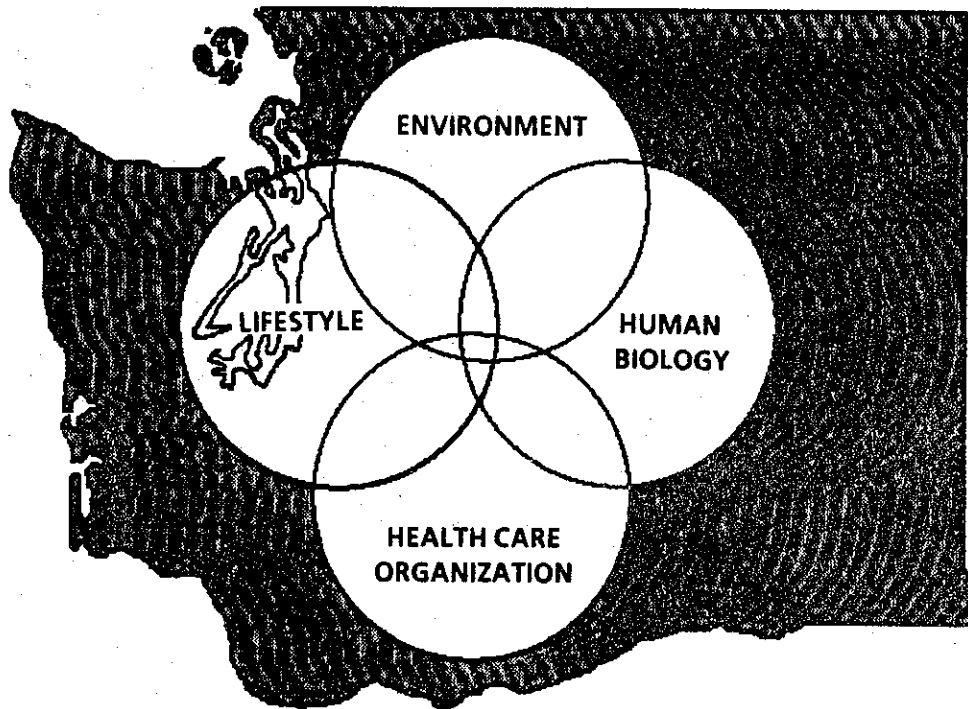


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WASHINGTON STATE HEALTH PLAN



VOLUME 2: PERFORMANCE STANDARDS FOR HEALTH FACILITIES AND SERVICES

Adopted by the State Health Coordinating Council
January 21, 1987

Approved by Governor Booth Gardner
May 12, 1987

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BOOTH GARDNER
GOVERNOR

May 15, 1987

Ward C. Miles, M.D., Chair
State Health Coordinating Council
Mail Stop OB-43F
Olympia, Washington 98504

Dear Mr. Miles:

I am pleased to approve the State Health Plan (SHP) developed by the State Health Coordinating Council under the provisions of the State Health Planning and Resources Development Act (RCW 70.38). This document presents ambitious and worthy objectives for the improvement of health status and development of health services in the state. Executive agencies should take appropriate steps within available resources to assure that their policies are consistent with the directions set forth in this plan.

The content of the State Health Plan has been developed over many months, and there are areas where recent events require an update of the situation described in Volume 1 of the Plan:

Acquired Immune Deficiency syndrome (AIDS). The plan was developed before the scope and severity of the AIDS problem was fully recognized. I am confident that the SHCC, the Department of Social and Health Services and other responsible entities will expand their consideration of this important issue.

Conditions in correctional institutions. The overcrowding of correctional institutions referred to in the plan is mitigated by the opening of a new state correctional facility at Clallam Bay.

Prenatal Care. Significant movement toward the plan's prenatal care goal has been made in recent months due to legislative action to appropriate additional funds for expansion of the program as I had requested. This action demonstrates the high priority placed on this goal by both the executive branch and the legislature.

Ward C. Miles, M.D.

May 15, 1987

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Basic health care. Progress also has been made toward the plan's goal of equitable access to health care and the provision of a basic level of health services to all state residents as a result of pending legislative action on the Basic Health Care Plan (House Bill 477).

I want to thank the members of the state Health Coordinating Council and the many health care consumers and providers around the state who contributed to the development of this State Health Plan. Your continuing interest and involvement will help us to develop an efficient and effective health care system and to seek ways to improve the health status of state residents.

Sincerely,



Booth Gardner
Governor

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A. INTRODUCTION

Volume II of the State Health Plan was originally developed by the State Health Coordinating Council, Department of Social and Health Services and Health Systems Agencies (HSAs) as a set of integrated state and local health planning and Certificate of Need (CON) review policies. Subsequently, federal funding for the regional HSAs was ended and these agencies began to modify their roles. Moreover, changes in health care payment systems made the long term status of the state CON program less certain. As a result of these developments, modifications were made in material originally put together for this document. The facilities and services plan now has the following characteristics:

1. Provisions for a unique planning or review role for standing "regional health councils" or some other local agencies is not initially included. However, the State Health Coordinating Council strongly supports the participation of local health care consumers and providers in health planning processes. For this reason, they will work and advocate for development, maintenance and funding of regional health councils cited in RCW 70.38.085.
2. Specific reference to CON review is not included in the plan. This feature recognizes that the specifications presented in the plan are "performance standards" or desired service characteristics that can have utility for purposes other than CON. For example, health care purchasers could use performance indicators to assess the efficiency or effectiveness of alternative providers competing for their business. Although specific reference to CON is not included, CON or other capital expenditure review decisions shall be consistent with performance standards in this plan, as required by RCW 70.38.115(4).
3. The document does not include performance standards for the public health programs cited in Volume I of the State Health Plan. It is expected that the State Health Coordinating Council and Board of Health will collaborate in the development of such performance standards in the future. Performance standards for other public health programs may also be included at a later date.

The scope and nature of health system performance standards that will be most useful in supporting purchasing and resource allocation decision-making in the future is uncertain. For this reason, it is expected that over the next few years the SHCC and DSHS will systematically assess the need for and utility of such performance standards, and alternative processes for their development. This evaluation will provide the basis for conclusions about the continuation and refinement of this plan.

B. HEALTH FACILITY/SERVICE PERFORMANCE STANDARDS

1. APPLICATION OF PERFORMANCE STANDARDS

State and local planning and monitoring, and any capital expenditure regulation decisions to establish, expand, replace or upgrade health facilities and services, shall be based on these performance standards.

2. GENERAL PERFORMANCE STANDARDS

- a. All health facilities and agencies providing health care services in the state shall meet applicable licensing standards.
- b. All health facilities and agencies providing health care services shall have an active utilization review program.
- c. All facilities and agencies providing health care services shall have a patient priority policy which requires acceptance of patients according to clinical evidence of medical need and potential benefit to patients.
- d. Preference shall be given to facilities and agencies providing health care services whose policy it is to serve patients without discriminating against those sponsored by public payment programs.
- e. Preference shall be given to facilities and agencies providing health care services which accept their responsibility to share equitably in the provision of care for those patients who are unable to pay.
- f. All facilities and agencies providing health care services shall have written policies evidencing a coordination and referral system that assures that patients receive care at the least intensive and restrictive level appropriate to their needs.
- g. All facilities and agencies providing health care services shall ensure effective continuity of care through discharge planning initiated early in the course of treatment.
- h. All facilities and agencies providing health care services shall have personnel with qualifications appropriate to the level and intensity of care they are providing and with training specific to the technologies they are using.
- i. In making decisions where benefits and costs are being weighed, community costs shall be calculated as the difference between the estimated net revenues (receipts) of a service in a particular area with the proposed project, for

its first three years, accounting for projected reduced caseloads in existing facilities, and the estimated net revenues of that service in that area without the proposed service. The net community cost result shall not be the sole basis for action.

- j. Planning and review decisions shall be based primarily on the needs of the population in the planning area.
- k. Radiation therapy, critical care, cardiovascular, ambulatory surgery, end-stage renal disease, computed tomography, magnetic resonance imaging, innovative technology, home health and hospice services should maintain a data collection system consistent with requirements established by the health planning system to implement policies of this plan. The data collection activity should be carefully defined and coordinated with other agencies, such as the Washington State Hospital Commission (WSHC) and with other provider associations and representatives to avoid unnecessary costs and issues of patient confidentiality and uniform disclosure.
- l. Special consideration shall be given to facilities that demonstrate the potential benefits of cooperative operating and/or ownership agreements, plus mutual granting of privileges to qualified physicians of participating institutions for the service proposed.

3. ACUTE CARE PERFORMANCE STANDARDS

a. General

- (1) Where defined, Level I health services shall be available within 30 minutes driving time (under normal road conditions) for ninety percent of residents of each health planning region.
- (2) The following guidelines should be used in planning for the geographic availability of more specialized health facilities and services:
 - (a) Where defined, one Level II or III unit should be available within 120 minutes driving time for 90 percent of the population in each health planning region.
 - (b) Level II and III units (when applicable) should be located in the smallest number of facilities that will meet the needs of the population taking into consideration concerns for access, quality, and cost of care.
- (3) Level III services shall coordinate consultation, education and transportation services for residents of their regions.

- (4) For equipment replacement, the alternative of upgrading existing equipment at lower cost to the provider and the health care system must be fully evaluated. Factors to evaluate include: overall replacement costs, equipment capabilities, and potential of length of service.
 - (5) All hospitals should be responsible for providing their fair share of uncompensated care.
 - (6) Preference for major medical equipment shall be given to projects operated by acute care facilities, unless it is demonstrated that other providers will operate equipment with appropriate utilization and quality controls and provide services at lower community costs.
 - (7) The most recent SHCC-approved version of the Washington State Hospital Bed Need Forecasting Method shall be used in projections of hospital bed need.
 - (8) Hospital planning areas identified by SHCC and DSHS shall be used in planning and in projections of hospital bed need, consistent with the requirements of the Hospital Bed Need Forecasting Method.
 - (9) New beds for a specific service shall not ordinarily be built in a planning area having a net excess of total hospital beds (before or after the addition), unless it is demonstrated that the area's needs cannot be met by conversion of use of hospital beds already existing in the area.
- b. Obstetric and Neonatal Services (OB)

Inpatient obstetric and neonatal care consists of hospital care during pregnancy, labor and birth, and care following birth. Neonatal special care services focus on life-threatening conditions for neonates from birth until hospital discharge in hospital areas designated, organized, and equipped to provide specialized care for high risk babies.

Family-centered maternity and newborn care are services provided in in-hospital birthing rooms, free-standing birth centers, and organized home birth services, designed to meet the needs of women seeking an alternative to traditional prenatal labor and delivery care and wanting a birth experience with more co-management capabilities.

There shall be a regionalized system of obstetric and neonatal services in Washington State. This regionalized system of services shall have the following characteristics:

- (1) There shall be four levels of obstetric and neonatal facilities/services, as follows:
 - Level IA: Out-of-hospital birthing services which provide an alternative for low-risk women.
 - Level I: Hospital services which primarily provide uncomplicated maternity and newborn care to low-risk patients and stabilization and referral to Levels II or III for high-risk patients. In-hospital birthing rooms and single unit delivery systems may be part of Level I care.
 - Level II: Hospital services which provide specialized services for the majority of complicated obstetric and neonatal problems.
 - Level III: Hospital services which receive referrals for and provide all the specialized services applicable to complicated obstetric and neonatal problems for a region.
- (2) Planning for a regionalized system of neonatal/obstetric care shall recognize the four geographic regions designated by the DSHS Office of Maternal and Child Health Services (MCH) as the service areas for which patient care, education, consultation, and transportation are planned and coordinated. These geographic regions are as follows: Northwest (Seattle), Eastern (Spokane), South Central (Yakima), and Southwestern (Tacoma).
- (3) Level I obstetric services shall have a minimum of 100 births/year. Level II and III obstetric services shall have a minimum of 1200 births per year and an average occupancy of 70 percent.
- (4) Level II neonatal special care shall be located only in facilities which provide Level II obstetric services.
- (5) All obstetric and neonatal units shall have written procedures for identification of acuity care level needed for each patient and for referral to or receipt by the appropriate level.
- (6) A single Level II or Level III neonatal special care unit shall contain a minimum of 15 beds; neonatal special care service shall be provided only in dedicated neonatal special care units.
- (7) For Level I obstetrics, preference may be given to those proposing a family-centered maternity and newborn care program.

- (8) Existing Level II and III neonatal services shall have an average annual occupancy rate of 75 percent. Proposals for new or upgraded Level II services shall project an occupancy rate of 75 percent by the end of the third year of operation, and shall demonstrate that all existing Level II and III services in the MCH planning area have an occupancy rate of 75 percent for the year prior to the application.

c. Pediatric Services (PEDS)

Inpatient pediatric services are medical/surgical services in acute care hospitals available to persons 0-14 years exclusive of neonatal, psychiatric and obstetric services offered this age group.

A pediatric bed is a medical/surgical bed that is licensed for inpatient use and is used by patients 0-14, exclusive of neonatal, psychiatric and obstetric patients.

A pediatric unit is a distinctly designated section, ward, wing, hospital, or unit devoted primarily to the care of medical and surgical pediatric patients.

There shall be a planned system of hospital pediatric services based on patient need for basic or specialized care. This system shall have the following characteristics:

- (1) There shall be two levels of pediatric facilities/services recognized in the state:
 - Basic services: hospital services which primarily provide uncomplicated pediatric care to meet the majority of pediatric needs. These services are not usually in a separate unit, but they should be designated pediatric beds distinct from medical/surgical beds.
 - Specialized services:* hospital services which primarily provide specialized services for complicated pediatric problems. These services shall be provided in dedicated pediatric units with appropriate specialized and sub-specialized personnel and a separate nurses' station.
- (2) Hospitals with dedicated pediatric units should have 16 or more pediatric beds, and shall maintain a minimum occupancy rate for the pediatric unit of 65 percent for up to 39 beds, 70 percent for 40-79 beds, and 75 percent for 80 beds or more.

*These services correspond to pediatric Levels II and III in WAC 248-19-230.

- (3) Hospitals which provide basic pediatric services should have dedicated pediatric beds if they have an average daily census of 10 or more pediatric patients, and should maintain an occupancy rate of 65 percent.
- (4) All hospitals providing pediatric services shall have written procedures for identification of level of care needed and for referral to and receipt by the appropriate level.
- (5) All specialized pediatric services shall have a pediatrician in house or on call 24 hours a day and should have available on staff or on contract for consultation a qualified mental health practitioner who specializes in children.
- (6) The three children's hospitals in the state should coordinate pediatric consultation and education networks and transportation services in the state.

d. Cancer Management Services (CMS)

Cancer management is the effective supervision of the cancer patient through all phases of illness through a system composed of the following services: prevention, detection, diagnosis, pre-treatment evaluation, treatment (surgery, transplantation, radiation therapy, chemotherapy), and continuing care (rehabilitation, maintenance, and terminal care).

Radiation therapy is the use of ionizing radiation to destroy or inhibit the growth of potential cancer cells. It may be curative or palliative. The most common type of radiation therapy is carried out by external beams of radiation that are classified by their energy range (superficial, orthovoltage, and megavoltage).

The two most common types of megavoltage equipment are the Cobalt-60 units and linear accelerator units. The Cobalt-60 produces 1.17 to 1.33 MeV (million electron volts). There is a continuing trend to replace Cobalt-60s with linear accelerators because of technical advantages and versatility. Linear accelerators are commercially available in three energy levels: 4-8 MeV, 10-20 MeV, and over 20 MeV.

Other types of radiation therapy involve the application, implantation (brachytherapy), or systemic administration of radioactive substances.

- (1) Each hospital providing cancer diagnosis and treatment services shall:

- Have written procedures to involve the referring primary care physician and social worker/counselors in pre-treatment planning and ongoing care for every patient with a major malignancy;
 - Participate in a cancer registry;
 - Have referral agreements with a cancer rehabilitation program which meets minimal service and staffing standards for its size as established by the Fred Hutchinson Cancer Research Center Committee on Rehabilitation (Appendix A).
- (2) Each hospital providing radiation therapy service shall have available in-house or by arrangement 1/ with other providers:
- A full range of diagnostic tests and procedures; and
 - The broad range of treatment modalities including superficial x-ray and brachytherapy capabilities.
- (3) Megavoltage radiation therapy is a specialized service which shall be regionalized according to the following criteria:
- (a) Need for units will be computed using area-specific data where possible. If unavailable, age-specific incidence from reliable sources such as the nationwide Cancer Surveillance, Epidemiology and End Results (SEER) Program may be applied to the entire area's population. The following assumptions shall apply:
- 50 percent of new cancer patients will require megavoltage therapy;
 - 30 percent of new cancer patients who received megavoltage therapy will require retreatment;
 - New, palliative, and returning patients will average 20 treatments;
 - One megavoltage unit will average 6,000 treatments per year.

1/ "Arrangement" refers to an existing referral/consultation network which may be a conjoint radiation oncology center.

- (b) A proposed megavoltage therapy unit shall show projected use by at least 300 cancer cases annually within three years after the beginning of operation.
- (c) Existing and approved megavoltage units in a health service area shall be utilized at a rate of 6,000 treatments per year within three years after the proposed operation begins. This standard does not apply to:
 - (i) Older megavoltage equipment used on a back-up basis, or
 - (ii) Dedicated special purpose machines and high energy research equipment which have limited but important applications.

e. Critical Care Services (CCS)

A Coronary Intensive Care Unit (CCU) is a specific location in an acute care hospital designated and equipped for the management of patients with life-threatening arrhythmias, suspected myocardial infarctions, or other coronary conditions requiring intensive care. (Open heart surgery and cardiac catheterization are addressed in a separate section of this Plan.)

A general medical-surgical Intensive Care Unit (ICU) is a specific location in an acute care hospital designated and equipped to accommodate patients with serious medical conditions including trauma requiring immediate and aggressive intervention.

A Critical Care Unit is a combined coronary and intensive care unit.

A Critical Care Bed is a hospital bed equipped and designed for intensive/coronary care patients. Five or more ICU, CCU or critical care beds require designation as a unit with its own nurses' station.

A Step-Down (Intermediate) Unit is a specific location in an acute care hospital designed and equipped for coronary and intensive care patients whose risk has diminished but who still require monitoring.

An Emergency Life Support Station is a designated location in a basic service hospital or a mobile unit equipped to provide emergency life support to patients with suspected myocardial infarctions or life-threatening arrhythmias.

ICU-CCU or their combined Critical Care Units shall be distributed according to the population density and the hospitals' service intensity/specialization.

(1) An Emergency Life Support Station or emergency room should be located within 20 minutes driving time of at least 90 percent of the population.

(2) A Coronary Care Unit shall be located within 60 minutes driving time of each Emergency Life Support Station. Travel time should be measured with consideration of both ground and air transportation systems.

(3) Acute care facilities averaging 25 or fewer diagnosed myocardial infarction admissions per annum during the immediately preceding five-year period shall not commit to capital projects for the purpose of constructing, expanding or substantially remodeling a coronary intensive care unit.

(4) There shall be no new coronary care beds developed within a hospital planning area unless it is demonstrated that development of additional step-down beds is not an appropriate alternative.

(5) The minimum size of a newly-constructed ICU, CCU or critical care unit shall be four beds.

f. Cardiovascular Disease Services (CD)

Cardiovascular services include both cardiac catheterization and open heart surgery procedures. They also include coronary care unit services addressed in the Critical Care Services Section of this Health Facilities and Services Plan.

Cardiac catheterization includes diagnostic and therapeutic procedures involving the heart and the cardiac arteries which supply the heart. There are two categories of diagnostic procedures:

- Coronary arteriography - passage of a thin tube through major blood vessels and into the coronary arteries, followed by injection of an opaque fluid permitting x-ray visualization of the coronary arteries.

- Left or right catheterization - passage of a tube into one of the heart chambers to evaluate how well the heart is pumping.

The use of cardiac catheterization for therapeutic purposes includes injection of the enzyme streptokinase or other substances to break down blood clots formed in coronary

arteries. It also includes percutaneous transluminal coronary angioplasty (PTCA) which involves inflation of a balloon catheter at the site of narrowing of a coronary artery to dilate the artery. Current literature and professional opinion recommend stand-by open heart surgery capacity where PTCA is performed. The emerging trends in therapeutic cardiac catheterization need to be evaluated for efficacy, patient benefits, cost, and their potential to substitute for more invasive procedures.

A cardiac catheterization unit is a laboratory room in which cardiac catheterization procedures are performed.

A cardiac catheterization procedure includes all of the diagnostic and therapeutic interventions defined above performed on a single patient in a single day.

Open heart surgery units perform surgery requiring the use of a heart-lung bypass machine to perform the functions of circulation during surgery. Prior to the late 1960s, open heart surgery was primarily used to correct or palliate congenital or valvular heart disease. In the late 1960s, procedures for aorto-coronary artery bypass surgery were developed; in 1976, coronary bypass surgery accounted for 82 percent of all open heart surgery in Washington.

An open heart surgery unit is an operating room dedicated to the use of surgery using a heart-lung bypass machine.

Cardiovascular services, including cardiac catheterization, a specialized service, and open heart surgery, a tertiary service, shall be regionalized according to the following criteria:

- (1) There shall be a minimum volume of 200 adult open heart surgery procedures (100 if pediatric) performed annually in each institution approved for open heart surgery within three years of initial operation. If institutions fall below 200 adult open heart surgery procedures, they should consider consolidation.
- (2) New open heart surgery services shall not result in a number of open heart operating rooms that exceeds the maximum number of open heart operating rooms needed in the area by 1990 determined by multiplying the state's 1983 adult or pediatric open heart surgery use rate by the area's 1990 adult or pediatric populations, and dividing the result by the minimum capacity of adult or pediatric units (200 or 100, respectively.)

- (3) There shall be no new open heart surgery operating rooms approved until all facilities providing open heart surgery in the planning area are experiencing at least 200 (100 for pediatric) open heart surgeries per year per open heart surgery operating room.
- (4) Cardiac catheterization services shall be closely associated with open heart surgery programs, and shall be able to demonstrate, explicitly and in writing, association and referral arrangements with an existing surgery program.
- (5) There shall be a minimum volume of 300 cardiac and noncardiac catheterization procedures per room (at least 100 of which should be cardiac catheterizations) performed annually in each institution approved for such services within three years of initial operation.

Proposed new cardiac catheterization services, adult and/or pediatric, should be able to project reaching this level within one year of operation.

g. End-Stage Renal Disease Services (ESRD)

End stage renal disease (ESRD) occurs when the kidneys suffer permanent loss of function. Two treatments are available to prevent the ESRD patient's death - kidney transplantation and maintenance dialysis. Maintenance dialysis is a process by which dissolved toxic impurities are removed from a patient's body by diffusion from the blood across a semi-permeable membrane into a dialyzing fluid. Maintenance dialysis in which the patient is connected to an artificial kidney machine for three to six hours, up to three times a week, is called hemodialysis. The other form of dialysis in common use is peritoneal dialysis, in which the patient's own abdominal membrane is used for diffusion.

A renal dialysis center is a hospital-based unit which furnishes the full spectrum (except renal transplantation) of diagnostic, therapeutic, and rehabilitative services required by ESRD patients. A renal dialysis facility is a free standing unit which furnishes maintenance dialysis to ESRD patients. Training for home dialysis and/or supervised self care may be provided by both free-standing and hospital based units upon federal certification.

A dialysis station with 100 percent utilization rate is defined as operating two shifts per day, six days a week, i.e., performing 12 dialyses per week and caring for four individual patients. A dialysis facility or center operating at an 80 percent utilization rate would perform 9.6 dialyses per station per week.

A renal transplantation center is a hospital unit which is approved to furnish kidney transplants and related services. These are located at University, Virginia Mason, Children's Orthopedic, and Swedish hospitals in Seattle and at Sacred Heart Hospital in Spokane. One hundred and three renal transplants were performed at Washington transplant centers in 1984.

Network Coordinating Council #2 (NCC #2) is an administrative organization designated and funded under Public Law 95-292 to assure adequate and quality ESRD services are available in Washington, Alaska, Idaho, Montana, and Oregon.

The ESRD service system shall be further developed in Washington State with the following characteristics:

- (1) Transplant centers shall perform at least fifteen transplants annually by the fourth year of operation.
- (2) Forecasted need for dialysis stations will be computed using health planning region-specific data and any regional goals for the percentage of patients on home dialysis (50 percent minimum goal).
- (3) The number and location of dialysis facilities and centers shall be determined for each health planning region using the federal guidelines for unconditional status as follows:
 - (a) Existing facilities and centers shall have an 80 percent utilization rate before approval will be granted for establishing a new facility or expanding an existing one within a reasonable driving time.
 - (b) A proposed new dialysis facility or center within a standard metropolitan statistical area (SMSA) of 500,000 population or more shall have a minimum of six stations and 80 percent utilization rate of its outpatient dialysis units by the fourth year of its establishment. If located outside of an SMSA of 500,000 population or more, it should have a minimum of three stations and 33 percent utilization rate.
 - (c) A proposed new dialysis center with 20 percent or less dialysis outpatients shall have a minimum of three outpatient stations and 33 percent utilization rate by the fourth year of its establishment.

(d) Approved dialysis facilities or centers proposing to add new stations shall achieve an 80 percent utilization for 52 weeks prior to expansion and should be able to estimate achieving this rate within two years of expansion.

(e) Based on the NCC #2 data, exceptions to (a)-(d) above are:

(i) each station on which at least six patients have been self/home trained annually shall be deducted from the approved stations on which the utilization calculation is made; and

(ii) the utilization rate may be reduced to 75 percent and 70 percent in facilities with 10 percent and 20 percent peritoneal dialysis patients respectively.

h. Facility Based Adult Rehabilitation Medicine Services (REHAB)

Patients' medical or surgical needs alone may not warrant inpatient hospital care, but hospitalization may nevertheless be reasonable and necessary because of their need for rehabilitative services. Patients are deemed to require a hospital level of care if they require a relatively intense rehabilitation program involving a multidisciplinary, coordinated team approach to upgrade their ability to function as independent as possible.

There shall be a coordinated system of facility-based adult rehabilitation medicine services in Washington State with the following characteristics:

(1) Multidisciplinary services:

- physiatry or the guidance of a physician with at least two years of rehabilitation training (physical medicine);
- intensive skilled rehabilitation nursing care;
- social worker/discharge planner;
- physical therapy;
- occupational therapy;
- speech therapy; and
- psychology.

(2) Services required to qualify for Medicare/Medicaid reimbursement under the guidelines established by the Health Care Financing Administration. These include 24-hour physician availability, and appropriate rehabilitation services as indicated by patient needs.

- (3) Operation in keeping with the guidelines established by a professional review organization under terms of Public Law 97-248 as amended by Public Law 98-21 and accepted by the Health Care Financing Administration. These guidelines shall include criteria for admission, patient care, and discharge.
- (4) Written policies which are used to define types of patients admitted and referred.
- (5) Participation in a communication and education network.
- (6) Outpatient continuing care or make appropriate referral arrangements for this.
- (7) Facilitate team communication and have documented procedures for same.
- (8) Bed need forecast consistent with the Washington State Hospital Bed Need Forecasting Method for hospital total bed supply.

i. Computed Tomography Services (CT)

Computed tomography (CT) scanning is a radiologic procedure which produces cross-sectional x-ray images of internal parts of the body. These images are obtained by passing x-rays through the patient, measuring the unabsorbed radiation with detectors, mathematically reconstructing by computer a cross-sectional image and recording the image on photographic film. This records much smaller increments in tissue density than conventional x-ray films and, therefore, provides a clearer picture of many body abnormalities than conventional x-ray methods.

A CT scan is a series of tomographic images through the same area of diagnostic interest.

A head equivalent CT (HECT) unit is a single, unenhanced CT scan. A body scan with and without contrast amounts to 2.51 HECTs.

The development of CT scanning services will be guided by the following policies:

- (1) CT scanners shall operate at a minimum of 2,800 head equivalent CT units (HECTs) for the second year of operation and thereafter.
- (2) Facility-housed computer tomography scanners may operate at less than 2,800 HECT units per year, or facilities planning acquisition of a CT scanner may project less

than 2,800 HECT units per year, if it is found that the adjustment is justified because of one or more of the following: (a) the costs of transporting inpatients to another facility for CT scans would be equal to or exceed the average fixed costs of operating the scanner; (b) 90 percent of the clients served by the CT scanner would have to travel more than 90 minutes driving time under average road conditions to obtain CT scanning services from the next nearest CT scanner(s); (c) cost and charge levels of the scanner are (will be) comparable to costs and charges of scanning services in other facilities of the same peer group having scanners of approximately the same price and capabilities; (d) the scanner is (will be) servicing a designated special population.

- (3) There shall be no additional scanners unless the utilization of each of the other facility-based CT scanners in the same and contiguous hospital planning areas equals or exceeds 2,800 HECT units annually during the last completed calendar year.
- (4) Forecasted utilization of proposed CT scanners shall be based on that hospital's existing case mix as measured by their discharge diagnoses for the most recent 12 months.
- (5) When more than one facility in the same hospital planning area is proposing CT scanning, a maximum of one CT scanner shall be installed initially, provided that the institution meets other policies in this section. The determination of which facility will initially provide CT scanning will be based on which facility has the highest volume of expected inpatient CT scans based on that hospital's discharge diagnoses for the prior twelve months.

j. Magnetic Resonance (MR)

Magnetic resonance is a technique that applies the atomic principle of magnetic spin and absorption of energy by atomic nuclei in the presence of radio waves to yield information about tissue being examined. The information may appear in spectroscopic form or as an image produced by magnetic resonance, the latter using computed tomography to produce the image. MR is clinically efficacious, according to criteria listed by the Office of Technology Assessment.

Present state law does not require a Certificate of Need review of magnetic resonance equipment located in physicians' offices or other non-hospital settings unless the service is proposed for inpatients and provided on equipment which costs more than the expenditure threshold.

A "patient visit" is defined as a single occurrence for a patient to visit the MR unit and be scanned. It is the equivalent to the American Hospital Association's "scan." One patient visit may require scanning several anatomical parts.

The development of MR services will be guided by the following performance standards:

1. Washington State should have an appropriate supply of MR services with adequate geographic distribution.
 - a. Certificate of Need should be granted to an applicant who can demonstrate a demand for at least 2500 patient visits a year in the second year of operation. The method of estimating demand will be the one in most current use by the American Hospital Association (AHA). This may require the application purchase services from the American Hospital Association. Existing MRs that have a utilization of 2500 patient visits in the twelve months prior to filing an application have already met this standard.
 - b. Preference will be given to applications that demonstrate they can best address the needs of inpatients.
 - c. Special consideration will be given to children's hospitals since the AHA method is not applicable and theoretic capacity of the equipment is different.
2. All physicians and technicians operating MR units shall have special training in diagnostic imaging.
 - a. Physicians performing the clinical interpretation of MR shall meet the standards set by the American College of Radiology. In September 1985 these were:
 - 1) Three months training or six months experience in nuclear radiology; and
 - 2) Six months training in cross-sectional body imaging to include at least three months training in computed body tomography or one year experience in cross-sectional body imaging to include computed body tomography; and
 - 3) Three months training or six months experience in neuroradiology; and
 - 4) Sixty hours of documented instruction in magnetic resonance imaging physics, instrumentation, and clinical applications.

b. Technologists assisting in MR studies shall be certified by a national board in at least one of the following fields prior to initiation of MR operations: radiology technology, nuclear medicine technology, or ultrasound technology.

3. MR units which have Certificate of Need approval shall periodically provide data in the SHCC-developed format requested. Non CN-approved units are encouraged to provide data also.

k. Innovative Technologies (IT)

Innovative Technology is new, potentially useful equipment or procedures for the diagnosis and/or treatment of disease requiring capital or operating expenditures which exceed the Certificate of Need thresholds. Present state law does not require CN review of IT located in physicians' offices or other non-hospital settings unless service is proposed for inpatients.

The Food and Drug Administration (FDA), National Center of Devices and Radiological Health, controls the introduction of medical devices into commerce. Medical devices are segregated into three classes:

--Class I devices are subject to the minimum level of control. General controls include the Good Manufacturing Practice Regulations.

--Class II devices have been declared to require performance standards to assure their safety and/or effectiveness. They must also meet the controls of Class I.

--Class III devices require formal premarket approval from the FDA for each make and model of the device to assure its safety and effectiveness. The controls of Class I are also required.

Investigational stage is the period during which manufacturer of a Class III device is testing it according to an established protocol in order to obtain the FDA's pre-market approval. During this stage the manufacturer cannot charge the sites or patients who are subjects of the investigation a price higher than necessary to recover costs of manufacturing, research, development, and handling.

Patient benefit refers to the aggregate: where scientific studies demonstrate that a significant number of patients receiving the services experience improved therapy and/or outcome; or if diagnostic, the information generated is

valid and not available by other diagnostic methods or is available only by means which are less safe, more uncomfortable to the patient, or which entail more expensive procedures.

Each innovative technology shall be initiated in the state of Washington according to the following process:

- (1) A Technical Advisory Committee (TAC) shall be appointed by the State Health Coordinating Council (SHCC) chair to provide guidance for CN review, taking into consideration the patient benefit to be derived from the IT.
- (2) Each TAC shall contain persons knowledgeable in the application of the technology under consideration and at least three SHCC members, one SHCC member being the TAC chair.
- (3) The director of the CN program shall alert the director of the SHCC regarding the need for initiating a TAC to address a specific new technology when he/she has reason to believe an application is forthcoming (i.e., consultation regarding the technology is requested, a letter of intent is received, etc.).
- (4) In consultation with the CN program, the SHCC may revise or reject the TAC's recommendation.
- (5) In consultation with the CN program, the SHCC will determine whether the original TAC should reconvene to develop guidance for subsequent CN review in light of experience with the first phase.

1. Ambulatory Surgery Services (AS)

Ambulatory Surgery is surgery for which an overnight stay in a health care facility is not anticipated as medically necessary. Also called outpatient surgery, short-stay surgery, in- and out-surgery, and same day surgery. Ambulatory surgery is performed in a variety of settings including a hospital surgery suite which is also used for inpatient surgery, a hospital unit designed and dedicated only for outpatient surgery use, and a free-standing facility which may be owned by ("part of") a hospital or owned by others.

Outpatient Operating Rooms are those in which ambulatory surgery is performed and may be dedicated to this.

Ambulatory Surgical Facility (as defined in WAC 248-19-220(4)) means a facility, not part of a hospital, which provides surgical treatment to patients not requiring inpatient care in a hospital. This term does not include a facility in the offices of private physicians or dentists, whether for indivi-

dual or group practice, if the privilege of using such facility is not extended to physicians or dentists outside the individual or group practice.

The development of operating room capacity in general and ambulatory surgical facilities in particular will be guided by the following policies:

- (1) The area to be used in planning for operating rooms and ambulatory surgical facilities is the hospital planning area.
- (2) Outpatient operating rooms should ordinarily not be approved in hospital planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need.
- (3) When a need exists in hospital planning areas for additional outpatient operating room capacity, preference shall be given to dedicated outpatient operating rooms.
- (4) An ambulatory surgical facility shall have a minimum of two operating rooms.
- (5) Ambulatory surgical facilities shall document policies to provide access to individuals unable to pay consistent with charity care standards established for hospitals affected by the proposed ambulatory surgical facility.
- (6) Community costs for an expansion in operating rooms shall be assessed by applying the established Community Cost Estimating Method to the impacted hospitals' surgery cost centers. In hospital planning areas where the ratio of ambulatory surgery is less than 30 percent of total surgical volume, community cost shall include savings associated with shifting inpatient surgeries to outpatient surgeries so that the ratio of outpatient surgeries reaches 30 percent.
- (7) The need for operating rooms will be determined by the method described in this plan.

m. Short Stay Psychiatric Services (PSYCH)

Short stay psychiatric hospital services are services in acute care general hospitals, in private psychiatric hospitals, or stays of 30 days or less in state mental hospitals or federal (Veterans Administration and military) hospitals, for severely and acutely mentally disabled persons who may be either civilly committed (Involuntary Treatment Act) or voluntarily admitted.

Short stay psychiatric residential services are services provided for persons experiencing acute psychiatric disorders

without medical complications (who may be civilly committed or voluntarily admitted), which are provided in residential programs with the following characteristics:

- Both residential care (room, board, skilled supervision) and treatment/stabilization are provided under a single administration.
- The residential facility either (a) is licensed by the Department of Social and Health Services (DSHS) as a boarding home or an adult residential treatment facility (ARTF); or (b) is certified by DSHS as an adult family home or child foster home; or (c) is within a licensed hospital, but operated as a separate residential program with separate financial accounting approved by the Washington State Hospital Commission.

Involuntary Treatment Act (ITA), Chapter 71.05 RCW, is the Washington State law governing involuntary civil commitment of individuals for psychiatric care.

The development of short stay psychiatric services in Washington State will be guided by the following policies:

- (1) Short-term patients with more severe medical involvement, and those with more severe, violent behavior disturbances (especially if requiring restraint), should be in specialized programs which can meet their needs. Usually these programs are hospital based.
- (2) Access to short stay psychiatric residential programs should be available to clients with private insurance coverage as well as those who are state paid (Medicaid or involuntary treatment) and those with sufficient personal resources to pay out of pocket.
- (3) The county is a fundamental administrative unit for mental health services in Washington. Therefore the planning areas for computation of short stay psychiatric resource needs are counties, with the exception that the following groups of counties, which jointly operate their mental health services, should be considered single planning areas:
 - Benton and Franklin Counties
 - Chelan and Douglas Counties
 - Thurston and Mason Counties
- (4) Because the hospital resources needed within the desired system of short stay psychiatric services are much more completely developed than the needed residential services, the following performance standards shall be in effect until replaced in this State Health Plan:

- (a) During this period, the need for short stay psychiatric hospital services is determined to be 13 beds per 100,000 population for the state as a whole. The need for short stay psychiatric residential services is determined to be 8 beds/100,000 population. These are normative standards determined by the SHCC to be appropriate.
- (b) Development of short stay psychiatric residential services should be a goal.
- (c) In the interest of increasing equity in geographic access to needed psychiatric services, those mental health planning areas with the lowest ratios of short stay psychiatric resources in relation to population should be priority locations for short stay psychiatric residential programs.

In planning areas where there is no concrete evidence of residential program development, consideration should be given to making determinations of need for a greater proportion of hospital services within the total need for short stay psychiatric services. Examples of concrete evidence of program development may include committed funding, contracts, letters of intent, appropriately zoned sites, and the like.

- (5) The need for short stay psychiatric hospital services in each mental health planning area shall be determined by the short-stay psychiatric service forecasting method within the most recent State Health Coordinating Council (SHCC)-approved version of the Washington State Hospital Bed Need Forecasting Method.
- (6) Within acute care general hospitals, the following capacity shall be considered available to meet short stay psychiatric hospital needs:
- The number of beds in designated psychiatric hospitals units;
 - In hospitals which do not have designated psychiatric units, the actual average daily census of psychiatric services provided during the data period which forms the basis for hospital bed need forecasting shall be counted.
- (7) The capacities of state mental hospitals and federal hospitals to provide the level of short stay psychiatric services assumed in detailed forecasting methods should be confirmed as part of the forecast adjustment process, and re-examined as part of the next State Health Plan development cycle.

- (8) The relative needs of children, aging individuals and other adults for services, and the relative availability of resources to meet their needs, should be considered in deciding the particular mix of hospital programs needed in an area, and the particular mix of residential programs.
- (9) The MHD should inform interested agencies of all applications or letters of intent concerning development of short stay psychiatric residential programs, and should solicit HSA comment on the proposals before reaching a decision about ITA certification or funding.

4. LONG TERM CARE PERFORMANCE STANDARDS

a. Nursing Home Services (NH)

The term "nursing home" includes entities licensed or required to be licensed under the provisions of chapter 18.51 RCW, and equivalent facilities owned and operated by the state. A nursing home is any home, place, institution, building or agency or distinct part thereof which operates or maintains facilities providing convalescent or chronic care, or both, for a period in excess of twenty-four consecutive hours for three or more patients not related by blood or marriage to the operator, who, by reason of illness or infirmity, are unable to properly care for themselves. Convalescent and chronic care may include, but not be limited to, any or all procedures commonly employed in waiting on the sick, such as administration of medicines, preparation of special diets, giving of bedside nursing care, application of dressing and bandages, and carrying out of treatment prescribed by a duly licensed practitioner of the healing arts.

The term "nursing home" does not include a swing bed program.

- (1) The areas used for planning nursing home services shall be: Clark and Skamania Counties combined, Snohomish County and Camano Island, Island County, excluding Camano Island and the other 35 individual counties in the state.
- (2) The appropriate supply of nursing home beds in each area of the state shall not exceed the number of beds determined to be needed by the Washington State Nursing Home Bed Need Projection Method, except that certain nursing home projects which are undertaken as part of a qualifying continuing care retirement community may choose to be considered under the special provisions of Performance Standard B.4.c.(4).

- (3) State approval to build, expand or acquire a nursing home shall not be given to owners or operators of existing nursing homes who, according to federal or this or another state's survey reports for at least the last three years, have had repeated and/or severe violations of standards of patient care.
- (4) Operators proposing to build or expand a nursing home shall document:
 - 1) joint planning with other health care and long-term care programs, 2) a commitment to placing clients in the least restrictive setting, and 3) services designed to assist clients to maintain maximum functional independence.
 - (a) Evidence of joint planning shall include written agreements with other providers for referral, consultation, service provision, and joint planning. It shall also include a list of other long-term care services informed about the project including at least the Area Agency on Aging, local home health agencies, the local Community Service Office (CSO) and the local hospitals.
 - (b) Evidence of a commitment to least restrictive placements shall include: 1) information provided to clients prior to admission on other long-term care services in the community. 2) the existence of a continuing patient assessment program for all clients regardless of their payment status, and 3) for existing nursing homes, a documented record of discharging clients to their homes or less intensive services and of maintaining no severe or repeated deficiencies cited in the discharge planning standard for the last three years.
 - (c) For existing nursing homes, evidence of adequate services to maintain client functional independence shall include documentation that for at least the last three years the nursing home has not had repeated and/or severe violations of standards of patient care.
- (5) Important considerations for which preference in meeting the bed needs in a planning area may be given are presented below. Preference shall be given to the project which meets the greatest number of the following criteria for preference.
 - (a) Nursing home operators who have the policy of admitting patients without regard to their source of income or payment.

- (b) Projects that include other institutional long-term care services or evidence relatively greater linkages to community-based long-term care services.
 - (c) Projects which improve the geographic distribution and/or provide access to nursing home beds in a currently underserved area.
 - (d) Nursing home operators having or proposing to have a Medicare contract in areas with less than the statewide proportion of Medicare nursing home beds to total nursing home beds.
 - (e) Nursing home operators serving or proposing to serve Medicaid clients.
 - (f) Nursing home operators proposing to serve additional heavy care patients in areas where CSO placement staff or hospital discharge planners document significant and continuing difficulties in placing heavy care patients in nursing homes.
 - (g) Existing nursing home operators in the state who are seeking to achieve a 100-bed minimum efficient operating size for nursing homes or to otherwise upgrade a facility with substantial physical plant waivers or exceptions, as determined by the State Aging and Adult Services Administration.
 - (h) Projects that propose to serve persons requiring mental health services and persons with dementias.
- (6) Nursing home projects which are undertaken as part of a continuing care retirement community shall meet the additional performance standards of Section B.4.c of this plan.

b. Swing Bed Services (SB)

"Swing beds" are hospital beds, available to provide either acute care or long-term care/nursing care services as required, which meet the following conditions:

- ° They are in a rural hospital (i.e., outside of U.S. Census defined "urbanized areas");
- ° The hospital has under 50 licensed beds, excluding any critical care beds and infant bassinets and any beds in a Medicare and/or Medicaid certified distinct long-term care wing;

- The total number of swing beds in the hospital does not exceed five;
 - Capital expenditures to establish the swing beds do not exceed the Certificate of Need capital threshold identified in WAC 248-19-220.
 - Services meet minimum requirements established by Medicare for rural hospital swing beds.
- (1) The establishment of a swing bed program, as defined above, shall not be subject to capital expenditure review unless it involves an increase in the hospital's total number of licensed beds.
 - (2) Swing beds shall be counted as hospital beds. They shall not be considered nursing home beds for the purpose of determining nursing home bed needs or available nursing home bed supply.
 - (3) Hospital programs providing long-term care/nursing care services which are not swing beds as defined above, shall be considered nursing home services. They shall be subject to capital expenditure review and all nursing home certification requirements, and shall be counted in the Nursing Home Bed Projection Methodology.

c. Continuing Care Retirement Communities (CCRCs)

Definitions

A "continuing care contract" means a contract to provide a person, for the duration of that person's life or for a term in excess of one year, shelter along with nursing, medical, health-related or personal care services, in exchange for payment of an entrance fee, periodic charges, or both. Continuing care contracts include (but are not limited to) life care agreements and mutually terminable contracts. The living space and services under a continuing care contract may or may not be provided at the same location.

A "continuing care retirement community" (CCRC) is any of a wide variety of entities providing shelter and services pursuant to continuing care contracts with its members. For clarity, three types of CCRCs are distinguished in this plan:

Type A CCRC - A "life care model" CCRC which provides its members (residents) with a contractually guaranteed range of services from independent living through skilled nursing, including some form of assistance with

activities of daily living. There must be no limits on days of medically needed nursing home care. With limited exceptions related to start-up periods, a Type A CCRC offers services only to contractual members. The member's financial responsibility is stated in contract, with the CCRC responsible for remaining costs. With the exception of insurance purchased by the CCRC or its members, no third-party -- including, after a limited start-up period, the Medicaid program -- is liable for costs of care, even if the member depletes his/her personal resources.

These characteristics of a Type A CCRC, as they apply to differential requirements for state approval of nursing home beds, are elaborated in Performance Standard (3) below.

Type B CCRC - A CCRC which does not meet all the requirements of Type A CCRCs, but does provide nursing home care or other facilities or services subject to state Certificate of Need review. A typical example would be a CCRC which operates an on-site nursing home, but contractually guarantees only a limited number of days of nursing care, after which additional payment is required of the member. Many Type B CCRCs have nursing home units which maintain Medicaid contracts and/or admit patients who are not CCRC members.

Type C CCRC - An entity offering continuing care contracts whose scope of services does not include state reviewable facilities or services. For example, a residential retirement community with long-term contracts which offers proximity to a separate nursing home, but no contractually guaranteed health services other than an on-call nurse to cover health emergencies, is a Type C CCRC.

A "member" of a CCRC is an individual who has signed a continuing care contract with the CCRC.

A "transition period" is a period not exceeding five years between the start-up of a Type A CCRC (i.e., the date its first member takes up residency under a Type A continuing care contract) and the date that it fully meets the requirements in Performance Standards (3)(b) and (3)(c) below for "self-containment" in financing and nursing home admission.

Introduction

CCRCs can provide a valued option in meeting the long-term residential, social and health needs of many of Washington's senior citizens. Continuing care contracts also have been acknowledged by the Washington State Legislature as distinct

from long-term care insurance (RCW 48.84.020(2)). However, consumers in Washington and nationwide have encountered serious, documented problems in dealing with some CCRCs, generally stemming from long-term financial instability of the community or insufficient disclosure to consumers. Based on the recommendations from a special advisory process*, the performance standards in this section have been developed to balance competing public needs and goals including:

- assistance in weighing the benefits and risks of CCRC membership for consumers who may have insufficient information for informed choice;
- the needs for nursing home care of both individuals who become CCRC members and those who cannot afford or do not choose this option;
- the cost containment interest of state government in encouraging those specific CCRCs which can give binding assurances that state funds will not be used to underwrite long-term care services for their members.

Current state Certificate of Need review processes deal with nursing homes and other specific types of health facilities and services, not with CCRCs as a whole (although Long Term Care Strategy 4.d(3) in Volume I of the State Health Plan recommends legislation which would establish independent oversight of CCRCs themselves). However, in order to correctly apply performance standards to a nursing home (or other reviewable activity) which is part of a CCRC, it must be reviewed differently from free-standing facilities because of its special characteristics:

- The nursing home is not a separate financial entity. Services are contracted, priced and paid for as a whole. The issue of cost containment cannot reasonably be addressed, from the consumer's point of view, for the nursing home service in isolation. Put another way, the consumer's price for the contract, if viewed as payment for nursing home services alone, would appear very high compared to charges for other new nursing home projects.

*During 1985 and 1986, the State Health Coordinating Council and the State Council on Aging jointly sponsored a 16-member CCRC Advisory Group representing citizen members of the two councils; state legislative committees with jurisdiction over financial institutions and social and health services; and pertinent state agencies (DSHS, Governor's Office, Insurance Commissioner and Consumer Protection Division of the Attorney General's Office). CCRC developers, technical experts, and consumers participated actively in this extended period of discussion, hearings and written comment.

- Many CCRCs involve a large "insurance effect:" including both a large deposit payment which prepays benefits and expenses and extensive cross-subsidy among members of different ages or of similar age but differing health care needs. Consequently, issues of pricing, cost containment and financial feasibility require a long-term view, including actuarial perspectives not necessary for review of "regular" nursing home projects.
- The financial risks of CCRC failure fall on consumers and state government as well as on facility operators and their lenders. This is true because CCRC financing generally includes members' deposits, and state government (at least in the case of Type A CCRCs) is given assurances of savings. In the framework of actuarial cost analysis, the likelihood of such losses must be considered as a factor relevant to cost containment as well as financial feasibility.
- When functioning well, a CCRC (especially if Type A) enhances continuity of care - a quality consideration - through its very design.

For these reasons, Certificate of Need review of a nursing home project within a CCRC requires information about the CCRC as a legal and financial whole. The performance standards which follow, therefore, are different in many respects than they would be for a free-standing nursing home. However, with one exception -- the consideration of certain CCRC nursing home projects outside of the area-specific bed need standards established under the state's projection method - this differential treatment does not exempt CCRC-based projects from any of the usual review criteria. Rather, it (1) adds information requirements pertinent to the special legal and financial arrangements surrounding CCRCs, and (2) offers operators/ developers of certain kinds of CCRCs the option of having nursing home projects they propose considered under different need rules, related to characteristics of members rather than the local general population, if the CCRC meets special conditions including guarantees that state funds will be conserved.

If legislation is enacted establishing direct regulation of CCRCs for consumer protection purposes, this section of the Health Facilities and Service Plan should immediately be reevaluated to eliminate any redundant or conflicting requirements and to coordinate review processes.

Performance Standards for Health Service Projects of CCRCs

- (1) All health facilities and services which would be reviewable if undertaken by another entity remain reviewable if undertaken by or as part of a CCRC of any type.
- (2) Any nursing home project which is undertaken by or as part of a CCRC shall meet all of the following performance standards.
 - (a) The project shall be financially and actuarially feasible, and shall contain costs, as demonstrated by all of the following:
 - (i) Submission of a feasibility study and financial plan based on marketing analysis, relevant literature, experience of other similar CCRCs, and specific actuarial study (ten-year minimum timeframe) which includes the components listed in Section 1 of Appendix B of this plan.
 - (ii) Submission of an actuarial opinion, written and signed by a qualified actuary as defined in 284-05-060 WAC, which indicates the likely feasibility of the project based on the feasibility study and financial plan (see (2)(a)(i) above) and the model contract (see (2)(c)(i) below).
 - (iii) Determination upon advisory review of the feasibility study and financial plan ((2)(a)(i)), the actuarial opinion ((2)(a)(ii)) and the model contract ((2)(c)(i)) by the Office of the Insurance Commissioner (or if this cannot be arranged, by an independent, qualified actuary contracted by DSHS), that the project is likely to be financially and actuarially feasible.
 - (iv) Submission of a written, legally binding commitment, supported by provisions of the model contract, that the CCRC shall maintain actuarially sound pricing structure and reserves or other mechanisms to assure future service obligations, based on actuarial restudy as necessary.
 - (v) Submission of an escrow plan, including identification of escrow agents and a copy of executed escrow agreements, and a statement of anticipated application of all escrows, which meets all requirements listed in Section 2 of Appendix B of this plan.

- (b) The project shall provide consumers (members and prospective members) with an accurate basis for informed decisions about CCRC participation and purchase (through this means) of nursing home or other health services. This shall be demonstrated by submitting a written, legally binding commitment, supported by provisions of the model contract, to disclose all information listed in Section 3 of Appendix B to consumers prior to offering a contract for sale (or, in the case of current members who have not received a complying initial disclosure, upon receiving state approval of any service or facility change), with update disclosure of changes at least annually to members.
- (c) In order to provide a firm basis for actuarial analysis and feasibility determination, and to document binding commitments to meet other performance standards, the project sponsor shall submit the following documentation related to contracts which are or will be used:
- (i) A model continuing care contract (between the CCRC and the member) which contains the provision listed in Section 3 of Appendix B.
 - (ii) A model waiting list agreement covering deposit amounts; any other fees; refund amounts in the events of admission, rejection of application or withdrawal of application; the amount of interest (if any) to be paid on deposits; the maximum time within which a required refund will be given to the contractee; and provisions for obtaining information on the likely time before a vacancy will occur.
 - (iii) A written, legally binding commitment that the CCRC will continue to use either the model contract or, in the event of contract changes, future contracts which also satisfy all requirements in this section of Volume II of the State Health Plan as of the date of project approval; and that any contract for transfer of any part of the CCRC will require the transferee to comply with these requirements.
- (d) If the project is a nursing home, it shall meet performance standards in Section B.4.a. of Volume II of the State Health Plan, with the exception

that Type A CCRCs approved under the provisions of CCRC Performance Standard (4) below, shall not be subject to the area bed need limits in Nursing Home Performance Standard B.4.a.(2).

(3) To be considered a Type A CCRC, a CCRC shall demonstrate that it meets the following performance standards (in addition to those in (2) above):

(a) From the start of operations (or the date of state project approval, if later), the CCRC shall contractually provide or arrange for at least the following specific services for its members:

- Residential (independent living) units.
- Nursing home care (including skilled nursing) without any limitation on days of care which is unrelated to medical need. This scope of nursing care must be provided for in the CCRC's contracts with members, but potentially could involve a higher monthly charge for persons receiving nursing care than for those living independently.
- Some form of assistance with activities of daily living.
- Services which are equivalent in scope to state chore services (including "individual provider" services) and to Medicaid home health services, for at least those members who otherwise would be eligible for such state-funded programs.

(b) By the end of a transition period not exceeding five years from the date the first CCRC member takes up residence in any CCRC area under a Type A continuing care contract (or, if sooner, from the date the first patient enters the nursing home unit), the CCRC:

- Shall not have a Medicaid contract for its nursing home unless this is a contract limited to continuation of payments for specific individuals who are not CCRC members and entered the nursing home unit during the CCRC's transition period as permitted in (3)(c).
- Shall not have a congregate care contract for any area which is licensed as a boarding home, unless this is a contract limited to continuation of payments for specific individuals who

are not CCRC members and entered the boarding home unit during the CCRC's transition period as permitted in (3)(c).

- Shall be providing, as required by (3)(a), services meeting needs of any members which otherwise would render those members eligible for state-supported chore services or Medicaid home health services.
- (c) By the end of a transition period not exceeding five years, the CCRC shall admit to its nursing home services only members who have signed continuing care contracts. However, nonmembers admitted earlier during a transition period (see (e) below) shall be permitted to remain for as long as they have medical need for nursing home care.
- (d) The CCRC shall provide written, legally binding assurances that conditions (3)(a), (b) and (c) will be met. These assurances must include a signed agreement with DSHS Aging and Adult Services Administration which either stipulates that a Medicaid contract will not be sought, or else limits any Medicaid contract to the restrictions in (3)(b).
- (e) If a Type A CCRC wishes to exercise a transition period, it shall submit a transition plan which describes whether and for how long nonmembers will be admitted to the nursing home unit; whether and for how long a Medicaid contract will be sought for the nursing home unit; and whether and for how long a congregate care contract will be sought for any boarding home unit. If there will be a congregate care or Medicaid nursing home contract, the CCRC shall document arrangements for the continuing financial support of any nonmembers remaining as indigent patients after the end of the transition period. The transition plan shall include a written, binding assurance that every nonmember admitted to the CCRC's nursing home unit (during a transition period) shall be informed at the time of nursing home admission of the particulars of the transition plan and how they affect the person's rights and charges. The transition plan shall include a sample disclosure statement for this purpose, written in plain English.
- (4) A nursing home project proposed by a Type A CCRC meeting all standards in (3) above, shall be considered, if the project sponsor requests, under the following special bed need standards:

- (a) The project size (number of nursing home beds) shall meet all of these standards:
- (i) The number of nursing home beds requested in a single project (whether initial or expansion) shall not exceed 60 beds.
 - (ii) No project shall result in a total CCRC nursing home capacity (including utilization of other facilities on contract) which exceeds one nursing home bed per four independent living units within the CCRC.
 - (iii) The CCRC shall justify the number of beds requested, not to exceed limits in (a)(i) and (a)(ii), based on actuarially sound forecasts of the expected age, sex and health characteristics of the CCRC's members in the ten years following the year of the application and evidence concerning demographically comparable nursing home use rates for the general public and within similar CCRCs.
 - (iv) In computing ratios for (4)(a)(ii), only independent living units of the CCRC which already exist or are scheduled for completion at the same time as the proposed nursing home beds, under the same financial feasibility plan, shall be counted.
 - (v) In computing demographic forecasts of CCRC membership for (4)(a)(iii), only independent living units and other living areas of the CCRC which already exist or are scheduled for completion at the same time as the proposed nursing home beds, under the same financial feasibility plan, shall be counted.
- (b) Any nursing home project by a Type A CCRC, which is proposed under and meets the standards in (3) and (4)(a), is not subject to the bed need standard for the Nursing Home Planning Area in which the project is located (see Nursing Home Performance Standard B.4.a.(2) of this volume of the State Health Plan). However, the total number of nursing home beds approved under this provision which are currently in "transition status" (see standard (3) above) shall at no point in time exceed 300 beds statewide. If approval of a Type A CCRC project involving a transition period would lead to exceeding 300 nursing home beds in such transition periods at the same time, that project shall not be approved.

- (5) Any Type A or Type B CCRC proposing a nursing home project may, at its discretion, designate it as an application against the special statewide pool of CCRC nursing home beds established under the Nursing Home Bed Need Projection Method (General Provision (f) ii and Step 2). No single project shall be considered simultaneously under both the CCRC statewide bed pool and the bed allocation of the Nursing Home Planning Area in which the project is located.

d. Home Health Agencies (HH)

Home health agency means an entity coordinating or providing the organized delivery of home health services.

Home health services means the provision of nursing services along with at least one other therapeutic service or with a supervised home health aide service to ill or disabled persons in their residences on a part-time or intermittent basis, as approved by a physician.

- (1) The performance standards policies presented below are interim. The health planning system shall evaluate these standards and revise them as necessary, when data on the costs and use of home health services in the state are available.
- (2) The following home health planning areas in each health planning region shall be used to determine population requirements for home health services:

Health Planning Region I

- (a) Clallam/West Jefferson
- (b) Whatcom (h) King
- (c) Skagit (i) Pierce
- (d) San Juan (j) Kitsap
- (e) Island (minus Camano Island)
- (f) East Jefferson
- (g) Snohomish/Camano Island

Health Planning Region II

- (a) Grays Harbor/Pacific
- (b) Thurston/Mason
- (c) Lewis
- (d) Cowlitz/Wahkiakum
- (e) Clark/Skamania/Klickitat

Health Planning Region III

- (a) Okanogan
- (b) Chelan/Douglas
- (c) Kittitas/Yakima
- (d) Grant
- (e) Benton/Franklin

Health Planning Region IV

- (a) Ferry/Stevens/Pend Oreille
- (b) Lincoln/Adams
- (c) Spokane
- (d) Walla Walla/Columbia
- (e) Garfield/Asotin/Whitman

- (3) The total annual number of home health visits needed in a home health planning area in the next year shall be estimated using the Interim Home Health Agency Need

Estimation Method described below. As utilization data become available, estimates used in this method shall be evaluated and adjusted.

$$\begin{aligned} & (\text{People under 65} \times .005) \times 10 \text{ visits} \\ & + (\text{People 65-79} \times .044) \times 14 \text{ visits} \\ & + (\text{People 80+} \times .183) \times 21 \text{ visits} \\ \hline & = \text{TOTAL VISITS} \end{aligned}$$

- (4) The appropriate number of home health agencies in each home health planning area shall be determined based on the following policies:
- (a) For planning purposes ten thousand (10,000) home health agency visits shall be considered to be the target minimum operating volume for a home health agency.
 - (b) Two home health agencies may be permitted in each home health planning area to allow competition and consumer choice. Where the projected aggregate need is less than 10,000 visits per year, the burden of proof shall be on a proposed new home health agency to demonstrate that competing agencies will result in greater levels of efficiency, effectiveness and equity in such an environment. In this regard, they shall address at least the considerations in Policies (5)(a)-(g) below.
 - (c) The maximum number of home health agencies permitted in a home health planning area shall not exceed the number of agencies derived by dividing the visits estimated under Step 3 above by the number 10,000.*
 - (d) For the purpose of determining the need for additional home health agencies in a home health planning area, existing home health agencies in the planning area are those agencies which can serve the area without further state approval and which provide service use and cost data requested by the health planning system.
- (5) Considerations for which preference may be given in reviewing competing proposals to meet a limited need in a planning area are presented below. Preference shall be given to the project that meets the greatest number of the following criteria for preference:

*Note: Fractional numbers derived under this calculation would be rounded down to the nearest whole number.

- (a) The proposed agency will meet state certification requirements.
- (b) The proposed agency will serve either directly or through formal agreements with other providers the entire planning area in which it is proposed to be located.
- (c) The proposed agency has a written policy and budget to serve clients without regard to their source of payment.
- (d) The agency has a lower charge per visit compared to similarly-organized agencies providing comparable services in the home health planning area. "Organization" refers to whether the agency is freestanding or hospital-based.
- (e) The agency assures continuity of care by having documented formal linkages to other levels of care.
- (f) The agency has arrangements to provide charity care to clients who are unable to pay for services.
- (g) The agency demonstrates a mechanism for measuring and responding to community concerns.

e. Hospice Services (HS)

Hospice means a private or public agency or part thereof that administers or provides hospice care.

Hospice care means care supervised by the attending physician and provided by the hospice to the terminally ill. Hospice care is primarily palliative or medically necessary care provided by a hospice multidisciplinary team with care available 24 hours per day 7 days a week.

Hospice multidisciplinary teams means a team of individuals that provides or supervises care and services offered by the hospice and that is composed of at least a physician (consultant), registered nurse, social worker, and a pastoral, spiritual or other counselor.

Hospice services are provided in a coordinated program of care organized for the purpose of providing palliative and supportive care which is designed to meet the psychosocial, psychological, and spiritual needs of patients and their families (which includes those persons related by blood, marriage, or other significant relationship as designated by the patient). Bereavement services are an essential part of hospice care.

- (1) The areas used for planning hospice services shall be: Clark and Skamania Counties combined, Snohomish County and Camano Island, Island County excluding Camano Island and the other 35 individual counties in the state.
- (2) Until more complete utilization data of services provided by hospices are available, the potential population who may choose hospice care in each area shall be estimated using the following Hospice Need Estimation Method.

The need for hospice services shall be determined using the following method.

- (a) Calculate the average annual number of cancer deaths for the past five years in the area.
 - (b) Multiply the average annual number of cancer deaths by 0.25 to obtain the number of potential hospice patients with a cancer diagnosis.
 - (c) Calculating the total number of expected hospice patients by dividing the number of cancer hospice patients by 0.90.
- (3) Proposed new hospices or hospices proposing expansion shall have a predominant home care emphasis and shall use existing community services.
 - (a) Hospices proposing additional inpatient beds* for hospice patients shall ordinarily have an inpatient bed to hospice patient ratio that is equal to or less than the statewide average for existing hospices.
 - (b) Hospices shall use and integrate existing community services to meet client care needs. Affected provider and consumer groups shall be involved in planning, development and governance of proposed programs. Hospices shall not plan new community services unless they document that existing community services do not have the capability or are not willing to meet program needs.
 - (4) New or expanded hospices shall meet state hospice certification standards or minimum hospice quality standards, when such standards are developed.

*Hospice beds may be located in a hospital, nursing home or free-standing facility.

- (5) Preference in the development of new hospice care programs shall be given to programs which (a) have the policy of serving clients without regard to their source of payment, and (b) will serve geographic areas that do not have access to a hospice care program and/or a specific population without access to a hospice care program.

C. FORECASTING METHODS

1. INTRODUCTION

This section of the State Health Plan presents officially adopted methods for forecasting the need for operating rooms, nursing home beds and hospital beds. These methods are designed specifically to meet requirements for state review of proposed projects, but they are appropriate for other uses as well.

The operating room need determination method is new in this plan State Health Plan (SHP). Earlier versions of the other two methods were included in the 1980 SHP and incorporated by reference in the 1982 SHP. This plan brings the three methods together in one document. However, because of their complexity and length, they are separated from related performance standards for planning and review.

2. OPERATING ROOM NEED METHOD

a. SUMMARY

This method is the quantitative basis for reviewing proposals for ambulatory surgery facilities. It also will be used in reviews of proposed new hospital operating rooms when the project is costly enough for review.

As noted above, this is a new forecasting method. The general approach is for the health systems agencies to adopt a reasonable method for forecasting the number of surgeries and, if they wish, policies on the proportion of surgeries which could be done on an outpatient basis. The method in the SHP then calculates the number of inpatient and outpatient operating rooms (ORs) needed to perform these surgeries. The method follows the State Health Coordinating Council (SHCC)-adopted policy that all existing inpatient and outpatient capacity must be efficiently utilized before new ORs may be added.

In estimating the capacity of current ORs and the number of added ORs which would be needed to satisfy any future need, different assumptions are made about the number of surgeries which can occur in ORs dedicated to outpatient use as opposed to those providing surgery for hospital inpatients. This is necessary because outpatient surgeries tend to be simpler and less time consuming (on average), and because outpatient ORs tend to be scheduled for fewer hours per week. The method estimates these and other time factors (e.g., set-up time between patients, level of realistic capacity compared to the "theoretical" maximum) so that calculations can be carried out.

With the method itself are two examples showing application in urban and rural areas with various substitutions of better data in place of the method's general assumptions.

b. DETAILED METHOD

The need for operating rooms in a hospital planning area shall be determined using the following method:

Existing Capacity:

- (1) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is 94,250 minutes. This is derived from scheduling 44 hours per week, 51 weeks per year (allowing for five week day holidays), a 15 percent loss for preparation and clean-up time, and 15 percent time loss to allow scheduling flexibility. The resulting 70 percent productive time is comparable to the Hospital Commission's definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed. HSA policies may vary the desired scheduled time to fit urban and rural areas.
- (2) Assume the annual capacity of one operating room dedicated to ambulatory surgery is 68,850 minutes. The derivation is the same as #1 except for 25 percent loss for prep/clean-up time and scheduling is for a 37.5-hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see #7). Where survey data are unavailable, assume 50 minutes per outpatient surgery, resulting in a capacity for 1,377 outpatient surgeries per room per year.
- (3) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.
- (4) Calculate the total annual capacity (in number of minutes) of the remaining operating rooms in the area, including dedicated specialized rooms except for 24-hour dedicated emergency operating rooms. Exclude cystoscopic and other special purpose rooms.

Future Need:

- (5) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the target year. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and adjusted for trends in surgeries per capita.

- (6) Subtract the capacity of dedicated outpatient operating rooms (#3) from the forecasted number of outpatient surgeries. The difference continues into the calculation of #8.
- (7) Determine the average time per inpatient and outpatient surgery from hospital planning area survey data. Where survey data are unavailable, assume 100 minutes per inpatient and 50 minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."
- (8) Calculate the sum of inpatient and remaining outpatient (from #6) operating room time needed in the target year.

Difference:

- (9) If #8 is less than #4, divide their difference by 94,250 minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.
- (10) If #8 is greater than #4, subtract #4 from the inpatient component of #8 and divide by 94,250 minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of #8 by 68,850 to obtain the area's shortage of dedicated outpatient operating rooms.
- (11) The percentage utilization of existing surgery suites can be calculated by dividing their annual billing minutes reported to the Hospital Commission by their annual capacity, adjusting for dedicated outpatient operating rooms.

EXAMPLE 1:

OPERATING ROOM NEEDS DETERMINATION METHOD

Example of Urban Hospital Planning Area (Central King) Using All Assumptions In Method Except Average Time Per Inpatient Surgery In Step 7

Discussion Of Outcome With Alternative Scheduling Times

Step 1

94,250 minutes per year = capacity of one inpatient operating room

Step 2

68,850 minutes per year or 1,377 surgeries per year = capacity of one dedicated outpatient operating room.

Step 3

10 dedicated outpatient rooms x 1377 = 13,770 capacity for outpatient surgeries.

Step 4

68 inpatient rooms x 94,250 = 6,409,000 minutes is capacity for inpatient surgeries.

Inventory derived by:

- 58 non-dedicated mixed rooms (inpatient & outpatient)
- 6 dedicated coronary OR
- 4 with approval for mixed use
- 68 rooms

Not counted in inventory:

- 1 24-hour emergency operating room at Harborview
- 7 unused for OR but could be made available with minimum capital expenditure
- 1 gastroenterology suite
- 2 special interventional radiology rooms
- etc.

Step 5

1986 forecast using linear regression of King County surgeries Central King Hospital Planning Area as a percentage of this, trend in Central King outpatient surgeries.

By 1986: 21,266 outpatient surgeries (32% of total)
45,190 inpatient surgeries

Step 6

21,266 forecasted outpatient surgeries - 13,770 existing capacity = 7,496 deficit

Step 7

146.5 minutes per inpatient surgery
50 minutes per outpatient surgery

Step 8

45,190 inpatient surgeries x 146.6 minutes = 6,620,335 minutes needed by 1986
7,496 deficit outpatient surgeries x 50 minutes = 374,800 minutes needed by 1986

Step 9

Step 8 is greater than Step 4. There is a deficit.

Step 10

6,620,335 minutes - 6,409,000 = 211,335 minutes + 94,250 = 2 inpatient operating rooms needed at 85% utilization.

374,800 minutes : 68,850 = 5.4 dedicated outpatient operating rooms needed at 85% utilization by 1986

DISCUSSION

Applying the method to the Central King Hospital Planning Area shows a deficit of 2 inpatient and 5.4 outpatient operating rooms. However, because the Central King hospitals schedule their operating rooms for use an average of 45.8 hours per week (instead of 44), each room has the productivity of 98,104 minutes. This eliminates the deficit of inpatient operating rooms and reduces the need for outpatient operating rooms to 4.7. There would be no deficit if the policy were to include in the inventory those operating rooms no longer used for surgery but which could meet licensing codes with a small capital expenditure.

EXAMPLE #2:

OPERATING ROOM NEEDS DETERMINATION METHOD

Example Of Use Of Operating Room Planning Method
For Rural Hospital Planning Area, With Discussion

Steps 1 & 2

Assume that there is a policy that all operating rooms in a rural hospital should be scheduled for use a minimum of 7.5 hours a day, five days a week, 51 weeks a year. Taking into account the small number of operating rooms in rural hospitals and allowing for scheduling flexibility, the policy is that 70 percent is an optimum utilization rate. In other words, no operating rooms are needed in a rural planning area where the average utilization rate is under 70 percent of the minimum scheduled time.

The minimum productivity of one room would be 80,325 minutes, including preparation and clean-up time. This is not comparable to the Hospital Commission's "billing minutes" which do not include preparation and clean-up time.

(7.5 hrs. x 5 days x 51 wks x 60 minutes x .70% = 80,325 minutes/yr)

Step 3

There are no dedicated outpatient operating rooms in the rural hospital.

Step 4

There are two operating rooms in this rural hospital. Both are used for inpatient and outpatient surgery and the outpatient surgery includes cystoscopic procedures which the hospital counts as surgical procedures in its reporting system. The hospital's surgical capacity is 160,650 minutes per year. (2 x 80,325)

Step 5

We observe the number of surgeries performed in the hospital over the past five years has been between 560 and 570, the population has remained stable, and we anticipate no more than 570 surgeries in 1990. Of these, about 40 percent have been outpatient surgeries and this proportion has remained stable. Thus we forecast 342 inpatient and 228 outpatient surgeries by 1990.

Step 6

There are no dedicated outpatient operating rooms.

Step 7

A survey of the hospital showed inpatient surgery required 150 minutes (120 for actual surgery + 30 for prep. & clean-up). Outpatient surgery required 90 minutes (60 surgery + 30 prep. & clean-up).

Step 8

342 inpatient surgeries x 150 minutes = 51,300 minutes
228 outpatient surgeries x 90 minutes = 20,520
TOTAL = 71,820 minutes needed by 1990

Step 9

160,650 minutes capacity - 71,820 minutes needed by 1990 = 88,830 minutes excess capacity

88,830 + 80,325 = 1 surplus operating room

Step 10

Step 8 was not greater than step 4, therefore, no deficit.

Step 11

Not applicable since the annual capacity in step 4 includes preparation and clean-up time.

DISCUSSION

It is doubtful that an agency would go through these calculations since they would observe the 1984 utilization was only 31 percent.

1984 minutes include prep. and clean-up = 70,230 minutes
capacity at 100 percent utilization = 229,500

70,230 ÷ 229,500 = 31%

In this example, the preparation and clean-up time is accounted for in Steps 7 and 8 rather than in Steps 1 and 2.

3. NURSING HOME BED NEED PROJECTION METHOD*

a. SUMMARY

Methods for forecasting nursing home bed need were incorporated in the 1980 and 1982 State Health Plans. They were significantly revised in 1984, by amendment of the SHP, following exhaustive study by an advisory group including SHCC members, DSHS executives, directors of nursing home trade associations and representatives of the state's aging services network, including the State Council on Aging. The method was amended in May 1985 to clarify treatment of swing beds in rural hospitals, based on recommendations from another special advisory process set in motion by the SHCC. Finally, it was amended to its present text following a major advisory group similar to that of 1984.

These forecasts are used as the primary quantitative basis for reviewing nursing home projects. Bed needs for developmentally disabled persons are developed separately by DSHS, and DSHS has the option of defining other special populations (e.g., certain mentally ill persons) for separate need forecasting. The May 1985 amendment stipulated that small rural hospitals may operate up to five "swing beds," available for either acute care or nursing care as needed, which will not be counted as nursing home beds. The latest amendment set aside a statewide pool of beds for projects for retirement communities. Certain retirement communities also are exempt from the area need standard for nursing home beds.**

The method calls for preparation of statewide and area (essentially county) forecasts of nursing home bed need for a date three years in the future, for nursing home supply deliberation, plus a longer-range forecast also is prepared for general policy advisory purposes. The forecasts ordinarily are updated every three years, with the next update scheduled for the second half of 1989.

* This 1987 revision of the nursing home beds projection method takes effect upon completion of DSHS preliminary decisions on Certificate of Need nursing home applications under review as of January 21, 1987. These review decisions are based on the previous method adopted in 1984.

**In 1985-86, an advisory group jointly appointed by the SHCC and the State Council on Aging developed recommendations on how to deal with nursing home beds within continuing care retirement communities. Further changes in the State Health Plan's nursing home policies have been made to implement those recommendations. See Long Term Care Performance Standard 4.c.

The statewide forecast for 1990 is based on a desired 1990 "target ratio" of 53.7 nursing home beds per thousand people age 65 or older, initially selected in 1984 and reaffirmed in 1987. While this ratio represents a reduction in the bed-to-population ratio which prevailed in 1984 (60.2 beds/1,000), it allows for the addition of over 900 beds during the 1984-1987 period and will permit approval of hundreds of additional beds between 1987 and 1990.

First priority in allocating the beds to counties is to bring all counties up to at least the bottom end of a "reasonable nursing home bed ratio range" defined in the method. This range is derived based on the 26th and 58th percentile points in the actual rank-order distribution of ratios (current beds per 1,000 target-year residents age 75+) for the state's counties. Remaining beds are divided among counties which have bed supplies within the reasonable bed ratio range in proportion to the number of beds each county would need to reach the top end of that range.

The method also contains ground rules for fine-tuning of the baseline forecasts by the Area Agencies on Aging and the DSHS Aging and Adult Services Administration. These adjustments, involving mutually agreed upon shifts and pooling of counties into larger areas, cannot increase the statewide total.

b. DETAILED METHOD

(1) Assumptions

- (a) Nursing home bed need projections should reflect variations in nursing home use by different age groups of the population.
- (b) Nursing home beds should ordinarily be located reasonably close to the people they serve.
- (c) Equity in the availability and use of nursing home beds within the state should be increased by reducing the wide variation in ratios of nursing home beds to elderly population among areas of the state.
- (d) Areas of the state that are underbedded, adequately bedded and overbedded should be identified and treated differently in the bed need projection process.
- (e) The overall supply of beds in the state should represent a reasonable and appropriate state nursing home bed to elderly population ratio.

- (f) Most current nursing home use in the state reflects an appropriate need for formal services that should be met by nursing home beds or other services in the long term care continuum.
- (g) To be responsive to unique local circumstances, the nursing home bed need projection process should include local discretion in defining nursing home planning areas and bed allocations.

(2) General Provisions

- (a) Nursing home bed need projections shall be developed for a three year period ending in the projection year and for at least one subsequent longer range period. Three year projections shall be the basis for nursing home bed supply decisions.
- (b) Projections shall ordinarily be updated every three years during the last half of the third year. Bed need projections shall be revised if, in the determination of the State Health Coordinating Council or Department of Social and Health Services, significant nursing home bed supply problems have developed.
- (c) The planning areas used for nursing home baseline projections shall be Clark and Skamania Counties combined, Snohomish County (with addition of Camano Island), Island County (excluding Camano Island), and the other 36 individual counties in the state.
- (d) Prior to developing revised nursing home bed need projections, the Department of Social and Health Services, in consultation with the State Health Coordinating Council, the State Council on Aging and the State Nursing Home Advisory Council, shall review and affirm or modify projection method terms.
- (e) The Department of Social and Health Services shall obtain, evaluate and respond to public comments prior to adopting revisions of the projection method or nursing home bed need projections.
- (f) The bed needs of special population groups shall be projected separately, and necessary adjustments in base data shall be made to reflect these separate projections.
 - i. Special populations shall include the developmentally disabled, and may include a mental health population defined by the State Department of Social and Health Services.

- ii. In addition to any other provision of the State Health Plan applying to continuing care retirement communities (CCRCs), a special statewide pool of beds shall be designated within the projection method for which only proposals for nursing home beds operated by CCRCs for their members shall be eligible to apply. The State Health Plan's definition of CCRCs shall apply.
- iii. Any bed need projections for special populations shall be developed by the Department of Social and Health Services using projection methods developed for this purpose.
- (g) Demonstration of nursing home bed need through application of the bed projection method is not sufficient evidence, by itself, to warrant the addition of nursing home beds. Even if there is a projected need for beds in an area, approval may be denied based on developer's not meeting state quality of care survey standards or based on other non-quality related conditions defined in explicit, measureable terms in applicable health plans and state rules.
- (h) Swing beds shall be counted as hospital beds. They shall not be considered nursing home beds for the purpose of determining nursing home bed needs or available nursing home bed supply.

"Swing beds" are hospital beds, available to provide either acute care or long term care/nursing care services as required, which meet the conditions specified in Section B.4.b. of this volume of the State Health Plan.

(3) Specific Baseline Projection Method Steps and Provisions

NOTE: Figure 1 is a graphic presentation of these steps.

STEP 1: DETERMINE THE APPROPRIATE NUMBER OF ADDITIONAL BEDS IN THE STATE IN THE PROJECTION YEAR.

Step 1.a. Define a state target nursing home bed to elderly (65+) population ratio for a target year.* (This ratio uses population age 65+ in

*Note that the target year for the state target bed ratio may not be the same as the projection year for which nursing home bed needs are developed.

GRAPHIC DESCRIPTION OF WASHINGTON STATE NURSING HOME BED NEED PROJECTION METHOD

DETERMINE NEW BEDS AVAILABLE FOR ALLOCATION TO PLANNING AREAS

STEP 1

Define a state target bed ratio and multiply this by projected population to determine total state bed needs; then subtract current beds to determine need for additional beds.

STEP 2

Allocate a fixed number of beds as a statewide pool for continuing care retirement communities only.

STEP 5

Determine the number of additional beds remaining for allocation to nursing home planning areas.

STEP 6

Estimate the number of people who will need other long term care services as a result of demographic changes in light of the target bed ratio.

ALLOCATE TO PLANNING AREAS

A county will be **OVERBEDDED** if current beds are greater than the projected high bed need for the area.

HIGH BED NEED ESTIMATES
An area will be **ADJUSTEDLY UNDERBEDDED** if its current bed supply is between the projected low and high bed need for the area.

LOW BED NEED ESTIMATES
An area will be **UNDERBEDDED** if the current bed supply is less than low projected bed need for the area.

THIRD: Base line beds are allocated to overbedded areas only if there are enough new beds to bring all areas up to the high bed need ratio.

SECOND: Remaining available beds are allocated to adequately bedded areas in proportion to the number of beds each area needs to reach its high bed need estimate.

FIRST: Underbedded areas are allocated all beds needed to bring them up to their low bed need estimate.

DETERMINE UNDER-, ADEQUATELY AND OVERBEDDED PLANNING AREAS

STEP 3

Develop a statewide reasonable nursing home bed-to-population range by identifying a middle range among the ratios of beds to projected future population for individual planning areas.

STEP 4a

Multiply low and high ends of range by projected population to estimate low and high bed need for each nursing home planning area.

STEP 4b,c

Compare current beds to projected low and high bed need for each area to identify underbedded, adequately bedded and overbedded nursing home planning areas.

MAKE ADJUSTMENTS (PART D)

Develop any adjustments needed to "fine-tune" allocation of additional beds among nursing home planning areas (may not exceed state total bed need from Step 1).

the denominator because most comparative information from other states is in this form. Note that ratios with the age 75+ population as denominator are used for other purposes in this method.)

- (1) The state target bed ratio shall constitute the number of beds needed for the appropriate use of nursing home beds in the state. Such target ratio shall be developed considering:
 - (a) The national bed ratio and the bed ratios of other states judged to have reasonable and progressive long term care policies, and
 - (b) state policy goals for the allocation of scarce resources between nursing home beds and other institutional and community based services in the long term care continuum, and
 - (c) the effects on nursing home bed needs of new health systems developments, such as hospital diagnostic related group (DRG) reimbursement and other changes in incentives stemming from governmental and private payment systems for acute and long-term care, and
 - (d) progress being made in developing other long term care services for the population at risk of nursing home placement (see Step 6 below).
- (2) The state target bed ratio for 1990 shall be 53.7 nursing home beds per thousand people 65 years of age or older. The preliminary target for 1993 also shall be 53.7 beds per thousand people 65+, subject to review by the State Health Coordinating Council and DSHS following the 1989 legislative session.

Step 1.b. Determine the total number of appropriate beds in the state in the target year by multiplying the projected population 65+ in thousands by the state target bed ratio.

Step 1.c. Determine the total number of additional beds needed statewide in the target year by subtracting the current bed total from the total number of appropriate beds.

STEP 2: RESERVE A STATEWIDE POOL OF BEDS FOR CONTINUING CARE RETIREMENT COMMUNITIES.

Step 2.a. Determine a number of beds, not exceeding one-quarter of the total additional beds needed statewide (Step 1.c.), which shall be designated as a special statewide pool for applications from continuing care retirement communities (CCRCs) anywhere in the state requesting new or expanded nursing home capacity primarily for their members' use.

- (1) In determining the number of beds in the pool, the effect of other provisions of the State Health Plan regarding CCRCs should be considered.
- (2) For the period 1987 through 1990, 120 beds shall be set aside for this purpose.
- (3) The eligibility of an applicant to apply for the CCRC beds shall be governed by definitions in the State Health Plan and DSHS administrative rules.

Step 2.b. Subtract the beds reserved for CCRC applications from the statewide need for new nursing home beds (from Step 1.c.), and allocate the remainder among nursing home planning areas as indicated in Step 5.

Step 2.c. Any adjustments of the baseline bed need forecast which would reallocate beds into or out of the CCRC pool shall require approval of the SHCC. (See (4) below on adjustments.)

Step 2.d. Any CCRCs qualifying under CCRC Performance Standard B.4.c.(4) of this volume of the State Health Plan for consideration of nursing home projects outside of the bed need projection method shall be counted as follows in developing projections of need for other nursing home beds:

- (1) The beds of such CCRC nursing home units shall not be counted as available bed supply in determining net need for nursing home beds to meet general community needs.

- (2) The members of such CCRCs (that is, all residents of all areas of the community, including the nursing home but also independent living and supported care residential units) shall be subtracted from the population of the state and of the nursing home planning area where the CCRC is located for purposes of computing total and net nursing home bed need under the projection method.
 - (i) Where age-specific population figures are used in the method, the same age groups shall be used in data collected from CCRCs on their members.
 - (ii) The estimates of future population and ages used in approved regulatory proposals (under Certificate of Need law and any future CCRC consumer protection legislation) shall be used as estimates of projection year membership/ages.
- (3) The subtraction of beds and population of such CCRCs shall occur after the CCRC is approved as meeting all requirements for development.

Note that not all CCRCs qualify under Performance Standard B.4.c.(4). Other CCRCs may apply for nursing home beds from the statewide CCRC pool.

STEP 3: DETERMINE A STATEWIDE REASONABLE BED-TO-POPULATION RATIO RANGE.

- Step 3.a. Rank order from low to high the ratio of base-year nursing home beds per 1,000 projection year population age 75+ for the various nursing home planning areas. Determine the percentile, or cumulative percent, of each successive point in the rank order.
- Step 3.b. Define a statewide reasonable nursing home bed-to-population ratio range by identifying the low and high percentiles for the ends of the range.

- (1) The low end of the range ("low reasonable bed ratio") shall constitute reasonable nursing home bed availability in all areas of the state, and generally

shall be deemed the minimum level at which the public need for nursing home beds is met.

- (2) The high end of the range ("high reasonable bed ratio") shall be considered to represent a high level of nursing home bed availability in any area of the state, such that this ratio should not be exceeded without carefully weighing equity concerns.
- (3) The low and high ends of the statewide reasonable bed supply ratio range shall respectively be set at the 26th and the 58th percentiles.

STEP 4: DETERMINE THE AREAS OF THE STATE THAT WILL BE UNDERBEDDED, ADEQUATELY BEDDED AND OVERBEDDED IN THE PROJECTION YEAR.

Step 4.a. Develop low and high bed need estimates for each area by multiplying the low and high statewide reasonable bed ratio from Step 3.b. by that area's projected population age 75+ in thousands.

Step 4.b. Determine the current number of beds in each area.

- (1) The current bed count shall consist of licensed nursing home beds, beds in hospital long-term care units, and as yet unlicensed beds for which state approval has been granted. (See Definition (6)(d).)
- (2) The current bed count shall be updated before each nursing home project review cycle.

Step 4.c. Compare the current beds in each area to projected low and high bed need estimates from Step 4.a. to identify areas that will be underbedded, adequately bedded and overbedded by the projection year.

- (1) An area shall be deemed underbedded if the current supply of beds is less than the low nursing home bed need estimate for the area.

- (2) An area shall be deemed adequately bedded if the current supply of beds is less than the high bed need estimate, but greater than the low bed need estimate for the area.
- (3) An area shall be deemed overbedded if the current supply of beds is greater than the high bed need estimate for the area.

STEP 5: DETERMINE THE APPROPRIATE NUMBER OF BEDS IN EACH NURSING HOME PLANNING AREA IN THE PROJECTION YEAR.

Note: Figure 2 is a graphic presentation of this bed allocation process.

Step 5.a. Determine the number of beds to be allocated to each underbedded area by subtracting current beds from each area's low bed need estimate.

- (1) The number of beds needed to bring underbedded areas up to their low bed need estimate shall be allocated to these areas.

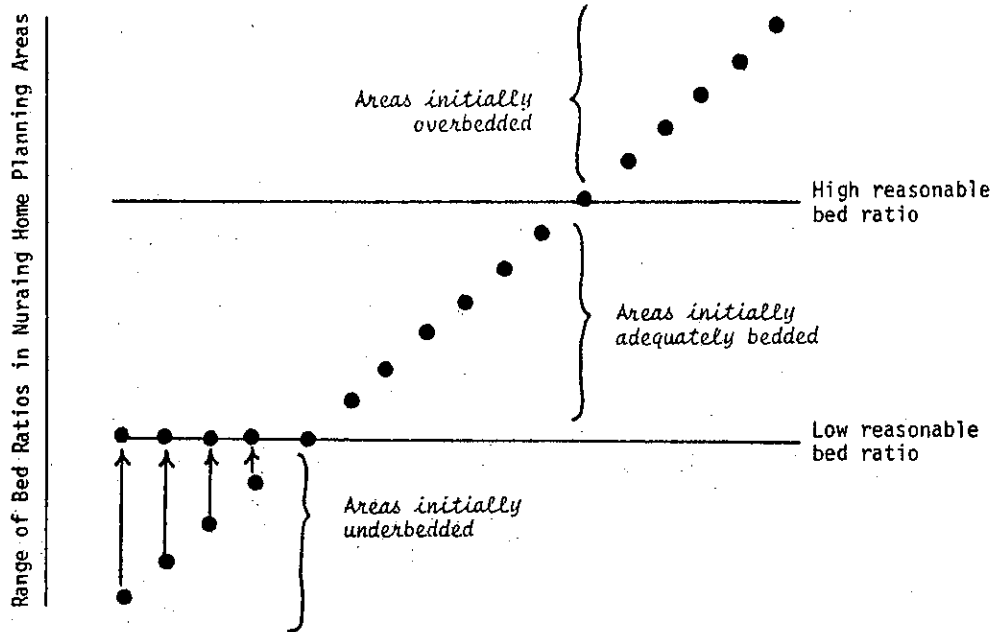
Step 5.b. Allocate remaining beds available for underbedded and adequately bedded areas.

- (1) Determine the remaining number of beds available for assignment to underbedded and adequately bedded areas by subtracting the beds apportioned to underbedded areas (in Step 5.a.) from the state's bed allocation (net of CCRC pool beds) for the projection year.
- (2) Determine each area's total beds thus far in the allocation process, equal to current bed supply (from Step 4.b.) plus any beds assigned to the area (if underbedded) in Step 5.a.
- (3) Determine how many more beds would need to be assigned to each area to bring it up to the high reasonable bed ratio in the projection year by subtracting total beds to this point in the calculation (Step 5.b.(2)) from the area's high bed need estimate (Step 4.c.).

FIGURE 2

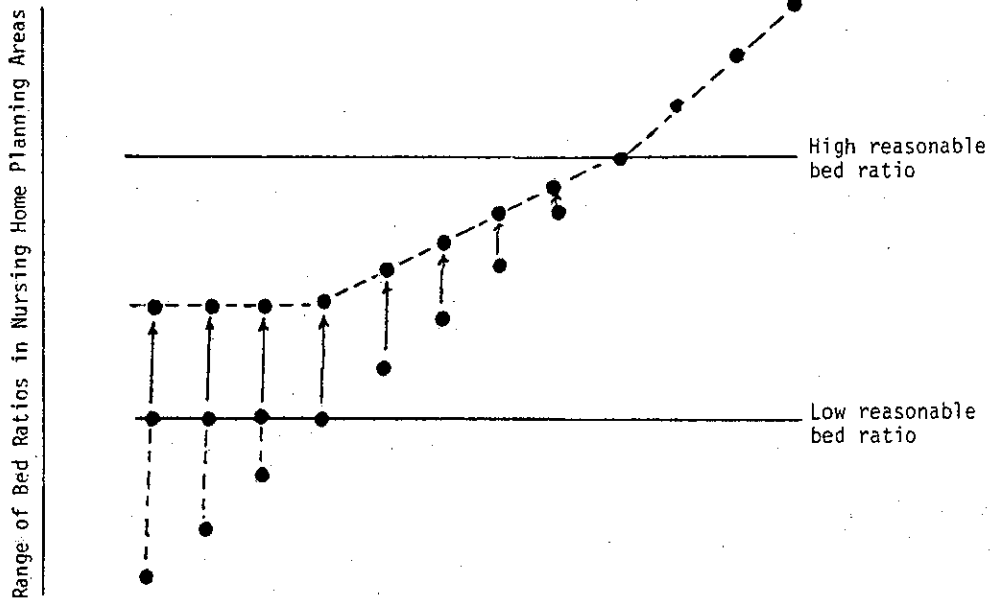
GRAPHIC REPRESENTATION OF ALLOCATION OF NURSING HOME BEDS AMONG AREAS IN THE BASELINE PROJECTION

Step 5.a.



Step 5.a. brings all areas to the low bed ratio.

Step 5.b.



Step 5.b. brings all areas not "overbedded" the same fraction of the way to the high bed ratio. For this step, "underbedded" areas start at the low bed ratio (to which Step 5.a. raised them).

- (4) Divide the number of beds available for assignment (Step 5.b.(1)) by the total statewide bed requirement to bring all areas up to the high reasonable bed ratio (sum of individual area's needs from 5.b.(3)) to determine what proportion of that total bed requirement can be met.
- (5) Assign each underbedded and adequately bedded area its proportional share of the remaining beds, equal to the proportion from Step 5.b.(4) times the area's need for additional beds to reach the high ratio (Step 5.b.(3)).

STEP 6: ESTIMATE FOR EACH AREA AGENCY ON AGING'S PLANNING AND SERVICE AREA (PSA) FOR THE PROJECTION YEAR THE NUMBER OF ADDITIONAL PEOPLE WHO WILL NEED OTHER LONG TERM CARE SERVICES AS A RESULT OF THE STATE TARGET BED RATIO.

- Step 6.a. If age-specific use data are available, estimate base year statewide nursing home use rates for each age group.
- Step 6.b. Estimate the patient days for the population at risk of nursing home placement in each age group in each PSA by multiplying the base year statewide use rate for each age group by that age group's projected population in thousands in the PSA.
- Step 6.c. Estimate the average daily number of at risk individuals in the area by summing patient days across age groups, and dividing the result by 365.
- Step 6.d. Estimate the number of nursing home beds that would be needed for the at risk population by dividing the average daily number of at risk individuals by the nursing home occupancy factor, which shall be 95 percent.
- Step 6.e. Estimate the number of additional people who will need other long-term care services by subtracting the number of beds allowed each PSA from the bed need estimate from Step 6.d.

(4) Adjustment of Baseline Nursing Home Need Projections

- (a) "Adjustments" (also called "bed reallocations") are authorized changes in the baseline nursing home bed need projections prepared under the step-by-step method above. Adjustments are shifts among planning areas of additional (incremental) beds allowed under the method's statewide total. The purpose of the adjustments is to "fine-tune" the more mechanical baseline, through a legitimate public process, without losing the positive features of the baseline calculation, including its definite statewide total and its guidance for improving geographic equity in bed distribution.
- (b) In the absence of a complete set of SHCC-designated Regional Health Councils* which can perform adjustments as part of comprehensive health planning activities, nursing home bed need adjustments shall be developed by Area Agencies on Aging subject to DSHS approval, under the following process:
- i. Area Agencies should develop any adjustments to the baseline bed need forecasts which they consider appropriate, following public input (see (f) below), in the form of bed reallocation plans which identify the new proposed distribution of beds and the changes from the baseline (or last adjustment) which it represents.
 - ii. Any shift of beds involving geographic areas represented by different Area Agencies must be supported by both Area Agencies.
 - iii. All bed need adjustments must be approved by the DSHS Aging and Adult Services Administration. The requirements in (f) must be met.
 - iv. No adjustment shall be approved which has the effect of exceeding the statewide total bed need under the baseline method.

In the event that funding for comprehensive Regional Health Councils is restored, the SHCC should immediately reevaluate what agencies should develop the adjustments.

*The role of Regional Health Councils, as established in state law, was filled by four Health Systems Agencies which lost their federal funding as of November 1986.

- (c) As part of the adjustment process, two or more nursing home planning areas for which baseline projections have been developed may be grouped into a single larger area. Where this is approved, the bed need for the entire pooled area shall be considered as a whole in reviewing specific project applications.
- (d) In developing adjustments, the following issues, among others, should be considered:
 - i. Patterns of movement of nursing home patients into and out of the area(s), including evidence from any available patient origin data.
 - ii. Any discrepancies between local forecasts of age-specific populations and the official Office of Financial Management population forecasts used in the baseline.
 - iii. The relative difficulty of arranging placement in different areas for patients needing nursing home admission.
 - iv. The relative availability of long-term care services which can offset some needs for nursing home supply.
 - v. Whether any overbedded areas are being awarded additional beds.
- (e) Adjustments are part of the planning process and must be completed and approved prior to the start of the regulatory reviews which will use the adjusted numbers. DSHS shall identify a specific date prior to the start of each year's concurrent review(s) of nursing home project applications which will be the deadline for approval of all adjustments for use during that cycle of reviews.
- (f) DSHS requirements for approval of bed reallocations plans (adjustments) shall include all the following:
 - i. An assurance, signed by the Area Agency director(s) concerned, that the bed reallocation plan was developed in a way which met the following process conditions:
 - a. The draft reallocation plan was distributed for review and comment by affected groups including nursing homes or nursing home associations, hospitals or hospital

associations, Regional Health Councils designated by the State Health Coordinating Council, and other local aging service providers and aging groups.

- b. The review and comment period for the reallocation plan was at least 30 days.
 - c. At least one public hearing was held on the bed reallocation plan following completion of Area Agency staff deliberations.
 - d. Subsequent to the review and comment period and hearing, the Area Agency's governing board, or a designated committee, systematically considered all comments and weighed them against each other, in developing the final bed reallocation plan. A written explanation of disposition of comments is available upon request.
- ii. The bed reallocation plan must conform to the State Nursing Home Bed Need Projection Method, including its statewide total bed need.
- (g) The baseline projection shall be in effect in all areas unless replaced by approved reallocations.
- (5) Data Sources and Methods
- (a) Patient day data used in developing projections shall be those reported by nursing homes and verified by the Aging and Adult Services Administration.
 - (b) Total area patient days shall be determined by allocating patients back to their area of origin on the basis of the latest available patient origin data, when such data are available on a statewide basis.
 - (c) Patient age data used in developing use rate estimates shall be that collected by the Aging and Adult Services Administration.
 - (d) The source of population estimates and projections shall be official publications of the State Office of Financial Management.

(6) Definitions

- (a) "Adjustments" mean approved shifts of nursing home beds among planning areas, developed as indicated in (4) above.
- (b) "Base Year" means the year in which projections are developed, or, in the case of data, the most recent information then available.
- (c) "Baseline projection" means the projection of need for nursing home beds, statewide and in each nursing home planning area, which is generated using the step-by-step method described.
- (d) "Current bed count" means the total number of beds, at any point in time, which are considered available for public use (Step 4.b.). Some clarifications:
- "Distinct-part" long-term care units in hospitals are counted, even though they are covered under the hospital's license.
 - Nursing home or long-term care beds in an HMO-operated hospital are counted.
 - Swing beds are not counted.
 - Nursing-level beds in state and federal institutions (including Veterans Administration Medical Centers and State Veteran Homes) do not have state licenses and are not counted.
 - Licensed nursing home beds which are operated as specialized developmental disabilities facilities under federal ICF/MR rules (Intermediate Care Facilities for Persons with Mental Retardation and Related Disabilities) are not counted as available to the general population in need of nursing home care. (However, the same facility might be counted if it ceased to operate as an ICF/MR.)
- (e) "Projection year" means the year which marks the endpoint of the three-year projection period.
- (f) "Target year" means the year targeted for attainment of a specified ratio of nursing home beds to population identified as a health planning objective. (Step 1.a.)

4. HOSPITAL BED NEED FORECASTING METHOD

a. INTRODUCTION

This document is a revision of the "Guide to the Use of the Washington State Hospital Bed Projection Methodology," prepared in 1979. The former version of the Guide was adopted by the State Health Coordinating Council (SHCC) in its entirety as part of the 1980 State Health Plan (SHP). It later was incorporated by reference in the 1982 SHP.

This version differs from the original in three ways:

- 1) It contains several substantive policy changes, including trend-adjustment of the hospital utilization rate used in forecasting.
- 2) It is different in format and includes some editorial improvements. For example, the order of presentation has been changed and the formerly separate psychiatric bed need forecasts have been brought into the same document with less duplication.
- 3) Certain step-by-step calculation methods and examples which were part of the 1979 Guide will be made available in comparable detail but will not be part of the State Health Plan in order to permit timely minor revisions (e.g., improved data sources).

b. SUMMARY

This plan consolidates two earlier hospital forecasting documents, maintaining a similar general framework and method but changing a number of particulars. The general hospital bed need forecasting method and related principles were initially adopted by the SHCC in 1979 in the "Guide to the Washington State Hospital Bed Projection Methodology." This was printed in the 1980 SHP and incorporated by reference in the 1982 SHP. A separate document, the "Short-Term Hospital Psychiatric Bed Projection Method," was adopted by the SHCC in 1981 and included in the 1982 SHP. While consistent in general principles with the overall forecasting method, this method contained elements specific to psychiatric services.

The hospital bed need forecasting method is the primary quantitative basis for review of hospital projects which fall under the Certificate of Need law. Review is required for all new hospital beds and for some changes in use of existing beds (depending on what new services are proposed and how large a capital expenditure is entailed). Forecasts clearly address the issue of total bed need for each geographic area. However some specific services (uses of beds) are reviewable, but not specifically forecast as a subtotal of bed need. In such cases, other methods, not formally adopted in the SHP, must be used as part of the assessment of public need for the beds.

The methods in this plan produce two forecasts, one for short-stay psychiatric bed needs in nongovernmental hospitals and one for non-psychiatric bed needs in all hospitals within the state. The non-psychiatric forecasts are prepared for the entire state, the health planning regions and for each of the geographic hospital planning areas. The psychiatric forecasts are prepared for the entire state, each health planning region and each county (or multi-county) mental health planning area.

It is possible for hospitals, as corporate entities, to establish services which fall outside the scope of the forecasts - for example, a hospital can open a long-term care wing which is counted and licensed as a nursing home - but in general, any "bedded service" of a hospital is within this scope unless clearly defined to the contrary in the State Health Plan. To give a few examples, obstetric beds, adult rehabilitation service beds, alcoholism treatment beds and rural hospital swing beds all are part of the nonpsychiatric bed need total.

The nonpsychiatric forecast method starts with information on the use of hospital services in a "base year." Hospital use rates are calculated for the residents of each hospital planning area. These rates are stated in patient-days per 1,000 population for two age groups: 0-64 and 65 or older. Long-term trends in the hospital use rate (currently downward) are assumed to continue; therefore, each hospital planning area's use rates are adjusted in proportion to the rate of change in use rates over the past ten years. The statewide or health planning region trend is used, whichever shows the slower change. (An alternate adjustment is used in a few HPAs where increasing reliance on health maintenance organizations complicates trend analysis.)

The trend-adjusted hospital use rates are applied to the projected future ("target year") population of each hospital planning area. This calculation produces a forecast of the number of patient-days of hospital care which the residents of each hospital planning area will use in the target year. However, these days of care will occur in a variety of hospitals, not only those hospitals located in the HPA where the individuals live. Expected patient-days of hospital care are redistributed to the planning areas where services are likely to be provided. In general, it is assumed that the same patterns of patient movement occurring in the base year will remain stable through the target year.

Finally, for each planning area where services will be provided, the forecasted number of patient days is converted to a forecasted need for hospital beds. Patient-days are divided by an occupancy standard calculated for each HPA based on the mixture of different hospital sizes in the area.

The psychiatric method really involves combining two different forecasts. The statewide forecast of short-stay psychiatric bed need is determined by applying a desired bed-to-population ratio to the expected population in the target year. This ratio, 13 beds per 100,000 residents, is a

normative standard, chosen by the SHCC in consultation with the state Mental Health Division. The selection of this ratio is related to a policy decision to encourage development of residential (nonhospital) short-stay psychiatric programs.

The other component of the psychiatric bed method is a demand projection for each health service area and county. It is derived using a method analogous to the nonpsychiatric forecast method, except that there is no attempt to adjust use rates in relation to trends. The results of the demand projection are adjusted to match the statewide (target-ratio) forecast. This way the statewide total of beds will observe the desired ratio, while the distribution of beds throughout the state will agree with observed patterns of service use and patient movement.

Both the psychiatric and nonpsychiatric methods result in baseline forecasts of needed beds in a future target year. These baseline figures can be adjusted subject to guidelines in the forecasting method document.

The hospital bed need forecasting method, in its entirety, addresses many detailed issues which cannot be adequately summarized here. A glance at the detailed contents will help the reader to identify areas of special interest.

This plan includes a considerable volume of changes in the hospital forecasting methods guide. Many of the changes are editorial and organizational. Some of the more important substantive changes are:

- Trend-adjustment of the hospital use rates used in nonpsychiatric forecasts (previously, use rates were assumed to remain constant from the base year to the target year);
- Use of a normative bed-to-population ratio in psychiatric forecasts (previously, the base year use rate was applied to target year population);
- Definite separation of the psychiatric forecast (previously unclear), and clarification of the relationship between overall forecasts and service- or age-specific forecasts (previously unstated and ambiguous);
- Statewide use of the same occupancy standards, related to hospital size (previously, no standards were stated for use in rural areas);
- Age-specific use rates for at least two age groups, 0-64 and 65+ (previously, a single use rate was computed for residents of all ages and a separate adjustment was carried out in forecasting to estimate, based on national data, the effect of changes in the proportions of residents over and under 65).

c. CRITERIA AND STANDARDS FOR EVALUATION AND USE OF METHOD

(1) Definitions

Should: The use of the term "should" in this document implies that there is an expectation and a probability that the particular criterion or standard will be carried out.

Shall connotes an absolute directive and an expectation that a standard definitely will be carried out.

Base year: The most recent year about which data is collected as the basis for a set of forecasts.

Target year: The future year for which patient days, populations and bed needs are forecasted.

Future bed capacity: Beds which will or could be available in the target year. See Hospital Forecasting Criterion 12.

Net bed need or unmet bed need: Forecasted bed need minus future bed capacity, for some target year.

Note: Additional relevant definitions are found in the Glossary to this plan.

(2) General Principles:

1. Forecasting involves both interpretation of trends and the application of judgment concerning the continuation or alteration of trends. All forecasts include such judgments.
2. Forecasting of need for services is not necessarily identical to forecasting of demand. Any need forecast which is not based on predicted demand must be based upon explicit normative statements about the appropriate level of a resource, which have been formally adopted by the health planning system.

(Explanation: The forecasting method for short-stay psychiatric hospital bed need incorporates elements of normative need. This principle establishes a policy base.)

3. In forecasting future use of hospital services, a clear distinction has to be made between what is, what will be, and what should be. Forecasts of what will be can be changed to reflect what should be only if there is an implementation strategy which realistically can accomplish that change.
4. Forecasts are not in themselves methods for eliminating shortages or surpluses of hospital services and facilities. Forecasts are evidence which can help in deciding whether shortages or surpluses

may develop. Given some evidence about the future, the health planning system has to decide whether it makes sense to try to change a potential surplus or shortage, has to decide whether it has the ability through some implementation strategy (e.g., the Certificate of Need process) to do so, and has to decide what type and degree of change it wants to accomplish.

5. The health planning system in the State of Washington does not have the ability to eliminate existing surpluses of capacity.
6. Hospitals within the state are encouraged to use this methodology. Of course, any hospital or other group within the state may challenge the methodology adopted by the planning system or the results of applying that methodology. Objections to forecasts or the forecasting methods should be stated as early in the planning process as possible, during the adjustment process at the latest.
7. Hospitals and the health planning system should jointly conduct the planning of hospital services in consultation with the Washington State Hospital Commission.
8. Hospitals are responsible for implementing specific services.
9. Starting in 1986 (using 1985 base year data)*, bed need forecasts should be prepared and adjusted at least every three years. The SHCC should decide annually if it is necessary to develop new forecasts in less than three years. This should be done only if it is determined that changes have occurred which would have a significant statewide impact on the forecasts.

As part of its decision on the need for new forecasts, the SHCC should consider the percent deviation (plus or minus) from the old forecast which would result from using more recent data on population, use rates, etc. The new data must be for a full year (same quarters as used in computing the original forecast) - i.e., less than a year of data should be considered insufficient to justify a new forecast.

If a new forecast is developed under this provision less than three years after the last full forecast/adjustment cycle, no changes should be made in the negotiated adjustment assumptions from the last full cycle.

*A baseline bed need forecast, which will not go through the adjustment process except for continuation of previously negotiated adjustment assumptions, will be prepared in 1985 or early 1986 using 1983 base year data. A 30-day period will be allowed after distribution of the baseline numbers for correction of any errors.

(3) Criteria and Standards

1. CRITERION: Planning for People

Hospital services and beds should be planned according to the needs of specific groups of people.

STANDARDS:

- a. It is not appropriate to assume that the people within the areas use or should use the hospitals within the area, nor should they assume that hospitals in the area serve only the people in the area.
- b. Hospital planning should be based on sound evidence about the actual patterns of use by the public. Since the public is free to choose physicians and hospitals regardless of location, plans for hospital services cannot assume that the people within a planning area use or should use only the hospitals within the area, nor should they assume that the hospitals in the area serve only the people in their area.
- c. It is not necessary to assume that patterns of use, especially improper patterns of use, or lack of use, will continue. However, plans based on a change in forecasted use patterns should thoroughly document either why the patterns are expected to change or how the patterns will be made to change. In a case where a change in use patterns is assumed, both patient admission rates and lengths of stay should be examined.
- d. To the degree that is practical, specific groups of people which use particular or special services not covered by service-specific or age-specific forecasts should have their need for beds calculated as a separate subset within overall forecasts (see Criterion 9).
- e. Medical care organizations which serve a separate group of people, such as a Health Maintenance Organization or the Veterans Administration, should not assume that all of the needs of their people have to be met by separate services and facilities owned or controlled by those organizations.

2. CRITERION: Need for Multiple Criteria

Hospital bed need forecasts are only one aspect of planning hospital services for specific groups of people. Bed need forecasts by themselves should not be the only criterion used to decide whether a specific group of people or a specific institution should develop additional beds, services, or facilities. Even where the total bed supply serving a group of people or a planning area is adequate, it may be appropriate to allow an individual institution to expand.

STANDARDS:

- a. The fact that a particular hospital has served a particular group of people in the past does not mean that the hospital will or should serve those people in the future. For a variety of reasons (e.g., the desire to develop a Health Maintenance Organization), the people may want to change the pattern of use.
- b. Under certain conditions, institutions may be allowed to expand even though the bed need forecasts indicate that there are underutilized facilities in the area. The conditions might include the following:
 - . the proposed development would significantly improve the accessibility or acceptability of services for under-served groups; or
 - . the proposed development would allow expansion or maintenance of an institution which has staff who have greater training or skill, or which has a wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or
 - . the proposed development would allow expansion of a crowded institution which has good cost, efficiency, or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations or lower productivity.

In such cases, the benefits of expansion are judged to outweigh the potential costs of possible additional surplus.

- c. Under certain conditions, existing institutions may be denied approval to expand facilities, beds, and inpatient services even though all facilities in an area are fully utilized. Some of these conditions might include the following:
 - . facilities in the area are not making maximum use of techniques and services which can increase the efficiency of the facilities; or
 - . project is not financially feasible, or
 - . it is determined that it is in the community's interest to develop an alternative type of service or facility rather than expand existing institutions; or
 - . use rates in the area are judged excessive.

In such cases, the benefits of denying development are judged to outweigh potential costs of possible service shortage.

- d. The mere fact that a group of people has an unmet need for services or facilities does not mean that any particular hospital has a right to try to meet those needs. Hospitals, DSHS and State Health Coordinating Council should develop criteria, standards, and plans to guide decisions about which hospitals should serve unmet needs.

(Explanation: It is recognized that hospital bed need forecasting should not be the only criterion against which a project is evaluated. The financial feasibility, the proposed staffing, and the potential for cost containment of the project as well as those conditions listed above should all be taken into consideration.)

In planning to meet the needs a group of people may have for services or facilities, consideration should be given to not only allopathic services, but to the special needs and circumstances of osteopathic hospitals and non-allopathic services. No forms of health care should be discriminated against during the development of plans for needed services.)

3. CRITERION: Age/Sex Categories

For the group of people being considered, patient day forecasts should, to the extent to which it is practical and to which data is available, be calculated separately for those age and sex groups which have significantly different use rates.

STANDARD:

- a. To the extent possible, patient day forecasts should be calculated separately or adjusted for the following:
 - . people age 0 through 14
 - . people age 15 through 64 (or people age 15 through 44 and 45 through 64).
 - . people age 65 or more
 - . women of childbearing age (age 15 through 44)
 - . for psychiatric services, ages 0-17, 18-64 and 65 or more.

(Explanation: Currently the age groups 0-64 are used in all forecasting. Additionally, the age groups 0-17 and 18-64 are differentiated in short-stay psychiatric forecasting, because psychiatric treatment programs for children and adolescents very often are separate from programs serving adults.)

4. CRITERION: Target Date

Because medical terminology and standards of practice change rapidly, because medical facilities and equipment become obsolete quickly, because communities and their goals change, and because, in general, long-range forecasts are unreliable, forecasts should go only as far into the future as needed to answer the type of policy question being asked.

STANDARDS:

- a. For most purposes, bed projections should not be made for more than seven years into the future. Each time forecasts are revised, a forecast target date should be agreed upon by the health planning system.

(Explanation: In the 1985 forecasting cycle, the target year is 1990.)

- b. For major policy questions, such as whether a community should have a hospital or additional hospitals, long-range forecasts should be prepared. For long-range forecasts, the health planning system may determine that a different method is preferable to the one used for short-term purposes. Any alternative method should be reviewed publicly and be adopted by the SHCC.

5. CRITERION: Population Forecasts

The most accurate population forecasts available at the time of forecasting should be used.

STANDARDS:

- a. Where future growth or decline of population may change significantly, ranges of projected population should be used. The health planning system should specify the most probable population estimate and should use it as the basis for bed forecasts.
- b. Population forecasts prepared by the Office of Financial Management (OFM) of the State of Washington, including age and sex-specific forecasts, should be the basic forecasts used. Other local forecasts may be used to deal with small areas, provided that totals equal the OFM forecast at the statewide and county levels.
- c. Hospitals may employ other more local forecasts (e.g., those produced by the councils of governments), if accurate, for specific service areas and negotiate with SHCC/DSHS in the development of forecasts for use in developing the hospitals' own plans. Use of population forecasts should be resolved during the adjustment process.

- d. If OFM issues updated county-specific population forecasts between hospital forecasting cycles, and the health planning system determines that these forecasts differ significantly from the baseline population forecasts used in the most recent bed need forecasts, revised hospital forecasts should be produced using the new population figures even if a new baseline forecast would not be necessary under General Principle 9. All other hospital forecasting data and assumptions (e.g., patient origin, market share, use rates) shall be unchanged. The revised population figures (only) shall be subject to adjustment.

6. CRITERION: Hospital Utilization Rates

The health planning system should determine the most appropriate future utilization rates* for use in bed need forecasting. A range of rates may be identified, if appropriate, so long as there is no ambiguity about what rates will be used.

STANDARDS:

- a. Use rates should be forecasted for each of the major services (adult medical/surgical, pediatrics, and obstetrics) and for other specific services as identified in Hospital Forecasting Criterion 10. It is assumed that the base year's utilization rate will be projected forward to the target date, subject to adjustment for age (all services), changes in fertility rates and obstetric use patterns (obstetrics), and to anticipated changes in policy.

However, a service's use rates may be forecasted to be higher or lower than in the base year if a specific analysis of past trends in admission and lengths of stay is conducted and the health planning system or hospital documents reasons for anticipated continuation in or change to such past trends.

- b. Based on analysis of annual data, for trends in patient days, admissions and lengths of stay, the forecasted use rates for the target year shall be determined by adjusting the base year non-psychiatric use rate upward or downward to reflect the slope of the ten-year use rate trend line. The trend for statewide or regional changes in use rate shall be used, whichever trend is

*The utilization rate is the number of hospital patient days per 1000 population.

The adult medical/surgical utilization rate is the number of medical/surgical patient days per 1000 population age 15 and older.

The pediatric utilization rate is the number of pediatric patient days per 1000 population ages 0 through 14.

The obstetric utilization rate is the number of obstetric patient days per 1,000 female population ages 15 through 44.

less pronounced (that is, whichever trend would result in the least change from the base-year use rates). This adjustment shall be carried out only if it is judged that the use rate trend will continue in the same direction.

(Explanation: A different procedure is used in certain hospital planning areas with high HMO enrollment and HMO-owned/operated hospital facilities. See step-by-step method for overall (non-psychiatric) forecasts, in this Guide.)

STANDARD

- c. No planning area's utilization rate for non-psychiatric (medical/surgical/obstetric/pediatric) services shall be forecast lower than the statewide age-adjusted use rate for HMO enrollees, unless that area's actual base-year use rate was that low.

(Explanation: The procedures for the latest forecasting cycle specify that no hospital planning area shall have a forecasted 1990 use rate less than its actual 1983 use rate or the 1983 statewide hospital use rate for HMO enrollees, whichever is lower. This check is applied on an age-specific basis.)

Note: It has been shown that there is some substitution effect between hospital and nursing home beds. Impacts should be carefully monitored in planning areas where the supply of one or both types of beds is being effectively constrained by the policies in this Plan.

7. CRITERION: Use of Planning Areas

Planning areas are tools for dividing the population of a large area into convenient geographic units practical for planning.

STANDARDS:

- a. Planning area boundaries should be defined by the health planning system and reviewed by provider and consumer groups.
- b. Planning areas should not, to the extent practical, divide communities which share a common set of interests. However, there are groups of people who make use of special health care services for whom it is sometimes not possible to create separate exclusive small geographic planning areas, such as Health Maintenance Organization enrollees, veterans, members of the armed forces, etc.
- c. Planning area boundaries should be drawn so that it is possible to make reasonable population estimates and projections. This means that the boundaries should follow census tract, county, and state boundaries.

- d. Planning areas may contain a number of hospitals, or no hospitals at all. A planning area which does contain one or more hospitals may not have available within its boundaries many of the services which its population needs and/or uses.
- e. There will often be considerable overlap between the market or service areas of the hospitals and the planning areas in which those hospitals are located. Despite any overlap, planning areas for groups of people should be distinguished from market or service areas of hospitals and specific services.
- f. Planning areas for specific services should, if possible, be coterminous with the basic hospital planning areas. Planning areas for more specialized services (e.g., psychiatric units, burn centers, neonatal intensive care units, etc.) which SHCC, DSHS and hospitals have determined should be offered over a larger area or regionalized, should be composed of groups of the basic hospital planning areas.

8. CRITERION: Planning Area Hospital Bed Needs

The availability of hospital resources, and the determination of resource requirements should be evaluated through an analysis of planning area bed needs.

STANDARDS:

- a. DSHS should develop baseline patient day and bed need forecasts for each planning area, using the given hospital bed need forecasting method upon which appropriate adjustments for planning area bed needs can be made.
- b. When necessary SHCC and DSHS in cooperation with area hospital councils, the Washington State Hospital Association, and hospitals within each planning area, should adjust the planning area baseline estimates using the given bed forecasting method to take into account mutually agreed upon or negotiated changes in population, use rates, market shares, out-of-area use, and/or upward revisions of the appropriate occupancy standards (as permitted in Hospital Standard 11.e). This adjustment process should ensure opportunity for participation and comment by the Hospital Commission, insurers, purchasers, labor and other interested parties.
- c. Upon receipt of a new set of baseline forecasts (regular three year cycle), hospitals should present their recommended adjustments to the SHCC and DSHS and negotiate any differences in bed forecasts.
- d. Separate planning area hospital bed need forecasts should be made in each planning area which contains both hospitals providing basic community-oriented services and hospitals providing region-

wide tertiary care services. The health planning system in consultation with affected hospitals should determine when and where these separate projections should be made.

(Explanation: Hospital patient day and bed need forecasts should be made for planning areas as a whole. These total forecasts would be made for planning areas not only with one facility, but also those with two, three, or more facilities. The baseline forecasts provide a common starting point for the analysis of planning area bed needs by the community, including consumers, planners, and providers.

Determining bed needs by planning area will foster an increasing shift toward thinking about the care needs of people within a community. It will also provide one starting point for long range and joint planning among the consumer, provider, and planning groups. While the SHCC and DSHS will provide the baseline patient day and bed need forecasts for each planning area, local councils and provider groups will have the opportunity to verify or suggest modification of these forecasts using the forecasting methodology. Where made, these changes might be the result of well-documented modifications to population estimates, use rates, market share, physician practice patterns, or out-of-area use.

Bed need forecasts for hospitals providing regional tertiary care services may need to be made separately from the forecasts for other hospitals in the planning area. These hospitals serve a relatively widespread clientele with a large proportion of their patients being drawn from outside of the planning area.)

9. CRITERION: Framework for Overall Forecasts and for Service Specific/Age Specific Forecasts

There is a distinction in bed need forecasting between services where the forecast is based at least in part on normative judgments about need, and those where the forecast is based exclusively on demand patterns and population changes. There also is a distinction between overall forecasts and sub-forecasts which are parts of an overall total.

STANDARDS:

- a. The need for hospital services shall be forecast in two distinct parts: need for short-stay inpatient psychiatric services (partially based on normative need) and need for non-psychiatric hospital services.
- b. Bed needs for non-psychiatric services, which are forecast on the basis of demand (utilization patterns) and population, shall be forecast as an aggregate. Specific service forecasts within this aggregate shall be treated as subsets of the total.

- c. Unless otherwise explicitly stated in a service specific forecasting method, all forecasts for specific hospital services are subsets of the total forecast for non-psychiatric services (i.e., medical/surgical/obstetric/pediatric services).

A finding of net need for a specific service does not by itself provide justification for adding beds to meet this need. Conversion of the use of beds in one or more hospitals within the planning area must be considered. Beds shall not ordinarily be added to meet a specific service need unless they also are needed to address a general unmet need for non-psychiatric hospital beds in the area.

- d. Specific services which are not individually forecast shall be considered part of the total forecast for non-psychiatric services. If an applicant to develop such services proposes to construct new hospital beds, there must be net unmet need for these beds within the area's total forecast of medical/surgical/obstetric/pediatric bed need.
- e. If age-specific service needs are separately forecast (e.g., need for short-stay psychiatric inpatient services for children and adolescents), these forecasts shall be interpreted as subsets of the total forecast for all ages. A finding of net need for a particular age group does not by itself provide sufficient justification for adding beds to meet the need.
- f. In the event of conflicting evidence about bed needs from overall bed need forecasts and service specific (or age specific) sub-forecasts, the overall forecasts ordinarily shall be considered binding. The sub-forecasts should be reduced in the adjustment process, if necessary, to avoid an excessive shift of an area's hospital capacity from general medical/surgical/obstetric/pediatric use to specialized units.

Explanation: It is theoretically possible for service specific and age specific sub-forecasts to add up to more than the total bed need for an area (overall forecast). This is true because occupancy standards have a different effect applied service-by-service than they have when applied overall at the planning area level. The overall occupancy standards used in forecasting (see Hospital Forecasting Standards 11.b. and 11.f) were chosen to allow sufficient leeway for hospitals to meet a variety of needs. Forecast need for a specific service therefore may overstate the number of beds which it is sensible to shift from general medical/surgical/obstetric/pediatric use to more specialized uses. The overall balance of general and specialized beds within an area is an appropriate topic for adjustments (so long as total area bed need forecasts are not exceeded) and for selective growth/

selective use planning. Regionalization plans developed by the health planning system for specific services also should influence this balance in certain instances.

10. CRITERION: Service Specific Resource Requirements

Forecasts of hospital resource requirements should recognize that all beds within a hospital or hospitals are not capable of providing nor are they intended to provide similar services.

STANDARD

- a. The State Health Coordinating Council shall prepare service-specific baseline forecasts of patient days and bed needs for short-stay psychiatric hospital services. These forecasts are needed as guidance for review of Certificate of Need applications for addition, expansion or replacement of specific service units in hospitals.

Except for psychiatric services, service-specific forecasts shall be subsets of the overall forecast for non-psychiatric (medical/surgical/obstetric/pediatric) services. As such, they shall not affect the calculation of the total non-psychiatric patient days and beds forecast for each planning area.

(Explanation: Note that need for a specific service does not by itself address the question of whether beds should (or may) be added to meet this need. See Hospital Forecasting Criterion 9.

Hospital resource requirements should be determined on a service/specific (e.g., medical/surgical, obstetric, psychiatric) basis. Many planning and certificate of need decisions require the knowledge of both service-specific capacity and future requirements.

All decisions should recognize that beds, even those within a particular facility, and medical staffs may not be inter-changeable in the short term. For example, a patient in a medical/surgical unit probably could not be placed in an obstetric bed.

Service specific forecasts could assist hospitals in developing long range plans. They may provide some guidance to a facility on the resources which may be required in the future. Because different services have different resource and personnel requirements, an accurate assessment of future need is essential in planning for the development of an area's resources).

11. CRITERION: Occupancy Standards for Use in Forecasting

Hospital bed capacity should be utilized efficiently without compromising necessary access to service. Bed need forecasting methods should use occupancy standards chosen to achieve this dual goal.

STANDARD: Statewide occupancy expectations

a. Average annual occupancy rates for hospitals and specific services should not be less than:

- . 75% statewide
- . 75% for adult medical/surgical services statewide
- . 55% for obstetric services statewide
- . 55% for pediatric services statewide

STANDARD: Occupancy standards for individual facilities for use in forecasting

b. In developing baseline forecasts of future bed needs, the occupancy standards for existing hospitals in planning areas shall not be less than:

- . 50% for hospitals with 1 through 49 beds.
- . 65% for hospitals with 50 through 99 beds.
- . 70% for hospitals with 100 through 199 beds.
- . 75% for hospitals with 200 through 299 beds.
- . 80% for hospitals with 300 beds or more.

(Explanation: These standards are for use in forecasting.)

STANDARD: Occupancy standards for use in forecasting specific services

c. In developing baseline forecasts of future need for specific hospital services, the occupancy standards for specific services already existing in hospitals shall not be less than:

- . 55% for services with 1 through 49 beds.
- . 70% for services with 50 through 99 beds.
- . 75% for services with 100 through 199 beds.
- . 75% for services with 200 through 299 beds.
- . 80% for services with 300 beds or more.

The minimum occupancy standards for some specific services may be higher. These are explicitly stated as part of the service-specific forecasting methods (e.g., for short-stay psychiatric hospital services).

If forecasts are developed for alcoholism/substance abuse service bed needs, the same occupancy standards should be used as in short-stay psychiatric forecasts.

(Explanation: These minimum occupancy standards have not been changed since 1979. However, as of this plan edition, they are being applied to all planning areas, rather than only those in urban areas. Since the health planning system has responsibility to plan for specific services whether in urban or rural areas, occupancy standards must exist for forecasting use in all areas.)

STANDARD: Occupancy standards for use in resource forecasts

- d. In evaluating the appropriate size (beds) for a proposed new facility or service, special facility-specific forecasts sometimes are needed. In these instances, forecasted volume (Average Daily Census, or ADC) is given and an appropriate bed complement must be determined. The following occupancy standards shall be used in these special resource forecasts.
- d.1. New facilities: For the purposes of making resource forecasts, occupancy rates for proposed new hospitals shall not be less than:
- . 50% for hospitals with an average daily census (ADC) of 25 or less.
 - . 65% for hospitals with an ADC between 26 and 65.
 - . 70% for hospitals with an ADC between 66 and 140.
 - . 75% for hospitals with an ADC between 141 and 225.
 - . 80% for hospitals with an ADC of 226 or more.
- d.2. New services in hospitals: For the purpose of making resource forecasts, occupancy rates for proposed new specific services should not be less than:
- . 55% for services with an ADC of 25 or less.
 - . 70% for services with an ADC between 26 and 65.
 - . 75% for services with an ADC between 66 and 140, and
 - . 75% for services with an ADC between 141 and 225.
 - . 80% for services with an ADC of 226 or more.

For services which have higher occupancy standards (see Standard 11.c above), the higher occupancy standards shall be used, but shall be applied to ADC rather than to beds.

STANDARD:

- e. SHCC and DSHS may negotiate appropriate occupancy standards for individual hospitals which are higher than the minimums presented in Standards 11.a, b, c and d above. Once developed, these shall be used in future baseline forecasts, as applicable.

STANDARD:

- f. The occupancy standard applied to each planning area or service within each planning area shall be based, for forecasting purposes, on the current weighted average of the appropriate occupancy standards for each facility in the planning area. This is calculated as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area. Where a specific service is concerned, the weighted average for all applicable service units is determined (weighted by unit size).

(Explanation: There is no change in this method since 1979).

12. CRITERION: Bed Capacity

In determining the future bed capacity which will serve a community, the count should include all beds which will be available or could be available for patient use. The count should not include beds which physically could not be used, and beds which will be eliminated within the span of the forecasts.

STANDARDS:

- a. The count of future bed capacity should separately identify:
- (1) beds which are currently licensed and physically could be set up without significant capital expenditure requiring new state approval;
 - (2) beds which do not physically exist but are authorized unless for some reason it seems certain those beds will never be built;
 - (3) beds which are in the current license but physically could not be set up (e.g., beds which have been converted to other uses with no realistic chance they could be converted back to beds);
 - (4) beds which will be eliminated;
- b. Occupancy standards for forecasting are computed based on beds which are licensed and physically could be set up, plus beds which do not physically exist, but which are authorized.
- c. SHCC and DSHS consulting with individual hospitals should decide what beds should be counted in what part of current and future bed counts (see 12.a(1) through 12.a.(4) above).

(Explanation: The count of future bed capacity should be used in conjunction with the hospital bed projections to determine future need. This count assists in the identification of areas with potential deficits or surpluses in the availability of resources.)

STANDARD

- d. For specific service categories, future beds are those which could be set up in an existing service unit, plus those authorized plus or minus any changes in service-specific capacity which do not require approval but which will occur prior to the target year. Definitions used in counting available beds are included in each service specific forecasting method.

(Explanation: This definition is necessary because not all changes in specific service capacity are subject to review. Forecasted net need for beds in a service should incorporate the best estimate of future capacity in all units within the planning area.)

13. CRITERION: Allocations to Individual Hospitals

The allocation of utilization to individual hospitals should be by a process which is reasonable, fair, and realistic.

STANDARD:

- a. Calculations of the current "market penetration" by hospitals of one planning area into another planning area should be based on patient origin and destination data. Baseline forecasts of future utilization and bed needs generally should assume continuation of current market share patterns, subject to change if necessary during the formal adjustment process.

d. **SPECIFIC METHODS**

This section presents the detailed methods used to forecast hospital bed needs.

- (1) Determination of Forecasting Policies and Availability of Methods Detail.

Policy decisions about how to forecast need for hospital resources are made by the State Health Coordinating Council, and adopted as part of the State Health Plan. However, there exists a level of technical detail which is administratively developed by SHCC staff, within the State Health Plan's policy framework.

Detailed explanations of how each calculation is carried out, including identification of data sources, shall be available from SHCC staff (DSHS).

Changes in procedure may be made at the technical (staff) level only to improve technical methods within policies adopted by the SHCC, or to improve clarity, or to add information previously unavailable. Any change which is not consistent with SHCC-adopted policy requires formal SHCC action (an amendment to the State Health Plan).

(2) Method for Overall Baseline Forecast of Non-Psychiatric (Medical/Surgical/Obstetric/Pediatric) Hospital Bed Needs.

Following is a step-by-step description of the method for forecasting the overall (aggregate) need for medical/surgical/obstetric/pediatric hospital beds. Many elements are elaborated in the Hospital Bed Forecasting Standards.

1. Develop trend information on hospital utilization

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

STEP 2: Subtract psychiatric patients days from each year's historical data.

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

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

2. Calculate baseline non-psychiatric bed need forecasts

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

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

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

Each hospital planning area's trend-adjusted use rate for every age group is tested against the statewide hospital use rate for HMO enrollees in the same age group. The trend-adjusted use rate is used in forecasting if it equals or exceeds the statewide HMO enrollees' hospital use rate. If not, forecasting will be done using the applicable statewide HMO enrollees' use rate or the hospital planning area's actual base-year use rate, whichever is lower.

STEP 7B: Alternate Adjustment: In lieu of Step 7A, in those hospital planning areas where:

1. HMO enrollees make up a significant and increasing portion of the population;
2. HMO enrollees are expected to use HMO-owned and operated hospitals;
3. base year HMO enrollment and hospital use (i.e., patient days) can be identified; and,
4. forecasts of the HMO future enrollment are made by or deemed reasonable by health planning system,

the following adjustment will be made instead of the hospital use rate trend adjustment, provided, the resultant hospital bed need forecast for the planning area is less than the use rate trend-adjusted hospital bed need forecast.

- Step 7B.1: Subtract the forecasted HMO enrollment from the target year population.
- Step 7B.2: Adjust the market shares of the hospital planning areas to exclude HMO hospitals.
- Step 7B.3: Set the target year use rate equal to the hospital planning area's base year non-HMO use rate. The non-HMO use rate equals total patient days minus HMO patient days, divided by total population minus HMO enrollment.

(Explanation: The effect of HMOs' increasing market penetration and low hospital use rates in individual hospital planning areas is difficult to separate from other factors in the historical trends of declining area-wide use rates. In those planning areas where this effect is likely to continue, separate forecasting of HMO/non-HMO patient days and beds is a more appropriate approach than the trend adjustment used for other areas. Therefore, until data become available which would allow a more exact analysis of the trend components, the above special adjustment will be used for those specific hospital planning areas. For the 1985 forecast cycle, the following hospital planning areas meet the conditions of this adjustment: Southwest Snohomish and North, East, Central, Southwest and Southeast King).

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

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

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

Explanation: Psychiatric beds in general acute-care hospitals are included in occupancy calculations. The occupancy standards in Standard 11.b were selected to allow sufficient leeway for hospitals to meet a variety of needs, including psychiatric, and these assumptions have been applied in the past to hospitals having psychiatric services as well as to those which do not.

3. Determine total baseline hospital bed need forecasts

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

Make Adjustments

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

(Explanation: In applying this method in the 1985 and 1986 forecasting cycles, the age groups used throughout are 0-64 and 65+, except for the psychiatric bed need forecasts which consider ages 0-17, 18-64 and 65+.

The forecasting method assumes that out-of-state residents will continue to use the same percentage of each area's hospital services (patient days) as they did in the base year. Similarly, it assumes that Washington State residents will continue to seek care in areas outside the state to the same extent as in the base year. In some hospital planning areas these out-of-area use assumptions are quite significant and warrant careful consideration during the adjustment process).

(3) Methods for Service-Specific Forecasts Within the Overall Non-Psychiatric Forecast

At present there are no formally approved statewide methods for forecasting service-specific components of the non-psychiatric forecast. It is anticipated that such methods will be developed in the future.

(4) Short-Stay Psychiatric Bed Forecasting Method

(a) INTRODUCTION

This section of the hospital forecasting guide provides a description of the Washington State Short-Stay Psychiatric Hospital Bed Need Forecasting Method. It is part of the adopted Hospital Bed Need Forecasting Method, while recognizing factors which are unique to psychiatric bed needs in hospitals.

The short-stay psychiatric hospital bed need forecasts are developed independent of other hospital bed need forecasts presented in the Washington State Hospital Bed Need Forecasting Method.

(b) THE BED NEED FORECASTING PROCESS

There are three phases to the short-stay psychiatric bed need forecasting process. These three phases will allow a consistent forecasting method to be used across the state as well as allowing adjustments for local conditions and plans which could not be used statewide. The process also includes the development of selective growth policies within each health service area.

- i. The baseline forecasting phase - The state agency develops a set of baseline bed need forecasts. The forecasts are developed using a uniform data base and assumptions and are consistent with the adopted psychiatric method.

- ii. The adjustment and selective growth policy phase - The SHCC and the Mental Health Division work with interested parties including consumers and providers, and county governments, as appropriate, to note any adjustments (which must follow the adjustment guidelines of this plan). The adjustments should reflect local conditions and plans.
- iii. The finalized forecasts phase - Once all Health Systems Agency adjustments have been reviewed and found to conform with the adjustment guidelines and selective growth policies developed, the state agency releases a finalized set of forecasts which are to be used in reviews, in developing future plans and for inclusion in the State Health Plan.

Each of these phases has a number of underlying assumptions and guidelines which are described in criteria and standards. Some of the criteria and standards apply to the methodology as a whole, some to individual phases, and others to specific steps within the projection method. Except where noted herein, criteria and standards contained in the Washington State Hospital Bed Need Forecasting Method are applicable to the psychiatric bed forecasts.

(c) DESCRIPTION OF THE STEP-BY-STEP METHOD

The method presented here shall be used to determine baseline short-stay psychiatric hospital bed needs. This method should be used in the context of the assumptions and guidance outlined in the criteria and standards. The forecasts should then proceed through the adjustments phase of the forecasting process. Any adjustments considered must be applicable to particular steps within this method. The adjustments phase is further described in Section IV.B of this hospital forecasting guide.

Summary of method: Forecasts for short-stay psychiatric hospital bed need are calculated so that the total short-stay beds available for state residents would equal a desired statewide normative bed-to-population ratio of 13 beds per 100,000 persons. It is assumed that federal hospital use will continue current demand patterns (use rate, patient origin), while needs for short stay psychiatric inpatient services in community and state hospitals are adjusted from base year use rates to achieve the desired overall bed target.

Hospital psychiatric bed need is forecasted for each mental health planning area (counties, with the exception of dual-county areas: Chelan/Douglas, Benton/Franklin and Thurston/Mason). The underlying demand forecasts (before adjustment to the target bed

ratio) are based upon age-specific use rates (for ages 0-17, 18-64 and 65+) and county market shares from the base-year patient origin study. The patient origin data base includes all discharges from community hospitals with a psychiatric primary diagnosis; all stays of 30 days or less in state mental hospitals (excluding criminal and sexual psychopath commitments); and all psychiatric discharges from federal (VA and military) hospitals with length of stay of 30 days or less. Group Health enrollees are included.

Forecast Based on Current Demand Patterns

Step 1: Using the latest patient origin data and Division of Mental Health-provided state mental hospital discharge data, allocate patient days (PDs) generated in each county's hospitals back to the county where the patient lives.

Step 2: Compute each county's age specific use rates (ages 0-17, 18-64 and 65+) by dividing the PDs generated by each age group by that age group's base year population.

Step 3: Assuming that each county's residents' demand for short stay psychiatric hospital services remains constant, calculate the number of PDs that would be generated by the residents of each county in the target year by multiplying each county's age specific use rates by its projected population in each age group. Total PDs equal the sum of PDs for the three age groups.

Step 4: Using the same patient origin data used in Step 1, and using the projected PDs from Step 3:

- a. Calculate the number of PDs which would be generated in each county's hospitals, in the target year, based upon the market shares for hospitals in that county;
- b. Calculate the number of PDs which would be generated in the state hospitals, in the target year, based upon those hospitals' market shares; and
- c. Calculate the number of PDs which would be generated in the federal hospitals, in the target year, based upon those hospitals' market shares.

Step 5: Calculate the projected average daily census (ADC) for each county's non-governmental hospitals and for the state and federal hospitals by dividing the number of PDs which would be generated in each county and each government hospital (from Step 4) by 365.

Step 6: Calculate the counties' and the state and federal hospitals' demand for beds in the target year by dividing their ADCs (from Step 5) by an appropriate occupancy standard:

- a. For counties or state/federal hospitals with a short stay psychiatric ADC of 10 or less, the occupancy standard is 70 percent;
- b. For counties or state/federal hospitals with a short stay psychiatric ADC of 11 or more, the occupancy standard is 85 percent.

Note: These demand projections do not include demand by out-of-state residents. This is corrected in Step 10.

Adjustment of Demand Forecast to Desired Target Bed-to-Population Ratio

Step 7: Calculate the statewide short stay psychiatric hospital bed supply needed in order to achieve the desired normative bed-to-population ratio of 13 beds per 100,000 persons in the target year by multiplying the projected statewide population in the target year by 13 and dividing the product by 100,000.

Step 8: Subtract from the statewide normative bed need (calculated in Step 7) those beds projected as needed in federal hospitals (calculated in Step 6). The remainder is statewide normative need for short stay psychiatric beds in non-federal hospitals.

Step 9: Calculate a factor to adjust statewide demand for non-federal beds to match the statewide normative need for such beds. This adjustment factor equals the remainder from Step 8 (statewide normative bed need for non-federal hospital beds) divided by the projected demand for beds in non-governmental hospitals and state hospitals (from Step 6).

Step 10: Using patient origin data, adjust each county's projected demand for non-governmental beds (Step 6) to account for patient flow into that county from out-of-state. It is assumed that the percentage of out-of-state use (PDs) in the hospitals in each mental health planning area will remain constant.

Step 11: Calculate each county's normative adjusted need for non-governmental hospital beds for short stay psychiatric services by multiplying the county's unadjusted demand for non-governmental beds (Step 10) by the normative adjustment factor calculated in Step 9.

Note: This forecast method assumes that federal hospitals and state mental hospitals will maintain sufficient short-stay psychiatric capacity to meet their share of total short-stay need. Federal hospitals are assumed to maintain their base year use rate and patient origin patterns. The state mental hospitals' short-stay use rates are assumed to decline slightly (by the same percentage as community hospital use rates are assumed to decline; see Steps 9 and

11), as a result of expanded short stay residential programs. The ability of federal and state hospitals to provide these service levels (ADCs) will be verified as part of the forecast adjustment process.

Step 12: Each county's net need for non-governmental short-stay psychiatric hospital beds is equal to the county's adjusted non-governmental bed need (from Step 11) minus the county's future non-governmental bed supply (as defined in Hospital Forecasting Criterion 12.d). Non-governmental short-stay psychiatric beds are those identified in Short Stay Psychiatric Services section of this plan.

(d) CRITERIA AND STANDARDS

The primary policy guidance for this forecasting method is Short Stay Psychiatric Services Section of the Plan. Other applicable standards are found in the general criteria and standards for hospital bed need forecasting, in the Guidelines for Adjusting Psychiatric Bed Need Forecasts and below.

General Criteria and Standards for Psychiatric Forecasting

The following criteria (and related standards) have broad significance beyond any single phase of the psychiatric forecasting method.

1. Planning Services for the Population

Short-stay inpatient psychiatric services should be planned on the basis of the needs of the population.

- a. Standard. The need for short-stay psychiatric inpatient/residential resources is specified in Planning and Review Policy 3.3.2.4 of the State Health Plan.
- b. Standard. In areas where the state agency (Mental Health Division) projects a change in the patterns of use due to state policy initiatives, interested agencies of the affected areas should provide a review and comment on the projected impact of policy initiatives. After analysis of comments, the state agency should provide the final decisions on the projected impact of the policies used in baseline bed need forecasts.
- c. Standard. To the degree to which it is practical, specific groups of people which use special services or facilities should have their needs for beds calculated separately through the use of selective growth policies. When selective growth policies have been applied, the total number of beds forecasted as needed must sum to no more than the total number forecasted in the finalized

forecast phase. Special subgroups should include children, adolescents, adults, involuntary, and voluntary patients, to the extent that separate facilities or programs are needed to serve these groups. (See Selective Growth Policies).

2. Areas for Planning Services

- a. Standard. The planning area for short-stay psychiatric hospital services is the county, with the exception of formal multi-county mental health authorities noted in short-stay psychiatric services section of this Plan.

Criteria and Standards for the Psychiatric Baseline Forecasting Phase

3. Psychiatric Use Rate

Forecasting of the need for psychiatric service resources should be based upon the best estimation of the appropriate utilization of those resources.

4. Occupancy Standard for Residential Programs

- a. Interim standard: For forecasting purposes, the occupancy standard for short-stay psychiatric residential programs shall be 85 percent (county-wide weighted average for all residential programs). This will be changed if necessary based on experience with the program.

Criteria and Standards for the Adjustments and Selective Growth Policy Phase of Short-Stay Psychiatric Forecasting

5. Documented Use Rate Variations

Short-stay psychiatric hospital resource need forecasts should reflect current and proposed federal and state initiatives and policies which would result in changes in the use rate of the population.

- a. Standard. The Mental Health Division should, at least biennially, list federal and state initiatives where such a change is documentable and quantify the impact of such initiatives. The State Health Coordinating Council in consultation with the state agency should make final decisions on the appropriateness and validity of proposed revisions.
- b. Standard. All forecasts incorporating impacts of state and federal policies and initiatives should be reevaluated as part of each full forecast/adjustment cycle to ascertain the effectiveness, feasibility, and appropriateness of

those policies and initiatives. The projected impacts of the policies and initiatives should also be re-evaluated to determine accuracy. Policies and initiatives which are no longer valid should be factored out of the forecasts. More frequent re-evaluation may be undertaken if justified based on General Principle 9 in this guide.

- c. Standard. Under the auspices of the SHCC and DSHS hospitals and other interested parties within each planning area should jointly adjust, if necessary, the baseline forecasts to account for local (nonpolicy) impacts. All adjustments to population, use rates, market shares, and out-of-area use should be well documented. Guidelines for local adjustments are contained in Sections IV.A and IV.B of this forecasting guide.
- d. Standard. Adjustments to the baseline forecasts should include consideration and analysis of the impacts on the utilization or potential utilization of psychiatric services by the under- and inappropriately served population in all short-stay service settings.

6. Psychiatric Service Selective Growth Policies

Psychiatric service selective growth policies should be developed.

(Explanation: There is a need for a selective growth policy for hospital inpatient psychiatric services which outlines the placement of beds within mental health planning areas, the number of beds to be placed in hospitals, the levels of psychiatric service to be provided by the various hospitals, and the population groups to be served by the hospital psychiatric beds. Selective growth policies should be developed as part of the adjustments phase of the forecasting method).

- a. Standard. Selective growth policies should reflect local circumstances and values toward acute inpatient/residential psychiatric care.
- b. Standard. During and after analysis of federal and state policies and proposed policies and adjustments in the adjustments phase of the method, selective growth policies should define:
 - (1) the placement of short-stay inpatient/residential beds in the following types of facilities:
 - (a) hospitals with or without designated psychiatric units,
 - (b) free-standing psychiatric hospitals,
 - (c) nursing homes,

- (d) boarding homes,
 - (e) other residential living situations.
- (2) the location of short-stay hospital psychiatric beds within mental health planning areas.
- (3) the relative priority and numbers of hospital psychiatric beds needed to provide service of the following types:
- (a) beds needed to serve
 - (i) voluntary commitments,
 - (ii) involuntary commitments;
 - (b) beds needed for population groups
 - (i) children,
 - (ii) adolescents,
 - (iii) adults (ages 20 through 64),
 - (iv) elderly (ages 65 and over);
 - (c) beds in facilities providing multiple levels and types of mental health care and having formal linkages with other community services providing less intensive care.
- (4) terms governing the meeting of priority needs (e.g., circumstances under which lower priority needs should be approved in the absence of competing applications for higher priority beds). These terms should include the meeting of needs through both hospitals and alternative settings.
- c. Standard. Resource availability or limitations for inpatient psychiatric services should be considered in the development of selective growth policies.
- d. Standard. Selective growth policies should indicate conditions under which (1) institutions could be allowed to expand or establish facilities, beds, or services even though forecasts show that there would be underutilized resources in the area, and (2) institutions could be denied approval to expand or establish facilities, beds, or services even though there may be a demonstrated need for such facilities, beds, or services.
- e. Standard: If there is lack of evidence of development of short-stay psychiatric residential programs, a bed allocation plan may allow for short-stay psychiatric hospital beds exceeding the normative adjusted bed need forecast (from Step 11 of the Short Stay Psychiatric Hospital Bed Forecasting Method) but not exceeding the demand for beds using unadjusted base-year psychiatric use rates (from Step 6 of this method).

e. GUIDELINES FOR ADJUSTING FORECASTS

(1) General Adjustment Guidelines

INTRODUCTION

This section serves to detail the types of adjustments which may apply to the baseline hospital patient day forecasts and outline the documentation which would be required to make these adjustments. The factors discussed here should be considered when adjusting the baseline patient day forecasts. Any adjustments should be the result of negotiations between the hospitals and DSHS, with opportunity for participation and comment by the Hospital Commission, insurers, purchasers, labor and other interested parties.

The discussion of adjustment factors is organized into the four components influencing total patient days. These factors are:

- . population
- . use rate
- . market share
- . out-of-area use

POPULATION

There are three population components to be considered in analyzing the affects of population on total patient days - the planning area population, the projected subscriber population using a Health Maintenance Organization (HMO) hospital, or the projected federal population. Changes in any of these components could affect the population forecasts used to calculate patient days. Each of these changes is discussed below.

Factors Affecting Population

1. Changes in the Projected Planning Area Population:

Population projections are based on a number of assumptions regarding net migration, fertility rates and mortality rates. A change in any of these factors would therefore affect the projected planning area population.

For example, land use policies designed to strictly control the growth of rural areas or fuel shortages would probably decrease migration to rural areas. This situation would result in an increase in the projected population of urban planning areas.

2. Changes in the Projected Planning Area Subscriber Population Using an HMO Hospital:

HMO population forecasts for a geographic area are usually based on historic trends and the HMO's growth policy. However, opening a new clinic or hospital in an area might increase an HMO's enrollment faster than anticipated and decrease the population projected to use community hospitals. If a ceiling on HMO penetration in an area were reached, the HMO enrollment might not grow as fast as anticipated. This situation would increase the population projected to use community hospitals.

3. Changes in the Projected Planning Area Population using Federal Hospitals:

Currently, there is some difficulty in obtaining precise data on the number of persons using VA and military hospitals, particularly on a planning area basis. However, even if the population using federal hospitals is not subtracted, changes in this population will affect the number of persons using community hospitals. For example, an expansion in the number of persons eligible for services at a VA Hospital could increase the population using federal hospitals and decrease the population using community hospitals. However, elimination of obstetric services at a military hospital would increase the projected population using community hospitals for this service.

Documentation for Adjusting Population Estimates and Projections

In order to adjust a population forecast, it is important to first establish that the initial method of projecting the population does not account for the anticipated change. If it does not, then it is important to find a substitute population projection which better explains the factors affecting population in an area.

Similarly, documenting that the number of enrollees using an HMO hospital in an area will be different from that projected by the HMO must be based on evidence of changes in the assumptions underlying the HMO projection. That is, it would be necessary to cite the reasons why the HMO enrollment in an area is not expected to grow according to historic trends.

Documenting changes in the federal population requires information from the military or the Veterans Administration on expected changes in eligibility requirements and/or expected changes in covered services. It is also important to establish that this is a permanent change rather than a temporary one in order to document the need to adjust the population component of the patient day projections.

USE RATE

Use rate is defined as the rate at which residents of an area use inpatient hospital services and is expressed as the number of patient days per 1,000 population. Because patient days are determined by the number of admissions and length of stay, changes in either of these variables would affect use rate.

A change in the use rate will usually change the total number of patient days which planning area residents spend at all hospitals, not just at hospitals within their own planning area. Many changes affect both use rate and market share. The six factors discussed below have a significant impact on use rate. Factors affecting market share are discussed in the next section of this guide.

Factors Affecting Use Rate

1. Demographic Changes in the Planning Area Population:

When the composition of a planning area's population changes, this is likely to result in a change in the rate at which area residents use hospital services. For example, if the average age of an area's population is increasing, both length of stay and the number of admissions are likely to increase, resulting in an increase in the area's use rate.

2. Changes in Provider Practice Patterns:

Changes in the way medicine is practiced would affect the rate at which residents of an area use inpatient services. Several types of changes in provider practice patterns may occur:

a. Inpatient to Outpatient Services or Vice Versa:

For example, the trend toward doing more surgery on an outpatient basis has decreased inpatient use rates.

b. Development of New Program:

For example, the development of a home-based hospice program might result in more terminally ill persons receiving care at home and decrease hospital use rates.

c. Changes in Diagnostic Technology:

For example, the extent to which CT scans reduce the need for exploratory surgery would decrease use rates.

d. Changes in Economic Access:

For example, changes in third party reimbursement patterns or adoption of new health insurance programs may alter existing use rates.

5. Changes in Government Regulations:

Several government regulatory programs are aimed at decreasing hospital use, primarily by decreasing the number of admissions and the length of stay. The principal example is the peer review program (PRO-W) which is intended to decrease hospital use by federally-funded patients.

6. Changes in Preventive Care Programs:

The development of new or the expansion of existing preventive care programs could reduce the number of inpatient days and decrease use rates. For example, implementation of a widespread blood pressure detection program is presumed to result in the prevention of heart attacks and therefore to decrease hospital use rates.

Documentation for Adjusting Use Rate

Before adjusting use rates it is necessary to document that there has been a change in the way persons use hospital services, not just a change in the use of one hospital.

To justify the adjustment of use rates, it is first necessary to demonstrate changes in a hospital's admissions and/or length of stay. If the number of admissions from an area is observed to be increasing, it is necessary to establish that this increase is greater than the projected population increase. If it is, an explanation for the increase needs to be found among the factors affecting use rate. For example, one explanation might be that the increased admissions are due to the recent expansion of coverage for inpatient alcoholism services by major employers in the area (factor #4) and to a change in consumer attitudes toward alcoholism treatment (factor #3).

A second way of justifying the adjustment of use rates is by documenting a change in the factors affecting use rate. Based on data which show that elderly persons use hospital services at five times the rate of non-elderly persons, planning area use rates may be adjusted to reflect expected changes in the proportion of elderly persons residing in each area.*

*Note that age-specific use rates are used in most baseline forecasting methods, greatly reducing the need for additional age-related use rate adjustments.

It is important to note that it is particularly difficult to document the impact of changes in accessibility on use rate, due to the fact that unmet needs must first be demonstrated. For example, in order to argue that the closure of a hospital is going to decrease an area's use rate, it must be shown that persons formerly served by the closed hospital will not seek care at other hospitals.

A final way of justifying the adjustment of use rates is by using data and information gained from the experience of other areas. This is particularly useful when arguing that a trend will end. For example, if an area's declining use rate is due to a downward trend in a length of stay, it may be presumed that this trend will continue unless the experience of other areas indicates that the length of stay will not fall below a certain minimum level.

MARKET SHARE

Market share is defined as the portion of a population's inpatient days which are met by a hospital or a group of hospitals. Any increase in the market share of one hospital, therefore, reflects an equal decrease in the market share of other hospitals.

A hospital's market share is determined by a number of circumstances over which the hospital has varying degrees of control. For example, a hospital usually cannot change the number of other hospitals which locate in the area. However, a hospital can determine its role, service mix, management style, and efficiency which when taken together affect the hospital's general attractiveness to physicians and the community. Hospitals consequently can alter their competitive position and thereby increase or decrease their market share. Six factors affecting market share are identified below.

Factors Affecting Market Share

1. Demographic Changes in the Population:

Changes in the composition of an area's population will affect area hospitals' market share of inpatient days just as it will affect use rates. This characteristic results from some socio-economic groups using hospital services within the area more than do the general population. Similarly, other groups are more likely to go out-of-area for hospital services. For example, patient origin studies indicate the elderly are more likely to "stay at home" for hospital services. Thus, if the proportion of elderly persons in a planning area increases, the result may be an increased market share for local hospitals.

2. Changes in the Number and Types of Physicians in a Planning Area:

The number and types of physicians in a community determines the size of local hospitals' physician referral base. The addition of

new physicians to the area may reduce the need of local residents to seek care out-of-area and should increase the local market share of the hospitals in the area.

3. Changes in Hospital Services:

Similarly, the addition of new types of hospital services reduces the need for local residents to seek care out of the area. For example, the development of a rehabilitation service at an area hospital will probably decrease the number of area residents going to out-of-area hospitals for this service and will increase the local hospital's market share of area residents.

4. Changes in Hospital Capacity:

A hospital's ability to treat people is limited by its capacity. An increase in local capacity can increase local hospitals' market share if some residents have been going out of the area during peak capacity situations.

Changes in capacity can be in the form of new beds, a change in room mix (i.e., relative number of single to multiple bedrooms) or in general operating efficiency.

5. Changes in a Hospital's Attractiveness to Practitioners:

A hospital's style of operation and resources affect its attractiveness to practitioners. These are characteristics over which hospitals have a fair degree of control, and include:

- . available services;
- . proximity to physicians' offices;
- . hospital's compatibility with physician treatment style;
- . support services within hospital;
- . efficiency of hospital;
- . restrictions on practice (e.g., utilization review, bylaws, requirements for staff privileges), and
- . physical plant.

To the extent that the attractiveness of a hospital changes and physicians admit patients who were previously hospitalized elsewhere, market share will be increased.

6. Changes in Consumers/Purchasers' Preferences for Hospital:

Although physician preference has been the primary determinant, consumers and, to an even greater extent, third party payers are likely to increase their role in deciding where acute care is purchased. In the near future, third party payers and consumers are likely to give greater attention to hospital efficiency and charges. Further, consumers are increasingly becoming interested in the hospital's general approach to care, responsiveness to patient/community desires, location, and physical plant.

For example, in some parts of the country, Blue Cross has issued guidelines that will only permit reimbursement for open heart surgery at hospitals meeting minimum volume standards. This restriction will probably decrease the market share of hospitals which do not meet these standards.

7. Small Sample Problem with Market Share Data:

A factor which needs to be considered in examining market shares is whether the sample from which a hospital's market share was determined is of sufficient size to not be distorted by chance events. Thus, it is important to examine the base data to ensure that random events during the sample period did not seriously affect the market share conclusion. For example, if a major accident results in a large number of residents being hospitalized out of the area during the same period, the study data would not accurately represent local hospitals' actual market share.

Documentation for Adjusting Market Share

The best justification of the need to adjust market share is an observed change in a hospital's market share over time. This type of documentation is only available through an areawide patient origin study.

If a hospital wants to document that this observed change indicates a trend which can be expected to continue, it is also necessary to explain the factors which brought the change. For example, if this increase was due to an increase in the number and types of physicians in the area (factor #2), it is necessary to document that the number and types of physicians in the community is expected to continue to increase and that area residents who were previously going out of the area for physician services are not staying at home. Thus, it is also important to indicate where these patients were previously going and which hospital's market share should be adjusted downward.

It is more difficult to document the need to adjust market share where the changes have not yet been observed. Unobserved changes should be discussed in terms of changes in the hospital's competitive position either as instigated by the hospital or as the result of changes in the competitive position of other hospitals.

Documentation should focus on changes in the number and types of physicians in the community or on the hospital's staff, and on changes in the hospital's service mix, capacity, and attractiveness to residents and third party payers.

An additional method of documenting the need to adjust market share is by obtaining verification from other hospitals that their market share of patients from a particular area is decreasing. This might occur, for example, in an instance where a referral hospital is near capacity and chooses to send out-of-area patients back to their home community for part of their hospital stay.

The weakest case for the need to adjust market share is a description of a hospital's marketing strategy to improve its attractiveness to physicians, third party payers, and the community. Although it is important to include this type of documentation, it is not enough to substantiate the need for a major expansion program.

Finally, it should be noted that the best way for a hospital-based HMO to document changes in market share is by using actual enrollment figures.

OUT OF AREA USE

Out-of-area use is defined as the number of days spent at planning area hospitals by persons residing outside the planning area. There are two types of out-of-area use: (1) use of planning area hospitals by persons who do not reside in the planning area but do reside within the health planning region, and (2) use of planning area hospitals by persons who do not reside within the health planning region. In the first case, out-of-area use is calculated by multiplying the planning area hospitals' market share of the other planning area by the other area's projected population. Thus, the computation of out-of-area use already takes into consideration any changes in use due to changes in population.

It should also be noted that out-of-area use includes both random use by visitors to an area and non-random use by out-of-area persons who are referred to or choose to use area hospitals. The first three factors discussed below affect non-random use; the fourth affects random use.

Factors Affecting Out-of-Area Use

1. Factors Affecting Market Share (See previous section)

Most of the factors which affect a hospital's market share of planning area residents could also affect its market share of out-of-area residents. For example, a change in hospital services such as the development of a rehabilitation service might attract out-of-area residents as well as area residents.

2. Changes in the Competitive Position of Hospitals in Other Planning Areas:

Just as initiatives area hospitals take may increase their market share of out-of-area residents, initiatives out-of-area hospitals take may decrease area hospitals' attractiveness to out-of-area patients. For example, the development of a rehabilitation service in a hospital in another planning area might decrease out-of-area use of area hospitals.

3. Changes in Physician Referral Patterns:

Physician referrals are responsible for much of the use of area hospitals by out-of-area residents. Changes in physician referral patterns will, therefore, affect out-of-area use. For example, the development of an affiliation agreement between an urban and rural hospital would probably result in more referrals to the urban hospital and thereby increase its out-of-area use.

4. Changes in Visits to the Area by Out-of-Area Residents:

Changes in the volume of visits to an area can influence the number of patient days generated on a random basis by persons from outside the area. For example, the development of a new recreational facility in an area may increase the number of tourists using local hospitals. Out-of-area use of local hospitals would also be expected to increase if there were an increase in the number of migrant workers coming to the area.

Documentation for Adjusting Out-of-Area Use

The best documentation of the need to adjust out-of-area use is an observed change in a hospital's market share of out-of-area patients. For persons residing outside the health planning region, this documentation can be provided by a hospital's own patient origin data. For persons residing in other planning areas within the region, the areawide patient origin study is needed to document this change and to provide the information necessary to adjust the market share of other hospitals within the region. In addition, this documentation of an observed change in a hospital's market share of out-of-area patients should be accompanied by a description of the factors which have caused the change and of the reasons why this trend is likely to continue.

Changes in out-of-area use which are anticipated but which have not yet been observed are more difficult to document. Unobserved changes should be discussed in terms of changes in a hospital's competitive position or in physician referral patterns.

(2) Psychiatric Bed Need Forecast Adjustments

This section presents guidelines as to the types of adjustments that may be applied to the baseline short-stay psychiatric hospital bed need forecasts and outlines the documentation needed to justify any adjustments. Any adjustments should occur during the the negotiations/adjustments phase and should be the result of discussions between community hospitals and DSHS.

These adjustment guidelines are organized into the four components influencing total patient days. These factors are:

- . population
- . use rate
 - influence of state and federal policy
 - availability of short-stay psychiatric services (beds) in other settings
 - other
- . market share
- . out-of-area use

1. Population

Factors affecting population are covered in Section IV.A. of this Guide.

2. Use Rate

a. Changes in federal or state policy (adjustments to steps 4c, 5 and 6 of the step-by-step method).

Any changes in programs or regulations will likely affect admission rates and average length of stay. These program changes could either increase or decrease the utilization of inpatient psychiatric services. Examples of programs and their intended effects are listed below:

- . policies aimed at moving patients out of the state hospitals - these programs would tend to increase the utilization of community hospitals.
- . development of short-stay psychiatric residential programs and other alternative services (such as emergency shelters, improved nursing home care for the mentally ill, and enhancement of the CCF program) would tend to decrease the hospital use rates. Budget restrictions or restrictive program changes in these areas would tend to increase the hospital use rate.

- . programs involving improved preplacement screening, discharge planning, and case management should tend to decrease to hospital use rate. Impacts here, however, depend heavily on placement criteria and on the availability of community services which can serve as an alternative to hospitalization.
- . programs promoting the use of mental health services and/or improving casefinding and general community resources may tend to increase the use rate. For example, an intensive program aimed at mentally ill children may increase the very low hospital use rate for persons in that age group.
- . changes in the involuntary treatment laws may either increase or decrease the use rate depending upon the nature of the statutory change.
- . changes in the state and federal budget will have a variety of impacts. Copayment increases in the Medicaid program may tend to decrease the use rate. Reductions in the mental health program budget, however, may tend to increase the use rate.

Documentation. Before adjusting use rates, justification of a change or expected change in use rates as a result of the initiation of a program should be provided. The mere desire to initiate a program or produce an intended effect is not sufficient to justify an adjustment of use rates. Documentation of a change should include and be based upon two factors:

- . evidence that a program will be initiated, continued, revised, etc. The program must have a budget, staff, appropriate commitments, or other resources sufficient to demonstrate that the proposed change will actually occur.
 - . effects of the program. Documentation should quantify the expected effects of program initiation or change. Adjustments should be based on past experience, pilot studies, follow-up research, or analysis of the effects of similar programs in other states.
- b. Availability of psychiatric services in other settings (adjustment to steps 4b, 4c, 5 and 6). The planned or future availability of short-stay psychiatric services in settings other than a hospital will likely affect utilization of these services in the hospital. Patients who may have used services at the hospital in the past may instead seek services at the other setting. In this instance, hospital utilization may decrease in the future, and a demand-based method would overestimate the need for hospital beds.

In some areas, the addition of short-stay psychiatric services in alternative settings may not decrease utilization of hospital services. Instead, the additional services may pick up much of the latent demand for an area which previously had a substantially depressed use rate.

Documentation. See a. above.

- c. Local factors affecting the use rate. These factors are addressed in detail elsewhere in this plan.

All of these adjustment factors are addressed in detail in earlier in this plan. Special attention should be given to market share changes for psychiatric services since the opening, closing, or expansion of a facility will tend to have a greater effect for this service than for most other hospital services.

4. Out-of-Area Use

Addressed in detail in elsewhere in this plan.

APPENDICES

APPENDIX A

IN-HOSPITAL CANCER REHABILITATION PROGRAM

Summary of Services and Staffing Standards Established by the Committee on Rehabilitation, Fred Hutchinson Cancer Research Center.

STANDARD I: Hospitals of all sizes which provide cancer diagnosis and treatment services should have a rehabilitation program which includes as a minimum eight basic service or staffing components.

1. Availability of patient and public information materials including Cancer Information Service (CIS).
2. List of the resources for cancer rehabilitation in the community and in the referral area (e.g., ACS office, state vocational rehabilitation service agencies, transportation, etc.), plus a knowledge of the resources.
3. Awareness by physicians, nurses and administrators of needs in cancer rehabilitation.
4. Availability of cancer specialists plus other needed medical specialists in the hospital, on call, or by referral.
5. Discharge planning and referral arrangements with home health care agencies.
6. Assurance of appropriate training in cancer rehabilitation for team coordinator.
7. Inclusion of the discussion of continuing care and the rehabilitation in review of cancer cases at tumor boards and other hospital meetings.
8. Opportunity for staff to participate in inservice training or continuing education programs in cancer rehabilitation.

STANDARD II: Hospitals of at least 100 beds which provide cancer diagnosis and treatment should provide the eight basic service or staffing components and the following:

1. Referral arrangements with physiatrist, maxillofacial, prosthodontist, dentist or dental hygienist, speech pathologist, occupational therapist, physical therapist, enterostomal therapist, dietitian and clergy.
2. Nurse, social worker or other staff designated as a coordinator for cancer rehabilitation (at least part-time) with a formal job description.

STANDARD III: Hospitals of at least 200 beds which provide cancer diagnosis and treatment should provide the eight basic service or staffing components and the following:

1. Referral arrangements for a physiatrist, maxillofacial prosthodontist, dentist or dental hygienist, speech pathologist, physical therapist, occupational therapist, enterostomal therapist, dietitian and clergy.
2. Designation of a medical director for the rehabilitation team.
3. At least one nurse and one social worker designated as responsible for coordinating the hospital's cancer rehabilitation programs; procedures for appropriate referral of cancer patients to the coordinator; arrangements for these members of the staff to meet as a group at regular intervals with the attending physicians and patients who have been referred to the cancer rehabilitation team.

STANDARD IV: Hospitals of at least 500 beds which provide cancer diagnosis and treatment should provide the eight basic service or staffing components and the following:

1. Physiatrist, maxillofacial prosthodontist, dentist or dental hygienist, speech pathologist, physical therapist, occupational therapist, enterostomal therapist, dietitian and clergy on hospital staff.
2. Designation of a medical director for the rehabilitation team.
3. At least one nurse and one social worker designated as responsible for coordinating the hospital's cancer rehabilitation programs; procedures for proper referral of cancer patients to the coordinator; arrangements for these members of the staff to meet as a group at regular intervals with the attending physicians and patients who have been referred to the cancer rehabilitation team.

APPENDIX B

REQUIREMENTS FOR CONTINUING CARE RETIREMENT COMMUNITY PROJECTS

SECTION 1: REQUIREMENTS FOR CCRC FEASIBILITY REPORT/FINANCIAL PLAN

1. The expected demographics (including numbers, age, sex, health and financial means) of CCRC members for at least a ten-year period;
2. Expected utilization levels and costs of contractually guaranteed services, in total and in relation to demographic categories, in each year of the study;
3. The proposed financing of construction and startup, including amounts and uses of any deposits applied to these expenses;
4. The proposed plan for securing future service obligations through one or a combination of: designated reserves; reinsurance, such as stop-loss insurance; bonding; and/or contractually-mandated purchase by CCRC members of group or individual long-term care insurance;
5. A proposed pricing plan, including amounts of initial and periodic fees; necessary increases in fees over at least a ten-year period to assure continued financial feasibility, and the anticipated application of reserves or other methods in 4 to safeguard future service obligations;
6. All other actuarial, financial, service use and cost assumptions necessary to derive the conclusions of the study.

SECTION 2: REQUIREMENTS FOR CCRC ESCROW PLANS

1. Safeguards all deposits received from consumers (members or prospective members), including initial membership fees, so that obligations for refunds and/or application of these funds to CCRC reserves and expenses according to the plan can be assured;
2. Identifies conditions under which each escrow shall be released, including provisions which assure that pre-construction deposits shall not be released (except for the purpose of refunds) until the following conditions have been achieved:
 - ° the CCRC is 50 percent subscribed (i.e., has received signed contracts and required deposits which constitute 50 percent of the total amount which would be received in deposits if all units were subscribed); and
 - ° commitments have been obtained for both construction and long-term financing; and

° funds at least equaling the total cost of construction and startup have been received, committed or (in the case of members' deposits) pledged.

3. Documents provisions in the model contract (see CCRC Performance Standard (2)(c)(ii)) which legally bind the CCRC to follow the escrow plan.

SECTION 3: REQUIREMENTS FOR CONTINUING CARE CONTRACTS

1. Contracts shall be in plain English.
2. Contracts shall identify all fees and charges which will be imposed, specify the amount of any initial payment(s) and the initial amounts of all periodic payments, and describe all methods by which the CCRC may change or add fees.
3. Contracts shall list all services to be provided, including the extent and limitations of all service benefits with particular attention to the nature and duration of health and nursing care benefits and the boundaries between covered and uncovered services.
4. Each contract shall identify the specific living unit contracted for and specify provisions governing issues of tenancy including transfers among living units, reoccupancy of units after an illness or other absence, and what will happen, in cases of dual tenancy, if one of the two residents dies, withdraws, is dismissed or needs to be transferred to a health facility.
5. Contracts shall describe all procedures by which a member may be evicted or otherwise required to leave a residence unit, or the contract terminated by the CCRC. Dismissal and contract termination shall be limited to good cause, and eviction or other retaliation against a member due to complaints against the CCRC shall be contractually prohibited.
6. Contracts shall clearly state all rights of cancellation by the member.
7. Contracts shall explain all refund policies, including those pertaining to situations where the member has cancelled the contract during the cooling-off period or probationary period (see 8), has withdrawn at a later time, has been dismissed, or has died.
8. Contracts shall provide for a pre-occupancy cooling-off period of not under seven days and a post-occupancy probationary period of not under ninety days, during which the new member may cancel with or without cause with a full refund less reasonable costs determined by a method specified in the contract.
9. Contracts shall specify the circumstances under which members will be permitted to remain in the CCRC if unable to pay fees, including any use of benevolent funds and any circumstances under which continuation of services would require the member to use public assistance or Medicaid funds.

10. Contracts shall guarantee residents the right to organize a resident council, including the right to collectively represent the concerns of residents in dealings with the CCRC's administration.
11. Contracts shall include provisions which bind the CCRC to adhere to commitments made under the following Performance Standards for CCRCs in Volume II of the State Health Plan.
 - a. Escrow plan requirements (see CCRC Performance Standard (2)(a)(v) and Section 2 of this Appendix).
 - b. Consumer disclosure (see CCRC Performance Standard (2)(b) and Section 4 of this Appendix).
 - c. Actuarially sound pricing and reserves or other mechanisms to assure future service obligations (see CCRC Performance Standard (2)(a)(iv)).
 - d. If a Type A CCRC, scope of services (see CCRC Performance Standards (3)(a)).
 - e. If a Type A CCRC exercising a transition period, the timely termination of contracts for Medicaid nursing home reimbursement or congregate care payment (see CCRC Performance Standards (4)).

SECTION 4: DISCLOSURE REQUIREMENTS FOR CCRC'S

1. The names, business addresses, legal/corporate forms, experience in establishing or operating CCRCs, nursing homes or other health facilities, and other existing and proposed CCRC properties, of the provider and of each individual constituting, owning an interest in, serving on the governing board of, or managing the CCRC.
2. Whether any of the persons in (1) has been convicted, enjoined or judged liable for damages as the result of a criminal or civil action claiming fraud, embezzlement, fraudulent conversion or misappropriation of property, or has had any state or federal license or permit revoked in connection with any business activities.
3. Whether the provider is, or is affiliated with, a religious, charitable or other non-profit organization, and the extent (if any) to which any such affiliated organization is responsible for any financial service liabilities of the CCRC.
4. A description of all services provided or proposed by the CCRC under its continuing care contracts, including the extent to which nursing, medical, health-related or personal care is furnished, the present or proposed costs of all services, and a description of any services made available by the CCRC at an additional charge (beyond initial and periodic fees in the contract).

5. A description of all fees required of residents, including initial and periodic charges, apartment resale fees, and special service fees; the manner by which the CCRC may adjust fees; the history of fee increases for at least five years for the CCRC (if in operation) and for any other CCRCs which the provider or manager operates; the circumstances under which members will be permitted to remain in the CCRC, including any use of benevolent funds, if the member is unable to pay charges; whether continuation of services may in any circumstances require the member to use public assistance or Medicaid funds; and the method of calculating fees that will be charged if the member marries while in the CCRC.
6. A description of health and financial conditions required to be accepted as a member and to continue membership, including provisions for the period between the date the continuing care contract is executed and the member occupies a living unit.
7. Income statements and balance sheets for the three most recent fiscal years (if in operation that long), plus a pro-forma income statement for the next fiscal year and a statement of any changes in operations or management that are expected to substantially affect financial position over the next three years.
8. If operation of the CCRC has not begun, a statement of the anticipated sources and application of funds to be used in the purchase or construction and startup of the CCRC; a description of any mortgage, loan or other long-term financing and its terms and conditions; an estimate of the total entrance fees to be received from members at or prior to the commencement of operations; and an estimate of any startup losses.
9. Professional summaries of accounting, audit and actuarial opinions received by the CCRC as part of professional accounting and actuarial studies or reports.
10. The general nature of any anticipated cost-shifting and cross-subsidization among CCRC members.
11. The term and renewability of the contract.
12. Unless demonstrably untrue, a statement to the effect that the individual contracts of various CCRC members may over time be different as to services and fees due to contract changes resulting from changing conditions.
13. Any other information necessary to understand the nature of the agreement and the risks involved in CCRC membership.
14. A list of the regulatory agencies with responsibility over various aspects of CCRC operation and their areas of responsibility.

NOTE: Periodic disclosure of changes under CCRC Performance Standard (2)(b) applies to all areas of disclosure above.

GLOSSARY OF TERMS

Acute Care - Acute care services focus on the diagnosis and treatment of medical problems generally, but not always, in a hospital setting, for persons with severe, short-term health problems. They are provided by physicians, nurses, and other skilled health personnel working as a team or individually, depending upon the severity of the problem. Acute care services generally are categorized into three types: primary, secondary and tertiary care. Secondary care services are often in a hospital setting and include medical/ surgical, pediatric, obstetric, radiology, and laboratory services. Tertiary care consists of complex diagnostic and therapeutic services requiring highly specialized personnel and equipment. In addition, tertiary services tend to be directed at emergency conditions, utilize high cost equipment, and are subject to rapid technological change.

Ambulatory Surgery Facility - A facility, either free-standing or hospital-based, where outpatient surgery is performed. An intermediate level of surgical care for procedures that are too complex to be done in a physician's office, but do not require inpatient hospitalization.

Case Management - A process that consists of a comprehensive assessment of an individual's needs and development of a detailed plan of services and related activities for the purpose of achieving and maintaining the maximum level of health and independence of which the person is capable at the appropriate minimum level of care. In the dual case management system now employed by DSHS, adults initially receive a standardized assessment conducted jointly by Community Services Office (CSO) staff and Information and Assistance (I and A) staff of Area Agencies on Aging (AAAs). Then, individuals referred to community care have their cases managed by I and A staff, and cases referred to residential care are managed by CSO.

Certificate of Need - Public regulatory approval for certain capital expenditures and additions, changes or terminations of health services as required under RCW 70.38.

Corporate Strategic Planning - Planning undertaken by a corporate entity in order to support internal decision making in pursuit of organizational goals which typically include (in a health services organization) the provision of services of adequate or better quality; financial success (at minimum, solvency); and sometimes expansion. Such planning usually occurs in a competitive environment.

Cost-based Reimbursement - A method of provider reimbursement based on the actual costs incurred in providing services.

Cost Shifting - The practice by which a provider redistributes the difference between normal charges and lesser amounts received from certain payers by increasing charges made to other payers.

Credentialing - The statutory regulation of a health profession by registration, certification or licensure. Proposals to credential new categories of allied health occupations in Washington are reviewed under RCW 18.120.040.

Dedicated Rooms - Spaces for a specific use. For example, dedicated outpatient operating rooms would not ordinarily be used for inpatient surgery.

Diagnosis Related Groups (DRG's) - A classification system that groups patients' hospital stays according to principal diagnosis, presence of a surgical procedure, age, presence or absence of significant comorbidities or complications, and other relevant criteria.

Health Care Facilities Authority - The Health Care Facilities Authority was established in 1980. Its authority and powers are defined in RCW 70.37. The Authority is empowered to issue municipal revenue bonds "for the construction, purchase, acquisition, rental, leasing or use by participants of projects for which bonds to provide funds therefore have been approved by the authority" and to loan the proceeds to qualified, non-profit hospitals. Since the income from these bonds is not currently subject to the same federal taxation rates as are corporate bonds, qualified hospitals benefit from lower interest rates (up to 3 1/2 percentage points less).

Health Maintenance Organization (HMO) - This term is defined specifically in the Health Maintenance Act of 1973 (P.L. 93-222) as a legal entity or organized system of health care that provides directly or arranges for a comprehensive range of basic and supplemental health care services to a voluntarily enrolled population in a geographic area on a primarily pre-paid and fixed periodic basis. Can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies and hospital medical plans.

Health Planning System State Health Coordinating Council (SHCC), Department of Social and Health Services (DSHS) regional health councils designated under RCW 70.38.085, and other local agencies specified by the State Health Coordinating Council, acting together through the processes of RHC plan development and project review.

Health Planning Region - A multi-county area identified by SHCC and DSHS for health planning and resource development purposes. Initially these regions are the health service areas defined under federal law.

Horizontal Integration - In traditional economic usage, an extension of economic control to include additional entities producing or selling the same good or service: in lay terms, "absorbing the competition." An example of "classical" horizontal integration in health care would be formation or enlargement of a chain of primary care clinics, a chain of nursing homes, etc. The term also is used, in health care, to denote economic control over health services which provide similar services: e.g., purchase or initiation of a free-standing diagnostic imaging center by a hospital or group of hospitals. (See also Vertical Integration in glossary.)

Hospital - A facility requiring licensure under RCW 70.41 and/or required to report to the Washington State Hospital Commission. The definitional scope of services within a "hospital" is determined for licensure purposes by the Department of Social and Health Services, and for purposes of budget and rate review, by the Hospital Commission.

Hospital Planning Areas - Those geographic areas designated by SHCC and DSHS for population-based planning of hospital services.

Inpatient - A person receiving health care services with board and room in a health care facility on a continuous twenty-four hour a day basis.

Managed Health Care System - An organization or entity with the following features: a) provision for insurance and responsibility for the delivery of health care services through the same organization, b) financial risk to the managed health care system through capitation payment, and c) utilization management of enrollees.

Medicaid (Title XIX) - Program administered by the states under provisions of Title XIX of the Social Security Act and rules of the federal Health Care Financing Administration (HCFA). It makes payments for approved health services provided by hospitals, other health service agencies and private practitioners to persons eligible for Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), and certain other persons whose income does not exceed maximum welfare benefits. Medicaid is funded on a state-federal shared basis. It should not be confused with Medicare (Title XVIII).

Medicare (Title XVIII) - A federal health insurance program that covers some of the costs of hospitalization and selected medical care for persons 65 or older, for physically disabled persons meeting certain requirements, for certain other citizens needing specific treatment (e.g., chronic renal dialysis for irreversible kidney ailment) and for some eligible beneficiaries.

Ordinarily - This word has a specific meaning in this State Health Plan which is clarified in the particular policies in which it is used.

Policy - A definite course (or method) of action selected by management from alternatives to determine present and future decisions.

Preference - Priority or higher ranking given in review to health facilities and services having those characteristics specified in the preference statement, when: 1) two or more health facilities or services are competing to meet a limited need in an area (i.e., a need that is not sufficient to justify all health facilities or services proposed in an area), and 2) the competing health facilities or services substantially conform to all other applicable standards.

Principle - A statement of the highest ideals toward which the health system should move.

Prospective Payment System - A payment system in which health service payment rates are based on expected classes and volumes of patients and are set before services are rendered.

Regional Health Council - An organization defined under the terms of RCW 70.38.085.

Regionalized Hospital System - A plan which organizes hospital services in a specific geographic region into a coordinated network of services. The services and facilities range from the simplest to the most complex with coordinated referral agreements among the participating institutions. The supply of services, especially tertiary services, is determined by the amount of demand which would use each service efficiently.

State Housing Finance Commission - A public body established under the terms of RCW 73.180 for the purpose of issuing bonds and participating in federal, state and local housing projects.

Sliding Fee Scale - A schedule of charges (fees) for specific health and/or social services which are keyed to a person's ability to pay, based on income level or some other type of means test.

Vertical Integration - In traditional economic usage, a shift in the economic organization, ownership, etc., of enterprises which places inputs for production of a good or service under the economic control of the same entity which controls production of end-products (or of other "intermediate products" which are closer in the chain of production to the consumer). An example of "classical" vertical integration of health care services would be the purchase of a pharmaceutical or hospital supply firm by a proprietary hospital chain. The term also is used in health care to denote economic control of additional levels of care through which a patient might pass: for example, purchase or initiation of home health services by a nursing home or a hospital. (See also Horizontal Integration in glossary.)

ACRONYMS

AAA - Area Agency on Aging
BAAS - Bureau of Aging and Adult Services
BNHA - Bureau of Nursing Home Affairs
CoN or CN - Certificate of Need
CSO - Community Services Office
DCD - Department of Community Development
DMA - Division of Medical Assistance
DSHS - Department of Social and Health Services
HMO - Health Maintenance Organization
HPA - Hospital Planning Area
L & I - Department of Labor and Industries
LTCPG - Long Term Care Planning Group
MCH - Maternal and Child Health Services
OFM - Office of Financial Management
OSPI - Office of the Superintendent of Public Instruction
RCW - Revised Code of Washington
SBOH - State Board of Health
SHCC - State Health Coordinating Council
SHP - State Health Plan
SHPDA - State Health Planning and Development Agency
WAC - Washington Administrative Code
WSHC - Washington State Hospital Commission