

HAWAII HEALTH SYSTEMS

C O R P O R A T I O N

Quality Healthcare For All

**REPORT TO
THE THIRTIETH
HAWAII STATE LEGISLATURE**

Pursuant to H.C.R. No. 95 S.D.1

from the Twenty-Ninth Legislature, 2018

**REQUESTING THE HAWAII HEALTH SYSTEMS CORPORATION REGIONAL BOARDS
FOR OAHU, EAST HAWAII, WEST HAWAII, AND KAUAI TO ASSESS THE
AVAILABILITY OF LONG-TERM CARE BEDS IN EACH REGION AND ITS IMPACT ON
WAIT TIMES FOR ACUTE CARE HOSPITAL BEDS.**

Submitted: December 20, 2018

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HHSC East Hawaii Region : Hilo Medical Center Waitlist Assessment

Background

Hilo Medical Center is a 186 bed acute and long term care facility located in Hilo town, on the eastern side of the Big Island of Hawaii. Hilo Medical Center (HMC) serves as a safety net facility and sole acute medical hospital for a large, relatively isolated geographic area. Primarily an acute care facility, HMC has a small long term care facility on campus and two affiliated critical access hospitals (CAH). As the only hospital, HMC necessarily accepts all patients regardless of insurance status and consequently is responsible for appropriate disposition of patients within the capacity of community resources. Hilo Medical Center has developed a significant amount of flexibility through active management of the long term care beds on campus and in the affiliated CAH facilities, but remains dependent on community resources and facilities for placement of the vast majority of patients who require continuing care or long term placement.

Community Resources

The following facilities provide the majority beds for skilled nursing (SNF) and intermediate care (ICF) patients from Hilo Medical Center. The Lehua Unit and Extended Care Facility are located on the hospital campus and provide placement almost exclusively from Hilo Medical Center. The other listed facilities have far broader catchment and admit patients from other acute care facilities and directly from the community.

Facility	Affiliation	Notes
Lehua	HHSC Hilo Medical Center	7 bed unit for high acuity SNF patients including patients on ventilators
Extended Care Facility	HHSC Hilo Medical Center	28 bed unit for patients not accepted by community facilities
Hale Ho'ola Hamakua	HHSC East Hawaii Region	77 Bed CAH and LTC facility located in Honoka'a
Ka'u Hospital	HHSC East Hawaii Region	26 Bed CAH facility located in Pahala, Ka'u district.
Life Care Center of Hilo	Life Care Centers of America	252 Bed SNF and LTC facility. Secured dementia ward
Hale Anuenue Restorative Care Center	Life Care Centers of America	120 Bed SNF and LTC facility.
Legacy		100 Bed SNF and LTC facility.
Yokio Okutsu State Veterans Home	HHSC Avalon	95 Bed SNF and LTC facility.
Care Homes ARCH	Independent Operators	HMC is very dependent on a network of Care Homes for placement of patients in the community.

Hilo Medical Center Discharges and Waitlist placement

Hilo Medical Center has 114 acute care beds, exclusive of Obstetrics and Behavioral Health, that can be used for acute medical care. Current utilization of acute beds is currently greater than 90% leaving little or no spare capacity. During fiscal year 2018, Hilo Medical Center discharged an average of 640 patients monthly, a rate that remained relatively consistent throughout the year. Of these discharged patients, roughly seven (7) percent were assigned to waitlist status because they could not be placed safely by the time their status changed to post-acute care. This resulted in an average of 46 patients placed on the waitlist service monthly with an average daily starting census of 22 waitlisted patients. The number of waitlist patients increased significantly from March to May for multiple reasons but has subsequently returned to baseline. Internally, the Lehua unit and ECF facility were able to accept roughly 9 patients monthly or 20% of the total, leaving 80% of the waitlist roster that needed placement outside of Hilo Medical Center. Average length of stay on the waitlist service was 14 days.

FY 2018	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Discharge Acute	687	569	613	697	653	667	696	593	665	606	649	582	7697
Waitlist Census	22	19	16	19	20	21	20	22	24	26	26	24	22
Waitlist Days	677	593	479	606	625	660	613	630	756	780	819	722	7960
Lehua admits	6	5	6	4	2	4	4	4	1	1	5	4	46 (4/mo)
ECF admits	7	8	8	8	7	5	5	5	1	4	1	0	59 (5/mo)

Waitlist patients

There are complicated and inter-related reasons that patients wait in acute hospital beds for placement. Although the availability of long term care beds is a critical long term community health care need, the availability of appropriate beds often has less impact on patient placement than difficult economic, social and psychiatric factors. The major factors contributing to retention of downgraded patients in acute hospital beds at Hilo Medical Center, in general order of difficulty and importance, are as follows:

- The patient's behavior is inappropriate for placement in LTC facility or a care home. This is usually because the patient is verbally abusive, combative, or has significant psychiatric issues. These patients often cannot be placed and become permanent residents of Hilo Medical Center.
- The patient is incompetent to make decisions and is socially isolated, or has been abandoned, with lack of surrogate or guardian. There is only one public guardian on Hawaii Island, who is extremely busy, resulting in a difficult and lengthy process to establish guardianship. Patients awaiting guardianship often remain on waitlist for six months or more. Many of these patients also become permanent residents.

- The patient has inadequate insurance coverage or insurance not acceptable to outside facilities because of low reimbursement. This often relates to patients who have no insurance, are Medicaid only, or Compact of Free Association (COFA) designees. Negotiating the insurance enrollment process is slow and tedious resulting in long delays. Patients who are uninsurable and COFA patients often remain on the waitlist until they recover or expire.
- The patient or the patient's family not cooperative in providing financial resources or helping to sign patient up for Medicaid and/or other insurance paperwork. This is often the case for patients who do not want to use Social Security benefits to pay for facility fees or have financial resources that they do not want to expend. The hospital has little ability to compel patients to use financial resources and is not allowed to complete insurance paperwork for the patient.
- The Patient is no longer acutely ill, but has complex medical needs not in the capacity of an outside facility. These include patients on ventilators, peritoneal dialysis or who need complex wound care. Patients with complex wounds often stay for four to six weeks, ventilator and peritoneal dialysis patients become permanent residents of HMC, usually on the Lehua or ECF units.
- LTC facility is full or LTC facility does not have the correct gender bed available. This is usually a self-limited problem but there are episodic problems when community SNF facilities close for influenza outbreaks or operational problems.

CONCLUSION:

Admissions to Hilo Medical Center have been relatively consistent over the last three years and numbers of waitlisted patients have also, with some exceptions remained relatively stable with a daily starting census of twenty-two. A progressive increase in acute patient acuity and associated increased length of stay at HMC has put pressure on the acute bed capacity of the hospital resulting in a dramatic increase of patients held in the Emergency Department pending availability of acute beds. HMC's problem with ED holds has been fully investigated and is under active management but is complex involving length of stay, waitlist numbers, total bed capacity, and distribution of beds at various levels of nursing care. Hilo Medical Center has a significant resources that can be applied to waitlist patients but analysis concludes there is no easy solution to the underlying logistical issues faced by waitlisted patients, and adding beds internally or in the community will minimally mitigate a problem with fundamental medical, legal and societal origins.

Every barrier to placement of waitlisted patients listed above is deserving of closer examination and adoption of systemic solutions. The patients and the acute care facilities would be better served by practices that improve efficiency in establishing guardianship, resources and insurance. The greatest challenge for Hilo Medical Center, though, is not resources but the care and placement for patients with behavioral and psychiatric problems severe enough to prevent placement in community facilities. Even with resources and guardianship in place, there are limited management strategies and few facilities capable of proper custodial care of these challenging patients. Hawaii

Island has only one secured dementia unit and that unit is not primarily intended for patients with behavioral or psychiatric issues. Hilo Medical Center is also not designed or equipped to manage wandering, verbally abusive or potentially violent patients. These patients often wind up as permanent residents of Hilo Medical Center, sometimes requiring long stays on our psychiatric unit for their protection or safety of the staff. A solution to this difficult placement problem will be hard to achieve but ultimately would serve the patients far better than the care they currently receive.



Kona Community Hospital (KCH) – Long Term Care placement assessment
5/30/2018

Patients waiting for placement into long term care, skilled nursing facilities, and intermediate care facilities is always challenging. There are a variety of underlying reasons for having patient's waitlisted, it is not always due to capacity issues. KCH social workers and case managers work closely with area facilities to ensure patients are placed appropriately and as timely as possible. Below is an assessment of placement of patients into LTC/SNF/ICF facilities from KCH.

FY 2018 data below:

Month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Total # Inpatient discharges	380	341	354	351	360	356	398	330	336	361
Total # Patients Discharged to LTC/SNF/ICF	16	18	31	22	19	21	20	17	23	25

Month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Total Waitlist days	32	47	76	38	31	68	104	95	180	146
Waitlist for SNF days	30	16	34	33	16	24	72	48	122	81
Waitlist for ICF days	2	31	42	5	15	44	32	47	58	65

West Hawaii SNF/ICF facilities available for KCH patients (not including Hilo facilities)

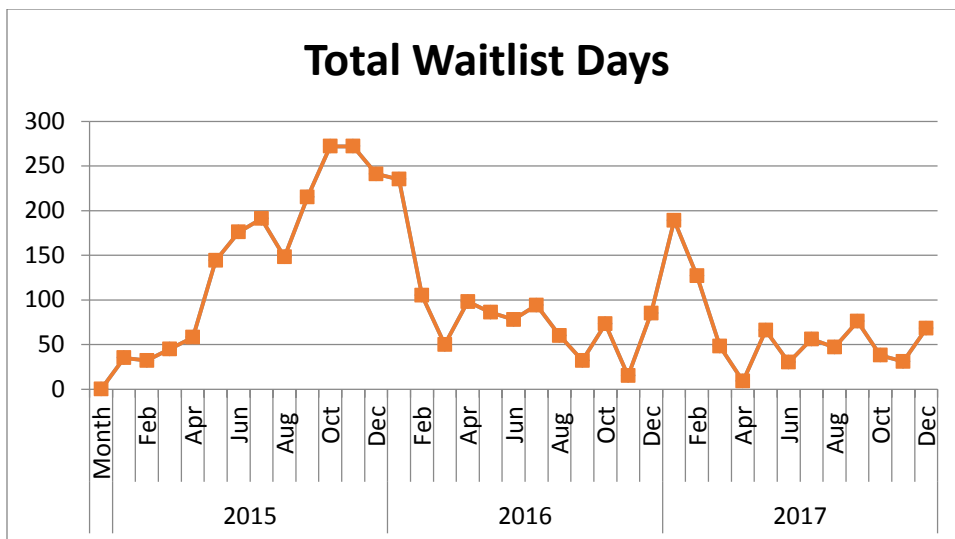
Facility	# of beds
Kohala Hospital - Kapaau	24
Life Care Center of Kona - Kona	94
Kau Hospital - Pahala	16
Hale Ho'ola Hamakua	66



Primary reasons for waitlisted patients:

- LTC facility does not have the correct gender bed available.
- Patient’s behavior is inappropriate for that setting, ie; combative, psychiatric issues.
- Lack of surrogate or guardian and patient is incompetent to make decisions.
- Patient is too large, no bariatric bed available.
- Various challenges with insurance coverage and/or facility not accepting certain payer types.
- Patient abandonment/guardianship, only 1 public defender on the island, who operates out of the East side of island and is extremely busy, resulting in a difficult and lengthy process to establish guardianship.
- Patient’s family not cooperative in helping to sign patient up for Medicaid and/or other insurance paperwork. Hospital is unable to do this for the patient.
- LTC facility is full.

KCH had 18 SNF beds up until 9/1/2015, at which time these beds were re-licensed to acute care beds. As the trendline shows, after the transition of existing patients, the waitlist days leveled off indicating that the waitlist days were not impacted by the closure of these beds. Data suggests that “number of beds” is not a factor, or at least not the primary reason for patients being waitlisted for SNF beds.





CONCLUSION:

The average daily census at KCH has been steadily climbing and holding for the past two years. Any waitlisted patients can create a throughput issue if not able to move patients to the proper setting and keep acute care beds open. However, to date, this has not risen to a critical level for KCH operations; we have effectively managed through the relatively small number of patients waiting for placement into LTC/SNF/ICF facilities and the appropriate level of care. Data analysis and investigation conclude there is no clear solution to fix all the underlying issues associated with waitlisted patients, and simply adding beds is not going to solve the placement issues that have been identified.

Currently, our greatest challenge is establishing guardianship. We have three patients, two of which we have been holding in the hospital for months, waiting for court appointment. Until guardianship is signed off by the circuit court judge, we are not able to process paperwork for Medicare/Medicaid coverage which is required by the LTC/SNF/ICF facilities in order to place these patients appropriately. Improving the process and expediting signatures in the state court system would provide the greatest benefit for decreasing waitlist days at KCH. Again, increasing bed capacity would not help the guardianship situation.

HHSC Kauai Region Waitlist Assessment for Legislature

Background:

Kauai Region hospitals include Kauai Veterans Memorial Hospital (KVMH) and Samuel Mahelona Memorial Hospital (SMMH). KVMH is located in Waimea Town on the west side of Kauai. KVMH is a Critical Access Hospital (CAH) that accepts all patients regardless of insurance status and serves as the safety net facility for the community. KVMH has 25 CAH beds and a 20 bed distinct part Long Term Care (LTC) Unit on campus. The LTC beds at KVMH are consistently full with a waitlist for admission. The CAH SWING beds are available to receive admissions from the acute care hospitals that require Skilled Nursing Facility (SNF) care. SWING census averages 5 patients per day with capacity to increase as needed.

SMMH is an 80 bed hospital which includes 5 CAH beds, a 9 bed distinct part Behavioral Health Unit and a 66 bed distinct part Long Term Care Unit (LTC). LTC bed daily census fluctuate between 47 – 55 residents. We do have capacity to assist our acute hospitals in taking their waitlist patients. SMMH has developed a significant amount of flexibility through active management of the LTC beds on campus and in the affiliated CAH facility in order to be a resource for the continuing care or long term placement of patients on our island. The Kauai Region is in active discussions with Wilcox Hospital to create coordinated priority process for transferring waitlisted patients from Wilcox to SMMH. This will help to ensure acute care beds remain available for high acuity patients.

Community Needs:

A medical challenge that Kauai faces is related to our limited inpatient renal dialysis beds. Currently, Kauai only has a maximum of 4 acute renal beds available on island at Wilcox Hospital. With such bed limitations, our renal dialysis patients needing inpatient acute care frequently have to be transferred off island for care. This creates an unnecessary burden for the patient and their family. In an effort to keep healthcare costs down it is more prudent to keep these patients on island for their healthcare needs. HHSC Kauai Region's KVMH currently has the capacity and could assist by providing acute inpatient dialysis care since the majority of dialysis patients reside on the west side of Kauai. Some renovations would be necessary to accommodate the inpatient dialysis units and nephrologist oversight could be accomplished with telemedicine. In addition, there are times when no inpatient dialysis beds are readily available in the State. The patient's are held until a bed is available which often compromises the care of these patients.

Other issues that result in longer waitlists in our acute care facilities is related to the difficulty in finding a Swing SNF or LTC bed for patients with complex social and psychiatric factors. These patients are often denied admission to other LTC facilities even though beds are available. Holding them in an acute care hospital provides a lesser quality of life for the patient, ties up needed acute care beds, and also places an undue strain on the hospital's resources. As a safety net facility, HHSC Kauai Region's SMMH often takes these patients that have nowhere else to go. In order to provide safe quality care to meet

their complex needs, new care environments are necessary. SMMH has space on its campus to build Alzheimer and Behavioral Health LTC Units.

REPORT TO THE THIRTIETH STATE LEGISLATURE 2019

PURSUANT TO HCR95, SD1
SESSION LAWS OF HAWAI'I 2018
REQUESTING

THE HAWAI'I HEALTH SYSTEMS CORPORATION
REGIONAL BOARDS TO ASSESS THE AVAILABILITY OF
LONG-TERM CARE BEDS IN EACH REGION AND ITS
IMPACT ON WAIT TIMES FOR ACUTE HOSPITAL BEDS

O'AHU REGION
HAWAI'I HEALTH SYSTEMS CORPORATION
DECEMBER 2018

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EXECUTIVE SUMMARY

The 2018 Hawai'i Legislature passed Resolution HCR95 SD1 that directs the Hawai'i Health Systems Corporation (HHSC) to assess how its [the O'ahu Region's] respective public hospitals are responsive to the need for long-term care placements and how they mitigate the waitlist problem of acute care hospitals. The Resolution requests that recommendations be developed regarding the effect of the availability of long-term care beds on wait times for acute care beds in its respective geographic areas.

The problem of post-acute patients inappropriately occupying acute care hospital beds because they cannot be appropriately discharged is well documented and has persisted without material resolution for many years. Symptoms of the problem remain fundamentally unchanged.

Waitlist patients can be defined as acute hospital patients who are medically ready for discharge because they no longer need acute level care services but are not accepted for admission to appropriate institutional or home and community-based care settings because they exhibit complex (multiple) clinical conditions often accompanied by co-presenting mental or behavioral disorders, limited financial means and may lack appropriate home/community resources.

For O'ahu acute care hospitals, according to the March 2014 Hawai'i Health Information Corporation (HHIC) report, "Acute Care Waitlisted Patients in Hawai'i 2006 to 2011" there was an estimated 32,948 days that waitlisted patients inappropriately occupied acute care beds awaiting discharge. The average length of stay per patient was 6.7 days.

The HHSC O'ahu Region Ad Hoc Working Group designated to respond to the Resolution was led by the Board Chair and O'ahu Region CEO. Meetings were held with 6 acute care hospitals and 5 legislators. The Working Group also participated in a series of stakeholder meetings organized by the Healthcare Association of Hawai'i regarding the Wait List problem. The Research Information Services Consulting firm was contracted to data mine, determine utilization, strategize and conduct financial analysis.

In responding to the requested items contained in Resolution HCR95, SD1, Item #1 requests the following:

Assess how [the O'ahu Region's] respective public hospitals are responsive to the need for long-term care placements and how they mitigate the waitlist problem of acute care hospitals.

The O'ahu Region's key finding is as follows: the number and availability of long-term care beds have very little bearing on the current waitlist problem as it stands today. Rather, the primary contributors to the waitlist problem appear to be financial risk (uninsured) and medical complexity of care, e.g. bariatric, behavior, or drug addiction.

Since waitlisted patients typically have limited financial resources, long-term care facilities are averse to admitting them from acute facilities because they may not be approved for Medicaid assistance or, even if approved, the reimbursements are too low to be financially feasible. With regard to complexity, most long-term care facilities simply do not have the infrastructure, resources or willingness to admit patients with certain medically complex conditions.

In fact, on average, only 84.2% of long-term care beds are in use on O'ahu (not including Maluhia and Lē'ahi). It is fair to say that most of the 430 (15.8% of total long-term care beds on average) available beds are unused precisely because of the previously stated financial and complexity issues.

There is shared risk between the O'ahu Region long term care facilities and private hospitals with significant waitlist days. Herein lies the opportunity for both parties to collaborate through partnerships that result in building the infrastructure and capability necessary for an effective community solution.

The reality is, the solution is a challenging one as both public and private providers will need to significantly invest in capability and infrastructure before they can present themselves as part of the solution.

Item #2 of Resolution HCR95, SD1, reads as follows:

Develop recommendations regarding the effect of the availability of long-term care beds on wait times for acute care beds in its respective geographic areas.

As a result of our examination of the waitlist problem and discussions with acute facilities, the O'ahu Region is working with a major acute hospital provider to demonstrate proof of concept based on a public-private Pilot Project, where risk is shared in addressing excessive waitlist days. A critical success factor is O'ahu Region's ability to adapt existing physical plants, create new clinical resident services, and staff with new skill sets to serve residents with complex physical and behavioral health conditions.

HHSC O'AHU REGION OVERVIEW

HHSC O'ahu Region (hereinafter, "O'ahu Region") is comprised of two important post-acute health care facilities, Lē'ahi Hospital and Maluhia caring for residents that live in our buildings, often for many years, adult day health participants supporting their living in the community, an outpatient physician clinic and in-patient TB unit. The mission, vision and values of the Region are as follows:

Our Vision

To be a proud center of long-term care excellence – *to inspire hope, aloha, and a feeling of 'Ohana to those entrusted to us.*

Our Mission

To provide the highest quality of life in long-term care.

Our Values

- **Integrity** - *We act respectfully, responsibly and are accountable for everything we do.*
- **Collaboration** - *We approach our work through teamwork and community partnerships.*
- **Caring** - *We treat those we serve and each other with respect and compassion.*
- **Commitment** - *We dedicate ourselves to continue our historic role in meeting the needs of our community.*
- **Innovation** - *We continuously look for better ways to improve our care and work processes.*

The O'ahu Region provides essential services to our community's most vulnerable populations through its operation of two long-term care facilities, Maluhia and Lē'ahi Hospital. Located respectively in lower 'Ālewa Heights and Kaimukī, Maluhia and Lē'ahi provide in-patient nursing and intermediate care services to the elderly, disabled and otherwise incapacitated population, most of whom are covered under the State's Medicaid programs.

Together, Maluhia and Lē'ahi also provide access to other much-needed programs and services which allow the participants and recipients to remain at home in the community and, equally as important, provide caregivers with much needed relief and support. These programs and services include, but are not limited to, Adult Day Health Centers, a Geriatric Outpatient Clinic, and nutritious hot meals for disabled elders through collaboration with the Hawai'i Meals on Wheels Program.

For many of our nursing home residents, day health participants and clinic patients – especially those receiving Medicaid benefits due to a lack of personal assets

(approximately 80% of our in-patients) – the O’ahu Region’s facilities are often the only options for quality post-acute and community-based health care services.

Likewise, through our partnership with the Hawai’i Meals on Wheels Program, the O’ahu Region has been able to regularly provide our disabled elderly on O’ahu with **nearly 350 hot meals per week**, thereby enabling them to continue to live at home and sustain their independence in the community.

Maluhia and Lē’ahi Hospital Services

Maluhia, located in lower ‘Ālewa Heights in Honolulu, Hawai’i, was established in 1923. Lē’ahi Hospital, located in the heart of Kaimukī in Honolulu, Hawai’i, was first established in 1901. Both facilities continue to evolve in order to meet the changing needs of the community and today provides the following services:

Long-Term Care Inpatient Services

- Maluhia and Lē’ahi, respectively operate 120 and 117 Dual Certified Skilled Nursing and Intermediate Care Beds
- With an average occupancy rate over 90%, operation of these beds has enabled us to provide nearly 78,000 in-patient service days per year
- Operating 9 Acute TB inpatient Beds

Ancillary and Other Services

- Recreational Therapy
- Dietary Services
- Social Services
- Speech Therapy
- Occupational Therapy
- Physical Therapy

Outpatient Services

- Primary Care Geriatric Outpatient Clinic
- Adult Day Health Center which also participates in the legislatively supported Kupuna Caregiver Program
 - Two of only six adult day “health” programs on O’ahu
 - Enables caregivers to work or be afforded respite while their loved one is provided quality health care during the week
 - Maluhia’s program has a current roster of 90 participants with 32 persons on a program waiting list
 - Lē’ahi’s current roster is 39 participants
- Collaboration with Hawai’i Meals on Wheels to provide 70 meals per day (Monday through Friday) to residents in the Kalihi/Liliha and Kaimuki/Kapahulu areas

MALUHIA AND LĒ'AHĪ OCCUPANCY RATES

Approximately 10% of all of O'ahu's long-term care patients are served at our facilities. Maluhia and Lē'ahi have relatively high occupancy rates compared to other O'ahu long-term care facilities.

Table 1: O'ahu Region Occupancy Rates

Lē'ahi	2015	2016	2017	2018
Beds in Operation	155	130	117	117
Inpatient Days	52,805	42,585	40,306	37,838
Occupancy %	93.3%	90.0%	94.4%	88.6%
Maluhia				
Beds in Operation	158	133	120	120
Inpatient Days	54,825	44,533	40,368	39,299
Occupancy %	95.1%	92.0%	92.2%	89.7%
All O'ahu long term care beds not including HHSC (a)				
Licensed Beds	2,383	2,413	2,723	Not available
Inpatient Days	743,995	774,123	840,201	
Occupancy %	85.5%	87.9%	84.2%	
(a) Source: State of Hawai'i Health Planning & Development Agency Utilization Reports per calendar year				

Table 1a: Resident's Age Demographic

	Maluhia	Lē'ahi Hospital
Number of Males	34	41
Number of Females	71	71
Average Length of Stay	979 days	1037 days
Average Age	86 years	75 years
Residents Age 30-39	0	3
Residents Age 40-49	2	7
Residents Age 50-59	2	11
Residents Age 60-69	7	22
Residents Age 70-79	15	15
Residents Age 80-89	28	24
Residents Age 90-99	46	26
Residents Age 100-105	5	4

Maluhia and Lē‘ahi payer mix is heavily slanted toward Medicaid patients, with about 80% of the patients needing Medicaid to cover the costs of their care.

Table 2: O‘ahu Region Payer Mix

Payer	Lē‘ahi	Maluhia
Medicaid	80%	79%
Hospice	11%	9%
Medicare Advantage	1%	3%
Medicare	1%	1%
Other	7%	8%
Total	100%	100%

Medicare and Medicaid rates are established by the Centers for Medicare and Medicaid Services (“CMS”) and the State of Hawai‘i Department of Human Services, Med-QUEST Division, respectively. Medicaid typically has the lowest reimbursement rates and, as such, the revenues derived from such reimbursements do not cover the actual costs of services provided. This creates financial difficulties for the O‘ahu Region. The following reimbursement rates include monies received through Certified Public Expenditures and excludes General Fund Appropriations.

Table 3: O‘ahu Region’s Reimbursement Levels

Medicaid	Lē‘ahi	Maluhia
Revenue per Patient Day	\$334	\$291
Estimated Cost per Patient Day	\$521	\$441

FINANCIAL CHALLENGE

During the State fiscal year 2018, the O‘ahu Region’s ability to effectively provide for the long-term care needs of our aged, blind and disabled community continued to be a financial challenge. Over the years, delayed payments and insufficient reimbursement levels from insurance providers (especially Medicaid) have had the anticipated adverse impact on our revenue stream. Additionally, having to fund the collective bargaining increases negotiated by the State of Hawai‘i and fringe benefits increases has significantly raised expenditures.

Due to the reimbursement of certified public expenditures through the Medicaid program, general fund and capital improvement project subsidies granted by the Legislature and the O‘ahu Region’s implementation of operational efficiencies and other cost-saving measures, the O‘ahu Region has been able to continue providing long-term care services and support for the existing 237 (estimated) persons who currently reside in its facilities and hundreds

of others in the community that are provided care through the Adult Day Health Programs and Geriatric Outpatient Clinic.

As noted above (Table 3), on average the cost per patient day exceeds the revenue per patient day. As such, it is important for the O'ahu Region to exercise due diligence to ensure that solving the waitlist issue does not compromise the financial situation of the Region. O'ahu Region cannot afford to start new programs and accept patients that would create an additional financial hardship for the Region.

If additional patients are admitted into the existing vacant beds, then the incremental cost should be minimized as these units are already fully staffed at 117 and 120 beds. However, if the O'ahu Region reopens closed units, then revenue funding must be sufficient to cover the incremental costs, including additional staffing. As such, it is looking to a Public-Private partnership to assist with the waitlist issue. As described in further detail in sections below, the Public-Private partnership would require funding from the acute care hospitals and/or other sources to ensure that O'ahu Region does not suffer additional financial losses.

It should be noted that the O'ahu Region is now making additional efforts to develop and improve programs to support O'ahu's seniors with community-based services. These programs provide support for caregivers that, in turn, enable them to continue caring for their loved ones in the comfort of their own homes.

THE O'AHU HOSPITAL PATIENT WAITLIST PROBLEM

A waitlisted patient is a patient in an acute care hospital facility who no longer needs the services of an acute care hospital and is awaiting placement in a facility that can adequately address the patient's clinical needs in a post-acute setting. These waitlisted patients create the following issues for Hawai'i's and specifically, O'ahu's health care community:

1. They occupy an acute care bed when it is no longer clinically needed. This may impact the ability of the hospital to admit a patient requiring acute care services. If no other beds are available, a patient may need to be transferred to another hospital; and
2. The operating costs for acute care beds are higher than long-term care beds while reimbursements for these waitlisted patients are relatively low. Under these circumstances, the hospital suffers financially on two fronts:
 - Low reimbursements received; and
 - Lost revenue that could have been generated from caring for acute-level patients in the occupied beds.

O'AHU HOSPITAL WAITLIST ASSESSMENT

The O'ahu Region has been working with most of the acute-care facilities on O'ahu to assess their respective waitlists. Based on discussions with the acute care facilities, the most significant waitlist issue appears to be at the Queen's Medical Center. The current estimated waitlist days and the barriers to discharge at the acute care facilities are as follows in Table 4:

Table 4: O’ahu Waitlist Patient Assessment

Hospital	Estimated Waitlist Patient Days	Waitlist Patient Discharge Barriers
Queen’s Medical Center	As of 9/13/2018 : 48 patients, collectively, at Queen’s Punchbowl and Hale Pulama Mau at Kuakini.	<ul style="list-style-type: none"> • Medicaid pending status • Guardianship • Costly Intravenous Antibiotics • Behavior • Condition requires isolation • Chemotherapy/Radiation
Hawai’i Pacific Health (Pali Momi Medical Center & Straub Medical Center)	As of 8/8/2018 : 2 patients at Straub; 3 at Pali Momi.	<ul style="list-style-type: none"> • Homeless • Younger drug abuse patients • Behavioral health issues
Adventist Health Castle	As of 9/14/2018 : 1 patient. On average, 3-4 patients on a daily basis.	<ul style="list-style-type: none"> • Medicaid pending status • Hemodialysis • Intermediate Care Facility level of care • Mentally incapacitated/guardianship • Wound care • Homeless/deficient personal, community & family resources
Kaiser Permanente Moanalua Medical Center	As of 9/7/2018 : 2 patients.	<ul style="list-style-type: none"> • Ventilator • Hemodialysis • Dementia/behavioral disorders • Medicaid-pending status
Wahiawa General Hospital	Not significant.	<ul style="list-style-type: none"> • Medicaid pending status with behavioral disorders • Does not meet Intermediate Care Facility level of care
Kuakini Medical Center	No major waitlist issues.	Generally able to manage the waitlist.

WAITLIST CAUSES

As noted in Table 1 on Page 7 of this report, the long-term care occupancy rate for all facilities on O‘ahu remained below 90% the past four years, despite the existence of many waitlisted patients in need of immediate placement (see above Table 4: O‘ahu Waitlist Patient Assessment).

This confirms the fact that the waitlist issue is not a result of a lack of long-term care beds in the community. Based on research conducted by the O‘ahu Region in collaboration with O‘ahu acute care hospitals, there are two major groupings of factors that create the waitlist:

1. **Lack of insurance coverage or “Medicaid Pending” patients** – While Hawai‘i has one of the lowest uninsured rates in the United States, medical insurance plans do not provide long-term care coverage. Medicare and commercial insurance generally have a limitation on the number of covered days and will only provide coverage if the patient needs skilled care. Medicaid is generally the only payer that provides long-term care coverage that includes patient custodial care. Many times, hospitals and post-acute providers will assist with a patient’s application for Medicaid coverage if the patient needs long-term care and is financially destitute.

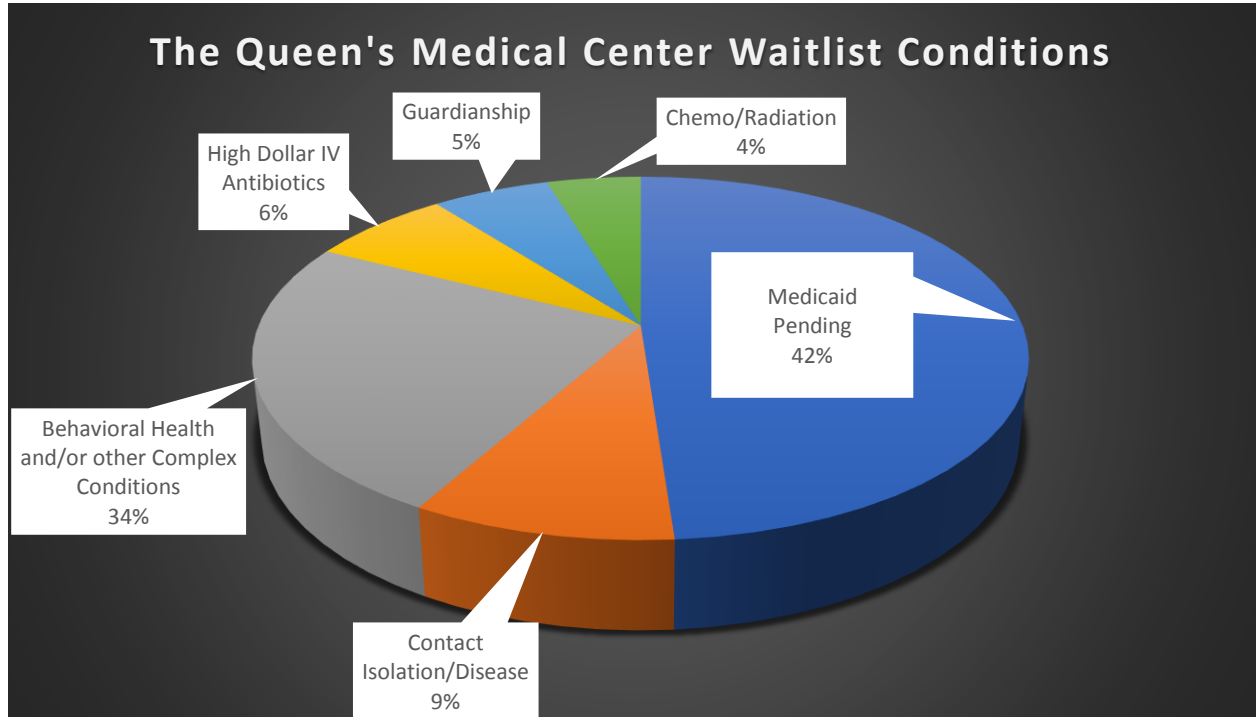
Medicaid will only provide long-term care coverage for an aged, blind or disabled (ABD) individual that is below an asset and income threshold. The application approval process can take several months as it requires the Medicaid agency to conduct interviews and verify assets and income. If deemed eligible, then the patient may qualify for long-term care coverage, retroactively, three months prior to the date of application. However, until the patient is deemed eligible, the patient typically does not have any insurance coverage for their stay **and the facility must front the costs of care.**

As a result, long-term care facilities are hesitant to admit these patients out of reasonable fear that:

- a. The patient may not be deemed Medicaid eligible and the facility will receive no reimbursements;
- b. The eligibility process will take a long time and – even if Medicaid is ultimately approved – the facility will have had to advance the costs of care for a protracted duration; or
- c. The Medicaid reimbursement rates are too low to be financially feasible.

Simply put, the low Medicaid reimbursement rates, coupled with the uncertainty over whether the patient will qualify for Medicaid coverage, causes patients to be waitlisted during the Medicaid application process.

Chart 1: The Queens Medical Center Waitlist Conditions on 9/13/18



2. **Patients with one or more medically complex issues or “medically complicated” patients** – Many of the waitlisted patients have multiple clinical and behavioral issues that require specialized training and staff, additional outside services, and/or medical equipment dedicated for its sub-population. These conditions may include:
- Bariatric patients.** In order to mitigate injury to patients and/or staff, a special lift is often needed to move these patients.
 - Hemodialysis patients.** These patients must be transported to and from dialysis centers three or four times per week. Dialysis facilities will not accept patients in a gurney (patient must be able to sit upright). Additionally, these patients usually require more frequent lab testing and tend to be more susceptible to infections and slow-healing wounds.
 - Ventilator patients.** In order to admit these patients, there must be respiratory therapists to monitor the patients’ oxygen levels as well as ready access to oxygen. These patients may also require additional services to clear fluids from their lungs and tend to be more susceptible to infections.
 - Wound care patients.** Nurses need special training to provide care to these patients. Slow-healing wounds may require debridement and antibiotics to prevent infection.

- e. **Patients with behavioral issues.** Specialized training and staff are typically needed for some behavioral health issues – particularly those that may put other patients and/or staff at risk of injury or abuse.
- f. **Others.** Other conditions, which occur in smaller numbers, include patients requiring the following care or coordination:
 - i. Chemotherapy/radiation
 - ii. Specific IV antibiotics
 - iii. Isolation/specific diseases
 - iv. Guardianship issues

Some long-term care facilities will admit patients that exhibit only one of the above-identified medical conditions; however, the real challenge is to provide proper care to patients who have multiple items from the list, which exponentially complicate their care. For example, a bariatric patient may also have wounds and behavioral issues. Patients with multiple issues are said to possess “co-morbidities.”

These medically complicated patients require more care coordination among various providers, added nursing care, additional medical equipment and/or supplies, outside services and coordination, etc. Despite the higher demands and costs on long-term care facilities, the reimbursement rate generally remains the same regardless of the number of co-morbidities.

Having to care for complex patients with limited staff and resources can negatively impact a facility that must provide quality care for all patients while mitigating safety risks for other patients, employees and visitors (which could also jeopardize a facility’s license to operate). As such, most long-term care facilities tend to decline patients with complex medical issues.

PATIENTS EXPERIENCING HOMELESSNESS

Some of the waitlisted patients were homeless prior to admission to the acute facility. Long-term care facilities are required to do a “safe discharge.” Understandably, a discharge from a long-term care facility to the street is unacceptable and not considered a safe discharge. This causes a waitlist situation for acute facilities because long-term care facilities would naturally be averse to admitting a homeless patient it will likely have difficulty discharging once such patient falls below the long-term care facility’s level of care. In such instance, the long-term care facility would not be paid for its care to that patient pending “safe” discharge and would also be unable to use that patient’s bed for another patient needing long-term care.

O‘AHU REGION’S PROPOSED PLAN TO REDUCE THE WAITLIST

PILOT PROGRAM OVERVIEW

The O‘ahu Region has been working with most of the acute-care facilities on O‘ahu to assess their respective waitlists. When analyzing the number of waitlisted patients at each facility – and the health and social care needs of those patients – the O‘ahu Region identified two primary categories of patients that comprise the current waitlisted population:

1. Those that could ***appropriately*** be placed at O‘ahu Region’s facilities under existing clinical capabilities; and
2. Those that could ***possibly*** be placed at O‘ahu Region facilities in the future, should there be investments in infrastructure, equipment, training and staff.

In an effort to reduce the waitlist losses sustained by acute-care facilities – while at the same avoiding unreasonable and unsustainable cost shifting – the O‘ahu Region has begun developing a proposed public-private pilot program (hereinafter, “Pilot Program”) in which some waitlisted patients would be admitted to O‘ahu Region facilities.

In return, participating acute-care facilities would provide the O‘ahu Region with financial subsidies necessary to cover a portion of the unreimbursed costs specifically related to these admissions. The Pilot Program is projected to save the acute-care facilities significant costs because their subsidies to the O‘ahu Region, under the program, would be far less than current costs to stay in the hospital. The community will also benefit as the number of hospital beds available for acutely ill patients would be freed up for patients truly in need of care in the hospital.

While the details of the Pilot Program are still being negotiated – and a formal agreement has yet to be executed – it is expected that the Pilot Program would initially address waitlisted patients who do not yet have long-term care insurance coverage, but who have applied for Medicaid coverage (“Medicaid Pending”).

As described earlier, Medicaid will only provide long-term care coverage for aged, blind or disabled (ABD) individuals that are below a certain asset and income threshold. The application process can take several months and requires the Medicaid agency to conduct interviews and verify assets and income. If deemed eligible, patients may qualify for long-term care coverage, retroactively, three months prior to the date of application. However, until a patient is deemed Medicaid eligible, that patient typically has no insurance coverage, and the facility must provide care with zero reimbursement.

It is plausible that a major medical center may be the initial Pilot Program partner since they currently have the most hospital waitlisted patients and have expressed a willingness to explore potential solutions to the waitlist problem. On September 13, 2018, this medical center had 20 waitlisted patients – or 42% of all waitlisted patients at that time – that fell into the category of Medicaid pending.

While the proposed Pilot Program remains preliminary and no formal agreements have been executed with any parties, we envision that the Partnership Objectives and the Pilot Program's Processes, Measurements of Efficacy and Benefits would develop along the following lines:

PARTNERSHIP OBJECTIVES

1. Reduce the number of waitlisted patients at a major medical center, thereby freeing up acute care beds for appropriate patients and reduce the financial losses for the medical center attributable to the waitlisted patients
2. Increase/maintain occupancy at Maluhia and Lē'ahi without substantially increasing expenses
3. Pilot program must not negatively impact O'ahu Region's financial situation

MEASURING PROGRAM EFFECTIVENESS

The Pilot Program outcome measures would include:

1. The O'ahu Region will maintain a log of all patients admitted through the Pilot Program and evaluate the impact on the waitlisted population and resulting financial impacts;
2. At the end of calendar year 2019, the O'ahu Region will evaluate the results of the Pilot Program to identify the lessons learned and to consider, along with the major medical center, a long-term arrangement and/or revisions to the current arrangement; and
3. The O'ahu Region will evaluate whether to expand the Pilot Program to other O'ahu acute care hospitals.

Please note: As previously stated, the Pilot Program remains solely a proposal at this time as all terms and conditions are still pending further development, negotiation and agreement. If a formal agreement can be realized, the O'ahu Region would likely be prepared to implement the Pilot Program by early 2019.

PILOT PROGRAM BENEFITS

The overall community goal is to maximize health care facility capacity. For the acute care hospital, a successful Pilot Program means freeing up a bed for an acute medical or surgical patient. For O'ahu Region LTC facilities, a successful Pilot Program means meeting a community need with new clinical programs and services. The Pilot Program has been structured to truly be a private-public partnership that, in our view, should result in a win-win situation for the major medical center, O'ahu Region and the O'ahu

healthcare community. From a care perspective, waitlisted patients would be moved into more appropriate long-term care settings and acute beds would become available for patients with higher needs.

From a financial perspective, it means shared risk with minimal downside for both the participating acute care hospital and the O'ahu Region LTC facilities

Likewise, the major provider of acute care would reduce its losses by moving waitlisted patients into the O'ahu Region's facilities. They would also gain the opportunity to generate more commensurate reimbursements from the newly available acute-care beds.

The O'ahu Region believes that, if implemented as anticipated, the Pilot Program would not negatively impact the O'ahu Region's financial situation, as incremental cost increases are expected to be lower than the reimbursement the Region anticipates to receive from the Medicaid program and/or the major medical center. Incremental cost increases will be minimized due to the fact that the O'ahu Region's facilities are already fully staffed for the 117 and 120 open beds, respectively, and it does not plan to increase bed capacity during the Pilot Program.

MEDICALLY COMPLEX PATIENTS

Should the Pilot Program meet initial success, the O'ahu Region intends to work with the major medical center and other acute facilities to explore ways to address waitlisted patients in the second group – those with medically complex conditions. Further cost/risk sharing initiatives, which may include mutual investment in the infrastructure, equipment, training and staff required to care for medically complex patients, will also be examined. We anticipate that this process will consist of the following steps:

1. Review the waitlist census over several months;
2. Identify reasons that the O'ahu Region is currently unable to properly care for medically complex patients;
3. Determine the required investments needed in order to care for these patients. Barriers may include a need for the O'ahu Region to address the following:
 - a. **Purchase or lease additional equipment** – for example, patient lifts for bariatric (obese) patients and negative pressure wound therapy machines
 - b. **Renovations to the facility** – for example, additional security measures and/or changes to furniture, fixtures and equipment to provide additional safety measures for behavioral health patients. This may also include repurposing closed units as needed;
 - c. **Changes to staffing mix** – for example, behavioral health patients may need a higher staffing mix to meet their needs and ventilator patients will require a respiratory therapist, as well as access to oxygen;
 - d. **Changes to processes** – for example, new protocols may need to be developed to handle wound care patients and/or behavioral health patients; and

- e. **Additional training or certifications for staff** – for example, staff may need to be trained on wound care, including how to properly debride a wound or other new procedures.
4. Determine if there is a sufficient waitlist population to justify investments needed to accommodate various categories of medically complex patients. The O’ahu Region must ensure there will be sufficient demand for the added investments in order to justify expenditures. For example, assessing whether the O’ahu Region can expect a sufficient number of bariatric patients in its facilities to justify the expenditure for a special lift;
5. Build additional strategic partnerships. The O’ahu Region will identify and examine opportunities with the Medicaid program (through the State Department of Human Services) as well as the various Medicaid health plans, acute care facilities and community agencies that may provide funding and support for the initial and ongoing resources required for medically complex patients. This includes working with other agencies to provide support for such services as psychiatric coverage for behavioral health patients and O’ahu Region staff training by drug abuse counselors. It may also include exploration of whether vacant spaces at O’ahu Region facilities should be leased to outside strategic partners that may mutually benefit from the close proximity to long-term care patients.

O’AHU REGION’S FUTURE

Unlike other HHSC Regions, O’ahu Region’s future lies primarily in long-term care and the provision of community-based and outpatient services. Its future direction is shaped by sustaining and broadening existing services as the aging and chronically ill population continues to grow and evolve.

The O’ahu Region received Capital Improvement Project funding for the development of a Lē’ahi Hospital Master Plan. The Master Plan is a work-in-progress strategic planning effort developed to include community services and possible partnerships with private entities. The O’ahu Region’s vision of a partnership includes active solicitation of public funds and private investment to design and construct new buildings to house operations for increased services and support for the aged, blind and disabled population.

This approach would increase outreach to the community and ensure that ancillary services and facilities are more accessible and sustainable. The O’ahu Region intends to play an active role in the development and control of all new operations under the master plan.

The O’ahu Region’s vision also includes partnering with the Kapi’olani Community College (“KCC”) and its health, institutional foods and other trade programs. The partnership with KCC culinary would be to develop chefs who can meet the dietary needs of older adults. Ideally would serve as a training site for making the workforce more geriatric friendly.

This partnership would enable collectively increased learning opportunities for both KCC students and employed staff and create a corridor for additional collaborative ventures.

The O'ahu Region currently is a training site for student nurses, physical and occupational therapy assistants, public health students, and nurse assistants. Beyond these students, KCC has many other programs within their health sciences department that need clinical training sites for their students. It is our intent to continue development of our partnership with KCC to provide these departments with further access to our facilities. The O'ahu Region also partners with other schools as well to encourage a pipeline for future care providers.

Currently, our Adult Day Health director provides community education on Alzheimer's for caregivers. Our goal is to include support groups for caregivers whose loved ones face other health conditions and challenges as well.

The O'ahu Region is also considering other projects to provide enhanced Adult Day Health Services as a resource for caregivers that will assist them in addressing social determinants of health and enable them to keep their elderly loved ones in the community longer. Our vision of enhanced Adult Day Health Services includes:

- Partnering with psychologists to enhance the behavior health program
- Financial planners to assist with access to insurance, including Medicaid eligibility
- Meal programs to support elders in the community
- Transportation services
- Home assessments
- Other community organizations to coordinate services for elders
- Community education center - be a site for Alzheimers' support group, Parkinsons' support group, Arthritis support group, Caregiver support group, etc.

Additional improved coordinated service efforts for the community continue to be developed with other state agencies including the University of Hawai'i and Department of Health (specifically, the Executive Office of Aging or "EOA," and the Hawai'i State Hospital). The O'ahu Region's investment in such efforts is based on the firm belief that coordination of community resources with other governmental agencies, possibly through formal partnerships, will generate more data and resource access and facilitate more efficient workflows.

The O'ahu Region's long-term plan for addressing the waitlist situation will be accomplished by forming partnerships with acute care providers, stakeholders and related community support services. It will require the O'ahu Region's facility and staff to increase competencies to manage a more complex, challenging patient population. As stated above, the O'ahu Region will also look to develop previously uncommitted spaces to enhance services and/or develop strategic partnerships within the community that will help the O'ahu Region address emerging needs and better serve the O'ahu community.

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O'ahu Region Board of Directors**

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