

Maui Health Task Force Initiative
Oct. 23, 2007 – Maui Coast Hotel
Draft Minutes

Task Force Members in attendance: Chair Rita Barreras, Vice Chair Tony Krieg, Dr. Noa Emmett Aluli, Norm Bezane, May Fujiwara, Hermine Harman, Mark Hyde, Dr. Guy Hirayama, Alan Lee, Phyliss McComber, Leonard Oka, Jeanne Skog, John Smith, Dr. Richard Weiland, Jan Yagi-Buen

Task Force Members excused: none

Chair Barreras called the meeting to order at 11:54 a.m.

The agenda was approved – after a motion by May Fujiwara and a second by Phyliss McComber with unanimous approval. Task Force members introduced themselves.

Public testimony

David Russell: As the director of Heart, Brain and Vascular Services at Maui Memorial Medical Center (MMMC), Russell said he was responding to critical attacks on MMMC that have appeared in the media. Russell explained the state-of-the-art improvements at MMMC that have provided three cath labs, advanced imaging and a stroke treatment program which has become the best or one of the best in the state with patients from other islands being transferred to MMMC.

Task Force members questioned Russell about the wisdom of performing such advanced procedures without being able to perform open-heart surgery. Russell acknowledged that could be a danger, but he said it has lessened and that heart surgery is being planned for MMMC. Vice Chair Tony Krieg asked how many surgeries a year are needed to maintain a quality program where the skills of the doctors are kept up – Russell said it's estimated that 200 a year are needed to reach that quality of care, but that number is higher than the number of surgeries performed at some hospitals. Russell said the MMMC projection for heart surgeries was 194 in the first year and 236 in the second. In response to questions from Hermine Harman, Russell said that those numbers did not take into account any patients from the Big Island being transferred to MMMC. Russell also said that Hilo Medical Center is

applying for a Certificate of Need (CON) for a diagnostic cardiac lab, not one that performs procedures. To go along with the upgraded services of a heart surgery program, Russell said MMMC will upgrade the level of staff training, hire nurses expert in the field and bring in outside resources skilled in heart surgery support.

MMMC executive Pat Saka, sitting in the audience, said the \$100 million bond for the heart surgery center has been appropriated by the Legislature, but not released by the administration. The release of the money is expected.

Patricia Ross: The widow of a World War II veteran, Ross pleaded for better care for veterans returning from the current war and aging veterans who served in World War II. MMMC and Kula Hospital ended contracts with the Veterans Administration (VA) and Hale Makua won't accept vets unless they use private pay because of government regulations. Ross said there are 3,500 aging vets on Maui; 14,000 vets in all. Ross also testified in support for a private hospital that would have more specialities available – she has a medical condition that can only be treated on Oahu.

Dr. Nancy Rogers; An Ob-Gyn specialist, Rogers is head of the Ob-Gyn Department at Kaiser Permanente and current chair of the Perinatal Safety Committee at MMMC that was initiated a year ago. Rogers said the Perinatal Safety Project emphasizes safety, common language and communications skills that are essential in times of crisis, teamwork and rehearsals for emergencies. All staff and physicians will be required to attend 13 hours of specialized training.

Rogers said she was proud of the care provided at MMMC. Deliveries have increased by 10 percent the past two years and expansion of facilities is needed. By upgrading the Nursery to Level II in the future, Rogers said it is hoped that some babies who otherwise would need more intense care available on Oahu will be able to remain at MMMC. She said MMMC wants to continue to collaborate with Kapiolani and Kaiser Moanalua which currently provides more high-level care for some Maui babies.

In response to a question from Hermine Harman, Rogers said that epidurals are not yet available at MMMC, but that a type of similar treatment that provides pain relief for up to 2 1/2 hours is. Rogers repeated the need for a Level II Nursery that would be able to care for babies who are 32-25 weeks

when born and now must be sent to Oahu. She said that would require an upgrade of personnel skills and space.

Dr. Michael Kim: An Ob-Gyn specialist, Kim noted the increase in births on Maui – a few years ago, the average was 130 a month; in May, there were 179 and since then, an average of 171 a month. More often patients have to wait or be triaged. With more development on Maui and a growing population, more labor rooms and other delivery-related services, etc., will be needed.

Kim said that he believed that MMMC had the highest quality of care for newborns. Krieg wondered at what point a hospital does tertiary care for newborns – it's the frequency and quality of care that's needed. Dr. Guy Hirayama pointed out that MMMC is a Level I hospital that sometimes does Level II care, meaning that the hospital can provide care for mildly ill infants who might need oxygen, have respiratory distress or have other illnesses, but do not require mechanical ventilation.

Dr. Pedro Giron: Giron is an emergency room physician and Chief of Staff at MMMC who was speaking on his own behalf. He said MMMC has emerged from a rural hospital to a modern facility with one of the nation's leading programs in treating people who have suffered strokes. Giron said the hospital administration pushed for the cardiac program because there often isn't enough time to get patients to Oahu. He said he believed the bill passed last year that granted regional autonomy to Maui county facilities will be "groundbreaking." A serious problem that remains and affects the entire state is the lack of a Trauma Center – he said there is a need for trauma care in general and pediatric care. Hawaii lacks a Level I Trauma Center, said Giron, a major missing piece, especially since the state is in the middle of the ocean. The counties provide Level II or III care. He urged the Task Force to make a statewide Trauma Center the top priority – he said such a center should be developed with the input of doctors, administrators and government officials. Giron said he found it hard to believe if the Task Force could be successful if they don't look at things from a statewide level – trauma, cardiac and neonatal. He said sometimes it makes sense to centralize some specialties. Chair Barreras asked if the Trauma Center was a statewide issue, then why was this being kicked back to the county? Giron found that ironic. Giron also said that, at full buildout, the ER at MMMC would have 30 bays. But it added that you can build more facilities for more people, but unless you have staff, you still have a problem. Regarding the

helicopter situation, Giron said he believed a helicopter with a fixed wing plane for air ambulance service was a good combination.

Approval of minutes of Oct. 13, 2007

Hermine Harman said the Home- and Community-Based Committee also includes members Anne Trygstad, Jan Yagi-Buen and Gladys Baisa, who were later added to the group.

Norm Bezane said the West Maui Hospital should be described as a medical facility and not a clinic.

Mark Hyde said that a comment he believed to be pertinent was not included in the summary of Jo Anne Johnson's testimony when she was discussing the health care needs of West Maui. He wanted a statement included that Johnson also said that she doesn't believe we have the workforce to staff medical facilities in West Maui, but once a medical facility is established, we need a financially sustainable model.

May Fujiwara said some words on the first page of the minutes were transposed.

With corrections, Hyde made a motion to approve the minutes with a second by Bezane. Approval was unanimous except for Krieg, who did not attend the previous meeting.

Presentations: These are the final presentations that will be made to the Task Force before members begin their deliberations on Nov. 3

Eric Shell, principal with Stroudwater Associates a national health care consulting firm that specializes in helping rural communities develop Critical Access Hospitals

Shell made his powerpoint presentation via speaker phone from the Big Island where he was on business. He gave an overview of Critical Access Hospitals (CAH), which include Kula Hospital, Lanai Community Hospital and Molokai General Hospital in Maui County. The proposed West Maui Hospital is also being planned as a CAH. There are nine CAHs in Hawaii and 1,200-plus in the entire United States.

Shell explained that a federal program created the CAH system in 1997 as a way to help rural hospitals that were struggling. The Balanced Budget Act established the Medicare Benefits Improvement and Protection Act. Medicare required the CAH to be located in a rural area with no more than 25 beds – originally, there was a limit of 15 acute-care beds with stays of 96 hours or less. The CAH had to be 35 miles away from the nearest hospital or, for a community hampered by mountainous terrain, have access only to a secondary road (not four lanes).

Hawaii State Medicaid program pays CAHs based on costs – reimbursements are based on costs, which is an advantage. Medicare pays for inpatient and Part A outpatient services on the basis of reasonable cost. Thus, CAHs lowers the risk for rural hospitals because many costs are fixed.

Only 39 CAHs were started in the US in the past eight years, but 41 will be established in the next year. The median population for a “zipcode” of a CAH was 6,000 – the median population for the service area of a CAH was 11,000. There are other CAHs serving more or fewer people – i.e. Lanai has a population of just 3,000 – a CAH in New Hampshire is located in a community of 50,000.

Some realities of CAHs in Hawaii: The median margin of CAHs in US is 2.63 percent – in Hawaii, it’s minus-10 percent; there are negative cash flow margins and returns on equity – Hawaii CAHs are not doing well.

Why?

Low volumes in CAH results in high unit costs – third party payers result in losses on a fully allocated cost basis; high labor costs. Cost-based Medicare, Medicaid, and HMSA 65-plus, reduce CAH losses significantly. For most CAHS, operating losses are primarily the result of high unit costs, third party reimbursements, clinics and costs associated with bad debt; Hawaii facilities are in desperate need of updating.

Shell said that HMSA pays “horribly” in reimbursements – he said he would say this even if HMSA representatives were at the meeting. He said Hawaii insurance rates are considered to be low.

Bezane said that West Maui, with a population of 50,000 on any given day, would qualify for a CAH – would the higher population mean that the

hospital would be more profitable? Shell said yes, that volume is important in bringing down unit costs.

Shell said that the West Maui Hospital could develop a transfer agreement with MMMC in case there was a need for more beds than the limit of 25.

Because the program requires that a CAH be an established hospital, the West Maui facility will most likely open as an acute-care hospital and then become a CAH.

John Blumer-Buell, Hana resident who has a longtime involvement with health care issues in Hana

Blumer-Buell said he was speaking on his own behalf, but had also been authorized to speak on behalf of Hui Laulima, the group of Hana residents trying to establish a dialysis center in Hana. He said that he has been involved with the Hana Community Association since the late 1980s.

The presentation by Blumer-Buell was regarding the controversy that has engulfed the Hana Community Health Center – now known as Hana Health – for the past 10 years. He asked the Task Force to help the community regain its role in guiding the health center.

Blumer-Buell gave a brief history: in the mid-1990s the Hana community began discussions about taking control of the state-run medical center that used to be licensed as a four-bed hospital. In 1990, the medical center was no longer licensed as a hospital, but the state did not change its CON so services were limited and costs high. The community had hoped to turn the health center into a community-based nonprofit organization that retain an affiliation with the state and be run by a board of directors elected by East Maui residents. Blumer-Buell said the Hana Community Association and Department of Health were part of the public discussions. A report indicating the community's wishes was submitted to the Legislature and approval for the Hana Community Health Center was granted in 1996. Initial community membership was 300.

In 1997, the first board that had been elected by the community changed the bylaws and essentially privatized the health center. Since then, said Blumer-Buell, the community has been left out of center's planning or decision-making while primary and emergency services have deteriorated. He said the

community wants those services back along with dialysis. The Hana controversy has been front-page news on occasion: Mayor Alan Arakawa and the Governor's Advisory Committee both told the Hana Health board to open its meetings to the public, but that never happened.

Blumer-Buell said it had been hoped that two other Hana organizations, Hui No Ke Ola Pona and Ohana Makamae, would share the facilities that would have included kupuna housing and a community health center. The public health nurse was also supposed to be located there.

The group running the center now has a proposal for a change in zoning to allow it to construct a "wellness center" that could cost anywhere from \$26 to \$52 million, according to Blumer-Buell. He asked the Task Force to make a series of recommendations that would reinstate the community membership of the health center –and that if the board refuses, then deny all county, state, federal and private funding except for emergency services. He also asked the Task Force to urge the Legislature to hold a meeting on the topic in Hana and that, if the life of the Task Force was extended, the group should also hold a meeting in Hana. He hoped the Task Force would support dialysis services in Hana as envisioned by Hui Laulima O Hana, the Hana community and the Maui County Council.

Blumer-Buell said a good health center with emergency services is also essential because 750,000 tourists a year visit Hana.

Bezane asked about the kind of medical care now available in Hana and what changes were hoped for. Blumer-Buell said that when the state-run Hana Medical Center was in operation there was good insurance coverage for people who worked (hotel workers, government workers, etc). In addition, there are Kaiser patients in Hana. He said Dr. Howell, who worked at the medical center for decades, lived in Hana and knew the patients and their families – in those days, many Hana residents went to the medical center. Today, new doctors come to Hana Health every six months or so, said Blumer-Buell. He said there's now a low level of confidence in the health center – many Hawaiians are choosing to go to Dr. Paul Kaiwi, who grew up in Hana and knows the families' histories, and that Kaiser patients are choosing to travel to Central Maui and Oahu, if needed. At Hana Health, said Blumer-Buell, emergencies are referred to the Hana EMT team which refers patients to MMMC.

In response to a question by Harman about dialysis, Blumer-Buell said he believed there were four people in Hana currently in need of the service in addition to a kupuna who had to move to Oahu, and now to Central Maui, to get dialysis.

On a related subject, Chair Barreras asked Blumer-Buell, who is a member of the General Plan Advisory Committee, if and how the Task Force can be involved with the GPAC in terms of submitting health care issues. Blumer-Buell encouraged the task force do provide information because future health facilities should be designated on planning maps with the appropriate language included.

Jan Shields of the Association for Improved Healthcare on Maui (AHIM)

Shields noted that she is an expert in neonatal medicine and a R.N.C. (registered nurse with extra certification in obstetrics training)

Shields posed the question: why would Maui reject a private NICU – Neonatal Intensive Care Unit? She said there were several reasons: the Hawaii Health Systems Corp. (Maui is wealthy – HHSC would drop Maui if it wasn't wealthy, according to Shields); the Healthcare Association of Hawaii which includes the Oahu hospitals that want to continue caring for the Maui babies sent there; HGEA (a private hospital would not have a government union for employees); MMMC (Shields complimented the doctors, but said they need another hospital) and others who are making money off the current system – NICUs on Oahu are bringing in good money from Maui.

An NICU is especially critical in the first 12 hours of life for babies in need. Six of those 12 hours are wasted for babies in need on Maui because they are waiting for transportation to Oahu and being cared for in an inadequate facility. Shields said these babies have poor longterm outcomes: blindness and other serious problems can result. In addition, transportation places the infant at risk – it can take a long time to stabilize a baby.

HHSC, said Shields, does not provide the kind of care and training needed to care for sick or premature infants. She said that in 2006, 2,287 babies were born in Hawaii – 1,827 born on Maui. There was a question about the

accuracy of these statistics. More than half of babies are born on Maui? Shields indicated the data is from Hawaii government.

MMMC says there were 1,757 total deliveries – 54 babies were of low birth rate (5 pounds or less) and nine babies were very low birth rate (3.3 pounds or less). Shields said that one in eight babies on Maui are born prematurely – one in 33 babies have birth defects of some kind.

From July 2006 to July, Kapiolani registered 40 deliveries of Maui babies and Kaiser registered 259 Maui babies born on Oahu.

Shields said the average hospital stay of premature infants is 20 days – that translates into 5,180 total patient days of Maui babies on Oahu – 14 Maui babies on Maui everyday.

Maui County has a population of 141,320; with 2.4 million tourists annually (48,854 average daily count), that gives Maui a total daily population of 190,174.

Shields claims she was fired by Kaiser Permanente on Maui because she was actively pushing for another hospital.

She said that 14 to 20 Maui preemies are hospitalized on Maui on any given day and that this number does not include sick babies – she said some of the sickest babies in Hawaii come from Maui because of the lack of staff training.

Shields believes that Maui has the numbers to support a mid-sized NICU – and that staffing would not be a problem. She said specialists from all over the nation and world want to work in an NICU on Maui. A neonatal team at a hospital, she said, is not cost effective and increases the number of lawsuits.

An NICU decreases the length of hospital stays, saves money, enables families to remain together during the baby's illness, eases the financial burden on families and ensures that breastmilk will be available for the infant. An average stay of 20 days in a hospital would cost a family \$7,960 in expenses (hotel, food, airfare, etc.) and lost wages – to say nothing of the emotional hardship of the separation.

Shields also said that Maui had a much higher rate of Caesarian deliveries: the US average is 30 percent; Hawaii average is 24 percent and Maui average is 40 percent.

Harman asked what was the minimal number required for a NICU. Shields said many NICUs have five babies a day; eight to 10 babies a day is often considered a workable number – Maui would have more than that. She said that government will never provide NICU in their hospitals – only private hospitals will. Bezane asked about the strengths and weaknesses at MCCC – Shields said she felt the personnel were a strength at the hospital, but that a weakness was that MMMC doesn't provide specialized services or train the staff sufficiently. She also said that there is not the opportunity for continuing education credits like there is on the Mainland. She said there was a lack of equipment at MMMC and that another weakness was the fact that MMMC was involved with government. She said many people would love to build a private hospital on Maui.

Dr. Hirayama said MMMC does Level I and sometimes Level II care for newborns – once they are on ventilators or are expected to be on ventilators, they need to be transported to Oahu for Level III care or more intense care. In response to a question from Dr. Weiland, Hirayama said that there were 32 neonatal transports from Maui to Oahu who required Level III care or higher in 2006 (21 to Kapiolani and 11 to Kaiser). He said 40 Maui mothers delivered at Kapiolani for various reasons, some simply because of personal preference. Thirty-five newborns from Maui were transferred or delivered at Kaiser Moanoloa on Oahu with six born with very low birth rates (3.3 pounds or less).

Hirayama said that 96 Maui babies were either born on Oahu or transferred there in 2006 (21 transported to Kapiolani, 40 delivered at Kapiolani for various reasons and 35 transported to or delivered at Kaiser on Oahu). Not all of those babies required NICU care.

Jan Yagi-Buen asked Shields if a private hospital would take all comers. Shields said yes, there would be no cherry picking of wealthy patients because that would be illegal.

Kathy Hass, Outreach Coordinator for the Community-based Outpatient Clinic, Veterans Administration

Hass said that there was no permanent resource for care of veterans on Maui until the Vietnam vets became vocal in the 1980s when they had U.S. Senate hearings that resulted in the establishment of clinics on all the Neighbor Islands in 1988. At that time, Hass transferred to Maui from Wisconsin. A full-time physician was added and Kathy started outreach clinics at Molokai, Lanai, Hana and Lahaina. The VA Clinic is now located in Kahului where third-floor facility is now expanding to the second floor. She said Senators Akaka and Inouye have been most helpful.

Wounded veterans from the Iraq War and Afghanistan are now returning with a higher incidence of traumatic brain injury and amputations – once returned, the VA needs to contact them and, if they are interested, schedule an appointment for them within 30 days. Whether the vets return for services after that is up to them. Many are in need of mental health – there has been an increase in those services and Maui is benefiting. The VA is trying to provide tele-mental health by making available a psychiatrist and a psychology tech via that technology.

World War II vets are aging – there are no nursing home beds reserved for them on Maui. A VA hospital will be opening in Hilo. Respite care is needed for caregivers of vets with Alzheimer's disease – the VA wants to help people to stay at home for as long as possible – they will be adding a home health nurse to provide support for those who want to age in place. Telemedicine is being used in more ways – “telehealth buddies,” teledermatology, telenutrition and patient medications through telemedicine.

There will always be mental health issues with veterans of war – even World War II vets are showing signs of PTST (post-traumatic stress syndrome). The veterans of the Korean and Vietnam wars are now also aging; the Vietnam vets seem to have a high rate of cancer (probably from Agent Orange, etc.) and are dying younger than the World War II vets.

Maui Long-Term Care Partnership is working with the Veterans Council on a 60-bed long-term care facility. Molokai is also working on developing its own facility.

Hass said that 3,000 vets are enrolled with the VA in Maui County and the 1,700 have been seen at the clinic in the most recent two-year period either because of illnesses, war-related wounds or low income level. The VA also brings in specialists.

In response to a question from Bezane about where the vets go for hospitalization, Hass said they go to MMMC – if they need heart surgery, they go to Oahu. Vets could be admitted to a private hospital on Maui if the specialties were available.

Michael Covich was asked to talk about the planned long-term care facility on Maui. Covich said the federal government will pay for 65 percent of the long-term care facility with the rest coming from the state or a bond. A location still must be found.

He said that Hale Makua doesn't have an affirmative action plan so the VA can't sign an agreement with the facility.

Dr. Hirayama asked if the planned facility would be open to only veterans or a mix of the aging population. Covich said that, traditionally, these types of long-term care facilities would be limited to veterans, but his preference was that if there are open beds, it would be wise to take in people from the general community. He said there are differing opinions on this subject: some vets want vets only; others want it open to the community. The Hilo facility will be just for veterans – Covich found it bizarre that a management firm from Texas has been hired to run the place instead of keeping the money in Hawaii with a local company.

Discussion of Draft Agenda for Nov. 3

Chair Barreras said that each of the Task Force's three committees will make reports of findings, conclusions, recommendations and outcomes on Nov. 3 – location to be determined. The all-day session will be facilitated by Joe Lapilio. Barreras said the H2P2 does not provide goals or objectives and that the Task Force could prove to be extremely helpful by doing that. The group will finalize its recommendations on Nov. 10 and review a draft report on Nov. 20.

Barreras had drawn up some guidelines for the committees to help them in developing their reports and statements. She said committees should focus on the needs of today as well as tomorrow – look at the current health care issues and what's available today, then “vision” to 2020 or 2030. Statements should be developed for current and future needs. Barreras acknowledged

that over the past couple of months, Task Force members have been presented with mountains of information to digest and sort through.

Committees should focus on health care outcomes – chairs should strive for consensus in their groups – and give each member an opportunity to express their own conclusions as a result of reviewing all the data presented.

Barreras also said she had confidence that the Task Force “as a group of very talented people” would “step up to the plate and do our best to influence systemic change.” She asked the group to be bold in thinking and come up with the best product possible which will be used to update the H2P2 (Hawaii Health Performance Plan), which is the first document listed on the matrix used by SHPDA to determine if criteria for a Certificate of Need application have been met.

Hyde said that not all the issues that have been discussed lend themselves to ready benchmarks and that the Task Force has not had the benefit of expert input to develop benchmarks since the executive branch has not released funds to enable the group to do their work.

Harman was also concerned that the money appropriated by the Legislature for Task Force operations still has not been released – Chair Barreras said she would ask that the process be sped up to release the funds.

Leonard Oka was concerned that other reports have been done, but nothing happens. He wanted to know if the Task Force could create some bills if it’s decided that specific things should be done. Barreras said that was definitely possible.

Jan Yagi-Buen said the Legislature asked for the report 20 days prior to the 2008 session – she said lawmakers need to be informed that the Task Force wants them to take this report seriously. Barreras said the Legislature does not want this to simply be another study.

Bezane said he was concerned that if the report was too long, it would not be read. He recommended that the report be only one or two pages long with an appendix. Dr. Hirayama agreed – the report needs to be brief and succinct.

Harman said that priorities must be determined. Barreras said she believes the Task Force has taken its responsibility very seriously and that she thinks

concrete steps will be taken to get Maui to the next level. As long as the CON process exists, the criteria that appear in the H2P2 for Maui County will be used by SHPDA panels to determine if all conditions for the CON have been met.

Harman said the H2P2 is not a valid plan.

Barreras suggested that the task force ask Ronald Terry, new administrator of SHPDA, to share his knowledge about the CON process – and how the Task Force product will be used.

Bezane said he has been hearing from others in the community that addressing the CON is a priority.

Harman said that since MMMC has been regionalized, SHPDA shouldn't be making any decision on CON applications from Maui – it should be done by a Maui panel.

Harman moved to adjourn the meeting with a second from Yagi-Buen. All of those still in attendance agreed. The meeting was adjourned at 4:10 p.m.