluntary, it is important to note that not all individuals eligible will accept the service. Of the cases receiving services we have had 81 discharges with 74 of them being successful transitions. **A successful transition is determined when a discharge occurs due to goals being met or consumer is referred to Long-Term Case Management.*

OUTCOMES OVERVIEW

Stakeholder Engagement (Community Conversations)		**20**
Locations: Cass, Mills, Pottawattamie, Woodbury **Participants**: Hospitals, Skilled Nursing Facilities, Discharge Planners		
Cases Screened	**595**	
Eligible Cases	**260**	
Voluntarily Admitted to the Return to Community Initiative	98	38%
Successful Outcomes	74	91%

RECOMMENDATIONS FOR IMPROVEMENT

To better evaluate program effectiveness and to validate longitudinal success moving forward, the decision was made to collect additional data points in the upcoming years. These data points include items such as:

- Referrals made to other partners to provide service(s)
- Identification of the types of services provided and the correlating funding source
- Provision of follow up services at 30, 60 and 90 Days focused on tracking readmissions or changes in consumer status such as:
    - Admission to a Hospital, Long-Term Care Facility or Skilled Care Facility
    - Emergency Room Visits
    - Living at Home in the Community
    - Unable to Contact
- Utilization of a Consumer Satisfaction /Evaluation to determine consumer ease in accessing programming and if the service was helpful in returning them to home, as well as learning what other interventions would be helpful to ensure success.

ELDERBRIDGE AAA IRTC PILOT FY 2020

PROGRAM OVERVIEW

In July, Elderbridge Area Agency on Aging (AAA) began an IRTC pilot in Spencer which includes consumers within a 50 mile radius. The Elderbridge program is a collaborative effort with a variety of partners including hospitals, long-term care facilities, home and community based service providers, Iowa Legal Aid, etc. that assists non-Medicaid individuals age 60 or older, return to their community following a long-term care facility or hospital stay. Potential participants who are in a long-term care facility and meet the criteria of the program are referred to the IRTC Options

Counselor (OC) at Elderbridge. Likewise, potential participants who are in the hospital and preparing to be discharged are referred to the IRTC Options Counselor (OC) at Elderbridge AAA by the hospital's care transitions team.

The IRTC OC meets with the consumer to introduce the program, identify potential needs and barriers and begin person centered planning discussions. When the consumer is dismissed from the long-term care facility or hospital, the implementation of the person centered plan begins. Person centered planning differs from traditional case management model by allowing the consumer to define their values and preferences that guide all aspects of their healthcare and supporting the consumer's realistic health and life goals. The consumer and IRTC Options Counselor work together to identify local/regional service providers to best meet the consumer's preferences and needs, provide information and support during the transition process and secure available funding sources.

A consumer is active in the program until supports and services are no longer needed from the IRTC program or after 90 days. If services and supports are still needed after 90 days, a referral is made to the case management program.

In the first quarter of FY 2020, Elderbridge received 47 eligible cases with 39 of those admitting voluntarily to the program. Of those 39, 82% were successful transitions.

FY 2020 FIRST QUARTER PRELIMINARY DATA

Combined Totals		
Stakeholder Engagement (Community Conversations)		**33**
Locations: Cass, Mills, Pottawattamie, Woodbury Counties- Spencer plus a 50 mile radius **Participants**: Hospitals, Skilled Nursing Facilities, Discharge Planners		
Cases Screened	**223**	
Eligible Cases	**148**	
Voluntarily Admitted to the Return to Community Initiative	67	45%
Successful Transitions	51	76%

Elderbridge IRTC Pilot		
Stakeholder Engagement (Community Conversations)		**16**
Locations: Spencer plus a 50 mile radius **Participants**: Hospitals, Skilled Nursing Facilities, Discharge Planners		
Cases Screened	**47**	
Eligible Cases	**47**	
Voluntarily Admitted to the Return to Community Initiative	39	83%
Successful Transitions	32	82%

Connections IRTC Pilot		
Stakeholder Engagement (Community Conversations)		**17**
Locations: Cass, Mills, Pottawattamie and Woodbury Counties **Participants**: Hospitals, Skilled Nursing Facilities, Discharge Planners		
Cases Screened	**176**	
Eligible Cases	**101**	
Voluntarily Admitted to the Return to Community Initiative	28	28%
Successful Transitions	19	67%

Each IRTC pilot has customized their model to fit the service and support needs of their local communities. Differing levels of partnerships and participation fluctuate to accommodate existing health care and long-term care systems. It is beneficial to implement a transition model which is flexible enough to allow for differing business systems and still provide the needed transitional supports and services to consumers who desire to return to their homes. These pilot projects will help determine best practices to optimize the collaborative systems providing smooth transitions for older Iowans.

IRTC SUCCESSFUL TRANSITION EXAMPLES

1. A referral was received from a skilled nursing facility regarding a consumer living in Pottawattamie County. She had been in the skilled nursing facility for a short-term rehabilitation due to weakness and wound care following a hospital stay. The consumer had a Medicare Advantage Plan and chose not to stay past day 20 which is when her high co-pay would begin. She desired to be a home and had a person living with her that could help with her care. An obstacle to her returning home was the need for medical care and follow up appointments. The consumer was unable to stand due to her morbid obesity and could only get in/out of her home by a stretcher; the home could not accommodate a wheelchair accessing the doorway. She already had a Hoyer lift, wheelchair and hospital bed at home.

The Options Counselor helped her identify and explore different possibilities and found a Program for All- Inclusive Care for the Elderly (PACE) that would see the consumer in her home. The Options Counselor assisted the consumer in finding an in-home health caretaker able to help her transfer with the Hoyer lift and provide in- home personal care and homemaking. The consumer benefited from the IRTC for 78 days and has had no readmissions to the hospital or skilled nursing facility.

2. A 98 year old Woodbury County consumer was referred to the IRTC by a local skill nursing facility. The consumer was receiving rehabilitation following a lumbar compression fracture. She desired to return home, live independently, manage her own finances, and make her own decisions. An Options Counselor assisted the consumer in scheduling follow up doctor and dentist appointments including transportation to those appointments. Previously, she was choosing not to go to the doctor or dentist because she did not want to take public transportation. The Options Counselor explained other private pay transportation and homecare agency options to which the consumer agreed.

The Home Health Agency helped her with the installation of grab bars, assistive devices, medication management, and household tasks. She is now able to go to her multiple dentist and doctor appointments and therapy. The Options Counselor assisted the consumer to sign up for home delivered meals. The consumer was discharged from the IRTC after a total of 68 days in the program and is now receiving case management services for continued services and supports for the future stages of decision making. Consumer had no readmissions to the hospital or skilled nursing facility.

3. Late August 2018, a hospital social worker made a referral to Iowa Return to Community (IRTC) regarding a 60 year old male consumer who was being discharged after being treated for a fractured back due to a fall. The consumer was unemployed, living with a friend, unable to afford medications, and had alcohol problems. The Options Counselor made a home visit and found the consumer lying on a broken bed frame with a bulging catheter

bag he did not know how to empty. He was threatening to hurt himself due to pain. The consumer did not have a primary care provider and therefore was discharged without orders.

The Options Counselor, through the IRTC, secured several assistive devices, coordinated homemaker services, set up transportation to appointments, scheduled physical and occupational therapy, assisted in getting his prescriptions filled, provided medication management, and coaching on transferring in and out of bed safely as per the care plan developed with the consumer. The consumer states he feels much better, has been getting stronger and has not been drinking alcohol. He is proud of his accomplishments which he attributed to being held accountable. He told multiple staff members that he appreciated everything that was done for him and for advocating for him as most health providers felt he was just pain seeking. The consumer was discharged from IRTC after 71 days and has not returned to the hospital or emergency department.

IDA LOOK FORWARD

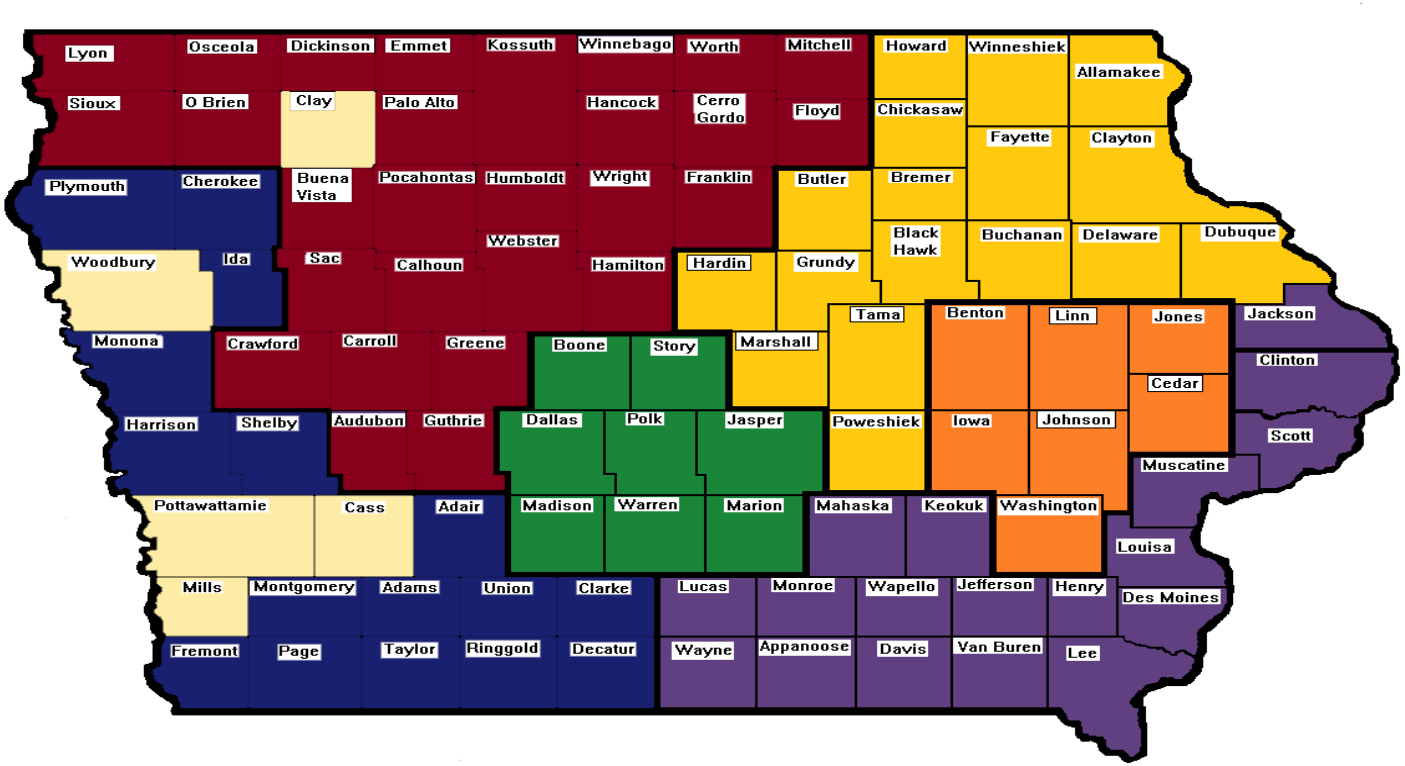
We have found that there is an increased interest in care transitioning and the IRTC initiative from stakeholders of Federal, State, local, non-profit and private organizations. While the IDA remains strategic in the IRTC program development and implementation, the relationships being formed and partners wanting to join in the initiative, continue to grow. We remain focused on deeper integration of our physical, behavioral, managed care and social services organizations to improve health outcomes and consumer experience, but more importantly, to improve the quality of life for older Iowans that want to remain in their communities.

The IDA will request additional funding this legislative session to provide every AAA with the seed money needed to develop a pilot unique to their area and consumers and to ensure that the gains made in the initiative are sustained and furthered.

The IDA and the participants in the IRTC initiative look forward to continuing the role of transforming and developing an infrastructure of solid and innovative community based networks of providers and supports to help seniors to maintain their independence.

Appendix

Appendix A
Map of Iowa Return to Community Counties



Appendix B
Project Process Flow Map

Iowa Return To Community Process

January 2019