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# IOWA RETURN TO COMMUNITY (IRTC)

The Iowa Return to Community initiative provides long-term care support planning to assist non-Medicaid eligible seniors who want to return to their community following a nursing facility or hospital stay. By helping to coordinate wrap-around services and supports for these individuals that enable them to live safely and comfortably at home, this initiative will provide increased quality of life by ensuring consumer choice; potentially producing cost savings for older Iowans and the State by preventing or delaying an individual's enrollment in Medicaid.

**Counties targeted:** Cass, Clay, Mills, Pottawattamie and Woodbury

**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 or hospital admissions and readmission, emergency department use

**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

**Funding Provides**

- Options Counselors
- Referral screening for eligibility
- Assessment of needs and person-centered care plan development
- Transition services and service coordination
- 30, 60 and 90 day follow up
- Continuous networking with hospitals, nursing facilities, health care entities, service providers, pharmacists, and other organizations to establish and maintain partnerships
- Consumer information and data collection

**Sustainability and Expansion Options**

- Partnerships
- Medicare Advantage
- Private Pay
- Grants

# IRTC 2019 Progress Report

***2019 Connections IRTC Pilot:*** Iowa Return to Community 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 have been 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.

| **Stakeholder Engagement (Community Conversations)** | **20** |
|---|---|
| **Locations:** Cass, Mills, Pottawattamie, Woodbury<br>**Participants**: Hospitals, Skilled Nursing Facilities, Discharge Planners | |

***Summary of 2019 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*

| **Cases Screened** | **595** |
|---|---|
| **Cases Eligible** | **260** |
| Voluntarily Admitted to the Return to the Community Initiative | 98 |
| Successful Outcomes | 74 |

***2019 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 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 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 an Consumer Satisfaction /Evaluation

***2019 Elderbridge IRTC Pilot:*** 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.

***Summary of 2020 IRTC Data through 12/2019***

| **Cases Screened** | **407** |
|---|---|
| **Cases Eligible** | **297** |
| Voluntarily Admitted to the Return to the Community Initiative | 90 |

Currently in FY 2020, there have been 79 cases discharged with 77 of them being successful. The average success rate since inception is 94%.

***Consumer Success Stories***

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. *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 that 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.*

# HOME MODIFICATIONS PROGRAM

In September, the Iowa Department on Aging (IDA) started working with the Livable Homes Coalition to start discussion on how the IDA could be involved moving forward. The Department also met with State partners and stakeholders to strategize on collaborative efforts to ensure awareness of current programs in the State. After several meetings, it was decided that IDA is the appropriate location for a Home Modifications / Safety at Home program to be housed. This program would align with our current and future priorities of being focused on individuals remaining safely in their homes, as modeled in our Return to Community initiative.

Last year the ACL extended federal grant opportunities and has shared that this year there is a $10 million appropriation in the HUD budget for Home Modifications. Upcoming changes in the Medicare Advantage plan that may include home modifications, reinforces the need for a state organization to pursue and develop these federal funding streams and to take the lead in policy decision making at the State level.

Recently, the IDA applied for a **CAPABLE (Community Aging in Place-Advancing Better Living for Elders)** Grant. The CAPABLE program addresses the needs of aging Iowans by decreasing fall risk, improving safe mobility in the home, and increasing the ability to safely accomplish daily functional tasks. This initiative is performed by an occupational therapist (OT), registered nurse (RN), and handyman (home modification specialist) who work together with the participant at risk for falls.

Many older adults want to "age in place" but are concerned about safety and getting around in their home. The participant, OT, and RN identify what the participant's barriers are within their home and create three goals that become achievable after home modifications are made. *"Roughly $3,000 in program costs yielded more than $30,000 in savings in medical costs driven by reductions in both inpatient and outpatient expenditures,"* according to Johns Hopkins (Johns Hopkins School of Nursing, Retrieved 2020).

**Counties Targeted:** Cass, Dallas, Mills, and Pottawattamie

**Purpose:** To improve the ability of older adults and adults with disabilities in the targeted counties to live safely in their own homes by significantly reducing in-home falls risk using the evidence-based CAPABLE program and concurrently building a sustainability strategy for these programs to flourish beyond the project period.

**Objectives:**

- Develop and train two client-directed CAPABLE teams
- Establish a key partner network to provide and identify resources needed to modify homes
- Develop and implement strategies to serve a projected 320 individuals
- Create an infrastructure to sustain and grow CAPABLE across Iowa

**CAPABLE Key partners:**

- Area Agencies on Aging
- Easter Seals Iowa
- Habitat for Humanity
- Iowa Association of Occupational Therapists
- Iowa Department of Public Health
- Iowa Falls Coalition
- Iowa Healthcare Collaborative
- Iowa Livable Homes Coalition
- John Hopkins School of Nursing
- League of Human Dignity
- Methodist Jennie Edmundson Hospital

# ELDER ABUSE / OFFICE OF PUBLIC GUARDIAN EXPANSION

Over the interim the IDA worked collaboratively, as encouraged by the Governor, and held discussions about options for improvement to the Elder Abuse system in Iowa. Multiple state agencies such as the Department of Human Services, Department of Inspection and Appeals, the Insurance Division, in conjunction with other providers and stakeholders, met and participated in a continuous improvement event to address possible strategies for system improvement.

Below are the recommendations of the Work Group from the final report.

**Develop a Single Point of Entry for Adult Abuse**

- Designation of a Single Point of Entry for Adult Abuse
- Creation of a Management Information System

**Restructure Elder Abuse Prevention and Awareness Service Delivery**

- Establish Statewide Standards
- Increase Public Awareness
- Public Awareness and Referrals for Scams and Predatory Lending
- Explore Current Elder Abuse Funding and Options for More Efficient and Effective Distribution

**Enhance the Office of Public Guardian (OPG)**

- Expand Capacity of Office of Public Guardian
- Increase OPG's Information and Resources Options
- Provide Effective Oversight and Monitoring of Guardians

**Office of Public Guardian Background:** *Established in Iowa Code (Chapter 231E), the Office of Public Guardian may act as an individual's guardian, conservator or representative payee.*

*The mission of the Office of Public Guardian is to preserve individual independence through a person-centered process by:*

- *Providing education*
- *Providing assistance to guardians, agents and powers of*
- *Assisting in guardianship and conservatorship proceedings, when necessary*
- *Providing guardianship and conservatorship services in the least restrictive manner*

*The Office of the Public Guardian currently has 63 open cases and a waiting list of 43 applications. In addition to the wait list, the Office of the Public Guardian has a* ***net increase of about 60 cases a year.*** *The Office of Public Guardian will only be appointed by the court as the guardian or conservator of last resort. To meet demand, expansion of the OPG is needed as the office has reached capacity.*

The next step in the process is for the Department on Aging to collaborate with the applicable partners and stakeholders to prioritize the outcomes identified below, and to establish Implementation Work Groups. These Work Groups will recommend strategies to achieve the identified outcomes.

# Medicaid Administrative Federal Financial Participation (FFP) for Iowa's Aging and Disability Resource Center (ADRC)

**Overview**

- FFP provides matching dollars (50%) to cover activities that contribute to the efficient and effective administration of the Medicaid program
- FFP can provide an ongoing source of funding for enhanced ADRC activities.
- Many ADRC functions are potentially eligible for Medicaid administrative funds.

**Potential ADRC Activities Reimbursed by Medicaid**

- Outreach
- Person Centered Counseling
- Facilitating Medicaid Eligibility
- Training
- Programming Planning
- Quality Improvement

**Other States**

- In 2018, 13 states were claiming for NWD/ADRC activities and 14 are in the planning phase according to the Administration for Community Living.
- Wisconsin has 80% of ADRC activities claimable by Medicaid

**Implementation Timeline-*(See table)***

- 3-6 Months: Wait for CMS approval
- 1 month: Implement claiming process

## Medicaid Administrative Claiming (MAC)

**Updated January 2020**

| | | 2019 | 2020 | | |
|---|---|---|---|---|---|
| **Activity** | **Staff** | **Dec** | **Jan** | **Feb** | **Mar** |
| IDA submit/finalize PACAP amend for IME's review and approval to CMS Submission | CMS | ~~30~~ | | | |
| IME Submit PACAP Docs to CMS | | | | ~~10~~ | |
| CMS review PACAP Amend | CMS | | | 10 | 30 |
| Determine Expenditure Basis for MAC (Administrative Contract or Direct reimbursement) | Zach | | | | 30 |
| IME/IDA contract to transfer federal funds to IDA to fund the AAA/ADRCs | Zach/IME | | | | 30 |
| Ongoing Time Study to for MAC | Shan | ONGOING | | | |
| Monitor ADRC TS & Cost Pooling Reports | Shan | ONGOING | | | |
| Perform quality control review of final claim calculation prior to submission | Shan | ONGOING | | | |