HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
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Statewide Health Coordinating Council – Plan Development Committee

DRAFT

Meeting Minutes

November 18, 2024 | 10:00 AM Hawaii Time
Virtually via Zoom and Physical Meeting Location at
The Keoni Ana Building, 1177 Alakea Street, Suite 402
https://www.zoomgov.com/rec/share/INsXnEWxJ-mHd-45R7M1QWG6IL-JMEHZF0q2XDaiXWJz_lRjoIbd_I7YJrcUvJAp.DlGp7Yf8podiaSlD
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MEMBERS: Tori Abe Carapelho, Stacy Haumea, Karen Holt, Jeanette Koijane, Michael Robinson, Wesley Sumida
MEMBERS ABSENT: Melissa Ah Ho-Mauga, Lance Ching, Adrienne Dillard, Robert Hirokawa, Jillian Kelekoma
GUESTS:
SHPDA: John Lewin, Wendy Nihoa, Darryl Shutter

ATTENDANCE RECORD OF APPOINTED MEMBERS

Date	6/19/23	9/1/23	10/27/23	12/1/23	1/26/24	9/19/24	11/18/24	TBD	TBD	TBD
Melissa Ah Ho-Mauga	/	X	X	X	X	O	O			
Tori Abe Carapelho	X	X	X	X	X	X	X			
Lance Ching	/	X	X	X	O	X	O			
Adrienne Dillard	/	X	O	X	X	X	O			
Stacy Haumea	/	/	/	/	/	X	X			
Robert Hirokawa	/	X	X	X	X	X	O			
Karen Holt	X	X	O	O	X	X	X			
Jillian Kelekoma	X	O	O	O	X	O	O			
Jeanette Koijane	/	O	X	X	X	X	X			
Paul Roeder	X	X	X	X	X	X	X			
Wesley Sumida*	X	X	X	X	X	X	X			

Legend: X=Present; O=Absent; /=No Meeting
*-Chair, **-Vice Chair

TOPIC	DISCUSSION	ACTION
Call to Order	The meeting was called to order at 10:03 a.m. by W. Sumida, Chairperson, Plan Development Committee (PDC) presiding.	
Roll Call	Welcome to members and staff. Note: former PDC member Paul Roeder, Chair, Universal Access Advisory Council resigned; and is replaced by the UAAC Vice Chair, Michael Robinson. A new backup will be identified in the future.	
Minutes	Motion to accept the minutes from the meeting on September 19, 2024. Vote: Unanimous. Motion carried. Public testimony – none.	
Certificate of Need Program	D. Shutter, Branch Administrator, State Health Planning and Development Agency (SHPDA) provided an overview of the Certificate of Need Program (CON). A copy of the presentation is attached to these minutes. A brief discussion followed. Public testimony – none.	
Health Services and Facilities Plan Updates	Subarea Health Council Priorities Updates: **Honolulu Subarea Health Planning Council (HONSAC)**. T. Carapelho provided no current updates. HONSAC is scheduled to meet in December 2024 to finalize its priorities. **Tri-Isle Subarea Health Planning Council (TISAC)**. K. Holt shared that all TISAC members have submitted their priorities, and the next step is to rank them. **Hawaii County, Kauai, and West Oahu Subarea Health Planning Councils**. W. Nihoa, Comprehensive Health Planning Coordinator for SHPDA, reported that these councils have either started or are nearing the completion of identifying and finalizing their priorities. Publishing Format Review. W. Sumida deferred this subject to the next meeting. Public testimony – none.	

Advisory Council Updates	Data (DAC). R. Hirokawa, Chair was absent. W. Nihoa reported that the last meeting took place on November 6, 2024. A Permitted Interaction Group (PIG) was formed to review various databases and determine the percentage of the uninsured in Hawaii. The report is currently being drafted and will be presented at the meeting on December 20, 2024. Keiki (KC): K. Ho, Chair, the KC met on November 1, 2024. All members have presented their individual priorities, and K. HO and W. Nihoa will be meeting to determine the next steps for the KC. Universal Access (UAAC): M. Robinson, Vice Chair, reported at the recent UAAC meeting on October 23, 2024, Judy Mohr-Peterson, Administrator of Med-QUEST, Hawaii Department of Human Services and recipient of the All-Payer Health Equity Approaches and Development (AHEAD) grant, provided an update on grant activities. She discussed her goals, how they align with the advancement of the HOPE Plan for Medicaid, and the consulting resources the grant will offer during the planning phase. Additionally, a PIG was established to develop a framework and a workable definition for "universal access", a key goals o both the UAAC and the AHEAD grant. Kupuna (KAC). M. Ah Ho-Mauga, Chair was absent. W. Nihoa reported the KAC met on October 29, 2024. Dr. Pedro Ayau-Aguilar, Fellow at the University of Hawaii, Manoa, reviewed the members' priorities and provided a summary that sparked discussion and ideas for advancing the KAC. The members are considering not referring to their priorities as "priorities", as it implies a hierarchy, and they believe all their priorities are equally important. It was suggested that these be referred to as "high needs" instead. Public testimony – none.	
Next Meeting & Agenda Items	First quarter of 2025. Exact date and time to be determined. Agenda item: Publishing Format	W. Nihoa to poll members to determine next meeting date and time.
Announcements	None.	
Adjournment	The meeting was adjourned at 11:00 a.m.	

Plan Development Committee

November 18, 2024

Certificate of Need Program Overview

CRITERIA BY WHICH CERTIFICATE OF NEED APPLICATIONS MUST BE JUDGED

	CRITERIA	MET	NOT MET	COMMENTS
RELATIONSHIP TO THE STATE PLAN	1. Relationship of the proposal to the state health services and facilities plan.			
NEED AND ACCESSIBILITY	2. The need that the population served or to be served has for the services proposed to be offered or expanded, and the extent to which all residents of the area, and in particular the elderly, low income persons, racial and ethnic minorities, women, persons with disabilities, and other underserved groups are likely to have access to those services. 3. In the case of a reduction, elimination, or relocation of a facility or service: A. the need that the population presently served has for the service; B. the extent to which that need will be met adequately by the proposed relocation or by alternative arrangements; and C. the effect of the reduction, elimination, or relocation 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.			
QUALITY OF SERVICE/CARE	4. The applicant's compliance with federal and state licensure and certification requirements. 5. The quality of the health care services proposed. 6. In the case of existing health services or facilities, the quality of care provided by those facilities in the past.			
COST AND FINANCES	7. The probable impact of the proposal on the overall costs of health services to the community. 8. The probable impact of the proposal on the costs of and charges for providing health services by the applicant. 9. The immediate and long-term financial feasibility of the proposal.			
RELATIONSHIP TO THE EXISTING HEALTHCARE SYSTEM	10. The relationship of the proposal to the existing health care system of the area. 11. The availability of less costly or more effective alternative methods of providing services.			
AVAILABILITY OF RESOURCES	12. The availability of resources (including health personnel, management personnel, and funds for capital and operating needs) for the provision of the services proposed to be provided and the need for alternative uses of these resources as identified by the Hawai`i Health Performance Plan, H2P2, (state health services and facilities plan).			

The Certificate of Need Criteria Checklist is available on the SHPDA Website and via this link SHCriteria.pdf

Chapter 3: Statewide and Regional Priorities

Statewide Health Coordinating Council (SHCC) Priorities

General Principles

1. Promote and support the long-term viability of the health care delivery system
2. Expand and retain the health care workforce to enable access to the appropriate level of care in a timely manner
3. Ensure that any proposed service will at least maintain overall access to quality health care at a reasonable cost
4. Strive for equitable access to health care services (i.e., remove financial barriers, increase availability of physicians)
5. Ensure all projects are appropriate for the regional and statewide continuum of care
6. Encourage and support health education, promotion, and prevention initiatives
7. Expand awareness of available human, financial, programmatic resources

Specific Health Areas of Concern

1. Ensure capacity and access to a continuum of long-term care services
2. Establish a statewide emergency and trauma system
3. Ensure capacity and access to primary care services
4. Increase and improve access to mental health programs, services, and education
5. Increase and improve access to substance abuse programs, services, and education

Subarea Health Planning Council (SAC) Priorities

HAWAII COUNTY/HAWAII SUBAREA PLANNING COUNCIL (HSAC)

In determining its priorities, HSAC notes that Hawaii, as compared to the rest of the State, has the:

Excerpt from Health Services and Facilities Plan, Page 31

Reference: Chapter 3, Health Services and Facilities Plan, Pages 33-37

A full copy of the Health Services and Facilities Plan is available on the SHPDA Website and via this link [Microsoft Word - Health Services & Facilities Plan 2009_22509_71409.doc]

Chapter 2: Thresholds and Suboptimization Clause

HRS § 323D-12 mandates that the HSFP must include standards for utilization of health care facilities and major medical equipment. Capacity (utilization) thresholds for certain standard categories of health care services are established to guide the initial determination of need for a service area.

Forecasting service use employs patient origin data and use rates of existing services and market share forecasting that takes into account actual utilization data. The number of new beds or new services is based on a need methodology that is reliable, probative, and substantial. Prevalence, presentation, and modality rates and average lengths of stay are modified as appropriate for different funding sources such as public funding or private-pay or private insurance funding.

Reference: Chapter 2, Health Services and Facilities Plan, Pages 29-32

A full copy of the Health Services and Facilities Plan is available on the SHPDA Website and via this link Microsoft Word - Health Services & Facilities Plan 2009_22509_71409.doc

UNIT/SERVICE	CAPACITY THRESHOLD
Computed Tomography (CT) Unit	For a new unit/service, the minimum annual utilization for each provider in the service area is 7,000 CT procedures per unit, and the utilization of the new unit/service is projected to meet the minimum utilization rate by the third year of operation. For expansion of existing units/services, the provider's utilization is an average of at least 8,500 CT procedures per year per unit.
Magnetic Resonance Imaging (MRI) Unit	For a new unit/service, the minimum annual utilization for each provider in the service area is 2,700 procedures per unit, and the utilization of the new unit/service is projected to meet the minimum utilization rate by the third year of operation. For expansion of existing units/services, the provider's utilization is an average of at least 3,200 MRI procedures per year per unit.
Positron Emission Tomography (PET) Unit	For a new unit/service, the minimum annual utilization for each provider in the service area is 600 procedures per unit, and the utilization of the new unit/service is projected to meet the minimum utilization rate by the third year of operation. For expansion of existing units/services, the provider's utilization is an average of at least 720 procedures per year per unit.
Lithotripsy Unit	For a new unit/service, the minimum annual utilization for each provider in the service area is 670 procedures per unit, and the utilization of the new unit/service is projected to meet the minimum utilization rate by the third year of operation. For expansion of existing units/services, the providers' utilization is an average of at least 800 procedures per year per unit.
Chronic Renal Dialysis	For a new unit/service, the minimum annual utilization for each provider in the service area is 600 treatments per unit, and the utilization of the new unit/service is projected to meet the minimum utilization rate by the third year of operation.
	For expansion of existing units/services, the provider's utilization is an average of at least 720 treatments per year per unit.

Radiation Therapy Unit	For a new unit/service, the minimum annual utilization for each provider in the service area is 7,200 procedures per unit and the utilization of the new unit/service is projected to meet the minimum utilization rate by the third year of operation. For expansion of existing units/services, the provider's utilization is at least 8,600 procedures per year per unit.
Gamma Knife	For a new unit/service, the minimum annual utilization rate for each provider in the service area is 335 procedures per unit and the utilization of the new unit/service is projected to meet the minimum utilization rate by the third year of operation. For expansion of existing units/services, the provider's unit utilization rate is an average of at least 400 procedures per year per unit.
Adult Cardiac Catheterization Unit	For a new service/unit, the minimum annual utilization for each provider in the service area is 1,000 diagnostic-equivalent procedures per unit, and the utilization of the new unit/service is projected to meet the minimum utilization rate by the third year of operation. For expansion of existing units/services, the providers' annual utilization is an average of at least 1,200 diagnostic-equivalent procedures per unit per year. Maximum capacity of a cardiac catheterization unit is 1,500 diagnostic equivalent procedures per year per unit, based on 6 diagnostic equivalent procedures per day, 5 days a week for 50 weeks a year. Cardiac catheterization utilization shall be determined by counting all therapeutic, pediatric or electrophysiology procedures as two (2) diagnostic equivalents, and other procedures as one (1) diagnostic equivalent. For diagnostic catheterizations, only one (1) diagnostic procedure will be counted per patient visit in the cardiac catheterization unit regardless of the number of procedures performed.
Open Heart Surgery	For a new service, the minimum annual utilization for each provider in the service area is 350 adult or 130 pediatric open-heart operations per year, and the new unit/service is projected to meet a utilization rate of at least 200 adult or 100 pediatric open-heart operations in the third year of operation.
Freestanding Ambulatory Surgery Center (less than 24 hours stay)	A collaborative arrangement shall be made with an existing acute care hospital in the county. This collaboration shall, without limitation: a. Include a transfer agreement b. Commit to support all training and recruitment of health care personnel for the benefit of the area c. Commit to enhance the EMS and trauma care systems of the area by using the ASC, when necessary, for cases such as natural disaster or pandemic.
Medical/Surgical Bed	For new or additional SHPDA-approved medical/surgical beds, the minimum annual occupancy rate for each provider in the service area must be 75% based on the number of licensed medical/surgical beds.
Obstetric Bed	For new or additional SHPDA-approved OB beds, the minimum annual occupancy rate for each provider in the service area must be 75% based on the number of licensed OB beds.

Psychiatric Bed	For a new or additional SHPDA-approved psychiatric beds, the average annual occupancy rate for licensed beds for each service provider in the service area is at least 80% for adult (age 18 and over) programs and at least 75% for children (ages 17 and younger) programs. The minimum bed size of a new acute psychiatric unit in a general acute facility is 8 beds. Children and adolescents are treated in units that are programmatically and physically distinct from adult patient units. Unit - refers to acute care hospital licensed beds that are dedicated to the treatment of psychiatric patients. These licensed beds are situated in a distinct part of the acute care hospital (a separate wing, nursing unit, contiguous nursing units, floor, or building), and staffed and supported by health care professionals with essential expertise and experience to properly care for and treat psychiatric patients.
Substance Abuse/Chemical Dependency Bed	For a new or additional SHPDA-approved special treatment facility beds that are designated for substance abuse/chemical dependency treatment, the average annual occupancy rate for licensed beds for each service provider in the service area is at least 75% . Children and adolescents ages 17 and younger are treated in units that are programmatically and physically distinct from adults (age 18 and over) patients units, except where the units are designed as parent/child treatment units.
Inpatient Rehabilitation Bed	For new or additional SHPDA-approved inpatient rehabilitation beds, the minimum annual occupancy rate for each provider in the service area must be 85% based on the number of licensed beds.
Long-term Care Bed	1. Define target population 2. National utilization rates should be applied to the estimated target population to determine need 3. Need estimates should be compared to current Hawaii licensed long-term care bed usage Compare current and anticipated licensed long-term care bed usage in service area

It is recognized that some service areas may not meet the required threshold for a health care service. Sub-optimum utilization may be proposed if the benefits clearly outweigh the costs to the community of duplicating or under-using services, facilities, or technologies.

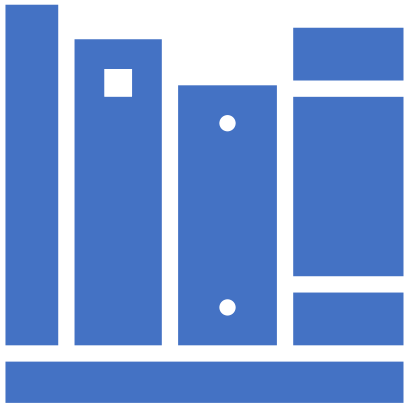
Benefits are defined as the form of improved access for the service area(s) population combined with significant improvement in quality and/or significant reduction in cost to the public.

In addition, beyond regional factors, thresholds may be modified to:

- Incorporate current and best clinical practices;
- Allow for the cost-effective transition and capital investment in moving traditional inpatient services to outpatient modalities;
- Allow for the cost-effective introduction of modern technology to replace existing technology;
- Address the documented needs of an actual population rather than basing care design on statistical generalizations;
- Create opportunities for price reduction through competition, without sacrificing quality or cost-effectiveness of care; and
- Encourage innovation in improving health care services that contribute to enhancing a community's health status.

Examples of situations where sub-optimum utilization was allowed by SHPDA include:

- CT for Molokai General Hospital: The population size of Molokai is too small to ever meet the threshold standard to justify a CT. However, concerns about access and quality of care (CT is a standard of care for hospitals) outweighed the sub-optimum utilization data. Therefore, SHPDA approved the certificate of need application for a CT from Molokai General Hospital.
- Gamma Knife for Hawaii: The gamma knife is used for specialized treatment of certain types of brain tumors. The current frequency of such brain tumors in Hawaii, and the surrounding Pacific Basin region, is below the utilization numbers needed for a gamma knife. However, given the fact that there was no other gamma knife in the Hawaii/Pacific Basin region and that the knife provides improved patient brain surgery outcomes, SHPDA approved the application for a gamma knife for St. Francis Hospital.




Questions & Answers

Thank you