

Maui Health Care Initiative Task Force
Sept. 18, 2007 -- Maui Memorial Medical Center
Minutes

Task Force members present: Chair Rita Barreras, Vice Chair Tony Krieg, Alan Lee, Dr. Guy Hirayama, Dr. Richard Weiland, Mark Hyde, Hermine Harman, Norm Bezane, Leonard Oka, Dr. Noa Emmett Aluli, John Smith

Task Force members excused: Jeanne Skog, May Fujiwara, Jan Yagi-Buen, Phyllis McOmber

Chair Barreras called the meeting to order at 5:05 p.m. and reminded everyone that the Task Force had been assigned to develop a comprehensive health care plan for Maui County.

Norm Bezane made a motion that immediately after public testimony, the task force discuss how the group will move forward, if consultants will be hired, etc. There was no second, motion failed. Chair Barreras said when flip-top chart notes from previous meeting are reviewed, there will be a chance to talk about the issues that Norm is concerned about.

Public testimony

Gina Flammer – Maui got control of its own hospital through recent legislative action, but the community must be willing take on that responsibility and support improvements at Maui Memorial Medical Center (MMMC) – take it from a safety net hospital to a state-of-the-art facility. The Regional Committee will focus on a mission statement. Community must not be divided – a strong community hospital can go head to head with another hospital. The community needs to work together and quit attacking the hospital. The shortages of physicians and must be addressed – more nursing education by MCC. The waitlist problem must also be addressed to get long-term patients out of acute-care facilities and into places better suited for them that also save costs.

Minutes of Aug. 25, 2007 approved – Motion by Hermine Harman, second by Guy Hirayama – passed unanimously except Mark Hyde abstained because he wasn't present at that meeting.

Darryl Shutter appeared via video from Oahu, and introduced Ron Terry, new administrator of SHPDA. Darryl commented on Sunshine Law requirements for TF: the booklet is on website, starts on Page 14 – six permitted interactions:

1. Two board members may discuss board business outside of meetings as long as no commitment to vote is discussed; it's not appropriate to have one-on-one discussions with several members on a topic;
2. The board can designate two or more members, but less than quorum to investigate board business; these subcommittees should report their findings to board in properly noticed meeting;
3. The board can assign two or more members but less than quorum to discuss any position board has adopted;
4. Two or more members, but less than quorum, can discuss the selection of the board's officers;
5. One or more members can meet with the Governor in a private meeting as long as they don't discuss a topic that the board will be deciding on;
6. Routine administrative matters can be discussed by two or more members of the board with an official of the department to which the board is assigned.

Mark Hyde asked if individual members can seek out information on their own – such as making a phone call to a third party, seeking information or do general searching for information, but outside the scope of a committee. Shutter said that's OK – a board member can discuss business with non-board members.

Tony Krieg asked if an investigative subcommittee is created, does the TF have to post meetings? Shutter said he didn't think so, that it wouldn't constitute a meeting, but that he would check.

Shutter said if there any additional questions on Sunshine Law requirements, call Office of Information Practices at 586-1400.

Bezane: Except for one-on-one conversations with another board member, can TF members have discussions only unless we form working investigative subgroups? Terry said yes.

Barreras: Subgroups must deliver findings at noticed meetings, but subgroup meetings don't have to publicly noticed meetings.

Barreras asked for input on preparation of the budget regarding travel reimbursements and whether or not lunch/dinner business meetings would include covering cost of meals. Shutter said that travel arrangements should be made through Amy; the state allows reimbursement for lunch/dinner meetings and will cover food and water as long as it's a working meeting – just let his office know in advance.

Harman: TF shouldn't pay for meals, but for bottled water is OK, shouldn't be wasting state money

Barreras asked the group and no one was interested in lunch or dinner meetings.

Shutter said his office had requested funds for the TF, but that the Director of Finance had decided not to release the \$100,000 because expenses would be minimal. But if a budget and plan of action is prepared, the Department of Health can resubmit the request.

Bezane said he was very dismayed by the Finance Director's decision – in the past, many studies on Maui County health care needs have been done, but what many of the studies lacked was expertise from consultants, professionals in field. If the TF to have any impact, a consultant should be hired who can provide the professional expertise, especially in the areas of finance and financial viability. Finance is the key to health care solutions, not only on Maui, but in the state. This action of not releasing the funds immediately prevents TF from moving to meet its deadline. If a consultant is to be hired, the TF must do so quickly because it will take two months for the research to be conducted and another month for the TF to review the information gathered. The TF has been given a difficult task – this TF is not only about needs, but about solutions. We've had studies about needs in the past, it's not a matter of this would be nice to have, but what can we do to get these things done.

Barreras said that from her previous experience of working in a state bureaucracy, the Finance Director is essentially telling DOH that it could absorb the expenditure and Dr. Chiyome Fukino (DOH Director) is now being asked to resubmit request. Rita welcomed Ron Terry to his new job.

Barreras noted that at the last meeting, the TF went over its allotted time and because five presentations are scheduled for tonight, it appears more time will be needed for this meeting, too. She asked if members could stay longer. Everyone agreed that they could.

Because of the length of meetings, Hirayama suggested that at the next meeting (Oct. 13), the agenda be changed so that the TF could discuss critical board business before public testimony and the presentations.

Panel Presentations

Invited guests: Wesley Lo, Chief Executive Officer of Maui Memorial Medical Center (also has oversight of Kula Hospital and Lanai Community Hospital); Lee Johnson, administrator of Kula Hospital; John Schaumburg, administrator of Lanai Community Hospital; Lance Segawa, executive director of operations for Hawaii Health Systems Corp. (speaking on Roselani Place) and Tony Krieg, executive director of Hale Makua

Wesley Lo, Maui Memorial Medical Center

(Lo provided the TF with a detailed handout of his power-point presentation)

Lo began by speaking of some of the notable services of MMMC: the only psychiatric unit for adolescents on the Neighbor Islands; the only two cardiologists who work in the Neighbor Islands, and a stroke program that is touted as being the state's best (at one time, said Lo, three air ambulances were heading to Maui at the same time bringing patients who had suffered strokes to MMMC). The hospital is currently working to improve its cardiac/thoracic program.

Challenges:

1. Access (availability) of medical specialists such as orthopedists, ob/gyn, general surgeons, psychiatrists, internal medicine specialists (Maui has the lowest number of primary care physicians in the state) and neurologists.
2. Kaiser impact is an issue because it tells patients where they go for care. Some specialty groups operate by using a hospitalist – where will they send their patients if you build another hospital. Urgent care clinics at Kaiser and MMG impact the MMMC ER.

3. Changes in how business is done. For example, orthopedic surgeries that used to be done at MMMC are now being conducted at surgery clinics.
4. Shrinking reimbursements.

Non-Acute Average Daily Census – People who shouldn't be in the hospital but are in the hospital add significantly to the costs. The number of waitlisted patients has been as low as 40 a day in recent years and as high as nearly 60 – currently there are about 40 people at MMMC who don't need that high level of care, but have nowhere to go. So the health care needs of Maui aren't just about building more skilled nursing beds, but building a variety of beds for the various needs. The cost for waitlisted patients to MMMC is \$1,000 a day – or \$50 million a year (if the average is 40 a day).

Medicaid pays 31 percent below cost on reimbursements; Medicare 18 percent below cost; these total 45 percent of patients at MMMC. Commercial payers pay 17 percent above costs, which cover some of the shortfalls of low Medicaid, Medicare reimbursements. Premiums in Hawaii are much lower than the rest of the nation.

MMMC is the second busiest ER in State, but is challenged by a staffing shortage, the waitlist that can cause patients in the ER to be unable to get a bed in the general wards, the low reimbursements and the demand for services that Maui doesn't have the critical mass (enough population) to economically support. A hospital ER requires an enormous amount of staffing with specialty physicians available and necessary support services, such as imaging and lab.

Data is critical in developing a health care strategy – as much data as possible is needed to make good decisions. A statewide strategic plan is needed that would address providing better access to all levels of care because some people are going to the hospital who don't need to go the hospital, but don't have a primary care physician.

There should be support of round-the-clock urgent care centers in key geographic locations and partnering to address needs – the hospital shouldn't have to be responsible for everything. An integrated approach is needed.

Lo sees the aging community and long-term care needs as a major issue.

If MMMC can provide services that no other Neighbor Island does or even that Oahu doesn't provide, Maui can have critical mass to provide some services not yet available.

Hirayama asked if the TF should create recommendations to look into raising premiums so that HMSA can raise premiums, etc. Lo replied that efficiencies are key and that premiums should be looked at, but also noted that everyone has to pitch in.

Bezane asked what Lo thought the setup should be for acute Emergency Room care. Using West Maui as an example, Lo replied that the community wants an ER, especially to address after-hours needs, but that current ambulance statistics from West Maui won't support a full-blown facility. Lo suggested that such a clinic or center start small with some specialties and grow. But if the community wants it, the community has to pay for it, said Lo. How can you sustain it? Bezane pointed out that many people from West Maui drive to MMMC on their own because they're worried the ambulance will take too long to pick them up and transport them, but Lo said the ER numbers from West Maui in general are still low.

Lee Johnson, Kula Hospital

(Johnson provided a handout of the power-point presentation)

Kula Hospital is a Critical Access Hospital that sits on 60 acres of ceded lands. There are 99 SNF (skilled nursing facility)/ICF (intermediate care facility) beds, nine ICF-MR (mental retardation) beds and five acute-care beds in addition to an ER and outpatient primary care clinic. There are four physicians for the ER, one physician for 113 hospital beds and two part-time physicians for the clinics.

Plans for the future:

There is opportunity. There are facilities to work with now --- MMMC, Lanai, Kula facilities. Kula Hospital has lots of land. Upcountry is growing – Hawaiian Homelands growing, more retirees are moving Upcountry; the projection is that Kula will need to double the number of long-term care beds, but where does the money come from?

Critical Access Hospitals were a federally mandated program created in 1997 for little hospitals in small, remote communities that can't survive on

the current reimbursement system – the feds pay costs to keep these little hospitals open so long as they meet the criteria – no more than 25 beds, but can have ER and outpatient services. Johnson says it's a great program -- Kula is one of seven HHHSC hospitals that takes advantage of it – and that it brings in more than \$2 million annually to the hospital.

In response to a question by Krieg, Johnson said Kula Hospital budgeted for a \$1.8 million loss this year.

Johnson said the land has been deeded by the state to HHSC. He said the hospital would like to explore the possibility of leasing a portion of the land to a private entity.

Dr. Noa Emmett Aluli noted that Kula Hospital sits on ceded lands, serves people who live on Hawaiian Homelands and has the opportunity to include Hawaiian health care as a component of care. Johnson said one of his personal goals is to integrate Hawaiian health.

John Schaumburg, Lanai Community Hospital

Schaumburg began by explaining the challenges of living on remote and isolated Lanai. There are five ferries a day to Maui, six planes a day to and from Honolulu; weekly barge service. Price of homes can range up to \$11 million. The population of 3,100 includes 14 percent over the age of 65.

Straub Clinic operates the Lanai Family Health Center. Physicians come and go, turnover in physicians can be one a year and when you only have two, that's a lot. Lanai also has a public health nurse, a senior center that provides activities and meals for 50 seniors a day; a Women's Health Center that has applied to be a federally qualified health center to augment services, but not duplicate and Ke Ola Hou O Lanai which is in conjunction with Na Puuwai Native Hawaiian Health Systems (based on Molokai) that helps with dental services. The Veterans Administration is beginning to have more of a presence

Lanai Hospital has 14 private rooms, 14 beds. The four acute-care beds have 6 percent occupancy; long-term care has 10 beds with 92 percent occupancy.

ER had 985 visits last year; lab draws 5,000 specimens a year and 80 percent must be shipped off island, which means they can sometimes spoil en route. An improved lab would allow more tests to be conducted on Lanai.

The hospital does 1,000 X-rays a year – four a day; space is rented to Fresenius for dialysis – there are 13 active dialysis machines which saves individuals \$60,000 a year and the time/stress of traveling on ferry, then car to Kahana, four hours of dialysis and then back.

WIC's 89 clients will be picked up by the Women's Health Center.

Legislature appropriated \$1.2 million to renovate the ER and provide for other improvements, such as replacing the old X-ray machine with a digital unit. The hospital is waiting for Gov. Lingle to release the funds.

MMMC has the best stroke program in the state – but if there's a waitlist and no beds, what can you do? Or if Lanai needs to send someone to Queens, but there's no orthopedic surgeon in the State – this is affecting everyone in State.

We need to look at the continuum of care – people want to be at home, stay at home and that's the lowest cost.

Schaumburg compliments Roy Katsuda for his senior housing complexes – a lot of senior programs are incorporated into the housing developed by Hale Mahaolu.

Again, the waitlist at MMMC affects everyone. When the hospital is full, it backs up the ER. When all beds are full at MMMC, this leads to Congestive Hospital Failure – the cost is \$14.9 million a year to MMMC, but there's a greater cost to the community. The number of seniors in Hawaii and across the nation will double soon.

Schaumburg believes there are lots of little solutions that can be put together in a strategic manner.

1. Think of home-based support as much as possible. Improve reimbursements to those who provide care at home; provide tax benefits, good finance rates; do this through education, planning, cooperative efforts.

2. There is a need to build long-term care facilities, both nursing home beds and greenhouse facilities, but do it in a cohesive matter.
3. It's not just long-term care, but the acute care and ER issues of South Maui and West Maui need to be addressed.

There are no nursing homes on Lanai – the community could use 20 more beds, Maui could use 40 more. Lanai needs Hospice – a volunteer program is being developed.

Alan Lee asked how has the change in lifestyle (from plantation life to tourist based economy) affected health care on Lanai. Schaumburg said the people he has talked to prefer working in the hotels compared to the fields, but that now everyone seems to be working all the time and there is parental “degradation.”

Aluli noted that federally qualified health centers come with lots of money, but that money can buy equipment that impacts current facilities. He said he hoped that the new program on Lanai would not result in the duplication of services and hurt the existing infrastructure.

Bezane asked if West Maui had a state-of-the-art hospital that could be accessed by people of Lanai and Molokai, would that be a good system? Schaumburg said that in the mid-70s, Kaiser didn't perform very complicated services on Oahu – they found it more economical to send patients to California where there was a higher level of expertise (due to critical mass). Another example: there was an offer to donate a mammography machine to Lanai, which would have been a \$100,000 donation, but the hospital would have lost \$50,000 a year in providing a service that wouldn't have been the high quality preferred – and so the offer was turned down. Lanai just doesn't have the population to support it at this point.

Schaumburg said that perhaps a small hospital could be built in West Maui with an ER attached and a greenhouse unit, but that it would need to be subsidized.

By having three hospitals in the Regional system, Schaumburg said the oversight of MMMC also means assistance. When Lanai has quality or infrastructure issues, they call MMMC, which also controls the budget, although Lanai fiscally responsible for maintaining the budget and quality.

Lance Segawa, Hawaii Health Systems Corp.

HHSC has oversight and responsibility for Roselani Place, which started in 2001 – 113 resident spaces. RP was an idea from the Maui region and HHSC embraced it as something to support the community. A separate 501-c-3 was established, Alii Community Care, but HHSC members on board. From 2001 to 2005, RP struggled – only about 50 beds occupied. A turn happened in early 2006 and as of tomorrow, RP will have 83 residents. In the last year there has been a big increase in occupancy. RP is managed by Paradigm Management Company out of the Pacific Northwest. About 71 people employed. Target for December is to get 90, 95 residents. Of the 83 residents, 77 percent are from Maui County. Average cost is \$3,500 a month. RP doesn't take insurance. Average age is 84. Turnover is 2 years – usually move on to nursing facility.

Hirayama asked where Maui County was with assisted living beds. Segawa said there is a definite need. Kalama Heights is more of an independent living situation. With the trends of the past year, it appears that Maui has the population base to support more assisted living facilities.

Hirayama asked about elders on Medicare who can't pay that full price. Segawa said RP has the opportunity to apply for Medicaid/Medicare license. Segawa wants to make RP financially sustainable – HHSC had to subsidize first five years.

Hyde asked about the breakeven cost. Segawa said it was above 110 beds. The property is owned by the Methodist Church; facility is owned by a separate corporation, but Segawa said HHSC doing business as Alii Community Care hopes to purchase the facility.

Tony Krieg, Executive Director of Hale Makua

(Krieg provided a handout of his power-point presentation)

Hale Makua started out when Pearl Harbor was bombed and 20 elderly men who were Americans of Japanese ancestry were kicked out of hospitals by the FBI – Buddhist churches responded to the needs of the men first and Hale Makua was eventually established 60 years ago.

What Hale Makua does: operates Wailuku and Kahului nursing homes that have 362 long-term care beds; has 112 skilled home health clients; case manages 15 families caring for one or two elders who otherwise would be in nursing home; has 50 enrolled in day health, 12 acute care rehab; all in all, caring for 500 frail elders – no subsidies, almost break even. The employees are part of three different unions.

85 percent of revenues for nursing homes are from Medicaid; 11 percent from private pay, 5 percent Medicare. Hale Makua makes money off the private pay, Medicare.

Severe shortage of labor has been driving up costs. Hale Makua has 10 empty beds because there's no one to staff them. Nurses are being flown in from the Mainland and cost 25 to 40 percent more, just to keep building open. Nurses will leave Hale Makua to work at MMMC because the pay is better.

There are also concerns about certain patients – people who are obese, psychotic or hurt others – who don't belong in a hospital, but don't belong in a nursing home, either.

Hale Makua has a staffer who goes to the hospital to see if people can be transferred. There is a waitlist at MMMC, but not all of them need to go to long-term care facilities. There needs to be more home and community based care.

We have one of fastest growing senior populations in nation and the cost of long-term care is gobbling up the state's budget.

There have been no new long-term care beds since 2000.

There are people at Hale Makua who should be elsewhere, but they're receiving Medicaid.

Medicare is not a long-term care plan – it covers physician visits, hospital stays for a certain period and 100 days for skilled care in a nursing home or home, but only if the patient keeps progressing. For long-term care, you either pay privately, pay with private long-term care insurance or Medicaid. In Hawaii, people figure if they have to pay \$75,000 a year, they want to pass down their homes and assets to their children so Medicaid pays their

nursing home expenses. But federal legislation has stiffened that makes that harder to do – if you dispose of your assets less than five years before you enter a nursing home, there are severe penalties. Home equity also comes into play.

It's not a pretty picture. Krieg says he tells people you can dispose of your assets to qualify for Medicaid, you might not get the quality of care. It's a golden movie ticket, but the theater is full. The system isn't growing.

How the Maui Long Term Care Partnership came into existence:

Five years ago, Hale Makua and MMMC were locking horns over waitlisted patients. So Krieg and the administrator of MMMC C got together and realized there needs to be more home and community based health care. Out of that, Maui became one of 13 grantees chosen by the Robert Wood Johnson Foundation to begin addressing the needs of long-term care. RWJ realized that there needs to community dialogues around the nation regarding long-term care. Although some critics say the Maui Long Term Care Partnership (MLTCP) has only talked and not acted, Krieg disagrees.

Accomplishments of MLTCP:

1. Advocated that Medicaid and Medicare waiver funds be combined to get waitlisted people out of the hospital and into foster care or other kind of care homes. This "Going Home" program has saved the state thousands of dollars.
2. Worked with state and county officials to develop statewide fire and building code to allow facilities to be developed at lower costs.
3. Set up searchable Website and print directory of services available.
4. Began addressing the labor shortage by creating an elder care curriculum in Maui's high schools. The students do practicums at Hale Makua and Maui Adult Day Care Center – they were once afraid of elders, now they enjoy working with them. The Honolua Senior's Club raises funds to purchase scrubs for the students for scholarships to the Maui Community College Nursing Program.
5. Worked with the Maui County Council and Mayor's office to get \$250,000 for workforce development – money will be managed by Maui Community College for courses for para-professionals who will assist nurses and allow nurses to be more efficient.

Krieg said that everybody wants to live in homes or home environments like RP – nursing homes were built on 1950s mentality. PACE – Program for All Inclusive Care for the Elderly – is for people who qualify for both Medicare and Medicaid – it's not a solution for the middle class – but has proven to keep people out of ER and out of hospital beds. Hale Makua is one of 14 PACE demonstration places in country – working with state, working with Kaiser. If someone goes to hospital on PACE, Krieg said we're going to get them out because we have to pay. However it won't help with the group of people who are psychotic or grossly obese, those folks who don't belong in hospital and don't belong in nursing home.

Krieg also noted that he's not optimistic about the future with the huge increase of people who will be aging and the smaller workforce. The Baby Boomers are not saving. A raise of hands around the room appeared to show that only one person on the panel has long-term care insurance. Krieg said he thinks most people don't trust the insurance companies, but that a few new options were finally being developed.

He said that 40 percent of a nurse's time is spent pushing a pill out of a blister pack – there needs to be more para-professionals to put nurses to best use. Nursing bidding war is out of sight.

Bezane said the TF doesn't just need to focus on needs, but on solutions.

Regarding people with early Alzheimer's Disease, Krieg said that RP has a Memory Care Unit and that Hale Makua has a similar program.

John Smith noted the discrepancy of Hale Makua having 10 empty beds because of a lack of staff and a waiting list to get in. Smith asked if Krieg saw that as a bellweather of staff shortages to come. Krieg said yes and that para-professionals need to be paid more, too.

Barreras said that, as Project Director of MLTCP, the country is at a crossroads regarding long-term care. In health-care discussions, they aren't even talking about long-term care. This isn't just a discussion about facilities, but home-based care.

Review and update of flip-chart notes from Aug. 25 and Sept. 4 meetings

Valerie Monson was introduced as the TF's staff person who will take minutes and prepare the reports for the group.

Barreras reviewed the upcoming schedule and itinerary. Hyde said the size of the task is elephantine. The group is challenged to do its best with what's available, but can stitch together some recommendations. Hyde said the group should break up into subcommittees, but Barreras noted that at the first meeting the TF said it wanted to work as an entire group. Harman said the panel should revisit the issue of working in subcommittees or the work wouldn't get done.

The TF decided to work in subcommittees. Possible topics: disaster preparedness, reimbursements (Hirayama suggested meeting with the office of the State Insurance Commissioner) and finances, facilities, specialty services, mental health, behavioral health and substance abuse, acute, primary and emergency services. Lee suggested meeting with the SHPDA subarea panel that represents Maui and Aluli said the TF needs to hear from Molokai General Hospital. Bezane said one of the paramount questions was about a second or third hospital on Maui.

Barreras asked about bringing back Joe Lapilio to facilitate the work of the TF. The vote was unanimous in favor of doing that except for Bezane.

Subcommittees will work on: Disaster Preparedness, Acute/Primary/Emergency Care and Long-Term Care. Each of those subcommittees will also consider finances (reimbursements), specialty services and mental health-behavioral-substance abuse services.

Members of the committees:

Disaster Preparedness: Dr. Richard Weiland, John Smith, Leonard Oka, Alan Lee

Acute/Primary Emergency Care: Mark Hyde, Norm Bezane, Dr. Emmett Aluli, Dr. Guy Hirayama, Hermine Harman, Rita Barreras

Long-Term Care: Tony Krieg, Rita Barreras, Hermine Harman

Subcommittees will get together after the meeting to plan when they should meet. Their reports should be submitted at the next meeting, Oct. 23.

The meeting was adjourned shortly after 9 p.m.

Valerie Monson, Recorder