EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED ON BEHALF OF KENNWICK PUBLIC HOSPITAL DISTRICT d.b.a. KENNEWICK GENERAL HOSPITAL PROPOSING TO ESTABLISH A TEN BED LEVEL II INTERMEDIATE CARE NURSERY

APPLICANT DESCRIPTION

Kennewick Public Hospital District (KPHD) d.b.a. Kennewick General Hospital (KGH), a public hospital located in the city of Kennewick, within Benton County provides Medicare/Medicaid acute care services to residents of Benton and Franklin counties and surrounding areas. KGH is currently licensed for 101 acute care beds (27 at the Auburn campus) and has a certificate of need to move 74 beds to the new Southridge site in the city of Kennewick. KGH holds a three year accreditation from the Joint Commission on Accreditation of Health Care Organizations.

The Auburn campus will provide women and children's services, (maternity, pediatric, and nursery services) ambulatory services, physician practices, ultrasound, urgent care, satellite lab, limited imaging, hospital support services, and some administrative services.

The Southridge campus will provide critical care, medical and surgical beds, emergency department, operating rooms, diagnostic imaging, pharmacy, administrative, and support services.

In addition to the hospital, KPHD also owns and operates Kennewick Home Health Services, Benton Franklin Elder Services and KGH Medical Mall. Inpatient services currently provided at KGH Auburn include medical-surgical services, emergency services, basic pediatric services, obstetrical services, ICU and CCU, progressive care unit, neurological services, diagnostic services, and physical therapy.

The Medical Mall offers ambulatory services, physician practices, outpatient surgery, outpatient imaging, G.I. services, and pharmacy.

PROJECT DESCRIPTION

This application proposes to establish a 10 bed Level II intermediate care nursery (ICN) and Level II obstetric services within space at the KGH Auburn campus. The existing bassinettes used for Level II ICN services are not currently included in the hospital's license and have not been approved through CON to be providing Level II care ICN. KGH proposes that the 10 beds would be an addition to KGH's acute care license. If approved, KGH would be licensed for 111 acute care beds as shown in the table below.

Southridge Campus		**Auburn Campus**	
Medical Surgical	74 beds	Pediatrics	27 beds
Intensive Care		Obstetrics	
Emergency Services	N/A	Level II ICN	10 beds
Ancillary Services	N/A	Urgent Care	N/A
		Speech Pathology	N/A
		Physical Therapy	N/A
Total	74	**Total**	37

The bassinettes proposed in this project will be located in an Intermediate Care Nursery which is defined in the Washington State Perinatal Level of Care (LOC) Guidelines. An "Intermediate Care Nursery means an area designed, organized and equipped to provide constant care and treatment for mild to moderately ill infants not requiring neonatal intensive care, but requiring physical support and treatment

beyond support required for a normal neonate and may include the following:

- Electronic cardio-respiratory monitoring;
- Gavage feedings;
- Parental therapy of administration of drugs; and
- Respiratory therapy with intermittent mechanical ventilation not to exceed a continuous period of twenty four hour for stabilization when trained staff are available.[Source WAC 246-320 Definition missing from reference sources]

A Level II obstetric service is offered in an area designed, organized, equipped, and staffed to provide services to provide a full range of maternal and neonatal services for uncomplicated patients and for the majority of complicated obstetrical problems. Such a service provides the coordination of care, communication, transfer, and transportation for Level II patients in their facility... For the rest of the evaluation, the proposed program will be referred to as "Level II ICN services." [Source: Washington Administrative Code 246-310-020]

Currently, KGH has the space to accommodate 10 bassinettes that it utilizes for the ICN Level II services. Prior to a renovation/remodeling project KGH was operating 5 Level II bassinets and has on occasion treated neonates that were classified as NICU Level III as necessary during the treatment of traditional ICN Level II births. On March 25 2008, KGH submitted a Letter of Intent to the department proposing to increase its bassinettes and expand their facility to a Level III neonatal unit. On April 23, 2008, the department responded to KGH's LOI with a Determination of Reviewability (DOR) letter[1] advising them they were authorized to provide level I services only. The letter went on to state that if KGH wanted to provide Level II ICN services, a CON application was required prior to submitting an application to Construction Review Services. When a facility is determined to be performing a service that requires prior CN review and approval and that authorization has not been obtained, the remedy may be to require the facility to close the service. The department did not require KGH to close its ICN Level II bassinettes during the pendency of this application. Approval of future proposals could be jeopardized if KGH fails to obtain approval for CON reviewable projects.

The capital expenditure associated with the project is $1,265,100. Of that amount, 95% is related to construction costs and 5% is related to fixed and moveable equipment, as shown in Table 1 on the following page.

Table 1
Estimated Capital Costs

Breakdown Of ECE	**Total**	**% Of Total**
Leasehold Improvements	$1,200,000	95%
Fixed & Moveable Equipment	$65,100	5%
Total	**$1,265,100**	**100.00%**

[1] DOR 08-23

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need Review as a change in bed capacity in a health care facility and the establishment of a new tertiary health service under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and (f) and Washington Administrative Code (WAC) 246-310-020(1)(c) and (d).

APPLICATION CHRONOLOGY

April 22. 2009	Letter of Intent submitted
July 31, 2009	Application submitted
August 1, 2009 - October 4, 2009	Department's Pre-Review Activities including screening and responses
October 5, 2009	Department Begins Review of the Application • public comments accepted throughout review
November 16, 2009	Public Hearing Conducted / End of Public Comment
December 3, 2009	Rebuttal Documents Submitted to Department
January 5, 2010	Department extends review period for 30 days
January 19, 2010	Department's anticipated decision due
September 13, 2010	Department's actual decision date

AFFECTED AND INTERESTED PERSONS

The following entity sought and received affected person status under WAC 246-310-010:

- Kadlec Regional Medical Center located within Benton County

SOURCE INFORMATION REVIEWED

- Kennewick General Hospital's July 31, 2009, Certificate of Need Application.
- Kennewick General Hospital's supplemental information dated September 25, 2009
- Community member's comments received throughout the public comment period and at the November 16, 2009 public hearing
- Kennewick General Hospital's rebuttal comments (December 3, 2009)
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Population data obtained from the Office of Financial Management dated November 2007
- Financial Feasibility and cost containment evaluation prepared by the Department of Health's Hospital and Patient Data Systems dated January 8, 2010
- Historical charity care data obtained from the Department of Health's Office of Hospital and Patient Data Systems (2005, 2006, 2007 summaries)
- Data obtained from Kennewick General Hospital's website
- Licensing and survey data provided by the Department of Health's Investigations and Inspections Office.
- Washington State Perinatal Levels of Care Criteria adopted by the Perinatal Advisory Committee February 2005, used as guidance
- Certificate of Need Historical Files
- Data provided by the Department of Health's Construction Review Services

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."

To obtain Certificate of Need approval, KGH must demonstrate compliance with the 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).[2] Where applicable, the applicant must demonstrate compliance with the above criteria by meeting the 2005 Perinatal Level of Care Guidelines established by the Washington State Perinatal Advisory Committee.

CONCLUSION

For the reasons stated in this evaluation, the application submitted on behalf of Kennewick General Hospital is proposing to establish a 10 bed Level II intermediate care nursery is consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need should be issued provided that the applicant agrees to the terms and condition stated below. Approval of this project does not authorize the provision of Level III NICU care.

TERMS

1. Within 90 days of issuing the Certificate of Need for this project, Kennewick General Hospital will provide a copy of the adopted written policies and procedures specific to neonatal transport as recommended by the Washington State Perinatal Levels of Care guidelines.

2. Within 90 days of issuing the Certificate of Need for this project, Kennewick General Hospital will provide a copy of the adopted guidelines for continued care during transport as recommended by the Washington State Perinatal Levels of Care guidelines

3. Prior to expanding to Level II B Intermediate Care Nursery, Kennewick General Hospital will provide documentation that its Director of Special Care Nursery is a Board Certified Neonatologist.

4. Kennewick General Hospital will provide confirmation of the collaboration for coordinating outreach education between hospitals recommended by the Washington State Perinatal Levels of Care guidelines.

CONDITION

1. Kennewick General Hospital will provide charity care in compliance with the charity care policies reviewed and approved by the Department of Health. Kennewick General Hospital 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 Central Washington Region. Currently, this amount is 1.91% of gross revenue and 4.45% of adjusted revenue. Kennewick General Hospital will maintain records documenting the amount of charity care it provides and demonstrating its compliance with its charity care policies.

The proposed capital expenditure for this project is $1,265,100.

[2] 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).

A. Need (WAC 246-310-210)

Based on the source information reviewed and with the applicant's agreement to the terms and condition identified in the "conclusion" section of this evaluation, the department determines that the applicant has 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 246-310-220 states (in summary) that a Level II obstetric service is to be in an area designated, organized, equipped, and staffed to provide a full range of maternal and neonatal services for uncomplicated patients and for the majority of complicated obstetrical problems.

Level II ICN services are considered tertiary services as defined by WAC 246-310-010. For some tertiary services, such as open heart surgery, the department uses an established methodology to assist in its evaluation of need for the services. For other tertiary services, including Level II ICN services, no such methodology exists. Given that the department has not developed an established methodology for Level II ICN services, an evaluation of the need criterion begins with an evaluation of the methodology provided by the applicant.

KGH rationale for Level II ICN services

The applicant used historical Comprehensive Hospital Abstract Reporting System (CHARS) data to assist in demonstrating need for a Level II ICN service. CHARS data is reported by each Washington State hospital to the department's Hospital and Patient Data Systems office (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 describes the corresponding definition for the DRGs included in MDC #15.[3]

DRG	Definition	Level of Care
385 / 789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	Level 3
386 / 790	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	Level 3
387 / 791	PREMATURITY WITH MAJOR PROBLEMS	Levels 2 or 3
388 / 792	PREMATURITY WITHOUT MAJOR PROBLEMS	Level 2
389 / 793	FULL TERM NEONATE WITH MAJOR PROBLEMS	Level 2
390 / 794	NEONATE WITH OTHER SIGNIFICANT PROBLEMS	Levels 1 or 2
391 / 795	NORMAL NEWBORN	Level 1

For ease of reference, the remainder of this evaluation will refer to the DRGs above using the current 700 numbers shown in the chart above, of the DRGs included in MDC #15, some do not correspond exactly with the Level of care definitions.

To support its establishment of Level II services, KGH applied a 5-step forecast methodology modeled on the department's acute care bed methodology. KGH defines Benton and Franklin counties as the service area in this methodology. Below is a discussion of KGH's numeric

[3] 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 the Washington State Perinatal Advisory Committee and October 16, 2007 testimony by Linda Wallen, MD also a board certified neonatologist.

methodology and the assumptions/data used by KGH in each step. Throughout the methodology and calculations, KGH used 10 years of historical data (1999 through 2008) from DRGs791, 792, 793, and 794 for Level II calculations. [Source: Application pg 22, September 21, 2009 Screening Questions pg3]

Step 1: Identify 10 year historic planning area provider days and use rate. Calculate the historic trend line, or slope, for these use rates:

(This step mirrors Steps 1-4 of the acute care bed methodology.)

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Benton Franklin Total Provider Level II Days (CHARS)	3,258	3,150	2,806	2,766	3,129	3,299	3,862	4,136	4,262	4,196
Female Pop. 15-44 (OFM)	39,964	40,455	40,828	41,220	42,116	43,183	44,176	45,183	46,651	46,750
Benton/Franklin Historical Level II Use Rates –Days per 1000 Females Age 15-44	81.5	77.9	68.7	67.1	74.3	76.4	87.4	91.5	92.5	89.8
1998-2007 Level II Use Rage Trend Slope	2.1									

Excludes Lourdes Counseling

Step 2: Calculate resident patient days and origin, provider market shares, and resident use rates for the baseline year (2008).

(This step mirrors Steps 5 and 6 of the acute care bed methodology.)

Benton and Franklin Planning Area
Baseline Year Data: 2008

	Total	**From Benton/ Franklin Residents**	**From Out-of-Area**	**Total Less Out-of-Area**	**Out-of-Area Ratio**
Benton/Franklin Provider Level II Days by Patient Origin	4,196	3,337	859	3,337	0.2574

	In WA	**In OR (07)**	**Total**
Benton/Franklin Provider Level II Days by Patient Origin	3,757	2	3,759

	In WA
Benton/Franklin Provider Market Share of All Benton/Franklin Resident Level II Days	88.8%

Pop. Fem 15-44	46,750

Total Benton/Franklin Resident Level II Use Rate	80.4

Step 3: Apply the historical use rate calculated in Step 1 to the baseline resident use rate from Step 2 to project future planning area rates.

Total Resident Level II Use Rate	80.4

	2009	2010	2011	2012	2013	2014	2015	2016
Trended Level II Use Rate	82.6	84.7	86.8	89.0	91.1	93.3	95.4	97.6

Step 4: Projections

Apply the projected use rates from Step 3 to the projected future population to calculate future total resident days. Adjust by the market shares and out-of-area ratio calculated in Step 2 to calculate future total level II days to planning area providers. (This step mirrors Steps 8-9 of the acute care bed methodology.)

Benton/Franklin Planning Area

	2009	2010	2011	2012	2013	2014	2015	2016
Trended Level II Use Rate	82.6	84.7	86.8	89.0	91.1	93.3	95.4	97.6
Pop. Fem. 15-44	47,468	48,195	48,934	49,564	50,326	51,101	51,890	52,692
Total Resident Patient Days	3,918	4,082	4,250	4,411	4,586	4,767	4,952	5,141
Resident Days to Benton/Franklin Providers at Current Market Shares	3,479	3,624	3,772	3,915	4,072	4,232	4,396	4,564
Out-of-Area Days	895	933	971	1,008	1,048	1,089	1,132	1,175
Total Days	4,374	4,557	4,744	4,923	5,120	5,321	5,527	5,739

Step 5 Bed Need

Use the total days projected in Step 4 to determine gross and net Level II bed need for the planning area.

(This step mirrors Step 10 of the acute bed need methodology.)

	2009	2010	2011	2012	2013	2014	2015	2016
Total Level II Days	4,374	4,557	4,744	4,923	5,120	5,321	5,527	5,739
Average Daily Census	12.0	12.5	13.0	13.5	13.0	14.6	15.1	15.7
Gross Bed Need at 65% Occupancy	**18.4**	**19.2**	**20.0**	**20.8**	**21.0**	**22.4**	**23.3**	**24.2**

Current Level II Bed Supply

Kadlec	12	12	12	12	12	12	12	12
KGH	10	10	10	10	10	10	10	10
Total	22	22	22	22	22	22	22	22

Net Bed Need	**(3.6)**	**(2.8)**	**(2.0)**	**(1.2)**	**(0.4)**	**0.4**	**1.3**	**2.2**

"*It should be noted that Kadlec has recently put forth a CN application related to its existing neonatal beds. Page 26 of its application projects the following Level II ADC and bed need."*

	2009	2010	2011	2012	2013	2014	2015	2016
Level II Average Daily Census	8.1	8.9	9.7	10.6	11.5	12.6	13.7	15.0

Gross Bed Need at 65% Occupancy	**12.5**	**13.6**	**14.9**	**16.2**	**17.7**	**19.3**	**21.1**	**23.0**

"Given that the actual Level II ADC in Benton/Franklin hospitals in 2008 was 11.5 (see Table A), we must conclude that Kadlec's projections-at least in the early years are-extremely conservative. Nonetheless, by mid 2015, well within the 7 year planning horizon for bed projects, both Kadlec and KGH identify a need for approximately 22 level II beds in the planning area."

[Source KGH September 21, 2009 Screening Question Response pg6]

Public Comments

During review of this application, the department received letters of support and testimony from many in the community. There was one letter from the Kadlec Regional Medical Center Administrator that did not specify opposition to this project but that raised issues regarding the number of licensed beds in the community, the financial feasibility analysis provided by KGH in the application and the necessity of KGH to satisfy all criteria in its application to be approved. Kadlec Regional Medical Center also submitted a rebuttal response to the public testimony submitted to the department prior to and at the hearing held on November 16, 2009 in Kennewick. The basic concerns expressed by Kadlec Regional Medical Center are as follows:

1. "*KGH's assertions regarding the level of growth at KGH are inaccurate, and are based on flawed interpretations of the available data."*
2. *KGH's patient-day forecasts are not reasonable.*
3. *KGH has not shown need for the 10 Level II bassinets being requested.*
4. *When correct Level II patient-day utilization statistics are used, KGH's proposed project does not satisfy the Department's financial feasibility criteria."*

Department's Evaluation

The department need review will begin with consideration of the underlying assumptions used by KGH in its need methodology. The main assumptions used by KGH are service area, population projections, current capacity at the hospital, Level II DRGs and Level II adjusted occupancy of 65%.

KGH Service Area

KGH defines its service area for this project to be Benton and Franklin Counties. Located in Benton County, Kennewick would be expected to serve that County. Franklin County is immediately north

and east of Benton County and is considered part of the KGH's service area. The applicant stated in the application that less than 10% of their admissions for newborns come from out of Benton/Franklin Counties. The applicant did count a significant number of out of area patient days for the total Level II patient days in their need calculation and this would indicate that most of these patient days should be allocated to Kadlec Regional Medical Center. The department analysis of patient days will use total patient days and thus will include these out-of area patient days. Table 1 illustrates the original data provided by the applicant: The historical data was verified using CHARS data provided by DOH HPDS staff.

Table 1
Applicant's Historical Level II Patient Days

	1987	1990	1995	2000	2005	2006	2007	2008
MS 791	117	116	65	152	44	69	89	106
MS 792	0	18	83	71	77	123	146	90
MS 793	508	654	360	469	276	394	470	500
MS 794	157	287	198	264	478	730	793	616
Total	782	1075	706	956	875	1306	1498	1312
ADC	2.1	2.9	1.9	2.6	2.4	3.6	4.1	3.6

The Level II patient days and ADC comparison for the first 3 years of operation are included in Table 2. The historical data provided in the initial application included all of the patient days for DRG 794. The department had previously only counted 25% of these patient days but recently has determined that 100% of the days within this DRG should be counted. The applicant had not provided their methodology at time of submission; therefore it was not possible to determine how the numbers were derived

Table 2
KGH Projected Patient Days/ADC Level II/III Combined

	2010	2011	2012	2013
KGH Level II/III Pt. Days from Application	1,703	1,908	2,125	2,279
KGH ADC from Application	4.7	5.2	5.8	6.2
KGH Level II Pt. Days Calc.		1755	1871	1997
KGH ADC		4.8	5.1	5.5

The projections submitted in the original application were overestimated due to the applicant including neonatal Level III patient days. The applicant provided substantial Level III services as indicated by the calculated patient days shown in line 3 of Table 2. The applicant revised their Level II projections in response to a screening question by the department. The historical data provided in the initial application included all of the patient days for DRG 794. The department had previously only counted 25% of these patient days but recently has determined that 100% of the days within this DRG should be counted. The applicant had not provided their methodology at time of submission; therefore it was not possible to determine how the numbers were derived.

Population Projections

In the September 21, 2009 response to screening questions, the applicant provided the projected female aged 15-44 population based upon the medium series projections produced by OFM for

Benton and Franklin counties. The department is in agreement with the applicant in using these population projections.

Current Available Capacity

Kennewick is currently treating level II newborns in 10 existing Level II bassinettes in a recently remodeled nursery. Prior to remodeling KGH operated 5 Level II bassinettes in their Intermediate Care Nursery. The 10 beds are not CN approved or added to KGH's license but for purposes of this analysis these bassinettes will be considered the capacity at KGH. Table 3 below shows both planning area and KGH's historical level II patient days.

Table 3
Planning Area/KGH Historical Patient Days/ADC for Level II

	2003	2004	2005	2006	2007	2008
Total Level II Days Benton/ Franklin Planning Area Prov.	3129	3299	3862	4136	4262	4196
KGH Market Share of Level II Days**	30.9	26%	22.6%	31.6%	35.1%	32.9%
Total Level II Days KGH*	969	859	875	1,306	1,498	1,380
ADC 5 bassinettes	2.7	2.4	2.4	3.6	4.1	3.8
% Occupancy 5 Bassinettes	54	47.9	47.9	63.2	82	76

*Based on actual 2005 to 2008 average market share of 30.6%.
**Total Benton/Franklin provider Level II patient days

As shown in Table 3, the applicant has exceeded the minimum ADC of 2-4 as recommended in the perinatal guidelines for Level II neonatal units. The historical data indicates that the applicant's Level II ICN unit has exceeded 65% occupancy for 2007 and 2008. This would suggest that with minimal growth the applicant may experience days where the unit is fully occupied. Since the 10 bassinettes are already operating, the historical data would support the applicant operating 10 bassinettes instead of the original 5.

Table 4
Department Proposed Level II Bed Supply

	2009	2010	2011	2012	2013
KGH Projected ADC	4.1	4.8	4.8	5.1	5.5
ADC based on Market Share	4.1	4.5	4.8	5.4	5.5
KGH Occupancy 10 Bassinettes	41%	45%	48%	51%	55%
KGH Occupancy 5 Bassinettes	82%	90%	96%	102%	110%

Table 4 illustrates the projected bed need for KGH's ICN Level II unit with a bed supply of 5 bassinettes and a bed supply of 10 beds. With 5 beds KGH's ICN Level II unit is projected to be operating at 110% occupancy by 2013 and with 10 beds KGH's ICN Level II unit is projected to be operating at 55% occupancy by 2013.

ICN Level II 65% occupancy

The applicant proposed the average daily census needed to be adjusted up to reflect the need to allow for census fluctuations. The projections in Table 4 indicate that the applicant should be operating at 55% occupancy with the 10 beds proposed in the application. This does not support the need to adjust

the occupancy level downward to allow for census fluctuations. Further as discussed in the next section on availability of existing services there are level II bassinettes available in Richland which borders the city limits of Kennewick. The applicant and Kadlec Regional Medical Center should be coordinating services to accommodate census fluctuations.

In summary the applicant has documented the ability to meet the minimum recommended ADC of 2-4 from the Washington State Perinatal Guidelines. The applicant has documented the potential to achieve close to 65% occupancy by the target year 2013. The department agrees that the ten bassinettes are reasonable for the applicant to operate. The department also considers this number of bassinettes appropriate since CON approved Level II and Level III services are available in the adjacent community of Richland.

Based upon the above information, the applicant has documented the need for a 10 bed Level II ICN. This sub-criterion is met.

b. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed;

KPHD is included in the Benton/Franklin Hospital Planning Area. KGH has defined its service area based upon the boundaries defined for the Kennewick Public Hospital District. Included with KGH in the Benton/Franklin Hospital Planning Area are Kadlec Regional Medical Center and Prosser Memorial in Benton County and Lourdes Medical Center in Franklin County. Kadlec Regional Medical Center is licensed for 188 acute care beds, Prosser Memorial (critical access hospital) is licensed for 25 acute care beds, and Lourdes Medical Center (critical access hospital) is licensed for 25 acute care beds. In terms of neonatal services, Kadlec Regional Medical Center is approved for a total of 27 bassinettes. Of these 27 bassinettes 15 are NICU

Level III and 12 are ICN Level II. Their project also proposes to expand their existing unit requiring a capital expenditure. Lourdes Medical Center and Prosser Memorial only operate Level I nurseries. Lourdes Medical Center and Prosser Memorial provided 436 of the ICN Level II patient days in 2008 which was 11.3 % of the ICN Level II patient days for the Benton Franklin hospital planning area. [Source: Hospital and Patient Data Systems, CHARS Data] The department considers these incidental to their Level I services, however with approval of KGH's bassinettes and the previously approved Kadlec Regional Medical Center application the department would expect these to decline.

The department has determined that approval of both the Kennewick ICN Level II services and the Kadlec Regional Medical Center ICN Level II and Neonatal ICU Level III services are appropriate and will not result in unnecessary duplication of services.

Based on the above information, this sub-criterion has been met.

(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.

KGH is currently a provider of health care services to residents of Washington State, including low-income, racial and ethnic minorities, handicapped and other underserved groups. As an acute care hospital, KGH also currently participates in the Medicare and Medicaid programs. To determine whether all residents of the service area would continue to have access to a hospital'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, KGH provided a copy of its current Admission Policy. The policy outlines the process/criteria that KGH uses to admit patients for treatment or care at the hospital. The policy also states that any patient requiring care is accepted for treatment at KGH without regard to race, religion, sex, age, or ability to pay. This policy is consistent with Certificate of Need requirements. [Source: KGH application, Exhibit 10]

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. KGH currently provides services to Medicaid eligible patients. Documents provided in the application demonstrate that it intends to maintain this status. For this project, a review of the policies and data provided for KGH identifies the facility's financial resources as including Medicaid revenues. [Source: KGH Application: p13 & Exhibit 6]

For this project, it is unlikely that residents with Medicare will need access to neonatal services. However, nothing in the application suggests that this project will impact the services provided to Medicare patients.

The applicant submitted a copy of their charity care policy; dated May 2007. CON staff reviewed the charity care policy from the Department's web site and the approved policy on the DOH website is dated September 2009. The approved policy outlines the process and level of charity care as required.

RCW 70.38.115(2)(j)requires and evaluation to determine if the hospital is meeting or exceeding the regional average of charity care. For charity care reporting purposes, the OHPDS, divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. KGH is one of 21 hospitals located within the Central Region. According to the 2006, 2007, and 2008 Charity Care Reports obtained from HPDS, KGH has generally provided annual charity care less than the Central Region average for the respective years.

Table 5
KGH Charity Care Comparison

	3-Year Average for Central Region	3-Year Average for KGH
% of Gross Revenue	1.91%	1.77%
% of Adjusted Revenue	4.45%	3.99%

The applicant's pro forma revenue and expense statements indicate that the hospital will provide charity care at approximately 2.28% of gross revenue, or 5.48 of adjusted, which is higher than the average charity care provided in the region. RCW 70.38.115(2)(j) requires hospitals to meet or exceed the regional average level of charity care. [Source: KGH application, Appendix 1&6]

KGH has historically provided less charity care than the regional average. Because KGH proposes to exceed the regional average as identified above, a charity care condition for the hospital is necessary.

KGH 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. KGH 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 Central Washington Region. Currently, this amount is 1.91 % of gross revenue and 4.45% of adjusted revenue. KGH 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 charity care condition, the department concludes this sub-criterion is met.

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

Based on the source information reviewed and with the applicant's agreement to the terms and condition identified in the "conclusion" section of this evaluation, the department determines that the applicant has 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.

To demonstrate compliance with this sub-criterion KGH provided its Statement of Operations for the Level II Cost Center only for projected years 2010 through 2013. [Source: HPDS Analysis, p3, Application, p102] A summary of the Statement of Operations for the Cost Center only is shown in Table 6 below.

Table 6
Level II Cost Center Projected Statement of Operations Summary
Years 2011 through 2013

	Projected Year 1 (2010)	**Project Year2 (2011)**	**Projected Year 3 (2012)**	**Projected Year 4 (2013)**
Total Operating Revenue	$2,122,912	$2,378,459	$2,648,966	$2,840,938
Total Operating Expense	$1,602,195	$2,398,352	$2,563,967	$2,686,412
Net Profit or (Loss)	**($92,069)**	**($19,893)**	**$84,999**	**$154,526**

[Source: Hospital and Patient Data Systems January 8, 2010 Report]

The 'Total operating revenue 'line item in Table 6 is the result of gross revenue minus any deductions for contractual allowances, bad debt, and charity care directly related to the Level II ICN cost center. The 'total operating expenses' line item includes staff salaries/wages and all hospital cost allocations related to the Level II ICN cost center.

KGH projects that the ICN Level II ICN will provide a profit by project year 3. This is based on the hospital achieving the patient days projected by the applicant. KGH also provided its Statement of Operations for the hospital as a whole with Level II ICN Services for projected years 2010 through 2013. [Source: Application, pgs 67-72]. A Statement of Operations summary is shown in Table 7 on the following page.

Table 7
KPHD Projected Statement of Operations Summary
Years 2010 through 2013

	Projected Year 1 (2010)	Projected Year 2 (2011)	Projected Year 3 (2012)	Projected Year 4 (2013)
Net Operating Revenue	$106,679,803	$110,191,321	$114,568,129	$118,894,241
Total Operating Expenses	$98,395,641	$101,127,461	$117,478,762	$119,770,346
Non-operating Revenue, net	$2,496,143	$4,307,893	$2,253,196	$2,715,402
Net Profit or (Loss)	**$10,780,306**	**$13,371,753**	**($657,437)**	**$1,839,294**

[Source: Hospital and Patient Data Systems January 8, 2010 Report]

The 'total operating revenue line item in Table 6 is the result of gross revenue, hospital district tax revenue, and non-operating revenue minus any deductions for contractual allowances, bad debt, and charity care. The 'total operating expense' line item includes all hospital staff salaries/wages. As shown in Table 7, the hospital as a whole is projected to be profitable in year 1, year 2, and year 4. In year 3 KGH is starting a major construction project that will have a major impact on its financial status for 2012.

To determine whether KGH would meet its immediate and long range capital costs for the ICN II nursery service HPDS reviewed current and projected balance sheets. Historical year [2008] and year 3 [2012] are shown in Tables 8 and 9 below. [Source: HPDS analysis, p2 and Application, p72]

Table 8
KPHD Balance Sheet for Current Year 2008

Assets		**Liabilities**	
Current	$22,032,346	Current	$13,935,746
Board Designated	$10,840,183	Long Term Debt	$19,119,3090
Prop./Plant/Equip.	$35,703,378	Other	-
Other	$8,500,114	Equity	$44,021,366
Total	$77,076,421	**Total**	$77,076,421

[Source: Hospital and Patient Data Systems January 8, 2010 Report]

Table 9
KPHD Hospital Balance Sheet for Projected Year 3 2012

Assets		**Liabilities**	
Current	$27,043,000	Current	$14,383,000
Board Designated	$43,277,000	Long Term Debt	$109,142,000
Prop./Plant/Equip.	$115,038,000	Other	-
Other	$21,100,000	Equity	$82,932,000
Total	$206,458,000	**Total**	$206,457,000

KGH's capital expenditure related to this project was $1,769,643. The hospital has already completed this expenditure and the results are included in the balance sheet.

"HPDS staff has also reviewed various ratios that can give a picture of the financial health of the hospital and the project. These ratios are shown in Table 10. The A means it is better if

the hospital number is above the State number and B means it is better if the hospital number is below the state number. This part of the review assumes KGH patient day projections can be met. KGH long-term debt to equity ratio at the end of the 2008 fiscal year is 0.434 which is better than the 2008 state average of 0.527 as calculated using CHS/Hospital and Patient Data. The hospital is embarking on several projects which require additional debt. Thus the 2013 ratio is 1.484 which is much worse than the 2008 state average."

Table 10
Current and Projected Financial Ratios for Kennewick General Hospital

Financial Ratio	Trend[4]	State 2008	KPHD 2008	Projected Year 1 2010	Projected Year 2 2011	Projected Year 3 2012
Long Term Debt to Equity	B	0.527	0.434	1.557	1.535	1.484
Curr. Assets/Curr. Liab.	A	1.946	1.581	1.885	1.887	1.898
Assets Funded by Liab.	B	0.432	0.429	0.633	0.632	0.625
Oper. Exp./Oper. Rev.	B	0.949	0.973	0.918	1.025	1.007
Debt Service Coverage	A	4.717	3.011	4.865	5.317	5.335

Definitions	Formula
Long Term Debt to Equity	Long Term Debt/Equity
Current Assets/Current Liab	Current Assets/Current Liabilities
Assets Funded by Liabilities	Current Liabilities +long term Debt/Assets
Oper. Exp./Oper. Rev	Operating Expense/Operating Revenue
Debt Service Coverage	Net Profit+Depr. and Interest Exp. /Current Mat. LTD and Interest Exp.

As noted previously HPDS staff, the hospital is in an expansion mode and the ratios reflect this. When a hospital is in a building phase and for a few years after, the ratios will be poorer, other things being equal than a hospital that has not been through a building phase. The operating expense/operating revenue ratio is above 1.0 which means the hospital is expecting to lose money on its hospital operations in 2013. However, the overall hospital or total margin does show the hospital with a profit. Assets funded by Liabilities are affected by the new debt and are out of range of the 2008 statewide ratios but are improving during the pro-forma years. The other ratios are within range. Review of the financing and ratios show the immediate and long range capital costs, as well as operating costs could be met. This sub-criterion is met.

(2) *<u>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.</u>*

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

KGH identified the capital costs as zero dollars; as a result there are no construction costs for this project. However, the applicant acknowledged it had completed a renovation and remodel on the ICN

[4] A is better is above the ratio, and B is better if below the ratio

at a cost of $1,265,100. This sub-criterion also requires the department to consider the operational costs of the project and the impact of these costs on the costs and charges for health services.

To assist the department in its evaluation of this sub-criterion HPDS reviewed hospital newborn cost information for KGH. Staff from HPDS provided the following analysis. [Source: HPDS analysis, p3]

"*There are several ways to review hospital newborn cost information. Hospitals report data to DOH through the financial format and the hospital inpatient format. In the financial reporting system, hospitals can report all newborn revenue and expense for delivery and post partum care under account 6100 Alternative Birth Center or they can report it under 6170 Nursery for the baby only and 6070 Acute Care for the mom. Newborns that need intensive care are reported under 6010 Intensive Care, which also includes Adult and Pediatric patients. Kennewick General Hospital currently uses 6100 Alternative birth Center when it reports its year end data to DOH. This applications projected revenue and expense in the middle for those hospitals that report only using 6100 Alternative Birth Center*
Newborn days in Intensive Care are usually a small percentage of the total. I reviewed the hospital inpatient database (CHARS) for comparison data. Revenue Code 0172 is Level II ICN care in the CHARS database. I calculated the average charges per day for those discharges that included Revenue Code 0172. The average charge per day in 2008 was more than the projections in the applicant's pro-forma."

The project costs to the patient and community appears to be comparable to current providers. This criterion is met."

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

KGH identified a capital expenditure for this project of zero dollars. However, KGH completed a recent remodel and expansion of its Level II ICN and while KGH did not consider it part of this proposal the department does. The expenditure for the recent remodel and expansion was $1,769,643. KGH used a combination of debt and reserves to finance the remodel and renovation.

The dollars used for this project have already been spent for the remodel and expansion are reflected in KGH's historical financial statements and were included in the review of the previous sub-criterion. The department will not review a capital expenditure directly to this project.

C. Structure and Process (Quality) of Care (WAC 246-310-230) and the Year 2005 Washington State Perinatal Level of Care Guidelines.

Based on the source information reviewed and with the applicant's agreement to the terms and condition identified in the "conclusion" section of this evaluation, the department determines that the applicant has met the structure and process of care criteria in WAC 246-310-230 and is consistent with the 2005 Washington State Perinatal Level 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.*

KGH stated in the project description portion of their application that they are increasing the number of ICN Level II bassinettes from 5 to 10 with this project. Table 11 shows the increase in staff anticipated for the additional bassinettes. Any impact on staff would be a direct result of increased patient volumes and staff would be adjusted as appropriate to meet the care delivery needs.

Table 11
KGH Current and Projected Number of FTEs

	Year 2009 Current	Year 1 Increase	Year 2 Increase	Year 3 Increase	Year 2012 Total
Clinical Director	0.50	0.00	0.00	0.00	0.50
RN	5.88	2.52	0.5	0.25	9.15
Clerical	0.10	0.00	0.00	0.00	0.10
Total	6.48	2.52	0.50	0.25	9.75

Since KGH is currently operating a Level II service, they will need to recruit minimal additional staff to meet the needs of additional patients. The applicant reports having a wage and benefit package competitive with other providers in the Tri-Cities area. They also offer additional benefits such as educational expense reimbursement refresher programs. The applicant does not anticipate any difficulty in recruiting additional staff.

Based on the information provided in the application and the small number of additional staff required for implementation of this project, the department concludes that KGH will be able to recruit and retain the staff necessary for the new facility. [Source: Application pp40-42]. This sub-criterion is met.

Key medical staff and other providers for the Level II service are recommended in the Washington State Perinatal Levels of Care staffing guidelines. These key medical staff positions are evaluated in conjunction with the department's evaluation of the project's conformance with the Washington State Perinatal Levels of Care guidelines that follows:

Washington State Perinatal Levels of Care Guidelines

In addition to the structure and process of care criteria found under WAC 246-310-230, the department 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 on February 2005, offer recommendations on facility and staffing standards for ICN Level II services. Within the guidelines, Level II services are separated into A, and B, -- with A being the least intensive of Level II services 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, KGH should already be providing Level I, or basic OB services before applying for Level II services. Within its Certificate of Need application, and verified by CHARS data, KGH meets this recommendation.

Even though KGH is purporting to meet the standards for its Level II ICN services; KGH provided a comparison chart as verification and documentation that its proposed level IIA services would meet or exceed the advisory committee's recommended guidelines. KGH has also provided verification and documentation that its proposed Level IIB services will meet or exceed the Level IIB guidelines. The department will compare this project using Level IIA guidelines. [Source: Application, pg 72-82] Table 12 beginning on the following page shows this comparison.

Table 12
Conformance with the Washington State Perinatal Guidelines

GUIDELINE LEVEL IIA	KGH's CURRENT PROGRAM (IIA)	PASS/FAIL
General Function		**Pass**
All Level I functions plus Diagnosis and management of selected complicated pregnancies and neonates ≤ 340/7 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 Mechanical ventilation may be provided for stabilization pending transport to a Level III facility	KGH's program currently meets all Level I and IIA requirements including diagnosis and care for neonates at >34/07and >1500 grams KGH's Special Care Nursery is equipped and staffed to manage the care of mildly ill neonates, including those that require oxygen KGH has the capacity to manage the recovery of neonates who can be appropriately back-transported from a referral center KGH arranges for developmental follow up care for high risk neonates at the appropriate facility. KGH's current program arranges for primary care follow up per AAP guidelines. KGH can and does provide mechanical ventilation for stabilization prior to transport to a Level III facility.	

GUIDELINE LEVEL IIA	KGH's CURRENT PROGRAM (IIA)	PASS/FAIL
Neonatal Patients: **Services and Capabilities**		**Pass**
OB Patients: **Services and Capabilities**		**Pass**
Level I patients and services plus: Pregnancies ≥ 34 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: Preterm labor judged unlikely to deliver before 32 weeks gestation	KGH's current program meets Level II A requirements including care for pregnancies ≥ 34 0/7 Current capabilities include management consistent with ACOG guidelines of selected high risk pregnancies	

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 III B intensive care nurseries.	KGH reports having the neonatologists from Kadlec Medical Center on the KGH's courtesy staff and that they consult with KGH staff on a regular basis. [Source: Functional Plan for Family Birthing Center and Special Care Nursery Remodeling/Expansion dated August 2007, pg 1]	
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 procedures 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.	"*KGH currently does transport mothers and/or babies as appropriate to Level III providers"* [Source: Application, pg76] KGH has provided a general hospital transfer policy however they report not having a specific maternal and neonatal transport policy and procedure. [Source: Response to Screening Questions dated September 21, 2009, pg7 and Attachment II] KGH does not address being a referral hospital for Level II newborns transferred from hospitals providing Level I care	KGH does not have an established written policy or procedures for maternal and neonatal transport. The only policy provided was the general hospital transfer agreement. Therefore, a term is necessary to ensure this guideline is met.
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 Collaborate with state contracted perinatal center for coordinating outreach education Maintain a 24/hr/day system for reliable, comprehensive communication between hospitals for immediate consultation, initiation, and approval of maternal and newborn transports Provide referring physicians with ongoing communications and recommendations for ongoing patient care at discharge		

GUIDELINE LEVEL IIA	KGH's CURRENT PROGRAM (IIA)	PASS/FAIL
Medical Director		**Pass**
Obstetrics: Board-certified in OB/GYN or Family Medicine Nursery: Board-certified in Pediatrics	KGH's OB Medical Director is a board-certified OB-GYN. KGH's Special Care Nursery Director is a board certified pediatrician/board eligible neonatologist. It is anticipated that the doctor will receive board certification in 2010; allowing KGH to expand its program to IIB by early 2010.	
Medical Providers		**Pass**
Level I coverage plus: 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, including assisting with chest compressions, intubation, and administering medications Radiologist on-staff with daily availability who can interpret neonatal studies such as chest and abdominal radiographs and cranial ultrasounds Ophthalmologist with pediatric experience available to do eye exams for neonates who are at high risk for retinopathy of prematurity (RPO) if accepting back transport of such infants; written protocol for referral or treatment Arrangements for neurodevelopment follow-up or referral per written protocol	All high risk deliveries are attended by the appropriate number and type of credentialed medical and clinical staff All staff in the Family Birth Center are trained in NRP. Patients are transported to a higher level of care as needed. KGH has clinical staff (radiologist, anesthesiologist, and ophthalmologist) to provide the services to neonates as needed GH arranges for developmental follow up care for high risk neonates at the appropriate facility	

GUIDELINE LEVEL IIA	KGH's CURRENT PROGRAM (IIA)	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 (c) Plans for delegation of selected clearly defined tasks to competent assistive 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 intuiting epidural anesthesia 1:1 circulation for caesarean 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 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 care 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. Adequate staff is needed to respond to acute and emergency situations.	KGH' staffing patterns are consistent with the Prenatal Level of Care Guidelines	

GUIDELINE LEVEL IIA	KGH's CURRENT PROGRAM (IIA)	PASS/FAIL
Nursing Management		**Pass**
Nurse manger of perinatal services Nurse manager of nursery services	KGH has a nurse manager for the Family Birthing Center and a nurse manager for the Special Care Nursery	
Capabilities include: 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 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 equivalency (FTEs)		
Pharmacy, Nutrition/Lactation and OT/PT		**Pass**
Pharmacy Services: Registered pharmacist available 24 hrs/day, 7 days/wk	KGH has 24/7 pharmacist support available	
Nutrition/Lactation: One healthcare professional who is knowledgeable in : Management of special maternal and neonatal dietary needs Enteral nutrition of low birth weight and other high-risk neonates Lactation services and consultation available Diabetic educator for inpatient and outpatient services	KGH provides lactation and consultation services Registered Dietician on staff is available for maternal and neonatal consultation	
OT/PT Services Provide for inpatient consultation and outpatient follow-up services	KGH provides inpatient consultation and outpatient follow-up as appropriate	

GUIDELINE LEVEL IIA	KGH's CURRENT PROGRAM (IIA)	PASS/FAIL
Social Services/Case Management		**PASS**
Level I Service plus: 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;	KGH has 2 case managers and 2 MSWs available for perinatal/neonatal patients. One of the case managers previously worked in the Special Care Nursery. These individuals are available to assist with discharge planning, education, community follow-up, referral process, and home care arrangements.	
Respiratory Therapy		**Pass**
The role of a Respiratory Care Practitioner is prescribed by the Medical Director and clearly delineated per written protocol. If attending deliveries or providing neonatal respiratory care should have current NRP Provider status	KGH has 2 respiratory therapists on staff 24/7. One RT has experience in a Level III nursery.	
X-Ray/Ultrasound		**Pass**
Level I Service Plus: Ultrasound equipment immediately accessible and available to the Labor and Delivery unit 24/hrs/day	Ultrasound and X-ray equipment is immediately available to Labor and Delivery. Portable X-ray equipment available in the Special Care Nursery. Performance and interpretation of neonatal X-rays and perinatal ultrasound available 24/hrs/day. Antepartum surveillance techniques available	

GUIDELINE LEVEL IIA	KGH's CURRENT PROGRAM (IIA)	PASS/FAIL
Laboratory		**Pass**
Same as Level I plus: Lab technician in-house 24hrs/day Personnel skilled in phlebotomy and IV placement in the newborn immediately available 24/hrs/day Micro technique for hematocrit and blood gases within 15 minutes	Special Care Nursery nurses or lab technician perform all blood draws for the neonates. Micro technique and blood gases are available within 15 minutes.	
Blood Bank		**Pass**
Blood bank technician on-call and available within 30 minutes for performance of routine blood banking procedures Provision for emergent availability of blood and blood products	Blood bank available within 30 minutes	

The sub criterion is met with agreement to the terms on page 21 of this analysis providing the applicant submit policies and procedures for patient transport as specified in the Washington State Perinatal Guidelines.

GUIDELINE LEVEL IIB	KGH's PROPOSED PROGRAM (IIB)	PASS/FAIL
General Function		**Pass**
Level II A functions plus: Diagnosis and management of selected complicated pregnancies and neonates $\geq$ 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 hours) or nasal CPAP Mechanical ventilation may be provided for stabilization pending transport to a Level III facility	KGH's program will care for neonates $\geq$ 32 0/7 and 1500 grams KGH currently has the capability to provide conventional mechanical ventilation and CPAP KGH can and does provide mechanical ventilation for stabilization prior to transport to a Level III facility	

GUIDELINE LEVEL IIB	KGH's PROPOSED PROGRAM (IIB)	PASS/FAIL
Neonatal Patients: **Services and Capabilities**		**Pass**
Level II patients and services plus: Neonates ≥ 32 0/7weeks 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 parental nutrition and/or medication and fluids • May include conventional mechanical ventilation for brief duration (<24 hrs.) or nasal CPAP Average daily census of at least two-four Level II patients	KGH's IIB program will care for neonates primarily at ≥ 32 0/7 and >1500 grams including those in need of nasal CPAP KGH will provide catheter insertion, administration of TPN and/or fluids/medication, and brief mechanical ventilation including CPAP KGH's ADC is expected to be about 6	

GUIDELINE LEVEL IIB	KGH's PROPOSED PROGRAM (IIB)	PASS/FAIL
OB Patients: **Services and Capabilities**		
Level II A patients and services 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: Preterm labor judged unlikely to deliver before 32 weeks gestation	KGH's program will meet IIB requirements, including care for pregnancies ≥32 0/7 When Level IIB service is initiated KGH will care for additional high risk pregnancies consistent with ACOG guidelines.	
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 III B intensive care nurseries. **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 procedures 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 a the referral hospital Collaborate with state contracted perinatal center for coordinating outreach education Maintain a 24/hr/day system for reliable, comprehensive communication between hospitals for immediate consultation, initiation, and approval of maternal and newborn transports Provide referring physicians with ongoing	No change from current. Established transfer arrangement with Seattle Children's, Mary Bridge, Sacred Heart Children's, and Kadlec KGH uses Medstar for air transport KGH did not provide specific policies and procedures for maternal and neonatal transport.	This finding was addressed on page 23 of this analysis

communications and recommendations for ongoing patient care at discharge		
Medical Director		**Fail**
Obstetrics: Board-certified in OB/GYN or Family Medicine Nursery: Board-certified in Neonatology	KGH's Special Care Nursery Medical Director is a board-certified pediatrician and a board-eligible neonatologist. It is anticipated that he will receive board certification in 2010, allowing KGH to expand its program to II B by early 2011	Prior to expanding to Level II B, KGH will provide documentation its Director of the special care nursery is a Board Certified Neonatologist
Medical Providers		**Pass**
Level II A coverage plus: Continuous in –house presence of personnel experienced in airway management and diagnosis, and treatment of pneumothorax when a patient is being treated with nasal CPAP or conventional mechanical ventilation Radiologist on staff with daily availability who can interpret neonatal studies such as chest and abdominal radiographs and cranial ultrasounds 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 Arrangements for neurodevelopment follow-up or referral for written protocol	No change from the current program, except we will have the availability of in-house staff for treatment of patients with nasal CPAP and mechanical ventilation KGH has clinical staff (radiologist, anesthesiologist, and ophthalmologist) to provide services to neonates as needed No change from current program	

GUIDELINE LEVEL IIB	KGH's PROPOSED PROGRAM (IIB)	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 (c) Plans for delegation of selected clearly defined tasks to competent assistive 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 intuiting epidural anesthesia 1:1 circulation for caesarean 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 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 care 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. Adequate staff is needed to respond to acute and emergency situations.	KGH's are consistent with the Perinatal Level of Care guidelines	

GUIDELINE LEVEL IIB	KGH's PROPOSED PROGRAM (IIB)	PASS/FAIL
Nursing Management		**Pass**
Nurse manger of perinatal services Nurse manager of nursery services	No Change	
Capabilities include: 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 One RN may manage both services but additional mangers may be necessary based on number of births, average daily census, or number of full-time equivalency (FTEs) Same as Level I plus: Advanced degree desirable		
Pharmacy, Nutrition/Lactation and OT/PT		**Pass**
Registered pharmacist with experience in neonatal/perinatal pharmacology available for, 24 hrs/day and 7 days/wk.	KGH will have 24/7 pharmacy support with experience in neonatal/perinatal pharmacology available	
Nutrition/Lactation Same as Level II A services plus: One healthcare professional knowledgeable in management of parenteral nutrition of low birth weight and other high risk neonates	KGH will have nutrition/lactation staff with experience in the management of low birth weight and other high risk neonates	
OT/PT Services Provide for inpatient consultation and outpatient follow-up services	No change from current program	
Social Services/Case Management		**Pass**
Level 1IA Service	No change from current program	
Respiratory Therapy		**Pass**
The role of a Respiratory Care Practitioner is prescribed by the Medical Director and clearly delineated per written protocol. If attending deliveries or providing neonatal respiratory care should have current NRP Provider status	KGH has 2 respiratory therapists on staff 24/7. One RT has experience in a Level III nursery.	

GUIDELINE LEVEL IIB	KGH's PROPOSED PROGRAM (IIB)	PASS/FAIL
X-Ray/Ultrasound		**Pass**
Level I Service Plus: Ultrasound equipment immediately accessible and available to the Labor and Delivery unit 24/hrs/day	No change from current program	
Laboratory		**Pass**
Same as Level I plus: Lab technician in-house 24hrs/day Personnel skilled in phlebotomy and IV placement in the newborn immediately available 24/hrs/day Micro technique for hematocrit and blood gases within 15 minutes	No change from current program.	
Blood Bank		**Pass**
Blood bank technician on-call and available within 30 minutes for performance of routine blood banking procedures Provision for emergent availability of blood and blood products	No change from current program	

With agreement to the term on page 28 of this analysis, the project is consistent with neonatal guidelines for a Level II ICN.

(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.

The applicant is currently providing ancillary and support services to existing OB and nursery services. Since this is a small unit, the anticipated growth in number of patient days should not exceed the capacity of existing ancillary and support services. Based on the information submitted by the applicant, this sub-criterion is 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.

Data from the department indicates that approximately 42% of obstetric patients are covered by Medicaid. The applicant is projecting that the percentage of revenue from this unit should be 68.5%. KGH also will continue to provide Medicare and Medicaid acute care services to the residents of the service area. KGH had a Joint Commission inspection on August 11, 2008 and was accredited for 18 months. The facility was re-licensed in November 2008 based upon the successful completion of the Joint Commission inspection [Source: ILRS data provided by Investigations and Inspections Office (IIO)]. KGH also operates a Medicare certified home health agency under the hospital license. The home health agency is also JCAHO accredited. Within the last two years, the Department of Health's Investigations and Inspections Office, which surveys hospitals within Washington State, has completed one compliance Survey for the hospital. The hospital survey revealed minor non-

compliance issues typical of a hospital, and KGH submitted a plan of correction for the non-compliance issues within the allowable response time. Documentation provided by the applicant and DOH's Investigations and Inspections Office indicates there is reasonable assurance that the project will be in conformance with applicable licensing and certification requirements.

On April 23, 2008, DOR 08-23 was issued to KGH concerning their operation of a level II intermediate Care Nursery. That DOR concluded that Kennewick had began offering Intermediate Care level II care without receiving prior CN approval. After receiving that DOR, KGH proceeded with expansion of their Level II ICN. Although this application is to correct this failure, the department is concerned by this behavior. Future projects could be jeopardized if additional CN infractions are documented.

Based upon Kennewick's compliance history with Joint Commission and the department's Investigations and Inspections Office, the department concludes that KGH that there is reasonable assurance that KGH would continue to operate in conformance with state and federal quality assurance regulations with the addition of the Intermediate Level II Services.

This sub-criterion is 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.

This project promotes continuity of care within KGH by allowing the hospital to keep neonatal patients that otherwise might need to be transferred to Kadlec hospital due complications before, during, or after birth. The data submitted by KGH in this application and by Kadlec in their application indicates that there are only 2 OB doctors who are on the medical staff at both hospitals, therefore the patients will be able to keep their same physician if no transfer is necessary.

Based on the applicant's adoption of the maternal and neonatal transport policies and procedures, KGH will be providing as part of the approval for this project, the department concludes that this sub criterion is 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.

The applicant has submitted documentation in sub-section 3 above that their Level II unit meets or exceeds the minimum Level of Care guidelines for Level II ICN services developed by the Statewide Perinatal Advisory Committee.

This sub-criterion is also addressed in sub-section 3 above. This sub-criterion is met

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

Based on the source information reviewed and with the applicant's agreement to the terms and condition identified in the "conclusion" section of this evaluation, the department determines that the applicant has 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 thru 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 criteria (tie-breaker) contained in WAC 246-310. The tiebreaker 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

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

STEP TWO

The applicant provided discussion on two options in the initial application and the department requested that the applicant discuss one additional option in their response to the screening questions. The two options first presented by the applicant were: **1)** do nothing and continue operating; and **2)** discontinue the service until CN approval could be obtained. The third option was to operate the 5 bed Level II ICN that the applicant had operated prior to remodeling the unit. KGH evaluated and ultimately rejected the two options before submitting this application. The applicant addressed the third alternative in their response to the screening questions and also rejected this option. A summary of each option and KGH's rationale for rejection is as follows:

Option 1-Do nothing and continue operating

KGH acknowledges in the application that their Level II ICN as not been recognized by the department through the CN process and that these bassinettes are not included in their licensed beds. KGH does not want to have these beds unrecognized by the department. [Source: Application, p9] There is another provider in the Benton Franklin hospital planning area that currently is providing ICN Level II Services and is requesting approval to provide ICU Level III Nursery Services. KGH's Level II ICN bassinettes are not counted in the bed supply as long as they are not recognized by the department. Therefore, to forestall any future uncertainty KGH has rejected this alternative.

Option 2-discontinue the service until CN approval could be obtained

The applicant reports that the number of Benton/Franklin families needing specialized nursery care, and choosing KGH for that care, continues to grow. If KGH were to lose or close their Level II service, fragmentation of the local system would significantly increase as babies would need to be transferred to other providers post-delivery, or expectant mothers would be forced to seek care elsewhere prior to delivery. Local families would be left with no choice but to either seek care at the area's on remaining Level II provider (Kadlec) – which according to its current CN application is running near capacity – or leave the area altogether for care, with the next closest Level II provider being Yakima Valley Memorial Hospital, 80 miles and an 80 minute drive from the Tri-Cities. [Source: Application, p45]

Option 3-Operate with the previous existing 5 Level II ICN bassinettes

The applicant states in response to the screening questions, that the high birth rate and the expected high growth in the number of Level II patient days would not make 5 bassinettes a reasonable option for capacity even in the near term. Also the space for the 10 bassinettes is already in service therefore these costs have already been incurred. Therefore, the applicant rejected this alternative.

The department approved the 10 bassinettes based on the applicant being able to achieve ADC of 5 to 6, thereby making the approval of 10 bassinettes a more logical option than approving 5 bassinettes.

STEP THREE

For this project, only KGH submitted an application to establish Level II services to the Benton/Franklin hospital planning area. As a result, step three is not evaluated under this sub-criterion.

Based on the information submitted, the department concludes the project is the best available alternative. This sub-criterion is met.

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

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

The Applicant identified zero dollars as the capital cost associated with this project. The department identified a capital cost of a nursery remodel and renovation of $1,762,643 associated with this project. The construction documents indicated that there was 3,420 square feet of new construction. The applicant reported in a letter to the department dated April 21, 2009 that the number of bassinettes would increase from 5 to 10.

The applicant indicated in the response to screening questions that minimal savings were possible due to the age of the facility and were primarily achieved due to consolidation of functions.

Based the information submitted in the application the applicant appears to have addressed cost of construction and energy conservation. 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.

KGH identified the capital expenditure for this project as zero dollars; as a result there are no construction costs for this project. This sub-criterion also requires the department to consider the operational costs of the project and the impact of those costs on the costs and charges for health

services. KGH did not provide any additional documentation or discussion to demonstrate compliance with this sub-criterion.

To assist the department in its evaluation of this sub-criterion, HPDS provided the following analysis:

"There are several ways to review hospital newborn cost information Hospitals report data to DOH through the financial format and the hospital inpatient format in the financial reporting system, hospitals can report all newborn revenue and expense for delivery and post partum care under account 6100 Alternative Birth Center or they can report it under 6170 Nursery for the baby only and 6070 Acute Care for the mom. Newborns that need intensive care are reported under 6010 Intensive Care, which also includes Adult and Pediatric patients. Kennewick General Hospital currently uses 6100 Alternative Birth Center when it reports its year end data to DOH. This application's projected revenue and expense is in the middle for those hospitals that report only using 6100 Alternative Birth Centers.

Newborn days in Intensive Care are usually a small percent of the total. I reviewed the hospital inpatient database (CHARS) for comparison data. Revenue Code 0172 is Level II ICN *care in the CHARS database. I calculated the average charges per day for those discharges that included Revenue Code 0172. The average charge per day in 2008 was more than the projections in the applicant's pro-forma."*

The report from indicates that the costs to the patient and community appears to be comparable to current providers. This sub-criterion is met.