HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #15-16A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title: **Expansion of Current Medicare-Certified home health agency for the remainder of Island of Hawaii**

Project Address: P.O.Box 859
Captain Cook, HI 96704

Applicant Facility/Organization: West Hawaii Home Health Services, Inc.

Name of CEO or equivalent: Kenneth T. Ono

Title: President and CEO

Address: P.O. Box 859, Captain Cook, HI 96704

Phone Number: 808-328-9883 Fax Number: 808-328-8052

Contact Person for this Application: Kenneth T. Ono

Title: President and CEO

Address: P.O. Box 859 Captain Cook, HI 96704

Phone Number: 808-328-9883 Fax Number: 808-328-8052

CERTIFICATION BY APPLICANT

I hereby attest that I reviewed the application and have knowledge of the content and the information contained herein. I declare that the project described and each statement amount and supporting documentation included is true and correct to the best of my knowledge and belief.

Signature

09/15
Date

Kenneth T. Ono
Name (please type or print)

President and CEO
Title (please type or print)

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:	____
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); **Not Applicable**
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.); **None**
C. Your governing body: list by names, titles and address/phone numbers

Chairperson: Kenneth T. Ono
P.O. Box 275
Captain Cook, HI 96704
Ph: 808-328-9883

Secretary: Julie E. Ono
P.O. Box 275
Captain Cook, HI
Ph: 808-328-9883

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: **Please see attachment A**
   - By-Laws: **Please see attachment B**
   - Partnership Agreements : **Not Applicable**
   - Tax Key Number (project's location): **Island of Hawaii**

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					
Outpatient Facility				X	
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
Not Applicable			
TOTAL			

6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

		AMOUNT:
1.	Land Acquisition	
2.	Construction Contract	
3.	Fixed Equipment	
4.	Movable Equipment	10,000
5.	Financing Costs	
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	
7.	Other:	
	TOTAL PROJECT COST:	**10,000**

B. Source of Funds

1.	Cash	10,000
2.	State Appropriations	
3.	Other Grants	
4.	Fund Drive	
5.	Debt	
6.	Other:	
	TOTAL SOURCE OF FUNDS:	**10,000**

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 new location to existing service - WHHHS is requesting expansion of its existing Medicare-certified home health services to the remainder of the Island of Hawaii.

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: **Not Applicable**
   b) Dates by which other government approvals/permits will be applied for and received: **None required**
   c) Dates by which financing is assured for the project,: **Available now**
   d) Date construction will commence: **Not applicable**
   e) Length of construction period: **Not applicable**
   f) Date of completion of the project: **Not Applicable**
   g) Date of commencement of operation: **October 1, 2015**

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.

West Hawaii Home Health Services, Inc. (WHHHS) provides Medicare-certified home health services to the residents of West Hawaii since 1996. In June, 2015, Hilo Hospital Home Care, as one of two Medicare-certified home health agency in East Hawaii, ceased accepting new home health patients. As a result, acute care patients are being forced to extend their acute care stay, at an increased cost and not consistent to high quality care. These acute care patients are from Hilo Hospital, Queen's Medical Center Oahu, and Kaiser Oahu to name a few. Some are forced to be sent home with no service.

WHHHS currently serves and will continue to serve underserved and rural populations in which other organizations do not or cannot service. We are delivering the same set of services with the same quality control standards and seek to do the same for the entire Island of Hawaii.

WHHHS seek to fill this critical void by expanding its current service to the remainder of the Island of Hawaii. Since the closure, WHHHS has been serving Kaiser patients successfully through its existing provider services agreement. Discussion has occurred to also extend our current VA home health services

provider agreement. This CON application seeks approval to serve Medicare patients who currently are not able to receive home health services.

In addition, WHHHS seeks to assist in the ability to provide home health services to help minimize the long-term care shortage in Hawaii County.

a. Relationship to the State of Hawai`i Health Services and Facilities Plan.

WHHHS understands the statewide and regional priorities indicated in the State of Hawaii, Health Services and Facilities Plan (HSFP).

As detailed in "Section A: Relationship to the State Plan Criterion", WHHHS is committed to continuing delivering quality home health care within the context of county and statewide values. We are based on the Big Island and have been providing high quality home health services for almost twenty years. Expanding to the remainder of the island will be relatively easy on a operational, clinical, and financial basis. Specifically, we share these common values:

*** Cost-effectiveness: WHHHS seeks to deliver home health services to residents of the Island of Hawaii. Home health has been shown to be a far less costly alternative to more expensive institutional care.**

*** Financial Viability: West Hawaii Home Health Services has been in operation on the Island of Hawaii since 1996. We are a financially sound company with strong and fiscally sound management.**

***Optimization of Service Delivery: Already present and providing home health services, geographical expansion to the remainder of the Island of Hawaii is a natural extension of our present services. We are familiar with the hospitals, physicians, and the various communities on the island. Service to Medicare patients can begin within two weeks of CON approval with little startup and ongoing costs.**

*** Regionalization of Services: With a base in West Hawaii, WHHHS would extend its clinical support throughout the island. Our current administrative and financial support would be strengthened by the West Hawaii base, thus eliminating any duplication and associated costs.**

The HSFP indicates capacity thresholds for certain specialized services. Home Health services are not an indicated service, and as such not applicable to this application. However, we have been and continue to support efforts of the State to assure optimization and appropriate utilization of these services.

b. Need and Accessibility

The closure of one of two Medicare certified home health agencies serving East Hawaii and adjacent communities has created a critical situation where there is limited access and, therefore, some patients are not being served. In particular, the target population for his project is Medicare beneficiaries who are 65 years of older or on renal dialysis and residing in Hawaii County and are in need of home health services.

WHHHS will assure quality care is delivered to all persons regardless of age, location, income, race, ethnicity, sex, sexual orientation, disability or other demographic indicator. We do not discriminate and we will provide services throughout all areas of Hawaii County.

c. Quality of Service/Care

WHHHS is committed to providing quality care to all residents of the Island of Hawaii. We utilize trained, qualified, and competent staff to provide home health services to our service population. We have served this community for almost twenty years and are actively engaged in our island community.

Please find a copy of our most recent federal Medicare and State Department of Health certification and licensing surveys. There is only one minor deficiency and no major deficiencies. See attachment C.

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

WHHHS is financially sound. As a locally owned freestanding company, we have been able to prudently operate a fiscally sound operation without any governmental loans or grants. We are self sufficient.

Please find attached three year revenue/cost projections. See attachment D.

e. Relationship to the existing health care system

As stated earlier, WHHHS has spent almost twenty years servicing patients and building community health relations across the island. WHHHS has the capacity to step in to replace Hilo Hospital Home Care and increase service availability. Serving the entire Big Island would further assure all patient needs are met by strengthening the net of comprehensive community health on our island. There will be minimal to no impact on current providers.

f. Availability of Resources.

WHHHS is fiscally sound and has existing financial resources to provide home health services to Hawaii County. We have an existing pool of clinical staff and with the addition of new staff will be able to serve this population. Our scheduling, billing, payroll, and administrative staff will be incrementally increased as volume dictates.

g. **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.

__x__ 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.