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Scott Ringgold, Land Use Planner
Department of Planning and Development
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Dear Mr. Ringgold,

Attached please find Field Associates' comments on the Draft Environmental Impact Statement prepared by the City of Seattle in relation to the Children's Hospital and Medical Center Major Institutions Master Plan. The Laurelhurst Community Club commissioned Field Associates, specialists in healthcare and hospital planning, to conduct a review of pediatric hospital bed need in accordance with the Washington State Department of Health's 12-step methodology for forecasting hospital beds. The resulting Bed Need Study is attached here as Appendix A. Please consider both this letter and the attached study as Field Associates' comments on the DEIS.

Field Associates' Principal, Nancy Field, has twenty-five years experience in the planning and development of healthcare and hospital services in the Northwest. Ms. Field led the strategic and facility planning activities of three major healthcare institutions in the Seattle, and, as a health planning consultant, has completed over fifty consulting engagements. She has taught strategic planning and market analysis as a member of the Clinical Faculty of the University of Washington's Masters in Healthcare Administration Program and is a published author in the area of bed need and hospital occupancy rates. With a graduate degree in urban planning, Ms. Field sat on the original city task force that designed Seattle's Major Institutions Master Planning process. Field Associates is one of 12 consulting firms whose names the Department of Health provides to organizations seeking technical assistance with preparation of Certificate of Need applications including hospital bed need projections. (See vita attached as Appendix B.)

List of issues
A review of the DEIS reveals the following shortcomings which must be addressed in the FEIS:

1. **Rationale for the project is lacking.**
   - The DEIS includes no independent assessment or validation of the rationale for the project
   - The project rationale provided by CHRMC is inconsistent with accepted methodologies
   - There is a large disparity between Field Associates' study results and the number of beds proposed by CHRMC.
2. **Square footage amounts proposed for both medical-surgical beds and for acute psychiatry beds are excessive in light of industry practice.**
3. **The rationale and plan for psychiatry beds does not meet minimum standards for credible health care planning.**

4. **There are downside risks to allowing too large a zoning envelope at CHRMC.**

5. **Real alternatives to the current proposals need to be developed.**

Issue: DEIS provides no assessment or validation of the rationale for the project
In January 2008, Field Associates provided information (See Appendix A Bed Need Study) that the proposed Master Plan would lead to a substantial over-building of the campus and a level of excess inpatient pediatric beds inconsistent with the public policy of the State of Washington. The DEIS does not recognize this information nor provide its own assessment of the benefit of adding 350 hospital beds to the Laurelhurst campus.

The content of the DEIS does not reflect the availability of any independent hospital planning expertise to those who prepared it. Instead, the DEIS quotes language directly from the application which purports to provide a basis for the Children's proposal to add 350 beds over the next 20 years. The broad generalizations provided by the CHRMC Master Plan have been neither corroborated nor validated. As noted below, they are completely at odds with the facts as ascertainable using the accepted methodology in Washington for assessing need and public benefit with regard to health care facilities. The Children's proposal depends on zoning changes that the City is not required to approve. In such circumstances, it is particularly important that the EIS used by decision-makers do more than repeat Children's health care planning rationale without scrutiny.

Issue: Rationale provided is inconsistent with accepted methodologies and a comparison with them results in substantial variance.
Children's Hospital and Regional Medical Center (CHRMC) is proposing a 1.5 million square foot facility expansion over the next 15 to 20 years, including approximately 350 new inpatient beds. This expansion would bring the hospital's total number of pediatric inpatient beds to 600. CHRMC is currently licensed by DOH for 250 beds. But, based on the Washington State Department of Health's published method of distributing hospital beds across the state, there is no support for the addition of any inpatient beds to CHRMC's current capacity of 250 beds until after the year 2015.

A small increase in beds – up to 40 – may be warranted by the year 2026 (the very end of CHRMC's 15- to 20-year master plan planning horizon). The DEIS shows that no effort has been made to compare the calculations of bed need provided by Children's to those properly utilizing Washington's method, as provided by Field Associates. Though offers of technical assistance in understanding the DOH 12-step method were made, none were accepted by the City.

Issue: There is a large disparity between study results and the number of beds proposed by CHRMC.
The Field Associates' Bed Need Study shows that the increase of 350 beds proposed by CHRMC is not consistent with the Department of Health's established methodology for projecting required hospital beds. If the additional 228 beds proposed for 2015 are built, the CHRMC planning area is projected to experience a surplus of 236 beds in 2015. If the proposed bed increases are implemented with the phasing illustrated by CHRMC, the planning area is projected to have a surplus of 308 beds by the end of year 2026. While such surplus might meet Children's objectives, it would be to the detriment of other health care institutions and to the over-all delivery of healthcare in the region.

In contrast, the Department of Health method of projecting inpatient beds supports CHRMC's adding 23-41 beds after 2015, depending on whether occupancy averages 75% or 80%.

Table 2: Beds Required at CHRMC, at 75% and 80% occupancy, Years 2015 & 2026

	Year 2015		Year 2026	
	75% occupancy	80% occupancy	75% occupancy	80% occupancy
Inpatient acute care	228.9	214.6	278.9	261.5
Inpatient psychiatry	12.3	11.6	11.9	11.2
Total licensed now	250.0	250.0	250.0	250.0
Additional CHRMC beds required	(8.8)	(23.8)	40.8	22.7

Numbers in ( ) parentheses are negative.

In order to illustrate the disparity in projections, assume that, based on this range of 23-41 beds, one adopts a goal to add 35 beds at CHRMC. Now, consider the contrast with CHRMC's own intention to add 350 new beds: CHRMC proposes ten times more new capacity than this study finds is warranted through application of the Department of Health's method.

Issue: Lack of Rationale - Conclusion

By law, the Washington Department of Health allocates a statewide pool of hospital beds according to geographic region and service type to ensure against over-expansions detrimental to the pubic interest. As recently as 2007, the Washington Legislature determined:

> That excess capacity of health services and facilities place considerable economic burden on the public who pay for the construction and operation of these facilities as patients, health insurance purchasers, carriers, and taxpayers. [RCW 43.370.030(2)(a)]

Under the Department of Health's projection method and using the data currently available, CHRMC's addition of any more than 40 pediatric inpatient beds before 2026 would create an oversupply of such beds in Washington. The CHRMC proposal to add 350 beds would create an imbalance in the distribution of hospital beds among the institutions that provide inpatient pediatric care for Washington's children.

The City's Major Institutions Code requires that the City determine

> "whether the planned development and changes of the Major Institution represent a reasonable balance of the public benefits of development and change with the need to maintain livability and vitality of adjacent neighborhoods."

In applying this criterion, the City's land use code requires that consideration be given to "reasons for institutional growth and change" as well as "the public benefits resulting from the planned new facilities and services." SMC 23.69.032.E.2 and .2.a.

Given the magnitude of the proposed expansion described in the DEIS, the FEIS must critically assess the consistency of the proposal with such plans, policies, and Code, and disclose and analyze -- independent of Children's construal -- the real environmental costs, risks, and public benefits to be derived from the proposed construction of 350 unneeded hospital beds. It is most crucial to note that the number of proposed hospital beds is a key driver of environmental impacts in terms of amount of construction, trip generation, and the like. For example, the Master Plan directly calculates each inpatient bed as requiring 4,000 square feet of construction. Therefore, any reduction in beds proposed results in a proportionate drop in building scale and bulk. For these reasons, it is essential that the FEIS incorporate the Field Associates Bed Need Study previously submitted to the CAC (attached), as well as these additional comments.

Issue: The impacts of the proposed CHRMC construction are a result of the hospital's using a square foot per patient ratio in excess of that reflected in objective industry data.

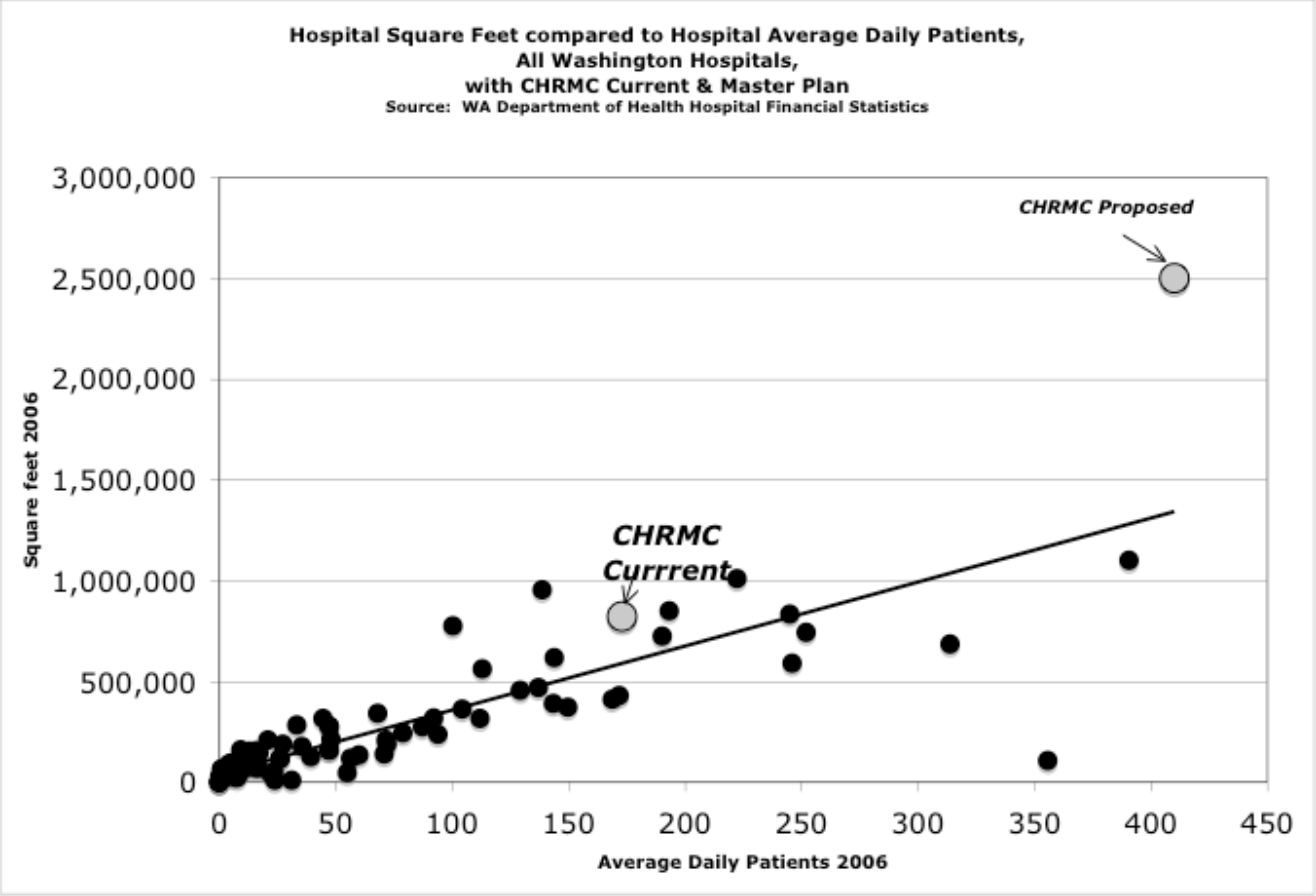
The FEIS must assess the proposed expansion as part of SEPA review of its consistency with City plans, code, and policy, including the questions of public benefit and neighborhood impact. In addressing these factors, CHRMC has suggested that the impacts its bed expansion will generate are unavoidable given the square footage such uses require. However, as shown below, that assertion is not borne out by objective and readily available industry data.

The chart on the following page compares, for Washington hospitals, their average daily census of patients with their facility size as reported in square feet to the Department of Health. (Note: Analyzing support space "per patient" instead of "per bed" avoids two confounding issues: 1) It normalizes the data for hospitals that operate at either very high or very low rates of bed occupancy. 2) It reflects the size of the infrastructure - operating rooms, laboratory, pharmacy - required for actual patient care not for the support of empty beds.)

Each hospital is represented by one dot that is placed horizontally on the x axis at its average number of patients and vertically on the y axis at its 2006 reported square feet. For example, a number of hospitals with about 150 patients are operating with 500,000 square feet or approximately 3,333 square feet per actual patient.

The solid black line reflects an average ratio of square feet to average daily census of patients and shows that a typical Washington tertiary care, referral hospital with an average census of 300 patients would use about 1,000,000 square feet. And, for CHRMC's projected 2026 census of 450 patients, one would expect to see a campus with approximately 1.5 million square feet. This contrasts with the 2.5 million total square feet that CHRMC proposes.

Specific to CHRMC, the chart shows the hospital's "Current" average daily patients and 2006 square feet as reported to the Department of Health. The CHRMC projected 2026 daily census and "Proposed" square feet in the Master Plan are plotted in the upper right corner of the chart. It shows CHRMC's intent to provide ratio 5,555 square feet for each patient, at least 2,000 more than the statewide pattern. Keep in mind, however, that since CHRMC has committed to develop its research and outpatient functions off campus, it will need <u>less</u> space per patient than other Washington hospitals, not more.



Issue: The FEIS must fully disclose and critically examine the drastic expansion in psychiatry beds that serve as the underpinning of CHRMC's public benefit justification and the FEIS must address alternatives as part of its analysis.

CHRMC proposes adding 350 beds by 2026 for a total of 600 beds. 194 of the 600 have been characterized as short-term psychiatry beds. Nevertheless, when it suits its purposes for advocacy of its proposal, CHRMC appears to treat the two types of beds interchangeably when they are not. This has resulted in less than full disclosure of Children's actual proposal and impairment of analysis of impacts and alternatives. For example:

- With regard to alternatives, the DEIS does not address a separate licensed psychiatric hospital nor does discuss an alternative location for its initial proposal of 194 psychiatric beds. SEPA review of such a proposal for an essentially new psychiatric facility – by far the largest in the state – must consider alternate sites and explain how the proposed site was selected and by what criteria. Any realistic set of alternatives in this case would include an alternate site for the proposed psychiatric hospital. This alternative would allow for the elimination of 800,000 square feet (4.000 sq. ft. times 200 beds) from the proposed Master Plan.

- CHRMC recently indicated that about 94 of the projected 194 psychiatry beds might instead be used for acute medical-surgical patients. If CHRMC does plan to build fewer than 194 psychiatric beds, as it has suggested to the CAC, the alternative use of those beds must be examined. The bed need

projections provided by CHRMC do not address any other possible uses for 94 additional non-psychiatry beds. The stated rationale for additional medical-surgical beds already varies substantially from any approach acceptable to the Department of Health -- and that is before one adds any of these beds, now labeled "psychiatric" that the hospital may want to put to unspecified uses.

- CHRMC has indicated that it requires 4,000 square feet per hospital bed. Yet short-term acute care of psychiatric patients does not require the diagnostic, treatment and support space that medical-surgical acute care does. Even apart from considerations of type of use, 4,000 square feet per bed is excessive by any industry standard for a hospital that will provide for its ambulatory care and research needs elsewhere.

CHRMC has not provided a consistent statement of the inpatient services it plans to offer. This is necessary to evaluate proposed alternatives for expansion. More detailed information is necessary in the FEIS to evaluate the need for either 100 or 194 psychiatric beds and to develop reasonable alternatives, including CHRMC's establishment of a pediatric psychiatric hospital at a location separate from the current campus.

In assessing square footage needs, the FEIS must acknowledge the difference between the care of medical surgical patients and those who are admitted for psychiatric care. The familiar underpinnings of most acute care, the operating rooms, laboratories, imaging departments etc, require vast space beyond that allocated to the nursing units themselves. But for psychiatry patients, such extensive support space and equipment is not as necessary. See the table below for the average number of square feet reported by the two freestanding psychiatry hospitals in Seattle:

Table: Square footage per available bed, freestanding psychiatric hospitals, 2006

Hospital	Square feet per bed
BHC Fairfax	482
West Seattle Psychiatric	498

To provide additional information on the CHRMC psychiatry plan, Field Associates selected four academic pediatric teaching hospitals with stature and reputations comparable to or greater than CHRMC's for comparison. The table below shows the size of the inpatient psychiatric service including those at 3 of the "top 10" pediatric hospitals nationally (Boston, Dallas, and Philadelphia).

Of the four, the average ratio of dedicated inpatient beds to the whole is 3%. CHRMC's current psychiatry unit represents 8% of the hospital's current beds. The DEIS accepts CHRMC's projection of 194 psychiatry beds by 2026 without any discussion of its public benefit implications including its likelihood and the potential deleterious impact on the other key providers of pediatric psychiatry and on Washington patients and residents. No EIS analysis can be adequate if it does not clearly call out and critically review the

impacts of CHRMC's proposal to build a campus with 32.5% of its beds dedicated to psychiatry.

Hospital/University/City	Total Pediatric Beds	Pediatric Psychiatry Beds
Children's Hospital, Harvard/Boston	436	16
Children's Medical Center Texas U/Dallas	411	12
Children's Hospital of Philadelphia U Pennsylvania	430	Off-site, integrated with pediatric outpatient and day treatment location
Floating Hospital for Children's, Tufts University/Boston	128	12
Children's Hospital, Seattle UW/Seattle - current	250	20
Children's Hospital UW/Seattle - proposed	600	195

CHRMC has not explained its rationale for providing so much of the state's pediatric care on an inpatient basis and in one urban location. Nor has CHRMC provided a rationale for increasing the use of inpatient psychiatric care when the national and industry trend is to provide such care on an outpatient basis and in the child's own community.

Neither is the burden on families acknowledged. Uprooting children and their parents from around the state for inpatient treatment is generally a last resort. In its calculation of future demand for inpatient psychiatry, CHRMC looks to states with high inpatient use rates. The inpatient use rates are in most cases high because of the lack of outpatient alternatives to hospitalization and the lack of less intense services that could prevent the need for hospitalization in the first place.

The University of Washington and its Psychiatry residency support the training of professionals and development of child psychiatry services across the 4-state WAMI region. Through Medicaid and other public programs, the state of Washington is a primary funder of acute and outpatient child psychiatry services. The state is currently drafting policies that direct provision of Medicaid mental health services toward the patient's own community. Centralization of this service in one location is a major policy decision regarding the availability and mode of psychiatric care in Washington. The distribution of child psychiatry services falls within the scope of SEPA concerns about, for example, impacts on delivery of public services, transportation, traffic, carbon footprint, and energy use. These should have been discretely assessed in the DEIS rather than treated in a generalized fashion.

CHRMC projects its number of psychiatry bed will need to increase from its current capacity of 20 beds to 194 by 2026. The Field Associates Bed Need Study projected approximately 13 beds for 2026 using the Department of Health's method. In addition, CHARS data shows that CHRMC averages less than 2% of its psychiatry patients from out of Washington thus suggesting that the multi-state role it plays for some pediatric specialty services does not extend to short-term, inpatient psychiatry.

There are a number of key providers for short-term, inpatient pediatric psychiatry services in Washington. The table below shows the relative sizes of these providers.

Key Pediatric Psychiatry Providers in Washington, 2006

Hospital	Key Counties Served	Percent of All Washington Residents Served, Age 0-14
Fairfax	King, Snohomish, Pierce	34%
CHRMC	King, Pierce, Snohomish	30%
Sacred Heart	Spokane	20%
Lourdes	Yakima, Benton	12%

Though these providers serve large numbers of Washington's children, they were excluded from the "Children's-only" statewide planning area acknowledged in the Department's 2002 analysis of CHRMC's bed requirements. The existing beds and services of these facilities cannot be ignored in statewide planning for short-term pediatric psychiatry inpatient beds.

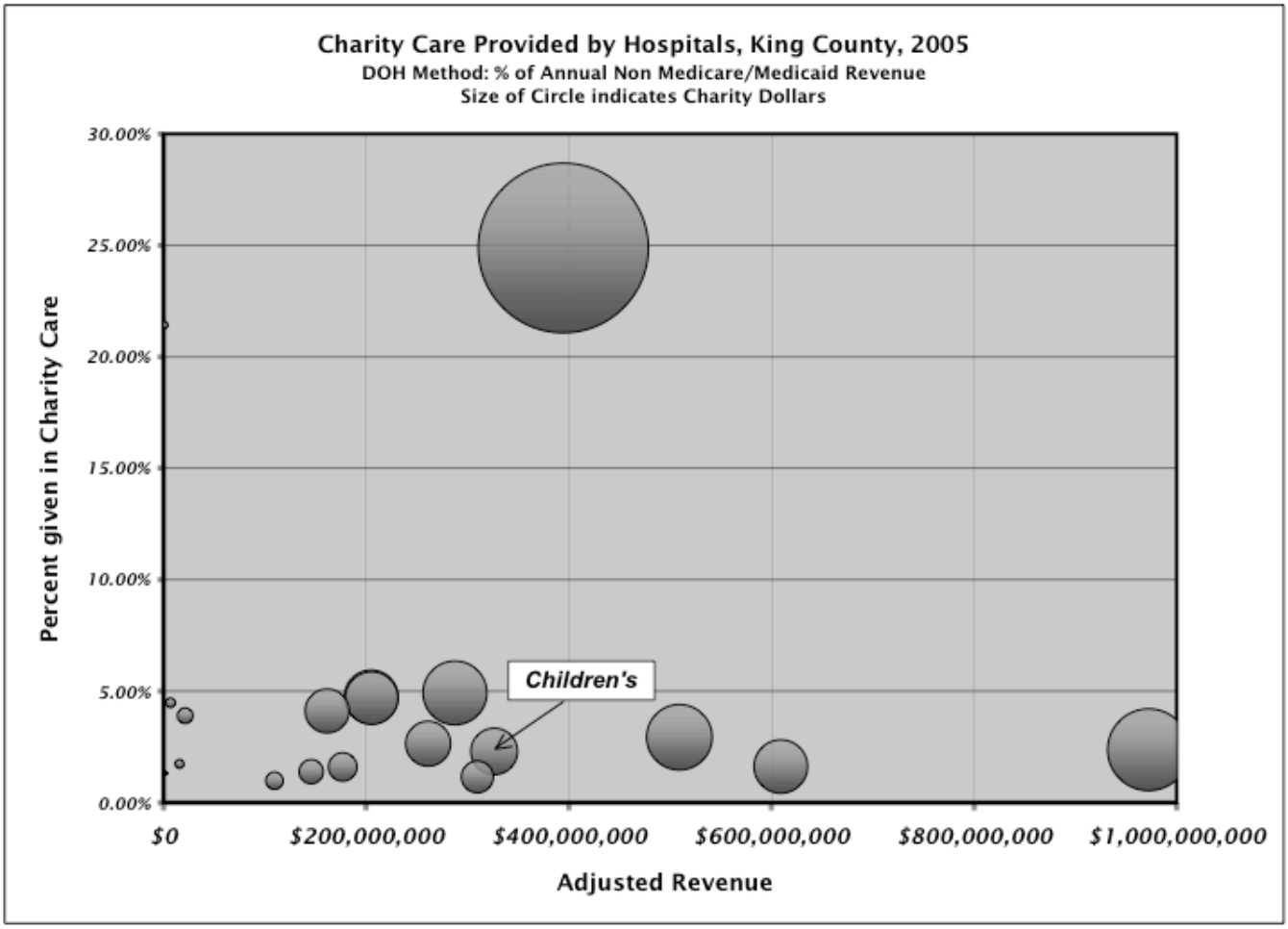
Issue: Other pediatric providers need to be acknowledged.

CHRMC proposal to add 350 hospital beds rests in part on a 20-year old "Children's-only" statewide pediatric planning area. Over the 20 years, however, other leading pediatric providers have emerged across the state:

- In 2003, and after the Department's 2002 decision to acknowledge a "Children's-only" planning area, Sacred Heart Children's Hospital was opened in Spokane.
- Substantial service development has taken place at Tacoma's Mary Bridge Children's Hospital and it is the state's recognized pediatric trauma center for Southwestern Washington.
- In Seattle, Swedish Hospital's inpatient pediatric services now care for more King County children than does CHRMC.

Additionally, a significant number of other hospitals – in the Seattle area and statewide – may be adversely affected by CHRMC's proposal to build more than its share of pediatric beds. Though Swedish Medical Center and CHRMC provide over half the care to King County children, many other area hospitals provide pediatric services as core to their purpose and commitment to the communities they serve.

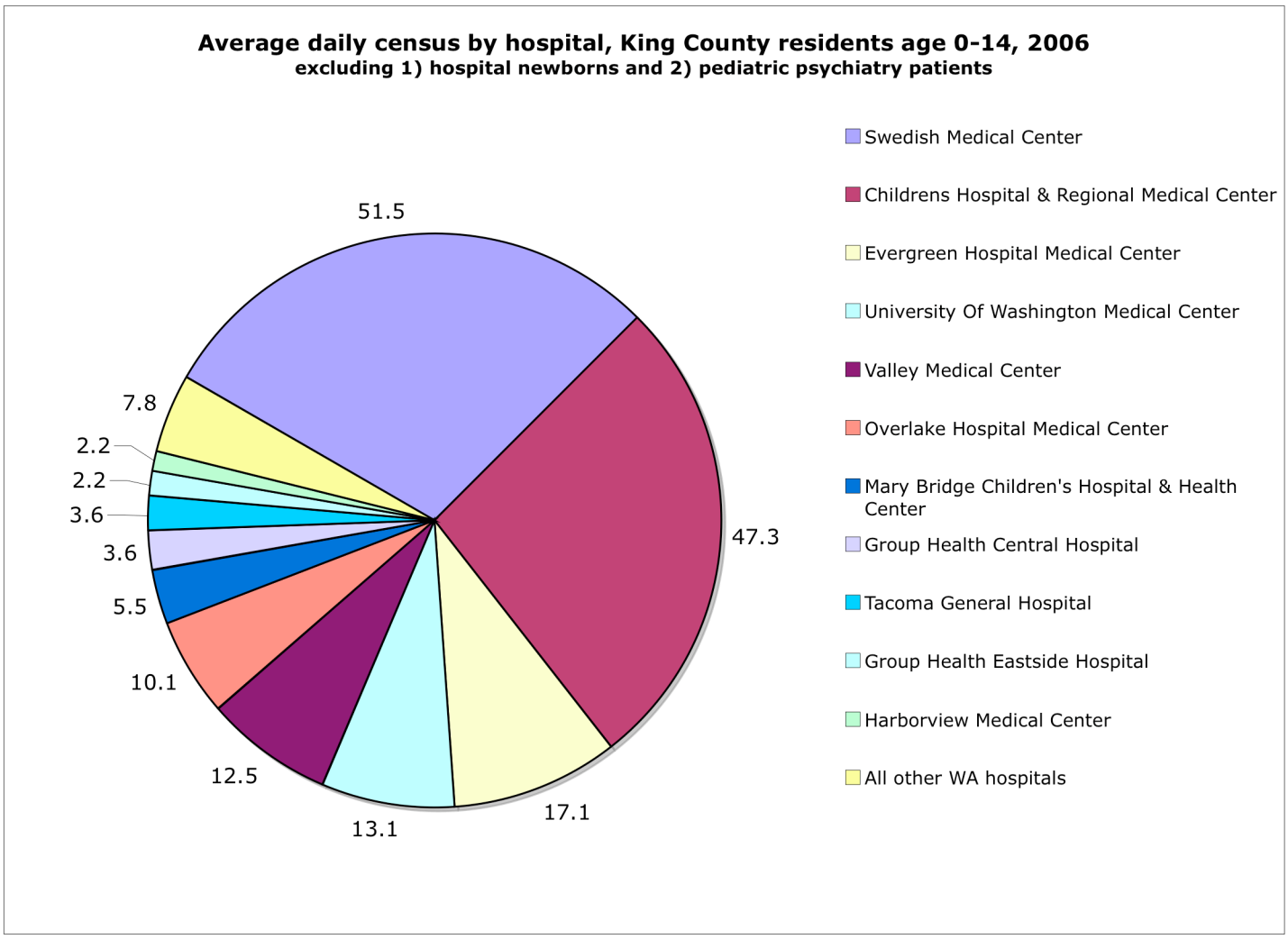
The FEIS should provide data and analysis of acknowledging potential impacts on other pediatric hospital roviders, their service array and population served.



The chart above shows "Charity Care provided by King County Hospitals, 2005." This table is built on the latest hospital financial data available from the Washington Department of Health. The Department tracks each hospital's efforts toward charity care, using the "charity care dollars as a percent of non-Medicare and non-Medicare revenue" as its measure of charity care. This effort is taken into account by the Department during its reviews of Certificate of Need Applications for hospital expansion. The table arrays each hospital in King County by its "adjusted revenue" (on the horizontal X axis) compared to the percent of that revenue given as charity care to its patients (on the vertical Y axis.)

The size of each hospital's "bubble" indicates the absolute dollar value of its charity contribution. This chart shows that CHRMC contributes charity care at a level slightly below the average of all King County hospitals.

As the pie chart below illustrates, CHRMC actually sees fewer King Count pediatric patients than does Swedish Medical center. Overall, CHRMC provides only about a quarter of the pediatric hospital care to the area. Many more families look to Swedish and other hospitals when their children get sick enough for hospital care.



Issue: The DEIS assumes, despite current Major Institution experience in the city to the contrary, that uses will remain dedicated to CHRMC and, therefore, inappropriately fails to assess the impacts of alternative scenarios.

At least two other major institutions in the City have sold or leased large portions of major institution campus real estate for non-institutional uses.

1. At the major institution campus of the former Pacific Medical Center, the Medical Center ceased inpatient operations even after significant infusion of public funds to keep it viable. The Pacific Medical Center patients and medical staff were shifted by contract to Providence Medical Center. After the closure, the Pacific Medical Center campus became the corporate home of Amazon.com, which is now the primary tenant.

2. Even more on point, the former Providence Medical Center campus includes approximately 1.2 million square feet of buildings. The Sisters of Providence sold

the hospital to Swedish Hospital. Swedish then sold most of the Providence major institution campus real estate to a private developer. Today the hospital operations at Swedish/Providence report using only 561,450 square feet on the campus. This leaves about 400,000 to 500,000 square feet for the use of private non-institutional uses. The traffic and parking impacts the City and Providence neighbors accepted when they thought it was for a non-profit Catholic hospital are now being generated by private/for-profit and non-institutional uses, and, of course, those impacts may be different than those assumed for actual hospital use.

Here, CHRC's implausible proposal for 800,000 square feet for 200 psych beds - far out of proportion to anything seen locally or nationally - demonstrates the need to examine the full impacts of such a scenario in light of other major institution experience. Any number of non-CHRMC functions, other hospitals, or bio-tech companies are chief examples of potential tenants CHRMC might seek out. CHRMC could invite tenants to build on its campus, providing just a ground lease for access to development rights that in any other circumstance (e.g., just outside of the major institution boundaries) would not be available.

The DEIS should have addressed such scenarios and the FEIS must do so. Further, it should propose as mandatory mitigation a binding condition on CHRMC Master Plan approval to the effect that the property and its buildings will be developed and used by Children's or a bona fide non-profit successor only, exclusively, and directly for nonprofit pediatric inpatient care.

In closing, thank you for the opportunity to comment. If you have any questions or would like us to review the Department of Health's 12-step bed need methodology with you in detail, please do not hesitate to contact me at 206-523-5009 or at nefield@seanet.com.

Sincerely yours,

Nancy Field
Principal