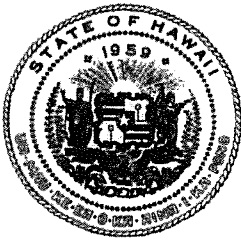

HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #15-18A Date of Receipt:
To be assigned by Agency

APPLICANT PROFILE

Project Title: Deletion of Home Health Agency Services

Project Address: 45 Mohouli St, Suite 201
Hilo, Hawaii, 96720

Applicant Facility/Organization: Hilo Medical Center

Name of CEO or equivalent: Dan Brinkman

Title: Regional Chief Executive Officer East Hawaii Region

Address: 1190 Wainuenue Ave., Hilo Hawaii 96720

Phone Number: (808) 932-3000 Fax Number: (808) 974-4746

Contact Person for this Application: Chasidee Bush

Title: Hilo Medical Center Home Care Manager

Address: 45 Mohouli St, Suite 201, Hilo, Hawaii, 96720

Phone Number: (808) 932-4345 Fax Number: (808) 974-4718

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]
Signature

10/19/15
Date

Dan Brinkman
Name (please type or print)

CEO
Title (please type or print)

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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: ____	

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) – **See Attachment 3**

B. A listing of all other permits or approvals from other government bodies (federal, state, co23unty) that will be required before this proposal can be implemented (such as building permit, land use permit, etc.) **Center for Medicare and Medicaid Services (CMS) Medical Enrollment Application (CMS-855A) - Completed**

C. Your governing body: list by names, titles and address/phone numbers – **See Attachment 1**

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 – **NA: Public Hospital, established by statute**
- By-Laws – **See Attachment 2**
- Partnership Agreements - **NA**
- Tax Key Number (project's location) - **NA**

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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					
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
TOTAL			

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6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

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

B. Source of Funds

1.	Cash	0
2.	State Appropriations	0
3.	Other Grants	0
4.	Fund Drive	0
5.	Debt	0
6.	Other: ______________________	
	TOTAL SOURCE OF FUNDS:	0

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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.

_ Deletion of Home Health Agency 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 – **See Attachment 3 (Lease for space used for Home Health Services Office, leased space will be used by the Hawaii Island Family Health Clinic – HMC family residency program)**
b) Dates by which other government approvals/permits will be applied for and received - **NA**
c) Dates by which financing is assured for the project - **NA**
d) Date construction will commence - **NA**
e) Length of construction period - **NA**
f) Date of completion of the project - **NA**
g) Date of commencement of operation – **Deletion of services to take effect upon approval of CON**

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. – **See Attachment 4**

a) Relationship to 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)

_____ 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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Attachment 4

9. Executive Summary

A. Relationship to the Plan

Nearly 90 employees will be laid off and some availability of services will be reduced at Hilo Medical Center, Ka'u Hospital and Hale Ho'ola Hamakua because of a projected $7 million deficit in the fiscal year starting July 1. Due to the budgetary deficit Hilo Medical Center plans to close our Home Care Services, which provides homebound individuals both chronic and transitional nursing care.

The region's estimated shortfall is the result of higher costs and lower reimbursement rates incurred while servicing a fast-growing population of more than 100,000 people who live in a vast and mostly rural 2,000-square mile area. The hospitals are the safety net for many in the community who are uninsured and have no other healthcare options. Approximately 75% of the East Hawaii Region's reimbursements come from Medicare and Medicaid/Quest and they do not cover the cost of care.

Our budget shortfall will have an impact on healthcare facilities in East Hawaii. Region-wide cost cutting measures have already been implemented and service cutbacks and layoffs are the only remaining option. As the first general principle of the Statewide Health Coordinating Council (SHCC) priorities is to promote and support the long –term viability of the health care delivery system, it has been determined that these cost cutting measures including the elimination of the Hilo Medical Center Home Care Service is crucial to maintaining our financial viability. Many scenarios were carefully weighed in our preparations to maintain essential healthcare services and minimize any potential harm to patients. Some healthcare services for our communities will be reduced and disrupted as a result of the planned closures, cutbacks and staff layoffs. As a result of operational efficiencies and cost reductions we've already instituted, we were able to complete our previous fiscal year intact, but those actions are not enough to make up for the current year's shortfall.

The proposed deletion is intended to make sure that Hilo Medical Center's acute hospital remains viable as it is the only hospital that services this area.

B. NEED AND ACCESSIBILITY

The elimination of HMC's Home Health services will not have any effect as two other facilities (Kohala Home Health Care of North Hawaii Community Hospital and West Hawaii Home Health Services, Inc.) have approved CON's to expand their current service area to East Hawaii – application numbers 15-12A and 15-16A.

Need that the population presently served has for the service

The Hilo Medical Center Home Care Service served 1,015 patients in fiscal year 2015, for a total of 3,934 visits with an average of 4 visits per patient.

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The extent to which that need will be met adequately by the proposed relocation or by alternative arrangements

We believe that the home health needs of our community will be adequately met through current community home health providers, Bayada Home Health Care and Careresourse Hawaii. In addition, Kohala Home Health Care of North Hawaii Community Hospital and West Hawaii Home Health Services, Inc. both have approved CON's to expand their service areas to include East Hawaii.

The effect of the elimination of the service on the ability of the elderly, low income persons, racial and ethnic minorities, women persons with disabilities and other underserved groups to obtain needed health care

We do not anticipate any adverse effects on the availability of services for the elderly, low income persons, racial and ethnic minorities, women persons with disabilities and other underserved groups due to the CON approval for Kohala Home Health Care of North Hawaii Community Hospital and West Hawaii Home Health Services, Inc.

C. QUALITY OF SERVICE/CARE

Proposal to delete Home Health Services is intended to maintain Hilo Medical Center's viability, in order to maintain the level of acute hospital services.

D. COST AND FINANCES

The deletion of Home Health Services is to reduce our deficit to maintain acute hospital services.

E. RELATIONSHIP TO THE EXISTING HEALTHCARE SYSTEM

The closure of the Hilo Medical Center Home Health Service and the expansion of the previously mentioned service providers into the East Hawaii Service Area would substitute's private providers for public providers. Private providers generally are less expensive providers of care. We need to reduce our deficit by deleting our Home Health Service to maintain other essential hospital services.

F. AVAILABILITY OF RESOURCES

NA no resources are required.