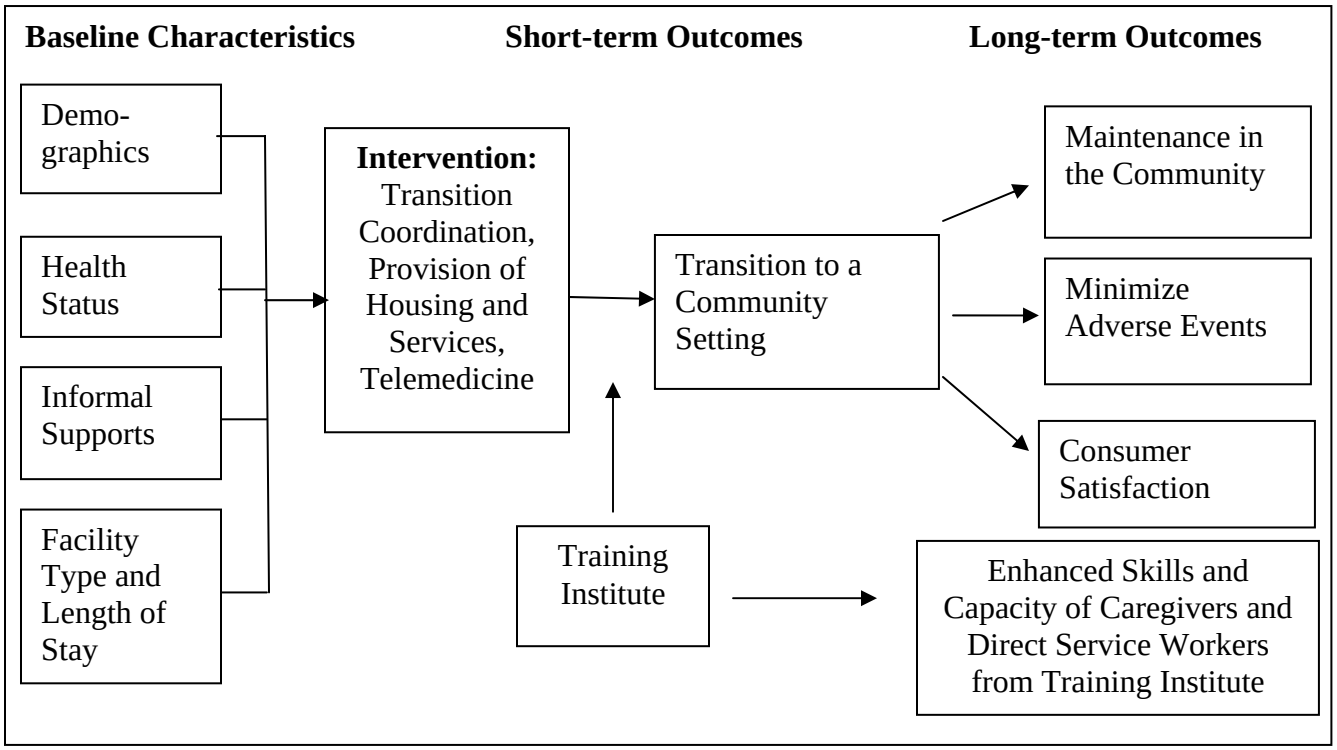
D. EVALUATION

a. Objectives of the State Evaluation:

The Hawai`i *Going Home Plus* evaluation is intended to test whether a project that transitions long-stay institutional residents to the community: 1) can be maintained in community settings 2) can minimize the number of adverse events through appropriate housing and services, telemedicine, and a training institute 3) can improve consumer satisfaction. The following logic model will be used as a guide for the state evaluation:

Figure 2. Logic Model for Local Evaluation Design



The study hypothesizes that participants in *Going Home Plus* will successfully remain in the community and will be satisfied with their new living situation. The following table highlights the research question, hypotheses, and outcomes.

Table 13. Research Questions, Hypotheses, and Outcomes

Overarching Research Question	Can a program that targets long-stay institutional residents successfully transition and maintain these residents in the community?
Outcomes	• Increased transition to the community • Maintenance of participants in the community • Minimize adverse events • Enhance consumer satisfaction

	• Improved skills and capacity of caregivers and direct service workers
Hypotheses	1. The project will facilitate the transitioning of long-stay institutional residents to the community through transition coordination, the provision of housing and services, and telemedicine. 2. Transitioned residents with shorter stays in the facility and lower acuity will remain in the community longer than residents with longer stays and higher acuity. 3. Transitioned residents with shorter stays in the facility and lower acuity are less likely to experience adverse events (i.e., ER, hospitalization) than residents with longer stays and higher acuity. 4. Transitioned residents will have a high level of satisfaction with the transition coordinator and telemedicine. 5. Caregivers and direct service workers trained through the training institute will have increased levels of skill and greater willingness to care for medically challenged patients.

Study Design

The evaluation will use a single group, pre-post design to measure the effects of the coordination of community-based housing and services on demonstration participants. A process evaluation will monitor the implementation of the demonstration project, including recruitment, enrollment, and transition coordination.

Outcome Evaluation Area #1-Transition and Maintenance in the Community. Key to the success of the *Going Home Plus* project is the successful transition of institutionalized residents to the community and maintenance in these settings.

Research Questions.

1. How many persons were transitioned each year?
2. How many days do participants remain in the community?
3. What are the reasons for re-institutionalization?
4. How many and what types of adverse events do participants experience?
5. Does telemedicine help to reduce the amount of adverse events experienced by participants?

The first question is a required benchmark for the MFP demonstration. The evaluator will help to collect this data to provide regular updates and comparisons to annual benchmarks. The second question looks at the number of days that participants remain in the community and the third question analyzes the reason for re-institutionalization. These questions will analyze re-institutionalizations before 365 days and the reason for the re-institutionalization. The evaluator will also examine the types and frequency of adverse events (i.e., ER visit, hospitalization) experienced by participants. The cause (e.g., fall) will also be recorded. Hawai`i's *Going Home Plus* project includes a pilot project that uses telemedicine to support challenging patients in the

community. The evaluation will examine whether the telemedicine units helped to reduce the amount of adverse events experienced by participants.

Data Sources. In their interactions with participants, transition coordinators will complete a transition coordinator log (see Appendix D). The last question is the date that the resident left the facility and transitioned to the community. These logs will be submitted to the project staff and evaluator immediately after a person's transition to the community. The evaluator will compile these data into a *Going Home Plus* database.

Upon transition to the community, the participant will be assigned to a waiver case manager. As part of their regular practice, case managers report dates and reasons for re-institutionalizations, ER visits, and hospitalizations using standardized forms. Project staff will collect this data on demonstration participants and provide to the evaluator on a monthly basis.

Analysis. Descriptive and inferential statistics will be used to analyze the research questions. The evaluation will present cross tabulations by island, target group membership, facility type, length of stay in the facility, housing type, age, gender, and race. A multiple regression model will examine the demographics, prior facility type, length of stay in the facility, current living arrangements, social support, and health characteristics that influence the length of stay in the community. A second multiple regression model will examine similar variables that may impact the number of adverse events. The use of telemedicine will be researched in a separate regression model to study the possible influences this technology has on the adverse events. Furthermore, the differences identified between groups or categories on length of stay in the community and adverse events will be further examined using t-test and ANOVA techniques.

Outcome Evaluation Area #2- Consumer Satisfaction. The state evaluation will also examine consumer satisfaction with specific components of the *Going Home Plus* project.

Research Questions.

1. Are participants satisfied with services provided by the transition coordinator?
2. Are participants satisfied with telemedicine equipment?

Data Sources. State staff responsible for Quality Management will administer the Mathematica Policy Research QoL survey to demonstration participants. As part of the state evaluation, a few additional questions on consumer satisfaction will be added to minimize burden on participants. The following additional questions will be added to the QoL survey:

Satisfaction with Transition Coordinator

1. How satisfied are you with the help your transition coordinator gave you?
   - Very Satisfied, Somewhat Satisfied, Not Satisfied, Comments

2. Were your wishes and preferences honored when the transition coordinator helped you to leave the facility?
   - Yes, No, Somewhat, Comments

Satisfaction with Telemedicine (for those receiving telemedicine services)

1. Do you find the telemedicine technology easy to use?
   - Yes, No, Somewhat, Comments

2. How satisfied are you with the help provided by the telemedicine units?
   - Very Satisfied, Somewhat Satisfied, Not Satisfied, Comments

3. Do you feel safer in your home because of the telemedicine technology?
   - Yes, No, Somewhat, Comments

Analysis**.** Descriptive and inferential statistics will be used to analyze the research questions. The evaluation will present cross tabulations by island, target group membership, facility type, length of stay in the facility, age, gender, race, and type of housing. A multiple regression model will examine the demographic, health, facility, and housing characteristics associated with consumer satisfaction.

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Outcome Evaluation Area #3- Capacity to Care for Medically Challenging Patients. The state evaluation will examine the role of the training institute in increasing caregiver capacity to support persons with challenging medical conditions.

Research Questions

1. Has the training institute improved the skills of caregivers and direct service workers?
2. Has the training institute increased the willingness of formal caregivers to accept medically challenging patients?

Data Sources. A short survey will be administered after each training to obtain feedback from participants on whether the training has improved caregiver skills and increased willingness to care for medically challenging patients (See Appendix e).

Analysis. Descriptive analyses will be used to examine feedback from participants.

Process Evaluation Area #1-Recruitment and Enrollment. The first part of the process evaluation will examine the process of identifying potential candidates, recruitment, and enrollment.

Research Questions

1. How many facilities are willing to participate in the GHP project?
2. How are potential candidates identified? How many are identified?
3. Of the candidates identified and approached, how many express a preference to transition?
4. Of the candidates who express a preference to transition, how many consented to participate in the project?

The first question will track the number and types of facilities (nursing facility, hospital, ICF-MR) that cooperate with the *Going Home Plus* project by allowing transition coordinators to speak with residents. At the same time, the evaluation will track the methods by which potential candidates are identified (e.g., MDS, referral). When the transition coordinator meets with

candidates, he/she will administer a preference interview (California Nursing Facility Transition Screen, CNFTS). The state evaluation will track the number of persons who express a preference to transition. Finally, the number of persons who consent to the participating in the project will be tracked. This information will be very valuable to project staff and policy makers in order to understand the time, effort, and resources needed to identify persons interested in transitioning to community settings.

Data Sources. Project staff will provide updates to the evaluator on a monthly basis on the number and types of facilities that cooperate with the *Going Home Plus* project. The evaluator will also work closely with project staff to get bi-monthly updates on the number of potential candidates identified and the mechanisms by which the person was identified. For candidates identified through the nursing home MDS reports, de-identified data will be provided monthly to the evaluator. The transition coordinator will complete a transition coordinator log during their interactions with all candidates. These logs contain data on whether the person had a preference to transition and consented to the project. These logs will be submitted to the project staff and evaluator immediately after a person's transition to the community. The evaluator will compile these data into a *Going Home Plus* database.

Analysis. A descriptive analysis will be conducted of the names and types of facilities approached and the number that agreed to support the project. Descriptive statistics will also be used to analyze the number of candidates identified, the number that indicate a preference to transition, and the number that consent to participating in the project. Data will be cross tabulated by island, the target group, length of stay in the facility, and type of facility.

To further analyze preference to transition, the evaluation will analyze common themes in the reasons that participants said yes or no. Bivariate analysis will also examine differences between the preference found in the CNFTS and MDS Q1a. Logistic regression analysis will be used to examine the demographic, health, length of stay, primary decision-maker, and housing factors associated with preference.

Transition coordinator logs will also be analyzed for common themes in the reasons that participants said yes vs. no to participation in the project.

Process Evaluation Area #2- Transition Coordination. The *Going Home Plus* project created a transition coordinator position to assist residents move to the community. The process evaluation will closely track this process to help in identifying the time and effort needed to assist facility residents and identify barriers and challenges.

Research Questions

1. How long is the transition coordination process?
2. What type of one-time transition services are used by participants?
3. What are the types of housing used?
4. What are the barriers to transitioning?

Data Source. The transition coordinator will complete a transition coordinator log during their interactions with all candidates. These logs contain data on the dates of the meetings with

participants, one-time transition services, housing, and barriers. These logs will be submitted to the project staff and evaluator immediately after a person's transition to the community. The evaluator will compile these data into a *Going Home Plus* database.

Analysis. A descriptive analysis will be conducted on the length of the transition process, the types of one-time transition services, and housing used. Data will be cross tabulated by island, self versus proxy, target group membership, type of facility, length of stay in the facility. Qualitative analyses will identify common themes in the barriers encountered and the types of solutions found.

Process Evaluation Area #3- Training Institute. The state evaluation will track the number and types of trainings offered to caregivers and direct service workers to support the transition of long-stay residents into the community.

Research Questions:

1. How many trainings are offered?
2. What types of trainings are offered (e.g., wound care, behavioral problems)?
3. Who is the target of the training (e.g., informal caregiver, professional caregiver)?
4. How many attend each training?
5. Are attendees satisfied with trainings?

Data Sources. The evaluator will keep a training log that tracks the types of training offered, number of trainings, the target group (e.g., informal caregivers, professional caregivers, direct service workers), and number attending. A short survey will be administered after the training to assess satisfaction.

Analysis**.** Descriptive analyses will be used to examine the number and types of trainings, and satisfaction with trainings.

Effects of the Demonstration and Other State Initiatives

In late 2008, the state will enroll all Fee for Service (FFS) Aged, Blind, and Disabled (ABD) Medicaid recipients into the QExA managed care program under the 1115 authority. It is difficult to project the impact and unintended consequences of this systemic change. The evaluator will create a Systemic Changes log that will: 1. Tracks steps in the implementation of the managed care program, and 2. Describe its influence on the project.

A similar log will be created to track systemic (e.g., lack of housing) and cultural barriers (e.g., attitudes toward caregiving, death and dying) faced by the project during the pre-implementation and implementation of the project. The barriers log will: 1. Track the type of barrier (cultural, systemic), 2.Describe the barrier, 3. Indicate the impact on the project, and 4. Describe the solutions (if any) that were developed. Data will be summarized and reported on an annual basis.

Variables

The following is a list of independent/control variables:

- Target Group
- Date of Birth
- Gender
- Race/Ethnicity
- Primary Language Spoken
- Date of Entry into Facility
- Type of Facility
- Island Where Facility is Located
- Capacity for Self-Consent
- Number of ADLs/IADLs
- Types of Diseases and Conditions
- Cognitive Impairment
- Number of informal supports (family, friends)
- Housing Type in the Community
- Island of Residence
- Date of Transition

The following is a list of outcome variables:

- Days in the Community
- Reasons for Re-institutionalization
- Occurrence of Adverse Events (ER, Hospitalization)
- Consumer Satisfaction with Transition Coordinator and Telemedicine

The following is a list of process variables to be used in the evaluation:

- Nursing Homes Approached
- Nursing Homes Cooperating with Project
- Hospitals Approached
- Hospitals Cooperating with Project
- ICF-MRcs Approached
- ICF-MRcs Cooperating with Project
- Identification by Referral
- Identification by MDS
- Identification by Other
- Preference to Transition
- Consent to Participation in Project
- Length of Transition Process (in days)
- One-time Transition Services Used
- Housing Barriers
- Service Barriers
- Date of Training
- Type of Training
- Location of Training
- Island that Training was Located
- Targeted Audience

- Number Attended Training
- Training Increased Knowledge
- Training Increased Confidence
- Training- Willingness to Accept Challenging Patient

See Appendix E for a list of independent and dependent variables, frequency collected, and the data source.

Reporting Interim Evaluation Findings
On a quarterly basis, a report on the status of the project will be provided to the project staff and in CMS quarterly reports. Data will include descriptive reports on the numbers of persons identified, recruited, enrolled, and transitioned. Data will be cross tabulated by island, target group, length of stay in the facility, and type of facility.

Annual reports (except for the first year of implementation, which is only 3 months long) will provide more detailed information. Data will include reports on the numbers of persons identified, recruited, enrolled, and transitioned. Reports on length of stay in the community and reasons for re-institutionalization will be included. Data will be cross tabulated by island, target group, length of stay in the facility, and type of facility. Reports on systemic barriers and changes, consumer satisfaction, and trainings will be included.

See Appendix E for a schedule of deliverables.

Evaluator
The state evaluation will be conducted by Christy Nishita, Ph.D., Assistant Professor at the University of Hawai`i Center on Disability Studies (CDS). She received her doctorate. in Gerontology from the University of Southern California (USC). As part of her postdoctoral work at USC’s Center for Long-term Care Integration, she was part of a joint UCLA/USC research team that developed and piloted the California Nursing Facility Transition Screen (CNFTS). The work was funded by a 2003 Real Choice Systems Change Grant for Community Living entitled “California Pathways: Money Follows the Person”. She was lead author of a recent article in the Journal of the American Geriatrics Society that utilized the CNFTS to examine the transition preferences of long-stay nursing facility residents. (See Nishita CM, Wilber KH, Matsumoto S et al. (2007). Transitioning residents from nursing facilities to community living: Who wants to leave? Journal of the American Geriatrics Society 56, 1–7). In September 2007, she joined CDS and will be .50 FTE on Hawaii’s Going Home Plus project. Please see Attachment E for Dr. Nishita’s resume.

Oversight
Jean Johnson, DrPH, Associate Director of CDS, will provide oversight to Dr. Nishita to ensure that the evaluation is conducted in a timely manner. A copy of her resume is included in Appendix E. Dr. Johnson and Dr. Nishita will meet on a bi-weekly basis to discuss the progress toward completing evaluation activities. Dr. Nishita will also meet with the Project Director on a bi-weekly basis to provide updates and obtain data (e.g., de-identified transition coordinator logs).The *Going Home Plus* stakeholder group will provide further oversight and feedback on the

evaluation. The group is proposed to meet quarterly over the course of the four year project. Dr. Nishita will provide updates at each meeting and ask the group for comments and suggestions.

Organizational Capacity

Established in 1988, the Center on Disability Studies (CDS) at the University of Hawaii conducts training, service, research, and evaluation on a local, regional, national, and international level. Over 100 faculty and staff work on projects under the guidance of its conceptual framework, see below.

Figure 3. UH-CDS Conceptual Framework