House District H District 2
Senate District S District 1

THE TWENTY-NINTH 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, LLC

Dba: Community First

Street Address: 280 Ponahawai St, Ste 203, Hilo, HI 96720

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

2. CONTACT PERSON FOR MATTERS INVOLVING THIS APPLICATION:

Name ANTHONY KENT

Title Community Engagement Manager

Phone # 808-675-2750

Fax # 808-935-4472

E-mail akent@communityfirst.co

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:

THE PATIENT CENTERED MEDICAL HOME FOR COMPLEX PATIENTS (C-PCMH)

4. FEDERAL TAX ID #: [redacted]

5. STATE TAX ID #: [redacted]

7. AMOUNT OF STATE FUNDS REQUESTED:

FISCAL YEAR 2018: $ 100,000

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 $_____
FEDERAL $_____
COUNTY $_____
PRIVATE/OTHER $_____

TYPE NAME & TITLE OF AUTHORIZED REPRESENTATIVE:

[redacted]
AUTHORIZED SIGNATURE

MIKE K. SAYAMA, PHD, EXECUTIVE DIRECTOR
NAME & TITLE

1/19/17
DATE SIGNED

Rev 12/2/16

RECEIVED
1/20/17

COMMUNITY FIRST

280 Ponahawai Street, Suite 203 | Hilo, Hawaii 96720 | Phone 808-675-2750

January 18, 2017

Senator Jill N. Tokuda
Senate Committee on Ways and Means
State Capitol, Rm. 207
Honolulu, HI 96813

Dear Senator Tokuda,

We have been working hard for the last three years to respond to the crisis of healthcare costs as a community in East Hawaii. For an area as rural as ours, we believe only together as a community do we have a chance to make a difference. We created Community First and a regional health improvement collaborative to serve as a neutral forum for all the healthcare stakeholders. In a series of meetings last November, this collaborative identified three priorities for 2017, the most significant being establishing a "Patient Centered Medical Home for Complex Patients (C-PCMH)." The report of these meetings is attached to the proposal and reflects the consensus that has been achieved in our community.

The C-PCMH would be located next to the Hilo Medical Center's emergency department and serve as a medical home for the top 200 most expensive and complex patients who utilize Hilo Medical Center's emergency department and inpatient facility frequently. These patients are predominantly Medicaid patients, often do not have a primary care provider (PCP), or are not in the habit of going to their provider, instead going to the ED for problems that are not emergencies, resulting in costly and fragmented care. Locating the medical home next to the ED will take advantage of their existing and entrenched patterns of accessing care.

We are requesting $100,000 to meet the non-medical needs of these patients, which are not met by health plan benefits or social service programs but which critically impair the treatment and health of these patients. These funds may pay for things like from taxi vouchers, simple cell phones, food vouchers, temporary housing, or whatever unique need a patient may have that their case manager and physician in the C-PCMH believe will significantly improve their care and health.

Other similar initiatives across the nation have developed the business case for addressing the non-medical needs of patients (http://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs). Notably in Oregon, emergency department visits decreased by 9%, and hospital admissions for patients with certain chronic conditions decreased

by up to 29%. In New York City, Montefiore Medical Center reduced the cost of care for 23,000 Medicare patients by 7% and received nearly $14 million in shared savings from CMS. In New Jersey, after working with the Camden Coalition for Healthcare Providers, monthly hospital charges among participants declined by 56% and emergency department visits declined by about 40%.

Last week at the State of Reform Health Policy Conference in Honolulu former Oregon governor, John Kitzhaber made a compelling case for spending more on social needs and less on medical services to achieve better health outcomes. He described one case of a woman in her 80's whose health was stable and living independently at home, but needed an air conditioner to cope with increasing temperatures in the summer. She suffered a heat stroke and was hospitalized. Medicare paid $50,000 for her care, but could not pay several hundred dollars for an air conditioner.

We believe that the house is on fire and that healthcare costs will consume our Nation and State's discretionary funds, the profitability of businesses and salaries of employees, and the viability of the State's ERS Trust Fund. At the community level, for its top 200 most expensive patients Hilo Medical Center receives health plan payments of about $3.3 million, but the costs to provide their care is $9 million. Unless this utilization of the hospital is decreased, Hilo Medical Center will lose more money on each patient increasing the funding needed from the State. The increasing utilization trend, moreover, will require the expansion of facilities, a major capital expense neither the State nor our community can afford.

We believe $100,000 will be a great investment to prove the concept that meeting the non-medical needs of the most expensive and complex patients will achieve the Triple Aim of better health, better care, and lower costs.

Thank you very much for your consideration.

Sincerely

[redacted]

Barry K. Taniguchi

President and Chair of Community First

Application for Grants

If any item is not applicable to the request, the applicant should enter "not applicable".

I. Background and Summary

This section shall clearly and concisely summarize and highlight the contents of the request in such a way as to provide the State Legislature with a broad understanding of the request. Please include the following:

1. A brief description of the applicant's background and summary of the project;

While Community First is the applicant, this is a joint project with the Hilo Medical Center (HMC). The name of this project is "The Patient Centered Medical Home for Complex Patients (C-PCMH)."

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 (Ex-officio 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 a community where we not only take personal responsibility for our own health, but help each other care for our mutual well-being. Our mission is to create a sustainable medical system which provides quality care for all the people of our community. 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

HMC is the Big Island's leading provider of inpatient and outpatient care. The facility contains 275 beds distributed throughout the acute hospital, behavioral health unit and long-term care facility. HMC has 1,000 employees with a medical staff of 250 community physicians, physician assistants and Advanced Practice Registered Nurses, representing 33 specialties. The hospital is a Level III Trauma Center which includes the second busiest emergency room in the state. Their ER provides 24-hour care to more than 43,000 patients annually.

HMC will establish a medical home within the Family Residency Program and locate it adjacent to the emergency department (ED) for patients who have frequent ED visits or admissions to the hospital. These patients often do not have a primary care provider (PCP) or are not in the habit of going to their provider, instead going to the ED for problems that are not emergencies, resulting in costly and fragmented care. Locating the medical home next to the ED will take advantage of their existing and entrenched patterns of accessing care. Building out this facility has already been budgeted for and existing staff will fill most of the roles need in the C-PCMH. This grant-in-aid request is for funds which can meet the unmet non-medical needs of patients which negatively impact the quality and costs of their care.

Other similar initiatives across the nation have developed the business case for addressing the non-medical needs of patients (http://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs). Notably in Oregon, emergency department visits decreased by 9%, and hospital admissions for patients with certain chronic conditions decreased by up to 29%. In New York City, Montefiore Medical Center reduced the cost of care for 23,000 Medicare patients by 7% and received nearly $14 million in shared savings from CMS. In New Jersey, after working with the Camden Coalition for Healthcare Providers, monthly hospital charges among participants declined by 56% and emergency department visits declined by about 40%.

Recently at the State of Reform Conference in Honolulu former Oregon governor, John Kitzhaber made a compelling case for spending more on social needs and less on medical services to achieve better health outcomes. He described one case of a woman in her 80's whose health was stable but needed an air conditioner to cope with increasing temperatures in the summer. She suffered a heat stroke and was hospitalized. Medicare paid $50,000 for her care, but could not pay several hundred dollars for an air conditioner.

Below are two cases from the Hilo Medical Center.
Case #1—a 70 yo female patient dependent on oxygen and insulin who moved to a new apartment was prevented from picking up her medications and oxygen tank from her temporary caregiver who had allowed her to stay at their house because she was told she owed them $50 for storage fees. The patient arrived at the physician's office with shortness of breath without her oxygen tank and consented the physician to contact Legal Aid on her behalf. A lawyer from Legal Aid was able to obtain the patient's insulin and oxygen from the temporary caregiver within a few hours.

Case #2-- a 56 yo male on dialysis with a significant cardiac history made frequent emergency room trips because he was worried he was having another heart attack and on initial application was denied a care home placement. In one

month alone, he accrued 19 ER visits. With case management's help and more frequent office visits, he was approved for a care home and he subsequently made it almost 1 year without another ER visit.

2. The goals and objectives related to the request;

The goal is to improve the care and lower the costs for the top 200 most expensive and complex patients whose quality and cost of care and can be improved by treatment services not currently provided or paid for and also by meeting unmet non-medical needs which negatively impact their medical care.

The objective is to decrease the number of avoidable ED visits and hospital admissions and to demonstrate that there is a positive return on investment in comprehensive care coordination and meeting the non-medical needs of these patients. Their medical costs will be lowered, and the savings will exceed the costs of meeting their non-medical needs.

3. The public purpose and need to be served;

Healthcare costs are a huge national crises that plays out on all levels. It is a large factor in driving the unfunded liability in the State ERS budget. Improving care and decreasing costs is a critical need for a sustainable healthcare system and to prevent healthcare consuming resources needed for other public services. The problem, however, cannot be solved just within the medical system. Nations which spend less on medical services and more on social services have better health outcomes without spending more in total. This project seeks to validate this in East Hawaii.

Even more urgently and specifically, if the trend of ED and hospital utilization is not bent, HMC will have to expand their facility to meet the increasing community need. This need will be exacerbated by the large aging population in East Hawaii. Expanding the HMC facility will require a very large capital expense which neither the State nor the community can afford.

4. Describe the target population to be served; and

The target population will be the top 200 patients as measured by the utilization and costs of services provided at the Hilo Medical Center, whose care can be improved by comprehensive care coordination and addressing their non-medical needs. This population consists almost entirely of Quest Medicaid patients. These patients costs health plans approximately $3.3 million for services from HMC, but they cost the hospital an additional $6 million in expenses not covered by the reimbursement from health plans.

5. Describe the geographic coverage.

Our project will concentrate on the Districts of East Hawaii including Hilo, Hamakua, and Puna. According to the 2010 U.S Census the population East Hawaii is approximately 93,000 residents. Hawaii County is the fastest growing in the state with a population increase of 24.5% from 2000 to 2010. Much of this growth is East Hawaii areas of Hilo and Puna. The Health Resource and Services Administration classifies Hawaii County as rural.

II. Service Summary and Outcomes

The Service Summary shall include a detailed discussion of the applicant's approach to the request. The applicant shall clearly and concisely specify the results, outcomes, and measures of effectiveness from this request. The applicant shall:

1. Describe the scope of work, tasks and responsibilities;

This project will create a C-PCMH which will provide comprehensive care coordination and which will meet the non-medical needs which negatively impact treatment of the top 200 patients utilizing services at HMC. HMC will be responsible for creating the medical home, both the facility and staffing for it. Community First will provide community oversight, facilitate the engagement of physicians in the community, and ensure that community resources, particularly the local service organizations, are leveraged for the maximum benefit to the patient.

2. Provide a projected annual timeline for accomplishing the results or outcomes of the service;

2017
January-June: Planning meetings with HMC, East Hawaii Independent Physicians Association, Hope Services, County Office of Aging, HMSA, State Medicaid Division. Preliminary discussions have already been initiated with all parties. Expand network to include among others, the Food Basket, Emergency Medical Services, and Legal Aid. HMC to develop program and staffing model.

July: Implement pilot program with 10-20 patients.

October: Complete re-location of Family Residency next to the ED, and implement full program.

2018
October: Project completed with 200 patients touched.

3. Describe its quality assurance and evaluation plans for the request. Specify how the applicant plans to monitor, evaluate, and improve their results; and

   The C-PCMH will be monitored, evaluated, and improved just like any other service or program of HMC, subject to all regular JACHO requirements. In addition to this there will be community advisory board managed by Community First to ensure the appropriate use of the grant-in-aid funds both with regard to the impact on improving care and its leveraging the services of local non-profit agencies.

4. List the measure(s) of effectiveness that will be reported to the State agency through which grant funds are appropriated (the expending agency). The measure(s) will provide a standard and objective way for the State to assess the program's achievement or accomplishment. Please note that if the level of appropriation differs from the amount included in this application that the measure(s) of effectiveness will need to be updated and transmitted to the expending agency.

   a. The number of patients involved and the services and needs which funds were used for will be reported.
   b. Patient satisfaction with the program
   c. Before and after utilization of ED visits and hospital admissions will be compared.
   d. Before and after costs will be compared

III. Financial

Budget

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

2. The applicant shall provide its anticipated quarterly funding requests for the fiscal year 2018.

Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total Grant
$10,000	$50,000	$30,000	$10,000	$100,000

It is imperative that we have the flexibility to meet the unique needs of the patients, which may be critical to their health and treatment. Generally speaking the funds will be used to meet patient housing, transportation, communication, food, and other miscellaneous non-medical needs.

Quarter 1 will begin with a pilot population of 10 – 20 patients. In Quarter 2 we will begin the full program. Program costs are weighted more heavily in Quarters

2 and 3 because we will begin meeting patient needs in earnest. Spending will taper off as the project progresses because patient needs will have been met.

3. The applicant shall provide a listing of all other sources of funding that they are seeking for fiscal year 2018.

   n/a

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.

   n/a

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.

   n/a

5. The applicant shall provide the balance of its unrestricted current assets as of December 31, 2016.

   $65,000

IV. Experience and Capability

A. Necessary Skills and Experience

The applicant shall demonstrate that it has the necessary skills, abilities, knowledge of, and experience relating to the request. State your experience and appropriateness for providing the service proposed in this application. The applicant shall also provide a listing of verifiable experience of related projects or contracts for the most recent three years that are pertinent to the request.

Community First is increasingly being recognized as a trusted convener of the community and healthcare stakeholders in East Hawaii. It is also gaining national recognition through the Network of Regional Health Improvement Collaboratives (NRHI). In late January a multi-sector team from Hilo consisting of Dan Brinkman, HMC CEO; Dr. Kay Nordling, HMC Family Residency Director; Brandee Menino, ED of Hope Services; Kimo Alameda, PhD, ED of the County Office of Aging; Mike Sayama, PhD, ED of Community Services; Justin Yoshimoto, Transformation Analyst of HMSA; and a representative from the State Medicaid Division will be a meeting in Austin, Texas. This meeting is convened by NRHI and Academy Health and is entitled "Striving Toward a

Culture of Health: How Does Care and Costs for Non-Medical Needs Get Factored into Alternative Payment Models?" Only five teams were selected, and Hilo will be joining Detroit, Cincinnati, Philadelphia, and Seattle at this meeting.

Community First has also created the community consensus that the C-PCMH will be a priority of the East Hawaii RHIC through meetings held in November of 2017 facilitated by Harold Miller, CEO and President of the Center of Healthcare Quality and Payment reform. The report of this meeting is attached as Appendix 1 and illustrates the context of this project and the broad support it has in East Hawaii.

Listing of Related Projects

2014-2015 Hawaii County Grant to establish a Regional Health Improvement Collaborative to explore development of a Community-centric Accountable Care Organization

2015-2016 HMSA Foundation Grant to develop "Best Heart Care in East Hawaii, A Community Governed and Data Driven Healthcare Initiative"

2016 Network of Regional Health Improvement Grant for East Hawaii's Regional Payment Reform Summit

2017 Network of Regional Health Improvement Grant to send a Multi-sector Hilo team to a Collaborative Convening in Austin, Texas called "Striving Toward a Culture of Health: How Does Care and Costs for Non-Medical Needs Get Factored into Alternative Payment Models?"

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.

The Complex Patient-Centered Medical Home will initially operate out of the facility located at 45 Mohouli Street, Hilo, Hawaii 96720. This facility houses the Hawaii Island Family Health Center (HIFHC). The HIFHC will continue to operate out of this facility throughout 2017 pending transfer to the acute campus of Hilo Medical Center scheduled for 2018. The facility at 45 Mohouli Street has the following clinical amenities (administrative offices were not included):

- Exam Rooms 13
- Procedure Room 1

- Behavioral Health Rooms 2
- Conference Rooms 2
- Waiting Room 1
- Nursing Stations 4

The HIFHC facility at 45 Mohouli Street will gain additional clinical and administrative space in July 2017. This expansion will increase the current rooms to the total numbers listed below:

- Exam Rooms 20
- Procedure Rooms 2
- Behavioral Health Rooms 3
- Conference Rooms 2
- Waiting Rooms 2
- Nursing Stations 5

During the calendar year 2018, the HIFCH will relocate to Hilo Medical Center adjacent to the Emergency Department. After this relocation, the following clinical amenities will be available for patient care areas:

- Exam Rooms 21
- Procedure Rooms 2
- Behavioral Health Rooms 3
- Conference Rooms 2
- Waiting Room 1
- Nursing Stations 1
- Pharmacy Consult Room 1

V. Personnel: Project Organization and Staffing

A. Proposed Staffing, Staff Qualifications, Supervision and Training

The applicant shall describe the proposed staffing pattern and proposed service capacity appropriate for the viability of the request. The applicant shall provide the qualifications and experience of personnel for the request and shall describe its ability to supervise, train and provide administrative direction relative to the request.

The proposed staffing for the Complex Patient-Centered Medical Home will be as follows:

- Family Physician 0.5 FTE
- Residency Physician Rotation 0.3 FTE
- Physician Extender 1.0 FTE
- RPN Care Coordinator 1.0 FTE
- Behavior Health Provider* 1.0 FTE
- Clerk IV 1.0 FTE

Supervision, training, and administrative oversight including quality and standard of care will be provided by the HIFHC Medical Director and HIFHC Nurse Manager.

* Behavior Health Provider may be a Therapist, Clinical Social Worker, and/or Psychologist

B. Organization Chart

The applicant shall illustrate the position of each staff and line of responsibility/supervision. If the request is part of a large, multi-purpose organization, include an organization chart that illustrates the placement of this request.

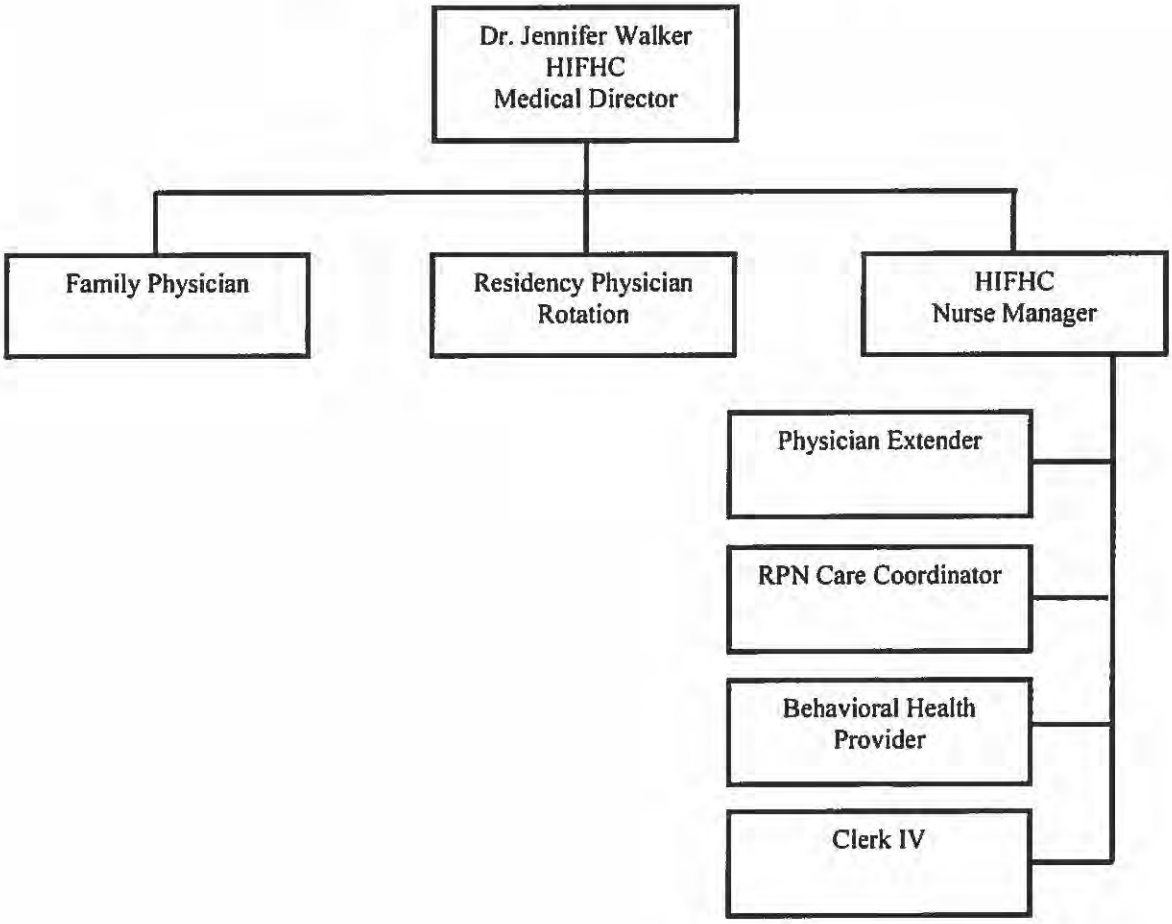
The Hawaii Island Family Health Center Medical Director in conjunction with the Nurse Manager will maintain operational oversight for the clinical and administrative staff including cost management, utilization review, strategic development, quality assurance and medical protocol development.

The Hawaii Island Family Health Center Medical Director, Jennifer J. Walker, MD, MPH, has the following clinical and administrative accomplishments:

Certified, American Board of Family Medicine
Fellow, American Academy of Family Physicians

- Aug 2016 – present: Medical Director, Hawaii Island Family Health Center and Core Faculty, Hawaii Island Family Medicine Residency.
- Sept 2016: Retired Colonel, US Army Medical Corps. Positions held on active duty include: Director, Graduate Medical Education, Womack Army Medical Center, Fort Bragg, NC; Chief, Clinical Operations, HQ US Pacific Command, Fort Shafter, HI; Deputy Commander/Chief Medical Officer, US Army Health Clinic, Schofield Barracks, HI; Deputy Commander/Chief Medical Officer, 21st Combat Support Hospital, Iraq; Chief, Soldier Care Services, Evans Army Community Hospital, Fort Carson, CO; Chief of Medical Services, 48th Combat Support Hospital, Afghanistan; Family Medicine Core Faculty, Madigan Army Medical Center, Fort Lewis WA, AND Dewitt Army Community Hospital, Fort Belvoir, VA; Family Medicine Clinic Chief, US Army Hospital, Heidelberg, Germany.

Patient Centered Medical Home For Complex Patients
Organizational Chart



C. Compensation

The applicant shall provide the annual salaries paid by the applicant to the three highest paid officers, directors, or employees of the organization by position.

Community First only has two paid staff:
Dr. Mike Sayama, PhD, Executive Director: $155,000 (No State funds requested)
Anthony Kent, MBA, Community Engagement Manager: $47,000 (No State funds requested)

VI. Other

A. Litigation

The applicant shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgement. If applicable, please explain.

n/a

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.

Member, Network for Regional Health Improvement (NRHI)

NRHI is a national organization representing over thirty five member Regional Health Improvement Collaboratives (RHICs). These multi-stakeholder organizations are working in their regions and collaborating across regions to transform the healthcare delivery system and achieve the Triple Aim: improving the patient experience of care, including quality and satisfaction; improving the health of populations; and reducing the per-capita cost of healthcare.

C. Private Educational Institutions

The applicant shall specify whether the grant will be used to support or benefit a sectarian or non-sectarian private educational institution. Please see Article X, Section 1, of the State Constitution for the relevance of this question.

n/a

D. Future Sustainability Plan

The applicant shall provide a plan for sustaining after fiscal year 2017-18 the activity funded by the grant if the grant of this application is:

(1) Received by the applicant for fiscal year 2017-18, but

(2) Not received by the applicant thereafter.

The sustainability of the C-PCMH will come from the savings it shows both from the benefit costs to the health plans and also savings from the losses to the hospital. The benefit costs to health plans is approximately $3.3 million to provide services at HMC to the top 200. The direct costs to the hospital are $5.4 million, and the indirect costs to the hospital are approximately $4 million, resulting in a net loss to HMC of about $6 million dollars a year on these patients. While health plans will have savings from lowered utilization of emergency department and inpatient services, HMC has the potential of greater savings from decreasing the losses it incurs. The sustainability of this program to fund meeting the non-medical needs that neither health plans nor social service programs cover will be a very small part of the savings that are realized. If utilization drops 10%, the total savings to health plans and HMC will be close to a $1 million.

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

If the applicant is an organization, the applicant shall submit one (1) copy of a certificate of good standing from the Director of Commerce and Consumer Affairs that is dated no earlier than December 1, 2016.

Attachment 1

BUDGET REQUEST BY SOURCE OF FUNDS

Period: July 1, 2017 to June 30, 2018

Applicant: Community First

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	0	0	0	0
2. Payroll Taxes & Assessments	0	0	0	0
3. Fringe Benefits	0	0	0	0
TOTAL PERSONNEL COST				
B. OTHER CURRENT EXPENSES				
1. Airfare, Inter-Island	0	0	0	0
2. Insurance	0	0	0	0
3. Lease/Rental of Equipment	0	0	0	0
4. Lease/Rental of Space	0	0	0	0
5. Staff Training	0	0	0	0
6. Supplies	0	0	0	0
7. Telecommunication	0	0	0	0
8. Utilities	0	0	0	0
9 Patient Housing*	20,000	0	0	0
10 Patient Transportation*	20,000	0	0	0
11 Patient Communication*	20,000	0	0	0
12 Patient Food*	20,000	0	0	0
13 Patient Miscellaneous Expenses*	20,000	0	0	0
14				
15	* Estimated expenditures. The nature of this project requires us to have maxiumum			
16	flexibility in the use of these funds. As illustrated by previous cases, patient's			
17	unique needs must be met in order to produce maximum impact.			
18				
19				
20				
TOTAL OTHER CURRENT EXPENSES	100,000			
C. EQUIPMENT PURCHASES	0			
D. MOTOR VEHICLE PURCHASES	0			
E. CAPITAL	0			
TOTAL (A+B+C+D+E)	**100,000**			

SOURCES OF FUNDING	
(a) Total State Funds Requested	100,000
(b) Total Federal Funds Requeste	0
(c) Total County Funds Requeste	0
(d) Total Private/Other Funds Requested	0
TOTAL BUDGET	**100,000**

Budget Prepared By:

Anthony Kent — 808-464-2800

Name (Please type or print) — Phone

[redacted] — 4/19/17

Signature of Authorized Official — Date

Anthony Kent, Community Engagement Manager

Name and Title (Please type or print)

BUDGET JUSTIFICATION - PERSONNEL SALARIES AND WAGES

Period: July 1, 2017 to June 30, 2018

Applicant: Community First

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	$155,000.00	25.00%	No State Funds Requested
Community Engagement Manager	1	$47,000.00	25.00%	No State Funds Requested
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
TOTAL:				

JUSTIFICATION/COMMENTS: We are not requesting funding for personnel. 100% of requested funds will go towards direct project costs.

BUDGET JUSTIFICATION - EQUIPMENT AND MOTOR VEHICLES

Period: July 1, 2017 to June 30, 2018

Applicant: Community First

DESCRIPTION EQUIPMENT	NO. OF ITEMS	COST PER ITEM	TOTAL COST	TOTAL BUDGETED
n/a			$ -	
			$ -	
			$ -	
			$ -	
			$ -	
TOTAL:				
JUSTIFICATION/COMMENTS:				

DESCRIPTION OF MOTOR VEHICLE	NO. OF VEHICLES	COST PER VEHICLE	TOTAL COST	TOTAL BUDGETED
n/a			$ -	
			$ -	
			$ -	
			$ -	
			$ -	
TOTAL:				
JUSTIFICATION/COMMENTS:				

BUDGET JUSTIFICATION - CAPITAL PROJECT DETAILS

Period: July 1, 2017 to June 30, 2018

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: 2015-2016	FY: 2016-2017	FY:2017-2018	FY:2017-2018	FY:2018-2019	FY:2019-2020
PLANS						
LAND ACQUISITION						
DESIGN						
CONSTRUCTION						
EQUIPMENT						
TOTAL:						
JUSTIFICATION/COMMENTS: n/a. Operation Application						

GOVERNMENT CONTRACTS AND / OR GRANTS

Applicant: Community First

Contracts Total: -

	CONTRACT DESCRIPTION	EFFECTIVE DATES	AGENCY	GOVERNMENT ENTITY (U.S. / State / Haw / Hon / Kau / Mau)	CONTRACT VALUE
1	n/a				
2					
3					
4					
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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
(Typed Name of Individual or Organization)

[redacted] 1-19-2017
(Signature) (Date)

Mike K. Sayama — Executive Director
(Typed Name) (Title)

Attachment 1

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

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

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

Issue Date: **01/18/2017**

Status: **Compliant**

Hawaii Tax#: W50900514-01
New Hawaii Tax#:
FEIN/SSN#: [redacted]
UI#: No record
DCCA FILE#: 243953

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
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 1

COMMUNITY FIRST

TAKING CONTROL OF HEALTHCARE COSTS IN EAST HAWAII

Recommendations of the November 2016 Regional Healthcare Payment and Delivery Reform Summit

CONTENTS

Preface

This report summarizes the findings and recommendations of the Regional Payment/Delivery Reform Summit convened by Community First on November 9 and 10, 2016. A multi-stakeholder group of leaders met for two successive half-day sessions to develop priorities for the work of the East Hawaii Regional Health Improvement Collaborative (RHIC) in 2017 and beyond. The participants were:

- Douglass Adams, Steering Committee Member, East Hawaii RHIC
- Kimo Alameda, Executive Director, Hawaii County Office of Aging
- Dan Brinkman, CEO, East Hawaii Region, Hawaii Health Systems Corporation, and Steering Committee Member, East Hawaii RHIC
- Roberta Chu, Senior Vice President, Bank of Hawaii
- Kurt Corbin, Chairman of the Board, East Hawaii Region, Hawaii Health Systems Corporation, and Steering Committee Member, East Hawaii RHIC
- Lynda Dolan, MD, Vice President, East Hawaii IPA
- Edward Fess, MD, Senior Medical Director, Ohana Health Plan
- Brenda Ho, CEO, Hospice of Hilo and Steering Committee Member, East Hawaii RHIC
- Anthony Kent, Community Engagement Coordinator, Community First
- Randy Kurohara, Managing Director, Hawaii County, and Steering Committee Member, East Hawaii RHIC
- Richard Lee-Ching, MD, Emeritus Board Member, East Hawaii IPA, and Steering Committee Member, East Hawaii RHIC
- Brandee Menino, Executive Director, Hope Services Hawaii
- Susan Mochizuki, Executive Director, East Hawaii IPA
- Mark Mugiishi, MD, Senior Vice President and Chief Medical Officer, HMSA
- Gary Okamoto, MD, Chief Medical Officer, AlohaCare
- Alan Okinaka, Chairman of the Board, Bay Clinic, and Steering Committee Member, East Hawaii RHIC
- Lisa Rantz, Executive Director, Hilo Medical Center Foundation, and Steering Committee Member, East Hawaii RHIC
- Mike Sayama, Executive Director, Community First
- Barry Taniguchi, Chairman and CEO, KTA Stores, and Chairman, East Hawaii RHIC
- Toby Taniguchi, President and COO, KTA Stores, and Steering Committee Member, East Hawaii RHIC
- Harold Wallace, CEO, Bay Clinic, and Steering Committee Member, East Hawaii RHIC
- Jerel Yamamoto, Vice President, Kanoelehua Industrial Area Association, and Steering Committee Member, East Hawaii RHIC

Financial support for the Summit was provided by the Network for Regional Healthcare Improvement (NRHI) through grant funding awarded by the Robert Wood Johnson Foundation. The Hilo Medical Center hosted the Summit. Harold D. Miller, President and CEO of the Center for Healthcare Quality and Payment Reform, prepared a framing paper for the Summit and facilitated the discussion at the Summit.

I. GOALS FOR HEALTHCARE DELIVERY AND PAYMENT IN EAST HAWAII

A. Priority Problems and Challenges Facing the East Hawaii Region

The Summit participants identified over two dozen problems and challenges related to healthcare costs and services that the East Hawaii region is facing. (The full list of problems and challenges is in the Appendix.) The participants identified four of these problems as the most critical:

- Many residents of East Hawaii are not taking sufficient responsibility for maintaining and improving their health;
- Stakeholders in East Hawaii do not have the necessary control over payment systems to enable reallocation of healthcare spending and resources into higher-value activities;
- The Hilo Medical Center and the other facilities and services that are part of the East Hawaii Region of the Hawaii Health Systems Corporation are facing serious financial challenges that threaten their ability to deliver high-quality care; and
- The lack of a common electronic health record (EHR) system and the lack of interoperability of the current EHRs used by healthcare providers in the region makes it difficult to coordinate care and to identify opportunities for improvement.

Of these, the group felt that **the most fundamental problem the East Hawaii Region must solve is the inability for the stakeholders in the region to direct healthcare resources to the highest-value approaches to care delivery**. Despite the fact that most of the healthcare services that East Hawaii residents receive are delivered by healthcare providers in East Hawaii, and that most of the money used to pay for those services comes from a combination of health insurance premiums and taxes paid by employers and residents located in East Hawaii:

- Employers, residents, and healthcare providers in East Hawaii do not have the ability to control which healthcare services their healthcare dollars will be spent on and how payments will be made for those services. Even if healthcare providers develop a new way of delivering services that improves the health of residents and/or reduces costs, employers and residents may not be able to ensure the providers are paid adequately to deliver services in that way.
- There is no mechanism to assure that savings generated by improving the health of the residents or by reducing the cost of the healthcare services local providers deliver will result in lower health insurance premiums for the employers and residents of the region.

B. The Need for Community-Driven, Collaborative Solutions

These problems are not unique to East Hawaii. They exist because all of the money that employers and residents of a region spend on healthcare first flows through other entities that are not located in the region – health insurance companies, state government, and the federal Centers for Medicare and Medicaid Services (CMS). Those entities decide how health insurance premiums and tax revenues will be used to pay for healthcare services, and the decisions are often made in ways that do not reflect community needs and priorities. Moreover, those entities also receive most of any savings in healthcare spending generated by local initiatives, and they control whether any of the savings are returned to local residents and employers. They may decide to use savings generated in one region to cover costs or losses generated in other region

rather than to return the savings to the employers and residents of the community where they were generated. While this can benefit the community if it spends more than average on healthcare services, it also reduces the incentive for a community to take greater control over the health of its residents and to improve the cost and quality of the healthcare services its providers deliver.

In a growing number of communities around the country, healthcare purchasers and healthcare providers are working to redesign both the way healthcare services are delivered and the way those services are paid for in order to improve the quality of services delivered to community residents, to control healthcare spending for employers and other purchasers, and to enable physicians, hospitals, and other healthcare providers to deliver care in a more financially sustainable way. A variety of different mechanisms are being used to achieve this, including:

- Alternative Payment Models (APMs), in which physicians, hospitals, and other healthcare providers have flexibility to determine how services will be delivered for a patient who has a specific health problem or who needs a specific procedure or treatment, with the providers taking accountability for the quality and cost of the care the patient receives;
- Clinically integrated networks (CINs) and accountable care organizations (ACOs), in which primary care physicians, specialists, and hospitals work together to take responsibility for all of the healthcare services needed by a group of patients;
- Direct contracting between self-insured employers and healthcare provider organizations, in which the healthcare providers deliver high-quality care to the employer's workers at a lower cost to the employer but with higher margins for the provider.

The most successful of these efforts are based on a collaborative partnership among all of the key stakeholders – the providers of healthcare (particularly physicians and hospitals), the purchasers of healthcare services (e.g., employers and government), the health plans or other entities that actually transfer money between the purchasers and providers and that ensure patients can receive needed services that are not delivered by the providers located in their own community, and the patients themselves. In order to be successful, the leaders of these collaborative partnerships must tackle both technical problems and adaptive challenges[1]:

- **Technical problems:** New ways of delivering care and new ways of paying for care require different approaches to scheduling services, hiring and training staff, designing facilities and purchasing equipment, coding and paying claims, etc. These are difficult technical problems that require time, money, and technical expertise to solve.
- **Adaptive challenges:** Implementing new approaches to delivering care and allocating resources requires all stakeholders to work together in new ways. Individual stakeholders will no longer be able to succeed using only the skills they have developed and the resources they have assembled in the past. Collaboration requires a high level of trust among stakeholders and a willingness to put aside past problems.

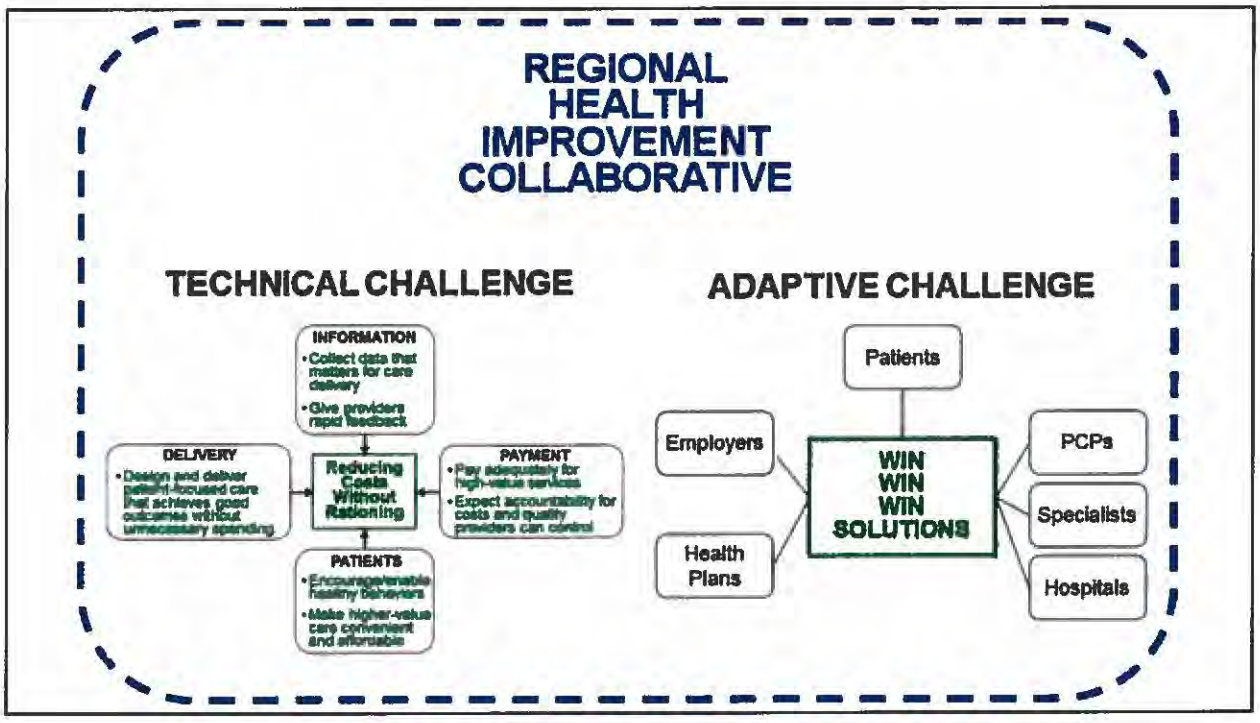
[1] Ronald A. Heifetz & Marty Linsky, *Leadership on the Line*, Harvard Business School Press, 2002.

C. The Role of the Regional Health Improvement Collaborative

Fortunately, in 2015, the leaders of the major stakeholders in East Hawaii created a new mechanism – the East Hawaii Regional Health Improvement Collaborative (RHIC) – to address both the technical problems and adaptive challenges needed to transform care delivery and payment in the region. Over the past 18 months, the top leaders and decision-makers from all of the key stakeholder organizations in the region have been actively involved in the work of the RHIC and have been meeting regularly to coordinate their activities and to advance several projects. Through the RHIC, these community leaders have built more collaborative working relationships with each other and between their organizations than have ever existed in the past.

This has been a significant accomplishment in less than two years. Most regions of the country do not have a Regional Health Improvement Collaborative at all, and of those that do, only a small number have the kind of regular, active engagement by top decision-makers that exists in East Hawaii.

The Summit participants agreed that it is time to build on this success and to use the Regional Health Improvement Collaborative as a platform for more aggressively pursuing fundamental changes in healthcare delivery and payment in the region.



D. Vision and Principles for Controlling Healthcare Cost and Quality in East Hawaii

The leaders at the Summit recommended that the East Hawaii Regional Health Improvement Collaborative pursue the following Vision for the future and follow five Guiding Principles to achieve the vision:

Vision: Provide high-quality, affordable, locally-delivered healthcare services for all residents that help them be healthy and productive. Federal and state governments and health insurance companies will enable the citizens, employers, and providers in East Hawaii to create the organizational and financial mechanisms required to achieve this.

Guiding Principles:

- **Only Together.** No one stakeholder or organization can transform healthcare on its own, and win-lose approaches will ultimately fail. While it may seem harder to develop win-win approaches in a collaborative way, they are more likely to be sustainable in the long run.
- **Make the Invisible Visible.** Successful collaboration requires trust, and trust requires honesty and transparency. Community leaders must place a higher value on discussion and resolution of conflict than on maintaining the appearance of harmony.
- **Community First.** To be successful, initiatives must address the unique needs of community residents in ways that are feasible with the resources available to the community. East Hawaii should not be forced to implement programs that do not match the needs and capabilities of the community.
- **Try But Don't Expect to Get It Exactly Right the First Time.** No one can know for sure what will work, and so all stakeholders should understand that some initiatives may fail and other initiatives will need to be revised. Purchasers and payers should encourage and assist those who try to change and fail, rather than penalizing them for failure to succeed.
- **A Sense of Urgency.** Healthcare costs are already unaffordable, and continuing rapid growth in costs threatens the financial viability of families, businesses, and the community as a whole. Aggressive deadlines for action need to be established and each of the stakeholders in East Hawaii must make it a personal and organizational priority to implement priority initiatives and to achieve a collective vision.

E. Organizing for Success

1. A Multi-Year Plan with Annual Priorities

The participants at the Summit agreed that no one program or initiative could achieve the full range of impacts needed to achieve the vision of more affordable healthcare for all residents. Multiple programs and initiatives will be needed to address the needs of residents who have different types of healthcare problems and who differ in terms of other challenges and resources.

Not all of these programs and initiatives can be designed and implemented at the same time. Although the small size of the East Hawaii region makes it more feasible to implement individual programs across the entire region than would be the case in larger regions or states, the size of the region's healthcare providers and the financial challenges they are facing make it impractical to pursue a large number of separate initiatives simultaneously.

Consequently, the Regional Health Improvement Collaborative will need to define a multi-year plan and set annual priorities. If each year's priority goals can be achieved, then additional initiatives can be pursued in subsequent years, leading to a large cumulative impact over a period of five years. (The priorities for 2017 that were recommended by the Summit participants are described in detail in Section II.)

Although this incremental approach is likely to be more feasible in terms of resources, it creates several challenges that the RHIC will need to be aware of:

- **Competing Priorities.** During the transition to a higher-value healthcare system, the aspects of healthcare delivery and payment that are not part of the initiatives will have to continue under current payment and delivery structures. Forcing both providers and payers to operate dual payment and delivery systems will, at best, require extra work and at worst, create conflicts in programs and incentives. It will be difficult for the new initiatives to receive sufficient attention during the transition period when most of the community's resources are still driven by traditional ways of delivering and paying for care.
- **Delay in Benefits.** It will be difficult for those not participating in the new initiatives to understand and accept that they have to wait to benefit from the transformation. Residents may perceive initiatives as special programs for other patients or providers rather than a transitional step to a more comprehensive approach that will also benefit them. Moreover, the short-term impact on healthcare premiums and provider revenues from individual initiatives will be much smaller than the ultimate aggregate impact after multiple initiatives are implemented, and so there may be a need for investment of additional resources in the short run in order to achieve savings in the long run.

Effective communication with the community about the overall vision and plan, and rapid progress in implementing initial priorities, will help to overcome these challenges.

2. Leadership, Staffing, Data, and Financial Support from Participants

Merely limiting the number of projects undertaken each year does not guarantee success in implementing those priority projects. The RHIC's ability to make significant progress on any individual project during the course of a year will be dependent on four things:

- **A Strong Community Leader.** Successful initiatives will likely require a strong civic leader who will make it a personal priority to obtain the necessary commitments from all other participants and to convene participants to solve problems when they arise.

- **Adequate, Capable Staffing.** Successful initiatives will also require support from capable staff who can dedicate adequate time to carrying out the necessary tasks in the timeframes needed to meet the project deadlines.
- **Financial Stake in Success for Participants.** No matter how effective a community leader and staff are, successfully changing the way care is delivered will depend on the willingness and commitment by the participating providers to make those changes. It is far more likely that they will follow through on such commitments if they have a financial stake in the outcome. For many initiatives, the RHIC may want to ask each of the participants to commit some of their own funds and staff to the project, so that they will see the project's success as a return on their own financial investment.
- **Timely, Detailed Data and Analysis.** Access to timely data and the ability to analyze data will be essential for developing successful business plans for initiatives and for monitoring progress.

3. Changes in Payment Systems from State and National Payers

In most cases, significant changes in care delivery by healthcare providers in East Hawaii will require significant changes in the way they are paid for their services by multiple payers – Medicare, Medicare Advantage, Medicaid, and commercial insurance. All of these payers operate across a geography that is larger than the East Hawaii Region, and so it will be challenging for them to make changes in payments for East Hawaii providers that are different from the payment systems they use for providers in other regions. Conversely, it will be difficult for providers in East Hawaii to implement care delivery initiatives successfully if they have to do so using payment systems that do not adequately support higher-value care, or if they have to incur the administrative costs needed to implement a different payment system from every payer.

The East Hawaii Regional Health Improvement Collaborative provides a forum through which East Hawaii providers, health insurance companies, and state government officials can work together to develop a common approach to healthcare payment changes across all payers that addresses the needs of both the East Hawaii providers and the payers. Two ways in which the RHIC can facilitate support from state and national payers are:

- **Choosing priorities and designing initiatives with broader applicability.** Although priorities should be driven by community needs, when there are choices about priorities, choosing an initiative that a payer could replicate in other communities would create a larger return on investment for the payer. The RHIC could encourage other regions to implement similar initiatives in order to make it easier for health plans to participate.
- **Demonstrating effectiveness of initiatives on cost and quality.** The RHIC is more likely to obtain support from payers if it can show that an initiative will be likely to have a significant impact on spending and/or quality and if it demonstrates success in achieving the promised impacts in the initial initiatives it pursues.

Employers in East Hawaii will have an important role to play in encouraging commercial health plans to support the community's strategy, since it is the employers' premiums that are being used to fund the payments, and since the employers and their employees will receive the benefits of the lower costs and higher quality that the payments will support.

II. PRIORITY PROJECTS FOR THE RHIC IN 2017

Priority #1: Creating a Medical Home for Complex Patients and an Urgent Care Clinic

A key issue facing the East Hawaii community is the high and growing utilization of the Hilo Medical Center (HMC) Emergency Department. Current utilization rates are straining the capacity of the Emergency Department (ED), and the hospital is facing the need to make a major capital investment to expand the ED. However, the hospital has found that a high proportion of the individuals using the ED are (1) complex patients who are uninsured or who have Medicaid coverage and use the Emergency Department as their principal source of care, and (2) insured patients who have a primary care provider but who use the Emergency Department for minor acute issues. Reducing utilization by these patients could avoid the need to expand the ED.

The participants at the Summit agreed that one of the highest priorities for the East Hawaii RHIC in 2017 should be to create alternative mechanisms for delivering care to patients currently using the HMC ED that would achieve three goals:

- sufficiently reduce utilization of the HMC Emergency Department in order to avoid the capital and operating expenses associated with expanding the hospital's ED without negatively impacting the hospital's operating margins.
- better address the health needs of complex Medicaid patients which will reduce total Medicaid spending on their care; and
- create a cost-effective means of addressing the urgent care needs of patients who have a primary care provider without requiring a visit to the ED.

The participants at the Summit felt that these goals could be achieved through a two-part initiative:

- **Creating a Patient Centered Medical Home for Complex Patients (C-PCMH)** for patients who do not currently have a primary care medical home or whose medical and non-medical needs are more complex than can be easily managed by community physician practices. The more intensive resources needed for management of these patients' care could be more efficiently be addressed through a medical home that specializes in their care. Most of these patients are likely to be either Medicaid patients or uninsured.
- **Creating one or more Urgent Care Clinics** to provide services to patients who have a primary care practice when they have non-emergency acute care needs, particularly during evenings and weekends. In order for primary care practices to successfully function as Patient-Centered Medical Homes and to control overall healthcare spending for their patients, the practices need to be able to respond to their patients' acute needs on a 24/7 basis and to address minor acute problems without an ED visit. A community Urgent Care Clinic could serve as a cost-effective way for other primary care providers in the community – both small physician practices and Bay Clinic – to collectively address urgent care needs while preserving continuity and coordination of care for their patients. In addition to a physical location for delivering face-to-face services to patients, it would be desirable for the Urgent Care Clinic to have a call center component to address patient issues over the phone when possible (e.g., assuring them when appropriate that they can safely wait until they can see their regular primary care provider).

Use of the Family Residency Program

The participants at the Summit agreed that the Family Residency Program at Hilo Medical Center could serve as a key mechanism for implementing both of these components. Because the Family Residency Program is going to be relocated directly adjacent to the HMC Emergency Department, it could enable patients who come to the ED to easily and seamlessly either (1) be linked with a primary care provider who is part of the Family Residency Program immediately following treatment in the ED or (2) be diverted from the ED to receive urgent care services from a primary care provider in the Family Residency Program.

Because 40% of the ED visits at the hospital are coming from the Puna community, the participants at the Summit noted that it may be necessary to operate similar types of services directly in that community in order to provide adequate access to care for residents of that area.

Coordination with Community Primary Care Providers

The participants at the Summit agreed that it would be important for the Medical Home for Complex Patients and the Urgent Care Center to deliver services in coordination with primary care physicians in the community and at Bay Clinic. The reasons include:

- A Medical Home for Complex Patients supported by the Family Residency Program will likely not have the capacity to serve all of the patients who do not have a regular primary care provider and come to the ED for care. Those patients whose primary care needs could be managed effectively by community physician practices or Bay Clinic should be transitioned to care by one of those providers so that there continues to be adequate capacity at the Family Residency Program to help new patients with complex needs.
- Services delivered by the Urgent Care Clinic to a patient who has a primary care provider should be coordinated with the patient's existing care plan, and any follow-up should be delivered by the patient's regular primary care provider. Ideally, the information needed for this coordination and follow-up should be derived from interoperable Electronic Health Records or a Health Information Exchange.

To ensure effective coordination, the participants at the Summit noted that it may be desirable for the Medical Home for Complex Patients and/or the Urgent Care Clinic to be jointly owned or overseen by a partnership of the Hilo Medical Center, the East Hawaii IPA, and Bay Clinic.

Alternative Payment Models to Support the Initiative

The participants at the Summit felt that it was unlikely that current payment systems would provide adequate support for these new approaches to delivering care, even though the services could reduce overall healthcare spending on the patients involved. Consequently, Alternative Payment Models (APM) will be needed to support each component of the initiative. These APMs might be structured as follows:

- **APM for Medical Home for Complex Patients.** For Medicaid patients, services delivered by the Medical Home for Complex Patients (C-PCMH) could be supported by:
  - a visit-based payment for the initial intake visit. This would support the initial process of assessing the patient's needs, making referrals for community services, and building a relationship with the patient.
  - a stratified per-member-per-month (PMPM) payment for patients who agree to receive ongoing care from the C-PCMH. Higher PMPM payments would likely be needed for

patients who have more significant needs, since they are at higher risk of complications and improved care will result in greater savings.

- a performance-based payment based on measures of the C-PCMH's success in improving the patient's health and avoiding future ED visits and hospital admissions.

- **APM for Urgent Care Clinic.** The appropriate mechanism for paying for urgent care services would depend on the mechanism being used to pay the patient's regular primary care provider:
  - For patients whose primary care provider is participating in an alternative payment model in which they have taken accountability for the rate at which their patients use the ED, the primary care provider could contract with the Urgent Care Clinic (UCC) to pay for the services the patient receives from the UCC, either on a fee-for-service basis or through a monthly payment for each of the primary care provider's patients. The primary care provider would save time and money by not having to deliver after-hours urgent care services directly, and the provider would receive higher payments by maintaining low rates of ED use, so those savings and payments would serve as the source of funds to pay the UCC.
  - For patients whose primary care provider does not have any financial accountability for ED utilization, the patient's health plan could provide a per-member-per-month payment to the Urgent Care Clinic (UCC) for each of those patients, with a portion of the payment dependent on the success of the UCC in reducing the rate of ED visits for the patients.

Participants at the Summit noted that an Alternative Payment Model for the ED itself may also be needed to ensure that the Hilo Medical Center continues to receive sufficient revenue to support the delivery of high-quality emergency services through its ED as the volume of ED visits is reduced.

Data and Analyses Needed

Participants at the Summit agreed that additional analyses of ED utilization will be needed in order to design the details of the care delivery and payment models. This will require detailed data on the reasons for ED visits, the days and times of the visits, the patient's health insurance coverage, whether the patient has a primary care provider, how the patient was transported to the ED, and the neighborhoods/communities in which the patients live.

Leadership and Staffing for Implementation

The participants at the Summit recommended the following leadership and staffing structure for this initiative:

- **Community Leader:** Barry Taniguchi should serve as the Community Leader for the Initiative.
- **Project Directors:** Dan Brinkman, CEO of the Hilo Medical Center, and Mike Sayama, Executive Director of Community First, should jointly serve as the Project Co-Directors for the Initiative.

A Steering Committee for the Initiative should be formed by Barry Taniguchi that includes decision-makers from all of the key stakeholders needed to ensure success.

Priority #2: Best Palliative Care for Patients with Advanced Illness

The participants at the Summit agreed that one of the most important components of the RHIC's Best Heart Care Initiative had been providing supportive (palliative) care to patients with advanced heart failure who were being hospitalized frequently in their final months and years of life. These patients were either not eligible for or willing to accept hospice care, but they needed more than what could be provided through the types of care management services delivered by primary care providers.

The Hospice of Hilo reported that it has invested considerable effort and money to build the capability to deliver this type of supportive care services to patients, but the combination of the current volume of services and the current payment rates for the services is not sufficient to sustain this important program even though it costs less to deliver supportive care to patients than to have them hospitalized frequently.

Participants at the Summit agreed that East Hawaii residents with advanced illnesses other than heart failure are also being hospitalized frequently and could benefit from the supportive care services being delivered to heart failure patients, enabling payers to save money in the process. Moreover, an increased number of patients receiving these services could make the supportive care program more financially sustainable.

Consequently, the Summit participants agreed that a priority for 2017 should be to transition the Best Heart Care Initiative into a broader Initiative to deliver supportive care to East Hawaii residents with all types of advanced illness.

Leadership and Staffing for Implementation

The participants at the Summit recommended the following leadership and staffing structure for this initiative:

- **Community Leader:** The participants nominated Charlene Iboshi to serve as the Community Leader for the Initiative. (Because Charlene indicated after the meeting that she would be unable to serve in this role, Karen Maedo was invited and agreed to serve.)
- **Project Director:** Brenda Ho, CEO of the Hospice of Hilo, should serve as the Project Director for the Initiative.

A Steering Committee for the Initiative should be formed by Charlene Iboshi that includes decision-makers from all of the key stakeholders needed to ensure success.

Priority #3: Recruiting and Retaining Physicians

The participants at the Summit agreed that the East Hawaii RHIC's existing Initiative for Recruiting and Retaining Physicians should remain a priority in 2017. The Initiative has been successful in obtaining sufficient funding from the key stakeholders on the RHIC to help recruit and retain physicians, and the first set of physicians to benefit from these funds will be selected in 2017. In addition, continued work is needed to assess the feasibility and desirability of establishing a management services organization to provide administrative services for new and existing physician practices in order to facilitate recruitment and retention.

Leadership and Staffing for Implementation

Leadership and staffing for this initiative are already in place:

- **Community Leaders:** Toby Taniguchi and Randy Kurohara serve as the Community Leaders for the Initiative.
- **Project Director:** Lisa Rantz, Executive Director of the Hilo Medical Center Foundation, serves as the Project Director for the Initiative.

Planning for Reducing the Proportion of Services Delivered on Oahu

Goals

In addition to the three priority initiatives, the Summit participants agreed that additional planning and analysis should be performed to explore ways to reduce the proportion of healthcare services that are delivered on Oahu rather than in East Hawaii. This could achieve three goals:

- East Hawaii residents would obtain needed healthcare services more quickly and with greater support and involvement by family members if they could receive the services in Hilo rather than Honolulu.
- Payers would spend less on services if the services could be delivered cost-effectively in Hilo rather than Honolulu.
- East Hawaii physicians and the Hilo Medical Center would be better able to financially sustain high-quality services with higher volumes of patients.

Opportunities

The Summit participants identified two types of opportunities for reducing the proportion of services delivered on Oahu:

- **Increasing use of underutilized services offered in Hilo.** The Hilo Medical Center and physician practices in East Hawaii have sufficient capacity to deliver some of the kinds of services that patients are currently going to Oahu to receive; they simply need the patients to come to them rather than go to Honolulu. For example, the Hilo Medical Center has surgeons and operating capacity to deliver some of the general surgery procedures that are currently being performed at hospitals in Honolulu.
- **Increasing the capacity and types of services offered in Hilo.** In other cases, the Hilo Medical Center is currently delivering the kind of services that patients are receiving in Honolulu, but HMC or its physicians do not have the capacity to deliver more of those services. In these cases, investments in additional physicians, personnel, equipment, or facilities would be needed in order to deliver more of the services in Hilo. For example, approximately half of elective orthopedic surgeries are performed in Hilo and half are performed in Honolulu, but an additional orthopedic surgeon would be needed to deliver a higher proportion of the surgeries in Hilo. In still other cases, the Hilo Medical Center is not offering a service at all, but it could begin delivering that service if there were sufficient startup funds and an assurance of sufficient referrals and adequate payments.

Barriers

The Summit participants identified several barriers that would need to be overcome in order to pursue these opportunities:

- Primary care physicians and citizens in East Hawaii do not have access to current, accurate information on the services that are available in the community.
- Primary care physicians and hospital-based specialists do not know each other or have opportunities to work together to help build referral relationships. The advent of hospitalists has meant that the hospital is no longer a place where primary physicians regularly meet and work with specialists.

- Both residents of the community and physicians believe that the quality of care is higher for services delivered in Honolulu rather than Hilo, even though data indicate that the Hilo Medical Center delivers high-quality care.
- It takes time to build up a new surgery or specialty practice, and a new practice will lose money until an adequate number of referrals is achieved.
- Specialty clinics operated by Oahu providers encourage referrals to Oahu hospitals for procedures rather than the Hilo Medical Center.

Potential Elements of an Initiative

The Summit participants identified the following as potential components of an Initiative to overcome these barriers and to pursue the opportunities:

- Social events could be organized to help primary care physicians and specialists meet and get to know each other.
- A Physician Organization (PO) could be formed that includes both community physicians and hospital physicians, or the hospital physicians could be invited to join the East Hawaii IPA.
- A "referral center" could be established that patients and primary care physicians (and their nurses or other office staff) could use as a one-stop shop to obtain information about the services available in East Hawaii and other islands. The referral center could provide information both by telephone and through a website.
- The Hilo Medical Center and its physicians could measure and publicly report the quality of the services they deliver. This information could be made available to the public through the referral center website.
- A proactive marketing campaign could be organized to educate residents and other physicians about the types of services available in Hilo and the quality of care provided. This could include recognized community leaders praising the services they received in Hilo.
- A pool of funds could be established to serve as working capital to cover the costs of physician recruitment, investment in equipment, and initial losses in the creation of new and expanded service lines. The pool of funds could be replenished through a portion of the revenues generated when services are delivered.
- A multi-stakeholder process could be used to set priorities for expanding services so that community physicians, employers, and others are involved in the decisions and are more willing to take the actions needed to make the expansions successful.

Responsibility for Additional Planning

The Summit participants felt that additional planning and analysis were needed in order to define an Initiative with enough specificity that it could be implemented by the RHIC.

Dan Brinkman agreed to carry out this work and to bring a detailed recommendation to the RHIC during 2017.

APPENDIX:
Health Care Problems and Challenges in East Hawaii

Participants at the Summit identified over two dozen healthcare-related problems and challenges facing the region before narrowing them down to the four priorities and the overarching priority discussed in Section I-A.

1. The potential for significant increases in health insurance premiums for small employers such as the insurance offered by KIAA
2. Legal barriers to diverse types of companies pooling their resources and experience in order to purchase affordable insurance
3. Difficulties in filling physician vacancies at Bay Clinic
4. Difficulties in integrating family members of new physicians into the community
5. Resistance by established physicians to work as a group with other physicians in the community in order to deliver better care to patients and participate in new payment models
6. Lack of a common EHR for physicians and lack of interoperability between the existing EHRs
7. Unwillingness of the East Hawaii IPA members to contract for services as a group
8. Disruption to referral relations and patient care when the Hilo Medical Center makes changes in physician staff
9. Lack of communication and working relationships among physicians and between physicians and other providers
10. Difficulties faced by patients in accessing specialty care, such as oncology.
11. Lack of financial stability for the Hilo Medical Center and the East Hawaii Region of the Hawaii Health Systems Corporation due to a variety of factors including:
    - Inadequate legislative appropriations to cover commitments to workers
    - Unpredictability of labor costs
    - Pension liabilities
    - High and growing fringe benefit costs
    - State support provided to avoid facility closures but not to assure high quality care
    - Lack of opportunities for further cost reductions
    - Insufficient funding to manage short-term cash flow variations and other risks
12. Financial challenges in maintaining the inpatient hospice program due to low utilization, low reimbursement, and lack of community support and advocacy
13. Financial challenges in maintaining the palliative care program due to low utilization, low reimbursement, and lack of community support and advocacy
14. Lack of behavioral health providers
15. Lack of housing for the homeless
16. Lack of information on the quality of services delivered by individual providers
17. Inadequate home care for seniors, due to workforce shortages and low pay rates

18. Lack of adequate coordination and transitional support services for patients with multiple health problems or who are receiving multiple services
19. Failure of residents of East Hawaii to take responsibility for maintaining and improving their health
20. Insufficient number of patients obtaining services from the Bay Clinic van
21. Lack of ability to reallocate healthcare spending and resources into higher-value activities;
22. Low Medicaid payment rates
23. Low Medicare payment rates
24. Lack of education and engagement by state officials
25. Failure of local stakeholders to advocate on behalf of each other's needs