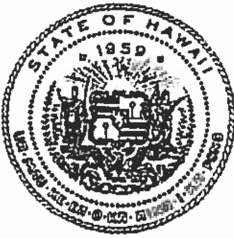

HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #20-02A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title: Acquisition of Surgical Robot System

Project Address: 347 N. Kuakini Street, Honolulu, HI 96817

Applicant Facility/Organization: Kuakini Medical Center

Name of CEO or equivalent: Gary K. Kajiwara

Title: President and Chief Executive Officer

Address: 347 N. Kuakini Street, Honolulu, HI 96817

Phone Number: (808) 547-9231 Fax Number: (808) 547-9547

Contact Person for this Application: Gregg Oishi

Title: Senior Vice President and Chief Administrative Officer / Chief Financial Officer

Address: 347 N. Kuakini Street, Honolulu, HI 96817

Phone Number: (808) 547-9231 Fax Number: (808) 547-9547

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] February 28, 2020

Signature Date

Gary K. Kajiwara President and Chief Executive Officer

Name (please type or print) Title (please type or print)

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

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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) 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):

Not applicable – the project is located onsite at Kuakini Medical Center.

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.)

Certificate of Need, State Health Planning & Development Agency.

c) Your governing body: list by names, titles and address/phone numbers

See Appendix A.

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: **See Appendix B.**
- By-Laws: **See Appendix C.**
- Partnership Agreements: **Not Applicable.**
- Tax Key Number (project's location): **170170020000**

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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

TOTAL	N/A	N/A	N/A

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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	$ 85,000
5.	Financing Costs	$ 207,000
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	$2,070,000
7.	Other:	
	TOTAL PROJECT COST:	**$2,362,000**

b) Source of Funds

1.	Cash	$ 292,000
2.	State Appropriations	
3.	Other Grants	
4.	Fund Drive	
5.	Debt	
6.	Other: Fair Market Value of leased equipment to be paid by monthly lease rent.	$2,070,000
	TOTAL SOURCE OF FUNDS:	**$2,362,000**

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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.

   This project does not include the establishment of a new service or a new location of an existing space. The project does exceed the $1,000,000 capital expenditure threshold for new medical equipment.

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: **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: **N/A**
   d) Date construction will commence: **N/A**
   e) Length of construction period: **N/A**
   f) Date of completion of the project: **April 30, 2020**
   g) Date of commencement of operation: **June 1, 2020**

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.

   This application seeks approval for the acquisition of a surgical robot system to assist surgeons in performing minimally invasive surgery. The initial surgeons that will utilize the surgical robot system are highly experienced in performing surgical robotic assisted procedures at other Oahu hospitals. The approval of this project will allow other surgeons to train and perform surgical procedures with the assistance of surgical robotic technology. The benefits of surgical robotic technology are lessening the pain for patients, decreasing the

average length of stay of patients in the hospital, and reducing the recovery time of patients.

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

This project will ensure that the overall access to quality health care at a reasonable cost is maintained for the adult and elderly population served by Kuakini Medical Center. Kuakini's patient population is comprised of 71% Medicare patients and 9% Medicaid patients. The acquisition of the surgical robot system will provide patients greater access to this technology that will improve patient safety and care. Patients will not experience higher costs, and there will be the benefits of decreased length of stay in the hospital, less blood loss and transfusions for patients, decreased complications, and reduced recovery time.

Also, the acquisition of the surgical robot system will support the physician workforce needs in Hawaii by offering technology that will reduce surgeon fatigue and will help with the recruitment and retention of surgeons as robot-assisted surgery continues to grow across the U.S., with increasing demand from both physicians and patients. On Oahu, 45% of the acute care hospitals perform robot-assisted surgery, and this technology is becoming a community standard of care.

b) Need and Accessibility

This project will be used to enhance the quality of care and patient outcomes for general surgery and urologic procedures performed at Kuakini Medical Center. The surgical robot system will support minimally invasive surgeries at Kuakini and benefit the patients by reducing recovery times, lessening the pain for patients, lessening blood loss and transfusions, and reducing risk of surgical complications and infections. Kuakini's mission, as a non-profit health system, is to improve the health status of the community by providing comprehensive health care services and programs at a reasonable cost, and continuously improving the quality of health care services. Kuakini will continue to serve the Oahu community with this technology – in particular, the elderly population, low-income persons, racial and ethnic minorities, women, persons with disabilities, and other underserved populations.

c) Quality of Service/Care

The proposed surgical robot system proposed will enhance the quality of care for patients and patient outcomes through the availability and accessibility of enhanced minimally invasive surgeries. Minimally invasive surgery provides the benefits of reduced recovery times, less blood loss and transfusions, and less risk of complications and infections.

This project includes the acquisition of Intuitive Surgical, Inc.'s da Vinci Xi (4th generation) which is the latest technology available. The surgical robot system will include simulation technology that enables surgeons to train on the system to refine their individual techniques by progressing through a sequence of realistic simulated exercises from novice to advanced levels. The simulation technology will allow the surgeons to operate the da Vinci Xi instruments in a virtual environment to develop and improve their skills.

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

This project is expected to realize net income in the first year of operation and is cost-effective as it utilizes the existing operating room facilities and support services. This project will also reduce overall healthcare costs by reducing the patient recovery time, reducing the risk of complications and infections, and reducing the patient length of stay in the hospital.

The surgical robot system will be leased to allow for more cost-effective access to technology upgrades for the robot system.

Year	Volume	Incremental Revenue	Incremental Cost*	Net Income
1	150	1,066,388	1,033,565	32,823
2	169	122,366	46,541	75,825
3	190	106,672	49,194	57,478

* Includes 5-year lease cost of surgical robot ($414k per year)

e) Relationship to the existing health care system

The acquisition of the surgical robot system will strengthen the existing health care system on Oahu and improve the quality of care and patient outcomes in the community. The use of the surgical robot system at Kuakini Medical Center will strengthen the healthcare workforce by providing greater access for surgeons and the surgical team to train and perform minimally invasive surgeries and advanced robotic surgical procedures. The introduction of the surgical robot system at Kuakini will provide greater access for patients to robotic assisted minimally invasive surgery and will enhance the delivery of health care services.

f) Availability of Resources

Kuakini Medical Center has the necessary healthcare clinicians and staff to fully support this project. The acquisition of the surgical robot system will utilize the existing operating room facilities and support services. The

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training of the surgical team will be supported by Intuitive Surgical, Inc. and the simulation technology that is included with the surgical robot system and available Kuakini resources. This project will be funded by operating cash and the surgical robot system will be leased from Intuitive Surgical, Inc.

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.