

ARCH/E-ARCH & RACCP-AFH Integration

Noemi Arzaga, RN, BSN

This practice inquiry project has been approved for meeting partial requirements for the  
Doctor of Nursing Practice Degree at the University of Hawa'i at Hilo  
School of Nursing

Committee Chair:

Katharyn F. Daub, EdD, CTN-A, CNE, CLNC

Committee Members:

Alice Davis, PhD, APRN

John Mizuno, JD, BA, House Representative

Joel M. Wagner-Wright, M.Ed.

### Table of Contents

List of Figures .....	5
Executive Summary .....	6
Chapter 1 Statement of the Problem .....	7
Background .....	8
Project Purpose .....	9
Project Aim and Objectives .....	10
Aim 1. ....	10
Objective 1. ....	10
Objective 2. ....	10
Aim 2. ....	10
Objective. ....	10
Aim 3. ....	11
Objective. ....	11
Chapter 2 Review of Literature.....	11
Concept Influence and Theoretical Framework.....	12
Adult Residential Care Homes and Adult Foster Homes .....	15
Statistics .....	16
Worldwide statistics.....	18
Hawaii statistics. ....	20
Caregiving and Long Term Care .....	23
Assisted Living and Residential Care .....	24
Adult Residential Care Homes and Extended Care Adult Residential Care Homes ....	26

Community Care Foster Family Homes (CCFFHs) or Adult Foster Homes (AFHs) ..	29
Hawaii Long Term Care Cost .....	29
Supporting Needs of Residential Care .....	30
Origin of the Concept and Preliminary Definition of Integration.....	31
Chapter 3 Research Design, Methods, and Evaluation Plan.....	32
Plan-Do-Check or Study-Act (PDCA) Model .....	33
Aim 1. ....	34
Objective 1.....	35
Objective 2.....	38
Aim 2. ....	39
Objective.....	40
Aim 3. ....	43
Ethnography and Qualitative Method.....	43
Chapter 4 Results .....	44
Aim 1. ....	45
Objective 1.....	45
Objective 2.....	51
Aim 2. ....	55
Objective.....	55
Aim 3. ....	56
Objective.....	56
Chapter 5 Recommendations and Conclusions.....	56
Recommendations.....	59

Conclusions.....	64
Chapter 6 Implications for Practice .....	67
References.....	73

### List of Figures

<i>Figure 1.</i> The 6-Step Systematic Approach to the M&E of Integration.....	13
<i>Figure 2.</i> Elderly Population as a Proportion of Total, Hawaii vs. U.S. – Graph .....	21
<i>Figure 3.</i> Elderly Population as a Proportion of Total by County – Graph.....	23
<i>Figure 4.</i> Model for Improvement – Plan Do Act Study or Check Act Process .....	34
<i>Figure 5.</i> The ALIVE Acronym in the Policy Making Process Solution Includes: Adopting, Living, Implementation, Valuing, and Evaluation.....	43
<i>Figure 6.</i> Integration Questionnaire.....	46
<i>Figure 7.</i> Did the information presented inform their understanding of ARCH and AFH?.....	51
<i>Figure 8.</i> Did the information presented influence their decision and recommendations for the DOH and DHS integration? .....	52
<i>Figure 9.</i> Did the comparison presentation clarify the concept of an integrated care system? ....	52
<i>Figure 10.</i> Did the presentation make a positive impact on their recommendation for the integration? .....	53
<i>Figure 11.</i> What part of the presentation was the most significant that helps clarify an integrated system?.....	53
<i>Figure 12.</i> Project Timeline – Phase 1: The Plan .....	61
<i>Figure 13.</i> Project Timeline – Phase 2: The Plan .....	61
<i>Figure 14.</i> The Concept Map of Integration Between DOH and DHS for ARCH and AFH. ....	63
<i>Figure 15.</i> The Concept Map of Integration Between DOH and DHS for ARCH and AFH and the ALIVE policy making process.....	64
<i>Figure 16.</i> Project Timeline – Phase 1: Meeting Goals.....	71
<i>Figure 17.</i> Project Timeline – Phase 2: Meeting Goals.....	72
<i>Figure 18.</i> Project Budget.....	72

### **Executive Summary**

Assuming the role of caregiving is never an easy task whether it is done out of love, devotion or simply being responsible for honoring the familial obligation. Decisions to care may occur suddenly due to emergent reasons, or it may be planned, but whatever the reason may be, long-term care decisions should be seamless and not cumbersome. The better equipped the individual is in knowing the available resources, the less anxiety and burdensome it will be for the patient and their family.

As life expectancy improves along with the unprecedented rate of baby boomers reaching retirement age, there is a great need for workers or caregivers to care for the elderly. Trends have shown that long-term care services that the elderly tend to utilize are those less restrictive than nursing homes. Thus, a rapid growth and demand in supply for alternative services such as those provided in a residential care setting in an Adult Residential Care Home (ARCH) or Adult Foster Home (AFH) are seen.

The historical separation of ARCH & AFH for the State of Hawaii, however, has long created overwhelming inefficiencies to care and management that are burdening the consumers, providers, and the state alike. A need of a polished integrated system that improves residents' quality of care, lowers operating cost, improves coordination of care, and helps caregivers and providers with the most vulnerable fragile persons, the elderly in the community, is greatly needed. All and all, policy engagement through education, evaluation, examination, and the development of new process methodologies with adaptation of new concepts for integration are key initiatives to taking a stand and making a difference. Community-based care services that fit the needs of the consumers without a major overhaul in their livelihoods and budgets are vital today and in the future.

## Chapter 1

### Statement of the Problem

Adult Residential Care Homes (ARCH) and Adult Foster Homes (AFH) in the State of Hawaii are currently managed by two government entities: Department of Health (DOH) and Department of Human Services (DHS). These two types of Community-Residential Care (CRC) services, ARCH and AFH, have separate policies and procedures, operating costs, leadership and governance; but both have the purpose of providing long-term care services for the elderly.

Historical separation of ARCH & AFH services between the Department of Health (DOH) and the Department of Human Services (DHS) has long created inefficiencies, lack of information, confusion, and redundancy of care that are burdening the state with unnecessary costs. Thus, the problem is that these two major home-based care services—ARCH and AFH, each with its own rules and regulations—through their independent management and functioning, have caused a breakdown in the delivery of care, wasting of resources, inadequate care services, and frustration to caregivers, providers, family members, and residents alike.

In order to combine and streamline the services needed for the ARCH and AFH a new policy had to be crafted, introduced, and passed by the Hawaii State Legislature. A workgroup was established through the legislative process to ensure that both programs were comprehensively debated and understood. A Home and Community-Based Services Working Group (HCBS) was formed and members consisted of leaders from these respected groups: Community Care Foster Family Homes; Adult Residential Care Homes; Adult Day Care Centers; caregivers of persons with developmental or intellectual disabilities; Adult Foster Homes; Licensed Case Management Agencies; agencies related to fees, rules, and regulations that affect all of these care setting providers; and legislators or policy makers. Numerous

meetings were held on a monthly to quarterly basis for one year and scattered information was obtained from everywhere.

Although the workgroup members were leaders from their respective agencies, there was very little quality input of background, mission, and goals of each agency and they were often at odds regarding the objectives of combining the two agencies. Yet, this workgroup was tasked with the responsibility for crafting a Senate bill that will eventually become a law with new rules and regulations around an integrated CRC system. Consequently, the far-reaching question is, How does the integration of DOH and DHS affect the economic viability of CRCs?

### **Background**

An effort to integrate ARCH and AFH under one management agency was made by the state legislature in House Bill 398. The purpose of HB 398 was to integrate the administration and management systems for both AFH and ARCH under a single agency in order to optimize both types of residential care services. From a practical point of view, it is more efficient to integrate these two services under one supervising agency in order to provide an economical cost-effective housing program while still ensuring quality care.

The collaboration of such services improves system efficiency, reduces administrative barriers to care, and ultimately, increases access to long-term care housing, which is an important step to improving health outcomes and enhancing quality of life and experiences for the elderly. House Bill 398 was introduced on January 18, 2013. This bill passed the House of Representatives on March 5, 2013, then passed the Senate on April 9, 2013, and was signed into law on July 2, 2013. The assimilation of ARCH and AFH under a single structure has the potential to reduce fragmentation of care while improving efficiency, delivery, and quality of care, while promoting patient wellness and at the same time, lowering the operating cost. In the



end, the unification will help agencies and services in the community to improve care coordination and ultimately assist providers and caregivers alike in providing economical care with great health outcomes.

Integrating DOH and DHS into one managing system for both AFH and ARCH in the proposed legislation HB 398 was a critical action in optimizing residential care services. The concept of integration would affect the environment for both ARCH and AFH as new sets of rules and regulations would be developed, enacted, and enforced. As new rules and regulations are developed, new sets of managing systems will take place. For consumers, they must seek and consider substantial diverse information when selecting from among groups of facilities that best suit their needs.

The intended goal of this integration is that caregivers and consumers alike will have a better understanding with less confusion of available services and whom to call when those services are needed. CRCs will be governed by one managing system and combining their services will standardize the process of care, licensure, and monitoring, while at the same time reducing cost. The environmental impact of integration will help to reduce public spending for adult residential services. This integration will also promote public awareness for the use of these services and provide much needed assistance to existing and future caregivers, resulting in more providers entering into this field.

### **Project Purpose**

The purpose of this project was to educate the Home and Community Based Services (HCBS) workgroup and policymakers on the differences and similarities of the services and explain how the integration of services and agencies would facilitate the overall goal of improved benefits for both programs and to evaluate a strategy to inform health policy through

education, evaluation, and performance review. In the end, the unification will help agencies and services in the community to improve care coordination and ultimately assist providers and caregivers alike in providing economical care and improving health outcomes.

### **Project Aim and Objectives**

The fundamental aim of this project was is to collaborate with selected policymakers and the Home and Community Based Services (HCBS) workgroup to identify existing flaws in the non-integrated system to generate a working plan that incorporates both ARCH and AFH guidelines and practices governing an integrated CRC network promoting patient satisfaction, quality driven care, and cost-effective services.

**Aim 1.** To work together with policy makers and the Home and Community Based Services workgroup and together glide forward in identifying the existing flaws of a non-integrated system.

**Objective 1.** Educate the workgroup on similarities and differences between ARCH and AFH and the problems generated by the historical separation of services between the two governing entities, the DOH and DHS in order to develop a policy that would integrate the two services under one governing body.

**Objective 2.** Evaluate the workgroup's overall understanding of the material presented during the educational session.

**Aim 2.** Analyze and develop a new methodology in policy engagement as a result of the process analysis for quality improvement.

**Objective.** Evaluate the methodology and processes involved using a quality improvement model. Analyze, evaluate, and identify the steps as well as the barriers

encountered in educating the workgroup and policymakers. Develop a new methodology with hope for future policy process solution to improve future policy processes.

**Aim 3.** To adapt the materials presented as part of the 2014 legislative session proposal for change.

**Objective.** As an end result of the presentation, the presented materials will be adopted as part of the 2014 legislative proposal for change, keeping in mind system efficiency, reducing administrative barriers to care, and ultimately increasing access to long-term care housing for the elderly.

## Chapter 2

### Review of Literature

In this chapter, the conceptual framework is presented followed by sections addressing long-term care issues for the elderly. A statistical overview of the long-term care needs for the elderly in Hawaii is presented. The next section discusses research literature on assisted living, adult foster homes and adult residential care homes. Implications and findings from the literature review will be discussed, as well as approaches in ensuring that an adequate quality of care and life is evident in these long-term care-housing options. In addition, defining what is long-term care with consideration to similarities and differences in adult residential care homes and adult foster homes will be enumerated, further dissected, and categorized. Discussion of the two governing bodies, DOH and DHS, as they relate to ARCH and AFH, is presented next, followed by the theoretical model of team effectiveness and the concept of team integration. The *plan do study act* model that guided the whole formation of this project is highly touched upon with concluding comments satisfying the implication for practice with the new methodology created as an end-result of this project.

### **Concept Influence and Theoretical Framework**

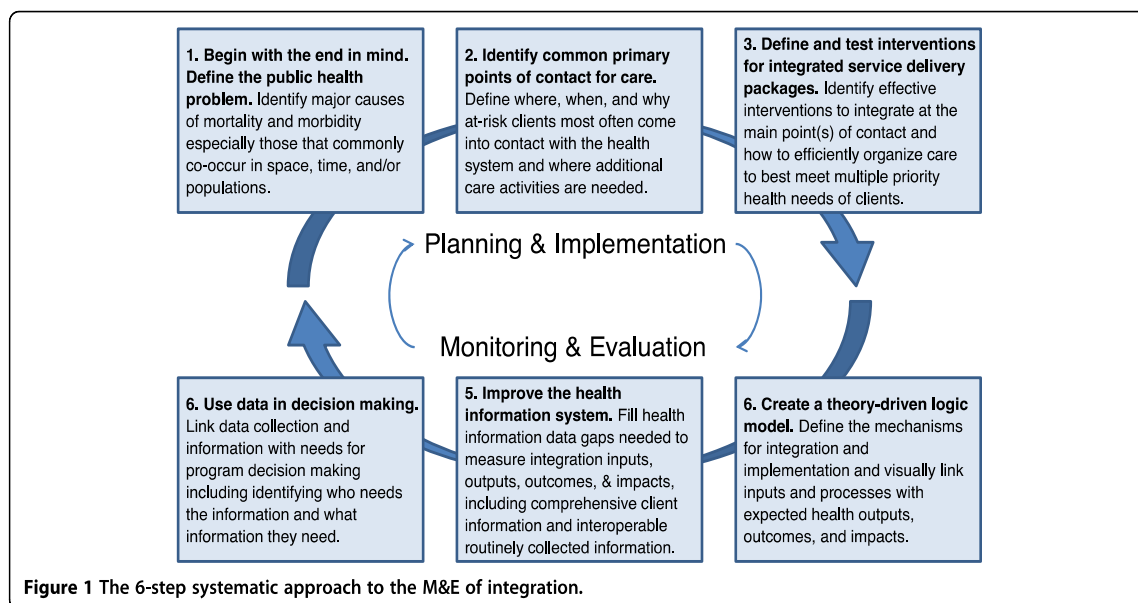
The integrated care framework has been in the works for many years and has utilized and been defined differently by other countries; thereby, terminology used to define this framework are not the same. Not having the same terminology and interpretation in terms of delivering information on “the way we think about, shape, deliver, manage, regulate, finance, and evaluate health care” (Kodner & Spreeuwenberg, 2002), is part of the problem in a non-integrated system. Speaking the same language is critical in communicating the role of integrated care in the health field arena and it is the heart of the system theory that is a central component of an organizational design (Kodner & Spreeuwenberg, 2002).

Based on the model of team effectiveness and concept of team integration, a collaborative interaction is required in order to perceive symmetrical power of the managing system between ARCH and AFH. A unified relationship between the workgroup’s participants from DOH, DHS, AFHs, ARCHs, CMAs, and lawmakers has to be maintained and respected, having one voice in the formulation of regulatory guidelines for the integration. A collaborative undertaking via sharing, partnership, interdependency, shared power with emphasis on transforming, structuring of collective action, and interpersonal process that is dynamic and evolving, derived from the workgroup recommendations and rationales, must be recapitulated.

The notion that AFH and ARCH are managed by two separate government entities embodied by separate managing systems necessitates the need to optimize the governing bodies of these residential services. It is evident that their existence at the current time as individual entities is not efficient and is not in the best interest of any government agency. The health system is a complex system comprising a set of functions that generally include leadership and governance, financing, planning, commodities, workforce, service delivery, and information

systems, with the ultimate goal to improve health outcomes. Integrating the management of these health services will address the housing needs of the elderly and frail individuals in the community calling for optimization to gain efficiencies, meet clients' varied health needs, and ultimately improve health outcomes.

The six systematic steps in monitoring and evaluation (M&E) of integration will be utilized to assess progress, generate information for program management and decision-making, and produce evidence of impact on health outcomes (see Figure 1). These steps include: begin with the end in mind, identify common primary points of contact for care, define and test interventions for integrated service delivery packages, create a theory-driven logic model, improve the health information system, and use data in decision making (Raynolds & Sutherland, 2005).



*Figure 1.* The 6-Step Systematic Approach to the M&E of Integration

Furthermore, Kodner and Spreeuwenberg (2002) have pointed to a patient-centric view on integrated care: “Integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors.” In conceptualizing and translating integrated care in more concrete practical terms, a continuum of strategies that looks at it not from a macro standpoint, but rather microscopically to be able to understand the humanistic patient outcomes and efficacy of the integrated care system, is a must.

Five interlocking domains that Kodner and Spreeuwenberg (2002) addressed warranting attention in the process of addressing barriers and bottlenecks in providing integrated care systems include funding, administrative, organizational, service delivery, and clinical. Funding: this is crucial in the integrated care system, as this is the heart and soul that virtually affects all systems. *Administrative*: structures where unnecessary programs can be eliminated and streamlined to better manage the integrated care resources. *Organizational*: looking at vertically and horizontally networking, collaborating, and jointly working on relationships within and in between agencies to optimize resources, facilitating an overall efficiency of care, thereby enhancing the capacity of “seamless care,” that is the core objective of integrated care. *Service delivery*: how tasks or works are distributed and how it relates to fulfilling an integrated patient care system that addresses the needs of the patient and their family. Variables such as access, availability and flexibility, continuity, coordination of care, consumer satisfaction, and quality cost outcomes, need to be looked upon and addressed. Lastly, *clinical*: to where there is a common language that everyone understands must be exercised or practiced at all times.

An agreed upon process or standard practice that addresses the lifecycles looking at holistic point of view, bearing in mind the maintenance of ongoing patient-provider

communication and feedbacks, are quality components that are essential in the integrated care system. Behind this approach is the desire, above all, to enhance quality and provide a better level of service, one that is more sensitive to the personal circumstances and wishes of the individual patient. Overall, this integration will greatly affect the elderly population seeking residential care needs and services for the State of Hawaii.

### **Adult Residential Care Homes and Adult Foster Homes**

Adult Residential Care Homes (ARCHs) and Adult Foster Homes (AFHs) are Community-Residential Care services (CRCs) provided to elderly and disabled individuals in the community. CRCs are a significant component of community living from congregate arrangements, to room-and-board housing, assisted living, care homes, adult foster homes and numerous other variations depending on the facility size, regulatory standards, funding resources, and residents' characteristics (Polivka, 2004). The variations in CRCs make it challenging to distinguish what services are available in one's community and which are Medicaid and Non-Medicaid waiver services. The disparities and differences within CRCs make it very difficult, if not nearly impossible; to have a broad consensus of what defines community-residential care. A clear CRC system network would be a great advantage to help researchers generate a regulatory framework that is universally accepted.

ARCHs and AFHs or Community Care Family Foster Homes (CCFFHs) are smaller parts of CRCs, and people often confuse them. These CRCs have received less recognition in policy matters over the years. In a much larger provision of community-residential care, especially for Medicaid recipients or less affluent elderly persons, there is a huge need in the deliberations of care over the future of CRC and long-term care (LTC) policy concerning these services. Why?

The number of elderly has increased dramatically; more are living longer, requiring more care and services, thus resulting in higher expenditures for the person, family, state and the nation.

The United States is noted to have the most expensive health care system in the world, but the nation ranks lowest in terms of “efficiency, equity, and outcomes,” according to Davis, Stremikis, Squires, and Schoen (2014). One of the most blaring revelations is that the high rate of expenditure for insurance is not proportionate to the satisfaction of patients or quality of service. The report summarized that the high out-of-pocket costs and gaps in coverage “undermine efforts in the U.S. to improve care coordination.” A remarkable lesson learned from the report is the need for health care equity throughout the nation. “Disparities in access to services signal the need to expand insurance to cover the uninsured and to ensure that all Americans have an accessible medical home” (Davis et al., 2014). With that said, the delineation of managing departments between DOH and DHS for the ARCH and AFH is a perfect example of how these agencies are working interdependently instead of working together as one, creating disparities in access to community residential care services. The two CRCs managed by two different agencies working in silos are costing the state tremendous amounts of money and are truly not cost effective. Most importantly, having two managing systems that provide care and services in residential homes creates confusion in care coordination and management for patients, resulting in negative outcome and high expenditure.

### **Statistics**

Caregiving is recognized as a core element of everyday life for millions of families and people around the world (National Alliance for Caregiving & AARP, 2009). As populations age, more families are providing care for their loved ones at home. For those who are not able to do so, they turn to friends, family, relatives, and physicians for recommendations and/or suggestions



about elder care and resources. Therefore, it is imperative to educate the community about the types of care that are available not just in a hospital or nursing-home-based care services but also the availability of community-based care services that many might want to fit in their needs.

As the population ages, more families are providing care for an older adult at home and an increasing number of people will need such care in the future. According to the National Alliance for Caregiving & AARP (2009), current demographic and healthcare trends make this issue even more significant. The massive Baby Boomer generation is at prime caregiving age, and soon many will become care recipients themselves. Although people are living longer, debilitating, age-related illnesses such as Alzheimer's dementia, Parkinson's, arthritis, diabetes and stroke, are occurring with increasing frequency. Hospital stays are becoming shorter, meaning more care is needed at home (Polivka, 2004). Women, who have traditionally been the caregivers for both children and the elderly, are now in the workforce taking on slightly more responsibility for care. They are less available to provide full-time care, and as a result, men are assuming more caregiving responsibilities and are greatly impacted as well (National Alliance for Caregiving & AARP, 2009).

As a whole, caregiving impacts not only a growing number of individuals, but their families and their workplaces as well. The Metlife study (MetLife Mature Market Institute, 2011) indicates that as many as 42% of employed Americans (more than 54 million people) have provided eldercare in the last five years. The average age of caregivers is 49 years old, a peak year for earnings and for career achievement. What does this tell us? One cannot stop working to care of their loved ones at home because they need to provide food, shelter, and resources to their own children and their own families. Therefore, one must look into alternative care

services for their loved ones, whether care should be provided in their homes, nursing homes, or community residential homes.

In the United States, older adults comprise the largest group of care recipients but also represent the greatest number of caregivers (either partners or adult children) for other elders (Spillman & Pezzin, 2000). Viewed in this light, caregiving can represent an intertwining of two frailty trajectories (Cartwright, Archbold, Stewart, & Limandri, 1994). A full 40 years between the period of ages 65 and 105 represent a large portion of one's lifespan. According to Young (2003), health care providers would never consider equating the health care needs of a newborn with the needs of a person in early middle age, both members of the cohort of the first 40 years of life. Likewise, as health care services are explored for older adults, also potentially spanning four decades, the developmental, biological, psychosocial, and functional diversity of an individual must all be anticipated and appreciated (Young, 2003).

With all of the aforementioned needs of caregiving, where does one turn to for the care of their loved ones? Therefore, there is a need of clear community-based care services that fit the needs of the consumers without major overhaul in their livelihoods and budgets. This is where CRCs come into play as other options for the care of the elderly and disabled in the community.

**Worldwide statistics.** Worldwide statistics gathered from the United Nations Population Fund (UNFPA, 2014) demonstrate that the world is getting much older: within 10 years, there will be one billion older people worldwide and by 2050, the number will reach two billion (22% of the total global population). There are several reasons why older people (65-74 years) matter worldwide: 47% of older men and 24% of older women actively participate in the workforce, and in developing countries that percentage is a staggering 90%. In China, by 2022 the average age of working farmers is predicted to be over 50 or even over 60. In East and Southern Africa,

grandparents care for 40-60% of vulnerable children. In Egypt, in 2010, people aged 60 and over made up 8% of the total population but accounted for 13.6% of the electorate. In Australia, women aged 65-74 contribute 16 billion Australian dollars per year in caregiving and voluntary work. Fifty-four percent of Americans aged 60 or over use the Internet and in 2012, 106-year-old Saburo Chochi from Japan became the oldest person to complete an around-the-world trip using only public transport (UNFPA, 2014). Lastly, T. Y., a resident of Arzaga's Adult Foster Care in Hilo, Hawaii, reached 101 years of age on October 20, 2014.

The *United States Census 2000* (2001) indicates that multiple generations in the "older" category, those over 65, are becoming more ethnically diverse. It is projected that between 2000 and 2030, the percentage of minority elders will increase by 328% for Hispanics, 285% for Asian and Pacific Islanders, 147% for American Indians and Aleuts, and 131% for African Americans, compared to 81% for Caucasians. According to Hayes-Bautista, Hsu, Perez, and Gamboa (2002), our community is increasingly a reflection of multiple ethnic histories and values.

These statistics indicate that more people are living longer and taking active participation in their communities, keeping themselves abreast with the ever-changing demands of technology and resources. It is therefore imperative for the formal system and the community to work together to come up with a plan that best suits the needs of the elderly and the disabled that is economically reliable and can weather out governmental adversities and cutbacks.

The largest population utilizing health care resources, both age-related health status and resources, are the elderly, because of the clear relationship between mortality and age, prevalence of chronic conditions, and level of disability. It has been clinically recognized and well established in numerous studies that frailty increases the risk for falls, disability,

hospitalization, iatrogenic complications, and mortality (Fried et al., 2001; Hart, Birkas, Lachmann, & Saunders, 2002; Mick & Ackerman, 2002). Therefore, it is imperative for health care providers, most especially nurses and caregivers who spend time with patients, to pay special attention to the needs of the elderly, providing them with resources they need should they require help with their activities of daily living.

Nurses have the potential to improve elder health across settings through effective screening and comprehensive assessment. Nurses can facilitate access to programs and services as well as educate and empower older adults and their families to improve their health and manage their chronic conditions. If unable to do so, nurses have the abilities to lead and coordinate the efforts in managing the health care team that provides services and care to patients. Thus, it is imperative for a nurse-managed community care system to be able to promote optimal clinical outcome, functional ability, and quality of life for patients or residents. The ultimate goal of the partnership is to provide autonomy, promote independence, and protect the patient's dignity, fulfilling their life experience with joy and contentment. This is a basis of care provided in AFH and Expanded ARCH community care services where a Registered Nurse manages and coordinates the services of the patients, maintaining a healthy community living.

**Hawaii statistics.** Until 2000, Hawaii's elderly population, aged 65 and older, was growing at a significantly faster pace than the nation's elderly population (*Health Trends in Hawaii, 2013*). Hawaii's elderly population growth is now only slightly faster than the national growth rate (*Health Trends in Hawaii, 2013*), and the question is, Why did this growth occur? Why will it continue? Consider the following facts. Since statehood; Hawaii's proportion of elderly to the total population has increased three-fold, from roughly 5% in 1960 to 15% in 2012. During this same period, the elderly segment of the nation's population increased by one-third,

from 9% to 14% (*Health Trends in Hawaii*, 2013). Between 1990 and 2012, the number of elderly aged 75 and older increased 47% nationally compared to a 116% increase in Hawaii (*Health Trends in Hawaii*, 2013). All counties experienced significant growth (13%-16%) in their elderly populations since 1970 (*Health Trends in Hawaii*, 2013). It is projected that by 2030, the elderly population will represent 20% of the populations of each county, the state, and the nation as a whole; that is, one out of every five individuals will be aged 65 or older (*Health Trends in Hawaii*, 2013) (See Figure 2 for Elderly Population as a Proportion of Total, Hawaii vs. U.S. – Graph and Figure 3 for Elderly Population as a Proportion of Total by County - Graph). In comparison, in 1970, one out of every 17 individuals was aged 65 or older (*Health Trends in Hawaii*, 2013).

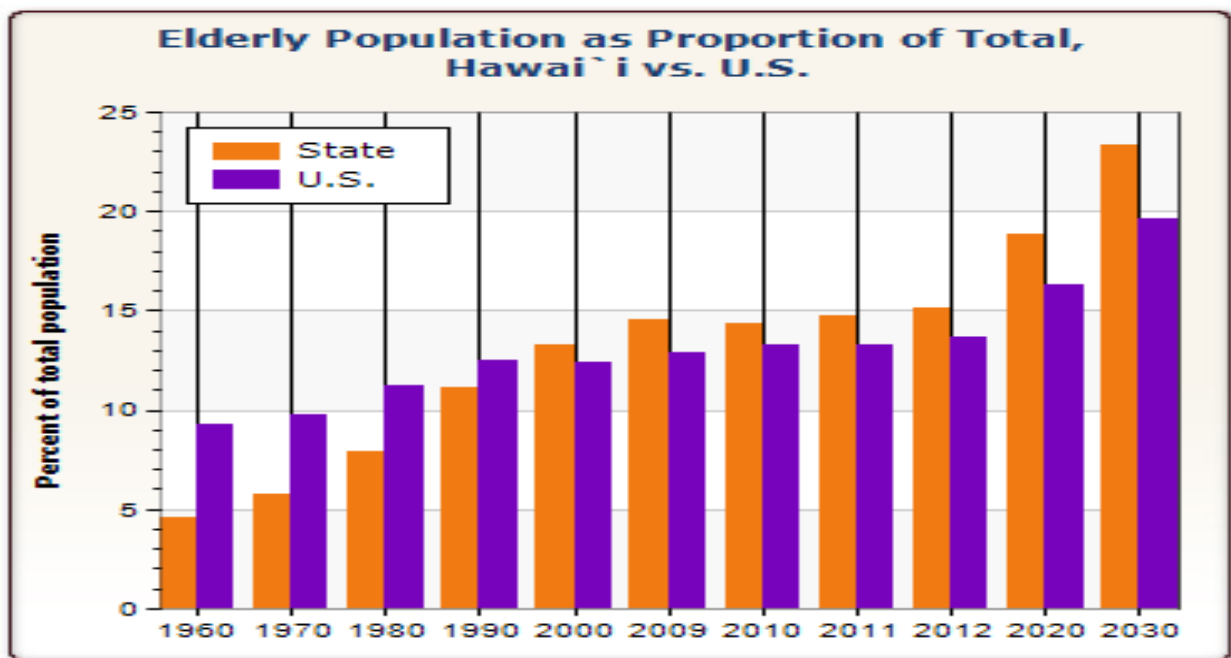


Figure 2. Elderly Population as a Proportion of Total, Hawaii vs. U.S. – Graph

Hawaii's long-term care admission rate increased from 25.1 per 1,000 population aged 65 and older in 1990 to 44.1 per 1,000 population for the same group in 2003 (Harrington, Chapman, Miller, Miller, & Newcomer, 2004). Significant differences exist between counties, with Kauai's admission rate much higher than the other counties (64.4 compared to 40.1-53.9 admissions per 1,000 population). Statewide, average length of stay (LOS) figures for long-term care show a steady decline from 1994, when both average LOS (368.6 days) and occupancy rates (97.8%) were at their highest. In 2002, occupancy rates averaged around 93% statewide remaining higher than the state's target occupancy of 90% (Harrington et al., 2004). Hawaii's certified nursing facility occupancy rate is 94.8%, the highest of all states. In contrast, only 1.6% of Hawaii's population aged 65 and older resides in a nursing home. In this regard, Hawaii ranks 49th among all states (Harrington et al., 2004; O'Keeffe & Wiener, 2004). Why? It is not known why the nursing home bed ratio is so much lower in Hawaii than in the nation as a whole, but one possible explanation is that the high level of three-generation households in the state combined with a strong tradition of informal caregiving has resulted in low demand for nursing home care. In addition, what constrains nursing home beds use are also attributed to the economic effect of high real estate costs in order to expand existing facilities and/or build new ones.

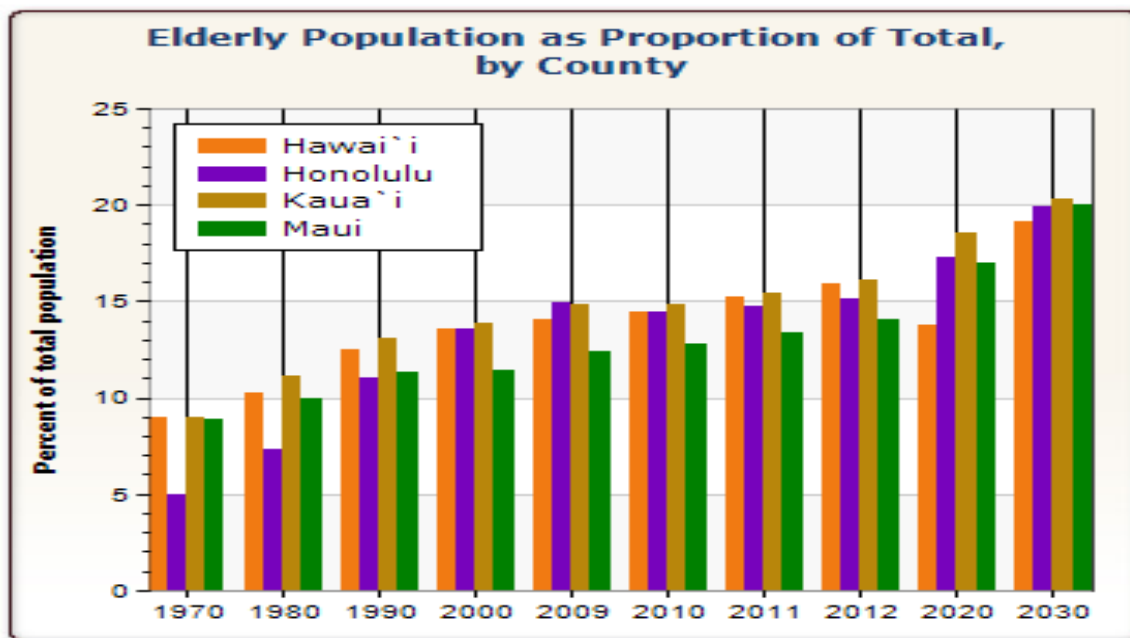


Figure 3. Elderly Population as a Proportion of Total by County – Graph

### Caregiving and Long Term Care

Caregiving is a profession or a job that encompasses many roles and responsibilities. Caregivers serve as home health aides and companions; they help feed, dress, and bathe patients. Caregivers arrange schedules, manage insurance issues, and provide transportation. They are legal assistants, financial managers, housekeepers, and the overall-in-charge of operations and the executive person in charge of their own businesses and homes. The demand related to these multiple roles and responsibilities limit the desirability of persons' interest in this profession. However, considering the growth expectation of older persons and the care they will need as they age, requires a great deal of understanding about caregiving.

O'Keeffe and Wiener (2004) describe long term care as a wide range of services supporting the needs of the elderly. Just to name a few, LTC provides assistance with activities of daily living (ADLs). ADLs include eating, bathing, dressing, transferring from bed to chair,

controlling bowel and bladder function, and moving about the house safely. Assistance with instrumental activities of daily living (IADs) includes preparing meals, shopping for food and personal items, managing medications, managing money, using telephones, doing housework, and using public transportation. In addition, assistance with other activities needed to maintain community living, such as heavy chores and supervision to safeguard health and safety, are also included. Physical and occupational therapy to maintain or improve functioning are provided with the skilled and unskilled nursing services. Lastly, services with the range of support needed to function in the community setting, such as habilitation and supported employment for persons with developmental disabilities or serious mental illness are provided (O’Keeffe & Wiener, 2004).

### **Assisted Living and Residential Care**

The most extensive and significant findings about assisted living and residential care have recently become available in the last few years. Although there are still major gaps in our knowledge of assisted living and important questions remain largely unanswered, we now have a good deal of information that can help us think constructively about the future of the assisted living industry.

Kane, Kane, and Ladd (1998) provided encouraging findings about the capacity of assisted living (ALFs) and nursing homes in Oregon who have reached comparable goals and outcomes in terms of ADLs, pain and discomfort, and psychological well-being. These findings are encouraging the beginning of “aging in place” discussion in the ALFs, which is the basis of development of adult foster home care services (AFHs) around the nation. A high level of residents’ satisfaction at 92% reported moving to these settings was good. The respect and care the residents received from the staff or caregivers were very satisfying, which signifies autonomy



and privacy influenced by the assisted living's (AL) philosophy and physical layout of separate rooms/apartments with lockable doors, and kitchenette (Hedrick et al., 2003).

Elderly who wish to remain in their community now have a sense of assurance that assisted living may be the optimal setting for many elderly individuals. Salmon (2001) found that the major predictor of quality of life was the degree of personal control the respondent experienced. Therefore, achieving an effective balance with personal control provided by the AL model of care has resulted in self-assurance fostering autonomy and control resulting in improved quality of life.

Assisted living facilities (ALFs), such as adult foster care and adult residential care, offers these kinds of resources, 24-hour staff services, transportation, and social activities, necessary to maintain self-control and autonomy. As regulations and processes are formulated, it is imperative to keep firmly in mind the full potential of these programs as viable alternatives to long-term care housing for the frail and elderly. Studies have shown that larger and newer facilities are better able to provide services and meet the privacy and autonomy desires of the residents. However, smaller facilities, such as adult residential care homes and adult foster homes, provide more familial, homelike settings that many impaired elderly seem to prefer. Therefore, they are willing to give up some privacy and autonomy in order to live in such facilities. Many may also prefer to age in place in smaller facilities, even in the absence of some of the health services offered by larger facilities. Aging in place has been attracting consumers due to less relocation or movements of residents should they require a more skilled, higher level of care. AFH provides services to elderly who require intermediate and skilled care services, which are thus a lucrative care option to those willing to venture on home- and community-based care programs.

The major point is that potential residents should have an array of facility types, including small, less-sophisticated facilities, to choose from. It should also be noted that smaller facilities are often more willing to take Medicaid and Social Security Income (SSI) supported residents than larger facilities. The Medicaid-waiver funds for long-term care have major implications for the state long-term care policy and is increasingly used to expand congregate alternatives to nursing homes. AFH is a Medicaid-waiver program that offers such services accommodating residents' autonomy/control, especially in comparison to the nursing home setting or even their own homes. In sum, the advantages and shortcomings of the whole range of assisted living options should be recognized without claiming that one style of assisted living is necessarily superior to another or better designed to meet everyone's needs, preferences or ability to pay (Polivka, 2004).

#### **Adult Residential Care Homes and Extended Care Adult Residential Care Homes**

Policies, funding and regulatory strategies should reflect the awareness and support for the different forms of assisted living. The need to provide consumers with as many options as possible should be consistent with the basic values and safety requirements of the assisted living philosophy. This means that small facilities should not be held to precisely the same standards, which they are not likely to meet as the larger, purpose-built, new paradigm facilities. Zimmerman, Sloane, and Eckert (2001) note that if regulation and funding turn on adherence to the new paradigm's parameters, it may mean the demise of the smaller facilities. This perspective will undoubtedly complicate the way assisted living is regulated, but if it results in maintaining or supporting the expansion of the range of community-residential options available to consumers of housing with services, then it should be considered worth the additional complexity. This type of long-term care setting may be especially appropriate for persons with

early- to mid-stage dementia who could benefit from the small scale and relatively intimate environment of foster care. Oregon made adult foster home care a major pillar of its home- and community-based long-term care system in the 1980s and now has over several thousand foster home beds compared to fewer than 2,000 in Florida. Oregon covers adult foster homes under their home- and community-based Medicaid waivers, but 70% of the residents are paying their own way (private pay), which reflects both the affordability and consumer appeal of the program (Polivka, 2004).

In Hawaii, adult residential care homes and adult foster homes are growing in numbers and are increasingly popular residential care settings for the elderly. These types of assisted living have become mainstream as residential long-term care options available in both upscale, elaborate homes, and in model homes in less-affluent neighborhoods. Hawaii has seen the need to address this ever-increasing impending doom of housing needs for the elderly and has captivated considerable opportunity to maximize the potential use of these services while utilizing Medicaid waivers to pay for services.

Hawaii Department of Health licensed ARCHs provide room and board, limited ADLs assistance, custodial care, and supervisory oversight. Type I ARCHs care for up to five residents in a private home whereas Type II ARCHs care for six or more residents in larger, more institutional settings. These type II ARCHs may care for as many as 50 to 60 residents. Medicaid does not pay for services provided in ARCHs. Residents either pay privately or turn over their Supplemental Security Income (SSI) federal benefit plus state supplement payment (minus a \$50 personal needs allowance) to the provider. In 2011, the state had 248 Type I ARCHs with 1,135 beds and four Type II ARCHs with 92 beds (O’Keeffe & Wiener, 2004).

Elderly individuals who opt to live in residential care facilities receive housing and supportive services because they cannot live independently but generally do not require the skilled level of care provided by nursing homes. Caffrey et al. (2012) reported key findings that the majority of residents living in residential care facilities in 2010 were non-Hispanic white and female. More than one-half of all residents were aged 85 and over and nearly 20% of residents were Medicaid beneficiaries, with almost 60% of residents under age 65 having Medicaid. Almost 40% of residents received assistance with three or more activities of daily living, of which bathing and dressings were the most common. More than three-fourths of residents have had at least two of the 10 most common chronic conditions; high blood pressure and Alzheimer's disease and other dementias were the most prevalent, which suggest a vulnerable population with a high burden of functional and cognitive impairment being served (Caffrey et al., 2012).

Extended Care Adult Residential Care Homes (EC-ARCHs) provide services to individuals who are eligible for SSI, Medicaid, or other financial assistance from the Department of Human Services. This program is licensed by the Department of Health but the Department of Human Services oversees placement and case management services to Medicaid-eligible clients. EC-ARCH operators must meet additional Department of Health staffing and other requirements to be allowed to offer expanded services and accept residents who need nursing home level of care. EC-ARCHs serve both private pay residents and those who are Medicaid eligible. Type I EC-ARCHs may serve up to two residents (out of five) who need a nursing home level of care. In Type II EC-ARCHs, only 20% of the residents may need a nursing home level of care. In 2011, the State of Hawaii had 225 Type I EC-ARCHs with a capacity of 1,109 beds and 20 Type II EC-ARCHs with a capacity of 306 beds (O'Keeffe & Wiener, 2004).

**Community Care Foster Family Homes (CCFFHs) or Adult Foster Homes (AFHs)**

Prior to 2014, the Department of Human Services certified CCFFHs or AFHs who serve both private-pay and Medicaid-eligible residents who meet the state's nursing home level-of-care criteria as certified by a physician. Case management is required with the AFH program and it must be licensed by the managing department to coordinate the health and long-term care services of those who are eligible. AFHs are required to serve at least one Medicaid-eligible resident and are certified to care for one, two, or three individuals. If an AFH is certified for two or three persons, the home is allowed to have one private-pay, non-Medicaid-eligible individual. If certain conditions are met, an AFH may accept a second private-pay.

Monthly Medicaid reimbursement rates differ by the level of care required: Level I reimbursement is \$724.48 and Level II clients get \$1,222.92. The monthly room and board payment for Medicaid-eligible residents was \$1,278.90, which is the amount of the SSI federal benefit payment plus the state supplement. Residents turn over their SSI payment to the facility to pay for room and board, except for a small personal needs allowance of \$50.00. Thus, an AFH serving Level I clients receives \$724.48 plus \$1,278.90, or \$2,003.38, per month minus the personal needs allowance (O'Keeffe & Wiener, 2004).

**Hawaii Long Term Care Cost**

Long term care in Hawaii is listed among the top ten most expensive in the U.S. (*Hawaii Long Term Care Insurance Costs, Quotes & Information*, 2014). Nursing home care requires assistance with daily activities due to impairment of physical or mental well-being. Due to the ever-increasing fee for caregivers, family members have been relied on heavily to care for their loved ones. Licensed caregivers, let alone skilled nurses, to care for their loved ones are far too expensive. According to *Hawaii Long Term Care Insurance Costs, Quotes, & Information*

(2014), in Hawaii, not even a person with a nest egg of half a million will be able to survive the cost of long-term care, and this has already outpaced the figures on the national level. An average of \$25 per hour helps with ADLs such as bathing, dressing, eating, and transferring from the bed to a chair or vice versa among others. At \$345 a day spent in a nursing home, the total translates into \$125,925 a year. For a private room, the amount is \$320 daily, while those confined in semi-private rooms are shelling out \$116,800 annually (*Hawaii Long Term Care Insurance Costs, Quotes & Information*, 2014).

### **Supporting Needs of Residential Care**

Instead of trying to abolish risk in terms of patient safety and financial instability through the imposition of extensive regulatory requirements, policy initiatives of integrating services should be one action that strengthens ARCHs and AFHs to make it more available for people in the community. Financial support to entice caregivers to enter this field of caregiving is highly recommended. A strong financial support including increased per diem rates and more funded slots (beds) should also be considered. Case management services that help with patient advocacy and residents' rights could contribute to a higher quality of care for the residents. Currently, in the State of Hawaii, only adult foster homes have a built-in case management agency that monitors the client's well-being. Certification occurs annually or at most every two years and to ensure the facilities, the state designee oversees this process and staff maintains all regulatory requirements stipulated.

Policymakers should accept the notion that care cannot be given without some risk to the vulnerable. In addition, high quality of care for residents is significantly dependent on the policymakers and the general public acknowledging and respecting the work of caregivers. It's reassuring to see the substantial amount of "aging in place" already occurring in ALFs. The

number of residents aging in place without ever entering a nursing home according to Polivka (2004) is likely to expand in the future. In that regard, unless the federal government elevates its commitment to subsidized housing, “by default” assisted living will increasingly become the housing option for many impaired elderly persons and low-income individuals in the next 20 years.

The pressure to impose a more medical-model-oriented regulatory scheme on assisted living is likely to grow as the population of more highly impaired residents increases. These regulatory changes may be necessary to some extent on a facility-by-facility basis. On the whole, however, to continue the efforts in achieving the original vision of assisted living, we should resist the medical-model but rather promote and enhance the social model of care and services for the elderly and disabled.

### **Origin of the Concept and Preliminary Definition of Integration**

The concept of integration was proposed to lawmakers by caregivers who have seen the deficiencies and redundancy of the system. Caregivers of ARCH and AFH who work in the field have seen the need to improve the managing systems in order to promote health and wellness of the residents. A polished system that improves residents’ quality of care, lowers operating cost, which in turn helps the states with Medicaid members, improves coordination of care, and helps caregivers or providers with the most vulnerable fragile persons, the elderly in the community. Policymakers have heard these caregivers and passed HB 398 and formed a workgroup representing individuals from each of the agencies, DOH, DHS, AFH, ARCH, and Case Management. Recommendations as new sets of rules and regulations governing both AFH and ARCH for the State of Hawaii will be presented from the workgroup to the legislatures for a policy change outlining the pertinent changes and processes in the overall management of ARCH

and AFH. Integrating the two managing systems will help to develop integrated care, which has been attracting international discussion due to its broad meaning that encapsulates a wide range of definitions.

The heart of systems theory according to Kodner and Spreeuwenberg (2002) is through “integration.” Health systems and health care institutions are among the most complex and interdependent entities known to society (Kane, 2001). Without integration, all various levels and aspects of health care performance suffers. Patients get lost, needed services fail to be delivered or are delayed, quality and patient satisfaction decline, and the potential for cost-effectiveness diminishes (Kodner & Spreeuwenberg, 2002). In order to interconnect components that are decentralized and specialized, organizations need design performance that fosters integration. This is where this project comes into play; integration is needed to “glue” the DOH and the DHS together in order to unite as one, accomplishing the intended goal of providing affordable housing needs for the elderly. Both entities once possessed individual and differing rules and regulations, intersectional boundaries owning their own funding streams, and their own institutional and professional cultures. Now, they are needed to integrate to meet a common goal fostering equality and efficiency, yielding to optimal results of providing quality elderly housing care and services and at the same time saving the state countless amounts of money, promoting economic viability.

### **Chapter 3**

#### **Research Design, Methods, and Evaluation Plan**

The fundamental aim of this project was to collaborate with selected policymakers and the Home and Community Based Services (HCBS) workgroup to identify existing flaws in the non-integrated system to generate a working plan that incorporates both ARCH and AFH



guidelines and practices governing an integrated CRC network promoting patient satisfaction, quality driven care, and cost-effective services.

### **Plan-Do-Check or Study-Act (PDCA) Model**

The design of the project was based on a quality improvement Plan, Do, Check or Study, Act model (see Figure 16 for PDCA Model for improvement). This cycle provides a simple but an effective approach for problem solving and managing change, making sure that appropriate ideas and interventions are fully tested before implementation. The initial phase is the *Plan* phase in which the problem is clearly identified and understood. This followed by the *Do* phase for which potential solutions are generated and tested on a small scale, and the outcome of this testing is evaluated during the *Check* phase. Do and Check phases can be iterated as many times as is necessary before the full, polished solution is implemented in the *Act* phase (Mind Tools Ltd., n.d.).

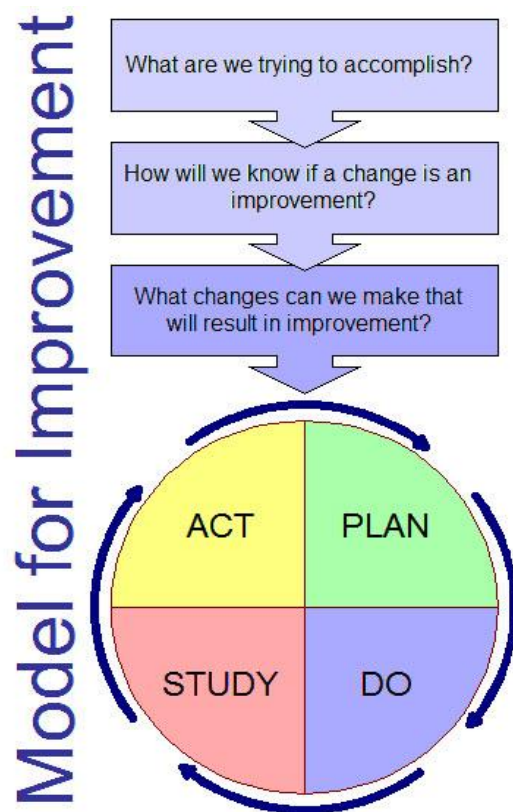


Figure 4. Model for Improvement – Plan Do Act Study or Check Act Process

In recognizing an opportunity for change, the Plan phase involves understanding the workgroup and finding a missing link that will provide an answer to the problem. Although the workgroup consisted of leaders from different agencies, it was identified that there was little quality input on the background, mission, and goals of the subject at hand, the integration of DOH and DHS. This workgroup was appointed to craft a new Senate bill that will eventually become a law governing an integrated CRC system, therefore, there must be comprehensive education provided to the workgroup to have a wide-range of understanding between the two bodies ARCH and AFH. This brings forth the first aim of this project.

**Aim 1.** To work together with policy makers and the HCBS workgroup and together glide forward in identifying the existing flaws of a non-integrated system. In order to achieve

that aim and fulfill the Do phase of quality improvement, the following objectives were accomplished.

*Objective 1.* Educate the workgroup on similarities and differences between ARCH and AFH and the problems generated by the historical separation of services between the two governing entities, the DOH and DHS in order to develop a policy that would integrate the two services under one governing body.

Develop a comprehensive summary presentation in order to consolidate, compare, and contrast the governance of ARCH and AFH to assist in the workgroup's formulation of a plan to satisfy SB 398 Section 1 (f) of Act 214. In order to accomplish such objective, the following must be accomplished.

*Objective 1(a).* Attend the workgroup's meetings in order to assess the workgroup's knowledge about the two CRCs and identify the missing links that can guide the workgroup to formulate a plan for integration.

*Objective 1(b).* Present a clear educational program bringing together the two CRCs into one systematic approach to education, addressing the comprehensive summary identified in Objective 1(a) in which the workgroup is required to submit a written report (Appendix B) of their findings and recommendations to the legislators, including a legislative proposal for change in relation to the said integration. Components of the educational program are listed below and a PowerPoint presentation is included in Appendix A.

Materials presented were captured as follows

1. The presentation first covered the objectives, which are to:
  - (a) understand the social model of care;
  - (b) understand the integration of DHS and DOH, and why;

- (c) compare and contrast ARCH and RACCP – AFH;
  - (d) understand caregivers' requirements – ARCH & AFH;
  - (e) make recommendations based on evidence based practices; and
  - (f) present additional recommendations for discussion.
2. Problems have been generated by the historical separation of services between DHS and DOH. The separation results in inefficiencies in care, lack of information, redundancy of care, confusion, and overlapping of services at an unnecessary cost.
  3. Statistics show that between 1990 and 2012, the number of elderly has risen by 47% nationwide but by 116% in Hawaii. There is a rising need for quality access to care.
  4. Social Model of Care is hoped to better the model by integrating services. It provides a home-like setting where clients have autonomy and a universal worker who takes care of all their needs. It is a less institutional kind of setting, and should provide clients with choices by emphasizing their resident and caregiver relationships. This should help result in increasing their socialization and improving their outcomes.
  5. Integration of DOH and DHS services should result in reduced fragmentation of care, improve the health and wellness of patients and their quality of care, and reduce operating costs.
  6. A comparison between ARCH and E-ARCH vs. RACCP-AHF, including the governing rules and regulations, numbers of residents, licensing requirements, monitoring, admissions, assessment of level of care, payments, physical structure, and liabilities.
  7. Recommended to keep the current regulations for E-ARCH and ARCHs, because they are working well. She recommended yearly evaluations, but stated that there is

no standard tool to give performance evaluations for caregivers, so these evaluations should include:

- (a) a DOH Consultant;
  - (b) processing and reporting of deficiencies;
  - (c) processing of delivering services;
  - (d) rules and regulations;
  - (e) interviews or surveys from patients.
8. Issues and concerns about certain Case Managers that need corrections include:
- (a) inconsistencies in nursing delegation methods;
  - (b) caregivers should be able to call doctors directly without going through nurses;
  - (c) Case Managers not reviewing prior authorization of patients in a timely manner, resulting in patient benefits being terminated;
  - (d) incomplete paperwork prior to home admission; for example, 1147 causing delays or problems with payments;
  - (e) silently soliciting clients previously placed in an AFH;
  - (f) being too heavily nurse-oriented; caregivers should be able to update medication lists or present service plans directly to doctors for signature;
  - (g) a biased referral system where some CMs refer only to some caregivers, which unfairly limits patients' options; and
  - (h) addressing whether, when a patient is discharged home with family members, the family members need nursing delegations.
9. Recommendations are as follows:

- (a) Keep CTA, or another body outside the agency, to look at quality of care. They were originally contacted to streamline the certification process and provide for unbiased care service where caregivers are seen as one and no one is more powerful than another. They can correct both contract management and caregiver deficiencies.
  - (b) Oppose HB 1208, which imposes a recertification fee. Caregivers already pay out great amounts of money for expenses, and some may be forced to close if they must pay additional fees.
  - (c) Encourage more caregivers; it is a growing business. They need to sell themselves so they can be profitable as well.
  - (d) Address areas which need improvement:
    - education and training to respond to and address deficiencies;
    - implement a standard process of placement from hospital discharges;
    - implement a standardized process for data collection; and
    - use data on adverse events to educate caregivers about the top adverse events that warrant teaching and evaluation.
10. Quality of care should definitely be examined—there is currently no oversight for it.  
Listen to feedback from residents and their families.
11. Could really use a checklist for evaluations.

**Objective 2.** Evaluate the workgroup’s overall understanding of the material presented during the education sessions. The workgroup’s understanding was evaluated by completing a written and electronic survey, followed by a telephone interview after the presentation. This

objective fulfills the Check of the quality improvement phase for which results were analyzed and identified.

The researcher asked five questions evaluating the significance of the presentation to the work group. The first four questions were analyzed using a Likert scale of agree, strongly agree, disagree, strongly disagree, and undecided. The last question required a qualitative response and contents; comparisons; concept map; fees; and governance were reactions that were gathered as the common responses among the participants. The following were the questions asked:

1. Did the information presented inform their understanding of ARCH and AFH?
2. Did the information presented influence their decision and recommendations for the DOH and DHS integration?
3. Did the comparison presentation clarify the concept of an integrated care system?
4. Did the presentation make a positive impact on their recommendation for the integration?
5. What part of the presentation was the most significant that helps clarify an integrated system?

Results were analyzed by manually counting the responses from each query to identify if the presentation has informed, influence, clarified, and made an impact in the workgroup's decision of an integrated system. Key terms used to identify the most significant part of the materials presented were extrapolated from the respondents responses. Results with similar responses were grouped and manually counted.

**Aim 2.** Analyze and develop a new methodology in policy engagement as a result of the process analysis for quality improvement. This phase is the Act phase for which actions are taken based on what is learned from the study step. Fulfilling this aim requires a different

approach depending on the results of the objectives. If the change does not work, go through the cycle again with a different plan. However, if the plan is successful, incorporate what is learned to plan a new improvement; beginning the cycle again is imperative.

**Objective.** Evaluate the methodology and processes involved using a quality improvement model. Analyze, evaluate, and identify the steps as well as the barriers encountered in educating the workgroup and policymakers. Develop a new methodology with hope for future policy process solution to improve future policy processes. This phase is the Act phase where action takes place. As previously stated, if change does not work, the cycle will start again with a different game plan. If it is successful, however, new improvement incorporating what is learned beginning the cycle again must be incorporated. This phase is where the new process methodology came into terms. New acronyms that best describe the emergence of a policymaking process solution *ALIVE*, which stands for *Adapt, Live, Implement, Value, and Evaluate*.

The first step in the ladder of the *ALIVE* process is Adopting a clear solution. The chosen topic or question must be well adopted and of great interest for the researcher to devote his or her full-time commitment with the research from the beginning to the end. Adopting a clear objective linking the long-term mission and vision of the research project is the foundation of the *ALIVE* policy-making process.

Living the solution in the second step of the legislative process calls for the researcher to live and breathe the project solution for which he or she needs to have an active participation in forums, discussions, and other initiatives that pertain to the solution. In this particular research, the researcher had participated in the workgroup meetings numerous times, as well as attended caregivers' meetings and legislative forums. One of the many engagements this researcher



undertook was talking to hundreds of caregivers in the presence of the governor and the DOH medical director for their continued support of residential care and the need for an integrated process. A comment received from the governor after the presentation was “that was splendid!”

Other meetings included a presentation to case managers and social workers involved in discharge planning in a local hospital. Distinctions between ARCH and AFH were made to have a better understanding of the two residential services and the need to provide alternatives to other residents besides nursing homes or institutionalization. The social model of care that benefits not just the health and well-being of the individual being served but their family as well, was highlighted to foster a family-like environment that one has been accustomed to.

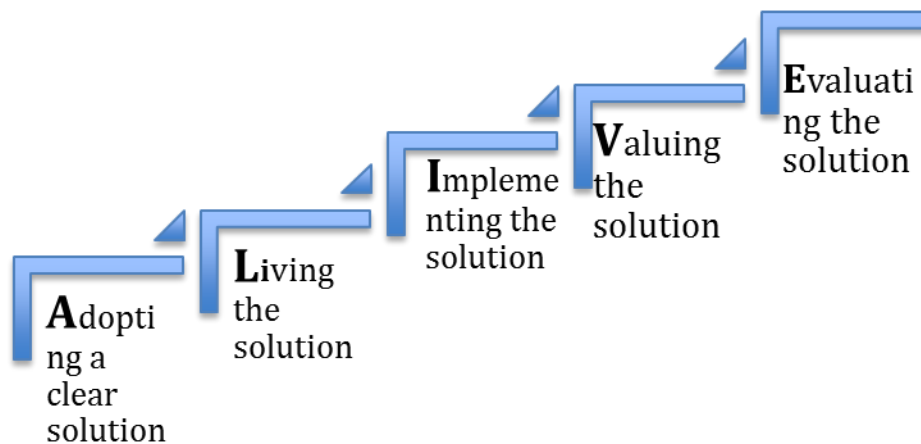
The third step in the ALIVE policy-making process is Implementation. Implementing the solution is taking the actual methodology and the objectives of the project and putting them into action. As the change agent or the spice that provides taste to the recipe, one must take the initiative to lead and implement the project solution. Implementation in this research involved attending the workgroup meetings and analyzing the discussed materials to find the missing link that must be presented to provide a better understanding of the subject. In this case, a comprehensive comparison between ARCH and AFH was identified as the missing link; therefore, a presentation to the workgroup was performed addressing these needs: Historical separation of services between the Department of Human Services (DHS) and Department of Health (DOH) resulted in fragmentation of care. The presentation also highlighted the Social Model of Care is intended to integrate services and provide a home-like setting to clients, fostering their autonomy and care provided by a universal worker.

The fourth step in the ALIVE policy-making solution process is Valuing. This step encapsulates the accountability of the researcher to the solution. The need for continued support

is essential in maintaining the strength and vitality of the proposed solution. The researcher must continue to support the issues surrounding the subject or the topic of interest for all it's worth.

The researcher must have an open mind of the topic at hand and know what other issues of concern pertain to the chosen topic. In this case, the researcher took the initiative to write testimonies and legislative involvement surrounding the issue. For example, the researcher has continuously provided written testimonies in support of the residential care services such as HB 1161, HB 1239, and HB 1195. In addition, this researcher has requested to be part of the email distribution group to receive updates on elderly care from the State Capitol from the Kupuna Caucus.

The final stage in the ALIVE policymaking process is Evaluate, which involves an ongoing process from the beginning to end. This stage is vital before, during, and after the project, making sure that policies that focus on complying with government regulations are up to date and that the proposed solution is reflected in the long-term goal of the project. The need for an Evaluation in the Plan-Do-Check-Act (PDCA) process is an imperative engagement in identifying the benefits and addressing the inefficiencies of the project design. This step supports new ideas or processes such as the creation of the ALIVE policy making processes as an end-result of this project.



*Figure 5.* The ALIVE Acronym in the Policy Making Process Solution Includes: Adopting, Living, Implementation, Valuing, and Evaluation.

---

**Aim 3.** Adapt the materials presented as part of the 2014 legislative session proposal for change. As the byproduct of this effort in educating the workgroup and keeping in mind system efficiency, reducing administrative barriers to care, and ultimately increasing access to long-term care housing for the elderly, the materials presented were adopted as part of the 2014 legislative proposal for change. This satisfies the Act phase of the PDCA cycle and the ultimate end result of this project.

### **Ethnography and Qualitative Method**

Among the most complex and interdependent entities known to society are the health systems and health care institutions; therefore, without integration, various levels and all aspects of health care performance suffer. Patients get lost, needed services fail to be delivered or are delayed, quality and patient satisfaction decline, and the potential for cost-effectiveness diminishes. The rationale for the use of integrated care systems presents an evidence-based practice that is well accepted and supported. Therefore, in an effort to describe the unification

and the nature or scope of ARCH and AFH in the State of Hawaii, an integrated care system must be fully understood.

Comparison presentations of ARCH and AFH to the workgroups were performed and triangulated data assessing the importance of the presentation were extrapolated using a qualitative approach. Sample population consisted of the Home and Community-Based Services Working Group (HCBS). Representatives from Community Care Foster Family Home (CCFFH), Adult Residential Care Homes (ARCH), Adult Day Care Centers (ADCC), caregivers of persons with developmental or intellectual disabilities, Adult Foster Homes (AFH), Licensed Case Management Agencies (CMA), and policymakers were represented. The purpose of the workgroup was to discuss issues and critical components that are needed to be worked out as DHS and DOH integrate into one managing system for both ARCH and AFH. A successful team-based approach sharing risk and accountability through the collaboration of the aforementioned workgroup needs to be practiced with the resident or the consumer of ARCH and AFH as the center of every decision.

## **Chapter 4**

### **Results**

The fundamental aim of this project was to collaborate with selected policymakers and the Home and Community Based Services (HCBS) workgroup to identify existing flaws in the non-integrated system to generate a working plan that incorporates both ARCH and AFH guidelines and practices governing an integrated CRC network promoting patient satisfaction, quality driven care, and cost-effective services. In this chapter, the results of the individual aim and objectives will be displayed.

**Aim 1.** To work together with policy makers and HCBS workgroup and together glide forward in identifying the existing flaws of a non-integrated system. In order to achieve that aim and fulfilling the Do phase of quality improvement, the following objectives were accomplished.

**Objective 1.** Educate the workgroup on similarities and differences between ARCH and AFH and the problems generated by the historical separation of services between the two governing entities, the DOH and DHS, in order to develop a policy that would integrate the two services under one governing body.

This project will accomplish a qualitative method of grounded theory and the symptom-action-timeline process (SATL), in which a systematic approach that provides a meaningful understanding of behavioral patterns from the participant's perspectives (Winters et al., 2013) will be exercised. This allows the interviewer not to impose his or her cultural biases to the world of the participants, enabling them to learn about their personal influences and interactions, as well as social and cultural beliefs with direct examination of the participants' world in a naturalistic manner (Winters et al., 2013).

A questionnaire utilizing a telephone interview will be utilized to assess the workgroup's point of view of the presented materials, whether the presentation has captured the intended objectives or the importance of an integrated care system (see Figure 6 Integration Questionnaire). A questionnaire was utilized assessing the HCBS workgroups satisfaction of the materials presented and their overall experience derived from the presentation. The presenter's performance will also be assessed gauging the presenter's readiness and knowledge of the topic to form a plan do act process for improvement. Expectations, validity, and usefulness of the materials presented captured from the workgroup's answers from the five queries will be appraised and plugged into a Likert scale system.

**Thank you for attending the ARCH & AFH presentation. Please rate your overall satisfaction of the presentation**

1. **Did the information presented inform your understanding of ARCH and AFH**  
 Strongly disagree    Disagree    Undecided  
 Agree    Strongly Agree
  
2. **Did the information presented influence your decision and recommendations for the DOH & DHS integration**  
 Strongly disagree    Disagree    Undecided  
 Agree    Strongly Agree
  
3. **Did the comparison presentation clarify the concept of an integrated care system**  
 Strongly disagree    Disagree    Undecided  
 Agree    Strongly Agree
  
4. **Did the presentation made positive impact on your recommendation for the integration**  
 Strongly disagree    Disagree    Undecided  
 Agree    Strongly Agree
  
5. **What part of the presentation was the most significant that helps clarify an integrated system**

---



---

**NOEMI LIBED ARZAGA**  
 Adult Residential Care Home (ARCH) & Adult Foster Home (AFH) Integration  
 A unified system provides an efficient housing option for the elderly in the State of Hawaii

**Questionnaire**  
**'Integration'**  
 ARCH & AFH

**Presentation Date: 3/17/14**  
**Presentation Location: Hawaii State Capitol**  
**Presenter: Noemi Arzaga**

Name : \_\_\_\_\_  
 Address: \_\_\_\_\_  
 E-mail: \_\_\_\_\_  
 Tel #: \_\_\_\_\_

Figure 6. Integration Questionnaire

The problems generated by the historical separation of services between the two governing entities, the DOH and DHS, in order to develop a policy that would integrate the two services under one governing body. A need for a comprehensive summary presentation is a must in order to consolidate, compare, and contrast the governance of ARCH and AFH to assist in the workgroup’s formulation of a plan to satisfy SB 398 Section 1 (f) of Act 214. The summary presentation is presented in Appendix A. The presentation was accomplished in the following ways:

1. Attendance at the workgroup's meetings in order to assess the workgroup's knowledge about the two CRCs and identify the missing links that can guide the workgroup to formulate a plan for integration. Issues identified during those meetings are listed below and captured in the summary presentation.

#### Issue 1. Caregiver & Family Needs

- (a) understand the social model of care;
- (b) understand the integration of DHS and DOH, and why;
- (c) compare and contrast ARCH and RACCP – AFH;
- (d) understand caregivers' requirements – ARCH & AFH;
- (e) make recommendations based on evidence based practices; and
- (f) present additional recommendations for discussion.

#### Issue 2. Historical separation of services.

Identified problems generated by the historical separation of services between DHS and DOH. The separation results in inefficiencies in care, lack of information, redundancy of care, confusion, and overlapping of services at an unnecessary cost.

#### Issue 3. Scope of the Need.

Statistics show that between 1990 and 2012, the number of elderly has risen by 47% nationwide but by 116% in Hawaii. There is a rising need for quality access to care.

#### Issue 4. Need for a New Care Model

Social Model of Care is hoped to better the model by integrating services. It provides a home-like setting where clients have autonomy and a universal worker

who takes care of all their needs. It is a less institutional kind of setting, and should provide clients with choices by emphasizing their resident and caregiver relationships. This should help result in increasing their socialization and improving their outcomes.

#### Issue 5. Integration of Agencies

Integration of DOH and DHS services should result in reduced fragmentation of care, improve the health and wellness of patients and their quality of care, and reduce operating costs.

#### Issue 6. Comparison of Services

A comparison between ARCH and E-ARCH vs. RACCP-AHF, including the governing rules and regulations, numbers of residents, licensing requirements, monitoring, admissions, assessment of level of care, payments, physical structure, and liabilities.

#### Issue 7. Regulations

Recommended to keep the current regulations for E-ARCH and ARCHs, because they are working well. She recommended yearly evaluations, but stated that there is no standard tool to give performance evaluations for caregivers, so these evaluations should include:

- (a) a DOH Consultant;
- (b) processing and reporting of deficiencies;
- (c) processing of delivering services;
- (d) rules and regulations;
- (e) interviews or surveys from patients.



### Issue 8 Social and Ethical Concerns

Concerns about certain Case Managers that need corrections include:

- (a) inconsistencies in nursing delegation methods;
- (b) caregivers should be able to call doctors directly without going through nurses;
- (c) Case Managers not reviewing prior authorization of patients in a timely manner, resulting in patient benefits being terminated;
- (d) incomplete paperwork prior to home admission; for example, 1147 causing delays or problems with payments;
- (e) silently soliciting clients previously placed in an AFH;
- (f) being too heavily nurse-oriented; caregivers should be able to update medication lists or present service plans directly to doctors for signature;
- (g) a biased referral system where some CMs refer only to some caregivers, which unfairly limits patients' options; and
- (h) addressing whether, when a patient is discharged home with family members, the family members need nursing delegations.

### Issue 9. Recommendations

- (a) Keep CTA, or another body outside the agency, to look at quality of care. They were originally contacted to streamline the certification process and provide for unbiased care service where caregivers are seen as one and no one is more powerful than another. They can correct both contract management and caregiver deficiencies.

- (b) Oppose HB 1208, which imposes a recertification fee. Caregivers already pay out great amounts of money for expenses, and some may be forced to close if they must pay additional fees.
- (c) Encourage more caregivers; it is a growing business. They need to sell themselves so they can be profitable as well.
- (d) Address areas which need improvement:
  - education and training to respond to and address deficiencies;
  - implement a standard process of placement from hospital discharges;
  - implement a standardized process for data collection; and
  - use data on adverse events to educate caregivers about the top adverse events that warrant teaching and evaluation.

#### Issue 10. Gaps

Quality of care should definitely be examined—there is currently no oversight for it. Listen to feedback from residents and their families.

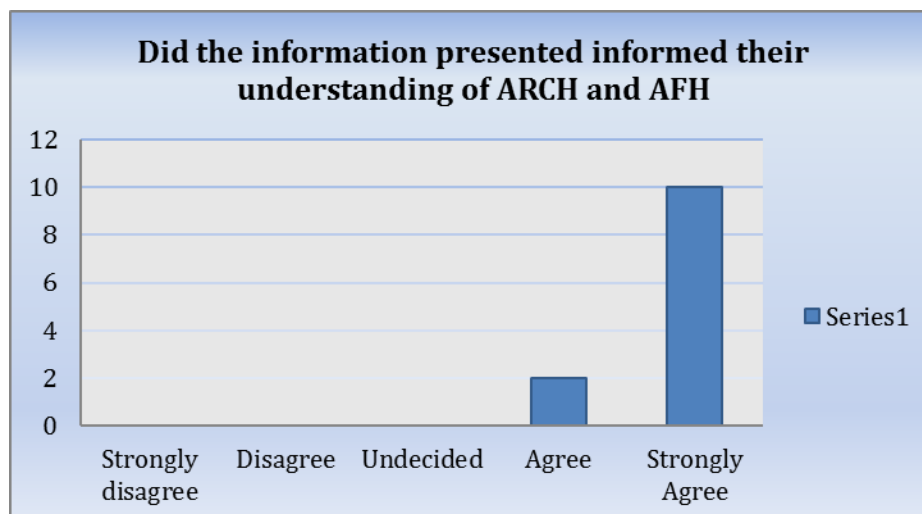
#### Issue 11. Evaluation

2. Provide a PowerPoint presentation to the workgroup and legislators. This presentation and recommendation can be found in Appendix B.

Assessing the workgroup's knowledge and identifying the missing links led to the creation and implementation of an educational presentation to the HCBS workgroup achieving Objective 1 on March 17, 2014. A copy of the presentation is provided as Appendix A. Section 2 (f) of Act 214 required the workgroup to submit a written report of their findings and recommendation to the legislators. This was achieved by adopting the materials presented to the

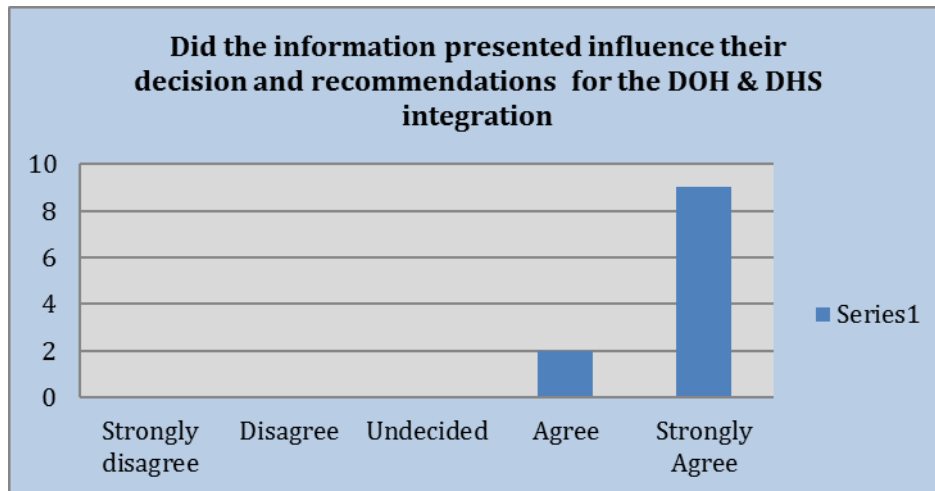
workgroup (provided as Appendix B). This satisfies Objective 1, (see Objective 1 above) which was to educate the HCBS workgroup bringing together the two CRCs into one systematic approach through educational presentation. In assessing the significance of the presentation, a survey was utilized and results were gathered and graphed as noted below, satisfying objective 2 (see objective 2 below).

**Objective 2.** Evaluating the workgroup’s overall understanding of the material presented during the education session was performed. A written questionnaire as well as an electronic monkey survey along with a telephone interview were performed to be able to capture the overall response of the workgroup to have a full understanding if the materials presented made an impact in their decision and recommendation of an integrated care system. Results of the questions were graphed as follows:



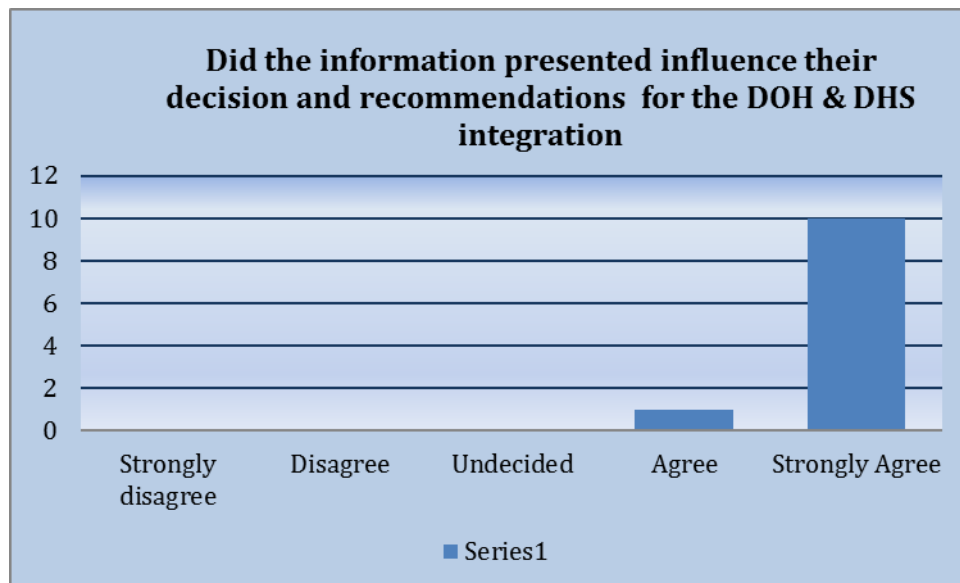
*Figure 7.* Did the information presented inform their understanding of ARCH and AFH? Strongly agree = 8, Agree = 3. Strongly disagree, Disagree, Undecided = 0. Out of the 11 respondents, 8 responded strongly agree and 3 agree that the information presented informed their understanding of ARCH and AFH.

---

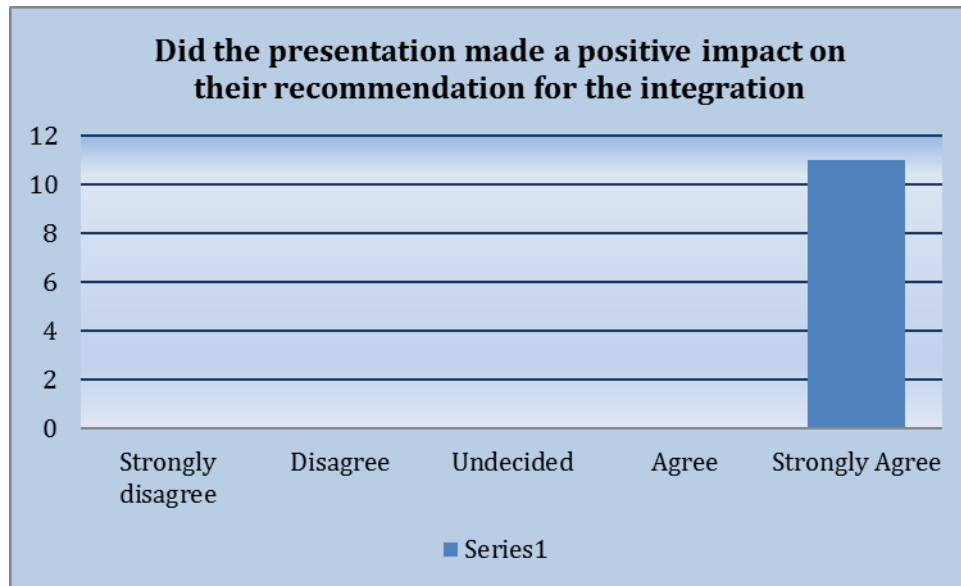


*Figure 8.* Did the information presented influence their decision and recommendations for the DOH and DHS integration?

Strongly agree = 9, Agree = 2. Strongly disagree, Disagree, Undecided = 0. Out of the 11 respondents, 9 strongly agree and 2 agree that the information presented influenced their decision and recommendations for the DOH and DHS integration

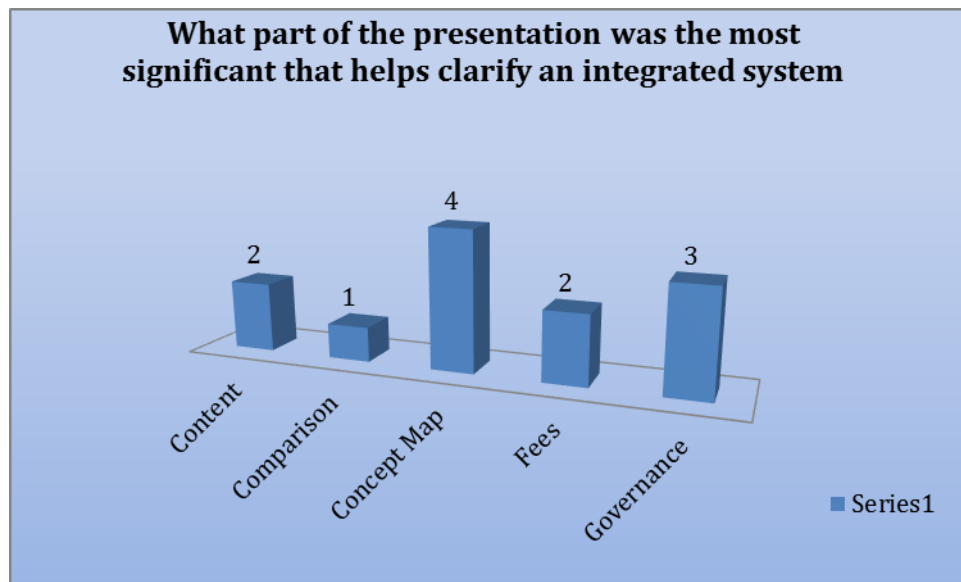


*Figure 9.* Did the comparison presentation clarify the concept of an integrated care system? Strongly agree = 10, Agree = 1. Strongly disagree, Disagree, Undecided = 0. Out of the 11 respondents, 10 strongly agree and 1 agree that the comparison presented influenced their decision and recommendation for the DOH and DHS integration.



*Figure 10.* Did the presentation make a positive impact on their recommendation for the integration?

Strongly agree = 11, Agree, Strongly disagree, Disagree, Undecided = 0. Out of the 11 respondents, 11 strongly agree that the presentation made a positive impact on their recommendation for the integration.



*Figure 11.* What part of the presentation was the most significant that helps clarify an integrated system?

Content = 2, Comparison = 1, Concept Map = 4, Fees = 2, Governance = 3. Out of the 11 respondents, 4 answered concept map, 3 governance, 2 contents and fees, and 1 comparison.

Overall, of the 11 participants, 36% (4 out of 11) reported that the concept map was the most significant in helping to clarify an integrated system (see Figure 11). Nearly the same proportion (27% or 3 out of 11 respondents) answered that governance was most significant, followed by fees and contents with 18% (2 out of 11) each. The comparison item of the presentation garnered 9% (1 out of 11) of the total responses.

In summary, Figures 7-10 demonstrated 85% (38 out of 44 responses) of the respondents strongly agree and 13% (6 out of 44 responses) agree that the presentation made an impact in their decisions and recommendations pertaining to the DOH and DHS integration. Disagree, strongly disagree, and undecided were zero each. The last question that required a qualitative response has extrapolated five key elements from the responses. These include contents, comparisons, concept map, fees, and governance. For example, one of the respondents said, “The concept map pretty much captured the overall objective of the presentation,” another one said, “The contents was comprehensive and the presenter must have poured so much time and effort in organizing such a detailed presentation.” Of the 11 participants who were questioned, 36% (4 out of 11) reported that the concept map was most significant in helping to clarify the integrated system. Nearly the same proportion (27% or 3 out of 11 respondents) answered that governance was most significant, followed by fees and contents with 18% (2 out of 11) each. The comparison part of the presentation garnered 9% (1 out of 11) of the total responses.

It is obvious after analyzing the data above that 85% (38 out of 44 responses) of the respondents strongly agree and 13% (6 out of 44 responses) agree that the presentation has made an impact in their decisions and recommendations pertaining to the DOH and DHS integration. Behind every effective presentation is the delivery of an effective message; it is therefore

imperative to note, given the data presented, that the platform used in delivering the message has demonstrated relevancy that captured the audience interest and their participation.

**Aim 2.** Analyze and develop a new methodology in policy engagement as a result of the process analysis for quality improvement.

**Objective.** Evaluate the methodology and processes involved using a quality improvement model. Analyze, evaluate, and identify the steps as well as the barriers encountered in educating the workgroup and policymakers. Develop a new methodology with hope for future policy process solution to improve future policy processes. The emergency of the ALIVE policy making process.

This participatory action research where *action* was more than just generating new knowledge, placed the knowledge into action in real time, thereby creation of the ALIVE policy making process supported by the PDCA methodology. As the ALIVE process relates to the concept of this project, a strong foundation that brings forth change and innovation will help remove the dead dendrites or the unnecessary cost that once held the system, but birthing a new life with sturdy foundation, an integrated process with a promise of a better tomorrow.

This research supports the integration of health care and research with the triple aim in mind of improving the individual's experience of care, improving the health of populations, and reducing the per-capita costs of care for populations (Berwick, Nolan, & Whittington, 2008). It is hoped for future researchers to take the ALIVE policy-making process and stride with the virtue to encouraging a more holistic, culturally congruent, and personalized approach to multidimensional health care needs for the elderly and beyond.

**Aim 3.** To adapt the materials presented as part of the 2014 legislative session proposal for change keeping in mind system efficiency, reducing administrative barriers to care, and ultimately increasing access to long-term care housing for the elderly.

**Objective.** Presented materials were integrated in the report to the twenty-seventh legislature for the State of Hawaii. The Social Model of Care that is intended to integrate services and provide a home-like setting to clients, fostering their autonomy and care provided by a universal worker were discussed. This model helped increase residents' socialization, thus improves health outcomes. This model provides a less institutionalized setting, providing residents with choices and emphasizing resident and caregiver relationships.

## **Chapter 5**

### **Recommendations and Conclusions**

In an effort to integrate the managing departments for both ARCH and AFH, House Bill 398 was introduced. Act 93, Session Laws of Hawaii 2012, healthcare services to the elderly in relation to Home and Community Based Services (HCBS) are needed to consolidate under one authority to the Department of Health (DOH). Historical separation of managing departments for ARCH and AFH has long created inefficiencies of services between ARCH and AFH. The two home-based care services that function independently, having their own sets of rules and regulations, causing breakdown in the delivery of care, resulting in wasteful resources and inadequate care services, creates frustrations to consumers and practitioners alike. It is, therefore, imperative to integrate the managing departments into one to reduce administrative barriers to care, thus promote patient satisfaction, and ultimately increase access to long-term care services in the residential care setting.



The conceptual and theoretic framework that guided this project from the beginning to an end is the utilization of the M&E integration process. The six systematic steps with this conceptual framework started with the notion of beginning with the end of mind. It was evident that change is needed due to the fragmentation of care; however, because of the complexity of this topic, how change will be implemented and what this researcher's role will be throughout this process were internally examined. As a researcher and a caregiver who's engaged in a leadership role that pertains to this subject, the role of a "consultant" in which all aspects of care and management surrounding ARCH and AFH were represented. The logic for which an inclusive presentation will provide a better understanding to the workgroup to formulate the recommendation for change governing the CRCs and actions were taken to implement such plan.

The second step was to identify primary points of contact for care and these are represented by the workgroup. Followed by defining and testing interventions for integrated services delivery package, exemplified by the actual presentation as well as the evaluation assessing the impact of that intervention to the workgroup. The fifth step was to create a theory-driven logic model epitomized by the creation of the ALIVE policy-making process as an end-result of this undertaking.

Lastly, the integration of health information system and data in decision making represented by the oral presentations and defense made for this project and the creation of this manuscript for future reference. The six systematic steps—(1) begin with the end in mind; (2) identify common primary points of contact for care; (3) define and test interventions for integrated service delivery packages; (4) create a theory-driven logic model; (5) improve the health information system; and (6) use data in decision making along with the PDCA model of quality improvement—have guided the fulfillment of these research aims and objectives.

Moreover, the five interlocking domains of funding, administrative, organization, service delivery and clinical were all intertwined, resulting in the development of a new process methodology in policy making process, ALIVE.

An agreed upon process or standard practice that addresses the lifecycles looking at holistic point of view, bearing in mind the maintenance of ongoing patient-provider communication and feedbacks, are quality components that are essential in the integrated care system. Behind this approach is the desire, above all, to enhance quality and provide a better level of service, one that is more sensitive to the personal circumstances and wishes of the individual patient. Overall, this integration will greatly affect the elderly population seeking residential care needs and services for the State of Hawaii.

The aim of working together with policy makers and the Home and Community Based Services (HCBS) workgroup and gliding forward in identifying the existing flaws of a non-integrated system was accomplished by performing an education via PowerPoint presentation presenting a comprehensive picture of an integrated system. This session conveyed the importance of an integrated system resulting in economically viable residential care services for the State of Hawaii.

Through process analysis, the second aim was accomplished through the development of a new methodology in policymaking process. As the PDCA model for quality improvement continues to guide the progression of this project, actions taken were methodologically thought out and examined. As an end result, the ALIVE (Adapt, Live, Implement, Value, Evaluate) policy making process was established guiding future healthcare leaders and professionals in policy engagement.

Lastly, the third aim of adapting the materials provided as part of the 2014 legislative session proposal for change submitted to the 27th Legislature for the State of Hawaii was accomplished. Presented materials were captured as part of the recommendation from the oversight of a home and community-based services working group. The adaptation of materials fulfilled the objective of this aim, which was the amalgamation of all interventions, from education, evaluation, and process analysis for quality improvement.

### **Recommendations**

The contribution of this project has led to the creation of the ALIVE policy-making process, which will help guide future researchers and health care advocates in the policy-making process. In retrospect, a trajectory timeline is created as the ALIVE policy-making process is translated into the design and scope of this project. Figure 12 shows the first step as the introduction of House Bill 398, an effort to integrate DOH and DHS, the managing systems for ARCH and AFH. Then Act 93, Session Laws of Hawaii 2012, was enacted integrating DHS and DOH into one monitoring agency, DOH. These two steps are the *Adopting* stage of the ALIVE process for which a clear solution was introduced and enacted. Through adopting, an identification of what research design to use is explored.

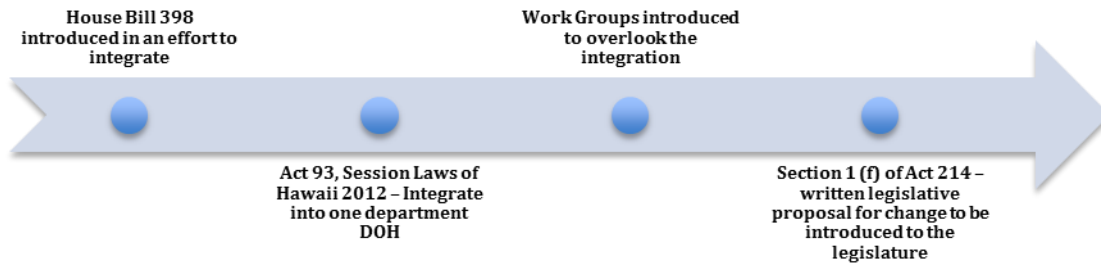
The next phase was the formation of the workgroups for which they overlook the integration and write a legislative proposal for change satisfying Section 2 (f) of Act 214. A qualitative approach or first hand experience as the topic was debated and understood was accomplished. It remains to be part of the Adaptation phase for which a participatory action research was exercised. This is where the particular topic is locally defined, facilitated rather than directed and ensured shared power among the workgroup participants (Barnes, Holmes,

Lindstrom, & Trytten, 2015). The researcher achieved first hand experience of listening to the workgroup to help generate a plan for intervention.

In the *Living* stage of the ALIVE process, the workgroups continue to meet and discuss the issues and concerns of the integration. This is a stage of an active engagement that is required to process what needs to be implemented. This process highlights the participatory action research to where ideas were formed as a result of an integrated discussion from the group. The active engagement of the researcher to the workgroup in identifying the pros and cons of the integration was imperative in developing and carrying out the plans and objectives of this project. In this research, there is a need for comprehensive information to be presented to the workgroup to have a strong knowledge base about the governing entities of ARCH and AFH. Therefore, a PowerPoint presentation was performed in the *Implementation* stage to fill in the identified need for a robust information about the two community residential care services, ARCH and AFH.

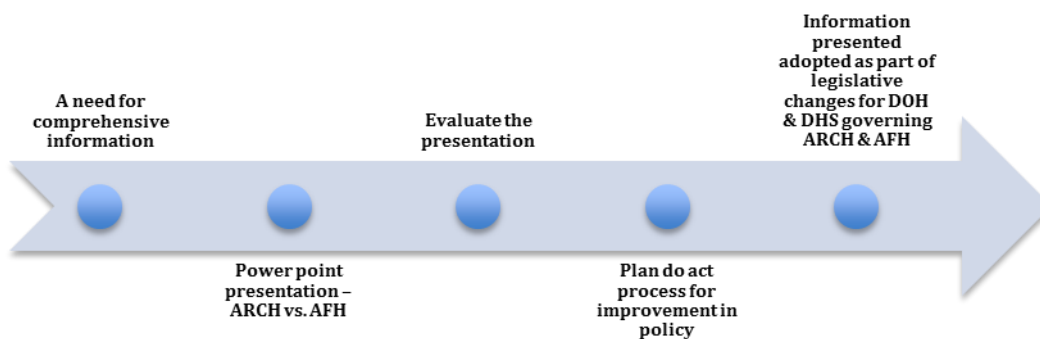
The fourth step in this timeline is *Valuing* the project for which a sense of worth and ownership must be exercised. The commitment of the researcher is of utmost importance, as it features their position and accountability in the project, helping them identify the appropriate actions and recommendations that need to take place.

Lastly, the need for an *Evaluation* and performing a plan to do check act (PDCA) process was quite beneficial in addressing inefficiencies of the chosen project design but also to promote improvement thereby creating new ideas for future research endeavors. As a result, the ALIVE policy making process was erected and identified.



*Figure 12.* Project Timeline – Phase 1: The Plan  
ARCH and AFH integration with ALIVE policy making solution – Part 1

---



*Figure 13.* Project Timeline – Phase 2: The Plan  
ARCH and AFH integration with ALIVE policy making solution – Part 2

---

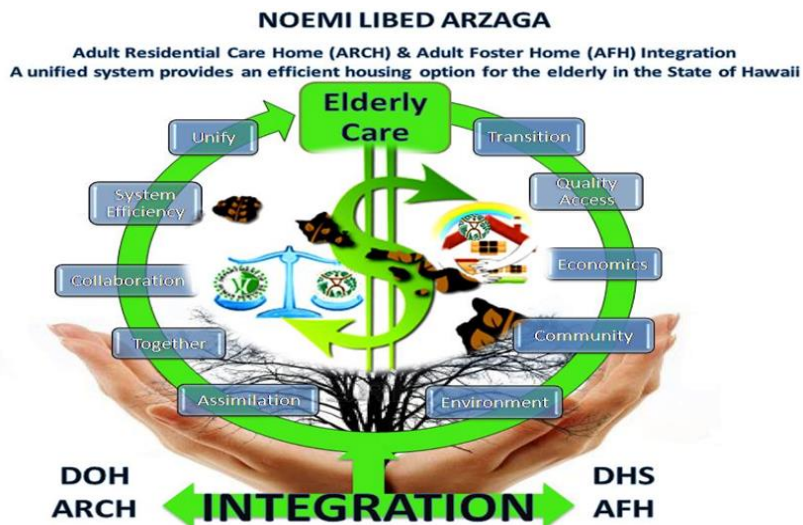
During the evaluation phase, the weaknesses, gaps and limitations of the project were also identified. Due to the overwhelming information that needs to be presented, the education process took one-and-a-half hours with questions and answers at the end. This researcher felt it was too long of a presentation; however, comments received at the end were quite reassuring as many have stated that the presentation was “awesome.” Additionally, the meetings were held in the State Capitol in Honolulu, resulting in a geographic challenge for this researcher who lives in Hilo, Hawaii. Thus, some meetings were missed but ongoing updates and minutes were received

from the Big Island Adult Foster Home Operators (BIAFHO) President, Ms. Cora Cariaga. The leadership of the said BIAFHO president has been instrumental in the engagement of this researcher with the workgroup. As the project neared completion, there were areas determined to be ineffective, thereby needing to be reassessed, and a revised process was created. An example was gathering of surveys post-presentation. Due to not having an immediate survey after the presentation, it was a challenge receiving the survey responses on a timely basis, as the next meeting was slated on the following month. Paper surveys were distributed to the workgroup participants one month post-presentation and gathered four responses. Some had forgotten to bring their copies or simply had misplaced their surveys. The researcher then decided to create a monkey survey and a mass notification was sent out to participants. Out of the 11 participants, there were seven that responded. Out of the seven respondents, two had already completed the paper survey, resulting in five responses obtained from the monkey survey.

As part of the project and while the integration of the agencies was occurring, members of the workgroup were contacted to participate in a survey to determine the usefulness of the education. All 11 members of the workgroup participated in the phone survey. The evaluation stage once again is a never-ending step; as each new process or new idea is presented, it would have to go through the ALIVE process. It is imperative for the need of timeliness and ongoing evaluation for the ALIVE cycle to prosper and to determine the need for optimization.

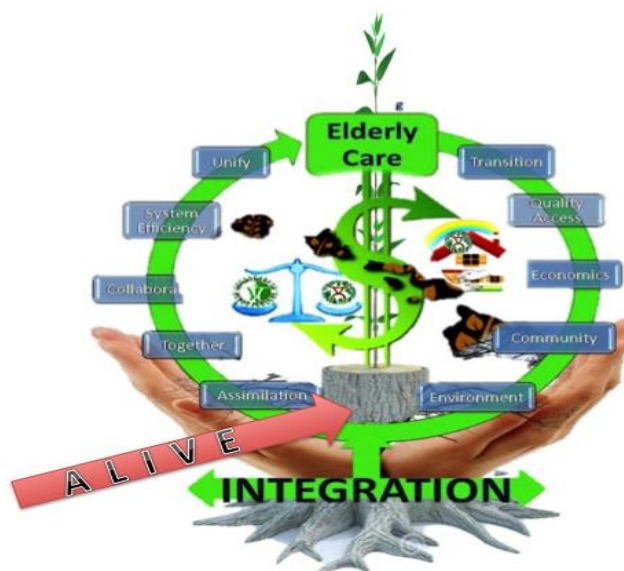
The process involved requires a great deal of transition that provides quality access, addressing economic concerns, involving the community and the environment. In addition, the assimilation, togetherness, and collaboration of the two systems will result in system efficiency and unity for the end result of providing integrated quality-driven care for the elderly. This

concept map (Figure 14) has virtually imprinted the overall meaning of this project that vertically and horizontally looked at the jointing relationships between agencies, facilitating efficiency and a seamless process that depicts the core objective of an integrated care system, the heart and soul of this project.



*Figure 14.* The Concept Map of Integration Between DOH and DHS for ARCH and AFH.

Appraising the ALIVE policy making process and its relation to the concept map that was literally designed specifically for this project marking its significance in the presentation was further digested. The two hands that hold the legal balance exemplify the two departments (DOH and DHS) that come together to address long-term care housing for the State of Hawaii. The black stems that hold the systems in place needed to be supported by a well-rooted structure replacing the dead dendrites supporting the structure from tipping or falling off. Having a sturdy foundation that sprouts new life and hope is the groundwork for change and innovation, the essence of the ALIVE policymaking process (Figure 15).



*Figure 15.* The Concept Map of Integration Between DOH and DHS for ARCH and AFH and the ALIVE policy making process

---

## Conclusions

In response to the provision of Act 215, Session Laws of Hawaii 2013, a workgroup was established to provide oversight with respect to the issues relating to the consolidation or integration of DHS and DOH. The workgroup, represented by different agencies having their own expertise in their own respective agencies, calls for a comprehensive summary presentation to consolidation, comparing, and contrasting the two residential care systems to form a cohesive plan for integration. Having a clearer picture will help the workgroup formulate a plan to satisfy Section 1 (f) of Act 214, in which the workgroup is required to submit a written report of their findings and recommendations to the legislators, including a legislative proposal for change in relation to the integration.

This is the birth of this participatory action research project for which obtaining the different perspectives of the stakeholders or the workgroup was first identified and noted. A need for comprehensive information is needed to fill in the gaps to fulfill the integrated



approach. A PowerPoint presentation to educate the workgroups about the differences and similarities of ARCH and AFH were performed covering the governing entities that make up both agencies. On March 17, 2014, a presentation to the workgroup was performed to educate them, raising awareness for the need to integrate the managing systems. A solid framework that addresses the needs for both AFH and ARCH must be captured in the written proposal for change to be integrated in the framework of DOH and DHS integration into one managing system.

Evaluating the presentation in a form of questionnaire to identify if presentation has made an impact in the workgroup's recommendation for change will be assessed. Taking the overall experience of educating the workgroup and the law makers, the presenter will evaluate the whole process and perform a plan do act process for improvement with a goal of creating a solution action plan for future policy engagement and above all, to make sure that the information presented is adopted as part of legislative changes for the DOH and DHS governing both ARCH and AFH integration.

The certificate of need and consumer's direction is quite favorable considering the growth of this industry with the utilization of the Medicaid waiver public funded sector that is likely to close the gap over the years to come. Residential care facilities need to be part of the comprehensive evaluations for all long-term care programs, especially those supported by public funds to monitor quality patient care. Changes in health conditions and impairments need to be maintained with the mentality of promoting health and wellness through autonomy, privacy, dignity, and experience of fuller life. Policy goals and perspectives enabling the frail elderly to remain in the community, utilizing services provided by the assisted living model of care such as ARCH and AFH, provide great credibility. Such facilities provide non-institutional care,

homelike environments with the philosophy of maximizing autonomy, choice, privacy, well-being, independence, and continuation of the normal lifestyle. It is appropriate, then, to note that care in assisted living facilities such as ARCH and AFH would seem to be a viable alternative to a nursing home for the elderly now and in the future.

Tending to the needs of family and work already requires an artful balance, but adding an ongoing need to find elder care can be overwhelming. Making decisions about living arrangement means that the best possible fit was made when considering the person(s), their ability to pay, family circumstances, and appropriate housing environment available. Medicaid funding from nursing homes to assisted living facilities could be a promising strategy for ever-increasing long-term care costs. ARCH and AFH are less intensely regulated than nursing homes and are considerably less expensive to operate and seem to have similar effects on their residents.

The need to look at policy change and funding allocations for the elderly is a huge undertaking that every citizen must take an active participation in. The integration of DOH and DHS is the first step in addressing the need for an integrated process to gain greater efficiency and effectiveness, less duplication and waste, more flexible service provision, and better coordination and continuity.

The promotion of healthy aging starting with primary prevention, improving general health, delaying the onset of disability, and increasing productivity and self-efficacy is proven to have significant cost-saving results (Leveille et al., 1998). Thus, an active engagement to the community is an approach that requires shared commitment among the elderly individuals, their family, caregivers, healthcare professionals, and the formal system of government that shapes policies, processes, and procedures. Engagement in policy development and collaboration

between formal and informal systems fostering self-efficacy and self-worth will not only improve quality of life for the aged, but optimize health care service utilization that brings forth economic vigor and vitality. It is time to take a stand, lead, and make a difference.

## **Chapter 6**

### **Implications for Practice**

As the workgroup continues to meet, some of the discussions that have been addressed and need to be integrated are consistent with Polivka's (2004) recommendations, which provide a useful framework for developing integrated regulations that pertain to residential care. First, all residential homes need to provide their philosophy of special care programs to the residents before admission, process and criteria for placement in, and transfer or discharge from, any specialized unit. Second, any additional cost or services provided must be discussed and agreed upon as well as staffing requirements, training, and continuing education such as special care programs that are relevant to the care of the patient. Third, the physical environment and design features that are appropriate to the support and functioning of the resident to maintain safety and well-being, while at the same time addressing their specific needs, must all be integrated as laws and regulations are coordinated. Fourth, the discussion of fire safety addressing standardized requirements of testing across the board, ensuring efficiency with safety standards, must all be available and required in the availability of community-residential care. Fifth, admission and retention criteria with staffing level that maximizes consumer's choice should all be inclusive making it affordable for both residents and the state for Medicaid waiver programs. Restrictive criteria in this environment will diminish the need of frail elderly seeking for this type of care as quality of life condition diminishes with strict restrictions. Criteria that meet the existing requirements should not be altered or modified as the two services are integrated. There

shouldn't be any additional requirements or process involved as the result of integration but rather a simplified process that warrants less duplication and redundancy of care and services.

End-of-life care discussions must also be integrated and address the residents' progressive and terminal care needs. The most effective care while considering the emotional needs of the resident is to not move them physically to another higher level of care where they are placed in a facility to receive palliative care services. If sufficient accommodations are made, residential care facilities are well equipped to accommodate residents who need end-of-life care and therefore, are able to work with hospice in addressing the individual needs of the residents. Working together as a team preserving a patient's health throughout the continuum of the patient's life should be supported. Thus, hospice engagement or palliative care services should be made available to ARCH and AFH homes to fulfill the age in place process in the community residential home services.

Another recommendation that needs to be integrated is dementia care. A set model or guidelines that standardize and address the needs of residents with dementia should be addressed and provided with collaboration to other agencies specialized in this field. Residential care due to lower patient-provider ratio has great potential to serve residents with this disease process; thus, careful monitoring and close collaboration with physicians or nurse practitioners in the community need to be practiced at all times to address the needs of these patients while not removing or separating them from the environment to which they are accustomed. Therefore, every effort must be made to keep the residents in the community, and resources for providing the specialized care for this group must be provided. Meeting the residents' demands as well as building on their strengths and capacities to accommodate a balance of safety and autonomy, reflecting their cognitive status that it will deteriorate over time, requires an integrated care at all

levels, from the resident, family, and the residential care facilities. Additional support, respite services, and training to caregivers must be provided in order to maintain a well-balanced care provided to both caregivers and the consumers.

The physical or environmental design is another aspect that must be addressed and not be overregulated in order to provide a homelike setting, a living environment where it is possible to provide privacy and enhance autonomy. The social model of care highlighting the homelike setting in the residential care must be kept in mind when regulations and standardization are introduced. After all, these facilities are home-based-like settings, thus the idea of keeping the homelike setting must be well preserved.

Training of staff or employees is a must in the realm of “generalist worker” which maintains an integrated, familial, homelike environment to help contain staff costs. In-service training especially for workers in facilities such as AFH who are serving more physically and cognitive impaired residents should be considered to keep up with current evidence-based practice focusing on the values of caregiving and resident interactions. A mutual respect between the RN case manager that provides the training to the caregivers must be acted upon at all times without showing inferiority to the caregivers who provide such care to the patients. Any signs of disrespect should be reported to the governing bodies and DOH, and disciplinary action must take place.

Quality of care is a great priority that should be measured and monitored. Quality of life outcomes need to be monitored based on fundamental values of autonomy, privacy, dignity, and full experience of life. These should all be assessed from the resident’s or family’s feedback with variables of enjoyment, meaningful activity, quality of relationships, spiritual well-being, as well as sense of security and physical comfort as noted by Kane, Kane, and Ladd’s (1998)

research on the use of measures in nursing homes. These measures should be practiced and in practical terms that pertain to the residential care setting. An internal quality-monitoring program to correct, improve, and/or enhance quality care in the residential setting must be introduced and exercised as well. The residents and their families, caregivers, and case managers should do this monitoring system.

Nurse delegation and medication management programs that are properly supervised by registered nurses allowing nurse delegation to non-licensed individuals, such as certified nurses' assistants, should continue as it benefits the resident and at the same time provides a capacity to help contain costs. Nurse delegation must be performed in order for the caregiver to reach its full potential of providing care to the residents. However, if an RN manages the home, a case manager should no longer be needed, as a redundancy of services is seen in that end. The primary RN who is taking care of the patient should be provided with additional training to help his or her caregivers perform certain tasks and should be given training to also perform certain paperwork to satisfy the requirement for the patient to continue to live in the home. The separate case managed fee for these homes should then be provided to the primary caregivers as incentives who will take the full responsibility of the patient from the caregiving aspect to the management portion of care. In doing this, more RNs will hope to be able to enter this field broadening the need for RN caregivers who have the training and knowledge base skills in taking care of the more challenged residents with multiple diagnoses.

Lastly, a standardized resident assessment tool has yet to be developed as current state CRCs utilize the Minimum Data Set (MDS), which is primarily a nursing home tool assessment. There is a big distinction between nursing homes and residential care homes; therefore, there must be a standardized tool that is conducive to the residential type setting only. As Polivka

(2004) has noted, there is a need of research in this area and I am totally in agreement as a need for an evidence-based assessment tool geared towards CRCs has yet to be determined to set the tone for standardization.

Systems ensuring healthcare providers delivering the best care at the lowest possible cost are needed (Laplante, 2005). Furthermore, the safest, most appropriate and most affordable elderly care does not necessarily come from multiple specialties visiting patients in a nursing home, but rather an efficient integrated healthcare system that is affordable, multidisciplinary, holistic, and under one oversight.

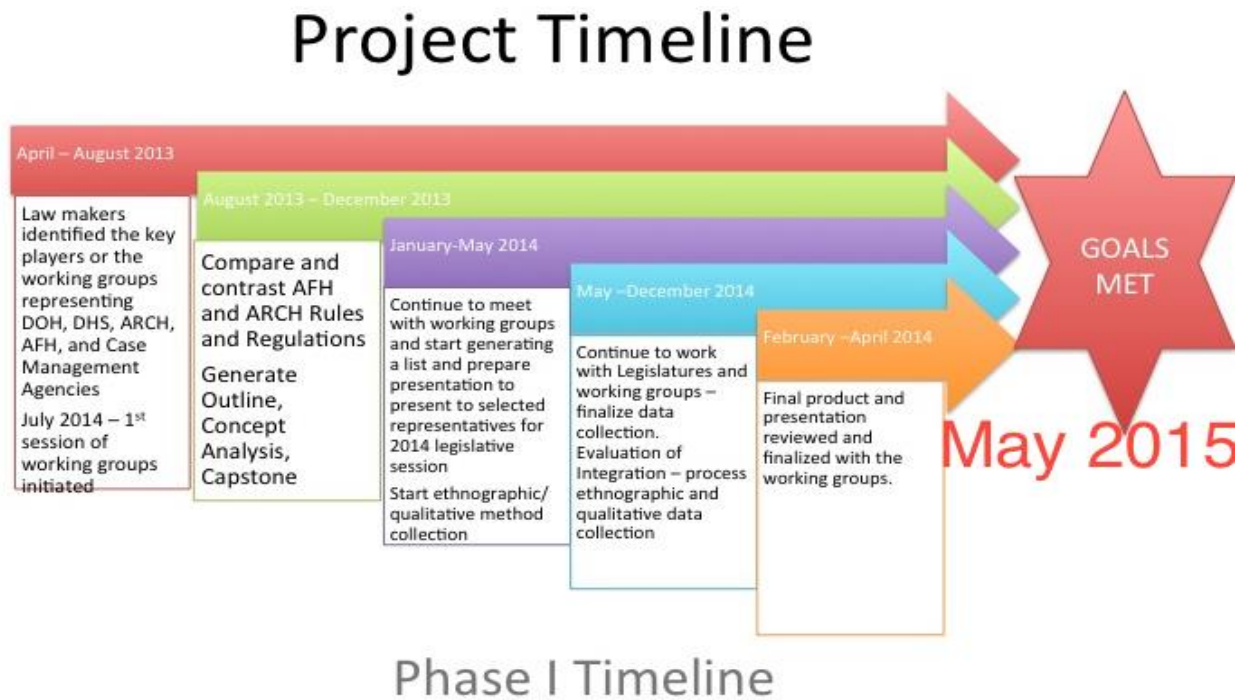


Figure 16. Project Timeline – Phase 1: Meeting Goals

## Project Timeline

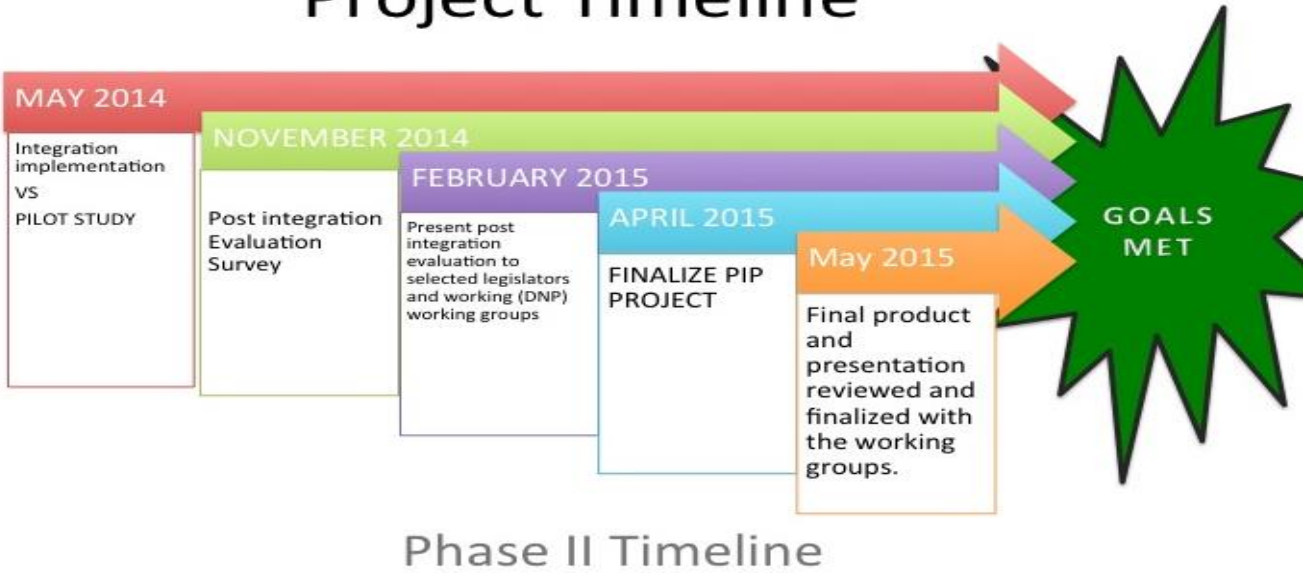


Figure 17. Project Timeline – Phase 2: Meeting Goals

## PROJECT BUDGET

PROJECT BUDGET	RESOURCES
\$1000 +	<ul style="list-style-type: none"> <li>-Interisland flight in attending</li> <li>-end of the month capitol - meeting with the work groups</li> <li>-Skype and internet availability</li> <li>-Research databases.</li> <li>-Personal computer.</li> <li>-Microsoft /PowerPoint office software.</li> <li>-Printer.</li> <li>-Printer ink cartridges.</li> <li>-Papers.</li> <li>-Misc. office supplies</li> </ul>

Figure 18. Project Budget



### References

- Barnes, R. O., Holmes, B. J., Lindstrom, R., & Trytten, C. (2015). Evidence-informed healthcare through integration of health research. doi:10.1177/0840470414562637
- Berwick, D. M., Nolan, T. W., & Wittington, J. (2008). *The triple aim: Care, health, and cost*. Retrieved from [http://content.healthaffairs.org/content/27/3/759.abstract?ijkey=c0480cbc666aeb21c0b878f2ae833b282459a626&keytype2=tf\\_ipsecsha](http://content.healthaffairs.org/content/27/3/759.abstract?ijkey=c0480cbc666aeb21c0b878f2ae833b282459a626&keytype2=tf_ipsecsha)
- Caffrey, C., Sengupta, M., Park-Lee, E., Moss, A., Rosenoff, E., & Harris-Kojetin, L. (2012). *Residents living in residential care facilities: United States, 2010*. Retrieved from <http://www.cdc.gov/nchs/data/databriefs/db91.pdf>
- Cartwright, J. C., Archbold, P. G., Stewart, B. J., & Limandri, B. (1994). Enrichment processes in family caregiving to frail elders. *Advances in Nursing Science*, 17(1), 31-43.
- Davis, K., Stremikis, K., Squires, D., & Schoen, C. (2014). *Mirror, mirror on the wall: How the performance of the U.S. health care system compares internationally*. Retrieved from [http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755\\_davis\\_mirror\\_mirror\\_2014.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf)
- Fried, L. P., Tangen, C. M., Walston, J., Newman, A. B., Hirsch, C., Gottdiener, J. . . .  
McBurnie, M. A. (2001). Frailty of older adults: Evidence for a phenotype. *Journals of Gerontology: Biological Sciences and Medical Sciences*, 56(3), M146-156.
- Harrington, C., Chapman, S., Miller, E., Miller, N., & Newcomer, R. (2004). *Trends in the supply of long-term care facilities in and beds in the U.S.* (Manuscript submitted for publication).

Hart, B., Birkas, J., Lachmann, M., & Saunders, L. (2002). Promoting positive outcomes for elderly persons in the hospital: Prevention and risk factor modification. *AACN Clinical Issues, 13*(1), 22-33.

Hayes-Bautista, D. E., Hsu, P., Perez, A., & Gamboa, C. (2002). The 'browning' of the graying of America: Diversity in the elderly population and policy implications. *Generations Journal of the American Society on Aging, 26*(3), 5-24.

*Health trends in Hawaii: A profile of the health care system.* (2013). Retrieved from [http://www.healthtrends.org/healthstatus\\_overview.aspx](http://www.healthtrends.org/healthstatus_overview.aspx)

Hedrick, S., Sales, A., Sullivan, J., Gray, S., Tornatore, J., Curtis, M., & Zhou, X. (2003). Resident outcomes of Medicaid-funded community residential care. *The Gerontologist, 43*(4), 473-482.

Kane, R. A., Kane, R. L., & Ladd, R. C. (1998). *The heart of long-term care*. New York, NY: Oxford University Press.

Kane, R. A. (2001). Long-term care and a good quality of life: Bringing them closer together. *The Gerontologist, 41*(3), 293-304.

Kodner, D. L., & Spreeuwenberg, C. (2002). Integrated care: Meaning, logic, applications, and implications – A discussion paper. *International Journal of Integrated Care, 2*.

Laplante, A. (2005). *Integrated systems improve medical care, control costs, according to Enthoven*. Retrieved from <http://news.stanford.edu/news/2005/october26/enthoven-102605.html>

Leveille, S. G., Wagner, E. H., Davis, C., Grothaus, L., Wallace, J., LoGerfo, M., & Kent, D. (1998). Preventing disability and managing chronic illness in frail older adults: A

- randomized trial of a community-based partnership with primary care. *Journal of the American Geriatrics Society*, 46(10), 1191-1198.
- MetLife Mature Market Institute, National Alliance for Caregiving, & Center for Long Term Care Research and Policy at New York Medical College. (2011). *The MetLife study of caregiving costs to working caregivers: Double jeopardy for baby boomers caring for their parents*. Retrieved from <https://www.metlife.com/mmi/research/caregiving-cost-working-caregivers.html#key%20findings>
- Mick, D., & Ackerman, M. (2002). New perspectives on advanced practice nursing case management for aging patients. *Critical Care Nursing Clinics of North America*, 14(3), 281-291.
- Mind Tools Ltd. (n.d.). *Plan-Do-Check-Act (PDCA): Implementing new ideas in a controlled way - Also known as the PDCA Cycle, or Deming Cycle*. Retrieved May 1, 2015, from [http://www.mindtools.com/pages/article/newPPM\\_89.htm](http://www.mindtools.com/pages/article/newPPM_89.htm)
- National Alliance for Caregiving & AARP. (2009). *Caregiving in the U.S. 2009*. Retrieved from [http://www.caregiving.org/data/Caregiving\\_in\\_the\\_US\\_2009\\_full\\_report.pdf](http://www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf)
- O’Keeffe, J., & Wiener, J. (2004). *Public funding for long-term care services for older people in residential care settings*. Prepared for the Robert Wood Johnson Foundation by the Center for Home Care Policy & Research, Visiting Nurse Service of New York, New York, NY.
- Polivka, L. (2004). *Community-residential care for the frail elderly: What do we know; What should we do?* Retrieved from <http://www.nga.org/files/live/sites/NGA/files/pdf/0408POLIVKA1.pdf>

- Raynolds, H. W., & Sutherland, E. G. (2005). A systematic approach to the planning, implementation, monitoring, and evaluation of integrated health services. *BMC Health Services, 13*, 168. doi:10.1186/1472-6963-13-168
- Salmon, J. R. (2001). The contribution of personal control and personal meaning to quality of life in home care, assisted living facility, and nursing home settings (Doctoral dissertation). University of South Florida, Tampa, FL.
- Spillman, B. C., & Pezzin, L. E. (2000). Potential and active family caregivers: Changing networks and the “Sandwich Generation.” *The Milbank Quarterly, 78*(3), 347-374.
- United Nations Population Fund (UNFPA). (2014). Retrieved from <http://www.unfpa.org/public/>
- United States Census 2000*. (2001). Retrieved January 3, 2003, from [www.census.gov](http://www.census.gov)
- Winters, C. A., Thomlinson, E. H., O’Lynn, C., Lee, H. J., McDonagh, M. K., Edge, D. S., & Reimer, M.A. (2013). Exploring rural nursing theory across borders. In C. A. Winters (Ed.), *Rural nursing: Concepts, theory, and practice* (4th ed., pp. 35-47). New York, NY: Springer Pub.
- Young, H. M. (2003). Challenges and Solutions for Care of Frail Older Adults. The Online Journal of Issues in Nursing. Retrieved from [http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/](http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No2May2003/OlderAdultsCareSolutions.aspx#United%20States%20Census%202000)  
[TableofContents/Volume82003/No2May2003/OlderAdultsCareSolutions.aspx](http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No2May2003/OlderAdultsCareSolutions.aspx#United%20States%20Census%202000)  
[#United%20States%20Census%202000](http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No2May2003/OlderAdultsCareSolutions.aspx#United%20States%20Census%202000)
- Zimmerman, S., Sloane, P., & Eckert, J. (2001). Emerging issues in residential care/assisted living. In S. Zimmerman, P. Sloane, & J. Eckert (Eds.), *Assisted living: Needs, practices, and policies in residential care for the elderly*. Baltimore, MD: Johns Hopkins Press.