Home and Community Based Care Moving Forward in Hawai'i

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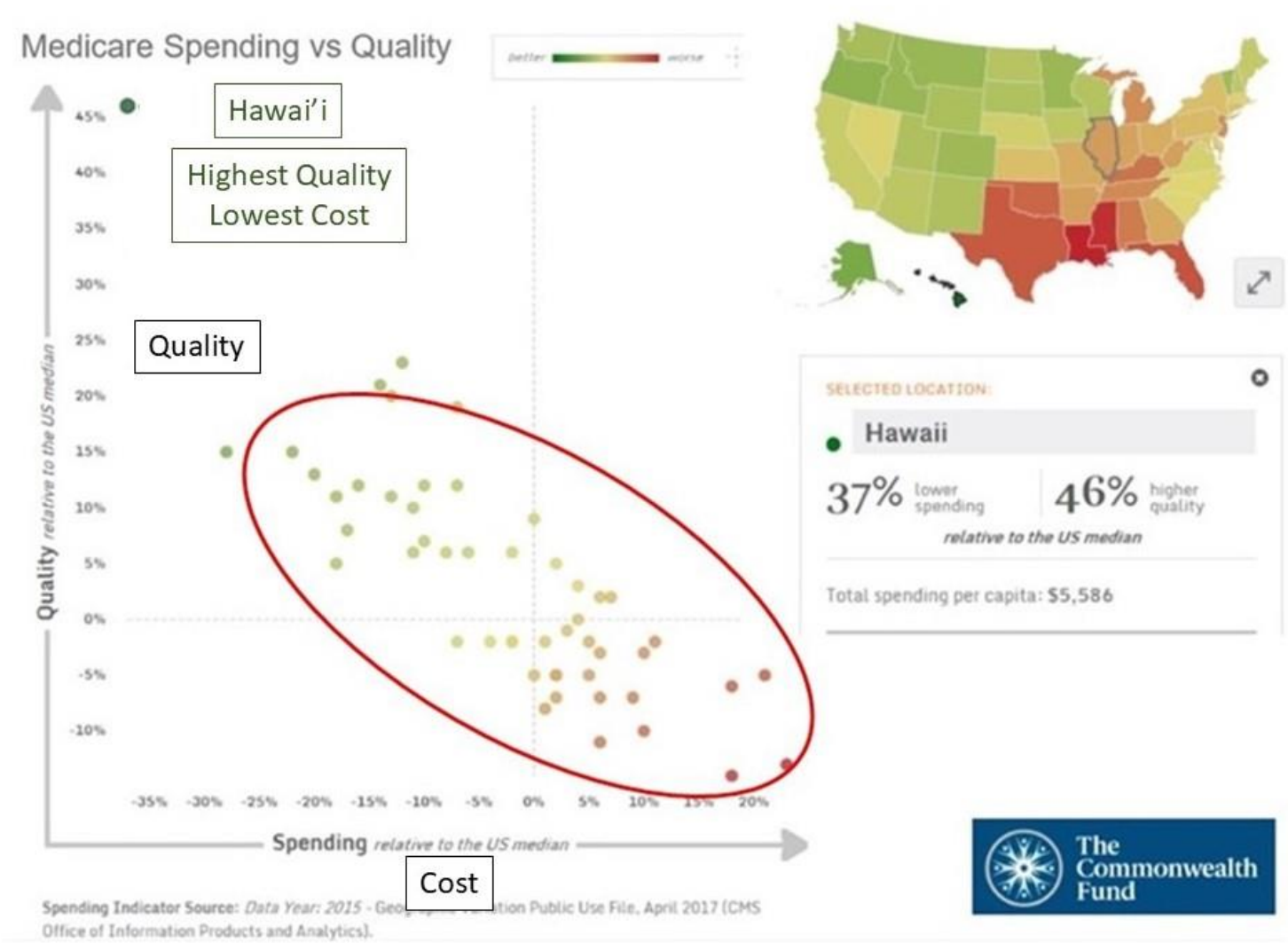
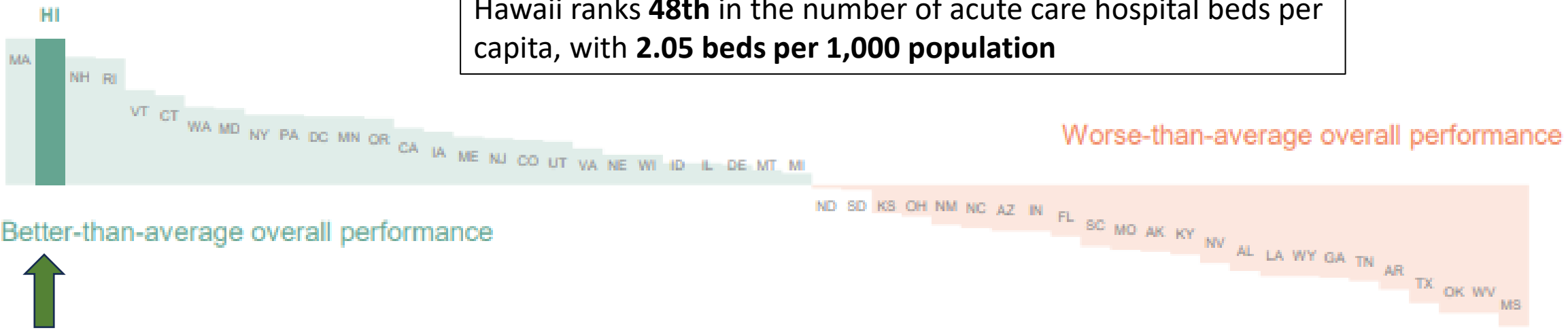


How Hawaii Compares to All States

Hawaii ranks **48th** in the number of acute care hospital beds per capita, with **2.05 beds per 1,000 population**



TIMEFRAME

2021

DISTRIBUTIONS

Clear All Selections

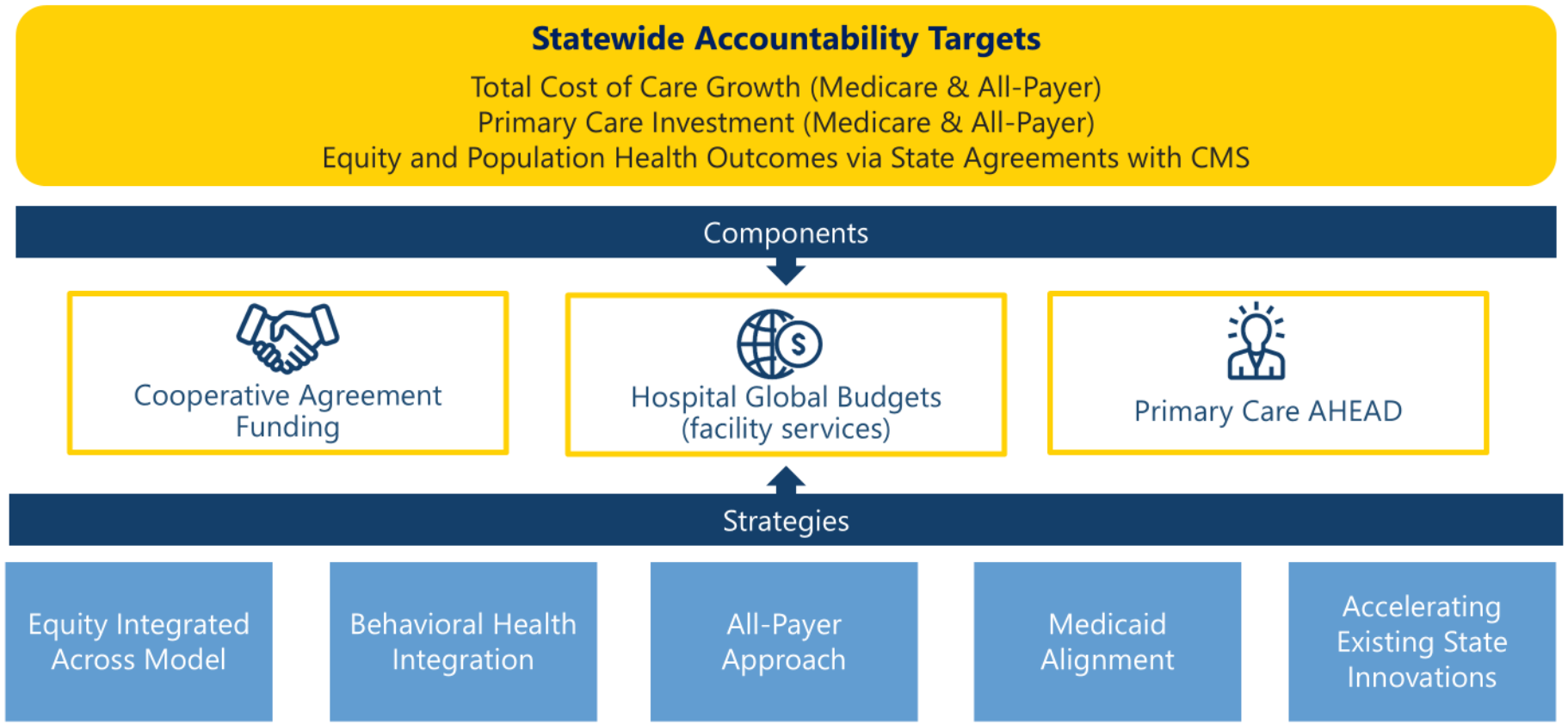
- [ ] Total Traditional Medicare Part A and/or Part B Enrollees
- [ ] Total Medicare Part A and/or Part B Persons With Utilization
- [ ] Medicare Part A and/or Part B Program Payments Per Person With Utilization

Location	Medicare Part A and/or Part B Program Payments Per Person With Utilization	Medicare Part A and/or Part B Program Payments Per Traditional Medicare Enrollee	Total Traditional Medicare Part A Enrollees	Total Medicare Part A Persons With Utilization
1. Hawaii	$9,372	$7,472	145,288	18,643
2. Montana	$9,449	$8,649	187,346	26,761
3. New Mexico	$9,553	$8,665	247,550	39,477
4. Oregon	$9,573	$8,610	458,526	70,798
5. Idaho	$9,576	$8,929	215,612	33,571
6. Washington	$9,750	$8,737	863,450	122,873

Jack is back

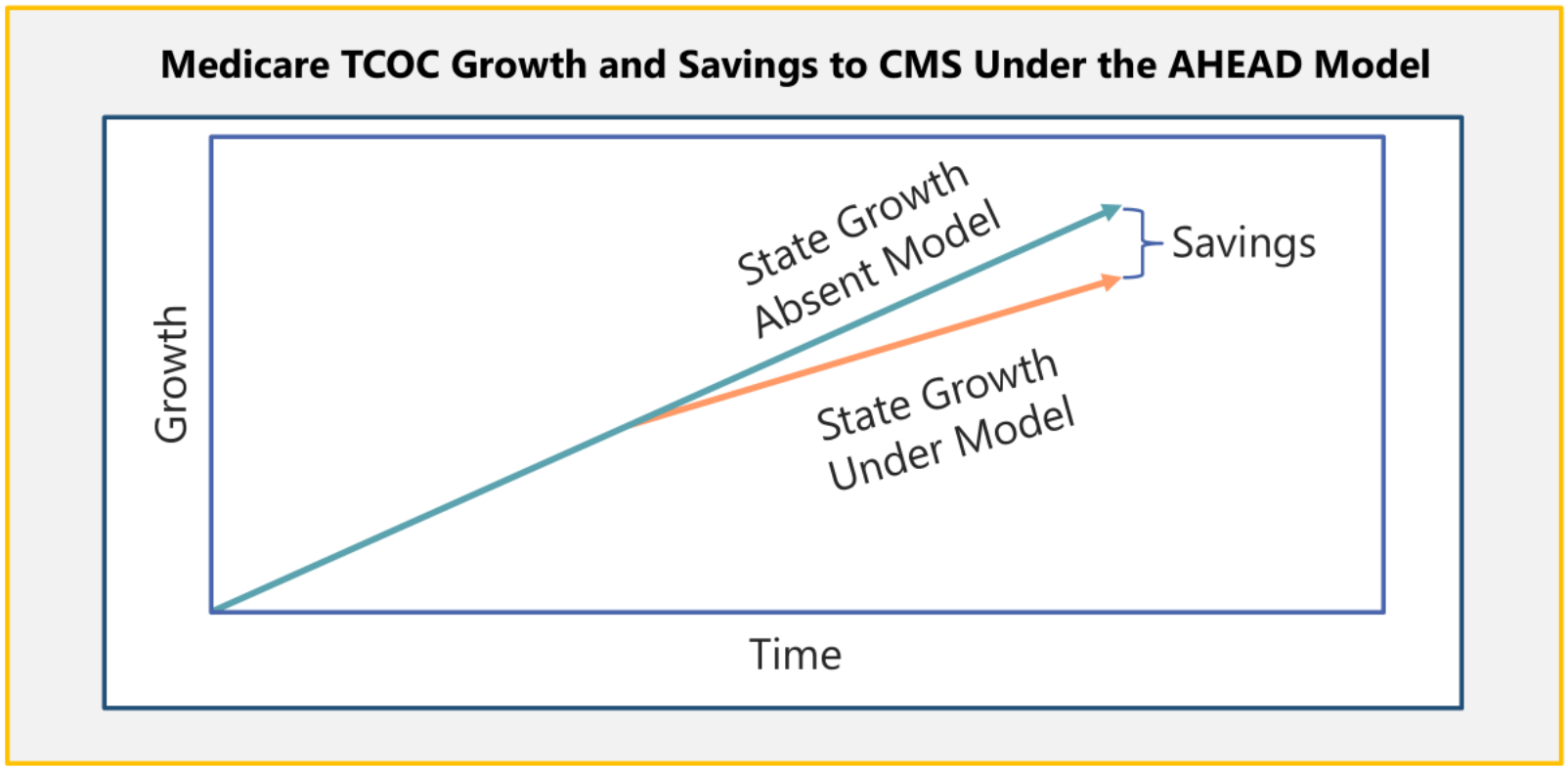
AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.



Medicare FFS TCOC Targets

AHEAD was developed in alignment with affordability and cost growth containment efforts underway in states across the nation, and the Medicare TCOC target holds states accountable for "bending the cost curve" for Medicare Part A and Part B expenditures of resident beneficiaries. By holding states accountable for cost growth, CMS hopes to support states in achieving a more affordable cost trajectory and increased long-term sustainability. CMS will work collaboratively with each state during the pre-implementation period to set state-specific Medicare FFS TCOC growth targets.



All-Payer and Medicare Primary Care Investment Targets Comparison

Goals for All-Payer Primary Care Investment Targets

- Build on existing state and national progress in the primary care investment space
- Include flexibility for states to adopt policies to their unique context
- Leverage state tools for increasing payer accountability to increase primary care investment

Shared Goals

- Increase primary care investment to strengthen the primary care system in participating states and regions
- Encourage thoughtful, targeted, equity-focused investment tactics across payers
- Build capacity for defining and measuring primary care spending

Goals for Medicare FFS Primary Care Investment Targets

- Bring Medicare FFS to the table for primary care investment efforts via Primary Care AHEAD Program
- Utilize CMS data to track Medicare FFS primary care investment in participating states
- Provide a standardized approach for defining primary care

What is a cost growth target program?

Cost growth target:

- A goal for how much total statewide health care spending should increase per year to make it affordable.
- Working together, state leaders, health insurers, health care providers, businesses, and consumer advocates agree to these targets and commit to achieving them.

Cost growth target program:

- Increases transparency by gathering, analyzing and reporting health care spending data
- Holds industry accountable by measuring performance against the target and identifying cost drivers
- Proposes shared solutions to make health care more affordable

Home and Community Based Care Moving Forward in Hawai’i

Community Health Navigator

- CHN engages assigned client at IP bedside
- CHN helps prepare client for admission to SNF or next level of care in conjunction with hospital case management team and/ or SNF admission team
- CHN officially enrolls client by getting signed consent for program
- CHN supports client in SNF in collaboration with the SNF care team (when applicable)
- CHN supports client in community post discharge from hospital or SNF and continues weekly meetings with clients and caregivers to work toward goals for up to 60 days post discharge
- APRN provides education, support, and goal development for chronic condition management (e.g. Congestive Heart Failure (CHF), Diabetes Mellitus (DM), Chronic Obstructive Pulmonary Disease (COPD), etc.) and reconciles medications within 3 days of discharge from SNF or hospital.

Impact

- **Reduce IP ALOS** by assisting with IP discharge/ SNF admit process, preparing clients for SNF, and managing client/ caregiver expectations
- **Reduce SNF ALOS** by preparing clients/ caregivers for home or next level of care and providing added support post discharge
- **Reduce inappropriate ED and IP utilization** by serving as advocates and educating on right care, right time, right place
- **Reduce medication errors** by assisting with medication reconciliation, education, and organization
- **Reduce 30-day all-cause readmission** by ensuring timely PCP follow-up, assisting with medication reconciliation, serving as advocates, ensuring care plans are carried out, providing education, and supporting clients/ caregivers with social needs.
- **Improve client experience of care** by maintaining a high client satisfaction with program and care system
  - **10/10 overall satisfaction, 10/10 would recommend program to family/ friends**
- **Improve health of population** by addressing Social Determinants of Health (SDoH), managing expectations, and improving health literacy, autonomy, engagement, and access

Vivia Model

Technology Enables Innovative New Service Model

Current Business Model
Time Based Care

3 hour minimum home visit

2:1

The Vivia Model
Goal Based Care

Vivia Cares, Inc.

Technology Enabled Home Care Leveraging Scarce Caregiving Resources

Ho'okele is now Vivia Cares

- Short, frequent visits
- No minimums
- Consistent Team
- Connected by Technologies
- Allows a Caregiver to help 20 Seniors vs. only 2

Pairing technology at home with the caring human touch

Vivia

Home-based palliative care is specialized medical care for people living with serious illnesses, provided in the comfort of their own home. Home-based palliative care typically involves a team of healthcare professionals, including doctors, nurses, social workers, and chaplains. This type of care can be offered alongside curative treatments and is appropriate at any stage of a serious illness

Current Landscape

Palliative care helps patients better cope with a serious illness and greatly improves their quality of life and health outcomes, but palliative care is under-utilized and not well understood.
The Centers for Medicare and Medicaid Services (CMS) recently announced that Hawai'i is the first state in the nation to offer a palliative care benefit for Medicaid recipients. The Department of Human Services, Med-QUEST Division, will be gathering information from the community for implementation.

Awarded a $3.6 million grant from the Department of Human Services in April 2024 to expand access to home and community based palliative care.

Veteran Directed Care

- The VDC program serves Veterans of any age who are at risk of nursing home placement
  - Veterans hire workers, including family, friends, and neighbors, to provide personal care services in accordance with a Veteran-developed and VA-approved spending plan
  - Veterans receive assistance to manage their employer responsibilities from person-centered counselors and financial management services (FMS) providers
  - Veterans Affairs Medical Centers (VAMC) purchase VDC services from VA-approved Aging and Disability Network Agencies (ADNA) using Veterans Care Agreements

VDC Program Components

- The Veteran is evaluated for their support needs with activities of daily living
- The level of need determines the amount of money the Veteran can spend for support
- The VDC provider works with the Veteran to develop a spending plan to address needs and goals
- Person-centered counselors (PCC) perform assessments, assist with enrollment, facilitate completion of employee new hire packets, and help develop spending plans
- PCCs maintain at least monthly contact with Veterans and conduct quarterly in-home visits

What do you think?