# Glenwood Resource Center
# Post-Move Monitoring Report

July 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 are 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 included 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 second report fulfilling that obligation. The first report is dated January 2025.

# 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 individuals returned to GRC after transitioning to the community. Subsequently, all four individuals transitioned back to the community.

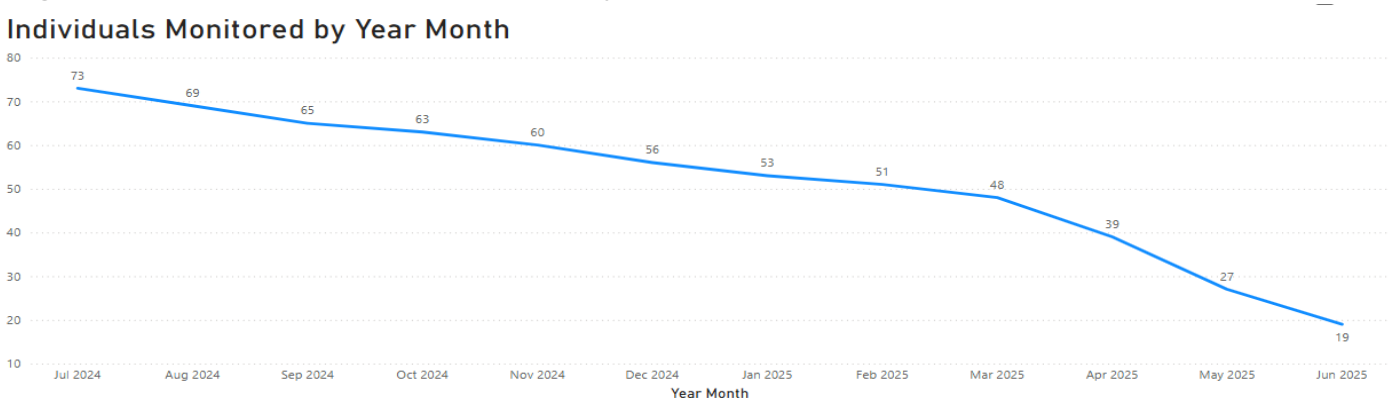
As of January 1, 2025, there were fifty-one (51) individuals remaining within their 365-day post-move monitoring follow-up period, with 39 individuals living in community settings and 12 individuals living in institutional settings. As of June 19, 2025, there are no individuals remaining within their 365-day post-move monitoring follow-up period.

## Figure 1: Individuals Residence at 365-Days

| | |
|---|---|
| # of individuals residing at WRC (ICF-IID) | 21 |
| # of individuals residing in HCBS Community homes | 73 |
| # of individuals residing in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) | 7 |
| # of individuals residing in host homes | 13 |
| # of individuals residing in nursing facilities | 8 |
| # of individuals in a hospice | 2 |
| # of individuals that moved out of state | 1 |
| Deaths after transition from GRC** | 22 |
| Deaths while residents of GRC (pre-discharge) | 5 |
| Total Individuals in Target Population | 152 |

* Numbers reported are based on where individuals were living as of their 365-day post-discharge visit.
**Deaths listed are deaths that occurred during the 365-day post-discharge follow-up period. Deaths may have occurred after the 365-day follow-up period and some of these deaths may have been included in the Limited Death Reviews.

## 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 receive 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 WRC Center of Excellence 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 was assigned a Post-Move Monitor (PMM). The PMM was 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 documented each visit using an individualized checklist that encompassed all areas of the individual's transition plan. The PMM was 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 the timely completion of PMM visits from July 2024 through June 2025. Of the

visits that did not meet the required cadence, only one PMM visit was not completed at all.

## Figure 3: PMM Cadence Compliance.

| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # of PMM Visits Due | 65 | 66 | 56 | 53 | 47 | 37 | 25 | 36 | 23 | 33 | 12 | 19 |
| # of PMM Visits Completed meeting the required cadence | 63 | 65 | 56 | 53 | 47 | 37 | 25 | 36 | 23 | 33 | 12 | 18 |
| % of PMM visits completed meeting the required cadence | 97% | 98% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 95% |

To ensure the quality of the PMMs' follow-up and documentation, beginning in 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), the 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 received written and verbal feedback and was 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 between July 2024 through June 2025.

## Figure 4: PMM Quality Assurance Reviews.

| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # of PMM QA Reviews Completed | 4 | 8 | 5 | 5 | 4 | 5 | 4 | 4 | 4 | 4 | 3 | 2 |

**Findings from PMM Quality Assurance Reviews:**

The Quality Assurance process revealed that there was a lack of follow up on lab tests, dental appointments, and other medical appointments. In addition, sufficient documentation was not consistently noted with the focus more on gathering information through the "interview" technique, rather than implementing documentation review and observation. These issues were addressed with the assigned Post-Move Monitor Social Worker following the review, and the Post-Move Monitors reviewed documentation and made corrections to address these concerns.

Post Move Monitor Social Workers were trained on September 14, 2024, to request and review documentation prior to and during Post Move Monitoring cadence visits. Additional coaching and training with the Post Move Monitors was completed on February 25, 2025, and included retraining on the following procedures/protocols:

- PMM Guidelines Procedure

- PMM Hospice Follow-up Protocol
- PMM Documentation Completion Procedure
- Quality Assurance Review of PMM Checklist Post Transition from GRC Procedure

The PMM Social Workers were also retrained on February 25, 2025, on the following expectations:

- If a support is not included in the individual's PMM document, the PMM will add the support and continue monitoring the support through the 365 days.
- If a support is discontinued, the PMM will document the date the support was discontinued, reason why the support was discontinued and who determined the support was to be discontinued.
- Documentation for each support will be reviewed at each cadence visit. If documentation is not received timely from the provider, note this in the PMM document and continue to follow until documentation is received from the provider.

Following this re-training, the Post Move Monitor Social Workers improved in obtaining and reviewing documentation. The Post Move Monitor Social Workers self-reported that this was due to increased confidence in requesting documentation, building relationships with providers, and increased follow-up with providers. Anecdotally, it appears that the Post Move Monitor Social Workers improved in obtaining and reviewing documentation, as discussed during Post Move Monitoring Quality Assurance Review meetings. This was consistent with self-reports from the Post Move Monitor Social Workers.

As part of the Consent Decree compliance process, PMMs tracked 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 people. This tracking process ensures that the former GRC residents receive 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 are adequately 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 required 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

[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.

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.

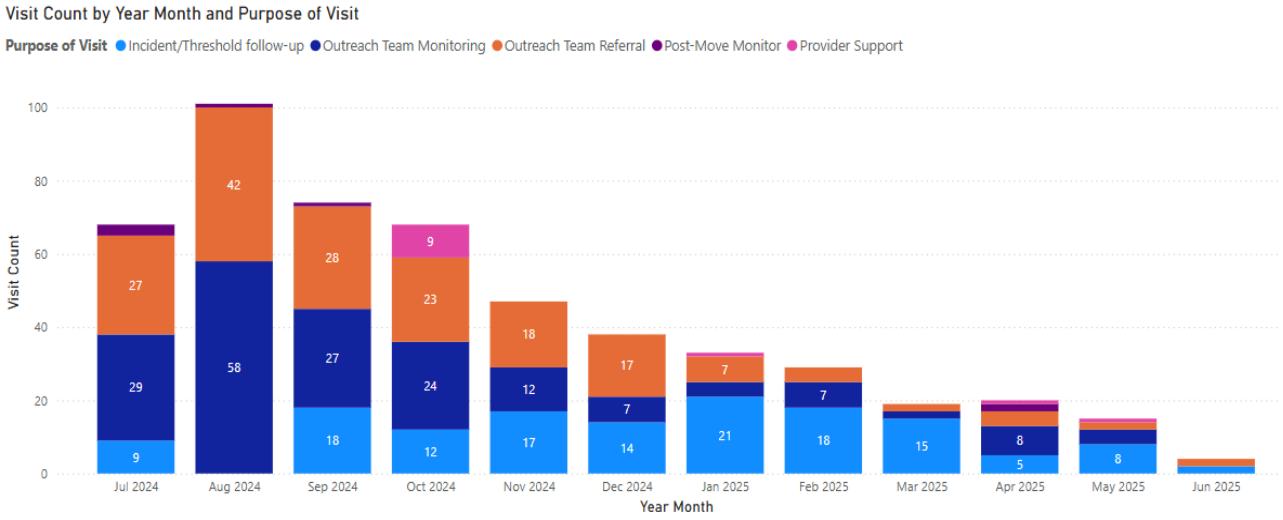
### 5. Woodward Resource Center (WRC), Center of Excellence (CoE) Outreach Team.

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 Behavioral Health Professional, a Behavioral Health Administrator, 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. Weekly PMM and Outreach Team meetings to discuss Community Thresholds and issues ended on June 25, 2025, as the last GRC individuals were no longer within their 365-day follow-up period.

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.

## Figure 5: Outreach Team Visits by Month and Year.




| Purpose of Visit | Jul 2024 | Aug 2024 | Sep 2024 | Oct 2024 | Nov 2024 | Dec 2024 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 | May 2025 | Jun 2025 | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Incident/Threshold follow-up | 9 | 0 | 18 | 12 | 17 | 14 | 21 | 18 | 15 | 5 | 8 | 2 | **139** |
| Outreach Team Monitoring | 29 | 58 | 27 | 24 | 12 | 7 | 4 | 7 | 2 | 8 | 4 | 0 | **182** |
| Outreach Team Referral | 27 | 42 | 28 | 23 | 18 | 17 | 7 | 4 | 2 | 4 | 2 | 2 | **176** |
| Post-Move Monitor | 3 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | **7** |
| Provider Support | 0 | 0 | 0 | 9 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | **12** |
| **Total** | **68** | **101** | **74** | **68** | **47** | **38** | **33** | **29** | **19** | **20** | **15** | **4** | **516** |

**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 WRC CoE 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 a list of thresholds that prompts 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.

First, the PMM must report the incident to the Woodward Resource Center Superintendent and WRC Center of Excellence. As noted above, the Center of Excellence 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. All Community Thresholds were resolved as of June 30, 2025, because there are no GRC individuals remaining in their post transition 365-day follow-up period.

### 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), Deputy Division Director, State-Operated Specialty Care Division (Iowa HHS Central Office) and Medicaid Division, Bureau Chief of Long Term Services and Supports (LTSS Bureau Chief). The regional CIMs are invited to view the monthly review group meetings.

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 sixty (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 HHS LTSS Compliance to reach out to the provider to discuss and debrief the issues.

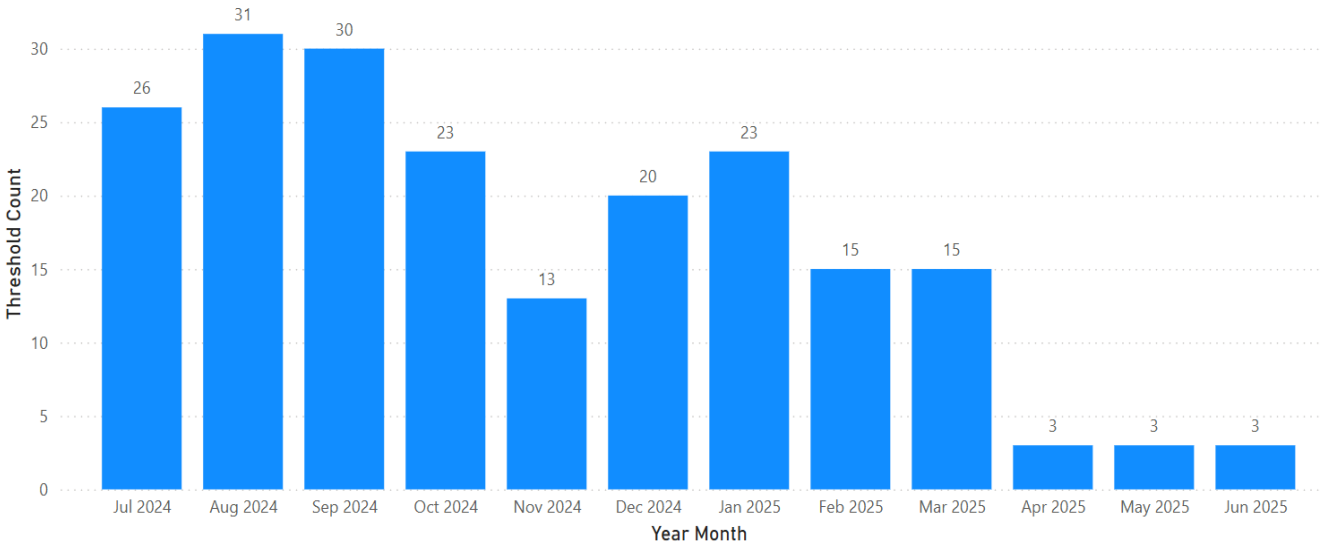
Beyond conferencing with the provider, where appropriate, the Data Review Group will require additional remedial action, which may include providing additional training and support to providers, following up on individual Community Thresholds, connecting the provider to additional supports and services,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

All Community Thresholds were resolved as of June 30,2025, because there are no GRC individuals remaining in their post transition 365-day follow-up period. The outstanding PIPs for three (3) providers are in process and will be reviewed by the LTSS Bureau Chief, a CIM and the HHS State-Operated Specialty Care Executive Officer 2 (SRC Liaison) to ensure resolution. The Data Review group will meet after each of the outstanding PIPs have been resolved to finalize the review and close the PIP.

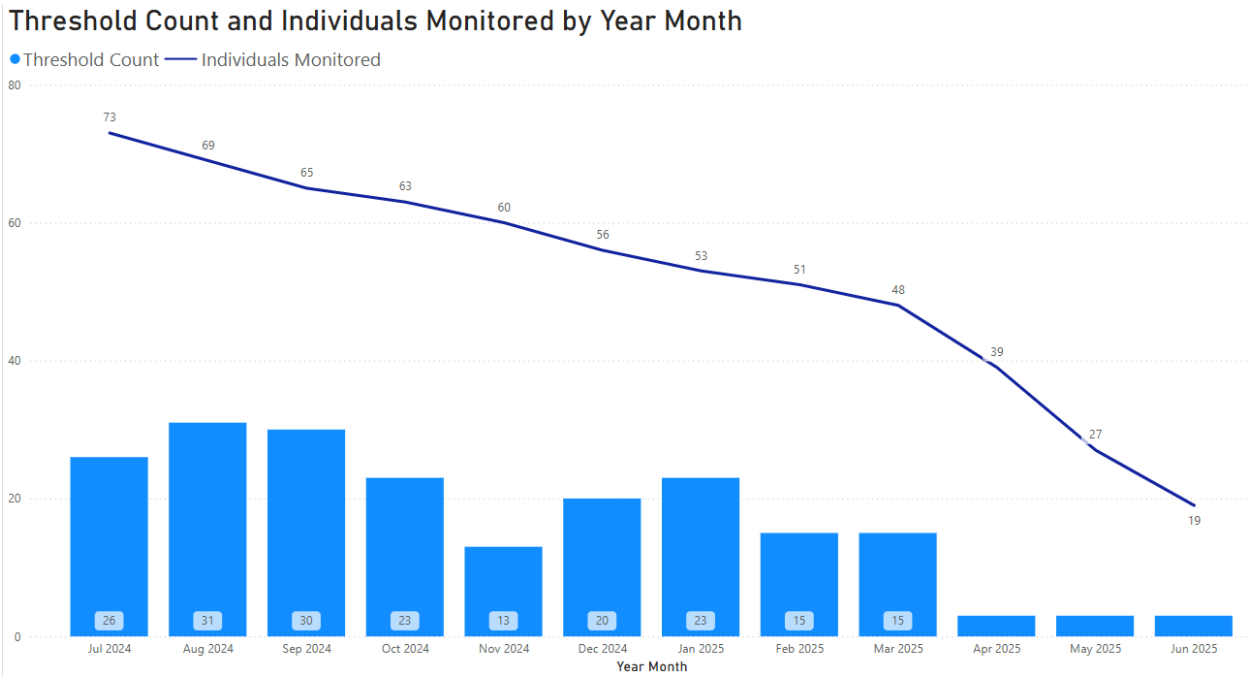
# III. Community Threshold Data.

Figure 6: Community Threshold Count by Month.




The Figure above shows the number of Community Thresholds met by month. Note: The decrease in thresholds reported reflects the decrease in individuals being monitored within their 365-day discharge follow-up period. As of June 19, 2025, there are no individuals remaining within their 365-day post-move monitoring follow-up period.

Figure 7: Individuals Monitored & Thresholds Met

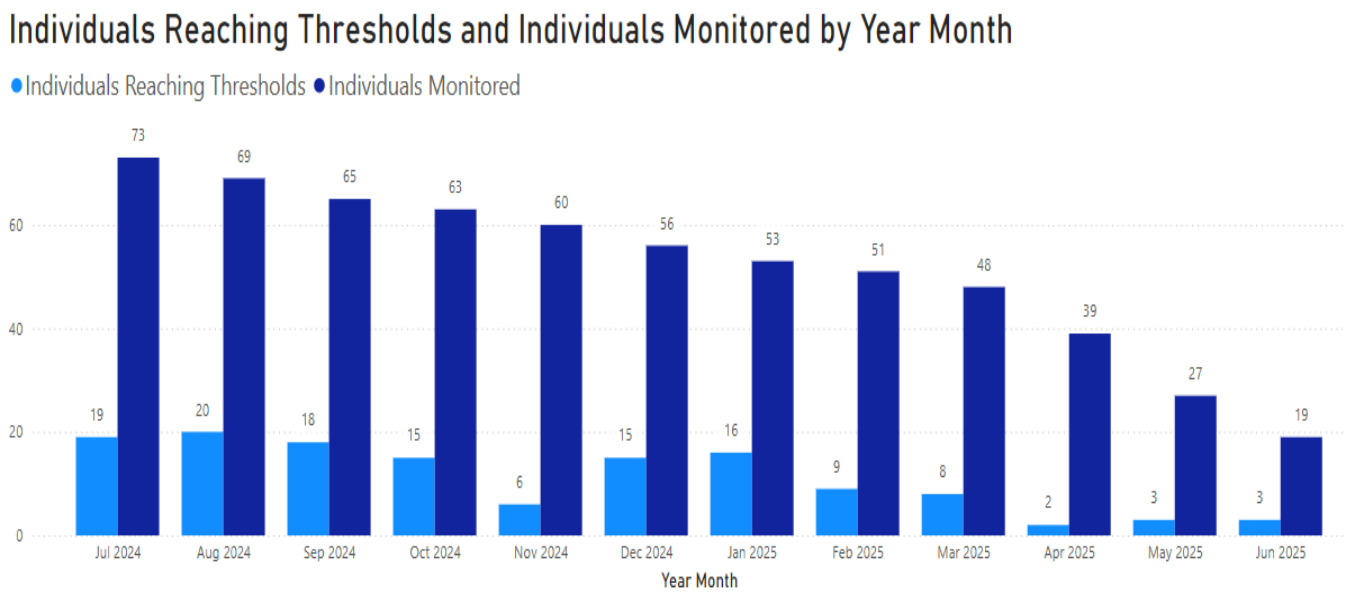


| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # of Thresholds Met | 26 | 31 | 30 | 23 | 13 | 20 | 23 | 15 | 15 | 3 | 3 | 3 |
| # of Individuals Monitored | 73 | 69 | 65 | 63 | 60 | 56 | 53 | 51 | 48 | 39 | 27 | 19 |
| Threshold Rate | 36% | 45% | 46% | 37% | 22% | 36% | 43% | 29% | 31% | 8% | 11% | 16% |

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. Note: As of June 19, 2025, there are no individuals remaining within their 365-day post-move monitoring follow-up period.

As the table in the figure above shows, the Threshold rate decreased over the past year, except for the brief spike in Community Thresholds reported in the last six months of 2024, as shown in December 2024 and then again in January 2025. However, after this spike, the Threshold rate for the first six-months of 2025 decreased steadily as the number of individuals being monitored steadily decreased to June 2025.

## Figure 8: Individuals Reaching Thresholds.




| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Individuals Reaching a Threshold | 19 | 20 | 18 | 15 | 6 | 15 | 16 | 9 | 8 | 2 | 3 | 2 |
| Individuals Monitored | 73 | 69 | 65 | 63 | 60 | 56 | 53 | 51 | 48 | 39 | 27 | 19 |
| % of Individuals Monitored Reaching a Threshold | 26% | 29% | 28% | 24% | 10% | 27% | 30% | 18% | 17% | 5% | 11% | 11% |

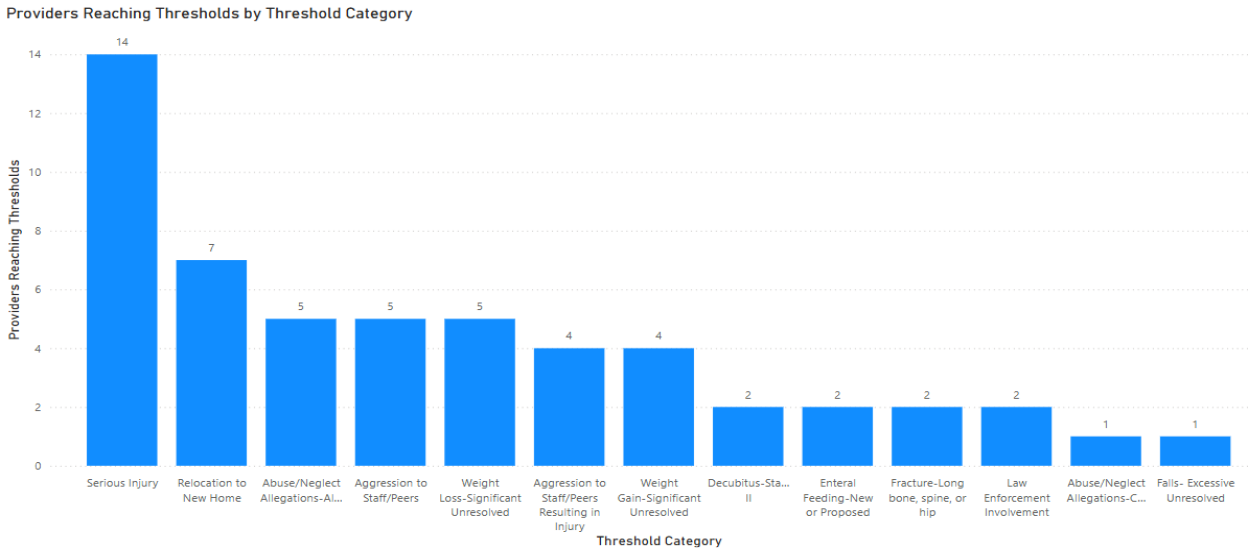
In the Figure above, for each month, the number of individuals that were within the 365-day post-move monitoring period is shown by the numbers associated with the dark blue bar. The light blue bar identifies the number of individuals meeting a Community Threshold by month. For example, in March 2025, forty-eight (48) individuals were within the 365-day post-move monitoring period and eight (8) of those individuals met Community Thresholds. Contrasting this Figure with Figure 6 illustrates that while there

was a total of fifteen (15) Community Thresholds in March (Figure 6), the number of individuals experiencing Community Thresholds during March was eight (Figure 8).

Note: The decrease in individuals involved in thresholds reported reflects the decrease in individuals being monitored within their 365-day discharge follow-up period. As of June 19, 2025, there are no individuals remaining within their 365-day post-move monitoring follow-up period.

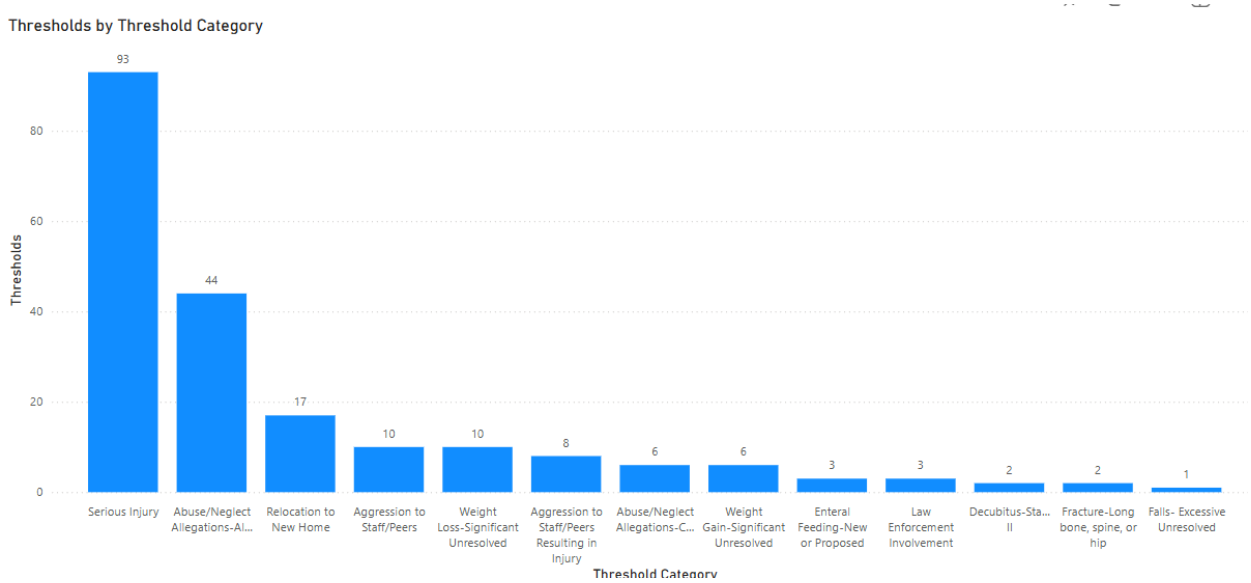
As the table in the figure above shows, the % of individuals meeting a Community Threshold decreases over the past year, except for the brief spike in the number of individuals meeting a Community Threshold in the last six months of 2024, as shown in December 2024 and then again in January 2025. However, after this spike, the % of individuals meeting a Community Threshold for the first six-months of 2025 decreases steadily as the number of individuals being monitored steadily decreases through June 2025.

## Figure 9: Providers Reaching Thresholds.



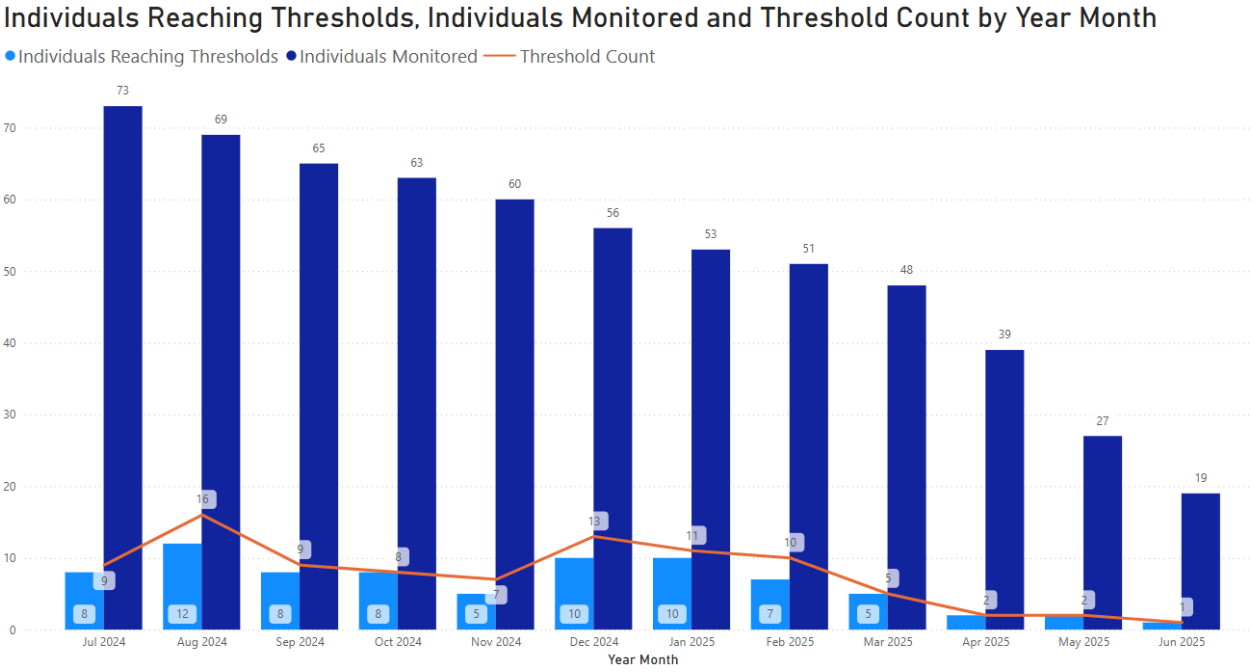

The above Figure shows the number of providers having met a Community Threshold between July 1, 2024, and June 30, 2025, by Community Threshold type. Between July 1, 2024, and June 30, 2025, there were 22 provider entities providing services to former GRC individuals within their 365-day discharge follow-up period. As of June 19, 2025, there are no individuals remaining within their 365-day post-move monitoring follow-up period.

## Figure 10: Threshold Count by Threshold Category




The above figure shows the total number of Community Thresholds met by Community Threshold type between July 1, 2024, and June 30, 2025. The five (5) highest categories of Community Thresholds are serious injuries, allegations of abuse or neglect, relocation to a new home, aggression to peers or staff, and significant weight loss. The five (5) highest categories met between July 1, 2024, and June 30, 2025, are discussed in more depth in the following figures and narratives.

## 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.

| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency Room Visits | 4 | 10 | 8 | 3 | 5 | 9 | 8 | 8 | 2 | 2 | 2 | - | **61** |
| Hospitalizations | 4 | 6 | 1 | 4 | 2 | 4 | 3 | 1 | 3 | - | - | 1 | **29** |
| Psychiatric Admissions | 1 | - | - | 1 | - | - | - | 1 | - | - | - | - | **3** |
| Provider On-site Medical Care | - | - | - | - | - | - | - | - | - | - | - | - | **0** |
| **Total** | **9** | **16** | **9** | **8** | **7** | **13** | **11** | **10** | **5** | **2** | **2** | **1** | **93** |

In Figure 12, of the 93 total "serious injury" Community Thresholds reported between July 1, 2024, and June 30, 2025, sixty-one (61) were trips to an emergency room, twenty-nine (29) were hospital admissions, three (3) were psychiatric hospitalizations, and none were an injury addressed by the facility medical provider.

Examples of issues that required an emergency room included, but were not limited to: gastro-intestinal issues due to a stomach bug, follow-up after a fall in which the individual hit their head requiring a CT scan, falls without head injury, seizure activity, replacement of a catheter, replacement of a feeding tube, urinary tract infection (UTI), receive extra fluids due to possible dehydration, and cellulitis. See the table below.

| Type of Injury/Incident - ER Visits | First 6- months of 2025 | Last 6-months of 2024 |
|---|---|---|
| Cellulitis | 1 | 1 |
| Change in bowel movements/diarrhea | | 3 |
| Choking | 1 | 1 |
| Congestion/Fever | 1 | 1 |
| Constipation | | 4 |
| Dental Infection | | 1 |
| Discomfort due to kidney stones | 1 | |
| Fracture | | 3 |
| Gastro-intestinal issues due to a stomach bug | 2 | |
| Head Injury - No Injury | 4 | |
| Head Injury from fall requiring CT Scan | 3 | 2 |
| Head Injury from fall requiring stitches | | 1 |
| Influenza | 1 | |
| Medication Refill | | 2 |
| PICA | | 1 |
| Pneumonia | | 4 |
| Receive extra fluids due to possible dehydration | 2 | 1 |
| Replace Catheter | 1 | 3 |
| Replace Feeding Tube | 2 | 4 |
| Seizure/Seizure Activity | 1 | 1 |
| Small Cut on Hand | 1 | |
| Urinary Tract Infection (UTI) | 1 | 4 |
| Urine retention | | 2 |
| **Total** | **22** | **39** |

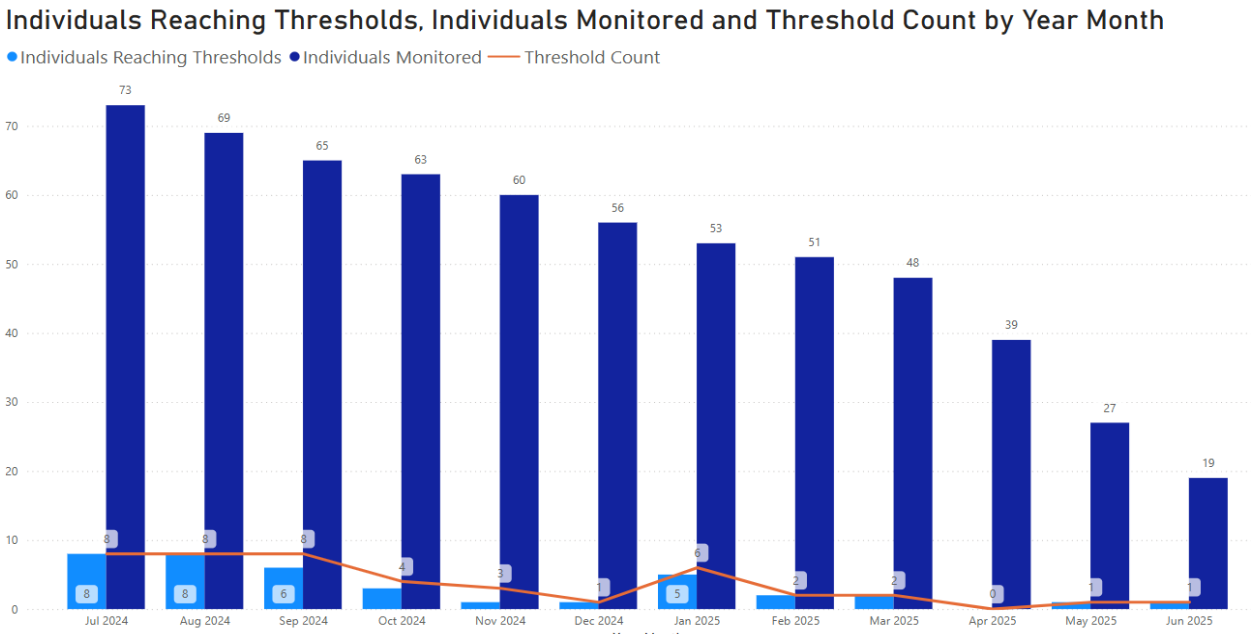
Examples of issues that required hospitalization, included, but were not limited to continued observation after a scheduled procedure, aspiration pneumonia, pneumonia, upper respiratory infection, hip fracture, dehydration, and constipation/bowel issues. See the table below.

| Type of Injury/Incident - Hospitalization | First 6- months of 2025 | Last 6-months of 2024 |
|---|---|---|
| Observation Following Scheuduled Procedure | 1 | 1 |
| Abdominal Distention | | 1 |
| Chronic Kidney Disease | | 1 |
| Choking | | 1 |
| Constipation | 1 | 2 |
| Dehydration | | 2 |
| Fracture | | 1 |
| Kidney Infection | | 1 |
| Pneumonia | 4 | 5 |
| Upper Respiratory Infection | 1 | |
| Replace Feeding Tube | 1 | |
| Seizure/Seizure Activity | | 1 |
| Stomach Infection | | 1 |
| Urinary Tract Infection (UTI) | | 3 |
| Urine retention | | 1 |
| **Total** | **8** | **21** |

The psychiatric hospitalizations were due to individuals being in crisis and needing an increased level of care.

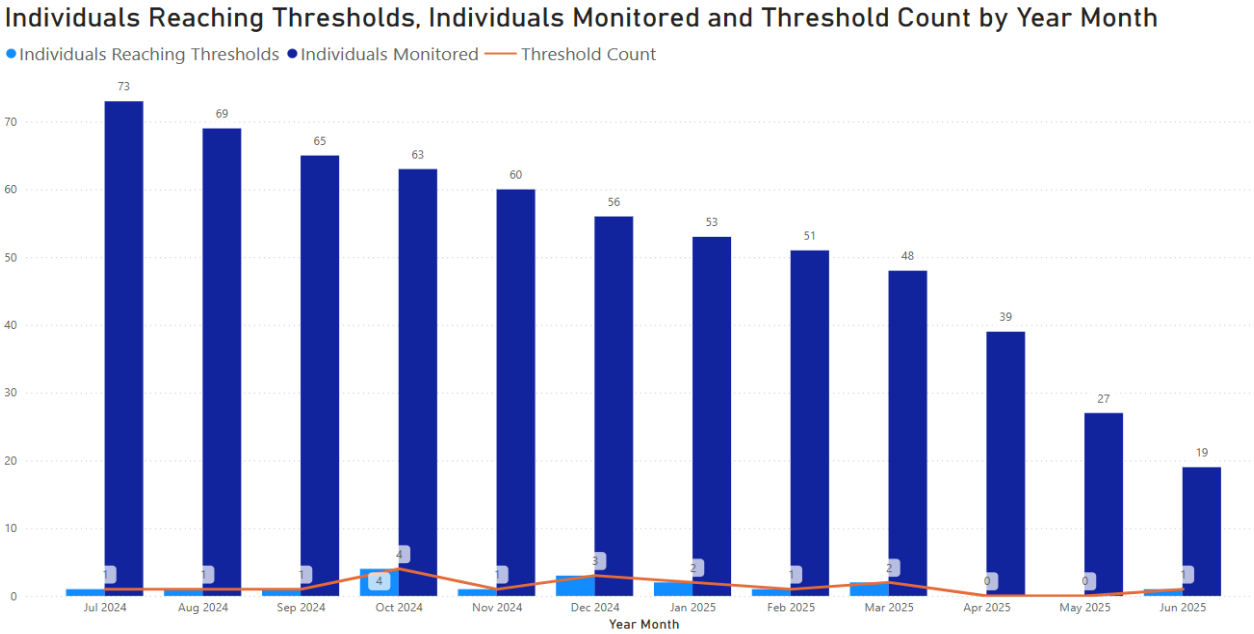
All serious injury thresholds were reviewed by the Outreach Team and additional support was recommended, as needed.

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



As illustrated by Figure 10, between July 1, 2024, and June 30, 2025, of the forty-four (44) total allegations of abuse/neglect reported, six allegations (6) 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.



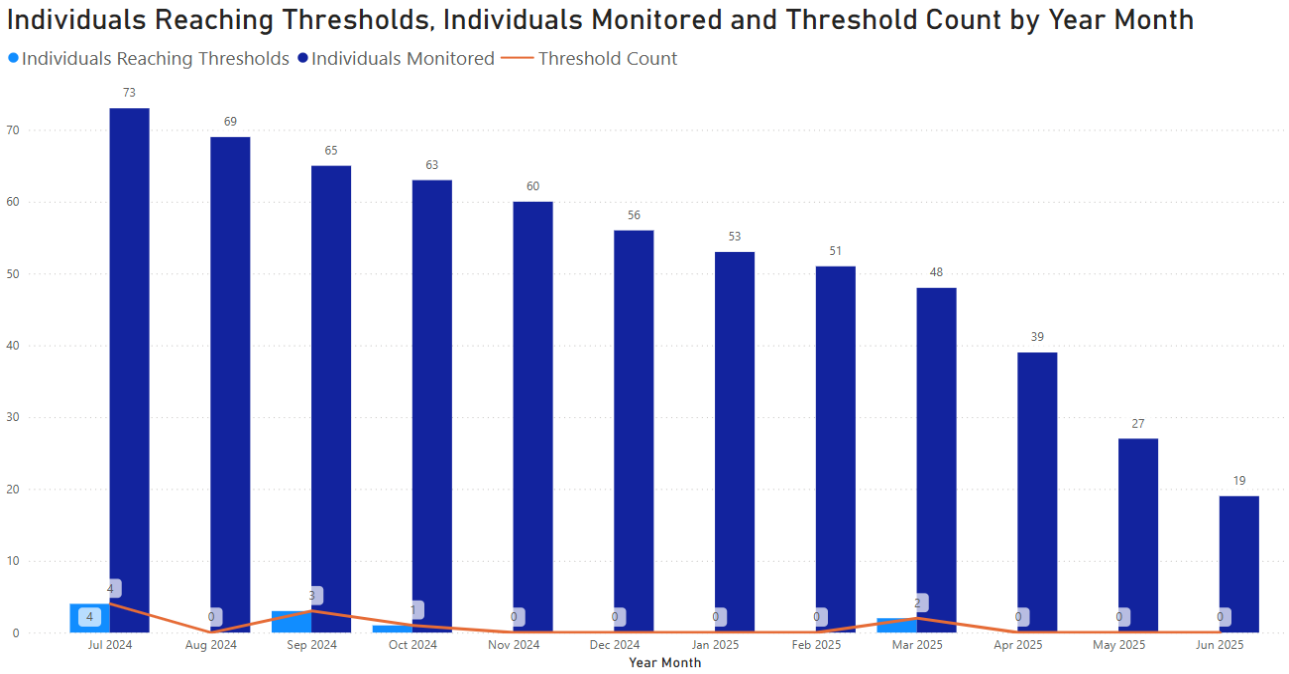

While Figure 14 identifies seventeen (17) relocation Community Thresholds in between July 1, 2024, and June 30, 2025, there were only sixteen (16) actual relocations. Because a relocation Community Threshold is triggered at the time the individual gives notice that they intend to move, a pending relocation was included in Figure 14.

Between July 1, 2024, and June 30, 2025, of the sixteen (16) individuals who relocated (Figure 14), eight (8) moved from one community setting to another, three (3) moved to different homes within their current provider, two (2) moved from a community setting to an institutional setting, two (2) individuals moved from a community setting to a nursing facility due to a change in level of care, and one(1) individual moved from one institutional setting to another institutional setting.[2]

[2] Specifically:
- Eight individuals relocated from HCBS Waiver provider to another HCBS Waiver provider.
- Three individuals moved between homes with their current provider.
- Two individuals 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 a nursing facility.
- One individual moved from one ICF-ID to another ICF-ID.

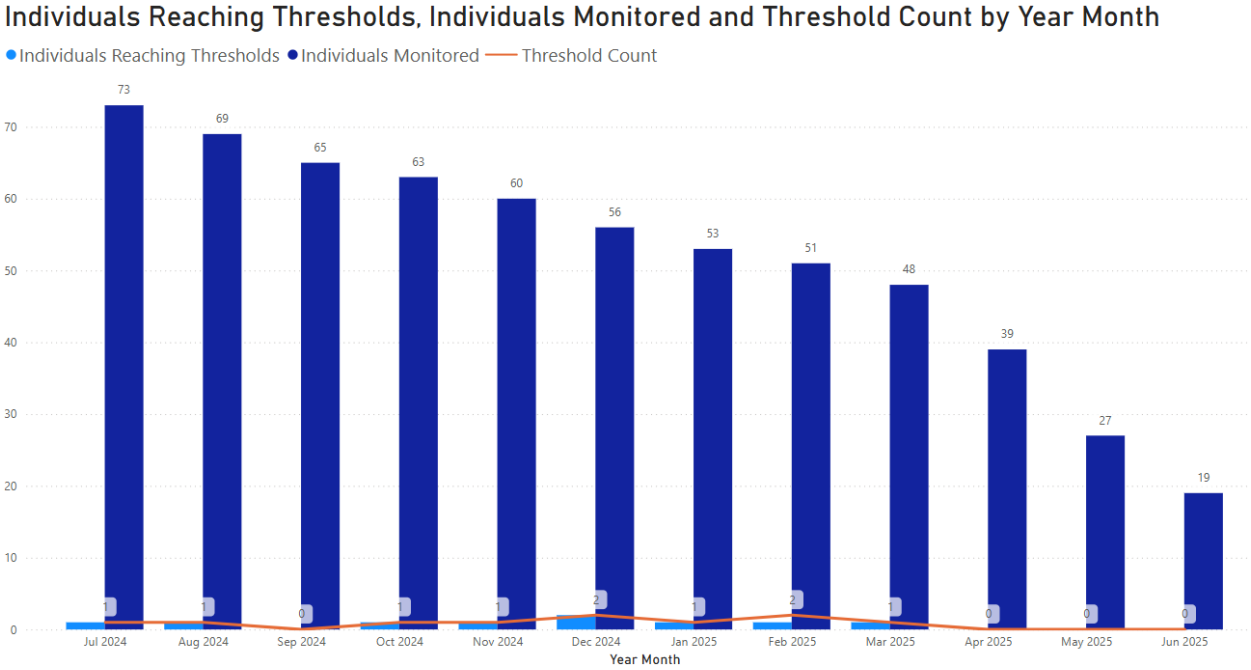
Additional information about the reason for the relocations is provided in the narrative under Part IV (A).

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



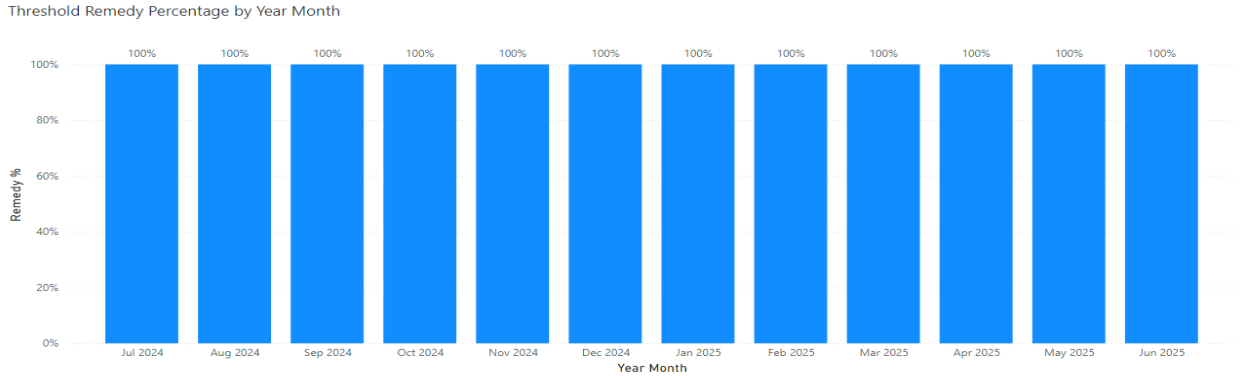

As illustrated by Figure 15, ten (10) Community Thresholds were reported for nine (9) individuals regarding weight loss. All individuals meeting the Weight Loss – Significant threshold received follow up from the Outreach Team Nurse Specialist and in some cases additional follow-up was completed by the Speech Language Pathologist (SLP) and Occupational Therapist (OT). Recommendations included, but were not limited to weekly weight tracking, meal/fluid intake tracking, addition of supplements (e.g. Ensure, Ensure Clear, Glucerna, etc.) if a meal is refused, and requests for a dietician and/or gastroenterologist to review the individual's case.

## Figure 16: Aggression by Year and Month.



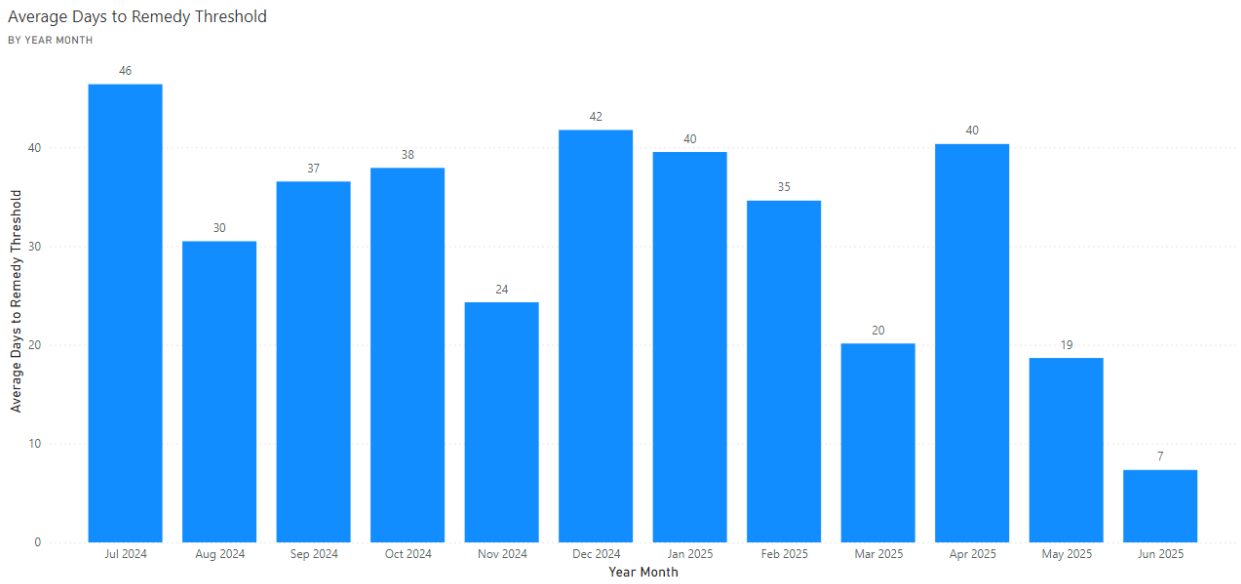

As illustrated by Figure 16, ten (10) Community Thresholds were reported for seven (7) individuals regarding aggression to staff/peers. One individual met four (4) thresholds for aggression to staff/peers. The Outreach Team provided additional support to the individual and provider including, but not limited to, medication and chart review, behavioral support including a historical data review, a mobility assessment, sensory needs assessment, and a review of mealtime supports. While the CoE was providing support to the individual and the community provider, the individual ended up in the hospital for psychiatric evaluation following an incident of aggression to staff and peers. The community provider decided to discharge the individual and the individual ended up in a safe environment with another provider.

## Figure 17: Community Threshold Remedy Percentage.

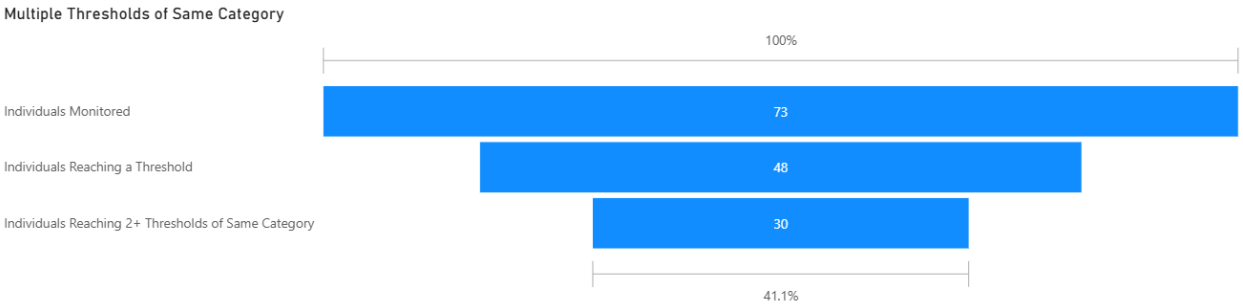



* All Community Thresholds were resolved as of June 30, 2025, as there are no GRC individuals remaining in their post transition 365-day follow-up period.

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.




Even though there was a recurrence of a Community Threshold as shown in the figure above, this is not indicative that appropriate recommendations and/or supports were not in place to prevent the recurrence of the threshold.

# 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, between July 1, 2024, and June 30, 2025, sixteen (16) individuals relocated. Eight (8) moved from one community setting to another, three moved to different homes within their current provider, two moved from a community setting to an institutional setting, two individuals moved from a community setting to a nursing facility due to a change in level of care, and one individual moved from one institutional setting to another institutional setting.[3]

Of the eight (8) individuals moving from one community setting to another, one individual moved to another HCBS Waiver home with nursing support due to change in level of care needed (current provider did not have nurse and individual required nursing care). Seven (7) individuals moved to a new provider at the guardian's request because the current provider was unable to meet the individuals' needs.

Of the three (3) individuals moving to different homes within their current provider, two individuals moved to different homes to be with a peer group that would better meet their needs, and one individual moved to another home because the home he was living in was closing.

Two individuals moved from two different community settings to WRC because the community provider was unable to meet the individual's needs.

Two individuals moved from a community setting to a nursing facility based on a physician's order requiring a higher level of nursing/medical care.

One individual moved from one institutional setting to another institutional setting at the guardian's request because the current facility was unable to meet the individual's needs.

Overall, HHS has successfully assisted GRC individuals in being integrated into the community. However, relocations to accommodate the needs of individuals and the wishes of guardians and individuals are not uncommon, and Iowa HHS continues to facilitate relocation as needed and requested.

[3] Specifically:

- Eight individuals relocated from HCBS Waiver provider to another HCBS Waiver provider.
- Three individuals moved between homes with their current provider.
- Two individuals 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 a nursing facility.
- One individual moved from one ICF-ID to another ICF-ID.

## B. Post Move Monitors.

As indicated by Figure 3, the PMMs cadence requirements improved throughout the last six months of 2024 and the first six months of 2025. PMMs meeting the cadence requirements never dropped below 95% between July 1, 2024, and June 30, 2025, and the PMMs met the cadence requirements 100% for nine of the twelve months in the reporting period. The improvement is likely a result of a change in procedure allowing PMMs to focus solely on post-move monitoring, as well as having the continued support of the Outreach Team.

As indicated by Figure 4, there were a total of fifty-two (52) reviews completed by the PMM QA Review Group between July 1, 2024, and June 30, 2025. As noted above, the Quality Assurance process revealed that there was a lack of follow-up on lab tests, dental appointments, and other medical appointments. In addition, sufficient documentation was not consistently noted with the focus more on gathering information through the “interview” technique, rather than implementing documentation review and observation. These issues were addressed with the assigned Post-Move Monitor Social Worker following the review and the Post-Move Monitors reviewed documentation and made corrections to address these concerns. 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 noted on several occasions that PMMs have implemented the Review Group’s feedback and recommendations to correct deficiencies beyond the particular documentation being reviewed.

To continue to improve upon Post-Move Monitoring processes and PMM Social Workers documentation, additional on-the-job training and coaching were completed in 2024 & 2025. Training included, but was not limited to:

- Post Move Monitor Social Workers were trained on 9/14/24, to request and review documentation prior to and during Post Move Monitoring cadence visits.
- Additional coaching/training with the Post Move Monitors regarding requesting documentation prior to and during Post Move Monitoring cadence visits was completed on February 25, 2025, and remains an on-going process.

Following re-training and coaching, the Post Move Monitor Social Workers improved in obtaining and reviewing documentation. The Post Move Monitor Social Workers self-reported that this was due to increased confidence in requesting documentation, building relationships with providers, and increased follow-up with providers. Anecdotally, it appears that the Post Move Monitor Social Workers improved in obtaining and reviewing documentation, as discussed during Post Move Monitoring Quality Assurance Review meetings. This was consistent with self-reports from the Post Move Monitor Social Workers.

## C. WRC Center of Excellence.

The addition of the Center of Excellence 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 June 30, 2025, the Outreach Team members logged 516 visits (Figure 5). The number of visits continued to decline throughout 2025 as the number of individuals within their 365-day post-move monitoring follow-up period decreased.

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 ad hoc advice 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 was its highest point in August 2024 and incidents and thresholds slowly trended downward over the next 10 months. The data does not reveal the cause for the downward trend. Anecdotally, it may be attributable to individuals settling into their new homes and because the number of individuals within their 365-day post transition follow-up period declined due to reaching the end of their follow-up period. Community Thresholds had a slight uptick in December 2024 and January 2025, but then followed a decreasing trend as seen in Figure 6. Again, in spite of reviewing the data collected to identify causal connections, the HHS team were unable to connect the trends to specific causes. This is not surprising because the type of Community Thresholds varies significantly and the individuals experiencing the thresholds each have a unique set of challenges and gifts (for example, medical, social, behavioral, intellectual, psychological).

A look at the trends in the various categories of Community Thresholds provides some insight into the statistics. 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 93 times between July 1, 2024, and June 30, 2025. There are likely reasons for this.

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 61. 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. There were seven (7) thresholds noted that could have been appropriately addressed by the individual's primary care physician (e.g., mild stomach issues, medication refills, minor injuries, and the common cold). For example, one community provider was noted to have protocols in place to send individuals to the emergency room following any fall incident or any incident in which the individual hit their head. The CIM worked with the provider to review and revise these protocols. 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. In review of the data, it was noted that there were ten (10) thresholds that could have been addressed by an urgent care clinic (e.g., vomiting with fever, colds with fevers, urinary tract infections (UTI), minor injuries, and minor follow-up after an alleged abuse allegation). 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. One example of this is routine changes of gastronomy (G-tubes) that must occur in the emergency room for some individuals. 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 is high, the monthly number of Serious Injury Community Thresholds does not exceed twelve (12) in one month. The trend for this category follows the decreasing trend for Community Thresholds overall.

The second highest category of Community Thresholds is Allegations of Abuse and Neglect with forty-four (44) occurrences between July 1, 2024, and June 30, 2025. 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, between July 1, 2024, and June 30, 2025, of the forty-four (44) allegations of abuse/neglect reported, only six (6) 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 sixteen (16) occurrences between July 1, 2024, and June 30, 2025, with no single month exceeding more than four (4). In Significant Weight Loss, the Community Threshold for the year reached was ten (10). The Threshold Count did not exceed four (4) for any given month and there were 0 occurrences during seven of the twelve months. The category of Aggression to Staff and Peers totals ten (10) for the year, reaches two (2) occurrences in two of the months, one occurrence in six of the months, and 0 for the remaining months.

Beyond the top five categories of Community Thresholds, of the remaining fifteen categories, for one Threshold category, Community Thresholds do not exceed eight (8); for two Threshold categories, the Community Thresholds do not exceed six (6); for two Threshold categories, the Community Thresholds do not exceed three (3); for two Threshold categories, the Community Thresholds do not exceed two (2); and for one category, the Community Thresholds do not exceed one (1). Seven categories have no Community Thresholds reported.

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 14% of those allegations are confirmed. For 75% of the 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 the recurrence 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.

Figure 18 reflects the average number of days for each month to remedy the Community Thresholds opened during that month. In the last six months of 2024 and the first six months of 2025, those averages ranged from seven (7) days to forty-six (46) 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, as seen in Figure 17. All Community Thresholds were resolved as of June 30, 2025, as there are no GRC individuals remaining in their post transition 365-day follow-up period.

## F. 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. Center of Excellence Training Through Trualta.

In April 2025, all CoE staff were required to complete the following list of trainings through Trualta – Family Caregiver Education and Support Platform. Many of the CoE members have facility-based backgrounds. Therefore, training was assigned based on those that would be most helpful for understanding community-based services and using a community-based lens.

The training courses included, but were not limited to:

- Approaches to Challenging behaviors A Life in the Community: A Review of the Olmstead Decision
- Home and Community-Based Services (HCBS) Philosophy and HCBS Settings Rule
- Medicaid Eligibility Basics
- Fatal Five
- Introduction to HCBS
- Person Centered Practices
- Person Centered Planning

### 2. 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):

- 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.

Additional CBT modules added to the LMS since January 2025:

- Suicide Prevention - System of Care - Uploaded to Trualta on February 24, 2025
- Guardianship & Decision-Making - Uploaded to Trualta on February 24, 2025

- I-START and PPSS - Uploaded to Trualta on March 24, 2025
- Relationship, Advocacy & Guardians - Uploaded to Trualta on April 14, 2025
- Informed Consent 101- Uploaded to Trualta on April 23, 2025
- Money Follows the Person - Uploaded to Trualta on May 19, 2025
- Long Term Services & Supports 101- Uploaded to Trualta on May 19, 2025
- Goal Writing & SMART Goals- Uploaded to Trualta on May 28, 2025
- Quality Management: Key Concepts- Uploaded to Trualta on May 19, 2025
- Adoption Informed Care - is estimated to be uploaded to Trualta on July 30, 2025.

### 3. Case Management Post-Transition Training.

On October 1, 2024, a 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.

As part of the Risk Reassessment Project that began in February 2025, lead case managers for former GRC individuals completed the Fatal Five Training before beginning the Risk Reassessment process.

Case Managers also attended the following training courses throughout 2025:

- “CIM-Based Training”, presented virtually by Latisha McGuire, LTSS Case Management SME, on February 27, 2025.
- "Goal Writing and SMART Goals”, CBT Training, May 1, 2025 (optional training).
- “LTSS CIM Community Case Management & DOJ Consent Decree” presented by Andrea Maher to the MCOs on June 11, 2025.
- MFP education on “Review of Critical Incidents and DOJ Monitor Report” in June 2025, presented by Lindsey Robertson to the Transition team supervisors
- Money Follows the Person (MFP) Partners Meeting in Des Moines on June 11, open to MCO Community-based Case Managers (CBCM), which included presentations from MFP Behavior Support, I-TABS, Provider Prevention and Support Services (PPSS), Iowa Compass, and Woodward Center of Excellence – attendance was optional.

- Case Management Initial Certification, for MCO CBCMs hired on or before November 1, 2024, deadline for completion: July 1, 2025.

### 4. CIM Training.

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

- 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.

The CIMS completed Fatal Five Training in March 2025. The CIMs also completed the Initial Community Based Case Management Certification Toolkit training that was completed by April 2025. The Case Management Certification Toolkit training topics were:

1. Medicaid
    - Medicaid 101
    - Community Integration Philosophy
    - Home and Community-Based Services Philosophy
    - Iowa's HCBS waivers
2. Working with consumers
    - Case management Roles and Responsibilities
    - Adopting a Trauma-Informed Lens
    - Developing and Maintaining Relationships with Members and Care Teams
    - Person-centered planning
3. Technical Skills and Compliance
    - Mandatory Reporter Training Series
    - Service Documentation and Service Monitoring
    - Incident Reporting
4. Transitions between settings

- Accessing Community-Based Supports and Resources
- Transitions in Care
- Transitions in Care: Hospitals to Community-Based Care
- Facility Diversion
- Providing Services to Children and Youth
- Transitions from Child to Adult Services

5. Dealing with Emergencies
   - Mental and Behavioral Health Crisis Response
   - Suicide Risk Screening and Safety Planning
6. Sub-population Specific Knowledge
   - Residential Assessment Application
   - Iowa DHS TBI Training
   - Person-Centered Planning for Medicaid-funded HCBS Employment Services
   - Consumer Choice Options for Case Managers
   - LTSS 101
   - Fatal Five

Additional training attended by the CIMs include "Goal Writing and SMART Goals", Competency Based Training (CBT), May 1, 2025, and the MFP Partners Meeting in Des Moines on June 11, 2025, which included presentations from MFP Behavior Support, I-TABS, Provider Prevention and Support Services (PPSS), Iowa Compass, and Woodward Center of Excellence.

## G. 2024/2025 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 four 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 Performance Improvement Plan 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 (4) providers were selected for the PIP process. In 2025, one additional provider was selected for the PIP process and two providers completed the PIP process. As individuals being followed for their 365-day post-move monitoring follow-up period decreased throughout 2025, so did the number of thresholds met and the need for a PIP. However, there are currently three (3) active PIPs that the Iowa Medicaid's

Long-Term Services and Supports Bureau (LTSS Bureau) Chief is overseeing through completion. The providers for the three (3) active PIPs continue to provide monthly data and have been willingly to work to meet the objectives of their assigned PIPs.

### 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, and an additional three reviews in 2025. Of the three reviews completed in 2025, two individuals had a Do Not Resuscitate (DNR) order with the guardian having a court-order to make end of life decisions. Causes of death for these three reviews include aspiration pneumonia, pneumonia, sepsis and hypoxia, failure to thrive and sepsis secondary to pancreatitis.

A common theme with the additional three reviews completed in 2025 was documentation. It was noted in one review that transparency of monitoring needs to occur between MCO Case Managers, MFP Transition Specialists and GRC PMM Social Workers. This issue was addressed in February 2025 with a TEAMS channel created for MCO Case Management notes, MFP notes, and GRC PMM documents in one central location. This allows for easy accessibility for the MCO Case Managers, MFP Transition Specialists and GRC PMM Social Workers to be able to see documents for individuals on their caseloads.

Another issue in one of the reviews was lack of documentation review by the PMM before and during a Post-Move Monitor visit and lack of follow-up of concerns noted during the visit. To address this concern, which was also noted in quality assurance audits, on September 14, 2024, Post Move Monitor Social Workers were trained to

request and review documentation prior to and during Post Move Monitoring cadence visits. On February 25, 2025, and continuing until June 19, 20205, Post-Move Monitors received additional coaching/training related to documentation requests and reviews as part of the Post Move Monitoring cadence visits. Following re-training, the Post Move Monitor Social Workers improved in documentation requests and reviews, which they reported was due in part to increased confidence requesting documentation and increased follow-up with providers. Anecdotally, it appears that the Post Move Monitor Social Workers improved in obtaining and reviewing documentation, as discussed during Post Move Monitoring Quality Assurance Review meetings. This was consistent with self-reports from the Post Move Monitor Social Workers.

A lack of provider quality assurance practices was noted in one review. Tracking was in place and occurred for bowel movements and oxygen saturations; however, there was no documented quality assurance review by the provider to ensure appropriate interventions were completed when parameters for intervention were met.

In one review, although the timely notification of abnormal vitals from the facility nurse to the facility medical provider did not contribute to the individual's death, the death review identified that facility nursing staff could improve on more timely notifications of abnormal vitals. It was determined there would be a benefit in using the NEWS 2 (National Early Warning Sign) score and SBAR (Situation, Background, Assessment, and Recommendation) when discussing a change in an individual's condition with the medical provider, to provide a more thorough picture of the individual's current condition to the medical provider. Training was provided for the facility nursing staff from June 4, 2025, to June 19, 2025, on completing the SBAR, NEWS 2, with a review of the facility's Vital Signs Procedure to ensure timely notification to the medical provider.

### 3. Risk Reassessment Project

In February 2025, the regional CIMs began the Risk Reassessment Project. The purpose of the Risk Reassessment Project was to reevaluate all of the former Glenwood residents residing in the community to ensure that their Individual Support Plans accurately identify risks and include appropriately implemented risk mitigation plans aligned with each individual's needs and preferences.

The project was undertaken in increments. Former GRC residents living in the community were divided into five "waves" to stage the risk reassessments. The first wave was completed on April 21, 2025, with the next three waves occurring over May and June, and the final wave being completed on June 30, 2025. As a part of the risk reassessment process, case managers received "fatal five" training to assist in identification of risks.

The risk reassessment process began with the case manager's thorough review of documentation to identify potential risks, followed by scheduling an IDT meeting- including the assigned CIM- to discuss the risks and explore mitigation strategies. With

guidance from the CIMs, the IDT and case manager conducted a thorough review of documentation to identify current risks and incorporated both risk identification and mitigation into a revised Individual Support Plan (ISP).

Case management entities involved in the risk reassessment process have provided positive feedback. The Fatal Five training proved to be highly beneficial from an educational standpoint, enhancing understanding of health risks individuals with IDD can face. The training equipped case managers to identify common, preventable, and potentially fatal health issues affecting this population. Previously, the ISP focused primarily on the new community living environment. At completion of the project, the CIMs noted a marked improvement in the integration of risk mitigation strategies into the ISP. The CIMs noted that by incorporating critical clinical considerations into the ISP, the case manager equips the provider to anticipate potential issues- preparing them for the "what if" scenario. This enables the direct care staff to take a proactive approach to recognizing early warning signs and symptoms that could otherwise be easily overlooked.

### 4. Case Management Audits

In February 2025, the CIMs began audits of case management notes for former GRC residents living in the community. The purpose is to ensure Managed Care Organization (MCO) Community Based Case Managers (CBCMs), Targeted Case Management (TCM), and Money Follows the Person Transition Specialists (MFP TS) follow a person-centered planning process in facilitating the interdisciplinary team (IDT). The CIM reviews records and audits community case management entity files to ensure thorough transition planning is identified from the assessment and adequately addressed by the IDT team and documented in the case management notes. The Case Management Audit tool was developed in collaboration with the LTSS Policy SMEs. Compliance team participants include Community Integration Managers from each region, LTSS Case Management SME, LTSS MFP SME, LTSS Bureau Chief, and representatives from Medicaid Program Integrity & Compliance Bureau and the QIO. As of June 30, 2025, the CIMs have completed two full audits and are working to complete a third by July 15, 2025.

For the first two audit rounds, members audited were former GRC individuals who were still within their 365-day post-move monitoring follow-up period. For the 1st round completed in March, entities audited were MFP (35) and Iowa Total Care (ITC) (2); for the 2nd round completed in May, entities audited were MFP (13), ITC (4), and Wellpoint (3). For the round due in July 15, 2025, all files being audited are the remaining GRC individuals (48) living in the community that completed their 365 days post move follow-up period before January 30, 2025.

The results of the audits are shared at HHS LTSS Compliance Meetings that are scheduled every other month. Meetings were held March 28, 2025, May 23, 2025, and July 25, 2025. The July 25, 2025, meeting will include representation from HHS Aging

& Disabilities Division. The meeting agenda includes sharing of audit results, identifying trends to uncover systemic issues, and highlighting case management training opportunities. Recommendations include the development of a universal care plan to reduce environmental inconsistencies in plan delivery, facilitate easier monitoring of member progress, and promote standardization across case management entities and care settings.

# V. Closing Summary

In 2025, HHS implemented additional processes, training, and quality management tools as were discussed above. In 2024, HHS put together solid post-move monitoring processes and identification of and response to Community Thresholds that continued to improve and evolve throughout 2025.

With the 365-day post-move monitoring follow-up period having been met for all prior GRC individuals as of June 30, 2025, several of these processes will no longer continue to be used such as Community Thresholds and Limited Death Reviews.

As seen above, the data revealed that as the number of individuals within their 365-day post-move monitoring follow-up period decreased, so did the number of thresholds.

Even though individuals are no longer within their 365-day post-move monitoring follow-up period, the Outreach Team is still available to be contacted by individuals or community providers if issues should arise and MCO Case Management will continue to be involved for all prior GRC individuals.