STATE OF WASHINGTON
DEPARTMENT OF HEALTH

August 12, 2011

CERTIFIED MAIL # 7008 1300 0000 7202 9959

Caitlin Hillary Moulding, Vice President
Strategy, Marketing, and Community Outreach
Overlake Hospital Medical Center
1035 – 116th Avenue Northeast
Bellevue, Washington 98004

RE: CN11-18

Dear Ms. Moulding:

We have completed review of the Certificate of Need application submitted on behalf of Overlake Hospital Medical Center proposing to add 12 Level II intermediate care nursery beds to the hospital's license. For the reasons stated in this evaluation, the application submitted by Overlake Hospital Medical Center is consistent with applicable criteria of the Certificate of Need Program, provided Overlake Hospital Medical Center agrees to the following in its entirety.

Project Description:

This project approves the addition of 12 intermediate care nursery beds to the hospital license, resulting in a license increase from 337 to 349, provided that Overlake Hospital Medical Center agrees to the following in its entirety.

Bed Type	# of Licensed Beds
General Medical/ Surgical	297
Level II ICN	12
Level III NICU	6
Dedicated Psychiatric	34
Total Number of Licensed Beds	**349**

Conditions:

1. Approved project as described above.
2. Overlake Hospital Medical Center will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. Overlake Hospital Medical Center will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the King County

Region. Currently, this amount is 1.42% for gross revenue and 2.51% for adjusted revenue. Overlake Hospital Medical Center will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

3. By September 30, 2011, Overlake Hospital Medical Center will provide to the department for review and approval a final and signed Medical Director Agreement. The final and signed agreement must be consistent with the draft agreement provided in the application.

Approved Costs:

There is no capital expenditure associated with this project.

You have two options, either accept or reject the above in its entirety. If you accept the above in its entirety, your application will be approved and a Certificate of Need sent to you. If you reject any provision of the above, you must identify that provision, and your application will be denied because approval would not be consistent with applicable Certificate of Need review criteria. Please notify the Department of Health within 20 days of the date of this letter whether you accept the above in its entirety.

Your written response should be sent to the Certificate of Need Program, at one of the following addresses.

Mailing Address:	Other Than By Mail:
Department of Health	Department of Health
Certificate of Need Program	Certificate of Need Program
Mail Stop 47852	310 Israel Road SE
Olympia, WA 98504-7852	Tumwater, WA 98501

If you have any questions, or would like to arrange for a meeting to discuss our decision, please contact Janis Sigman with the Certificate of Need Program at (360) 236-2955.

Sincerely,

for Steven M. Saxe, FACHE
Director, Health Professions and Facilities

Enclosure

EXECUTIVE SUMMARY

EVALUATIONS OF THE FOLLOWING TWO CERTIFICATE OF NEED APPLICATIONS RELATED TO INTERMEDIATE CARE LEVEL II OBSTETRIC SERVICES IN KING COUNTY.

- **OVERLAKE HOSPITAL MEDICAL CENTER PROPOSING TO ADD 12 INTERMEDIATE CARE LEVEL II BEDS TO THE HOSPITAL LICENSE**
- **SWEDISH HEALTH SERVICES PROPOSING TO ESTABLISH A 14-BED INTERMEDIATE CARE NURSERY WITHIN SPACE AT ITS NOT-YET-OPERATIONAL ISSAQUAH HOSPITAL CAMPUS**

BRIEF PROJECT DESCRIPTIONS

Overlake Hospital Medical Center

Overlake Hospital Medical Center (OHMC) proposes to add 12 existing intermediate care nursery (ICN) beds to its hospital license. OHMC states that it was not aware that ICN beds must be included within the hospital license. OHMC proposes to correct this licensure oversight by adding 12 ICN beds to its total licensed bed capacity. If this project is approved, OHMC licensed beds would increase from 337 to 349. [source: Application, p7]

There is no capital expenditure associated with this project. [source: Application, pp 8 & 25]

If this project is approved, OHMC would immediately begin the process with the department's licensure office to increase its hospital license from 337 to 349. [source: Application, p14]

Swedish Health Services

Swedish Health Services (SHS) proposes the establishment of a 14-bed ICN within space at the not-yet-operational Issaquah hospital campus. The 14 ICN beds would be licensed within the total of 175 beds approved under CN #1379. [source: Application, p13]

The capital expenditure associated with the establishment of the 14-bed ICN is $2,113,123. [source: Application, p48]

SHS anticipates the 14 ICN beds would be added in two phases. Phase one is the addition of 8 beds when the hospital becomes operational by mid-year 2012 with 80 acute care beds. Phase two is the addition of the remaining 6 ICN beds. SHS does not specifically identify the projected month or year associated with the implementation of phase two; rather, SHS plans to add the remaining 6 ICN beds once occupancy of the first 8 beds exceeds 65%. [source: Application, p13; March 28, 2011, supplemental information, pp6-7]

APPLICABILITY OF CERTIFICATE OF NEED LAW

Overlake Hospital Medical Center

OHMC's application is subject to Certificate of Need review as the change in bed capacity at a health care facility which increases the total number of licensed beds under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

Swedish Health Services

SHS's application is subject to Certificate of Need review as the establishment of a new tertiary service under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(f) and Washington Administrative Code (WAC) 246-310-020(1)(d)(B).

CONCLUSIONS

Overlake Hospital Medical Center

Project Description:

This project approves the addition of 12 intermediate care nursery beds to the hospital license, resulting in a license increase from 337 to 349, provided that Overlake Hospital Medical Center agrees to the following in its entirety.

Bed Type	# of Licensed Beds
General Medical/ Surgical	297
Level II ICN	12
Level III NICU	6
Dedicated Psychiatric	34
Total Number of Licensed Beds	**349**

Conditions:

1. Approved project as described above.
2. Overlake Hospital Medical Center will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. Overlake Hospital Medical Center will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the King County Region. Currently, this amount is 1.42% for gross revenue and 2.51% for adjusted revenue. Overlake Hospital Medical Center will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.
3. By September 30, 2011, Overlake Hospital Medical Center will provide to the department for review and approval a final and signed Medical Director Agreement. The final and signed agreement must be consistent with the draft agreement provided in the application.

Approved Costs:

There is no capital expenditure associated with this project.

Swedish Health Services

For the reasons stated in this evaluation, the application submitted on behalf of Swedish Health Services proposing to establish a 14-bed intermediate care nursery and level II obstetric services within space at its not-yet-operational Issaquah hospital campus is not consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is denied.

EVALUATIONS OF THE FOLLOWING TWO CERTIFICATE OF NEED APPLICATIONS RELATED TO INTERMEDIATE CARE LEVEL II OBSTETRIC SERVICES IN KING COUNTY.

- **OVERLAKE HOSPITAL MEDICAL CENTER PROPOSING TO ADD 12 INTERMEDIATE CARE LEVEL II BEDS TO THE HOSPITAL LICENSE**
- **SWEDISH HEALTH SERVICES PROPOSING ESTABLISH A 14-BED INTERMEDIATE CARE NURSERY WITHIN SPACE AT ITS NOT-YET-OPERATIONAL ISSAQUAH HOSPITAL CAMPUS**

APPLICANT DESCRIPTIONS

Overlake Hospital Medical Center

Overlake Hospital Medical Center (OHMC) is a not-for-profit corporation and a 501(c)(3) exempt organization. OHMC is located at 1035 – 116th Avenue Northeast in Bellevue, within King County. OHMC provides Medicare and Medicaid healthcare services to the residents of east King County and surrounding areas through its hospital and ambulatory surgery center that are both located in Bellevue. [source: CN historical files; Application, p2]

Swedish Health Services

Swedish Health Services (SHS) is a not-for-profit corporation and a 501(c)(3) exempt organization with 100% ownership of Swedish Medical Center.[1] Swedish Medical Center is also a Washington private, not-for-profit corporation and a 501(c)(3) exempt organization. Swedish Medical Center provides Medicare and Medicaid acute care services at the following four campuses.

SHS-First Hill Campus	747 Broadway, Seattle	King County
SHS-Ballard Campus	5300 Tallman Avenue Northwest, Seattle	King County
SHS-Cherry Hill Campus	500 – 17th Avenue, Seattle	King County
SHS Edmonds[2]	21601 76th Avenue West, Edmonds	Snohomish County

In addition to the campuses above, the department issued SHS Certificate of Need (CN) #1379 on May 31, 2007, for the establishment of a new 175-bed hospital in Issaquah.[3] [source: CN Program's May 31, 2007, remand evaluation] The construction of the hospital is nearing completion, and SHS anticipates the first phase—80 acute care beds—would be operational by mid-year 2012. [source: Application, p13]

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[1] Swedish Health Services also has ownership percentages in a variety of other healthcare entities, such as home health, ambulatory surgery, and urgent care clinics. Since these entities are not pertinent to this project, they will not be discussed in this evaluation.

[2] On February 26, 2010, SHS created a separate corporation known as Swedish Edmonds, where SHS is 100% sole member. On August 26, 2010, CN #1426 was issued to Swedish Edmonds approving a long-term lease agreement with Public Hospital District #3-Stevens Hospital located in Edmonds, within Snohomish County. The lease agreement became effective September 1, 2010, and is expected to continue for 30 years, with two 10-year options to renew.

[3] Subsequent to the November 2006 approval, SHS was also issued CN #1379A approving a change in the approved site to another parcel of land in Issaquah, within King County. SHS was also issued CN #1379A2 approving a change in the financing for the hospital. These two amendments to CN #1379 are not pertinent to this project, they will not be further discussed in this evaluation.

PROJECT DESCRIPTIONS

Overlake Hospital Medical Center

On November 25, 2002, OHMC was issued CN #1251 approving the establishment of a 6-bed neonatal intensive care unit (NICU) to be co-located with its ICN. Within that approval, the department acknowledged OHMC was operating a 12-bed ICN. [source: Application, #01-03, executive summary and the department's November 25, 2002, evaluation] OHMC states that at the time of the 2002 approval for its 6-bed NICU, it was not aware that the existing 12 ICN beds must also be included within the hospital license.

With this application, OHMC proposes to correct this licensure oversight by adding 12 ICN beds to its total licensed bed capacity. If this project is approved, OHMC's licensed beds would increase from 337 to 349. [source: Application, p7]

Since OHMC has been providing ICN services since at least year 2002, there is no capital expenditure associated with this project. [source: Application, pp 8 & 25]

If this project is approved, OHMC would immediately begin the process with the department's licensure office to increase its hospital license from 337 to 349. OHMC anticipates this would occur by the end of year 2011. Under this timeline, year 2012 would be the facility's first full calendar year of operation with 349 licensed beds and 2014 would be year three. [source: Application, p14]

Swedish Health Services

On May 31, 2007, the department issued CN #1379 to SHS for the establishment of a 175-bed hospital. Subsequent to the issuance of CN #1379, the department issued CN #1379A approving the change in the site of the hospital. The new approved site is 401 Blakely Drive in Issaquah. [source: CN historical files]

This project under review proposes the establishment of a 14-bed ICN within space at its not-yet-operational Issaquah hospital campus. The 14 bassinettes would be licensed within the 175 beds approved under CN #1379. [source: Application, p13]

The capital expenditure associated with the establishment of the 14-bed ICN is $2,113,123. Of that amount 35% is related to construction costs; 47% for fixed/moveable equipment; 10% is related to fees; and the remaining 8% is related to state taxes. [source: Application, p48]

SHS anticipates the 14 bassinettes would be added in two phases. Phase one is the addition of 8 bassinettes when the hospital becomes operational by mid-year 2012 with 80 acute care beds. At that time, SHS's Issaquah hospital would be operating with 72 medical surgical beds and 8 ICN beds.

Phase two is the addition of the remaining 6 ICN bassinettes. SHS does not specifically identify the projected month or year associated with the implementation of phase two; rather, SHS plans to add the remaining 6 ICN bassinets once occupancy of the first 8 bassinettes exceeds 65%. Based on the two-phase timeline, year 2013 would be the hospital's first full calendar year of operation with an 8-bed ICN. Year three of this project is undetermined. [source: Application, p13; March 28, 2011, supplemental information, pp6-7]

APPLICABILITY OF CERTIFICATE OF NEED LAW

Overlake Hospital Medical Center

OHMC's application is subject to Certificate of Need review as the change in bed capacity at a health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

Swedish Health Services

SHS's application is subject to Certificate of Need review as the establishment of a new tertiary service under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(f) and Washington Administrative Code (WAC) 246-310-020(1)(d)(B).

CRITERIA EVALUATION

WAC 246-310-200(1)(a)-(d) identifies the four determinations that the department must make for each application. WAC 246-310-200(2) provides additional direction in how the department is to make its determinations. It states:

"Criteria contained in this section and in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240 shall be used by the department in making the required determinations.

(a) In the use of criteria for making the required determinations, the department shall consider:

(i) The consistency of the proposed project with service or facility standards contained in this chapter;

(ii) In the event the standards contained in this chapter do not address in sufficient detail for a required determination the services or facilities for health services proposed, the department may consider standards not in conflict with those standards in accordance with subsection (2)(b) of this section; and

(iii) The relationship of the proposed project to the long-range plan (if any) of the person proposing the project."

In the event the WAC 246-310 does not contain service or facility standards in sufficient detail to make the required determinations, WAC 246-310-200(2)(b) identifies the types of standards the department may consider in making its required determinations. Specifically WAC 246-310-200(2)(b) states:

"The department may consider any of the following in its use of criteria for making the required determinations:

(i) Nationally recognized standards from professional organizations;

(ii) Standards developed by professional organizations in Washington state;

(iii) Federal Medicare and Medicaid certification requirements;

(iv) State licensing requirements;

(v) Applicable standards developed by other individuals, groups, or organizations with recognized expertise related to a proposed undertaking; and

(vi) The written findings and recommendations of individuals, groups, or organizations with recognized expertise related to a proposed undertaking, with whom the department consults during the review of an application."

For these projects, WAC 246-310 does not contain service or facility standards in sufficient detail to make the required determinations. To obtain Certificate of Need approval, each applicant m ust demonstrate compliance with the applicable criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment).[4] Where applicable, meeting the September 2010 Perinatal Level of Care Guidelines establish by the Washington State Perinatal Advisory Committee assists in demonstrating compliance with the criteria.

APPLICATION CHRONOLOGY

Since both applications focus on tertiary services, the department reviewed the projects concurrently. Below is a chronologic summary of the projects.

Action	SHS	OHMC
Letter of Intent Submitted	November 19, 2010	January 18, 2011
Application Submitted	January 20, 2011	February 28, 2011
Department's Pre-review Activities including Screening and Responses	January 21, 2011 through May 16, 2011	
Beginning of Review	May 17, 2011	
End of Public Comment	June 21, 2011	
Rebuttal Comments Received[5]	July 7, 2011	
Department's Anticipated Decision Date	August 22, 2011	
Department's Actual Decision Date	August 12, 2011	

CONCURRENT REVIEW

The purpose of the concurrent review process is to comparatively analyze and evaluate competing or similar projects to determine which of the projects may best meet the identified need. In the case of the projects submitted by OHMC and SHS, the department will issue one single evaluation regarding whether one, both, or neither of the projects should be issued a Certificate of Need.

AFFECTED PERSONS

Washington Administrative Code 246-310-010(2) defines "affected person as:

"...an "interested person" who:

(a) Is located or resides in the applicant's health service area;

(b) Testified at a public hearing or submitted written evidence; and

(c) Requested in writing to be informed of the department's decision."

For each application, the other applicant sought and received affected person status under WAC 246-310-010(2). Additionally, one acute care provider sought and received affected person status for these two projects.[6]

[4] Each criterion contains certain sub-criteria. The following sub-criteria are not discussed in this evaluation because they are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6).

[5] All public comments focused on SHS's application. Only SHS provided rebuttal comments.

- Evergreen Healthcare is an acute care hospital located at 12040 Northeast 128th Street in Kirkland, within east King County. Evergreen Healthcare provides Medicare and Medicaid services to the residents of King County and surrounding areas. Evergreen Healthcare operates a combined ICN and neonatal intensive care unit (NICU) within space at the hospital.

SOURCE INFORMATION REVIEWED

- Overlake Hospital Medical Center's Certificate of Need application submitted February 28, 2011
- Swedish Health Service's Certificate of Need application submitted January 20, 2011
- Overlake Hospital Medical Center's supplemental information dated May 4, 2011
- Swedish Health Service's supplemental information dated March 28, 2011
- Public comment received during the review
- Swedish Health Services rebuttal comments received July 7, 2011
- September 2010 Statewide Perinatal Advisory Committee Washington State Perinatal Level of Care Guidelines
- Licensing and/or survey data provided by the Department of Health's Investigations and Inspections Office
- Licensing and/or survey data provided by out of state health care survey programs
- Certificate of Need historical files

CONCLUSIONS

Overlake Hospital Medical Center

Project Description:

This project approves the addition of 12 intermediate care nursery beds to the hospital license, resulting in a license increase from 337 to 349, provided that Overlake Hospital Medical Center agrees to the following in its entirety.

Bed Type	# of Licensed Beds
General Medical/ Surgical	297
Level II ICN	12
Level III NICU	6
Dedicated Psychiatric	34
Total Number of Licensed Beds	**349**

Conditions:

1. Approved project as described above.
2. Overlake Hospital Medical Center will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. Overlake Hospital Medical Center will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the King County

[6] While Providence Regional Medical Center-Everett submitted a request for affected person, it did not submit public comment for either project. As a result, Providence Regional Medical Center-Everett received 'interested person' status as defined in WAC 246-310-010(34).

Region. Currently, this amount is 1.42% for gross revenue and 2.51% for adjusted revenue. Overlake Hospital Medical Center will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

3. By September 30, 2011, Overlake Hospital Medical Center will provide to the department for review and approval a final and signed Medical Director Agreement. The final and signed agreement must be consistent with the draft agreement provided in the application.

Approved Costs:

There is no capital expenditure associated with this project.

Swedish Health Services

For the reasons stated in this evaluation, the application submitted on behalf of Swedish Health Services proposing to establish a 14-bed intermediate care nursery and level II obstetric services within space at its not-yet-operational Issaquah hospital campus is not consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is denied.

A. Need (WAC 246-310-210)

Based on the source information reviewed, the department concludes:

- Overlake Hospital Medical Center's project has met the need criteria in WAC 246-310-210(1) and (2) with agreement to the conditions identified in the 'conclusion' section of this evaluation; and
- Swedish Health Services' project has not met the need criteria in WAC 246-310-210(1) and (2).

(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.

WAC 246-310 does not contain an ICN need methodology. As a result, the evaluation of the need criterion for ICN projects begins with an evaluation of the methodology provided by the applicant. It is noted that both applicants relied on historical Comprehensive Hospital Abstract Reporting System (CHARS) data as a foundation for the numeric methodology. CHARS data is reported annually by each Washington State hospital to the department's Hospital and Patient Data Systems program (HPDS). The CHARS data provides historical trends in discharges and lengths of stay for newborn patients for the major diagnostic category (MDC) #15 - NEWBORNS AND OTHER NEONATES WITH CONDITIONS ORIGINATING IN THE PERINATAL PERIOD. MDC #15 is made up of seven diagnosis related groups (DRGs). For years 2003 through 2006, those DRGS were identified as 385 through 391. Beginning in year 2007, the DRGs are identified as 789 through 795. The chart below provides the DRG and corresponding definition for MDC #15.[7]

DRG	Definition	Level of Care
385 / 789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	Level III
386 / 790	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	Level III
387 / 791	PREMATURITY WITH MAJOR PROBLEMS	Level II or III
388 / 792	PREMATURITY WITHOUT MAJOR PROBLEMS	Level II
389 / 793	FULL TERM NEONATE WITH MAJOR PROBLEMS	Level II
390 / 794	NEONATE WITH OTHER SIGNIFICANT PROBLEMS	Level II
391 / 795	NORMAL NEWBORN	Level I

For ease of reference, the remainder of this evaluation will refer to the DRGs above using the current 700 series number, rather than the former 300 series number.

As shown in the chart above, of the DRGs included in MDC #15, some do not correspond exactly with the level of care definitions. However, the majority of level III patients are included in DRGs 789 and 790, with a few level III patients in DRG 791. The majority of level II patients are included in DRGs 791, 792, 793, and 794. Both applicants used data from DRGs 791, 792, 793, and 794 for level II calculations. Below is a summary of the data points each applicant used for its ICN need methodology.

[7] Each DRGs corresponding level of care is based on October 3, 2001, testimony provided by Louis Pollack, MD, a board certified neonatologist and member of Washington State Perinatal Advisory Committee, and the October 16, 2007, testimony provided by Linda Wallen, MD, also a board certified neonatologist.

Overlake Hospital Medical Center

Based on 2000 through 2009 historical CHARS data, OHMC provided a 4-step numeric methodology and projected ICN capacity for years 2010 through 2014. Below is a summary of the numeric methodology. [source: Application, pp20-23]

Step 1 – Identify 10-year historic planning area resident days, discharges, and use rates

OHMC used the following data points for this step.

- Patient day statistics obtained from years 2000-2009 CHARS data for the level II DRGs identified above.
- Average length of stay (ALOS) was calculated by dividing patient days by discharges for each of the years 2000 through 2009. ALOS was calculated separately for each year. The ALOS for year 2009 of 3.95 was used in step 3 below.
- The number of females within the age cohort of 15-44 (childbearing age) were compiled from Claritas population data for the east King planning area for each year 2000-2009. A 1.7% decrease in women of childbearing age for years 2000 – 2009 was noted and factored into the projected populations for years 2010 through 2014.
- A level II use rate was calculated based on discharges per 1,000 women of childbearing age for each year 2000-2009.
- With the exception of year 2009, OHMC noted that the use rates exhibited a mild upward trend. A review of partial year 2010 demonstrated that the use rate would remain close to the 2009 level. Based on this information, OHMC opted to hold the use rate flat at the 2009 level for future projections.

Based on the factors above, OHMC calculated the following.

	Projected Use Rate	Projected ALOS
2011 - 2014	18.3	3.95

Step 2 – Calculate resident patient discharges and origin, provider market shares, and resident use rates for baseline year 2009

- Using year 2009 CHARS data as a baseline, OHMC identified the following factors to apply to projection years 2010 through 2014.

East King provider level II discharges by patient origin	East King Residents - 1,509 Outside east King Residents – 1,071 Total 2009 level II discharges 2,580
In-migration ratio	0.7097
Planning area provider market share	Year 2009 – 81.5
Total East King Resident Level II Use Rate (from step 1 above)	18.3

Step 3 – Apply the 2009 use rates to the projected future population to calculate future total resident days

- The 2009 use rate of 18.3 calculated in step 1 was applied to the forecast years 2010 through 2014.
- The number of women of childbearing age (15-44) were projected using Claritas projections for each year of the forecast period.
- Planning area resident level II discharges were forecast by multiplying the projected use rates (from step 1) by the forecast number of women of childbearing age for each year of the forecast period.
- The total number of planning area resident level II discharges was calculated.
- The in-migration ratio calculated in step 2 was applied to the projected non-planning area residents.
- The forecast level II patient days were determined by multiplying the forecast level II discharges for the planning area hospitals by the ALOS of 3.95 calculated in step 1.

The table below shows the total level II patient days OHMC projected for east King providers.

	2010	2011	2012	2013	2014
Total Level II Patient Days	10,143	10,101	10,059	10,018	9,976

Step 4 – Use total patient days projected in step 3 to determine forecast gross and net level II bed need for the planning area

- Based on the calculated 1.7% decrease in women of childbearing age for years 2000 – 2009, OHMC's method projects population decreases in projection years 2010 - 2014.
- Using the expected decrease stated above, OHMC projected a decrease in level II patient days for the planning area.
- The average daily census (ADC) was calculated for each year of the forecast period.
- The forecast ADC was adjusted to reflect the occupancy standards for the level II ICN of 65%. These forecasts represent gross bed need for level II bassinettes.
- OHMC was unsure of the total level II capacity of existing providers in the planning area—calculating either 37 or 42 existing level II beds. The 37 or 42 level II bassinettes are broken down below:
  - Overlake Hospital Medical Center with 12 level II bassinettes; and
  - Evergreen Healthcare with 25 to 30 level II bassinettes.
- Net need for level II bassinettes was calculated by subtracting current planning area supply of either 37 or 42 from gross bed need.

The table on the following page summarizes the results of the calculations described above.

	2010	2011	2012	2013	2014
Total Level II Patient Days	10,143	10,101	10,059	10,018	9,976
ADC	27.80	27.7	27.6	27.4	27.3
Gross Bed Need at 65% occupancy	39.7	39.5	39.4	39.2	39.0
Minus Current Level II Supply	42.0	42.0	42.0	42.0	42.0
Net Level II Bed Need or (Surplus)	(2.3)	(2.5)	(2.6)	(2.8)	(3.0)

	2010	2011	2012	2013	2014
Gross Bed Need at 65% occupancy	39.7	39.5	39.4	39.2	39.0
Minus Current Level II Supply	37.0	37.0	37.0	37.0	37.0
Net Level II Bed Need or (Surplus)	2.7	2.5	2.4	2.2	2.0

In summary, based on the factors and assumptions above, OHMC projects a surplus of level II beds for years 2010 through 2014 if there are 42 level II beds in the planning area and a need for at least two level II beds if there are 37 beds in the planning area. It is noted, however, that OHMC counts its own level II beds at 12 within the existing planning area capacity of 42 or 37. OHMC further estimates that its own discharges will grow by an average of 3% per year; which is calculated to be approximately half of the historic growth rate for OHMC for the past three fiscal years.

Swedish Health Services

Based on 2000 through 2009 historical CHARS data, SHS also provided a 4-step numeric methodology. Because SHS proposes a two phase project, its projection years are 2010 through 2020. Below is a summary of the numeric methodology. [source: March 28, 2011, supplemental information, Exhibit 19 & additional sources where noted]

Step 1 – Identify 10-year historic planning area resident days, discharges, and use rates

SHS used the following data points for this step.

- Patient day statistics obtained from years 2000-2009 CHARS data for the DRGs identified above.
- Average length of stay (ALOS) was calculated by dividing patient days by discharges, for each of the years 2000 through 2009. ALOS was calculated separately for each year. The resulting ALOS was held constant when applied in step 3 below.
- The number of females within the age cohort of 15-44 (childbearing age) were compiled from Claritas population data for the east King planning area for each year 2000-2009.
- A level II use rate was calculated based on discharges per 1,000 women of childbearing age for each year 2000-2009.
- Using the same rate estimates for years 2000 – 2009, a use rate trend adjustment factor of 0.56 was calculated. SHS noted that the use rate had generally increased from years 2000 through 2009.

Based on the factors above, SHS calculated a projected ALOS of 3.96 and the projected use rates for years 2010 through 2020 shown on the following page.

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Use Rate	19.4	20.0	20.5	21.1	21.7	22.2	22.8	23.3	23.9	24.5

Step 2 – Calculate planning area provider level II patient origin, in-migration ratio, and planning area provider market share

- Based on year 2009 CHARS data, the number of level II discharges for the east King planning area providers were estimated. The east King planning area providers are Overlake Hospital Medical Center and Evergreen Healthcare. The level II discharges include residents in the planning area and residents outside the planning area.
- Based on the patient origin figures, the level II in-migration ratio for east King providers was calculated by dividing out-of-area resident discharges by resident discharges to east King providers.
- Planning area level II discharges from both Washington and Oregon were summed to determine the number of level II discharges for planning area residents.
- The 2009 planning area provider market share of all planning area resident level II discharges was calculated to be 81.5%.
- Assuming the addition of a new hospital in the planning area would increase the number of planning area residents who remain in the planning area for care, beginning in 2012, the planning area provider market share of level II discharges were projected to increase by 2% for years 2012, 2013, and 2014, and remain constant beginning in year 2015.

Using the factors described above, SHS's calculations are shown below.

Planning area provider level II patient origin	East King Residents - 1,506 Outside east King Residents – 1,074 Total 2009 level II discharges 2,580
In-migration ratio	0.7131
Planning area provider market share	Year 2012 - 83.1% Year 2013 - 84.8% Year 2014 - 86.5%

Step 3 – Calculate future total discharges based on forecast use rates and forecast population of women of childbearing age. Apply the market share figures and in-migration ratio from step 2 to calculate future total level II discharges to planning area providers. Apply base year ALOS to forecast discharges to calculate planning area patient days

- The projected use rates trend calculated in step 1 were applied to the forecast years.
- The number of women of childbearing age (15-44) were projected using Claritas projections for each year of the forecast period.
- Planning area resident level II discharges were forecast by multiplying the projected use rates (from step 1) by the forecast number of women of childbearing age for each year of the forecast period.
- The total number of planning area resident level II discharges for planning area hospitals was determined using the market share forecast calculated in step 2.

- The in-migration ratio calculated in step 2 was applied to the projected non-planning area residents.
- The forecast level II patient days were determined by multiplying the forecast level II discharges for the planning area hospitals by the ALOS of 3.96 calculated in step 1.

The table below shows the total level II patient days SHS projected for east King providers.

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total Level II Patient Days	10,964	11,460	11,970	12,254	12,533	12,811	13,088	13,365	13,642	13,918

Step 4 – Use total patient days projected in step 3 to determine forecast gross and net level II bed need

- The average daily census (ADC) was calculated for each year of the forecast period.
- The forecast ADC was adjusted to reflect the occupancy standards for the level II ICN of 65%. These forecasts represent gross bed need for level II bassinettes.
- SHS identified the total level II capacity of existing providers in the planning area at 42 as shown in the breakdown below:
  - Overlake Hospital Medical Center with 12 level II bassinettes; and
  - Evergreen Healthcare with 30 level II bassinettes.
- Net need for level II bassinettes was calculated by subtracting current planning area supply from gross bed need.

The table below summarizes the results of the calculations described above.

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total Level II Patient Days	10,964	11,460	11,970	12,254	12,533	12,811	13,088	13,365	13,642	13,918
ADC	30.0	31.4	32.8	33.6	34.3	35.1	35.9	36.6	37.4	38.1
Gross Bed Need at 65% occp'y	46.2	48.3	50.5	51.6	52.8	54.0	55.2	56.3	57.5	58.7
Minus Current Level II Supply	42.0	42.0	42.0	42.0	42.0	42.0	42.0	42.0	42.0	42.0
Net Level II Bed Need	4.2	6.3	8.5	9.6	10.8	12.0	13.2	14.3	15.5	16.7

In summary, based on the factors and assumptions above, SHS projects a need for 8 level II beds in year 2013, which SHS proposes to meet when it opens its Issaquah hospital in year 2012. Need for an additional 6 level II beds materializes in year 2018, which SHS intends to meet when it implements phase two of this level II project.

To further demonstrate need for additional level II bed capacity, SHS provided year 2009 level II patient day statistics for the two level II providers in the planning area—OHMC and Evergreen Healthcare (EH). Table 1 on the following page is a summary of that information.

Table 1
East King County Level II Capacity

	OHMC	EH
2009 Level II Patient Days	2,914	6,476
2009 ADC	8	18
Number of Level II Bassinettes	12	30
Occupancy %	66.5%	59.1%

During the review of these applications, the department received three letters of public comment related to SHS's application and no comments on OHMC's application. Of the three letters, two were in support of SHS and one letter was in opposition. The letter of opposition was provided by Evergreen Healthcare and addresses two topics: **1)** the existing capacity in the planning area; and **2)** SHS's ability to meet the recommendations outlined in the September 2010 Perinatal Level of Care Guidelines. In this section of this evaluation, the department will discuss the existing capacity topic. The Level of Care Guidelines topic is addressed in the Structure and Process of Care portion of this evaluation.

Department's Review

The department's need review will begin with the underlying assumptions used by OHMC and SHS in their respective need methodology. Both applicants provided essentially the same need methodology. For ease in discussion, the department will reference each of the four steps and discuss similarities and differences.

Step 1 – Identify 10-year historic planning area resident days, discharges, and use rates

Similarities:

- CHARS data 2000 through 2009
- DRGs 791, 792, 793, and 794
- Claritas population data for females aged 15 – 44 (childbearing age)
- Decrease in projected years population data for females of childbearing age
- Level II use rate was calculated based on 1,000 females of childbearing age
- Projected ALOS

Differences:

- East King planning area – 26 of the same zip codes; OHMC also included zip codes from Bothell (98041), Kirkland (98083) and Woodinville (98077); SHS included zip codes from Baring (98224) and Skykomish (98288).
- Based on years 2002 through 2009, SHS applied a 0.56 trend adjustment factor for its projected use rates; OHMC used the 2009 use rate of 18.3 held constant

Comparison Table:

	2011	2012	2013	2014	2015
SHS ALOS	3.96	3.96	3.96	3.96	3.96
OHMC ALOS	3.95	3.95	3.95	3.95	----

SHS Use Rate	19.4	20.0	20.5	21.1	21.7
OHMC Use Rates	18.3	18.3	18.3	18.3	----

As shown in the comparison table, the ALOS used by both OHMC and SHS is essentially the same.

SHS applies a higher use rate than OHMC's in year 2011. In subsequent years, OHMC holds its use rate steady while SHS applies a 0.56 trend adjustment for each year, resulting in a higher use rate through 2020. Noted in SHS's use rate table shown in step one of its methodology, year 2011 use rate is 19.4 and year 2020 use rate is 24.5.

Trend adjustment may be an approach that should be considered at some time in certain application types; however, this approach has not been used in ICN or NICU decisions to date. Appropriate planning for tertiary services ensures that projections are not over-estimated. This approach protects against unnecessary duplication that may lead to increased costs for a service, staff shortages, and compromise quality of care. As a result, SHS's use rate trend adjustment for projected years is not reasonable for this project.

Step 2 – Calculate planning area provider level II patient origin, in-migration ratio, and planning area provider market share

Similarities:

- The factors used to calculate in-migration ratio and planning area provider market shares

Differences:

- None

Comparison Table:

	SHS	OHMC
East King Resident Level II Discharges	1,506	1,509
Outside East King Resident Level II Discharges	1,074	1,071
Total 2009 East King Level II Discharges	2,580	2,580
In Migration Ratio	0.7131	0.7097
Planning Area Provider Market Share Year 2011	------	81.5%
Planning Area Provider Market Share Year 2012	83.1%	------
Planning Area Provider Market Share Year 2013	84.8%	------
Planning Area Provider Market Share Year 2014	86.5%	------

As shown in the comparison table above, the in-migration ratio used by both OHMC and SHS is essentially the same.

OHMC determined a planning area provider market share for year 2011 only and applies that percentage forward for projected years. SHS projects a planning area market share for three years and begins with year 2012. Based on the increases used by SHS in years 2013 and 2014, it is possible that SHS and OHMC would have had similar market share percentages in year 2011.

Step 3 – Calculate future total discharges based on forecast use rates and forecast population of women of childbearing age. Apply the market share figures and in-migration ratio from step 2 to calculate future total level II discharges to planning area providers. Apply calculated ALOS to forecast discharges to calculate planning area patient days

Similarities:

- The factors used to project future discharges in the planning area.

Differences:

- None

Comparison Table:

	2011	2012	2013	2014	2015
SHS Population	100,243	99,822	99,414	99,053	98,672
OHMC Population	100,177	99,763	99,352	98,942	----

SHS Projected Pt Days	10,964	11,460	11,970	12,254	12,533
OHMC Projected Pt Days	10,101	10,059	10,018	9,976	----

As shown above, both OHMC an SHS projected similar population figures and both recognized a declining population for the child-bearing age group. The decline in OHMC's projected patient days is a result of OHMC's static use rate applied to the declining population. The increase in SHS's patient days is result of SHS's trend adjusted use rate calculated in step 1 and applied to the declining population.

Step 4 – Use total patient days projected in step 3 to determine forecast gross and net level II bed need

Similarities:

- The factors used to project future discharges in the planning area.

Differences:

- The current level II bed supply subtracted from the projected Level II supply. OHMC subtracted both 37 and 42; SHS subtracted 42. In its public comment, Evergreen Hospital clarified that it had 29 level II beds, for a planning area total of 41.

Comparison Table:

The comparison calculations below show both OHMC's and SHS's 2011 through 2014 projections using a planning area total of 41 ICN bassinets.

OHMC	2011	2012	2013	2014
OHMC Total Level II Patient Days	10,101	10,059	10,018	9,976
ADC	27.7	27.6	27.4	27.3
Gross Bed Need at 65% occupancy	39.5	39.4	39.2	39.0
Minus Current Level II Supply	41.0	41.0	41.0	41.0
Net Level II Bed Need or (Surplus)	(1.5)	(1.6)	(1.8)	(2.0)

SHS	2011	2012	2013	2014
SHS Total Level II Patient Days	10,964	11,460	11,970	12,254
ADC	30.0	31.4	32.8	33.6
Gross Bed Need at 65% occupancy	46.2	48.3	50.5	51.6
Minus Current Level II Supply	41.0	41.0	41.0	41.0
Net Level II Bed Need or (Surplus)	5.2	7.3	9.5	10.6

As shown in the tables above, OHMC projects a planning area need for 39.5 bassinets in 2011 which decreases to 39.0 in 2014. The slight decrease is a direct result of OHMC's static use rate applied to the declining childbearing age population. The projected population decrease is not large, which results in a difference of one-half of one ICN bassinet in the four-year projections.

SHS projects a need of 5.2 bassinets in years 2011, which is projected to more than double by the end of year 2014. These projections are a direct result of SHS's trend adjusted use rate calculated in step 1 and applied to the declining childbearing age population. As previously stated, SHS's trend adjustment is not reasonable for this project.

Conclusion of OHMC Methodology Review

Other than providing a numeric methodology to support its existing 12 ICN beds, OHMC did not provide any other discussion to support its application. Historical data shows OHMC's ICN has been in operation for many years. As an existing provider of both level II and level III services for many years, OHMC has already established a reliable patient base and market share in its service area. OHMC does not request an increase in capacity or to alter any existing referral patterns for level II or level II services. Instead, this application requests approval to add the existing capacity to its license. As a result, for OHMC's project, its methodology is reasonable.

Based on the above evaluation, this project is consistent with applicable criteria of the Certificate of Need Program. **This sub-criterion is met for Overlake Hospital Medical Center.**

Conclusion of SHS Methodology Review

In addition to its numeric methodology outlined above, SHS also submits that its project should be approved based on the following factors:

- projected planning area population increase; and
- community demand in the planning area.

[source: Application, pp27-45]

SHS's projected planning area population increase was addressed in the numeric methodology discussion above and does not need further discussion.

Related to the community demand in the planning area, SHS states that the Issaquah/Sammamish area is one of the largest communities in King County, and residents should be able to obtain ICN services at their community hospital—Swedish's Issaquah campus. SHS's Issaquah hospital campus is not yet operational, and is not expected to become operational until 2012. There was no documentation submitted by community members, existing healthcare providers, or referral healthcare providers that suggest that level II services are not currently available in the planning area.

The planning area has two well-established providers of both level II and level III services. While SHS is certainly not a new healthcare provider in Washington State, its Issaquah hospital is not yet operational in the planning area and does not have an established patient base for basic hospital services. With this application, SHS is requesting to add a new tertiary service to a hospital that is not yet operational and has no inpatient patient base. For this reason, the department considers this application to be premature.

SHS states that if this project is denied, its Issaquah hospital would be the only hospital in King County "*that delivers more than 500 newborns annually that is not authorized to provided level II services.*" [source: July 7, 2011, rebuttal documents, p4] This statement is inaccurate. SHS's Issaquah hospital has not opened, so zero newborns have been delivered. SHS's statement is based on its projections that it would have 1,338 level I (normal newborn) discharges by its third full year of operation. However, until the hospital becomes operational, neither SHS nor the department will know how many level I newborns will be delivered nor how many or level II patients will be transferred. Again, the department considers this application to be premature.

Based on the above evaluation, this project is not consistent with applicable criteria of the Certificate of Need Program. **This sub-criterion is not met for Swedish Health Services.**

(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.*

As previously stated, both applicants currently provide health care services to residents of Washington State, including low-income, racial and ethnic minorities, handicapped and other underserved groups. As providers of acute care services, both applicants participate in the Medicare and Medicaid programs. Below is a review of each applicant's conformance with this sub-criterion.

Overlake Hospital Medical Center

To determine whether all residents of the east King County planning area would have access to an applicant's proposed services, the department requires applicants to provide a copy of its current or proposed admission policy. The admission policy provides the overall guiding principles of the facility as to the types of patients that are appropriate candidates to use the facility and any assurances regarding access to treatment.

To demonstrate compliance with this sub-criterion, OHMC provided a copy of the Admission Policy currently used at the hospital. The Admission Policy outlines the process/criteria that OHMC uses to admit patients for treatment, and ensures that patients will receive appropriate care at the hospital. The Admission Policy also states that OHMC admits any patient without regard to race, color, gender, age, religious creed, ancestry, disability/handicap, payer source, or inability to pay. [source: Application, Exhibit 3]

To determine whether low-income residents would have access to the proposed services, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination.

To demonstrate compliance with this sub-criterion, OHMC stated that it currently contracts with Medicaid and intends to maintain this status. Further, financial data provided in the application includes Medicaid revenues. [source: Application, p3 & p9]

To determine whether the elderly would have access or continue to have access to the proposed services, the department uses Medicare certification as the measure to make that determination.

To demonstrate compliance with this sub-criterion, OHMC stated that it currently contracts with Medicare and inclusion of the ICN beds to the hospital's license would not affect this status. Hospital-wide financial data provided in the application includes Medicare revenues. [source: Application, p3, Exhibit 4, and May 4, 2011, supplemental information, p4]

A facility's charity care policy should confirm that all residents of the service area including low-income, racial and ethnic minorities, handicapped and other underserved groups have, or would have, access to healthcare services of the applicant. The policy should also include the process one must use to access charity care at the facility.

OHMC demonstrated that it currently provides charity care to the residents of the service area and surrounding communities and intends to maintain this status by submitting its current charity care policy that outlines the process one would use to access this service. The charity care policy is recently revised and approved by the department's Hospital and Patient Data Systems office. [source: Application, Exhibit 5 & OHMC Charity Care Policy dated March 23, 2011] Further, OHMC also included a 'charity care' line item as a deduction from revenue within the pro forma income statement documents. [source: May 4, 2011, supplemental information, Attachment 5]

For charity care reporting purposes, HPDS divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. OHMC is located in

King County within the King County Region. Currently there are 20 hospitals located within the region, including OHMC. According to 2007 - 2009 charity care data obtained from HPDS,[8] OHMC has historically provided less than the average charity care provided in the region.[9] OHMC's most recent three-year (2007 - 2009) average percentages of charity care for gross and adjusted revenues are 0.92% and 1.39%, respectively. The 2007 - 2009 average for the King County Region is 1.42% for gross revenue and 2.51% for adjusted revenue. [source: HPDS 2007-2009 charity care summaries]

OHMC's pro forma revenue and expense statements indicate that the hospital will provide charity care at approximately 1.45% of gross revenue and 2.66% of adjusted revenue. RCW 70.38.115(2)(j) requires hospitals to meet or exceed the regional average level of charity care. Since OHMC's historical charity care is currently less than the average for the region, the department concludes the charity care condition stated below is necessary to approve the project.

> Overlake Hospital Medical Center will provide charity care in compliance with the charity care policies provided in this Certificate of Need application, or any subsequent polices reviewed and approved by the Department of Health. Overlake Hospital Medical Center will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the King County Region. Currently, this amount is 1.42% for gross revenue and 2.51% for adjusted revenue. Overlake Hospital Medical Center will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

With the applicant's agreement to the condition above, the department concludes that all residents, including low income, racial and ethnic minorities, handicapped, and other underserved groups would have access to the services provided by the hospital. **This sub-criterion is met for Overlake Hospital Medical Center**.

Swedish Health Services

To determine whether all residents of the east King County planning area would have access to an applicant's proposed services, the department requires applicants to provide a copy of its current or proposed admission policy. The admission policy provides the overall guiding principles of the facility as to the types of patients that are appropriate candidates to use the facility and any assurances regarding access to treatment.

To demonstrate compliance with this sub-criterion, SHS provided a copy of the Patients Rights and Responsibilities currently used by SHS at its hospitals. The document states that SHS admits any patient without regard to race, color, gender, age, religious creed, ancestry, disability/handicap, payer source, or inability to pay. The documents does not outline the process/criteria that SHS uses to admit patients for treatment, rather it outlines the roles and responsibilities of the patient and SHS. The document does not take the place of a patient admission policy, rather it would be used

[8] As of the writing of this evaluation, 2010 charity care data is not available.

[9] Harborview Medical Center is subsidized by the state legislature to provide charity care services. Charity care percentages for Harborview make up almost 50% of the total percentages provided in the King County Region. Therefore, for comparison purposes, the department excluded Harborview Medical Center's percentages.

to supplement an Admission Policy. [source: Application, Exhibit 12] The department concludes that a condition requiring SHS to submit an Admission Policy is necessary if this project is approved.

To determine whether low-income residents would have access to the proposed services, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination.

To demonstrate compliance with this sub-criterion, SHS stated that it currently contracts with Medicaid at its existing hospitals and intends to maintain this status. For the Issaquah campus where the proposed ICN would be located, SHS states that it will also contract with Medicaid and provided supporting financial data in the application to demonstrate this intent. [source: March 28, 2011, supplemental information, Revised Exhibits 14B and 14C]

To determine whether the elderly would have access or continue to have access to the proposed services, the department uses Medicare certification as the measure to make that determination.

To demonstrate compliance with this sub-criterion, SHS stated that it currently contracts with Medicare at its existing hospitals, intends to contract with Medicare at its Issaquah campus, and inclusion of ICN services at the campus would not affect this status. Hospital-wide financial data provided in the application includes Medicare revenues. [source: Application, Exhibit 14A]

A facility's charity care policy should confirm that all residents of the service area including low-income, racial and ethnic minorities, handicapped and other underserved groups have, or would have, access to healthcare services of the applicant. The policy should also include the process one must use to access charity care at the facility.

SHS demonstrated that it currently provides charity care to the residents of the service area and surrounding communities at its existing campuses and intends to maintain this status. For the Issaquah campus, SHS also intends to provide charity care services. SHS submitted its current charity care policy used at SHS hospitals and proposed to be used at its Issaquah campus. The policy outlines the process one would use to access this service. The charity care policy is recently revised (May 2010) and approved by the department's Hospital and Patient Data Systems office. [source: Application, Exhibit 12] SHS also included a 'charity care' line item as a deduction from revenue within the pro forma income statement documents. [source: Application, Exhibit 14A; March 28, 2011, supplemental information, Revised Exhibits 14B and 14C]

For charity care reporting purposes, HPDS divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. SHS's Issaquah campus would be located in King County within the King County Region. Currently there are 20 hospitals located within the region. Once the Issaquah campus opens, there will be 21 hospitals in the region. According to 2007 - 2009 charity care data obtained from HPDS, SHS has historically provided more than the average charity care provided in the region.[10] SHS's most recent three-year (2007 - 2009) average percentages of charity care for gross and adjusted revenues are 1.64% and 2.51%, respectively. The 2007 - 2009 average for the King County Region is 1.42% for gross revenue and 2.51% for adjusted revenue. [source: HPDS 2007-2009 charity care summaries]

[10] IBID

SHS submitted two separate pro forma revenue and expense statements with proposed ICN bed capacity. One statement includes the Issaquah campus and a 14-bed ICN [source: Revised Exhibit 14B] and the second statement includes the Issaquah campus and an 8-bed ICN. [source: Revised Exhibit 14C] Both statements indicate that the Issaquah campus will provide charity care at approximately 1.70% of gross revenue. RCW 70.38.115(2)(j) requires hospitals to meet or exceed the regional average level of charity care. Since SHS's historical charity care is currently more than the average for the region and SHS projects to provide more than the regional average at its Issaquah campus, generally the department would not require a charity care condition. However, since the Issaquah campus is not yet operational, to ensure that SHS maintains its percentages of charity care at all campuses, the department concludes the charity care condition is necessary if this project is approved.

Provided that SHS agreed with the condition related to the Admission Policy and the condition related to the percentage of charity care, the department concludes that all residents, including low income, racial and ethnic minorities, handicapped, and other underserved groups would have access to the services provided by the hospital. **This sub-criterion is met for Swedish Health Services.**

B. Financial Feasibility (WAC 246-310-220)

Based on the source information reviewed, the department concludes:

- Overlake Hospital Medical Center's project has met the financial feasibility criteria in WAC 246-310-220 with agreement to the conditions identified in the 'conclusion' section of this evaluation; and
- Swedish Health Services' project has not met the financial feasibility criteria in WAC 246-310-220.

(1) The immediate and long-range capital and operating costs of the project can be met.

WAC 246-310 does not contain specific WAC 246-310-220(1) financial feasibility criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what the operating revenues and expenses should be for a project of this type and size. Therefore, using its experience and expertise the department evaluates if the applicant's pro forma income statements reasonably project the proposed project is meeting its immediate and long-range capital and operating costs by the end of the third complete year of operation.

Overlake Hospital Medical Center

If this project is approved, OHMC would immediately begin the process with the department's licensure office to increase its hospital licensed from 337 to 349. [source: Application, p7] Based on this timeline, calendar year (CY) 2012 would be the facility's first full year of operation with 349 acute care beds. To demonstrate compliance with this sub-criterion, OHMC provided two separate projected revenue and expense statements. One statement shows the level II ICN cost center only and the second shows OHMC as a whole with the 12 bed ICN and 349 acute care beds.

Table 2 below illustrates the projected revenue, expenses, and net income for CY 2012 through 2014 for OHMC's ICN cost center. [source: May 4, 2011, supplemental information, Attachment 5]

Table 2
OHMC Level II ICN Cost Center Only
Projected Revenue and Expenses Calendar Years 2012 - 2014

	CY 1 2012	CY 2 2013	CY 3 2014
# of ICN Bassinettes	12	12	12
#of Patient Days	3,125	3,219	3,316
# of Patients	702	723	745
% of Occupancy	71.3%	73.5%	75.7%
Net Patient Revenue	$4,686,177	$4,827,138	$4,972,597
Total Operating Expense [1]	$4,532,195	$4,641,907	$4,764,406
Net Profit or (Loss) [2]	$162,982	$185,231	$208,191

[1] includes allocated costs
[2] includes deductions for bad debt, charity care and contractual allowances

As shown in Table 2 above, OHMC projects the 12 bed ICN would be averaging more than 70% occupancy and operating at a profit in year 2012 through 2014.

Table 3 below shows OHMC as a whole with the 12 bed ICN. [source: Application, Exhibit 4 and May 4, 2011, supplemental information, Attachment 5]

Table 3
Overlake Hospital Medical Center with a 12 bed ICN
Projected Revenue and Expenses Calendar Years 2012 - 2014

	CY 1 2012	CY 2 2013	CY 3 2014
Net Patient Revenue	$425,070,000	$431,746,000	$438,558,000
Total Operating Expense	$403,697,000	$412,305,000	$420,715,000
Net Profit or (Loss) [1]	$21,373,000	$19,441,000	$17,843,000

[1] includes deductions for bad debt, charity care and contractual allowances

As shown in Table 3 above, the inclusion of OHMC's 12 level II ICN beds to its current hospital license does not affect the financial viability of the hospital as a whole.

Swedish Health Services

If this project is approved, SHS would establish its 14-bed level II ICN in two phases. Phase one is the addition of 8 bassinettes when the hospital becomes operational by mid-year 2012 with 80 acute care beds. Phase two is the addition of the remaining 6 ICN bassinettes. SHS does not specifically identify the projected month or year associated with the implementation of phase two; rather, SHS plans to add the remaining 6 ICN bassinets once occupancy of the first 8 bassinettes exceeds 65%. [source: Application, p13; March 28, 2011, supplemental information, pp6-7]

Table 4 on the following page illustrates the projected revenue, expenses, and net income for partial year 2012 and full calendar years 2013 through 2018 for SHS's ICN cost center. [source: Application, Exhibit 14 and March 28, 2011, supplemental information, Exhibit 14B]

Table 4
SHS Level II ICN Cost Center Only
Projected Revenue and Expenses Calendar Years 2012 - 2018

	CY 1 2012	CY 2 2013	CY 3 2014	CY 4 2015	CY 5 2016	CY 6 2017	CY 7 2018
# of ICN Bassinettes	8	8	8	14	14	14	14
#of Patient Days	1,505	1,722	1,971	2,255	2,468	2,701	2,958
# of Patients	339	390	449	516	625	687	721
% of Occupancy	51.5%	59.0%	67.5%	44.1%	48.3%	52.9%	57.9%
Net Patient Revenue	$1,119,705	$1,289,825	$1,485,787	$1,703,419	$1,868,203	$2,049,122	$2,247,771
Total Operating Expense [1]	$2,087,304	$2,176,985	$2,402,797	$2,695,959	$2,903,574	$3,136,017	$3,368,815
Net Profit or (Loss) [2]	($967,599)	($887,160)	($917,010)	($992,540)	($1,035,371)	($1,086,895)	($1,121,044)

[1] includes allocated costs
[2] includes deductions for bad debt, charity care and contractual allowances

As shown in Table 4 above, SHS's financial projections are based on the 8 bed ICN operating above 65% occupancy by the end of year 2015, then the remaining 6 bassinets would be added. From years 2012 through 2018, SHS projects that the ICN would operate at a deficit, which increases each year.

Table 5 on the following page shows SHS's Issaquah hospital as a whole with the level II ICN for years 2012 through 2016, three years after SHS projects the hospital would be operating at the profit. [source: Application, Exhibit 14B]

Table 5
Swedish Issaquah Hospital with a 14 bed ICN
Projected Revenue and Expenses Calendar Years 2012 - 2016

	CY 1 2012	CY 2 2013	CY 3 2014	CY 4 2015	CY 5 2016
Net Patient Revenue	$100,377,039	$148,493,778	$187,505,513	$223,146,466	$234,039,902
Total Operating Expense [1]	$116,167,181	$150,765,921	$177,805,032	$205,796,398	$216,173,415
Net Profit or (Loss) [2]	($15,790,142)	($2,272,143)	$9,700,481	$17,350,068	$17,866,487

[1] includes allocated costs
[2] includes deductions for bad debt, charity care and contractual allowances

As shown in Table 5 above, the inclusion of SHS's 14-bed level II ICN does not affect the overall financial viability of the Issaquah campus. However, the net revenue shown above is based on SHS's projected patients and patient days, which are based, in turn, on SHS's numeric

methodology. In the need section of this evaluation, the department concluded that SHS's methodology was not reasonable. The department concludes that SHS may not be able to meet its short and long term costs of the level II ICN. **This sub-criterion is not met.**

There was no public comment submitted related to this sub-criterion.

Overlake Hospital Medical Center
Based on the above information, the department concludes that OHMC's projected revenues and expenses are reasonable and can be substantiated. **This sub-criterion is met.**

Swedish Health Services
Based on the above information, the department concludes that SHS's projected revenues and expenses are not reasonable and cannot be substantiated. **This sub-criterion is not met.**

(2) *The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.*
WAC 246-310 does not contain specific WAC 246-310-220(2) financial feasibility criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what an unreasonable impact on costs and charges would be for a project of this type and size. Therefore, using its experience and expertise the department compared the proposed project's costs with those previously considered by the department.

Overlake Hospital Medical Center
OHMC's application proposes to add 12 existing ICN beds under OHMC's license. OHMC states that it recently became aware that the existing 12 ICN beds must also be included within the hospital license. As a result, the 12 ICN beds have not been included in OHMC's licensed bed capacity. With this application, OHMC proposes to correct this licensure oversight which would increase by its acute care license from 337 to 349. [source: Application, p7]

Since OHMC has been providing ICN services since at least year 2002, there is no capital expenditure associated with this project. [source: Application, pp 8 & 25]

As a result, this sub-criterion is **not applicable to OHMC's application**.

Swedish Health Services
SHS anticipates the 14 bassinettes would be added in two phases. Phase one is the addition of 8 bassinettes when the hospital becomes operational by mid-year 2012 with 80 acute care beds. Phase two is the addition of the remaining 6 ICN bassinettes once occupancy of the first 8 bassinettes exceeds 65%. [source: Application, p13]

Construction for all 14 beds will occur during phase one. The capital expenditure associated with the establishment of the 14-bed ICN is $2,113,123. A breakdown of the costs is shown on the following page. [source: Application, p48]

Item	Cost	% of Total
Construction Costs	$ 729,000	34.5%
Fixed & Moveable Equipment	$ 992,305	47.0%
Architect & Engineering Fees	$ 115,457	5.5%
Financing Fees	$ 112,836	5.3%
Washington State Sales Tax	$ 163,524	7.7%
Total Estimated Capital Costs	**$ 2,113,122**	**100.0%**

To demonstrate compliance with this sub-criterion, SHS provided a non-binding construction cost estimate from its contractor, with the following statements.

"...The ICN space at Swedish Issaquah is currently being shelled for future build-out, therefore, this construction cost estimate is for the build-out portion of the ICN space."
[source: Application, Exhibit 13]

SHS also provided a table showing the costs of the project per gross square foot. The breakdown is replicated below. [source: Application, p48]

Table 6
SHS ICN Cost Center Construction Cost Breakdown

Estimated Gross Square Footage (GSF)	3,120
Number of Level II ICN Beds	14
Construction Cost per GSF	$588.71
Total cost per GSF	$677.28
Total Cost per Bed	$150,937.34

The department recognizes that the majority of the construction and planning for ICN space likely occurred in the early stages of creating the floor plans and submission of architectural designs for the 175-bed hospital. As a result, the costs for this 14-bed ICN are lower when compared to costs to retro fit and construct new space in an existing facility.

There was no public comment submitted related to this sub-criterion. Based on the above information, the department's conclusion regarding this sub-criterion follows.

Overlake Hospital Medical Center
This sub-criterion is **not applicable to OHMC's application**.

Swedish Health Services
Based on the above information, the department concludes that the costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services. **This sub-criterion is met.**

(3) *The project can be appropriately financed.*

WAC 246-310 does not contain specific source of financing criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how a project of this type and size should be financed. Therefore, using its experience and expertise the department compared the proposed project's source of financing to those previously considered by the department.

Overlake Hospital Medical Center

OHMC's application proposes to add 12 existing ICN beds under OHMC's license. OHMC states that it recently became aware that the existing 12 ICN beds must also be included within the hospital license. As a result, the 12 ICN beds have not been included in OHMC's licensed bed capacity. With this application, OHMC proposes to correct this licensure oversight which would increase by its acute care license from 337 to 349. [source: Application, p7]

Since OHMC has been providing ICN services since at least year 2002, there is no capital expenditure associated with this project. [source: Application, pp 8 & 25]

As a result, this sub-criterion is **not applicable to OHMC's application**.

Swedish Health Services

SHS proposes the establishment of a 14-bed intermediate care nursery (ICN) within space at the not-yet-operational Issaquah hospital campus. The 14 bassinettes would be licensed within the approval 175 beds approved under CN #1379. [source: Application, p13]

As stated above, the capital expenditure associated with the establishment of the 14-bed ICN is $2,113,122. SHS intends to finance the project with tax-exempt bonds. SHS provided the following information related to a cost comparison review for the funding source.

> *"Swedish evaluates each capital expenditure in terms of its relative cost, its effect on cash reserves, and the organization's opportunity costs of capital at that time. Financing for this project through bonds instead of cash will permit Swedish to take advantage of market conditions that have driven bond financing cost down. At this point in time, this financing vehicle has relatively lower costs than alternatives, including use of cash reserves. In summary, based on current bond finance costs and the opportunity costs of cash reserves, bond financing was determined to be the most fiscally prudent source for financing this project at this time."*
>
> [source: Application, p51]

There was no public comment submitted related to this sub-criterion. Based on the above information, the department's conclusion regarding this sub-criterion follows.

Overlake Hospital Medical Center

This sub-criterion is **not applicable to OHMC's application**.

Swedish Health Services

Based on the above information, the department concludes that SHS's project can be appropriately financed. **This sub-criterion is met.**

C. Structure and Process (Quality) of Care (WAC 246-310-230) and the Washington State Perinatal Levels of Care Guidelines

Based on the source information reviewed, the department concludes:

- Overlake Hospital Medical Center's project has met the structure and process of care criteria in WAC 246-310-230 and the Washington State Perinatal Levels of Care Guidelines with agreement to the conditions identified in the 'conclusion' section of this evaluation; and
- Swedish Health Services' project has not met the structure and process of care criteria in WAC 246-310-230 and the Washington State Perinatal Levels of Care Guidelines.

(1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

WAC 246-310 does not contain specific WAC 246-310-230(1) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what specific staffing patterns or numbers of FTEs that should be employed for projects of this type or size. Therefore, using its experience and expertise the department concludes that the planning would allow for the required coverage.

Overlake Hospital Medical Center

OHMC currently operates a level II ICN and a level III NICU located on the sixth floor of the hospital in a contiguous unit, which allows sharing of some staff. [source: May 4, 2011, supplemental information, pp3 & 9]

To demonstrate that staff is currently available or can be recruited for both services, OHMC provided two separate staff tables. One table shows only level II ICN staff and the second table shows combined ICN and NICU staff. For the combined ICN and NICU staff, OHMC expects its current (2010) staff of 34.3 FTEs would increase to 39.8 FTEs by the end of year 2014. [source: May 4, 2011 supplemental information, pp8&9] Table 7 shown on the following page focuses on level II ICN staff only.

Table 7
OHMC Level II ICN 2011 Current FTEs
and 2012 – 2014 Projected FTEs

Staff/FTEs	2011 Current	2012 Increase	2013 Increase	2014 Increase	Total FTEs
Medical Director*	Professional Services Contract				
Clinical Director	1.00	0.00	0.00	0.00	1.00
Charge Nurse	1.10	0.00	0.00	0.00	1.10
RN	9.50	0.30	0.30	0.30	10.70
LPN	0.20	0.00	0.00	0.00	0.20
Social Worker	0.60	0.00	0.00	0.00	0.60
Clerical	1.40	0.00	0.00	0.00	1.40
Nurse Practitioner*	3.20	0.00	0.00	0.00	3.20
Neonatologist*	3.20	0.00	0.00	0.00	3.20
Total FTE's	**20.20**	**0.30**	**0.30**	**0.30**	**21.40**

*Contracted positions

As shown in Table 7 above, OHMC already has the necessary staff for the ICN and expects a minimal increase in FTEs based on the slight projected increase in patients and patient days for the years shown. [source: Application, p31]

OHMC states it expects no difficulty in recruiting staff for its ICN because of its competitive wage and benefit package offered to employees. Further, OHMC is a training site for nearly 30 technical colleges, community colleges, and four-year universities. OHMC also offers scholarships to employees for education advancements allowing much of its needed tertiary staff to be recruited from within OHMC. [source: Application, p31].

Table 7 above also includes key medical staff and other providers for the level II ICN services recommended in the Washington State Perinatal Levels of Care staffing guidelines. These key medical staff positions are further evaluated in conjunction with the department's evaluation of the project's conformance with the Washington State Perinatal Levels of Care guidelines shown below.

Washington State Perinatal Levels of Care Guidelines

The department also uses the standards of care guidelines outlined in the Washington State Perinatal Levels of Care Criteria as guidance in evaluating this project. The guidelines, adopted by the Perinatal Advisory Committee in September 2010, offer recommendations on facility and staffing standards for level II services. Within the guidelines, level II services are separated into A and B -- with A being the least intensive and B as the most intensive.

The Perinatal Levels of Care Criteria recommend that an applicant be providing the previous level of services before applying for the next higher level. For this application, OHMC should already be providing level I, or basic OB services before applying for level II services. Since OHMC is currently a provider of level III NICU services, OHMC exceeds this recommendation. OHMC provided a comparison chart as verification and documentation that its level II services meet or

exceed the advisory committee's recommended guidelines. [source: Application, Exhibit 6] The comparison chart is provided in Appendix A attached to this evaluation.

Swedish Health Services

To demonstrate that staff is currently available or can be recruited for its proposed 14-bed ICN, SHS provided a staff table showing calendar years 2012 through 2018 specific to its level II ICN staff. [source: March 28, 2011 supplemental information, Exhibit 16A] Table 8 below shows that information.

Table 8
SHS Level II ICN Projected FTEs
Years 2012 through 2018

Staff/FTEs	2012 Year 1	2013 Inc	2014 Inc	2015 Inc	2016 Inc	2017 Inc	2018 Inc	Total FTEs
RN	7.00	0.70	1.20	1.30	1.00	1.00	1.20	13.40
Agency	0.60	0.00	0.10	0.10	0.10	0.10	0.10	1.10
Nursing Assistant	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Management	1.70	0.00	0.00	0.00	0.00	0.00	0.00	1.70
Other Direct	0.80	0.10	0.10	0.20	0.10	0.10	0.10	1.50
Total Level II FTE's	**10.10**	**0.80**	**1.40**	**1.60**	**1.20**	**1.20**	**1.40**	**17.70**

SHS states it expects no difficulty in recruiting staff for its ICN because it has a strong core of level II and level III trained nurses at its First Hill campus that would support and augment staffing of the Issaquah level II ICN. Further, as a large provider of advanced neonatal care in the state, SHS states it has the ability to accommodate many new learners in its current clinical setting and then transfer them to the Issaquah campus when they are prepared. [source: Application, p56]

During the review of this application, the department acknowledged that SHS provided a listing the perinatologist and neonatologist on the active medical staff of SHS, and requested SHS identify the physicians, including the medical director, from the list that are anticipated to staff the ICN at its Issaquah hospital campus. SHS was unable to identify the specific physicians because the ICN was not expected to open for several months. As a result, key medical staff and other providers for the level II ICN services recommended in the Perinatal Levels of Care staffing guidelines are not included in the table above. [source: March 28, 2011, supplemental information, pp1-2]

Washington State Perinatal Levels of Care Guidelines

As previously stated, the Perinatal Levels of Care Criteria recommend that an applicant be providing the previous level of services before applying for the next higher level. For this application, SHS's Issaquah hospital should already be providing level I, or basic OB services before applying for level II services. SHS provided a comparison chart as verification and documentation that the Issaquah hospital meet or exceeds the advisory committee's recommended guidelines. [source: Application, Exhibit 5] The comparison chart is provided in Appendix B attached to this evaluation.

Evergreen Healthcare (EH) provided comments related to this sub-criterion. Specifically, EH states that SHS cannot meet the recommendation in the level of care guidelines that state a facility

be operating at the previous level of care before expanding [to the next level of care]. For this project, SHS should be providing basic OB services at the Issaquah campus before establishing its level II ICN. [source: Evergreen Healthcare public comment received June 21, 2011].

In response to EH's public comment, SHS states that the guidelines no longer contain this recommendation. Additionally, SHS states that the guidelines and recommendations are designed to ensure quality of care and although SHS does not provide this level of care at its Issaquah campus, as a long-time provider of both level II and level III services in the state, there should be no concern about SHS's competence or quality of care in its level II ICN. [source: SHS rebuttal documents, pp2-3]

Department's Review

The September 2010 guidelines are replicated in Attachments A and B to this evaluation. Below is the first line in each section in the guidelines.

Basic Care	**Intermediate Care**		**Intensive Care**		
Level I	**Level IIA**	**Level IIB**	**Level IIIA**	**Level IIIB**	**Level IIIC**
	Level I function plus:	Level IIA function plus:	Level IIB function plus:	Level IIIA function plus:	If obstetrical services are offered, same functions as Level IIIB

As shown above, the guidelines clearly recommend that a facility be operating at the previous level of care before expanding to the next level of care. Since SHS's Issaquah hospital is not yet operational, it does not meet this recommendation.

SHS's assertion that that the recommendations were established to ensure quality of care for the various levels of pediatric care is correct. However, the recommendations also ensure that the applying hospital will have appropriately trained and adequate staff, specific equipment, and ancillary services and transfer agreements in place. While all of these requirements are related to the establishment of a quality provider, they also ensure that providers continue to work within the existing healthcare system's infrastructure. For this project, SHS is not yet operational at its Issaquah campus. Until the hospital is operational, approval of this project would be premature.

Based on the above information, the department's conclusion regarding this sub-criterion follows.

Overlake Hospital Medical Center

Based on the information reviewed, the department concludes OHMC demonstrated adequate staffing for the 12-bed level II ICN is available or can be recruited. **This sub criterion is met.**

Swedish Health Services

Based on the information reviewed, the department concludes that SHS did not demonstrate that adequate staffing for the 14-bed level II ICN is available or can be recruited. **This sub criterion is not met.**

(2) *The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.*

WAC 246-310 does not contain specific WAC 246-310-230(3) criteria as identified in WAC 246-310-200(2)(a)(i). There are no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that a facility must meet when it is to be Medicare certified and Medicaid eligible. Therefore, using its experience and expertise the department assessed the applicant's history in meeting these standards at other facilities owned or operated by the applicant.

Overlake Hospital Medical Center

As an existing provider of both level II ICN and level III NICU services, OHMC has already established appropriate relationships with ancillary and support services. To demonstrate compliance with this sub-criterion, OHMC provided a copy of the following documents:

- Neonatal Health Care Services Agreement between Seattle Children's Hospital and Overlake Hospital Medical Center [source: May 4, 2011, supplemental information, Appendix 3]
  Under this agreement, Seattle Children's Hospital (SCH) provides medical director services, physician services, neonatal nurse practitioner services, and administrative manager services to OHMC for its ICN and NICU. This agreement outlines roles and responsibilities for each hospital and identifies costs associated with the services. The agreement was executed in 2009.
- Transfer Agreement between Seattle Children's Hospital and Overlake Hospital Medical Center [source: May 4, 2011, supplemental information, Appendix 7]
  Under this agreement, SCH provides back up support for OHMC for critically ill patients whose care needs are beyond OHMC's expertise. This agreement outlines roles and responsibilities for each hospital, identifies costs associated with the services. The agreement was executed in 2011.
- [Draft] Medical Director Agreement between Martin Walker, MD and Overlake Hospital Medical Center [source: May 4, 2011, supplemental information, Appendix 8]
  This agreement identifies Martin Walker, MD as the medical director for OHMC's ICN and NICU. Under this agreement, Dr. Walker's responsibilities include teaching and other non-patient care duties for OHMC medical staff and committees, conducting clinical reviews of patient records, and consulting with appropriate directors in the development of policies and practices that optimize patient care at OHMC. This agreement outlines roles and responsibilities for OHMC and Dr. Walker and identifies costs associated with the services. The agreement is considered a draft because is not signed or dated by Dr. Walker or OHMC.

Swedish Health Services

Since the Issaquah campus is not yet operational and the proposed level II ICN would not be operational until year 2012, SHS does not have its ancillary agreements in place. To demonstrate conformance with this sub-criterion, SHS .provided the following three documents:

- [Draft] Level IIB Intermediate Care Nursery Functional Plan [source: Application, Exhibit 6]
  The draft functional plan provides a description of the ICN unit and discusses space for families, hallways, and staff, as well as electrical rooms, closets, storage, and patient rooms. This document appears to be specific to the construction and design of the proposed ICN area.

- [Draft] Medical Director Agreement [source: March 28, 2011, supplemental information, Exhibit 18]
  The draft medical director agreement does not identify a specific medical group or physician, and does not identify specific costs associated with the services. Further, the agreement covers a one year term. The department has stated that draft medical director agreements are acceptable if the draft identifies a physician, roles and responsibilities of each entity, all costs associated with the medical director services are identified, and any exhibits referenced in the agreement are included. This document does not meet the requirements of an acceptable draft agreement.

There was no public comment submitted related to this sub-criterion.

Based on the above information, the department's conclusion regarding this sub-criterion follows.

Overlake Hospital Medical Center
Based on this information, the department concludes OHMC currently has, or intends to have, appropriate relationships with ancillary and support services. If this project is approved, the department would include a condition requiring OHMC to provide a copy of the executed medical director agreement consistent with the draft agreement provided in the application. Provided OHMC agrees to the condition, **this sub-criterion is met.**

Swedish Health Services
Based on this information, the department concludes SHS did not demonstrate it would have appropriate relationships with ancillary and support services for its proposed ICN at its Issaquah campus, and would continue to have appropriate relationships, if this project is approved. **This sub-criterion is not met.**

(3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.
WAC 246-310 does not contain specific WAC 246-310-230(3) criteria as identified in WAC 246-310-200(2)(a)(i). There are no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that a facility must meet when it is to be Medicare certified and Medicaid eligible.[11] Therefore, using its experience and expertise the department assessed the applicant's history in meeting these standards at other facilities owned or operated by the applicant.

Overlake Hospital Medical Center
As stated earlier, OHMC provides healthcare services to the residents of east King County, and Washington State as a whole, through its various healthcare facilities. OHMC does not operate any healthcare facilities outside of Washington State.

[11] Also pertains to WAC 246-310-230(5).

As part of its review, the department must conclude that the proposed services would be provided in a manner that ensures safe and adequate care to the public. Since January 2008, the Department of Health's Investigations and Inspections Office has completed at least four compliance surveys for OHMC or its related healthcare providers.[12]

Of the compliance surveys completed, all revealed minor non-compliance issues related to the care and management at the OHMC healthcare facilities. These non-compliance issues were typical of the specific type of facility and OHMC submitted and implemented acceptable plans of correction. [source: facility survey data provided by the Investigations and Inspections Office]

OHMC identified its current staff for the ICN and NICU units. [source: May 4, 2011, supplemental information, Appendices 2, 8, and 9] A review of the compliance history for all staff, including the proposed medical director, Martin Walker, MD, revealed no current recorded sanctions.[13] [source: DOH ILRS database]

Swedish Health Services

As stated earlier, SHS provides healthcare services to the residents of east King County, and Washington State as a whole, through its various healthcare facilities. SHS does not operate any healthcare facilities outside of Washington State.

As part of its review, the department must conclude that the proposed services would be provided in a manner that ensures safe and adequate care to the public. Since January 2008, the Department of Health's Investigations and Inspections Office has completed at least six compliance surveys for SHS or its related healthcare providers.[14]

Of the compliance surveys completed, all revealed minor non-compliance issues related to the care and management at the SHS healthcare facilities. These non-compliance issues were typical of the specific type of facility and SHS submitted and implemented acceptable plans of correction. [source: facility survey data provided by the Investigations and Inspections Office]

SHS proposes to locate the ICN at its Issaquah hospital campus. Since the Issaquah hospital is not yet operational, there is no quality of care history for that site.

Given that the ICN would open approximately mid-year 2012, SHS did not identify its medical director for the ICN or any of the specific staff for the ICN. As a result, the department cannot verify licensure and state compliance for any of these individuals. [source: March 28, 2011, supplemental information, pp1-2]

There was no public comment submitted related to this sub-criterion. Based on the above information, the department's conclusion regarding this sub-criterion follows.

[12] Compliance surveys completed May 2009, January 2010, February 2010, and December 2010.
[13] Two physicians were recently released from Stipulation to Informal Disposition in year 2009.
[14] Compliance surveys completed August 2008, January 2010, September 2010, November 2010, June 2011, and July 2011.

Overlake Hospital Medical Center
Given the compliance history of OHMC and its healthcare facilities, the compliance history of the proposed medical director, and the compliance history of the current staff of the ICN and NICU, the department concludes that there is reasonable assurance that OHMC's level II ICN would operate in compliance with state and federal regulations. **This sub-criterion is met.**

Swedish Health Services
The department concludes that SHS did not provide documentation to demonstrate there is reasonable assurance that its level II ICN at the Issaquah hospital campus would operate in compliance with state and federal regulations. **This sub-criterion is not met.**

(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.*
WAC 246-310 does not contain specific WAC 246-310-230(4) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how to measure unwarranted fragmentation of services or what types of relationships with a services area's existing health care system should be for a project of this type and size. Therefore, using its experience and expertise the department assessed the materials in the application.

Overlake Hospital Medical Center
For this sub-criterion, the department considered OHMC's history of providing care to residents in Washington State. The department concludes that the applicant has been providing healthcare services to the residents of Washington State for several years and has been appropriately participating in relationships with community facilities to provide a variety of medical services. Nothing in the materials reviewed by staff suggests that approval of this project would change these relationships. [source: CN historical files]

Swedish Health Services
The department recognizes that SHS is a long-time provider of health care services in Washington State, and as such, has already established long term relationships within the healthcare system. [source: CN historical files]

For this project, the department has concluded that submission of this application for level II ICN tertiary services at a hospital that is not yet operational is premature. This conclusion is substantiated throughout the application where SHS is unable to provide draft documents, identify key staff for the service, or meet recommendations by the Statewide Perinatal Advisory Committee.

There was no public comment submitted related to this sub-criterion. Based on the above information, the department's conclusion regarding this sub-criterion follows.

Overlake Hospital Medical Center
Approval of this project would promote continuity in the provision of health care for the planning area, and would not result in an unwarranted fragmentation of services. Further, OHMC demonstrated it has, and will continue to have, appropriate relationships to the service area's existing health care system within the planning area. **This sub-criterion is met.**

Swedish Health Services
SHS was unable to demonstrate that approval of this project would promote continuity in the provision of health care for the planning area, and would not result in an unwarranted fragmentation of services. Further, SHS did not demonstrate it has, and will continue to have, appropriate relationships to the service area's existing health care system within the planning area for its level II ICN at the Issaquah campus. **This sub-criterion is not met.**

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.
Overlake Hospital Medical Center
This sub-criterion is addressed in sub-section (3) above and is **considered met.**

Swedish Health Services
This sub-criterion is addressed in sub-section (3) above and is **not met.**

D. Cost Containment (WAC 246-310-240)
Based on the source information reviewed, the department concludes:

- Overlake Hospital Medical Center's project has met the cost containment criteria in WAC 246-310-240 with agreement to the conditions identified in the 'conclusion' section of this evaluation; and
- Swedish Health Services' project has not met the cost containment criteria in WAC 246-310-240.

(1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.
To determine if a proposed project is the best alternative, the department takes a multi-step approach. Step one determines if the application has met the other criteria of WAC 246-310-210 thru 230. If it has failed to meet one or more of these criteria then the project is determined not to be the best alternative, and would fail this sub-criterion.

If the project met WAC 246-310-210 through 230 criteria, the department would move to step two in the process and assess the other options the applicant or applicants considered prior to submitting the application under review. If the department determines the proposed project is better or equal to other options the applicant considered before submitting their application, the determination is either made that this criterion is met (regular or expedited reviews), or in the case of projects under concurrent review, move on to step three.

Step three of this assessment is to apply any service or facility specific (tie-breaker) criteria contained in WAC 246-310. The tie-breaker criteria are objective measures used to compare competing projects and make the determination between two or more approvable projects which is the best alternative. If WAC 246-310 does not contain any service or facility criteria as directed by WAC 246-310-200(2)(a)(i), then the department would look to WAC 246-310-240(2)(a)(ii) and (b) for criteria to make the assessment of the competing proposals. If there are no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b), then using its experience and expertise, the department would assess the competing projects and determine which project should be approved.

Step One

Overlake Hospital Medical Center

For this project, OHMC's project met the review criteria under WAC 246-310-210, 220, and 230. Therefore, the department moves to step two below.

Swedish Health Services

For this project, SHS's project does not meet the review criteria under WAC 246-310-210, 220, and 230. Therefore, the department concludes this project is not the best available alternative for the community. The department does not review steps two or three below for this project.

Step Two

Overlake Hospital Medical Center

Within the application, OHMC stated that it is currently operating both level II and level III services at the hospital. OHMC stated it was not aware that ICN beds must be included within the hospital license. As a result, OHMC had no other option than to submit this application to add its ICN beds capacity to its acute care license.

Since submission of this application was the only option available to OHMC moving forward with this application is ultimately the best option for the residents of the community.

Step Three

This step is used to determine between two or more approvable projects which is the best alternative. Both OHMC and SHS submitted applications for level II ICN services, however, SHS's application did not meet the review criteria under WAC 246-310-210, 220, and 230. As a result, this step does not apply to OHMC's project.

Based on the above information, the department's conclusion regarding this sub-criterion follows.

Overlake Hospital Medical Center

Based on the documentation provided in the application, OHMC demonstrated that its project is the best available option for the community. **This sub-criterion is met.**

Swedish Health Services

Based on the documentation provided in the application, SHS did not demonstrate that its project is the best available option for the community. **This sub-criterion is not met.**

(2) *In the case of a project involving construction:*

(a) The costs, scope, and methods of construction and energy conservation are reasonable;

WAC 246-310 does not contain specific WAC 246-310-240(2)(a) criteria as identified in WAC 246-310-200(2)(a)(i). There are known minimum building and engergy standards that healthcare facilities must meet to be licensed or certified to provide care. If built to only the minimum stanardards all construction projects could be determined to be resonable. The department, through its experience knows that construction projects are usually built to exceed these minimum standards. Therefore, the department considered information in the application that addressed the reasonableness of the constuction projects that exceeded the minimum standards.

Overlake Hospital Medical Center

This project does not involve construction. As a result, this sub-criterion is **not applicable to OHMC's application.**

Swedish Health Services

As stated in the project description portion of this evaluation, this project involves construction. This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-220(2). Based on that evaluation, the department concludes that **this sub-criterion is met.**

(b) The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

Overlake Hospital Medical Center

This project does not involve construction. As a result, this sub-criterion is **not applicable to OHMC's application.**

Swedish Health Services

As stated in the project description portion of this evaluation, this project involves construction. This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-220(2). Based on that evaluation, the department concludes that **this sub-criterion is met.**

APPENDIX A

APPENDIX A
Overlake Hospital Medical Center and Perinatal Levels of Care Criteria Comparison

GUIDELINE	OHMC	PASS/FAIL
General Function		**Pass**
All Level I functions plus: ***Level IIA***- • Diagnosis and management of selected pregnancies and neonates ≥34 0/7 weeks gestation and 1500 grams • Care of mildly ill neonates with problems that are expected to resolve rapidly and are not anticipated to need Level III services on an urgent basis • Management of recovering neonates who can be appropriately back-transported from a referral center • Arrangement for developmental follow-up for high risk neonates ***Level IIB***- Level IIA plus: • Diagnosis and management of selected complicated pregnancies and neonates ≥32 0/7 weeks gestation and 1500 grams • Care of moderately ill neonates including those who may require conventional mechanical ventilation for brief duration (<24 hrs) or nasal CPAP Mechanical ventilation may be provided for stabilization pending transport to a Level III facility	OHMC's existing level IIIA program is staffed to accept and care for complicated pregnancies of gestational age > 27 weeks. OHMC provide CPAP, mechanical ventilation, advanced respiratory therapy, and performs procedures for central venous catheter. OHMC participates in the Vermont-Oxford database	
Neonatal Patients: Services and Capabilities		**Pass**
Level I patients and services plus: ***Level IIA***- • neonates ≥34 0/7 weeks gestation and > 1500 grams • Mildly ill neonates whose problems are expected to resolve rapidly and without need for CPAP, assisted ventilation, or arterial catheter • Neonates requiring supplemental oxygen but not > 60% after 1st six hours • Management of recovering neonates who can be back transported from a referral center Capabilities include: • Space designated for care of sick/convalescing neonates • Cardiorespiratory monitor for continuous observation • Peripheral IV insertion, maintenance and monitoring for fluids, glucose, antibiotics • Neonatal blood gas monitoring Average Daily Census (ADC) of at least 1-2 level II patients.	OHMC's level III program provides care for infants of gestational age > 28 weeks and gestation and 1000 grams. OHMC's program provides prolonged conventional mechanical ventilation and minor surgical services. OHMC's actual 2009 combined ADC was greater than 10	

APPENDIX A
Overlake Hospital Medical Center and Perinatal Levels of Care Criteria Comparison

Level IIB **Level IIA plus** • Neonates ≥32 0/7 weeks gestation and 1500 grams • Moderately ill neonates at low risk for needing mechanical ventilation beyond nasal CPAP Capabilities include: • Umbilical or peripheral arterial catheter insertion, maintenance and monitoring • Peripheral or central administration of total parenteral nutrition and/or medication and fluids Capability may include conventional mechanical ventilation for a brief duration (<24 hrs) or nasal CPAP Average Daily Census (ADC) of at least 2-4 level II patients.		
GUIDELINE	**OHMC**	**PASS/FAIL**
Obstetrical Patients: Services and Capabilities		**Pass**
Level I patients and services plus: ***Level IIA*** Pregnancies ≥34 0/7 weeks gestation and estimated birthweight > 1500 grams Capabilities include: management consistent with ACOG guidelines of selected high risk pregnancy conditions such as • Complications not requiring invasive maternal monitoring or maternal intensive care • Preterm labor judged unlikely to deliver before 34 weeks gestation ***Level IIB*** **Level IIA plus** Pregnancies ≥32 0/7 weeks gestation and estimated birthweight > 1500 grams Capabilities include: management consistent with ACOG guidelines of selected high risk pregnancy conditions such as • Preterm labor or other complications of pregnancy judged unlikely to deliver before 32 weeks gestation	OHMC's program cares for selected complicated pregnancies > 27 weeks gestation and estimated birth rate of 1000 or more grams. OHMC's current capabilities include immediate cesarean delivery. OHMC also provides maternal intensive care	

APPENDIX A
Overlake Hospital Medical Center and Perinatal Levels of Care Criteria Comparison

Patient Transport		Pass
All hospitals demonstrate capabilities to stabilize and initiate transport of patients in the event of unanticipated maternal-fetal newborn problems that require care outside the scope of the designated level of care. Access to return transport services may be a necessary capability for Level IIIA and Level IIIB intensive care nurseries. Transport patients: • who are anticipated to deliver a neonate of earlier gestational age than appropriate for the facility's designated level of care in accordance with COBRA laws and should not transport if the fetus or mother is unstable or delivery is imminent • whose illness or complexity requires services with a higher level of care than provided at the admitting facility A hospital that transports patients to a higher level of care facility should; • Demonstrate on-going relationships with referral hospital(s) for education, immediate consultation, urgent transport facilitation, and quality assurance • Establish a written policy and procedure for maternal and neonatal transport that includes an established triage system for identifying patients at risk who should be transferred to a facility that provides the appropriate level of care • Establish guidelines that ensure a provider's continuing responsibility for and care of the patient until transport team personnel or receiving hospital personnel assume full responsibility for the patient A hospital that accepts maternal or neonatal transports in order to provide a higher level of care than is offered at the referral hospital, should: • Participate in perinatal and /or neonatal case reviews at the referral hospital • Maintain a 24 hr/day 7 days/week system for reliable, comprehensive communication between hospitals for immediate consultation, initiation, and approval of maternal and newborn transports • Provide referring physicians with ongoing communication and recommendations for ongoing patient care at discharge.	OHMC has arrangements with other organizations to provide transportation for neonates. OHMC transfers primarily to Swedish Health Services and University of Washington Medical Center. Immediate consultation is provided by Eastside Maternal Fetal Medicine. A written policy for transport and triage is in place.	

APPENDIX A
Overlake Hospital Medical Center and Perinatal Levels of Care Criteria Comparison

Medical Director		**Pass**
Level IIA Obstetrics: board certified in OB/GYN or family medicine Nursery: board-certified in pediatrics ***Level IIB*** Obstetrics: board certified in OB/GYN Nursery: board-certified in neonatology	OHMC's medical director's are appropriately board certified	
Medical Providers		**Pass**
Level I coverage plus: ***Level IIA*** Every **high-risk** delivery is attended by at least two people one of whom is a pediatrician, family practice physician, or nurse with advanced practice capabilities, capable of a complete resuscitation, inc luding assisting with chest compressions, intubation, and administering medications ***Level IIB*** Level IIA coverage plus continuous availability of personnel experienced in airway management, diagnosis and treatment of pneumothorax when a patient is being treated with high flow nasal cannula or nasal CPAP, and continuous in-house presence of personnel experienced in airway management, diagnosis and treatment of pneumothorax when a patient is being treated with conventional mechanical ventilation.	OHMC operates with the capacity to provide immediate availability of an obstetrician who is capable of managing complicated labor and delivery patients. OHMC operates with the immediate availability of neonatologists or neonatal nurse practitioner to manage all severely ill neonates.	
Level I staff: Anesthesiologist or nurse anesthetist available to initiate cesarean section within 30 minutes of decision to do so. Consultation arrangement with genetic counselor per written protocol; ***Plus:*** ***Level IIA and IIB*** Radiologist on staff with daily availability who can interpret neonatal studies such as chest and abdominal radiographs, and cranial ultrasound Ophthalmologist with pediatric experience available to do eye exams for neonates who are at high risk for retinopathy of prematurity (ROP) if accepting back transport of such infants; written protocol for referral or treatment Arrangement of neurodevelopment follow-up or referral per written protocol	Obstetrical anesthesiologist are immediately available Pediatric echocardiography services with written protocols for pediatric cardiology consultation, including videotape interpretation, a complex range of genetic diagnostic services and genetic counselor on staff; referral arrangement for geneticist and diagnostics per written protocol and an arrangement for perinatal pathology services are all available.	

APPENDIX A
Overlake Hospital Medical Center and Perinatal Levels of Care Criteria Comparison

GUIDELINE	OHMC	PASS/FAIL
Nurse:Patient Ratio		**Pass**
Staffing parameters should be clearly delineated in a policy that reflects (a) staff mix and ability levels; (b) patient census, intensity, and acuity; and (c) plans for delegation of selected, clearly defined tasks to competent assertive personnel. It is an expectation that allocation of personnel provides for safe care of all patients in a setting where census and acuity are dynamic Intrapartum: • 1:2 patients in labor • 1:2 induction or augmentation of labor • 1:1 patients in second stage labor • 1:1 patients with medical or obstetric complications • 1:1 coverage for initiating epidural anesthesia • 1:1 circulation for cesarean delivery Antepartum/postpartum • 1:6 patients without complications • 1:4 recently born neonates and those requiring close observation • 1:3-4 normal mother-baby couplet care • 1:3 antepartum/postpartum patients with complications but in stable condition • 1:2 patients in post-op recovery Newborns • 1:6-8 neonates requiring only routine care* • 1:4 recently born neonates and those requiring close observation • 1:3-4 neonates requiring continuing care • 1:2-3 neonates requiring intermediate care • 1:1-2 neonates requiring intensive care • 1:1 neonates requiring multisystem support • 1:1 or greater unstable neonates requiring complex critical care *Reflects traditional newborn nursery care. A nurse should be available at all times, but only one may be necessary, as most healthy neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by ancillary personnel under the nurse's direct supervision. Additional staff is needed to respond to acute and emergency situations. The use of assistive personnel is not considered in the nurse: patient ratios noted here.	OHMC follows the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) guidelines for staffing which are the industry standards. They are comparable to these staffing ratios.	

APPENDIX A
Overlake Hospital Medical Center and Perinatal Levels of Care Criteria Comparison

Nursing Management		**Pass**
Level IIA Same as Level I (see. below) ***Level I:*** *nurse manager of perinatal services and *nurse manager of nursery services *=One RN may manage both services, but additional managers may be necessary based on number of births, average daily census, or number of full-time equivalents (FTEs) • Maintains RN licensure • Directs perinatal and/or nursery services • Guides perinatal and/or nursery policies and procedures • Collaborates with medical staff • Consults with higher level of care units as necessary ***Level IIB*** Same as Level I plus: • Advanced degree is desirable	NICU supervisor reports directly to the director of Women and Infant's Services	
Support Providers: Pharmacy, Nutrition/Lactation and OT/PT		**Pass**
Pharmacy Services ***Level I:*** Registered pharmacist available for telephone consultation, 24 hrs/day and 7 days/wk; Provision for 24 hrs/day and 7 days/wk access to emergency drugs ***Level IIA*** Registered pharmacist available for telephone consultation, 24 hrs/day and 7 days/wk ***Level IIB*** Registered pharmacist with experience in neonatal/perinatal pharmacology available 24 hrs/day and 7 days/wk **Nutrition/Lactation** ***Level I:*** Dietary and lactation services and consultation available ***Level IIA*** One healthcare professional knowledgeable in • Management of special maternal and neonatal dietary needs • Enterable nutrition of low birth weight and other high-risk neonates Lactation services and consultation available Diabetic educator for inpatient and outpatient services	OHMC already has pharmacy services with experience in neonatal/perinatal pharmacology in –house 24/7 OHMC has in-house lactation consultants	

APPENDIX A
Overlake Hospital Medical Center and Perinatal Levels of Care Criteria Comparison

Level IIB Same as level IIA services, plus: One healthcare professional knowledgeable in management of parenteral nutrition of low birth weight and other high risk neonates **OT/PT** *Level IIA and IIB* Provide for inpatient consultation and outpatient follow-up- services	OHMC has contracted OT/PT services for patients. These are available on an as needed basis (either inpatient consultation or outpatient services).	
Support Providers: Social Services/Case Management, Respiratory Therapy, Nurse Educator/Clinical Specialist		**Pass**
Social Services/Case Management **Level I services plus:** *Level IIA* Personnel with relevant experience whose responsibilities include perinatal patients; specific personnel for discharge planning and education, community follow-up, referral process and home care arrangements. *Level IIB* *Level IIA, plus* At least one MSW with relevant experience whose responsibilities include perinatal patients; specific personnel for discharge planning and education, community follow-up, referral process and home care arrangements. **Nurse Educator/Clinical Nurse Specialist** *Level IIA and IIB* No specific recommendations **Respiratory Therapy** *Level IIA* Same as Level I (see. below) The role of a respiratory care practitioner is prescribed by the medial director and clearly delineated per written protocol. If attending deliveries or providing neonatal respiratory care, should have current NRP provider status. *Level IIB* Same as Level I plus: Respiratory Care Practitioner (RCP) with documented competence and experience in the management of neonates with cardiopulmonary disease; when CPAP in use, an RCP should be in-house and immediately available	OHMC currently has an MSW that serves the Family Birthing Center and NICU. This individual is experienced with the problems of high-risk mothers and babies. MSW services are available 24/7. OHMC has a nurse educator to coordinate staff education and development. OHMC has a respiratory care practitioner dedicated to the NICU for all infants requiring any oxygen needs whether it is CPAP or any other ventilator.	

APPENDIX A
Overlake Hospital Medical Center and Perinatal Levels of Care Criteria Comparison

GUIDELINE	OHMC	
X-Ray Ultrasound		**Pass**
Level IIA and/or IIB Level I services plus ultrasound equipment immediately accessible and available to the labor and delivery unit 24 hrs/day and 7 days/wk	OHMC has advanced level ultrasound available within the unit.	
Laboratory and Blood Bank Services		**Pass**
Laboratory ***Level IIA and/or IIB*** Same as level I plus; • Lab technician in-house 24 hrs/day and 7 days/wk • Personnel skilled in phlebotomy and IV placement in the newborn immediately available 24 hrs/day and 7 days/wk • Microtechnique for hematocrit and blood gasses within 15 minutes **Blood Bank** ***Level IIA and/or IIB*** Blood bank technician on-call and available w/n 30 minutes for performance of routine blood banking procedures Provision for emergent availability of blood and blood products	OHMC in-house laboratory provides comprehensive services 24/7. RNs do all phlebotomy and IV placements on all neonates. OHMC has blood bank services available for both urgent and non-urgent needs.	

APPENDIX B

APPENDIX B
Swedish Issaquah Hospital and Perinatal Levels of Care Criteria Comparison

GUIDELINE	SHS-ISSAQUAH	PASS/FAIL
General Function		**Fail**
All Level I functions plus: ***Level IIA***- • Diagnosis and management of selected pregnancies and neonates ≥34 0/7 weeks gestation and 1500 grams • Care of mildly ill neonates with problems that are expected to resolve rapidly and are not anticipated to need Level III services on an urgent basis • Management of recovering neonates who can be appropriately back-transported from a referral center • Arrangement for developmental follow-up for high risk neonates ***Level IIB***- Level IIA plus: • Diagnosis and management of selected complicated pregnancies and neonates ≥32 0/7 weeks gestation and 1500 grams • Care of moderately ill neonates including those who may require conventional mechanical ventilation for brief duration (<24 hrs) or nasal CPAP Mechanical ventilation may be provided for stabilization pending transport to a Level III facility	Level IIA plus: • Diagnosis and management of selected complicated pregnancies and neonates ≥32 0/7 weeks gestation and 1500 grams • Care of moderately ill neonates including those who may require conventional mechanical ventilation for brief duration (<24 hrs) or nasal CPAP Mechanical ventilation may be provided for stabilization pending transport to a Level III facility Mechanical ventilation available in neonatal resuscitation room 24/7	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements.
Neonatal Patients: Services and Capabilities		**Fail**
Level I patients and services plus: ***Level IIA***- • neonates ≥34 0/7 weeks gestation and > 1500 grams • Mildly ill neonates whose problems are expected to resolve rapidly and without need for CPAP, assisted ventilation, or arterial catheter • Neonates requiring supplemental oxygen but not > 60% after 1st six hours • Management of recovering neonates who can be back transported from a referral center Capabilities include: • Space designated for care of sick/convalescing neonates • Cardiorespiratory monitor for continuous observation • Peripheral IV insertion, maintenance and monitoring for fluids, glucose, antibiotics • Neonatal blood gas monitoring Average Daily Census (ADC) of at least 1-2 level II patients.	Information not provided	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements.

APPENDIX B
Swedish Issaquah Hospital and Perinatal Levels of Care Criteria Comparison

Level IIB **Level IIA plus** • Neonates ≥32 0/7 weeks gestation and 1500 grams • Moderately ill neonates at low risk for needing mechanical ventilation beyond nasal CPAP Capabilities include: • Umbilical or peripheral arterial catheter insertion, maintenance and monitoring • Peripheral or central administration of total parenteral nutrition and/or medication and fluids Capability may include conventional mechanical ventilation for a brief duration (<24 hrs) or nasal CPAP Average Daily Census (ADC) of at least 2-4 level II patients.		
GUIDELINE	**SHS-ISSAQUAH**	**PASS/FAIL**
Obstetrical Patients: Services and Capabilities		**Fail**
Level I patients and services plus: ***Level IIA*** Pregnancies ≥34 0/7 weeks gestation and estimated birthweight > 1500 grams Capabilities include: management consistent with ACOG guidelines of selected high risk pregnancy conditions such as • Complications not requiring invasive maternal monitoring or maternal intensive care • Preterm labor judged unlikely to deliver before 34 weeks gestation ***Level IIB*** **Level IIA plus** Pregnancies ≥32 0/7 weeks gestation and estimated birthweight > 1500 grams Capabilities include: management consistent with ACOG guidelines of selected high risk pregnancy conditions such as • Preterm labor or other complications of pregnancy judged unlikely to deliver before 32 weeks gestation	Level IIA plus: Pregnancies > 32 0/7 weeks gestation and estimated birth weight > 1500 grams Capabilities include management consistent with ACOG guidelines of selected high-risk pregnancy conditions such as (*ref 3*) Preterm labor judged unlikely to deliver before 32 weeks gestation	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements.

APPENDIX B
Swedish Issaquah Hospital and Perinatal Levels of Care Criteria Comparison

Patient Transport		Fail
All hospitals demonstrate capabilities to stabilize and initiate transport of patients in the event of unanticipated maternal-fetal newborn problems that require care outside the scope of the designated level of care. Access to return transport services may be a necessary capability for Level IIIA and Level IIIB intensive care nurseries. Transport patients: • who are anticipated to deliver a neonate of earlier gestational age than appropriate for the facility's designated level of care in accordance with COBRA laws and should not transport if the fetus or mother is unstable or delivery is imminent • whose illness or complexity requires services with a higher level of care than provided at the admitting facility A hospital that transports patients to a higher level of care facility should; • Demonstrate on-going relationships with referral hospital(s) for education, immediate consultation, urgent transport facilitation, and quality assurance • Establish a written policy and procedure for maternal and neonatal transport that includes an established triage system for identifying patients at risk who should be transferred to a facility that provides the appropriate level of care • Establish guidelines that ensure a provider's continuing responsibility for and care of the patient until transport team personnel or receiving hospital personnel assume full responsibility for the patient A hospital that accepts maternal or neonatal transports in order to provide a higher level of care than is offered at the referral hospital, should: • Participate in perinatal and /or neonatal case reviews at the referral hospital • Maintain a 24 hr/day 7 days/week system for reliable, comprehensive communication between hospitals for immediate consultation, initiation, and approval of maternal and newborn transports • Provide referring physicians with ongoing communication and recommendations for ongoing patient care at discharge.	Meets Level IIB criteria for patient transport	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements.

APPENDIX B
Swedish Issaquah Hospital and Perinatal Levels of Care Criteria Comparison

Medical Director		**Fail**
Level IIA Obstetrics: board certified in OB/GYN or family medicine Nursery: board-certified in pediatrics ***Level IIB*** Obstetrics: board certified in OB/GYN Nursery: board-certified in neonatology	Obstetrics: board certified in OB/GYN Nursery: board-certified in neonatology	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements .
Medical Providers		**Fail**
Level I coverage plus: ***Level IIA*** Every **high-risk** delivery is attended by at least two people one of whom is a pediatrician, family practice physician, or nurse with advanced practice capabilities, capable of a complete resuscitation, inc luding assisting with chest compressions, intubation, and administering medications ***Level IIB*** Level IIA coverage plus continuous availability of personnel experienced in airway management, diagnosis and treatment of pneumothorax when a patient is being treated with high flow nasal cannula or nasal CPAP, and continuous in-house presence of personnel experienced in airway management, diagnosis and treatment of pneumothorax when a patient is being treated with conventional mechanical ventilation.	Level IIA coverage plus: Continuous in-house presence of personnel experienced in airway management, diagnosis and treatment of pneumothorax when a patient is being treated with conventional mechanical ventilation.	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements .
Level I staff: Anesthesiologist or nurse anesthetist available to initiate cesarean section within 30 minutes of decision to do so. Consultation arrangement with genetic counselor per written protocol; ***Plus:*** ***Level IIA and IIB*** Radiologist on staff with daily availability who can interpret neonatal studies such as chest and abdominal radiographs, and cranial ultrasound Ophthalmologist with pediatric experience available to do eye exams for neonates who are at high risk for retinopathy of prematurity (ROP) if accepting back transport of such infants; written protocol for referral or treatment Arrangement of neurodevelopment follow-up or referral per written protocol	Level IIA staff plus: Radiologist on staff with daily availability who can interpret neonatal studies such as chest and abdominal radiographs, and cranial ultrasound Ophthalmologist with pediatric experience available to do eye exams for neonates who are at high risk for retinopathy of prematurity (ROP) if accepting back transport of such infants; written protocol for referral or treatment Arrangement of neurodevelopment follow-up or referral per written protocol	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements .

APPENDIX B
Swedish Issaquah Hospital and Perinatal Levels of Care Criteria Comparison

GUIDELINE	SHS-ISSAQUAH	PASS/FAIL
Nurse:Patient Ratio		**Fail**
Staffing parameters should be clearly delineated in a policy that reflects (a) staff mix and ability levels; (b) patient census, intensity, and acuity; and (c) plans for delegation of selected, clearly defined tasks to competent assertive personnel. It is an expectation that allocation of personnel provides for safe care of all patients in a setting where census and acuity are dynamic Intrapartum: • 1:2 patients in labor • 1:2 induction or augmentation of labor • 1:1 patients in second stage labor • 1:1 patients with medical or obstetric complications • 1:1 coverage for initiating epidural anesthesia • 1:1 circulation for cesarean delivery Antepartum/postpartum • 1:6 patients without complications • 1:4 recently born neonates and those requiring close observation • 1:3-4 normal mother-baby couplet care • 1:3 antepartum/postpartum patients with complications but in stable condition • 1:2 patients in post-op recovery Newborns • 1:6-8 neonates requiring only routine care* • 1:4 recently born neonates and those requiring close observation • 1:3-4 neonates requiring continuing care • 1:2-3 neonates requiring intermediate care • 1:1-2 neonates requiring intensive care • 1:1 neonates requiring multisystem support • 1:1 or greater unstable neonates requiring complex critical care *Reflects traditional newborn nursery care. A nurse should be available at all times, but only one may be necessary, as most healthy neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by ancillary personnel under the nurse's direct supervision. Additional staff is needed to respond to acute and emergency situations. The use of assistive personnel is not considered in the nurse: patient ratios noted here.	Staffing plan will meet all required nurse: patient ratios as delineated	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements .

APPENDIX B
Swedish Issaquah Hospital and Perinatal Levels of Care Criteria Comparison

Nursing Management		**Fail**
Level IIA Same as Level I (see. below) ***Level I:*** *nurse manager of perinatal services and *nurse manager of nursery services *=One RN may manage both services, but additional managers may be necessary based on number of births, average daily census, or number of full-time equivalents (FTEs) • Maintains RN licensure • Directs perinatal and/or nursery services • Guides perinatal and/or nursery policies and procedures • Collaborates with medical staff • Consults with higher level of care units as necessary ***Level IIB*** Same as Level I plus: • Advanced degree is desirable	Same as level I plus advanced degree is desirable	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements .
Support Providers: Pharmacy, Nutrition/Lactation and OT/PT		**Fail**
Pharmacy Services ***Level I:*** Registered pharmacist available for telephone consultation, 24 hrs/day and 7 days/wk; Provision for 24 hrs/day and 7 days/wk access to emergency drugs ***Level IIA*** Registered pharmacist available for telephone consultation, 24 hrs/day and 7 days/wk ***Level IIB*** Registered pharmacist with experience in neonatal/perinatal pharmacology available 24 hrs/day and 7 days/wk **Nutrition/Lactation** ***Level I:*** Dietary and lactation services and consultation available ***Level IIA*** One healthcare professional knowledgeable in • Management of special maternal and neonatal dietary needs • Enterable nutrition of low birth weight and other high-risk neonates Lactation services and consultation available Diabetic educator for inpatient and outpatient services	Pharmacy Services: same as level II B Nutrition/Lactation: At least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special need of high-risk mothers and neonates OP/PT Services: Provide for inpatient consultation and outpatient follow-up services	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements .

APPENDIX B
Swedish Issaquah Hospital and Perinatal Levels of Care Criteria Comparison

Level IIB Same as level IIA services, plus: One healthcare professional knowledgeable in management of parenteral nutrition of low birth weight and other high risk neonates **OT/PT** ***Level IIA and IIB*** Provide for inpatient consultation and outpatient follow-up- services		
Support Providers: Social Services/Case Management, Respiratory Therapy, Nurse Educator/Clinical Specialist		**Fail**
Social Services/Case Management **Level I services plus:** ***Level IIA*** Personnel with relevant experience whose responsibilities include perinatal patients; specific personnel for discharge planning and education, community follow-up, referral process and home care arrangements. ***Level IIB*** ***Level IIA, plus*** At least one MSW with relevant experience whose responsibilities include perinatal patients; specific personnel for discharge planning and education, community follow-up, referral process and home care arrangements. **Nurse Educator/Clinical Nurse Specialist** ***Level IIA and IIB*** No specific recommendations **Respiratory Therapy** ***Level IIA*** Same as Level I (see. below) The role of a respiratory care practitioner is prescribed by the medial director and clearly delineated per written protocol. If attending deliveries or providing neonatal respiratory care, should have current NRP provider status. ***Level IIB*** Same as Level I plus: Respiratory Care Practitioner (RCP) with documented competence and experience in the management of neonates with cardiopulmonary disease; when CPAP in use, an RCP should be in-house and immediately available	Level IIA services plus: At least one MSW with relevant experience whose responsibilities include perinatal patients; specific personnel for discharge planning and education, community follow-up, referral process and home care arrangements. Same as level I plus: Respiratory Care Practitioner with documented competence and experience in the management of neonates with cardiopulmonary disease; when CPAP in use, an RCP should be in-house and immediately available.	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements.

APPENDIX B
Swedish Issaquah Hospital and Perinatal Levels of Care Criteria Comparison

GUIDELINE	SHS-ISSAQUAH	
X-Ray Ultrasound		**Fail**
Level IIA and/or IIB Level I services plus ultrasound equipment immediately accessible and available to the labor and delivery unit 24 hrs/day and 7 days/wk	Level I services plus ultrasound equipment immediately accessible and available to the labor and delivery unit 24 hrs/day and 7 days/wk	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements.
Laboratory and Blood Bank Services		**Fail**
Laboratory ***Level IIA and/or IIB*** Same as level I plus; • Lab technician in-house 24 hrs/day and 7 days/wk • Personnel skilled in phlebotomy and IV placement in the newborn immediately available 24 hrs/day and 7 days/wk • Microtechnique for hematocrit and blood gasses within 15 minutes **Blood Bank** ***Level IIA and/or IIB*** Blood bank technician on-call and available w/n 30 minutes for performance of routine blood banking procedures Provision for emergent availability of blood and blood products	Same as level I plus; • Lab technician in-house 24 hrs/day and 7 days/wk • Personnel skilled in phlebotomy and IV placement in the newborn immediately available 24 hrs/day and 7 days/wk • Microtechnique for hematocrit and blood gasses within 15 minutes Will meet blood bank criteria	SHS unable to document that Issaquah Hospital meets level I and level IIA requirements.