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VIA ELECTRONIC DELIVERY

December 14, 2020

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

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Progress Report on the Pilot Initiative to Provide Long-Term Care Options Counseling – Iowa Return To Community

House File 2643 Section 1.4, House File 766 Section 1.7

12/15/2020

Linda J. Miller | Director
Iowa Department on Aging

IOWA DEPARTMENT ON AGING

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REQUIRED LEGISLATIVE REPORT

House File 2643 (FY 2021 Omnibus Appropriations Act), Section 1, subsection 4 repeated the requirements of House File 766 (FY 2020 Health and Human Services Appropriations Act), Section 1, subsection 7.

> *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, 2020.*

IOWA RETURN TO COMMUNITY INITIATIVE HISTORY

In 2018, the Iowa Department on Aging (IDA), in accordance with Senate File 2418 (FY 2019 Health and Human Services Appropriations Act), collaborated with stakeholders to design a pilot initiative to provide long-term care options counseling utilizing support planning protocols—resulting in the Iowa Return to Community (IRTC) Initiative. This is the third progress report on the initiative, the FY 2018 and FY 2019 reports can be found on the General Assembly's webpage.

Using evidence-informed interventions, IRTC 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 wraparound 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 Initiative is a collaborative effort with a variety of partners that include hospitals, long-term care facilities, Area Agencies on Aging

(AAAs), 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 wraparound 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, and 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 services and resources such as family caregiver counseling 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 Transitions to the Community
- Total Number of Successful Transitions
- Total Number of Referrals
- Average Length of Time in IRTC
- 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 holding off on eligibility and/or avoiding enrollment.

PARTICIPATING AREA AGENCIES ON AGING

- Connections Area Agency on Aging: Cass, Mills, Pottawattamie, and Woodbury Counties.
- Elderbridge Agency on Aging: 50-mile radius of Spencer, Iowa (Clay County and portions of Buena Vista, Dickinson, Emmet, O'Brien, and Palo Alto Counties).

Types of services provided by the AAAs or their subcontractors to IRTC consumers include:

Assistive Devices | *Home or Vehicle Modification* | *Case Management* | *Material Aid* | *Homemaker* | *Emergency Response System* | *Home Delivered Meals* | *Transportation*

IRTC consumer referrals made to local partner providers for services not available through the AAAs or their subcontractors include:

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

IOWA RETURN TO COMMUNITY OVERVIEW

Person centered planning and coordination of services are critical to help individuals and their families navigate the health care system and to ensure that services are in place to meet their care needs and preferences. Potential participants who are in a long-term care facility and meet the criteria of the service are referred to the IRTC Options Counselor at the AAA. Likewise, potential participants who are in the hospital and preparing to be discharged, are referred to the IRTC Options Counselor at AAA by the hospital's care manager. Referrals are screened prior to meeting with consumers

to determine eligibility. If not eligible for IRTC, referrals are made to other Aging and Disability Resource Center services.

The IRTC Options Counselor meets with the consumer to introduce the service, 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. IRTC allows for flexibility in following the consumer whether they are discharged to a community setting or a long-term care facility for rehabilitation. 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.

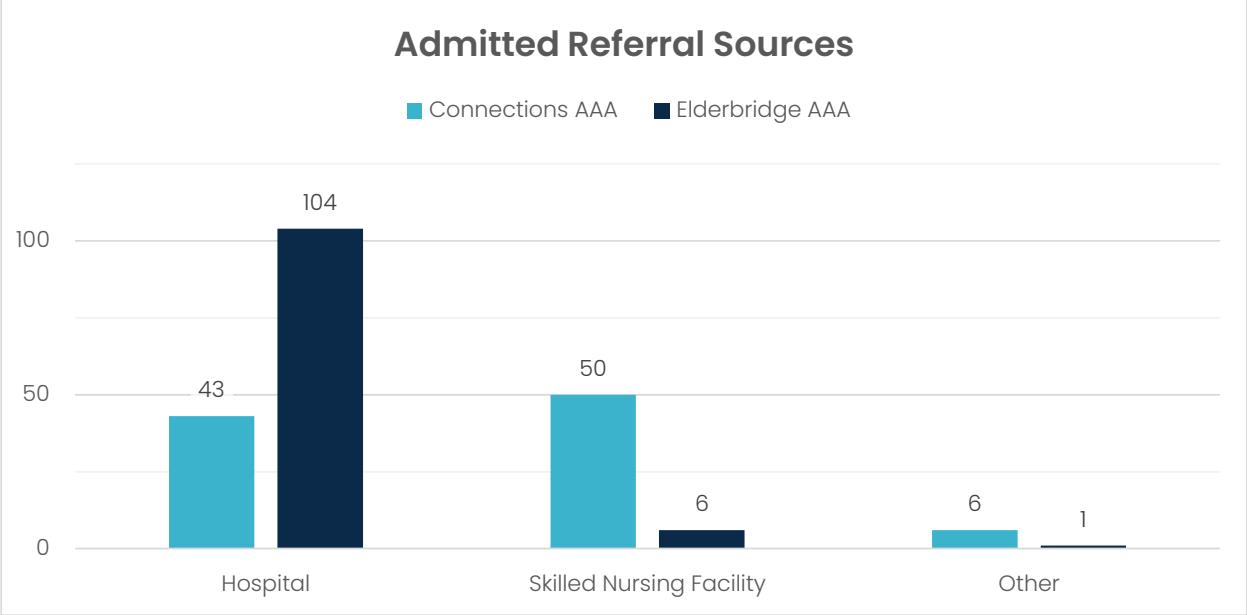
A referral to case management or other appropriate services may take place any time during the 90-day period. It is not necessary to wait 90 days before transitioning the consumer if there is a need. A visual of the process flow can be found in Appendix B.

FY 2020 PERFORMANCE METRICS DATA

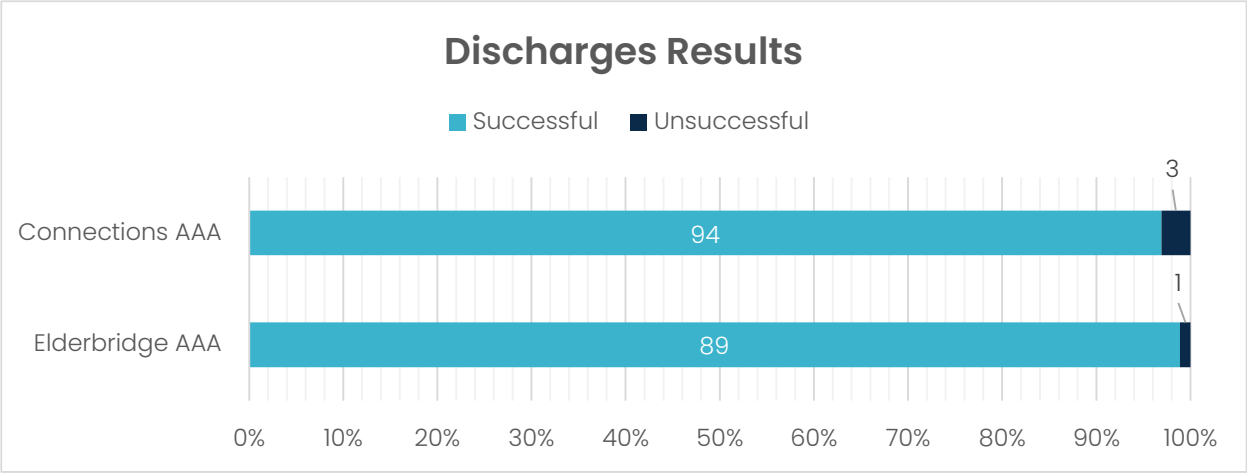
Due to the nature of pilot initiatives building an awareness base and growing during the year, and the service disruption impacts from the COVID-19 global pandemic, year-to-year comparisons between FY 2019 and FY 2020 do not yield consequential insights. Additionally, a fiscal year can be an arbitrary starting and stopping point for evaluating components of a human service delivery program, when an individual could be admitted to the program near the end of FY 2020, but their 90-day service window stretches into FY 2021. The IDA is beginning to examine FY 2021 data on a month-to-month and rolling 12-month basis to see what further insights can be gleaned.

During the FY 2020 timeframe, a total of 210 individuals were admitted into the initiative. While each participating AAA admitted approximately the equivalent number of

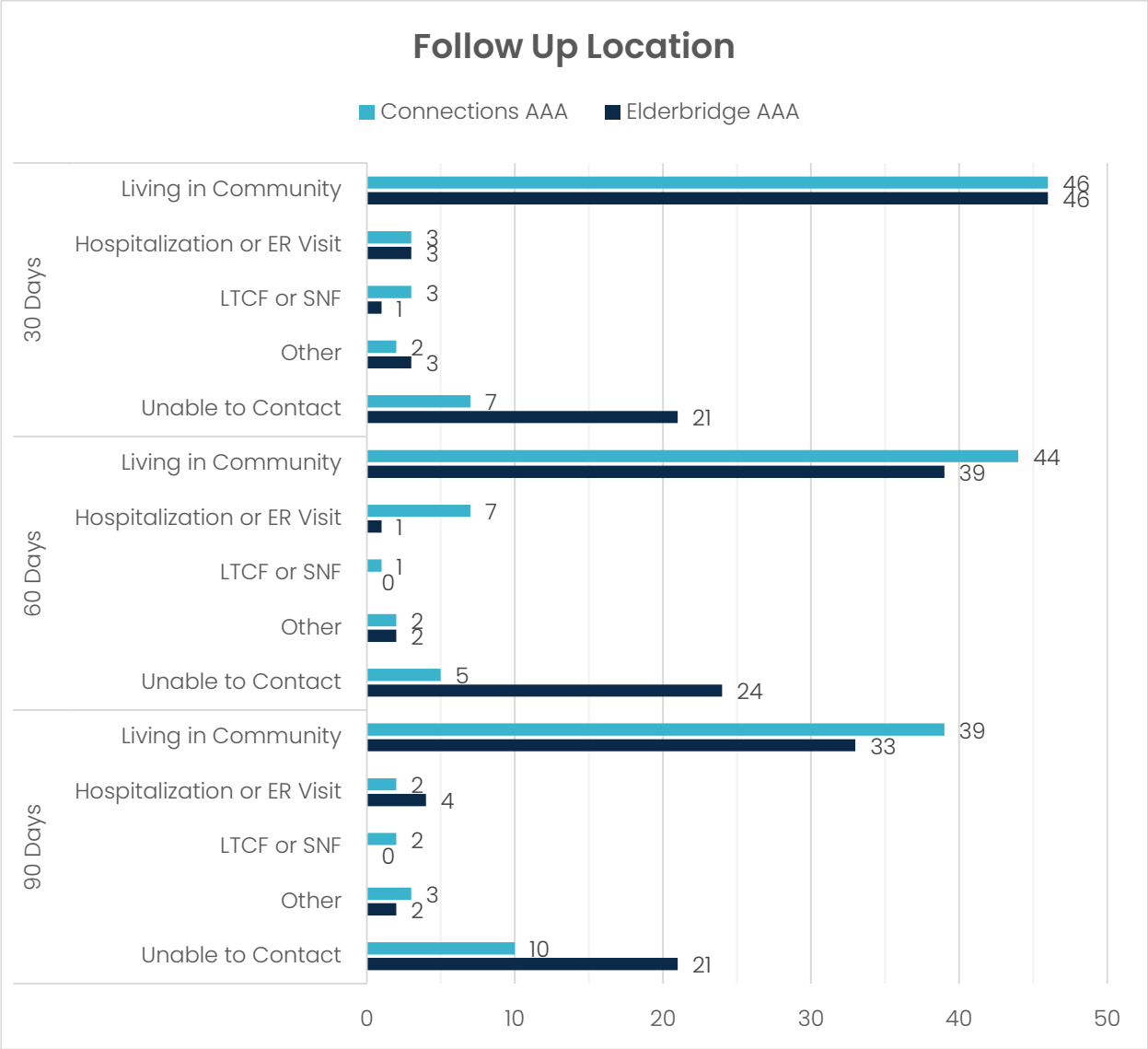
individuals for the fiscal year, the source of referrals was rather different. The breakdown of referral sources and each AAA is presented in the following chart.



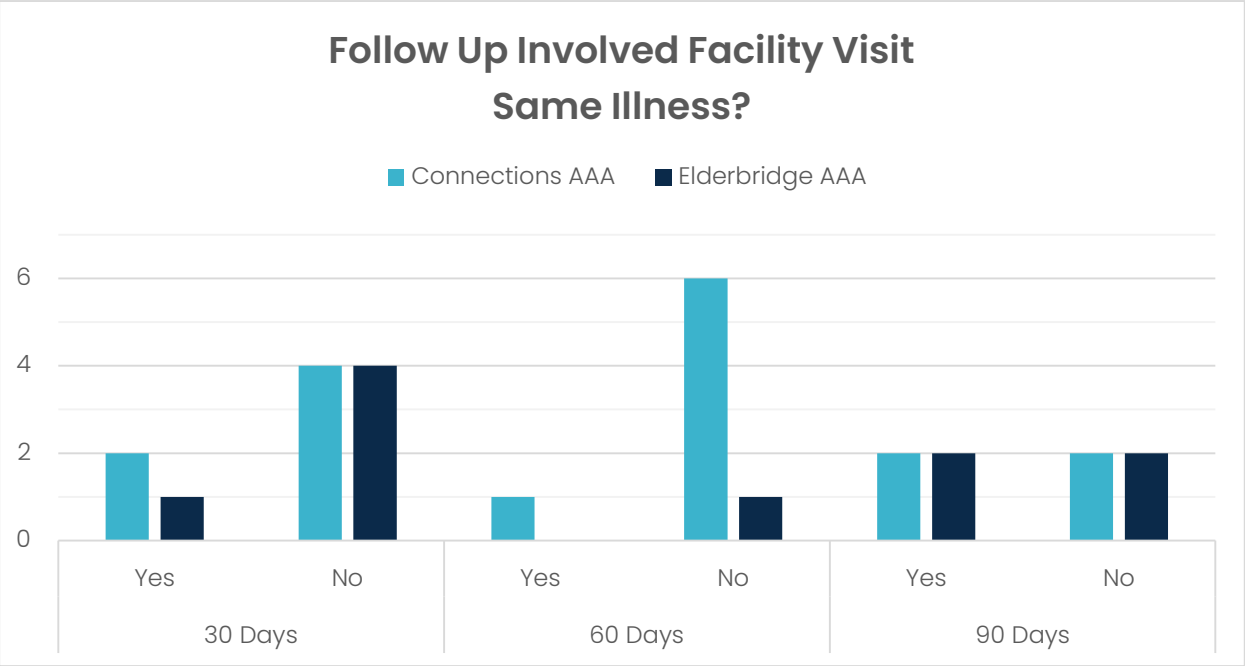
The next measure of the service is whether or not there is a successful transition out of the IRTC service at discharge. An unsuccessful discharge is defined as the individual being readmitted to the hospital for the same illness or moving into a long-term care facility, but not by the individuals choice. For FY 2020, both AAA implementation sites were exceptionally successful, with 97% of discharge transitions at Connections AAA and 99% of discharge transitions at Elderbridge AAA being successful.



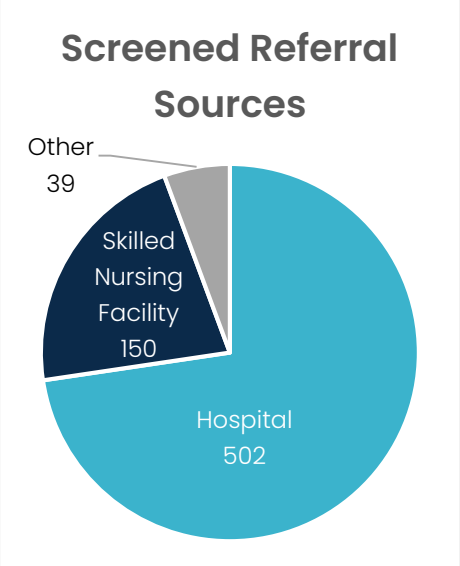
Additionally, at the 30-, 60-, and 90-day follow up periods, 66% of individuals reported that they were still living at home in their communities. Individuals reported additional hospital and emergency department (ER) visits in the same timeframes accounted for 5% of responses, 4% reported a Long-Term Care Facility (LTCF) or Skilled Nursing Facility (SNF) stay. Challengingly, the AAAs were not able to contact about 23% of individuals served in the follow-up time frames despite multiple calls made at different times. Satisfaction survey reviews from individuals receiving this service are very positive, with one participant reporting they don't know what they would have done without it that first week home. These results by AAA are outlined in the following charts.

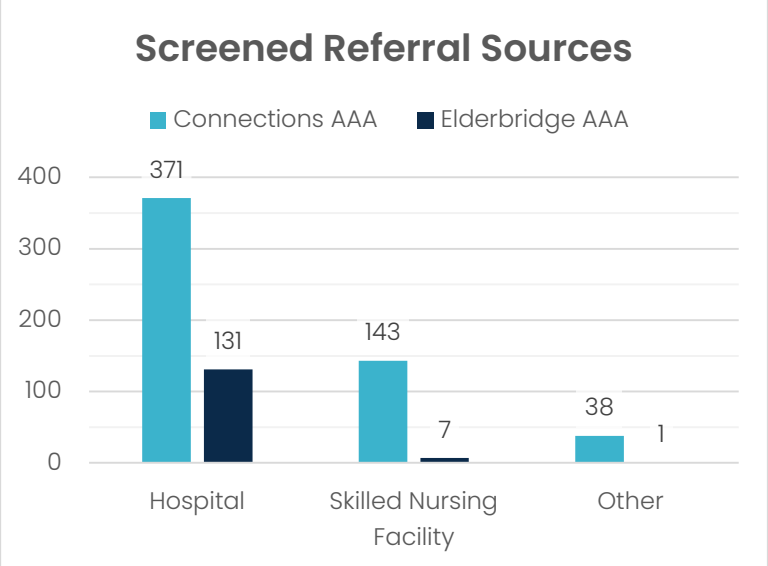


Of those individuals that had a hospital, ER, LTCF, or SNF stay from the prior chart, only eight were admitted for the same illness as their prior stay. This chart provides further details on the timing and AAA project.



Another measure of functionality for this service is whether there are sufficient appropriate referrals coming from the hospitals, skilled nursing facilities, and other providers in the community. In FY 2020, there were a total of 691 referrals made to the IRTC. The sources of referrals are presented in the following chart.





Of these referrals to the service, about one-third were for individuals that were ineligible for IRTC. The most common reason for being ineligible was due to the individual being enrolled in Medicaid (48%). Other major reasons included living outside of the current service area of the pilot (29%), or for being under 60 years old (19%). Of the remaining referrals, 210 (43%) were admitted, and the remaining individuals voluntarily declined services or did not begin receiving services for various other reasons.

INFORMATION ON INDIVIDUAL INITIATIVES

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 are helping determine best practices to optimize the collaborative systems providing smooth transitions for older Iowans.

CONNECTIONS AAA IRTC PILOT

The Connections Area Agency on Aging has operated the Iowa Return to Community (IRTC) for two years in Cass, Mills, Pottawattamie, and Woodbury Counties. Locally, the initiative is funded through this state allocation, funding secured by Connections AAA through contracts with local hospitals, and grant funding.

In September 2020, the IRTC service at Connections AAA was recognized by the National Association of Area Agencies on Aging (n4a) as an Aging Achievement Award winner in the category of Health and Long-Term Services and Support Integration. The award recognizes AAAs that have found new and innovate ways to support older adults, people with disabilities, and caregivers as they live in their homes and communities for as long as possible.

ELDERBRIDGE AAA IRTC PILOT

In July 2019, Elderbridge Area Agency on Aging began an IRTC pilot in Spencer for consumers within a 50-mile radius. This covers Clay County and portions of Buena Vista, Dickinson, Emmet, O'Brien, and Palo Alto Counties. The primary current source of referrals is the Spencer Hospital, but other partnerships are also being developed with hospitals in Dickinson County and Palo Alto County despite the challenges of the impacts COVID-19 has had on service delivery.

IRTC SUCCESSFUL TRANSITION EXAMPLES

With the exception of the first story, the names of the individuals in the following examples have been changed and the specific provider is withheld to maintain their privacy.

Paula was a very independent 69-year-old who lived alone, drove, worked outside in her yard, and took care of most everything she needed to in her two-story house. In the winter of 2020, Paula slipped and fell on black ice, breaking her femur and hip, requiring a hospital stay followed by 20 days in a skilled nursing facility before her insurance coverage concluded. She was discharged to her home, without a friends or family available for caregiver support, and was not able to walk, being on a toe-touch weight bearing restriction.

She was restricted to living in the basement of her two-story home, hopping around for two and half months. The Connections AAA IRTC initiative was able to provide her with supplies (commode, incontinence pads, grabber), connections to Meals on Wheels, and a Lifeline Assistance cellphone. "The stuff they provided to me, helped me to heal and also be reunited with my Cat. You heal faster at home and I was able to do this with the help of Connections." She continued to be at home during her follow up calls at 30, 60, and 90 days. She constantly thanked staff and Connections for everything that was done for her with the service and "wouldn't have been able to do it without them." Paula agreed to a video interview with Connections AAA that can be viewed here: https://youtu.be/4S7EhgFdHto

"Tom" is a paraplegic who lives alone with very few supports. When Tom was discharged he had no one to turn to. After enrollment into the IRTC initiative the transition coach was able to coordinate all of his care. Before his hospital discharge Tom declined home health services. However, once he arrived home the transition coach was able to help Tom understand the value of having home health. Once Tom agreed, the transition coach coordinated with his primary physician, the home health agency, and wound care nurses. The transition coach also set up in home care services of laundry, light housekeeping, and transportation for him. The transition coach also identified a mental health need, and after Tom's acceptance, he was referred to the Behavioral Mental Health Center for services. Without IRTC care coordination, Tom would have ended back up in the hospital or potentially becoming and Dependent Adult Abuse Case due to his self-denial of critical care.

"Betty" has several chronic health conditions and when she was released from the hospital her son Bob had no clue how to help navigate the medical supports she needed in order to remain at home. Betty needed to transition to a new renal and diabetic accommodating diet and the IRTC initiative at the AAA helped by ordering Mom's Meals that were shipped directly to her door. Not understanding what a renal diet consisted of, she also met with the AAA's registered dietician, who was able to provide nutritional counseling.

Betty was very weak after her hospitalization. To ensure her safety while showering and using the restroom, the IRTC transition coach coordinated a handyman to install grab bars, purchased a VersaFrame, and transfer bench. Home care services for laundry, light housekeeping, and bathing assistance were also coordinated for while she was recovering. Without IRTC Bob would not have known where to start to help his mom. Betty is so thankful for the supports and information she has received during her recovery.

An IRTC coach received a referral for "Joe" who was in a skilled nursing facility and receiving rehabilitation after a surgery due to a fall and broken hip. Joe lives with his daughter, Sue, and her family. Sue is Joe's caregiver and she voiced concern about the stress of caring for him and her family during the COVID-19 mitigation restriction

measure. Sue worked at the school which had gone to remote learning and the spring as was at home without a job. The transitions coach referred her to caregiver specialist supports available at the AAA.

When Joe returned home, he was still weak, using a walker to get around and having difficulty showering independently. Joe's goals were to walk without the walker, be independent outside, and go camping again; all while remaining at home. The coach worked with his therapy provider to get safety equipment recommendation for his situation. The therapy provider recommended a shower chair and grab bars. The coach then worked with the local Center for Independent Living to get a shower chair. Unfortunately, the shower chair was too low to the ground and Joe did not find it helpful. The Coach then utilized some grant funding to purchase an adjustable shower chair and the grab bars. The supplies were delivered to the home, and the family was able to install them. Joe's therapy provider worked with him on the safe use of the equipment, and he was able to independently perform his care. Joe met all his goals and is living at home still.

RECOMMENDATIONS

The IDA continues to find increased interest in care transitioning and the IRTC initiative from stakeholders of Federal government, State government, non-profits, and private organizations. While the IDA remains strategic in the IRTC service 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 is working with every AAA to explore potential seed money sources to develop a pilot unique to their area and consumers and to ensure that the gains made in the initiative are sustained and furthered.

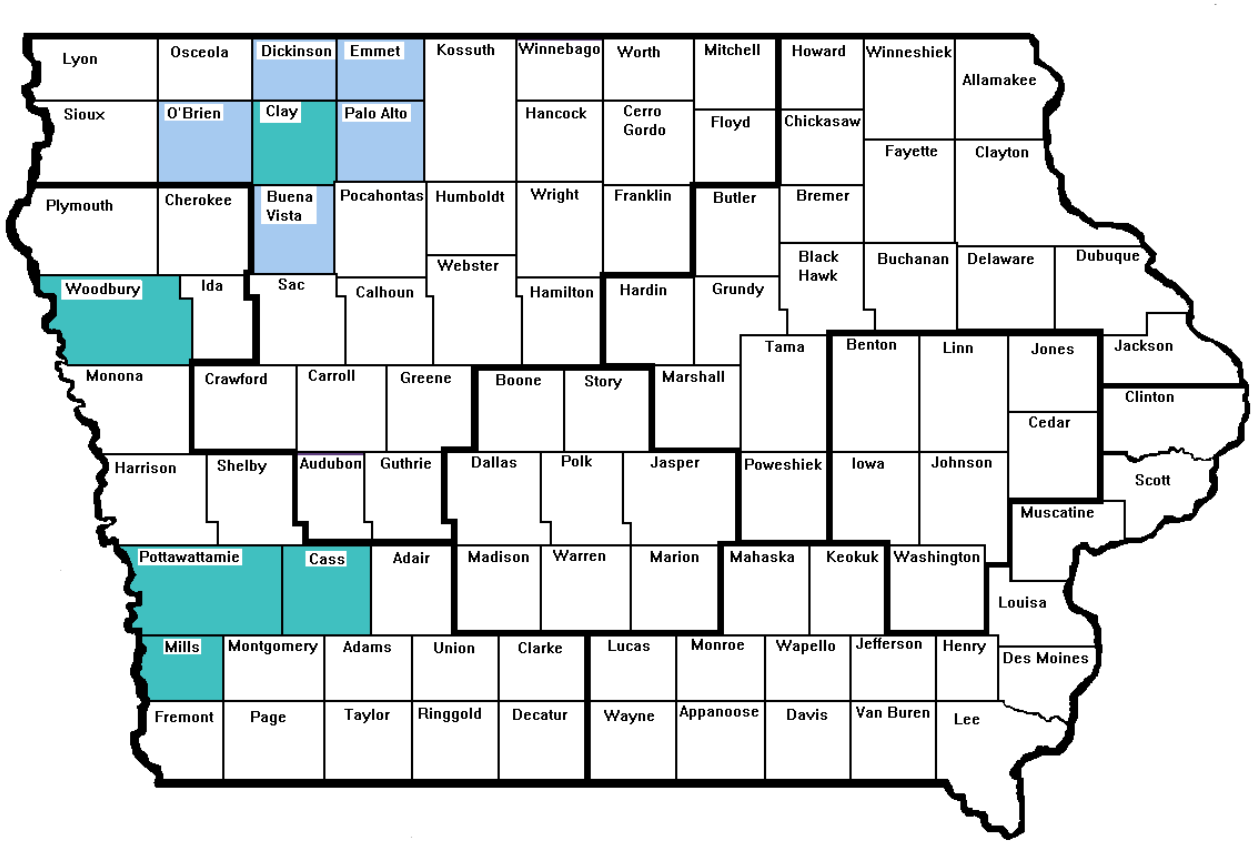
The IDA and the participants in the IRTC initiative look forward to continuing the role of transforming and developing an infrastructure of solid and innovative community-based networks of providers and supports to help seniors to maintain their independence and lower health care costs.

APPENDICES

IOWA DEPARTMENT ON AGING

APPENDIX A

Map of Iowa Return to Community Counties



Lighter shaded counties are partially served if within 50 miles of Spencer, Iowa.

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APPENDIX B