Glenwood Resource Center
Post-Move Monitoring Report

January 2025

IOWA Health and Human Services

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Introduction

On January 11, 2023, the United States and Iowa entered into a court-approved Settlement Agreement and Consent Decree to resolve a Department of Justice lawsuit related to investigation of Glenwood Resource Center (GRC) (Unites States of America v. State of Iowa, Civil No. 22-cv-00398). On December 9, 2024, a court-approved Amended Settlement Agreement and Consent Decree was filed modifying the original agreement. For the purposes of this report, the Consent Decree and Amended Consent Decree will be referred to collectively as the "Consent Decree."

GRC was a state-owned intermediate care facility for individuals with intellectual disabilities (ICF-IID). The Consent Decree requires the State to follow individuals who formerly resided at GRC for 365 days after the individual transitions to a new placement to ensure that the individual is receiving the services and supports that they need. The State has complied with this requirement by creating a post-move monitoring process with post-move monitors who follow individuals at a defined cadence throughout the 365 days. Throughout this report, references to former GRC residents or former GRC individuals is intended to include only those individuals who fall within the 365-day post-move monitoring process.

The Consent Decree requires the State to create an annual implementation plan. The State's Year 1 Implementation Plan was completed in July of 2023, and its Year 2 Implementation Plan was completed in July of 2024.

As a part of compliance with the Consent Decree and the State's Year 1 Implementation Plan, the State created the GRC Post-Move Monitor (PMM) SharePoint site, which collects and evaluates reliable data related to former GRC residents who have transitioned to the community for 365 days following their transition. The State uses that data at both an individual and systemic level to ensure that individuals are receiving the services and supports that they need. The Year 2 Implementation Plan includes an obligation to continue to use and refine the GRC PMM SharePoint site in this manner. In addition, the Year 2 Implementation Plan obligates the State to create reports (every six months) that include data, measures, and trends; preventive, corrective, and improvement actions; and evaluation of the effectiveness of those actions. This is the State's first report fulfilling that obligation.

I. Where Are Former GRC Residents Now?

On April 7, 2022, the State announced that GRC would close in 2024. At that time, 152 residents were living at the center. On April 27, 2022, individuals began to transition to other placements with the final transitions taking place on June 18, 2024. GRC officially closed its doors on June 30, 2024.

Of the 152 former GRC residents, 147 individuals transitioned to other placements and five (5) individuals passed away while still residents of GRC. Of those 147 transitions,

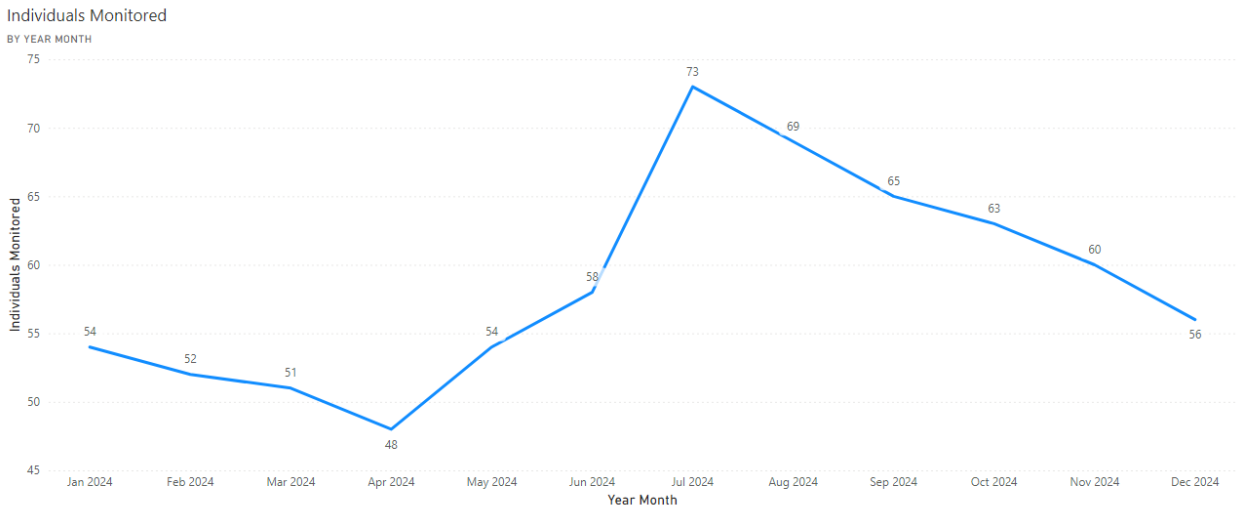
twenty-seven (27) individuals transitioned to the Woodward Resource Center (WRC), eight-two (82) individuals transitioned to Home & Community Based Services (HCBS) waiver homes, nine (9) individuals transitioned to an Intermediate Care Facility for Individuals with an Intellectually Disability (ICF-IID), sixteen (16) individuals transitioned to community-based host homes, six (6) individuals transitioned to nursing facilities, and seven (7) individuals transitioned to receive hospice services. Before GRC closure, four (4) individuals returned to GRC after transitioning to the community. Subsequently, all four (4) individuals transitioned back to the community.

Figure 1: Transition Placements

# of transitions from GRC (ICF-IID)	147
# of transitions to WRC (ICF-IID)	27
# of transitions to HCBS Community homes	82
# of transitions to an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)	9
# of transitions to host homes	16
# of transitions to nursing facilities	6
# of transitions to hospice	7

Between January and December of 2024, the number of individuals within the post-move monitoring period varied from 48 to 73 with increases and decreases reflecting moves out of GRC and individuals falling out of the 365-day post-move monitoring period. As of January 4, 2025, 51 individuals remain within their 365-day post-move monitoring follow-up period, with 39 individuals living in community settings and 12 individuals living in institutional settings.

Figure 2: Individuals Monitored by Year & Month.



II. What Is Iowa Doing to Ensure Former GRC Residents Are Receiving the Services and Supports They Need?

A. The Post-Move Monitoring Team and Standard Processes.

A post-move monitoring team ensures that individuals who have transitioned from GRC are receiving the services and supports they need. Some components and members of the post-move monitoring team are required by the Consent Decree. Other components and members are an integral part of the HHS standard system for following individuals in the community. Yet other components and members are not required by the Consent Decree, but are an outgrowth of the Consent Decree. The post-move monitoring team consists of post-move monitors, community integration managers (CIMs), case management and transition specialists, and the Woodward Resource Center (WRC) Center of Excellence (CoE) Outreach Team (the Outreach Team). Each of these arms will be discussed below. Additionally, members of HHS leadership and the WRC team are involved. Their involvement will be discussed in conjunction with the discussion of each arm of the post-move monitoring team.

1. Post-Move Monitors.

In compliance with the Consent Decree, the State, acting through the Iowa Department of Health and Human Services (HHS), has developed and implemented a system to monitor individuals who transitioned from GRC for 365 days following transition to ensure health and safety; ensure a current support plan is in place; ensure whether supports identified in the individual's transition plan and current support plan are in place and achieving outcomes that promote their social, professional, and educational growth and independence in the most integrated settings; identify any gaps in care; and address proactively any such gaps to reduce the risk of readmission, crises, or other negative outcomes.

Each individual who transitioned from GRC has been assigned a Post-Move Monitor (PMM). The PMM is required to conduct an in-person post-transition monitoring follow-up visit at 7, 30, 60, and 90 days. The PMM must complete additional monthly follow-ups, in-person, virtually, or by telephone contact, in 30-day increments at 120, 150, and 180 days, with subsequent follow-ups at 240 days and 300 days. The PMM must schedule a final in-person post-transition visit between 350 – 365 days. The PMM documents each visit using an individualized checklist that encompasses all areas of the individual's transition plan. The PMM is required to document each PMM visit into the individual's record in the Interdisciplinary Records Program (ISP).

To ensure that PMMs follow the required cadence, HHS tracks each PMM. Figure 3 reflects timely completion of PMM visits. Of the visits that did not meet the required cadence, only one PMM visit was not completed at all.

Figure 3: PMM Cadence Compliance.

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
# of PMM Visits Due	39	30	45	41	55	82	65	66	56	53	47	37
# of PMM Visits Completed meeting the required cadence	38	28	41	39	52	80	63	65	56	53	47	37
% of PMM visits completed meeting the required cadence	97%	93%	91%	95%	95%	98%	97%	98%	100%	100%	100%	100%

To ensure the quality of the PMMs' follow-up and documentation, beginning February of 2024, a quality assurance review of a random 10% sample of the PMM checklists was completed each month by the Post Move Monitor Quality Assurance Review Group at WRC (the PMM QA Review Group).

The PMM QA Review Group membership includes: HHS State-Operated Specialty Care Division Executive Officer 2 (SRC Liaison), HHS Community Integration Manager (CIM) or designee, WRC Director of Quality Management, WRC Human Services Quality Assurance Coordinator – Habilitation Services, WRC Human Services Quality Assurance Coordinator – Quality Management, and WRC CoE Nurse Specialist and any other members as assigned by the HHS State-Operated Specialty Care Division Executive Officer 2 (SRC Liaison).

The QA process uses an audit tool to review the PMM checklist notes. The PMM receives written and verbal feedback and is required to make timely corrections, which, in turn, are re-checked by the PMM QA Group. Figure 4 reflects the number of audits completed by the PMM QA Group since its inception.

Figure 4: PMM Quality Assurance Reviews.

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
# of PMM QA Reviews Completed	NA	4	9	6	11	12	4	8	5	5	4	5

As part of the Consent Decree compliance process, PMMs track incidents known as Critical Incidents, incidents related Community Thresholds, and Community Thresholds. These will be described in greater detail below. PMMs may become aware of these incidents and Community Thresholds as part of their required visits with former residents or by being notified by Community Integration Managers, case managers, transition specialists, caregivers, providers, and other involved persons. This tracking process ensures that the former GRC residents are receiving the services and supports they need and that HHS is able to identify trends in incidents and implement corrective action for providers when needed.

2. Community Integration Managers.

Under the terms of the Consent Decree, HHS was required to create a Community Integration Manager (CIM). The role of the CIM is to oversee transition activities, including working with the individuals, GRC, providers, case managers and transition specialists, the individual, and the individual's interdisciplinary team to identify barriers to transition and assist in a safe and effective transition to the community.

While the role of the CIM as defined by the Consent Decree was focused on the transition process, that role has become more expansive as individuals moved into the community. The role has expanded to ensure that case management and transition specialist activities following transition adequately are identifying and addressing the needs of individuals in the community, as well as working with PMMs, the Outreach Team, and providers to resolve any issues identified through any aspect of the post-move monitoring process.

With the expanding role of the CIM, in July and August of 2024, HHS hired four additional regional CIMs to assist with oversight of ongoing individual needs revealed during the post-move monitoring process.

3. Managed Care Entity Case Managers.

This post-move monitoring process required by the Consent Decree is supplementary to case management and transition specialist services required by Iowa Medicaid. Iowa Medicaid contracts with managed care entities (MCEs) to provide community-based case management to certain individuals living in community-based settings and this includes the individuals who formerly resided at GRC. Both the Consent Decree and the Iowa contract with MCEs require that individuals receive community-based case management. Case managers must meet with individuals face-to-face at least every 30 days and one visit every two months must be at the individual's residence.

The role of the case manager is to ensure that the individual is receiving the services and supports they need in the community. The case manager working with the individual's interdisciplinary team (the IDT) creates an individual support plan (ISP) for the individual that identifies the services and supports needed by the individual. Through their interaction with the individual, observation of the individual's environment, working with the IDT, and communicating with the PMMs and CIMs, the case managers ensure that services and supports are in place and facilitate risk mitigation, consistent with the individual's strengths and preferences in the most integrated setting appropriate to the individual's needs. If the case manager notes any deficiencies, they alert the IDT, which considers changes to the ISP. When the individual experiences an unfavorable issue, the case manager works with the provider, the CIM, the PMMs, and transition specialists as appropriate to ensure resolution of the issue.

4. Money Follows the Person Transition Specialists.

Money Follows the Person (MFP) Partnership for Community Integration Project is a $51 million grant from the Centers for Medicare and Medicaid Services (CMS). It provides opportunities for individuals in Iowa to move out of Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) and into their own homes in the community

of their choice.[1] Grant funds provide funding for the transition services and enhanced supports needed for the first year after individuals transition into the community. An individual is not required to participate in this opportunity. The MFP program is not required by the Consent Decree.

Under the MFP program, Transition Specialists provided enhanced case management for one year following a transition. For those individuals that have chosen to participate in this opportunity, the Transition Specialist takes the lead in providing the case management services generally provided by MCE case managers. However, the Transition Specialist does not replace the MCE case manager who continues to follow the individual according to the cadence noted above, but instead the two work hand-in-hand throughout the first year of transition. The MCE case manager's continued involvement ensures that there is a "warm hand-off" when the one-year period expires.

5. Woodward Resource Center (WRC), Center of Excellence (CoE) Outreach Team.

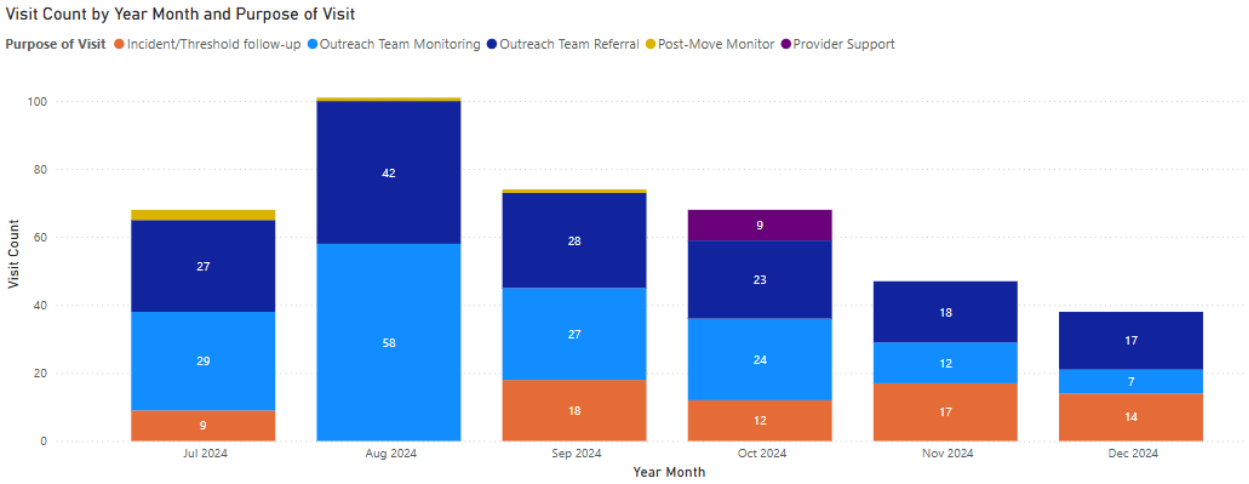
The WRC CoE Outreach Team (the Outreach Team) was established in June 2024. The team members began their work in July 2024 immediately following GRC's closing. Members of the Outreach Team include a Social Worker 3, an Occupational Therapist, a Physical Therapist, a Speech and Language Pathologist, a Registered Nurse, a Board-Certified Behavioral Analyst, a Psychology Administrator (Licensed Psychologist), two Training Specialists 1, and an Accounting Technician 2. The Outreach Team is supervised by the WRC Superintendent.

As will be discussed below, an Outreach Team member may be assigned to assist in completing follow-up of a Community Threshold. Additionally, an Outreach Team member may be involved because a PMM has reached out for assistance with individuals in their caseload, or a CIM, case manager, transition specialist or a community provider has requested assistance from the Outreach Team. The PMMs and the Outreach Team meet weekly to discuss Community Thresholds and issues in which the Outreach Team has become involved or upon which the PMMs seek advisement.

The Outreach Team supports community providers and former GRC individuals in their community homes by offering quality clinical oversight and consulting services, completing assessments, providing global and individualized training, and assisting with plan development or revisions. The focus of the Outreach Team is to use their clinical knowledge and skills to assist in keeping individuals safe and healthy in their homes while allowing them to remain in the most integrated and least restrictive setting possible.

[1] While not relevant to this Report, individuals living in nursing facilities, Psychiatric Mental Institutes for Children (PMIC) and inpatient hospital settings may also qualify.

Figure 5: Outreach Team Visits by Month and Year.



Purpose of Visit	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	**Total**
Incident/Threshold follow-up	9	0	18	12	17	14	**70**
Outreach Team Monitoring	29	58	27	24	12	7	**157**
Outreach Team Referral	27	42	28	23	18	17	**155**
Post-Move Monitor	3	1	1	0	0	0	**5**
Provider Support	0	0	0	9	0	0	**9**
Total	**68**	**101**	**74**	**68**	**47**	**38**	**396**

Provider Support: This is the global work completed by the Outreach Team. This may include training and additional support provided to individuals or providers that is unrelated to Community Thresholds.

Incident/Threshold Follow-up: This is the start to finish actions completed to resolve a threshold incident or a Community Threshold. This could include, but is not limited to, assessment, training, consultation, and intervention.

Outreach Team Referral: This is a referral to the Outreach Team based on individualized need and unrelated to a threshold incident or Community Threshold. This could include, but is not limited to, an assessment, training, consultation, or intervention provided.

Outreach Team Monitoring: Further monitoring and follow-up of an Outreach Team Referral after the assessment, training, consultation, and/or intervention.

Post Move Monitor (PMM): This is PMM visits that were completed by the Outreach Team members for the GRC PMM.

B. Processes Related to Community Thresholds.

1. Identifying Critical Incidents and Community Thresholds.

As noted earlier, PMMs track incidents known as Critical Incidents and incidents related to what have been designated as Post-Move Monitoring Community Thresholds (Community Thresholds). Under pre-existing Iowa regulation and the State's Intellectual Disability Waiver, community providers are required to report Critical Incidents to HHS. Critical Incidents include "major incidents" and "minor incidents." Major incidents include events such as physical injury requiring treatment, death of an individual, involvement of law enforcement, and so forth. Minor incidents include things such as bruising, seizure activity, and so forth. A complete list of major and minor incidents can be found at 441 Iowa Admin. Code 77.37(8).

In addition to Critical Incidents, in collaboration with the Consent Decree Monitor, HHS identified additional incidents that community providers must report to the PMM. These incidents are related to thresholds that prompt HHS action. The thresholds are known as Community Thresholds.

The Community Thresholds are:

1. Two choking episodes in one year. (Choking means a blockage of the upper airway by food or other objects, preventing an individual from breathing effectively. Choking occurs when physical intervention, such as the abdominal thrust, is needed).
2. Recurrent Aspiration pneumonia and/or recurrent non-aspiration pneumonia in one year.
3. Unresolved falls related to balance and medical issues of more than six in 90 days, excluding behavior, voluntary sitting/lowering to the ground, or peer-to-peer aggression. Unresolved falls of any type more than six in 30 days or more than 9 in 90 days. An unresolved fall: action or inaction of the provider that resulted in an additional fall.
4. New or proposed enteral (g, j or g/j tube) feeding.
5. Unresolved Gastro-intestinal (GI) issues including bowel obstruction and unresolved vomiting (>6 episodes in 30 days not related to viral infection or other known causes).
6. Unresolved significant/unplanned/verified weight loss or gain that is not improving in 90 days with IDT management/Acute Care Plan or for individuals for whom the IDT requests special assistance:
    a. >7.5% of body weight in 30 days.
    b. 12% of body weight in 90 days; or
    c. if no progress has been made by the IDT to prevent further weight loss or gain in 90 days.

7. Two or more stage II decubitus in 12 months, any stage II with delayed healing, any stage III or IV decubitus, or any unstageable wound.
    - Stage I pressure injuries are not open wounds. The skin may be painful, but it has no breaks or tears. The skin appears reddened and does not blanch (lose color briefly when you press your finger on it and then remove your finger). In a dark-skinned person, the area may appear to be a different color than the surrounding skin, but it may not look red. Skin temperature is often warmer. And the stage 1 injury can feel either firmer or softer than the area around it.
    - Stage II pressure injuries are open wounds. The skin breaks open, wears away, or forms an ulcer, which is usually tender and painful. The wound expands into deeper layers of the skin. It can look like a scrape (abrasion), blister, or a shallow crater in the skin. Sometimes this stage looks like a blister filled with clear fluid. At this stage, some skin may be damaged beyond repair or may die.
    - Stage III pressure injuries extend through the skin into deeper tissue and fat but do not reach muscle, tendon, or bone.
    - Stage IV pressure injuries extend to muscle, tendon, or bone.
    - Unstageable pressure injuries are when the stage is not clear. In these cases, the base of the wound is covered by a layer of dead tissue that may be yellow, grey, green, brown, or black. The doctor cannot see the base of the wound to determine the stage.
8. Fracture of a long bone, spine, or hip.
9. Inability to obtain needed support, equipment, and/or medical/behavioral consultation.
10. Involvement with law enforcement
11. Sexual incident includes any sexual incident, peer to peer, increased sexual interest, etc.
12. Aggression to staff or peers in home (3+ or one with serious injury). Serious injury is defined as requiring emergency and/or medical intervention.
13. Unauthorized elopement or leaving home/work etc. (x2)
14. Restraint (3x in one mo.)
15. > 3 restraints in 30 days or > 6 restraints in 60
16. Any Abuse, Neglect, or Exploitation allegations reported to Adult Protective Services (APS).
17. Any confirmed Abuse, Neglect, or Exploitation allegations reported to Adult Protective Services (APS).
18. Serious Injury (requiring emergency care. this would include fracture #8)
19. Relocation to a new home.
20. New onset seizure(s).

As noted above, providers are required to report Critical incidents and incidents related to Community Thresholds to the PMM. However, the PMM may become aware of the incident not only through a report from a provider, but as a result of the PMMs interactions with the individual, or through notification from a CIM, a case manager, a

transition specialist, an individual, an individual's guardian or any other source. Regardless of how the PMM becomes aware of a Critical Incident or incidents related to a Community Threshold, the PMM must do several things as follows:

First, the PMM must report the incident to the Woodward Resource Center (WRC) Superintendent and WRC Center of Excellence (CoE). As noted above, the WRC CoE is an arm of HHS set up to assist providers in ensuring services and supports are provided to individuals.

Second, the PMM must document the incident in the individual's electronic medical record in the Interdisciplinary Program Record (IPR). The IPR is an internal medical records system to which both PMMs and the Outreach Team have access.

Third, the PMM must ensure that incidents related to Community Thresholds are documented in what is known as the GRC PMM SharePoint site (PMM SharePoint), a data collection SharePoint created to collect Community Threshold data and to create a process for following up on Community Thresholds and incidents related to Community Thresholds.

2. Data Collection and Community Threshold Review.

As noted, the PMM must enter any incidents related to the Community Thresholds into the PMM SharePoint as a PMM incident report. Once a Community Threshold has been met, a record will be created in the Community Threshold Log within the PMM SharePoint. This record generates an email notification to members of the Community Threshold Team, which includes the PMM and a variety of individuals intimately involved in the post-move monitoring process.

The Community Threshold Team must review and address the Community Threshold no later than the next business day after notification that a Community Threshold has been met. Based on the severity of the incident, a review may occur immediately upon notification.

In determining what steps to take, the Community Threshold Team consults the GRC Community Thresholds Clinical Pathways (the Pathways). The Pathways, created by HHS in consultation with the Consent Decree Monitor, identify suggested approaches for addressing the different Community Thresholds. The Pathways are not intended to be an all-inclusive response to a Community Threshold. Rather, the response is individualized based upon the specifics of the case, the individual's needs, the level of urgency, identified risks, and other similar factors. The Community Threshold Team may identify additional or different supports, services, assessments, and the like outside the Pathways that are needed to mitigate the identified risks. The Community Threshold Team consults clinical therapists as outlined in the Pathways or where it is otherwise appropriate.

Once the review has been completed by the Community Threshold Team, an Outreach Team member may be assigned to complete follow-up on the Community Threshold and the response.

Whenever possible, any decisions made and actions recommended should be reviewed and accepted by the individual and/or guardian and the individual's community interdisciplinary team (IDT). In most circumstances, if an individual meets a Community Threshold, the IDT should meet to determine whether the individual's Individual Support Plan (ISP) should be modified.

There is a two-step process for ensuring the individual Community Threshold is followed to resolution. The Outreach Team Social Worker reviews all Community Threshold logs for completion. That Social Worker then forwards to the SharePoint Approving Party, a member of the WRC leadership team, who re-checks to ensure complete resolution of the issue and that all documentation supporting resolution is recorded in the PMM SharePoint.

3. Community Threshold Data Review Group.

The HHS PMM Threshold Data Review Group (Data Review Group) was established in June 2024 and have been meeting monthly to review aggregate Community Threshold and incident data collected by the PMM SharePoint to identify trends in the data by individual, provider, or threshold type. Further, the Data Review Group determines whether further remedial action should be taken, including whether a Performance Implementation Plan (PIP) may be warranted for a particular provider.

Members of this review group include the HHS State-Operated Specialty Care Executive Officer 2 (SRC Liaison), the HHS State-Operated Specialty Care Executive Officer 3, WRC Superintendent, HHS Social Worker 6 (Community Integration Manager) and the Division Director, State-Operated Specialty Care Division (Iowa HHS Central Office). Additional membership to the review group is currently being reviewed.

The group reviews data for the previous one-month, six-month, and twelve-month periods for both threshold incidents and Community Thresholds. The data is dissected by provider, individual, and Community Threshold type. The group also reviews each individual's data for the past three-month period. The group reviews the progress toward remedy for each outstanding Community Thresholds for the current month and more deeply evaluates any outstanding Community Thresholds with remedies that have been outstanding past 60 days.

Currently, the Data Review Group uses the following definitions:

> "Individual Threshold" means that a single individual has experienced any type of Community Threshold.
>
> "Systemic Threshold" means that two or more individuals experience the same numerated type of Community Threshold.

Data Review Group remedial action is prompted when the group identifies a single provider has met one of the following Provider Thresholds:

- More than 4 Individual Thresholds in a six-month period.
- More than 8 Individual Thresholds in an eight-month period.
- A System Threshold has been met within one (1) year.
- The Data Review Group identifies concerns related to the data reviewed.

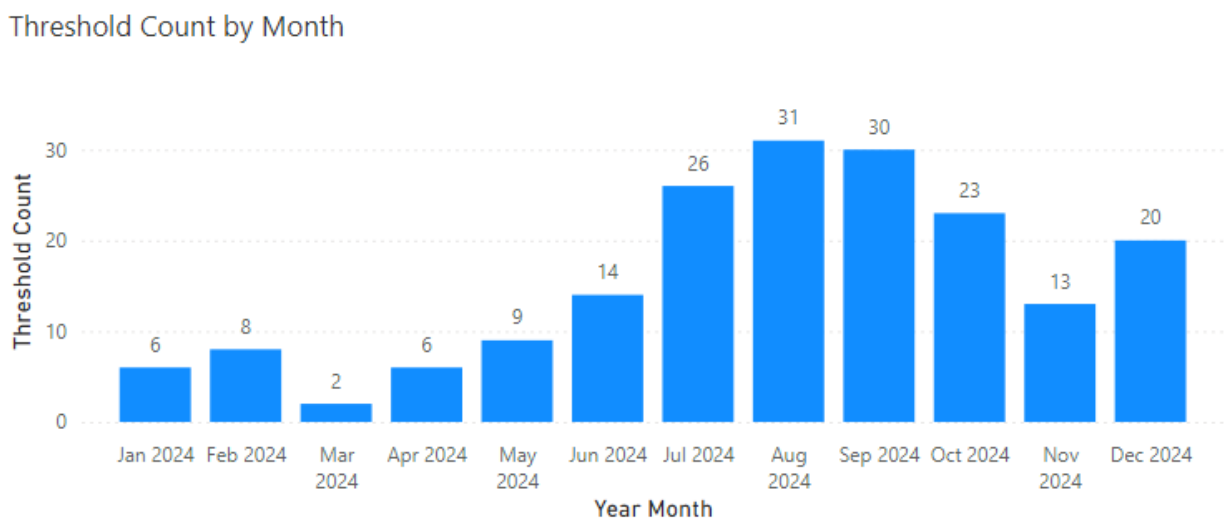
In addition, if the Data Review Group determines that two or more providers are struggling with certain Community Threshold types or have met multiple thresholds in an identified time frame, the Data Review Group will assign Iowa Medicaid's Long-Term Services and Supports (LTSS) Bureau to reach out to the provider to discuss and debrief the issues.

Beyond conferencing with the provider, where appropriate, the Data Review Group will require additional remedial action, which may include providing additional training and support to providers, following up on individual Community Thresholds, connecting the provider to additional supports and services, or putting in place a provider PIP.

A PIP identifies clear expectations for improvement from a provider and is an opportunity to collaborate with the CIMs who facilitate the PIP process. The PIP process affords the provider the opportunity to evaluate their current processes, identify any gaps in services provided, and address how the provider will resolve the issues identified.

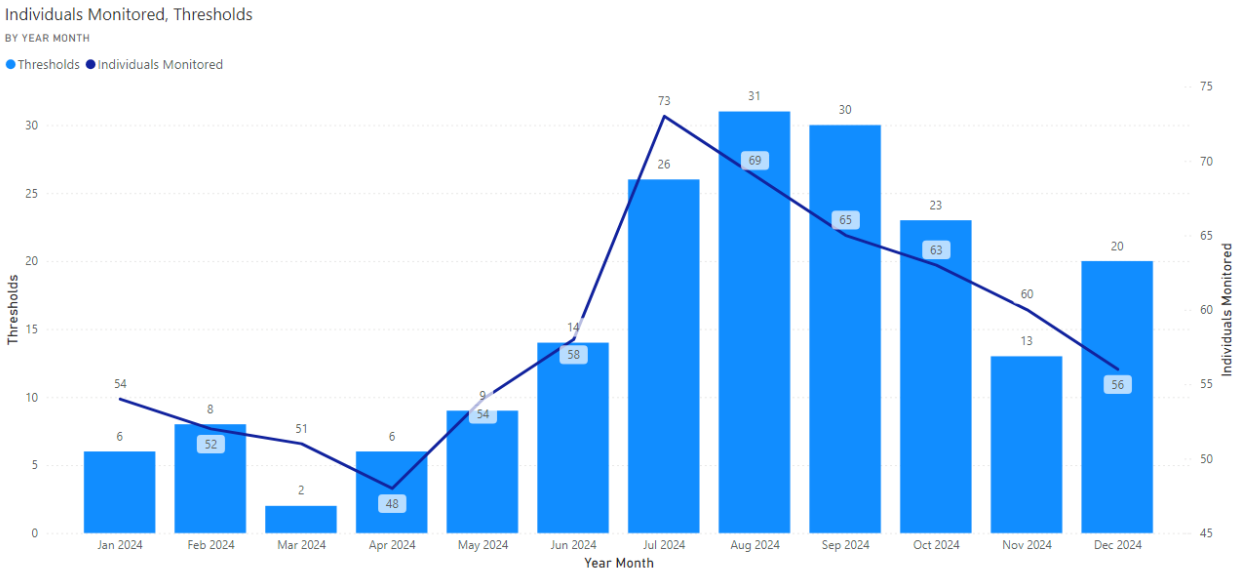
III. Community Threshold Data.

Figure 6: Community Threshold Count by Month.



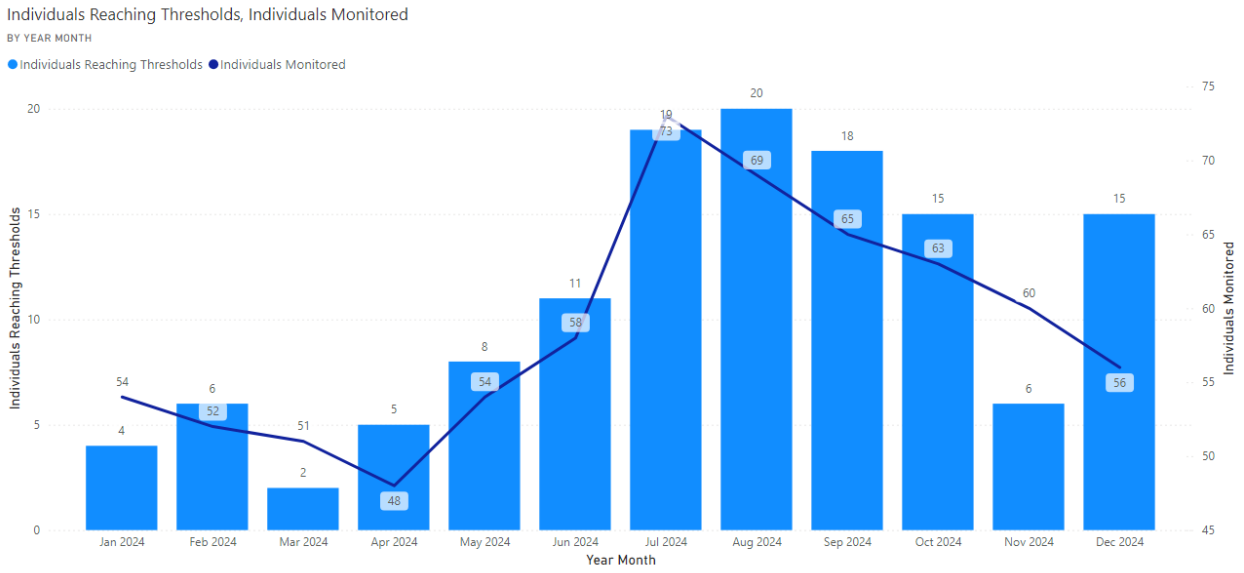
The Figure above shows the number of Community Thresholds met by month.

Figure 7: Individuals Monitored & Thresholds Met



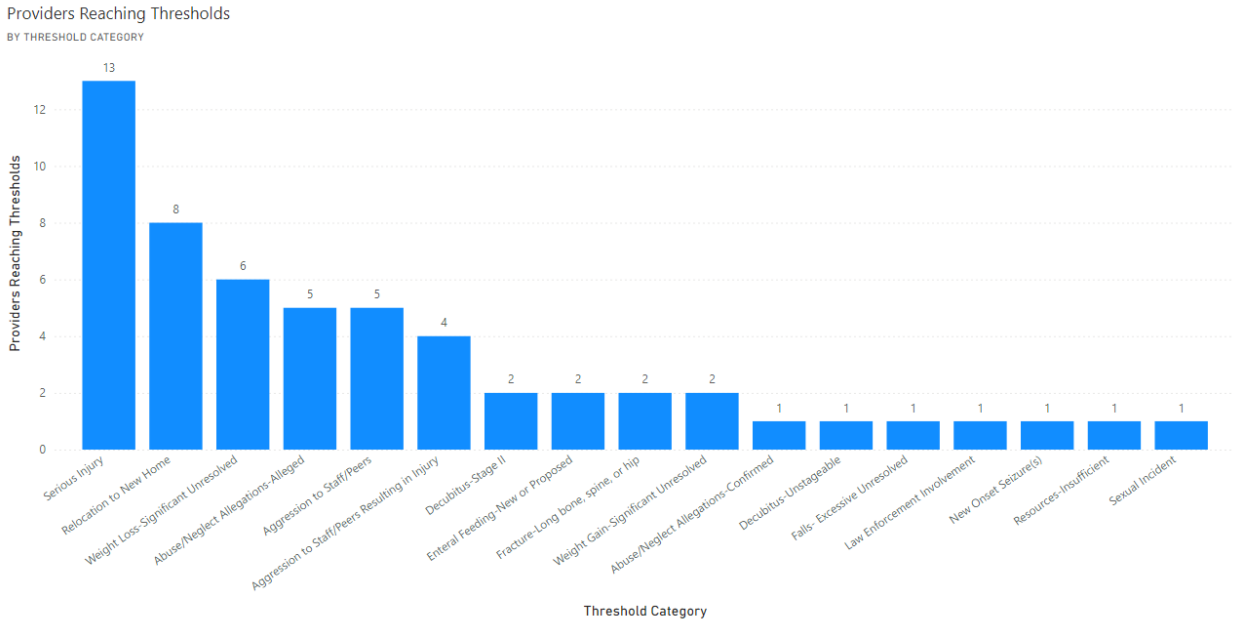
In the Figure above, for each month, the number of individuals that were within the 365-day post-move monitoring period is shown by the numbers associated with the blue line. The number of Community Thresholds identified for each month is shown by the blue bar.

Figure 8: Individuals Reaching Thresholds.



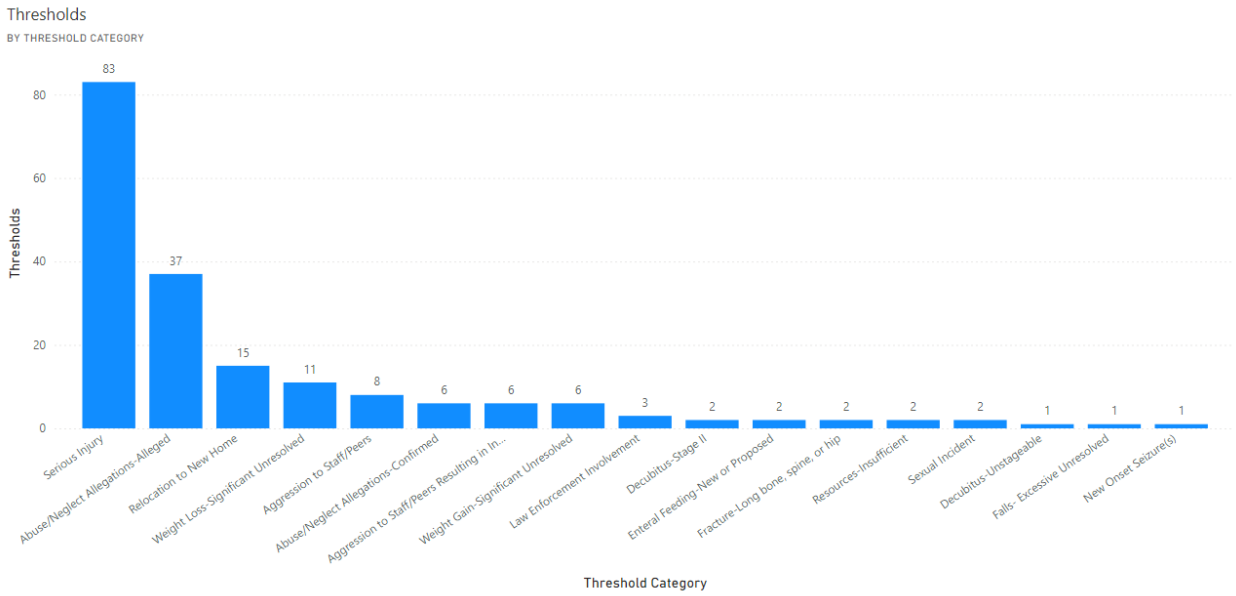
In the Figure above, for each month, the number of individuals that were within the 365-day post-move monitoring period is shown by the numbers associated with the blue line. The blue bar identifies the number of individuals meeting a Community Threshold by month. For example, in November of 2024, 60 individuals were within the 365-day post-move monitoring period and six of those individuals met Community Thresholds. Contrasting this Figure with Figure 6 illustrates that while there was a total of 13 Community Thresholds in November (Figure 6), the number of individuals experiencing Community Thresholds during November was six (Figure 8).

Figure 9: Providers Reaching Thresholds.



The above Figure shows the number of providers having met a Community Threshold in 2024 by Community Threshold type.

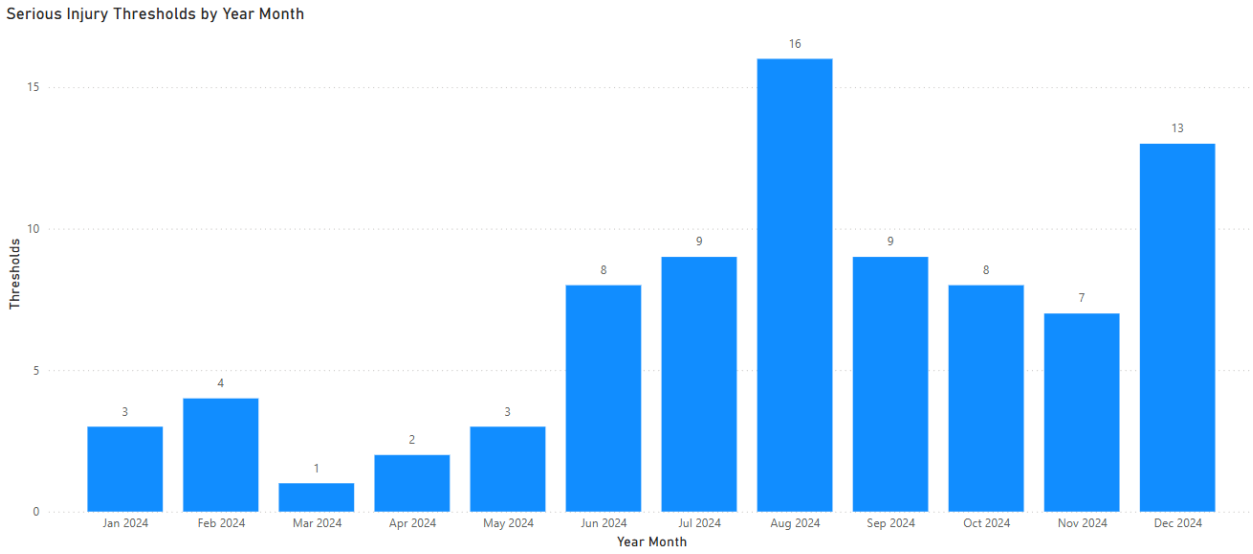
Figure 10: Threshold Count by Threshold Category



The above figure shows the total number of Community Thresholds met by Community Threshold type in 2024. The five highest categories of Community Thresholds are

serious injuries, allegations of abuse or neglect, relocation to a new home, significant weight loss, and aggression to peers or staff.

Figure 11: Serious Injury Thresholds by Year and Month.



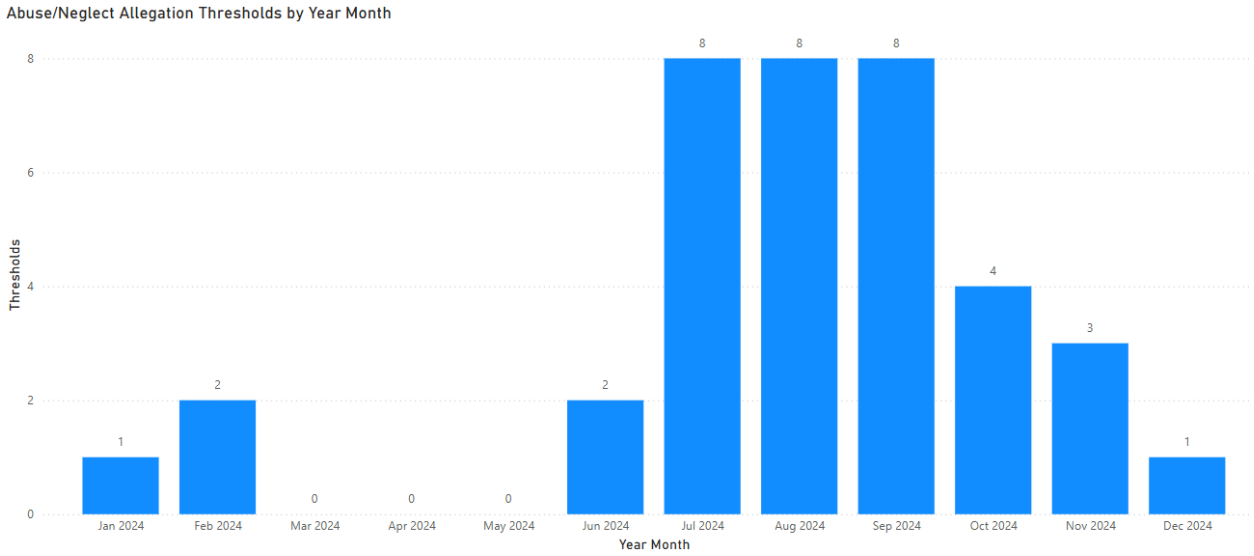
The Community Threshold type of Serious Injury includes admission to a hospital, visits to an emergency room, admission for a psychiatric hospitalization, or injury addressed by the facility medical provider.

Figure 12: Serious Injury by Category.

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Total
Emergency Room Visits	3	2	0	1	1	4	4	10	8	3	5	9	**50**
Hospitalizations	0	1	2	1	2	3	4	6	1	4	2	4	**30**
Psychiatric Admissions	-	-	-	-	-	-	1	-	-	1	-	-	**2**
Provider On-site Medical Care	-	-	-	-	-	1	-	-	-	-	-	-	**1**
Total	**3**	**3**	**2**	**2**	**3**	**8**	**9**	**16**	**9**	**8**	**7**	**13**	**83**

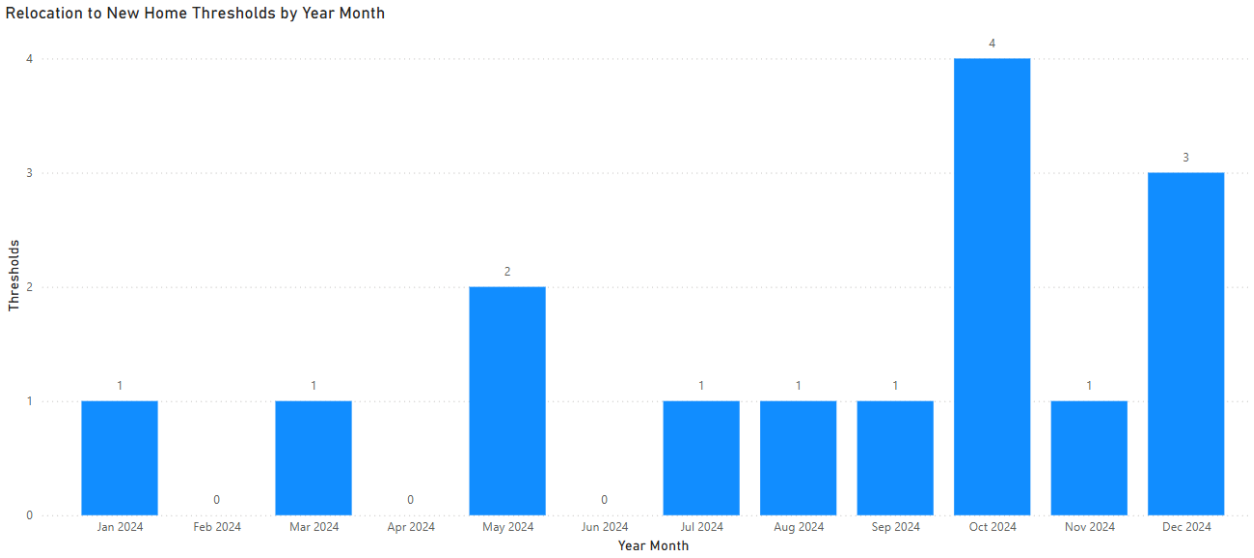
In Figure 12, of the 83 Serious Injury Community Thresholds reported in 2024, 50 were trips to an emergency room, 30 were hospital admissions, two were psychiatric hospitalizations, and one was an injury addressed by the facility medical provider.

Figure 13: Abuse/Neglect Allegations by Year and Month.



As illustrated by Figure 10, during 2024, of the 37 allegations of abuse/neglect reported, eight allegations were confirmed. Allegations of abuse/neglect occurring in a HCBS Waiver home or host home are investigated by HHS. Allegations of abuse/neglect occurring in a nursing facility or ICF-ID facility are investigated by the Iowa Department of Inspection, Appeals, and Licensing (DIAL).

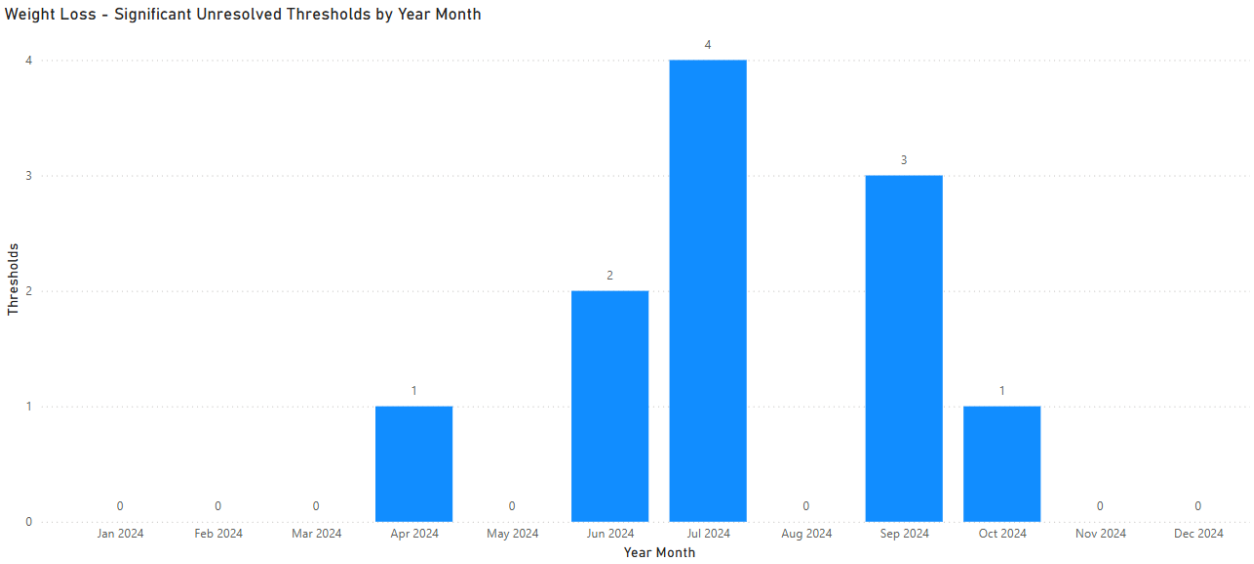
Figure 14: Relocation to New Homes by Year and Month.



While Figure 14 identifies 15 relocation Community Thresholds in 2024, there were only 14 actual relocations in 2024. Because a relocation Community Threshold is triggered at the time the individual gives notice that they intend to move, a pending relocation was included in Figure 14. In 2024, of the 14 individuals who relocated (Figure 14), eight moved from one community setting to another, three moved from one institutional

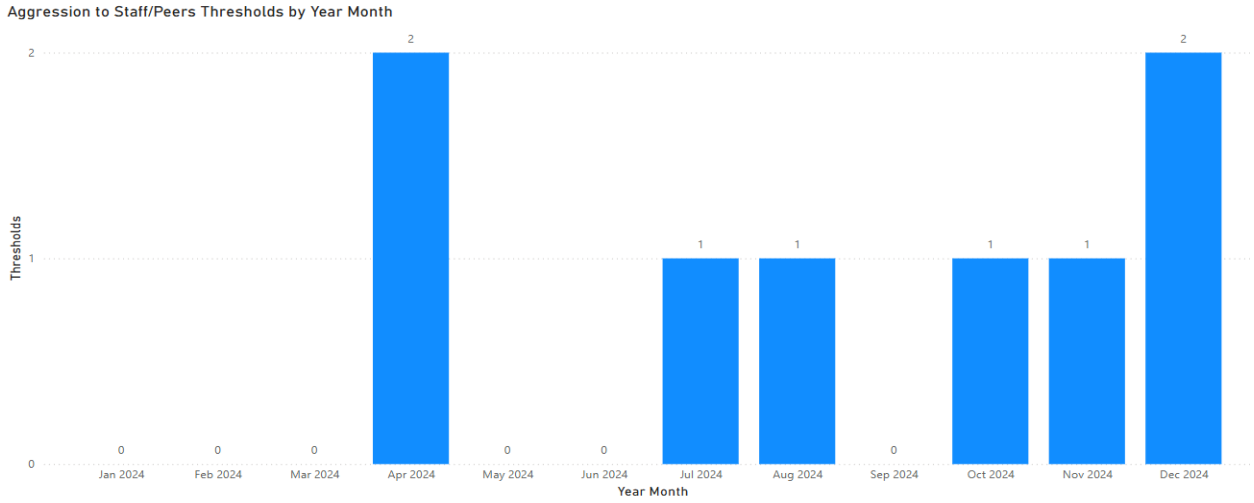
setting to another institutional setting, and three moved were from a community setting to an institutional setting.[2]

Figure 15: Weight Loss – Significant by Year and Month.



As illustrated by Figure 15, 11 Community Thresholds were reported for 10 individuals regarding weight loss.

Figure 16: Aggression by Year and Month.



[2] Specifically:

- Six individuals relocated from HCBS Waiver home to another HCBS Waiver home.
- One individual moved from a community-based host home to an HCBS Waiver home.
- One individual moved from a HCBS Waiver home to a community-based host home.
- One individual moved from a HCBS Waiver home to an Institution for Individuals with Intellectual Disabilities (ICF-ID).
- Two individuals moved from an HCBS Waiver home to nursing facilities.
- Two individuals moved from nursing facilities to nursing facilities.
- One individual moved from one ICF-ID to another ICF-ID.

Figure 17: Community Threshold Remedy Percentage.

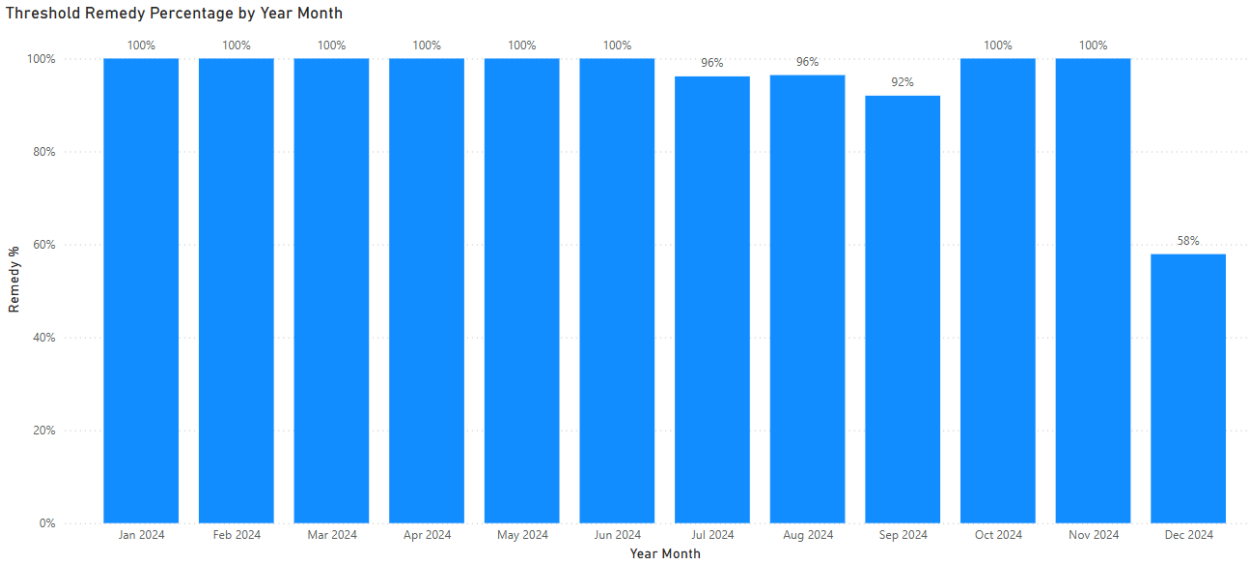
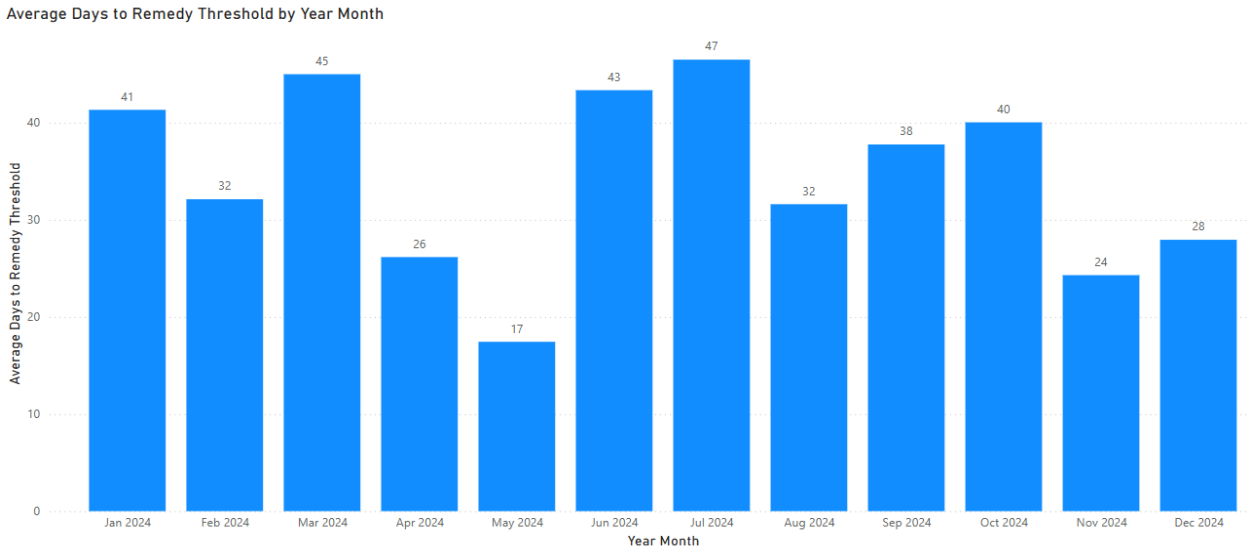


Figure 18: Average Days to Remedy Community Thresholds Met



Each Community Threshold is closed when (1) all appropriate recommendations and/or supports are in place to prevent reoccurrence of the threshold; (2) the individual has returned to their baseline or is at their new baseline following the incident; and (3) the Outreach Team and medical professionals have no further concerns.

IV. Conclusions, Outcomes and Progress.

A. Community Integration.

As indicated by Figure 1 above, out of the 147 individuals who transitioned from Glenwood, the majority of those individuals (98) were able to transition to community settings. Of those 98, only four individuals initially had unsuccessful transitions to the community and those four were able to successfully transition to the community later.

As noted in the text following Figure 14, in 2024, 14 individuals relocated. Eight individuals moved from one community setting to another, three moved from one institutional setting to another institutional setting, and three moved were from a community setting to an institutional setting.[3]

From these statistics, one can conclude that overall HHS has been successful in integrating former GRC residents into the community. Once situated in the community, the failure rate is very low, with only three individuals moving from a community setting to an institutional setting in 2024.

Of the 51 individuals who remain within the 365-day post-move monitoring period, the majority of those individuals (39) are living in community settings.

B. Post Move Monitors.

As indicated by Figure 3, the PMMs cadence requirements have improved throughout 2024. PMMs meeting the cadence requirements never dropped below 91% in 2024, and the PMMs met the cadence requirements 100% for the last four months of 2024. The improvement is likely a result of a change in procedure allowing PMMs to focus solely on post-move monitoring.

As indicated by Figure 4, there were a total of 68 reviews completed by the PMM QA Review Group in 2024. In every case where deficiencies were noted, the PMM QA Review Group provided feedback to the PMM, and the PMM timely corrected deficiencies. The PMM QA Review Group has noted on several occasions that PMMs have implemented the Review Group's feedback and recommendations to correct deficiencies beyond the particular documentation being reviewed.

[3] Specifically:

- Six individuals relocated from HCBS Waiver home to another HCBS Waiver home.
- One individual moved from a community-based host home to an HCBS Waiver home.
- One individual moved from an HCBS Waiver home to a community-based host home.
- One individual moved from an HCBS Waiver home to an Institution for Individuals with Intellectual Disabilities (ICFID).
- Two individuals moved from an HCBS Waiver home to nursing facilities.
- Two individuals moved from nursing facilities to nursing facilities.
- One individual moved from one ICF-ID to another ICF-ID.

Noting that the PMMs performance has not been without deficiency, the following training occurred with the PMMs in 2024:

- Post Move Monitoring (PMM) Guidelines Procedure.
- Post Move Monitoring (PMM) Hospice Follow-up Protocol.
- Post Move Monitoring (PMM) Documentation Completion Procedure.
- Post Move Monitor (PMM) Community Thresholds Clinical Pathways Procedure.
- Quality Assurance Review of PMM Checklist Post Transition from GRC Procedure.

C. Woodward Resource Center (WRC) Center of Excellence (CoE).

The addition of the WRC CoE Outreach Team (the Outreach Team) to the post-move monitoring team has provided significantly increased resources to assist community providers and PMMs. While PMMs are primarily social workers whose training allows them to identify environmental, physical, medical, behavioral, social, and other types of issues, the Outreach Team consists of professionals who are able to assist in resolving the clinical issues identified. Although the Outreach Team's work is broken into five separate categories for tracking purposes, each one of those categories includes assessment of individuals, training, consultation, and intervention. These professionals are able to provide training that is both specific to the subject matter and to the former GRC individual. From the date the Outreach Team began their work on July 1, 2024 through the end of 2024, the Outreach Team members logged 396 visits (Figure 5), an average of 66 visits each month. Notably, the work of the Outreach Team does not end with making identifiable visits to individuals in the community but also includes providing direction and input to PMMs at weekly meetings and providing consultation to PMMs, providers, CIMs, case managers, and transition specialists. Anecdotally, community providers have highly praised and valued the assistance provided by the Outreach Team.

D. Community Thresholds

The number of incidents and Community Thresholds trended upward between May 2024 – July 2024 (Figure 6). This was not surprising because between March 2024 – June 2024, the highest number of individuals (52) transitioned from GRC to the community.

Additionally, it was difficult to find suitable and desirable placements for many of the more medically vulnerable residents and, therefore, the most medically vulnerable were among residents who transitioned in the last months leading up to GRC's closure. Between August 2024 and November 2024, there is a general downward trend in

Community Thresholds (Figure 6) as former GRC residents settled into their new homes. Notably, there is a spike of Community Thresholds in December 2024, which is a cause for concern.

A look at the trends in the various categories of Community Thresholds provides some insight into the statistics. A first stop is looking at the highest-ranking category of Community Thresholds. As noted in Figure 10, out of the 20 categories of Community Thresholds, the category of Serious Injury was identified as meeting a Community Threshold at a significantly higher rate than any other category. The Serious Injury category was met 83 times in 2024. There are likely reasons for this such as the following:

The Serious Injury category is composed of several different types of incidents: trips to the emergency room, hospital admissions, psychiatric hospitalizations, and injuries addressed by a facility provider. The fact that the Serious Injury category is inclusive of several types of incidents may account for the number of times the Community Threshold is reached.

In addition, a closer look at emergency room visits provides some insight into the statistics. The incidents of emergency room visits numbered 50. However, in analyzing this trend, the Data Review Group found that providers were using emergency room visits to follow up on issues more appropriately followed by the individual's primary care physician or for routine medical care needs. The Data Review Group also found that providers were using the emergency room to address issues that could readily be resolved by a visit to an urgent care clinic. While the emergency room visit is still a component of the Serious Injury category, the Community Thresholds group and the Data Review Group now analyze the underlying circumstances for the emergency room visit rather than attributing it to negative causes. Remedial action is not taken by these groups where the emergency room visit is routine medical care or care that could be treated in an urgent care setting.

With respect to the Serious Injury category, while the overall number for the year is high, the monthly number of Serious Injury Community Thresholds does not exceed 16 in one month. The trending for this category follows the trending for overall Community Thresholds.

The second highest category of Community Thresholds is Allegations of Abuse and Neglect with 37 occurrences in 2024. Allegations of abuse/neglect occurring in a HCBS Waiver home or host home are investigated by HHS. Allegations of abuse/neglect occurring in a nursing facility or ICF-ID facility are investigated by the Iowa Department of Inspection, Appeals, and Licensing (DIAL). Confirmed determinations of abuse/neglect fall within a separate Community Threshold. As illustrated by Figure 10,

during 2024, of the 37 allegations of abuse/neglect reported, only eight allegations were confirmed.

When looking at the top five categories of Community Thresholds, after the initial two categories, the numbers drop off sharply. For individuals relocating to new homes, there were only fifteen occurrences over the course of 2024, with no single month exceeding more than four. In Significant Weight Loss, the total number of Community Thresholds for the year was eleven. The Threshold Count did not exceed four for any given month and there were zero occurrences during seven of the twelve months. The category of Aggression to Staff and Peers totals eight for the year, reaches two occurrences in two of the months, one occurrence in four of the months, and zero for the remaining months.

Beyond the top five categories of Community Thresholds, for three Threshold categories, Community Thresholds do not exceed six; for one Threshold category, the Community Thresholds do not exceed three; for five categories, the Community Thresholds do not exceed two; and for three categories, the Community Thresholds do not exceed one.

Thus, while the Serious Injury category has a high rate of meeting Community Thresholds, there is information indicating that the rate may be inflated because providers were improperly using the emergency room for routine care. Additionally, while allegations of abuse and neglect are quite high, only about one-fifth of those allegations are confirmed. For most other categories, the monthly rates are quite low. Nevertheless, regardless of explanations related to some of the more highly rated categories and the low rates in others, HHS treats each and every Community Threshold seriously and expects that, through the post-move monitoring process, each and every Community Threshold will be resolved.

E. Resolution of Community Thresholds.

Each Community Threshold is closed when (1) all appropriate recommendations and/or supports are in place to prevent reoccurrence of the Threshold; (2) the individual has returned to their baseline or is at their new baseline following the incident; and (3) the Outreach Team and medical professionals have no further concerns. The time it takes to remedy a Community Threshold may vary depending on the category of the threshold, the scope of the individualized recommendations by clinicians and medical providers, receipt of positive or negative provider feedback on progress, the time needed to review documentation, and whether additional training and resources are needed.

For example, a significant weight loss or gain is not closed until the individual has returned to their healthy weight or has shown significant improvement and adequate supports are in place to ensure weight maintenance.

Variance in remediation time is also seen in the Serious Injury category. It is a broad category and includes things as simple as a routine procedure to a complex diagnosis requiring consultation with specialists with routine procedures generally being closed in a more abbreviated time.

Relocations begin with notification that an individual will be moving and are not closed until all training for the new provider has been complete and the person has successfully moved to their new home. Training may be more complex and lengthier for individuals with more complex conditions. For those individuals, the completion of the move may take longer as well.

The data reflects the lag time in remediation and the remediation time variances. Figure 17 reflects the rate at which Community Thresholds opened during a particular month have been resolved. The data reflects that 100% of Community Thresholds opened in January through June of 2024 have been resolved; that remediation rates for July, August, and September are, respectively, 96%, 96%, and 92%; and the remediation rate for October and November is again 100%. A sharp drop is noted in December with a remediation rate at 58%, not because remediation success has dropped, but because the data was collected as of 1/21/2025, without the needed time for 100% remediation. In sum, HHS's expectation is that it will achieve a 100% remediation rate for all months, but that for more recent months that rate of remediation will take a bit of time to be reflected in the data.

HHS's expectation is supported by the data in Figure 17, which reflects the average number of days for each month to remedy the Community Thresholds opened during that month. In 2024, those averages ranged from 17 days to 47 days reflecting those variances in the time to remedy very different Community Thresholds.

Overall, HHS is achieving a high rate of remediation with the expectation that all Community Thresholds are followed to resolution.

F. 2024 Training.

In addition to individualized provider training provided during the post-move monitoring process or in response to identification of a Community Threshold or other provider need related to the Consent Decree, HHS has provided pre-transition and post-move monitoring training, specific topic training to HHS staff and providers, and case management and transition specialist training.

1. Pre-Transition Training and Post-Move Monitoring Training.

On February 21, 2024, the Consent Decree Monitor provided two training modules: (1) pre-transition focused training; and (2) post-move monitoring training. More than 45

members of GRC leadership and staff attended the training. The pre-transition training used the Monitor's audit tool to walk attendees through the expectations for planning for and documentation of transition activities. The post-move monitoring training identified the role of the CIM and the cadence for visits. In addition, it provided guidance on the scope of the PMM visits, how to use the PMM template tool to document post-move monitoring, and Community Thresholds.

2. Training on Psychopharmacology & Developmental Disabilities.

The Monitor facilitated training on Psychopharmacology & Development Disabilities, which was held on March 20, 2024. This training provided education on the following: (1) a review of the assessment process necessary when considering treatment with psychotropic medications; (2) identification of symptom clusters and appropriate psychotropic medications to address specific symptoms; (3) review of the side effects of selected psychotropic medications; (4) review of the difference between medication side effects and adverse drug reactions; (5) the specific challenges of psychotropic medication in relation to people with development disabilities; and (6) review of the role of data in prescribing psychotropic medication. The training was attended by GRC psychiatrists, social workers, the CIM, and other GRC leadership and staff.

3. Provider Training: Gastrostomy and Jejunostomy Care.

In April and May of 2024, in response to concerns about Gastrostomy and Jejunostomy care in the community, HHS contracted with Clarkson College to provide training consisting of both on-line coursework and in-person hands-on training. The on-line training and testing included training on Enteral Medication and Enteral Nutrition Administration, Enteral Nutrition via Tube, Placement of Gastrostomy and Jejunostomy Tube, Medication Administration via Tube, and Accessing Tube procedures. After completion of the on-line course, those who received a passing score (80% or higher) were able to take in-person hands-on training providing the trainee the opportunity to practice and be evaluated on their skills.

GRC nurses were trained and, in conjunction with the in-person training, completed a competency based "train the trainer" segment. Community providers were then given the opportunity to complete the on-line training and received the hands-on training from the GRC nurses who had completed the train the trainer segment.

4. Learning Management System

Iowa HHS launched a Learning Management System (LMS) on May 1, 2024, the purpose of which is to provide a state-wide web-based learning management system for long-term services and supports (LTSS) providers, direct support professionals, family caregivers, case managers, and transition specialists to enhance and improve the delivery of long term services and supports.

Specific to case managers, HHS created a certification toolkit. Modules in the toolkit include (among others) the following:

- A Life in the Community: A Review of the Olmstead Decision
- Home and Community-Based Services Philosophy and HCBS Settings Rule
- Case Management Roles and Responsibilities
- Developing and Maintaining Relationships with Members and Care Teams
- Service Documentation and Service Monitoring
- Accessing Community-Based Supports and Resources
- Transitions in Care
- Facility Diversion
- Mental and Behavioral Health Crisis Response
- Person-Centered Planning for Medicaid
- Funded HSBS Employment Services

Not only case managers, but also providers, direct support professionals, and family caregivers, are able to access the LMS competency-based training, which offers an array of training specific to individuals with intellectual disabilities.

5. Case Management Post-Transition Training.

On June 14, 2024, HHS facilitated a training for case managers and transition specialists led by the Consent Decree Monitor's team focused on post-transition monitoring of former GRC residents. It provided education on the role of the CIM, the PMMs, case managers, and transition specialists. The training focused on improved delivery of case management services including providing specific questions for following up on individuals, specific documentation guidance for identifying concerns or gaps in support, steps for following up on those concerns and gaps, and identification of Community Thresholds.

On October 1, 2024, another training was held specifically for case managers and MFP transition specialists involved in the post-move care coordination for former GRC residents. The training covered post-transition monitoring under the Consent Decree; responsibilities of CIMs and post-move monitors; the role of case managers and MFP transition specialists; creating detailed documentation; and reviewing provider documentation.

6. CIM Training.

When regional CIMs were hired in July and August of 2024, they received Learning Management System (LMS) training on the following:

- HCBS, Behavior Support Plan Development
- Mental Health Crisis Response
- Approaches to Challenging Behaviors
- Adopting a Trauma lens
- State Transition Plan update
- Person Centered Planning
- HCBS Service Documentation
- Service Documentation and monitoring
- QA Improvement
- Monitor and follow up Case Management
- Behavior Intervention strategies
- Guardian- Conservator payee
- Person Centered Practices.

G. 2024 Developments and Improvements.

There have been many developments and improvements within the post-move monitoring team, their processes, and the Community Thresholds process as the team has implemented and identified how the team and its processes can be improved. For the purposes of this Report, HHS has identified two processes that merit discussion.

1. Performance Improvement Plans.

The Performance Improvement Plan (PIP) process has proved beneficial to providers and individuals. As noted in Part II.B.3, a PIP is a tool that is initiated by the Data Review Group and facilitated by the CIM to focus on individual provider improvement.

In 2024, four providers were selected for the PIP process. While the PIP process has produced positive outcomes, implementation of that process provided fodder for improvement. In 2025, Iowa Medicaid's Long-Term Services and Supports (LTSS) Bureau, which oversees the CIMs, has partnered with the State-Operated Specialty Care Division and members of the Data Review Group to create better precision and outcomes for this process.

2. Limited Quality Assurance Death Reviews.

The Monitor requested that GRC implement quality assurance limited death reviews of individuals who have transitioned to other placements. While mortality reviews of Resource Center residents are statutorily authorized while residing at the Resource Center and for five days after transition, thereafter, HHS is not statutorily authorized to obtain the medical records of former residents. However, the purpose of the death reviews is intended to be limited to focus on the quality of care during the transition process, the quality of post-move monitoring, and the quality of provider care in the community as opposed to the purpose of a mortality review, which evaluates medical

care and requires a review of all medical records of the individual. Thus, HHS implemented a procedure for conducting those reviews occurring 6-365 days post-transition.

The process requires HHS to gather and request any relevant documents within its legal authority. In conjunction with this procedure, HHS implemented a process for seeking guardian consent to medical record release before the resident left GRC. In spite of this procedure, HHS is often unable to procure the release. The limited quality assurance death review is completed by a quality assurance death review committee.

The committee completed seven reviews in 2024. While providing some insights into the quality of care, the reviews have not proved to be a particularly effective tool because the ability to gather records is so limited.

V. Closing Summary

HHS has put together a solid post-move monitoring team and post-move monitoring processes. These processes have benefitted from the identification of and response to Community Thresholds at both an individual level and a systemic level. All of these processes work together to ensure that individuals are safe in their homes and living in the most integrated setting of their choice.

The data reveals that most individuals have transitioned to community settings and have been successful in those community settings. The data also indicates that HHS has room to improve by increasing quality oversight and reducing incidents related to Community Thresholds. In keeping with that data, HHS is currently crafting additional processes and quality management tools that will be implemented in 2025.