Report on the Pilot Initiative to Provide Long-Term Care Options Counseling

Senate File 2418 Section 9

12/14/2018

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SENATE FILE 2418 LEGISLATIVE MANDATE

Of the funds appropriated in this section, $100,000 shall be used by the department on aging in collaboration with the department of human services and affected stakeholders, to design a 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 the design plan as well as recommendations for legislation necessary to administer the initiative, including but not limited to legislation to allow the exchange of contact information for nursing facility residents appropriate for discharge planning, to the governor and the general assembly by December 15, 2018.

OVERVIEW

The Iowa Department on Aging (IDA), in accordance with Senate File 2418, collaborated with stakeholders to design a pilot initiative to provide long-term care options counseling utilizing support planning protocols. This pilot initiative assists consumers, age 60 or older, who are not Medicaid-eligible, who indicate a preference to return to their community, and are deemed appropriate for discharge following a nursing facility or hospital stay. The initiative is called Iowa Return to Community (IRTC). Local stakeholders include area hospitals, long-term care facilities, Connections Area Agency on Aging (AAA), home and community based service providers, Iowa Legal Aid, pharmacies, and other local providers.

Connections AAA was a natural selection for this pilot initiative because they have an existing program called Caring for Our Communities (CFOC), which is being enhanced and expanded to IRTC. The CFOC program was created in 2015 in partnership with Jennie Edmundson Hospital, Connections AAA, Iowa Legal Aid, Heartland Family Services, local transportation providers, home health agencies, and pharmacies, to create a care transition program.

To expand the existing initiative into RTC, Connections Area Agency on Aging hosted multiple community meetings throughout the region to introduce the program, build interest in it, and secure partnerships for referrals to the program. Collaboration among state entities included IDA communications with both the Department of Inspections and Appeals (DIA) and the Iowa Department of Public Health (IDPH) to introduce the IRTC project, determine any common programming in the targeted areas and to establish the best methods of disseminating information to their agencies.

The IDA worked closely with the IDPH *Data Management and Health Equity Program* to obtain current and reliable data regarding hospital discharge information. The IDA will continue communicating with both IDPH and DIA, providing them with data reports as they are released. Additional data was obtained by reaching out to Telligen, a Medicare Quality Innovation Network Quality Improvement Organization, for data on Medicare beneficiary hospitalizations and nursing facility stays after hospitalizations and readmissions for the target area. In addition, the IDA is also partnering with the State Long Term Care Ombudsman's (SLTCO) Office to ensure the LTCO program is accessible and available to residents until they transition out of the long-term care facility.

The Department of Human Services has been provided information on the IRTC; however, there is limited collaboration at this time since the target populations for the IRTC are non-Medicaid consumers. Iowa Medicaid Enterprise (IME) Director Michael Randol invited IDA Director Linda Miller to present at an IME monthly meeting with the Managed Care Organizations on the value the AAA services add to a consumer's ability to remain healthy and engaged in living in their community. The IRTC was one of the highlighted programs.

IRTC PROJECT DEMAND

The need for a project like the IRTC is supported through a variety of data sources. According to the *2018 Long-Term Services & Supports Scorecard*: *A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*, Iowa ranks forty-seventh out of fifty-one states and the District of Columbia in Effective Transitions. More specifically, Iowa ranks last (fifty-first) with only 4.1% of people with at least a ninety day nursing home stay successfully transitioning back to the community. In addition, Iowa also has a significantly higher incidence of nursing home residents with low care needs (16.8%) versus the national median (11.2%). The same report indicates that Iowa ranks forty-third with 16.8% of nursing home residents with low care needs, which is 5.6% higher than the national median. These statistics demonstrate the need for Iowa to develop a comprehensive strategy to address the long-term care needs of older Iowans.

DESIGN PLAN

Purpose Using evidence-informed interventions, the Iowa Return to Community initiative provides long-term care support planning to assist non-Medicaid-eligible seniors who want to return to their communities following a long-term care facility or hospital stay. The goal is to delay or avoid enrollment in the Medicaid program, and thereby achieve cost savings for the consumer and the State of Iowa. The Iowa initiative is closely modeled after the award-winning, evidence-informed Minnesota model of transition planning launched in 2010.

Counties Targeted: Cass, Mills, Pottawattamie and Woodbury (see Appendix A)

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, unnecessary hospital admissions and readmission, 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 programs and resources such as the family caregiver program to fully optimize available resources.
- Develop and implement a consumer satisfaction survey to document the quantitative and qualitative benefits and outcomes.

Performance Metrics

- Total Number of Referrals
- Total Number of Successful Transitions
- Total Number of Transitions To The Community
- Average Length of Time in the IRTC Program
- 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 delaying or avoiding enrollment in the Medicaid Program.

Client Eligibility

- Age 60 or older
- Resident of Iowa
- Discharged from a hospital to the community or a long-term care facility skilled rehabilitation
- Medicare and/or Private Pay
- Desire to return to their community
- Agree to participate in the Iowa Return to Community (IRTC) Program

HOW IT WORKS

The Iowa Return to Community (IRTC) Program is a collaborative effort with a variety of partners that include hospitals, long-term care facilities, Area Agencies on Aging (AAA), 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.

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 the Connections AAA. Likewise, potential participants who are in the hospital and preparing to be discharged are referred to the IRTC Options Counselor (OC) at Connections AAA by the hospital's care manager.

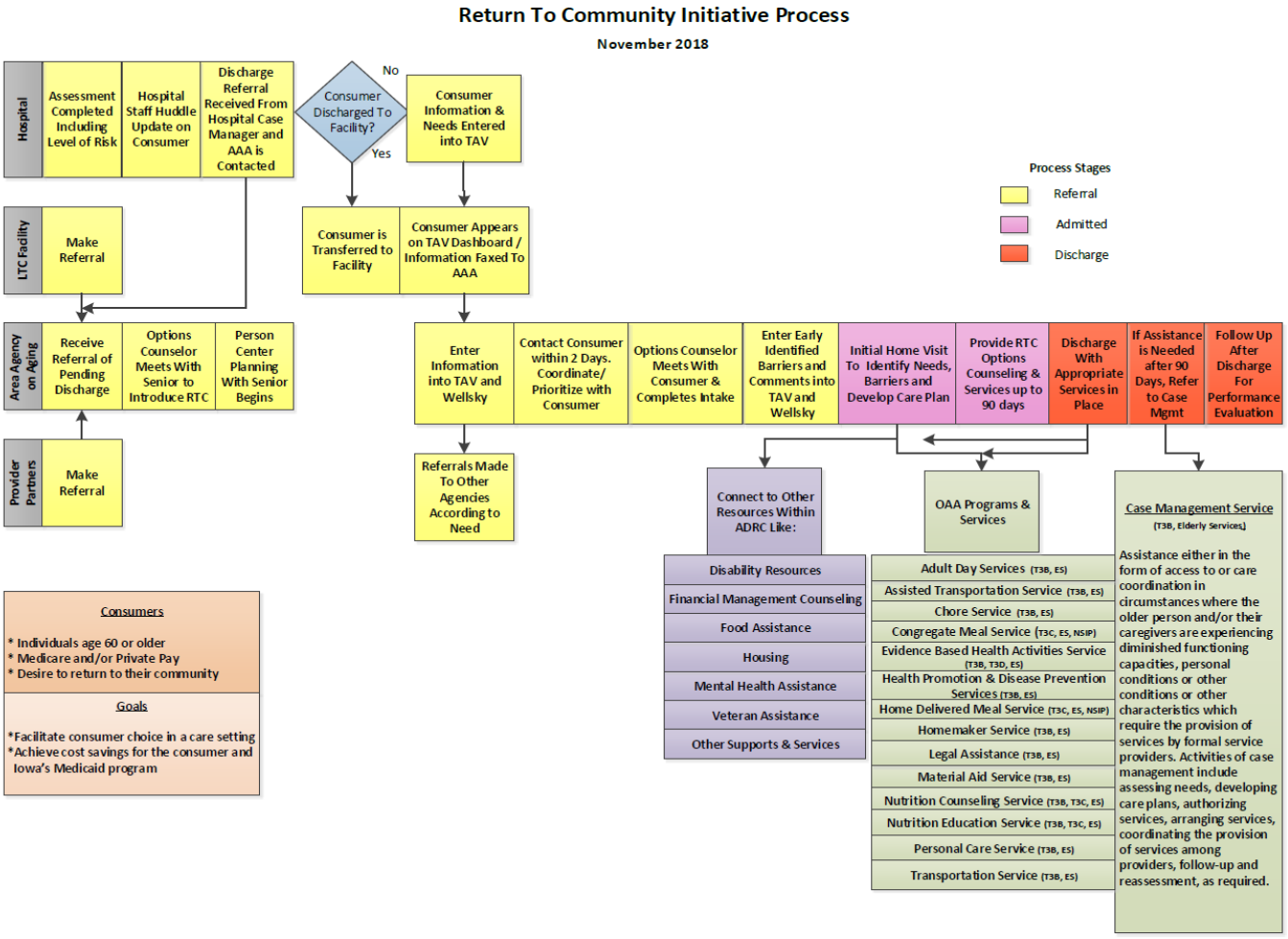
Referrals are made to partner agencies electronically via the TAV Health platform to address the social determinants of health critical to the consumer's long-term health and a successful transition. The IRTC OC meets with the consumer to introduce the program, identify potential needs and barriers, and to 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 in that it allows the consumer to use their values and preferences to guide all aspects of their healthcare and establish and work toward their own realistic health and life goals. The IRTC program 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 and regional service providers that best meet the consumer's preferences and needs, to provide information and support during the transition process, and to secure available funding.

The referral stage begins when the IRTC OC is notified of a consumer who potentially meets the program criteria, whether the consumer is in the hospital or in a long-term care facility. The referral period ends once the consumer is admitted into the IRTC Program or chooses not to participate.

A consumer meeting the IRTC Program criteria is admitted to the program when discharged from the hospital or long-term care facility and is transitioning to the community. A consumer is active in the program until supports and services are no longer needed from the IRTC program or after 90 days. If services and supports are still needed after 90 days, a referral is made to the case management program.

The following is a visual of the process flow (see Appendix B):



ESTIMATED NUMBER OF PEOPLE TO BE SERVED

The IRTC Program has defined the target population as individuals that are:

- Age 60 or older and reside in the project's four-county area
- Between 138-300 percent of the federal poverty level
- Eligible to be discharged back into the community from the hospital or nursing facility

There are an estimated 14,335 individuals living in the four project counties who meet the program criteria. Previous data from the *Caring for Our Community* show 990 referrals with 633 individuals reporting a successful transition to the community in a two year period. The remaining individuals declined to participate due to a lack of familiarity with the program. Considering the prior program data and the IRTC increasing the potential population served to include both hospital and long-term care facilities, a realistic number of individuals to be referred to the IRTC program over the course of FY19 is 950. This number also considers the additional time required to educate additional partners, formalize partnerships with providers, develop the necessary infrastructure to operate the program, and prepare the additional resources necessary for expansion in the four county area.

DATA COLLECTION AND PERFORMANCE MEASURES

Collaborative activities with the IRTC project include:

- Identifying eligible participants
- Working with other local referral sources to inform them about the project and instruct them on how to refer consumers.
- Training hospitals and long-term care facility discharge planners on best practices.
- Ensuring that the LTCO Program is accessible to residents transitioning out of long-term care facilities.
- Developing a comprehensive outreach and public awareness campaign to raise public awareness of person-centered planning and how to access it through Iowa's Aging and Disability Resources Center (ADRC), Lifelong Links.

Evidence-informed transitions will be implemented for eligible consumers aged 60 or older living in Cass, Mills, Pottawattamie, and Woodbury Counties who are transitioning from hospital or long-term care facilities. Measureable outcomes include:

Referrals
Total Number of Referrals • **Number Referred from the Hospital** • **Number Referred from a Long-Term Care Facility** **Number Declining Participation** **Reason for Declining Participation**
Admitted
Total Number Admitted • **Home from the Hospital** • **Home from a Long-Term Care Facility** **Average Length of Time in IRTC Program** • **Home from the Hospital** • **Home from a Long-Term Care Facility**
Transitions
Total Number of Transitions to the Community • **From the Hospital** • **From the Long-Term Care Facility**
Discharged
Total Number Discharged • **Services No Longer Needed** • **To Case Management Program** • **Back to the Hospital** • **Back to a Long-Term Care Facility**
Consumer Satisfaction / Evaluation
Total Number of Successful Transitions • **From the Hospital** • **From a Long-Term Care Facility**

EVALUATION AND PERFORMANCE REVIEW

The IRTC project is designed around person-centered planning, thinking, and practice. It is essential to listen to the voice of the consumer when trying to ascertain the value and impact of the system and the person-centered counseling it provides. The methods for monitoring the project to ensure high performance and data driven outcomes include the following:

- Standardized protocols and tools are utilized to ensure high quality and consistent service provision;
- Response time following receipt of referral, including but not limited to prioritization based on consumer need, immediacy of discharge, or other factors, is followed;
- Documented review of intake, assessment, planning, and follow-up processes, including addressing efficiency and effectiveness of processes, timeliness and methods of documentation, coordination with appropriate entities, clarity of AAA roles that will enhance, not replace other partners functions;
- On site with the consumer and IRTC OC to ensure a person-centered approach is followed in all consumer interactions to establish appropriate and effective local supports and services;
- Monthly conference calls and/or in-person site visits to provide technical assistance, contract review and guidance on the project work plan (see Attachment C); and
- A consumer satisfaction survey has been developed and will be implemented to document the quantitative and qualitative benefits and outcomes of their experience. The survey is based on the goals developed by the consumer with assistance of the IRTC OC and will capture the reported satisfaction levels among consumers regarding access, self-direction, and quality.

LOOKING FORWARD

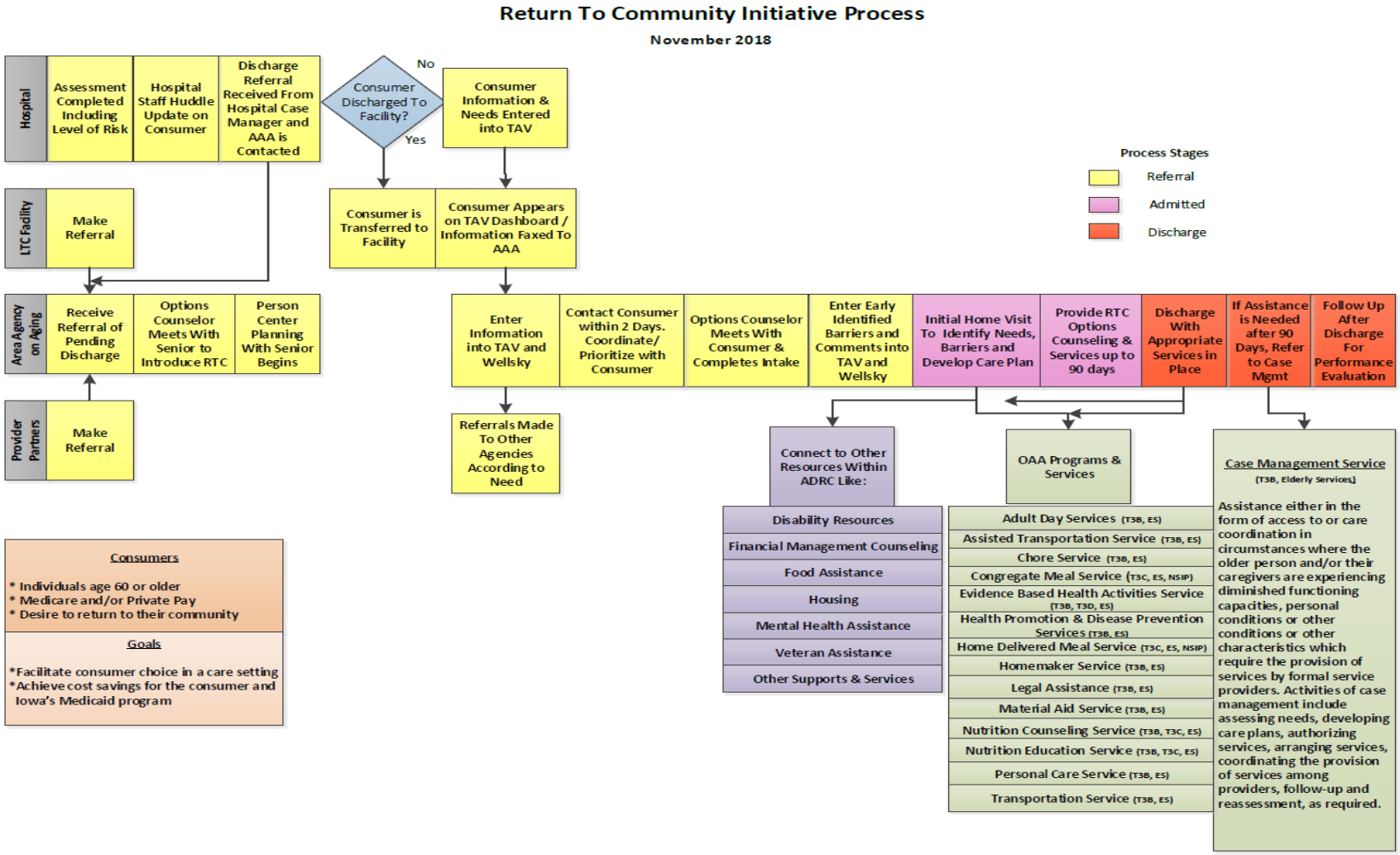
During the next year the IDA, in partnership with Connections AAA, will continue to gather the information necessary to keep the legislature informed on the progress of Return to Community. After another year of data is collected, the IDA will be able to demonstrate the potential return on investment. The IDA, Connections AAA and our local partners look forward to demonstrating the impact of community transitions that help seniors to maintain their independence.

Appendix

Appendix A

Map of Iowa Return to Community Counties

Appendix B
Project Process Flow Map



Appendix C
Timeline and Work Plan
Work Plan
July 1, 2018 – June 30, 2019

Major Objectives	Key Tasks	Lead Person	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
1) Implement evidence-informed interventions for older Iowans who are transitioning from hospital or nursing facilities in target counties	**Initiate Evidence-Informed Models(S) With Health Care Institution(S) And Nursing Homes** -Secure contract with Connections AAA to begin implementation	IDA Project Director Connections AAA	X											
	Project Expansion -Facilitated conversations with Connections AAA, health care entities, nursing facilities, & local partners on enhancing and expansions. -Reach out to and collaborate with partners for data	Connections AAA IDA Project Director IDA Data Analyst	Ongoing											
	Policies & Protocols -Develop an IRTC Manual, applicable forms and process flow chart	Connections AAA IDA Project Director IDA Data Analyst					X							
	Hire Staff -Advertise, interview and hire Options Counselors to cover 4 county areas.	Connections AAA					X							
	Develop Outreach Materials -Brochures, talking points, booklet for consumers and family members, etc.	Connections AAA IDA Project Director IDA Outreach Coordinator					X							

Major Objectives	Key Tasks	Lead Person	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	IRTC Options Counselors Complete Mandatory Training - ACL endorsed PCC Training by Elsevier -Mandatory Reporter Training	Connections AAA IRTC OC						X					X	
	Project Evaluation -Evaluate consumer participation data (referrals, enrollments, service information, partnerships). -Contract Monitoring, Technical Assistance, Site Visits, Quarterly Progress Review	IDA Project Director IDA Data Analyst Connections AAA Connections AAA IDA Project Director IDA Data Analyst												
2) Implement consumer satisfaction survey to document the quantitative and qualitative benefits and outcomes of person-centered counseling	**Consumer Survey** -Development of customer satisfaction survey, process, and evaluation. -Identify database to serve as repository for survey results. -Participants complete survey to ensure PCC practice and satisfaction.	IDA Project Director Connections AAA Connections AAA Connections IDA Project Director IDA Data Analyst												
	Outcomes Evaluation -Evaluate response rate and survey outcomes. -Training and Technical Assistance, Site Visits, Quarterly Progress Review	Connections AAA IDA Project Director & Data Analyst												