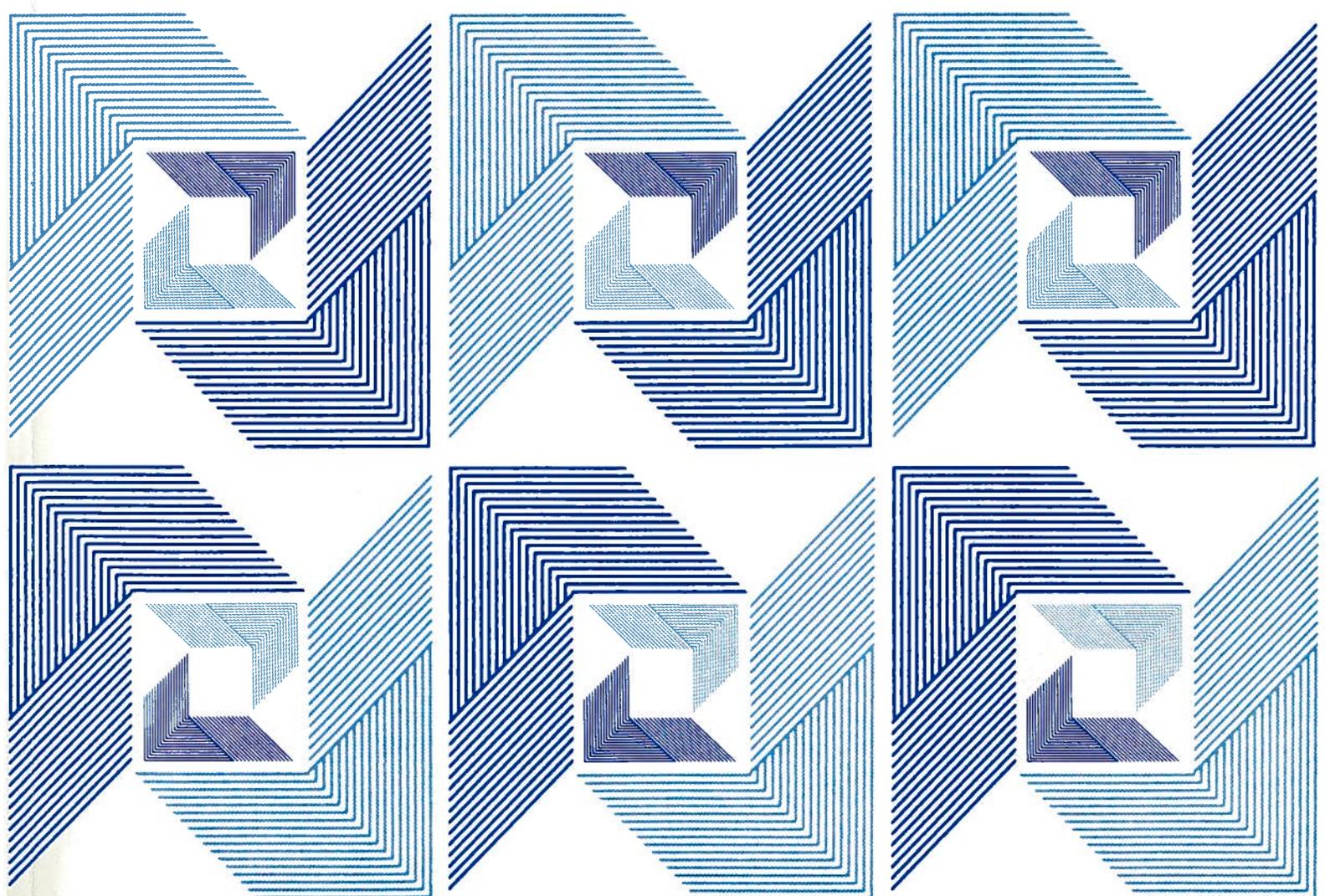


REPORT NO. 88-8
JANUARY 1988

OFFICE OF THE
LEGISLATIVE AUDITOR

A STUDY OF THE COUNTY / STATE HOSPITAL PROGRAM

A REPORT TO THE GOVERNOR AND THE LEGISLATURE OF THE STATE OF HAWAII



THE OFFICE OF THE LEGISLATIVE AUDITOR

The office of the legislative auditor is a public agency attached to the Hawaii State legislature. It is established by Article VII, Section 10, of the Constitution of the State of Hawaii. The expenses of the office are financed through appropriations made by the legislature.

The primary function of this office is to strengthen the legislature's capabilities in making rational decisions with respect to authorizing public programs, setting program levels, and establishing fiscal policies and in conducting an effective review and appraisal of the performance of public agencies.

The office of the legislative auditor endeavors to fulfill this responsibility by carrying on the following activities.

1. Conducting examinations and tests of state agencies' planning, programming, and budgeting processes to determine the quality of these processes and thus the pertinence of the actions requested of the legislature by these agencies.
2. Conducting examinations and tests of state agencies' implementation processes to determine whether the laws, policies, and programs of the State are being carried out in an effective, efficient, and economical manner.
3. Conducting systematic and periodic examinations of all financial statements prepared by and for all state and county agencies to attest to their substantial accuracy and reliability.
4. Conducting tests of all internal control systems of state and local agencies to ensure that such systems are properly designed to safeguard the agencies' assets against loss from waste, fraud, error, etc.; to ensure the legality, accuracy, and reliability of the agencies' financial transaction records and statements; to promote efficient operations; and to encourage adherence to prescribed management policies.

5. Conducting special studies and investigations as may be directed by the legislature.

Hawaii's laws provide the legislative auditor with broad powers to examine and inspect all books, records, statements, documents, and all financial affairs of every state and local agency. However, the office exercises no control functions and is restricted to reviewing, evaluating, and reporting its findings and recommendations to the legislature and the governor. The independent, objective, and impartial manner in which the legislative auditor is required to conduct his examinations provides the basis for placing reliance on his findings and recommendations.



LEGISLATIVE AUDITOR
KEKUANAO'A BUILDING, RM. 500
465 SOUTH KING STREET
HONOLULU, HAWAII 96813

**A STUDY OF
THE COUNTY/STATE HOSPITAL PROGRAM**

A Report to the Governor and the Legislature of the State of Hawaii

**Submitted by the
Legislative Auditor of the State of Hawaii
Honolulu, Hawaii**

**Report No. 88-8
January 1988**

FOREWORD

The county/state hospitals were transferred to the State in 1965, making state government a significant provider of hospital services. This preeminent position is especially marked on the neighbor islands. The system is financed largely by private insurance, Medicare, and Medicaid, but state general funds have also been provided through the years to keep the hospitals functioning. Large capital improvement projects, in addition, have been state financed.

The financial viability of the county/state hospitals and adequate health care for rural residents have always been major concerns of the Legislature. In light of these concerns, the Legislature has directed the Legislative Auditor to undertake this study. This report is in response to that request.

We wish to express our appreciation for the cooperation and assistance extended to us by personnel of the Department of Health, especially those at the County/State Hospital Division and the various hospitals.

Clinton T. Tanimura
Legislative Auditor
State of Hawaii

January 1988

TABLE OF CONTENTS

<i>Chapter</i>		<i>Page</i>
1	INTRODUCTION	1
	Objectives of the Study	1
	Scope of the Study	2
	Organization of the Report	2
2	THE ENVIRONMENT FOR HOSPITALS	5
	Historical Development of American Hospitals	5
	The Scope of the Hospital Industry Today	9
	Issues and Trends in the Hospital Environment	12
3	INTRODUCTION TO COUNTY/STATE HOSPITAL SYSTEM	19
	Historical Background of the County/State Hospital System	19
	The Structure and Programs of the County/State Hospitals	24
4	A FRAMEWORK FOR ANALYSIS: A SYSTEM PERSPECTIVE	31
	State Government Responsibility for Public Health	31
	Objectives of the County/State Hospital Program	32
	Management of a Multihospital System	34
5	GOVERNANCE OF THE COUNTY/STATE HOSPITAL PROGRAM	37
	Summary of Findings	37
	The Existing Governance Structure	38
	Function/Role of the MACs	42
	Recommendations	48

<i>Chapter</i>		<i>Page</i>
6	THE DELIVERY OF HEALTH CARE SERVICES . . .	51
	Summary of Findings	51
	Background Information	52
	Planning for the Delivery of Health Services	55
	Ensuring Quality of Care	67
	Conclusion	80
	Recommendations	80
7	MANAGEMENT OF THE COUNTY/STATE HOSPITALS	83
	Summary of Findings	83
	Organization of the County/State Hospital Division	83
	Lack of a Systems Perspective	84
	Failure to Provide Leadership	89
	Inadequate Management of Resources	91
	Recommendations	96
8	A CASE STUDY IN POOR MANAGEMENT	97
	Summary of Findings	97
	Background: DOH Neglect of a Long Standing Problem	98
	Poor Management of a Questionable Pilot Project	101
	Improper Contract Terms and Conditions	108
	Contract Not Administered in a Responsible Manner	115
	Potential Violation of Patient Rights	119
	HBM Given Preferential Treatment	121
	Confidence in DOH Management and Fairness Undermined	122
	Conclusion	124
	Recommendations	125

<i>Chapter</i>		<i>Page</i>
9	FINANCIAL MANAGEMENT OF THE COUNTY/STATE HOSPITAL SYSTEM	127
	Summary of Findings	127
	Evolution of Hospital Finance	128
	Financing the County/State Hospital System	129
	Obscure Financial Status	131
	Lack of Systemwide Financial Management	140
	Conclusion	145
	Recommendations	145
10	ALTERNATIVE ORGANIZATIONAL STRUCTURES	147
	Creating a New Department	149
	State Hospital Authority	150
	Independent Nonprofit Corporation	150
	Contracting With a Private Management Firm	152
	Concluding Note on Organizational Activities	154

Chapter 1

INTRODUCTION

State government in Hawaii is an active provider of hospital services. In 1965, the State assumed responsibility for the majority of the hospitals on the neighbor islands and, eventually, for two on Oahu. The 13 hospitals have collectively become the County/State Hospital System.

The hospitals have required state general fund support and state financing of their capital improvement projects. More importantly, in most neighbor island communities, the state-operated hospitals are the only acute care providers and the major long-term care providers.

The county/state hospital program will function this year on a budget of \$96 million of which \$8 million will be from the general fund. Major capital investments in the recent past have included \$68 million for Hilo Hospital. By proviso in Act 216, the General Appropriations Act of 1987, the Legislature expressed its concern over the financial management of the county/state hospital program and directed the Legislative Auditor to undertake this study.

Objectives of the Study

The objectives of the study were:

1. To identify the State's objectives for the county/state hospital program.
2. To assess whether the county/state hospital system is organized and managed in a manner which facilitates the achievement of program objectives.

3. To assess the financing of the county/state hospital system and the Department of Health's management of its revenues and expenditures.

4. To make recommendations on how the system can best be structured to meet the needs of the communities which the hospitals serve.

Scope of the Study

The hospital program was viewed in terms of health care needs, especially in the rural areas where the county/state hospitals are such an important presence. The study focused on more than the financing of the hospital system. We examined governance of the hospital program since the Legislature has repeatedly been approached with proposals to change the governance of the public hospital system. We also examined the services that the system delivers and the effectiveness of the current management of that program.

Organization of the Report

This report consists of the following ten chapters:

Chapter 1 is this introduction.

Chapter 2 provides some background on American hospitals and the environment facing the industry today.

Chapter 3 presents the historical background of Hawaii's county/state hospital system and describes the current organizational context.

Chapter 4 provides the framework for analysis, a system perspective.

Chapter 5 examines the current governance of the county/state hospitals.

Chapter 6 discusses the delivery of health care services.

Chapter 7 assesses the Department of Health's management of the system.

Chapter 8 presents a case study illustrating poor management practices which have adversely affected morale.

Chapter 9 examines the financial management of the system with a particular focus on the various means of financing and the management of the special funds.

Chapter 10 summarizes several alternative organizational structures.

Chapter 2

THE ENVIRONMENT FOR HOSPITALS

Hospitals comprise an important segment of the health care programs available to Americans today. Expenditures for hospital care on both a national and a state basis constitute about 50 percent of total health care expenditures. American hospitals have become a major force, utilizing large-scale fiscal and personnel resources. At the same time, hospitals are affected by the social, economic, and scientific environments in which they operate and over which they may have little control. In this chapter we review the historical development of American hospitals and the current environment in which they function.

Historical Development of American Hospitals

The almshouse origins. American hospitals evolved from an institution of poor social status—the colonial almshouses. Almshouses were started during the seventeenth century primarily to keep off the streets the poor and those too burdensome for their families; curing their ailments was incidental. Dependent persons of all kinds were thrown into the almshouses—orphans, the aged, the insane, the feeble, the ill. Almshouses were the only form of governmental aid to the poor. They were meager, squalid, and overcrowded.

After the Civil War, social reformers created specialized places such as orphanages, mental institutions, and almshouse infirmaries. As cities grew, publicly supported hospitals developed from these infirmaries. Among the best known are Bellevue Hospital in Manhattan and Philadelphia General.

The voluntary hospitals. A few voluntary hospitals also were established for the "more acceptable poor" with curable illnesses and for the well-to-do in special circumstances such as when traveling. With their greater cleanliness, better maintenance, and their practice of turning away the incurable and the dangerously contagious, the voluntary hospitals began to dispel the image of hospitals as places of death and social stigma.

Doctors, who at that time did not have the economic and social standing that they do now, began to see hospitals as a way to improve medical education and to gain prestige. They sought the support of wealthy and powerful sponsors to raise the necessary capital to build hospitals and to establish their legitimacy. In exchange for patronage, the supporters were given some authority. Thus was established the structure of hospital governance which continues until today: boards of managers or trustees consisting of prominent business, professional, and political sponsors.

Hospital expansion. Hospital development accelerated during the latter third of the nineteenth century due to several factors: (1) the professionalization of nursing, (2) the discovery and use of antiseptic surgery, (3) the growth in medical technology, and (4) the resolution of conflicts between doctors and hospital management. Improvements had actually begun during the Civil War, with the Union building 130,000 beds and the hospitals reducing death rates by following Florence Nightingale's advice to improve hygiene.

Trained nurses did not exist before the 1870s. Hospital care was provided by lower class women, sometimes drafted from the penitentiaries and the almshouses. Change was brought about by women at the other end of the socio-economic ladder who took upon themselves the task of reform. Three nurses' training schools were

established in 1873 through the support of philanthropic families. By 1910, there were 1,129 schools.

Hospital development was also greatly aided by major advances in surgery. In the mid-1800s, the discovery and use of ether made possible more careful and slower surgical procedures. In the latter third of the 19th century, the sterility of surgical procedures and the hospital environment were improved, and surgeons could then dare to enter the major body cavities.

As hospitals became increasingly adept and more important in health care, the medical community wrestled with the problem of control over patients. Practitioners hesitated to refer patients to hospitals for fear of losing the case and hence the fee to hospital staff. But undertaking surgery in the home became more and more inconvenient, dangerous, and time consuming. Some physicians were able to build their own small hospitals and private medical boarding houses for nursing and hotel-like services.

But overall, demand for hospital space grew as hospitals became successful in providing care. Cities were increasing in number and size, settled by the waves of immigrants to the United States. The newcomers often arrived in poor health and became public charges, which often meant hospitalization in the public hospitals.

Although surgery made hospitals profitable and socially acceptable, costs significantly increased with the various improvements in technique. Physicians rather than trustees became instrumental in bringing in revenues. By the turn of the century, physicians gained the right to charge fees from their hospitalized patients. Hospitals began to need the referrals from private practitioners. Hospitals then expanded their staff appointments to include significant percentages of a community's doctors.

Some physicians were attracted into hospital administration, raising the status of that line of work. The administrators organized into the Association of Hospital Superintendents in 1899; in 1908, this became the American Hospital Association. University degree programs in hospital administration were started in the 1920s, becoming a separate curriculum from doctors' training. Professional administrators increasingly challenged the authority of physicians. The doctors regarded hospitals as their workshops, or extensions of their office practices, while hospital administrators saw the facilities as medical centers for the community, coordinating myriad health services.

Authority in fact shifted to administrators. Changing technology and the need to run hospitals as business organizations tilted the scale. Today, three groups still claim authority in American hospitals: trustees, physicians, and administrators. The relative powers of each vary, depending, to some extent, on whether the hospital is for-profit, nonprofit, or government operated.

Regulation and federal influence. American hospitals have been subject to governmental regulation and influence since at least the early 1930s. Health planning began in the 1930s, stimulated by rising costs. But the major federal impact was felt through the Hospital Survey and Construction Act of 1946, commonly known as the Hill-Burton Act. Intended to distribute health care facilities and physicians more equitably throughout the United States, the Hill-Burton program dispensed more than \$4 billion over 30 years, giving preference to rural areas. The program succeeded in improving the supply of rural hospital beds but was less successful in redistributing physicians. Hill-Burton also required recipient hospitals to provide some uncompensated care; this obligation is near expiration.

The Comprehensive Health Planning Act of 1966, the National Health Planning and Resources Development Act of 1975, and subsequent amendments were intended to mobilize and distribute resources in some rational manner. The attempts to regulate and influence health care and hospital resources included setting out planning areas, providing for local participation in health planning, and defining priorities for services.

The Scope of the Hospital Industry Today

The national picture. Health care in the United States is big business. Expenditures for health care in 1987 will total \$458 billion—10.9 percent of the gross national product.¹

Hospitals, and paying for hospitalization figure prominently in the health care picture. Nationally, 963,000 acute care beds were available in 1986.² American hospitals discharged 35.1 million inpatients, excluding newborn infants, in 1985.³ The average cost per hospital case has been soaring and was \$3,527 in 1985.⁴ This despite the fact that average hospital stays have been declining, from 7.7 days in 1975 to 6.5 days in 1985.⁵

Hospitals in Hawaii. In Hawaii, health care is likewise a large and growing industry. Total expenditures are estimated at \$1.9 billion for 1985, or 11.5 percent of the gross state product.⁶

Health care organizations are significant businesses in the State. Two of the top four health care entities, each generating more than \$100 million in annual revenues, are hospitals: Queen's Medical Center and Straub Clinic and Hospital. The parent nonprofit holding company of Queen's had \$150 million in operating revenues and 2,100 employees in 1986. Queen's also operates Molokai General

Hospital and is planning other neighbor island ventures. Straub is a for-profit firm established by a group of doctors in 1921. It maintains a major facility and six clinics, all on Oahu, and employs 120 doctors and 1,300 other staff.

A third significant provider is the Hawaii Division of Kaiser Permanente, part of the national prepaid Kaiser health system. Revenues in 1986 totaled \$140 million. Care is provided in the 10 facilities of the local Kaiser system on Oahu and Maui which employ 2,000 persons.⁷

The leading insurer for medical care in the State is the Hawaii Medical Service Association (HMSA). With approximately 567,000 members and \$330 million in membership dues in 1985, HMSA represents more than 60 percent of Hawaii's civilian population.

Medicaid. Prior to 1967, federal expenditures were less than half of all government expenditures for health care. By 1983, federal expenditures were more than double state and local expenditures. The reasons were the establishment of Medicaid in 1965 and Medicare in 1966 and their subsequent growth.

Medicaid, authorized by Title XIX of the Social Security Act, is a joint state-federal program of payments for medical care for two groups of needy: (1) the "categorically needy"—recipients of cash assistance programs (Aid to Families with Dependent Children and Supplemental Security Income for the Aged, Blind and Disabled); and (2) the "medically needy" or "medically indigent"—those with sufficient income for basic living expenses but not for medical expenses. Coverage for the first group is required by the federal government; coverage for the second is up to each state.

Hawaii has one of the most generous Medicaid programs in the United States, both in terms of recipient eligibility and services provided. For 1987-88, Hawaii's

Medicaid program was appropriated \$114 million in state funds and \$81 million in federal funds.¹⁴

Hospital and nursing home payments comprise a major portion of Medicaid budgets. Nationally, federal and state payments for inpatient hospital care totaled over \$9.4 billion in 1985, or over 25 percent of all Medicaid vendor payments. Nursing homes were in first place as Medicaid vendors; hospitals were second. Hospital outpatient and emergency rooms were paid another \$1.8 billion by Medicaid.⁹

In terms of hospital revenues, Medicaid varies greatly from hospital to hospital, depending on a variety of factors. Nationally, Medicaid accounts for only 10 percent of all hospital revenues,¹⁰ but the range is from 7 percent to 65 percent for Hawaii's county/state hospitals.¹¹ This is because a significant portion of the beds in the county/state system are long-term care beds. Medicaid reimbursements are an important revenue source for the public hospitals.

The Department of Human Services determines eligibility for Medicaid and contracts with HMSA to pay the providers. Medicaid reimbursement rates are reported to be below the prevailing rates set by practitioners and institutions. As a result, some private providers are refusing to accept Medicaid patients. The public hospitals accept them but pass on at least part of the unreimbursed costs to private paying patients.

Medicare. The second major federal health care program, Medicare, is administered under the Social Security Administration which provides hospital and medical insurance for those aged 65 and older and those under age 65 receiving certain federal benefits. Medicare consists of two parts: Part A, compulsory hospitalization insurance, financed by employers and employees; and Part B,

voluntary supplemental insurance, financed by voluntary monthly premiums paid by enrollees and by the federal government. Under both parts, the enrollee must pay specified deductibles.

Nationally, Medicare accounts for three-eighths of hospital revenues.¹² For the county/state hospitals, Medicare comprises from 3.4 percent to 33.5 percent of revenues.¹³ Medicare's 1983 shift from a retrospective, cost reimbursement system to a prospective (diagnosis-based) payment system (PPS) has had a major impact on hospital administration as discussed in the next section.

Issues and Trends in the Hospital Environment

American hospitals are facing a period of changing demand, increasing costs, shifting demographics, personnel shortages, and major adjustments in revenue sources. In the remainder of this chapter, we summarize these issues and trends.

Cost and revenues. Most of the issues impacting hospitals revolve around costs and revenues. This cost-conscious environment began to emerge in the 1970s as the cost of hospital care rose steeply. The federal government, a major payor of hospital costs, called a halt in 1983 to open-ended reimbursements by changing to a prospective payment system (PPS). An average cost for each of 467 medical procedures called diagnostic related groups (DRGs) has been set by Medicare. The program reimburses at these standardized rates regardless of cost. Under the prior cost reimbursement system, hospitals simply passed on the costs they incurred. Under PPS, however, hospitals have had to become much more cost-conscious; they have to determine whether a given DRG is making money or losing money. If their costs are less than a given DRG reimbursement, they can keep the margin. But if their costs are greater, they must absorb the difference.

According to the American Hospital Association, 1986 growth in revenues has been slower than the growth in expenses, resulting in revenue margins dipping sharply in 1986.¹⁴ Hospitals are beginning to feel the full impact of Medicare's prospective payment system.

The increasingly costly hospital environment has spurred the development of different arrangements of care and insurance. Among these are health maintenance organizations (HMOs) and preferred provider organizations (PPOs). HMOs are prepaid arrangements whereby subscribers pay fixed insurance premiums and possibly small first-dollar amounts per visit for all their medical care. Emphasis is on prevention and early detection. PPOs consist of participating health care providers; subscribers must obtain services from the members of the PPOs who also serve as gatekeepers to other providers. Also, physicians and other health care entities are entering joint ventures of all kinds to capture markets and reduce costs.

Another response to the changing revenue mix, and to some extent to the new tax laws, has been hospital diversification and corporate restructuring. Hospitals have begun to offer nontraditional programs, such as wellness programs and sports medicine centers, and to restructure their legal bases with various umbrellas and subsidiaries to cope with new definitions of nonprofit and profit generating centers.

Multihospital systems have proliferated since the 1970s. Over 30 percent of the community hospitals in the United States are now members of multihospital systems; this is expected to increase to at least 43 percent by 1990.¹⁵ The advantages include the potential for cost savings through shared services, bulk purchasing, and greater capacity for raising capital.

Public hospitals have also been sold or leased to private, proprietary hospital management firms when governments have no longer found them viable. Among the

better known are some county hospitals in California and Georgia. Others have been closed.

Where payment for a hospital service does not equal the cost of that service, the hospital is faced with "uncompensated" or "unsponsored" care. The magnitude of uncompensated care nationally in 1984 was estimated to be \$5.7 billion, or 4.6 percent of hospital expenses.¹⁶ In Hawaii, a partial index of uncompensated care might be the \$11.8 million in the general fund appropriation for the public hospitals in 1987-88.

Medicare's movement to the prospective payment system has also meant an increase in uncompensated care for those hospitals with expenses higher than the federal reimbursement rates. Medicaid has not been the solution, either, with its coverage of only 40 percent of the poor. In fact, three-fourths of Medicaid expenditures are made on Medicare beneficiaries, leaving less available for the non-Medicare poor population.¹⁷ These Medicaid expenditures are mainly for long-term care which has only limited coverage under Medicare.

The problem of uncompensated care is not new; hospitals have always provided some uncompensated care. But hospitals are now less able to shift costs to paying patients. The Medicare and Medicaid reimbursement rates are beyond their control, and to defend against cost shifting, some medical insurance carriers have placed caps on what they are willing to pay for services.

Changing demographics. The population to be served—their age and their distribution—is another concern for hospitals. The American population is living longer as life expectancy reached a new high of 74.7 years in 1984.¹⁸ The residents of Hawaii live the longest, especially the women: 80.33 years in 1981.¹⁹

The longer life spans mean more medical and institutional care. Some hospitals, including Hawaii's county/state hospitals, have had to keep elderly patients in regular hospital beds while they are wait-listed for long-term care. Medicare reimbursements for wait-listed patient days, however, have been at less than regular hospitalization rates. Ironically, should new construction of long-term care facilities begin to meet demand, transfers from the more costly hospitals to SNF and ICF facilities will reduce the hospital revenues derived from that population.

Changing demographics in terms of where people live is especially pertinent for Hawaii. As will be seen in the next chapter, the history of Hawaii's hospitals is replete with openings and closings as population shifted. In the past two decades, the closing down of plantations has lessened demand in certain areas. On the other hand, the development of major tourist destinations along the Kona coast is expected to create an increase in demand.

Personnel shortages. The nationwide shortage of nurses has received widespread attention. By 1990, the demand is expected to exceed supply by 390,000; by the year 2000, the projected shortage is 1 million. In Hawaii's hospitals, 13.5 percent of the nursing positions are vacant. There were 420 vacancies in March 1987; by 1989 there will be 744.

Hospital officials maintain that basic patient care continues, but they also admit that patients have had to wait at home until staffed beds are available, and nurses have had to work extended shifts. Local hospitals are scrambling to recruit nurses from the mainland, competing with private nursing agencies. The county/state hospital system has been especially hard hit, particularly the small rural hospitals.

Shortages in other hospital personnel categories, although not as widely publicized as the nursing shortage, have also plagued the county/state hospital system. Allied health professionals of several kinds are in short supply as well.²⁰

AIDS. The rising incidence of acquired immune deficiency syndrome (AIDS) and the need for hospitalization for at least a portion of the illness have prompted alarm from many quarters: insurance companies, hospitals, medical personnel, and others.

The New York City Health and Hospitals Corporation (HHC), the largest municipal health care system in the United States, provides almost half of all inpatient care for New York City residents with AIDS. It estimates that it will have spent \$258 million on AIDS services in 1987; by 1988 the cost will escalate to \$335 million. The minimum cost to the HHC hospital for an AIDS patient is estimated to be \$800 per day. The non-AIDS patient costs \$650 per day, a difference of 25 percent.²¹

The National Centers for Disease Control estimated in 1985, based on the first 10,000 AIDS deaths in the United States, that each patient averages 168 hospital days at \$878 per day for a total cost of \$147,000 for hospitalization.²²

Public hospitals are especially concerned about the financial impact of AIDS. They see themselves as providers of last resort becoming repositories for patients who have nowhere else to go. The entire issue of who should be responsible for catastrophic illnesses like AIDS continues to be debated.

Both public and private hospitals have been faced with all these emerging issues and trends, but the effect of each issue varies from hospital to hospital. The county/state hospitals function within state government which has, in effect, acted as their guarantor of funding and solvency. The State has shielded the hospitals

from these trends, but in other ways, it has exacerbated the problems. In the next chapter we describe the evolution and present context of the county/state hospitals.

Chapter 3

INTRODUCTION TO COUNTY/STATE HOSPITAL SYSTEM

Hawaii's county/state hospital system has evolved over more than a century. This chapter reviews that evolution and describes the structure of the current hospital system and the programs provided by state government.

Historical Background of the County/State Hospital System

The legacy of institutional health care largely supported by government in Hawaii spans four overlapping phases: (1) the monarchy's establishment of hospitals in the middle to late 19th century; (2) the provision of plantation hospitals during the Republic and the Territory; (3) the care of tuberculosis victims in the first decades of the 20th century; and (4) the development of county, then county/state, hospitals in the middle to late 20th century.

The Monarchial initiatives. The ancient Hawaiians cared for illnesses by self-ministrations, by seeking the kokua (assistance) of an experienced kupuna 'ohana (elder member of the family), or by visiting a kahuna lapa'au (physician) at the heiau ho'ola (healing temple). Foreign medicine arrived with Don Francisco de Paulay Marin in 1793. The earliest missionary group in March 1820 included the first of the missionary doctors from the American Board of Commissioners for Foreign Missions. However, eleven years passed before a structure resembling a hospital—the "health station" at Waimea, Hawaii—was built. This facility and the British Hospital for Seamen that opened in Honolulu in 1833 provided only the simplest kind of medical care.

What historians consider the first real hospital in Hawaii was opened in 1837 by the American government. Called the U.S. Hospital, it ministered to seamen under the Federal Marine Hospital Service. Private hospitals date from 1852 when Dr. Seth Porter Ford and Dr. George A. Lathrop started a "Hydrop establishment" in Nuuanu Valley. The effort soon failed, replaced by Dr. Ford's City Hospital in 1853. Before long this venture likewise proved unsuccessful.

Meanwhile, the need for a hospital to care for the general populace became dramatically clear. The effects of foreign contact had reduced the indigenous population from approximately 300,000 in 1778 to 73,138 in 1853. Catastrophic epidemics of gonorrhea, syphilis, tuberculosis, influenza, measles, smallpox, leprosy and other diseases decimated the population. The absence of any adequate public facility to treat the medically indigent—which encompassed a large proportion of the Hawaiian people—prompted King Kamehameha IV and Queen Emma to found Queen's Hospital in 1859.

Typical of other hospitals of its time, Queen's functioned more as a boarding house for the indigent sick than as a place of healing. Only those who could not be cared for in their own homes patronized the hospital. This soon changed with increased knowledge of methods of treatment spurred on by rapid advances in medical science and technology. Today, Queen's is the oldest continuing hospital in Hawaii.

The monarchy responded to other ailments in the 19th century. When Hansen's disease (leprosy) became a major health problem, the Kingdom set up treatment centers in Kalihi, Kalaupapa, and Kakaako. For more humane treatment of the mentally ill, the Oahu Insane Asylum (later renamed the Hawaii State Hospital) was

established in 1866. And in 1881, recurrent smallpox epidemics led to the building of a special Small-Pox Hospital in Honolulu.

Beginning in the 1880s, the monarchy extended hospital service to the neighbor islands by organizing a system of district hospitals: Malulani Hospital at Wailuku, Maui in 1884; Koloa Cottage Hospital at Koloa, Kauai in 1888; and Hilo Memorial Hospital on the Big Island in 1897. The district hospitals later formed the basis of the county hospitals which make up the current county/state hospital system.

The plantation hospitals. The plantations assumed responsibility for their workers' health care by establishing a number of hospitals at the major growing areas between 1896 and 1908: among them were Makaweli on Kauai, Ewa on Oahu, Paauilo on the Big Island, and Paia on Maui. Plantation medicine reached its peak around the end of World War I when there were some 21 hospitals. Thereafter, the numbers steadily declined. The last survivor, the Waiialua Clinic Hospital, closed its doors in 1969. However, traces of the plantation hospital system persisted into the 1970s with plantation staff physicians often providing most of the medical services at county/state hospitals in rural areas.

Plantation workers and their families were reportedly well-served by these facilities. For instance, in 1942 there were 45 percent more hospital beds in plantation towns than thought necessary in a well-ordered United States community; the infant mortality rates were well below national and territorial averages; the incidence of new tuberculosis cases fell by half; and the mortality rate for appendectomies stood at 1.2 per 1,000 compared to 10.8 in the U.S.¹

The response to the tuberculosis problem. Tuberculosis centers sponsored or supported by government became necessary in Hawaii because (1) those afflicted with the disease were refused admission to regular hospitals and were left to die

miserably in squalid conditions, and (2) at the turn of the century, tuberculosis was the leading cause of death. In 1910, the mortality rate was 330 per 100,000 population compared to 6.6 per 100,000 in 1955.² Specialized institutions were needed to prevent and control the spread of the disease. Leahi Hospital, known then as the Home for Incurables, opened in April 1900 followed by similar institutions on the neighbor islands: Maui County Farm and Sanitarium at Kula in 1910; Puumaile Hospital at Hilo in 1912; and Samuel Mahelona Hospital at Kapaa in 1917. With eventual success in the fight against tuberculosis, these facilities were converted into long-term care facilities.

The county (then county/state) hospitals. After a period of mostly government operated facilities, privately sponsored hospitals began to increase. The movement toward privatization was led by the plantation hospitals followed by numerous other facilities. Among the largest were two general hospitals: Japanese Hospital (later renamed Kuakini) in 1900 and St. Francis Hospital in 1927.

By 1929 Hawaii had 48 hospitals with 4,664 beds.³ Shortly before World War II, the total had climbed to 56 hospitals providing 5,984 beds.⁴ But by 1959, the fading of plantation hospitals from the scene left about 30 hospitals to serve the new state. Capacity declined to about 4,000 beds.⁵ Today, there are 3 hospitals on Kauai, 12 on Oahu, 5 in Maui County, and 5 on Hawaii, for a total of 25. Thirteen of these form the county/state hospital system.

The county/state hospitals are primarily a system for the neighbor islands. The two hospitals on Oahu provide long-term care beds; the State does not operate any acute care facilities on Oahu. The five hospitals on the Big Island provide virtually all of the beds there. The four Maui County facilities are the sole providers in their respective communities. On Kauai, the State's hospital is the only

facility on the west side. On the east side, a private hospital dominates acute care with 75 percent of the beds while the State provides 46 percent of the long-term care beds. Viewed another way, the State provides the only acute care beds on the Big Island, Lanai, and Maui.

The neighbor islands' dependence on their county hospitals explains their ambivalence and concern over state control of the hospitals. In the 1960s, county officials and residents were torn between the desire to keep local control and the reality of hospital costs escalating beyond their means. For example, the chair of the Maui County Council feared that state control of county hospitals would:

- . have a detrimental effect on the community's health and medical services;
- . bring about rigid controls and inflexibility;
- . be contrary to legislative intent which aimed to strike a balance between responsiveness to local conditions and a statewide uniformity in medical services and facilities; and
- . result in less efficient and responsive hospital services.⁶

Despite such concerns, the State gradually assumed full control between 1965 and 1970. Act 97, SLH 1965, assigned responsibility for the hospitals to state government. However, to prevent interruption of services, the State was to contract with the counties for a year. Act 14, SLH 1966, extended the state/county contracts for another year.

Act 203, SLH 1967, required the counties to operate the hospitals on behalf of the State, with the State bearing the full costs. County hospital advisory councils appointed by the Governor were to advise the Director of Health on hospital policy and operations in each respective county.

Act 265, SLH 1969, concluded the transfer by providing for the direct operation and maintenance of the public hospitals by the State. All real property, other property, and personnel were transferred to the State. Act 265 also replaced the county advisory committees with a management advisory committee for each county general hospital. Each committee was to nominate a hospital administrator for gubernatorial appointment. The counties were assigned selected health care functions such as medical care of inmates in county jails and other functions.

The issue of local autonomy resurfaced in 1984 with the dismissal of Hilo Hospital's administrator by the state health director. Supporters of autonomy for Hilo Hospital succeeded in obtaining the passage of Act 5, SLH 1984, which authorized the transfer or lease to the County of Hawaii of all functions and facilities for the operation and maintenance of Hilo Hospital. The act additionally required the county to accept the transfer of functions by ordinance and assume financial responsibility for the facility.

A group of physicians, along with other members of the community, attempted to obtain such a transfer to the county and in turn obtain a contract for the operation of the hospital by a private group. For a variety of reasons, sentiment turned against the county's reassumption of operating responsibility. In January 1986, Hilo Hospital's chief of staff, other hospital officials, and members of the medical community expressed the opinion that the hospital should remain under state control.⁷

The Structure and Programs of the County/State Hospitals

Article IX, Section 1, of the State Constitution affirms the State's commitment to health care by requiring the state "to provide for the protection and

promotion of the public health." Primary responsibility for this function resides with the Department of Health (DOH). Section 26-13, Hawaii Revised Statutes, assigns to DOH the programs to protect, preserve, care for, and improve mental and physical health.

For budgeting purposes, health is one of eleven major program areas of state government. The health program consists of six subprograms: physical health; mental health; mental retardation; community health services; medical facilities—standards, inspection, and licensing; and overall program support. The county/state hospitals are budgeted under the hospital care program within the physical health subprogram. The objective of the hospital care program is to "assure that all persons in the state in need of hospital care are provided such services in those hospitals offering the required services."⁸

The 13 hospitals on all inhabited islands except Molokai and Niihau offer a wide range of general and specialized medical services to in-patients and out-patients. There are 1,137 beds systemwide: 431 general, 47 psychiatric, 21 tubercular, 158 skilled nursing facility (SNF), 130 intermediate care facility (ICF), 342 SNF/ICF, and 8 mentally retarded. Or, grouped another way, there are 456 acute care, 630 long-term care, and 51 other beds in the system. Another 44 long-term care beds are scheduled for renovation. Occupancy rates vary from 2.74 percent to 68.78 percent for acute care beds and from 37.45 percent to 98.31 percent for long-term care beds. Table 3.1 depicts the size and scope of the program and its individual units.

Organizational structures. Governance of the system is vested in the Director of Health. The current director has, as others before him, delegated that authority to the deputy director for county/state hospitals. A nine-member hospital

Table 3.1

SIZE AND SCOPE OF THE COUNTY/STATE HOSPITAL PROGRAMS FY 88
BY COUNTY/STATE IN TERMS OF BEDS, TYPE OF BEDS, AUTHORIZED POSITIONS
AND AUTHORIZED EXPENDITURES

	TOTAL NO. OF BEDS	TYPE OF BEDS FY 86				AUTHORIZED FY 88	
		ACUTE	OCCP. %	LONG TERM	OCCP. %	POSITION	EXPENDITURES
HAWAII							
Hilo	274	166	55.39	108	92.80	554.20	22,120,283
Honokaa	35	27	17.38	8	93.63	45.00	1,891,073
Ka'u	15	7	29.75	8	96.92	32.00	1,247,796
Kohala	26	8	14.52	18	86.54	36.50	1,457,094
Kona	75	53	52.96	22	75.21	197.00	8,641,501
TOTAL	425	261	51.53	164	85.24	864.70	35,357,747
MAUI							
Memorial	145	145	68.78	0-	--	461.00	20,169,275
Hana Medical Center	4	4	2.74	0-	--	7.00	481,534
Kula	105	4	3.08	93	97.39	176.00	5,343,140
Lanai	14	6	34.00	8	95.00	22.00	843,058
TOTAL	268	159	64.00	101	97.19	666.00	26,837,007
KAUAI							
Veterans	44	27	31.56	6	76.82	128.00	5,084,521
Samuel Mahe Iona	76	9	39.24	61	97.32	145.00	4,116,809
TOTAL	120	36	33.47	67	74.44	273.00	9,201,330
OAHU							
Leahi	166	0-	--	140	94.87	291.00	9,072,158
Maluhia	158	0-	--	158	98.31	187.00	5,624,897
TOTAL	324			298	97.33	487.00	14,697,055
TOTAL STATEWIDE	1,137****	456		630		2,281.70 ¹	86,093,139 ²

*MR
**TB

***Acute/SNF Swing

****Acute/ICF Swing

*****Forty-four SNF (long-term) beds at Leahi Hospital are temporarily out of service because of hospital renovations. Once the work is completed (scheduled for December 1987) the bed count is expected to increase accordingly.

Source: Hawaii, Department of Health, County/State Hospital Division 1987.

1. Figure does not include staff positions at the division administration level.
2. Figure does not include expenditures at the division administration level.

management advisory committee has been appointed by the governor for each county to advise the director on the administration, maintenance, and operation of public hospitals and other public health and medical facilities within each respective jurisdiction.

Organizationally, the 13 hospitals comprise one operating division headed by the deputy director for county/state hospitals. The division is responsible "for the planning, construction, improvement, maintenance and operation of certain public hospitals and other health and medical facilities" ⁹ The division staff provides consultation, coordination and decision-making on personnel and financial management, program budgets, management reorganization, policy development, hospital rates, contract negotiations, and special studies, among other functions.

Each hospital functions as an individual entity and occupies the branch level in the state government hierarchy. Each facility, with the exception of Hana Medical Center, is headed by a hospital administrator who reports directly to the deputy director. The larger facilities also have an assistant administrator. Those administrators and assistant administrators appointed before July 1, 1983, have civil service status; those appointed after that date are exempt. This means they may be dismissed for cause more easily than they could under civil service protections.

Personnel, budget, and fiscal impact. The county/state hospital division is by far the department's largest in terms of both personnel and budget. The division's appropriated operating budget for 1987-88 of \$87.6 million makes up 40 percent of the DOH budget, and its 2,301.70 authorized position count constitutes 45 percent of the departmental total.

As described in our 1985 budget review of the county/state hospital program, ¹⁰ the county/state hospitals operate on an enterprise basis whereby fees

and charges to customers are expected to cover a substantial portion, if not all, of expenses incurred. The hospitals are established as special fund agencies and in their budgeting must consider revenue raising as well as expenditure control. The degree of reported self-sufficiency varies greatly. Maui Memorial Hospital and Hilo Hospital have reportedly been self-sufficient or almost self-sufficient in recent years. The others, especially the small rural hospitals, depend heavily upon subsidies from the state general fund. Dependency on state funds has declined sharply since the early 1970s. Prior to 1975, general funds comprised 45 percent of the budget; today, about 13 percent of the hospitals' operating budget is subsidized by the state general fund and 87 percent consists of special funds. Table 3.2 compares the means of financing for each hospital.

Table 3.2

County/State Hospitals
Comparison of Funding Sources
1987-1988

Hospitals	General Funds (%)	Special Funds (%)
Hilo	01	99
Honokaa	33	67
Kau	47	53
Kohala	43	57
Kona	24	76
Maui Memorial	0	100
Hana Medical Center	74	26
Kula	19	81
Lanai	12	88
Kauai Veterans Memorial	30	70
Samuel Mahelona Memorial	16	84
Maluhia	16	84
Leahi	33	67

Source: Act 216, SLH 1987.

Sources of revenue. Most of the special fund revenues generated by the county/state hospitals come from Medicaid and Medicare reimbursements. Medicaid provides 35 percent of the system's revenues; Medicare is responsible for 30 percent of the revenues. Private parties, mostly through third party insurance, make up the remaining 35 percent of the revenues.¹¹ However, depending upon the kinds of beds they have, the proportions vary from hospital to hospital.

The considerable reliance on Medicaid and Medicare means that any vigorous federal and state health care cost containment initiatives will have an impact on the county/state hospital system. These initiatives and other developments described in the previous chapter have raised some concern for the county/state hospital system's viability and self-sufficiency. In the remainder of this report, we examine the purpose and direction of the system, its programs, its finances, and various organizational alternatives.

Chapter 4

A FRAMEWORK FOR ANALYSIS: A SYSTEM PERSPECTIVE

In this chapter we set out the framework for our assessment of the county/state hospital program. The framework is based on the constitutional provisions for state government's role in providing health care, the Hawaii State Plan, the objectives of the county/state hospital program, and the requirements for the management of a multihospital system.

These documents establish the scope of the county/state hospital program as one that will:

- . provide for the protection and promotion of the public health where these are not provided by the private sector;
- . ensure prompt, appropriate, quality medical care for all residents of the State; and
- . operate a multihospital system that is properly managed with clear delineations of responsibility and authority through all levels of the system.

State Government Responsibility for Public Health

Governmental concern for public health in Hawaii dates back at least as far as 1869. A Board of Health was established in the Kingdom of Hawaii, joining a trend just then beginning in the U.S. The wide-ranging Shattuck Commission report of 1841 on improving health conditions for the residents of Massachusetts had recommended an aggressive role for state and local governments. Shattuck's

recommendations were adopted by other states, with the majority establishing state health departments by 1900. In Hawaii, the Board of Health was granted broad powers to "have general charge, oversight and care of the health and lives of the people" including the power to enforce quarantine.¹

The Organic Act, which established the government of the Territory of Hawaii, confirmed the legitimacy of that board. During the years of territorial government, the Legislature expanded government's role in response to the health emergencies of the period, authorizing such actions as banishment and inoculations.

By the time the Constitutional Convention met in 1950 to draft a constitution in anticipation of statehood, there was a long-held precedent for the view that government is responsible to protect and promote the public's health. The Committee of the Whole recommended the inclusion of "the State shall *provide* for the protection and promotion of the public health" instead of the term, "be responsible," to indicate a more positive mandate upon the State.² The constitutional provision has been reaffirmed by the constitutional convention of 1968 and 1978.

Objectives of the County/State Hospital Program

According to the Hawaii State Plan, the State's health care program is intended to meet two broad objectives: (1) fulfillment of basic individual health needs and (2) maintenance of sanitary and environmentally healthful conditions.

At the next level of specificity, policies that relate to the county/state hospital program include the following:

1. Provide adequate and accessible services and facilities for prevention and treatment of physical and mental health problems;

2. Provide effective short-term and long-term assistance to prevent, alleviate, or cope with mental health problems of individuals and families;

3. Encourage improved cooperation among public and private sectors in the provision of health care to accommodate the total health needs of individuals throughout the State;

4. Provide services and activities that ensure sanitary conditions.⁴

The State Planning Act requires the preparation of functional plans to spell out the objectives and priorities in further detail. The latest State Health Functional Plan was adopted in April 1984 by the Twelfth Legislature. The functional plan and the supporting technical document were authored by the Department of Health (DOH) with comments and suggestions from the Health Functional Plan Advisory Committee and other groups. According to the plan, the mission of the DOH is to "protect, preserve, care for, and improve the physical and mental health of the people of the State."⁵

The objectives for state programs are also spelled out in the budget documents prepared by the executive branch. According to the current Multiyear Program and Financial Plan, the hospital care program is intended "to assure that all persons in the state in need of hospital care are provided such services in those hospitals offering the required services."⁶ Each hospital, in turn, is to work toward this objective: "To restore, maintain and promote the health of all individuals in the community by providing prompt, appropriate, quality medical care and facilities, and educational services."⁷

This entire array of documents expresses the State's commitment to its residents, no matter where they live nor their economic means, to access to

appropriate hospital care of some level of quality. Such terms as "equitable access," "quality of care," and "single tier system" express the essence of this commitment.

Continuing legislative interest in the financial viability of the county/state hospital program has also led to the goal of "self-sufficiency." The term appears to mean reliance only on special fund revenues through sound financial management of the program.

Management of a Multihospital System

The basic structure of the county/state hospital program is that of multihospitals managed as a *system*. A system is "a regularly interacting or interdependent group of items forming a unified whole."⁸ A multihospital system is more than an association of autonomous units. It is an amalgam of parts that should be held together by a system perspective. This system perspective is based on an understanding of the mission of the system and how the various parts contribute to the attainment of program objectives.

Most important to the proper management of a system is a clear delineation of the authority and responsibility of the components of the system. The authority and responsibility of the governing body should be distinguished from that of the chief operating officer of the system. In turn, the authority and responsibilities of the chief operating officer of the system should be differentiated from those of the hospital administrators.

Governance is at the top of the list of functions necessary for management of a multihospital system. The governing body develops and articulates the mission of the system with input from appropriate advisory bodies. It sets policies for the system and makes sure that bylaws are officially adopted as guidelines for system

operations. The governing body is responsible for monitoring the operations of the system to make sure that policies and procedures are followed and that operations further the attainment of the objectives of the county/state hospital program.

The governing body should retain the authority to adopt overall policies and procedures; approve budgets; appoint, monitor, and evaluate the chief operating officer for the system and other high level positions; and approve plans and programs developed by the system and the hospitals. Since the governing body is ultimately responsible for the quality of care extended to patients, all evaluations conducted by outside licensing and accrediting agencies should be brought to its attention.

The chief operating officer is accountable to the governing body for the day-to-day operations of the system. The chief operating officer both facilitates and supervises the operations of all units in the system. The officer uses systems level staff to coordinate the operations of hospitals, provide guidelines for implementation of programs, and conduct research and analysis to assist hospitals in their operations. Where hospitals encounter roadblocks, system staff should identify causes of specific problems and find means to resolve these. At the same time, the chief operating officer exercises oversight of hospital operations. The officer monitors and evaluates these operations to make sure that they follow necessary policies and procedures and, most importantly, that they are providing patient care that meets standards of quality.

Finally, the hospital administrators have primary authority and responsibility for the day to day functioning of the hospital. They must manage the physical, human, and financial resources at each facility to bring to patients health care that meets accepted standards of quality. The goal for hospital administrators is to

manage *effectively* to achieve program objectives, and to manage *efficiently* to conserve resources in the achievement of those objectives.

Chapter 5

GOVERNANCE OF THE COUNTY/STATE HOSPITAL PROGRAM

The problems of the county/state hospital program which will be discussed in later chapters stem largely from a history of inadequate management. One cause of this inadequacy lies in the exercise of the governance function. In this chapter, we focus on the functions, roles, and responsibilities of the Director of Health, designated by law as the program's governing authority, and those of the Hospital Management Advisory Committees (MACs).

Summary of Findings

We find that:

1. The Director of Health has not performed as the governing authority for the county/state hospital program. Consequently, the role of the director is not clearly differentiated from that of the deputy director of health. This has led to several problems including the following:

- . conflicting goals and a lack of clarity or consensus regarding the direction in which the program should be moving; and
- . confusion regarding the respective authority and responsibilities of the Director and Deputy Director of Health.

2. The MACs, which are supposed to advise the governing authority, also lack a clear direction or mission and are struggling to find their appropriate function and role.

The Existing Governance Structure

The Director of Health, as the official governing authority, holds overall responsibility for all policy and operational decisions for the hospital system. The director is assisted in the governance function by four hospital management advisory committees (MACs), one for each of the counties.

The county/state hospital division bylaws, the basic internal governance document, stipulate that the governing authority for the public hospitals and medical facilities in the county/state hospital program shall be the Director of Health. Under the bylaws, the director is empowered with all of the rights, duties, and responsibilities delineated in the statutes relating to the department of health and the administration of hospitals.¹

As the governing authority, the director has overall responsibility for the county/state hospital program but not the responsibility for the day-to-day administration of the program. Instead, the director is primarily a leader—responsible for developing and clearly communicating the philosophy and mission of the program; seeing that long-range and strategic plans are developed; setting overall policies for the program; and ensuring that the multihospital program functions as an organized, interdependent, coordinated system. The director is also responsible for monitoring and evaluating how the system is functioning and for evaluating the performance of those who report to him, in particular, the performance of the Deputy Director of Health who has immediate responsibility for administering the program.

We find that these functions have been overlooked. There is no overall plan or mission for the county/state hospital program and little differentiation between the authority and responsibility of the director and that of the deputy director.

Unclear system direction. In the next chapter, we discuss the lack of a clear mission for the county/state hospital program. Here we note that there appears to be some confusion over the direction that the hospital program should be taking. For example, at the individual hospital level, administrators, staff personnel, and community members ask whether they are free to "compete" with the private sector. In their thinking, "compete" means aggressively developing new services and markets and securing greater market shares in an environment that is shared with the private sector.

At the division level and at the acute care hospitals, "self-sufficiency" appears to be the goal. In this context, self-sufficiency means that the hospital no longer relies on state general fund support. The thinking seems to be that self-sufficiency would give the program a stronger argument for independence from state government controls.

At the departmental level, the director speaks of quality of care and a "single tier"* of hospital care. As will be discussed in the next chapter, however, taking action to assure quality of care has not occurred.

Also under consideration is the somewhat contradictory concept of "spinning off" by lease or sale those hospitals which achieve financial self-sufficiency. The State would retain only those hospitals which still require state funds. But by relinquishing the hospitals which are beginning to show profits, thus enabling each

*"Single tier care" means that a hospital treats patients from all economic backgrounds with the same kind of care, regardless of ability to pay. The term also means that separate hospitals are not operated for different economic classes.

such hospital to use its profits only for itself, the State may in effect promote a multiple tier program of hospitals.

The concept of "joint venturing"—the sharing of resources by the public and private sectors—is already practiced by the county/state hospitals and more is advocated. Joint venturing has taken the form of leasing of county/state hospital space to private concerns.

In a changing health care environment, the governing authority should assume a stronger leadership role to assure that all levels are agreed on the basic direction of the program.

Need to differentiate role of deputy director. The division bylaws state that the director's designated representative is the Deputy Director of Health for the County/State Hospitals. The bylaws also assign a more specific and somewhat different set of duties and responsibilities to the deputy director. These include:

- a. Administer, manage, and control the operations of the county/state hospitals in accordance with the rules and regulations of the DOH and the State.
- b. Provide staff assistance and advisory services to the hospitals in the administrative areas of planning, construction, improvement, maintenance, and operation of the hospitals.
- c. Control the fiscal, budgetary, personnel, and capital improvement functions of the hospitals.
- d. Initiate program changes and improvements in hospital operations to more effectively provide care to patients in the state.
- e. Ensure compliance by the hospitals with state and federal laws relating to hospitals and health care.
- f. Ensure liaison between the hospitals and state departments and agencies in matters requiring compliance with state policies, rules and regulations.²

Thus the deputy is responsible for overall administration of the system. This function should be differentiated from that of the director who provides leadership and governance but does not directly administer the division. This differentiation should be made in the form of official, written delegations of authority that are communicated to employees of the division, and in policies and procedures that delineate those matters which should be brought to the attention of the director and can proceed only with his approval and those which are within the purview and authority of the deputy.

These delineations have not been made. Consequently, it is unclear which responsibilities the director has retained and which have been delegated. For example, the governing authority has a primary, leadership role to play in the division's strategic planning process. It is the director's responsibility to articulate, with the assistance of MACs, a mission for the county/state hospital program. It is then the deputy director's responsibility to manage the planning process and to keep the director posted on the progress of plans. However, all directives issued on strategic planning so far have been from the deputy director. This lack of clarity limits not only the effectiveness of the governing authority but also that of the entire county/state hospital program.

Currently, there are too few safeguards. It is not clear what matters must have the director's approval. Although the Director of Health retains the right of rescission, this is a negative form of authority. Unless instructed otherwise, the deputy director has the latitude to assume duties and responsibilities that may not be appropriate to his position. Such a situation can jeopardize the governing authority's legitimate powers and authority and undermine the integrity of the entire program.

We believe that certain improvements should be implemented.

In delegating authority, the governing authority should focus his attention on the overall mission, direction, and purpose of the program and its interface with other divisions within the department, other executive departments or agencies, and the State's medical care system. Conversely, it should be left to the deputy director, as the system manager, to focus on the specific day-to-day operational and managerial problems and needs. The governing authority should establish some mechanism to ensure that evaluation and accountability for program effectiveness and financial viability occur. We urge that a more formalized delineation of responsibilities be written and implemented.

Function/Role of the MACs

Community input is important for ensuring that the county/state hospital program is meeting local health needs and is providing quality care. Existing statutes authorize the establishment of a nine-member hospital management advisory committee within each of the four counties for this purpose. However, the division has not used these committees productively or helped MACs to become effective organizations.

Under the law, each MAC serves "in an advisory capacity to the director of health on matters concerning the planning, construction, improvement, maintenance, and operation of public hospitals and other public health and medical facilities within their respective jurisdictions" ³ Members are appointed by the Governor and serve four-year terms. The MACs are free to select their own chair and vice chair and may adopt necessary rules and regulations to conduct their business.

These hospital advisory committees were first established under state sponsorship in 1967 when Act 203 created "county hospital advisory councils" for each of the four counties within the State. These advisory councils were created "to strike a balance between responsiveness to local conditions and statewide uniformity in services and facilities, which balance would be impossible to achieve if responsibility were left solely to either the counties or the State."⁴

Under Act 265, SLH 1969, the county hospital advisory councils were officially replaced by the hospital management advisory committees. The Legislature stressed the need for local responsiveness and participation.

Lack of defined role. A 1971 management audit of the hospital program by this office found that there was a lack of clarity regarding the appropriate role and responsibilities of MACs. The audit report stated: "The Management Advisory Councils established under Act 265 for each general acute care hospital have a confusing and somewhat vague set of advisory responsibilities . . . and . . . they have assisted in areas beyond their basic statutory responsibility . . ."⁵

This problem remains unresolved. There is no clear mission for MACs or consensus on the proper function, role, duties, and responsibilities of these advisory groups.

The MAC members, hospital administrators, administration officials, and other community resource persons acknowledge this confusion. The members struggle with this issue in their meetings. Understandably, this situation has been frustrating for all parties concerned and has limited the effectiveness of these committees.

Unclear mission or purpose. One cause of the lack of clarity is that neither DOH nor MACs have ever formulated any kind of mission statement for these

advisory committees. The closest thing to such a statement is a paragraph in the division bylaws:

"The management advisory committee offers a formal means for involving more community representatives in the affairs of the hospital, for providing the Governing Authority with an outside source of ideas and advice and for providing the Hospital Management ready access to a variety of expertise."⁶

In addition, neither the enabling legislation nor the various MAC bylaws provide clear guidelines delineating the purpose of MACs or how they should be organized, administered, or operated. For example, Section 27-22, HRS, merely empowers MACs to "sit in an advisory capacity to the director of health on matters concerning the planning, construction, improvement, maintenance, and operation of public hospitals and other public health and medical facilities within their respective jurisdictions"⁷ Although the statute clearly establishes the advisory nature of MACs, it provides few specific guidelines on how MACs should carry out their function.

Oftentimes, executive departments and agencies will promulgate rules or regulations to further define and detail the function and role of statutorily-created boards, commissions, or committees which are administratively placed within those executive agencies. We find, however, that DOH has not promulgated any rules either for MACs' purpose or for the guidance of its own personnel.

We also find that the existing MAC bylaws are inadequate and probably contribute to the confusion. One of the biggest problems is that separate and different bylaws have been established for the four MACs. These different bylaws have led to some misunderstanding over their purpose and function. For example, each one has a different purpose statement. One purpose statement directly contradicts the intent of Section 27-22, HRS, by expanding the responsibilities of that MAC as follows:

"The Committee shall be responsible to and under the Director of Health to advise and assist in carrying out all policies of the Department of Health."⁸

The statute, however, only empowers MACs to advise the director of health on matters related to the public hospitals and other medical facilities within MACs' jurisdiction.

One MAC has developed a purpose statement that appears quite appropriate and might well serve as a model. It includes the following:

- . To monitor the operations, policies, and activities of the county/state hospitals;
- . To assess on an ongoing basis the impact of each county/state hospital in the community or population served;
- . To serve as a public forum for the discussion of matters pertinent to the county/state hospitals, and solicit and receive the input of the consumer public as to the operations of the county/state hospitals, and, as necessary, act as a liaison between the public and the county/state hospitals;
- . To meet with the director of health and report to the director on its activities such as accounts of specific problems encountered with any county/state hospital in meeting its health care role, evaluation of specific components of health care associated with county/state hospitals, and any recommendations relating to the committees, or to the county/state hospitals.⁹

The various bylaws also differ regarding the duties and powers of the chair, vice chair, and secretary; the election of officers; committee vacancies; and the use of committees or subcommittees. For example, only one MAC is required to

"establish such committees as the Governing Authority deems necessary to carry out its duties and functions, and consistent with applicable JCAH [Joint Commission on Accreditation of Hospitals] standards for committee structure."¹⁰

Given the lack of statutory guidelines and procedures and departmental rules detailing the operations of MACs, the MACs' bylaws must serve as the basis for committee operations. We believe that, as a minimum, updating and standardizing these bylaws would help to clarify some of the confusion and misunderstanding surrounding their function, role, duties, and responsibilities.

Need for orientation. Another factor in the confusion over MACs' role is the absence of well-planned, structured, and on-going orientation and continuing education programs for both new and experienced MAC members.

If committee members lack a clear understanding of their duties and responsibilities and if they possess only minimal or piecemeal information about the facilities and the county/state hospital system, their effectiveness individually and as a group will be limited.

We recognize that DOH has provided some orientation and continuing education opportunities for MAC members. They have been provided with necessary and relevant materials including various statutes, bylaws, organizational charts, rosters, Ethics Commission handouts, etc.; given tours of various hospitals and medical facilities; given an opportunity to meet with different resource personnel; and encouraged to attend a variety of workshops, conferences, and conventions.

At the September 1987 general MAC meeting, for example, the members were addressed by three resource persons including the deputy director and a state legislator and were given a tour of two hospitals. Also, a brief orientation program was conducted for new members.

Despite these efforts, however, the department can take additional steps to strengthen and improve orientation and continuing education programs for MAC members. Department officials and MAC members must be willing to acknowledge the importance of and need for orientation training and continuing education and be genuinely committed to developing and utilizing these programs. This commitment, more than any other factor, will determine the success of such programs.

Also, it is essential that the department create the expectation that preparing to be an effective MAC member, as well as keeping informed and knowledgeable, is a customary part of a member's role. One means of achieving this is by formalizing and structuring both the orientation and continuing education programs. This can be promoted, for example, by developing written procedures and guidelines for both programs; creating "training/education" subcommittees in each or at least assigning one or two members to work in those areas; and by scheduling brief training/education sessions as a regular part of committee meetings.

This last point is important since new committee members often need an orientation period spread out over several months to acquire the knowledge and understanding to perform effectively. In fact, it probably takes at least one year before members feel knowledgeable and comfortable enough to be active committee members.

Administration officials, hospital administrators and other relevant hospital personnel as well as MAC members all need to participate in programs to upgrade and strengthen these orientation and continuing education programs. This collaborative effort would help ensure well planned and relevant education programs and would also help to foster better understanding among the various parties.

However, it is crucial that the needs of MAC members be kept foremost, and these programs should be tailored specifically to their needs.

Value of MACs. The MACs should play a role in the governance of the county/state hospitals. Although advisory, MACs are appropriate and valuable mechanisms to ensure state responsiveness to local needs and concerns; to monitor the operations, policies, and activities of the county/state hospitals; to assess the impact of county/state hospitals on the community and populations served; to serve as a public forum to discuss issues relevant to these hospitals; and to act as a liaison between the public and the county/state hospitals.

In an early 1971 report, we noted the potential of MACs even as their value was not being fully realized:

"The Director of Health has wisely realized their potential and has tried to keep them broadly informed about and involved in hospital activities Members of MACs who were interviewed showed a surprising depth of knowledge and verve in pursuing matters relating to the health care needs of their fellow citizens. It would be a disservice to the talents of these public spirited citizens if their expertise were not applied"11

The value of these advisory bodies has not diminished since that report was published. If these MACs can be properly strengthened and if they receive the support necessary to function effectively, there is no reason why MACs cannot serve as an integral component of the county/state hospital program.

Recommendations

We recommend that the Director of Health do the following:

- . assume the proper responsibilities and authority of a governing authority, differentiating between these and those of the deputy director.*

- . *provide written delegations of authority for those responsibilities he wishes to delegate to the deputy director.*
- . *provide support to the Hospital Management Advisory Committees to assist them in defining their mission and to adopt bylaws. And also provide them with sufficient orientation to enable them to function effectively as community advisory groups.*

Chapter 6

THE DELIVERY OF HEALTH CARE SERVICES

In this chapter, we examine the delivery of health care services by the county/state hospital program. Specifically, we examine whether the program is adequately planned and organized to ensure access to needed medical services that meet commonly accepted standards of care.

Summary of Findings

We find that the health care interests of neighbor island residents are seriously jeopardized because the program does not systematically address community needs or ensure compliance with standards of care. Specifically,

1. Health care services are delivered with inadequate statewide direction and control, little attention to the needs of individual communities, and inadequate consideration of issues relating to quality of care. This has resulted in misguided initiatives and a failure to ensure the availability of services in some communities.

2. The department has not ensured that all facilities meet commonly accepted standards of care. As a result, individual facilities are continuously cited by external monitoring agencies for deficiencies that could be prevented. In particular, the Joint Commission on Accreditation of Healthcare Organizations has indicated that it may deny accreditation to Hilo Hospital and Maui Memorial Hospital, and it has found serious deficiencies in the operations of Kona Hospital and Kauai Veterans Memorial Hospital.

Background Information

Characteristics of a medical care system. Health care services are delivered in the context of a medical care system which provides three levels of increasingly specialized care: primary, secondary, and tertiary. At each level of care, services are provided by a variety of health professionals.

Primary care. Primary care includes services which are offered at the point of entry into the medical care system. Consumers normally enter the system by visiting a "primary care" physician who is a family practitioner, pediatrician, internist, or obstetrician-gynecologist. Since these physicians act as "gatekeepers" to the medical care system, it is widely advocated that they should be available to consumers within a 30-minute driving radius. Consumers may also enter the medical care system by seeking emergency services which are provided by ambulance, clinic, and hospital-based personnel. Since all communities must have the capability to resuscitate and stabilize emergency patients, many states train non-physician health care personnel to perform lifesaving procedures in the absence of a physician.

Secondary care. Secondary care includes services which are provided by specialty physicians, community hospitals, nursing homes, and related programs. Consumers usually gain access to these services through referral from primary care physicians or emergency medical personnel.

Specialty physicians take care of health problems which cannot be treated definitively by primary care providers. They include "specialists" who are trained to handle a wide range of health problems in their field (e.g. general surgeons) and "subspecialists" who focus on a limited number of health problems (e.g.

neurosurgeons). In general, specialty physicians practice in medical groups which are located near community hospitals and major medical centers.

Community hospitals deliver acute inpatient services to approximately 10 percent of the population each year.¹ Small and rural hospitals which serve primary care physicians usually offer basic emergency, medical, surgical, and obstetric services. Larger hospitals which also serve specialty physicians offer a broader range of services. All hospitals must have arrangements to refer patients requiring medical care beyond their capabilities to another hospital or a major medical center.

Nursing homes deliver long-term inpatient services to an estimated 5 percent of the elderly population each year.² They also care for disabled persons, such as quadriplegics. Nursing home residents must live in an institution because they cannot independently carry out activities of daily living. However, they do not require acute hospital care. Their care needs include services which enable them to maintain their physical, mental, and social independence for as long as possible. Since it has been shown that visits from family and friends improve health status, nursing homes should be located as close as possible to the community.³

A number of other secondary care services are delivered on an outpatient basis through specialty medical clinics, rehabilitation centers, home health agencies, day hospitals, and hospice programs. These services are often affiliated with community hospitals and nursing homes.

Tertiary care. Patients who require highly specialized medical services, such as open-heart surgery, are referred by physicians and community hospitals to major medical centers which constitute the tertiary level of care. In the course of a year, only 1 percent of the population will require treatment in a tertiary care facility.⁴ Because of the limited need for these services, and because they rely on highly

trained health professionals and sophisticated medical technology, major medical centers are usually affiliated with universities and located in large cities.

County/state hospital system. The county/state hospital program delivers services at the primary and secondary levels of care.⁵ The program's scope of services and the role it plays in the medical care system vary from island to island.

The county/state hospital program is the sole provider of community hospital services on the Big Island. It operates more than 40 percent of the island's nursing home beds, including all the beds located outside of Hilo. It also provides ambulance, emergency room, and home health services throughout the island.

The program is the sole provider of emergency room and community hospital services on the islands of Maui and Lanai. It operates slightly more than one-quarter of the nursing home beds on Maui, and all of the beds on Lanai. It operates the only ambulance services in the remote rural communities of Hana and Lanai, and also provides ambulance services in Wailuku. It employs primary care physicians who work in Hana and care for residents of Kula's nursing home. And it provides office space so that physicians can deliver primary care services to residents of upcountry Maui.

The program is the sole provider of emergency room and community hospital services on the west side of Kauai. It also provides ambulance services in west Kauai, operates 40 percent of the island's nursing home beds, and operates an islandwide hospice program for terminally-ill patients.

On Oahu, the program focuses on the needs of very sick, frail, and elderly consumers who require long-term care. It operates nearly one-sixth of the island's nursing home beds, a day hospital program, and the only hospital beds in the state dedicated to the care of tuberculosis patients.

Planning for the Delivery of Health Services

In view of the county/state hospital program's dominant and significant responsibility for health care on the neighbor islands, the department should have a systematic process for planning services that meet community needs and ensure an adequate standard of care. This process should include overall direction and control by the governing authority, research and evaluation by its administrative and professional staff, and community involvement in determining the need for and acceptability of health services.

The planning process should be based on a clear understanding of the program's philosophy, the communities it will serve, and the kinds of health care needs it will address. This understanding should be set forth in a mission statement which is approved by the governing authority. In the case of a multihospital system, mission statements should be developed for the system and for each individual facility.

The planning process should also be based on planning guidelines which specify the basis for decisionmaking on the development of health services. At a minimum, these guidelines should require hospital administrators to analyze the needs of specific communities, determine whether they are capable of delivering needed services at an acceptable level of care, and make alternative arrangements for the delivery of needed services that cannot be provided at an acceptable level of care (e.g., through transfer agreements with other health care providers). In addition, they should require the phasing out of services which no longer meet community needs or commonly accepted standards of care.

The planning process should include the development of plans which specify what kinds of health services will be offered in line with the program's mission and planning guidelines, how resources will be allocated, and how the services will be

evaluated. The plans should be approved by the governing authority which should also monitor their implementation.

Inadequate State health planning framework. The county/state hospital program operates within a general policy framework established by the Department of Health (DOH) and the State Health Planning and Development Agency (SHPDA). The DOH prepares the *State Health Functional Plan* which sets policies, goals, and objectives for the delivery of public health services, including medical care. The SHPDA prepares *The Health Services and Facilities Plan for the State of Hawaii* which sets goals and objectives for the state's medical care system.

The two plans do not provide an adequate framework for decisionmaking on the development of county/state hospital services. They are not comprehensive, they do not touch upon the health care needs of specific communities, and they do not address key issues relating to quality of care.

The functional plan only covers public health services which fall under the jurisdiction of DOH. Since the plan does not look at the statewide medical care system, its value in providing a framework for the county/state hospital program is quite limited.

The SHPDA plan sets goals and objectives for some primary, secondary, and tertiary care services. However, it does not address the needs of specific communities. For example, although the plan establishes a ceiling on the number of hospital beds which can be built in each county, it does not state where these beds should be located. Therefore, the county/state hospital program must engage in additional planning to determine the best allocation of beds on the basis of community need and standards of care.

Flawed strategic planning initiative. In 1986, the division office launched a strategic planning process to identify the mission, goals, and objectives of the county/state hospital program. Separate strategic plans were developed for the division office and each individual facility. The first set of plans was compiled shortly before the current departmental administration was appointed in December 1986. One month later, the new administration launched another planning cycle to update the strategic plans. By November 1987, this effort had resulted in the development of a new division plan and updated plans for all but two hospital facilities (Maui Memorial Hospital and Lanai Hospital).

The strategic planning initiative suffered from inadequate statewide direction and control, a lack of community participation, and a failure to address community health needs and quality of care issues. In addition, it did not result in the development of an approved *systemwide* plan. Therefore, the strategic plans do not provide an adequate basis for decisionmaking on the development of the county/state hospital program.

Inadequate mission statements. The planning process proceeded without a common understanding of the mission of the county/state hospital program. The governing authority did not develop and approve an adequate mission statement to guide the initial planning process. And hospital administrators were frustrated in developing their strategic plans because fundamental questions remained unanswered such as whether they should compete with the private sector, whether they should focus on the health care needs of specific groups (e.g. the elderly or disabled), and whether they should plan for the delivery of primary care services.

The new deputy director issued a mission statement at the start of the second planning cycle which defines the program's philosophy as promoting "mutual

collaboration and cooperation" with public and private agencies. According to the deputy director, this means that the program will enter into "joint ventures" with other health care providers in an effort to reduce financial burdens and spread risks across a broader base. However, most of the updated strategic plans do not reflect this philosophy since they merely reiterate the goals and objectives stated in the original plans.

The new mission statement does not define the communities that will be served by the program or describe what kinds of health care needs will be addressed. Instead, it merely states that:

"The mission of the County/State Hospitals Division is to provide a formal, integrated organization through which the State of Hawaii may fulfill its health service obligations and enable its health facilities and services to continue to operate efficiently and effectively....The governance and management activities of the entire system are directed toward the preservation of public trust and confidence, the maintenance of quality standards of performance, the delivery of essential health care services and the responsible use of human, financial and other resources."⁸

The current Director of Health has spoken about focusing on the needs of the elderly, the disabled, and gap group individuals. He has also spoken about expanding nursing home services and delivering primary care services in remote rural communities. However, these visions are not communicated in the mission statement and hospital administrators are forced to guess about the program's new directions.

With few exceptions, the mission statements developed by individual hospital facilities also fail to define the communities they will serve or the health care needs they will address. For example, all of the small rural hospitals and one nursing home plan to "restore, maintain and promote health" by delivering "medical care,

facilities, and educational services." Such basic questions as whether the facilities will deliver primary care, community hospital care, nursing home care, or related services remain unanswered.

As a result, hospital administrators plan new services without regard to their facility's specific mission in delivering essential medical services. For example, the strategic plan for Mahelona Hospital, which is primarily a nursing home, calls for the construction of three medical offices for primary care physicians at an estimated cost of \$1.24 million. However, primary care physicians already practice in the community of Kapaa where the nursing home is located. Therefore, there is little need to expand the facility's role to include the delivery of primary care services.

Inadequate planning guidelines and support. The division office did not provide hospital administrators with adequate planning guidelines or analytical support to help them identify community health needs and analyze quality of care issues. For example, it did not issue any guidelines delineating the basic services that should be available in remote rural communities or establish standards for the safe and effective delivery of inpatient hospital services. Consequently, hospital administrators lacked a context for planning services and could not assess their ability to ensure an acceptable level of care.

Most of the individual facility plans justify their goals and objectives as meeting community health needs. However, these needs are not based on sound analysis. For example, Honokaa's plan states that the community "needs" fast emergency room service. However, it does not substantiate this claim with information on delays in obtaining emergency room treatment, a description of factors contributing to the delays, or an analysis of alternative approaches to

solving the problem of slow response. It merely calls for the acquisition of new emergency room equipment and a new ambulance at an estimated cost of \$77,000.

The strategic plans are not always based on SHPDA's planning guidelines. For example, Kona's plan calls for the addition of two critical care beds by 1991. However, the SHPDA plan states that only 12 critical care beds will be needed *in the county* by 1990, and notes that there are currently 21 beds on the Big Island. Since the occupancy rate in Kona Hospital's critical care unit during the first six months of 1987 was only 33 percent,⁷ there is little justification for its recommendation on critical care beds.

The strategic plans also fail to address important issues relating to quality of care. For example, many facilities want to expand services in order to increase utilization and generate additional revenues. However, they are also experiencing serious staffing shortages. The plans do not address the question of how these facilities can provide additional services without jeopardizing current staffing ratios and quality of care.

Lack of a systemwide plan. The planning process did not result in the development of a systemwide health services plan. Instead, the division office issued a strategic plan which contains goals and objectives for financial management, budget planning, medico-legal issues, the recruitment and training of nurses, personnel management, and computerization. Since this is essentially a workplan for division staff, hospital administrators are not sure how its goals and objectives can be incorporated into their planning which is more service-oriented.

The governing authority did not approve the strategic plans prepared by individual facilities. Instead, the division office is preparing an "executive summary" that will outline the plans for more widespread public consumption.

Hospital administrators are unsure about which of their goals and objectives will be supported by the division office and DOH administration, and they are forced to continue planning services which could be derailed at any point during the budgetary cycle.

Lack of community participation. The strategic plans were developed by hospital administrators with little community input. The management advisory committees were not asked to identify community needs, evaluate alternative approaches to meeting these needs, or comment on the strategic plans before they were submitted to the division office. In addition, most hospital administrators did not establish community-based planning committees to identify needs and evaluate alternative approaches to delivering services. As a result, there is no assurance that the plans address community concerns.

Planning for a new North Hawaii hospital. The most glaring example of what goes wrong when the community is not involved in planning for the delivery of health services relates to the development of a new hospital in North Hawaii on the Big Island. Although the need for this hospital has been projected for more than 20 years, the county/state hospital program did not establish a community-based planning effort to identify the location of the hospital and define its scope of services.

In 1967, the Health Facilities Planning Council of Hawaii published an areawide plan for the County of Hawaii. This plan called for the establishment of a general hospital in the Kamuela area to meet the future health needs of a growing population in North Hawaii. The new facility would replace Honokaa Hospital, which was not in compliance with Medicare standards due to structural deficiencies.

This plan was never implemented. During the past 20 years, Honokaa Hospital has continued to operate on Medicare waivers for structural deficiencies. The hospital only operates eight skilled nursing beds, and the occupancy rate for acute care beds dropped to 31 percent in early 1987.⁸ During the first six months of 1987, fewer than 300 persons were hospitalized and more recently the hospital's critical care unit was closed.

There are serious questions about the facility's ability to ensure quality of care in the delivery of acute inpatient services. The hospital is not accredited by the Joint Commission, and it has been cited by Medicare for outdated surgical policies and procedures and failing to develop a quality assurance program. In addition, it has not been able to develop an effective peer review program for its one-person surgery service.

Despite these problems, the Honokaa plan merely states that a "new facility" should be built to replace the existing facility at a cost of approximately \$6 million. The plan does not address community health needs or quality of care issues. And it does not recommend where the new facility should be located or what scope of services it should provide.

While the strategic plan was being drafted, State officials notified the county/state hospital program that Honokaa's license was in jeopardy due to new deficiencies cited during the annual survey and a lack of progress in correcting longstanding deficiencies. In light of this development, the division office gave priority to the development of a new facility and the 1987 Legislature appropriated \$300,000 to design the facility. At that time, there was still no agreement about where the facility would be located or what scope of services it would provide.

In fall 1987, an intensive grassroots campaign was launched by private interests to build a new community hospital in Kamuela. Their rationale is based on Kamuela's central location in the service area, the availability of related medical services at the Lucy Henriques Medical Center, and the availability of private funds to help build the new facility.

This campaign is not endorsed by county/state hospital program officials on the Big Island. The Hawaii County management advisory committee has gone on record as supporting the development of a new hospital in North Hawaii. However, it has not taken a position on where the facility should be located. The Honokaa Hospital administrator has stated that the new facility should be located in Honokaa. However, other hospital administrators have different opinions on the need for a new hospital and its location.

At the State level, DOH has issued a position paper on the Honokaa Hospital issue stating that it favors developing a combined hospital and nursing home facility in the Kamuela area. However, the department notes that there is as yet no community consensus on this approach. And it cannot wait for such a consensus to develop due to pressure from State licensing and Medicare program officials.

Therefore, the department proposes developing a new facility in Honokaa which will include emergency services, limited hospital services (no inpatient surgery or obstetrics), and nursing home beds. The new facility will include 10 beds which can accommodate acute or skilled nursing patients, and 40 beds which can accommodate skilled nursing or intermediate care patients. The responsibility for acute care services will be transferred when a new community hospital is built.

The department has stated that planning and design activities for the new Honokaa Hospital will be based on this proposal. However, "should the North Hawaii

communities reach a consensus on where a new facility should be located, the Department of Health will effect the adjustments necessary to reflect the communities' decision."⁹

The department's proposal addresses issues relating to community need (providing nursing home beds for frail elderly and disabled patients) and quality of care (phasing out the current facility's inpatient surgery service). However, it still lacks a community consensus about the best approach to meeting health care needs. It appears that the lack of community participation will result in two separate, and less efficient, facilities being constructed for North Hawaii. This will increase the total cost of health care to the State.

Development of the Mahelona hospice program. Another illustration of problems which arise from a lack of community-based planning is the Mahelona hospice program on Kauai. In June 1986, the administrator of Mahelona Hospital submitted a certificate-of-need application to establish a hospice program that would provide home health services and an 8-bed inpatient facility for the care of terminally-ill patients on Kauai. The SHPDA approved this application administratively without submitting it for review by the community-based subarea health planning council on Kauai.

The hospice program was justified with demographic information, data on the incidence of cancer in the community, and the results of an opinion survey of physicians and community leaders. However, there was no analysis of alternative approaches to delivering hospice care or community involvement in determining which approach was best for the community. Therefore, the hospice program had very poor utilization during its first year of operation. Although an average daily census of between 11 and 15 patients was projected, the program treated only a handful of home health patients and one inpatient.

The program does not ensure access to hospice services because it is not based on an extensive volunteer network, it limits admissions, and it is not well coordinated with related programs. Community participation in the planning process could have identified these problems and ensured a more accessible hospice program.

Ad hoc decisions are seriously flawed. The lack of adequate planning means that ad hoc decisions are made without any systemwide perspective. For the most part, these decisions do not reflect community health needs and quality of care issues. As a result, essential medical services are not developed, new services are developed which bear no relationship to the county/state hospital program's role as "provider of last resort," and important quality of care issues are overlooked.

Lack of access to essential medical services. The absence of effective planning has resulted in the unavailability of essential medical services in some communities. For example, the communities of Ka'u and Lanai each have only one full-time primary care physician. The Ka'u physician must run a private practice and provide 24-hour coverage of the hospital. Her work is supplemented by contract physicians who cover the hospital's emergency room on weekends.

The Lanai physician must also run a private practice and provide 24-hour coverage of the hospital. Although his work is supplemented from time to time by a resident from the University of Hawaii medical school, there is no contract with other physicians to relieve him of emergency room duties on weekends and holidays.

Both hospital administrators have expressed concern over the lack of adequate primary care coverage. The Ka'u administrator has stated that the absence of the community's solo practitioner is one of the paramount issues facing the hospital. The Lanai administrator has expressed the same concern, and added that the island's

sole physician is not yet trained to provide advanced life support services in the hospital's emergency room.

Primary care should be delivered by at least two qualified physicians in order to ensure continual coverage of community health needs. Remote rural communities, such as Ka'u and Lanai, require external subsidies to support this level of care. The county/state hospital program sponsors two-physician primary care practices for the remote rural community of Hana and as well as for Kula Hospital. However, it has neglected to ensure the same level of care for Ka'u and Lanai.

The county/state hospital program has also neglected to ensure the delivery of adequate emergency care in these isolated communities. Both hospitals lack enough trained personnel to guarantee resuscitation and stabilization of emergency patients prior to the arrival of a physician. And since they operate the only ambulance service in their respective communities, the lack of trained personnel applies to prehospital as well as hospital-based emergency care.

Development of lucrative and glamorous services. In the absence of adequate mission statements and planning guidelines, hospital administrators have developed plans to establish services that are lucrative and glamorous but add little to the community's health status. For example, Kona Hospital plans to recruit a plastic surgeon who can perform cosmetic surgery for tourists and part-time residents who might otherwise take their business to Honolulu. Kauai Veterans Memorial Hospital is also establishing an ophthalmology service for patients who currently drive to Lihue. Since this specialty is rarely needed in an emergency, there is little justification for developing the new service in a facility which is already desperately understaffed.

Inadequate attention to quality of care issues. The lack of a clear program has also led to problems in ensuring quality of care. For example, Hilo Hospital operates a megavoltage radiation therapy service for cancer patients that does not meet national utilization guidelines. Although SHPDA has called for an external review of this service, the review has not been carried out. In the meantime, the hospital purchased a new linear accelerator to replace outdated radiation therapy equipment at a cost of \$400,000 without legislative approval.

Kauai Veterans Memorial Hospital established a special care unit to provide intensive and coronary care to seriously ill patients. The unit is staffed by private agency nurses at a cost of \$200,000 per year because the hospital is not able to provide trained in-house nurses who are needed in other departments. In 1987, the unit was cited by the Joint Commission for numerous problems relating to staffing, infection control, and quality assurance.

The 1987 Kona Hospital strategic plan also calls for the immediate establishment of separate medical and surgical inpatient services which will require the addition of 8 registered nurse and 10 licensed practical nurse positions. Although the plan also notes that there is a 20 percent vacancy rate for registered nurses and a 40 percent vacancy rate for licensed practical nurses, it does not determine how the hospital can recruit and retain the additional nurses while at the same time reducing its very severe nursing shortage.

Ensuring Quality of Care

We find that there is no system to ensure quality of care, thereby unnecessarily jeopardizing the health and safety of patients and employees. A facility-based health care program should ensure that services are delivered safely,

effectively, and in accordance with commonly accepted standards of care. In order to accomplish this objective, the governing authority should establish a systematic process to monitor and evaluate the delivery of health care services, including both internal and external monitoring and evaluation activities. This process should result in the timely identification and resolution of problems relating to patient care and employee health and safety.

Internal monitoring activities focus on the delivery of professional services as well as environmental health and safety concerns. These activities are usually carried out by hospital committees which ultimately report to the governing authority. Standards for internal monitoring activities relate to such areas as quality assurance, infection control, and safety management.

External monitoring activities include licensing, certification, and accreditation surveys. The most comprehensive survey programs are operated by state health departments (licensing programs), the federal Health Care Financing Administration (Medicare certification programs), and the Joint Commission on Accreditation of Healthcare Organizations (accreditation programs).

State licensing and Medicare certification standards are designed to ensure a *minimum* level of safe and effective care. However, Joint Commission accreditation standards are much more stringent. Therefore, accreditation is viewed by many in the healthcare industry as a key indicator that a facility is capable of delivering quality health care.

The Joint Commission rates health care facilities according to their level of compliance with standards and required characteristics set forth in accreditation manuals for hospitals, nursing homes, and ambulatory care centers. These standards relate to governance, management, quality control, patient care services, and ancillary services.

A health care facility which fails to meet a standard or required characteristic is deemed to be in "noncompliance" which may lead to loss of accreditation. A facility which minimally meets a standard or required characteristic is issued a "contingency" which results in close monitoring by the commission.

A contingency generally indicates that a health care facility is not able to ensure a uniform level of quality care. One private hospital system uses contingencies to evaluate the performance of hospital administrators, and views certain contingencies as grounds for dismissal. Therefore, a finding that a hospital is not in compliance, the next higher level of deficiency, is extremely serious.

Participation in Medicare and Joint Commission survey programs is voluntary. However, most health care facilities participate in the Medicare program in order to qualify for federal reimbursements. And most hospitals participate in the Joint Commission program since accreditation enables them to bypass the annual Medicare survey.

Inadequate direction and control. All county/state hospital facilities participate in State licensing and Medicare certification programs. In addition, the four facilities located in Hilo, Maui, Kona, and West Kauai participate in the Joint Commission's hospital accreditation program.

The county/state hospital division has not provided individual facilities with adequate support to enable them to meet commonly accepted standards of care. This is partially due to the fact that the division's staff is not well versed on the standards. For example, they have not attended Joint Commission training programs which are designed to familiarize hospital personnel with standards and

required characteristics. Private hospital administrators report that this training is essential for understanding the commission's requirements and preparing for accreditation surveys.

The division office has issued very few policy directives relating to external standards, and these directives have not been accompanied by adequate consultation or resources to ensure their effective implementation. For example, in 1981 all hospital administrators were instructed to establish quality assurance programs. However, they were not provided with the necessary training or personnel to implement the new requirement. Consequently, one facility does not have any quality assurance program while most of the existing programs are extremely inadequate.

The division office does not have any internal monitoring program to ensure that problems in individual facilities are identified and resolved prior to a survey visit. In addition, key division staff members do not routinely review copies of survey reports and they only become directly involved in correcting deficiencies at the request of hospital personnel or the Hospital and Medical Facilities Branch. Staff members report that their role is "supportive," and they do not want to "impose" themselves on the hospitals. This lack of oversight and participation in quality control activities permits numerous deficiencies to go uncorrected each year.

The division office does not evaluate the performance of hospital administrators based on the results of external surveys. As a result, there is no incentive for the administrators to identify and resolve problems on a timely basis. The absence of performance appraisals which are tied to the maintenance of standards of care limits the program's ability to ensure quality medical services. Consequently, most county/state hospital facilities do not meet commonly accepted standards of care.

Extremely poor performance on external surveys. The county/state hospital program has not performed well on external surveys. Individual facilities are routinely cited for noncompliance with key standards, many problems continue from year to year without correction, and some problems which are corrected during one survey cycle reappear in subsequent surveys. Some problems are common throughout the system, while others are related to a certain type of facility. For example, most facilities have difficulty complying with standards relating to quality assurance while small rural hospitals also have difficulty meeting standards for laboratory services.

Since the division office does not routinely review survey results or followup to ensure that problems are corrected, external monitoring agencies are forced to threaten county/state hospital facilities with loss of licensure, certification, or accreditation in order to get its attention and cooperation in correcting serious deficiencies. Even the State licensing program, with the least stringent external criteria, has issued warnings to facilities which are at risk of losing their license. Without a license, a facility must close. The federal government has routinely notified at least one facility per year that its Medicare or Medicaid certification is in jeopardy. And the Kula Hospital intermediate care program for mentally retarded persons was recently decertified by Medicare. After corrections were made, the program was recertified.

Tentative adverse recommendations by the Joint Commission. In late 1987, the Joint Commission notified Hilo Hospital and Maui Memorial Hospital, the two largest facilities in the state system, that their accreditation was in jeopardy due to *noncompliance*, the most serious level of deficiency. The commission gave the hospitals an opportunity to respond to its tentative findings with additional

information. However, even if accreditation is ultimately granted, it is clear that there are serious problems in the quality of care provided.

Noncompliance status for both hospitals was the result of the following conclusions: inadequate surgical case review by the medical staff; inadequate monitoring and evaluation of special care units, dietetic services, and pharmacy services; and inadequate safety management.

In addition, Hilo Hospital was not in compliance because of inadequate division support of the quality assurance program, inadequate monitoring and evaluation of numerous patient care services, and inadequate life-safety provisions. The surveyors specifically noted that the hospital's nursing home continued to have fire-safety problems which had been reported previously. These problems could jeopardize the health and safety of residents and employees.

Maui Memorial Hospital was also judged not in compliance because of inadequate blood review and infection control by the medical staff, inadequate monitoring and evaluation of ambulatory care services, inadequate fire-safety provisions, and inadequate equipment management. The surveyors specifically noted that there was gross contamination of the hospital's histology laboratory "with old blood splattered on the wall and work areas."¹⁰

The commission has also notified both facilities that they will receive contingencies relating to medical staff operations, nursing services, quality assurance, and utilities management if their accreditation is renewed. Hilo will receive additional contingencies relating to infection control, monitoring and evaluation of emergency services, and equipment management. And Maui will receive contingencies relating to monitoring and evaluation of nuclear medicine, pathology and medical laboratory, and diagnostic radiology services. The surveyors

specifically noted that Maui's nursing staff did not develop care plans for newborns as required by hospital policy. Prompt correction of these problems will be required to retain accreditation.

Numerous contingencies on successful Joint Commission surveys. In 1987, the commission awarded three-year accreditation to Kona Hospital and Kauai Veterans Memorial Hospital, the next two largest acute care facilities in the system. However, both facilities were also cited for numerous contingencies. The contingencies applied to governance; medical staff operations; nursing services; infection control; quality assurance; special care units; pathology and medical laboratory services; diagnostic radiology services; and plant, technology, and safety management.

The following services at Kauai Veterans Memorial Hospital also received contingencies for inadequate monitoring and evaluation: anesthesia, emergency care, respiratory care, physical rehabilitation, social work, nuclear medicine, dietetic, and pharmaceutical.

The commission noted in its survey reports that many of the contingencies had been previously reported—some as many as three times. It plans to conduct "focused surveys" of both hospitals within the next year to determine whether they have improved operations in key areas. A failure to make the required improvements could result in loss of accreditation.

Substandard performance on State licensing and federal certification surveys. County/state hospital facilities are routinely cited by State and federal surveyors for deficiencies relating to patient care and environmental health and safety. According to survey reports for public and private facilities, the State's program is far less likely to comply with external standards and far less likely to take timely action to correct deficiencies than private organizations.

Patient care problems noted in recent county/state *hospital survey* reports include such items as inadequate emergency response time, inadequate nursing care plans, inadequate infection control procedures, inadequate quality assurance programs, outdated surgical policies and procedures, inadequate food and dietary services, and inadequate laboratory operations. One hospital was cited for mixing adult and pediatric hospital patients with nursing home patients in the same unit. The DOH surveyor has noted that this could result in serious errors such as the improper administration of medications.

Recent county/state *nursing home* survey reports have noted problems in many of the same areas. In addition, surveyors have criticized some nursing homes for such items as failing to provide adequate care to nonambulatory patients, improper administration of medications, inadequate assessment of rehabilitation potential, and inadequate activities programs. One nursing home was cited for failing to provide an adequate number of pillows for proper positioning to prevent deformities in bedridden residents, failing to provide enough lounge chairs to allow residents to get out of bed, and leaving one-third of its patients in bed all the time.

Environmental health and safety problems noted in county/state hospital and nursing home survey reports include such items as failing to meet life-safety codes (including fire code provisions), failing to properly maintain diagnostic and therapeutic equipment, mixing clean and dirty supplies, inadequate call-bell systems in patient rooms and bathrooms, improperly storing equipment in working areas and corridors, and loose toilet seats and tissue holders. The surveyors have criticized peeling paint; dirty walls, windows, and floors; mildew; cockroaches; and rats. One hospital was also cited for a depressing psychiatric environment with peeling paint, old beds, rusty screens, old furnishings, and no privacy—"to name a few."¹¹ One

nursing home was cited for improper procedures in disposing of drugs. And several facilities were cited for failing to keep medication carts locked.

Failure to respond to deficiency notices. The county/state hospital program has a dismal record of responding to deficiency notices issued by external survey agencies. In some cases, this failure to respond has led to longstanding substandard conditions in aging facilities. Until replacement facilities are built, patients and employees are being exposed to unnecessary risks, and some nursing home residents must endure unpleasant living conditions.

Chronic life-safety code deficiencies at Honokaa Hospital. Honokaa Hospital has been operating on State and federal waivers of life-safety code requirements for approximately 20 years. One of these waivers relates to fire safety problems arising from the facility's wooden construction. This waiver was granted on the stipulation that the hospital have an adequate fire protective system in place at all times. However, in recent years, this stipulation has not been honored.

In 1985, the life-safety code inspector noted the following deficiencies: (1) a broken central fire control panel, (2) a broken fire alarm and smoke detector system, (3) a poorly maintained fire sprinkler system whose effectiveness "may be seriously compromised," and (4) inadequate fire drills on the night shift.¹² The Hospital and Medical Facilities Branch notified the Director of Health of these findings and concluded:

"As the Honokaa Hospital Life Safety Code waiver was granted on the condition that there would be at all times a functioning and complete fire protective system as described, we are now unable to recommend the continuation of the waiver. We do not believe that the facility should be permitted a license to continue operating under these obviously hazardous conditions. Continuation of the recommendation for Medicare/Medicaid Participation, also dependent on the waiver, is also no longer possible. We believe because of the seriousness of the matter, a copy of this report [should] be communicated to the Hawaii County Fire Department."¹⁴

The director responded by sending a facilities planner to develop a plan of corrections to upgrade the hospital's fire protective system. The survey agencies accepted the plan and reissued the waiver.

The following year, surveyors found additional deficiencies. The Hospital and Medical Facilities Branch notified Honokaa Hospital that "licensing of the facility is in jeopardy" but that a provisional license would be issued until progress was made in obtaining planning money and awarding contracts for a new facility.¹⁴ The Legislature subsequently appropriated funds for the design of a new facility.

In the meantime, surveyors have once again found deficiencies in the hospital's fire protective system. In July 1987, they noted that the facility's sprinkler system had not been inspected since August 1985.

Failure to upgrade obstetric facilities at Maui Memorial Hospital. For many years, Maui Memorial Hospital has been cited for failing to provide adequate access to toilet facilities for women occupying the obstetric unit. The Hospital and Medical Facilities Branch has granted a waiver for this deficiency because: (1) the building was constructed more than 30 years ago when patient needs were met in a different way; (2) renovation would cause undue hardship and prohibitive costs; (3) plans are underway to renovate the building that houses the unit; and (4) health and safety is not jeopardized by this situation.

In the meantime, there is only one toilet for six labor and delivery beds and one shower for 19 postpartum beds. This means that some women in labor must wait in line to use the single toilet. And some women who have recently given birth must wait in line to use the single shower.

There are other problems in the obstetric unit which have not been cited in external survey reports. For example, since the unit is not air-conditioned, patients

bring their own fans from home. The use of personal electrical appliances in a hospital facility could result in falls (e.g. tripping over wires) and fires (e.g., if the personal appliance is not well maintained). Also, the hospital has been unable to get a telephone installed in the labor and delivery room. Professional personnel report that this is essential to enable them to respond quickly to emergencies and maintain adequate patient care.

All of these deficiencies have been present for many years, during which time millions of dollars have been spent on other renovation projects at the hospital. In October 1986, the division obtained a \$2 million ceiling increase from the Governor to renovate the obstetric unit. However, this money was allowed to lapse and another \$3 million ceiling increase was requested for the same purpose. This request was approved by the Governor in September 1987. At this time, it appears that some progress is finally being made to upgrade the obstetric unit.

Deteriorating conditions at Hilo Hospital's nursing home. In October 1985, October 1986, March 1987, and October 1987, the Hilo Hospital nursing home was cited by State and federal surveyors for failing to repaint the facility and replace ceiling tiles. One surveyor has noted that the quality of life for nursing home residents is adversely affected by poor maintenance of the facility. After each deficiency notice, the hospital administrator stated that the painting and repair jobs would be included in the next budget request. However, these deficiencies had not been corrected as of November 1987.

The hospital administrator excused the lack of action by such explanations as: (1) the projects had to be included in a budgetary request; (2) the projects were included in a master plan report that would be submitted for legislative approval;

(3) the master plan submittal was "shot down" by the Department of Accounting and General Services; and (4) the projects would be requested again in the next budgetary cycle or ceiling increase.

However, the nursing home could have been painted and repaired if there had been a commitment to doing so. The work would have cost \$45,000. In 1986, Hilo Hospital was allowed by the Governor to raise its spending ceiling by \$844,000. The money was available because systemwide revenues had exceeded expectations. The approved spending included \$125,000 to repair and waterproof the new hospital facility and \$400,000 to purchase a new piece of radiation therapy equipment. But \$45,000 to paint and repair the nursing home was not included in the request to the Governor.

Failure to establish standards for quality of care in unaccredited hospitals. Small rural hospitals are required to meet State licensing and federal certification standards but they are not accredited by the Joint Commission. And the division office has not established statewide standards to ensure quality of care in the delivery of services by unaccredited hospitals.

Instead, it reacts in an ad hoc fashion to problems which arise. For example, when one small rural hospital experienced difficulty providing adequate emergency care to five accident victims, the division office evaluated the hospital's response but did not develop guidelines to ensure better handling of multiple emergencies by all small rural hospitals.

Small rural hospital administrators have not been provided with adequate technical assistance from the division office to determine what standards are essential for ensuring quality of care. For example, although the division office has encouraged them to comply with Joint Commission standards as much as possible, it

has not assisted them in identifying which standards are essential. The absence of statewide standards means that a uniform level of quality care cannot be established or maintained.

The Director of Health has requested the division office to explore the feasibility of obtaining Joint Commission accreditation for unaccredited facilities. According to the director, facilities which cannot qualify for accreditation should be reorganized to ensure quality of care. This might entail changing the mission of some facilities. For example, a small rural hospital which cannot achieve accreditation might be converted to focus on the delivery of outpatient and/or nursing home services.

This approach could improve the delivery of health services by ensuring a uniform level of care throughout the county/state hospital program. However, the division office has not yet analyzed the feasibility of Joint Commission accreditation or developed a position on the matter. Instead, it is waiting for individual hospital administrators to determine whether they can achieve accreditation.

Since most small rural hospital administrators do not think it is feasible to develop accreditable programs, and since they are extremely reluctant to eliminate current services or develop alternative approaches to meeting community health needs, there has been little progress in responding to the director's request. In the meantime, unaccredited hospitals continue to deliver emergency, critical care, medical, surgical, and obstetric services without statewide standards for quality of care.

Conclusion

The county/state hospital program must be revamped in order to ensure the delivery of needed services in a safe, effective, and acceptable manner. The program should focus on providing essential medical services at the primary and secondary level of care instead of developing more glamorous services that will ultimately drain limited resources from basic patient care centers.

The division office must establish a systematic process to ensure that existing and proposed health care services meet community needs and provide quality care. And it should develop a statewide program to ensure that individual facilities meet commonly accepted standards of care.

Recommendations

We recommend the following:

1. *The Director of Health should:*
 - . *clarify the philosophy, mission, and goals of the county/state hospital program, including the basic functions to be performed by individual facilities; and*
 - . *routinely monitor and evaluate the performance of the county/state hospital program on external surveys, and ensure that timely and appropriate actions are taken to upgrade substandard operations.*
2. *The division office should:*
 - . *establish a decisionmaking process to review and approve existing and proposed health care services to ensure that they fall within the program's mission, meet community needs, and ensure quality of care. This process should include research and analysis by*

administrative and professional staff, and community involvement in identifying health needs and evaluating alternative approaches to meeting these needs;

- . prioritize the development of adequate primary care services in the communities of Ka'u and Lanai;*
- . establish an internal monitoring program to ensure that all facilities meet commonly accepted standards of care. At a minimum, this program should include education and training of key hospital personnel, internal surveys to ensure routine compliance with external standards, prompt correction of deficiencies, and performance assessment based on the results of external surveys; and*
- . evaluate alternative approaches to ensuring quality of care in unaccredited hospitals and report its findings to the Director of Health.*

3. Hospital administrators should:

- . develop health service plans that focus on the delivery of essential medical services which meet community needs and can be delivered at an acceptable level of care without adversely affecting existing services; and*
- . routinely monitor their facilities' compliance with commonly accepted standards of care and promptly correct deficiencies to ensure the safe and effective delivery of services.*

Chapter 7

MANAGEMENT OF THE COUNTY/STATE HOSPITALS

The County/State Hospital Division is managed by the division office in Honolulu. In this chapter, we assess the adequacy of management, focusing on the respective roles and responsibilities of the division office and the hospitals.

Summary of Findings

The division does not manage the county/state hospitals as a system. More specifically:

1. Respective roles and responsibilities of the division office and the hospitals have not been delineated, systemwide policies and procedures that can guide decisionmaking are lacking, and operations are inconsistent and fragmented.
2. The division office has not provided the leadership and responsiveness that should be provided by a system headquarters.
3. The division office has not exercised adequate management control over the hospitals in their programs, procurement, and expenditures. Contracts are managed in a haphazard and questionable manner and there is no planned, managed program for training personnel or for their staffing.

Organization of the County/State Hospital Division

The County/State Hospital Division consists of the 12 hospitals, one clinic, and the division office in Honolulu. The formal organization chart shows a regional

organization based on county lines with one hospital administrator in each county designated as that county's hospital system administrator. The four county system administrators report to a Hospital Systems Executive Officer in the Honolulu division office who in turn reports to the deputy director of the division.

In practice, however, the county administrator concept has long been abandoned. All 12 hospital administrators report directly to the deputy director. In 1986, the Department of Health (DOH) submitted a reorganization proposal to the governor that reflected the status quo; however, this was withdrawn in 1987. The DOH currently supports retaining the county system on paper while it considers its options in changing the governance structure for hospitals or interdepartmental reorganizations.

The division office is responsible for overseeing the management of the hospitals. Its permanent staff of 20 advises and assists the deputy director "in planning, organizing, administering and evaluating" all responsibilities assigned to the DOH in connection with the hospitals. The division office is organized into six units: medical staff services and affairs, nursing services and affairs, personnel, management, fiscal, and the computer unit.

Lack of a Systems Perspective

The county/state hospitals remain a "loose federation of autonomous units," as they were described by our office in 1971.¹ Today, as then, many of the weaknesses of the hospitals stem from the division's failure to organize hospitals into a health care system.

A "system" is a group of integrated, coordinated, established, and specialized components working toward some common goal. It is distinguished by defined

boundaries and a pattern of interrelationships. Hawaii's public hospitals exhibit few of the characteristics of a system. As in the past, they have retained their independence from a central office. Virtually all significant operations, from strategic planning and developing policies and procedures through staff development, budgeting, and expenditures, fall within the purview of the individual hospitals.

The division provides minimal oversight, direction, or control. Consequently, the county/state hospitals are a system in name only.

Unclear roles and responsibilities. There should be a clear delineation between the roles and responsibilities of the system headquarters and the hospitals in a multihospital system. Here, the division office functions both as staff to the de facto governing authority—the deputy director—and as staff to the chief operating officer of the system—also the deputy director. This dual role consolidates much authority in the headquarters office, making even more compelling the need for the division office to function as system headquarters. The delineations between the division office's responsibility for systemwide decisionmaking and the hospitals' authority should be clear and current.

This has not been the case. The basic documents that underlie the system are inaccurate. Actual operations deviate from official organization charts and duties and responsibilities do not follow official functional statements. The county systems concept which is ostensibly the official assignment of powers and functions is out-of-date and misleading. Keeping it on the books merely confuses everyone as to which "official" organization chart applies.

Functional statements which describe the duties and responsibilities, lines of supervision, and qualification of each position are an integral element of state

government. The higher the position, the more crucial a current and applicable functional statement becomes, because the scope and impact of the decisions made by an incumbent are greater. But the functional statements for at least several of the top staff positions in the division office are inconsistent with the work they actually perform.

Despite various statements to the effect that the Hospital Systems Executive Officer is the division's second in command, this is not the case in practice. As the one nominally assigned the task of operational direction and supervision over the hospitals, he should be assisting the Director of Health and deputy director of the division on the full range of hospital administration. Instead, the executive officer manages the computerization of the hospital system and performs some purchasing duties.

The computerization project no doubt requires staff level leadership but this assignment has skewed responsibilities at the top of the division. In practice, the deputy director has assumed both his and the executive officer's job. This combination of responsibilities involving the governing and administration of hospitals is an unnecessarily large burden for one individual to handle effectively.

The functional statement for the personnel management specialist IV position was approved in 1971. It is supposed to be in the DOH personnel office with the position reporting to the DOH personnel officer. In fact, the position heads the personnel section of the division office and reports to the deputy director of the division.

In another example, the functional statement for the fiscal officer VI position, approved also in 1971, calls for the position to be supervised by the deputy director and the hospital system executive officer. The incumbent is responsible for

planning, developing, and implementing the fiscal activities of the division, initiate the development of the division budget, supervise the maintenance of fund control ledgers, and generally take a very active role in financial management. In fact, the fiscal officer does not report to the hospital system executive officer and has few budget preparation or execution responsibilities for the hospitals. In practice, the fiscal officer's role in systemwide financial management is loosely interpreted.

The division office attempted to clarify the staffs' duties through a memorandum issued in April 1987. But it further confused the situation. The memorandum stated that the fiscal section prepares bids, sole source requests, and materials procurement requests. In practice, these are done by the management section and, in some instances, by the computer section. The memorandum says the management section is responsible for contracts, but in practice, other sections occasionally prepare and process contracts.

The unclear roles and responsibilities result in confusion and lack of accountability. It also lends itself to conflict and misperceptions. Some division personnel see themselves as facilitators while some hospital personnel in the field see them as seeking to control the key decisions. Some other division staff believe that hospitals rely on them to make decisions that should be made at the hospitals in order to avoid responsibility and accountability. There is some degree of distrust both ways.

Lack of systemwide policies and procedures. Many of the deficiencies and ambiguities can be attributed to the lack of policies and procedures for the system. An audit conducted in 1971 by our office concluded that, "the need for consistent policies throughout the County/State Hospital Program is probably the single most important missing link for organizing the county/state hospitals into a true

statewide system."² Nearly two decades later, the system still does not have an adequate policies and procedures manual. There is nothing on paper which clearly defines how operational functions and activities will be carried out, by whom, and at which points.

The American Hospital Association's guidelines on the role and functions of the hospital governing board state clearly that policies and procedures are necessary for the governing authority to discharge its responsibilities. It advises, "The structure and composition of the governing board and the policies and procedures it follows to ensure orderly conduct of its business are critical in fulfilling the institution's mission and goals to serve the community."³

Policies established by the governing board should document the delegation of responsibilities and establish accountability. Instead, we find no policy even on how the governing body develops its bylaws, a basic system document. This has resulted in confusion and suspicion. Under the previous administration, the hospitals had a chance to review drafts of the bylaws. The current administration approved a new set of bylaws without review by all the hospitals. However, the administration did give hospitals the opportunity to review the division office's strategic plan. This kind of inconsistency and the resulting confusion could be avoided if policies and procedures had been adopted on how basic documents are to be developed and approved.

At the operational level, the lack of policies has led to confusion, inconsistencies, and inequities. The division office rarely reviews hospital practices, and there are divergent practices on such basic matters as temporary pay and standby status. For example, when a director of nursing is off duty, some hospitals pay temporary duty compensation to other nurses who assume supervisory

responsibility. Hospitals use standby status to ensure minimum staffing at all times and require certain off duty employees to be on call to work if needed. The staff are paid for being on standby status, but compensation practices differ among the hospitals. Also, financial auditors have repeatedly called for formal collection policies and procedures at three hospitals. Some variations among hospitals are needed to accommodate individual requirements; however, certain operations should be standardized.

Failure to Provide Leadership

The division office's responsibility for providing leadership, support, and consulting services to the hospitals is supposed to be carried out through its six sections, executive officer, and deputy director. It is not surprising that in the absence of policies and a clear assignment of roles there is some paralysis and uncertainty by division staff as to how far they should proceed. However, even in the most obvious situations, the division office has not provided leadership and guidance.

One illustration is the handling of legislation. Bills passed by the Legislature which affect hospital operations are normally disseminated to the field without any guidelines. Each hospital is left to establish its own policy, thereby resulting in the possibility of 12 interpretations.

Reports of all kinds (personnel, budget, fiscal, etc.) from the division office frequently contain only raw data. Division office reports should be valuable tools for the headquarters to communicate noteworthy trends, ensure a common understanding of the significance of the data presented, enable the hospitals to measure themselves, and offer recommendations for improvement. However,

generally the division office develops no trend data, makes no comparisons among the hospitals, and does not comment on whether the figures are favorable or unfavorable.

Instead of managing the system, the division office spends much of its time on crash projects or responding to requests. According to some staff, working on field inquiries leaves little time for anything else. Broader guidance is not ordinarily provided unless specifically requested. Division office operations are reactive rather than proactive. For example, only recently has the division office begun to develop policies to deal with AIDS in the county/state hospitals.

Lack of responsiveness. The division office exemplifies the worst characteristics of government bureaucracy in its failure to respond expeditiously to the hospitals. Division office files are replete with letters and memoranda inquiring about the status of requests submitted *months*, or in some instances, *years* earlier. In one case, at least 13 followup letters were sent to the division office between January 1985 and June 1986 over the status of an October 1984 request for management of collections. In other instances, as many as a dozen letters were sent over a gamut of hospital concerns—equipment replacements, personnel practices, etc. Occasionally, memoranda are misplaced. This lack of responsiveness has been noted by outside financial auditors. The 1985–86 audit of Kauai Memorial Hospital pointed out that the hospital's request for assistance in correcting several deficiencies identified the year before had gone unheeded and unanswered.

In an effort to correct the problem, the deputy director has instructed division office staff to respond to equipment purchasing requests within five working days. While this is a step in the right direction, every request deserves a timely response.

We recognize that the new administration has attempted to rectify some of the shortcomings. Division personnel now make more field visits, and more are scheduled. In addition, the deputy director has created a hospitals executive committee composed of himself and representatives of rural, long term, and acute care hospitals. Also, various ad hoc committees have been established to address specific areas of concern although the committees authorized by the division bylaws have yet to be established. It is hoped that these initial efforts will begin to improve relationships between the division office and the hospitals.

At some point, management of the hospitals should include evaluation and feedback on program performance. The county/state hospital division currently has no mechanism by which the hospitals would know whether they are headed in the right direction. The division should make better use of the ongoing quality of care evaluations made by outside licensing and accrediting agencies.

Inadequate Management of Resources

The resources that the division office manages include personnel, financial, and program resources. Chapter 9 discusses the financial management of the division. In this section, we discuss management of other resources.

Faulty analysis. The totality of program development is treated in Chapter 6; here we present examples of programs already under way that merit careful monitoring. It is a management responsibility to ensure any new programs that are undertaken meet the needs of the community they serve. Financial analysis of the project should also be a standard element. Decision makers should know whether a project will be self-sufficient and if not, what the deficit will be and how it will be paid for. The division office has not carried out this responsibility adequately.

For example, Samuel Mahelona's hospice program, consisting of an outpatient program and eight inpatient beds, was dedicated in September 1986 on the expectation that it would generate \$254,847 in revenues after the first year. Operating expenses of \$74,914 were expected, so a profit of \$179,933 was projected. However, by September 1987, actual receipts totaled \$4,114 and the accounts receivable balance was \$26,368. Expenses were \$43,201 as of June 1987. As discussed in the previous chapter, the community's needs and demands for hospice care had not been examined carefully.

Haphazard and questionable contract management. State law imposes a number of requirements on state agencies in expending public funds for the procurement of goods and services. This is to ensure that the State is receiving value for public funds expended and private firms and individuals are given a fair opportunity at the business. We find that the division manages contracts in a questionable manner.

In 1985, we found that the hospitals were using purchase orders instead of written contracts even though the Attorney General had notified state agencies that securing the services of individuals or consultants with purchase orders "is ill-advised and not in the State's best interest." The Comptroller, in turn, circulated a memorandum to all agency heads forbidding this practice. The DOH instituted a policy requiring written contracts for all services exceeding \$4,000 a year.

Despite these strictures, the division still relies on purchase orders. For example, one hospital retained two professionals through purchase orders even though the value of each contract exceeds \$4,000. As of September 1987, a total of \$11,814 had been paid to one individual and \$6,441 to the other. Since the individual

will probably be retained through the current fiscal year, by June 30, 1988, the value of the first purchase order will exceed \$50,000. This situation does not appear to be unusual. In FY 1984-85, one auditor noted the acquisition of services without written contracts and recommended that management comply with State policies and procedures when procuring professional services. This recommendation was ignored, and the hospital purchased additional services the next year in the same manner. The auditor made the same recommendation again.

In the next chapter, we discuss a prime example of highly irregular contract management.

Inadequate training program. In-service training of personnel is a useful function in any organization but in a hospital environment, it is an absolute necessity. The American Hospital Association requires the governing body to ensure that training is carried out. It also requires educational programs to be consistent with the hospitals' mission and "that the educational programs are of demonstrable quality, are properly funded, are evaluated regularly, and that the dignity of patients is stressed in all programs."⁴

In Hawaii's public hospitals, however, responsibility for training is left to each hospital. The division office gives little direction, and it does not monitor the efficacy of hospital based training programs. Occasionally, it may sponsor or coordinate training—primarily in nursing—but there is no overall training program. The division office maintains instructional tapes, but otherwise, it is primarily a passive participant. Hospitals must request assistance or make arrangements on their own. This is largely a hit or miss approach to training.

Hospitals recognize their needs for training and refer to it in their strategic plans. Kauai's plan identifies as a weakness the hospital's lack of trained people to

staff the intensive care and critical care units and the lack of a trained in-service person. Kona's plan notes its inability to develop and use the potential talents of the hospital staff. Maluhia's plan stresses the need to intensify in-service training, especially among the nursing staff. Samuel Mahelona cites unqualified personnel in key positions as a weakness. Maui's plan documents the need for more training in a number of key areas: accounting, purchasing, radiology, nursing administration, and oncology. Clearly, training is of great concern to hospitals, and the division office could be of great service and help by taking an active role.

However, despite this need, no one in the division office is responsible for training. Thus efforts made by the hospitals are not coordinated or organized. No one knows what types of programs are being offered at the hospitals at any particular time. Although the division office has discussed taking on this function, nothing has come about.

Poor personnel practices. Appropriately trained personnel in adequate numbers are crucial to hospitals. Instead, we find heavy reliance on temporary positions and emergency hires. The use of temporary positions makes it difficult to attract and hold qualified employees and the use of emergency hires presents a distorted picture of the division's personnel needs. We had reported in 1985 that these practices had become entrenched, distorting personnel requirements and making an accurate assessment of staffing needs difficult.⁵

The situation has worsened. The division has been authorized 52.5 additional permanent positions and 54 additional temporary positions since 1984. Despite the increase in permanent and temporary positions, the division continues to rely heavily on emergency hires to fill both permanent and temporary positions instead of filling them according to customary civil service procedures.

Under state employment practices, a position is officially "vacant" even though occupied by an emergency hire employee. For example, of the 220 authorized temporary positions, 106 are reported to be filled leaving the impression that 114 remain vacant. However, 72 of the 114 positions are occupied by emergency hires. Thus, there are 42 positions that are actually vacant. Since the position is reported as "vacant" when occupied by an emergency hire employee, staffing needs can be misconstrued. The hospitals may appear to be grossly undermanned when in fact they are not.

Need for staffing review. Staffing in the hospitals has been inconsistent despite numerous recommendations for comprehensive staffing studies. The 1983 legislature's Conference Committee on the executive budget pointed out the need to review and analyze personnel requirements, citing inconsistencies in the division. To date, only a nursing study has been done.

As an example of disparities among hospitals, Maui Memorial performed 26,000 X rays with 12 positions while Hilo Hospital performed 21,118 X rays with 13 positions. The Legislature attempted to correct this by adding two more positions to Maui. However, this was done on an ad hoc basis.

The division office acknowledges that staffing patterns among the hospitals require review. It is included among the division's goals. However, there are no firm plans which lay out how the division office intends to assess the nature and scope of the problem, analyze alternatives, and secure the cooperation and compliance of hospital staffs and their bargaining units.

Recommendations

We recommend that the County/State Hospital Division do the following:

1. Develop systemwide policies and procedures clarifying the respective roles, functions, and responsibilities of the division office and the hospitals. As part of this effort, the division office should update its organization chart, functional statements, and develop more meaningful performance measures.

2. Provide better leadership and responsiveness by assuming the duties appropriate to a system headquarters such as coordinating operations among the hospitals, initiating better employment practices, undertaking staffing studies, analyzing proposed programs, implementing training programs, giving adequate guidance on all requests and instructions sent to the hospitals, and monitoring hospital operations.

Chapter 8

A CASE STUDY IN POOR MANAGEMENT

Since October 1986, the county/state hospital program has contracted twice with a private firm, Hospital Business Management, Inc., (HBM) to increase hospital reimbursements, primarily by assisting noninsured patients to qualify for Medicaid. As of December 31, 1987, HBM has been paid a total of \$563,973.92. During January 1988, at least another \$105,000 will have been processed for payment to HBM.

The contractual agreements and the contracting process are improper, illustrating many poor and highly irregular management practices in the hospital program. These practices include agreeing to a contract that is to be kept secret, one-sided financial arrangements which provide extremely generous compensation to the contractor, inexplicable contracting procedures, preferential treatment, and a disregard for patient rights. This chapter presents this case study.

Summary of Findings

Overall, we find that the public trust and the public interest have not been served by public officials in their dealings with HBM. Specifically, we find that:

1. The Department of Health (DOH) allowed Hilo Hospital to enter into a questionable pilot project which resulted in many unresolved problems. Despite this, DOH expanded the project statewide.

2. The DOH entered into a contract with HBM which contains improper terms and conditions. Among the most startling are the overgenerous compensation terms and a requirement that the contract be kept *secret*.

3. The terms of the current contract make it impossible to administer in a responsible manner. For the four months between September 1, 1987 and December 31, 1987, HBM was paid \$368,125 without a clear basis for payment or any performance requirements.

4. The degree of latitude DOH has given to HBM may have violated patient rights.

5. The contractor is being accorded preferential treatment by the executive branch.

6. The DOH's handling of the HBM contract has undermined confidence among hospital employees in the leadership and management of the department, and the private business sector has questioned DOH's fairness.

Background: DOH Neglect of a Long Standing Problem

The county/state hospitals have, as have other hospitals, the problem of patients who cannot or do not pay their bills. Sometimes patients have no private insurance or their insurance may be inadequate. Sometimes they are unable to pay the copayment portions of their bills. And sometimes, although they may be eligible, they have not sought coverage under available government programs.

Most hospitals, especially the county/state hospitals, do not turn away those who do not have assured means of payment. But when a patient does not pay for some time, or third party reimbursements are not forthcoming, the hospitals then turn delinquent accounts over to collection agencies.

Each hospital contracts with the collection agencies of its choice. The agreed-upon commission rate, usually 30 to 50 percent, is applied to whatever amount the collection agencies manage to collect. The commission is deducted

from the collected amount, retained by the collection agency, and the balance is transmitted to the hospital. Collection agencies have been regulated to varying degrees in Hawaii since 1907.

The hospitals have been aware that many of their delinquent accounts are for indigent patients who could qualify for reimbursement under Medicaid but have not done so. County/state hospitals have not aggressively acted upon this knowledge because they are assured of state general fund support. However, the emphasis on self-sufficiency and the advent of capitation payments have made hospitals more concerned about capturing all possible revenue sources—including Medicaid reimbursements.

Unless one automatically qualifies for Medicaid because the patient is already under the State's public welfare programs, the procedure requires the patient—or the patient's family—to take the initiative in order for the patient to become certified eligible for Medicaid benefits. The patient must apply with the Department of Human Services (DHS), provide the information required by DHS, fill out the appropriate forms, be interviewed by DHS personnel, return to pick up the coupons which certify eligibility for a designated period of time, and turn the coupons over to those who provide the services, such as hospitals and physicians. The providers can then submit the coupons with their claims for reimbursement.

The process entails at least two trips by the patient to DHS. It is daunting to most people and especially for those who are physically or mentally ill. Since county/state hospitals provide treatment regardless of assurance of payment, the patients have little incentive to go through this process. To the extent that the hospitals do not obtain all the revenues to which they are entitled through such

programs as Medicaid, these lost revenues must be made up from other sources such as the State's general fund.

In the absence of any overall effort by the division to deal with this problem, some hospitals approached DHS to assign some of its social workers to the hospitals to assist patients with the paperwork and to certify eligibility. When this was refused, the hospitals requested DHS to permit former DHS social workers, hired by the hospitals, to be authorized to certify eligibility. This was also disapproved. One hospital finally managed to obtain division office approval to create a social worker position to assist patients with the eligibility process. The approval came just as the new contract with HBM was being implemented, making it necessary for the hospital to redescribe the social worker's duties.

In contrast, for at least the past three years, private hospitals have hired social workers to help patients qualify for Medicaid eligibility. They have managed to obtain DHS approval to do everything short of certifying eligibility. For example, they assist patients to complete the application and gather all the necessary supporting documents, an average of 7 to 8 documents. They make sure that these are submitted promptly to DHS. Once DHS notifies patients of their eligibility, one hospital has even obtained Medicaid coupons and DHS approval to sign these on the patients' behalf and distribute these to the hospitals and physicians for submittal of claims.

The services rendered to assist patients in qualifying for Medicaid make good sense to providers because they are then assured of timely reimbursements. However, as the experience in private hospitals shows, the services are not extraordinary and are handled pretty much as a supplementary function to admissions routine.

Poor Management of a Questionable Pilot Project

On October 20, 1986, Hilo Hospital signed a brief, one-and-a-half-page agreement for HBM to provide two kinds of services: (1) to assist patients in qualifying for Medicaid or other government programs and (2) to handle all "non-governmental collections" on accounts assigned to it by the hospital. The contract was for a three-year pilot project.

On its face, the project had not been carefully thought out. The hospital confused (1) services to assist patients to qualify for Medicaid with (2) services for the collection of delinquent accounts. Treating these two disparate services under a single approach led to a number of problems.

First, state statutes require that collections be done only by agencies that are bonded. HBM was not bonded as a collection agency.

Second, helping patients qualify for Medicaid is done at the time of admission whereas collections are done after patients have been billed at least several times and their accounts are judged to be delinquent. By confusing the two, Hilo Hospital gave HBM the latitude to decide which accounts it would pursue and collect *at the time of admission*, thus violating patient rights and identifying accounts as potentially "bad" even before delinquency had occurred.

Third, Hilo Hospital paid for both services on the basis of standard collection commission fees. Thus instead of paying HBM a fee commensurate with time and effort for assisting patients to qualify for Medicaid, the hospital paid HBM a commission of 30.1 percent of the patient's *total bill* for a 12-month period. This resulted in an exorbitant payment, totally disproportionate to the services

rendered. Moreover, there is the possibility that a patient's family or friends would have eventually helped that patient to qualify for Medicaid.

Fourth, allowing HBM to treat patient qualification services in the same manner as collection services made it possible for HBM to collect and retain cash from patients up front without any controls on the part of the hospital.

These problems are discussed more fully below.

Unofficial agreement with unbonded collection agency. Hilo Hospital entered into an unofficial agreement with HBM. There was no official contract and customary state contracting procedures were not followed. In other words, competitive bids were not solicited from others who might be interested in performing the same services, and the agreement commenced without having been approved as to form by the Department of the Attorney General and without having the necessary approvals from the division, the Director of Health, the Department of Accounting and General Services (DAGS), or the Governor—although months later, those approvals necessary to process HBM's bill for payment from the State treasury were retroactively obtained.

The scope of work under the agreement encompassed that of a collection agency. State statutes in effect at the time defined a collection agency as any person who "offers to undertake or holds oneself out as being able to undertake or does undertake to collect for another person, claims or money due on accounts or other forms of indebtedness for a commission, fixed fee, or a portion of the sums so collected." Further, "person" was defined to include "an individual, partnership, joint venture, corporation, association, business, trust, or any organized group of persons, or any combination thereof."¹

The statutes prohibited any agency from acting or assuming to act as a collection agency unless it had filed evidence of a bond with the Department of Commerce and Consumer Affairs (DCCA). The required bond was \$25,000 for the first office and \$15,000 for each subsequent office.

Thus Hilo Hospital entered into a collection agreement with an agency that was not legally authorized to do business as a collection agency. It remained unbonded for eight of the ten months of the pilot project while it was working as a collector taking in cash receipts and billing Hilo Hospital for collection service fees.

No guidelines to protect patients. Hilo Hospital entered into the agreement without considering its possible impact on patient rights. Neither the division nor Hilo Hospital assumed responsibility for assuring the protection of patients. Upon execution of the agreement, Hilo Hospital immediately provided HBM with several hundred square feet of office space in the hospital facility, telephone lines, and furnishings. On its part, HBM proceeded to obtain patient accounts.

Hospital staff were given no written instructions on the relationship of the contractor to the hospital and how they were to protect the patients' rights and the hospital's interests. Since it was authorized to have access to patients at the time of admission to help them qualify for Medicaid, it has been reported that HBM interpreted the agreement to mean that it—not the hospital—had the right to determine which patients would be turned over to the firm and, initially, picked and chose the most promising accounts.

It is also reported that HBM had free access to patient records, free access to relatives of patients who might need help in qualifying for government programs, and free access to physicians who might also refer their uninsured patients to HBM.

No guidelines for compensation of HBM. The terms in the letter of agreement on how HBM was to be compensated were confusing. They provided that HBM be paid a total fee of 45 percent for helping patients through the Medicaid certification process. However, HBM was to pay the hospital 10 percent for the billing that the hospital performed, resulting in a net fee of 35 percent of the patient's total bill.

It was not clear how this was to be calculated—i.e., 10 percent of what? In any case, the letter of the terms of agreement was not implemented, and in practice, HBM discounted to 30.1 percent its fee for Medicaid services; all other collections were multiplied by 35 percent to arrive at HBM's fee. There was no written explanation for the use of the 30.1 percent.

More importantly, the use of the term "collections" for Medicaid qualification services was inappropriate and confusing. The definition of "collections" was not clarified and hospital personnel had no instructions on how it was to be interpreted. Compensating these services on the basis of a commission rate resulted in a disproportionately large fee for the relatively few hours needed to assist a patient in qualifying for Medicaid. However, HBM claimed it was entitled to even more. HBM defined collections as the value of the hospital's *charges*—i.e. the amount of the bill—and claimed it was entitled to 30.1 percent of the total patient charges. However, Medicaid's reimbursement rates are approximately one-third less than charges. Hospital personnel maintained that HBM fees should be based on a percentage of the lower, actual reimbursement levels.

For example, for the last three months of the pilot project, charges for HBM Medicaid patient accounts totaled \$89,384.43. HBM was paid \$26,904.73 at the fee rate of 30.1 percent. However, if the HBM rate of 30.1 percent had been applied to

actual reimbursements received, the estimated payment would have been approximately \$17,757.

Failure to control cash retentions. The method by which HBM was paid was not controlled. Since HBM was allowed to operate as a collection agency before accounts were determined to be delinquent, in the beginning, HBM took its fees up front in the form of the cash which it collected from patients. This was possible because in some instances, Medicaid patients must pay a costshare portion—the amount determined by DHS to be within the patient's capacity to pay. HBM retained this costshare portion and credited it against the running balance of its commissions. HBM also obtained cash in the form of cash payments for copayments or deductibles from patients insured under other programs. HBM also kept out-of-pocket payments from uninsured patients.

Sections 40-31, 40-32, and 40-33, HRS, require that all persons receiving revenues on account of the State place those revenues into the state treasury within a week if in Honolulu and within a month if out of Honolulu. By not insisting that HBM make these deposits, Hilo Hospital may have been, on the face of it, promoting violation of the statutes.

However, part way into the pilot project agreement, Hilo Hospital required HBM to turn over all cash retentions because of the large sum involved. But no statements were sent to patients by the hospital to confirm account balances. No audit was ever conducted, and the hospital does not know how much cash HBM actually collected from patients or if the hospital received all monies to which it was entitled.

Finally, it was not clear how Hilo Hospital planned to pay any commissions over and above the cash that HBM retained. The agreement stated that the hospital

would pay HBM the balance of its collection fee when it was reimbursed by Medicaid or other insurers. This is because Medicaid and other third party insurers will only make payments to providers. However, there was no official contract filed with DAGS to process payment for HBM's bill.

Other questionable practices. The lack of DOH controls and oversight over the project allowed such questionable practices as the following.

A patient whose account was assigned to HBM was found by HBM to have assets beyond the Medicaid threshold. It was reported that HBM collected the cash or the assets to reduce the patient's assets to a level where the patient would qualify for Medicaid benefits. This might constitute deception of Medicaid if it were not reported to Medicaid. It is not known whether HBM reported this collection to Medicaid, and if reported, how it was reported, i.e., as a cost-share, as payment of medical expenses, or as a collection fee. In any event, the cash was retained by HBM and applied to its commission.

In another case, HBM accepted the deed to a piece of land from an individual who had power of attorney from a patient who owed \$69,874. HBM reported that net proceeds from the sale of the land would be applied to the patient's bill. Five months later, HBM reported a payment of \$7697.11 for this patient which it later corrected to \$7692.04. The latter amount was paid to the hospital by an HBM check. On January 6, 1988, HBM informed the hospital that the patient had died with no assets and that it was returning the account to the hospital. A balance of over \$62,000 remains due.

According to individuals in both the collection agency business and hospital credit departments, accepting title to land is not a customary practice in either

field. It is fraught with all kinds of uncertainties and legal dangers for the accepting party.

Failure to evaluate pilot project before expansion. The purpose of a pilot project is to test a concept on a limited scale before applying it to a larger context or before it becomes a permanent program. If it is a failure, the damage will have been limited. If it is a success, then program planners can proceed to design its implementation on the larger or the permanent scale. However, the division ignored such evaluation as was made of the HBM pilot project and proceeded to expand the program statewide.

In the spring of 1987, the county/state hospital division held discussions on expanding HBM's services to all hospitals following approximately the same terms as the pilot project. At that point, the division office staff raised questions about the propriety of using an outside agency to provide eligibility assistance for governmental benefits, contracting with an unregistered and unbonded collection agency, and exempting the project from statutory bidding requirements. The staff also pointed out the vagueness of the October 1986 agreement and the compensation terms.

The staff questioned how HBM could legally be paid the balance of its fees under the State's vendor payment process without an official contract filed with DAGS. By May 30, 1987, HBM's claimed fees totaled \$144,223.98. It had retained \$89,802.63 in cash payments from patients, but it claimed an unpaid commission of \$54,421.35. The division office staff recommended that an audit be conducted of all HBM transactions and the deputy director was urged to terminate the HBM agreement immediately.

Despite the many unresolved questions, the pilot project was expanded, and HBM's claim for \$54,421.35 was paid by DAGS in August 1987 after the governor's approval. By August 31, 1987, HBM claimed to have collected \$594,015.27 and claimed fees of \$195,848.63. Except for excise taxes, this sum was paid to HBM.

On August 20, 1987, the Director of Health and the president of HBM signed a contract which expanded the services that HBM had been providing to Hilo Hospital to all the hospitals of the county/state hospital system. The new contract replaced the pilot project after it had been in operation for 10 months. With the new contract, departmental and other officers further acted contrary to public trust and public interest.

Improper Contract Terms and Conditions

Contracts between state government and private parties are governed by statutes intended to protect the interests of both parties and also to ensure that public funds are expended in a fair manner. The public has a right to expect that public officials will protect the public interest and uphold the public trust. But such was not the case with the second agreement with HBM; public interest and public trust were violated even further.

We find that the terms and conditions of the State's August 1987 contract with HBM are improper. There are several issues of concern. The contract was again awarded without any competitive bidding to an unregistered collection agency. In addition, the contract contains a *secrecy* clause which is both illegal and unenforceable, and the terms are overgenerous to HBM.

Sole source procurement is questionable. Section 103-22, HRS, requires that any expenditure of public funds greater than \$8000 must be let to public bid except

when the services or products do not admit of competition—i.e., the product or service cannot be obtained from any other person. Ordinarily, the State's interpretations of the requirements for exemption are quite narrow. For example, even patented products must be put out to bid.

On August 25, 1987, five days *after* the signing of the nonbid HBM contract, the Director of Health sent the State Comptroller a request for exemption from bidding and justification for sole source procurement. The justification claimed that HBM had a unique expertise and that the immediate performance of the contract was crucial to the financial health of the state hospitals. The director estimated that the proposed project could result in the collection of \$20 million and the department was relying on this to offset the \$4 million cut that had been made in the hospital budgets. The Comptroller did not approve the exemption from bidding until October 1, 1987, six weeks after the contract had already been signed.

The validity of the department's justification can be questioned. HBM was not incorporated until October 1, 1986—less than three weeks before the pilot project agreement was signed with Hilo Hospital. The justification claimed "extensive experience in hospital consulting" on the part of the president but there was no supporting documentation, and HBM as a firm had no track record in qualifying patients for Medicaid or in collecting delinquent accounts except what it had gained during the pilot project.

The qualification functions performed by HBM were not unique. They were already being performed in private hospitals. According to DHS, much of the work could also be performed by clerical staff. As for the collection functions, they are like those performed by ordinary collection agencies.

The alleged urgency to protect hospital finances was not valid. None of the county/state hospitals were cash short; as we shall see in the next chapter, the hospitals had excess revenues. The justification incorrectly claimed that the department was "relying heavily on the success of this project to offset the \$4,000,000 budget cut" when the system already had \$4 million in carryover funds from previous years. The estimated collectible sum of \$20 million was grossly inflated; it included charity care and write offs that should have been taken care of years before and which included amounts with little hope of recovery.

Contract with unregistered collection agency. The 1987 Legislature enacted Act 191 which repealed the former statute governing collection agencies. The major change was to require DCCA to acknowledge collection agencies' bonds and to register anyone doing collection work. Collection agencies must submit evidence of a bond of \$25,000 for its first office and \$15,000 for each additional office. No one may operate as a collection agency until evidence of bonding has been filed with DCCA and DCCA has registered it as a collection agency.

In June 1987, HBM submitted an application for registration as a collection agency. On July 15, 1987, DCCA informed HBM that it was required to submit its bond information on a new form. On September 4, 1987, HBM presented to DCCA its bonds for three branch offices: Maui Memorial, Kauai Veterans, and Leahi Hospitals. It has not yet opened an office at Leahi but one was opened at Kona Hospital in September (Kona was not bonded as of December 31, 1987). On September 4, DCCA sent HBM a deficiency notice that the \$25,000 bond needed to be on the new form and returned a copy of that bond. DCCA sent a second deficiency notice on October 15, and a third notice on December 10 for the main office bond. As of December 31, 1987, it had received no response from HBM.

Thus, HBM is not officially registered as a collection agency with DCCA. Although the requirement to register on the new forms may be a technicality, the fact remains that HBM has not yet complied with the new law. So at the time the contract was executed on August 20, 1987, the Director of Health contracted with an unregistered firm.

Illegal and unenforceable secrecy clause. The contract between HBM and the Director of Health imposes a secrecy requirement on both parties which is contrary to statute and unenforceable by either party. The clause is unprecedented. It is the first we have encountered in over 20 years of reviewing state and local government contracts. The clause reads as follows:

"1. Entire AGREEMENT Confidential

Each party acknowledges that this entire AGREEMENT and all material and information which has or will come into the possession or knowledge of each in connection with this AGREEMENT or the performance hereof, consists of confidential and proprietary data and information, disclosure of which to or use by third parties will be damaging. Both parties, therefore, agree to hold such material and information in strictest confidence to the extent permitted by law, and to make no use thereof other than for the performance of this AGREEMENT. The parties hereto shall release it only to the Director or Deputy Director of the DEPARTMENT (sic) employees of the Department of Accounting and General Services requiring such information, and not release or disclose it to any third party without the prior written approval of the other party hereto. Each party hereto shall be entitled to enforce this paragraph by suit for injunctive relief in a court of competent jurisdiction. Each party hereto shall also be entitled to a claim for damages resulting from the breach of this provision including attorney's fees and costs unless the release of such material and/or information is in compliance with a specific court order.

2. Guidelines Only

CONTRACTOR shall not be required to reveal any of the terms of this AGREEMENT to any Hospital Administrator except to provide sufficient guidelines approved by the Director or Deputy Director to fully inform the Hospital Administrators of their rights and responsibilities with regards to the HBM collection process."²

Both statutory authority and case law in other jurisdictions come down against this secrecy clause. Hawaii's Public Agency Meetings and Records Law, the "sunshine law," provides that "any written or printed report, book or paper" is a public record which is subject to disclosure. In interpreting similar disclosure laws, courts across the nation have held that state contracts, and even settlement agreements with the state containing confidentiality provisions, are subject to disclosure.

The only records not subject to disclosure under Section 92-50, HRS, are those which "invade the right of privacy of an individual." But HBM is not an individual. Nor has it asserted a right of privacy in the agreement. Assuming that HBM might assert that the agreement contains "trade secrets" which fall within the scope of its right to privacy, such data would still be subject to disclosure since the statutes make no exception for trade secrets and most courts are inclined to release such information as public record. In any event, this is not a justification since the contract did not disclose HBM's methodology.

Nonetheless, the contract with its secrecy clause was approved as to form by the Department of the Attorney General (AG). We find it surprising that the AG would approve a contract which contained such an unusual provision as secrecy—secrecy even from those hospital personnel whose assistance would be required to implement the contract.

The DOH and the AG appear to have gone along with the contractor's position that secrecy was not an extraordinary feature of the contract. In defending the secrecy clause before the hospital administrators in December 1987, the deputy director indicated that "other vendors may have a confidentiality clause written into their contract, as long as it is approved by the Attorney General." Also, the minutes

of that meeting record HBM's attorney as maintaining that the confidentiality clause is a "'matter of policy' with the Department, vis-a-vis the method of collection and the way the contract is written."³

Overgenerous guarantees and compensation. The compensation terms in the current contract differ somewhat from the terms in the pilot agreement. The current contract provides a windfall for HBM. No longer is HBM's compensation contingent upon its success at qualifying patients for governmental benefits or at collecting debts. Rather, the contract provides for either (a) a net collection fee or (b) a guaranteed *monthly* minimum fee of \$105,000, *whichever is greater*.

The net collection fee, term (a) above, is similar to the previous terms: 35 percent plus 4 percent excise tax on any "completed account," which is defined again as a patient's medical *bill*, not *actual reimbursement*. Accounts referred to an attorney will earn a 50 percent fee.

The second compensation term, the guaranteed monthly minimum fee, is unique to HBM. It is not a customary practice with collection agencies in Hawaii. Nor could DOH officials offer an adequate explanation for the provision of a guaranteed monthly minimum. The contract appears to indicate that Hilo Hospital will pay \$45,000 per month; Maui Memorial, \$30,000; Kona Hospital, \$15,000; and Kauai Veterans, \$15,000, for the total of \$105,000, and that these sums will also cover the smaller hospitals listed in the contract.

There are two provisos to this guaranteed monthly minimum fee: (a) "where the amounts actually collected by HBM multiplied by 35% fails to meet or exceed the gross monthly minimum fee for three (3) consecutive months on a statewide basis, then said gross monthly minimum fee shall be adjusted to reflect the average of the actual amounts collected multiplied by 35% over said three (3) month period;"

and (b) "said above stated gross monthly minimum fee may be adjusted every two years where both parties agree" ⁴ These provisos are confusing and it is not clear if they will bring the guarantees in line with actual collections.

If HBM is indeed paid the guaranteed gross monthly minimum, in a year's time the hospitals must pay at least \$1.26 million regardless of what HBM "collects" on their behalf. The guaranteed monthly minimum fee of \$105,000 is payable from the date of the agreement. Although the agreement was signed in late August 1987, it sets the starting date of the contract at June 1, 1987.

As overgenerous as these terms might be, they are reductions from the original draft which the contractor first presented to DOH. HBM originally provided itself a guaranteed monthly minimum of \$120,000 and an eight-year contract. A DOH official objected, warning that the State faced a possibility of paying HBM a total of *\$11.5 million*. The monthly minimum was reduced by \$15,000 to \$105,000, but even the lower amount remains unexplained. As executed, the contract is binding for two years and will be automatically renewed "for two (2) year terms" unless there is written notice of intention not to renew the contract six months prior to the end of each two-year period.

The DOH continued to misuse the collection fee concept by applying it to Medicaid qualification services. The contract requires HBM's net collection fee to be applied to the patient's bill for the entire hospital stay or first day of treatment and any subsequent hospitalizations or treatments within a 12-month period. This means that patients who are placed in long-term care in any of the county/state facilities will yield a fee disproportionate to any services performed. For example, an average monthly bill for a long-term care patient is approximately \$3000 and the average length of stay in nursing homes is 18 months. Over 12 months' time, the

reimbursement from Medicaid might total \$24,000 since Medicaid reimbursements are about one-third less than the charges. Even if HBM were paid 30.1 or 35 percent of the reimbursement instead of the charges, it would receive a fee of between \$7,200 and \$8,400 for having spent four to eight hours in qualifying that patient.

State assumes overhead costs for HBM. The compensation provisions described are even more profligate when one considers the few startup costs that HBM incurred, the few risks it assumed, and the generous overhead that the State is providing.

HBM has had no business office apart from the current president's residence. The current contract requires that *each hospital, not the contractor*, "provide telephones, conference rooms and computer terminals and printers. Provide a well-lit window, private office space in each State hospital large enough to comfortably accommodate the staff needed with furniture, phones, and one interisland 'Watts'(sic) line where available in each office. Furniture such as desks, chairs and file cabinets will be provided from the existing inventory at each hospital."⁵

**Contract Not Administered
in a Responsible Manner**

The conditions of the contract have made it impossible to administer in a responsible manner. Hospital administrators do not have copies of the contract and have received no written guidelines on how to implement the project. The lack of clarity about the guaranteed monthly minimum and HBM's fees has led to differing practices among the hospitals. It has been up to the hospitals to press the deputy

director and the division office for interpretations of the contract, especially in response to HBM's claims of what the contract contains.

Hospital administrators denied copies of the contract. HBM invoked the secrecy clause in the contract and the division office acquiesced in denying hospital administrators copies of the contract. Instead, HBM distributed excerpts of the contract—those portions which laid out the hospital's obligations to refer accounts, provide facilities and furnishings, and provide access to hospital records.

When the hospital administrators protested, the division office sponsored meetings in September, October and December 1987 to discuss the matter. But the administrators were not shown the contract until December. Moreover, they were not allowed to keep any of the copies which were retrieved after the discussion.

The deputy director acquiesced to HBM's rationale—that the hospital administrators had no need to know the details, they already had the excerpts they needed, and the secrecy clause was not an indication of distrust. HBM's attorney defended the secrecy clause as departmental policy which HBM requested and which DOH granted. In fact, the minutes of that meeting reported that the attorney recommended the confidentiality clause for all contracts to avoid "'fishing expeditions' by other businesses."⁶ The deputy director acquiesced to HBM's offer to develop a "checklist" of the contract's contents rather than release copies of the contract.

No written guidelines to hospitals. The division office failed to provide written instructions on guidelines for implementation. The division office now acknowledges the need for written guidelines but offers no explanation for why none were developed.

One hospital staff member attempted to get a better understanding of specifics of the project by putting together a draft of the staff member's understanding of a meeting with HBM, the deputy director, and hospital staffs. The draft contained the guidelines under which they were to operate and the terms they had all agreed to at the meeting. The staff member's draft memo of understanding was sent to HBM for concurrence, but after three months, there was still no response.

Conflicting interpretations of "guaranteed monthly minimum fee" and "collections." HBM began its business under the new contract at Hilo Hospital, Honokaa Hospital, and Kona Hospital in September; at Maui Memorial and Kohala in October; and at Kauai Veterans and Ka'u Hospitals in November 1987.

HBM has been presenting invoices for the guaranteed monthly minimum to the four acute care hospitals. The business managers were instructed to process the payment immediately even though state statutes permit state agencies up to 45 days after services and products have been delivered to make their payments. The following sums have been paid or processed by the following hospitals as of the end of December 1987:

Hilo Hospital: \$180,000

Kona Hospital: \$60,000

Maui Memorial Hospital: \$90,000

Kauai Veterans Memorial Hospital: \$30,000

Some of the acute care hospital administrators thought that the guaranteed minimum monthly fees would cover HBM services at their hospitals only, while the smaller hospitals thought that the guaranteed minimum would encompass them as well. The latter group soon discovered they were in error. They have been billed by

HBM at 30.1 or 35 percent of the accounts that they referred. Although the records are sketchy, the smaller hospitals have paid HBM more than \$8100 through November 1987. Thus between September 1 and December 31, 1987, a period of four months, HBM was paid \$368,125.29.

All of the hospitals are under the impression that at some point soon there will be a reconciliation—that the guaranteed monthly minimum will stop and the 35 percent will be applied to actual reimbursements received. This is because the HBM contract is a losing proposition for the hospitals. The revenues attributed to HBM, however liberally the term "revenues" might be used, are *far below what it has been paid*. HBM would have had to have generated \$1.05 million to have earned \$368,125 in four months. As of November 30, 1987, with three of the four months gone, HBM reported charges of about one-fourth that amount.

Moreover, HBM's reports of revenues generated are open to question. Maui Memorial has been maintaining its own records of HBM activity. For October 1987, HBM claimed to have generated \$16,295, but the hospital maintains it referred \$150,914 in billings and received actual receipts of \$7962. For November 1987, HBM claimed to have generated \$12,026. The hospital, however, reports that it referred charges of \$63,612 and has collected one cash payment of \$225.00.

The question of the definition of "collection" was raised throughout the pilot project and continues to be raised under the current contract. Hilo Hospital is currently, on its own, reconciling every patient account on HBM's activity reports with its own records of referrals. It is trying to identify the differences between the hospital's charges and the actual reimbursements it received. It expects the reimbursement for Medicaid overall to be about two-thirds of the billing.

In view of these problems, hospital personnel have begun to resist referring accounts to HBM. Many object to the contract and believe that reconciliation of accounts should be done soon.

Nevertheless, at the end of December, hospital staff were instructed—again, orally—that they must continue to pay the guaranteed monthly minimum until the deputy director and the HBM president can agree on the hospitals' *obligations* to turn over more accounts to HBM.

Potential Violation of Patient Rights

Disclosure of confidential patient information. When patient accounts are referred to HBM, the portion of the admitting form which reveals the admitting diagnosis is given to HBM. The State Constitution specifically grants to individuals the right of privacy and state statutes provide a number of rights to patient privacy.

There exists the physician–patient privilege for all communications made for the purpose of diagnosis or treatment. That privilege cannot be breached even by the physician, who can claim the privilege only on behalf of the patient. Without the patient's *knowing* waiver of the privilege, such confidential communications can be disclosed only to those present to further the interest of the patient or to those persons reasonably necessary for transmission of the communication.

No such waiver is requested or obtained before HBM receives the diagnostic information. In contrast, when delinquent accounts are turned over to ordinary collection agencies, the diagnostic information is not revealed.

The Fair Information Practice Law, Chapter 92E, HRS, also prohibits the disclosure of personal records by any agency of the State. Also, Section 84–12, HRS, prohibits state employees from disclosing such information on pain of fines. It

has been left up to each hospital to determine how much information to allow HBM to have. HBM has reportedly demanded access to the hospital's census—the listing of all admissions for each day. The hospital staffs, on their own, have been resisting.

Questionable access to patients. HBM has varying degrees of access to patients and patient charts in the treatment areas. Because of reported abuses of patients' rights at Hilo Hospital during the pilot test phase, one hospital keeps all charts at the nurses' stations and requires HBM personnel to show the signed authorization forms before they will allow HBM to leave forms for patients' or for physicians' signatures. At that hospital, HBM must show the authorization to have access to patients.

But other hospitals admit that HBM has free access not only to the patients, but also to the patient's charts, any other patients' charts, any doctors, relatives, etc. The HBM personnel can roam some hospitals at will, and do. It has been found that HBM has submitted claims for fees for patients that had not been officially referred by the hospital but for those it had solicited on its own.

HBM's standing and role are unclear. None of the county/state hospitals have any systematic procedures in place to ensure that patients understand the role and legal standing of HBM. As one hospital staff member put it, since they don't know themselves what HBM is to the hospital, they cannot prepare informational material for the patients. Thus it is not clear whether HBM is an agent of the hospital and the State, an agent of the patient when it represents the patient before DHS and when it signs documents on the patient's behalf, or an agent of Medicaid.

It would be natural for patients to misunderstand HBM's role as a collector. HBM has not been instructed on how it should represent itself in approaching patients. HBM employees wear hospital-issued identification tags even though

"HBM" is also included. They may enter patient rooms with varying degrees of freedom, they are seen in the corridors like other hospital staff, and they have offices on hospital grounds. Patients whose accounts have been referred to HBM are reported to have called hospital business offices to inquire about their bills, an indication, at least in those cases, that the patients perceived HBM as being part of the hospital.

HBM Given Preferential Treatment

At a number of points during both the pilot agreement and the current contract, HBM appears to have received preferential treatment. Some have already been mentioned: the exemption from bidding, the overgenerous compensation, and the furnishing of office space and other office requirements.

The sequence of approvals for the current contract also reflects preferential treatment. The contract was signed prior to the Governor's granting his approval to enter into a contract. On August 20, 1987, the same day that the contract was signed, the Director of Health submitted a request to the Governor to approve the contractual agreement between HBM and the county/state hospital division. The Governor did not approve this request until October 19, 1987—two months after the contract was signed and well after implementation of the contract was already under way. The nonbid contract was signed six weeks before the Comptroller approved the exemption from bidding.

Both DOH and the rest of the executive branch move with uncharacteristic speed where payment of HBM is concerned. The vendor payment process ordinarily can take several weeks. However, with HBM, the process starts when HBM presents its invoices to hospital administrators within the first day or two of the month for

that month's guaranteed monthly minimum. The division office recently instructed hospital business managers to "red tag" HBM's invoices, which means that DAGS should give it priority treatment for payment. Hospital staff have observed that the turnaround time for HBM to receive payment is unprecedented.

In October 1987, the department asked the Department of Budget and Finance to increase its budget allotment by \$1.26 million, specifically to accommodate the costs of the HBM contract. Between August and November 1987, a number of requests for ceiling increases had been submitted. The requests ranged from \$5000 for a sprinkler system to \$4 million for various purposes. The increase of \$1.26 million for HBM was the third largest sum. It took only four days to approve the ceiling increase for HBM. The other requests took approximately one month.

Confidence in DOH Management and Fairness Undermined

The DOH's handling of the HBM contract over the past 15 months has raised questions among its own employees and in the private sector. Confidence among hospital division employees in their managers and leaders has been undermined and the evasiveness of DOH management has generated a protest by a firm in the business community.

Employee resistance and dismay. DOH employees in the hospitals, in the division office, and in other divisions of DOH have objected to the HBM contracts.

Despite HBM's attempts to maintain secrecy, knowledge of HBM's favorable contract and preferential treatment is widespread among the hospital staffs. The problems of administering the pilot project at Hilo Hospital were communicated to other hospitals and several hospitals attempted to avoid a repetition of those

problems in tailoring their own implementation when they discovered that they, too, would be receiving HBM's services.

Some hospitals attempted to minimize the damage by limiting the number and kinds of accounts to be turned over to HBM and attempting to control the referrals despite what the contract excerpts said. Some adamantly refused the free access to patients and information that HBM demanded. One hospital staved off HBM's demands that it be given prime space that was already occupied by an existing hospital department.

The overall tone is one of dismay that DOH leadership has awarded what departmental personnel consider a one-sided contract. Division employees at varying levels have sought to protect their respective units' interests and their personal integrity. They have refused to follow instructions they believe to be morally unacceptable and they have made their objections known.

Private sector objections. The HBM contract has also raised the ire of at least one private firm, primarily because of the evasiveness with which it has been treated by DOH officials.

Having heard that a large collection contract might be available at Hilo Hospital, a collection agency submitted its own proposal in June 1986. It received no response for more than a year. Subsequently, the collection agency heard general descriptions of HBM's contract and, in September 1987, the collection agency formally asked the Director of Health to confirm the legality of the use of public facilities by HBM to pursue private business interests. The agency also inquired whether the contract had ever been put out to bid. Again, the agency received no response.

After the private agency learned of the statewide expansion of HBM's services it wrote the Director of Health again in October 1987, this time with pointed questions on the nonbid nature of the HBM contract. The agency finally received a response from the director which failed to address the issues raised but indicated that all further communication was to be referred to the deputy director.

Still unsatisfied with the October response from the director on the HBM matter, the agency sent the deputy director another letter in early December 1987, reiterating the unanswered points. As of late December, it had not received a reply.

Conclusion

The State's contract with HBM illustrates almost everything that could possibly be wrong with a government project and contract. The *public interest* is not being served through the financial windfall which the State has been providing to the contractor. Just as seriously, the *public trust* is ill-served in the the department's agreement and efforts to keep the contract secret. Many other aspects can be subject to criticism, as detailed in this chapter, but the two foregoing circumstances alone have been enough to seriously undermine confidence in the leadership of the department in the views of the department's own employees.

Meanwhile, the financial health of the hospitals is being weakened rather than promoted through the HBM project. Quick intervention is required to protect hospital financial resources.

This entire matter should be viewed as a matter of great concern, not only as it has applied to hospitals, but because of recent information that HBM has presented a proposal to DOH to provide similar qualification and collection services for the State's mental health centers. We had pointed out to the department in 1984

that it lacked adequate procedures for the collection of fees at its various centers throughout the State.⁷ Apparently, the problem continues unattended or unresolved at the mental health centers, but it would be most unwise for the department to compound its problems by using the same approach as for hospitals.

We hope that the officials of the department and other officials of the executive branch will view the situation with seriousness and urgency and take all actions necessary to protect the public interest and restore the public trust.

Recommendations

We recommend the following:

1. *The Department of Health take action to cancel the August 20, 1987, contract between the Director of Health and Hospital Business Management, Inc.*

2. *The hospitals be instructed—in writing and with specific guidelines—to audit all transactions with and by HBM, including all transactions at Hilo Hospital during the term of the pilot project. All reconciliations should be made in terms of the patients actually referred by each hospital and actual revenues received by the hospital.*

3. *The Department of Human Services be advised to review all Medicaid qualifications handled by HBM to determine whether any violations of Medicaid statutes or rules have occurred.*

4. *The Department of Health institute its own qualification assistance capability at the various hospitals with the Department of Human Services cooperating and assisting fully in this endeavor.*

Chapter 9

FINANCIAL MANAGEMENT OF THE COUNTY/STATE HOSPITAL SYSTEM

The county/state hospital system has been financed in essentially the same way ever since the hospitals were transferred to the State. Those hospitals which cannot cover operating costs through patient and third-party payments are assisted by state general revenues. In this chapter we examine the financial management of the county/state hospital system.

Summary of Findings

We find that:

1. The county/state hospital system lacks an adequate financial management program and an accurate assessment of the system's financial viability cannot be made. The poor financial management is evidenced by practices such as:

- . Accumulation and expenditure of revenues in excess of budgeted amounts;
- . Use by division administration of an unauthorized special fund;
- . Misuse of the general fund subsidy; and
- . Nonpayment of statutorily mandated assessments to the state treasury.

2. As with its management of programs and services, the county/state hospital division has not brought a system perspective to the management of its finances. The division administration provides scant leadership, and hospitals are given much autonomy. Consequently, there is no assurance that revenues are maximized or that expenditures are made wisely.

Evolution of Hospital Finance

Hospitals have historically been nonprofit enterprises operated with funds derived from patients and charitable donations. As hospital services became more diverse and expensive, medical insurance and government programs made payments on behalf of patients.

However, as the cost of health care escalated, the sources of reimbursement shrank. Although Medicare and Medicaid continue to be in place, government agencies and other third-party payers have increasingly moved to capitation payments. Since capitation rates are set by outside agencies on the basis of reasonable costs, hospitals have had to pay much closer attention to the management of their finances. The actual cost for a given service is now crucial to the hospital's operating within anticipated receipts.

The development of cost-reimbursement and other cost containment strategies have especially affected rural hospitals by requiring them to spread fixed costs over reduced revenues. Because most rural hospitals are also small facilities, they cannot as readily expand services to generate additional revenues as can larger urban hospitals.

Rural hospitals have developed two strategies to cope with revenue shortages. First, they may diversify services through swing beds (e.g., flexible acute care, skilled nursing, and intermediate care beds), thus meeting the patient case mix necessary to sustain operations. Second, rural hospitals have become part of multihospital systems which spread the fixed costs of administration and technological advances among the units of the system.¹

Financing the County/State Hospital System

Section 27-23, Hawaii Revised Statutes, authorizes the establishment of a separate special fund for each hospital. This special fund is used as the sole operating fund for the receipt and disbursement of revenues at each hospital. According to the committee reports prepared in support of these special funds, they were established on the recommendation of the Director of Health in 1971 who claimed that the special funds would allow for a "continuing relationship between receipts and expenditures for hospital rate setting." Further, the special fund was considered a mechanism which would "recognize the full cost of rendering services, reflect actual cost of services, and permit more flexibility in fiscal administration to meet emergencies of hospitals".²

The proportion of general funds to special funds in the financing of the county/state hospital system has changed in the past 20 years. Whereas general funds represented 66 percent of the budget in the second year after the county/state hospitals were transferred to the State, in the current fiscal year, general funds will constitute 14 percent of the system's appropriated budget, or \$11 million.

As discussed in Chapter 3, the government funded programs of Medicare and Medicaid comprise 30 and 35 percent, respectively, of the special funds. Private parties, mostly third party insurance companies, make up the remaining 35 percent of the special funds. The proportions among the three sources differ from hospital to hospital.

As a program of state government, the budget for the county/state hospital system is part of the executive budget. The executive budget and the Multiyear Program and Financial Plan (PFP) submitted by the Governor include separate program budgets for each of the 12 hospitals (Hana Medical Center is budgeted with

Maui Memorial). The budget and the PFP also include a program, HTH 907—General Administration, which includes special funds for the operation of the county/state hospital division administration.

Those hospitals which require general fund support identify that funding request as a separate budget item from their anticipated special fund revenues. At the time the current budget was developed, only Maui Memorial was expected to be totally special funded. Thus, 11 of the 12 hospitals were authorized both general and special funds in Act 216, the General Appropriations Act of 1987. The hospitals are also authorized capital improvement projects like other state agencies in both the General Appropriations Act and the General Improvements Act, again on a hospital-specific basis, and to be financed by general obligation bonds and general revenues. Additional capital improvement projects have been paid for by special funds at the system's initiative.

The overall 14 percent level of general fund support is not a sufficient indicator of the soundness of financial management, however. Our assessment leads us to believe that general fund support could be reduced even further if the county/state hospital system were to apply the improvements we suggest in this report. In fact, there is reason to question whether the general fund subsidy is actually still necessary. It may be in effect serving as a disincentive to maximize special fund revenues.

In the remainder of this chapter, we discuss the various practices which obscure accurate conclusions about the system's financial viability. We also discuss the lack of systematic financial management.

Obscure Financial Status

There is no clear picture of the financial status of the county/state hospitals. The division operates consistently with excess revenues, uses an unauthorized special fund to hold and transfer revenues among the hospitals and the division administration, draws on and combines general fund appropriations with hospital special funds, and has not paid statutorily mandated assessments.

In a multihospital system, consistent policies and procedures should be applicable to the preparation of the individual facility budgets and to the meshing of the entire system's budget request for review at higher administrative and governing levels. Once approved, the budget then becomes the basis for revenue and expenditure management. The purpose of budgeting is to allocate resources. Although based on estimates developed months before it is presented to the Legislature for approval, the hospitals' budgets should be expected to reflect as accurate a plan to allocate resources as possible.

Hospitals generating excess revenues. However, for at least three prior fiscal years, the hospitals' budgets have underestimated revenues significantly. Table 9.1 compares estimates with actual receipts.

Table 9.1

County/State Hospitals
Comparison of Actual with Estimated Revenues

Fiscal Year	Actual Rev. \$(millions)	Estimated Rev. \$(millions)
1986-87	\$82.8	\$67.8
1985-86	78.2	74.3
1984-85	71.4	67.5

Sources: FAMIS 430-A, and Variance Reports for FY 1985-86 and FY 1984-85.

Most of the excess revenues are spent, which means that hospitals' expenditures exceed the levels authorized by the Legislature. The extent of this spending is seen in Table 9.2.

Table 9.2

County/State Hospitals
Comparison of Expenditures with Appropriations

Fiscal Year	Expenditures \$(millions)	Appropriations \$(millions)
1986-87	\$81.7	\$79.4
1985-86	76.9	79.3
1984-85	76.2	71.5

Sources: FAMIS 430-A, and Variance Reports for FY 1985-86 and FY 1984-85.

Additionally, for the past three fiscal years, an excess cash balance has been reported at the end of the fiscal year. The following sums were reported as unencumbered cash balances for the respective fiscal years:

Table 9.3

County/State Hospital System
Unencumbered Cash Balances

Fiscal Year	\$(millions)
1986-87	\$13.2
1985-86	10.9
1984-85	6.2

Sources: FAMIS 430-B, and Annual Financial Report of the State of Hawaii for FY 1985-86 and FY 1984-85.

Several factors have contributed to the accumulation of excess revenues. *First*, the budget acts have had conflicting provisions on the operation of the special

funds. *Second*, the county/state hospital division administration operates an unauthorized special fund in which excess hospital receipts are held. *Third*, the general fund subsidies are deposited in quarterly allotments into the special fund and expended as if they were hospital-generated revenues. *Finally*, several statutory provisions which allow for the transfer of special funds have not been implemented.

Conflicting budget provisos. The Legislature has attached provisos to the hospital appropriations since their transfer to the State. In some years, the provisos required the hospitals to return excess funds and in other years allowed them to retain excess funds. For example, in 1966, there was a provision that "the [general fund] appropriation shall be reduced to the extent that the actual receipts and recoveries less expenditures shall exceed the estimated sums approved for these hospitals."³ In 1967, the language requiring the reduction of the general fund appropriation was dropped.⁴ For the 1981-83 fiscal biennium, however, the proviso on excess funds reappeared, to wit: "Provided, that if special fund receipts exceed the authorization, the general fund appropriation shall be reduced to the extent of the excess, except as provided elsewhere in this Act."⁵

The conflict occurs with the following general proviso:

"Where the operation of a department or program is financed by general appropriation as well as by nongeneral appropriation funds, the general appropriation portion shall be decreased to the extent that the receipts of nongeneral appropriation funds approved in this act are exceeded, provided, that such decrease shall not jeopardize the receipt of such increased nongeneral appropriation funds; provided further that this section shall not apply to any fund if such excess receipts are to be expended for a purpose or purposes approved by the Governor or the director of the Department of Budget and Finance if such authority is so delegated by the Governor."⁶

This proviso has been in every budget act since the transfer of the hospitals to the State. Further, this proviso was changed in 1981 to read: "For the fiscal biennium 1981-83, where a program is authorized under this Act to expend from a

revolving, special, or trust fund, agencies responsible for such funds are authorized to expend so much as may be necessary to carry out the purpose of such fund; provided that such expenditures in excess of the amount indicated are approved by the Governor or Director of Finance if so delegated; and provided further, that such expenditure shall not exceed the amounts available in such funds."⁷

The simultaneous existence of the proviso specific to the hospitals and the general proviso cited above has required the county/state hospitals to operate under conflicting instructions. The original intent was for the general fund appropriation to be a subsidy in the event receipts did not cover operating expenditures. Yet, depending on which provision was enforced, the hospitals have either been allowed to retain and expend excess funds or been required to return them.

The county/state hospital system currently operates under the general proviso above. The division routinely requests ceiling increases—gubernatorial approvals to spend more than their appropriations. Because special funds do not lapse at the end of the fiscal year as do general funds, the excess is carried forward to the next fiscal year—in fact, can be carried indefinitely—and in some years the hospital system has spent more than it received in revenues. This is shown in Table 9.4 below.

Table 9.4

County/State Hospital System
Comparison of Total Revenues with Expenditures

Fiscal Year	Revenues \$(millions)	Expenditures \$(millions)
1986-87	\$82.8	\$81.7
1985-86	78.2	79.3
1984-85	71.4	76.2

Sources: FAMIS 430-A, Variance Reports for FY 1985-86 and FY 1984-85.

Unauthorized special fund. The only special funds allowed the county/state hospitals are those established by Section 27-23, HRS: "Any other law to the contrary notwithstanding, each public hospital and related public health and medical facility transferred to the State pursuant to this chapter shall place its revenues and all other moneys collected or acquired or made available for the use of said hospital into a special fund to be used for the payment of its lawful expenditures."

Note that the language is clear that the special fund is for the use of *hospitals*. However, an additional special fund, not authorized by law, is being used as a means to pay for the costs of the division administration.

The division is funded under the program component "General Administration," HTH 907, which is the DOH administration budget. HTH 907 consists of three sources of funding: general fund, special fund, and federal fund. The special fund is comprised of assessments made against the hospital receipts by the division administration. For 1987-88, the authorization totals \$1.53 million and 20 permanent positions; for 1988-89, the totals are \$1.56 million and 20 positions.

It is necessary to provide funds and positions for the administration of the county/state hospitals division, but there is no statutory authority to finance the division's administration through a special fund. Further, this particular special fund is significant because it is being used to transfer funds between hospitals and as a holding account for hospitals' excess funds. Often, with no explanation, hospitals are instructed to transfer monies out of their accounts to the division's special fund in order to cover cash shortages at other hospitals. Also, excess hospital revenues are transferred to the division special fund and invested by the division administration, because interest income on cash cannot be shown as revenue to the individual hospitals under federal reimbursement rules governing the Medicare and Medicaid programs.

The administration special fund has carried balances for the past several fiscal years as follows:⁸

FY 1986-87:	\$2.9 million
FY 1985-86:	2.3 million
FY 1984-85:	2.4 million

Since the HTH 907 special fund has not been established by the Legislature, the issue should be addressed as soon as possible. If the Legislature chooses to permit hospital revenues to be used solely for hospital operations, it can provide general funds for the administrative costs of the county/state division, just as it provides general funds for the administration of the rest of the department of health. This would be preferable to having what, in effect, is a super special fund the purpose of which has not been specified by the Legislature and which consequently has been used entirely at the discretion of the division administration.

General fund not used as a subsidy. According to legislative policy, the general fund subsidy to hospitals was provided so that hospital care might be available to all residents wherever they might be living. Despite the Legislature's original expressed intent, the general fund subsidy does not function as a true subsidy for meeting revenue shortfalls when receipts do not equal patient costs. Rather, the division treats the general fund as a cash flow cushion and another source of income.

The general fund is drawn down in quarterly allotments and deposited automatically into the special fund of each hospital. No prior determination is made by either the Department of Budget and Finance or the Department of Health as to whether there are sufficient special funds before the general funds are released. There is also no separate accounting for the general fund once it is placed into the

hospital's special fund; it is expended in the same way as operating revenues. Thus, the hospitals are not required to spend operating revenues prior to spending the general fund subsidy.

Additionally, because of the way the subsidy is used, it is difficult to determine whether the hospital system is in fact generating enough operating revenues to meet its expenses during any period. Those hospitals which might otherwise be able to operate only on special fund revenues if they properly managed their finances have little incentive to do so when they have the general fund support as a cushion.

Special funds not appropriate for most hospitals. A large part of the problem of lack of incentives to generate more revenues through more methodical collections and the realization of maximum revenues through third-party payers such as Medicaid is the special fund status of the hospitals.

The conventional wisdom among government program managers is to seek special fund status when possible because: (1) a special fund budget does not receive the scrutiny that a general fund budget receives from the central budget agency and the Legislature; (2) special funds provide greater flexibility because they do not lapse at the end of the fiscal period but can be retained for future expenditures; (3) revenues generated by the program are retained for special fund use and are not assigned to the general fund.

It is for similar reasons but from a different perspective that since the 1960s, the Hawaii State Legislature has been very selective in establishing special funds, the most notable exception being the hospital special funds.

We have long held that a special fund for a government program is probably appropriate if that program is closely akin to that of a private business—that is, if

the full cost of the services rendered by that program is paid for solely by an identifiable clientele rather than by the taxpayers generally, or if the expenditures for the program are limited to the revenues derived from that program. In such a situation, the revenues from the program can be appropriately earmarked into a special fund for the exclusive use of that program.

In the case of the county/state hospitals, they are all akin to private businesses, but most of the hospitals do not generate sufficient revenues to be self-supporting and they require general fund appropriations.

By providing special fund status to these hospitals, they receive all of the benefits of special funds but have no incentive to maximize revenues because of the virtual guarantee of general fund support.

We believe that the way to structure the right incentives into the system is to withdraw special fund status from those hospitals which are not self-sustaining and to confer special fund status only when they "earn" it by generating sufficient revenues to meet their expenditures.

Those hospitals with special fund status would still be required to comply with all departmental budgeting and expenditure controls. The department should ensure that excess revenues be used to improve the program of services in accordance with some overall approved plan for all facilities in the system.

If the foregoing standard is used, only Maui Memorial Hospital would qualify for special fund status at this time, according to the 1987-89 General Appropriations Act, although Hilo Hospital could be on the verge of qualifying. Given the incentive of obtaining special fund status, several other facilities may also be in a position of improving their revenues to the point of qualifying for such status.

To be sure, it is unrealistic to expect some of the smaller rural hospitals ever to be completely self-sustaining, but in such cases, it would be more appropriate to fund them through general fund appropriations.

One approach would be to apply the self-sustaining standard not immediately but effective at the beginning of the next biennium (July 1, 1989). This would enable at least Hilo Hospital, and perhaps one or two other hospitals, to improve their revenue-expenditure picture, become self-sustaining beginning FY 1989-90, and retain special fund status.

Mandated assessments not paid. Finally, there are statutory mandates relating to excess revenues which are not observed. As a consequence, the financial condition of the hospitals is distorted.

Section 36-27, HRS, requires that special fund programs help pay for executive branch central service expenses in the amount of 5 percent of all receipts of each such special fund, to be transferred to the general fund by the Director of Finance. Further, section 36-30, HRS, requires that each special fund be responsible for its pro rata share of the administrative expenses incurred by the department responsible for the operations supported by the special fund. The Director of Finance may determine this amount and transfer it to the general fund.

A review of the hospitals' financial records indicates that the hospitals neither budget for nor actually pay either of the administrative expenses. Additionally, for the purposes of financial reporting, they are required to enter these expenses as liabilities against their assets. Because these expenses have not been paid for a number of years, they have accumulated into a large liability which the hospital system could not pay if required: \$28.0 million as of June 30, 1986.⁹ This figure grossly distorts the actual financial condition of the hospital system by carrying a large liability against assets which continues to grow each year.

Lack of Systemwide Financial Management

The absence of systemwide financial management begins with the absence of policies and procedures. Accounting, budgeting, expenditure control, revenue management, and financial analysis are left to each hospital's own devices. As a multihospital system, all hospitals' revenues should support the system and expenditures should be prioritized and authorized within the system. Instead, the hospitals function as separate entities, submitting separate budget requests, receiving separate appropriations, and managing separate finances.

The situation has been exacerbated by a 1986 memorandum from the Department of Budget and Finance which states, "for the purposes of budget preparation, execution, and computation of excess receipts, each hospital should be considered a separate program."¹⁰ It is not clear why this position was taken, but no attempt has been made to obtain a reversal.

Budgeting. Budgeting is done at the individual hospital level using different methodologies. Most hospitals continue to use patient days and ancillary procedures to project cost. Some hospitals use the prior year's actual figures, while others use prior year appropriation amounts plus an inflation factor.

They all submit their budgets for review by the division administration, but each request is analyzed separately and then merely combined into one budget document. There appears no analysis of need relative to other hospitals. Departmental level review is essentially meaningless. Any modifications made to the hospitals' budgets are usually based on the general budget guidelines issued for all state agencies and are not specific to the system itself.

Accounting. Because of changes in reimbursement practices, hospital accounting systems today are more sophisticated in assigning costs and identifying

profit centers. Traditional definitions using patient days and ancillary procedures are being replaced by diagnosis-related groups (DRGs) or major diagnostic categories (MDCs). However, the county/state hospitals continue to use the traditional definitions.

For everyday purposes, county/state hospital accounting records are kept on a cash basis for recording revenues and expenditures. The hospitals are not set up to accumulate data for determining costs based upon the DRGs or other types of reimbursement systems. Additionally, since the hospitals are part of the state system, their accounting records must be reconciled at the end of the fiscal year with those of the State's Financial Accounting and Management Information System (FAMIS), because these records are kept on an accrual basis. That is, revenues are recorded at the time earned, and not when payment is received; expenses are recorded at the time committed, and not when payment is made.

The hospitals must also keep a separate manual log of their cash receipts to reconcile with the monthly FAMIS revenue reports. Even though the hospitals indicated that they do make regular reconciliations with FAMIS, vouchers for paying vendors have been rejected by FAMIS because there were insufficient funds in the hospitals' accounts. For example, near the end of FY 1986-87, one hospital had only \$5.25 remaining in its account but continued to process vouchers which were rejected by FAMIS.

The situation prompted a letter from the Comptroller to the Director of Health which admonished: "At some point within your department there must be an assignment of responsibility for controlling the funds to be charged in accordance with funds availability in the various accounts for which your department is the expending agency."¹¹ But not much improvement occurred. With about a month

remaining in the first quarter of FY 1987-88, another hospital had only \$6.74 in its account. (These situations were eventually covered by budget ceiling increases.)

The management letters which accompany the annual financial audits have pointed out that some hospitals do not make timely deposits of their receipts or monthly reconciliations of cash accounts. The division administration has done little to assist or provide guidelines to correct these problems even as it pays over \$250,000 each year for these audits. Even with the installation of a new computer system, reconciliation with FAMIS must still occur on an item by item basis.

Expenditure control. Expenditure control can only be described as "flexible" since the hospitals have not had to operate within their appropriated budgets. In fact, hospitals frequently spend first, then secure the funds to cover their expenditures through ceiling increases. Requests for transfers of cash from prior year carryover funds or increases in the hospitals' allotments are commonly granted.

The magnitude of the ceiling increases is sometimes great, as seen below:

Table 9.5

County/State Hospital System
Ceiling Increases Granted

Fiscal Year	Amounts
1986-87	\$11.6 million
1985-86	680,000
1984-85	4.6 million

Sources: County/State hospital division memoranda requesting approval for ceiling increases during FY 1986-87, 1985-86, and 1984-85.

These increases have usually been for items which were questionable as emergency purchases. Most often they have been granted for unbudgeted equipment and maintenance projects. For example, repainting, repairing windows, fumigating, expanding administration offices, asbestos removal, and acquiring upgraded equipment could not uniformly and reasonably qualify as "emergency, unanticipated, urgent expenses."

The division administration exercises little control over these unplanned, unbudgeted expenditures. While hospitals by their nature will need to purchase some items unexpectedly, it appears that both the hospitals and the division administration promote these ad hoc expenditures in the face of excess revenues. These expenditures are made outside legislative scrutiny and without legislative approval, no matter the magnitude.

For example, the large ceiling increase for FY 1986-87 includes \$4.6 million for the purchase of the County/State Hospital Information Processing System, known as "CHIPS." The division administration did not present this request to the Legislature through the budget process, and the division also plans to spend another \$1 million in the current fiscal year for CHIPS expansion. The purchase was approved with reservations by the Governor who questioned what the personnel ramifications of CHIPS will be, both as it is installed in the coming two years and over the long term. It is also not clear what its long-term maintenance costs will be nor what the benefits and savings might be. All of these questions, and more, should have been answered in a budget request submitted to the Legislature.

It is not defensible for the division to treat excess special funds as its "own" money, for at least some of the excess and perhaps all of it is the result

of the general fund subsidy. CHIPS is a major expenditure and its implementation will affect the overall program operations and finances of the entire system—a matter for appropriate legislative deliberation and decision.

Revenue control. Revenue management is a crucial element in the financial direction of hospitals. The billing and collection system sustains the hospital. Timely collection of reimbursements allows the hospital to maintain sufficient working capital. Once reimbursed, hospitals can reconcile their charge for service with the actual payment received from the payer and determine their profitability.

Those patient charges still pending payment comprise the hospital's accounts receivable. The central task in controlling accounts receivable is to reduce the collection time. The financially well managed hospital is aware of, and takes action upon, the costs attached to accounts receivable, such as credit and collection services and lack of return on investments. Also, the hospital that misclassifies charity care as bad debt wastes collection resources and inflates accounts receivable.

For years, the county/state hospitals have held accounts receivable much longer than they should in terms of hospital industry standards as well as by comparison with other hospitals within the State. The county/state hospitals' accounts receivable are held two to three times as long as comparable institutions. The elapsed time before payments are made on accounts receivable for the county/state hospitals range from 81 days to 253 days, with the average being 173 days. Comparable figures for other Hawaii hospitals ranged from 54 days to 86 days.

The poor accounts receivable performance of the hospitals and the lack of an effective accounts receivable policy indicate that the hospitals are not very much concerned with generating optimal revenues for their operations. Hospital auditors

have repeatedly pointed out these failings. For the FY 1985–86 audit cycle, the citations include late billings (seven hospitals); no followup billing statements (three hospitals); failure to maintain monthly aged accounts receivable listings (six hospitals); lack of any formal collection policies (three hospitals).

Conclusion

The division allows each county/state hospital to operate according to its specific financial needs and condition, without consideration for the financial condition of the system as a whole. We find that the system has been capable of generating revenues beyond its estimates since its expenditures have exceeded budgeted amounts. The present practice of spending all of the general fund appropriations without regard to how much more the hospital might receive of its own revenues is not conducive to sound financial management. As a matter permitted by legislative provisos, it is a matter for legislative attention.

Recommendations

We recommend the following:

1. *The Legislature withdraw special fund status from those hospitals which are not projected to be self-sustaining from hospital-generated revenues beginning with the 1989–90 fiscal year.*

2. *Alternatively, if special funds are continued for those hospitals requiring general fund appropriations, the Legislature specify and the Department of Budget and Finance enforce a budgetary provision that special fund revenues be used for hospital expenses prior to allotment of any general fund subsidies. Excess general*

fund subsidies should automatically lapse at the end of each fiscal year. Any subsidies allotted should be accounted for separately and not commingled in special fund accounts.

3. The Legislature establish a nonlapsing contingency fund to be used first, to support hospitals which encounter revenue shortfalls within their appropriated ceilings, and second, to allow hospitals with insufficient funds to correct deficiencies cited in certification reviews by DOH, Medicaid/Medicare, and JCAHO. The division should be required to make an annual report to the Legislature on the balance in the fund, describing expenditures made from this fund, and identifying corrections made with such expenditures.

4. The county/state hospitals division administration establish divisionwide policy requiring:

- . 60-day average elapsed time for collecting of accounts receivable;*
- . annual write-offs of bad debts to be sent to Attorney General; and*
- . annual expenditure plans citing equipment and renovation needs based on lifecycle analyses and accreditation reports.*

5. The Department of Health abolish the unauthorized special fund for county/state division administration, transfer the fund balance to the general fund on June 30, 1988, and submit a general fund appropriation request to the Legislature to finance the division's administrative operations for FY 1988-89.

6. Beginning in FY 1988-89, DAGS collect the five percent central services fee from special funds if excess revenues are available. However, past liability should not be assessed against the special funds.

Chapter 10

ALTERNATIVE ORGANIZATIONAL STRUCTURES

Up to this point, our report has been written on the assumption that the organizational structure of the county/state hospital system will continue much as it has since the 1960s—as an integral part of the Department of Health. Some of the recommendations we have made, however, would apply to the hospitals regardless of how they are structured or organized.

In our assessment of the hospitals in the early 1970s, we were of the persuasion that hospitals were different from the type of programs normally conducted by government. In the provision of vital health services, we believed that hospitals should not be bogged down by the control procedures inherent in a bureaucracy. We also were influenced by the observation that the Director of Health could not possibly give adequate leadership to the county/state hospital system because of the widening responsibilities of the department and the corresponding reduction of time that the director could give to any one program.

Some of these conditions have been undergoing change. Since the latter part of 1987, the Office of the Governor, through workshops involving all of the executive agencies, has served as the catalyst for the agencies to identify the principal problems of line agency versus staff agency relationships and to devise solutions so that actions can be accomplished more quickly while maintaining a modicum of control and accountability. While it is too early to assess how successful these efforts will be, they can be viewed as a promising beginning.

On the other hand, the Director of Health carries an even greater burden now than the burden carried by earlier directors, which we believed was already too heavy. In particular, environmental health responsibilities have required a large share of attention by the directors as requirements and responsibilities grew in the 1970s and 1980s. Some even contend that the growth and importance of responsibilities for environmental health alone would justify the establishment of a separate department. Thus, directors have even less time to provide effective leadership for the county/state hospitals than when we first reported on it.

On balance then, what changes have taken place continue to confirm our earlier view that a major organizational restructuring is needed for the hospitals. We continue to believe that a separate semi-autonomous unit (such as a hospital authority) would be the best organizational arrangement for the county/state hospitals. However, a recommendation for a hospital authority is unlikely to gain acceptance unless there were some signs—or at least a glimmer—of an emerging executive-legislative consensus, and we find none.

In this chapter, we review the principal alternative organizational arrangements for the county/state hospitals without pressing our preference, which is already a matter of record in our earlier report.

In the ensuing section, we examine the advantages and disadvantages of: (1) establishing a new state department of county/state hospitals; (2) creating a hospital authority; (3) establishing an independent nonprofit corporation; and (4) contracting out the entire system or individual hospitals to a private hospital management firm.

Creating a New Department

This option would elevate the county/state hospitals division to a department. As a member of the cabinet, the director would have a direct and greater access to the Governor, other department heads, and other government officials. This model would place the county/state hospitals program in a more competitive position for available state funding, personnel, and other resources. The program's recruitment efforts would also become more competitive with the subsequent boost in salary for key program personnel.

However, even with the elevated departmental status, the program would almost certainly continue to struggle with many of the same kinds of budgetary, resource, and allocation constraints it now faces. Additionally, even as a department, the program would basically remain a line agency and, consequently, would remain subject to the same kinds of central staff agency controls exercised over such processes as budgeting, accounting and purchasing, and personnel actions.

Perhaps, the largest consideration weighing against a new, separate department is that the option may not generate executive or legislative support given the State's constitutionally-mandated limit on the number of executive departments. The State Constitution currently limits the number of principal state departments to 20. In the 1987 session, the Legislature created a new Department of Corrections bringing the number in place to 18. It is questionable whether there exists sufficient justification and support to establish another new executive department.

State Hospital Authority

Most of the ensuing summary on the advantages and disadvantages of a hospital authority is drawn from our earlier report on the county/state hospital program.¹

Under a hospital authority, the county/state hospitals would be governed by a board of trustees and administered by a general manager. It would be semi-autonomous, and it would be located in the Department of Health for administrative purposes only. The authority would have full powers to operate the hospital system, and it would not be subject to the fiscal or personnel controls now exercised over the state/county hospitals by the State's central staff agencies.

The reason for establishing authorities generally is that they can speed up and simplify the making of decisions and the execution of actions. Freed from external bureaucratic controls, they have the potential of providing services more efficiently and more effectively.

However, the disadvantage of authorities is that they can amass too much power. And since the very purpose of the authority is to insulate it from the political process, it can exercise power without being checked directly by that process.

Independent Nonprofit Corporation

A corporation is a legal entity with specific and clearly defined purposes and powers based on a charter or statute granted under law. It can retain contract and financial accounts in its own name, can sue or be sued, can use and reuse revenues, can own assets, and have liability distinct from that of its officers or the authority that chartered it.

Recently, more and more hospitals are undergoing restructuring into corporations. Surveys show that 34 percent of all hospitals have undergone corporate restructuring in the past five years.² Many public hospitals represent part of this trend and have become nonprofit corporations. According to the American Hospital Association, 128 public hospitals underwent restructuring between 1983 and 1986.³

There appear to be several reasons for this growth in public hospital corporate restructuring. Community hospitals, whatever their ownership, were originally established as charitable enterprises to serve the community. Today, however, these institutions are being pressured to operate like private sector businesses which must compete to survive.

Certain advantages are apparent in converting a government-owned public hospital into a nonprofit corporation. One of the biggest is increased flexibility. Although these private nonprofit corporations are controlled by the community, they have freedom to compete more effectively than government-owned hospitals because they are not hindered by state restrictions on mixing public and private funds, government procurement procedures, and other governmental requirements applicable to state agencies.

Additionally, nonprofit status allows public hospitals to compete for new business ventures and for private-pay patients, both of which can provide needed additional revenues that help finance indigent care and help ensure long-term success. Also, depending on state laws, nonprofit hospitals might be able to invest in private business ventures, raise capital more easily, and eliminate political influences on board decisions.

Public hospital conversions can be difficult—especially if there is organized community opposition as has been evidenced in other states. Officials at Cleveland Metropolitan General/Highland View Hospital have tried for two years to convert the public facility into a nonprofit organization. However, community groups have opposed the conversion and contend that the conversion would deny indigent patients access to medical care and continued public accountability.

In other states, community groups are seeking to determine whether corporate restructuring has weakened health care for the indigent, reduced accountability, or resulted in less efficient delivery of health care services. Some of these restructurings have resulted in charges of poor medical treatment and services, administrative confusion, and legal action.

Contracting With a Private Management Firm

Contract management is an arrangement whereby the day-to-day management and administration of a hospital are assumed by a separate contracting organization which answers to the board of trustees of the managed hospital.

Contract management is largely an outgrowth of the investor-owned hospital chains that proliferated in the 1960s and early 1970s when large sums of money were available in the health care field. During the recession of the 1970s, however, financing for further growth was no longer available. Consequently, many of these firms began to market their hospital management expertise to maintain their revenue base and to maximize the use of their available personnel and resources.

Contract management is probably the most rapidly growing form of multi-institutional arrangements in the hospital industry. From 1970 to 1981, the number of hospitals utilizing management contracts grew from 14 to 497. These

approximately 500 hospitals represented about 50,000 beds and included voluntary, nonprofit, religious, government, and investor-owned facilities.⁴ More public hospitals are under management contracts than any other type of hospital. In 1982, for example, 104 public hospitals with over 11,000 beds were managed by private firms.⁵

Supporters of contract management contend that contract management: (1) cuts costs by utilizing modern, sophisticated, and efficient management techniques; (2) further reduces costs through the use of joint or shared purchasing of supplies, equipment, and services for all the hospitals in the firm's corporate chain; and (3) facilitates management and operations by centralizing such administrative support services as improved fiscal decisionmaking, data processing, preparation of required reports, and planning.

The contract management firms claim that they can immediately relieve local governments of the day-to-day responsibility. They claim they can provide management expertise in such areas as federal and state regulations and third-party reimbursement procedures. They can institute successful and proven management systems which have increased productivity at other hospitals. Through bulk purchasing and arranging shared services among several hospitals, the firms can reduce costs and avoid duplicating or having to establish costly and new services.

Despite these claims, there are a number of critics of contract management who argue that these private firms offer no panacea for ailing public hospitals, question the cost savings contentions of these firms, and go so far as to warn that these takeovers can seriously jeopardize public accountability and welfare.

These critics are concerned that utilizing profit-motivated private sector management techniques and incentives will threaten the poor and disenfranchised

members of society--those very individuals who have traditionally been served by public hospitals. They caution "that such arrangements contribute to the decline of equity in access to quality health care services by extending what they perceive to be 'skimming' and 'dumping' practices (use of expected profitability for the hospital as a criterion for accepting patients for hospital admission) by large, investor-owned hospital chains."⁶

Another major concern "is that the contracting company will contract for management and then, bargaining from strength, offer to 'buy' the financially debilitated institution. One multi-institutional system has purchased at least 22 county- and/or city-owned public hospitals. In many cases, the public hospital acquired was the only source of health care in the area."⁷

The critics also point out that there is little evidence to indicate that management firms can successfully reduce operating costs. Savings under these firms are often in the net cost to the local government and not in unit operating costs. They report that several nationwide studies of management contracting firms have found that investor-owned multihospital chains focus primarily on maximizing reimbursements from third parties rather than on keeping unit costs low.

Concluding Note on Organizational Alternatives

Both the current director of health and his deputy acknowledge that problems exist within the county/state hospitals program. They appear also to believe that the system can be improved without wholesale changes to the program's basic organizational structure. The administration believes that many problems can be eliminated with increased operational and managerial flexibility. The

administration, in fact, will be seeking this flexibility through legislation and new inter-departmental and intra-departmental working agreements.

There are other indications that a change in governance structure at this time might not be fully supported or feasible. During the 1987 legislative session, the administration had planned to introduce legislation to establish a new statewide hospital authority. However, some Management Advisory Committee (MAC) members thought such a bill might be premature and requested that the administration seek additional MAC and community input and discussion before proceeding with the legislation.

During the legislative interim, the administration and the MACs helped arrange and sponsor various public forums on the Neighbor Islands to discuss the authority bill. These forums indicated that there are still many questions and concerns regarding any change to the program's governance structure and organization. The forums also seemed to indicate that there was not a lot of strong community support for the proposed new authority.

Thus, unless there is an unexpected rising tide for change, it appears that the most practical course for now is to seek improvements within the current organizational structure.

NOTES

Chapter 2

1. "National Health Bill Expected to Reach \$1.5 Trillion by 2000," *Honolulu Advertiser*, June 10, 1987.
2. American Hospital Association, "Key Trends in 1986," *Economic Trends*, Vol. 3, No. 1, Spring 1987, p. 3.
3. U.S., Department of Health and Human Services, Public Health Service, National Center for Health Statistics, "1985 Summary: National Hospital Discharge Survey," *NCHS Advance Data*, No. 127, September 1986, pp. 1-2.
4. American Hospital Association, *Economic Trends*, p. 4.
5. U.S., Department of Health and Human Services, National Center for Health Statistics, "Discharge Survey," pp. 1-2.
6. Bank of Hawaii, "Hawaii's Health Care Industry," *Business Trends*, Vol. 31, No. 5, September/October 1986, pp. 1-3.
7. "Health Care: Adding Momentum to Hawaii's Economic Well-Being," *All About Business in Hawaii*, 15th ed., Crossroads Press, Inc., 1987, p. 30.
8. 1987 Haw. Sess. Laws, Act 216.
9. Lawrence Bartlett, "The Management of Medicaid Inpatient Hospital Expenditures," in *Affording Access to Quality Care: Strategies for State Medicaid Cost Management*, ed. by Richard Curtis and Ian Hill, National Governors' Association for Policy Research, Health Policy Studies, July 1986, p. 128.
10. *Ibid.*, p. 129.
11. Hawaii, Department of Health, *1986-87 Strategic Plan for Samuel Mahelona Hospital*, p. 3.
12. Frank A. Sloan, James F. Blumstein, and James M. Perrin, *Uncompensated Hospital Care: Rights and Responsibilities*, Baltimore, The Johns Hopkins University Press, 1986, p. 112.
13. Hawaii, Department of Health, *1986-87 Mahelona Plan*, p. 3.
14. American Hospital Association, *Economic Trends*, p. 4.

15. Donald C. Wegmiller, "Management Issues in the Development and Maturation of Multihospital Systems," *HCM Review*, Spring 1985, p. 9.
16. Statement by Jack Owen, President, American Hospital Association, in Hearings by Subcommittee on Intergovernmental Relations, Committee on Governmental Affairs, U.S. Senate, Ninety-Ninth Congress, Second Session, June 26, 1986, Washington, U.S. Government Printing Office, 1986, p. 6.
17. *Ibid.*, p. 5.
18. U.S., Department of Health and Human Services, Public Health Service, National Center for Health Statistics, *Vital Statistics of the United States, 1984: Life Tables*, Vol. II, Sec. 6, DHHS Publication No. (PHS) 87-1104, Washington, U.S. Government Printing Office, 1987, pp. 2-3.
19. Hawaii, Department of Planning and Economic Development, *The State of Hawaii Data Book 1986: A Statistical Abstract*, Honolulu, 1986, p. 81.
20. "Hawaii's Nursing Shortage: A Health Care Crisis," *Honolulu Star-Bulletin*, September 21-23, 1987.
21. Jo Ivey Boufford, "AIDS and the Public Hospital System in New York City," presented at Project Hope Conference on the Socioeconomic Impact of AIDS on Health Care Systems, March 25-26, 1987.
22. Anne A. Scitovsky and Dorothy P. Rice, "Estimates of the Direct and Indirect Costs of Acquired Immunodeficiency Syndrome in the United States, 1985, 1986, and 1991," *Public Health Reports*, Vol. 102, No. 1, January-February 1987, pp. 5-6.

Chapter 3

1. Helen Gay Pratt, *Hawaii Off-Shore Territory*, New York, Charles Scribner's Sons, 1944, pp. 376-377.
2. Robert C. Schmitt, "Hawaii's Hospitals, 1831-1956," *Hawaii Medical Journal*, v. 15, no. 4, 1956, p. 340.
3. Raymond G. Nebelung and Robert C. Schmitt, *Hawaii's Hospitals Past, Present and Future*, Honolulu, Chamber of Commerce of Honolulu, 1948, Table 34.
4. *Ibid.*, Table 45.
5. "30 Hospitals Ready to Care for Isle Ills," *Honolulu Advertiser*, June 23, 1959.
6. Testimony on House Bill 235 and House Bill 740 presented by Goro Hokama, Chairman, Maui County Council, to the Hawaii House Committee on Public Health, Youth and General Welfare, April 7, 1969.

7. "'Healthy' Hilo Hospital Should Remain Under State Control, Lawmakers Told," *Honolulu Star-Bulletin*, January 11, 1986.

8. Hawaii, *The Multi-Year Program and Financial Plan and Executive Budget for the Period 1987-1993 (Budget Period: 1987-89)*, v. II, December 1986, p. 760.

9. Hawaii, Department of Health, County/State Hospitals Division, "Functional Statement," p. 4.

10. Hawaii, Legislative Auditor, *Budget Review and Analysis: County/State Hospital Program and the Health Care Payments Program*, Report No. 85-10, Honolulu, 1985.

11. Hawaii, Department of Health, County/State Hospitals, "Estimated Cash Revenues Projections Using Current Rates for the Fiscal Year 1985-1986."

Chapter 4

1. Hawaii Revised Laws 1955, Section 46-8.

2. Hawaii, *Proceedings of the Constitutional Convention of Hawaii 1950, Vol. I: Journal and Documents*, Honolulu, 1960, p. 296.

3. Hawaii Revised Statutes, Section 226-27.

4. Hawaii Revised Statutes, Section 226-20.

5. Hawaii, Department of Health, *State Health Functional Plan*, Honolulu, 1984, p. iv.

6. Hawaii, *The Multi-Year Program and Financial Plan and Executive Budget for the Period 1987-1993*, Vol. II, December 1986, p. 760.

7. *Ibid.*, p. 767.

8. *Webster's New Collegiate Dictionary*, 7th ed., 1969, p. 895.

Chapter 5

1. Hawaii, Department of Health, *County/State Hospitals Division Bylaws and Regulations*, Honolulu, 1987.

2. *Ibid.*, pp. 8-9.

3. Hawaii Revised Statutes, Section 27-22.

4. House Standing Committee Report 726 on House Bill 705, Fourth Legislature, 1967, State of Hawaii.

5. Hawaii, Legislative Auditor, *Audit of the County/State Hospital Program*, Report No. 71-2, Honolulu, 1971.
6. *County/State Hospitals Division Bylaws and Regulations*, p. 3.
7. Hawaii Revised Statutes, Section 27-22.
8. Hawaii, Department of Health, *Maui County Hospital System Management Advisory Committee By-Laws*, 1983.
9. Hawaii, Department of Health, *By-Laws of the Honolulu County Hospital Management Advisory Committee*, 1980.
10. *Maui County Hospital System Management Advisory Committee By-Laws*, p. 3.
11. *Audit of the County/State Hospital Program*, p. 27.

Chapter 6

1. Ira Moscovice and Roger Rosenblatt, *The Viability of the Rural Hospital*, Washington, National Center for Health Services Research, 1982, p. 32.
2. Roger Rosenblatt and Ira Moscovice, *Rural Health Care*, New York, John Wiley and Sons, 1982, p. 235.
3. Institute of Medicine, *Improving the Quality of Care in Nursing Homes*, Washington, National Academy Press, 1986, p. 46.
4. Moscovice and Rosenblatt, p. 33.
5. Hilo Hospital also operates a megavoltage radiation therapy unit for cancer treatment which is classified at the tertiary level of care.
6. "Division Mission Statement," memorandum from Deputy Director for Hospitals to All Hospital Administrators, February 19, 1987.
7. Hawaii, State Health Planning and Development Agency, *Acute Care Hospital Utilization Statistics*, Honolulu, November 3, 1987, p. 1.
8. *Ibid.*
9. Hawaii, Department of Health, *Report on Honoka'a Hospital*, Honolulu, 1987, p. 9.
10. Letter from John Milton, Director, Hospital Accreditation Program, Joint Commission on Accreditation of Healthcare Organizations, to Frederick Burkle, Administrator, Maui Memorial Hospital, November 2, 1987.

11. Hawaii, Department of Health, "Statement of Deficiencies and Plan of Corrections: Hilo Hospital," Honolulu, October 1986, p. 4.

12. "Life Safety Code Waiver – Honokaa Hospital," memorandum from Frances Larsen, Medicare Certification Officer, Hospital and Medical Facilities Branch to Leslie Matsubara, Director of Health, August 22, 1985.

13. *Ibid.*

14. Letter from Benjamin Lambiotte, Chief, Hospital and Medical Facilities Branch, to Yoshito Iwamoto, Administrator, Honokaa Hospital, August 14, 1986.

Chapter 7

1. Hawaii, Legislative Auditor, *Audit of the County/State Hospital Program*, Report No. 71-2, Honolulu, 1971, p. 14.

2. *Ibid.*

3. American Hospital Association, *Guidelines—Role and Functions of the Hospital Governing Board*, American Hospital Association, 1982, p. 1.

4. *Ibid.*, p. 4.

5. Hawaii, Legislative Auditor, *Budget Review and Analysis: County/State Hospital Program and the Health Care Payments Program*, Report No. 85-10, Honolulu, 1985, p. 44.

Chapter 8

1. Section 443A-1, Hawaii Revised Statutes; repealed by Act 191, Session Laws Hawaii 1987.

2. Agreement between the State of Hawaii Department of Health, by its Director of Health, and Hospital Business Management, Inc., August 20, 1987, pp. 10-11.

3. Department of Health, County/State Hospital Administrators, Minutes of Meeting, Honolulu, December 1, 1987, p. 2.

4. Agreement between the Director of Health and Hospital Business Management, Inc., August 20, 1987, pp. 6-7.

5. *Ibid.*, p. 8.

6. Minutes, p. 5.

7. Hawaii, Legislative Auditor, *Budget Review and Analysis of the Mental Retardation and Mental Health Programs*, Report No. 84-9, Honolulu, January 1984, pp.9-10.

11. Hawaii, Department of Health, "Statement of Deficiencies and Plan of Corrections: Hilo Hospital," Honolulu, October 1986, p. 4.

12. "Life Safety Code Waiver – Honokaa Hospital," memorandum from Frances Larsen, Medicare Certification Officer, Hospital and Medical Facilities Branch to Leslie Matsubara, Director of Health, August 22, 1985.

13. *Ibid.*

14. Letter from Benjamin Lambiotte, Chief, Hospital and Medical Facilities Branch, to Yoshito Iwamoto, Administrator, Honokaa Hospital, August 14, 1986.

Chapter 7

1. Hawaii, Legislative Auditor, *Audit of the County/State Hospital Program*, Report No. 71-2, Honolulu, 1971, p. 14.

2. *Ibid.*

3. American Hospital Association, *Guidelines—Role and Functions of the Hospital Governing Board*, American Hospital Association, 1982, p. 1.

4. *Ibid.*, p. 4.

5. Hawaii, Legislative Auditor, *Budget Review and Analysis: County/State Hospital Program and the Health Care Payments Program*, Report No. 85-10, Honolulu, 1985, p. 44.

Chapter 8

1. Section 443A-1, Hawaii Revised Statutes; repealed by Act 191, Session Laws Hawaii 1987.

2. Agreement between the State of Hawaii Department of Health, by its Director of Health, and Hospital Business Management, Inc., August 20, 1987, pp. 10-11.

3. Department of Health, County/State Hospital Administrators, Minutes of Meeting, Honolulu, December 1, 1987, p. 2.

4. Agreement between the Director of Health and Hospital Business Management, Inc., August 20, 1987, pp. 6-7.

5. *Ibid.*, p. 8.

6. Minutes, p. 5.

7. Hawaii, Legislative Auditor, *Budget Review and Analysis of the Mental Retardation and Mental Health Programs*, Report No. 84-9, Honolulu, January 1984, pp.9-10.

Chapter 9

1. Ira Moscovice and Roger Rosenblatt, *The Viability of the Rural Hospital*, 1982, pp. 51–59, 64–65.
2. Senate Standing Committee Report 208 on House Bill 366, Sixth Legislature, 1971, State of Hawaii; House Standing Committee Report 45 on House Bill 366, Sixth Legislature, 1971, State of Hawaii; 1987 Haw. Sess. Laws, Act 216, sec. 3, item E13–E25.
3. 1966 Haw. Sess. Laws, Act 8, sec. 1, Act 97—Health Functions.
4. 1967 Haw. Sess. Laws, Act 54, sec. 1, Act 97—Health Functions.
5. 1981 Haw. Sess. Laws, First Special Session, Act 1, sec. 24.
6. 1966 Haw. Sess. Laws, Act 8, sec. 15 and 1979 Haw. Sess. Laws, Act 214, sec. 142.
7. 1981 Haw. Sess. Laws, First Special Session, Act 1, sec. 114.
8. Hawaii, Department of Accounting and General Services, *FAMIS Report MBP477–A*, Honolulu, Nov. 12, 1987, p. 3019 and Hawaii, Department of Budget and Finance, *Supplemental Detail to the Annual Financial Report of the State of Hawaii*, For the Fiscal Year ended 1986; and for the Fiscal Year ended 1985.
9. Grant Thorton, *Financial Statements and Auditor's Report, State of Hawaii, Department of Health, June 30, 1986*, Honolulu, December 5, 1986, p. 8.
10. "Clarification of the Definition of 'Program' Relating to the County/State Hospitals," memorandum from the Director of Finance to Leslie S. Matsubara, September 15, 1986.
11. "Insufficient Funds, County/State Hospital Accounts," Memorandum from Russel S. Nagata to Dr. John C. Lewin, July 16, 1987.

Chapter 10

1. Hawaii, Legislative Auditor, *Audit of the County/State Hospital Program*, Report No. 71–2, Honolulu, March 1971, pp. 28–29.
2. Jeffrey A. Alexander and James E. Orlikoff, "Hospital Corporate Restructuring Gains Widespread Acceptance," *Trustee*, January 1987, pp. 16–17.
3. Kari E. Super, "Public Hospitals Restructuring," *Modern Healthcare*, September 11, 1987, p. 44.

4. Jeffrey A. Alexander and Bonnie L. Lewis, "Hospital Contract Management: A Descriptive Profile," *Health Services Research*, 19, No. 4, October 1984, pp. 461-462.

5. Thomas G. Rundall and Wendy K. Lambert, "The Private Management of Public Hospitals," *Health Services Research*, 19, No. 4, October 1984, p. 520.

6. Thomas G. Rundall, "Introduction from the Guest Editor: Organizational and Public Policy Issues," *Health Services Research*, 19, No. 4, October 1984, pp. 458-459.

7. Rundall and Lambert, p. 528.