IOWA DEPARTMENT ON AGING

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

House File 2578, Section 1.6

December 2022

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Legislative Report Requirement

House File 2578 (FY 2023 Health and Human Services Appropriations Act), Section 1, subsection 6 required the following:

> *Of the funds appropriated in this section, $850,000 shall be used by the Department on Aging, in collaboration with the Department of Human Services and affected stakeholders, to continue 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; and shall be used by the Department on Aging to fund home and community-based services to enable older individuals to avoid more costly utilization of residential or institutional services and remain in their homes. 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, 2022.*

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.

Iowa Return to Community Activities

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 admission into a nursing facility and potential full enrollment in Medicaid.

Person centered planning and coordination of services are critical to ensure that services are in place to meet their care needs and preferences. Potential participants who are in the hospital and preparing to be discharged are referred to an IRTC Options Counselor. Likewise, potential participants who are in a long-term care facility and meet the IRTC

program criteria of the service are referred IRTC. The Options Counselors screen referrals prior to meeting with consumers to determine eligibility. If not eligible for IRTC, they provide referrals to other Aging and Disability Resource Center services.

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.

IRTC Target Population

The target population are Iowans, 60 and older, who want to live in the community and need support. Older Iowans who are dually eligible receiving limited Medicaid benefits such as Medically Needy (Spend-down), Medicare Savings Program (MSP) Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Benefits (SLMB) are eligible for IRTC because the services do not duplicate the Medicaid benefit being received in those categories. Medicaid members receiving full Medicaid health benefits, including those receiving HCBS Waiver services and are enrolled with a Managed Care Organization are not eligible for IRTC services.

Transition Planning & Service Coordination

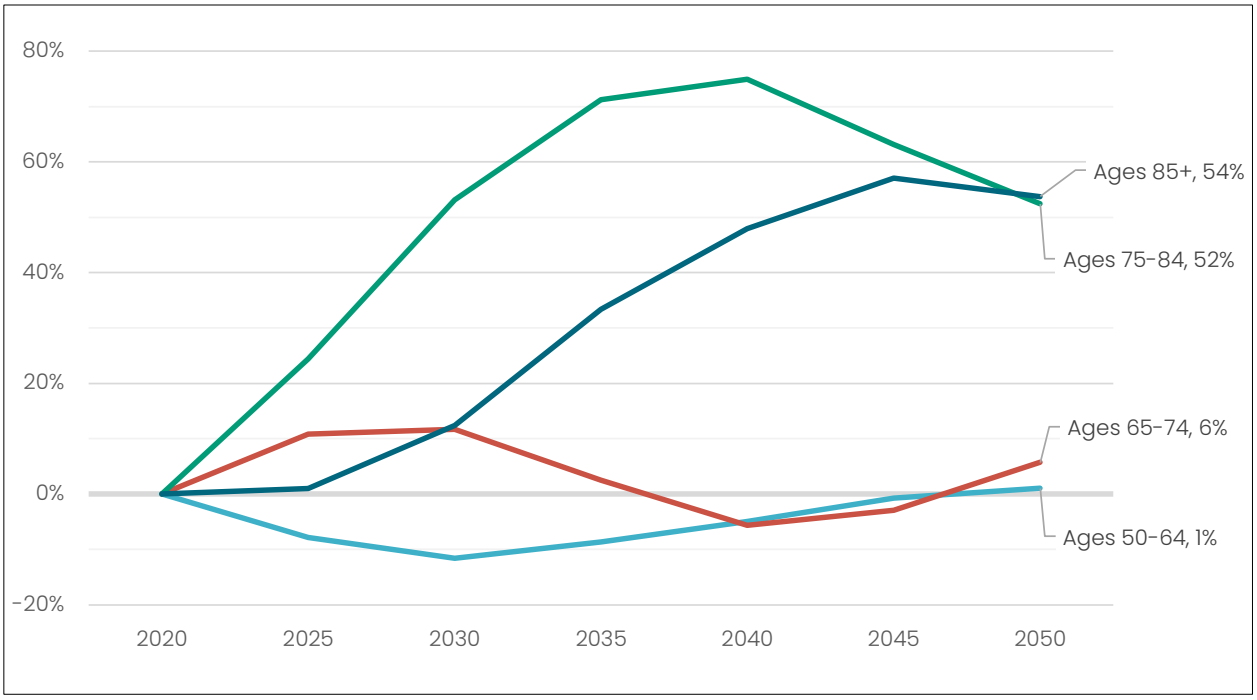
The IRTC Options Counselor meets with the consumer to introduce the service, identify potential needs and barriers and to implement the person-centered plan. Person centered planning ensures that services are based on the individual's values and preferences and support the consumer's realistic health and life goals. 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.

Iowa Demographic Context & Need for the Service

Demographic projections demonstrate the importance of focusing community living support services for all older Iowans, as shown in **Figure 1**.

Figure 1 | Projected Growth of 50+ Population 2020 to 2050



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, clinics, long-term care facilities, home- and community-based service providers, Iowa Legal Aid, and other organizations that assist no or limited Medicaid benefit individuals age 60 or older following a hospital or long-term care facility stay or identified as at risk for hospitalization by a clinic. 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 and has difficulties with at least five out of eight instrumental activities of daily living.[1] Difficulties with maintaining personal care, in obtaining and preparing nutritious food, managing medications, or getting to follow up appointments slows

[1] For an explanation of ADLs and IADLs see page 8.

recovery and leaves the person at risk for hospitalization, facility care, or readmittance. The program addresses these needs and results in improved outcomes for those served.

IRTC Program Evaluation

Outcomes

The program's intended outcomes include:

- 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 eligibility and/or avoiding enrollment.

Performance Metrics

IDA and participating AAAs track these metrics to evaluate progress on achieving outcomes.

- 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

Performance Results (FY 2019-FY 2022)

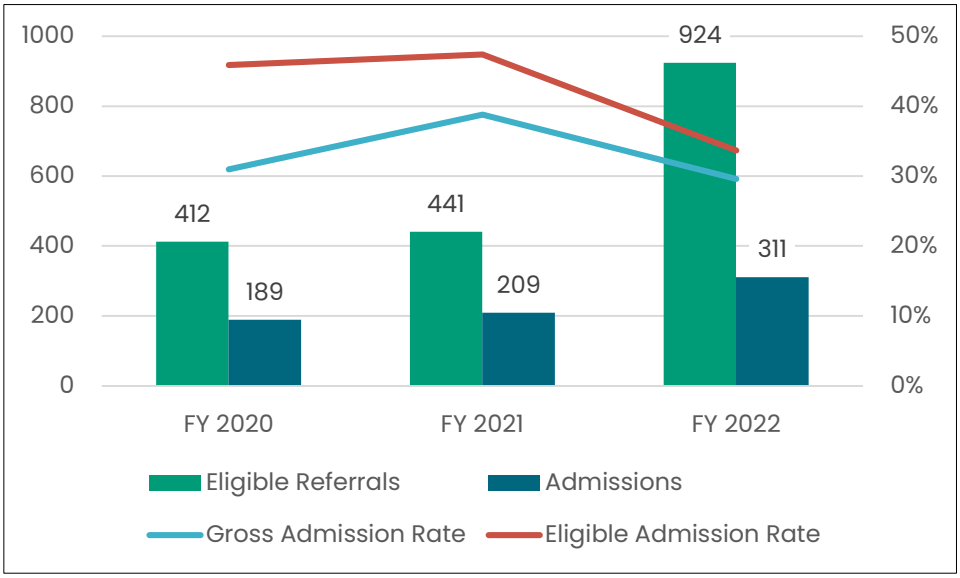
Being the fifth report to date, IDA staff reviewed year-to-year trends and the total services delivered over the four fiscal years of service delivery.

Referrals

From FY 2019 to FY 2022, a total of 2,556 older Iowans (unduplicated) were referred resulting in 3,032 transition episodes.[2] **Figure 2** outlines the past three years of eligible referrals and individual's acceptance rates for the service.

[2] A consumer can have multiple care transition episodes in a single year or different years.

Figure 2 | Referrals and Admissions FY 2020–FY 2022



The large increase in referrals in FY 2022 is attributed to two new AAAs participating in the pilot initiative. At one of the sites, the participating hospital automated referrals into its discharging protocols. This protocol resulted in a period of time with high referral volume and low acceptance rate, as the site's referrals were not targeted towards addressing consumers with identified barriers, and those being referred not having an introduction to the service being offered by a discharge planner. The addition of two AAAs contributed to the increase of additional 102 consumers being served during FY 2022.

Transition Services

In the FY 2019 to FY 2022 timeframe, a total of 750 consumers completed 840 care transitions. Of those, half lived in rural areas, half lived in urban areas, and nearly half lived alone. Females represented 59% of consumers admitted, and 15% of consumers admitted had incomes classified as living in poverty.

During this timeframe, an array of supportive home- and community-based services were delivered to consumers in a person-centered manner to fit their preferences and needs. **Figure 3** outlines the top ten services delivered by episode count, total units delivered, and the average number of units per episode.

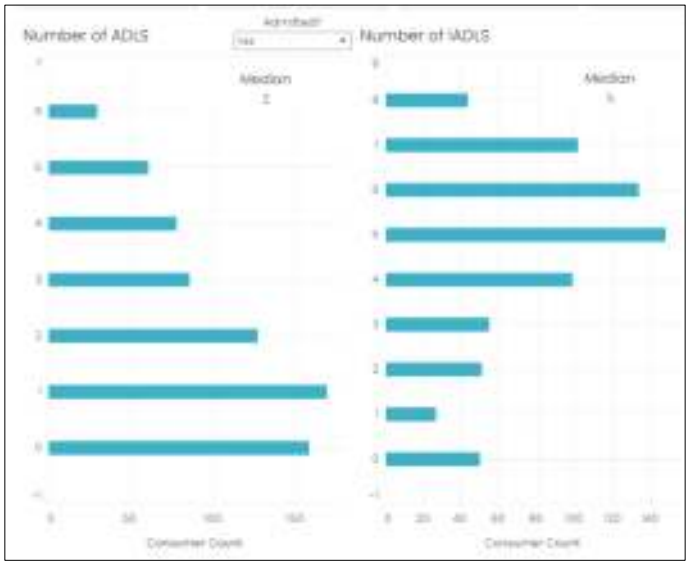
Figure 3 | Ten Most Common IRTC Services FY 2019 to FY 2022

Service	Episodes	Units	Unit Measure	Average Units
Options Counseling	840	8,285	Hour	10
Home Delivered Nutrition (HDN)	276	3,040	Meal	11
Material Aid	276	2,436	Item	9
Homemaker	267	2,230	Hour	8
Nutrition Education	80	167	Session	2
Transportation	47	302	One way trip	6
Emergency Response System	38	112	Device and Monthly Subsription	3
HealthPromo: Non Evidence-Based	27	35	Started an Evidence-Based Progoram but didn't finish on other health promotion information	1
Caregiver HDN	19	74	Meal	4
Health Promotion: Evidence-Based	19	19	Completed Evidence Based Program	1

Needs of Consumers

The six ADLs are walking, bathing, getting out of bed or a chair, dressing, eating, and ability to use the toilet. The eight Instrumental ADLs (IADLs) are preparing meals, managing medications, managing finances, shopping, using transportation, doing light housework, doing heavy housework, and using a telephone. The majority of consumers need help with two or more ADLs and four or more IADLs. **Figure 4** outlines the number of consumers that have multiple ADL and IADL needs that have entered the program from FY 2019 to FY 2022.

Figure 4 | Number of ADLs and IADLs for IRTC Consumers



Transition Outcomes

IRTC Options Counselors track the discharge reason at the conclusion of a care transition (also known as an episode). Follow Up calls occur at 30, 60, and 90-days post discharge. Staying in contact with consumers throughout the 90-day post discharge period present some challenges. Broadly analyzing, of the 400 post IRTC discharge contacts made at these intervals:

- approximately 67-74% report living in the community.
- 25-30% were Unable to Contact.
- 2-5% report having Visited an Emergency Department, being admitted to a hospital, or now living in a facility during the 90-day period.

Consumers Satisfaction

Consumers report exceptionally high levels of satisfaction with the service. Of the 300 surveys completed by consumers to date, only four (1.3%) consumers reported not feeling listened to by their coach. This is a testament to the person-centered approach AAA staff strive to bring to the program. Direct quotes from consumers included:

> *Very helpful, understanding and listened very well and came up with the best plan for me.*
>
> *Coach Lori is a good listener and answered all of her questions.*
>
> *Coach Amy was very helpful in giving information and helping with forms.*
>
> *Coach Pam is very courteous and helpful. She's not nosey and wants to get to know you.*
>
> *The program needs to be put out to the public more so people know about it.*
>
> *The IRTC program helped maintain my dignity and gave me a positive place to turn.*
>
> *I was down and out and the program helped me with recovery. It's a great program.*

AAA 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. **Appendix A** has a list of recurrent AAA, hospital, and nursing facility partnerships. The map in **Figure 6** shows from which 45 counties at least one consumer has been admitted into IRTC from FY 2019 to FY 2022.

Figure 6 | At Least on IRTC Transition in County FY 2019 to FY 2022

Connections AAA IRTC Pilot

Initially starting in Cass, Mills, Pottawattamie, and Woodbury Counties, video-calls during COVID-19 face-to-face restriction also opened the opportunity to serve a limited number of consumers Connections AAA service area, some of which did remain in place after required home visits resumed. The primary referral partnerships for Connections include Jennie Edmundson Hospital in Council Bluffs, Saint Luke's UnityPoint, and MercyOne Siouxland hospitals 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 which includes Clay County and portions of Buena Vista, Dickinson, Emmet, O'Brien, and Palo Alto Counties. The primary source of referrals is 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 and MercyOne in Cerro Gordo County have started this past fiscal year. Elderbridge is also working to set up a referral system in Webster County as well.

Milestones AAA IRTC Pilot

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

Northeast Iowa AAA IRTC Pilot

Beginning in July 2021, NEI3A joined the IRTC pilot and data collection process, partnering with the UnityPoint Waterloo Region. NEI3A is working to develop other partnership opportunities in Dubuque and Winneshiek counties. NEI3A staff do rounds at the hospitals to meet with patients and also receive referrals electronically through access to the electronic health records EPIC system.

Heritage AAA Pilot

Heritage AAA has spent the past several months working with Mercy Medical Center in Cedar Rapids to establish an IRTC referral process and hire staff to implement the service. The first care transitions for consumers are beginning in December 2022.

Stories from Iowans

Mother and Daughter Several Towns Apart

One Iowa woman who lives alone suffered a stroke that affected her vision. Here's more of the story recounted in a thank you letter from her daughter.

> *My mom recently had some significant health issues. As an adult child living far away from my aging parent, I found myself leaning on family members that also live in the same town as her, but fairly quickly needed to take some of the load off of them. I was delighted to be referred to an IRTC Coach at Connections AAA. Connections AAA was an incredibly essential element to getting my mom successfully settled back in at home. She wanted to preserve as much independence and dignity as possible and with Connections AAA, she was able to do that. It meant that a scary, complicated process was that much less scary and unknown. This was an incredibly powerful and invaluable resource.*

The woman received ten frozen meals from Connections (ten units of Home Delivered Nutrition); ten hours (units) of Homemaker Services; minor home modification supports

and supplies to remain safe at home including a hand-held shower, shower bench, and incontinent supplies (six units of Material Aid); referrals to Easterseals of Iowa Lending Library and the Iowa Department for the Blind to help with supplies for reading; and additional staff support in figuring out why her SNAP Card wasn't working. The time Pam spent assisting her is reflected in 18 units (hours) of Options Counseling.

Leaving a Skilled Nursing Facility and Navigating Medicare Advantage

Connections AAA received a call from "**Ronald's**" family member seeking help. Ronald had a stroke, went to hospital, and then a skilled nursing facility until his Medicare covered days were utilized. An IRTC Coach who met with the family, and all agreed to work together with proper releases signed.

Ronald was discharged home with the determination that he would need a hospital bed in his home. He is not able to stand or transfer without assistance of 1-2 people.

The IRTC Coach helped the family find these services which they were able to pay themselves:

- Personal care for Ronald twice daily.
- Information for Mom's Meals.
- Referral to a transportation provider for medical transportation.
- Referral to Family Caregiver support services offered at Connections AAA.

Ronald has remained at home with no falls or hospitalization. He now has an electric wheelchair. Ronald is also an avid cook who is enjoying the ability to do that at home again. And at the time of this writing is looking forward to helping prepare Thanksgiving dinner.

A Safety Net for Seniors

"**Marlene**" is an 86-year-old woman who has had repeated hospitalizations in the last few months. During her most recent hospitalization, both Marlene and her family felt that discharging to a skilled facility for rehab would be the best option for her given her frequent hospitalizations. However, her doctors and nurses were adamant that she could safely return home with home health services.

Marlene nervously discharged home and the home health agency did their initial assessment the next day. Marlene was so weak that she was unable to do any steps, had to sleep in a lift chair, and couldn't toilet herself without physical assistance.

NEI3A's IRTC Coach was able to get Marlene set up with a ramp, personal care services, and homemaker services (someone to clean, cook, run errands), and provide transportation. Marlene has successfully remained out of the hospital for nearly two months. Marlene attributes her success to the IRTC program and the help provided by NEI3A.

Looking Forward

Currently, IDA is undertaking three major steps to address funding expansion and sustainability for the initiative:

1. The IDA is currently developing a cost methodology and analyzing data to identify potential savings. The IDA continues collaborating with researchers at the University of Iowa College of Public Health to measure the impact of services reducing rehospitalizations; identifying consumer demographics for targeting; and next steps.
2. The IDA is also assisting an AAA in discussions with a local hospital on contracting models for IRTC services (utilizing a transition unit rate with milestone payments and/or participating in shared savings of an Accountable Care Organization). As part of this discussion includes determining the program costs to ensure return on investment for the program and for the hospital systems.

Appendix A | Participating Area Agencies on Aging and Referral Partnerships

Partnerships between Area Agencies on Aging and frequent referrals from hospitals and nursing facilities. This list is not exhaustive of referral sources.

Area Agency on Aging	Hospitals	Nursing Facilities
Connections AAA	Methodist Jennie Edmonds Hospital MercyOne Siouxland UnityPoint St. Luke's	Bethany, Risen Son, Midlands, Northcrest, Prairie Gate, Oakland Manor, Pioneer Valley, Embassy, Holy Spirit, Westwood, Countryside, Sunrise, Casa De Paz;
Elderbridge Agency on Aging	Spencer Hospital Dickenson County Regional Hospital Palo Alto County Health System Franklin General Hospital MercyOne North Iowa	Oakwood Care Center, Lake Mills Care Center
Milestones AAA	MercyOne Centerville	Keosauqua Care Center
NEI3A	UnityPoint Waterloo Region (Allen Hospital, Marshalltown, and Grundy County) MercyOne Waterloo	
Heritage AAA	Mercy Medical Center Cedar Rapids	