HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION – CERTIFICATE OF NEED PROGRAM

Application Number 02-12A

Applicant: Hilo Medical Center

Project Title: Change of 22 Medical/Surgical Beds to SNF Beds & Addition of 4 SNF/ICF Beds

Project Address: Hilo Medical Center
1190 Waianuenue Avenue
Hilo, HI

1. **TYPE OF ORGANIZATION**: (Please check all applicable)

Public	__X__
Private	_____
Non-profit	__X__
For-profit	_____
Individual	_____
Corporation	__X__
Partnership	_____
Limited Liability Corporation (LLC)	_____
Limited Liability Partnership (LLP)	_____
Other: _____	_____

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2. **PROJECT LOCATION INFORMATION**

A. Project will be located in:

State Senate District Number: ___2__

State House District Number: ___2__

County Council District Number: ___2_

Neighborhood Board District Number (O`ahu only): _____

B. Primary Service Area(s) of Project: (please check all applicable)

Statewide:	_____
O`ahu-wide:	_____
Honolulu:	_____
Windward O`ahu:	_____
West O`ahu:	_____
Maui County:	_____
Kaua`i County:	_____
Hawai`i County:	__X__

3. **DOCUMENTATION** (Please attach the following to your application form):

A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent) N/A
B. A listing of all other permits or approvals from other government bodies (federal, state, county) that will be required before this proposal can be implemented (such as building permit, land use permit, etc.) N/A
C. Your governing body: list by names, titles and address/phone numbers Tab GOV BODY
D. If you have filed a Certificate of Need Application this current calendar year, you may skip the four items listed below. All others, please provide the following:

- Articles of Incorporation
- By-Laws
- Partnership Agreements
- Tax Key Number (project's location)

previously withdrawn application #02-04A

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4. TYPE OF PROJECT. This section helps our reviewers understand what type of project you are proposing. Please place an "x" in the appropriate box.

	Used Medical Equipment (over $400,000)	New/Upgraded Medical Equip. (over $1 million)	Other Capital Project (over $4 million)	Change in Service	Change in Beds
Inpatient Facility					X
Outpatient Facility					
Private Practice					

5. BED CHANGES. Please complete this chart only if your project deals with a change in your bed count and/or licensed types. Again, this chart is intended to help our reviewers understand at a glance what your project would like to accomplish. Under the heading "Type of Bed," please use only the categories listed in the certificate of need rules.

Type of Bed	Current Bed Total	Proposed Beds for your Project	Total Combined Beds if your Project is Approved
Med/Surg	102	-22	80
SNF	-0-	+22 SNF	22 SNF
SNF/ICF swing	108	+ 4 SNF/ICF swing	112 SNF/ICF swing
TOTAL	210	+4	214

6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:		AMOUNT:
1.	Land Acquisition	___N/A____
2.	Construction Contract	_____
3.	Fixed Equipment	_$3,708 _
4.	Movable Equipment	$10,450
5.	Financing Costs	_____
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	_____
7.	Other: _____	_____
	TOTAL PROJECT COST:	**$14,158**

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B. Source of Funds

1.	Cash	_____
2.	State Appropriations	_____
3.	Other Grants	_____
4.	Fund Drive	_____
5.	Debt	
6.	Other: __Special Funds___	**$14,158**
	TOTAL SOURCE OF FUNDS:	

7. **CHANGE OF SERVICE:** If you are proposing a change in service, then please briefly list what services will be added/modified. Be sure to include the establishment of a new service or the addition of a new location of an existing service. Please reference the Certificate of Need Rules Section 11-186-5 for the categories of services. If you are unable to determine which category best describes your project, please consult with agency staff.

___N/A_____

8. **IMPLEMENTATION SCHEDULE:** Please present a projected time schedule for the completion of this project from start to finish. Include all of the following items that are applicable to your project:

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a) Date of site control for the proposed project, N/A
b) Dates by which other government approvals/permits will be applied for and received, N/A
c) Dates by which financing is assured for the project, 3/25/02
d) Date construction will commence, 4/22/02
e) Length of construction period, 12 weeks
f) Date of completion of the project, 6/1/02
g) Date of commencement of operation 7/1/02

Please remember that the Agency does monitor the implementation of Certificates approved. Non-implementation of a project as described in your application may result in a fine and/or withdrawal of the certificate of need.

9. **EXECUTIVE SUMMARY:** Please present a brief summary of your project. In addition, provide a description of how your project meets each of the certificate of need criteria listed below. If a new location is proposed, please attach an easy to read map that shows your project site.

Refer to pages 7– 14

a) Relationship to the Hawai`i Health Performance Plan (H2P2), also known as the State of Hawai`i Health Services and Facilities Plan.
b) Need and Accessibility
c) Quality of Service/Care
d) Cost and Finances (include revenue/cost projections for the first and third year of operation)
e) Relationship to the existing health care system
f) Availability of Resources.

10. **Eligibility to file for Administrative Review.** This project is eligible to file for Administrative review because: (Check all applicable)

__X__ It involves bed changes, which will have a capital expense of $1,000,000 or less, and which will have an increased annual operating expense of less than $500,000.

_____ It involves service changes which will have a capital expense of $1,000,000 or less, and which will have an increased annual operating expense of less than $500,000.

_____ It is an acquisition of a health care facility or service, which will result in lower annual operating expenses for that facility, or service.

_____ It is a change of ownership, where the change is from one entity to another substantially related entity.

_____ It is an additional location of an existing service or facility.

__X__ The applicant believes it will not have a significant impact on the health care system.

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9. Executive Summary

Due to changes in the population demographics as well as a growing elderly population on the island of Hawaii, the number of residents needing long-term care has grown steadily, resulting in over 30 waitlisted patients[1] on any given day in Hilo Medical Center. Although there are four long-term care facilities within the Hilo area, they are almost filled to capacity. The hospital does not receive additional reimbursement for downgraded skilled nursing (SNF) patients with Medicare or HMSA 65C+ coverage, unless these patients are in a licensed SNF bed so this large amount of waitlisted patients has a detrimental impact on the hospital's finances. The large number of waitlisted patients also has a detrimental impact on the Emergency Department as these ER patients have difficulty being admitted for acute care in a timely manner.

As a long range solution, the hospital's leadership is actively involved in a collaborative plan with the Veterans' Administration to build a new long-term care facility on the grounds of HMC.

For a short-term solution, Hilo Medical Center is requesting to add four SNF/ICF swing beds to its existing Extended Care Facility. Additionally, Hilo Medical Center is seeking approval to temporarily convert 22 existing acute licensed beds to SNF licensed beds.

A. Relationship to the Plan

The Hawaii Health Performance Plan (H2P2) indicates that the average annual occupancy rate for all existing long-term care beds in the service area must be at least 95% for additional beds to be approved. The average annual long-term care occupancy rate for the island of Hawaii from 1996 – 2000 according to SHPDA was 94.02%.[2] However, according to the Medicare Hospital Manual, section 155.2, hospitals cannot force patients into a long-term care facility that is in excess of a 50-milie radius of the hospital, referred to as Medicare Geographical Region Guidelines.

The actual occupancy rate for facilities within 50 miles of Hilo Medical Center from December 1, 2001 through February 29, 2002 are:

Facility[3]	Occupancy Rate[4]
Hilo Medical Center's Extended Care Facility	99.2%
Life Care Center	97.5%
Hale Anuenue	95.0%
Hale Ho'ola Hamakua	95.4%

[1] Source: HMC Case Management for period 12/01 – 2/02
[2] Source: SHPDA website
[3] Kau is outside of the 50-mile radius of HMC
[4] Based on Monday-Friday data provided by each facility and collected by HMC Case Management

Based on the above occupancy rates, the Hilo area exceeds the minimum 95% required by H2P2 with a community average of 96.8%, thus leading to Hilo Medical Center's request to add four beds to its existing long-term care facility and to temporarily convert 22 acute beds to SNF. Additionally, on June 1, 2002, there were only three residents of Hilo Medical Center's 108 bed Extended Care Facility whose home address was in Kau or Honokaa and beyond, and two residents with addresses on Oahu (possibly next of kin residing on Oahu). Therefore, the majority of Extended Care Facility residents actually are from the immediate area.

Hawaii County's Sub-Area Council identified "adequate facilities for long-term care" was a "critical and essential service" for the Big Island[5]. Two of the three subgroups that met stated that having an appropriate number of long-term care beds should be a part of the County's action plan for services. Allowing HMC to add four SNF/ICF beds to the current Extended Care Facility and temporarily converting 22 of its acute care beds to SNF beds supports this identified need.

In the chapter on Diabetes and Other Chronic Disabling Conditions, Part 3 discusses Alzheimer's Disease (AD). "The disease eventually leaves its victims unable to care for themselves." "The prevalence of the disease increase(d) with the advancement in age." "The Alzheimer's Disease and Related Disorders Association (ADRDA) estimates that 17,000 people in Hawaii suffer from AD." "...50% over the age of 85 (years) have AD."[6] Many who have advanced Alzheimer's Disease, require long-term care. Adding long-term care beds to HMC will assist the individuals who have the onset of this disease.

The Heart Disease and Stroke chapter states that "improved health services...will improve the health outcomes and quality of life for our population..." "But it will, in essence, shift the burden of these disease conditions to an older age..." " ...the number of those 65 and older who will need chronic care is projected to rise...and those needing long-term care could be two to three times that many."[7] Again, adding long-term care beds to HMC will assist with this need.

B. NEED AND ACCESSIBILITY

Demographics

According to the US Census Bureau[8] the County of Hawaii made up 12.27% (148,677) of the state's population. Over 14% of these residents were 65 years or older; almost one-fourth is 55 years or older.

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[5] Hawaii Health Performance Plan; 1999; pg. III-14 – 16.
[6] Ibid; pg. VI-14 – 20.
[7] Ibid; pg. VII-2 – 3.
[8] U.S. Census Bureau – Census 2000

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Unlike private entities, Hilo Medical Center is a safety net provider and as a result, provides care for those whose options and access to healthcare are limited. The median income for Hawaii County is lower than the State median income[9]. Additionally, those age 65 and older who fell at the poverty level as defined by the US Census Bureau made up almost half (49.04%) of the Hawaii County's population of those 65 and older[5]. Hilo Medical Center's payer mix reflects the US Census Bureau's demographic data. In fiscal year 2002 (FY2002), Medicare, Medicaid, HMSA 65C+ and Quest made up 70% of the hospital's payer mix[10]. Hilo Medical Center remains the safety net provider in our community enabling access to those who cannot seek care elsewhere due to finances or other reasons.

Our responsibility as the safety net hospital for our community, also means that we accept all racial and ethnic minorities, women, persons with disabilities, elderly and low-income persons, and any other underserved groups of individuals. Increasing the number of long-term care beds will better serve these population groups.

Waitlisted Patients at Hilo Medical Center

The number of waitlisted patients in Hilo Medical Center's acute hospital has steadily climbed over the past year. As a result, the hospital is often full, with patients being held in the Emergency Department, awaiting an acute bed.

As the sole safety net healthcare provider in East Hawaii, Hilo Medical Center's acute hospital has had an average of 36.5 waitlisted patients per day, between December 2001 through April 2002 (see tab DATA, Att. 1). Further, an average of five patients were downgraded from acute to SNF or ICF level of care daily during this same period, providing a constant feed to the waitlisted patient days (see tab DATA, Att. 1). While the number of waitlisted patients in the acute hospital fluctuates between mid-twenty to mid-thirty on a month-to-month basis, the average number of SNF patients in the acute facility *far exceed* the number of SNF patients in the long-term care facility. In fact, for the month of February 2002, the average number of SNF patients in the acute hospital was more than double the average number of SNF patients in the Extended Care Facility (see tab DATA, Att. 2, 3, 4, 5).

Four SNF/ICF swing beds is being requested for the Extended Care Facility (ECF) because the current unit is already 100% SNF/ICF swing. Requesting the same type of bed level would enable ECF to be flexible with regards to patient movement if all beds remain at the same classification.

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[9] U.S. Census Bureau – Census 1990
[10] Source: HMC Business Office

Regarding the acute bed conversion, from the current data, there appears to be a greater need at the present for SNF beds than for ICF beds at Hilo Medical Center. There are community homes such as Expanded ARCHes (Adult Residential Care Homes) that the State Department of Health allows ICF and SNF patients to enter. The DOH requires a registered nurse for residents who are at a skilled nursing level.[11] The Expanded ARCH program operator must pay for a case manager, and now an RN to visit the SNF resident, thus increasing the ARCH expenses and decreasing its revenues. Also, families with ICF level patients sometimes choose to take the patient home and provide the care privately. Although only about 10% of downgraded patients do go directly home, the number of ICF patients who choose this option far outnumbers the SNF patients.[12]

Requesting SNF/ICF swing beds would not be ideal for Hilo Medical Center's acute hospital. According to Medicare regulations, once a long-term care patient is assigned a bed, it is their residence. Thus, the facility cannot move the resident without their permission. The intention of the temporary conversion of 22 acute beds to SNF beds is to have a more frequent turnover of SNF residents, rather than ICF residents staying in the acute hospital. If HMC were to have SNF/ICF swing beds in the acute hospital, they could eventually be filled with ICF residents who prefer to be in a hospital setting. When SNF residents are downgraded to ICF, if the beds were SNF/ICF swing, the new ICF resident could elect to remain in their current room and bed, resulting in no resident movement. If the beds are licensed as SNF only, the hospital can work to place the newly downgraded ICF resident in another facility, including its own Extended Care Facility, making the bed available for another SNF waitlisted patient, resulting in patient movement. Further, it would be more efficient for acute hospital staff who provide services to long-term patients, if the patients with higher acuity (SNF versus ICF) were in the acute hospital. This would affect the respiratory care services for residents on ventilators or needing other types of oxygen therapy, rehabilitation services, and dietary services, as these serves are home-based in the acute hospital building.

Further, according to a study conducted by the University of Minnesota, the state of Hawaii ranked number one in the nation for the highest level of long-term care patient acuity[13]. This data is supported by the growing number of SNF patients who are waitlisted in the medical center.

The increase of four additional beds in ECF and converting the 22 acute beds to long-term care beds will help to reduce our waitlisted patients in the acute hospital and enable the medical center to appropriately serve the needs of an aging population which is made up of a significant number of elderly who are at the poverty level.

[11] Source: Department of Health, Hawaii District Health Office
[12] Source: HMC Case Management Department
[13] Propac Acuity Index – Severity of Impairment Average Facility Scores by State

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Waitlisting of Patients

Hilo Medical Center downgrades and places patients on the waitlist and in appropriate facilities without regard to all age levels, income levels, racial and ethnic minorities, gender, persons with disabilities, religion, or any other discriminatory measure. Gender is considered in placement only in compliance with §11-94-8 (4) which requires that "All occupants of any bedroom shall be of the same sex except for semi-private rooms which may be occupied by married couples upon request."[14] Patients are placed on the waitlist in chronological order by downgrade date as per HMC's policies and procedures.

When a physician orders a change in a patient's level of care from acute to SNF or ICF, and the patient will remain in the HMC acute facility awaiting appropriate bed availability, the patient is listed on HMC's waitlist via notification to the admissions office of the date and change in level of care. The case manager, physician, or nurse will notify the patient of the level of change. Since discharge planning begins at the time of admission, the case manager and the social worker have been working with the patient and family upon admission and will have already provided discharge options to the patient, family and physician. Discharge options include availability of bed space in alternative nursing facilities (in and outside of the geographical area if the patient agrees/requests), and/or community-based care settings (care homes, RACC-residential alternatives community care program, ARCH, Expanded ARCH & home with Home Care services, etc.) when appropriate. These discharge options will be re-discussed if an alternative has not been decided upon at the time of the downgrade. Whatever discharge plan is chosen will be implemented by the nurse, case manager or social worker. If a patient and or family refuses a transfer or discharge, the case manager will refer the case to the medical director and he may direct the case manager to issue a notification of financial responsibility letter. The patient will then become financially responsible for any hospitalization costs for remaining in an acute care bed.

In addition to waitlisting patients for HMC's Extended Care Facility, the case managers will also waitlist the patients at all of the nursing facilities (Life Care, Hale Anuenue, Hale Ho'ola Hamakua, and even Kau Hospital, though it is just outside the 50 miles radius as per the Medicare Geographical Region Guidelines).

On a daily basis (Monday – Friday) the Case Management department contacts all of the long-term care nursing facilities which HMC waitlists patients for, to obtain bed availability information, to refer patients, to waitlist patients and to check on the progress of any patient(s) which the facility is(are) planning to admit/accept. Case Management will enter this information into HMC's daily census database and generates the Daily Census/LTC Bed Availability Report (see tab P & P, Att. 3), which is distributed to all case managers, social workers, nursing units and senior managers and is posted in the

[14] HRS Chapter 94, Section 8-4

physician's lounge. Case Management works with the patient, family and physician to actively place patients in an appropriate long-term care option as soon as possible, by using a fair and equitable system.

C. QUALITY OF SERVICE/CARE

Hilo Medical Center is accredited by the Joint Commission on Accreditation of Healthcare Organizations and is Medicare certified.

All departments and services at Hilo Medical Center are included in the facility-wide Performance Improvement Plan. Quality is managed by the hospital's Quality Management Department and driven by the Medical Staff. The Long-Term Care Continuous Quality Improvement Committee (LTC CQI) meets monthly to review data and concerns on various issues.

Nursing and other clinical support services will be provided to the four additional SNF/ICF swing beds in the Extended Care Facility in the same manner as the current 108 SNF/ICF swing beds.

The conversion of 22 acute beds to SNF beds will increase the level of activities, rehabilitation services, and clinical dietary services than is currently provided under an acute care setting. The individual and small group activities that are appropriate for holistic care in a residential setting provide for increased socialization, and increases, maintains and/or prevents cognitive degeneration, and prepares the individual to return to his/her home setting. Space constraints in the acute hospital will make group dining difficult for the SNF converted beds. Hilo Medical Center is seeking a waiver from the state licensing agent regarding the dining requirements and a large activities area.

D. COST AND FINANCES

The cost to add four swing beds in ECF is small as the converted office was once a four-bed resident room. Financing is available entirely from the hospital's operating budget (special funds). There are no major costs to converting the 22 acute beds to SNF as all plant requirements were met from the existing structure. Waivers are being sought for the dining and activities area. The cost of additional staff will also come from the hospital's operating budget.

The impact of these changes are to the hospital finances in terms of reimbursement. As of March 2002, there were 5,945 waitlisted patient days for which Hilo Medical Center received no additional reimbursement for care beyond the acute DRG (diagnostic related group) rate. This represents approximately 74% of the total waitlisted patient days. Medicare and HMSA 65C+ do not reimburse for care provided to a patient beyond the acute DRG rate once that patient has been downgraded to an SNF level and the patient is not in an appropriate level of care bed. Those waitlisted in our

Medical/Surgical unit are considered to be receiving acute care, and therefore, these insurances do not pay for what is considered "inappropriate" level of care. If waitlisted SNF patients were instead in a long-term care bed, there would be an average daily net revenue of $347 ($347 average daily reimbursement is specific to Hilo Medical Center). For the four swing beds in ECF, it is difficult to estimate the revenue since the resident could either be ICF or SNF, and the reimbursement is different for both. Assuming ECF beds are filled with SNF patients and the ECF beds are filled 100% of the time (based on current occupancy rate of 99.2%), the annual net revenue would be $496,400. For the planned 22 SNF beds in the acute hospital, assuming the beds would be full 94.6% of the time (based on YTD 2002 data), the annual net revenue would be $2,583,415. A three-year proforma is attached (see tab FINANCES, Att. 2).

The cost of care to the patients/community will not change in most cases. If patients have Medicare/Medicaid insurance coverage, then long-term care is covered when patients are admitted to a long-term care facility. If a patient is self-pay, then there obviously will be a charge for the stay; or if a patient has a form of commercial insurance, the patient may experience additional out-of-pocket expenses.

The least costly alternative to long-term care placement of a downgraded acute patient is to discharge the patient to the home with or without home care services. Based on HMC experience, this occurs only 10% of the time. Community residential placement into care homes, RACC, ARCH or Expanded ARCH beds is the next cost-efficient level placement and the availability of these homes is very limited in the Hilo area. According to the Department of Health, Hawaii District Health Office, currently, there are only six residents in our community who are ICF or SNF level because of the licensing criteria and restrictions. Community homes licensed for Expanded ARCH are only allowed two ICF/SNF level residents per home, regardless of the number of beds licensed for that home. Institutional long-term care placement is the most costly, but is the final alternative to placement. HMC makes every effort to place downgraded and waitlisted long-term care patients into the least costly setting as long as that setting is appropriate for the patient.

The additional total of 26 beds (22 SNF, 4 SNF/ICF swing) will result in an estimated operating margin of $2,700,254 in year one (see tab FINANCES, Att. 2). Hilo Medical Center realizes this is a short-term, and only a partial fix to the current situation. HMC and HHSC, are actively working with the Veterans Administration and the State to develop a long-term solution.

E. RELATIONSHIP TO THE EXISTING HEALTHCARE SYSTEM

The existing healthcare system in the area has an average occupancy rate of 96.8% for all four long-term care facilities. In addition, Hilo Medical Center has had an average of 36.5 waitlisted patients per day in its acute hospital. The changes requested in this CON would make available beds and thus services, which are appropriate to the level of

care for the resident/patient, which include individual and small group activities important in maintaining and increasing cognitive and social orientation.

The increased revenue will enable Hilo Medical Center, as the safety net provider in the community and the sole provider for several healthcare services, to continue to support hospital services vital to the community which do not generate sufficient revenue to sustain itself. These services include obstetrics and emergency services.

This alternative to increase and convert more long-term care beds is probably the most effective and least costly alternative, as it involves minor construction of the current building plus the purchase or lease of additional furniture and equipment. The long-term solution will be costly, as it will involve building a new facility. The medical center understands that the 22 SNF beds is a temporary measure and will continue to pursue the long-term resolution to the community's health needs regarding long-term care. The addition of the four SNF/ICF swing beds in ECF is not considered to be temporary.

Several years ago, Hilo Medical Center's Case Management Department entered into a memorandum of agreement with the Department of Health Public Health/Community Interdisciplinary Team Meeting program. A Case Management representative attends the monthly team meetings. The team members include personnel from DOH/PHN, Legal Aid, APS, CPS, LCCH, HA, home health agencies, RACC, ARCH, BIACC, Coordinated Care Services, Meals on Wheels, Kaiser, Hui Malama, Hospice and others, to discuss and develop goals/plans for patients/residents requiring case management or monitoring in the community after a hospital discharge. Collaboration has resulted in improved efforts to address the patient's/resident's continuity of care, fostered communications between community agencies and explored additional alternatives to care/community resources for appropriate outpatient placement.

F. AVAILABILITY OF RESOURCES

The funding for this project will come from special funds available within the operating expenses of Hilo Medical Center and the Hawaii Health Systems Corporation (HHSC). No additional management resources would be needed for the addition of the beds.

For the four additional SNF/ICF swing beds in ECF, an increase in nursing staff of two certified nurses aids (CNA), one each for the evening and nite shift, would be recruited from within our community and the state.

For the 22 SNF beds in the acute hospital, the hospital intends to recruit four CNAs and two activities aides from within the community and the state. We do not anticipate any problems recruiting CNAs from our community. The clinical support services personnel may need to be recruited from the mainland. These include one full time physical therapist, one full time physical therapy assistant, one full time dietetic technician, and a medical social worker.