BFED Committee

From: Kate Griffiths
Sent: Thursday, April 8, 2021 12:15 PM
To: BFED Committee
Cc: Gabe Johnson
Subject: BFED - Information documents from Councilmember Johnson
Attachments: Aloha House Budget Proposal.docx; MHK LEAD Wailuku Expansion Proposal - 2021 Version 2.pdf; Ho`omaikai Services Lahaina LEAD Proposal - 2021 Version 2 (1).pdf; Hale Mahaolu Budget proposal.docx

Aloha,

Please find attached documents that provide more information and cost breakdowns to Councilmember Johnson's proposals including funding for Aloha House, Mental Health Kokua, Lahaina LEAD program, and Hale Mahaolu.

Mahalo,
Kate

Kate Griffiths
Legislative Research & Policy Analyst (EA)
Office of Councilmember Gabe Johnson
Lānaʻi Residency
808.270.8071
Kate.griffiths@mauicounty.us

http://mauicounty.us/johnson/

ALOHA HOUSE
A Maui Behavioral Health Resources Agency

Enhanced Coordinated Care Program:

Providing enhanced access and support services for homeless individuals with Behavioral Health issues.

How we impact those with substance use and/or behavioral health issues:

- Provide immediate housing, detox service, crisis support services, and substance abuse treatment and behavioral health counseling, as well as ongoing psychiatric services and case management for those with serious mental illness.
- Address issues that may lend themselves to homelessness, and those that may be generated by homelessness.
- Provided residential treatment, and extended housing options through Sober Living Programs, along with intensive outpatient substance abuse counseling.

This interaction can last from a week to over a year. We know that to best support recovery, it is necessary to find housing for clients who may not have a home to return to, or do not have one that supports sobriety.

According to the National Coalition for the Homeless, addiction can be *both* a cause and a result of homelessness. By addressing substance use and behavioral health issues, we seek to solve one *cause* of homelessness, as well as issues that are sometimes the *result* of homelessness.

Goals:

To improve our quality of care, reduce incidence of relapse, and end the cycle of homelessness by implementing the Enhanced Coordinated Care Program, which provides enhanced access and support services for homeless individuals with behavioral health issues.

Strategies:

1. Enhance services by adding a behavioral health specialist care coordinator to support those with co-occurring disorders (Substance Use Disorder and Behavioral Health Diagnosis) so that this high-needs population can also have access to a continuum of care and long-term recovery support through our Sober Living Programs. At this time we don't have the capacity/expertise to effectively support this population.
2. Improve our ability to provide clients with appropriate treatment with the addition of an Intake Specialist to our admissions team.

3. Increase our capacity to reach clients where they are located and assist with the admissions process with a Field Specialist to work in coordination with our admissions team.
4. Track the results of this enhanced service, to more clearly determine the quantity of needs, the type of services that have the most impact, and the ultimate result of providing this care as it relates to reducing homelessness.
5. Increase support for the LCRS Crisis Services program, which is often the intake point for many homeless clients, to ensure these critical services are in place and fully functioning.
6. Better track individual clients' progress through our programs, and in and out of "the system" to ensure they don't "fall through the cracks" and miss receiving services.
7. Provide direction and supervision for the Enhanced Coordinated Care Program with support from the Program Director.
8. Use data from this tracking to make adjustments as necessary to enhance program services and to share with other community providers.

Outcomes:

1. Reduce the number of people experiencing homelessness due to drug use or behavioral health issues.
2. Reduce recidivism, which will reduce strain on our programs and other community resources.
3. Improve sober support, and ultimately, recovery rates.
4. Build on Aloha House's capacity to track client outcomes and have greater awareness of the impact of our services on this population. Over time, expand tracking system to support more programs of Aloha House.

Requests for Funds:

To implement this plan, we are requesting $377,300. These funds would be used as follows:

$75,000	Salary and fringe expenses for one Care Coordinator for one year
$59,000	Salary and fringe expenses for one Intake Specialist for one year
$37,000	Salary and fringe expenses for one Field Specialist for one year
$33,000	Salary and fringe expenses for .5FTE Program Director for one year
$124,800	Salary and fringe for 20% of nurses' expense in LCRS for one year
$5,500	Database software and licenses
$6,500	Laptop and necessary hardware for users
$2,500	IT Consultant expenses
$34,000	Management and Administration

Additionally, if we were to plan for a new dorm in order to increase our residential capacity by 12 beds, the estimated cost would be:

~$205,000 design & consulting
~$950,000 construction, permitting, sitework, etc.

LEAD–Safe Haven Expansion

Mental Health Kokua & Maui Police Dept.

LEAD-MHK Safe Haven Services Proposal

- To expand the LEAD program in Wailuku-Kahului to help divert homeless adults from legal encounters and arrest, and instead engage homeless adults in social services and housing placement.

History

- LEAD is the Law Enforcement Assisted Diversion best practice program established in Seattle, WA.
- In Maui, MHK's LEAD-Safe Haven program began as a pilot in Kahului-Wailuku in 2019 to 2020.
- The Maui LEAD partners included Mental Health Kokua (MHK), Maui Police Dept.
- Low-level, non-violent Maui homeless adult offenders with serious mental illness (often psychotic) were given the option of arrest or social services. LEAD services are voluntary by client choice.

LEAD Program Features

- Preventing initial incarceration as a primary goal because incarceration predicts more incarceration.
- Promoting outreach and engagement with treatment for substance use through mental health courts may help to prevent induction into the incarceration-RE-incarceration spiral.
- Positive social supports may prevent incarceration.

LEAD-MHK Safe Haven Program

- LEAD Partnerships. MHK's Wailuku-Kahului LEAD program collaborates with Maui Police Dept.
- Eligibility. Homeless adults with serious mental illness (SMI), ages 18 and older, voluntarily willing to participate in LEAD.
- LEAD Psychosocial Rehab (PSR) Social Worker. Homeless encounters are conducted in collaboration with the Maui Police Dept. MHK's 1-FTE, LEAD-PSR Social Worker assists homeless adults with SMI, who are provided options for social services, which are located at 105 Market St., Wailuku. Homeless individuals are documented in the Homeless Management Information System (HMIS) and in electronic medical records. The LEAD-PSR Social Worker, also helps conducts classes and assessment under clinical supervision (see below), and coordinates referrals to Aloha house, MHK psychiatry, KHAKO, and medical services.
- TWO Additional LEAD Homeless Safe Haven Stabilization Beds. 1.2 FTE Residential Assistant adds to already, existing Safe Haven staffing at 133 Market St., providing 24/7 staffing coverage for SMI homeless adults who are psychotic and need constant supervision. With the two additional beds this provides MHK's Safe Haven with 7 total stabilization beds.
- Clinical Supervision by a MHK Licensed Clinical Social Worker to supervise personnel and provide clinical oversight for the homeless adults served by the MHK's LEAD program.
- Registered Nurse (MHK) provides wound care/medical attention 5 hours/week for homeless adults.
- Psychiatrist. A MHK psychiatrist is available weekly to provide medication evaluation/management.

Outcomes

- 2 unduplicated homeless adults/day with serious mental illness in Safe Haven stabilization beds located at 133 Market St., Wailuku, HI.
- 3-months average length of stay.
- 5 people placed in permanent supported housing.
- 10 unduplicated homeless adults served in first year.
- 50 homeless adults/day with serious mental illness served in MHK's Psycho-social Rehab program.

Budget (See Attached)

- $128,576 per year.

LEAD–Safe Haven Wailuku Expansion

Mental Health Kokua & Maui Police Dept.

Operational Budget

Support & Revenue		Budget	Comments
Revenues			
Maui County Support	$	128,576	
ADAD LEAD Funding	$	24,000	$2000/month Outreach + $100/day stabilization bed x 30 residents = $39,000
Total Revenue	**$**	**152,576**	
Operating Expenses			
Salaries & Wages			
Residential Assistants	$	37,440	1.2 FTE's x $15/hour = $37440
Psychiatrist	$	15,600	$150/hour x 2 hours/week x 52 weeks/year = $15,600
Registered Nurse	$	7,800	$30/hour x 5 hours/week x 52 weeks/year = $7,700
Clinical Supervisor	$	16,640	$40/hour x 2 hours/week x $40/hour X 52 weeks = $16,640
LEAD PSR Soc Worker	$	43,000	1 FTE x $20.67/hour x 2080 hours/year
Total Salaries & Wages	**$**	**120,480**	
Benefits and Taxes			
Benefits	$	24,096	
Total Salaries & Benefits	**$**	**144,576**	
Other Expenses			
Mileage	$	3,600	$300 per month*12
Telephone/internet	$	2,400	LEAD Outreach Soc Worker mobile phone and WIFI
Technology/computers/DAAS	$	2,000	LEAD Outreach Soc Worker laptop and accessories
Total Other Expenses	**$**	**8,000**	
Total Expenses & Salaries	**$**	**152,576**	
Net Revenue Gain/(Loss)	**$**	**(0)**	

Ho`omaikai Services

Lahaina LEAD Program Executive Summary

Ho`omaikai Services Proposal

- To implement a LEAD program in Lahaina to help divert homeless adults from legal encounters and arrest, and instead engage homeless adults in social services and housing placement.

History

- LEAD is the Law Enforcement Assisted Diversion best practice program established in Seattle, WA.
- In Maui, the LEAD program began as a pilot in Kahului and Wailuku in 2019 to 2020.
- The Maui LEAD partners included Mental Health Kokua (MHK), Maui Police Dept., Ka Hale A Ke Ola (KHAKO) and Aloha House.
- Low-level, non-violent Maui homeless adult offenders were given the option of arrest or social services. LEAD services are voluntary by client choice.

LEAD Program Features

- Preventing initial incarceration as a primary goal because incarceration predicts more incarceration.
- Promoting outreach and engagement with treatment for substance use through mental health courts may help to prevent induction into the incarceration-RE-incarceration spiral.
- Positive social supports may prevent incarceration.

Ho`omaikai Services Lahaina LEAD Program

- LEAD Partnerships. The Ho`omaikai Services Lahaina LEAD program collaborates with the Maui Police Dept., Mental Health Kokua, Ke Hale A Ka Ola, and Aloha House.
- Eligibility. Homeless adults ages 18 and older, voluntarily willing to participate in LEAD.
- LEAD Outreach Social Worker. Homeless encounters are conducted in collaboration with the Lahaina-Maui Police Dept., and 2 FTEs LEAD Outreach Social Worker hired by Ho`omaikai Services: 1 FTE conducts street outreach in Lahaina town, and 1 FTE conducts case coordination at the KHAKO Pallet Houses. Homeless adults are provided options for social services. Homeless are documented in the Homeless Management Information System and in electronic medical records. The LEAD Outreach Social Worker conducts an assessment under clinical supervision (see below), and coordinates referrals to Aloha house, MHK psychiatry, and other medical services.
- Pallet Houses are available for 10 homeless adults as stabilization beds for adults with medical and/or psychiatric conditions, staffed and supervised 24-hours per day 7-days per week by Ke Hale A Ka Ola (KHAKO), including meals and medical care. The breakdown of homeless adults is about 50% with serious mental illness, and 50% with other issues.
- Clinical Supervision by a MHK Licensed Clinical Social Worker to supervise personnel and provide clinical oversight for the homeless adults served by the Lahaina LEAD program.
- Registered Nurse (MHK) provides wound care/medical attention 5 hours/week for homeless adults.
- Psychiatrist. A MHK psychiatrist is available weekly to provide medication evaluation/management.

Outcomes

- 10 homeless adults at a time in pallet house-stabilization beds.
- 3-months average length of stay.
- 25 people placed in permanent supported housing.
- 30 unduplicated homeless adults served in first year.

Budget (See Attached)

- $523,400 per year.
- $17,000 per homeless adult per year.

Ho`omaikai Services

Lahaina LEAD Program Executive Budget Summary

Support & Revenue		Budget	Comments
Revenues			
Maui County Support	$	463,600	
Health Plan - Outpatient	$	20,800	$100/visit x 4 visits/week x 52 weeks (for patients without health plan coverage)
ADAD LEAD Funding	$	39,000	$2000/month Outreach + $100/day stabilization bed x 30 residents = $39,000
Total Revenue	**$**	**523,400**	
Operating Expenses			
Salaries & Wages			
Residential Assistants	$	139,776	4.2 FTE's x $16/hour = $27747/year
Ho`omaikai Director	$	18,200	$35/hour x 10 hours/week x 52 weeks/year = $18,000
Registered Nurse	$	7,800	$30/hour x 5 hours/week x 52 weeks/year = $7,700
Clinical Supervisor	$	4,160	$40/hour x 2 hours/week x $40/hour X 52 weeks = $4,160
LEAD Outreach Soc Worker	$	86,000	2 FTE x $20.67/hour x 2080 hours/year
Total Salaries & Wages	**$**	**255,936**	
Benefits and Taxes			
Benefits	$	51,187	
Total Salaries & Benefits	**$**	**307,123**	
Other Expenses			
KHAKO Management Fee	$	12,000	$1,000/month x 12 months
Accounting/ Audit Fees	$	816	
Payroll Fees	$	1,143	
Legal Fees	$	554	
Psychiatrist	$	15,600	$150/hour x 2 hours per week x 52 weeks
Medications/Bus Passes/Fees	$	2,600	$10 x 5 people/week x 52 weeks
Food Supplies	$	87,600	$8/meal x 10 people x 3 meals/day x 365 days/year from other sources
Household Supplies	$	2,400	
Office Supplies	$	2,000	
Utilities	$	12,000	$1000 Water and Electric/ month x 12 months = 12000
Hygiene Shipping Container	$	28,733	Laundry, toilets, showers, cleaning service
Wastewater (hygiene center)	$	36,000	$3000/month x 12 months = $36,000
Liability Ins	$	646	
Property Ins	$	455	
Crime/Fidelity Bond	$	40	
Auto Insurance	$	348	
Mileage	$	3,600	$300 per month
Blanket/Data Insurance	$	248	
Telephone/internet	$	2,400	
Technology/computers/DAAS	$	2,000	
Postage	$	120	
Repair & Maintenance	$	4,800	$400 /month x 12 months = 4800
Bank Fees	$	175	
Total Other Expenses	**$**	**216,277**	
Total Expenses & Salaries	**$**	**523,400**	
Net Revenue Gain/(Loss)	**$**	**(0)**	
Cost Per Client	**$**	**17,447**	Based on 30 homeless individuals = $17,000/person/year (rounded)

Ho`omaikai Services

Lahaina LEAD Program Executive Budget Summary

Start Up Budget

Support & Revenue		Budget	Comments
Revenues			
Maui County Support	$	100,000	
Total Revenue	**$**	**100,000**	
START-UP Expenses			
Electric	$	50,000	Connect power from local pole
Pallet Houses	$	20,000	Move from warehouse and set-up
Hygiene Center	$	15,000	Move from Wailuku and set-up
Water	$	15,000	Connect from KHAKO.
Total Start Up Expenses	**$**	**100,000**	
Net Revenue Gain/(Loss)	**$**	**(0)**	

Hale Mahaolo
Adult Personal Care Program
Program Proposal
(Limit: 10 page including tables)

I. Executive Summary:

Executive Summary

Hale Mahaolu Adult Personal Care Program will provide a minimum of 4,680 units (hours) of subsidized personal care services to approximately 20 unduplicated individuals. This Program assists individuals living on the islands of Maui, Molokai and Lanai, in locating a suitable and affordable personal care attendant (PCA) through the Program's registry of PCAs, and reimbursing part or the entire fee charged by the PCA to the individual client who meets the income guideline. Maui County residents looking for affordable in-home personal care services may also receive referrals through our registry. There is no referral fee to clients. For disabled adults, the need may be even greater, since there are fewer programs available to them than to the elderly. Services not covered by insurance may be too costly for many disabled adults on a fixed/limited income.

Hale Mahaolu Personal Care Program provides in-home personal care services to frail elderly, disabled and chronically ill adults (18 years of age and older), including cognitive and/or emotional problems, which impair the individual's ability to perform activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs). The individual served by this Program must require personal care services to remain safely at home, as determined by a physician, an osteopath, a chiropractic doctor, public health nurse, or a discharge plan from an acute care, rehabilitation, or nursing facility.

The goals of this Program are to safely maintain our clients in the privacy of their residence and prevent premature or inappropriate institutionalization, to prevent or remedy abuse or neglect of such individuals, and to promote their self-sufficiency, independent living, and self-direction. Caring for these clients in their own home will also help to prevent skin breakdown, prevent falls and fall hazards, prevent/reduce caregiver burn out, and reduce costs of long-term care for clients, families, communities, and government. These goals can be realized through the provision of in-home personal care, as described in this proposal.

II. Background:

Frail elderly, disabled and chronically ill adults (18 years of age and older), including cognitive and/or emotional problems, which impair the individual's ability to perform activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs) need personal care assistance to help them with their ADLs and/or IADLs to remain safely in their place of residence. For disabled adults, the need may be even greater, since there are fewer programs available to them than to the elderly. Services not covered by insurance may be too costly for many disabled adults on a fixed/limited income. Adult clients may not be Medicaid eligible as their income is slightly over the Medicaid income eligibility; however, their income may be too low to afford out-of-pocket personal care services.

Clients who are not safely maintained in their homes are prone to falls, skin breakdown, and self neglect. These conditions may lead to hospitalization and unnecessary extended stays when there is no one at home to help them. Occupying needed acute hospital beds, or long term care beds, create a shortage of acute and long term care beds in the community which becomes very costly for the community. This very cost effective Program could potentially save $100,000-300,000 per client, per year, for families, our community, and government.

Hale Mahaolu Personal Care Program has been serving Maui County's frail elderly and disabled adults since 1985 with funding from the State of Hawaii, Department of Human Services, and intermittent funding from Maui County for fiscal years 2010, 2011, 2013, 2016 and 2018. We have also been contracted by the Maui County Office on Aging to provide personal care services for the Kupuna Care Program since July 2004, and Medicaid waiver (Quest Intergraded) personal care services since January 2004.

Hale Mahaolu lines of authority begin with our voluntary Board of Directors to whom the Executive Director reports. The Personal Care Program Director, under the general supervision of Hale Mahaolu Executive Director, administers the Personal Care Program. The Personal Care Program Director oversees the Program Manager, Program Supervisor (RN) and Program Specialist and monitors the registry of personal care attendants and client services.

Table 1 - Program Personnel

Position Title (Please match titles between this narrative and the budget)	**Name** (List employee name OR indicate if position is currently vacant.)	**Required position qualifications**	**Brief description of main duties for this program**	**Position is funded in full or in part by Maui County?** (Yes or No)
Program Director (FT)	Reuben Ignacio	Social Work degree; Minimum 2yrs supervisory experience; 2yrs experience in personal care/home care; Working with elderly, disabled, cognitively impaired; Grant writing, budgets	Interview and assessment of potential clients; Prepare, maintain care plans and files on clients; Monitor client progress, conduct home visits; Interviewing, hiring, on-boarding; Grant writing, budget management; Program publicity and attending community events	Yes
Program Supervisor (Casual)	Christine Gumpal	Registered Nurse with current State of Hawaii license; Personal care/home care experience	Part-time position with primary focus being available as consultant to the PCA's; Conduct initial and ongoing home visits, monitoring aide performance; Create safety and training flyers	Yes
Program Manager (PT)	Leslie Kidani	High school graduate; 2yrs direct experience working with elderly, disabled; 2 yrs supervisory experience; CPR, 1st Aid, TB clearance	Supervision of housekeepers; Monitors compliance with service delivery, timesheet accuracy; Conduct annual evaluations; Scheduling; Conduct home visits with new and existing clients	Yes
Program Specialist (PT)	Lorraine Gibo	Minimum 1 year experience health care field; Spreadsheet experience; Face to face and call handling experience; CPR and 1st aide certified; High organizational and filing skills	Attend to incoming phone calls, walk-ins; Handling correspondence; Clerical duties including file maintenance, payroll handling, check distribution; Notify aides of annual requirements and record-keeping	Yes
Personal Care Aides	Nurse Aides (Independent Contractors)	Nurse aide training, current CPR/1st Aid certification; TB clearance; Pass criminal history/background check and drivers' abstract	Assist clients with activities of daily living (bathing, dressing, hygiene, ambulation, etc.) and instrumental activities of daily living (meal prep, medication reminders, house chores) to maintain clean and safe environment;	No

III. Program Description:

This Program intends to provide a minimum of 4,680 units (hours) of personal care (assistance with bathing, grooming, hygiene, skin care, hair care, nail care, toileting, exercise, feeding, meal preparation, light housekeeping, errands, companionship, etc.) to approximately 20 individuals July 1, 2020-June 30, 2022. These individuals shall be maintained in their own homes for a minimum of six continuous months.

Hale Mahaolu Personal Care Program provides in-home personal care services to frail elderly and disabled adults (18 years of age and older) or who may have a chronic or acute condition(s), including cognitive and/or emotional problems, which impair the individual's ability to perform activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs). The individual served by this Program must require personal care services to remain at home, as determined by a physician, an osteopath, a chiropractic doctor, a registered nurse from a program recognized by a department, or a discharge plan from an acute care, rehabilitation, or nursing facility.
This Program assists individuals living on the islands of Maui, Molokai and Lanai, in locating a suitable Personal Care Attendant (PCA) through the Program's registry of PCAs, and reimbursing part or the entire fee charged by the PCA to the individual client. There is no referral fee to clients.

Personal care services provided may include any of the following services in the client's individualized care plan:

a. Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing;
b. Assistance with bowel and bladder care needs;
c. Assistance with ambulation; Escort services to clinics, doctor visits, pertinent trips
d. Assistance with medications that is ordinarily self-administered, when ordered by the client's physician;
e. Assistance with wound care and respiratory care, by a PCA with specific training, satisfactory documented performance, and case manager's consent, when ordered by the client's physician;
f. Assistance with feeding, nutrition, meal preparation, and other dietary activities;
g. Assistance with exercise, positioning, and range of motion to maintain and/or strengthen muscle tone, and prevent contractures, decubitus ulcers, and/or deterioration;
h. Taking and recording vital signs, including blood pressure;
i. Maintain environment to prevent trips and falls, housekeeping to maintain sanitary conditions (e.g. cleaning of living space, bathroom, adaptive equipment and bedding)
j. Assistance with adaptive equipment and supplies, including care of such equipment and supplies;
k. Observing and reporting changes in client behavior, functioning, condition, and/or self-care abilities, which may necessitate more or less service;

The Program subsidizes clients' PCA fees for up to 4 hours per day, 7 days per week. PCAs are available 24 hours a day and are scheduled based on clients' preference and need. Program staff is accessible in the office from 8:00 a.m. to 4:30 p.m., Monday through Friday. Program staff is on-call after hours and weekends to handle emergencies that may arise.

The Program Director conducts home visits to each client semi-annually to monitor the delivery of personal care as well as any changes in the client's behavior and functioning which may necessitate a reassessment and/or revision of the client's care plan. The Program Supervisor (RN may become involved as deemed necessary.

Client satisfaction questionnaires are distributed annually in July after the end of the fiscal year. All input will be recorded and carefully considered. Viable suggestions for improvement will be implemented.

For admission into the Program, applicants must:

a. Be assessed as disabled and recommended for admission by a physician, osteopath, a chiropractic doctor, public health nurse or a discharge plan from an acute care, rehabilitation, nursing facility, or home health agency.
b. Be at least 18 years of age.
c. Be within the income brackets specified on the Program's sliding fee scale.
d. Be capable of contracting with, supervising, and dismissing the PCA, or be under the guardianship or supervision of a person capable of performing those duties on behalf of the applicant.
e. Not be receiving duplicate personal care services from another funding source such as Kupuna Care or Medicaid programs.

The intake process begins upon inquiry from a potential client or a referral. Each applicant must meet all admission criteria. Applicants who do not qualify are eligible for referrals to PCAs, but may not receive subsidy or reimbursement through this Program. All requests for service shall be logged along with referrals provided and, if applicable, reasons why services were not provided. This Program also refers applicants to other agencies or programs whose services may better suit the clients' needs.
When a client meets the Program criteria, a home visit is conducted by the Program Director (along with the Program Supervisor, a registered nurse) to assess the need for services within 48 hours of receiving a request for services. The Program Director completes the intake process, reviews the Statement of Understanding (statement acknowledges the independent contractor status of the PCA and the responsibilities of client to contract with the PCA) and to submit reimbursement requests to the Program, which must be signed by the client, guardian, or designated power of attorney. Hale Mahaolu confidentiality, grievance, and discharge policies are also reviewed with the client and/or their representative.

Program staff verifies the applicant's income before determining clients' reimbursement rate according to the sliding fee scale. The Program refers to each client, PCAs whose skills (including languages spoken and special needs) are commensurate with the needs of the individual client. The client selects which PCA, if any, to contract with. PCAs go through initial and subsequent criminal background and driver abstract screenings. Failure to pass screenings or substantiated reports of abuse will disqualify a PCA. Clients are responsible for paying their PCA and for submitting reimbursement requests to the Program. In case of PCA illness, family emergency, etc., the Program staff shall make every effort to locate a suitable replacement.

When funds for subsidies are not available, clients are waitlisted in the order in which they are received. When funds become available, the primary selection of clients on the waitlist to be served is on a first-come, first-serve basis. During the interim period, clients who are waitlisted for subsidies may receive affordable PCA referrals to help meet their needs.

A client is discharged from the Program when: the service is no longer desired; it is determined by the client's physician services are no longer needed; client receives long-term placement, misuse or fraud by client or PCA; lack of funding; death.

Clients are provided with the Program's grievance policy upon admission to the Program. Hale Mahaolu follows the following procedure should a grievance occur:

a. Complaints filed will be addressed immediately and documented in the client's file.
b. Program staff will work with client to resolve complaint to the client's satisfaction.
c. The client may address the grievance in writing with Hale Mahaolu Executive Director if dissatisfied with the handling of a complaint by Program staff.
d. The client may seek redress through the Hale Mahaolu Board of Directors and/or the appropriate government or judicial agencies should a grievance still remain unresolved after discussion with the Executive Director.

Affordable in-home personal care services will promote the individuals' self-sufficiency, dignity, and to help them achieve, restore, or maintain their quality of their independent life style and self-direction.

Outcomes and outputs reported quarterly to the Maui County Office on Aging will be measured by the number of individuals served, the units of service provided, how many individuals served were safely maintained in their homes for at least six months, and how many individuals served remained free from abuse and or neglect.

IV. Collaboration in Providing Services:

Table 2

FY 2021 Projected Collaboration in Providing Services			
Agency, service or community resource	**Type of coordinated activities**	**Number of persons to be served**	**Outcomes to be supported by this collaboration**
Maui County Office on Aging and ADRC	Referrals for client services whose needs are not met by MCOA	20	Clients receive in-home care services needed to remain safely at home. Prevent duplication of services.
Department of Human Services/Adult Protective Services	Referrals for potential clients who are abused, neglected/self-neglect.	20	Referred clients will remain free from harm/abuse, neglect and/or self-neglect.
Quest Intergraded Carriers (United Health Care, Ohana Health Plan, HMSA, Kaiser)	Referrals for client services whose needs are not met by Quest Intergraded carriers.	20	Clients receive in-home care services needed to remain safely at home. Prevent duplication of services.

Table 2.1

FY 2022 Projected Collaboration in Providing Services			
Agency, service or community resource	**Type of coordinated activities**	**Number of persons to be served**	**Outcomes to be supported by this collaboration**
Maui County Office on Aging and ADRC	Referrals for client services whose needs are not met by MCOA	20	Clients receive in-home care services needed to remain safely at home. Prevent duplication of services.
Department of Human Services/Adult Protective Services	Referrals for potential clients who are abused, neglected/self-neglect.	20	Referred clients will remain free from harm/abuse, neglect and/or self-neglect.
Quest Intergraded Carriers (United Health Care, Ohana Health Plan, HMSA, Kaiser)	Referrals for client services whose needs are not met by Quest Intergraded carriers.	20	Clients receive in-home care services needed to remain safely at home. Prevent duplication of services.

Explain how collaborations will achieve program Outcomes, and ensure non-duplication of services.

Clients will remain free from abuse/neglect during the period personal care services were provided. Collaboration with known resources in the community help to avoid duplication of services.

V. Cost Effectiveness

This Program is highly cost effective as clients often have a cost share for services they receive. The cost share is income based which allows for an affordable out-of-pocket cost to each client. A sliding fee scale is used to determine each clients' cost share. The Program's cost share allows for additional units of service annually for additional unduplicated clients served during the year.

We also maintain our registry of personal care attendants for clients in the community who rely on our registry for referrals of personal care attendants to provide affordable personal care services. There is no cost to people in the community for a referral of a PCA.

As Hale Mahaolu is contracted to provide personal care for Kupuna Care and Quest Intergraded clients, personnel costs are allocated fairly among all contracts.

This Program services individuals whose needs are not met by other resources due to the frequency of services usually authorized by other programs (e.g., an individual 60 years and older who may qualify for services through MCOA would be authorized for 2-3 hours per week for personal care services, whereas through this Program, the same individual who is incontinent and needs to be toileted and cleaned throughout the day to prevent skin breakdown, can receive up to 4 hours a day of personal care services); the age of the individual (this Program serves chronically ill and disabled adults 18 years and older), and/or ineligibility of services due to income for those individuals who over income for Quest Intergraded services, but too low an income to afford out-of-pocket personal care services.

VI. Other Funding Resources:

Hale Mahaolu will continue to pursue Program funds through the State of Hawaii through the *Grant-in-Aid* process and pursue a *Purchase of Service* contract with the State Department of Human Services or Executive Office on Aging.

Hale Mahaolu continues to pursue other community grants to sustain the Personal Care Program to service our clients in their home, and help them maintain a safe and independent lifestyle for as long as possible.

VII. Program Evaluation:

Table 3-1 Program Evaluation

FY2021 Program Evaluation Projected Impacts (List appropriate measure – number of persons, activities, etc.)	**ANNUAL GOAL**	**1ST QTR**	**2ND QTR**	**3RD QTR**	**4TH QTR**
Total Unduplicated Persons Served:	**20**				
Outcome: Prevent premature or inappropriate institutionalization of 20 frail elderly, disabled and chronically ill adults 18 years and older.	20				
Output: Individuals receiving personal care services shall be maintained in their residence with personal care for six months or longer, preventing premature or inappropriate institutionalization.	20				
Outcome: 20 Individuals who are frail elderly, disabled and chronically ill who are 18 years and older will be maintained safely at home.	20				
Output: Provide assistance to 20 unduplicated individuals with their personal care needs such as bathing, grooming, hygiene, dressing, nutritional needs, toileting and skin care to maintain good skin integrity. Assist with ambulation and maintain environment to prevent falls to safely maintain these individuals in their home	20				
Outcome: Provide an annual minimum of 4,680 units (hours) of personal care services.	4680				
Output: Clients served will receive up to four hours of personal care services on a daily basis to meet their personal care needs.	4680				
Outcome: Prevent or remedy abuse or neglect for individuals receiving personal care services.	20				
Output: Individuals served will remain free from abuse/neglect during the period personal care services are provided.	20				
Outcome: Promote the individuals' self-sufficiency, dignity, and to help them achieve, restore, or maintain their quality of their independent life style and self-direction.	20				
Output: Individuals serviced will express services received promoted their self-sufficiency, dignity, and have helped them to achieve, restore or maintain their quality of their independent life style and self-direction as evidenced by client satisfaction surveys.	20				

Table 3-2 Program Evaluation

FY2022 Program Evaluation Projected Impacts (List appropriate measure – number of persons, activities, etc.)	**ANNUAL GOAL**	**1ST QTR**	**2ND QTR**	**3RD QTR**	**4TH QTR**
Total Unduplicated Persons Served:	**20**				
Outcome: Prevent premature or inappropriate institutionalization of 20 frail elderly, disabled and chronically ill adults 18 years and older.	20				
Output: Individuals receiving personal care services shall be maintained in their residence with personal care for six months or longer, preventing premature or inappropriate institutionalization.	20				
Outcome: 20 Individuals who are frail elderly, disabled and chronically ill who are 18 years and older will be maintained safely at home.	20				
Output: Provide assistance to 20 unduplicated individuals with their personal care needs such as bathing, grooming, hygiene, dressing, nutritional needs, toileting and skin care to maintain good skin integrity. Assist with ambulation and maintain environment to prevent falls to safely maintain these individuals in their home.	20				
Outcome: Provide an annual minimum of 4,680 units (hours) of personal care services.	4680				
Output: Clients served will receive up to four hours of personal care services on a daily basis to meet their personal care needs.	4680				
Outcome: Prevent or remedy abuse or neglect for individuals receiving personal care services.	20				
Output: Individuals served will remain free from abuse/neglect during the period personal care services are provided.	20				
Outcome: Promote the individuals' self-sufficiency, dignity, and to help them achieve, restore, or maintain their quality of their independent life style and self-direction.	20				
Output: Individuals serviced will express services received promoted their self-sufficiency, dignity, and have helped them to achieve, restore or maintain their quality of their independent life style and self-direction as evidenced by client satisfaction surveys.	20				