A.1 Case Studies

The target groups for *Going Home Plus* project include the elderly, persons with developmental disabilities, and persons with physical disabilities. The following three successful case studies are presented to demonstrate the process that will be used to follow individuals in each of these categories through the identification-referral, transition-planning, transition, and post-transition phases of implementation.

Sam Kapuna – Physically Disabled

Identification-Referral. The 47-year-old male, through his social worker, contacted local Protection and Advocacy (P&A) Agency for assistance in moving from the hospital to his home community. The P&A Agency attorney was a member of the *Going Home Plus* Stakeholders Group and referred the individual to the project.

Medical History. Mr. Kapuna is from the island of Kaua‘i. He is quadriplegic following injuries sustained in an automobile accident in 2003. Following five months of acute care at Wilcox Memorial Hospital on Kaua‘i, he was transferred to the only skilled nursing facility on that island. He was discharged after marijuana was discovered in his back pack following the visit of several friends. He went to his family home, but was there for only two days until he was readmitted to Wilcox Memorial Hospital for pneumonia. Subsequently, he was medically evacuated to an acute-care hospital on O‘ahu for an ileal conduit, due to chronic urinary tract infections. One month later he was moved to SNF level of care, and discharge planning began.

Social History. Prior to the accident, Mr. Kapuna was married, the father of three children, and employed in highway maintenance. Following the accident, his wife obtained a divorce. He remains in contact with his adult children, two of whom live on Kaua‘i. He also has an extended family on Kaua‘i. His parents are divorced, and his father lives with his sister and her family in Lihue. His mother and step-father live several blocks away. He has been receiving Medicaid since 2005 and has no source of income except his Social Security Disability Income. His parents (father-82, mother -78) visit him weekly, flying over from Kaua‘i at considerable expense. His mother is employed at the airport gift shop; his father is retired.

Discharge Efforts. Mr. Kapuna had been waitlisted for nursing home placement for 14 months. Discharge efforts have been extensive and unsuccessful. The only SNF on Kaua‘i refused to accept him because of the drug issue. Due to his size (275 pounds), no facility on O‘ahu was willing to accept him. In response to his frustration, the hospital social worker contacted the P&A Agency who referred Mr. Kapuna to the Going Home Plus Project.

Pre-Transition Planning. The *Going Home Plus* transition coordinator from the contracted agency met initially with Mr. Kapuna to discuss potential options. He has no cognitive impairment and can authorize his own consent. Mr. Kapuna requested a follow-up meeting be held with him, his parents, and the hospital social worker. At this meeting, the project and the home and community based waiver programs were fully explained to the family. They were eager to take advantage of this opportunity to get Mr. Kapuna back to Kaua‘i as soon as possible. A preference interview (based on the California Nursing Facility Transition Screen) confirmed

Mr. Kapuna’s desire to leave the facility**.** The Informed Consent for Participation Agreement form and the Participant Rights and Responsibilities form were read by him and his family. He gave verbal consent to participate; his consent was witnessed by his parents and the hospital social worker. He was given a copy of the Participation Agreement and the Participant Rights and Responsibilities form. In addition, he signed consents for the release of information so the transition coordinator could obtain copies of pertinent medical records. During the next visit, the transition coordinator conducted a comprehensive assessment and together with Mr. Kapuna developed the transition plan.

Housing Arrangements. His family was very anxious for him to return to Kaua‘i. Mr. Kapuna’s sister wanted him to come live with her family. The plan was to renovate the garage of her home (formerly owned by Mr. Kapuna’s father). His mother obtained approval for a bank loan to fund the construction and had blueprints completed for a fully accessible unit. The family asked assistance in expediting the building permit (which generally takes four months to obtain). The P&A attorney wrote to the County Office explaining the need and asking assistance in obtaining approval as soon as possible. The State Representative for the family’s district was also asked to contact the office. As a result, the permit was issued within 10 days and construction began. Construction was completed in six weeks. [In Mr. Kapuna’s situation, the modification was a full garage renovation and the family was financially capable of financing the construction. Under HCBS, the State does not contribute piecemeal to large renovation projects.]

Identification of Needs. Mr. Kapuna will need extensive support for all his activities of daily living and instrumental activities of daily living (phone calls, managing finances, etc.) Because of his weight, a single caregiver would be unable to turn him without assist. He is not a behavioral problem but has experienced depression over his long stay in a neighbor-island hospital. In addition, Mr. Kapuna has reported problems over the 5 years since his accident to allay the spastic pain he experiences in his legs and lower back.

Support System. By returning to Kaua‘i, Mr. Kapuna has an extensive support system of family and friends. At the home where the garage was renovated, his sister lives with her husband, daughter, grandchild, and father (Mr. Kapuna’s father). His mother and step-father live in the same neighborhood. The original plans for the garage renovation were revised to include two bedrooms, so that family members could alternate sleeping in the second bedroom for over-night care.

Weight Loss. Sam has experienced a significant weight gain in the hospital. During the period prior to discharge, a diet management program was instituted to reduce his weight prior to discharge. He was able to lose 20 pounds over the four-month period. He knows he will need to carefully manage his diet to continue to lose weight.

Transition. Once construction started on the renovations to the family home, the transition coordinator worked extensively with Mr. Kapuna and his parents during their weekly visits to the hospital to identify the services that would be needed, to locate providers, and to develop a back-up emergency plan. Since Mr. Kapuna would be returning to a family home it was agreed that he would be admitted to the Nursing Home Without Walls (NHWW) waiver program on Kauai. His discharge was planned to occur prior to the new QExA Medicaid managed care enrollment in October 2008. A list of Kauai –based waiver contracted case management and home care

agencies was reviewed for his choices. The transition coordinator had noted next to each case manager and home care agency's name which QExA health plans they had signed contracts with. Since Mr Kapuna had not yet been enrolled in a QExA health plan, he selected a case manager and all the home care agencies who had signed contracts with each available health plan on Kauai. He then signed a consent form and a copy of his vital information sheet, social summary, medical history, 1147level of care form and the transition plan were sent to the Kauai case manager.

Because the waiver participant would be transferring to another island, additional coordination was required to complete the NHWW admission. In this case, the Kauai NHWW case manager contacted the Oahu NHWW office to request transition assistance. Copies of pertinent paperwork were sent to the Oahu NHWW case manager who set up a team meeting at the hospital with Mr. Kapuna, the transition coordinator, hospital discharge planner and his family, including a teleconference with the Kauai NHWW case manager. The initial service plan, which included personal assistance, adult day health, non-medical transportation, PERS, nutrition counseling and telehealth services was reviewed, updated and agreed upon then signed by Mr.Kapuna and the Oahu NHWW case manager.. After that, all the waiver admission paperwork was reviewed and copies were given to Mr. Kapuna. The effective date of both the MFP and waiver admission would be the day of hospital discharge. Everyone agreed that the Kauai NHWW waiver case manager would meet Mr. Kapuna at his Kauai home on the day of discharge to conduct a reassessment, and update and resign the service plan.

Service Planning. The plan called for Mr. Kapuna to initially receive a more-intensive level of services that would be gradually reduced as he achieved greater independence and his family was able to assume more support. The plan called for 10 hours of personal assistance service each day to assist with bathing, dressing, and toileting. A family member agreed to be available several times during the day to assist the personal assistant in moving or turning Mr. Kapuna. He was to have a weekly visit from the home health nurse to assess his physical status during the first month at home. He would also attend an Adult Day Health center, for 6 hours a day Monday-Friday, as he is desirous of maintaining social connections. Mr. Kapuna chose the Wilcox Adult Day Health Center and Nursefinders home care agency to provide his services. Both agencies agreed to provide the services. Nursefinders claimed they had sufficient staff for the time of day Mr. Kapuna was requesting. The transition coordinator arranged for Meals on Wheels to deliver one hot meal daily, as the family's diet is influenced by local traditions of heavy carbohydrate intake, and would not be conducive to his desire to reduce weight. Three nutrition counseling and training sessions with Mr. Kapuna and his family were also authorized.

Medical Care. Mr. Kapuna selected a new primary care provider (PCP) who provided an initial assessment upon Mr. Kapuna's return to Kaua‘i. With the new level of health supervision, the family hopes to avoid future inpatient hospitalizations that would require medical evacuation to O‘ahu. The PCP will continue to monitor Mr. Kapuna's weight. Mr. Kapuna has also been exploring other pain control options with the new PCP A new drug combination will be initiated that the PCP is confident will prove helpful. Somewhat more challenging was locating a psychiatrist who would accept a new Medicaid client. Hawai'i has experienced a mass exodus of physicians leaving the islands due to low reimbursement rates, and many who have stayed will not accept new clients. A doctor on Oahu was found, however, who agreed to treat Mr. Kapuna

and his depression via telemedicine. The remote access video equipment was installed in his home on the day of discharge.

Supplies. Arrangements were made to provide the supplies needed to support Mr. Kapuna in the home. This includes diapers, gloves, incontinent pads, and ostomy supplies for his ileal conduit. The contracted SME provider will deliver supplies to the home on a monthly basis. Mr. Kapuna's sister agreed to be trained by the home health nurse to change the ileal conduit catheter.

Medical Equipment.
Wheel Chair: In the month prior to his discharge from the hospital, a power wheel chair was ordered for Mr. Kapuna. The consultation by the physical therapist determined that he would need to use a chin-control. The chair was only available for a week prior to his discharge from the hospital. His transition plan included weekly consultant visits by the physical therapist to assist him in learning to safely use the wheel chair in a variety of settings.
Hoyer Lift with Sling: As Mr. Kapuna is too heavy to turn or lift, a hoyer lift with a sling adaptation for use in the shower was obtained to assist personal care staff with locomotion. The home health nurse trained the household family members on transfer techniques and how to perform the daily range of motion exercises.

Personal Emergency Response System (PERS). As the garage area is somewhat separate from the rest of the home, a PERS was set up for the participant to ensure communication in the event of an emergency when staff were not in attendance. The Transition coordinator assisted with the installation of a land line to meet the system requirements.

The weekend before discharge, Mr. Kapuna's mother and sister came to Oah'u to receive "live-in" training at the hospital and to accompany him home to Kaua'i.

Post-Transition. The transition coordinator conducted the quality of life survey with Mr. Kapuna upon discharge on Oahu, and then scheduled the Quality of Life 12 and 24 month surveys with DHS's contracted provider. A satisfaction survey was conducted aannually thereafter. A transition coordinator living on the island of Kauai trained Mr. Kapuna and his family to operate the Telehealth equipment and visited Mr. Kapuna every three days for the first month to problem-solve any glitches in the transition. He is becoming increasingly capable in the use of his electric wheel chair. He began attending the ADH center in Lihue about a month after his discharge, and has even established a friendship with an elderly woman who also attends. In the second month he was home, his sister had to take on a part-time job outside the home, so was not as available to serve as a caregiver as she had suggested when the back-up plan was initially developed. On a couple of occasions, the regularly scheduled staff was unable to cover their shift, and due to the chronic workforce shortage on Kauai, a replacement could not be found. The staff on duty had to stay overtime on both occasions until Mrs. Kapuna could leave work and return to help with her brother-in-law. The case manager facilitated a meeting with the family members to revise the emergency back-up plan. Mr. Kapuna's two adult children agreed to attend and commit to caregiving on a weekly schedule. The revised back up plan identified daily primary coverage (including agency and day program services) and at least one secondary backup for various times each day of the week. Everyone received a copy of the schedule with phone numbers. At the meeting, the case manager also explained the consumer directed services

option, but everyone agreed to try the new back-up plan first. Mr. Kapuna would contact the case manager if the secondary plan didn't work out.

Now that Mr. Kapuna has been spending more time with his family (approximately nine months after returning to Kauai), he chose to return the remote access video equipment he had been using to communicate with the psychiatrist on Oahu. Mr. Kapuna's goal is to eventually return to a form of gainful employment. A referral has been made to Department of Vocational Rehabilitation, but Mr. Kapuna is waitlisted for services at this time. The transition coordinator continued to monitor Mr. Kapuna's progress for the first three months after transition, at which time the coordination services were fully relinquished to the waiver case manager. **Both** transition coordination and telehealth services are MFP demonstration services that would not continue beyond the demo.

David Araluka – Developmentally Disabled

Identification-Referral. David Araluka is a 55 year old male with severe cerebral palsy (spastic quadriplegic). He is cognizant of his surroundings and is not shy about expressing his needs and opinions, although intelligibility is approximately 75%. Confined to a reclining wheelchair, David has limited use of his left hand.

Mr. Araluka is the youngest of three children. He attended school until the fourth grade when his parents decided to keep him at home. He lived with his parents in a rural town until he was 42. At that time, his parents concluded that they could no longer meet his total care needs due to their decreasing capacities and their lack of supports – his two siblings had not returned to Hawai'i after attending college, settling in Arkansas and California with their families. He was subsequently admitted to a long-term care facility

Intermittently, David would express his desire to live in the community - he attends an adult day program in the community for four hours a day, Mondays through Fridays. The *Going Home Plus* contracted transition coordinator was introduced to David at the ICF/MR facility on Oahu where he was living. David was identified as a potential candidate by the transition coordinator by a 1150 level of care tool report**.** The transition coordinator met with Mr. Araluka to explain the project. The transition coordinator included his older brother, Kenneth Araluka, in a teleconference as the facility staff identified him as authorized to sign for Mr. Araluka. After the transition coordinator explained the project's goals and outcomes and administered a preference interview (which ensured that Mr. Araluka was educated about community options before stating his preference toward transition), Mr.Araluka agreed to participate in the project, and his brother concurred.

Pre-Transition Planning: However, when verifying the participant's legal status, the transition coordinator ascertained that his older brother was not the legal representative, but he had a power of attorney signed by Mr. Araluka's parents prior to their deaths. As Mr. Araluka had not been adjudicated incompetent, and with both parties agreeable to participation in the Project, Mr. Araluka reviewed and signed/marked his "X" on the *Going Home Plus* Informed Consent for Participation form. The Participant and Care Givers Rights and Responsibilities form was read

to both Mr. Araluka and his brother over the phone. Copies of the Informed Consent and the Rights and Responsibilities were given to Mr. Araluka and mailed to his brother.

The transition coordinator accomplished the following activities over the next few weeks.

- With Mr. Araluka and his brother, the transition coordinator facilitated the identification of Mr. Araluka's circle of support, those individuals whom he felt were integral to his support system, both in the facility and in the community, who knew him well, who would be able to actively participate in planning for his life in the community.
- With consents in hand, the transition coordinator reviewed information/assessments, facility care plan and met with his health care providers to identify the types of supports, adaptations, durable medical equipment, and augmentive communication devices that would be needed by the participant in the community.
- The transition coordinator met with Mr. Araluka and his circle of support to identify goals, his preferences regarding his likes and dislikes, the kind of staff he would like to support him, things he would like to do;
- With information about his financial status, the transition coordinator began to explore community resources and entitlements available to the participant, including potential housing options and applications for assistance;

A planning meeting was held with Mr. Araluka and his circle of support. His brother flew in from the mainland to participate in the meeting. The transition coordinator invited to this meeting his primary care physician, facility therapists (speech pathologist, physical therapist, occupational therapist and psychologist) who had worked with him, nursing and direct care staff, a community housing agency representative, a community advocacy agency representative and a community DD agency representative. The transition coordinator outlined the following needs that would be critical to the participant's successful transition to community living.

- The residence had to be fully accessible – walk in shower with bath aids large enough to accommodate a reclining bath chair, hallways and doorways wide enough to accommodate a reclining wheelchair, bedroom large enough for a hospital bed and hoyer lift, living space to allow easy maneuverability, temperature controls, and easy egress in case of emergency.
- Some basic equipment would be required, including a reclining wheelchair preferably with body mold for his scoliosis, suitable bath equipment and bath aids, a hoyer lift, and a hospital bed.
- Since he requires total care, his support 24-hour support staff would require training to adequately meet his basic needs – e.g., positioning, transferring, feeding, bathing.
- His health needs require oversight as he is on several different types of medication, including morphine, and at least one is currently given on a per need basis. He is also at risk for aspiration and pressure sores.
- The general consensus of the facility staff was that Mr. Araluka had difficulty understanding complex abstract concepts. However, he is able to express his opinions and desires. His decision making is sometimes based on an understanding of alternatives and consequences, albeit inconsistent and generally based on what he wanted as opposed to reason.

- Mr. Araluka receives a monthly SSI check ($30), the facility had some monies ($1000) in his account. He would have to apply for SSI and other entitlements and benefits to help pay for his living expenses.

At the meeting, the transition coordinator opened the meeting by explaining the *Going Home Plus* project. Mr. Araluka's physician voiced his concerns about the challenges the participant would face living in the community given his multiple medical needs and his need for 24 hour supports seven days a week. But after Mr. Araluka and his bother articulated his desire to live in the community, the physician, although somewhat skeptical was willing to contribute to the planning process, reserving his approval until he was sure the needed supports would be in place.

The transition coordinator then led the team through a discussion of issues and the development of an action plan where various persons committed to follow up actions:

- Identification of a Primary Care Physician. The transition coordinator would explore with various community physicians to identify one willing to be Mr. Araluka's primary care physician. The facility physician agreed to work with the community physician in the transition.
- Equipment. The facility physician agreed to work with the facility therapists to order a suitable wheelchair, bath chair, hospital bed, and hoyer lift. The therapists agreed to test whether the participant would be able to manipulate a power wheelchair. The therapists also agreed to visit the prospective residence to assess suitability and determine what types of adaptations are needed.
- Housing. The community housing representative noted that section 8 housing applications were closed. However, there were possibilities of HUD housing with one of the local agencies, including fully accessible one bedroom apartments. The alternative of living in an adult foster home for individuals with developmental disabilities was also offered as a potential transition option. Mr. Araluka agreed to visit the available options with the transition coordinator.
- Communication. The facility speech-language pathologist agreed to work with a community specialist to ascertain whether David would be able to use an augmentive communication device. The need for a telephone or cell phone would be explored.
- Activities of Daily Living. The consensus was that the participant was totally dependent on care givers to meet his daily living needs. Mr. Araluka expressed a desire to eat various Hawai'ian foods. The physician and therapists noted that he required his meals to be soft and blended; however, there were no restrictions due to allergies. The physician stressed that his liquids needed to be thickened to avoid aspiration – he would order a thickener. The nurse and daily care staff also suggested that feeding could be challenging and that care givers should be trained on positioning and feeding techniques.
- Health Care, The staff nurse noted that he requires changes in positioning at least once every two hours to avoid bed sores. Since he was currently on morphine, the physician stated he would decrease the morphine and substitute it with another medication. The issue of prn medications was raised and the physician was willing to see whether the medications could be given on a regular basis, avoiding per need doses. In addition, telemedical communication was identified to facilitate quick identification of any medical concerns (e.g., aspiration, pain complaints, respiratory difficulties) given the potential distance to the community physician and the desire to reinforce care-giver training.

- Supports. Since Mr. Araluka would need 24 hour supports seven days a week, the community representative for services with individuals with developmental disabilities explained the DD/MR Medicaid Waiver program. As he was already Medicaid eligible, the representative would work with the transition coordinator to complete an application for services, including admission to the waiver. The waiver menu of services included personal assistance/habilitation, skilled nursing, training and consultation, specialized equipment, environmental adaptations, adult day program, residential habilitation, and habilitation-supported employment. Mr. Araluka would need to select the agencies to provide services, whereupon the agencies would work with him on the selection of staff. One critical concern was the need for 24 hour staffing which would probably mean the coordination of various agencies for back-up plans and staffing.
- Financial. Mr. Araluka needed a checking account established for him. The details of signature, money management and oversight required further discussion with Mr. Araluka and his brother.
- Personal Emergency Response System (PERS). A PERS would be set up for the participant to ensure communication in the event of an emergency. The transition coordinator would set up a simple list of questions requiring “yes” and “no” responses to identify the help he needed.
- Circle of Supports. Mr. Araluka had made some friends at the facility and in the day program he attended. Two of them volunteered to be part of his friendship circle.

Transition. The transition coordinator kept in contact with all the persons to ensure that actions were completed and problems were identified and resolved as soon as possible. The transition coordinator explored various residential options with Mr. Araluka, one of his friends, and the DOH/DD targeted case manager. As there was no vacancy in the supported apartment HUD setting, he made a decision to put his name on the waitlist and to live in a large studio apartment in the interim. The participant, with his team, also developed a back up plan to explore potential adult foster homes, including allowing periodic “respite” visits to potential foster homes to determine a “fit” in the event apartment living did not work out. To identify potential adult foster homes, the transition coordinator worked with Mr. Araluka to list his personal preferences, personal habits and goals; locate homes with vacancies, match requested qualities and caregiver skill-sets; and set up trial visits.

The transition coordinator worked with the facility staff and the landlord to identify modifications which could be done and to work out adaptations to accommodate the participant’s needs. These modifications (a qualified waiver service) included removing the bathroom door and widening the bathroom entry, removing the glass sliders on the tub and replacing the thresholds at the front door of the studio and the bathroom entry to facilitate wheelchair access in and around the apartment.

Prior to discharge, the transition coordinator with the DOH/DD targeted case manager facilitated the development of an individualized service plan (ISP) which identified David’s goals and supports. The date of admission to the MFP and the DD/MR Medicaid waiver program was identified as the date of discharge from the facility. Mr. Araluka had selected the agencies to provide skilled nursing, personal assistance/habilitation, adult day health, non-medical transportation, PERS, supplies and equipment, training and consultation, and respite services and worked with the agencies to select staff.

The team also developed a list of “red flags” which would signal that Mr. Araluka’s supports were not optimally in place. These red flags include staff having to work overtime/double shifts more than three times a week, health issues (as decubitis, aspiration, pneumonia, or lack of pain management. Also, if more than two staff raised concerns during a week period, or if the participant expressed dissatisfaction with services, or if there were more than two PERS calls during a week, then a meeting with his circle of supports was needed. Satisfied that all necessary items were in place, Mr. Araluka was discharged from the facility.

Post-transition. For the first three months, the transition coordinator conducted weekly visits with the participant. The transition coordinator conducted the quality of life survey with Mr. Araluka upon discharge. A satisfaction survey was conducted at three month intervals thereafter. With the DOH/DD targeted case manager, the transition coordinator was able to ensure that services and supports were in place, scheduling meetings with all the support staff supervisors once a month. At one point, staffing for the 24 hour care was not available on a regular basis so he opted to temporarily live in the “respite” adult foster home. At the end of three months, he decided to leave his apartment and live with the adult foster family as he felt he enjoyed sharing in their activities and interacting with their children more than he enjoyed living in the apartment setting with just staff. Mr Araluka continued to leave his name on the supported apartment living waitlist, but wanted to have a two-bedroom apartment to share with a live-in care giver.

As the DOH-DD targeted case manager made contact with him every month and received monthly reports from the DD/MR Medicaid waiver service providers, the transition coordinator coordinated a timely transition plan to decrease contacts within over the year. The Quality of Life 12 and 24 month surveys were scheduled with DHS’s contracted provider. Both transition coordination and telehealth services are MFP demonstration services that would not continue beyond the demo. Mr. Araluka’s telehealth equipment was returned when he moved to the foster home.

Susannah Chung – Elderly

Identification-Referral. Ms. Chung, age 84, is a retired teacher’s aide who has lived alone on the island of Oahu all her life. She never married and helped care for her parents prior to their death. She has lived in the same home since she was a child. She has three elderly siblings and one elderly sister-in-law. Ms. Chung has osteoporosis, hypertension and coronary artery disease. She had a triple by-pass operation ten years ago, and surgery followed by radiation and chemotherapy for breast cancer five years ago. Her appetite decreased and she had poor nutrition after the chemotherapy/cancer treatment causing her to become more frail and decreasing her immunity. She continued to live alone and care for herself and her home but she became depressed because she was not able to perform her ADLs/IADLs e.g. was not cooking regularly and unable to manage her hygiene. In the past three years, Ms. Chung was hospitalized twice for syncope (fainting spells) and found to have abnormal heart rhythms. She was sent home each time with two weeks of home health services because she lived alone. She was no longer able to drive, her shopping needs, medical appointments, and other community needs were irregularly met by her aging family and friends.

As she was becoming increasingly frail, her family and friends encouraged her to move to an assisted living facility. However, she refused to do so, insisting that she wanted to remain in her home. Eight months ago she fell at home, and was unable to get up to call 911. Two days later she was found at home on the floor by a friend coming to visit. She went to the hospital by ambulance and was found to have fractured her hip as well as several ribs, ulcers from being in the same position, severe dehydration, and deteriorated health and nutrition status. She had surgical repair of the hip fracture. Her recovery was complicated by a nosocomial pneumonia identified as MRSA. Her physical therapy was compromised by the dyspnea associated with the pneumonia, the end result that she will likely need to use a walker for ambulation for some time. She remained in the acute care unit for three weeks prior to transfer to the skilled nursing facility where she has lived for the past seven months. She remains depressed, wanting to return to her home. She dislikes communal living and not having choices about her daily schedule.

Medicaid Eligibility. In October 2008, the social worker at the nursing facility assisted Ms. Chung to complete the Medicaid application when it became clear that her resources would be exhausted before the next monthly payment. The Medicaid eligibility worker determined her eligibility and made a referral to the QExA Enrollment Counselor contractor for assistance to select a health plan. An Enrollment Counselor came out to the facility and explained the QExA program. Together they identified all of Ms. Chung's medical providers and selected the plan that had all of her current medical providers in their network. Ms. Chung's managed care plan would be effective on February 1. The Enrollment Counselor also explained to Ms. Chung that a pre-assigned service coordinator (case manager) from her QExA plan would be scheduling a visit before the end of 90 days to conduct a health and functional assessment.

A friend, visiting her at the skilled nursing facility, saw a *Going Home Plus* poster and told Ms. Chung about the project. Ms. Chung got very excited in anticipation that the project could help her do what she wanted – to move back to her own home. Ms. Chung called the phone number that was on the poster.

Pre-Transition Planning. The *Going Home Plus* transition coordinator from the contracted agency arranged a meeting in the SNF with Ms. Chung, her older sister, and her primary care physician to explain the Going Home Plus project and the QExA HCBS service package to them. Ms. Chung was adamant that she wanted to move back to her own home. and the preference interview confirmed that she wanted to leave the facility and felt it was feasible. She read and signed the *Going Home Plus* Informed Consent for Participation form and was given a copy of the Participant Rights and Responsibilities. In addition, she signed consents for the release of information so the transition coordinator could obtain copies of pertinent medical records. The transition coordinator arranged to return the next day to conduct a comprehensive assessment and together with Ms. Chung they developed the transition plan. A copy of the completed assessment and transition plan were sent to the QExA service coordinator.

Housing Issues. A follow-up meeting was held with Ms. Chung, two of her siblings, the social worker, and her friend who holds her health-directive. Worried about Ms. Chung's increasing medical problems and their own limitations to regularly help her, her family and friends succeeded to convince her that returning to her home was not a realistic option because of the structural challenges it would present until home modifications could be completed to provide a safe environment. Ms. Chung agreed. The transition coordinator offered to explore other

available housing options for her in the meantime that would give her the privacy she craves while allowing her to live in a safe environment and strengthen her mobility until the home modifications could be completed**.**

The transition coordinator explored available options in the community. She identified two options. The first was a multi-story assisted living facility. This facility would provide her a private room and bath with meals brought in three times a day. She would have access to communal living and recreation areas and outdoor garden areas. The second was a small senior-citizen apartment complex. A first floor studio apartment was available. The apartment contained call buttons for emergency assistance. Ms. Chung would have a private entrance, mail box, and kitchen. There were no communal facilities.

The transition coordinator accompanied Ms. Chung to visit the two options, but she was still not happy that she was unable to move back into her home immediately. The transition coordinator re-examined Ms. Chung's home with a contractor, who identified three major areas of concern that could be addressed quickly by making structural changes to the residence, including 1) the entranceway which could be outfitted with a ramp instead of stairs, 2) the bathroom (widening the door, adding grab bars near the toilet and in the shower, and 3) building a seat inside the shower. The transition coordinator updated the QExA service coordinator regarding the modification status. She was able to obtain three bids and fast-track the environmental modifications, so Ms. Chung could return to her own home as she had so adamantly preferred. Environmental modifications are a covered HCBS qualified waiver service**.**

Transition. Knowing that she sometimes had lapses in memory, Ms. Chung agreed to assign her power of attorney to her sister-in-law who would be responsible for handling her financial affairs.

Prior to the transition coordinator requesting bids for the home modification, the QExA service coordinator scheduled a visit to perform Ms. Chung's initial QExA assessment. [*QExA requirement: Upon enrollment to the QExA, the health plan is required to conduct a face-to-face Health and Functional Assessment (HFA) to determine the health and functional capability of each QExA member. For members whose first day of enrollment into the health plan falls during the first ninety (90) days following February 1, Commencement of Delivery of Services, the service coordinator shall conduct the HFA and the LOC assessments (as needed) within the first ninety (90) days of enrollment into the health plan. For members enrolling in QExA after the transition enrollment period, the health plan shall complete a HFA and LOC assessment within fifteen (15) business days following enrollment.]*

Immediately following the assessment, they were joined by the transition coordinator, and Ms. Chung's sister-in-law to discuss her progress, identify her goals and supports, develop her service plan for the community and set a tentative date of discharge to the community. The date of admission to the MFP and QExA HCBS services would be the date of discharge from the facility. The QExA service coordinator reviewed the QExA HCBS options and Ms. Chung's choice of institutional or community based services. She also explained that she has a choice of health plan case managers and showed her how to submit a change request.

Service Needs. Ms. Chung uses a walker in the home and a wheelchair for outings and medical visits. She enjoys her privacy and was weary about having strangers in her home. Consumer directed (CD-PA) services were explained, but further discussion was postponed until after she returned home. She needs access to emergency care, personal assistance, and household chores. She will receive Chore services weekly. Ms. Chung limited the number of personal assistance services to 2 hours each day to assist her with activities of daily living. She chose Heaven's Helpers agency to provide her services. Telehealth services were also explained but rejected as too technological in favor of starting out with PERS.

Her friends developed a schedule whereby someone would visit her weekly and check in with her several times a day. Friends or relatives were willing to take her for needed medical appointments.

Meals on Wheels
Her family and physician did not think she should be cooking. Arrangements were made with Meals on Wheels to deliver one hot and one cold meal daily, to ensure that she maintains adequate nutrition despite her limited mobility. The person providing household chores will make sure she has a snack available for the evening and fruits available for breakfast.

Personal Emergency Response System (PERS). To prevent a similar incident in the future, a PERS was set up for Ms. Chung to ensure communication in the event of an emergency when staff was not in attendance. The Transition coordinator assisted with the installation of a land line to meet the system requirements.

Post-Transition. The transition coordinator conducted the quality of life survey with Ms.Chung upon discharge. The transition coordinator established a plan with the QExA case manager and Ms. Chung to taper visits over the first three months post transition. She continued to visit Ms. Chung weekly during the first month in the community. However in month two, she became concerned that Ms. Chung was still having a lot of pain when she ambulated. She discussed this with the QExA service coordinator, who arranged a follow-up visit with the orthopedic surgeon. On X-ray he was able to detect that the hip fracture was not healing properly. Ms. Chung underwent another surgical procedure, during which the doctor determined that the MRSA infection had traveled to the femur, and necrosis had occurred. A total hip replacement was done. She remained in the hospital for two weeks, then in the SNF for a month. She was eager to return home. Supports were re-instituted, this time with the addition of a Physical Therapist, who provided rehabilitation services in her home and six (6) hours of personal assistance daily split three (3) hours in the morning and three (3) hours in the afternoon.. Heaven's Helpers began to have difficulty providing services from their agency once word got around that this was a 'MRSA case.' The case manager contacted the other personal assistance agencies on Ms. Chung's backup list but was unable to secure all the hours. The transition coordinator, who remained involved with Ms. Chung because of her re-hospitalization, offered to make a presentation on MRSA to Heaven's Helpers staff, but the director insisted they had already done that and it wouldn't make any difference. The staff was just too afraid. The back-up plan, which involved her sister, Jolaine, coming to her home to provide services as a consumer-directed personal assistant (CD-PA), was activated. The QExA service coordinator performed a skills competency evaluation of Jolaine to assure that she could adequately perform the services. Jolaine also was willing to take a CPR and First Aid class, but Ms. Chung declined to have

Criminal Record or APS Registry Checks done, insisting that she “knows her own sister.” This plan worked so well for both Ms. Chung and Jolaine, they decided to cancel services with the personal assistance agencies and just go with the CD-PA services Heavens’ Helper’s agreed to provide back-up and respite services when needed. In addition, Ms. Chung and Jolaine were successful to recruit and train two of her grand nieces as back-up (CD-PA) providers. The QExA service coordinator performed the skills competency evaluations, enrolled the grand-nieces as substitute caregivers then reviewed and updated the emergency back up plan together with Ms. Chung and her family. The grand nieces each came in twice a week to assist with the bath, monitor her blood pressure, supervise her medication management, and help escort her to medical appointments.

During the MFP demonstration period, Ms. Chung had four episodes of syncope, two of which resulted in trips to the emergency room (ER). Following the first episode of syncope in the home, Jolaine moved into the home with her sister Ms. Chung. After each ER visit, the Cardiologist ordered a Holter monitor for Ms. Chung but she refused the device each time. After each episode the QExA service coordinator conducted a face to face reassessment at the home and made necessary revisions to the service plan.

On the 365th day in the community, the DHS contractor conducted the Quality of Life (QOL) survey**.** A satisfaction survey was conducted after 12 months. The syncope episodes continued to occur after the demo period. The case manager assisted with follow up appointments with the PCP, Cardiologist and Neurologist to rule out the causes for the ongoing syncope and adjust her medications. There was no definite determination made as to the increase in syncope episodes. Unfortunately Ms. Chung passed away in her sleep before the 24 month QOL survey was conducted.

Both transition coordination and telehealth services are MFP demonstration services that would not continue beyond the demo.