House District H District 2

Senate District S District 1

THE TWENTY-EIGHTH LEGISLATURE
APPLICATION FOR GRANTS
CHAPTER 42F, HAWAII REVISED STATUTES

Log No:

For Legislature's Use Only

Type of Grant Request:

☒ GRANT REQUEST – OPERATING ☐ GRANT REQUEST – CAPITAL

"Grant" means an award of state funds by the legislature, by an appropriation to a specified recipient, to support the activities of the recipient and permit the community to benefit from those activities.

"Recipient" means any organization or person receiving a grant.

STATE DEPARTMENT OR AGENCY RELATED TO THIS REQUEST (LEAVE BLANK IF UNKNOWN):

STATE PROGRAM I.D. NO. (LEAVE BLANK IF UNKNOWN):

1. APPLICANT INFORMATION:

Legal Name of Requesting Organization or Individual: Community First, Inc.

Dba:

Street Address: 280 Ponahawai St., Suite 203 Hilo, HI 96720

Mailing Address: 280 Ponahawai St., Suite 203 Hilo, HI 96720

2. CONTACT PERSON FOR MATTERS INVOLVING THIS APPLICATION:

Name ANTHONY KENT

Title Community Engagement Coordinator

Phone # 808-675-2750

Fax # 808-935-4472

E-mail akent@ponocorp.com

3. TYPE OF BUSINESS ENTITY:

☒ NON PROFIT CORPORATION INCORPORATED IN HAWAII
☐ FOR PROFIT CORPORATION INCORPORATED IN HAWAII
☐ LIMITED LIABILITY COMPANY
☐ SOLE PROPRIETORSHIP/INDIVIDUAL
☐ OTHER

6. DESCRIPTIVE TITLE OF APPLICANT'S REQUEST:

TRANSFORMING HEALTHCARE IN EAST HAWAII: A COMMUNITY SOLUTION

4. FEDERAL TAX ID #: [redacted]

5. STATE TAX ID #: [redacted]

7. AMOUNT OF STATE FUNDS REQUESTED:

FISCAL YEAR 2017: $ 232,483

8. STATUS OF SERVICE DESCRIBED IN THIS REQUEST:

☐ NEW SERVICE (PRESENTLY DOES NOT EXIST)
☒ EXISTING SERVICE (PRESENTLY IN OPERATION)

SPECIFY THE AMOUNT BY SOURCES OF FUNDS AVAILABLE AT THE TIME OF THIS REQUEST:

STATE $232,483
FEDERAL $
COUNTY $
PRIVATE/OTHER $100,000

[redacted]VE:

Barry R. Taniguchi, President
NAME & TITLE

Jan. 22, 2016
DATE SIGNED

RECEIVED
1/22/16 MA

Application for Grants

Transforming Healthcare in East Hawaii: A Community's Solution

Submitted by Community First

I. Background and Summary

1. Brief Description of Community First

Community First is a 501 (c)(3) organization established in 2014. Its Board consists of Barry Taniguchi, President and Chairperson (CEO and Chairman of KTA Super Stores), Dr. Richard Lee-Ching, Vice-President (Managing Director of the East Hawaii Independent Physicians Association), Roberta Chu, Treasurer (SVP of Bank of Hawaii), Ka'iu Kimura, Secretary (ED of 'Imiloa Astronomy Center), and Dan Brinkman, (CEO of Hilo Medical Center), Charlene Iboshi, (Retired, Formerly Deputy Prosecuting Attorney of Hawaii County).

The vision of Community First is a community where we all help each other care for our well-being. Our mission is to create a sustainable medical system which provides quality care to all the people of East Hawaii. Our strategy is twofold: 1. To tip the idea of healthcare from treating disease to caring for health through grass roots initiatives to promote well-being. 2. To create collaboration among the healthcare stakeholders in the community so that they can transform the system to achieve sustainability.

For more information please go to our website: http://www.CommunityFirstHawaii.org.

2. Goals and Objectives

Grass Roots Initiatives

Our first grass roots initiative was a campaign to get Hawaii Island residents to complete well-being assessment sponsored by HMSA. It was a campaign which ran from November through December of 2014 with radio and TV spots, newspaper ads and articles, flyers, community meetings with Mayor Billy Kenoi and Auggie T as the spokespersons. The message was: Help Yourself, Help Puna, Take the Challenge. 1,198 assessments were collected, and HMSA through the Hawaii Island United Way made a $10,000 donation to the Puna Community Center which had suffered significant unbudgeted expenses for a temporary move necessitated by the lava flow which threatened Puna.

Our current initiatives are Blood Pressure Educators, a program to end high blood pressure, and East Hawaii Choices, a program to end uniformed and unnecessarily painful dying.

Blood Pressure Educators: Working with UHH School of Nursing, the East Hawaii Independent Physicians Association, and KTA's Pharmacy Department, we have created and are expanding a campaign around school children, employers, and primary care providers. The focal intervention will be for nursing students to educate 6th graders about the dangers of high blood pressure, equip them with digital blood pressure monitors, and have them take readings of family and friends.

The third round of the program will run this spring. To date we have worked with seven schools and educated more than 340 sixth graders. All partners are overwhelmingly enthusiastic about continuing this project. The community organizations see the value in engaging elementary aged children and are excited about the long term impact this program can have. Sixth graders enjoy the hands on teaching sessions and being able to take a piece of medical equipment home for a week. Sixth graders describe the program as "fun and empowering," and would recommend participation for future student. We believe this a highly effective way for teach children that they are accountable for their own health.

East Hawaii Choices: Particularly with the large elderly population in East Hawaii, unless we stop the unwanted, intensive medical services in the last few months and weeks of life, there will be an explosion of costs without value. If we knew and followed the wishes of people for care at the end of life, however, we could allow more people to die more gracefully, fully honoring the choices of all and have more resources for other critical services. Community First in partnership with Hospice of Hilo is promoting a grass-roots campaign to train residents to facilitate the "Conversation" about choices for care at the end of life.

Community First has offered eight training session in the last seven months to our many community partners. Training has been offered to Hilo Hongwanji, HGEA retirees, County employees, Hui Malama Ola Na Oiwi cancer support, and the general public at the ADRC. The organizing committee is made up of extremely dedicated community volunteers and meets monthly to continue the growth of this initiative. Additional partners are being engaged and unsolicited requests for training are starting to come from the community. More than 100 residents have attended the training sessions and community awareness around the topic of advance health care planning is building.

A Regional Healthcare Improvement Collaborative

The mechanism for achieving collaboration among stakeholders and systemic change is the Regional Healthcare Improvement Collaborative (RHIC). Similar organizations have been established in over 30 communities across the nation. It is a neutral forum where all stakeholders can collaborate to achieve win-win-win solutions in healthcare. The RHIC makes decisions only by consensus. We have created a RHIC in East Hawaii with East Hawaii Independent Physician's Association (EHI), Hilo Medical Center (HMC), HMSA, Hospice of Hilo, AlohaCare and business/community leaders. We have been accepted into the national association, the Network for Regional Healthcare Improvement, as an associate member. We created the RHIC at the suggestion of Harold Miller, President and CEO of the Center for Healthcare Quality and Payment Reform, who was engaged by HMSA, EHI, and HMC to do an a viability study for an accountable care organization in East Hawaii. This study, "Achieving the Triple Aim in East Hawaii: Creating a Regional Health Improvement Collaborative and a Community Accountable Care Organization to Create High-Quality, Affordable, Sustainable Healthcare," details the role of the RHIC and its functioning and is attached (Appendix A). Our first two initiatives are designing the best heart care and recruiting and retaining physicians in East Hawaii.

Best Heart Care: We view this project as a first step in learning to collaborate across the healthcare system. Despite the small size of East Hawaii, both in area and number of providers, healthcare still tends to be delivered in silos with care and patients suffering because of poor communication between the hospital, primary care providers, and other specialized providers like Hospice. This project will focus on providing care coordination and supportive care services to heart care patients, in particular to ensure that patients with later stages of heart disease can benefit from services like home visits and palliative care services without having to forgo treatment.

Recruit and Retain Physicians: There is consensus in East Hawaii that the shortage of physicians is a critical problem for healthcare in the community. Various initiatives have been tried with limited success in part because not all of the key stakeholders were engaged. The RHIC has brought together the hospital, private practice physicians, and community leaders to identify the specific needs and to create a funding mechanism to enable private practices to be responsible for the hiring of new physicians. Community First will be the fiscal agent for this process.

3. The Public Purpose and Need

The costs of healthcare are increasing at an unsustainable rate. In the last ten years, national expenditures on healthcare doubled, from $1.3 trillion to $2.6 trillion a year. The United States spends 18% of our GDP on health care, which is twice per capita than most industrialized nations. Since 2000, health care premiums for a family of four have increased 114%. The costs of healthcare threaten our financial viability at every level of society. It is the largest driver of the Federal deficit by a wide margin. Ever increasing health insurance premiums are squeezing margins and make it more and more difficult for businesses to survive.

In a presentation on January 13, 2016 Gordon Ito, Hawaii's Insurance Commissioner, showed slides illustrating the exponential rise of small business rates and how health insurance premiums far outpaces workers' earnings and overall inflation. In 1975 health premiums was 2.5% of the average wage in the private sector. In 2012 it was 13.06% of wages. Commissioner Ito said that the State's unfunded liability for healthcare would grow from $16 billion to $32 billion in 10 years at the current trajectory. In 2015 family coverage was over $20,000 in Hawaii's community rated free choice plan.

Short-Term: Medical System Solution: Short-term, the medical system must improve quality of care generally and realize immediate cost savings by ensuring that high cost patients have comprehensive care coordination. Whatever improvements the medical system can make without structural reform in business models and the integration of information, however, will be too incremental to succeed given the magnitude of the crisis. Reforming the fee for service payment model, integrating information across stakeholder, coordinating care comprehensively, and engaging the community are essential processes which must happen simultaneously.

Long-Term: Community Well-Being Solution: Tipping the idea of healthcare from treating disease to caring for health and getting individuals to take responsibility for caring for their own health is the only long term solution given the magnitude of the cost crisis, and the impending "epidemics" of obesity and dying. Even with the structural changes in payment models and information integration described above, the medical system alone cannot successfully address the cost crisis. A community approach is necessary to change the idea of healthcare.

Community First is East Hawaii's response to the healthcare cost crisis. Although Community First was established only two years ago, East Hawaii has been working on its response for over 5 years. There is an operational data platform integrating health plan, hospital, and primary care records. 13 physicians are off fee for service. Physician-led care coordination is being developed. The community is very engaged through Community First. We have a strategy map developed by a national expert after extensive interviews stakeholders in East Hawaii. We believe we can create the "Community-governed, patient-centered, Physician-led, Data-driven, and Health plan-enabled Healthcare System" that can be a model and catalyst for transformation throughout the State, particularly for rural communities.

4. The Target Population

Community First serves all of East Hawaii. We are a rural community with unique challenges. Approximately 21% of the population is over the age of 60 occurs in East Hawaii. Nationally, between 2000 and 2010, the population aged 45 to 64 grew at a rate of 31.5 percent and the population aged 65 and over grew at a rate of 15.1. From 2010 to 2030, the population aged 65 and over is expected to grow by 75%. This will greatly increase health care spending and put a tremendous strain health care providers.

Unemployment in the County of Hawaii 5.1%, the highest of all counties in the state.

Access to health care is a critical issue on Hawaii Island. There are physician shortages in primary and specialty care. According to the 2015 University of Hawaii Physician Workforce report Hawaii Island needs approximately 24 FTE general internal medicine physicians and 11 FTE pediatricians. The dire need for primary care has been recognized by the US Department of Health and Human Services through multiple Health Care Professional Shortage Area designations (HPSA): County of Puna, County of Ka'u, Bay Clinic, Hamakua Health Center, and West Hawai'i Community Health Center.

5. The Geographic Coverage

According to the 2010 U.S Census the resident population of the County of Hawaii was 185,079 with approximately 93,000 residents in East Hawaii. Hawaii County is the fastest growing in the state with a population increase of 24.5% from 2000 to 2010. Hawaii County is also geographically the largest in the state at 4,028 square miles. The Health Resource and Services Administration classifies Hawaii County as rural.

II. Service Summary and Outcomes

The work of Community First for the funding period will consist of two grass roots initiatives, Blood Pressure Educators and East Hawaii Choices, and two RHIC projects, Best Heart Care and Recruit and Retain Physicians. Work plans, responsible parties, timelines, and outcome measures for each of these are detailed below.

Blood Pressure Educators

1. The scope of work, tasks and responsibilities

Working with UHH School of Nursing (SON), the East Hawaii Independent Physicians Association, and KTA's Pharmacy Department, we are creating a campaign around school children, employers, and primary care providers. The focal intervention will be for nursing students to educate 6th graders about the dangers of high blood pressure, equip them with digital blood pressure monitors, and have them take readings of family and friends.

EHI and KTA have provided blood pressure monitors and funding to purchase additional materials. In the spring semester SON students coordinate with the local schools to schedule teaching sessions, provide the training, and provide Community First with a final report. In the fall semester nursing students will follow up with families who participated to see if healthcare has been sought or habits have changed. Community First and KTA initiated the project and continue to provide administrative and program management support.

2. Projected annual timeline for accomplishing the results or outcomes

Year	Month	Activities
2016	January	• Confirm project team from partner organizations • Procurement of additional materials and equipment completed • Contact partner schools for permissions
	February	• Confirmation of school sites • Receive and calibrate blood pressure monitors
	March – April	• SON students present Blood Pressure Educator curriculum at partner schools
	May	• Final report for spring semester project completed
	June - August	• Integration of follow up protocol for SON
	September - October	• Follow up interviews with families
	November	• Final report for fall semester project completed • Planning for spring project begins • Next cohort of SON students identified • Program needs assessed
	December	• Procurement of program materials, supplies, and equipment begins •

3. Quality assurance and evaluation plans including measures of effectiveness

The goals of this project are to instill an attitude of healthy living in young students, give nursing students the experience of community outreach and communication, and foster cooperation between community stakeholders. An additional benefit we hope to see is that undiagnosed cases of hypertension will be identified and those patients will seek care from their physicians.

During the spring semester 2016 at least two hundred sixth grade students will attend teaching sessions conducted by nursing students. During this phase of the project six hundred unique blood pressure readings will be taken in the community. At least twenty families will receive follow up calls in the fall semester 2016. After action reviews will be conducted with SON and Community First after teaching sessions to identify best practices and opportunities to improve the program. Partner schools will complete evaluations of SON and the Blood Pressure Educators program in general. This feedback will be used to improve SON curriculum and the effectiveness of the community education.

East Hawaii Choices

1. The scope of work, tasks and responsibilities

When a family member is close to death, the stress and confusion for the family can be overwhelming. Without the ability to communicate with the patient family members are forced to make healthcare decisions that may be contrary to the patient's wishes. Disagreements on care decisions can have lasting repercussions on family relationships. Community First has undertaken a grass roots campaign to help local families begin having conversations about end of life wishes for healthcare. We have partnered with local faith organizations and provide education on having end of life conversations, how to document the wishes of each individual, and the importance of communicating those wishes to family members and healthcare professionals. Our partners include the County of Hawaii, HOSPICE of Hilo, the Alzheimer's Association, Pono Health, HMSA, Hilo Hongwanji, and The Church of the Holy Apostles, and the Hilo HGEA office.

2. Projected annual timeline for accomplishing the results or outcomes

In addition to the activities listed in the table there are regular monthly functions that East Hawaii Choices will complete. The organizing committee meets monthly to strategically advance our effort and growth the initiative. New partners referred or engaged by the committee to broaden community education and outreach. A newsletter will be produced each month to keep current partners informed and to increase awareness of the initiative in the community.

Year	Month	Activities
2016	January	• Community outreach with HOSPICE of Hilo • Monthly strategy meeting with organizing committee • Key dates added to the annual calendar
	February	• Outreach with Church of the Holy Apostles • Monthly strategy meeting • The Conversation Project Community Starter Kit completed • Plan for April 16 (National Healthcare Decisions Day) event finalized
	March	• Monthly Strategy Meeting • Begin writing Community First article to support April 16 event • Engage Church of the Holy Cross
	April	• Monthly Strategy Meeting • April 16 – National Healthcare Decision Day event
	May	• Formation of a strategy for synergizing East Hawaii Choices activates with Hawaii County ADRC advance care planning measures
	June – Ongoing	• East Hawaii Choices will repeat this cycle with faith based and community organizations with the goal of education all residents in East Hawaii over the age of 65.

3. **Quality assurance and evaluation plans including measures of effectiveness**

Community First has already built strong relationships in East Hawaii. In order to reach a

critical mass for this project we need to expand our partner base. We will engage six additional partner organizations. Advance care planning training sessions will be held with each of the new partners. We will also continue to work with our existing partners to increase the number of advance health care directive forms that have been completed in East Hawaii.

The volunteers on the East Hawaii Choices organizing committee are dedicated and passionate about the cause. Monthly strategy meetings will be held to evaluate the campaign's effectiveness and plan future activities. The number of East Hawaii residents with completed advance healthcare directives will be measured annually with the help of our partners. We hope to work with the Blue Zones Project Gallup Poll to measure the community's adoption of advance care planning resources on a year over year basis. We will develop three additional trainers who will be able to conduct public presentations. Over the next cycle we will train 100 residents with the goal of having them reach out to their own family and friends. During each training session participants will complete evaluation forms that will help the committee to improve training and outreach strategies.

Best Heart Care

1. The scope of work, tasks and responsibilities

Locally and nationally the treatment of patients with chronic diseases accounts for a significant portion of healthcare costs. Among patients with chronic diseases patients with heart failure are hospitalized the most frequently. On average, 6% of HMSA patients of EHI primary care physicians in East Hawaii who have heart failure are hospitalized during the course of the year. Hospitalizations have steadily increased from 2012, 2013, and 2014 from 468 to 677 to 783 per thousand. Emergency Department visits have similarly increased from 687, 870, to 1,039 per thousand. There is considerable variation in care among primary care practices and in the continuity of care between the hospital and physicians. Quality of care can be improved and costs reduced by reducing the variance from "the best heart care" in East Hawaii.

In addition to the direct benefit to heart care patients and costs, the East Hawaii RHIC intends to develop a model of analysis, intervention, and evaluation which can be applied to other condition based groups such as cancer patients or COPD patients. By designing the best care within a community for a particular condition and redesigning, if necessary, payments to support that care, we believe we can systematically achieve greater quality at lower costs to the overall community. Harold Miller detailed a business model for this in his paper "Redesigning Care and Payment for Patients with Heart Failure." (Appendix B).

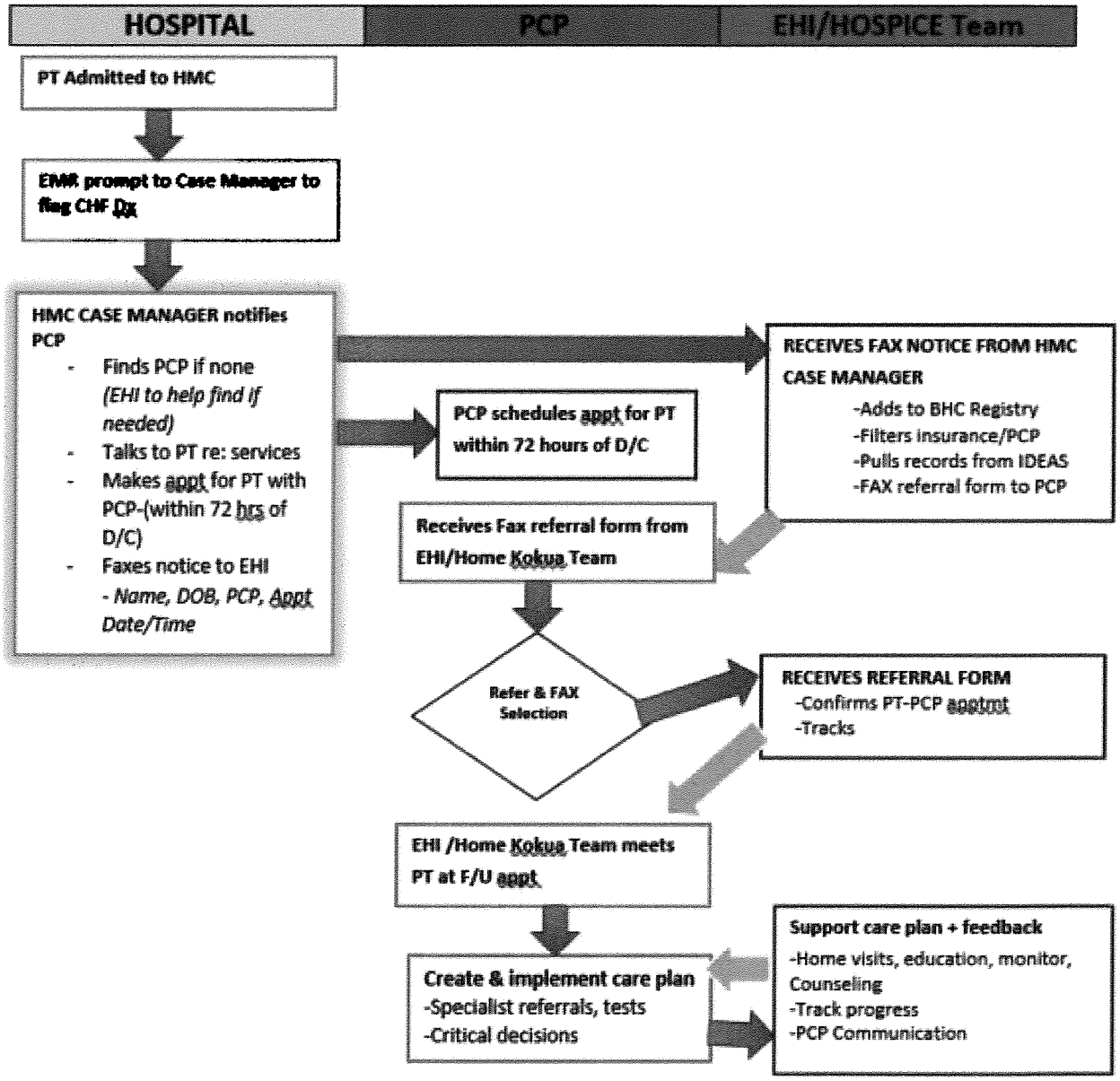
A multi-stakeholder workgroup was convened in April in Hilo and facilitated by Harold Miller. They developed a plan for how care should be delivered to East Hawaii residents with heart failure from the early stages of the condition through the end of a patient's life. The plan contains improvements for care in three areas: ambulatory care, hospital and post-discharge care, and palliative and end-of-life care.

Since then a Heart Care Taskforce has been formed to further refine and implement the plan. The task force is chaired by Dr. Craig Kadooka (EHI PCMH Medical Director) and Susan Mochizuki (EHI IPA Administrator), with executive and clinical leadership from Brenda Ho (Hospice of Hilo CEO), Dr. Dr. Lynda Dolan (Hospice of Hilo, Medical Director), Dr. Ted Peskin (HMC Chief Medical Officer), and Dr. Seren Tokumura (HMC Resident Physician). A complete listing of members can be found in Section V. Personnel, under sub-section B. Organization Chart.

The Task Force has met five times to articulate the specific activities required to implement the ideal care paths for ambulatory care, hospital and post-discharge care, and palliative and end-of-life care. There are significant gaps to overcome. For example in any scenario, having a PCP and belonging to a patient centered medical home is of fundamental importance. While access to primary care generally is beyond the scope of this Task Force, the Task Force will implement policies and procedures to ensure that any patient admitted to the hospital for heart failure be connected to a PCP by discharge. On the other hand, there are resources which have been underutilized such as HMSA's Supportive Care program. The Supportive Care program is a pilot program which allows for specialized medical care including, home health and comprehensive care coordination services, for patient with potentially life-threatening conditions. Such services are normally not covered benefits but have been shown to improve patient and provider satisfaction which decreasing costs. The Task Force will focus on increasing referrals to this program as an early win. The workflow for heart patients admitted to HMC can be found below.

BEST HEART CARE

REFERRAL WORKFLOW FOR CHF PATIENTS ADMITTED TO HMC



2. Projected annual timeline for accomplishing the results or outcomes

Year	Month	Activities
2016	January	• Identification of patients eligible for Supportive Care and increase referrals and participation to the program • Identification of existing resources in East Hawaii and their current capacities • Development of process to connect all heart failure patients who are admitted to the hospital or treated in the emergency room and who do not have a PCP with a PCP
2016	February	• Identify in a report to the EHI Quality Improvement Committee variances in admissions, emergency department visits, specialist visits, stress tests, and costs among the PCP panels • Design care management program to cover patients not eligible for supportive care but need care coordination services which many include home visits • Provide education to PCPs regarding care management and supportive care services available • Proposals to other health plans (United Health, UHA, AlohaCare) to cover services provided by HMSA's Supportive Care to enable a standard workflow in the community
2016	March	• Implement QI process across the continuum of care including both private practice physicians, the hospital, and care coordinators to decrease negative variances in patient care • Standardize covered services across health plans
2016	April	• Development of treatment protocols for use in primary care setting by physicians, staff, and care management teams, including rapid response orders for exacerbation of conditions • Development or protocols for continuity of care between the hospital and PCPs
2016	May - December	• Refinement of analysis and processes leading to a final report detailing the Best Care for Heart Failure Patients in East Hawaii • Create proposal to fund ongoing care-management program
2016	June-Ongoing	• Continued referral to care management and supportive care programs

3. Quality assurance and evaluation plans including measures of effectiveness

The task force will meet bi-monthly to ensure workflows are being implemented. Issues which cannot be resolved will be elevated to the RHIC Steering Committee. On a quarterly basis the following indicators will be tracked through HMSA and HMC claims data in the IDEAS data platform:

- Decrease in total medical spend for heart failure patients
- Decrease in hospitalizations and emergency department visits
- Decrease in unnecessary stress tests
- Increase in number of heart failure patients with PCPs
- Increase in satisfaction as measured by a survey of patients and providers

More generally the following outcomes are expected:

- Continuity of care between the hospital and private practice physicians will be improved.
- The East Hawaii IPA, Hilo Medical Center, Hospice of Hilo, and health plans will have learned to collaborate better.
- Employers and the general community will have a greater understanding of the complexity of healthcare and also what can be done to improve the system.

Recruit and Retain Physicians

1. The scope of work, tasks and responsibilities

The lack of both primary care physicians and specialists have long been a problem in East Hawaii. The most significant recent efforts to address this are Hilo Medical Center's Hawaii Island Family Medicine Residency Program and their development of clinics which hired specialists. The clinics were not financially viable, and most have been closed. The Residency Program was started on the belief that residents were likely to stay and practice in the communities where they did their residency. It is a three year program with the first class scheduled to graduate in the spring of 2017. Whether it is specialists or family practice residents, physicians generally do not want to open a private practice and cope with the increasingly difficult administrative requirements of billing, electronic medical records, quality measurements. All these make starting a solo practice a daunting enterprise and can consume the physician's time.

Community First formed a task force headed by Toby Taniguchi, President of KTA Super Stores, and consisting of the following members: Douglass Adams (Community Representative), Dr. David Camach, MD. (Owner, Radiologist, Hawaii Radiologic Associates), Kurt Corbin (Board Chair, HMC), Randall Kurohara (Deputy Managing Director, County of Hawaii), Paul Schnur (VP, HMSA), Dr. Peter Matsuura, MD. (Director, East Hawaii IPA), Dr. Mike Sayama, PhD

(VP, Pono Health), Dr. Ted Peskin, MD. (Chief Medical Officer, HMC), Lisa Rantz (Exec. Director, HMC Foundation), Susan Mochizuki (Administrator, East Hawaii IPA), and Dan Brinkman (CEO, HMC). Using Harold Miller's paper "Attracting and Recruiting Physicians in East Hawaii' (Appendix C) and after considering several options including creating a professional service corporation to hire physicians, this task force determined that subsidizing existing private practices to hire physicians would be the most effective for several reasons. The employment structure of the hospital increases both the compensation and support costs for physicians significantly. It does not create a new entity with additional administrative overhead. Hiring physicians into existing private practices would also connect them more closely with primary care physicians and the personal connections to the community of the practice they work in.

A pilot project was agreed upon and is described below. Community First provided the critical framework which allowed HMC and EHI to reach this agreement. A total of $260,000 in funds from EHI, HMC, and the HMC Foundation have been committed.

EAST HAWAII
REGIONAL HEALTH IMPROVEMENT COLLABORATIVE
NEW PHYSICIAN SUBSIDY PROGRAM

The task force expects to fund no more than two placements. New physicians will be expected to sign a three year work commitment. The subsidy funding will be distributed over the first two years of the commitment.

I. **Funds Will Be Disbursed To Existing Practices**
II. **Community First Will Be The Fiscal Agent**
Community First (CF) is a neutral third party and will function as the fiscal authority for the collection and disbursement of funds.
III. **Application Is Open To Any EHI IPA Practice Bringing On A New Physician**
Any existing EHI IPA practice may apply for the subsidy.
IV. **Funding And Award Decisions Will Be Made By Community First**
CF will accept nominations for the selection committee and appoint committee members. The selection committee will finalize the selection criteria and screen all applications. Based on these criteria the selection committee will make the final award decisions.
V. **Preference For At Least One HHSC Resident**
The selection committee will give preference to at least one HHSC resident student.

There will be three application types.

1. Low interest loan. A standard loan at the best interest rate CF can issue at. The loan is payable even if the new resident does not complete their work commitment.
2. Low risk loan. This loan would be forgivable if the partnership is not profitable.
3. Grant

Priority will be given to the applications that allow funds to be returned to the pool for future use. Low interest loans will be given highest priority. Low risk loans will be second. Grants will be given the lowest priority.

Funding Sources

Source	Per Physician	Total
East Hawaii IPA	$30,000	$60,000
Hilo Medical Center	$60,000	$120,000
HMC Foundation	$40,000	$80,000
Health Plans According to Membership	$60,000	$120,000
Local Business	$10,000	$20,000
TOTAL	**$200,000**	**$400,000**

2. Projected annual timeline for accomplishing the results or outcomes

Year	Month	Activities
2016	January	• Selection Committee finalized
	March	• Selection Criteria finalized • First draft of full program finalized
	April – August	• Raise remaining funds for pilot • Solicit Applications for pilot • Award subsidies for pilot
	September-Ongoing	• Implement full program

3. Quality assurance and evaluation plans including measures of effectiveness

The measures of effectiveness are straightforward: Number of physicians recruited and retained for at least 3 years. The need and quality of the physicians will be ensured by the selection committee with three community leaders representing the community's need and two physicians, Drs. Ted Peskin and Laurie Hopman assuring the quality of the physicians. Dr. Peskin is the Chief Medical Officer of HMC, and Dr. Hopman is a very respected and experienced primary care physician in EHI who has formed a subcommittee of 5-6 physicians to review applications. Finally the Steering Committee of the RHIC will have ongoing oversight at their bimonthly meetings. The Community First Board will exercise fiscal oversight over the funds.

III. Financial

A. Budget

Community First has been operating primarily through resources from the Learning Health Homes Project of HMSA and EHI. To achieve the project goal of a sustainable healthcare system in East Hawaii, it became clear that an overarching, trusted entity to pull the health plan, hospital, and physicians together was essential, hence the formation of Community First out of this project. The executive director role has been filled by Mike Sayama, Ph.D. who is the project director of Learning Health Homes, and the project coordinator role has been filled by Anthony Kent, MBA who is the community engagement coordinator of Learning Health Homes. The Learning Health Homes Project will end in January of 2017, thus the need for funding.

1. The applicant shall submit a budget utilizing the enclosed budget forms as applicable, to detail the cost of the request.

2. The applicant shall provide its anticipated quarterly funding requests for the fiscal year 2017.

Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total Grant
$56,250	$56,250	$56,250	$56,250	$225,000

3. The applicant shall provide a listing of all other sources of funding that they are seeking for fiscal year 2017.

   AstraZeneca Connections for Cardiovascular Health Grant
   East Hawaii Regional Health Improvement Collaborative
   HMSA Foundation

4. The applicant shall provide a listing of all state and federal tax credits it has been granted within the prior three years. Additionally, the applicant shall provide a listing of all state and federal tax credits they have applied for or anticipate applying for pertaining to any capital project, if applicable.

   Not applicable

5. The applicant shall provide a listing of all federal, state, and county government contracts and grants it has been and will be receiving for program funding.

   County of Hawaii - $25,000

6. The applicant shall provide the balance of its unrestricted current assets as of December 31, 2015.

Community First's balance of unrestricted funds as of December 31, 2015 is: $36,900.

IV. Experience and Capability

A. Necessary Skills and Experience

The Board of Community First provides leadership of exceptional expertise in both healthcare and business. All Directors have senior executive positions in their organizations. As an iconic community leader, Barry Taniguchi is ideally suited to convene all stakeholders. Dan Brinkman and Dr. Lee Ching are well-positioned to engage HMC and EHI as CEO and Managing Director respectively.

Staff and data support will be provided by Pono Health. The project director will be Mike Sayama, Ph.D., who has a doctorate in clinical psychology, was in private practice and was the Hawaii area director of a managed behavioral healthcare company before joining HMSA where he spent 17 years as a vice-president with diverse responsibilities such as utilization management and customer relations. At HMSA he ended pre-authorizations for hospital admissions without an increase in utilization, implemented Online Care, oversaw the rollout of the core system replacement, created the Model Office for the private practice of primary care in which 10 EHI physicians moved off of fee for service payments, and established call centers in Hilo. He has been working in Hilo for the past six years and has developed close working relations with physicians, the hospital, and business and community leaders. He left HMSA to join Pono Health and lead the Learning Health Homes, a 3 year, $4.2 million project between HMSA and EHI to implement payment reform, a unified information platform, and community engagement in East Hawaii. The project coordinator will be Anthony Kent, MBA, who is the Community Engagement Coordinator for Pono Health. He has extensive project management experience for grant funded projects in previous positions at the Hawaii Community College and UH Office of Research Services in Hilo. Pono Health, which developed the IDEAS data platform, will provide analytical support to identify opportunities to improve care and lower costs and to track progress.

Community First seeks to achieve its goals not by building its own organizational capacity, but partnering with existing entities and creating synergies to realize common goals.

B. Facilities

The applicant shall provide a description of its facilities and demonstrate its adequacy in relation to the request. If facilities are not presently available, describe plans to secure facilities.

Community First utilizes the office space and meeting facilities of the member organizations. Primary facilities uses are East Hawaii Independent Physician Association office and meeting space and KTA Superstores meeting space. Additional facilities are available at Life Care Center of Hilo, Hilo Medical Center, and Hilo Medical Center Foundation.

The office space provides all required computers, internet, fax, and phone access. The proposed budget include the necessary funds to create a stand-alone office for Community First.

V. Personnel: Project Organization and Staffing

A. Proposed Staffing, Staff Qualifications, Supervision and Training

Currently Community First is staffed by volunteers on a part time basis, primarily Mike Sayama, PhD and Anthony Kent, MBA. Their qualifications are described under Section IV. Experience and Capability, Sub-Section A. Necessary Skills and Experience. Dr. Sayama brings a wealth of executive management and health care experience to Community First. Barry Taniguchi, CEO and Chair of KTA, is uniquely suited to be the convener of stakeholders in East Hawaii as he has a lifetime record of philanthropy and community service. Working closely together, they have already demonstrated the capability of creating collaboration among healthcare leaders in East Hawaii. The organizational chart reflects the capability of the many people working on the initiatives of Community First.

B. Organization Chart

Please see attached. The breadth of the organizational chart reflects the breadth of Community First's activities and the talents and experience of its volunteers.

C. Compensation

Dr. Mike Sayama, PhD, Executive Director: $100,000 (1.0 FTE)
Anthony Kent, MBA, Project Coordinator: $47,000 (1.0 FTE)
TDB, Administrative Assistant: $35,000 (1.0 FTE)

VI. Other

A. Litigation

Not applicable

B. Licensure or Accreditation

The applicant shall specify any special qualifications, including but not limited to licensure or accreditation that the applicant possesses relevant to this request.

C. Private Educational Institutions

The grant will not be used to support or benefit a sectarian or non-sectarian private educational institution.

D. Future Sustainability Plan

Community First currently has no paid staff. Instead, contributions of resources from the community along with staff support from the Learning Health Homes Project between EHI and HMSA have created substantial value and change in a short period of time. This grant in aid will allow Community First hire the full time staff that reflect the resources needed support an effort of this magnitude.

There will be two sources of funding for the sustaining operation of Community First. The primary funding for Community First after fiscal year 2016-2017 will be generated by the healthcare efficiency savings realized by new model of healthcare delivery. The new model should generate a significant funding pool that will support healthcare improvement efforts in East Hawaii well beyond the sustainability of Community First. Under the reasonable assumption that a population of 30,000 generates $130 million in total healthcare expenses, a 5% health care savings would exceed $5 million. Community First serves as the convening body for the key stakeholders to collaborate on these critical and innovate solutions, and should receive support through the value that is created.

As Community First is a 501 (c)(3) with the ability to accept donations and seek grants, the second source of funding will be donations from stakeholders of the East Hawaii RHIC who recognize the value of a neutral, credible, overarching entity and ongoing grants focused on creating a sustainable healthcare system. We have been awarded three previous grants and will continue to create value for sponsors and our community.

E. Certificate of Good Standing (If the Applicant is an Organization)

Attached is Community First's certificate of good standing from the Director of Commerce and Consumer Affairs that is dated no earlier than December 1, 2015.

BUDGET REQUEST BY SOURCE OF FUNDS

Period: July 1, 2016 to June 30, 2017

Applicant: Community First, Inc.

BUDGET CATEGORIES	Total State Funds Requested (a)	Total Federal Funds Requested (b)	Total County Funds Requested (c)	Total Private/Other Funds Requested (d)
A. PERSONNEL COST				
1. Salaries	182,000			
2. Payroll Taxes & Assessments	19,733			
3. Fringe Benefits	30,750			32,950
TOTAL PERSONNEL COST	**232,483**			**32,950**
B. OTHER CURRENT EXPENSES				
1. Airfare, Inter-Island				4,800
2. Insurance				3,500
3. Lease/Rental of Equipment				
4. Lease/Rental of Space				12,000
5. Staff Training				
6. Supplies				2,500
7. Telecommunication				1,500
8. Utilities				3,600
9. Consulting Services				25,000
10. NRHI Membership Fee				2,750
11. Meetings				6,600
12				
13				
14				
15				
16				
17				
18				
19				
20				
TOTAL OTHER CURRENT EXPENSES				**62,250**
C. EQUIPMENT PURCHASES				**4,800**
D. MOTOR VEHICLE PURCHASES				
E. CAPITAL				
TOTAL (A+B+C+D+E)	**232,483**			**100,000**

SOURCES OF FUNDING	
(a) Total State Funds Requested	232,483
(b) Total Federal Funds Requested	
(c) Total County Funds Requested	
(d) Total Private/Other Funds Requested	100,000
TOTAL BUDGET	**332,483**

Budget Prepared By:

Name (Please type or print) Phone

Signature of Authorized Official Date

Name and Title (Please type or print)

BUDGET JUSTIFICATION - PERSONNEL SALARIES AND WAGES

Period: July 1, 2016 to June 30, 2017

Applicant: Community First, Inc.

POSITION TITLE	FULL TIME EQUIVALENT	ANNUAL SALARY A	% OF TIME ALLOCATED TO GRANT REQUEST B	TOTAL STATE FUNDS REQUESTED (A x B)
Executive Director	1	$100,000.00	100.00%	$ 100,000.00
Progam Coordinator	1	$47,000.00	100.00%	$ 47,000.00
Administrative Assistant	1	$35,000.00	100.00%	$ 35,000.00
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
TOTAL:				182,000.00

JUSTIFICATION/COMMENTS:

BUDGET JUSTIFICATION - EQUIPMENT AND MOTOR VEHICLES

Period: July 1, 2016 to June 30, 2017

Applicant: Community First, Inc.

DESCRIPTION EQUIPMENT	NO. OF ITEMS	COST PER ITEM	TOTAL COST	TOTAL BUDGETED
Printer	1.00	$1,000.00	$ 1,000.00	
Office Phone	2	$200.00	$ 400.00	
Computer	1	$1,500.00	$ 1,500.00	
Office Desks	2	$650.00	$ 1,300.00	
Office Chairs and lights	2	$300.00	$ 600.00	
TOTAL:	8		$ 4,800.00	
JUSTIFICATION/COMMENTS:				

DESCRIPTION OF MOTOR VEHICLE	NO. OF VEHICLES	COST PER VEHICLE	TOTAL COST	TOTAL BUDGETED
Not applicable			$ -	
			$ -	
			$ -	
			$ -	
			$ -	
TOTAL:				
JUSTIFICATION/COMMENTS:				

BUDGET JUSTIFICATION - CAPITAL PROJECT DETAILS

Period: July 1, 2016 to June 30, 2017

Applicant: Community First

FUNDING AMOUNT REQUESTED						
TOTAL PROJECT COST	ALL SOURCES OF FUNDS RECEIVED IN PRIOR YEARS		STATE FUNDS REQUESTED	OF FUNDS REQUESTED	FUNDING REQUIRED IN SUCCEEDING YEARS	
	FY: 2014-2015	FY: 2015-2016	FY:2016-2017	FY:2016-2017	FY:2017-2018	FY:2018-2019
PLANS						
LAND ACQUISITION						
DESIGN						
CONSTRUCTION						
EQUIPMENT						
TOTAL:						

JUSTIFICATION/COMMENTS:

Not Applicable

GOVERNMENT CONTRACTS AND / OR GRANTS

Applicant: Community First

Contracts Total: 25,000

	CONTRACT DESCRIPTION	EFFECTIVE DATES	AGENCY	GOVERNMENT ENTITY (U.S. / State / Haw / Hon / Kau / Mau)	CONTRACT VALUE
1	REGIONAL HEALTH IMPROVEMENT COLLABORATIVE	11/25/15 - 10/31/2016	Research & Development	County/Haw	25,000
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					

DECLARATION STATEMENT OF APPLICANTS FOR GRANTS PURSUANT TO CHAPTER 42F, HAWAI'I REVISED STATUTES

The undersigned authorized representative of the applicant certifies the following:

1) The applicant meets and will comply with all of the following standards for the award of grants pursuant to Section 42F-103, Hawai'i Revised Statutes:

   a) Is licensed or accredited, in accordance with federal, state, or county statutes, rules, or ordinances, to conduct the activities or provide the services for which a grant is awarded;

   b) Complies with all applicable federal and state laws prohibiting discrimination against any person on the basis of race, color, national origin, religion, creed, sex, age, sexual orientation, or disability;

   c) Agrees not to use state funds for entertainment or lobbying activities; and

   d) Allows the state agency to which funds for the grant were appropriated for expenditure, legislative committees and their staff, and the auditor full access to their records, reports, files, and other related documents and information for purposes of monitoring, measuring the effectiveness, and ensuring the proper expenditure of the grant.

2) If the applicant is an organization, the applicant meets the following requirements pursuant to Section 42F-103, Hawai'i Revised Statutes:

   a) Is incorporated under the laws of the State; and

   b) Has bylaws or policies that describe the manner in which the activities or services for which a grant is awarded shall be conducted or provided.

3) If the applicant is a non-profit organization, it meets the following requirements pursuant to Section 42F-103, Hawai'i Revised Statutes:

   a) Is determined and designated to be a non-profit organization by the Internal Revenue Service; and

   b) Has a governing board whose members have no material conflict of interest and serve without compensation.

Pursuant to Section 42F-103, Hawai'i Revised Statutes, for grants used for the acquisition of land, when the organization discontinues the activities or services on the land acquired for which the grant was awarded and disposes of the land in fee simple or by lease, the organization shall negotiate with the expending agency for a lump sum or installment repayment to the State of the amount of the grant used for the acquisition of the land.

Further, the undersigned authorized representative certifies that this statement is true and correct to the best of the applicant's knowledge.

Community First, Inc.
(Typed Name of Individual or Organization)

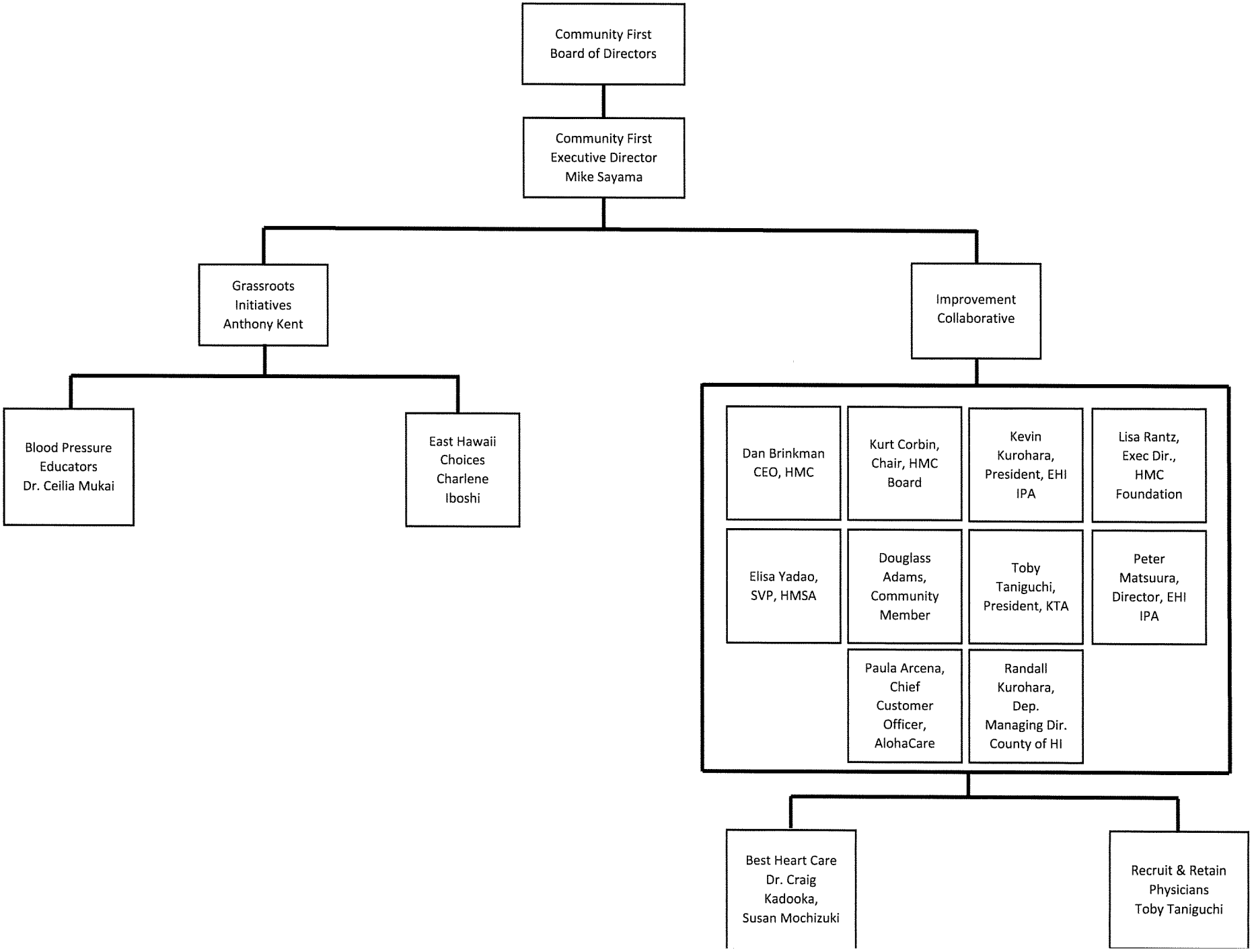
[redacted]

January 21, 2016
(Date)

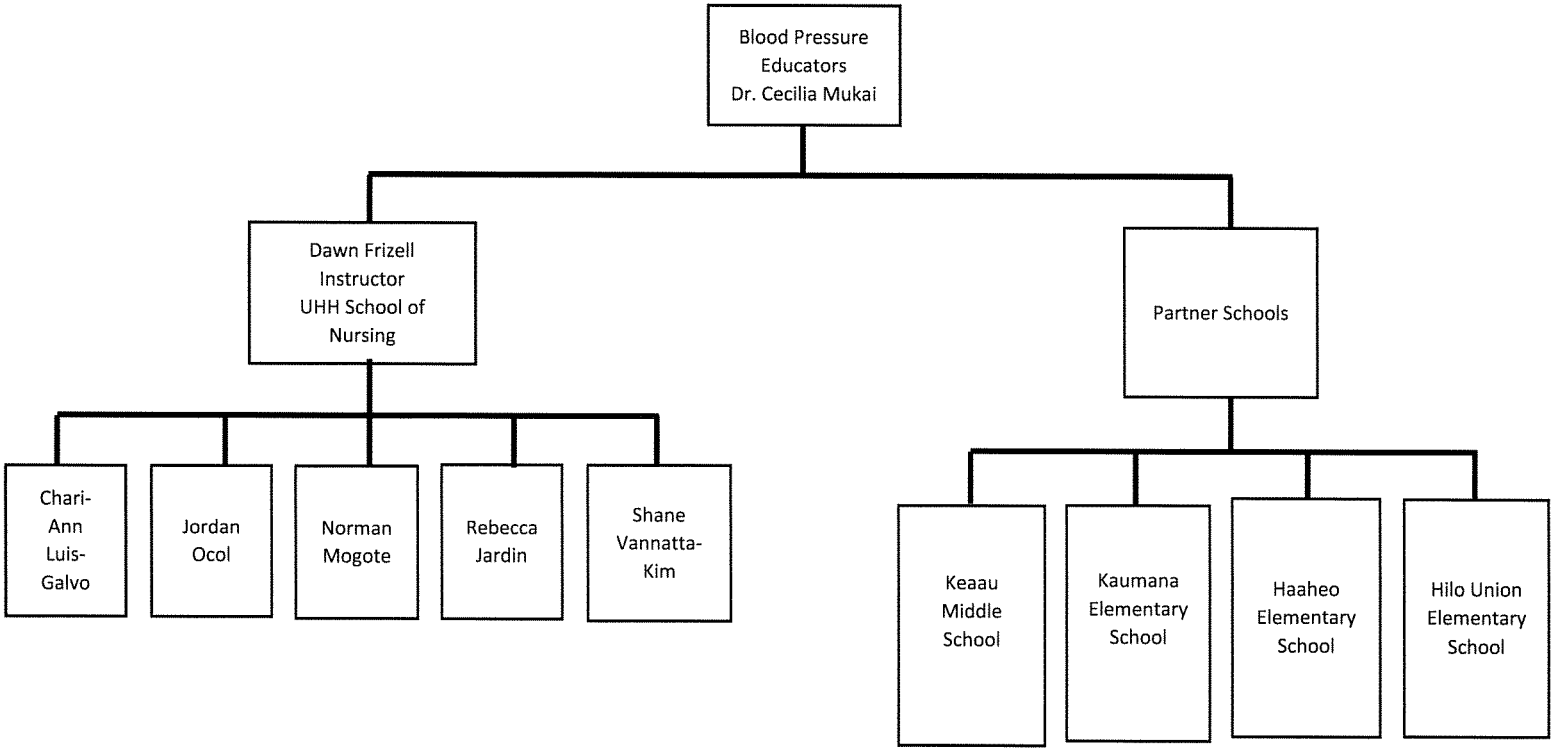
Mike Sayama
(Typed Name)

Executive Director
(Title)

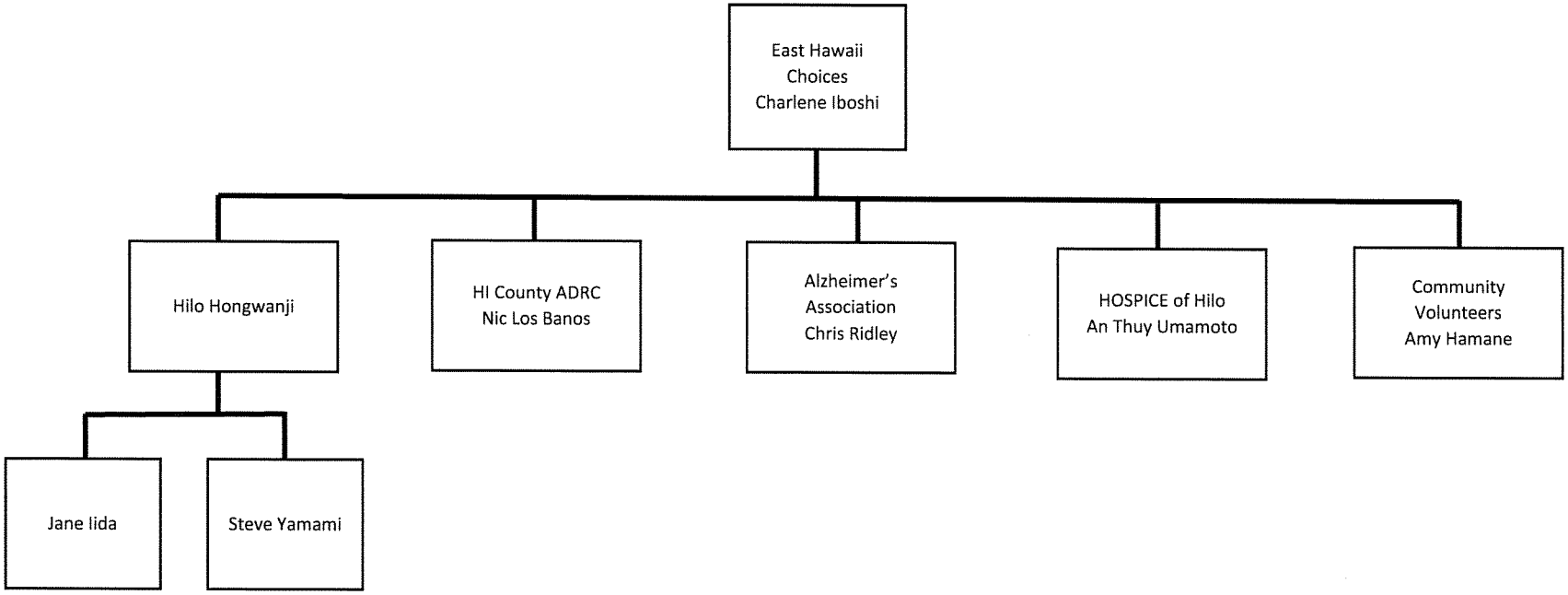
Community First Organizational Chart



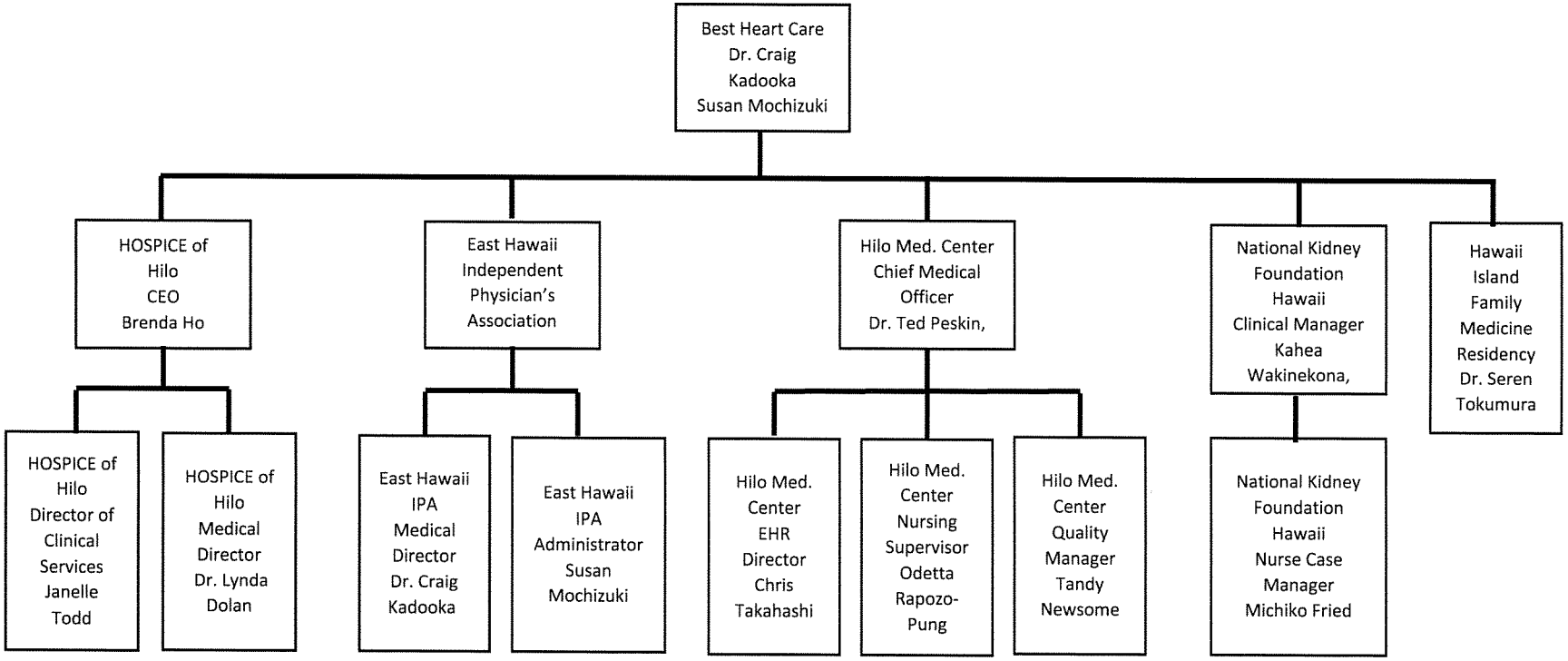
Community First
Blood Pressure Educators



Community First
East Hawaii Choices

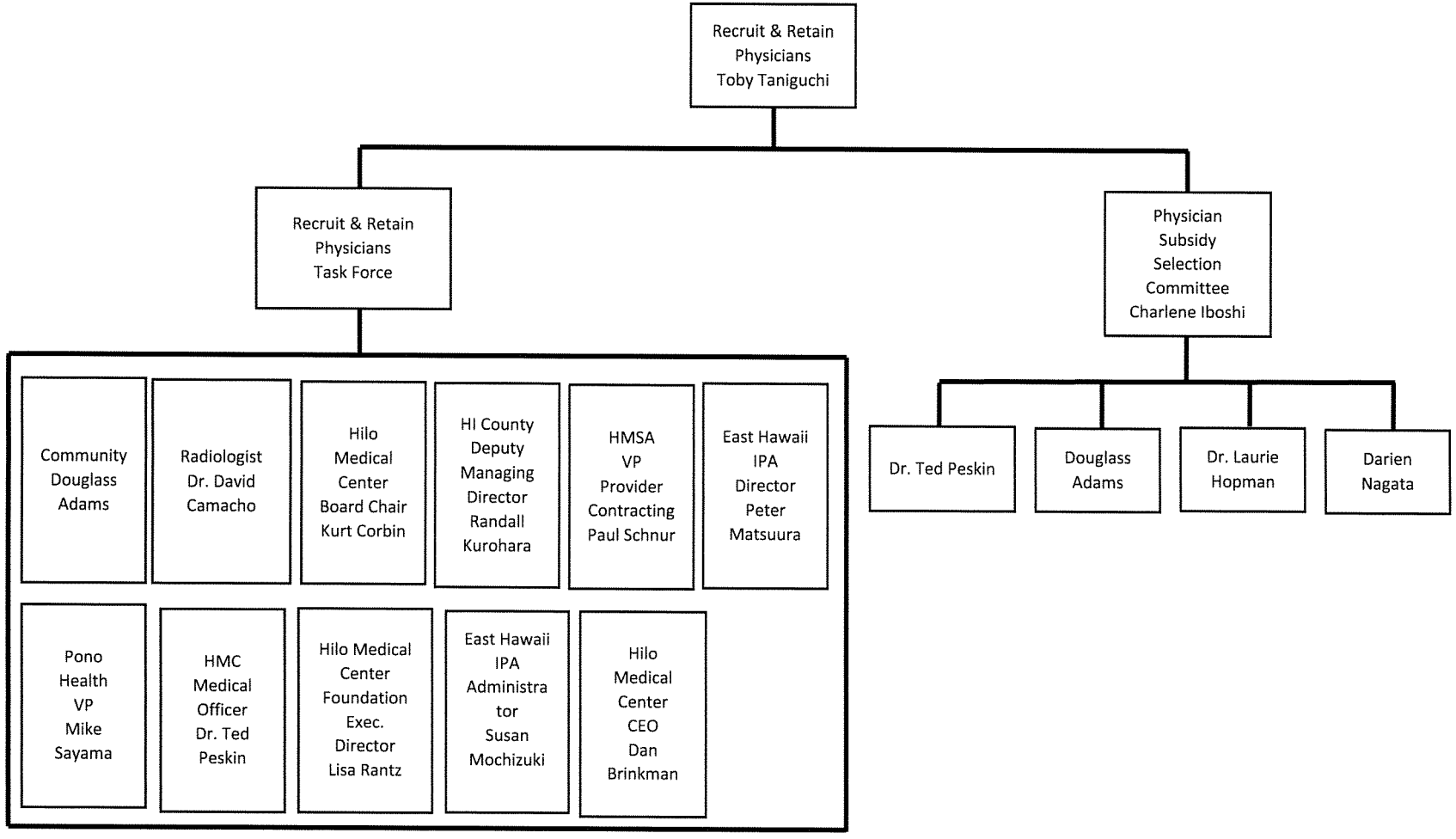


Community First
Best Heart Care in East Hawaii



Community First

Recruiting & Retaining Physicians in East Hawaii



STATE OF HAWAII
STATE PROCUREMENT OFFICE

CERTIFICATE OF VENDOR COMPLIANCE

This document presents the compliance status of the vendor identified below on the issue date with respect to certificates required from the Hawaii Department of Taxation (DOTAX), the Internal Revenue Service, the Hawaii Department of Labor and Industrial Relations (DLIR), and the Hawaii Department of Commerce and Consumer Affairs (DCCA).

Vendor Name: **COMMUNITY FIRST, INC.**

DBA/Trade Name: **COMMUNITY FIRST, INC.**

Issue Date: **01/14/2016**

Status: **Compliant**

Hawaii Tax#: [redacted]
FEIN/SSN#:
UI#: No record
DCCA FILE#: [redacted]

Status of Compliance for this Vendor on issue date:

Form	Department(s)	Status
A-6	Hawaii Department of Taxation	Compliant
	Internal Revenue Service	Compliant
COGS	Hawaii Department of Commerce & Consumer Affairs	Compliant
LIR27	Hawaii Department of Labor & Industrial Relations	Compliant

Status Legend:

Status	Description
Exempt	The entity is exempt from this requirement
Compliant	The entity is compliant with this requirement or the entity is in agreement with agency and actively working towards compliance
Pending	The entity is compliant with DLIR requirement
Submitted	The entity has applied for the certificate but it is awaiting approval
Not Compliant	The entity is not in compliance with the requirement and should contact the issuing agency for more information

Appendix A

Version 5.0 January 22, 2016

ACHIEVING THE TRIPLE AIM IN EAST HAWAII: Creating a Regional Health Improvement Collaborative and a Community Accountable Care Organization to Create High-Quality, Affordable, Sustainable Healthcare

CONTENTS

EXECUTIVE SUMMARY

The Need to Improve the Quality and Reduce the Cost of Healthcare in East Hawaii

There are problems with the quality and affordability of the healthcare system in East Hawaii that are growing more serious every year. If these problems are not addressed quickly, they could threaten not only the health of the residents but the economic viability of the community. Although many communities across the country are also facing serious healthcare challenges, the East Hawaii community is fortunate to have many unique strengths that create a strong foundation for solving its current challenges and it has already made significant progress toward creating a healthier community and a high quality, affordable healthcare system. However, much more must be done. There is both an urgent need and unique opportunity for all of the stakeholders in East Hawaii – citizens, private employers, county government, primary care physicians, specialists, the hospitals, HMSA, and other payers – to work together to achieve a "Triple Aim":

1. A healthy population and a productive workforce;
2. Access to high-quality healthcare services in the community; and
3. Affordable healthcare services and health insurance premiums.

The Need for a Regional Health Improvement Collaborative to Pursue Win-Win Approaches

An East Hawaii Regional Health Improvement Collaborative (EH-RHIC) should be created so that the stakeholders in the community can develop win-win-win approaches to the Triple Aim. The EH-RHIC would not deliver or pay for healthcare services; its key roles will be to:

- Facilitate regular, face-to-face communication among the leaders of the key stakeholder organizations to enable mutual understanding of each other's capabilities and needs, to establish goals and objectives that all stakeholders can support, to design initiatives in ways that will be mutually beneficial, and to rapidly address and resolve problems and conflicts;
- Provide data and analyses about the quality and costs of healthcare that all participants can trust in order to design and implement win-win-win initiatives; and
- Measure and report on progress in improving the quality and cost of healthcare in the community and in implementing specific initiatives designed to achieve the Triple Aim.

Initial Priorities for Advancing the Triple Aim Through the RHIC

- **Redesign Care and Payment for Patients with Heart Failure.** Many individuals in East Hawaii with chronic conditions are being hospitalized for problems related to their condition, and many of these hospitalizations could likely be prevented through improved services in the community. As an initial step, a significantly improved approach to delivering and paying for care of patients with heart failure should be implemented to improve the quality of life for these patients while reducing the total amount being spent on their care. The strategies for improving their care will likely be adaptable to patients with other types of chronic conditions, such as asthma, COPD, and diabetes.
- **Create a Mechanism for Attracting and Retaining Physicians in the Community.** In order for residents to obtain high quality healthcare services, the community needs to create mechanisms to attract and retain an adequate number of primary care physicians and key specialists.

Creating a Community Accountable Care Organization

In addition to the Regional Health Improvement Collaborative, an East Hawaii Community Accountable Care Organization (EHCACO) should be created as an organizational mechanism by which physicians, the hospital, and other healthcare providers can work together to deliver healthcare services in higher-quality, lower-cost ways and to be paid in ways that solve the problems in the current fee-for-service payment system.

Next Steps for the East Hawaii Regional Health Improvement Collaborative

Redesigning Care and Payment for Patients with Heart Failure

- The RHIC Steering Committee should appoint a Heart Failure Task Force to continue development of the plan for improving the delivery of heart failure care in the community and provide the facilitation support it needs to do so.
- The RHIC should assemble the necessary data to develop a detailed business case for the proposed changes in care that quantifies both the costs and savings expected.
- The RHIC should obtain support from the physicians, hospital, and other providers to implement the proposed care changes if the necessary resources to support those changes can be provided.
- The RHIC should facilitate discussions between the providers and payers to reach agreement on how to provide the resources needed to support implementation of the Task Force's recommendations.

Creating a Mechanism for Attracting and Retaining Physicians in the Community

- The RHIC should meet with the physicians in the Hilo Medical Center Residency Program to encourage them to stay in the community after graduation and determine what kinds of practice arrangements they would prefer; then it should identify existing physician practices willing to help create those practice arrangements and determine what assistance they would need to do so.
- The RHIC should appoint a Task Force to develop a business plan for Hilo Healthcare Partners (a new Physician Support Services Corporation).
- The RHIC should develop a more accurate estimate of the need for primary care physicians in the community, including estimating how the capacity of existing PCPs could be increased through practice redesign and payment reform.
- The RHIC should survey physicians in the community to identify administrative burdens they are facing and encourage changes to be made in the requirements causing those burdens.

Creating and Implementing the Community Accountable Care Organization

- The RHIC should facilitate discussions between the East Hawaii IPA and Hilo Medical Center to reach agreement on the most appropriate organizational and legal structure for a Community ACO that will enable them to jointly contract with payers and share in profits and losses for managing a population of patients.
- The RHIC should arrange for the data analysis and facilitate the discussions needed in order for the providers in the community to develop a business plan for the changes in care delivery that will be made, the costs of new services, and the savings expected through the Community ACO.
- The RHIC should facilitate discussions between the Community ACO participants and HMSA and other payers to develop the structure of a payment agreement to support the improved care for the selected group(s) of patients.

I. IMPROVING HEALTH AND HEALTHCARE IN EAST HAWAII

A. A Growing Healthcare Crisis in East Hawaii

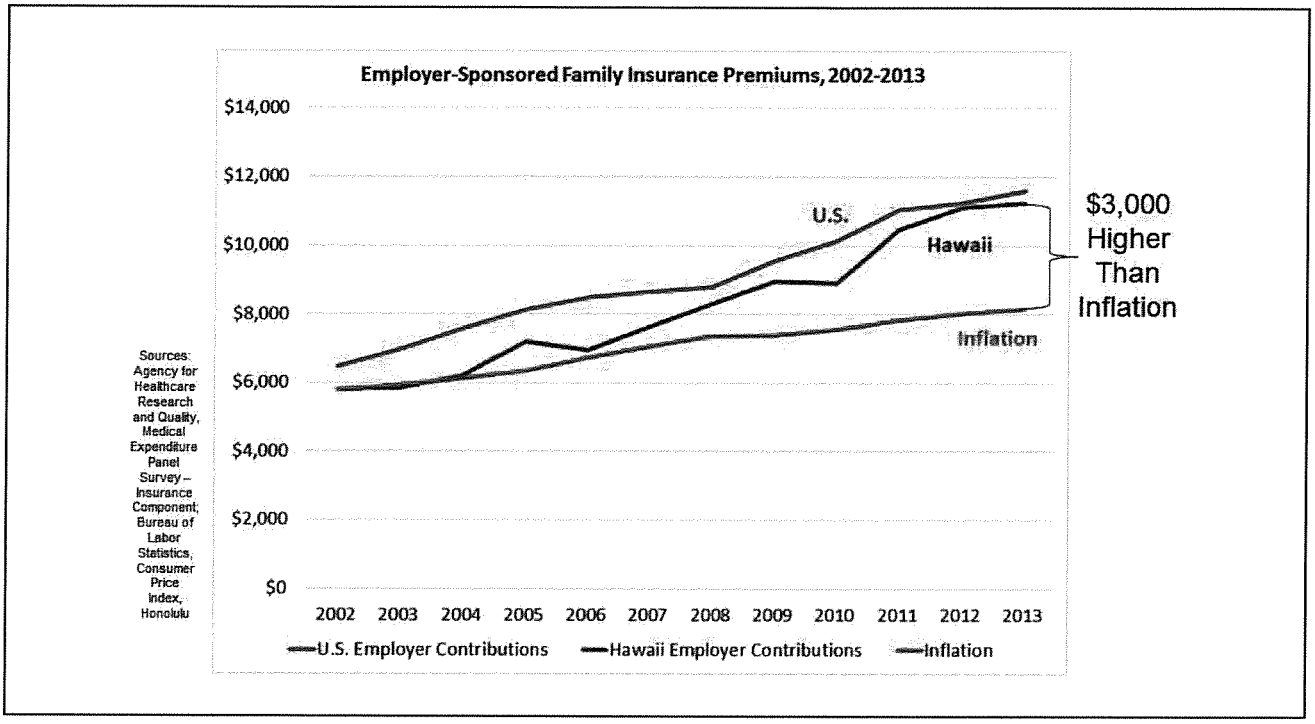
There are problems with the healthcare system in East Hawaii that are growing more serious every year. If these problems are not addressed quickly, they could threaten not only the health of the residents but the economic viability of the community.

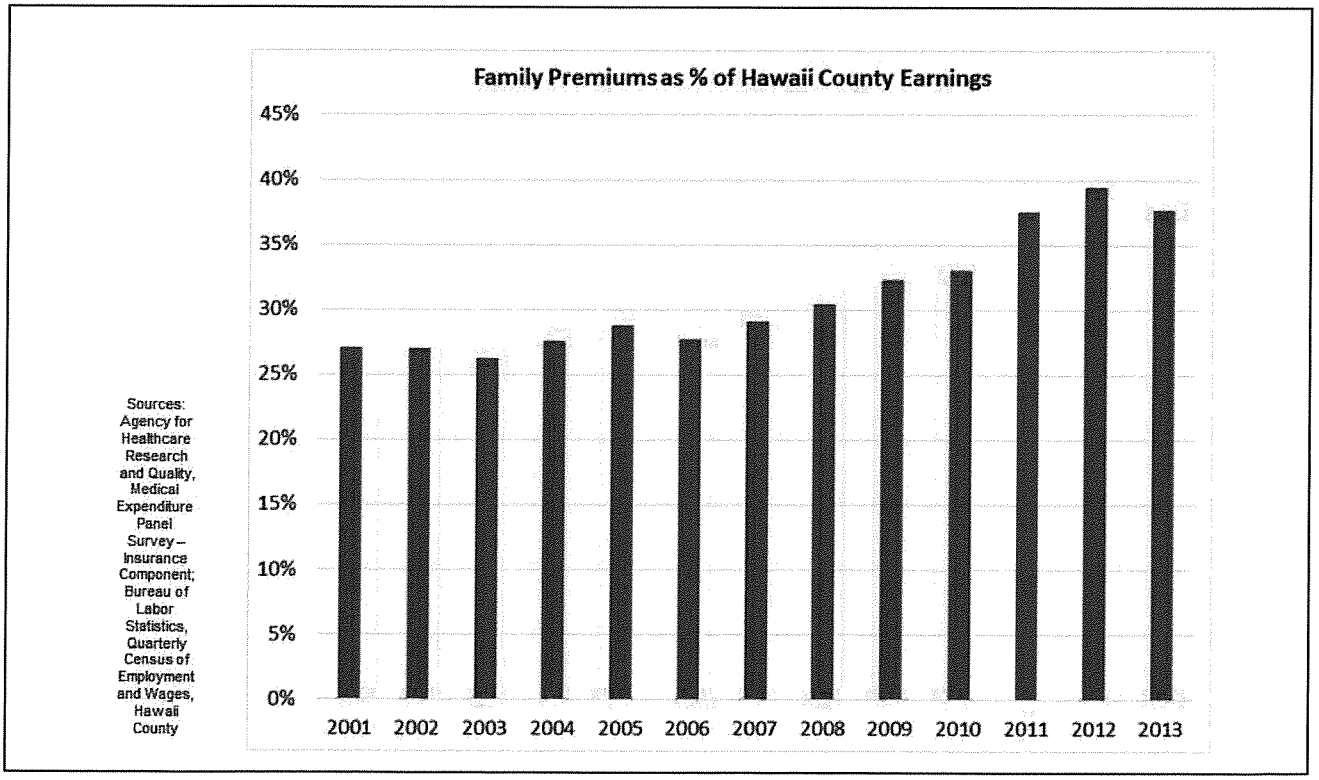
- Data from the National Center for Health Statistics indicate that East Hawaii residents are less healthy than those living in the rest of the state and in some cases have higher rates of health problems than the national average (such as the death rate from stroke).
- Health insurance premiums in Hawaii have been rising faster than in the nation as a whole, yet average wages in East Hawaii are lower than in other communities. As a result, in relative terms, healthcare is less affordable for residents and employers are less able to increase wages due to high healthcare costs.
- Many residents of the community report having trouble finding a primary care physician or seeing a physician in a timely fashion. As a result, it appears that many residents with chronic health conditions are being hospitalized for problems that could have been prevented.
- Studies have determined that East Hawaii has a shortage of physicians in key specialties, and many residents must wait for care or travel to Oahu to receive services.
- Physicians report they are spending increasing amounts of time on administrative burdens which reduces the time they can spend on patient care.
- Physician practices report that they are struggling financially, which could exacerbate shortages of physicians in the future.
- The Hilo Medical Center is also struggling financially and has been forced to cut staff, which makes it difficult for it to provide the highest quality care for residents. The hospital is controlled by the state, not by local leaders, and work rules prevent it from being as efficient as it could be.
- There are poor relations between the hospital and community physicians, which can lead to duplication of services and problems in coordinating care.
- Employers indicate they do not have the information they need to encourage appropriate solutions.

Many of these problems stem from the method by which physicians and hospitals are paid as well as the amounts of payment they receive. For example:

- Most physicians only receive payment for office visits, not for responding to phone calls from patients about a symptom or problem, even though responding to a phone call might avoid a far more expensive visit to the emergency room and be more convenient for the patient. A physician practice that organizes proactive outreach to high-risk patients, hires staff to provide patient education and self-management support, or uses non-health care services (such as transportation or housing) to help patients better manage their health care problems typically can't be reimbursed for the costs of these services, even if they help avoid expensive hospitalizations or allow health problems to be identified and treated earlier and less expensively.
- Under the current fee for service payment system, hospitals and physicians lose revenue if they perform fewer procedures or lower-cost procedures, but their costs of delivering the remaining services generally do not decrease proportionately, which can cause operating losses for the providers. The community needs the Hilo Medical Center to have its emergency room, surgery suites, labor and delivery services, and physicians available 24/7, but the hospital isn't paid to maintain that important standby capacity, it is only paid when it actually has patients.

- In many cases, additional spending on preventive care today could avoid more expensive health problems in the future, but there is no easy way for employers to make those kinds of investments and ensure an appropriate financial return.
- There are many low-income residents who do not have insurance or whose insurance does not pay adequately for either physician or hospital services, which makes it difficult for them to get the care they need except in emergencies.





B. A Community with a Strong Foundation for Creating Successful Solutions

Although many communities across the country are also facing serious healthcare challenges, the East Hawaii community has many unique strengths that create a strong foundation for solving its current challenges and it has already made significant progress toward creating a healthier community and a high quality, affordable healthcare system.

Healthcare Providers

- Unlike many communities, East Hawaii has independent physicians who know how to run their practices efficiently, have been recognized as delivering good quality care, and are committed to the community.
- Although some communities with small, independent practices have difficulty ensuring that patient care is coordinated, East Hawaii's independent physicians have organized themselves to work together through the East Hawaii Independent Practice Association (EHI) to improve the quality of care they deliver.
- Whereas some communities have too many hospitals and others have no hospital at all, East Hawaii has a non-profit community hospital that provides essential services, has been recognized as delivering good quality care, and is working to improve quality.
- Both the Hilo Medical Center and some physician practices have invested their own resources in order to bring new primary care providers and specialists to the community.
- Through IDEAS Health, the community has access to a sophisticated data analysis system to measure quality and identify opportunities for improvement.

Purchasers, Payers, and Patients

- In contrast to many communities, most of East Hawaii's employers are locally-owned, are committed to the community, and work together to support community initiatives, including programs to improve health and healthcare.
- A large portion of residents are insured by a large, locally-based health plan (HMSA) that has low administrative costs, has implemented a variety of innovative initiatives to improve quality and reform healthcare payment, and has demonstrated the willingness to implement special initiatives in East Hawaii.
- Employers, physicians, and hospital leaders know each other and have experience working together on community initiatives.
- The community has created a multi-stakeholder organizational mechanism (Community First) to advance innovative health and healthcare initiatives in the community.

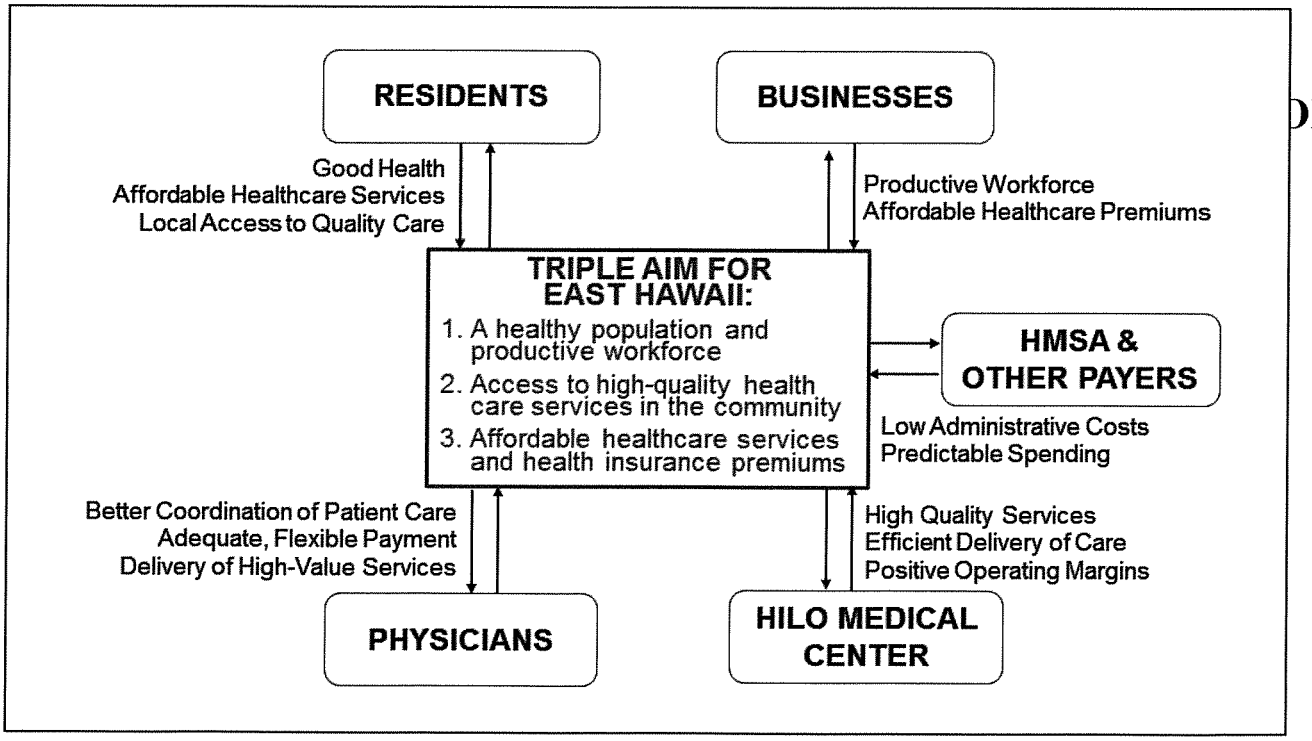
C. Pursuing a Triple Aim for East Hawaii

The combination of challenges and strengths means that East Hawaii is "halfway to greatness." There is an both an urgent need and a unique opportunity for all of the stakeholders in East Hawaii – citizens, private employers, county government, primary care physicians, specialists, the hospitals, HMSA, and other payers – to work together to make additional progress toward the "Triple Aim":

1. A healthy population and a productive workforce;
2. Access to high-quality healthcare services in the community; and
3. Affordable healthcare services and health insurance premiums.

These three aims are mutually reinforcing, so all three can and should be pursued simultaneously by the East Hawaii community:

- If residents of East Hawaii are healthy, they will be more productive at work, and they will need fewer healthcare services, thereby reducing the cost of health insurance;
- If residents of East Hawaii have access to affordable healthcare services in the community, they will be able to obtain the services they need to stay healthy, they will need to spend less time away from work obtaining healthcare services, and they will be more productive during times they are working;
- If healthcare services in East Hawaii are delivered in the highest quality way, there will be fewer expensive complications and lower health insurance costs, and residents will be more willing to use the services available in the community, which will improve the financial viability of physicians, hospitals, and other healthcare providers in the community; and
- If affordable, high-quality healthcare services are available in East Hawaii, it will help the community attract more residents and businesses, which in turn will make it easier to sustain a broad range of high-quality healthcare services in the community.



II.

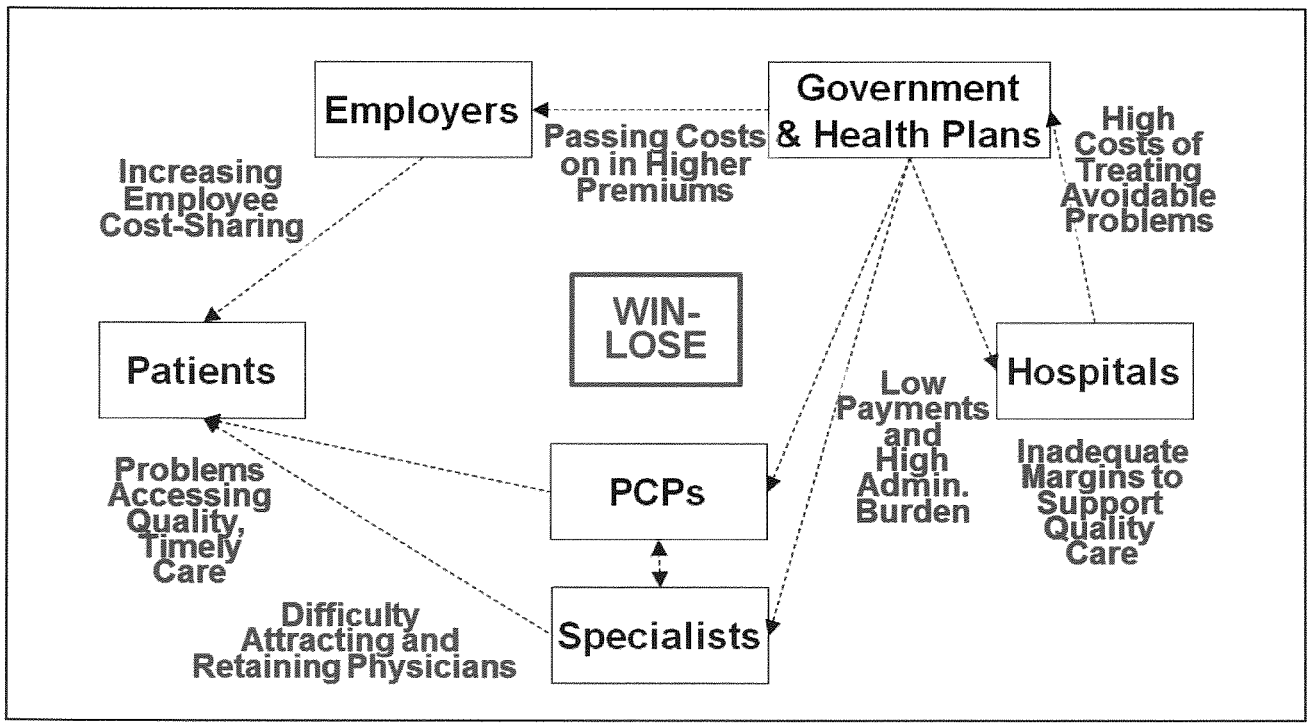
A.

Alt hou gh ma ny co m mu niti es acr oss the cou

ntry have said they want to achieve this kind of "Triple Aim," all too often, each stakeholder tries to advance only those aspects of the Triple Aim they are most interested in or does so in a way that is most favorable to them even if it causes problems for other stakeholders. For example, in many communities:

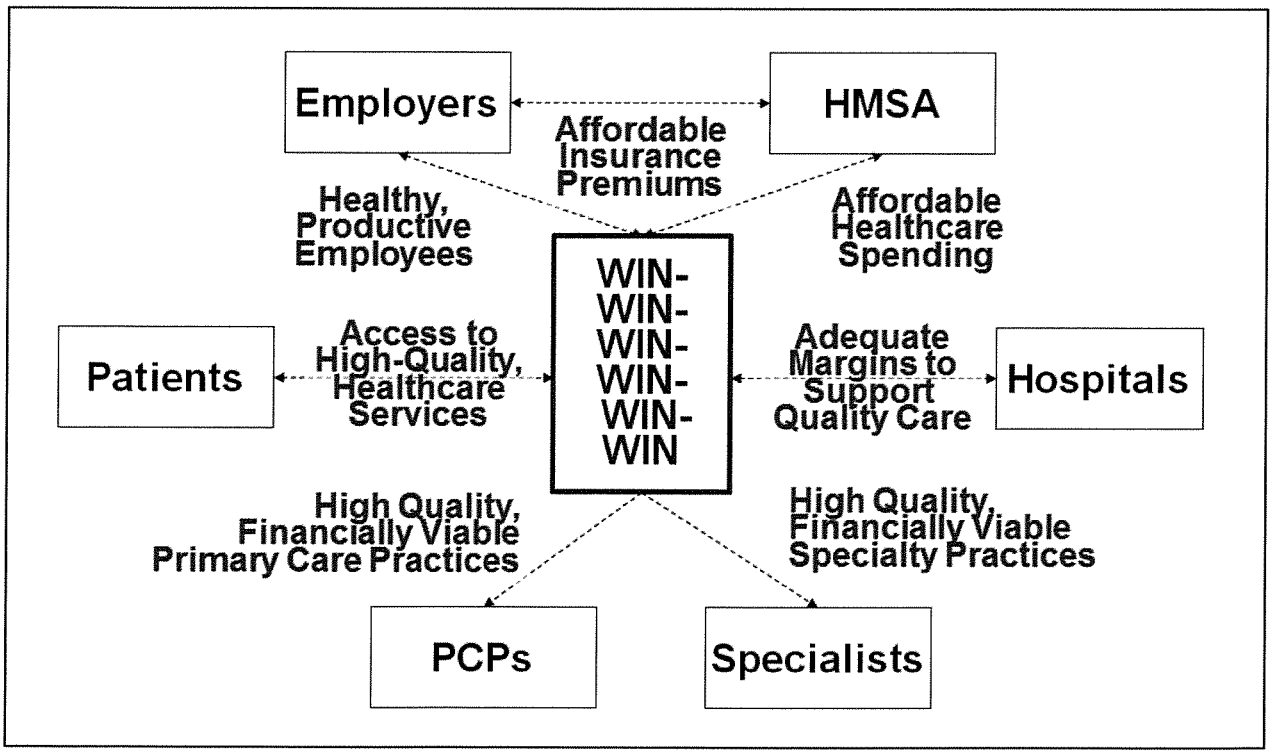
- Government and health plans cut the amounts they pay physicians and hospitals for services, jeopardizing the financial viability of providers and making it more difficult for patients to obtain needed care.
- Physician practices and hospitals merge and consolidate in order to raise prices for services without improving the quality of care.
- Payers reward physician practices with higher payments if they reduce hospital admissions, but the payers do not ensure that hospitals can cover the costs of essential services with the reduced revenues they receive when admissions are reduced.
- When government cuts payment rates to physicians and hospitals, private health plans and employers are forced to pay more in order to cover the providers' costs.
- Employers and health plans faced with increasing premiums shift costs to employees through higher copayments and high deductibles, making healthcare less affordable for individuals and families.

These "win-lose" approaches are generally unsuccessful, and moreover, they destroy the trust that stakeholders need in order to work together to find better approaches.



In contrast, "win-win" approaches are more likely to be successful, since all stakeholders benefit. For example:

- Rather than cutting payment levels for existing services and failing to pay at all for some high-value services, payers can give physicians the flexibility to use different types of services that cost less to deliver and achieve equal or better outcomes for patients.
- Since hospitals' per patient costs will increase when they have fewer admissions (because essential fixed costs must be covered by a smaller number of patients), payers can provide higher per-patient payments to cover these costs but still achieve savings through the reduced number of patient admissions.
- Rather than simply increasing cost-sharing across the board, employers and health plans can create value-based benefit designs that encourage the use of necessary healthcare services and discourage the use of unnecessary services.
- By delivering services in a more efficient, coordinated, and timely way, physicians and hospitals can not only reduce healthcare spending but reduce the amount of time employees have to spend away from their jobs.



Win-win approaches are far more likely to be sustainable than win-lose approaches, since it is unlikely that the losers will be willing or able to continue losing indefinitely. However, developing win-win approaches requires that all stakeholders understand the other stakeholders' needs and goals and to work together collaboratively to find creative approaches that balance those needs and goals in a feasible and sustainable way.

Although there has been considerable focus nationally on creating "Accountable Care Organizations" (ACOs) as a mechanism of achieving the Triple Aim, many of these ACOs have been unsuccessful because they were not based on a win-win strategy developed collaboratively by payers and providers.

B. The Need for a Regional Health Improvement Collaborative for East Hawaii

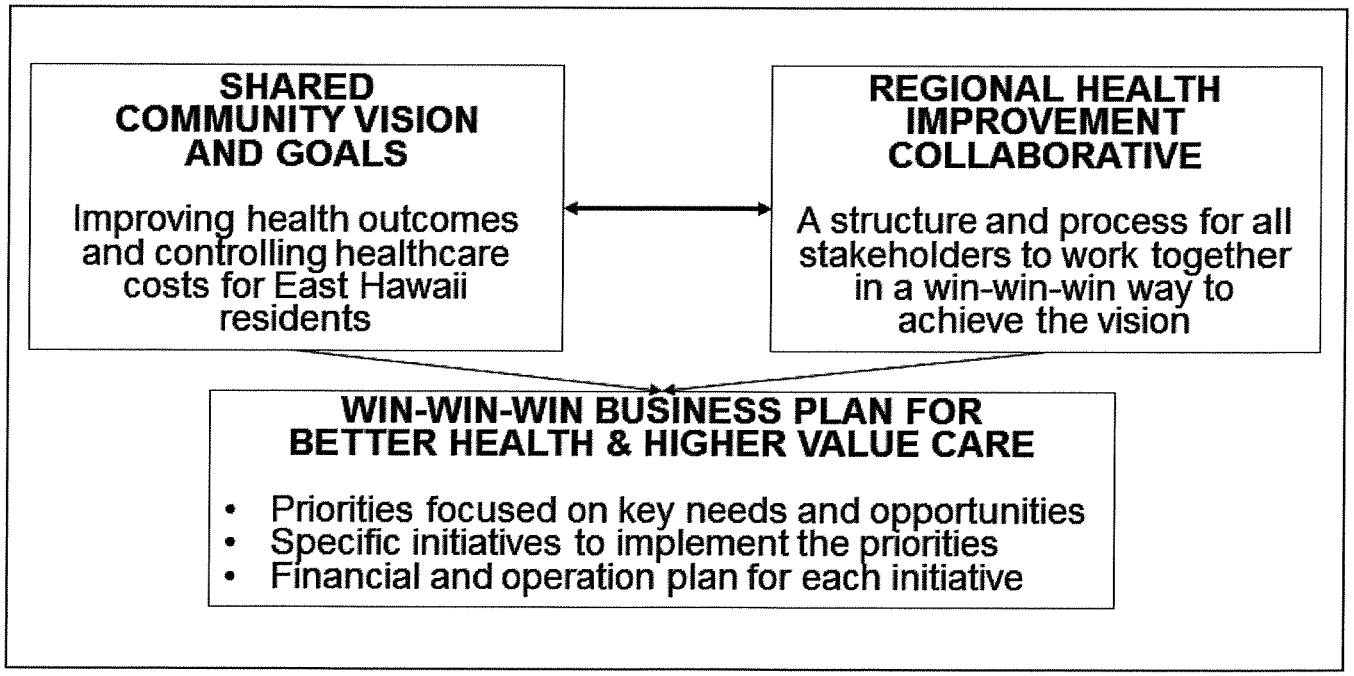
Although most of the key stakeholders in East Hawaii *know* each other, they need a mechanism to *talk with each other* and *work collaboratively* to develop *win-win-win approaches* to the Triple Aim, i.e., approaches that are:

- **A win for residents and patients**, i.e., enabling residents of East Hawaii to receive higher quality healthcare and health improvement services;
- **A win for employers and payers**, i.e., reducing and/or controlling the growth in health care spending and insurance premiums; and
- **A win for physicians and hospitals**, i.e., enabling physician practices and hospitals to be financially viable.

To accomplish that, an East Hawaii Regional Health Improvement Collaborative (EH-RHIC) should be created. The EH-RHIC should not deliver or pay for healthcare services; its key roles will be to:

- Facilitate regular, face-to-face communication among the leaders of the key stakeholder organizations to enable mutual understanding of each other's capabilities and needs, to establish goals and objectives that all stakeholders can support, to design initiatives in ways that will be mutually beneficial, and to rapidly address and resolve problems and conflicts;
- Provide a common set of data and analyses about the quality and costs of healthcare that all participants can trust in order to design and implement win-win-win initiatives; and
- Measure and report on progress in improving the quality and cost of healthcare in the community and in implementing specific initiatives designed to achieve the Triple Aim.

The East Hawaii Regional Health Improvement Collaborative would serve as a mechanism for the stakeholders in the community to agree on a shared vision and goals for the future and for translating that vision into an actionable "business plan" for higher-value care.

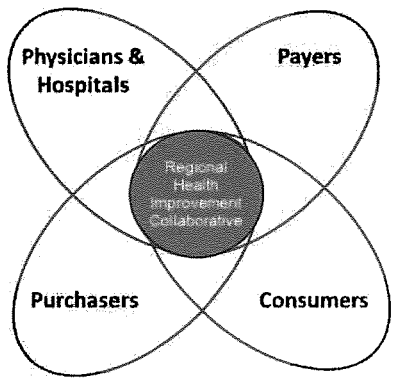


A growing number of communities across the country have created Regional Health Improvement Collaboratives for similar reasons:

- Aligning Forces for Quality – South Central PA
- Better Health Greater Cleveland
- California Quality Collaborative
- Center for Improving Value in Health Care (Colorado)
- Finger Lakes Health Systems Agency
- Greater Detroit Area Health Council
- The Health Collaborative (Greater Cincinnati)
- Healthcare Collaborative of Greater Columbus
- HealtheConnections (Syracuse)
- Healthy Memphis Common Table
- Institute for Clinical Systems Improvement
- Integrated Healthcare Association
- Iowa Healthcare Collaborative
- Kansas City Quality Improvement Consortium
- Kentuckiana Health Collaborative
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Massachusetts Health Quality Partners
- Michigan Center for Clinical Systems Improvement
- Midwest Health Initiative
- Minnesota Community Measurement
- New Jersey Health Care Quality Institute
- Nevada Partnership for Value-Driven Healthcare (HealthInsight)
- New Mexico Coalition for Healthcare Quality (HealthInsight)
- North Texas Accountable Healthcare Partnership
- Oregon Health Care Quality Corporation
- P^2 Collaborative of Western New York
- Pittsburgh Regional Health Initiative
- Quality Counts (Maine)
- Utah Partnership for Value-Driven Healthcare (HealthInsight)
- Washington Health Alliance
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Health Information Organization

REGIONAL HEALTH IMPROVEMENT COLLABORATIVES IN THE UNITED STATES

THE MULTI-STAKEHOLDER STRUCTURE OF REGIONAL HEALTH IMPROVEMENT COLLABORATIVES



Although they differ in the types of programs they operate based on the needs of their own communities, they are similar in serving as a neutral convener of all stakeholders in the community and using shared, trusted information to analyze problems and measure progress.

C. The Structure of an East Hawaii RHIC

Composition of the Steering Committee

The East Hawaii Regional Health Improvement Collaborative (EH-RHIC) should be led by a small Steering Committee composed of representatives from each of the key stakeholder groups – employers, citizens, physicians, hospital, and payers. Each of the individuals who serves on the Steering Committee must be a *leader* within their respective stakeholder group who is *willing and able to encourage the necessary actions by the stakeholders they represent* in order to successfully implement the strategies developed by the Steering Committee.

The initial size and composition of the Steering Committee should be as follows:

- The Chair of the Steering Committee should be a community leader who is not a provider of healthcare nor a direct payer (i.e., health plan)
- Two of the officers of the East Hawaii IPA; one should be a primary care physician and one should be a non-primary care specialist
- The Board Chair and the CEO of the Hilo Medical Center
- Two representatives of large employers in East Hawaii, ideally one representing a public employer (the county) and one representing a private employer
- Two citizens who are community leaders (in addition to the Chair)
- A senior official of HMSA.

Initial Membership of the Steering Committee

The proposed initial members of the EH-RHIC Steering Committee for 2015 are:

- Barry Taniguchi, Chair (Community Leader – Community First)
- Kevin Kurohara (President of the East Hawaii IPA, Primary Care Physician)
- Peter Matsuura (Director of the East Hawaii IPA, Specialty Physician)
- Dan Brinkman (Interim CEO of the Hilo Medical Center)
- Daniel Belcher (Incoming Board Chair of the Hilo Medical Center)
- Randy Kurohara (Public Employer - County of Hawaii)
- Toby Taniguchi (Private Employer - KTA Superstores)
- Lisa Rantz (Community Leader - Hilo Medical Center Foundation)
- Douglass Adams (Community Leader – Rotary Club of South Hilo)
- Elisa Yadao (HMSA)

Frequency and Location of Meetings

The Steering Committee should meet monthly during 2015. Because there have been few opportunities to date for the stakeholders to understand each other's needs and challenges and to develop the kind of mutual trust necessary for success, it will be important to meet frequently enough to build this mutual understanding and trust. The Steering Committee can then transition to quarterly meetings.

The locations of the meetings should rotate among the offices of the individual stakeholder members.

Threshold for Decisions and Actions

At its meetings, the Steering Committee should only make decisions and take actions that are supported by *all* of the stakeholders on the Steering Committee, and it should work to build the consensus necessary for unanimous support. If only a majority or even super-majority of the Steering Committee vote in favor of an action, it likely indicates that one or more stakeholders view the action as a "win-lose" rather than the "win-win" that the EH-RHIC is intended to create.

Obtaining and Maintaining Support from the Entire East Hawaii Community

The East Hawaii Regional Health Improvement Collaborative has no direct power to make any changes in the healthcare system, only the individual stakeholders do. However, the members of the Steering Committee can play three key roles in encouraging change in the commuinity:

- Identifying the actions that the stakeholders they represent could take to advance the Triple Aim and the barriers and challenges they face in doing so, and educating other stakeholders about those opportunities and barriers;
- Working with the other members of the Steering Committee to develop solutions to the barriers in order to design win-win-win strategies to achieve the Triple Aim; and
- Educating and building support for the solutions and strategies among other members of the stakeholder groups they represent.

Performing these roles successfully will require mechanisms for communicating with all of the stakeholders in the community. To do this, the EH-RHIC could:

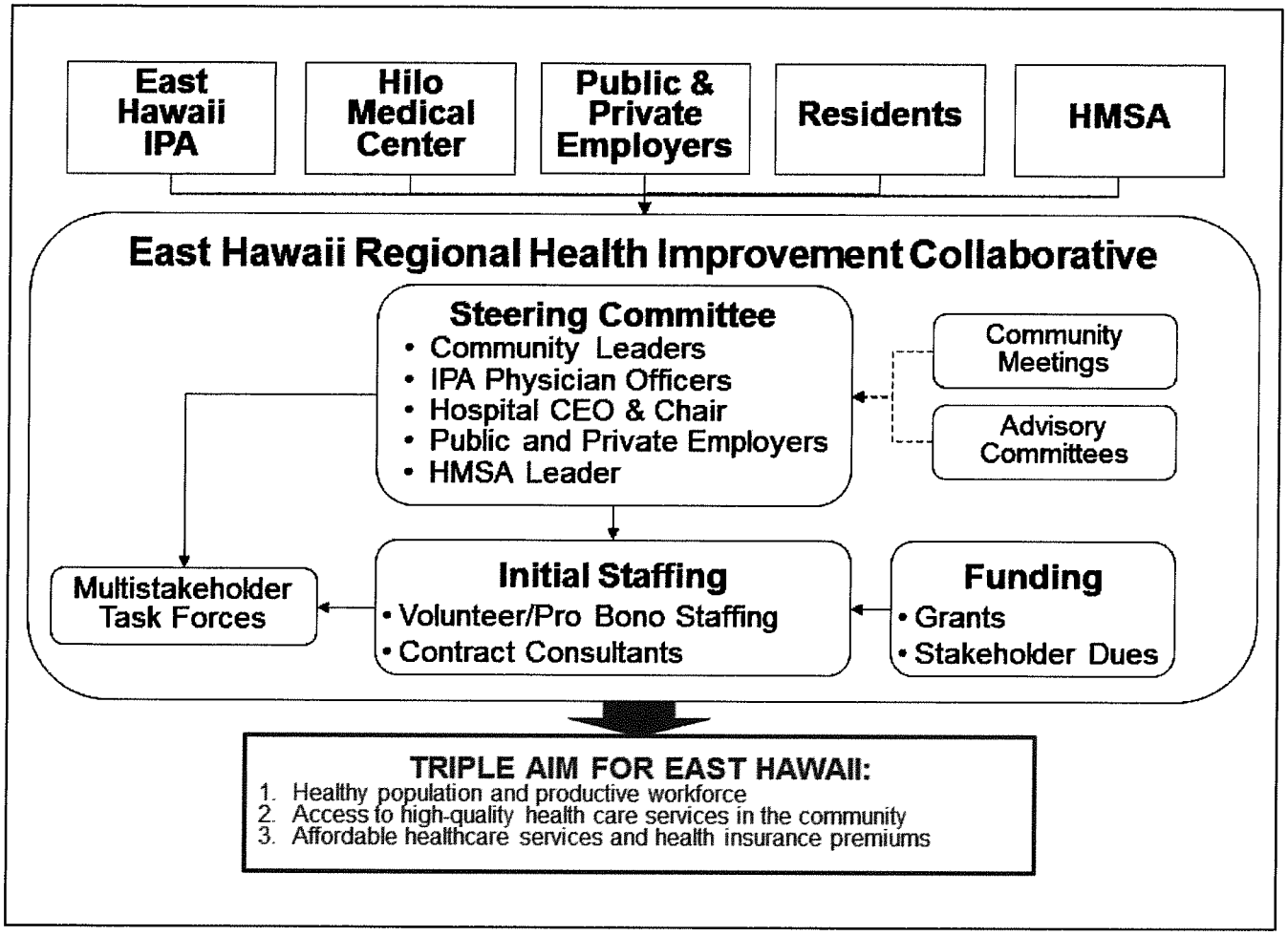
- Hold a community forum at least annually to seek input and support from all members of the community. During 2015, there should be two such meetings, one in early summer and one in the fall.
- Meet with existing stakeholder groups to obtain their input and support.
- Form advisory committees to obtain input and support from specific groups of stakeholders where there is no existing organization or committee, e.g., residents of the community, healthcare workers, etc.

Funding and Staffing

Most of the resources needed to support staffing, meetings, and data collection/analysis for the East Hawaii Regional Health Improvement Collaborative will need to be contributed by the stakeholder members of the EH-RHIC. To the maximum extent possible, during the initial years of operation, all administrative support for the EH-RHIC should be provided on a *pro bono* basis by the stakeholder members and through short-term consulting services paid for through contributions from all of the stakeholder organizations.

The stakeholders have agreed to provide the following in-kind support during 2015:

- Elizabeth Dykstra will serve as the Lead Facilitator for the EH-RHIC, thanks to in-kind support from Hawaii County
- Support for data analytics will be provided by Pono Health, thanks to in-kind support from the East Hawaii IPA and HMSA
- Logistical support for Steering Committee meetings will be provided by each of the members of the EH-RHIC Board on a rotating basis.



It will be difficult for the EH-RHIC to rely solely on in-kind support indefinitely, and so it will need to have sufficient funding to support staffing, data analysis, etc. Although grant funding from external sources can and should be pursued, it will likely be difficult to obtain significant or ongoing grant funding to support the core operations of the EH-RHIC as opposed to specific projects. Moreover, it will be important for the EH-RHIC to have the flexibility to use funds where needed, rather than only in the ways permitted by the terms of grants.

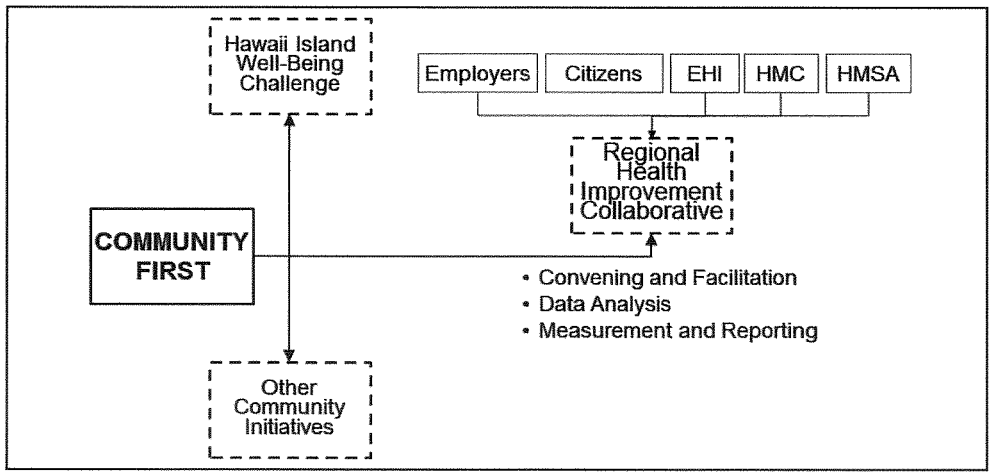
Consequently, each of the stakeholders will need to contribute some unrestricted funding each year to support the EH-RHIC. In order to maintain the neutrality of the EH-RHIC, no one stakeholder should contribute a disproportionate share of these funds. These contributions should be thought of as annual "dues" from each of the stakeholder groups, so that the EH-RHIC Steering Committee can rely on a stable source of funding and not have to divert too much of its limited time to fundraising efforts.

The EH-RHIC Steering Committee would adopt a budget defining the amount of unrestricted funding it needs to support its operations. This amount would then be converted into contribution amounts from each of the stakeholder members based on a formula approved by the Steering Committee. For example, the Steering Committee might determine that $200,000 was needed each year to cover the costs of a facilitator, basic shared data analytics, consulting support on specific projects, and meeting expenses, and it might agree that 25% of that ($50,000) should be contributed by the East Hawaii IPA, 25% should be contributed by the Hilo Medical Center, 25% should be contributed by the employers in the community, and 25% should be contributed by HMSA. Each of the individual stakeholder organizations would then determine on its own how to obtain those contributions from their own members.

The EH-RHIC Steering Committee would regularly assess whether the EH-RHIC was achieving its goals and providing sufficient value to each of the stakeholders. For example, since a key function of the EH-RHIC initially would be analyzing data to assist in developing multi-stakeholder strategies for success, the Steering Committee would assess whether the data analyses being generated were successfully identifying new opportunities for savings and quality improvement and if the analyses were sufficiently detailed so that providers and payers could determine how to successfully take action.

Corporate Home

The East Hawaii Regional Health Improvement Collaborative will need to obtain grants and contributions to support its work, so it will need an incorporated entity to accept funds and pay expenses. Rather than trying to create a new corporate entity for this purpose, the EH-RHIC should be housed within Community First. The EH-RHIC would be treated as a new and separate "project" that is administratively supported by Community First and Community First would maintain separate financial accounts for the EH-RHIC. All policy decisions related to the work of the EH-RHIC and how its funding would be generated and spent would be made by the Steering Committee of the EH-RHIC, except that the Community First Board would maintain overall fiduciary responsibility for funds flowing through the corporation to ensure that all revenues and expenses were permissible under its legal and tax structure.



Facilitating Communication and Collaboration Among Stakeholders

In addition to selecting specific priorities and overseeing efforts to implement those priorities, it will be important for the members of the Steering Committee to proactively identify and address issues that could threaten the ability of the stakeholders to work collaboratively. At each Steering Committee meeting, time should be allocated so that each of the stakeholders can share two types of information:

- **Information about new initiatives or programs being planned.** It is easier for stakeholders to coordinate with each other if they know what each other is doing, so regular sharing of information about plans can facilitate that coordination. Moreover, there are often situations in which an initiative designed by one stakeholder has an unintentional negative impact on other stakeholders, and it is better to identify this in advance and try to avoid it rather than trying to correct the harm after it occurs.
- **Information about problems or challenges being experienced and areas where help is needed**. In many cases, one or more stakeholders would be willing and able to help another stakeholder to address a problem it is experiencing or to take advantage of an opportunity, but they can only do so if they know about it.

D. Choosing Priorities and Measuring and Reporting on Progress

At least once each year, the Steering Committee for the East Hawaii Regional Health Improvement Collaborative should establish specific priorities that would advance the Triple Aim goals, and it should also identify specific initiatives for implementing those priorities. The priorities and initiatives should be selected and designed in ways that would provide benefits to each of the stakeholders and to the residents of the community, and they should also be designed so as to minimize negative impacts on the stakeholders or to balance negative impacts with benefits. The EH-RHIC should not adopt a priority without also agreeing on the specific initiatives that would be pursued to achieve the priority and obtaining commitments from each of the stakeholders to carry out the specific activities needed for implementation of the initiatives.

The following process could be used for selecting priorities and defining implementation plans:

1. **Seek Input from Stakeholders on Potential Priorities.** The Steering Committee for the East Hawaii Regional Health Improvement Collaborative would ask the stakeholders in the community to suggest potential priority areas that would be of particular interest or benefit to them, and to provide feedback on priorities suggested by others.
2. **Conduct Preliminary Data Analysis for Each Potential Priority.** Data should be used to estimate the magnitude of the current problem/opportunity for each potential priority area. The primary source of data will be the IDEAS Health data platform, but additional data may need to be obtained from the HHIC, the HHIE, and individual stakeholders. To the extent possible and appropriate, analyses would include:
   - Number of East Hawaii residents affected by the problem/opportunity
   - Total amount of healthcare spending associated with the problem/opportunity
   - Whether the problem/opportunity has been growing and is expected to grow in the future
3. **Select a Subset of Priorities for Detailed Planning.** The EH-RHIC Steering Committee would select a subset of priorities for detailed planning based on the following criteria:
   - Magnitude and timeframe of the potential benefit
   - Magnitude of potential negative impacts and likelihood of mitigating/eliminating them
   - Complementarity (or lack of conflict) with initiatives already being pursued
4. **Develop a Plan for Addressing Each Priority in a Successful, Mutually Beneficial Way.** The EH-RHIC Steering Committee would appoint a Multistakeholder Task Force for each potential priority area composed of representatives from each of the stakeholders that would need to be involved for success or that could be affected by that initiative. The Task Force would recommend to the EH-RHIC Steering Committee whether to pursue the priority and the specific initiatives that should be implemented to achieve the priority in a win-win-win way for all stakeholders.
5. **Select Priorities and Initiatives for Implementation.** Based on the work of the Task Force(s), the EH-RHIC Steering Committee would select the priorities to be pursued and obtain commitments from each of the affected organizations to support implementation according to the plan.
6. **Monitor Progress and Refine the Priorities and Plans as Needed.** The EH-RHIC Steering Committee would monitor and report to the community on progress in implementing the priorities, and would periodically revise the priorities and implementation plans as necessary.

III. CREATING A COMMUNITY ACCOUNTABLE CARE ORGANIZATION

A. The Need for Better Ways to Deliver and Pay for Care

There are many significant opportunities to improve the quality and reduce the cost of health care in East Hawaii and in other communities across the country. Many patients develop health problems that could have been prevented, receive tests and procedures that are unnecessary, are hospitalized because their health problems were not effectively managed, and experience complications and infections that could have been avoided. If these unnecessary and avoidable health problems and health care services could be eliminated, spending could be reduced and the quality of life for the patients would be improved.

Helping people stay healthy, improving the quality of health care services, and reducing spending on health care will require redesigning the way care is delivered. Physicians and hospitals will need to deliver different kinds of services in different ways, and primary care physicians, specialists, and hospitals will need to work together to ensure patient care is coordinated effectively to achieve the best outcomes at the lowest cost.

An important barrier to delivering higher quality, more efficient and coordinated care is the current fee-for-service payment system. In many cases, it pays inadequately or not at all for new or redesigned services, and it financially penalizes healthcare providers for keeping patients healthy and treating health problems with fewer tests and procedures: Consequently, in addition to better ways of *delivering* care, better methods of *paying* for care are needed.

Physicians and hospitals will need new organizational mechanisms to enable them to work together to deliver care in more coordinated ways and to accept payments that are based on outcomes rather than the number of services delivered. Although some people assert that the only way to achieve successful coordination or to participate in different payment models is to have physicians and hospitals working for a single corporate entity, experience has shown that this is neither necessary nor sufficient. There are many examples across the United States of independent physicians and hospitals working together to successfully deliver care in more coordinated ways and to participate in more flexible and accountable payment models, and there are also many examples of integrated delivery systems that have not improved care or reduced costs regardless of the payment system that is being used.

B. Creating a Community Accountable Care Organization in East Hawaii

A Community Accountable Care Organization (CACO) is needed to enable the physicians in East Hawaii and the Hilo Medical Center to coordinate care and participate in better payment systems in a way that is a "win-win-win-win" for patients, payers, physicians, and the hospital. A Community Accountable Care Organization would serve as a mechanism by which the physicians and hospital can jointly contract with payers to manage the care of a population of patients at lower cost and better quality than would normally be expected. Through the CACO, the physicians and hospitals could be paid in ways that overcome the barriers in the current payment system.

Most of the Accountable Care Organizations that are being formed across the country only involve a subset of the physicians and hospitals in a community, and in some cases, one of the strategies by which these ACOs plan to succeed is to take business away from the providers who are not part of the ACO. In some cases, the ACO only involves physicians and the physicians succeed at the expense of the hospital or vice versa. In an unfortunate number of cases, the formation of an ACO has simply been a poorly-disguised effort to consolidate providers and raise prices.

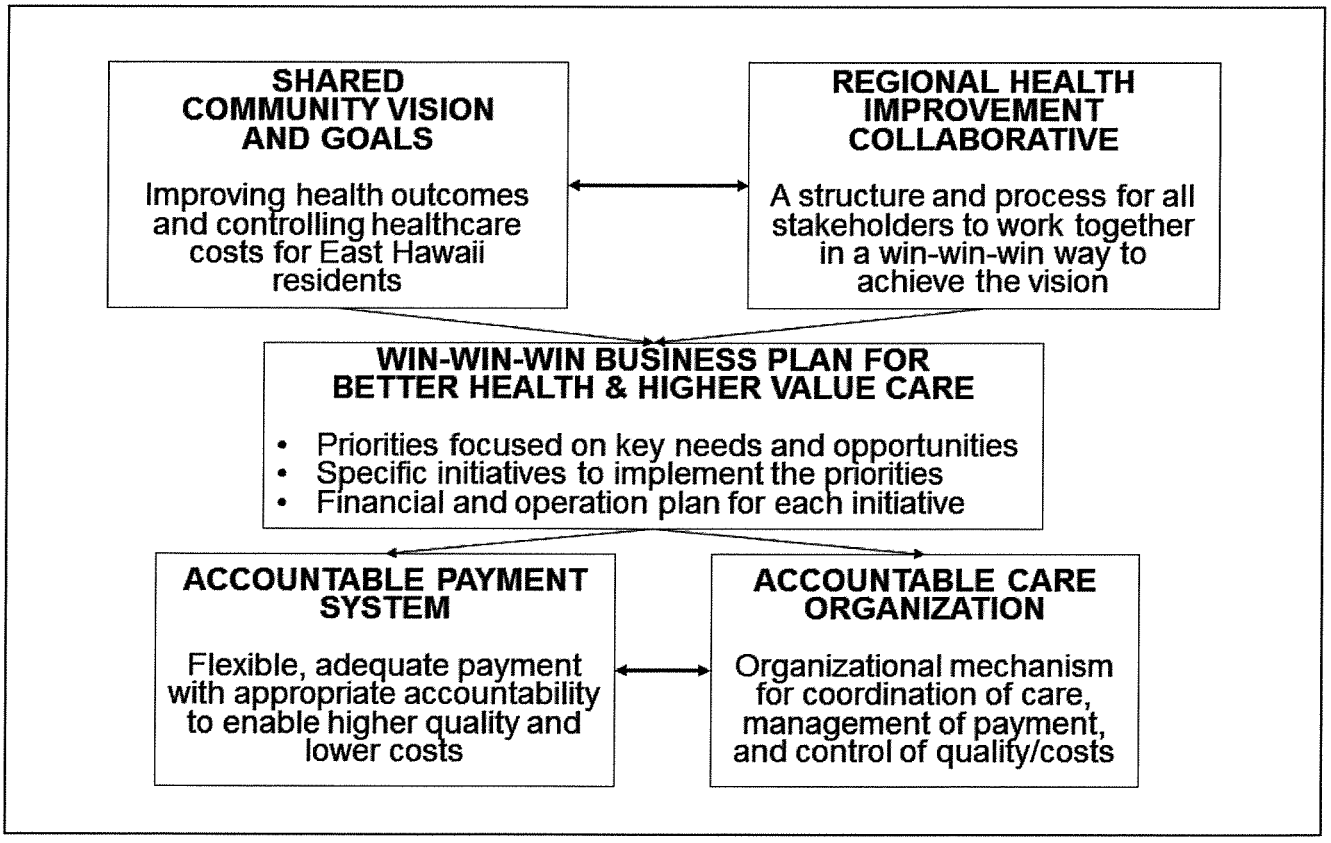
In contrast, in East Hawaii, the goal should be to create a *Community* ACO, in which all of the physicians in the community and the Hilo Medical Center can collaborate in order to improve the quality of care for the residents, reduce insurance costs for employers and government, and enable the physicians and hospital to be more financially viable.

C. The Need for Support for the ACO from Purchasers and Payers

It is unrealistic to expect the physicians, hospital, and other health care providers who are involved in the Community ACO, no matter how motivated they are to provide higher-value care, to improve quality or reduce spending if the payment system does not provide adequate financial support for their efforts. On the other hand, it is also unrealistic to expect that patients, employers, or payers will be willing to pay more or differently to overcome these barriers without assurances that the quality of care will be improved, spending will be lower, or both.

Consequently, while it will be the responsibility of providers to form the Community ACO and manage its operations, they will need the employers in the community, government agencies, and health plans to implement payment systems that will support the changes in care that the Community ACO makes in ways that are financially feasible for providers. The Regional Health Improvement Collaborative can facilitate discussions between payers and the providers in the ACO about how to structure a payment system that works for both providers and payers.

Because of the visibility of the programs that Medicare is using to support ACOs, many people have mistakenly assumed that the shared savings method that Medicare is using to pay ACOs is ideal or essential. However, there are different and better ways for payers to pay providers in ACOs, and one of the roles of the RHIC would be to facilitate agreement about how that should be done with the East Hawaii Community ACO.



D. The Difference Between the RHIC and the Community ACO

There is a need for both a Regional Health Improvement Collaborative and a Community Accountable Care Organization because the two entities will have different structures and they will play different, but complementary roles:

- **The Regional Health Improvement Collaborative:**
  - should be "owned" and financially supported by *all* of the major stakeholders in the community – employers, the East Hawaii IPA, the Hilo Medical Center, and HMSA – who have a financial stake in improving healthcare quality and cost
  - should enable *all* of the stakeholders in the community to work together to address a broad range of issues and opportunities affecting health, healthcare services, and healthcare costs in the East Hawaii community in "win-win-win" ways
  - should not contract to deliver or pay for healthcare services
  - should facilitate discussions and agreements (1) among providers about how the ACO should be structured and (2) between payers and providers about how the ACO should be paid
  - should help resolve disagreements between payers and providers to preserve a win-win-win approach
- **The Community Accountable Care Organization:**
  - should be "owned" and financially supported by the East Hawaii IPA, the Hilo Medical Center, and other healthcare *providers*
  - should enable the *healthcare providers* in the community to work together to deliver healthcare services in ways that improve patients' health, control the growth in healthcare costs, and enable healthcare providers to be financially viable
  - should serve as a mechanism for providers to jointly contract with payers to manage an overall budget for specific patients/health conditions using different approaches to delivering and paying for existing and new services
  - should determine how to divide payments and to distribute profits or losses among participating providers based on the ACO's performance

E. How the ACO Will Improve Care for Patients, Reduce Spending for Payers, and Improve Payment for Providers

Step 1: The RHIC will help the ACO identify and quantify areas for different types of patients and health conditions where there are healthcare expenses that can be reduced without harming patients and potentially helping them, such as duplicative and unnecessary tests and procedures, preventable infections and complications, and avoidable hospitalizations and readmissions.

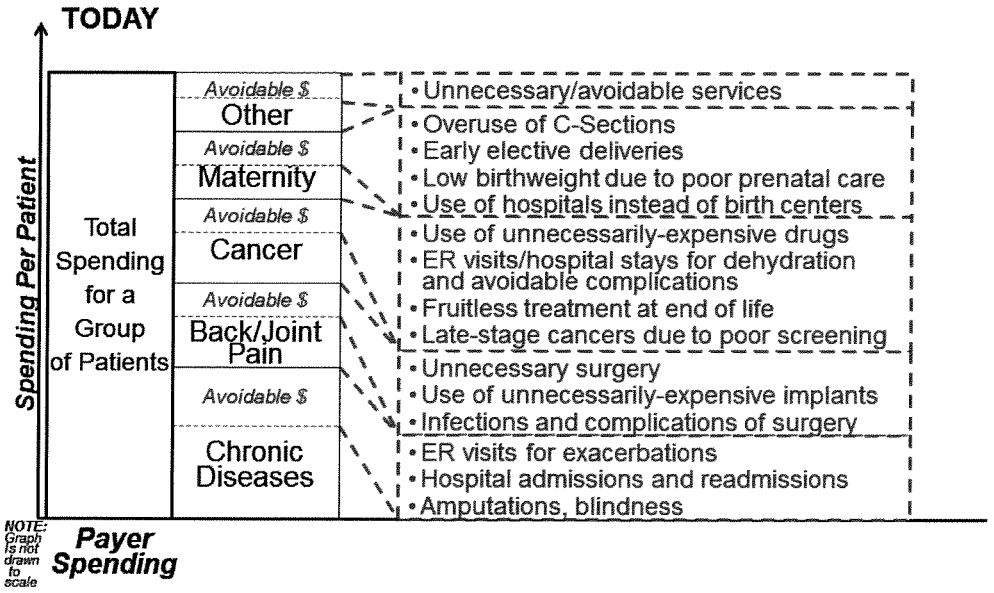
Step 2: The providers within the ACO will determine how they could redesign care for patients with each type of condition to reduce the avoidable expenses.

Step 3: The ACO will estimate the costs the hospital and physicians will incur when they deliver fewer current services and more new types of services, so that the amount of payment needed to cover those costs can be determined.

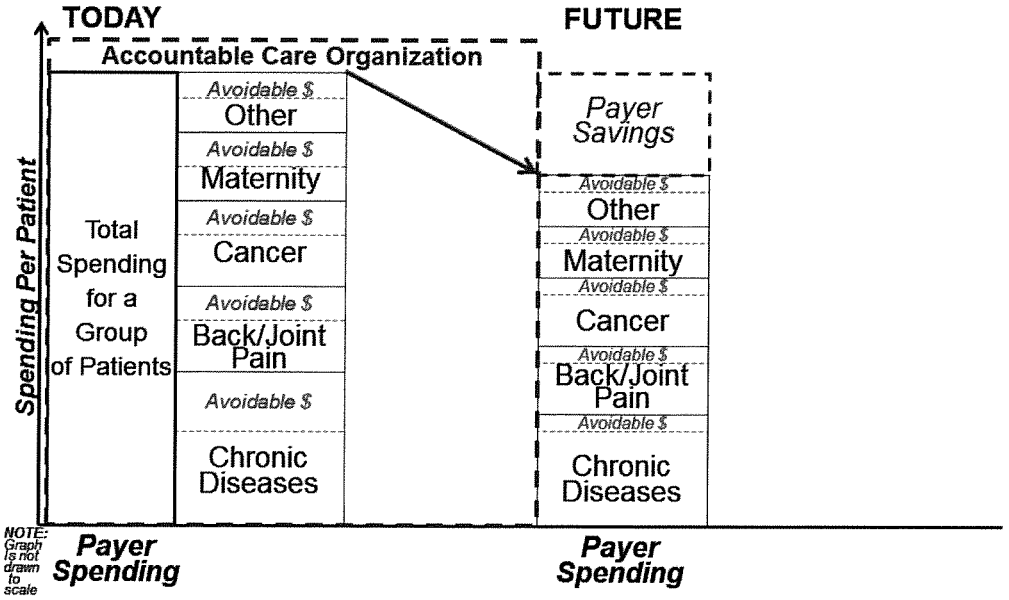
Step 4: The ACO and each payer will agree on a budget for managing services and costs related to patients with a particular health problem. This budget will be lower than spending is projected to otherwise be. The providers in the ACO will then work to manage care of the patients and reduce avoidable spending in order to meet the budget target. The physicians and hospital will continue to be

paid through the current fee for service structure, but if they hold spending levels below the overall budget, the ACO will receive the difference as a bonus payment and be able to allocate that among the physicians and hospital in order to cover their costs. Risk adjustment and risk corridors will be used to protect providers against increases in spending due to sicker patients or uncontrollable costs.

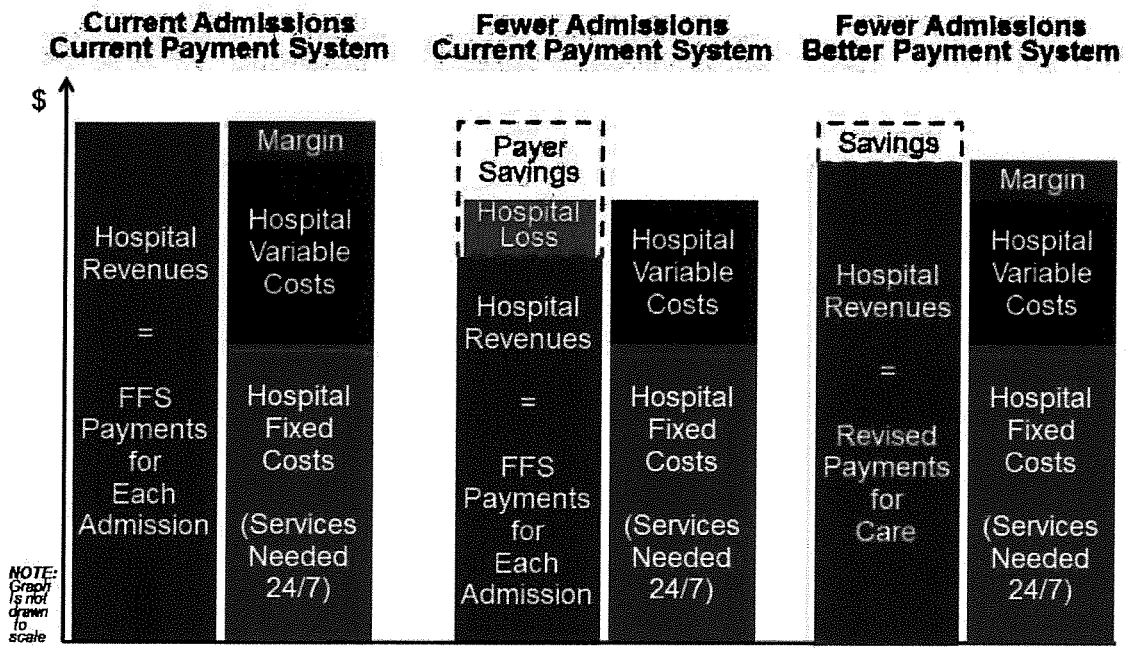
STEP 1:
IDENTIFY AREAS WHERE SPENDING CAN BE REDUCED WITHOUT HARMING PATIENTS



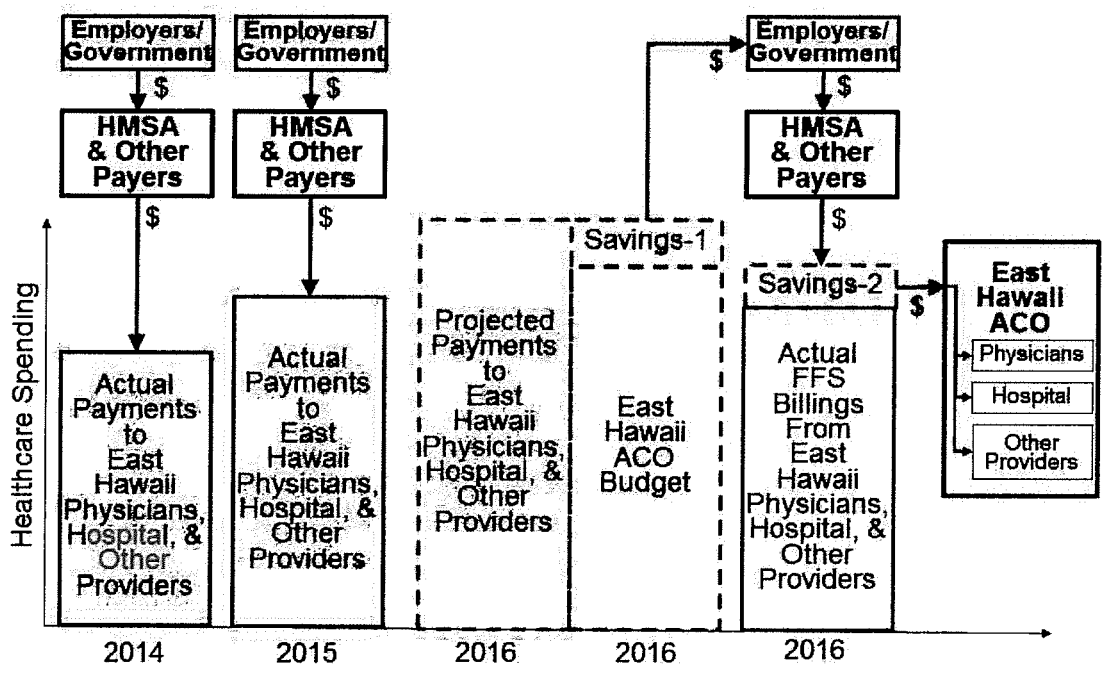
STEP 2:
DESIGN CHANGES IN CARE TO REDUCE AVOIDABLE SPENDING



STEP 3:
DETERMINE THE COSTS OF DELIVERING FEWER SERVICES AND HOW PAYMENT WILL NEED TO CHANGE TO SUPPORT THAT

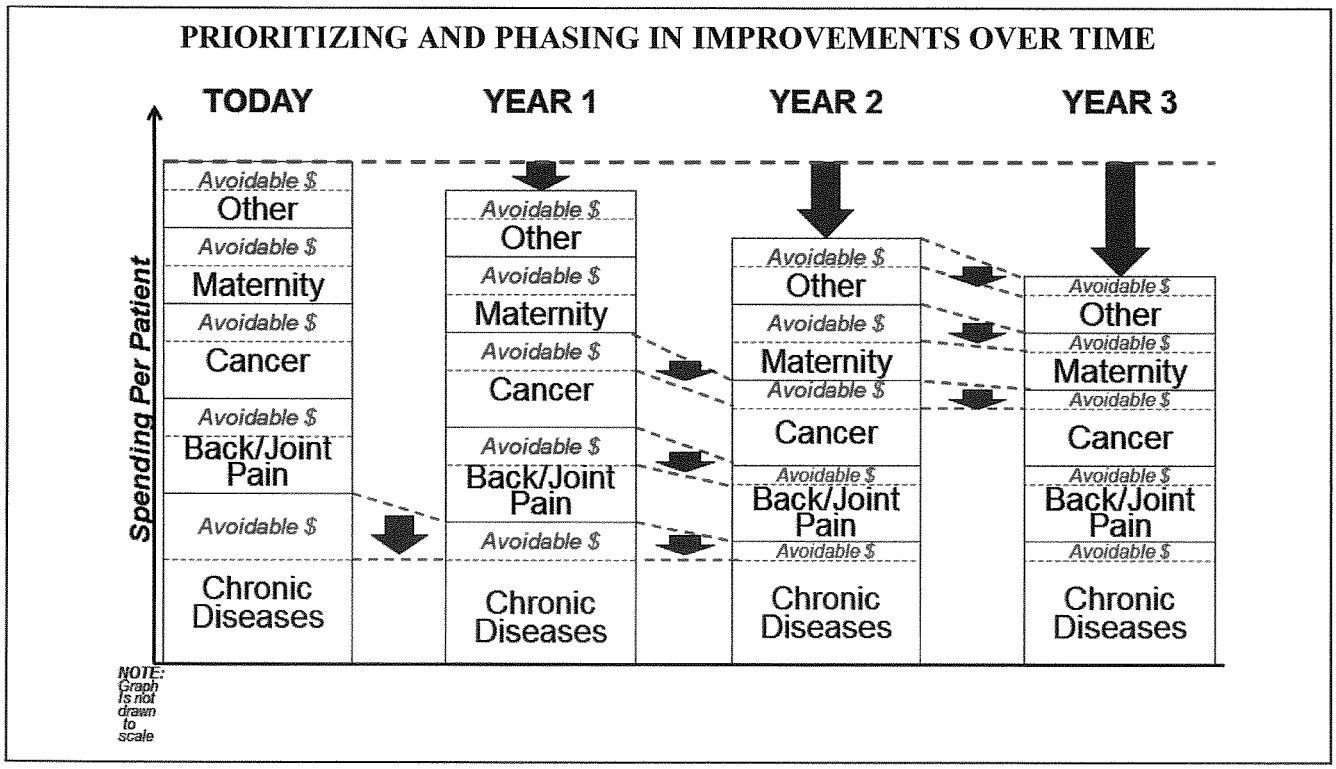


STEP 4:
ESTABLISH A BUDGET FOR PATIENT CARE THAT PROVIDES ADEQUATE RESOURCES FOR QUALITY CARE AT LOWER SPENDING THAN PROJECTED



F. Implementing the Community ACO in a Phased Approach

Although the Community Accountable Care Organization should ultimately seek to improve the quality and reduce the costs of all aspects of healthcare delivery in East Hawaii, it is not practical to try and do everything all at once. One of the roles of the Regional Health Improvement Collaborative will be to help the providers in the ACO and payers identify and agree on initial priorities for improving quality and cost and then the ACO can phase in additional areas of improvement over time.



G. How the RHIC Can Support the Success of the Community ACO

The East Hawaii Regional Health Improvement Collaborative can help facilitate the formation and successful operation of a Community ACO in several ways:

- The RHIC can facilitate discussions between the East Hawaii IPA and Hilo Medical Center as to the type of organizational and legal structure needed to enable them to jointly contract with payers and share in profits and losses for managing a population of patients.
- The RHIC can arrange for the data analysis and facilitate the discussions needed in order for the providers in the community to select one or more groups of patients for initial management through the Community ACO and to develop a business plan for the changes in care delivery that will be made, the costs of new services, and the savings expected.
- The RHIC can facilitate discussions between the ACO participants and HMSA and other payers to develop the structure of a payment agreement to support the improved care for the selected group(s) of patients.

IV. INITIAL PRIORITIES FOR THE EAST HAWAII REGIONAL HEALTH IMPROVEMENT COLLABORATIVE

Although there are many areas where improvements are needed and there are a number of opportunities to make those improvements, the time and resources of the East Hawaii Regional Health Improvement Collaborative will be limited, particularly initially, and trying to pursue too many initiatives at the same time could spread its resources too thinly and result in none of the initiatives being successful.

The stakeholders involved in planning for the EH-RHIC discussed a variety of different potential priorities and agreed that initial efforts should focus on two initiatives:

- **Improving the Quality and Reducing the Cost of Care for Heart Failure Patients.** Many individuals in East Hawaii with chronic conditions are being hospitalized for problems related to their condition, and many of these hospitalizations could likely be prevented through improved services in the community. Patients with heart failure appear to represent the biggest opportunity for potential savings, and the strategies for improving their care will likely be adaptable to patients with other types of chronic conditions, such as asthma, COPD, and diabetes.
- **Creating a Mechanism for Attracting and Retaining Physicians in the Community.** In order for East Hawaii residents to obtain high quality healthcare services, the community needs appropriate mechanisms to attract and retain an adequate number of primary care physicians and key specialists.

These initiatives are mutually complementary because efforts to improve care to patients with chronic conditions such as heart failure requires an adequate number of primary care physicians and access to key specialists. In addition, these two initiatives will help set the stage for creation and successful operation of a Community ACO:

- A Community ACO will not be successful unless it improves the way care is delivered to patients with chronic conditions. Conversely, improving care for patients with heart failure and other chronic illnesses will require PCPs, specialists, and the hospital to work together in a coordinated way, which is difficult to do without an organizational mechanism such as an ACO.
- The Community ACO will not be successful unless there are an adequate number of PCPs and specialists to provide preventive services and high-quality care. However, it will likely be easier to attract and retain physicians if the Community ACO can offer them the ability to practice medicine in more effective ways and to pay them adequately for delivering high-quality care. The mechanism used to attract and retain physicians can also help to facilitate the implementation of new approaches to care delivery by both new and existing physician practices that will support the success of the Community ACO and the broader goals of the RHIC.

A. Improving the Quality and Reducing the Cost of Care for Heart Failure Patients

Rationale for Heart Failure as an Initial Priority for Improving Quality and Reducing Costs

Both nationally and in Hawaii, treatment of patients with chronic diseases accounts for a significant portion of healthcare costs and has been a major cause of the growth in healthcare spending. The IDEAS Health data analysis platform allowed the stakeholders in East Hawaii to carry out preliminary analyses of opportunities for improving care and reducing costs for HMSA patients. Among patients with chronic diseases (i.e., asthma, diabetes, COPD, heart failure, etc.), patients with heart failure are hospitalized the most frequently. On average, 6% of HMSA patients in East Hawaii who have heart failure are hospitalized during the course of the year.

In addition, there is considerable variation among primary care practices; in five practices, 15-20% of HMSA heart failure patients are hospitalized during the year, whereas in others, none of the patients are hospitalized. This suggests that management of heart failure could be improved in order to avoid more hospitalizations and reduce healthcare spending. If all primary care practices had kept the rate of hospitalization for heart failure patients at 5% or less, 24 hospitalizations for HMSA members would have been avoided, saving over $200,000.

Not every employer may benefit directly or significantly from improved care for heart failure patients, simply because not every employer has employees with heart failure or is providing insurance coverage for individuals with heart failure. Similarly, patients with heart failure may not represent the biggest opportunity for savings for some payers, depending on the particular patients they insure. However, it is likely that once methods are developed for improving care for patients with heart failure, similar approaches can also be used for patients with other types of chronic disease, which will increase the likelihood that all employers and payers will see benefits in terms of lower healthcare spending and healthier and more productive workers and residents.

Resources Needed for Effective Care of Patients with Heart Failure in East Hawaii

A multi-stakeholder workgroup met in Hilo on April 8 to discuss how to improve care of patients with heart failure. The workgroup developed a draft plan for how care should be delivered to East Hawaii residents with heart failure from the early stages of the condition through the end of a patient's life. The plan describes how care should be delivered in three areas:

- Ambulatory care for heart failure patients
- Hospital and post-discharge care for heart failure patients who are hospitalized
- Palliative and end-of-life care for heart failure patients

In the limited time available, the workgroup was able to develop a broad outline of the care process, and additional details will need to be added.

Some portions of the plan will require providers to improve scheduling and coordination of existing services, e.g., ensuring that a heart failure patient's primary care provider is contacted when the patient comes to the emergency department or is hospitalized, connecting the patient to a primary care physician if they don't have one, ensuring that the patient has a post-discharge visit with their primary care provider scheduled before discharge, arranging a palliative care consultation for a patient with advanced disease, etc.

However, additional resources will likely be needed for new and expanded services in the following areas:

- **A Primary Care Provider for Each Heart Failure Patient.** Each heart failure patient needs to be connected to a primary care practice that is able and willing to provide evidence-based care. It is not clear whether there are an adequate number of PCPs who are willing and able to take on care of heart failure patients who do not currently have a PCP. Improved payment of PCPs for managing heart failure patients may improve access if PCPs have capacity to take on additional patients, or it may be necessary to create a special heart failure clinic in the community to help patients without a PCP to obtain appropriate care and avoid hospitalization.
- **A Community Heart Failure Clinic for Patients with More Severe Heart Failure or Complex Conditions.** An additional reason for creating a clinic that specializes in heart failure is that it may be able to more effectively manage the care of the heart failure patients who are at greatest risk of hospitalization than a primary care practice that is managing a large and diverse patient panel.
- **Nurse Care Managers Connected to Primary Care Practices to Make Home Visits to Patients After Hospitalizations.** The primary care practices in the community should collectively have one or more appropriately trained Registered Nurses who can visit heart failure patients in their homes at least once immediately following a hospital stay and who can make similar visits to a subset of patients who appear to be at high risk of hospitalization. The role of the nurses is to ensure that the patient understands how to manage their heart failure, when and how to take their medication, how to address any unique challenges in the home, etc. and to help the physician tailor the patient's care plan in a way that will be feasible for the patient to follow and successful in preventing hospitalizations and slowing the progression of the disease. Since individual primary care practices will likely not have enough patients to justify a dedicated nurse, the nurse(s) should be employed by a separate entity, such as the East Hawaii IPA. Wherever the nurses are employed, they must work as an integral part of each primary care practice's team.
- **Telephone and Electronic Consultations Between Physicians.** Currently, cardiologists are not paid for telephone or email consultations to assist PCPs in managing heart failure patients, and hospitalists are not paid to identify and consult with PCPs, which discourages the kinds of communication and coordination that could prevent hospitalizations and readmissions.
- **Palliative Care Services for Patients with Advanced Disease.** Many patients with advanced disease need more intensive support than can be provided by a primary care practice, even those with access to a nurse care manager, but the patient may not qualify for or need traditional hospice care or may not be willing to choose hospice care with the standard restrictions (i.e., forgoing treatment for their condition). Palliative care services for these patients could help to avoid hospitalizations and facilitate a transition to hospice care at the appropriate time.

Using the Additional Resources to Reduce Total Spending on Heart Failure Care

Although *additional resources* are needed in *these specific areas*, this does not imply that *total spending* on care of heart failure patients should increase. If the additional resources are targeted effectively to the patients who are most at risk of emergency department visits, hospitalizations, and hospital readmissions, it is likely that the reductions in utilization of those high cost services will result in a net decrease in overall spending. However, under current healthcare payment systems, it is generally impossible for providers to shift resources from one type of care to another type of care, even if it would result in better outcomes for patients and lower overall costs.

Consequently, the East Hawaii RHIC will need to work with the stakeholders in the community to determine the best way to redirect resources to support better approaches to care delivery. For example,

the providers and a payer such as HMSA could agree on a *condition-based payment for heart failure*, i.e., a risk-adjusted budget to cover the costs of all of the care for the payer's heart failure patients. The providers could use this budget to pay for the enhanced services defined above, but it would also be accountable for ensuring that sufficient savings were achieved from avoided hospital admissions and other services to keep the total costs of care for the patients within the defined budget. When a Community ACO is formed, it could use similar mechanisms for enabling multiple providers to coordinate and target healthcare services for other types of patients who need them and for providing a mechanism by which payers can be assured that paying for new and enhanced services will reduce overall spending.

Next Steps for the EH-RHIC in Improving Heart Failure Care

- The RHIC Steering Committee should ask the workgroup that met on April 8 to serve as a formal Heart Failure Task Force to continue development of the plan for improving the delivery of heart failure care in the community. The RHIC should provide the facilitation support the Task Force needs to do that.
- The RHIC should assemble the necessary data to develop a detailed business case for the proposed changes in care that quantifies both the costs and savings expected.
- The RHIC should request support from the physicians, hospital, and other providers to implement the proposed care changes and develop a consensus on the best way to provide the additional resources needed to support the changes.
- The RHIC should facilitate discussions between the providers and payers to reach agreement on a payment model for supporting implementation of the Task Force's recommendations.

B. Creating a Mechanism for Attracting and Retaining Physicians

The Problems of Attracting and Retaining Physicians in East Hawaii

East Hawaii has a shortage of primary care physicians and also has insufficient local physicians in key specialties. The community has faced significant challenges both in attracting new physicians and retaining existing physicians in the community due to a combination of several factors:

- New physicians entering private practice in East Hawaii must generally start their own practice rather than join an existing practice, and the challenges and startup costs of a new practice make this difficult, expensive, and risky for young physicians. Delays in reimbursement from payers also have a bigger impact on new practices.
- Most practices in East Hawaii are small, which makes it more difficult and expensive for them to purchase and implement expensive new technologies or to hire non-physician staff (such as nurse care managers) who would only provide services to a subset of their patient panels.
- The cost of living in Hawaii is higher than many parts of the country, payments for physician and hospital services are lower than in many other communities, and a high proportion of residents are low income, making it difficult for a practice to maintain positive operating margins and adequate physician compensation.
- The community is small, rural, and isolated from other communities, limiting the ability of specialty physicians to work with colleagues in their own specialties, and thereby making it less attractive as a place for subspecialists to practice.
- Existing physician practices report that the administrative burdens imposed by payers and the associated costs of operating a practice require long hours of work and limit profitability.

Many physicians currently practicing in the community are nearing retirement age and both these physicians and younger physicians are contemplating leaving practice because of these problems. Losses of existing physicians will increase the need for new physicians if these problems are not addressed.

Inadequate access to physicians is exacerbated by factors that reduce the number of patients individual physicians are able to care for. The primary care physicians who are practicing in East Hawaii report that they cannot provide care for as many patients as they would like because of the time they currently have to spend on administrative tasks, such as documentation to support numerous quality measures and submitting authorization requests to payers. Eliminating unnecessary administrative requirements and finding more efficient ways to carry out administrative tasks could not only free up time to see more patients, but could also make practices more profitable and help attract and retain physicians in the community.

Enabling a patient to get appointments with appropriate physicians is necessary but not sufficient; the physicians must also be able to work together effectively to deliver high-quality, coordinated care to the patient. Because physicians no longer routinely interact at the hospital and because the volume of patient visits and administrative work make it difficult for physicians to find time to make phone contacts, effective electronic systems of sharing information are essential. The fact that different physicians use different EHRs and that most EHRs do not easily support information sharing has made it difficult for physicians to share information effectively. The lack of effective methods of health information exchange can also be a deterrent for new physicians to practice in the community.

Priorities for Physician Recruitment and Retention

A multi-stakeholder workgroup met in Hilo on April 8 to discuss how to improve recruitment and retention of physician practices. During the course of the meeting, the group also discussed ways to help physician practices achieve greater efficiency and clinical integration to support the East Hawaii community's overall goal of improving the quality and affordability of care.

The focus for physician recruitment should likely be in three areas:

1. primary care physicians, since there is general agreement that there would be a shortage of PCPs in the community even if current PCPs could see more patients;
2. physicians in broad specialties where there are likely to be a large number of patients in the community; and
3. physicians in subspecialties that the hospital needs to provide adequate coverage for the services that it delivers.

Although it would be desirable from the perspective of residents of East Hawaii to have a wide range of subspecialists in the community, the limited size of the community means that the operating costs for such practices would have to be subsidized and it would likely be difficult to attract high-quality subspecialists if there are not enough patients for them to care for. If the community wants to attract/retain a specialty physician practice that is not sustainable through standard payment mechanisms, the stakeholders in the community will need to agree to make the initial investment and provide the ongoing subsidy that is necessary.

Because of the community's aspirations to redesign care delivery to achieve higher quality and lower costs, existing workforce projections may not accurately indicate the number and types of physicians that the community needs. Consequently, special analyses will likely be needed to determine exactly how many primary care physicians and which types of specialists the community will need. These analyses will need to be based on a clear community vision of how healthcare should be delivered, on accurate information about the specific kinds of services that existing physicians are willing and able to provide, and on realistic expectations about the kind of care local residents will be willing to seek in Hilo versus Honolulu.

Moreover, new approaches to care delivery in the community will not only affect the number and specialties of physicians needed in the community; it will also be important to attract (and retain) physicians who are willing and able to practice in new and more collaborative ways and to take accountability for quality and costs.

Many believe that due to the challenges described earlier, broad-based efforts to recruit new physicians will have limited success, and the strategy that is most likely to be successful is to focus on (1) physicians who are originally from the community and want to return and (2) physicians who are currently training in Hawaii and want to stay. These physicians do not have to be convinced that they want to come to Hilo and practice medicine, they merely need to be convinced that they can succeed if they do practice in Hilo. Moreover, they are more likely to simply want to make an adequate living practicing in a community where they want to live, rather than demanding above-average income in order to practice in a community where they do not want to live.

Although attention has naturally tended to focus on recruiting new physicians, there will obviously be less need for new physicians if the community can be more successful in retaining existing physician practices. Most existing practices in the community are solo or small practices and they are struggling to survive. These existing practices indicate that high overhead costs and the growing administrative burdens of operating a physician practice are making it increasingly difficult to sustain their practices. Particular attention should be paid to the practices that have been started recently by young physicians

who still have significant medical school debt to pay off in addition to their practice expenses; helping these existing young physicians succeed will not only increase the likelihood that they will continue to practice in the community, but it will also help in efforts to attract additional new physicians.

Experience in other communities has shown that if administrative and payment barriers can be removed in ways that restore the joy of practicing medicine, some physicians will delay their retirements, thereby reducing the gap that needs to be filled with new physicians. It is inevitable, however, that existing physicians will want to retire at some point, and the community needs to plan ahead for these retirements, rather than waiting to recruit new physicians until after retirements have occurred. New physicians may be better able to succeed and to achieve success more quickly by taking over an existing physician's panel of patients with guidance from that physician, rather than forcing the patients to find new physicians and forcing the new physician to attract new patients.

The most immediate priority should be to ensure that when the members of the Hilo Medical Center Residency Program graduate in 2016, they can find at least one practice or employment arrangement in the community that is structured in a way that is attractive to them.

Practice Structures Needed for New Physicians

Nationally, many new physicians have indicated that they would prefer salaried/employment arrangements rather to practice independently. Until recently, the Hilo Medical Center was the only entity in East Hawaii offering employment arrangements, and in recent years, it has served as the primary mechanism for employing new physicians in the community. However, experience nationally indicates that physicians in private practice are more productive than those who work for hospitals. The Hilo Medical Center has indicated that it would prefer that new physicians be employed by community physician practices rather than be employees of the hospital whenever possible.

A promising approach is for existing physician practices in East Hawaii to bring new physicians into their practice, either as employees or as partners. For example, the East Hawaii Medical Clinic was formed by several physicians in the community as way of employing new primary care providers, and Big Island Medical Associates has been formed to ensure long-term continuity of some existing East Hawaii practices. However, the East Hawaii Medical Clinic has struggled to be successful financially during the startup phase, and so financial assistance will likely be needed by physician groups that want to employ new physicians in order for them to do so successfully.

Some new physicians will want to practice independently rather than be employed or be part of an existing practice. The primary care physicians who have started new independent practices in East Hawaii in recent years report that they have struggled to succeed, and so it will be difficult to expect new physicians to pursue the same path unless additional support is available. In addition, some physicians may only want to practice part-time, and the community should also be willing to support them if they can fill a gap in services.

Support Needed by Physician Practices

There are seven major ways that the East Hawaii community could help improve the ability of both existing and new physician practices to succeed:

- **Reducing Overhead Costs for Physician Practices.** It can be inefficient for small physician practices to try and manage the many administrative aspects of a physician practice on their own. Either the physician ends up spending too much time doing administrative work, which reduces his or her ability to care for patients, or if staff is hired to perform those functions, the costs of these staff significantly increase the overhead in the practice. In addition, it is inefficient for each practice to independently try to understand and comply with the many regulations and payer rules

they face. Consequently, it would be desirable if there were easy ways for practices in East Hawaii to share these administrative costs and responsibilities. This would give physician practices and the community the benefits that are associated with larger group practices and health systems while retaining the benefits of small, entrepreneurial practices. In addition, the administrative requirements should be simplified or restructured so they are less burdensome.

- **Enabling Multiple Practices to Share Services.** Some of the services that patients need cannot cost-effectively be delivered by individual small practices, but they can be delivered cost-effectively if several practices share those services. For example, using nurse care managers to provide education and self-management support to chronic disease patients can significantly reduce the likelihood of expensive hospitalizations. No individual physician has enough chronic disease patients to support hiring a nurse, but several practices could jointly share a nurse to support care for all of their patients. As with shared administrative supports, shared clinical services would give physician practices and the community the benefits that are associated with larger group practices and health systems while retaining the benefits of small, entrepreneurial practices.
- **Supporting Information Sharing for Clinical Integration.** An important special case of both overhead cost reduction and shared services is health information technology. It is more expensive for individual physician practices to independently purchase and maintain an Electronic Health Record (EHR) system than it is for large group practices to do so, and having multiple EHRs makes it more difficult for physicians to share information. Consequently, it would be desirable to have ways for physician practices to jointly purchase and support a common EHR system, and it would also be desirable to have effective ways for physician practices to share information electronically regardless of which EHR system they are using.
- **Reducing Startup Costs and Bridging Cash Flow Gaps for New Physicians.** Both a new physician practice and an existing practice hiring a new physician will need to incur significant expenses for space, equipment, staff, insurance, and a variety of other costs immediately, but it will take time for the physician to build up a patient panel, so the practice will experience losses initially and inadequate income for an additional period of time. Consequently, there will need to be ways to ensure that physician practices in East Hawaii can obtain adequate capital (i.e., equity capital and affordable loans) to cover cash flow needs during this startup period.
- **Ensuring Availability of Employment Options for Physicians Who Want Them.** It seems likely that some physicians will only be willing to practice in East Hawaii if they can do so in an employment arrangement. Consequently, a proactive effort should be made to ensure such arrangements are available when needed, in addition to efforts to reduce overhead costs and startup costs for employing new physicians.
- **Supporting Joint Problem-Solving and Mentoring.** New physician practices will likely experience problems or challenges that experienced physicians could help them solve more quickly and successfully than they could on their own. In addition, both new and established physician practices will experience challenges in implementing new regulations, new approaches to care delivery, new payment systems, etc. and it would be more efficient for them to develop solutions to these problems jointly rather than duplicating efforts. Consequently, facilitating connections among practices for mentoring and joint problem-solving could help make all practices more successful.
- **Reforming Payment Systems.** The current fee-for-service structure does not adequately support current approaches to delivering care, and it is even less well-suited to make new approaches to care delivery financially viable. Consequently, the community needs to encourage HMSA and other payers to pay physician practices in ways that make high-quality, coordinated care

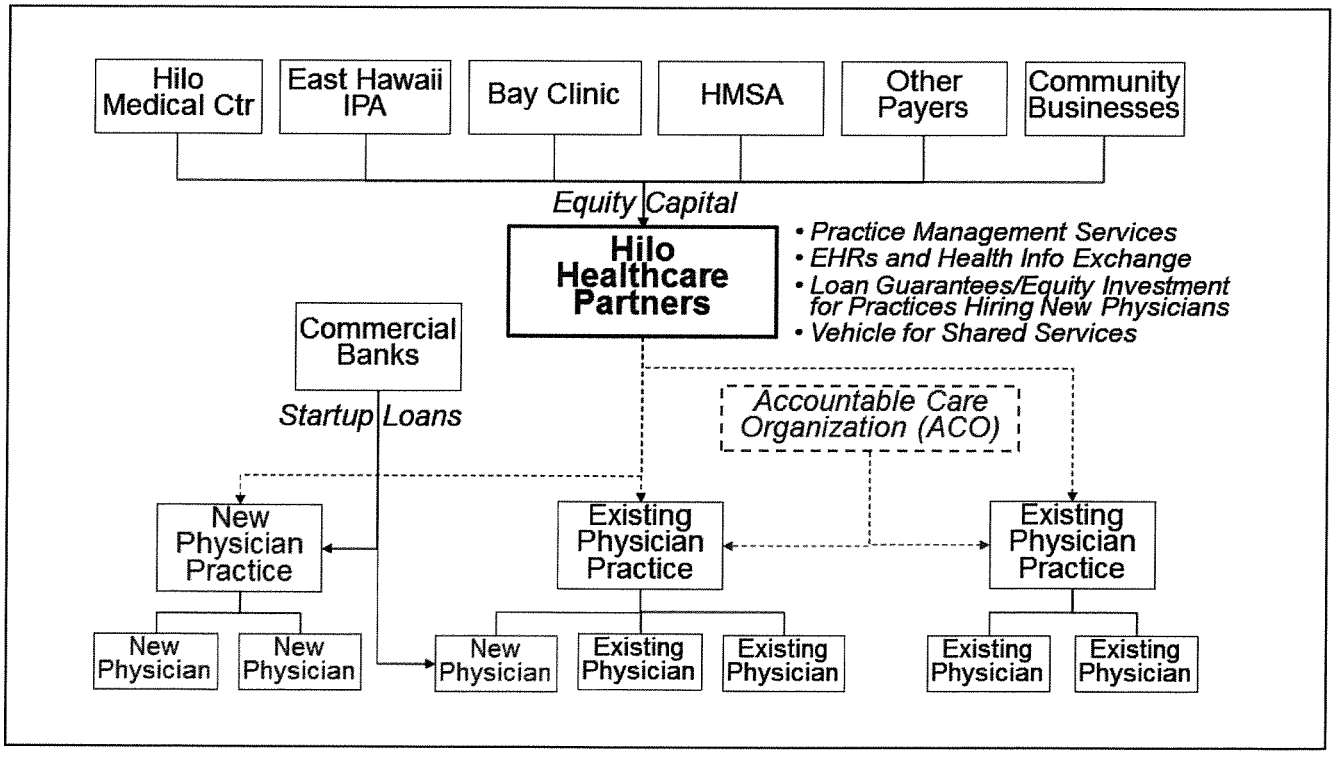
financially viable. Physician practices will then need assistance in transitioning their billing systems, information systems, and methods of delivering care to function efficiently and effectively under the new payment systems.

Creating a Physician Support Services Organization

An organizational mechanism is needed in Hilo to deliver specific types of services to physician practices that want support in the areas described above. The organization will need enough scale to be able to deliver services efficiently, and it will need enough capital to support these services during the startup phase.

The most appropriate organizational mechanism would be to create a new non-profit corporation – Hilo Healthcare Partners – that would provide four categories of services:

- **Practice Management Services.** Hilo Healthcare Partners could offer a menu of practice management services to physician practices in East Hawaii that are designed to help reduce operating costs for the practices and enable the practices to be more successful in carrying out the administrative responsibilities of a physician practice.
- **Electronic Health Records and Health Information Exchange.** Hilo Healthcare Partners could make a common Electronic Health Record system available to physician practices and also provide the software or systems needed to support exchange of information among practices about individual patients from different EHR systems.
- **Shared Patient Care Services.** In cases in which multiple physician practices need similar staff or equipment but do not have a sufficient volume of patients or revenues to justify hiring the staff or purchasing the equipment for their exclusive use, Hilo Healthcare Partners could employ the individual or purchase the equipment and lease the services back to the individual practices.
- **Financial Support for Hiring New Physicians.** Hilo Healthcare Partners could partner with local banks to ensure that physicians wishing to start a new practice or existing practices wishing to recruit a new physician can obtain the necessary financial support to do so. Hilo Healthcare



Partners would not employ physicians directly, but could invest in either new or existing physician practices that would employ physicians.

All of these services would be provided in return for fees from physician practices. The fees would need to be sufficient to cover Hilo Healthcare Partners' costs of providing the services, but the fees would also need to be lower than what it would cost practices to carry out the functions themselves or to purchase similar services from for-profit consultants.

In order to begin providing these services, Hilo Healthcare Partners (HHP) would need startup capital. Because HHP would be selling services to practices and making investments or loans, not grants, it would be able to generate a return on this capital and ultimately repay it.

An ideal approach would be for the major stakeholders in the community – the physicians, the hospital, the payers, and the business community – to serve as the owners of Hilo Healthcare Partners, contributing capital to the corporation and retrieving that capital over time through the returns generated on the services HHP provides. This could allow the rate of return to be kept at a modest level so that services and financing could be provided to physician practices at a more affordable cost. The Surgery Center and East Hawaii Medical Associates are existing example of stakeholders jointly investing to provide new and expanded services in the community, and the planning for HHP should draw on the lessons from these experiences.

In some cases, it may be infeasible or undesirable to recover the total cost of services and financing through fees from practices, and so Hilo Healthcare Partners may also need some funding that it can use to subsidize these services. Since all the stakeholders would benefit if HHP can improve the success of physician practices and help attract new physicians to East Hawaii, it makes sense for all of the stakeholders to share in both the capital investment and subsidies:

- The employers and residents in the community need access to an adequate number of high quality physicians who work together in a coordinated way, and an adequate number of primary care physicians in order to improve health and reduce avoidable costs.
- The Hilo Medical Center needs to have physicians in appropriate specialties to support the services that it delivers.
- The members of the East Hawaii IPA need support services beyond what the IPA can currently provide.
- HMSA, which has made considerable investments in bringing new physicians to Hawaii, needs effective mechanisms for ensuring those physicians stay and succeed.

Beyond providing the capital needed by HHP, it will also be important for all of the stakeholders to be involved in the governance of HHP in order to ensure that its services complement and do not conflict or compete with other services in the community. For example, if HHP provides support for employing a new physician, this should not be done in a way which creates unfair competition with existing physicians in the community.

Complementary Roles for HHP, the RHIC, and a Community ACO

Hilo Healthcare Partners would complement the work of both the East Hawaii Regional Health Improvement Collaborative (EH-RHIC) and a Community Accountable Care Organization (ACO):

- The role of the Regional Health Improvement Collaborative should be to provide neutral facilitation of discussions among all stakeholders in order to develop an overall strategy for improving the quality and controlling the costs of healthcare in the community and to monitor progress in achieving the community's goals. The RHIC should not be in the business of selling management services to

practices or investing in new physician startups, and it should be able to independently assess whether Hilo Healthcare Partners is successfully addressing the needs of physician practices and filling gaps. The RHIC could support HHP by carrying out independent analyses of how many and which types of physicians are needed as the care delivery model in the community evolves.

- The role of an ACO should be develop specific plans for changing care delivery and accepting and distributing payments to providers for delivering care. An ACO will be more successful if Hilo Healthcare Partners can help individual practices to become more efficient and effective, but physician practices should not feel compelled to join an ACO in order to receive support from HHP. It is also possible that more than one ACO could be created in the community, and HHP would be able to provide services to practices regardless of which ACO they are participating in.

Next Steps for the EH-RHIC in Supporting Physician Recruitment and Retention

- The RHIC should ask the participants at the April 8 meeting to serve as a Physician Practice Support Task Force and to develop a detailed business plan for Hilo Healthcare Partners.
- The Physician Practice Task Force should contact organizations in other states and communities that are providing services similar to what is envisioned for Hilo Healthcare Partners in order to learn from their experience.
- Leaders from the RHIC should meet with the physicians in the Hilo Medical Center Residency Program to encourage them to stay in the community after graduation and determine what kinds of practice arrangements they would prefer; then it should identify existing physician practices willing to help create those practice arrangements and determine what assistance they would need to do so.
- The RHIC should work with the Physician Practice Support Task Force to prioritize the number and specialties of physicians that the community should be working to attract and retain, including estimating how the capacity of existing PCPs could be increased through practice redesign and payment reform.
- The RHIC should survey physicians in the community to identify administrative burdens they are facing and encourage changes to be made in the requirements causing those burdens.

V. POTENTIAL FUTURE PRIORITIES

Although choosing a small number of priorities initially will help to ensure early successes, it will be important for the Regional Health Improvement Collaborative and a Community Accountable Care Organization to pursue additional opportunities over time so that improvements can be made on a broader range of patient needs, so that a bigger impact can be made in reducing and controlling healthcare costs and insurance premiums, and so that the financial challenges facing physicians and hospitals can be more comprehensively addressed. During the course of planning discussions regarding the East Hawaii Regional Health Improvement Collaborative and Community Accountable Care Organization, a number of other potential priorities were identified that could be considered for implementation in future years, including:

Reducing Deaths from Strokes and Heart Attacks Among East Hawaii Residents

Potential initiatives to pursue this priority could include:

- **Screen residents to identify those at risk of stroke and heart attack.** A community-wide effort could be organized to identify patients who are overweight, have uncontrolled hypertension, have uncontrolled diabetes, or other factors that put them at high risk of stroke and/or heart attack and encourage them to take the necessary actions to reduce their risk factors.
- **Create a focused program to help high-risk patients reduce risk factors.** A coordinated effort by PCPs, cardiologists, endocrinologists, Community First, the East Hawaii Blue Zone, and others could be organized to help a group of willing patients at high risk of stroke or heart attack to lose weight, control their blood pressure, etc.
- **Ensure rapid, effective treatment of individuals with symptoms of stroke or heart attack.** Community residents could be educated about how to recognize the symptoms of stroke and heart attack and what to do if they have such symptoms, and the Hilo Medical Center could be given the resources necessary to respond quickly and effectively when residents have such symptoms.

Reducing Delays and Need to Travel to Obtain High-Quality Healthcare Services

Potential initiatives to pursue this priority could include:

- **Provide tele-consults with specialists through primary care practices.** Patients could "see" a specialist, including a specialist on another island, through a phone or email consultation between their PCP and the specialist. This would encourage patients to use their PCPs, enable specialists to assist more patients more quickly, and enable patients to have their problems addressed more quickly and at lower cost.
- **Encourage use of East Hawaii services with available capacity.** If the Hilo Medical Center or other providers in East Hawaii has the capacity to deliver services that patients are currently going to Honolulu to receive, residents could be encouraged to use the services available in Hilo.
- **Invest in additional capacity or improved services in East Hawaii for tests and procedures currently received on other islands.** If patients are currently going to Honolulu for services that the Hilo Medical Center or other East Hawaii providers cannot currently provide, investments could be made to strengthen service capacity in Hilo.

Reducing Unnecessary Testing and Unnecessarily Expensive Testing

Potential initiatives to pursue this priority could include:

- **Implement American College of Cardiology appropriate use criteria for stress testing.** Primary care physicians could be encouraged to use the American College of Cardiology's

appropriate use criteria when ordering stress tests for stable angina and to consult with a cardiologist in cases where appropriateness is uncertain.

- **Implement Choosing Wisely criteria for other testing.** All physicians in East Hawaii could be encouraged to utilize the Choosing Wisely criteria adopted by their specialty society and to measure their performance in adhering to the criteria.

Improving Maternity Care

Potential initiatives to pursue this priority could include:

- **Reducing the use of Cesarean Sections for low risk pregnancies.** Women and their physicians could be encouraged to avoid C-Sections whenever possible in order to improve outcomes for both mothers and babies.
- **Improving teenage pregnancy outcomes**. Better education and prenatal care could be provided to teenage mothers to reduce the number of low birthweight babies and infant deaths.

APPENDIX: How This Report Was Developed

In the summer of 2014, the East Hawaii IPA, the Hilo Medical Center, and HMSA entered into a unique partnership to plan for a new approach to delivering and paying for healthcare services in East Hawaii.

The three organizations jointly contracted with the Center for Healthcare Quality and Payment Reform (CHQPR) to help them develop a plan for creating a Community Accountable Care Organization in East Hawaii.

A Steering Committee was formed to guide this effort consisting of the following individuals:

- Money Atwal
- John Baleix
- Dan Brinkman
- Randy Kurohara
- Richard Lee-Ching
- Peter Matsuura
- Paul Schnur
- Toby Taniguchi

In addition, Katy Akimoto, Kevin Kurohara, and Elisa Yadao participated in some of the Steering Committee discussions.

Over the course of six months, Harold Miller, President of CHQPR, met with the Steering Committee to obtain their input on how a plan should be structured, met with a wide range of stakeholders in the community in March and April 2015 to obtain their input on priorities and their feedback on draft recommendations, and facilitated in-depth discussions by stakeholders in the community about the specific initiatives needed in the major priority areas. Staff support for this extensive effort was provided by Mike Sayama, Susan Mochizuki, Melissa Oshiro, and Brandon Kobashigawa from Pono Health.

This report summarizes the findings and recommendations from these discussions.

Appendix B

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

Version 1.0 April 2015

REDESIGNING CARE AND PAYMENT FOR PATIENTS WITH HEART FAILURE

CONTENTS

I. Designing Improved Services for Patients With Heart Failure

Assume that the healthcare providers in a hypothetical community have decided to examine the way they are delivering care to the patients in the community who have heart failure to determine how care could be improved.

A. Identifying the Problems With Care Delivery Today

The providers start by summarizing the way care is delivered today. They might find that:

- The primary care physicians see the patients frequently – 4 times per year – but they do not have enough time during the visits to provide extensive education to the patients.
- As a result, the patients do not manage their condition effectively and they do not reliably take their medication, and half of the patients experience an exacerbation during the year that is sufficiently severe to require hospitalization.
- In most cases, the only involvement the cardiologists have with the patients is when they are hospitalized.
- After the patients are discharged from the hospital, the cycle begins again.
- For patients with advanced disease, the rate of hospitalizations increases. Few patients are willing to choose hospice care and in many cases their physicians are uncomfortable trying to predict how long they will live.
- Ultimately, the patients die in the hospital, even though they would have preferred to have spent their final days at home.

B. Designing Improvements in Care

The providers agree this is unacceptably fragmented, poor quality, and unnecessarily expensive care, and after discussion, they feel that the following changes are needed:

- There should be one or more nurse care managers working with the primary care and cardiology practices in order to provide several types of services for heart failure patients that the physicians are not able to deliver today:
  - intensive education for patients about their condition and how to manage it effectively;
  - proactive contacts with the patients, including home visits, to verify that they are taking their medications and following other aspects of their treatment plan, particularly after a discharge from the hospital.
  - immediate availability for phone calls from patients who are experiencing the early signs of exacerbations, such as fluid buildup or shortness of breath, in order to adjust medications or take other actions to prevent problems from worsening.
- The primary care physicians and cardiologists should communicate with each other more frequently by telephone and email to discuss how to manage patients who are experiencing difficulties. They also should work closely with the nurse(s) to customize treatment plans for patient needs and respond quickly when patients have problems.
- The patients with advanced heart failure should be enrolled in a palliative care program that can begin helping the patients address their symptoms while they are still being treated and provide a more seamless transition to hospice care.

II. Identifying the Payment Barriers to Improving Care

However, the providers also identify four barriers in current payment systems that make it infeasible to implement the proposed changes in care without a change in payment. The barriers are:

- Medicare and health plans do not pay for nurses to provide the proposed services. If the physician practices hired nurse care managers to deliver these services, expenses for the physician practices would increase without revenues to cover them, even though the payer would save money on avoided hospitalizations.
- The primary care physicians and cardiologists will not be paid for the additional time they need to spend in telephone and email consultations with each other to discuss how to manage patients who are experiencing difficulties, and they will not be paid for extra time they spend working with nurses to address patient problems outside of office visits. The additional time physicians spend on these services will reduce the available time for seeing patients in the office, which in turn will reduce revenues for the practice since the only way the practice can be paid is if the physician sees patients in the office.
- Medicare and health plans do not pay for palliative care services except when patients enroll in hospice, and hospice eligibility requires physicians to determine that the patient has 6 months or less to live and requires the patient to forego coverage for treatment of their condition in order to obtain access to palliative care.
- If the improved services were implemented, they would be expected to reduce the frequency with which heart failure patients have emergency department visits and hospital admissions related to their condition. However, the result would be a reduction in revenues to the hospital in the community, and the loss of revenue would be greater than the hospital's costs would decrease, thereby threatening the hospital's already low operating margins.

III. Developing the Business Case for Reform

In order to convince payers to make changes in payment, the providers develop a business case analysis which projects that if their proposed new approach to care is implemented, the total cost of care for their patients will be lower than it is today.

A. Current Spending for Heart Failure Patients

The providers determine that there are currently 500 patients with moderate-to-severe heart failure in the community who are being cared for by a number of different primary care practices and several cardiologists. Figure 1 shows their estimates of current spending for these types of patients, assuming that:

1. the PCPs are paid $100 for each office visit with a heart failure patient (round numbers are used for simplicity);
2. the cardiologists only see the patients when they are hospitalized and they are paid $100 for four visits with each patient during their hospitalization;
3. the hospital is paid $10,000 for each admission.

A total of $2.8 million is being spent on the care of the 500 patients during the course of the year, or an average of $5,600 per patient ($467 PMPM).

FIGURE 1

	CURRENT			
	Payment Per Visit	Visits Per Patient	Patients	Total
Physician Services				
PCP	$100	4	500	$200,000
Specialist	$100	4	250	$100,000
Subtotal			500	$300,000
Hospital Care	$10,000		250	$2,500,000
Total Revenue/Pmt	*$5,600*		500	$2,800,000

B. The Business Case for Better Payments to the Physicians

The PCPs and the cardiologists want payments that would not be limited to office visits, that would cover the time they spend working together to jointly manage the patient's care, and that give them the ability to hire a nurse or other staff who could provide education and self-management support for the patient. This might be accomplished by paying the PCP and specialist on a per patient basis for each of the patients, rather than paying them on a per-visit basis, and also providing them with enough money to hire a nurse care manager.

Figure 2 gives an example in which the PCPs are paid $50 per patient per month ($600 per patient per year) regardless of how many office visits they have with the patients, the cardiologists are paid $25 per patient per month or $300 per patient per year (the payment is made for all of the patients, not just those who are hospitalized), and the physicians jointly receive $80,000 to hire a nurse to work with the patients. This would be a 50% increase in payments to each of the physicians, and a total increase of 77% in spending on care by the physicians and nurse over what is being spent today.

Is this affordable? The physicians feel that by redesigning care in the way they have planned, they will be able to reduce the rate of hospital admissions by one-third. As shown in Figure 2, they calculate that the resulting savings on hospitalizations would more than pay for the increased payments for the physicians and the nurse.

FIGURE 2

	CURRENT				FUTURE			
	Payment Per Visit	Visits Per Patient	Patients	Total	Payment Per Patient	Patients	Total	Change
Ambulatory Care								
PCP	$100	4	500	$200,000	$600	500	$300,000	50%
Specialist	$100	4	250	$100,000	$300	500	$150,000	50%
RN Care Manager							$80,000	
Subtotal			500	$300,000		500	$530,000	77%
Hospital Care	$10,000		250	$2,500,000		165	$1,650,000	-34%
Total Revenue/Pmt	*$5,600*		500	$2,800,000		500	$2,180,000	-22%

C. The Business Case for Adjusting Payments to the Hospital

Reducing admissions for these patients by 34% would reduce the hospital's revenues for these patients by the same percentage, representing an $850,000 loss in revenue. If one assumes that 60% of the hospital's current revenues are used to cover fixed costs that won't change in the short run with fewer patients, Figure 3 shows that the improved chronic disease management would create a nearly half-million dollar reduction in the hospital's operating margin. The hospital would now be losing money for taking care of the 165 patients who still need to be hospitalized.

FIGURE 3

	CURRENT				FUTURE			
	Payment Per Visit	Visits Per Patient	Patients	Total	Payment Per Patient	Patients	Total	Change
Ambulatory Care								
PCP	$100	4	500	$200,000	$600	500	$300,000	50%
Specialist	$100	4	250	$100,000	$300	500	$150,000	50%
RN Care Manager							$80,000	
Subtotal			500	$300,000		500	$530,000	77%
Hospital Care								
Fixed Costs	$6,000	*60%*		$1,500,000			$1,500,000	0%
Variable Costs	$3,700	*37%*		$925,000	$3,700		$610,500	-34%
Margin	$300	*3%*		$75,000			($460,500)	-714%
Subtotal	$10,000	100%	250	$2,500,000	$10,000	165	$1,650,000	-34%
Total Revenue/Pmt	*$5,600*		500	$2,800,000		500	$2,180,000	-22%

A win-win-win solution can be developed, however. A 34% reduction in admissions would cause the hospital's variable costs to decrease by $314,500, which is more than the $230,000 increase in payments to the physicians, meaning that total spending could still be reduced by $80,000 (3%) without harming the hospital's margin and potentially even improving it. Figure 4 shows that if the physicians and hospital committed to reduce total spending by 3% below the average of $5,600 per patient the payer is spending now, they would have sufficient resources to provide improved ambulatory care to the patients and improve the hospital's operating margin, while still reducing spending for the health plan by 3%.

FIGURE 4

	CURRENT				FUTURE			
	Payment Per Visit	Visits Per Patient	Patients	Total	Payment Per Patient	Patients	Total	Change
Ambulatory Care								
PCP	$100	4	500	$200,000			$300,000	50%
Specialist	$100	4	250	$100,000			$150,000	50%
RN Care Manager							$80,000	
Subtotal			500	$300,000	*$1,060*	500	$530,000	77%
Hospital Care								
Fixed Costs	$6,000	*60%*		$1,500,000			$1,500,000	0%
Variable Costs	$3,700	*37%*		$925,000	$3,700	165	$610,500	-34%
Margin	$300	*3%*		$75,000			$78,750	5%
Subtotal	$10,000	100%	250	$2,500,000	*$13,268*	165	$2,189,250	-12%
Total Revenue/Pmt	*$5,600*		500	$2,800,000	$5,438.50	500	$2,719,250	-3%

If the physicians agreed to reduce the overall cost of care by 3% but failed to reduce hospital admissions by the goal of 34%, the hospital costs would be higher than projected, but the "risk" associated with this is not the $10,000 payment the hospital currently receives per admission, but the smaller marginal (variable) cost of an additional admission. As shown in Figure 5, if the number of admissions was 10% higher than planned (i.e., only a 27% reduction instead of a 34% reduction), the hospital's margin would be lower, but still positive. If the number of admissions was reduced even more than the goal, the hospital's margin would increase.

FIGURE 5

	PROJECTED BUDGET			MORE ADMISSIONS				FEWER ADMISSIONS			
	Payment Per Patient	Patients	Total	Payment Per Patient	Patients	Total	Change	Payment Per Patient	Patients	Total	Change
Ambulatory Care											
PCP			$300,000			$300,000	0%			$300,000	0%
Specialist			$150,000			$150,000	0%			$150,000	0%
RN Care Manager			$80,000			$80,000				$0	
Subtotal	*$1,060*	500	$530,000	*$1,060*	500	$530,000	0%	*$1,060*	500	$530,000	0%
Hospital Care											
Fixed Costs			$1,500,000			$1,500,000	0%			$1,500,000	0%
Variable Costs	$3,700	165	$610,500	$3,700	182	$673,400	10%	$3,700	149	$551,300	-10%
Margin			$78,750			$15,850	-80%			$137,950	75%
Subtotal		165	$2,189,250		182	$2,189,250	0%		149	$2,189,250	0%
Total Revenue/Pmt		500	$2,719,250	$0	500	$2,719,250	0%	$0	500	$2,719,250	0%

D. Why "Shared Savings" May Not Address the Payment Barriers

Under a "shared savings" payment model, there would be no upfront money to hire the nurse care manager or to pay the physicians more flexibly. Moreover, if the physicians invested the money to hire the nurse care manager themselves and were able to reduce admissions to the hospital significantly, a 50% shared savings payment would not be adequate to cover both the hospital's costs (since 60% of the hospital's costs are fixed) and provide increased payments to the physicians. For example, Figure 6 shows that even if only enough of the shared savings payment was allocated to the physicians to cover the cost of the nurse care manager and to offset the loss in revenue to the specialist, but not to provide any increase in payments to the primary care physician or specialist, the remainder of the shared savings payment would still not be sufficient to cover the hospital's costs for the remaining admissions.

FIGURE 6

	CURRENT				SHARED SAVINGS YEAR 1			SHARED SAVINGS YEAR 2		
	Payment Per Visit	Visits Per Patient	Patients	Total	Patients	Total	Change From Year 0	Patients	Total	Change From Year 0
Ambulatory Care										
PCP	$100	4	500	$200,000	500	$200,000	0%	500	$200,000	0%
Specialist	$100	4	250	$100,000	165	$66,000	-34%	165	$66,000	-34%
Shared Savings				$0		$0			$114,000	
Revenue				$300,000		$266,000	-11%		$380,000	27%
RN Care Manager				$0		($80,000)			($80,000)	
Net Revenue			500	$300,000	500	$186,000	-38%	500	$300,000	0%
Hospital Care										
Fixed Costs	$6,000	*60%*		$1,500,000		$1,500,000	0%		$1,500,000	0%
Variable Costs	$3,700	*37%*		$925,000		$610,500	-34%		$610,500	-34%
Margin	$300	*3%*		$75,000		($460,500)	-714%		($460,500)	-714%
Revenue	$10,000	100%	250	$2,500,000	165	$1,650,000	-34%	165	$1,650,000	-34%
Shared Savings				$0		$0			$328,000	
Total Revenue				$2,500,000		$1,650,000	-34%		$1,978,000	-21%
Margin + Shared Svgs				$75,000	165	($460,500)	-714%	165	($132,500)	-277%
Total Revenue/Pmt	*$5,600*		500	$2,800,000	500	$1,916,000	-32%	500	$1,916,000	-32%
Savings from Year 0						$884,000			$884,000	
Shared Savings Payment						($442,000)			($442,000)	
Net Savings						$442,000			$442,000	

E. The Business Case for Expanding Palliative Care

The previous calculations assume that all patients are "average," have an equal risk of being hospitalized, and can all benefit from the same type of services. However, the providers know that there is a subset of patients with advanced heart failure who need much more than proactive management from their physicians and support from a nurse care manager. They need intensive palliative care support in their homes, and the lack of that support is leading those patients to be hospitalized frequently. Figure 7 shows a subset of 100 patients who are hospitalized at a much higher rate than average. Payers incur not only the costs of hospitalization, but most patients also have a skilled nursing facility stay after discharge unless they have died in the hospital.

FIGURE 7

	CURRENT			
	Payment Per Visit	Visits Per Patient	Patients	Total
Ambulatory Care				
PCP	$100	4	100	$40,000
Palliative Care Phys.				$0
Palliative Care Team				
Subtotal			100	$40,000
Hospital Care	$10,000		80	$800,000
SNF Care	$15,000		60	$900,000
Total Revenue/Pmt	*$17,400*		100	$1,740,000

It would be better for the patients if the money being spent on hospitalizations and skilled nursing facility visits could be spent instead on helping them remain in their own homes and to die at home rather than in a hospital or nursing home. Figure 8 demonstrates that if a palliative care physician and palliative care team could reduce hospitalizations by 40%, it could pay for a significant amount of palliative care support ($50/patient/month for the palliative care physician and $350/patient/month for the palliative care team, for a total of $400 per patient per month in palliative care support) in addition to the improved payment for the primary care physicians, and still reduce total spending for the payer by 10%.

FIGURE 8

	CURRENT				FUTURE			
	Payment Per Visit	Visits Per Patient	Patients	Total	Payment Per Patient	Patients	Total	Change
Ambulatory Care								
PCP	$100	4	100	$40,000	$600	100	$60,000	50%
Palliative Care Phys.				$0	$600	100	$60,000	
Palliative Care Team					$4,200	100	$420,000	
Subtotal			100	$40,000		100	$540,000	1250%
Hospital Care	$10,000		80	$800,000	$10,000	48	$480,000	-40%
SNF Care	$15,000		60	$900,000	$15,000	36	$540,000	-40%
Total Revenue/Pmt	*$17,400*		100	$1,740,000		100	$1,560,000	-10%

What about the hospital? The same kind of payment redesign described earlier could be considered here, but in this case, there is a good chance that the hospital's costs of caring for these patients exceeds the payment the hospital is currently receiving, since the patients may spend many days in the intensive care unit or die there. Figure 9 shows that if the hospital is currently losing money on these patients, a reduction in admissions may be financially desirable for the hospital.

FIGURE 9

	CURRENT				FUTURE			
	Payment Per Visit	Visits Per Patient	Patients	Total	Payment Per Patient	Patients	Total	Change
Ambulatory Care								
PCP	$100	4	100	$40,000	$600	100	$60,000	50%
Palliative Care Phys.				$0	$600	100	$60,000	
Palliative Care Team					$4,200	100	$420,000	
Subtotal			100	$40,000		100	$540,000	1250%
Hospital Care								
Hospital Cost	$15,000		80	$1,200,000	$15,000	48	$720,000	
Margin	($5,000)			($400,000)	($5,000)		($240,000)	-40%
Payment	$10,000		80	$800,000	$10,000	48	$480,000	
SNF Care	$15,000		60	$900,000	$15,000	36	$540,000	-40%
Total Revenue/Pmt	*$17,400*		100	$1,740,000		100	$1,560,000	-10%

F. Risk-Stratifying Services

In any population of patients, there will be some patients who are at higher risk of hospitalizations and other adverse events, and some who are at lower risk. Figure 10 shows that among the 500 patients in this hypothetical community, 50 have a very high rate of hospitalization (1.2 admissions per patient per year on average), 100 have a moderate risk (0.8 admissions per patient per year), and the remaining 350 have a lower risk (0.3 admissions per year).

FIGURE 10

	CURRENT			
	$/Admit	Admits/ Patient	# Patients	Total $
High Risk Patients				
Hospital and SNF	$21,250	1.2	50	$1,275,000
Medium Risk Patients				
Hospital and SNF	$21,250	0.8	100	$1,700,000
Low Risk Patients				
Hospital and SNF	$21,250	0.3	350	$2,231,250
TOTAL – ALL PATIENTS				
Hospital and SNF		0.5	500	$5,206,250

It would not be cost-effective to provide intensive palliative care support to the patients who are relatively healthy and who are hospitalized infrequently. Conversely, a single nurse care manager cannot provide the kind of home support that patients in the advanced stages of heart failure need. Consequently, both sets of services are needed, but they must be targeted appropriately based on patient needs in order to ensure that the improved services are not only better for the patients, but that they reduce overall costs rather than increasing spending.

Figure 11 illustrates how this type of targeting can be factored into the business case analysis. For the highest risk patients, intensive palliative care services are used, and a palliative care specialist takes the lead in designing and supervising the patient's care, working in collaboration with the primary care physician and cardiologist. For the lowest risk patients, the PCP and cardiologist manage the patient's care with support from a nurse care manager. For medium risk patients, the cardiologist may take the lead role, working with the PCP and introducing palliative care services to the patient at the appropriate time.

FIGURE 11

	CURRENT				FUTURE					
	$/Visit	Visits/ Patient	# Patients	Total $	$/Patient	$/Visit	Visits/ Patient	# Patients	Total $	Chg
High Risk Patients										
PCP	$100	4	50	$20,000	$600			50	$30,000	
Cardiologist	$100	5	50	$24,000	$200			50	$10,000	
Palliative Care Specialist				$0	$600			50	$30,000	
RN Care Manager				$0						
Palliative Care Team			0	$0	$7,200			50	$360,000	
Hospital and SNF	$21,250	1.2	50	$1,275,000		$21,250	0.72	50	$765,000	-40%
Total	$26,380		50	$1,319,000	$23,900			50	$1,195,000	-9%
Medium Risk Patients										
PCP	$100	4	100	$40,000	$600			100	$60,000	
Cardiologist	$100	3	100	$32,000	$600			100	$60,000	
Palliative Care Specialist					$600			100	$60,000	
RN Care Manager				$0	$400			100	$40,000	
Palliative Care			0	$0	$3,600			100	$360,000	
Hospital and SNF	$21,250	0.8	100	$1,700,000		$21,250	0.48	100	$1,020,000	-40%
Total	$17,720		100	$1,772,000	$16,000			100	$1,600,000	-10%
Low Risk Patients										
PCP	$100	4	350	$140,000	$600			350	$210,000	
Cardiologist	$100	1	350	$42,000	$300			350	$105,000	
RN Care Manager				$0	$120			350	$42,000	
Palliative Care Team			0	$0	$0				$0	
Hospital and SNF	$21,250	0.3	350	$2,231,250		$21,250	0.18	350	$1,338,750	-40%
Total	$6,895		350	$2,413,250	$4,845			350	$1,695,750	-30%
TOTAL -- ALL PATIENTS										
PCP				$200,000					$300,000	50%
Cardiologist				$98,000					$175,000	79%
Palliative Care Specialist				$0					$90,000	
RN Care Manager				$0					$82,000	
Palliative Care Team				$0					$720,000	
Hospital and SNF		0.5	500	$5,206,250			0.3	500	$3,123,750	-40%
Total Spending			500	$5,504,250				500	$4,490,750	-18%

IV. Designing a Payment System to Support Improved Care

A. Four Different Approaches to Support Changes in Care

The business case analysis shows that it is possible to deliver better care at lower cost, but only if the barriers in the current payment system are removed. Table 1 shows four different ways in which the payment system could be changed to overcome the payment barriers described in Section II. Each approach uses a different combination of options for each of four Payment Building Blocks defined in the Appendix. Each approach has its advantages and limitations, but each approach accomplishes the goal of creating a payment system that better supports the changes in care that the providers need to make in order to improve quality and reduce costs. The different options for each Building Block provide the ability to customize a payment system to a specific approach to care delivery, to the capabilities of the providers who will be receiving the payment, to the needs and capabilities of the purchasers and payers who will be making the payments, and to the unique characteristics of the market in which the providers and payers are located.

TABLE 1
ALTERNATIVE PAYMENT REFORMS TO ELIMINATE BARRIERS TO BETTER CARE FOR HEART FAILURE PATIENTS

Approach to Payment Reform	Services Covered by a Single Payment	Mechanism for Controlling Utilization and Spending	Mechanism for Assuring Desired Quality and Outcomes	Mechanism for Assuring Adequacy of Payment
Approach #1	• Create a billing code to allow nurses to bill for time spent with heart failure patients (1-A) • Create a billing code to allow physicians to bill for time spent on issues related to heart failure patients outside of office visits (1-A)	• Reduce payment amounts for the new services if there is an increase in the total combined spending on the newly billable services, existing billable services from the physician practices, and ED visits and hospitalizations for heart failure, after adjusting for any changes in the severity of heart failure among the patients (2-B)	• Survey heart failure patients to measure their quality of life, and reduce payment amounts if quality of life decreases and increase payments if quality of life improves, adjusting for any changes in the severity of heart failure or other comorbidities among the patients (3-B)	• Set payment amounts for nurses and physicians based on expected costs per hour for their time and the likely volume of services (4-E) • Increase the hospital's payment amounts for ED visits and hospitalizations for heart failure patients if the volume declines, based on the hospital's cost per patient (4-D)

Approach to Payment Reform	Services Covered by a Single Payment	Mechanism for Controlling Utilization and Spending	Mechanism for Assuring Desired Quality and Outcomes	Mechanism for Assuring Adequacy of Payment
Approach #2	• Pay a new bundled payment for each heart failure patient to the primary care practice in addition to current fee for service payments for those patients (1-A) • Create a billing code to allow cardiologists to bill for time spent on calls or email contacts with the primary care physicians and nurses (1-A)	• Reduce the amount of the new bundled payment if there is an increase in the total combined spending on the new bundled payment, the individual billed services from the physician practices for the patients, and ED visits and hospitalizations for heart failure, after adjusting for differences in patient characteristics (2-B)	• Reduce the amount of the new bundled payment if quality of life for heart failure patients decreases and increase the payment if quality of life improves, adjusting for any changes in the severity of heart failure or other comorbidities among the patients (3-B)	• Set the bundled payment amount based on expected costs for nursing and physician time needed for patients (4-E) • Adjust the bundled payment amount based on the severity of patients' heart failure and comorbidities (4-A) • Increase the hospital's payment amounts for ED visits and hospitalizations for heart failure patients if the volume declines (4-D)
Approach #3	• Pay a single bundled payment for each heart failure patient to the primary care and cardiology practices to cover all of the services they provide to heart failure patients (1-D)	• Reduce the amount of the new bundled payment if there is an increase in the total combined spending on the new bundled payment and ED visits and hospitalizations for heart failure, after adjusting for differences in patient characteristics (2-B)	• Reduce the bundled payment amount if quality of life for heart failure patients decreases and increase the payment if quality of life improves, adjusting for any changes in the severity of heart failure or other comorbidities among the patients (3-B)	• Set the bundled payment amount based on expected costs for nursing and physician time needed for patients in both the primary care and cardiology practice (4-E) • Adjust the bundled payment amount based on the severity of patients' heart failure and comorbidities (4-A) • Increase the hospital's payment amounts for ED visits and hospitalizations for heart failure patients if the volume declines (4-D)

Approach to Payment Reform	Services Covered by a Single Payment	Mechanism for Controlling Utilization and Spending	Mechanism for Assuring Desired Quality and Outcomes	Mechanism for Assuring Adequacy of Payment
Approach #4	• Pay a single condition-based payment for each heart failure patient to the primary care and cardiology practices to cover all of the services they provide plus the costs of any ED visits or hospitalizations (1-D)	• The accountability mechanism is provided by the bundled payment itself, i.e., all spending for which accountability is needed is included in the payment (2-C)	• Reduce the bundled payment amount if quality of life for heart failure patients decreases and increase the payment if quality of life improves, adjusting for any changes in the severity of heart failure or other comorbidities among the patients (3-B)	• Set the bundled payment amount based on average expected costs for all physician services and hospital costs at the expected lower rate of ED visits and hospitalizations (4-E) • Adjust the payment amount based on the severity of heart failure and other patient characteristics (4-A) • Provide an outlier payment for patients with unusually expensive hospitalizations (4-B) • Create a risk corridor to protect the practices against large random variations in costs (4-C)

B. Transitioning to Greater Flexibility and Accountability Over Time

The four different approaches described above are not just options for how to structure payment, but they also define steps that could be used to help providers and payers *transition* from the current fee for service system to better payment models over time. For example:

- A group of physicians and a payer could start by using Approach #1, i.e., creating new billing codes for the services that are currently unpaid and creating a pay-for-performance structure designed to ensure that net savings are achieved through reductions in avoidable emergency department visits and hospitalizations.
- After the physician practices have some experience in delivering the new services with the financial support of the new billing codes, the billing codes could be replaced by a monthly bundled payment as described in Approach #2. This would provide more predictability for the practices and the payer, and it would provide more flexibility for the practices.
- After the primary care practice develops a closer working relationship with the cardiologists and they reorganize services to deliver more coordinated care to patients, they could agree to take the type of monthly bundled payment described in Approach #3 in place of fee for service payments for individual services to heart failure patients.
- After the primary care physicians and cardiologists are comfortable with their ability to manage patient care in order to avoid emergency department visits and hospitalizations and have developed a close working relationship with the hospital, the physicians could agree to be paid through a condition-based payment covering not only their own services but the costs of ED visits and hospitalizations, as described in Approach #4.

C. The Need for Payer-Provider Collaboration in Payment Reform

Regardless of the type of payment model chosen, there will likely need to be a transition process in getting the details right. Although creating a business case analysis will help in designing the care change and the parameters for a payment system to support it, it is highly likely that some of the data or assumptions used in the business case analysis will turn out to be wrong. The costs of delivering a service may be higher or lower than projected, more or fewer services may be needed than expected, and it may be more or less difficult to achieve the desired outcomes than hoped.

Consequently, when a provider and a payer agree to implement a change in care and a change in payment to support it, they should do so in a collaborative fashion, with the expectation that adjustments will need to be made to ensure that all of the key stakeholders—the providers, the payer, and most importantly, the patients—will benefit. This will generally require neutral facilitation and analytic support to reach agreement on improved approaches to care delivery and payment and to help resolve the problems that will inevitably arise during the implementation process.

APPENDIX: Building Blocks of Payment Reform

A. Goals for Successful Health Care Payment Reforms

It is unrealistic to expect physicians, hospitals, and other health care providers, no matter how motivated they are, to provide higher value care, to improve quality or reduce spending if the payment system does not provide adequate financial support for their efforts. On the other hand, it is also unrealistic to expect that patients, businesses, or government will be willing to pay more or differently to overcome these barriers without assurances that the quality of care will be improved, spending will be lower, or both. In order to be successful from the perspective of patients, purchasers/payers, and providers, a payment reform needs to be explicitly designed to achieve four separate goals:

1. **Sufficient Flexibility in Care Delivery.** The revised payment system should provide sufficient flexibility to enable providers to deliver care in a way that they believe will achieve high quality or outcomes in the most efficient way and to adjust care delivery to the unique needs of individual patients.
2. **Appropriate Accountability for Spending.** The revised payment system should assure purchasers and payers that spending will:
   - decrease by the amount expected, if the principal goal of the change in care is to reduce spending without harming the quality of care; or
   - stay the same or increase by no more than the amount expected, if the principal goal of the change in care is to improve the quality of care or the outcomes for the patients.

   The payment system should hold providers accountable for utilization and spending they can control, but not for services or costs they cannot control or influence.
3. **Appropriate Accountability for Quality.** The revised payment system should assure purchasers and payers that the quality of care and/or outcomes for patients will:
   - remain the same or improve, if the principal goal of the change in care is to reduce spending without harming the quality of care; or
   - improve by the amount expected, if the principal goal of the change in care is to improve the quality of care or the outcomes for patients.

   The payment system should hold providers accountable for quality and outcomes they can control, but not for aspects of quality and outcomes they cannot control or influence.
4. **Adequacy of Payment**. The size of the payments in the revised system should be adequate to cover the providers' costs of delivering the new approach to care at the levels of quality that are expected for the types of patients they see and at the levels of cost or efficiency that are feasible for them to achieve.

B. Four Building Blocks of Payment Reform

Each of the four goals defined in the previous section is addressed by one of four fundamental "Building Blocks" in a payment system:

1. **The definition of the services that will be covered by a single payment.**
2. **The mechanism for controlling utilization and spending.**
3. **The mechanism for ensuring good quality and outcomes.**
4. **The mechanism for ensuring adequacy of payment.**

No design for a payment system or a payment reform is complete until decisions are made about how all of the Building Blocks will be structured, and there are multiple ways to design each Building Block.

Building Block 1: Services Covered by a Single Payment

The more services that are covered by a single payment, the more flexibility a provider has to change the number and types of services they provide to their patients without resulting in financial losses. There are several different options for providing additional flexibility in payment:

Option 1-A: **Adding new service-based fees or increasing existing fees.** Payment would be made for one or more specific services that are not currently eligible for payment or for specific circumstances in which current payments are inadequate.

Option 1-B: **Creating a treatment-based bundled payment for a single provider.** A single payment would be made for a group of existing or new services that a provider delivers as part of a particular type of treatment, with no change in payment based on which or how many services from the group are delivered.

Option 1-C: **Creating a multi-provider treatment-based bundle.** A single payment would be made for a group of services delivered by several different providers as part of a particular type of treatment.

Option 1-D: **Creating a condition-based payment.** A single payment would be made for addressing a particular health problem, with no difference in payment based on which particular approach to treatment is used.

Option 1-E: **Creating a population-based payment**. A single payment would be made for all of the services a provider or group of providers delivers to a group of patients for all of the health problems managed by those providers.

In multi-provider bundled payment structures, the less-bundled options (i.e., those with fewer services or providers included in the bundle) can be used as mechanisms for compensating individual providers. The payer would make a bundled payment to one of the providers or to an organizational entity formed by all of the providers. The entity receiving the payment would then use those funds to pay the individual providers for the services they deliver to patients using a payment/compensation method that reduces or eliminates any barriers they would face to implementing the desired changes in care delivery.

Building Block 2: Mechanism for Controlling Utilization and Spending

There are three basic options for how accountability for utilization and spending can be incorporated into a payment system:

Option 2-A: **Adjustments in payment (pay for performance) based on utilization.** This would involve a) setting targets for the rates of utilization for specific services, and b) defining adjustments in payments to the provider based on achievement of the utilization targets. Only the utilization of the service would be measured, not the spending.

Option 2-B: **Adjustments in payment (pay for performance) based on spending or savings.** This would involve setting targets for spending on specific services and defining adjustments to payments based on achievement of the spending targets. This requires the provider to take accountability for the price of services as well as how many and which types of services are used.

Option 2-C: **Bundled payment.** The target amount of spending for specific services would be bundled into the provider's payment, and the provider would then be responsible for covering any spending beyond the target amount.

The specific measures of utilization or spending used in these mechanisms will depend on which types of services are bundled into individual payments to the provider through Building Block 1. Bundling a larger number of services into a single payment not only provides greater flexibility but also requires providers to control more types of utilization and spending, reducing the need for separate payer-managed mechanisms for utilization/spending control.

Building Block 3: Mechanism for Assuring Adequate Quality and Outcomes

There are three basic approaches for how accountability for quality can be incorporated into a payment system:

Option 3-A: **Establishing minimum performance standards.** Under this approach, if the provider does not meet a minimum level of performance in delivering a service, there would be no payment, even if the service has already been delivered.

Option 3-B: **Payment adjustments (pay for performance) based on quality.** A quality-based pay for performance system would involve a) setting targets for performance on specific quality measures, and b) defining adjustments in payments to the provider based on achievement of the quality targets.

Option 3-C: **Warrantied payment.** If a provider offers a warranty on a service or bundle of services, the provider would be responsible for treating preventable complications or correcting quality problems that occur, with no additional payment from the payer. The total amount of payment for the service or bundle would be designed to cover the costs of preventing quality problems and correcting those that cannot be prevented.

The specific measures of quality used in these mechanisms will depend on which types of services are included in a single payment. The larger the range of services incorporated into a bundled payments, the greater the risk of underuse of services, increasing the need for quality measures to protect against underuse.

Building Block 4: Mechanisms for Assuring Adequacy of Payment

Greater flexibility in payment under Building Block 1 may make it easier to deliver a lower-cost mix of services that achieves better outcomes for patients than is possible under the current payment system. *Flexibility* is not sufficient, however; the amount of the payment must be *adequate* to cover the cost of the new mix of services. Before attempting to design a change in the payment system, a business case analysis should first be conducted. A key part of this analysis is to project what costs will be under the new approach to care delivery. This analysis can then be used to determine the appropriate amount of payment needed to support the planned changes in care.

The payment system should also ensure that both the *amount* and *type* of financial risk for providers that would be required under the payment system can be successfully managed by the providers receiving the payments. An effective payment system should ensure that *payers retain insurance risk* (i.e., the risk of whether patients have health problems or more serious health problems) and that *providers accept performance risk* (i.e., the risk of whether care for a particular health problem is delivered efficiently and effectively).

There are several options for adjusting payments to ensure they are adequate to enable providers to deliver high quality care and to ensure that providers only take on performance risk and not insurance risk:

Option 4-A: **Risk adjustment or risk stratification.** A risk *adjustment* system increases or decreases the amount of payment for a bundle of services based on a risk score derived from characteristics of the patient that cause more or fewer services to be needed for that patient. Risk *stratification* defines two or more discrete levels of payment for a particular bundle of services based on different severities or combinations of patient characteristics.

Option 4-B: **Outlier payments.** An outlier payment is an additional payment made to a provider if an *individual patient* needs services that are significantly more expensive than the predefined amount of payment would cover.

Option 4-C: **Risk corridors.** In a risk corridor, the provider receives an additional payment if its total spending on *all of the patients* treated under a bundled payment exceeds the aggregate amount of payments it receives.

Option 4-D: **Volume-based adjustments to payment.** A volume-based adjustment increases the amount of payment for a service if fewer services are delivered or if the service is delivered by a smaller provider, in order to address the fact that the average cost of delivering services will be higher with a lower volume of services if significant fixed costs are involved in the service.

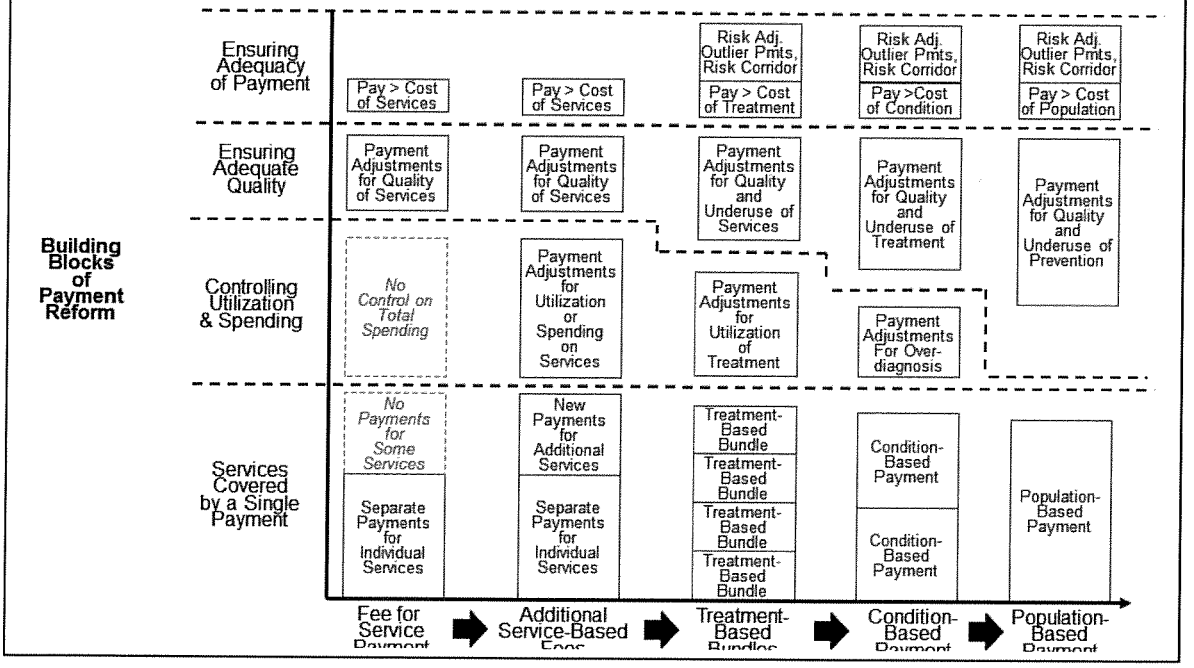
Option 4-E: **Setting and periodically updating payment amounts to match costs.** The amounts paid for services or bundles of services are set and periodically evaluated and revised to ensure that they cover the costs of delivering those services.

Multiple options in Building Block 4 can and often should be used as part of a payment system, since each option addresses a somewhat different issue needed to ensure the adequacy of payment for a provider and the appropriate separation of insurance and performance risk. The greater the degree of bundling defined in Building Block 1, the more likely it is that multiple options from Building Block 4 will be needed.

C. Transitioning to Greater Flexibility and Accountability Over Time

The different options for the four Building Blocks provide a way to help providers and payers incrementally *transition* from the current fee for service system to better payment models over time. As illustrated in Figure 12, a provider and payer might start with more incremental changes, such as new fees for currently uncompensated services combined with targets for reducing avoidable services. Treatment-based bundles of services could then be implemented, followed by condition-based payments and ultimately population-based payments. Providers and payers with greater capabilities to manage bundled payments and accountability mechanisms could move immediately to more advanced steps; other payers and providers could work to develop those capabilities while still paying and being paid in a way that overcomes the barriers

FIGURE 12
ALTERNATIVE WAYS OF STRUCTURING PAYMENT SYSTEMS AND TRANSITIONING TO DIFFERENT SYSTEMS OVER TIME



to better care.

Appendix C

Attracting and Retaining Physicians in East Hawaii

A multi-stakeholder workgroup was convened in Hilo on April 8, 2015 by the East Hawaii Regional Health Improvement Collaborative (EH-RHIC) to discuss how to attract and retain physicians in East Hawaii. During the course of the meeting, the group also discussed ways to help physician practices achieve greater efficiency and clinical integration to support the East Hawaii community's overall goal of improving the quality and affordability of care. The participants in the meeting are listed in the Appendix.

I. Barriers to an Adequate Supply of Physicians in East Hawaii

East Hawaii has a shortage of primary care physicians and also has insufficient local physicians in key specialties. The community has faced significant challenges both in attracting new physicians and retaining existing physicians in the community due to a combination of several factors:

- New physicians entering private practice in East Hawaii must generally start their own practice rather than join an existing practice, and the challenges and startup costs of a new practice make this difficult, expensive, and risky for young physicians. Delays in reimbursement from payers also have a bigger impact on new practices.
- Most practices in East Hawaii are small, which makes it more difficult and expensive for them to purchase and implement expensive new technologies or to hire non-physician staff (such as nurse care managers) who would only provide services to a subset of their patient panels.
- The cost of living in Hawaii is higher than many parts of the country, payments for physician and hospital services are lower than in many other communities, and a high proportion of residents are low income, making it difficult for a practice to maintain positive operating margins.
- The community is small, rural, and isolated from other communities, limiting the ability of specialty physicians to work with colleagues in their own specialties, and thereby making it less attractive as a place for subspecialists to practice.
- Existing physician practices report that the administrative burdens imposed by payers and the associated costs of operating a practice require long hours of work and limit profitability.

Many physicians currently practicing in the community are nearing retirement age and both these physicians and younger physicians are contemplating leaving practice because of these problems. Losses of existing physicians will increase the need for new physicians if these problems are not addressed.

Inadequate access to physicians is exacerbated by factors that reduce the number of patients individual physicians are able to care for. The primary care physicians who are practicing in East Hawaii report that they cannot provide care for as many patients as they would like because of the time they currently have to spend on administrative tasks, such as documentation to support numerous quality measures and submitting authorization requests to payers. Eliminating unnecessary administrative requirements and finding more efficient ways to carry out administrative tasks could not only free up time to see more patients, but could also make practices more profitable and help attract and retain physicians in the community.

Enabling a patient to get appointments with appropriate physicians is necessary but not sufficient; the physicians must also be able to work together effectively to deliver high-quality, coordinated care to the patient. Because physicians no longer routinely interact at the hospital and because the volume of patient visits and administrative work make it difficult for physicians to find time to make phone contacts, effective electronic systems of sharing information are essential. The fact that different physicians use different EHRs and that most EHRs do not easily support information sharing has made it difficult for physicians to share information effectively. The lack of effective methods of health information exchange can also be a deterrent for new physicians to practice in the community.

II. Strategy for Improving Physician Recruitment and Success of Physician Practices

A. Priorities for Physician Recruitment

The focus for physician recruitment should likely be in three areas:

1. primary care physicians, since there is general agreement that there would be a shortage of PCPs in the community even if current PCPs could see more patients;
2. physicians in broad specialties where there are likely to be a large number of patients in the community; and
3. physicians in subspecialties that the hospital needs to provide adequate coverage for the services that it delivers.

Although it would be desirable from the perspective of residents of East Hawaii to have a wide range of subspecialists in the community, the limited size of the community means that the operating costs for such practices would have to be subsidized and it would likely be difficult to attract high-quality subspecialists if there are not enough patients for them to care for. If the community wants to attract/retain a specialty physician practice that is not sustainable through standard payment mechanisms, the stakeholders in the community will need to agree to make the initial investment and provide the ongoing subsidy that is necessary.

Because of the community's aspirations to redesign care delivery to achieve higher quality and lower costs, existing workforce projections may not accurately indicate the number and types of physicians that the community needs. Consequently, special analyses will likely be needed to determine exactly how many primary care physicians and which types of specialists the community will need. These analyses will need to be based on a clear community vision of

how healthcare should be delivered, on accurate information about the specific kinds of services that existing physicians are willing and able to provide, and on realistic expectations about the kind of care local residents will be willing to seek in Hilo versus Honolulu.

Moreover, new approaches to care delivery in the community will not only affect the number and specialties of physicians needed in the community; it will also be important to attract (and retain) physicians who are willing and able to practice in new and more collaborative ways and to take accountability for quality and costs.

Many believe that due to the challenges described earlier, broad-based efforts to recruit new physicians will have limited success, and the strategy that is most likely to be successful is to focus on (1) physicians who are originally from the community and want to return and (2) physicians who are currently training in Hawaii and want to stay. These physicians do not have to be convinced that they want to come to Hilo and practice medicine, they merely need to be convinced that they can succeed if they do practice in Hilo. Moreover, they are more likely to simply want to make an adequate living practicing in a community where they want to live, rather than demanding above-average income in order to practice in a community where they do not want to live.

Although attention has naturally tended to focus on recruiting new physicians, there will obviously be less need for new physicians if the community can be more successful in retaining existing physician practices. Most existing practices in the community are solo or small practices and they are struggling to survive. These existing practices indicate that high overhead costs and the growing administrative burdens of operating a physician practice are making it increasingly difficult to sustain their practices. Particular attention should be paid to the practices that have been started recently by young physicians who still have significant medical school debt to pay off in addition to their practice expenses; helping these existing young physicians succeed will not only increase the likelihood that they will continue to practice in the community, but it will also help in efforts to attract additional new physicians.

Experience in other communities has shown that if administrative and payment barriers can be removed in ways that restore the joy of practicing medicine, some physicians will delay their retirements, thereby reducing the gap that needs to be filled with new physicians. It is inevitable, however, that existing physicians will want to retire at some point, and the community needs to plan ahead for these retirements, rather than waiting to recruit new physicians until after retirements have occurred. New physicians may be better able to succeed and to achieve success more quickly by taking over an existing physician's panel of patients with guidance from that physician, rather than forcing the patients to find new physicians and forcing the new physician to attract new patients.

The most immediate priority should be to ensure that when the members of the Hilo Medical Center Residency Program graduate in 2016, then can find at least one practice or employment arrangement in the community that is structured in a way that is attractive to them.

B. Practice Structures Needed for New Physicians

Nationally, many new physicians have indicated that they would prefer salaried/employment arrangements rather to practice independently. Until recently, the Hilo Medical Center was the only entity in East Hawaii offering employment arrangements, and in recent years, it has served as the primary mechanism for employing new physicians in the community. However, experience nationally indicates that physicians in private practice are more productive than those who work for hospitals. The Hilo Medical Center has indicated that it would prefer that new physicians be employed by community physician practices rather than be employees of the hospital whenever possible.

A promising approach is for existing physician practices in East Hawaii to bring new physicians into their practice, either as employees or as partners. For example, the East Hawaii Medical Clinic was formed by several physicians in the community as way of employing new primary care providers, and Big Island Medical Associates has been formed to ensure long-term continuity of some existing East Hawaii practices. However, the East Hawaii Medical Clinic has struggled to be successful financially during the startup phase, and so financial assistance will likely be needed by physician groups that want to employ new physicians in order for them to do so successfully.

Some new physicians will want to practice independently rather than be employed or be part of an existing practice. The primary care physicians who have started new independent practices in East Hawaii in recent years report that they have struggled and continue to struggle to succeed, and so it will be difficult to expect new physicians to pursue the same path unless additional support is available. In addition, some physicians may only want to practice part-time, and the community should also be willing to support them if they can fill a gap in services.

C. Support Needed by Existing and New Physician Practices

There are seven major ways that the East Hawaii community could help improve the ability of both existing and new physician practices to succeed:

1. **Reducing Overhead Costs for Physician Practices.** It can be inefficient for small physician practices to try and manage the many administrative aspects of a physician practice on their own. Either the physician ends up spending too much time doing administrative work, which reduces his or her ability to care for patients, or if staff is hired to perform those functions, the costs of these staff significantly increase the overhead in the practice. In addition, it is inefficient for each practice to independently try to understand and comply with the many regulations and payer rules they face. Consequently, it would be desirable if there were easy ways for practices in East Hawaii to share these administrative costs and responsibilities. This would give physician practices and the community the benefits that are associated with larger group practices and health systems while retaining the benefits of small, entrepreneurial practices. In addition, the administrative requirements should be simplified or restructured so they are less burdensome.
2. **Enabling Multiple Practices to Share Services.** Some of the services that patients need cannot cost-effectively be delivered by individual small practices, but they can be

delivered cost-effectively if several practices share those services. For example, using nurse care managers to provide education and self-management support to chronic disease patients can significantly reduce the likelihood of expensive hospitalizations. No individual physician has enough chronic disease patients to support hiring a nurse, but several practices could jointly share a nurse to support care for all of their patients. As with shared administrative supports, shared clinical services would give physician practices and the community the benefits that are associated with larger group practices and health systems while retaining the benefits of small, entrepreneurial practices.

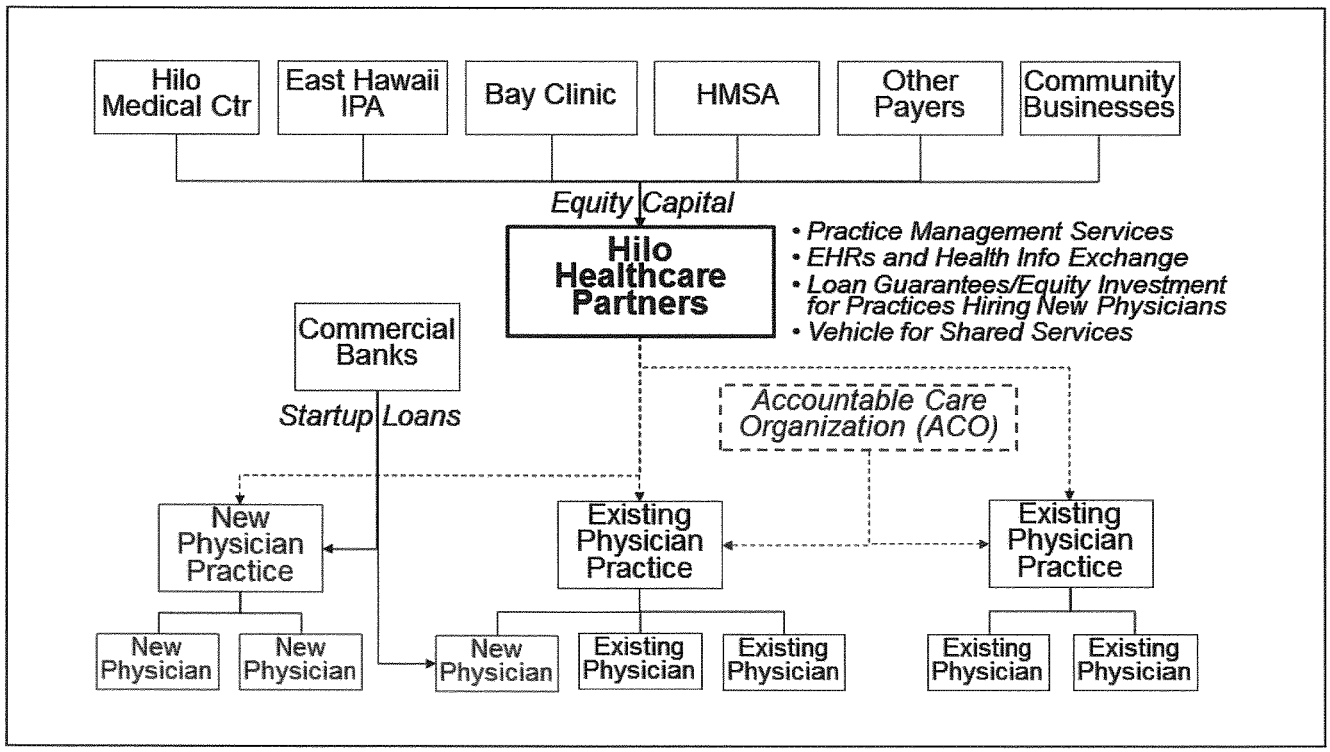
3. **Supporting Information Sharing for Clinical Integration.** An important special case of both overhead cost reduction and shared services is health information technology. It is more expensive for individual physician practices to independently purchase and maintain an Electronic Health Record (EHR) system than it is for large group practices to do so, and having multiple EHRs makes it more difficult for physicians to share information. Consequently, it would be desirable to have ways for physician practices to jointly purchase and support a common EHR system, and it would also be desirable to have effective ways for physician practices to share information electronically regardless of which EHR system they are using.
4. **Reducing Startup Costs and Bridging Cash Flow Gaps for New Physicians.** Both a new physician practice and an existing practice hiring a new physician will need to incur significant expenses for space, equipment, staff, insurance, and a variety of other costs immediately, but it will take time for the physician to build up a patient panel, so the practice will experience losses initially and inadequate income for an additional period of time. Consequently, there will need to be ways to ensure that physician practices in East Hawaii can obtain adequate capital (i.e., equity capital and affordable loans) to cover cash flow needs during this startup period.
5. **Ensuring Availability of Employment Options for Physicians Who Want Them.** It seems likely that some physicians will only be willing to practice in East Hawaii if they can do so in an employment arrangement. Consequently, a proactive effort should be made to ensure such arrangements are available when needed, in addition to efforts to reduce overhead costs and startup costs for employing new physicians.
6. **Supporting Joint Problem-Solving and Mentoring.** New physician practices will likely experience problems or challenges that experienced physicians could help them solve more quickly and successfully than they could on their own. In addition, both new and established physician practices will experience challenges in implementing new regulations, new approaches to care delivery, new payment systems, etc. and it would be more efficient for them to develop solutions to these problems jointly rather than duplicating efforts. Consequently, facilitating connections among practices for mentoring and joint problem-solving could help make all practices more successful.
7. **Reforming Payment Systems.** The current fee-for-service structure does not adequately support current approaches to delivering care, and it is even less well-suited to make new approaches to care delivery financially viable. Consequently, the community needs to encourage HMSA and other payers pay physician practices in ways that make high-quality, coordinated care financially viable. Physician practices will then need assistance in transitioning their billing systems, information systems, and methods of delivering care to function efficiently and effectively under the new payment systems.

III. Creating a Physician Support Services Organization

An organizational mechanism is needed in Hilo to deliver specific types of services to physician practices that want support in the areas described in Section II. The organization will need enough scale to be able to deliver services efficiently, and it will need enough capital to support these services during the startup phase.

The most appropriate organizational mechanism would be to create a new non-profit corporation – Hilo Healthcare Partners – that would provide four categories of services:

- **Practice Management Services.** Hilo Healthcare Partners could offer a menu of practice management services to physician practices in East Hawaii that are designed to help reduce operating costs for the practices and enable the practices to be more successful in carrying out the administrative responsibilities of a physician practice.
- **Electronic Health Records and Health Information Exchange.** Hilo Healthcare Partners could make a common Electronic Health Record system available to physician practices and also provide the software or systems needed to support exchange of information among practices about individual patients from different EHR systems.
- **Shared Patient Care Services.** In cases in which multiple physician practices need similar staff or equipment but do not have a sufficient volume of patients or revenues to justify hiring the staff or purchasing the equipment for their exclusive use, Hilo Healthcare Partners could employ the individual or purchase the equipment and lease the services back to the individual practices.
- **Financial Support for Hiring New Physicians.** Hilo Healthcare Partners could partner with local banks to ensure that physicians wishing to start a new practice or existing practices wishing to recruit a new physician can obtain the necessary financial support to



do so. Hilo Healthcare Partners would not employ physicians directly, but could invest in either new or existing physician practices that would employ physicians.

All of these services would be provided in return for fees from physician practices. The fees would need to be sufficient to cover Hilo Healthcare Partners' costs of providing the services, but the fees would also need to be lower than what it would cost practices to carry out the functions themselves or to purchase similar services from for-profit consultants.

In order to begin providing these services, Hilo Healthcare Partners (HHP) would need startup capital. Because HHP would be selling services to practices and making investments or loans, not grants, it would be able to generate a return on this capital and ultimately repay it.

An ideal approach would be for the major stakeholders in the community – the physicians, the hospital, the payers, and the business community – to serve as the owners of Hilo Healthcare Partners, contributing capital to the corporation and retrieving that capital over time through the returns generated on the services HHP provides. This could allow the rate of return to be kept at a modest level so that services and financing could be provided to physician practices at a more affordable cost. The Surgery Center and East Hawaii Medical Associates are existing example of stakeholders jointly investing to provide new and expanded services in the community, and the planning for HHP should draw on the lessons from these experiences.

In some cases, it may be infeasible or undesirable to recover the total cost of services and financing through fees from practices, and so Hilo Healthcare Partners may also need some funding that it can use to subsidize these services. Since all the stakeholders would benefit if HHP can improve the success of physician practices and help attract new physicians to East Hawaii, it makes sense for all of the stakeholders to share in both the capital investment and subsidies:

- The employers and residents in the community need access to an adequate number of high quality physicians who work together in a coordinated way, and an adequate number of primary care physicians in order to improve health and reduce avoidable costs.
- The Hilo Medical Center needs to have physicians in appropriate specialties to support the services that it delivers.
- The members of the East Hawaii IPA need support services beyond what the IPA can currently provide.
- HMSA, which has made considerable investments in bringing new physicians to Hawaii, needs effective mechanisms for ensuring those physicians stay and succeed.

Beyond providing the capital needed by HHP, it will also be important for all of the stakeholders to be involved in the governance of HHP in order to ensure that its services complement and do not conflict or compete with other services in the community. For example, if HHP provides support for employing a new physician, this should not be done in a way which creates unfair competition with existing physicians in the community.

Complementary Roles for HHP, the RHIC, and a Community ACO

Hilo Healthcare Partners would complement, not duplicate the work of the newly-formed East Hawaii Regional Health Improvement Collaborative (EH-RHIC) and a Community Accountable Care Organization (ACO) if one is created:

- The role of the Regional Health Improvement Collaborative should be to provide neutral facilitation of discussions among all stakeholders in order to develop an overall strategy for improving the quality and controlling the costs of healthcare in the community and to monitor progress in achieving the community's goals. The RHIC should not be in the business of selling management services to practices or investing in new physician startups, and it should be able to independently assess whether Hilo Healthcare Partners is successfully addressing the needs of physician practices and filling gaps. The RHIC could support HHP by carrying out independent analyses of how many and which types of physicians are needed as the care delivery model in the community evolves.
- The role of an ACO should be develop specific plans for changing care delivery and accepting and distributing payments to providers for delivering care. An ACO will be more successful if Hilo Healthcare Partners can help individual practices to become more efficient and effective, but physician practices should not feel compelled to join an ACO in order to receive support from HHP. It is also possible that more than one ACO could be created in the community, and HHP would be able to provide services to practices regardless of which ACO they are participating in.

IV. Next Steps in Supporting Physician Practice Success

- Interested and willing participants at the April 8 meeting should agree to serve as a Physician Practice Support Task Force and develop a detailed business plan for Hilo Healthcare Partners (a new Physician Support Services Corporation).
- Members of the Physician Practice Support Task Force should meet with the physicians in the Hilo Medical Center Residency Program to encourage them to stay in the community after graduation and determine what kinds of practice arrangements they would prefer; then it should identify existing physician practices in the community who would be willing to help create those practice arrangements and determine what assistance they would need to do so.
- The Physician Practice Task Force should contact organizations in other states and communities that are providing services similar to what is envisioned for Hilo Healthcare Partners in order to learn from their experience
- The East Hawaii Regional Health Improvement Collaborative should work with the Physician Practice Support Task Force to prioritize the number and specialties of physicians that the community should be working to attract and retain, including estimating how the capacity of existing PCPs could be increased through practice redesign and payment reform.
- The Regional Health Improvement Collaborative should survey physicians in the community to identify administrative burdens they are facing and encourage changes to be made in the requirements causing those burdens.

APPENDIX:
Participants in April 8 Planning Session

Dan Brinkman
David Camacho
Elizabeth Dykstra
Stefan Harmeling
Marilynn Hata
Laurie Hopman
Ruthie Kai
Brandon Kobashigawa
Randy Kurohara
Curtis Lee
Raymond Lee
Peter Matsuura
Wendy Matsuura
Susan Mochizuki
Karen Nakamoto
Ted Peskin
Paul Schnur
Mike Sayama
Barry Taniguchi
Harold Miller, Facilitator

STATE OF HAWAII
STATE PROCUREMENT OFFICE

CERTIFICATE OF VENDOR COMPLIANCE

This document presents the compliance status of the vendor identified below on the issue date with respect to certificates required from the Hawaii Department of Taxation (DOTAX), the Internal Revenue Service, the Hawaii Department of Labor and Industrial Relations (DLIR), and the Hawaii Department of Commerce and Consumer Affairs (DCCA).

Vendor Name: **COMMUNITY FIRST, INC.**

DBA/Trade Name: **COMMUNITY FIRST, INC.**

Issue Date: **01/14/2016**

Status: **Compliant**

Hawaii Tax#: [redacted]
FEIN/SSN#:
UI#: No record
DCCA FILE#: [redacted]

Status of Compliance for this Vendor on issue date:

Form	Department(s)	Status
A-6	Hawaii Department of Taxation	Compliant
	Internal Revenue Service	Compliant
COGS	Hawaii Department of Commerce & Consumer Affairs	Compliant
LIR27	Hawaii Department of Labor & Industrial Relations	Compliant

Status Legend:

Status	Description
Exempt	The entity is exempt from this requirement
Compliant	The entity is compliant with this requirement or the entity is in agreement with agency and actively working towards compliance
Pending	The entity is compliant with DLIR requirement
Submitted	The entity has applied for the certificate but it is awaiting approval
Not Compliant	The entity is not in compliance with the requirement and should contact the issuing agency for more information