HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION – CERTIFICATE OF NEED PROGRAM

Application Number: #07-31A

Applicant: CARE Hawaii, Inc.
606 Coral Street, 2nd Floor
Honolulu, Hawaii 96813

Phone: 808 791-6158

Project Title: Addition of two Special Treatment Facility (STF) beds
Project Address: 5165 Likini Street, Honolulu, Hawaii

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

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

2. **PROJECT LOCATION INFORMATION**

A. 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)
See Attachment A-Lease Agreement

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.)
Special Treatment License application to follow.

C. Your governing body: list by names, titles and address/phone numbers
See Attachment B-Governing 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 and bylaws submitted previously in calendar year. See application #07-17A.

- Articles of Incorporation
- By-Laws
- Partnership Agreements-N/A
- Tax Key Number (1-1-058-14)

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
STF	14	2	16
TOTAL	14	2	16

6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

		AMOUNT:
1.	Land Acquisition	
2.	Construction Contract (Renovation)	25,000.00
3.	Fixed Equipment	0
4.	Movable Equipment (Appliances, Furniture, Phone System)	2,000.00
5.	Financing Costs	
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	
7.	Other: _____	0
	TOTAL PROJECT COST:	**27,000.00**

B. Source of Funds

1.	Cash	27,000.00
2.	State Appropriations	0
3.	Other Grants	0
4.	Fund Drive	0
5.	Debt	0
6.	Other: Rental Income	0
	TOTAL SOURCE OF FUNDS:	**27,000.00**

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.

CARE Hawaii, Inc. is approved to provide 14 Special Treatment Facility beds under Certificate of Need Application #07-17A. We are proposing to add an additional 2 Special Treatment Facility beds to provide Licensed Crisis Residential Services.

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.....**04/16/07**
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.....**05/01/07**
D. Date construction will commence.....**11/01/07**
E. Length of construction period...approximately 3 months of renovations
F. Date of completion of the project.....**12/31/07**
G. Date of commencement of operation.....**03/01/08**

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.

CARE Hawaii, Inc. is proposing to provide 16 Special Treatment Facility Beds to be utilized for crisis residential services in Salt Lake, on the island of Oahu for the Severely Mentally Ill population.

This new project's services will help to better meet the needs of this population as well as reduce the number of inappropriate hospital admissions, thereby reducing the costs of psychiatric health care state-wide.

A brief description of how this project will meet each of the Certificate of Need Criteria listed below as follows:

A. Relationship to the Hawai'i Health Performance Plan (H2P2), also known as the State of Hawai'i Health Services and Facilities Plan.

Projects relationship to H2P2 was established in Certificate of Need Application #07-17A. The additional request for 2 Special Treatment Facility beds will not affect the proposals relationship to H2P2.

B. Need and Accessibility

The target population for this project is the mentally ill consumer, 18 years or older, who is in need of crisis residential services. The project will provide services for the residents of Oahu as well as those consumers residing on the neighbor islands for whom this level of service is not available.

There has been an increased demand for crisis residential bed days since 2001 when the Adult Mental Health Division focused on reducing the usage of more expensive inpatient services and on utilizing community support systems that support consumers in the least restrictive environment. The Adult Mental Health Division (AMHD) 2001 Service Development Implementation Plan reports that approximately 15% of mental health consumers are in need of crisis and intensive 24 hour rehabilitation services. Based on these studies that report an estimate of seriously mentally ill adults in Hawaii to be between 16,000 to 22,000, approximately 2400 consumers in the state, per year, it might be expected to utilize the proposed level of services.

Therefore there continues to be a deficit of beds to meet the need/demand for services. Crisis Mobile Outreach Services on Oahu are identifying new consumers on the average of 5.6 calls per day, with at least 22% of these consumers requiring housing options that provide 24 hour monitoring and nursing services otherwise available only in an acute hospital setting.

The proposed services accept all referrals from the DOH access line and private insurers without regard to income, race, ethnicity, gender, disability, or age. Services will be accessible regardless of financial status, thus there is no financial barrier for consumers requiring these services. The proposed services accept all referrals from the DOH access line and private insurers without regard to income, race, ethnicity, gender, disability, or age. Services will be accessible regardless of financial status, thus there is no financial barrier for consumers requiring these services. Funds from the DOH/AMHD are the primary source of payment, supplemented by funds from private insurers.

The need for 14 Special Treatment Facility Beds was established in Certificate of Need Application #07-17A. The State of Hawaii, Department of Health, Adult Mental Health Division has identified the need to have two (2) more additional beds totalling16 STF beds to serve this population as utilization is expected to increase as

they implement new programs in the community designed to make use of the additional beds being requested.

C. Quality of Service/Care

The Quality of Service/Care criteria was met in Certificate of Need Application #07-17A. No new staff will be required for the 2 additional Special Treatment Facility Beds. All Quality Service/Care criteria established in Certificate of Need Application #07-17A will be followed

The proposed services will improve the quality of care by

- providing medication management/monitoring by psychiatric nurses under the direction of a psychiatrist 24 hours per day,7 days per week
- providing services in a home-like atmosphere
- providing on-going quality assurance monitoring
- encouraging consumer involvement and consumer choice
- continuous quality improvement through the activities of the Quality Assurance Committee
- utilization of internal policies and procedures to monitor and evaluate quality of CARE
- continuing high standards for treatment outcomes and consumer satisfaction
- maintaining appropriate staff to consumer ratios
- maintaining a qualified staff of registered nurses, mental health technicians, bachelors level mental health workers, psychiatrists, etc.
- providing continuing education in crisis intervention and management techniques as well as substance abuse, dual diagnosis, forensic issues, CPR and safety issues

- Obtaining licensure as a Special Treatment Facility with the Office of Health Care Assurance
  maintaining CARF accreditation

D. Cost and Finances (include revenue/cost projections for the first and third year of operation)

The primary cost of the proposed additional project is the renovation cost to add bedrooms to accommodate the additional two (2) beds being requested plus furniture. The estimated cost for renovation is $25,000.00 plus furnishings of $2,000.00 totaling, $27,000.00. Cash from the company will supply the additional funds required for the renovation and furnishings. The project will reduce health care costs by providing less expensive alternatives to emergency room visits ($1000 or more per visit), and acute hospitalizations ($700-$1000/day). Minimum cost savings per bed day is $500-$800/day for Specialized Residential Rehabilitation services. Alternatives for the proposed project include the more costly hospitalization and emergency services that do not adhere to the evidenced based best

practices in providing services in the least restrictive environment. Less costly alternatives would require less qualified or fewer staff which would compromise safety for the consumer and the community as well as the quality of care and services.

E. Relationship to the existing health care system

CARE Hawaii, Inc. has established the relationship to the existing health care system in Certificate of Need application #07-17A. Relationship to the existing health care system will not change to add 2 additional Special Treatment Facility Beds

F. Availability of Resources.

Availability of Resources was met in Certificate of Need Application #07-17A. No additional staffing will be required for the 2 additional Special Treatment Facility Beds. Cash from the company will supply the additional funds required for the renovation and furnishings.

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

_____ 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.