Webinar:
Community Transitions:
Creative Collaborations Move People Home

August 4, 2022 | Transcript

LORI GERHARD:
Hello everyone; we will get started in a few minutes. We still have people joining the room; the numbers keep going up.

Well, hello and welcome to the Housing and Services Resource Center webinar. USAging, "Community Transitions, Creative Collaborations Move People Home." You will learn a lot from the presenters, and we've built in a variety of opportunities for you to be active participants as well. Thank you so much for joining us.

My name is Lori Gerhard, and I am the Director of Office of Interagency Innovations, Administration for Community Living, an operating division within the US Department of Health and Human Services. I will facilitate today's webinar. It is a privilege to have so many of you here with us. Your active involvement in this webinar is essential for us to have an engaging discussion.

First, there are a few housekeeping items we want to address. This meeting is being recorded. By staying to participate, you are consenting to the recording. All attendees are muted for audio quality. One hallmark of our webinars is active participation from attendees. Please frequently use the chat, make comments and submit your questions anytime in the Q&A feature in the same dashboard. Or you may email a question or comment to hsrc@acl.hhs.gov

You can also use the chat if you have a comment for another attendee. I would like to tell you about the HSRC. It's a partnership with ACL; the Centers for Medicare & Medicaid Services, or CMS; the Substance Abuse and Mental Health Services Administration (SAMHSA); and the US Department of Housing and Urban Development, or HUD; and the Assistant Secretary for Planning and Evaluation at the US Department of Health and Human Services, or ASPE.

We have come together to collaborate and use our resources to best support states and communities. In every state and community, there are number of entities that help people access housing and supportive services.

Sometimes the services work in partnership in a coordinated fashion. However, often these systems work separately and apart from one another. This is challenging for the people we serve and the organizations that support them in both 2 systems. Stronger collaboration between the systems would enable more older adults and people with disabilities and people experiencing homelessness to achieve housing stability, live with dignity and independence in the community and avoid homelessness and costly institutional care. The Housing and Services Resource Center, or HSRC, brings together housing, homelessness services, aging and disability services, physical behavior and mental health services.

After the webinar, I hope you will look at the HSRC website, and at the end of the webinar we will share an email address so you can be in touch with us and get periodic updates as well. Today we will hear about innovative programs and partnerships in Minnesota and Iowa that are working together to transition people out of institutions and back to the community.

It is my distinct pleasure to introduce our first two speakers:

with us today is Karen Britton, the Manager of the Senior LinkAge Line for the Minnesota Board of Aging, and joining Karen is s Kathy Vondrum, who is a Senior LinkAge Line Coordinator for the Minnesota Board on Aging. Karen, the floor is yours.

KAREN BRITTON:
Thank you so much, it is really an honor to be here with you today. We want to take just a little different approach about how we see, how we are trying to with every conversation with people that we serve, find out their need to make sure that they know what is available in Minnesota to help them with whatever needs as they are all aging and we hope, eating well. One of our biggest goals is how they can do well at home and make those housing choices and provide the services they need so that those choices can be met.

So what might be unique about Minnesota is that we have consolidated so many programs, both state and federal programs, to our partnerships with our Area Agencies on Aging, but we call them the Senior LinkAge Line services, and that incorporates many different federal and state services such as a preadmission screening. We have returned to community, our SHIP and Medicare counseling, and then Minnesota also has a statute that requires us to do counseling for anyone going into assisted living to make sure they understand that there might be other options to stay in their homes. We look at all these different contacts as an

opportunity to find out what their needs are and what programs might be helpful for them to be successful at home.

As I went over, we have all of these different programs housed within the Senior LinkAge Line services. The first ones I am highlighting, housing options, is for everybody that is considering a move into assisted living. They have to get a verification code from us to sign a contract to make sure they know and understand what assisted living is and what it isn't. To talk with them about how their needs might change as they age and want to make sure it is a good option for them.

Then we have preadmission screening, and both of these are regardless of age. It is the same with all our programs. Even though the majority of people are over 65, it is a service offered to everybody in Minnesota for most of the services. Preadmission screening is to screen everybody that goes into a skilled nursing 3 facility in Minnesota. They are screened to make sure their needs are met there, and if there is a concern, that they have a higher level of care needed. It is referred to the county to do additional screening. Return to Community, which we are talking about today, is everybody leaving a skilled nursing facility. There are many other ways that people can be referred to us to provide the service.

That includes hospitals, providers or for the family. So we have a way to find out the information of everybody from the Department of Health coming out of a nursing facility so that we can contact them and make sure they have the help they need to move home.

We add SHIP in here because Medicare counseling is definitely an area we find out, especially if they are having trouble affording Medicare Advantage programs or other programs. This is really a key place where we can connect with people to bring down their monthly cost in a variety of ways or find out if they are struggling in-home. We use this as an opportunity as well […] we do Medicare counseling.

Also was Senior Medicare Patrol. We are in the community, and this is how we can show them the different ways they can reduce the cost and find different ways how we can be in their home. And we have a prescription drug assistance program to help them with drug costs as well.

It's always a work in progress not to be, but look at these different programs as an opportunity to find out all the different needs they may have. Along with these, we direct them to fill out the information to apply for many of the programs. Mostly it is one form they have to fill out for Minnesota that links them to the other services. We try to lead people in that way if we know financially they need assistance.

As I said, we are very fortunate in Minnesota, it is a combination of state and federal funding for the programs, and what we really like is they match each other.

When we have a gap in one program, Minnesota has been able to provide some of that information to link all the services together.

So the first point of contact for many people is this counseling before they go on to assisted living. We see 10 to 15,000 people we talk with on a given year as they are moving, so it is really our first opportunity to connect with them and hopefully before they are in a crisis situation, to make sure that the move is something they want to do and that they can afford to do it. We give them alternatives to stay in their home if that is what they would like to hear about.

And again, when we go through that, the demographics in Minnesota. Close to 97% of the people over 70 are white. We know this is an issue. Are we reaching the people we need that are underserved? That is something we are continually challenged with. Finding out who is not calling and doesn't know about our services. That is one of our challenges.

So preadmission screening is the next point of contact, and that is where we have a lot of contact with people. That is something that we are provided from the state. of 4 all the names of the people, in the context of people going into a nursing facility for the screening.

We don't talk to 67,000 people by all means. We process many of them and don't have a concern, but we talk with the hospitals and the nursing facilities. We might find out more, and we try to get in touch with people in the nursing facility to see if the stay there is acceptable and find out more about where they will move back to. This is a key place where if, when we are working with our preadmission screening specialist, we understand that this seems like a problem that is at risk of not succeeding when they return to their home, they can contact their colleagues in the Return to Community group so that it continues that care without them having to be referred.

This is a service not for people just over 65; it is for anybody going into a nursing facility.

So, I'd like to move on to Return to Community, which is the main focus today. Our goal is to help people live in the least restrictive setting of their choice. Minnesota gives us $8 million per year to provide this service. We help an average of 2,000 people a year develop a plan.

It doesn't mean many people we call seem perfectly capable and have a good support network, but at least they know we are there and we can help them if we can. So there is a lot of follow-up. It is a lot more personal contact, including going into their homes.

I would like to turn this over to Kathy Vondrum. We are so happy that she joined our staff, but she was a manager for the Return to Community in our metropolitan agency, so can you give a little flavor of what the Return to Community specialists do.

KATHY VONDRUM:
Yes, absolutely, and thank you, Karen. During my time during the Return to Community work, I was a Community Living Specialist for most of those years, and what we would do is go out and visit the client either in the nursing home or we also started getting referrals of people who were living in their home and wanted to continue living in their home, but they needed resources and services to do that, and they didn't know where to turn.

The majority of our work was in a care center or nursing home, and we were able to go visit with them. And sometimes they had their families with them when they were visiting with us, and we would talk about what they could do, and basically what we did was we would do an assessment. A person-centered assessment and talk to them about what their needs were, what were their goals and the things important to them.

If their goal was to return to their home, whatever their home might be, whether it was a townhome or apartment or a single-family home, we would talk about what are the barriers. What things are keeping you from going home? Is it a ramp 5 because you had a stroke and you need a wheelchair? Maybe they needed Meals on Wheels or something like that.

We would do the assessment and help them, work with them and the social worker. It was very important to have a good relationship and work in collaboration with the social workers at the care centers, because they were the discharge planners. We would work with them and develop a support plan of the resources that we felt might be helpful for them. Whether it is a Lifeline type button in case they fell, or I gave the example of a ramp or something like that.

And then another, we would walk through with them their discharge home. But like Karen described earlier, a really big important part of it was that we would follow up with people once they were home. So we had a follow-up shortly after they got home, just to make sure that their home care showed up or that they had their medications. We had a list of things we would go through and make sure the transition going home was going well.

We would offer, if they wanted, staying with the person-centered focus, if they wanted us to continue to follow-up periodically to check in to make sure they were still doing okay. Or if they developed different needs, we would help them get linked with new resources. We had some people that would continue following up

with us for a short time, and we also had people that followed up with us for about five years.

KAREN BRITTON:
Thank you. I see something in the chat:

Why are we using the term least restrictive setting. (Reads) Thank you. I think that is a great term that makes more sense. I have probably borrowed slides from earlier ones and that is a good catch, thank you.

So again, Return to Community is certainly a population, as we see people leaving nursing facilities on the older end; 75+ is the majority, but we have many that are around 60 and under 60. That is because it could be a couple or for other reasons that we are helping them or caregivers, so that is why there are people less than 60.

And again, the gender pretty much stays the same as almost all our demographics.

One of the questions that was asked—what we were talking about in the presentation is how do people get referred? If you can see at the very bottom, the majority of referrals is through our Department of Health. It provides a list to us every Tuesday of people that will be departing, and I can't remember, Kathy, where they are in the nursing facility of when they are going to depart, what the timeframe is. They provide a list to us that we carried and distributed across the AAAs to review them and make contacts with people.

KATHY VONDRUM:
The list was of people who had been in the nursing home for 35 days.

KAREN BRITTON:
I knew there was a reason. We also get a lot of direct referrals from nursing facilities. Previously they might know our services and ask for support from friends, family, clinics or doctors. We take family referrals, and we have an online site where anyone can make a referral for assistance. A lot of times we will vet the call to our Senior LinkAge Line regular service, but they would refer them to the Return to Community team. We get a lot of referrals from different areas.

And I just wanted to point out the great partnership we have with our Area Agencies on Aging across the states. This is an in-person service a lot of times. They also have connections and rapport with hospitals, nursing facilities, assisting living to make sure we are not a threatening presence. We are there to partner with them across the state. Even though it is a statewide service, we try to have those personal connections in the community to make people feel they can trust, that they can contact us to help them.

And just some of our goals:

One thing we really struggle with—well, I just can't give the agencies, our Area Agencies, enough credit for during COVID-19. This was an in-person service, and what did we do? We went virtual, and they did Zoom-type calls and other ways, a lot more reassurance on the phone, called people more. They have turned it upside down to realize that there are people that would prefer to talk over the phone or do a teleconference because they don't feel comfortable, especially with COVID-19 and other reasons of having someone come into their home, even though many times it is the best place to evaluate the situation.

We are respectful of privacy and feel like we can serve more people. As you can see, Minnesota is a very large state with lots of distance, so we can serve more people if some people prefer virtual, just for the amount of time it takes to drive to remote communities and people that live in rural areas.

We also are concerned about isolated seniors; this is definitely one of the main issues. We think we need to have more online service options, for a Monday through Friday call center that doesn't always serve the needs of people when transitioning. To understand outreach to underserved populations. We are blessed with having 11 Tribal nations in our state, and working with them in unique ways and partnering with them is another one of our goals so we can assist them as well.

And I believe that's the end of my slide. I am looking at the chat to see if we have a question. (Reads) "What about services for disabilities under age 65?" Thank you for mentioning that! We have some close memberships with what in Minnesota is called the Disability Hub and vets as well. When we are working with people and we identify those special needs, we don't want to ever just tell them to call one of those entities. We try to do the calling and might do a warm transfer and work with them to see if there are additional services or better services for them, depending on their needs.

We call it the Disability Hub and work with them on a daily basis. Because we had the Medicare […] for the state, they transfer all the Medicare cost to us and then, so we have a very close report with the CILs and more of a referral, and when I say 7 referral, I mean a warm transfer. We work closely with them, so we know to provide both services and don't have to be the experts. Same with the Veterans Administration and the local counties. We work very closely with them to make sure we can look at all the different services.

(Reads) "Use of Money Follows the Person?" We do not get money from them. Once someone applies for assistance in Minnesota, and we have another service call Elderly Waiver, once they apply for that, then the Money Follows the Person would apply and the ability to have all those services. We assist them to get signed up for

the services, and that team takes over and partners with their care coordinators. These programs available in all states? I will leave that to Lori or one of the other panelists.

How did all your services get consolidated under one agency? I am not as familiar with the history. I know it was a long process to try to get over many years of trying to get preadmission screening, and it used to be done by our counties and the initial screening was done by our team. The Senior LinkAge line has grown a reputation to bring on more stuff. From the administrative process, it was much easier to have an all-in-one area to train them because so many programs overlap. So it was definitely overtime.

LORI GERHARD:
I was going to jump in. We will take some more questions and, but I want to thank you. We will take more questions later so everybody stay and if you have more questions put them in the Q&A because Karen and Kathy will be back with us after we get a chance to do a quick poll with all of you, and I will hear from our team from Iowa. Thank you so much for that overview on Minnesota's Return to Community and how things are integrated in your state.

Before we introduce the Iowa panelist, we would like to hear from all of you. We would like to know about how you might be involved in transitions back to the community. In the sidebar you should see a Zoom poll. (Reads) "Please choose one of the options. Actively support, provide occasional support, do not currently provide support but maybe in the future, and not applicable."

The poll is for anybody who is helping people transfer out of institutions at any age. Thanks for the question. And I will look to you to give us a signal. Some people can't see the poll. 65% of you said you actively support transitions, 6% are not currently providing support and 10% indicated it is not applicable.

OK, so it looks like many of you are already engaged in the work, so thank you for that. And those of you who are somewhat engaged and those of you who are interested to get engaged, we thank you for that interest as well.

We will send out the slides and links after the webinar. I want to remind everyone again to share your questions in the Q&A. In the chat could you include what you and a key partner might be doing to currently support transitions?

Okay, great; we are getting some responses. Maryland is working with some 8 partners. We are looking for a time when maybe you can share your story with others. It is the work you do in your communities and states that enable us to see different ways we can be working together across the sectors to support the same people.

So thank you all for sharing. I am seeing lots of responses come in. This is really, really helpful. We will keep the responses coming and maybe we could move on to the next slide.

So at a neighboring state, Iowa, they decided to replicate part of the Minnesota Return to Community approach. I saw the chat (reads) "does our state have this and can we do it too?" You will hear it firsthand from Kent Ohms, who is the Community Living Director for the Iowa Department on Aging and how they went about replicating components of this. After this overview, he is going to be joined by two more Hawkeyes. Sherrie McDonald, who is the Lifelong Links Director of Connections Area Agency on Aging, and Robin Shaver, who is the Director of Care Management for Methodist Jenny Edmundson Hospital. The floor is yours.

KENT OHMS:
Thank you very much. Hello, everybody. I am Kent, and we started the Iowa Return to Community initiative after finding out quite a bit about Minnesota's Return to Community initiative. The name similarity is not a coincidence. I will walk you through a few parts of what we have done. Next slide please.

So for our Return to Community initiative goals, this is focused on non-Medicaid consumers for our pilot. Medicaid consumers and we do have Money Follows the Person here in Iowa, and I saw somebody in the chat mentioned that it is focused primarily on brain injury and developmental disability consumers.

We also have an Elderly Waiver, which kind of covers a lot of the similar services as well. So what we kind of want to do is to help seniors maintain their independence by keeping them in their homes with wraparound and supportive services, and the related initiative is about finding the consumers at their most vulnerable point instead of waiting for the phone call.

So we focus on skilled nursing facilities for at least 30 days for the care transitions, but we also started working with a lot of the hospitals to start identifying consumers who would be coming and returning to their homes and some ambulatory sensitive conditions during those times. To that point, especially when COVID-19 came around and our first one or two pilots were up and going, there were concerns from people not wanting to go into care facilities. The Return to Community initiative was a strong partner and option in working with that.

So overall the Return to Community initiative's goal is to reduce unnecessary facility placement and reduce unnecessary hospital admissions and readmissions and emergency department use. One statistic is that we are actually the fourth highest state in the number of low care nursing needs residents living in nursing facilities. There are a lot of people that could be served in community settings if 9

they just kind of would know about the services and have the connection and coordination for them.

So the key elements are much like Minnesota's program. We have service coordination at discharge, with the home visit for the consumer usually trying to get to that home within a couple of days of getting there […] during that March 2020 through that summer and fall stretch prior to vaccines picking up. There had to be creativity with phone calls and meeting just at the door or window and talking to people with the use of (Indiscernible) and other communication devices.

We provide up to 90 days of intensive services for them based on their needs and preferences to the person-centered planning. A lot of it is transportation to follow up appointments, and there is also personal care and homemaker needs for a while and certainly some nutrition and after that, at the endpoint of 90 days, many times these are the senior is stabilized and back to their level of living in the community successfully, or they might discharge into our Older Americans Act case management services.

So currently we said we are at a pilot funding stage and not statewide yet. We have five out of our six local Area Agencies on Aging participating in Return to Community, and we have built partnerships with the hospitals and skilled nursing facilities.

We are also looking at moving a little further upstream at seniors identified with need in a clinic setting who are, or may be at risk of being, hospitalized or going into a nursing facility but haven't had the inpatient stay yet.

The funding is pilot funding from the General Assembly, and as we build this out, we are trying to find the future direction and figure out how it fits into hospital and ACO value purchasing models or if there is potential for Medicaid 1115 waiver. There are options out there.

That is the end of the Return to Community introduction for Iowa. I saw a question come by that said how are AAAs funded. There is the Older Americans Act that comes through ACL that is allocated by formula based on populations and the number of people living in poverty and some base (Indiscernible) amounts. We also have what are called Elderly Services dollars, which is the state matching funding that we get from the General Assembly that is appropriated on an annual basis and allocated by formula.

LORI GERHARD:
Thank you for that presentation. I guess we would like to maybe start to answer. Respond to some of the questions we've got. So I will ask all of our panelists to come back, and maybe we can start with a question for Minnesota:

How have nursing homes and assisted living communities been involved in the design of […] Return to Community?

KAREN BRITTON:
This program has been in Minnesota for quite a long time. I think a lot of it was started from a statute perspective than anything else. We had 10 statutes about counseling people. He used to be housing with services and now we finally have licensed assisted living. The fact that we are part of even though we are not part of the Department of Health, we are part of the state services, so we can share the information freely within Minnesota and we can share with Disability Hub so we can try to break down those barriers between them. They were definitely involved in the design phase and before it went to legislation, so there were listening groups and those types of things.

One thing that AAAs do now really well is visit hospitals and nursing facilities to keep the line of communication and understand the needs, partner with care coordinators not only at the facilities but also with insurance companies that have the role as well. I am not sure of the original ones, but I know they were stakeholders. I won't say it was an easy pass, if I read to the history, it was before my time. It's a struggle to bring them in but has been effective, because one key thing they do is continue to dialogue with those people. Kathy, I don't know if there's anything you did to work with nursing facilities to make them work better with you during the transitions. It seemed like they appreciated the help.

KATHY VONDRUM:
Sometimes there was a little bit of they weren't quite sure what we were doing and we had to really collaborate and not take over the job of the social workers at the nursing homes, but just be there to help support the transition for the person, the resident in the nursing home. It took a while to develop relationships, but we were definitely able to.

LORI GERHARD:
Thank you, Karen and Kathy. We know there needs to be strong partnerships across the healthcare sector, the nursing homes, the hospitals and disability and aging network, the housing sector, so I would like to turn to Iowa right now and ask Kent and Sherrie and Robin, can you talk a little about the partnership in Iowa and how you are working with hospitals?

SHERRIE MCDONALD:
Prior to going to IRTC, we had a hospital relationship with a local community hospital, and that was a great start for us. We started adding the IRTC piece is what we were already doing. Finally reached out to other hospitals and added as we could.

ROBIN SHAVER:
Thank you, Sherrie. We are always focused on reducing readmissions and even ED utilization, which can be costly. We know that housing insecurity or social determinants of health affect access, and so we have a very close working relationship with Connections, and often those referrals utilize a referral platform for health services and social services and the community.

We make the referrals straight to Connections, and then they can reach out to the patient once they are back in the community. We have, somebody posted a question about return on investment, from our perspective, looking at it from a healthcare standpoint, the return on investment is clear when we reduce those readmissions and hospitalizations. We've got several success stories, and that is directly due to those connections that the organization makes with the patients after they leave here in the community.

We also work pretty closely with our community health center for low- or no income individuals. And they often have those social services or care coordinators that can do that outreach to those patients and families. It takes diligence but it can be done successfully. I know that patients and families really, really appreciate that.

SHERRIE MCDONALD:
I was going to say to answer some of the questions coming up in the Q&A, was our relationship with the hospital. We tried to get the coaches in there sooner before they are discharged so the social workers or case managers at the hospital start talking with them about their needs for home. And then we are able to get a lot of those things to them so when they discharge, we can get a toilet riser or grab bars, handheld shower head, we can get those out to them in pretty short notice.

We have noticed as well the shortage of staff, and so we have incorporated a rapid response worker through our agency as a new program. That is frequently the individual that will make those visits initially just to drop off equipment after a coach talked to the people and found out what they need. That is one way we have been able to work through some of the shortage.

LORI GERHARD:
That is really helpful. When Sherrie says SNF she's talking about skilled nursing facilities. And so I know there was interest from many states as well and how can we replicate the Return to Community initiative? So Kent and Sherrie and Robin, if you had to have one piece of advice on how to do it, what would be a key strategy people should think about if their state doesn't currently have a program similar to Return to Community?

KENT OHMS:
I will start with something right off the top, and this is almost verbatim how one of the other AAAs and I got started. It said get your Executive Director into the community at the Rotary meetings talking to people. That was the moment that the executive director bumped into the hospital president, and the hospital president was talking about the problems they were having with readmissions, and she was able to say, I am the agency that solves a problem for you.

So it is just about making the meetings and having the coffee to start the conversations and learn who is running the different agencies really locally within your area. Iowa was different from Minnesota in that we have started at a local, pilot level of agency to agency. Minnesota was a little more built in at the higher level structure with those automatic referrals at a systems level. They started at the top, but we are working our way backwards up from the bottom.

SHERRIE MCDONALD:
The other thing I would suggest is getting to know the partners in your community. I thought I knew them, and when we first started our transition program and pulled other community partners in, I was amazed at how many I did not know. So developing the relationships with the nursing homes and assisted living, with the clinics and the food pantries, the housing authorities, those are all beneficial relationships as we go forward with transitions.

ROBIN SHAVER:
I would add that our health system is very fortunate to belong to a post-acute care collaborative involving Nebraska and Iowa skilled nursing facilities. There are about 25 of those. We work very closely with those facilities. It truly is a partnership. You get to know everybody; you understand what services they can and cannot provide. It really helps the transition of care not just from the hospital to the facility but also from the facility and getting the patient or that person back home or some longer-term care options.

LORI GERHARD:
These are great suggestions. Karen and Kathy, […] into the conversation as well. If you were talking about -- with a state or partners in another place across the country, what advice would you give them? What would you tell them to try first if they wanted to develop a program like Return to Community?

KAREN BRITTON:
Kathy, you can jump in as well. What is really valuable is trying to ask those questions at earlier than a crisis point. I'm sure you also will have information and assistance. A way that older adults contact you and find it within the interviews:

What is the need and what program is already out there to help them?

For us, partnering with the CILs, Disability Hub and looking at the different network of services and we have learned so much from them on how we can support people better. Another one, I think there was a question there about how do we reach underserved populations. We have been working hard in finding those trusted partners in the community, and we have a really diverse community. Finding out from them first what they need, not what there is. One big thing we found working with some cultures within Minnesota is if we said bring in chore service it would be offensive in their community. That their family is not doing what they need to do to take care of their family. So that is another thing:

We are trying to be sensitive in partnering with the people that understand the culture and the needs might be completely different than other cultures. And I don't know if you had anything else to add. What if unsuccessful.

KATHY VONDRUM:
I think the question of how do you start this is a really good question. I feel very fortunate to be in Minnesota where the state funding is always an issue. So the state has funding like Kent was saying. We have it at the state level already and I didn't have to go out and find it, funding to fund my program, I was fortunate to have the state of Minnesota that funded our program. I think that is very important.

Like you have already said, partnering with the people that know that this is an important service and the people that (Indiscernible) in the nursing home. Community centers. The other thing I agree with Kent when he was talking about trying to do this a little more upstream. I would love to see us really connecting with clinics. I think that doctors and nurses at the clinics can identify people that maybe we can get services in the home before somebody falls and breaks their hip 13 and has to go to the hospital and nursing home. So it is making the connections with people and letting them know there is value in this so you can get the funding you need to start.

KAREN BRITTON:
As an interesting piece on that, when we got the money for Return to Community, it wasn't some altruistic, "we need to help older adults," it was really too, there were studies from the University of Minnesota on how can we reduce spending. People were going into assisted living with no idea how expensive, and they became wards of the state because it spent down so quickly. So it was about reducing taxes to support people if they spend it down quickly. It is an interesting […] on why it came to be.

LORI GERHARD:
This is really full information. I think people are getting great ideas about how they could get started in their state. There are some questions as well around, "How long do you provide case management services?" That is for both Minnesota and Iowa.

SHERRIE MCDONALD:
I can answer for Iowa. We do pretty much a 30 day fairly intense program with a coach, and then our hope or goal is at the end of 30 days we have connected them with the resources they need and gotten equipment they need. Helped provide stable transportation program if needed. Then, we do monthly phone calls at 30, 60 and 90 days post the original 30 days. We have people who are stable at the end of 30 days, so we will carry it forward with the services they continue to need. Until we can get them connected and sometimes they do go into case management with our Area Agency for ongoing service and assistance.

KATHY VONDRUM:
I can talk about it from the Minnesota standpoint. We never referred to ours as case management services. It always had kind of a different (Indiscernible) to us. It is very intense. Especially, I live in the Metro area near St. Paul and Minneapolis, and the number of people we helped in the area was very large. So in order to be a case manager your caseload would become too large quickly.

Having said that, it is very similar, we would go see them soon after they were discharged from the nursing home, and they always had our phone number that they could call if something came up. We would check in with them shortly after, and then about 14 days later we would check in with them. Again, they could call us if anything came up in between and we did a very similar thing, the 30, 60, 90 day checkup with them. That is us reaching out, but they could call us if something came up. And then like I said, it spread out over time. A few case management services work a little bit differently than what we did in Minnesota because the case managers are very, very involved. It is similar to how it was described also.

LORI GERHARD:
This is really helpful, and I know we are out of time, it is 2:55, and we will stay true to time so people can commit to their 3 o'clock. I want to tell you we have 24 open questions from the group and there are probably several in the chat we haven't gotten to. I would like to quickly ask that maybe we could after 14 the webinar today share the questions and see if there are some answers we can may be provided in writing to people just so you all get the benefit of the great work of Minnesota and Iowa. This has been fabulous, what you have provided to us today, and I know a lot of people are interested in your experience and strategies. We appreciate you sharing them.

We will move on. And if we can go to the next slide. I just thanked the Minnesota and Iowa speakers, and if you are able to use the reactions button to show your appreciation and give them a little applause, that would really be great. We really appreciate you all and all the work in preparing today, your leadership and developing state-funded programs Return to Community and the strategies you've shared.

We hope everyone has gained an initial understanding. A rapid response worker, partnerships with hospitals and nursing homes, the post-acute care collaborative in Iowa and Nebraska. Connecting with clinics and primary care physician offices. Great partnerships we have heard of today. All of us have heard opportunities we can act on in the coming weeks, and after the webinar we will send you the slides and post recordings later in August.

Another resource is the ACL website for care transitions programs. There will be a link in the chat, and we hope you will visit that and take a look at it. It has been amazing the work that the disability and aging networks have been able to do in transitioning people out of agencies and into the community. You can send them an email and staff will put that email address in the chat.

If we go on to the next slide, before we close, there are couple of things I want to make sure you hear. One is I want to remind everyone that in the coming days we will post the recordings of the webinar on the website, and in the meantime please keep using the site, which staff is providing in the chat. We post resources there on a regular basis as announcements come out from the organizations that the federal agencies are supporting the Housing and Services Resource Center.

I want to call your attention to two really exciting webinars coming up. On August 22, 2:00 PM Eastern time, we will feature working together to empower community inclusion. It is so vital and important to housing stability. Moving people out of transition without community inclusion really sometimes doesn't work in a way that enables ongoing housing stability. We know there are several factors that go into it, but community inclusion is a key one.

On August 22, we will hear from a team in North Carolina that includes a Center for Independent living, health plan, some seasoned professionals that have been working in the space for a long time. They will share stories and strategies on how they really help not only transition people back to their homes, but help them live and be vital members of the community and engaged. So tune in and watch for information to register for that one.

Then the second one that is really exciting as well is on August 29, from 3 to 4 PM Eastern time. Continuums of care. The homeless network has developed continuums of care for several years since like the ‘70s. We want to bring together

the aging and disability networks and continuums of care to create an integrated infrastructure or network across the country to really help create more stable housing and help people stay stable and live in the community.

You will receive information about this webinar as well and if you go to the next slide, please complete this feedback form for Survey Monkey. It is helpful to hear from you on how we can design these webinars to provide the information you are looking for. We want to hear from you, because we look at that and try to make improvements as we go forward. We want to hear from you; please email us if you have anything you would like or if there is information that you are seeking, we are here to help you.

Finally, we want to thank Mission Analytics, USAging, Jessica the interpreter, and our CART specialists, and Alicia Anderson leads on the federal side. Carolyn Ryan who leads transitions work and all our partners and for today's webinar, our speakers, and we are especially grateful for all of you joined us today. It is the participation, the information we share ourselves that strengthens our opportunities to respond to the people we serve. Thank you so much and have a great afternoon.