

Hawai'i's "Going Home Plus" Project: A New Option to Support Community Living

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Abstract

The *Going Home Plus* project facilitates the transition of individuals from hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MRs) into community settings. The project is a collaborative effort between the State of Hawai'i Department of Human Services (DHS), the University of Hawai'i Center on Disability Studies and their community partners to help elderly and younger persons with disabilities who have been living in an institution for at least six months and express a choice for community living. The project, which provides services such as transition coordination and telemedicine, strives to become a valuable resource for institutionalized patients, their families, and medical professionals.

The right of persons with disabilities to live in integrated community settings is a core value within the *Olmstead v. L.C.* 1999 Supreme Court decision. This decision requires States to provide services in the "most integrated setting appropriate" for persons with disabilities, and determined that unnecessary institutionalization violated the Americans with Disabilities Act (ADA).¹ But for many older adults and persons with disabilities who have lived in institutions for a long time, returning to the community is difficult. Despite a preference to live in a home of one's choice in the community, there may be a lack of supportive services or accessible, affordable housing to make this move possible.

To assist States in promoting community-based alternatives, the Centers for Medicare & Medicaid Services (CMS) started providing Nursing Home Transition Grants in 1998. The Deficit Reduction Act of 2005 enacted the Money Follows the Person Rebalancing Demonstration to assist States in making changes to their long-term care support systems by reducing reliance on institutional care and developing community-based options. In 2007, Hawai'i received a Money Follows the Person grant to assist institutionalized persons with a preference to live in the community. This grant is funding the *Going Home Plus* project, which strives to become a valuable resource for institutionalized patients, their families, and medical professionals.

Project Purpose and Background

Going Home Plus is a collaborative effort between the State of Hawai'i Department of Human Services (DHS), the University of Hawai'i Center on Disability Studies and their community partners to discharge individuals from hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MRs) and transition them into community settings. The project targets Medicaid-eligible individuals institutionalized for at least six continuous months. Eligible Medicaid populations include the elderly, persons with physical disabilities, and persons with developmental disabilities who express a choice for community living.

Going Home Plus builds on the success of the *Going Home* project implemented by DHS in July 2003. The original project provides the State's acute waitlisted Med-

icaid patients requiring a nursing home level of care with the choice to leave the hospital and live in residential or foster family homes. This program provides more choices for clients, frees much-needed beds in acute-care facilities, and saves taxpayers about \$78,000 per patient each year.

The new *Going Home Plus* project builds on *Going Home* by reaching out to long-stay residents of nursing facilities and ICF-MRs. The project is supported by a stakeholder group composed of community partners representing hospitals, nursing home associations, policymakers, key advocacy groups, and consumers. The group provides regular input and oversight of the project's implementation.

Rebalancing the System

The overarching goal of *Going Home Plus* and CMS Money Follows the Person projects in other States is to rebalance the long-term care system, which is biased toward care outside the home. Nationwide, Medicaid spent \$67 billion on long-term care in 2000, 75% of which paid for nursing home and institutional care.² Nursing home care has become a form of entitlement, while community-based care is more difficult to access. For example, it is easier for persons in need of long-term care to become eligible for Medicaid payments by entering a nursing home.²

One exception is the Medicaid Waiver program, which provides a range of services to nursing home-eligible persons living in the community. In many States, however, Medicaid Waiver programs cap both the number of participants and the amount of allowable expenditures.² The imbalance between institutional and community care, coupled with the *Olmstead* Decision, serve as an impetus for States to transition individuals from institutional to community settings. In Hawai'i, *Going Home Plus* intends to demonstrate:

- An increased number of persons with long-term care needs living in the community;
- An improved quality of life for community-based individuals;
- Increased provider capacity to manage complex care in the community; and
- Reduced average annual costs compared to institutional services.

Identification of Candidates and Key Services

Potential transition candidates are identified through self-referral, referral from medical professionals or family members, or by review of health assessment reports (e.g., 1147 and 1150 level of care assessments, Minimum Dataset 2.0 (MDS)). A transition coordinator meets with candidates and conducts a preference assessment to ensure the person wants to return home and is aware of community options. Candidates and family members who want to participate in *Going Home Plus* work with the transition coordinator and facility staff to develop a transition plan that includes community-based services as well as a back-up plan.

A *Going Home Plus* housing coordinator helps find a community residence, which could include an individual's own home or apartment, a public or subsidized apartment, or a licensed/certified residence. Transition and housing coordinators arrange for goods and services needed to establish a community residence, such as:

- Housing coordination;
- Housing locator services;
- Roommate locator services;
- Trial visits to qualified community residences;
- Initial housing deposits;
- Utility hook-ups and deposits;
- Essential furniture, appliances, household items and clothing;
- Initial food stocking; and
- Financial services.

Once in the community, individuals have access to a range of services that support independent living, including:

- Case management;
- Nursing and medical services;
- Personal care assistance;
- Environmental modifications;
- Adult day health;
- Home-delivered meals; and
- Transportation.

These services are currently provided in Hawai'i by Medicaid Waiver programs. When the State transitions approximately 37,000 aged, blind and disabled (ABD) clients into the new QUEST Expanded Access (QExA) managed care program in February 2009, two health plans will provide all of the above-mentioned services and expanded home- and community-based services for these Medicaid beneficiaries. Under the QExA contracts, DHS requires the health plans to expand home- and community-based services by at least 5% each year. DHS will financially reward the health plans if they exceed the requirement, and financially penalize the plans if they do not meet the requirement.

QExA will ensure continuity and quality of care for ABD clients by providing comprehensive medical treatment coordinated by teams of healthcare professionals. QExA will also offer additional health services for the beneficiaries, including special programs focused on home- and community-based care, diabetes, heart disease, obesity, and neurotrauma.

Persons transitioning to the community who have complex medical or behavioral problems can also benefit from two telehealth services: remote patient monitoring and video monitoring. The former monitors vital signs, reports certain labs (e.g., blood sugar), provides timely medical reminders, and alerts clinicians when vital signs or other information are out-of-range or missing. The latter system allows clinicians to remotely manipulate video cameras so they can view specific areas of concern (e.g., skin infections). It is hoped that these telehealth services will help transitioned residents remain in the community and reduce the number of re-hospitalizations, emergency room visits, or emergency transports between Islands.

Finally, to support informal and paid caregivers in the community, *Going Home Plus* established a "training institute" to help them care

for persons with medical conditions and behavioral health issues. The curriculum covers subject areas such as behavioral interventions, wound care, obesity, vent care and home dialysis.

Challenges in Hawai'i

Compared to other States, Hawai'i faces unique challenges in transitioning institutional residents to the community. In many other States, nursing homes are "over bedded" with many nursing facility residents who are higher functioning. Transition programs in other States are thus aimed at higher-functioning nursing home residents who are inappropriately living in the facility. Hawai'i, on the other hand, is "under bedded," meaning there is an excessive demand for or shortage of nursing home beds. Hawai'i is ranked second in the nation in nursing home occupancy with 94% of beds in the State occupied, compared to the national average of 85%.³

With beds in short supply, nursing homes can be more restrictive in determining which patients to admit. Persons with lower acuity levels may be preferred over persons with more complex medical conditions. As a result, there is a list of individuals residing in hospitals and waiting for nursing home beds. Finding placement in a nursing home is difficult because these hospital patients often have challenging medical conditions, such as obesity or behavioral problems.

To address this problem, *Going Home Plus* relocates clients to community-based settings, rather than nursing homes. Transition coordinators partner with social workers, nurses and discharge planners at local hospitals to discuss patients on the waitlist and meet with these patients individually. If the patient meets project eligibility requirements and expresses a preference to return to the community, the transition planning process begins.

Hospital staff, transition coordinators, families and patients work together to assure that adequate community-based services, a supportive home environment, and a back-up plan are in place. The training institute supplies family and formal caregivers with skills to care for these medically challenging patients in the community. Another problem in Hawai'i is ensuring an adequate supply of public or subsidized housing for transitioned individuals. According to the Hawai'i Public Housing Authority, Hawai'i is plagued with long waitlists within its public housing and Section 8 programs. Currently, there are over 9,000 persons on the waitlist for about 8,000 public housing units. For the Section 8 voucher program, there are over 3,000 on the waitlist, and the waitlist is closed to new applicants (M. Flores; Director, Hawai'i Public Housing Authority; oral communication; January 2008). The *Going Home Plus* project has a housing coordinator to help participants who are interested in public or subsidized housing. The housing coordinator helps individuals complete housing applications, navigate the tight waiting lists and become competitive renters in the private landlord-tenant sector.

Next Steps

The *Going Home Plus* project began transitioning facility residents in August 2008. An evaluation of the project is being conducted by the University of Hawai'i Center on Disability Studies to monitor the implementation, outcomes and impact of the project. *Going Home Plus* intends to make a lasting positive impact on the long-term care system by ensuring adequate pathways and support for institutionalized individuals who prefer community living. Therefore,

it is important for healthcare professionals to be aware of this project so they can identify and refer potential transition candidates.

Individuals who live in an institution for long periods of time have limited options to transition to the community because they often have lost their prior housing and need assistance in coordinating appropriate housing and services. Successful transitions to the community are a collaborative effort among patients, their families, physicians and other medical professionals. The involvement of the medical community is key, as *Going Home Plus* enables individuals to express their preference and choice for community living – a freedom that is supported by the Olmstead Decision.

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