

**RECONSIDERATION EVALUATION OF THE CERTIFICATE OF NEED
APPLICATION SUBMITTED ON BEHALF OF EVERGREEN HOSPITAL MEDICAL
CENTER PROPOSING TO ADD EIGHTY ACUTE CARE BEDS TO THE EXISTING
HOSPITAL IN EAST KING COUNTY**

PROJECT DESCRIPTION

King County Public Hospital District #2 dba Evergreen Hospital Medical Center (EHMC) is a public hospital located at 12040 Northeast 128th Street in the city of Kirkland within King County. EHMC is a provider of Medicare and Medicaid services to the residents of Kirkland and surrounding areas. The hospital is currently licensed for 244 acute care beds,¹ holds a three-year accreditation from the Joint Commission on Accreditation of Healthcare Organizations, and is designated as a level IV trauma hospital. EHMC owns and operates a Medicare certified/Medicaid eligible home health agency and a Medicare certified/Medicaid eligible hospice agency, known as Evergreen Home Health and Evergreen Hospice, respectively. [DOH Office of Health Care Survey, Office of Emergency Medical and Trauma Prevention, and CN historical files]

This application proposes to add 80 acute care beds to the existing 227 acute care beds at the hospital, for a facility total of 307 acute care beds. The 80 beds would be added in two phases as described below. [Application, p10]

Phase One

Evergreen intends to reopen existing medical/surgical space within the hospital that was closed when CN 1242 approved a 78-bed patient tower expansion that became operational in 2007. This space will house the initial 48 bed addition proposed in the application. The result at the end of Phase one, originally planned for early 2009, will be a total of 275 acute care beds. The cost for this phase of the project totals \$1,574,403.

Phase Two

The remaining 32 beds will be made operational within the additional floor space shelled in during the 2007 hospital expansion. Phase two would be complete and operational by January 2013. The total number of acute care beds would then be 307. The cost for this phase of the project totals \$13,182,989.

BACKGROUND INFORMATION ON THE PROJECT

On May 12, 2008, EHMC submitted its Certificate of Need application to add 80 beds to the hospital. The anticipated date of commencement of construction of the facility is April, 2009. The facility is expected to begin serving patients in June, 2010. Under this timeline, the first full year of operation is projected to be calendar year 2011. The estimated capital expenditure for this project is \$14,757,392 and is a compilation of the individual costs detailed below. [Initial application, p13 & 27]

¹ EHMC also has 17 skilled nursing beds banked under the full facility closure provisions of RCW 70.28.115(13)(b).

Evaluation Breakdown Of ECE	Total	% of Total
Building Construction	\$ 8,286,980	56%
Fixed & Moveable Equipment	\$ 3,561,862	24%
Architect / Consulting Fees	\$ 1,321,230	9%
Supervision and Inspection	\$ 550,980	4%
Taxes & Review Fees	\$ 1,036,340	7%
Total Estimated Capital Costs	\$ 14,757,392	100.00%

On December 2, 2008, the Program denied EHMC application primarily based on its failure to meet the criteria related to numeric need. On December 23, 2008, EHMC submitted its "Request for Reconsideration" in response to the Department's denial, which included information related to the need criteria. The Program granted EHMC's reconsideration request and the reconsideration hearing was conducted in Tumwater on January 28, 2009. This document is the evaluation of the reconsideration information.

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need review as the establishment of a new health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(a) and Washington Administrative Code (WAC) 246-310-020(1)(a).

APPLICATION CHRONOLOGY

A chronological summary of the initial review and this reconsideration review is below.

Initial Review

December 24, 2007	Letter of Intent Submitted
May 12, 2008	Application Submitted
May 13, 2008 through July 8, 2008	Department's Pre-Review Activities <ul style="list-style-type: none"> • 1st screening activities and responses
July 9, 2008	Department Begins Review of the Application <ul style="list-style-type: none"> • Public comments accepted throughout review
August 15, 2008	Public Hearing / End of Public Comment
October 23, 2008	Department's Anticipated Decision Date
November 24, 2008	Department's Updated Decision Date
December 2, 2008	Department's Actual Decision Date

Reconsideration Review

December 23, 2008	Applicant Submits Request to Program for Reconsideration
January 12, 2009	Program grants Applicant's Request for Reconsideration
January 28, 2009	Reconsideration Public Hearing Conducted in Tumwater <ul style="list-style-type: none">• public comments submitted at the public hearing
February 12, 2009	Rebuttal Documents Received at Department
March 30, 2009	Department 's Anticipated Reconsideration Decision Date
March 31, 2009	Department 's Actual Decision Date

CRITERIA EVALUATION

The review for a reconsideration project is limited to only those criteria that were denied in the initial evaluation. To obtain approval for this project, EHMC must demonstrate compliance with the relevant criteria found in WAC 246-310-210 (need); WAC 246-310-230 (structure and process of care); and WAC 246-310-240 (cost containment).

AFFECTED PERSONS

Throughout the initial review of this project, the three entities sought and received affected person status under WAC 246-310-010. During the reconsideration review, the entities maintained their affected person status.

- Swedish Medical Center – Operator of a 175 hospital being constructed in Issaquah
- Providence Health System – Operator of Providence Everett Medical Center in Everett
- Overlake Hospital Medical Center – Operator of a hospital currently in the planning area

SOURCE INFORMATION REVIEWED

Initial Review

- Evergreen Hospital Medical Center's Certificate of Need Application received May 12, 2008
- Evergreen Hospital Medical Center's supplemental information dated June 26, 2008
- Public comment received throughout the review of the application
- Public hearing documents received at the August 15, 2008, public hearing
- Evergreen Healthcare rebuttal comments received September 8, 2008
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Financial feasibility and cost containment evaluation prepared by the Department of Health's Office of Hospital and Patient Data Systems (November 7, 2008)
- Historical charity care data obtained from the Department of Health's Office of Hospital and Patient Data Systems (2004, 2005, and 2006 summaries)
- Population data obtained from the Office Financial Management based on year 2000 census published January 2007.

- Healthcare Cost and Utilization Project (HCUP) database of Oregon State Hospital Discharge Data - 2006
- Licensing and/or survey data provided by the Department of Health's Office of Health Care Survey
- Acute Care Bed Methodology extracted from the 1987 State Health Plan
- Data obtained from Evergreen Hospital Medical Center's website

Reconsideration Review

- EHMC Hospital and Regional Medical Center's Reconsideration Request dated December 24, 2008
- Comment submitted to the Certificate of Need Program office between December 25, 2008 though January 14, 2009
- Public comment received at the January 14, 2009 public hearing in Tumwater
- Rebuttal comments from EHMC Hospital and Regional Medical Center received January 30, 2009
- Population estimates and forecasts obtained from the Claritas, Inc.

CONCLUSION

For the reasons stated in this evaluation, the Certificate of Need application submitted on behalf of EHMC to add 80 acute care beds to the hospital is not consistent with the Certificate of Need review criteria. However, the addition of 48 beds to EHMC (phase one) is consistent with those criteria. With this reduction, the project meets the applicable criteria for the project, and a Certificate of Need should be issued for the addition of 48 beds, resulting in a total of 275 acute care beds.

The approved capital expenditure associated with this project is \$1,574,403.

RECONSIDERATION EVALUATION

A. Need (WAC 246-310-210)

Based on the source information reconsidered, the Department determines that the EHMC application has met the applicable need criteria in WAC 246-310-210.

- (1) *The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need.*

The department uses the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan to assist in its determination of need for acute care capacity. This forecasting method is designed to evaluate need for additional capacity in general, rather than identify need for a specific project. The department prepared bed need forecasts to determine baseline need for acute care capacity. This set of projections is completed prior to determining whether the applicant should be approved to meet any projected need.

Initial Evaluation Summary

In the initial application, EHMC provided a methodology which established a need for beds in the planning area beginning in 2010; reaching a high of 53 in 2012. The supplied methodology continues to demonstrate various degrees of needed capacity through the reported projection years and accounts for a new hospital being constructed in the planning area. The Department's version of the need methodology did not confirm the results provided by the applicant. Appendix 10a of the Department's original projections indicate a need of 23.99 beds in 2012 before establishing a surplus in the following projection years. The Department determined that the applicant did not demonstrate that the population to be served has need for the project or that other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need. In conclusion, the project failed to meet the applicable criteria under WAC 246-310-210(1). [Application Supplemental Information, p53; Initial Evaluation, p12 & Exhibit A]

Reconsideration Evaluation

EHMC believes that the Department materially erred in the production of the acute care bed need methodology. The applicant identified two specific calculations that, in combination, inaccurately represent the projected need for the planning area. EHMC contends that the Department should have formed its sub-county population values on a single data source. The applicant asserts that the use of two separate population estimates lead to an obvious abnormality in the 65+ population projections. EHMC also states that the Department inappropriately and un-necessarily adjusted the calculation of the 65+ age cohort in the production of the age specific use rate. Each issue will be addressed below. [EHMC Reconsideration Request, p1-2]

Population Estimates and Projections

The East King County planning area is described in State Health Coordinating Council documents as a set of 22 zip codes in King County. The production of the acute care need methodology requires population estimates and projections for the specific areas of the county,

identified by zip code. The Washington State Office of Financial Management (OFM) is the primary data source for the Department in population estimates for the state and health service area population projections. When possible, the Department also relies upon OFM small area projections that are derived from zip code boundaries. In the original decision methodology, OFM data was utilized in steps 1 through 6 of the methodology to account for population estimates prior to 2008.

After reviewing source data regarding the production of the small area data from OFM, the program determined that the small-area growth projections may not be as reliable as the county and state historical estimates. In order to address this possibility, and to account for issues of disproportionate growth of the 65+ age cohort as presented in EHMC's application, the Department defaulted to available population estimates from Claritas, Inc., a recognized source of demographic information. The Claritas data provided zip code specific figures and a steeper growth curve for the 65+ age cohort throughout the projection years 2008 through 2013.

Not identified by the program in the initial evaluation, was that the cross-over from OFM data in 2007, to Claritas for 2008 forward, produced a precipitous drop in the totals for this age group. The result was a 65+ population in 2007 of 60,081 and a 2008 population estimate of 56,952. Though Claritas figures surpass OFM estimates in the long term, the initial loss of approximately 3,100 residents directly impacted the projected need for the initial years of the bed forecast. Using a single data source for estimates and projections of the planning area would be more appropriate for any estimates and forecasts of a targeted geographic population. [Application, p30; Supplemental Information, p53; Initial Evaluation, p13 & Exhibit A]

65+ East King Age Cohort Use Rate

The second issue raised by EHMC concerns the factor used to separate out the 65+ age cohort in the population totals found in steps 3 and 6 of the methodology. After determining the number of patient days recorded for the 0-64 and 65+ aged groups in the planning area, the age specific use rates for 2007 were computed for the planning area.

To account for the potential for disproportionate growth of the 65+ age group cited above, the Department calculated the average percent of the total population that the 65+ age cohort represented in the OFM estimates from 2003-2007. Estimates indicated that 11.65% of the total population of King County residents was 65+ and this was applied to the 2007 population estimates for the planning area. This was necessary to establish the number of residents in the 65+ age cohort which is not reported in the OFM data totals. The resulting value totaled 60,081 and produced an East King 65+ use rate of 891.65. [Initial Evaluation, p8-9]

In contrast, EHMC applied a factor of 10.42% to establish the 65+ population total. This produced a 65+ use rate of 997.76. This discrepancy led the Department to project a lower number of patient days in the years 2008 through 2014. EHMC contends that, "with an adjustment to the 2007 baseline 65+ population cohort, the Department should have adjusted the subsequent projection for year populations in that cohort to accurately project growth and future need". Although, by maintaining the integrity of the population data source addressed above, the Department can reference age group totals provided with the Claritas population data. This eliminates the need to apply a separately tabulated population factor to determine the 65+ age cohort utilized in step 6. [Reconsideration Request, p1-2]

Department's Reconsideration Methodology

The determination of numeric need for acute care hospital beds is performed using the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan (SHP). Though the SHP was “sunset” in 1989, the department has concluded that this methodology remains a reliable tool for predicting the baseline need for acute care beds.

The 1987 methodology was a revision of an earlier projection methodology prepared in 1979 and used in the development of subsequent State Health Plans. This methodology was developed as a planning tool for the State Health Coordinating Council (SHCC) to facilitate long-term strategic planning of health care resources. The methodology is a flexible tool, capable of delivering meaningful results for a variety of applications, dependent upon variables such as referral patterns, age-specific needs for services, and the preferences of the users of hospital services, among others.

The 1987 methodology is a twelve-step process of information gathering and mathematical computation. The first four steps develop trend information on hospital utilization. The next six steps calculate baseline non-psychiatric bed need forecasts. The final two steps are intended to determine the total baseline hospital bed need forecasts, including need for short-stay psychiatric services: step 11 projects short-stay psychiatric bed need, and step 12 is the adjustment phase, in which any necessary changes are made to the calculations in the prior steps to reflect conditions which might cause the pure application of the methodology to under- or over-state the need for acute care beds.

The completed methodology is presented as a series of appendices to this evaluation. (Attachment A) The methodology presented here incorporates all adjustments that were made following preparation of the methodology. Where necessary, both adjusted and un-adjusted computations are provided. The methodology uses population and healthcare use statistics on several levels: statewide, Health Service Area (HSA)², and planning area. The planning area for this evaluation is the East King planning area located in HSA 1.

As stated above, the East King County planning area is described in State Health Coordinating Council documents from 1987 as a set of 22 zip codes in King County bounded on the west by Lake Washington, on the south by Interstate 90, on the east by the county line and on the north by the county line, with the exception of inclusion of parts of the city of Bothell that lie in Snohomish County and the exclusion of areas of northeastern King County that are accessible only through Snohomish County. Zip codes are assigned by the US Postal Service for mail delivery purposes and do not necessarily correspond to fixed areas over long periods of time. Zip codes may also be added or deleted in an area as necessary. Because some zip codes have been added in East King County in the intervening years and some zip code boundaries have changed, the 1987 list of 22 zip codes no longer corresponds with the geographic area intended

² The state is divided into four HSAs by geographic groupings. HSA 1 is composed of Clallam, Island, Jefferson, King, Kitsap, Pierce, San Juan, Skagit, Snohomish, and Whatcom Counties. HSA 2 is composed of Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum counties. HSA 3 is composed of Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Okanogan, and Yakima Counties. HSA 4 is composed of Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman counties.

to be considered the East King planning area. EHMC provided its current interpretation of the East King planning area. In examining EHMC interpretation of East King, it appears to accurately reflect program records that have been updated to show additional zip codes within the original East King planning area. The department will evaluate the planning area in relation to all applicable non-post office box zip codes. [Application, p29; USPS Website; CN Historical Files]

When preparing acute care bed need projections, the department primarily relies upon population forecasts published by the Washington State Office of Financial Management (OFM). OFM publishes a set of forecasts known as the “intermediate-series” county population projections, based on the 2000 census, developed January 2007³. OFM data is also available regarding Small Area population estimates for past years.⁴ However, forecasts are not available for any area smaller than an entire county. Because OFM does not provide population estimates at the level necessary for this project, the department relied upon estimates and projections developed by Claritas, Inc. for the East King planning area population.

This portion of the evaluation describes, in summary, the calculations made at each step and the assumptions and adjustments made in that process relevant to this reconsideration. It will also include a review of any deviations related to the assumptions or adjustments made by EHMC in its application of the methodology.

The titles for each step are excerpted from the 1987 SHP.

Step 1: Compile state historical utilization data (i.e., patient days within major service categories) for at least ten years proceeding the base year.

For this step, attached as Appendix 1, the department obtained utilization data for 1998 through 2007 from the Department of Health’s Office of Hospital and Patient Data Systems’ CHARS (Comprehensive Hospital Abstract Reporting System) database. Total patient days were identified for the East King Planning Area, HSA #1, and Washington State as a whole, excluding psychiatric patient days [Major Diagnostic Category (MDC) 19] and normal newborns [Diagnostic Related Group (DRG) 391⁵], according to the county in which care was provided. Normal newborn days were excluded because the normal newborn patients (babies) do not occupy a licensed acute care bed. The mothers of the normal newborns are included in the patient days (MDC 14 and DRG 370-384).

EHMC followed this step as described above. The application uses slightly different totals from 2004-2006 for the East King patient days than those calculated from Department records. Though the totals reported for 2007, used in subsequent calculations, match Department figures.

³ Found on the World Wide Web at <http://www.ofm.wa.gov/pop/estimates.asp> and at <http://www.ofm.wa.gov/pop/poptrends/default.asp> and compiled internally by DOH

⁴ Current available OFM Small Area zip code estimates range from 2000-2008

⁵ In October 2007, CMS released a new listing (v. 25) of DRG classifications. Data up to 2006 will continue to use the 391 citation, 2007 forward will use DRG 795.

Step 2: Subtract psychiatric patient days from each year's historical data.

This step was partially accomplished by limiting the data obtained for Step 1, above. The remaining data still included non-MDC 19 patient days spent at psychiatric hospitals. Patient days at dedicated psychiatric hospitals were identified for each year and subtracted from each year's total patient days. The adjusted patient days are shown in Appendix 2.

EHMC followed this step as described above with no deviations.

Step 3: For each year, compute the statewide and HSA average use rates.

The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days in each HSA by that HSA's OFM population figures and multiplied by 1,000. Using the same process, the average use rate was also determined for the state and is attached as Appendix 3. For the production of the need methodology in this reconsideration evaluation, historical population estimates for the East King planning area were established using Claritas, Inc. data.

EHMC followed this step as described above with no deviations.

Step 4: Using the ten-year history of use rates, compute the use rate trend line, and its slope, for each HSA and for the state as a whole.

The resulting trend lines from the ten-year history, 1998-2007, of rates uniformly exhibit an upward slope in HSA and State trends. A trend line for the specific planning area also indicates an upward trend. This conclusion is generally supported by increasing utilization reported by hospitals throughout the state in recent years. More significant than overall population growth is the fact that the state's population is growing older as the number of "baby boomers" (those born from 1946 to 1964) age and begin to demand more health services. Utilization of hospital beds by patients aged 65 and older is significantly higher than bed utilization by younger patients, as demonstrated in subsequent calculations.

EHMC followed this step as described with no deviations.

Step 5: Using the latest statewide patient origin study, allocate non-psychiatric patient days reported in hospitals back to the hospital planning areas where the patients live. (The psychiatric patient day data are used separately in the short-stay psychiatric hospital bed need forecasts.)

The previous four steps of the methodology involved data identified by the planning area where care was provided. In order to determine the need for services for residents of a given planning area, patient days must be identified, instead, by the area where the patients live. Step 5, included as Appendix 5, identifies referral patterns in and out of the East King planning area and illustrates where residents of the planning area currently receive care. For this calculation, the department separated patient days by age group (0-64 and 65 and older), and subtracted patient days for residents of other states. The department also used data reported by EHMC representing the 2007 patient days for Washington residents obtaining health care in Oregon to have some accounting to the out migration (the department is not aware of similar data for the state of Idaho).

The original purpose for this methodology was to create comprehensive, statewide resource need forecasts. For this project, the state was broken into two planning areas – East King and the State as a whole minus East King. Appendix 5 illustrates the age-specific patient days for residents of the East King planning area and for the rest of the state, identified here as “WA – EK.”

At the start of this step, EHMC uses a figure of 131,709 to represent the total patient days for East King County, 796 days more than the total presented for 2007 in step 2 of applicant’s methodology. This leads to a slight inflation of the applicant’s values throughout the remaining steps of the methodology and the related percentages. (September 8, 2008 Rebuttal comments, p43 & 46, Initial Evaluation, Exhibit A)

Step 6: Compute each hospital planning area’s use rate (excluding psychiatric services) for each of the age groups considered (at a minimum, ages 0-64 and 65+).

Appendix 6 illustrates the age-specific use rates for the year 2007, as calculated in Step 3, for the East King planning area and for the rest of the state.

Statements by the applicant, and comments submitted by the community, attempt to address growing populations for the East King County planning area. Though statements regarding the degree of growth and the potential migration patterns vary, indications are that past assumptions made in relation to the two age cohorts in projected population numbers have changed. The initial attempt to account for this disproportionate growth led EHMC to assert that the Department’s efforts negatively affected the use rate for the 65+ age cohort. [Public Comment; Application, p22]

To remove any invalid cross-over in sub-county planning area population assumptions by using unrelated data sources, the Department established the East King populations with Claritas data. Specifically, the Department used the 2007 population derived from Claritas estimates for 2000 and 2008. It remains necessary to produce a statewide use rate for each of the age cohorts. The Department continued to rely upon the statewide OFM data, as did the applicant, to compute a statewide use rate for these age groups. [Application, p30; Public Comment]

EHMC followed this step as described above. However, to establish the population estimate for the 65+ age cohort to be used to determine the 65+ use rate, the applicant did not rely solely upon the Claritas age specific data. Rather, the applicant applied a factor of 10.42% to the total planning area population reported by Claritas. This produced a population estimate of 53,735 for the 65+ age cohort in 2007. In contrast, a linear growth projection based upon Claritas age specific data produces a value of 55,583 for the same year.

Further analysis of the historical population figures used by the applicant show that the 2007 65+ population total accounts for only 71% of the total growth represented in the Claritas data from 2000 to 2008. This requires a growth rate of 29% in the age cohort from 2007 to 2008 to reach the Claritas data point of 56,952. Table 1 below details the comparison.

Table 1
65+ Age Cohort Population Values for 2000 though 2008

	Claritas 65+ 2000	Applied 65+ 2007 Population	Claritas 65+ 2008	Increase from 2000 - 2007	% Growth Total 2000 - 2007	Increase from 2007 - 2008	% Growth Total 2007 - 2008
EHMC	46,000	53,735	56,952	7,735	70.6%	3,217	29.4%
DOH	46,000	55,583	56,952	9,583	87.5%	1,369	12.5%

The result of using the increased East King patient days outlined above (step 5) divided by the applicant’s lower 65+ population total depicted in Table 1, the applicant reports a planning area use rate for this age group to be 997.76. This is approximately 34 days per 1000 residents higher than the Department’s use rate of 963.80. [Supplemental Information, p47; Reconsideration Evaluation, Exhibit A]

Step 7A: Forecast each hospital planning area’s use rates for the target year by “trend-adjusting” each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the appropriate health planning region’s ten-year use rate trend, whichever trend would result in the smaller adjustment.

As discussed in Step 4, the department used the ten-year use rate trends for 1998-2007 to reflect the use patterns of Washington residents. The 2007 use rates determined in Step 6 were multiplied by the slopes of both the Health Service Area’s ten-year use rate trend line and by the slope of the statewide ten-year use rate trend line for comparison purposes. The HSA trend is a lower projected rate (an annual increase of 2.7353) than the state planning area rate of increase of 2.9333. As directed in Step 7A, the department applied the HSA trend to project future use rates.

The methodology is designed to project bed need in a specified “target year.” It is the practice of the department to evaluate need for a given project through seven years from the last full year of available CHARS data, or 2007 for purposes of this analysis. Therefore, the target year for this analysis will be 2014.

EHMC applied this portion of step 7 with no apparent modifications. Due to the cumulative effect of the disparities outlined above, the applicant reports a projected use rate of those 65+ in the population for 2014 to be 1,018.36; 3.5% higher than the Department’s calculation of 982.95 days.

Step 8: Forecast non-psychiatric patient days for each hospital planning area by multiplying the area’s trend-adjusted use rates for the age groups by the area’s forecasted population (in thousands) in each age group at the target year. Add patient days in each age group to determine total forecasted patient days.

Using the statewide forecasted use rate for the target year 2014 and age cohort population projections derived from Claritas data for the planning area, the department’s projected patient days for East King planning area residents is illustrated in Appendix 8. As noted in Step 7

above, forecasts have been prepared for a series of years and are presented in summary in Appendix 10a & 10b as “Total East King Res Days.”

EHMC used this same approach in its projections.

Step 9: Allocate the forecasted non-psychiatric patient days to the planning areas where services are expected to be provided in accordance with (a) the hospital market shares and (b) the percent of out-of-state use of Washington hospitals, both derived from the latest statewide patient origin study.

Using the patient origin study developed for step 5, Appendix 9 illustrates how the projected patient days for the East King planning area and the remainder of the state were allocated from county of resident to the area where the care is projected to be delivered in the target year 2014. The results of these calculations are presented in Appendix 10a & 10b as “Total Days in East King Hospitals.”

EHMC prepared this step as above. Previously noted variations in calculations resulted in higher patient day totals, and their related percentages, than those derived by the department.

Step 10: Applying weighted average occupancy standards, determine each planning area’s non-psychiatric bed need. Calculate the weighted average occupancy standard as described in Hospital Forecasting Standard 11.f. This should be based on the total number of beds in each hospital (Standard 11.b), including any short-stay psychiatric beds in general acute-care hospitals. Psychiatric hospitals with no other services should be excluded from the occupancy calculation.

The number of beds in the planning area was identified in accordance with the SHP standard 12a, which states:

1. beds which are currently licensed and physically could be set up without significant capital expenditure requiring new state approval;
2. beds which do not physically exist but are authorized unless for some reason it seems certain those beds will never be built;
3. beds which are currently in the license but physically could not be set up (e.g., beds which have been converted to other uses with no realistic chance they could be converted back to beds);
4. beds which will be eliminated.

The SHP determines the number of available beds in each HSA, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. This information was gathered through CN and Facilities and Services Licensing records. There are currently three acute care hospitals in the East King planning area – Overlake Hospital Medical Center, Snoqualmie Valley Hospital, and the applicant. Group Health Eastside Hospital previously operated within the planning area but has recently delicensed the beds at that facility. Also considered is the approval of a 175 bed hospital in Issaquah being constructed by Swedish Health Services which will begin operation in 2013. [CN and OHCS files]

The weighted occupancy standard for a planning area is defined by the SHP as the sum, across all hospitals in the planning area, of each hospital’s occupancy rate times that hospital’s

percentage of total beds in the area. In previous evaluations, the department determined that the occupancy standards reflected in the 1987 SHP are higher than can be maintained by hospitals under the current models for provision of care. As a result, the department has adjusted the occupancy standards presented in the SHP downward by 5% for all but the smallest hospitals (1 through 49 beds). As a result of this change, the East King planning area's weighted occupancy has been determined to be 72.11% for 2008. This is reflected in the line "Wtd Occ Std" in Appendix 10a.

EHMC proposed adding 48 beds by January 2009 for a total of 275 acute care beds. Phase two of the project is scheduled to be operational in January 2013 with the addition of the remaining 32 beds, making the final bed count equal to 307. The Department prepared the bed need methodology to show the effect of implementing the entire project as proposed and detailed in Appendix 10b.

While the methodology states that short-stay psychiatric beds should be included in the above total, the fact that all psychiatric patient days were excluded from the patient days analyzed elsewhere in the methodology makes their inclusion inconsistent with the patient days used to determine need.

EHMC also reduced the weighted occupancy consistent with the reductions outlined by the department, and did not include short stay psychiatric beds within its calculations.

Step 11: To obtain a bed need forecast for all hospital services, including psychiatric, add the non-psychiatric bed need from step 10 above to the psychiatric inpatient bed need from step 11 of the short-stay psychiatric hospital bed need forecasting method.

The applicant is not proposing to add psychiatric services at the facility. In step 10, the department excluded the short stay psychiatric beds from the bed count total. For these reasons, the department concluded that psychiatric services should not be forecast while evaluating this project.

EHMC also did not provide psychiatric forecasts within its methodology.

Step 12: Determine and carry out any necessary adjustments in population, use rates, market shares, out-of-area use and occupancy rates, following the guidelines in section IV of this Guide.

Within the department's application of the methodology, adjustments have been made where applicable and described above in relation to the 65+ age cohort.

Referring back to step 10, Appendix 10a calculates the planning area bed need without the project. Appendix 10b calculates the planning area bed need with the project phased in. A summary of those appendices is shown below.

Table 2
Department Methodology
Appendix 10A – Without Project - Summary

	2008	2009	2010	2011	2012	2013	2014
Planning Area # of beds	548	548	548	548	548	628 ⁶	628
Adjusted Gross Need	502.31	521.10	540.02	559.07	578.24	610.60	630.45
Need/(Surplus) – Without Project (Appendix 10a)	(45.69)	(26.90)	(7.98)	11.07	30.24	(17.40)	2.45

Appendix 10B – With Project – Summary

	2008	2009	2010	2011	2012	2013	2014
Planning Area # of beds	548	596 ⁷	596	596	596	708 ⁸	708
Adjusted Gross Need	502.31	522.33	541.29	560.38	579.60	611.15	631.02
Need/(Surplus) - With Project (Appendix 10b)	(45.69)	(73.67)	(54.71)	(35.62)	(16.40)	(96.85)	(76.98)

For the current year, Appendices 10a and 10b both illustrate a planning area surplus of beds. Appendix 10a indicates the planning area is projected to experience a continued surplus through 2010. Need is present for 2011 and 2012, reaching 30 beds, until the anticipated introduction of the Issaquah beds in 2013. [Reconsideration Evaluation, Exhibit A; September 8, 2008 Rebuttal Comments, p53; Swedish Progress Reports]

Appendix 10b illustrates the effect on the planning area of this project. By adding 48 beds in 2009, EHMC increases the existing surplus to nearly 74 beds. The surplus continues, but drops each year through 2012. The surplus then spikes up to nearly 97 beds in 2013, the year EHMC proposes to complete Phase 2 of this proposed project coinciding with when the Swedish Issaquah facility reports the first 80, of 175 total beds, will become available.

In contrast, the applicant’s need methodology produced a numeric need for beds beginning in 2010 and continuing throughout the projection years. By defaulting to a population factor in step 6 to calculate a 65+ population total lower than a linear growth curve would indicate, the applicant computes a greater 2007 use rate than the Department. A similar review of the population projections used by the applicant from 2008-2014 indicate disproportionate growth in the opposite direction. Beginning with Claritas data in 2008, EHMC projects that 95% of the population growth projected between 2008 and 2013 will occur by 2012, totaling 70,951. To reach the Claritas data point of 73,035 for 2013, the 65+ population growth in the final year falls to 5.35%. When the applicant’s uneven population totals for both 2007 and 2012 are inserted, EHMC produces a need of 53 beds in 2012. [Supplemental Information, p47; Reconsideration Evaluation, Exhibit A]

This application proposes to add 48 beds in 2009 as the first phase of a two phase project. These beds would be made operational within space currently available at the hospital

⁶ Introduction of 80 beds at the Swedish Issaquah Hospital

⁷ Inclusion of EHMC Phase 1 – 48 beds

⁸ Inclusion of EHMC Phase 2 – 32 Beds in addition to 80 Swedish Beds

campus. The re-construction of the need methodology provides the basis to consider this first phase to assure the residents of the planning area continue to have access to acute care services in the years preceding the opening of the first phase of the new hospital in Issaquah. At the completion of phase one, the surplus reaches 73 beds. This surplus diminishes through 2012, falling to a surplus of 16 beds immediately prior to the introduction of the Issaquah hospital beds.

Based on the numeric need methodology prepared by the Department in this reconsideration, consistent with the guidance of the methodology, EHMC's proposal to add 80 acute care beds is not supported. The methodology does support the approval of 48 new acute care beds as outlined in Phase one of the project. Therefore, based on the above evaluation, EHMC's proposed Phase one of this project, to add 48 acute care hospital beds, is consistent with this sub-criterion.

- (2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

In its December 2, 2008 initial evaluation, the Department concluded that the project met the accessibility criteria outlined in WAC 246-310-210(2). There was no additional information provided during this review that would change the Department's conclusion regarding the accessibility criteria; therefore, these sub-criteria remains met.

B. Structure and Process (Quality) of Care (WAC 246-310-230)

Based on the source information reviewed for the approval of Phase one of this project, the Department determines that EHMC application meets the structure and process (quality) of care criteria in WAC 246-310-230.

- (4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

Initial Evaluation Summary

In its December 2, 2008 evaluation, the Department concluded that EHMC's project met four of the five sub-criteria outlined in this section. The sub-criterion not met – (4) above - related to the project's failure to meet the need criteria. [Initial evaluation, p20-22]

Reconsideration Evaluation

Based on information provided during the reconsideration review, the Department concluded that EHMC's application met all applicable need criteria. As a result, the department's conclusion under (4) above would be met, along with the other four sub-criteria.

D. Cost Containment (WAC 246-310-240)

Based on the source information reviewed for the approval of Phase one of this project, the Department determines that the EHMC application to add 48 acute care beds meets the cost containment criteria in WAC 246-310-240.

(1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.

Initial Evaluation Summary

In its December 2, 2008 evaluation, the Department concluded that EHMC project only met two of the three sub-criteria outlined in this section. The sub-criterion not met – (1) above - related to the project's failure to meet the need criteria. [Initial evaluation, p23]

Reconsideration Evaluation

As addressed in detail above, the planning area is currently experiencing a surplus of bed capacity, with a short-term need projected in 2011 and 2012. The pending Swedish hospital will provide capacity to address long-term need in the area after 2013. Since EHMC proposed a two phase project, the Department has determined that the Phase one addition of 48 can be supported by the acute care bed methodology.

Based on information provided during the reconsideration review, the Department concludes that EHMC application to add 48 acute care beds meets all applicable need criteria. As a result, the department's conclusion under section (1) would be met.

Exhibit A