HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION – CERTIFICATE OF NEED PROGRAM

Application Number 03-29A

Applicant: Opportunities for the Retarded, Inc.
64-1510 Kamehameha Hwy.
Wahiawa, HI
Phone: 808-622-3929

Project Title: Addition of 10 small Intermediate Care Facility Mentally Retarded (ICF/MR) beds

Project Address: 64-1510 Kamehameha Hwy.
Wahiawa, HI

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

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

2. **PROJECT LOCATION INFORMATION**

A. Project will be located in:

State Senate District Number: 22

State House District Number: 46

County Council District Number: II

Neighborhood Board District Number (O`ahu only): 27

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

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

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

A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent) – please refer to ATTACHMENT 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.) – please refer to ATTACHMENT B
C. Your governing body: list by names, titles and address/phone numbers – ATTACHMENT C
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: – ATTACHMENT D
   - Articles of Incorporation – enclosed
   - By-Laws – enclosed
   - Partnership Agreements – not applicable
   - Tax Key Number (project's location) – 6-4-003-005

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
ICF/MR	25	10	35
TOTAL	25	10	35

6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

		AMOUNT:
1.	Land Acquisition	N/A
2.	Construction Contract	N/A
3.	Fixed Equipment	$ 20,000.00
4.	Movable Equipment	N/A
5.	Financing Costs	N/A
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	- 0 -
7.	Other: _____	N/A
	TOTAL PROJECT COST:	$ 20,000.00

B. Source of Funds

1.	Cash	$ 20,000.00
2.	State Appropriations	
3.	Other Grants	
4.	Fund Drive	
5.	Debt	
6.	Other: _____	
	TOTAL SOURCE OF FUNDS:	$ 20,000.00

No other capital funds are required. Lease payments are funded through federal and state 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.

Addition of 10 Small ICF/MR beds

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:

a) Date of site control for the proposed project, (Already have site control)
b) Dates by which other government approvals/permits will be applied for and received, (Please see enclosed narrative.)
N/A c) Dates by which financing is assured for the project, (Not applicable)
N/A d) Date construction will commence, (Not applicable)
N/A e) Length of construction period, (Not applicable)
f) Date of completion of the project, (Please see enclosed narrative.)
g) Date of commencement of operation (Please see enclosed narrative.)

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. (Please refer to ATTACHMENT E.)

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.

EXECUTIVE SUMARY

A) RELATIONSHIP TO THE HAWAI'I HEALTH PERFORMANCE PLAN (H2P2), ALSO KNOWN AS THE STATE OF HAWAI'I HEALTH SERVICES AND FACILITIES PLAN.

ORI currently has 25 small ICF-MR beds (or 5 small ICF-MR homes with 5 beds each). ORI currently operates 4 Domiciliary Care Homes, of which 2 are currently slated for conversion to ICF/MR. Due to the increased number of referrals, ORI proposes to convert two (2) more of its Domiciliary Homes into 2 small ICF-MR facilities, each having 5 licensed beds. This change, if approved, will result in an addition of 10 small ICF-MR beds under ORI.

The client referrals ORI has received need a higher level of care. The only modifications needed for the conversion would be to retrofit a fire sprinkler system to meet regulations. An initial submission of five (5) client 1150 applications for ICF-MR certification was approved by the Department of Human Services (DHS). We are currently working on submission of additional 1150 client applications for ICF-MR certification.

The State Health Planning and Development Agency (SHPDA) reports in the Hawaii Health Performance Plan that Hawaii's community continues to identify the need for an adequate and comprehensive continuum of care. SHPDA further states that, "more fully developed community-based, outpatient service levels that foster continuity of care are crucial" for an effective health care system. With the recent closing of at least 8 ICF-MR homes in the community, the state will have a shortage to fill.

Many persons with developmental disabilities have challenges that can be better addressed with an ICF-MR level of care service. The state currently does not have sufficient resources to meet the needs of these individuals.

B) NEED AND ACCESSIBILITY

The 2 small ICF-MR homes proposed by ORI will accommodate 10 persons with developmental disabilities who are in danger of being institutionalized or need to be transferred from other ICF-MR homes due to closure. The clients for these additional ICF-MR homes will benefit from the specialized ICF/MR level of care, which will assist with prevention of long-term institutionalized care or assist with the transition from institutional care to a more normal quality of life.

From nationally accepted studies, there are approximately 30,000 persons with developmental disabilities / mental retardation in Hawaii. Many of them are persons with mental retardation over the age of 40 who are living with parents and/or family. These individuals are considered at risk of institutionalization, especially when their caregivers grow older or pass away. Moreover, there are an undetermined number of ICF/MR eligible clients who are currently placed in other community-based residential setting but would actually be more appropriate or currently need the type of specialized care offered in ICF-MR facilities. ORI has a waiting list of 47 individuals who are seeking community-based residential services and whose higher level of care needs can best be served in a facility such as an ICF-MR The majority of these individuals are from Oahu.

C) QUALITY OF SERVICE / CARE

ORI has 3 small ICF-MR homes, each with 5 licensed beds, since 1995. In 2003, ORI was approved for 2 additional small ICF-MR homes, each with 5 beds. This brings the total number of ICF-MR beds under ORI to 25. Attachment F includes a copy of three (3) homes' current state and federal certification and a copy of the SHPDA approval for the additional two (2) homes approved this year.

D) COST AND FINANCES **(Include revenue/cost projections for the first and third year of operation)**

Attachment G includes the Statement of Revenue and Expenses for House 3-A and House 3-B.

ORI is eligible to receive state and federal funding with its current ICF-MR certification. ORI has been operating 3 small ICF/MR homes for 8 years and added on 2 more ICF/MR homes this year. ORI has also been operating a Waiver (Home and Community-Based Services) program and receiving Medicaid funds for 12 years.

ORI offers its services at the current rate **of $ 255.74 per client per day**. ORI complies with all Federal and State standards. This proposal will utilize currently existing State funds and draw in 50% of the cost from Federal matching funds.

E) RELATIONSHIP TO THE EXISTING HEALTH CARE SYSTEM

One objective in the State Health Performance Plan with respect to services for persons with mental retardation and developmental disabilities is to assure the availability of services and activity programs to enable persons with mental retardation / developmental disabilities to live and

develop successfully within the community. ORI's proposal will support the implementing action to meet people's health and wellness needs as they change over time, to prevent institutionalization into long-term care, and to plan, develop and implement community-based programs, services and facilities made available under Title XIX (Medicaid) including community based intermediate care facilities for the mentally retarded (ICF/MR) and Home and Community Based Services.

There is no reason why the addition of these 10 beds will overburden the existing health care services in the State. Since the demand for ICF/MR beds exceeds the supply, there will be no effect on utilization rates or other institutions in the service area. The availability of the ICF/MR program service is the most cost-effective, humanitarian way for full inclusion of these clients into the community.

The existing health care plan also calls for less costly alternative methods of delivering care and for de-institutionalizing persons with ICF/MR needs. This proposal satisfies this requirement by establishing 2 small ICF/MR homes with a combined total of 10 beds, which are still half the cost per day per client as compared to a long-term care facility or a large institutional facility.

Personnel, management and funds are available to carry out the specialized nature of care. ORI will train other potential staff to meet its needs. This 10-bed change will definitely NOT have any significant impact on the health care system of the State of Hawaii.

F) AVAILABILITY OF RESOURCES

We currently have the necessary staff to start with the ICF/MR program since ORI's two existing Domiciliary homes will be converted into ICF/MR homes and ORI currently has 5 ICF/MR homes already. An additional 2 to 3 staff will be needed for this change. ORI is currently receiving federal and state revenues for the operation of the licensed homes and programs it operates. Upon approval of this Administrative Certificate of Need, ORI will be applying for state licensing and federal certification concurrently for its proposed two small ICF/MR homes.