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

House File 891 Section 1.7

12/15/2021

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IOWA DEPARTMENT ON AGING

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LEGISLATIVE REPORT REQUIREMENT

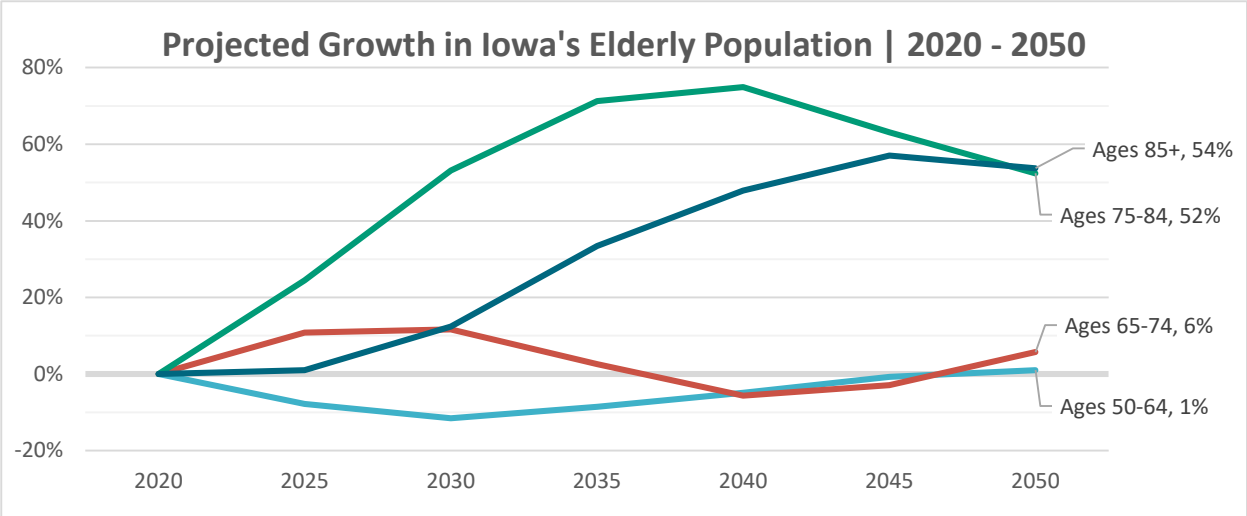
House File 891 (FY 2022 Health and Human Services Appropriations Act), Section 1, subsection 7 required the following:

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, 2021.

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 report is the fourth on the initiative's progress. The FY 2018, FY 2019, and FY 2020 reports are posted 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. This community living support services for all senior's focus is important in the context of the projected proportions of the aging of Iowa's elderly population as presented in the following graph.



Source: Woods & Poole 2021 Iowa Population Projection.

The Iowa Return to Community Initiative is a collaborative effort with a variety of partners that include Area Agencies on Aging (AAAs), hospitals, long-term care facilities, home- and community-based service providers, Iowa Legal Aid, and other organizations that assist non-Medicaid individuals age 60 or older following a hospital or long-term care facility stay. Person-centered planning and coordination of services is critical in assisting individuals and their families navigate the health care system and ensuring that services are in place to meet their care needs and preferences. To date, enrollment data has shown that the typical program consumer is a female Iowan, between the ages of 75-84, lives alone, has difficulties with at least two out of six actives of daily living (e.g. walking, bathing, getting out of bed or a chair, dressing or eating) and has difficulties with at least ***five*** out of eight instrumental activities of daily living (e.g. preparing meals, managing medications, shopping, using transportation, or doing light or heavy housework). Difficulties with maintaining personal care, in obtaining and preparing food, managing medications, or getting to follow up appointments slows recovery and leaves the person at risk for re-hospitalization or facility care. The program addresses these needs and results in improved outcomes for those served. 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.
- 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
- Elderbridge Agency on Aging
- Milestones Area Agency on Aging
- Northeast Iowa Area Agency on Aging (NEI3A)

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

Assistive Devices | Minor Home 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.

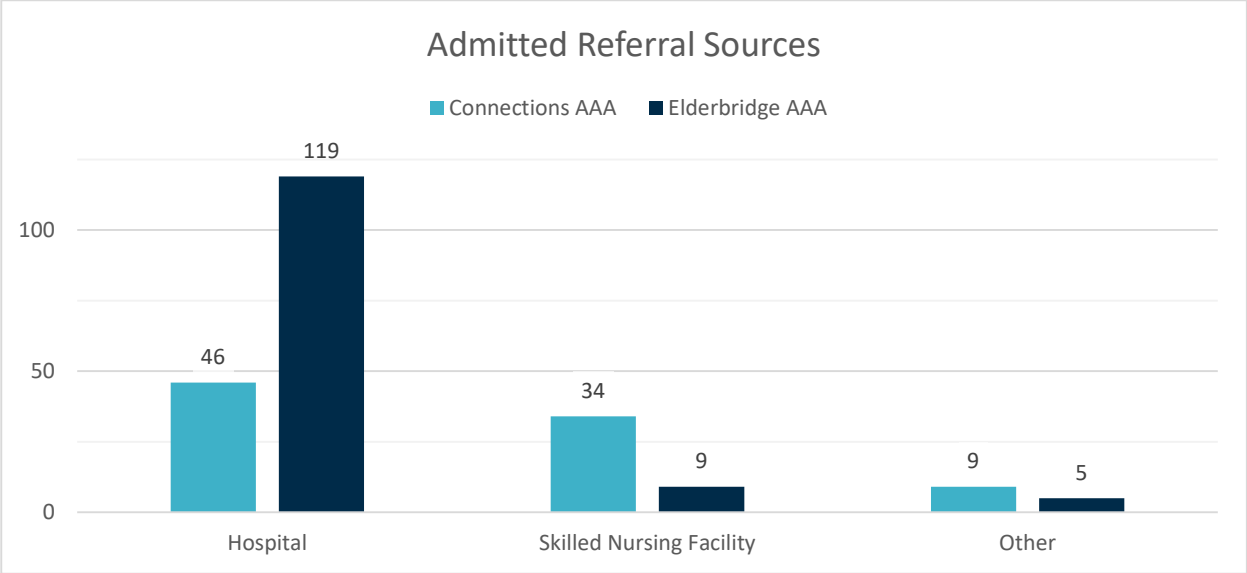
The IRTC Options Counselor meets with the consumer to introduce the service, identify potential needs and barriers and begin person centered planning discussions. When the consumer is discharged from the long-term care facility or hospital, the implementation of the person-centered plan begins. Person centered planning ensures that services are based on the individual's values and preferences and support 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. The 90-day period is waived if needed. A visual of the process flow can be found in **Appendix B**.

FY 2021 PERFORMANCE METRICS DATA

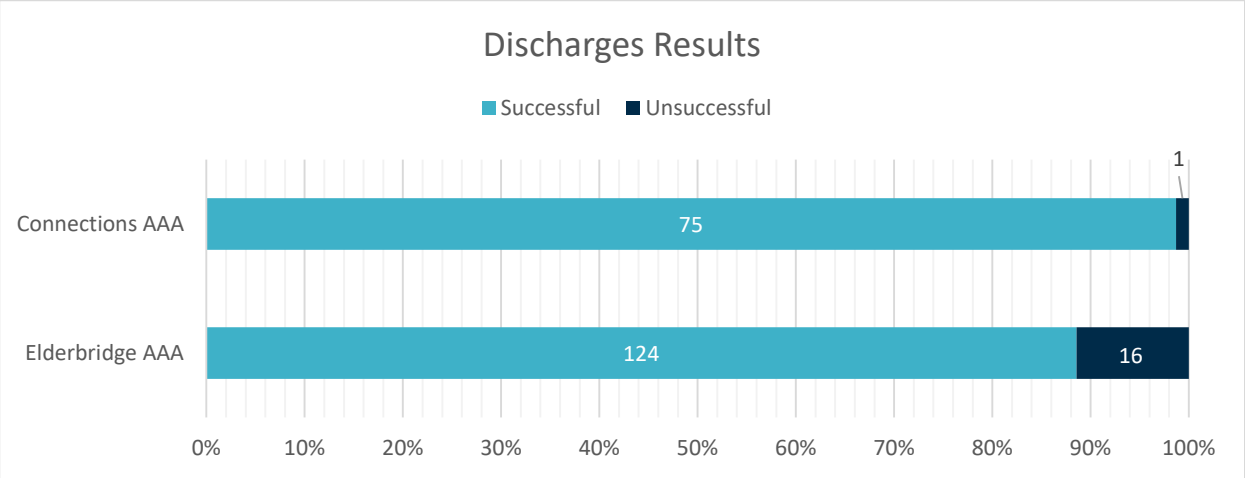
Due pilot awareness growing during the year, and the service disruption impacts from the COVID-19 pandemic, year-to-year comparisons between FY 2019 and FY 2020 do not yield consequential insights. Additionally, a fiscal year can be an arbitrary starting and stopping point for evaluating components of 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 service data on in total and rolling 12-month basis to see what further insights can be gleaned.

During the FY 2021 timeframe, a total of 222 individuals were admitted into the initiative. The breakdown of referral sources and each AAA is presented in the following chart.

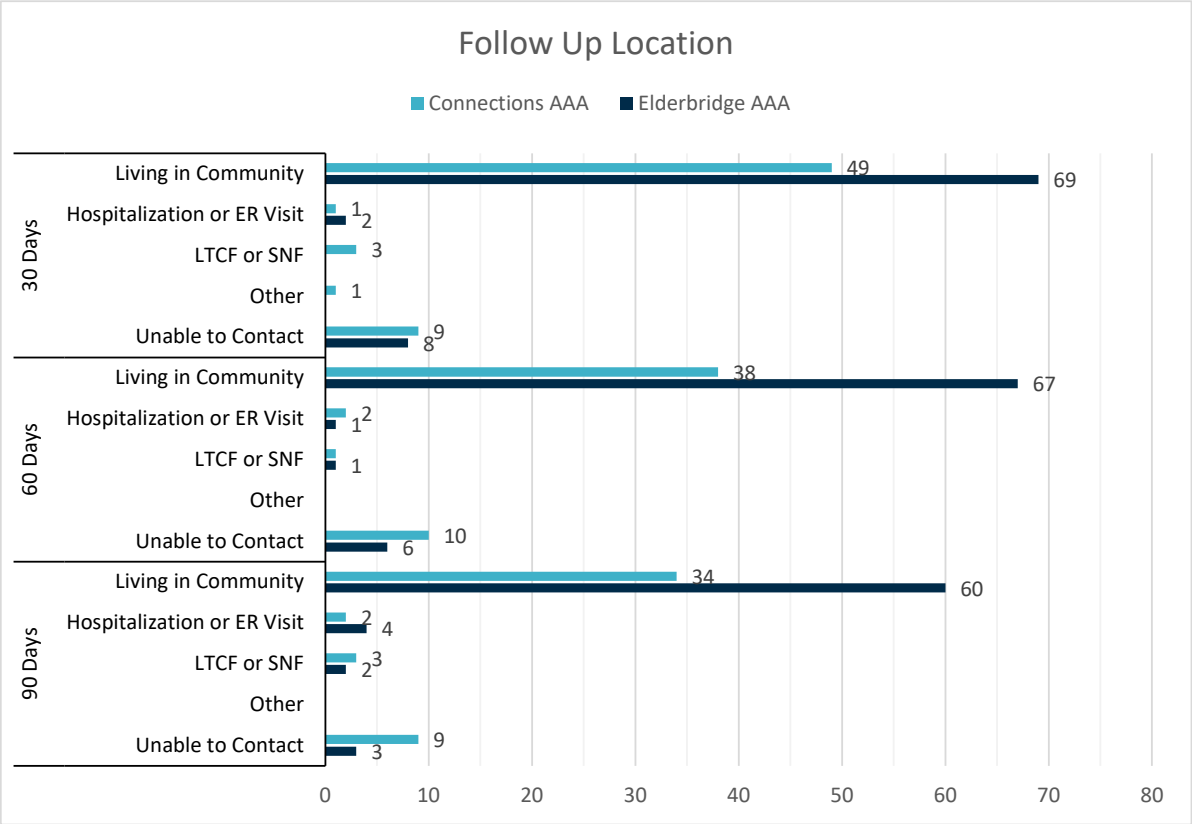


The next measure of the service is whether the consumer successfully transitioned out of the IRTC service at discharge. An unsuccessful discharge is defined as the individual being readmitted to the hospital for the same illness or moving into a long-term care facility, but not by the individual's choice. For FY 2021, both AAA implementation sites were successful, with 99% of discharge transitions at Connections AAA and 89% of discharge transitions at Elderbridge AAA being

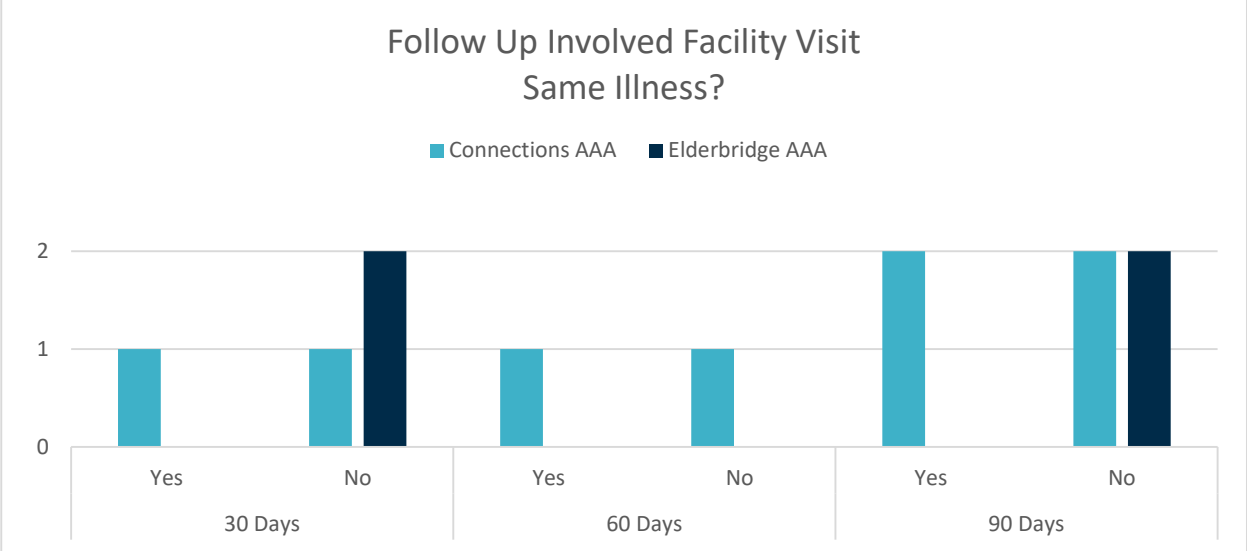
successful. Unsuccessful discharges involved the consumer being readmitted to the hospital for the same illness, or a consumer moving to a long-term care facility, not by their choice.



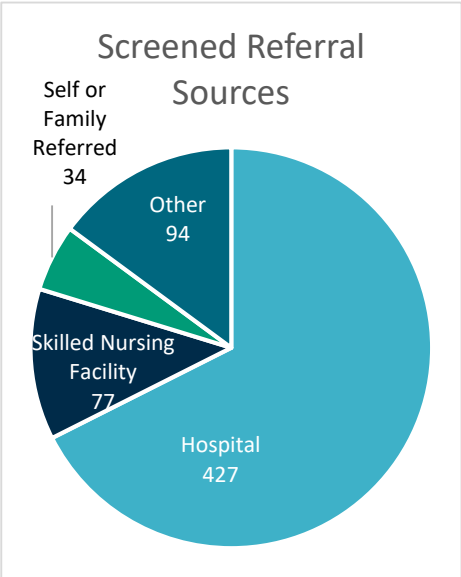
Additionally, at the 30-, 60-, and 90-day follow up periods, 82% of individuals reported that they were still living at home in their communities. Individuals reporting additional hospital and emergency department (ER) visits in the same timeframes accounted for 3% of responses, 3% reported a Long-Term Care Facility (LTCF) or Skilled Nursing Facility (SNF) stay. Improving this year, the AAAs were not able to contact about 12% of discharged participants 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.

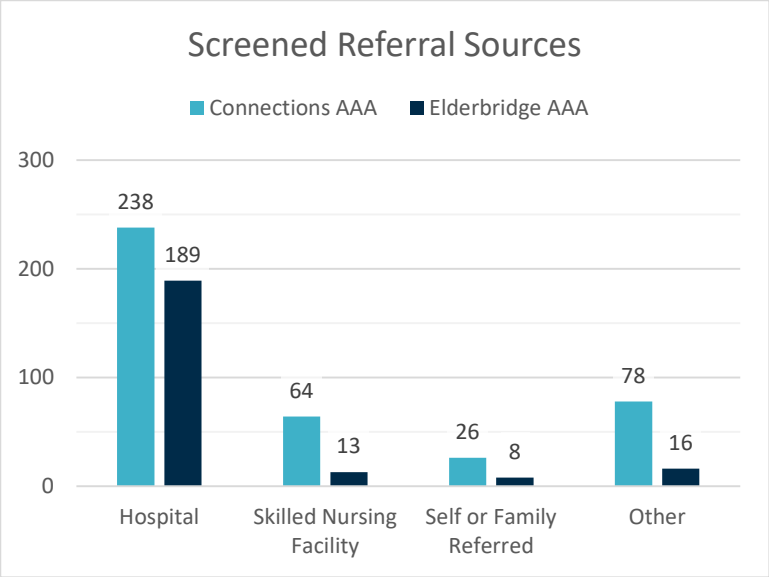


Of those individuals that had a hospital, ER, LTCF, or SNF stay from the prior chart, only four were admitted for the same illness as their prior stay. This chart provides further details on the timing and AAA project.



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 2021, IRTC received a total of 632 referrals. The sources of referrals are presented in the following chart.





Of these referrals to the service, about 20% were for individuals that were ineligible for IRTC. The most common reason for being ineligible was due to the individual being enrolled in Medicaid (43%). Other major reasons included for being under 60 years old (31%) and living outside of the current service area of the pilot decreased significantly due to virtual service delivery and project expansion (14%). Of the remaining referrals, 198 (43%) were admitted, and the remaining individuals voluntarily declined services or did not begin receiving services for various other reasons.

Finally, the types of home and community-based services that are identified through options counseling and delivered to consumers for FY 2021 are presented in the chart below, which includes the number of consumers who had enrolled date in that timeframe receiving services, and the units of services delivered.

INITIATIVE BUDGET AND TOTAL FUNDING

The proof of concept support for this initiative has been supported through an initial allocation of funding from the Iowa General Fund. However, that does not get at the total cost of the service delivery. AAAs have also secured grant funding, and utilized federal and state Older Americans Act block grant funding in the service delivery. In FY 2022, the IDA seeking to scale the proof of concept further and expand the participating AAAs chose to direct the $600,000 General Fund allocation for innovations in home and community-based services that support individuals living in their homes in the community towards IRTC. This brings the total state support in FY 2022 to $850,000.

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 is in its fourth year of operation of the Iowa Return to Community (IRTC) initiative. Initially starting in Cass, Mills, Pottawattamie, and Woodbury Counties, video-calls have also opened the opportunity to serve a limited number of consumers in Monona, Montgomery, and Page counties. Locally, the initiative is funded through this state allocation, funding secured by Connections AAA through contracts with local hospitals, and grant funding. The primary referral partnerships for Connections include Jennie Edmundson Hospital in Council Bluffs, Saint Luke's UnityPoint Hospital, and MercyOne Siouxland hospital and associated clinics in Sioux City.

ELDERBRIDGE Agency on Aging IRTC PILOT

In July 2019, Elderbridge 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 have been developed with Buena Vista Regional Medical Center and Lakes Regional Medical Center. A second pilot site partnering with Hancock County Health System is also at the early launch stage.

MILESTONES AAA IRTC PILOT

The Milestones Area Agency on Aging began participating in the IRTC initiative in April 2020, primarily working with a nursing facility in Van Buren County and is also currently working to develop other partnerships in the service area.

NEI3A IRTC PILOT

Northeast Iowa Area Agency on Aging (NEI3A) has been operating a care transition service partnering primarily with Allen Hospital in Waterloo for two years. Beginning in July 2021, NEI3A joined the IRTC pilot and data collection process and is working to develop other partnership opportunities in the service delivery area.

IRTC SUCCESSFUL TRANSITION EXAMPLES

The names of the individuals in the following examples have been changed to maintain their privacy. The first story is written by a woman whose husband was an IRTC consumer.

*My husband "**Bob**" tested positive for COVID-19 on Jan. 2, 2021. He was a very sick man!! A few days later he entered the Spencer Hospital with bacterial pneumonia!! While in the hospital, I received a phone call asking if we'd like Iowa Return to Community services. I said "YES" even though I didn't know anything about their services. I'm so glad I said yes!!*

Elderbridge stepped right in with phone calls, special deliveries and so much support. My main contact was Thomasina Hegg. When visiting with her, I felt like I had made a new friend. She was so easy to visit with as she was friendly, so kind, and a very caring person. She started by telling me what they offered to help ease our situation. I was amazed!!

When Bob finally started to eat again, we had food sent to us every two weeks. He could choose from a menu, then Thomasina would send in the order and it would arrive at our back door. What a help in this stressful time! He could choose what he wanted, and I would pop it in the microwave and two minutes later, it was ready for him to enjoy. They also ordered Ensure for him to drink, which he loved, and I know it helped him get some strength back. I would even put it in ice cream to make a malt and he enjoyed that too.

Thomasina also mentioned other services, such as, shower heads and grab bars. Bob was very weak, so we said YES. A very nice young man arrived to look over the shower area. He would always call ahead of time on when he would arrive, so it was convenient for us. Within a few days he returned with the head and bars. He did a great job of installing them. We were very pleased!!

These services were awesome and we would recommend them HIGHLY to anyone that could benefit from them. On a scale of 1-10, we rank them a 100!!!!! Truly a gift from above!!! We are so thankful for everything.

"Nora" is 98 years old, and her only living relative lives three hours away. She was living on her own taking care of herself before illness struck and landed her in the hospital in July of 2021. She was in a hospital or care facility until October when she returned home and was connected to IRTC at Milestones AAA. For the 30 days after discharge, IRTC helped with homemaker services to do light cleaning of her home. The homemaker service also taught her a new and safer way to do her laundry using some minor home modifications in the laundry room that included a platform in front of the washing machine so she would not lean over so far, hand railings for stability, and the dryer put on a platform for easier access. She also sits on her sofa to fold clothes comfortably. Nora now uses Older American's Act home delivered meals through Milestones out of convenience, and continues to live successfully in the community.

"Betty" a woman in her late 80s went to the emergency department due to falling during the night. While in the ED, it was discovered that her blood pressure was very erratic. She was admitted to the hospital for two weeks and then transferred to skilled nursing facility for strengthening prior to going home.

Betty's family was already involved with the Caregiver program through Connections AAA. The Caregiver program referred the family to IRTC since she had been admitted to the hospital and then SNF. Her family was anxious because she had been falling at home. The staff at the SNF would not discharge to home until she had a standard wheeled walker. The Connections IRTC Coach was able to access a walker through the Leagues of Human Dignity for the family to pick up.

Betty was discharged from the SNF with health and home care. At a health and home care therapy visit three days later, the staff person determined she need to go back to the emergency department due to very low blood pressure. Betty would need to have her blood pressure checked at different times throughout the day, and have the results recorded and reported to her primary care physician. The IRTC program provided an automatic wrist blood pressure machine that Betty could use. She recorded her blood pressures and reported her readings as her primary care physician directed. Betty's blood pressure is now stabilized and she has not fallen again.

RECOMMENDATIONS

The IDA continues to find increased interest in care transitioning and the IRTC initiative from stakeholders in 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.

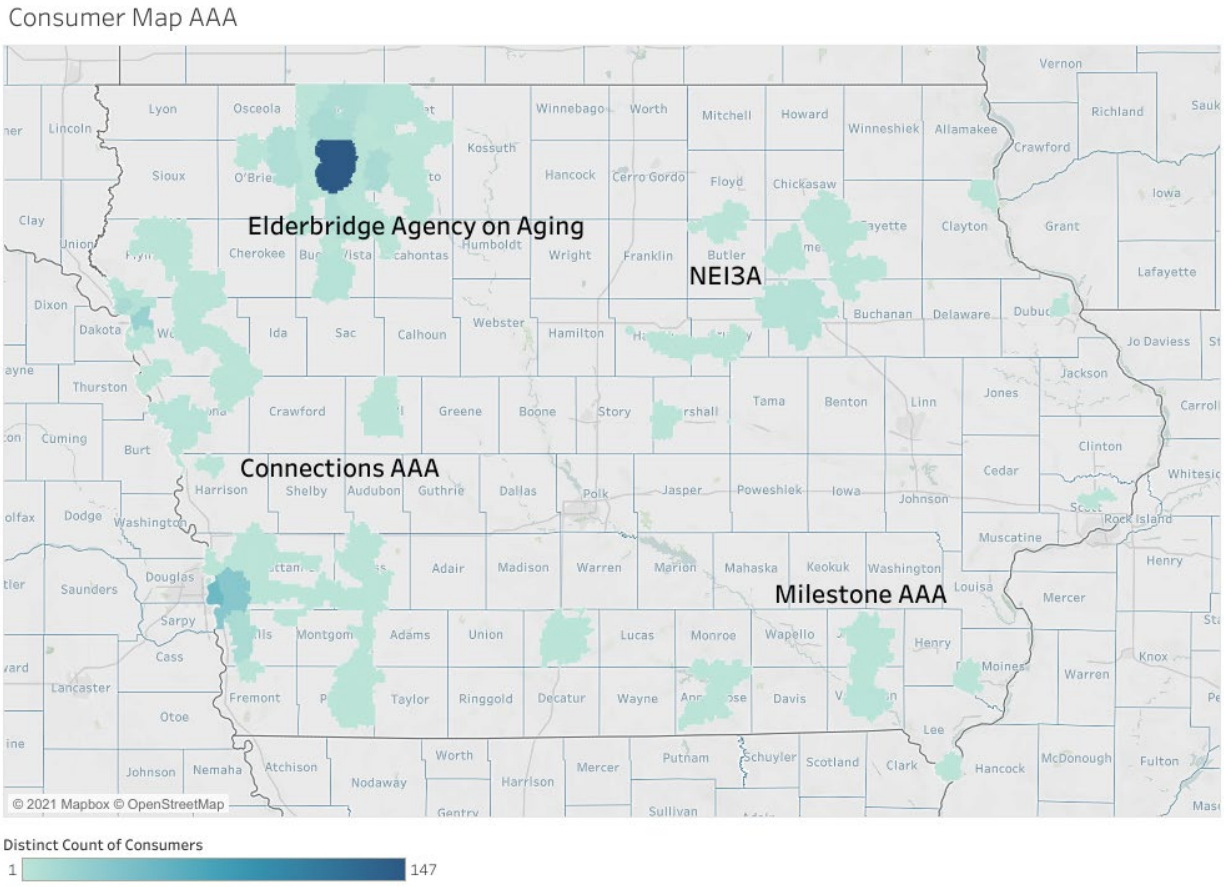
The IDA and the IRTC initiative will continue to transform and develop an infrastructure of solid and innovative community-based networks of providers to deliver home and community based services helping seniors to maintain their independence and lower health care costs for providers and the State.

APPENDICES

APPENDIX A

Map of Iowa Return to Community

Count of distinct consumers enrolled by zip code since the beginning of FY 2020 to FY 2022 Quarter 1.



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APPENDIX B