STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

PROGRESS REPORT ON THE PILOT INITIATIVE TO PROVIDE LONG-TERM OPTIONS COUNSELING: IOWA RETURN TO COMMUNITY

DECEMBER 2023

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Introduction

Iowa Return to Community Initiative Overview

In 2018, the Legacy Department on Aging (now the Division of Aging and Disability Services or ADS), in accordance with 2018 Iowa Acts, Senate File 2418 (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 sixth on the initiative's progress. The FY 2018, FY 2019, FY 2020, FY 2021, and FY 2022 reports are posted on the Iowa General Assembly's webpage.

2023 Iowa Acts, Senate File 561, Section 3, subsection 6, (Health and Human Services Appropriations Act) provides:

> *Of the funds appropriated in this section, $850,000 shall be used by the Department of Health and Human Services, in collaboration with 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 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 shall submit a report regarding the outcomes of the pilot initiative to the Governor and the General Assembly by December 15, 2023.*

Goals

- Help older Iowans maintain their independence by keeping them in their homes with person-centered community-based wraparound services and supports.
- Achieve person-centered planning by enabling older Iowans to have the information and assistance they need to stay in their homes if they so choose.
- Integrate health care and social care services through 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 a hospital, transitioning from a nursing facility, frequently utilizing an emergency department, or are identified as at risk for a hospitalization by a clinic due to health risk factors and an identified social need; 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.
- Utilize consumer satisfaction surveys to document the quantitative and qualitative benefits and outcomes.

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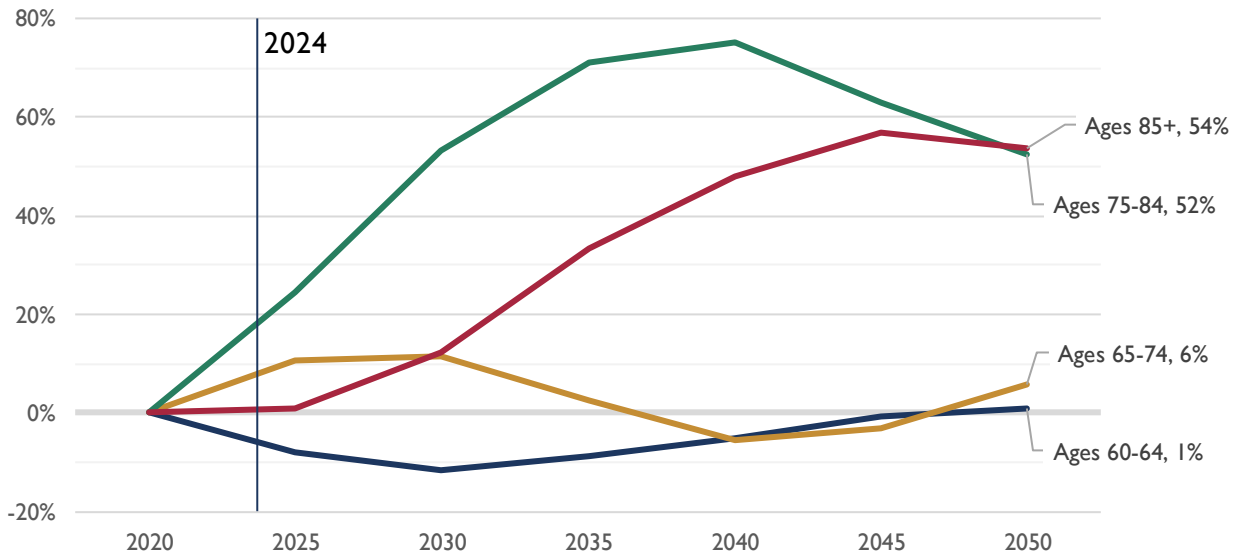
Target Population

Older individuals who are hospitalized for medical illness often leave the hospital with increased disability in activities of daily living, even when the condition that led to admission is successfully treated. This syndrome is often referred to as hospital-acquired disability (HAD).[1, 2] The National Institute for Health (NIH) published several studies on HAD impacts on community living. One study looked at twelve years of data and found that 5.6 percent of hospitalized individuals resided in a nursing home six months later; compared with 0.5 percent of non-hospitalized control patients.[3] That same study highlighted that three-quarters of all new nursing home placements are precipitated by a hospitalization.

People who are not eligible for Medicaid do not have, or are not aware of, other options in planning for long term services and supports (LTSS). This lack of planning and the perception that Medicaid-funded nursing facility stay or community-based services are the only options available often lead to families spending down assets or impoverishing themselves to become eligible for Medicaid. The need to expand and support LTSS planning and less intensive community-based supports is evident in the projected expansion of the older Iowans population, as shown in **Figure 1**.

Figure 1 | Projected Growth in 60+ Population 2020 to 2050



For the purposes of IRTC, older Iowans who are Medicaid members receiving full Medicaid health benefits, including those receiving HCBS Waiver services and who are enrolled with a Managed Care Organization (MCO), are not eligible for IRTC services. Older Iowans who are dually eligible receiving limited Medicaid benefits such as Medically Needy (Spend-down), Medicare Savings Program (MSP) Qualified Medicare Beneficiary (QMB), or Specified Low-Income Medicare Benefits (SLMB) are eligible for IRTC because the services do not duplicate the Medicaid benefit being received from those categories.

[1] Hospital-Acquired Disability: An Overview: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6185224/
[2] Prevalence of Hospital-Associated Disability in Older Adults: A Meta-Analysis: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7469431/
[3] Risks of Continued Institutionalization after Hospitalization Among Older Adults: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3210963/

Person-centered planning and coordination of services are critical to help older Iowan and their families navigate the health care system and to ensure that services are in place to meet their care needs and preferences. Potential consumers who are in the hospital and preparing to be discharged, are referred to an IRTC Options Counselor at the Area Agency on Aging (AAA) by a hospital's discharge planner. Likewise, potential consumers who are in a long-term care facility and meet the IRTC program criteria of the service are referred to the IRTC Options Counselor at the AAA. Another potential pool of eligible consumers are older Iowans identified by a health system clinic as having both ambulatory sensitive care conditions and an identified social need. IRTC services for these high-risk individuals could prevent or reduce inpatient hospitalization, therefore, eligibility was expanded to this referral point as well. IRTC Options Counselors screen referrals prior to meeting with consumers to determine eligibility. If consumers are determined ineligible for IRTC, counselors provide referrals to other Aging and Disability Resource Center services.

Figure 2 | Partners in the Aging and Disability Resource Center Network

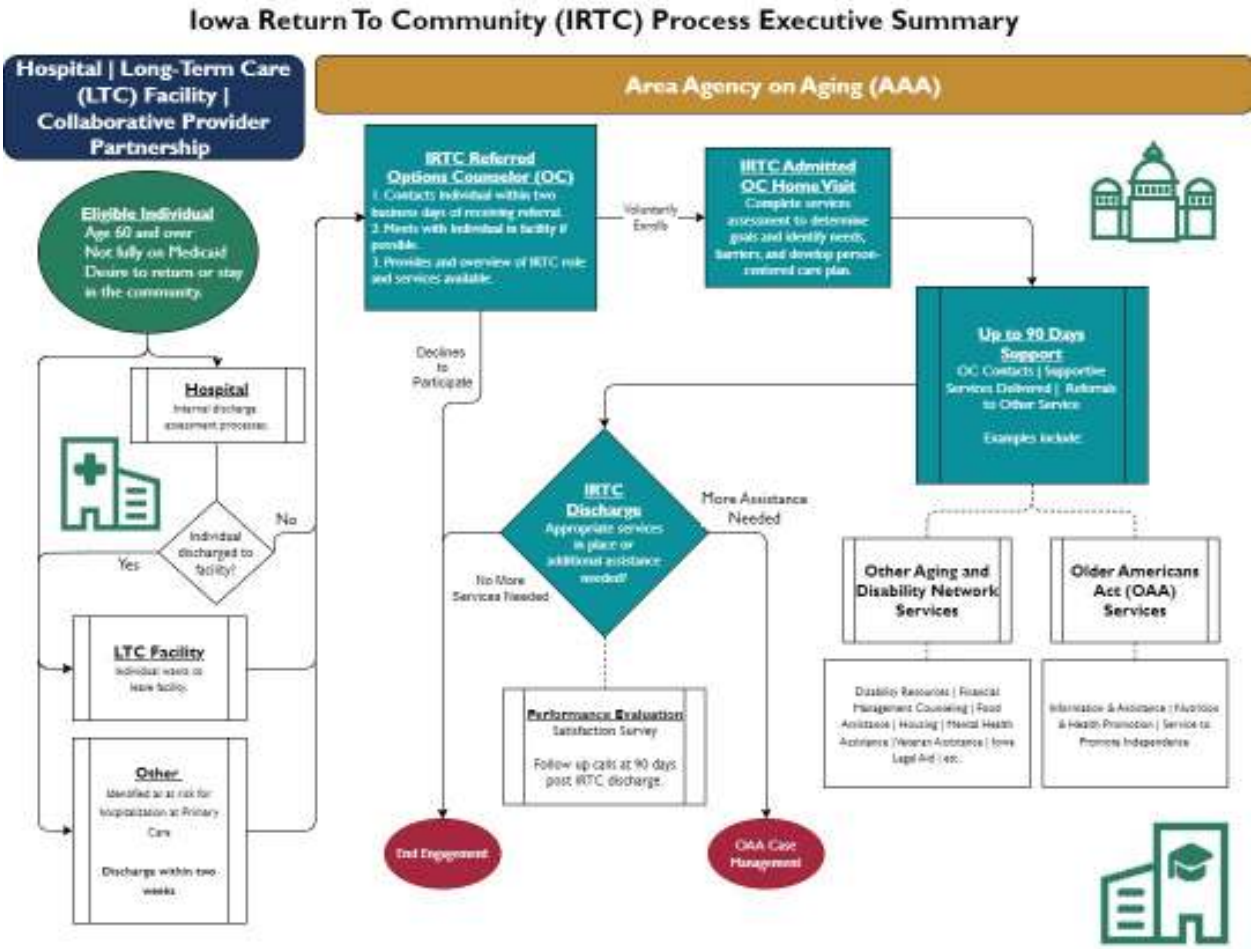
Agency	First Year of IRTC
Connections Area Agency on Aging	FY 2019
Elderbridge Agency on Aging	FY 2020
Milestones Area Agency on Aging	FY 2022
Northeast Iowa Area Agency on Aging	FY 2022
Heritage Area Agency on Aging	FY 2023

Transition Planning & Service Coordination

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 consumer'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 **Figure 3.**

Figure 3 | IRTC Process Diagram



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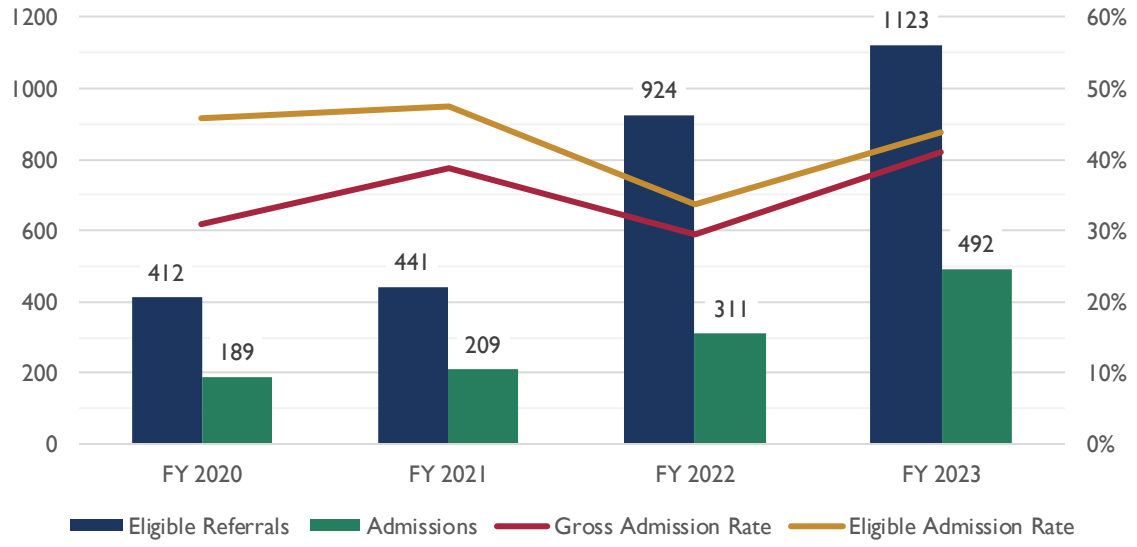
Program Performance

This section shows year-over-year trends, total services delivered during the five fiscal years of the IRTC Initiative, and broader impacts as modeled with assistance from faculty at the University of Iowa.

Referrals

From FY 2019 to FY 2023, a total of 3,642 referrals of older Iowans (unduplicated) were made, resulting in 4,342 transition episodes.[4] **Figure 4** outlines the past three years of eligible referrals and individual's acceptance rates for the service.

Figure 4 | Referrals and Admissions FY 2020 to FY 2023



The large increase in referrals in FY 2022 is attributed to two new AAAs participating in the pilot initiative. The increase seen in FY 2023 can be attributed to referral relationships at one site maturing even further. The increase demonstrated in the Eligible Admission Rate back to about 45 percent could be explained by a couple factors. First, the AAAs are reporting seeing higher degrees of need for services among their consumers. Second, word of mouth about the initiative has spread and people have shared the benefits of participation.

Transition Profile

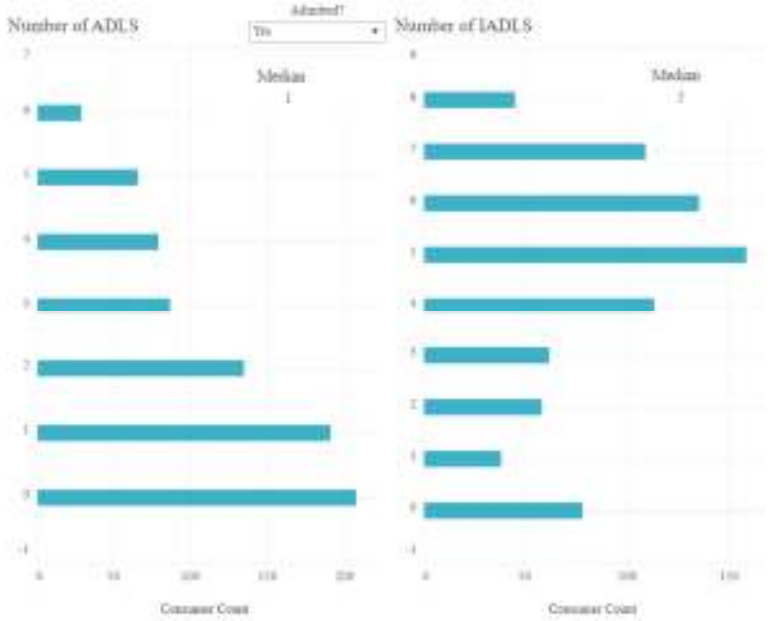
In the FY 2019 to FY 2023 timeframe, a total of 1,204 consumers completed 1,373 care transitions. Of those consumers, 52 percent lived in rural areas, 48 percent lived in urban areas, and 53 percent lived alone. The average consumer is 78 years old. Females represented 62 percent of consumers admitted, and 19 percent of consumers had incomes at or below 100 percent of the federal poverty level.

The frailty of consumers is evaluated using activities of daily living (ADLs) and instrumental activities of daily living (IADLs). 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

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

medications, managing finances, shopping, using transportation, doing light housework, doing heavy housework, and using a telephone. The half of consumers need help with one or more ADLs and five or more IADLs. **Figure 5** outlines the number of consumers that have multiple ADL and IADL needs that have entered the program from FY 2019 to FY 2022.

Figure 5 | Number of ADLs and IADLs for IRTC Consumers



Transition Services

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 6** outlines the top ten services delivered by episode count, total units delivered, and the average number of units per episode.

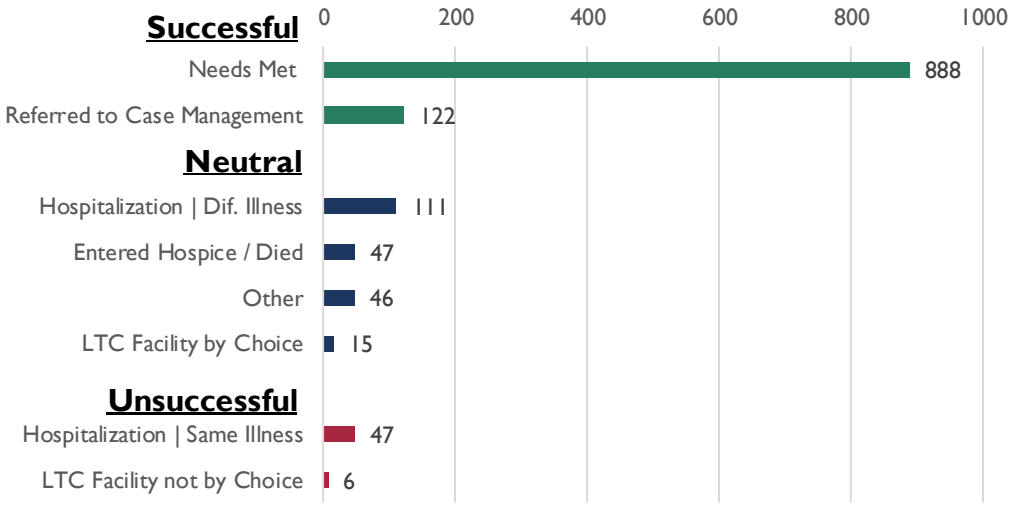
Figure 6 | Ten Most Common IRTC Services FY 2019 to FY 2023

Service	Episodes	Units	Unit Measure	Average Units
Options Counseling	1,372	13,070	Hour	10
Home Delivered Nutrition (HDN)	517	10,382	Meal	20
Homemaker	515	5,846	Hour	11
Material Aid	432	5,103	Item	12
Nutrition Education	148	320	Session	2
Emergency Response System	112	268	Device and Monthly Subscription	2
Transportation	72	492	One-way trip	7
Health Promotion: Non Evidence-Based	44	61	Started an Evidence-Based Program but didn't finish on other health promotion information	1
Personal Care	29	434	Hour	15
Health Promotion: Evidence-Based	27	27	Completed Evidence-Based Program	1

Transition Outcomes

Program staff define a successful discharge from IRTC as any discharge that did not have the consumer re-hospitalized related to the same illness or did not move into a long-term care facility against their preferences. Using this metric, from FY 2019 to FY 2023, 96 percent of all IRTC discharges are considered successful or neutral discharge. Changing the definition of a successful discharge to no re-hospitalizations or moves to a long-term care facility even if by consumer choice, IRTC discharges are still 86 percent successful or neutral. **Figure 7** presents detailed information on the discharges for this time frame.

Figure 7 IRTC Discharge Reasons FY 2019 to FY 2023



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 IRTC discharge. Staying in contact with consumers throughout the 90-day post IRTC discharge period has always presented challenges, and as the volume of consumers served increases, this challenge is growing. Strategies for improving outcome tracking are being evaluated. Broadly analyzing, of the 550 post IRTC discharge contacts made at these intervals:

- approximately 47-49 percent report living in the community.
- approximately 50 percent were considered Unable to Contact.
- approximately 1-2 percent report having Visited an Emergency Department, being admitted to a hospital, or now living in a facility during the 90-day period.

University of Iowa Impact Research

The ADS and faculty at the University of Iowa are examining the effectiveness of the IRTC Initiative and potential for savings through a return on investment formula. The first paper, which has been peer reviewed and in consideration for publication, analyzed IRTC service delivery data and outcomes to demonstrate that the initiative does reduce unnecessary health care use while supporting individual preferences to remain at home.

Further research is focused on modeling the long-term impacts of the initiative. This second analysis is also examining the impact of caregivers in the care coordination process for older adults. Researchers conducted a population-level Markov analysis that simulated and tracked transition pathways and costs associated with these transitions for four different cohorts of older adults. It provides comparisons between IRTC participants and non-participants and IRTC participants with caregiver assistance against those without such support.

The analysis suggests that implementing a care coordination program linking older individuals to essential community-based support services can lead to substantial cost savings. More specifically, over a ten-year span, there is a potential for an average savings of nearly $15,000 per individual. The majority of the savings stem from the decreased cumulative costs associated with extended institutional care. As supported by prior studies, the direct expenses tied to hospitals, nursing homes, and other short-term and long-term care facilities are considerably greater than those of community-based living. In line with this, the cost evaluations of the IRTC program reveal that the expenses related to support services for an older individual are nearly one-half compared to a single hospital stay or residency in a nursing home. Therefore, while the upfront savings might appear minimal, when considering that an estimated 80 percent of older individuals would remain in community settings by the tenth year, as opposed to being institutionalized, the merits of such care coordination models become evident and warrant further exploration.

Another dimension of cost savings not considered in this analysis is the positive economic impact that such programs have on families of older adults. The IRTC program, by enabling older adults to live within their communities, often provides secondary results for family members or close relatives who are able to continue their regular work routines without the disruptions that come with institutionalized care of a loved one. This continuity can prevent potential income losses, thus indirectly contributing to the broader economic benefits of the program.

In September 2023, an application was submitted to the federal Agency for Healthcare Research and Quality (AHRQ) to further study IRTC's producing evidence about program effectiveness and identifying feasible strategies to scale up and sustain program implementation.

Looking Forward

AAAs are experiencing increased demands for services greater than the pilot funding can sustain, and additional one-time supplemental funding has expired. With increased need comes a need to assess options for long-term programming. A long-term solution should have a volume or unit basis in the service delivery to avoid a situation where limited funding could lead to waitlists.

IRTC funding is spread among five out of six participating AAAs. Three AAAs that have been participating since the beginning of the project receive more funding due to the length of their relationships with health care systems, coverage area, and referrals received. Two AAAs in a launch phase receive less funding, and will need additional funding in the near future as their service delivery capacity matures and expands. Expanding participation to the sixth AAA would require additional funding.

An expansion of the IRTC program to a statewide service delivery would require a three-year phased approach. Options could include further expanding IRTC as a state-funded endeavor, seeking a federal-state partnership under Medicaid Waiver authority, or encouraging health care payers and providers to contract and partner with the AAAs in a public-private partnership. With the forecasted growth in the aging population and escalating health care costs, identifying and developing a funding model is central to sustaining service delivery and for scaling of service delivery to meet the anticipated growing demand. It is also anticipated this initiative will fit into the Multi-sector Plan on Aging (MPA) and how systems and services can be better designed to support older adults living in their community of choice.